Sacramento County
Domestic Violence Death Review Team

Annual Report

December 2005

Presented to:
Sacramento County Board of Supervisors
& Sacramento County
Domestic Violence Coordinating Council

I. Introduction and Background

This is the fifth report of the Sacramento County Domestic Violence Death Review Team (DVDRT). In a departure from previous reports, the DVDRT is addressing suicide, the often over-looked fatal outcome of domestic violence (DV). Suicide is a major public health problem in the United States, with over 30,000 deaths per year. In 1999 there were over 700,000 emergency room visits due to attempted suicide and 152,000 hospital admissions (D'Orio 2004). Suicide is the second leading cause of injury related death for women. While the FBI's Uniform Crime Reports include data on homicides attributed to domestic violence, there is no comparable database for tracking suicide in persons who have been victims of domestic violence. The CDC's National Violent Death Reporting System collects data on suicides from different states without specific cross-reference to prior violence victimization.

Prior sexual assault and intimate partner violence (IPV) have been implicated as precursors of suicide attempts (Kaslow 1998, Kingree 1999, Davidson 1996, Thompson 1999, Stepakoff 1998, Widerman 1998). Depression is the most common mental health outcome of intimate partner violence (Campbell 2002, Golding 1999). The severity of the intimate partner violence is significantly correlated with the severity of depression (Dienemann 2000). Depression increases the lifetime risk of suicide by 2% to 4%, compared to the general population (U.S. Department of Health and Human Services 2000). This increased risk results in a 15% mortality rate (APA 2000).

Long-term studies have examined the rate and type of hospitalization of women domestic violence victims compared to women who were not victimized, and found admission rate for suicide attempts significantly higher for women exposed to IPV (Bergman 1991, Kernic 2000). A study of 648 women in an urban health care setting found 81% of women who had attempted suicide at any time had a lifetime history of abuse. In contrast, women who had no history of suicide attempt had a 19% lifetime history of abuse. Twenty-six percent of women exposed to acute or prior domestic violence had suicide attempts, while only 8% of those not exposed to domestic violence attempted suicide (Abbot 1995). Vitanza's examination of suicide ideation in female victims of domestic violence found 43.8% of the women experiencing severe domestic violence had attempted suicide, compared to 13.4% of women experiencing moderate abuse and 22.6% experiencing psychological abuse (Vitanza 1995).

Women exposed to domestic violence are at high risk for depression, suicide and homicide. In New Mexico, all female suicide deaths from 1990-1994 were reviewed. Domestic violence was documented in 5.1% of female suicide deaths. In an additional 22.1% of the deaths reviewed, a male intimate partner fought with or separated from the decedent immediately preceding her suicide (Olson 1999). Internationally, investigators

have confirmed higher rates of female suicidal behavior where the status of women is low and married women are not recognized as being equal to their husbands (Cannetto 1995). In an analysis of data from all New Zealand public hospitals there was a significant risk of suicide associated with previous hospitalization for self-injury, injury of undetermined cause and assault (Connor 2005). Bailey et al found the risk of suicide five times greater in homes where the victim had ready access to a gun. Guns have appeared to be more prevalent in domestic violence homes than non-domestic violence homes (Bailey 1997).

Involvement in an abusive relationship has been cited as in important risk factor for self-destructive behavior. Suicidal behavior is thought to reflect the powerlessness evident in the social and economic positions of the affected women (Pilley 2001). Unfortunately, one third of women who are abused never disclose their experience of domestic violence (Coker 2002). The California Women's Law Center report "Murder at Home" found of the 100 intimate murder cases they surveyed, 86% of the victims never sought help from legal or community resources for domestic violence. Researchers have advocated standing protocols that require assessment for suicidal ideation and domestic violence of women experiencing depression (Mattevia 2002). It is equally important that women seeking assistance for domestic violence be assessed for depression, suicidal ideation and danger. Factors placing women at significant increased risk for suicide and homicide include abusive relationship, availability of lethal means (guns), substance abuse and separation/divorce (Simon 1998, Campbell 2003)

Simon's report of a domestic violence homicide, "Murder Masquerading as Suicide", advocates the use of forensic psychiatrists in equivocal suicide cases. The forensic psychiatrist conducts a postmortem suicide risk assessment of the victim that reviews relevant collateral information including interviews, death scene analysis, and autopsy (Simon 1998). Simon asserts though the staging of murder as a suicide is rare, it is more likely to go undetected or remain unsolved if the victim has a history of mental illness (Simon 1998).

The Sacramento County Domestic Violence Death Review Team has examined domestic violence and suicide for the 2005 report. The domestic violence victimization and suicide risk in the cases presented in this report were overshadowed in many of these women's lives due to their depressive or mental illness. Increased public awareness of the inter-relationship between domestic violence, depressive disorders and suicide risk will facilitate increased intervention and prevention. Examination of suicide fatality for a history of domestic violence is an important focus for Domestic Violence Fatality Review Teams.

II. Summary of Key Findings and Recommendations

From January 2005 to November 2005, the Sacramento County Domestic Violence Death Review Team (DVDRT) conducted an in depth analysis of five female suicide fatalities from a list of 42 cases provided by the Sacramento County Coroner. The 42 cases were female suicides that occurred from January 1, 2004 to December 31, 2004. At the

initiation of this review, 38 cases had been closed. The five victims selected for review were women between 22 and 39 years of age.

The DVDRT examined each woman's case to determine if domestic violence was a factor in her life. If the presence of domestic violence was identified, the DVDRT sought to determine if there existed opportunities for improvement of the following:

a) earlier identification of domestic violence victims' risks for suicide

b) earlier identification of women with risks for suicide as victims of domestic violence

c) crisis response of professional service providers who assisted or provided care for the victim and/or her children prior to her death

d) crisis response of professional service providers to the care of the victims children following her death

e) investigative response of law enforcement and other legal agencies to determine if there is evidence of violence or threats of violence against the victim to rule out homicide as a cause of death

f) medical communities' identification and response to patients at risk for suicide and domestic violence

g) Sacramento County's strategies for primary, secondary and tertiary suicide and domestic violence prevention.

Of the five suicides reviewed, the DVDRT found evidence of a history of domestic violence in childhood and/or in adult relationships in 100% of the cases. Assuming the unlikely event that no evidence of domestic violence exists in the remaining 37 fatalities, this finding indicates a history of domestic violence in a minimum of 12% of female suicides in this one- year period.

1. **Key Finding:** In each of the five cases reviewed, the victim had a history that indicated problems with domestic violence either in childhood or in adult relationships.
2. **Recommendation:** Our limited sample is consistent with national findings pertaining to the co-occurrence of mental health issues and suicide with domestic violence, and consistent with long term outcome studies of children exposed to domestic violence. Resources for suicide prevention in the context of domestic violence should be a priority for the community.

3. **Key Finding:** Four of the five suicide victims had contact with mental health service providers and reported domestic violence in their past or current relationships.
4. **Recommendation:** Mental health professionals should work with the Domestic Violence Coordinating Council (DVCC) to increase their staff awareness of domestic violence issues. Improved education regarding the co-morbidity of depression (and other mental disorders), substance abuse, domestic violence and suicide is essential.

5. **Key Finding:** Four of the five victims had contact with two or more community service agencies (CPS, WEAVE, Mental Health Care, law enforcement) regarding domestic violence or domestic violence related issues, with no apparent coordination of services.
6. **Recommendation:** The DVCC should explore mechanisms that will allow community service agencies, with the victim's permission, to collaborate regarding coordination of and access to DV services victims do not fall through the safety net.

7. **Key Finding:** The Sacramento Coroner's Office does not routinely include the existence of domestic violence in its' investigations of female suicide cases. When domestic violence was identified, it was addressed to rule out homicide.
8. **Recommendation:** We know at least 12% of all female suicide victims in Sacramento County had a history of domestic violence. The Coroner's Office should examine police reports and consult with Women Escaping a Violent Environment (WEAVE), CPS and Mental Health Care agencies for evidence that domestic violence abuse or neglect may have contributed to the victim's fatal outcome. Equivocal cases should be referred for forensic psychiatric postmortem suicide risk assessment. WEAVE should include language in the Release of Information that would allow information to be shared with the Coroner's Office, in the event of the victim's death.

9. **Key Finding:** One of the five suicide victims was admitted to the hospital prior to her death. She was incapable of making life and death decisions when admitted, and her husband filled this role.
10. **Recommendation:** Since there is a high association of homicide, suicide and severe injury with domestic violence victimization, health care providers might consider contacting law enforcement to see if there is any suspicion of domestic violence. If found, this may place into question the appropriateness of the surrogate decision maker to make decisions on the patient's behalf.

11. **Key Finding:** Three of the five suicide victims had documentation of domestic violence in their medical records. Another patient had multiple risk factors for domestic violence and suicide including physical signs of sexual abuse. Despite

her repeated complaint of severe depression and feelings of guilt one week prior to her suicide, no DV screen, suicide risk assessment or referrals were made.

12. **Recommendation:** The County of Sacramento and the DVCC, in conjunction with the Department of Health Services, should promote compliance with State mandates and State regulations regarding screening and reporting of domestic violence by health care providers. Health care providers should be cognizant of the inter-relationship between domestic violence, depression and suicide to facilitate appropriate referrals and documentation.

13. **Key Finding:** Each of the five victims had at least one child. One child was found deceased in the home with her deceased mother. There are six surviving children, ages 2-10 years. Four of the children had records with CPS and another stayed at a WEAVE Safe House with the mother. Presently, five of the six children are thought to be in the custody of the suspected or documented abuser.
14. **Recommendation:** Child Protective Services should be notified when there are surviving children of a suicide with a suspected or documented history of domestic violence. Placement of the child and continued case management should be supervised by CPS to assure his or her continued safety and welfare.
15. **Key Finding:** One of the victims committed suicide by use of a firearm.
16. **Recommendation:** Women are at a greater risk for death by homicide committed by an intimate partner with a firearm than by a stranger with all methods combined. That is why domestic violence restraining orders often direct police to remove all firearms from the home. This finding should further motivate law enforcement to remove all firearms for the protection of all persons living in a home where there is domestic violence and where the court has ordered the defendant to surrender all firearms.

III. Summary of cases reviewed for this report

A. **Age of Suicide Victims**: The ages of the suicide victims were 39, 31, 22, 34 and 37. Their mean age was 32.6 years. The age range of all female suicides reported in Sacramento County in 2004 was 20-87 years, with a mean age of 46.

B. **Gender of Suicide Victims**: Only female suicides were examined this year. Examination of male suicide might find histories of domestic violence. Previous DVDRT reports have included several cases of DV homicide/suicides involving both genders.

C. **Relationship Status of Suicide Victims**: Two of the suicide victims were married or cohabitants at the time of death. Two victims were divorced and the relationship status of one was not known.

D. **Locations of the Event that Resulted in the Fatality**: Four of the fatalities occurred at the victim's residence and one occurred at the hospital.

E. **Mechanism of Death or Weapons Used**: One suicide victim died of asphyxia from hanging. Another died from a gunshot wound to the head. Another died from a gunshot wound to the head. Two of the women ingested drugs and one injected over the counter medications.

F. **Minor Children Impacted**: The victims had a total of eight minor children. All had at least one child. Two of the eight children are deceased. One child died prior to the mother's suicide and the other was found deceased in the home with the mother. Of the six surviving children, four lived with their mother at the time of suicide and two resided with family members. One victim was pregnant at the time of her death.

G. **Victims' Contact with Professional Intervention Services Prior to Fatal Event**:

1. Law Enforcement: two women had prior contact with law enforcement for a domestic violence related event. None of the victims had filed for orders of protection

2. Social Services: Three victims were receiving social welfare benefits.

3. WEAVE: Three victims had contact with or had consulted WEAVE. One of the three utilized the WEAVE Safehouse with her child.

4. CPS: Four of the six surviving children of suicide victims had records with CPS.

5. Mental Health Care System: Four victims had contact with mental health professionals. During these contacts, three of the five had domestic violence identified. One of those identified had documented interventions for DV (WEAVE Safe House).

6. Medical Health Care System: All five women had multiple contacts with medical health professional over several year periods.

IV. Fatality Data for Sacramento County

A. Suicide data for 2004:

1) Means of Suicide:

i.	Ingestion of Drugs/Narcotics	11
ii.	Asphyxia	11
iii.	Gunshot Wound	9
iv.	Various Means	7

2) Race of Victim:

i. Caucasion	31/38	82%
ii. African/American	2/38	5%
iii. Asian/Pacific Islander	4/38	10%
iv. Native American	1/38	3%

3). Relationship Status:

i. Married	9/38	24%
ii. Divorced:	10/38	26%
iii. Widowed	7/38	18%
iv. Separated	1/38	3%
v. Unkown	11/38	29%

4). Narcotics in System at Time of Death:

i. Yes	11/38	29%
ii. No	27/38	71%

B. Qualitative Data :

All of the victims studied by the DVDRT were at risk due to the violence they experienced in the home as children or adults. These women were in great need of neuropsychological assessment. In most cases they either did not avail themselves or were not appropriately referred for mental health evaluation and assistance. Too often victims who had contact with the medical system were not referred for mental health evaluation. In one case the victim referred to her home as a “war zone”. In another, the victim wrote that she took the life of herself and her child because of her intimate partner, during the course of a tumultuous five year relationship. In that particularly shocking event, the woman took her own life and that of her even year old daughter. This does not bode well for us as a caring community.

In another case, a woman was labeled an alcoholic and had her child removed from her. She reported to the medical community that she was a victim of abuse at the hands of her ex-husband and was depressed. All of the clues were never connected and then when she had access to a gun, she took her own life.

Without detailing each case, we come to the inescapable conclusion that in our community the link between violence in the home, depression, drugs and alcohol abuse is strong and must be addressed.

V. Summary and Responses to Prior Recommendations

This is the 5th report of the DVDRT. A summary of recommended actions and response thus far is noted in the tables below.

DVDRT Report 2000

Recommended Action	Response
The Domestic Violence Coordinating Council should study and propose laws or procedures that would enable the DVDRT to obtain mental health records.	The DVDRT now has access to mental health records when evaluating a domestic violence homicide/suicide.
Minor children either present or in a family in which a DV homicide occurs should be immediately and separately interviewed.	While this is occurring on occasion, it is still not required that first responders in Sacramento County interview children separately.
CPS should be notified whenever there are surviving children after a DV homicide, and whether or not child was at the scene, to supervise placement.	Although inconsistent, there has been improvement in reporting by police agencies and supervision of placement by CPS of children surviving a DV homicide.
A system should be put in place to notify the DA's Victim-Witness Unit in murder-suicide cases, so surviving children can receive services.	DA Victim-Witness contacts families in DV homicides even before receiving a crime report, if it comes to their attention via the media or other sources, and notifies family members about available services.
DA's Victim-Witness Unit should notify the guardians of all children surviving DV homicides that victim-witness funds for counseling are available.	The victim/witness advocates routinely now notify the guardians of the children of DV homicide of funds for counseling.
All first responders should prepare incident reports after responding in a DV case and submit to appropriate law enforcement agency.	*The fire department has begun this process.*
Health care providers make more efforts to ensure patients are screened for DV and appropriate referrals are made.	Health care institutions in Sacramento County are either presently screening or developing policies to implement DV screening, as required by law; screening of minors is still an issue.

Sacramento County should facilitate community education about DV through the faith community, media and employers.	WEAVE did a media campaign in 2001, "Break the Silence"; the Catholic diocese incorporated DV education classes; the Hmong church did outreach after the Xiong family deaths in 1999; Sacramento employers need to be encouraged to educate workers. The City of Sacramento has trained most of their workforce and adopted a no-tolerance policy in DV. The Sacramento Sheriff's DV Response Team in 2001 provided community education and law enforcement training in a total of 81 presentations.
Sacramento County should educate the community about mental illness to (1) de-stigmatize counseling and (2) to help families recognize, not minimize, lethal threats in DV situations.	None, yet the DVDRT's 2001 Report listed organizations willing to provide speakers to educate others on this issue.
Health care providers should screen for mental illness in DV situations, foster mental health assessments and intervention.	Sacramento County Division of Mental Health in 2001 contacted with UCD Dept. of Psychiatry to provide 8 hours/week psychiatric consultation and treatment at a primary care clinic. *Any other action?*
911 dispatchers should receive additional training on the dynamics of domestic violence.	Only dispatchers, not operators, receive updated yearly training on DV, although all receive initial DV training. CHP dispatchers received special training in 2001 on DV calls from the Sacramento County DA's office.
Educate law enforcement agencies on interviewing/videotaping child witnesses at DV scenes.	Yearly advanced officer training at the Sacramento Sheriff's Dept. includes 2 hours training by a DA investigator on reporting in DV cases; Sacramento Police Department may call investigators from Family/Youth Services to interview child, depending on situation. More specific training needed.
Sacramento County should establish a pilot program to identify high-risk cases in DV and monitor high-risk families with home visits.	There has been a partial effort that implements this recommendation. The Family Support Collaborative offers a support program for pregnant parents and families with newborns, "Birth & Beyond," which identifies families at high risk for DV. As of 2001, WEAVE services were to be integrated in this program.

DVDRT Report 2001

Recommended Action	**Response**
Sacramento County's DVCC reactivate the Workplace Violence committee to train Labor Commission field organizers on DV, and explore legislation to require posting employee's rights to leave in DV cases	None.

Sacramento County should ensure that appropriate authorities develop a standard statewide DV reporting form.	Work is still being done on the completion of a statewide reporting form.
Advocates within each of Sacramento's immigrant communities be identified and educated in DV, through education and outreach to community leaders by Sacramento County.	The Sacramento Police Department, the D.A.'s Office and various county agencies have been actively educating in our immigrant population regarding domestic violence and fatality.
Combined effort by government, community leaders and faith community needed to train law enforcement and first responders to deal with cultural obstacles in responding to DV situations.	A collaborative educational conference sponsored by law enforcement, WEAVE, the Attorney General, & Dept. of Health Services to be held in April 2004 will include training on outreach to the immigrant communities.

DVDRT Report 2002

Recommended Action	**Response**
Sacramento County should act to ensure a sufficient number of shelter beds are available for victims of DV and their families. WEAVE should keep data on this issue.	WEAVE's data shows that they turn away dozens of people each month. Sacramento County has not appropriated funds to increase the number of shelter beds since 1985.
Train law enforcement to inform parties in a DV incident that law enforcement has a mandatory reporting duty if children are present and that CPS may take action to protect children in violent homes.	Law enforcement routinely notifies CPS when children are present during a DV event.

DVDRT Report 2003

Recommended Action	**Response**
Sacramento County should seek outside funding in the amount of $50,000 per year for 3 years for the implementation of guidelines from "Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice" (Recommendations from the National Council of Juvenile and Family Court Judges Family Violence Department).	Funding was never forthcoming from the Board of Supervisors. It should be noted that during 2003-4, the County dealt with a great many financial challenges which caused budget cuts to many agencies.

Sacramento County should seek funds to increase shelter bed capacity by a minimum of 15 beds each year over the next three years.	Weave and My Sister's House have acted without partnership with the County of Sacramento.
Sacramento County should seek ways to raise public awareness of the impact of domestic violence on children	There has been a hightened awareness due to the resurgence of the DVCC and numerous conferences and seminars.
Sacramento County should encourage all community service agencies to explore the implementation of procedures for lethality assessment and appropriate response protocols.	Lethality assessment tools are in the possession of all concerned agencies. It is eimply a matter of using the tools to make an assessment.
Sacramento County should explore possible funding for staff support for DVDRT meetings, data collection, data analysis and preparation of the annual report.	No such funding has been forthcoming.

VI. Description of DVDRT, Process and Enabling Statutes

A. Description of the Committee and its Process: The Domestic Violence Death Review Team of Sacramento County is a committee of the Sacramento County Domestic Violence Coordinating Council.

B. Mission statement: The purpose of the DVDRT is to bring together a multi-disciplinary team to review deaths associated with domestic violence, with a view towards making recommendations to help prevent domestic violence related deaths, and to develop strategies to deal with domestic violence.
C. Objectives: To review domestic violence homicides and produce a report to the Board of Supervisors.
D. Organizational Structure: Committee
E. Review Process: Monthly
F. Enabling Statutes of the California Penal Code (Sections 672.001 – 672.003)
G. Copy of Confidentiality Agreement (see attached).
H. Membership:

Sacramento District Attorney's Office
Sacramento Sheriff's Department
Sacramento Police Department
Folsom Police Department
Sacramento Probation Department
Sacramento Coroner's Office
Law Enforcement Chaplaincy – Sacramento
California Attorney General's Office
California Department of Justice Automated Systems Programs
Sacramento Fire Department
Sacramento County Department of Health and Human Services
Division of Public Health Promotion and Education
Division of Child Protective Services

Division of Mental Health
Sacramento County Office of Education Prevention and Student Services
Kaiser Permanente
University of California, Davis, Medical Center
Sutter Medical Center, Sacramento
Catholic Healthcare West/Mercy Sacramento
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