COUNTY OF SAN DIEGO
DOMESTIC VIOLENCE FATALITY REVIEW TEAM

2004 REPORT

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY
OFFICE OF VIOLENCE PREVENTION

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Introduction

This is the second report of the San Diego Domestic Violence Fatality Review Team (DVFRT). The DVFRT's first report was issued August 3, 2001, and covered case review from October 1997 through August 2000. The content of this report is based on the information obtained since the inception of the team in 1996. A total of 61 cases are chronicled in this 2004 DVFRT report.

The team identified the following as the eight major domestic violence lethality risk factors:

DOMESTIC VIOLENCE LETHALITY RISK FACTORS

History of domestic violence between the couple - 67%

Access to firearms - 44%

Victim ended relationship prior to death - 39%

Alcohol and/or drug abuse in relationship - 39%

Mental health issues in relationship - 33%

Suicidal issues - 33%

Death threats towards victim from perpetrator - 25%

Victim obtained restraining order prior to death - 16%

Recommendation: Access to Firearms

Background

Use of firearms accounted for 44% of victim fatalities in the 61 cases reviewed between 1997-2003. The DVFRT recognizes that each of the systems involved - court, law enforcement, prosecution, and probation - has the responsibility to ensure that those ordered by the court have relinquished their weapons. Domestic violence fatalities occur even though many perpetrators are barred access to firearms, either by a restraining order or having prior domestic violence convictions.

Of the eight risk factors, the DVFRT has chosen to devote its sole recommendation to addressing the risk of *"Access to Firearms."* This following recommendation is directed at the multiple law enforcement systems integrally involved in addressing domestic violence:

A search of the California Law Enforcement Telecommunications System (CLETS) would be advisable for each of the following situations to determine if the perpetrator possesses any firearms:

- after law enforcement responds to a domestic violence-related call,
- at the first court hearing for the perpetrator,
- after the restraining order is filed,
- after an order is entered following the hearing.

RECOMMENDATION

Based on the DVFRT's six years of review, the team's recommendation is directed at **"access to firearms"** because firearms **accounted for 44% of victim fatalities**. The primary systems addressing this risk include the courts, law enforcement, prosecution and probation. The team recognizes that there are standard procedures already in place; the team's recommendation is to closely adhere to these procedures and follow through on seeking information regarding weapons in a perpetrator's possession.

Specifically, the DVFRT has identified four instances where the coordinated and proactive actions of the criminal justice system can make a difference in ensuring victim safety:

1. Law enforcement should inquire if there are weapons in the home, if the weapons were used in the incident, and confiscate any weapons found at the scene.

2. At the first court hearing in a domestic violence case, a registered firearms check should be made through the California Law Enforcement Telecommunications System (CLETS). After conviction, the court order should require that the defendant show proof of relinquishment as a condition of probation.

3. When an order after the hearing is entered, after a domestic violence restraining order is requested, a firearms registration check (CLETS) should be made. The firearms registration information should be included in the restraining order. With this instituted, an officer serving the restraining order is alerted to the potential for weapons and the perpetrator is required to show proof of relinquishment of the registered firearm(s).

4. The courts, law enforcement, District Attorney, and San Diego City Attorney should work together to develop and implement standardized policies and procedures for the safe relinquishment and destruction of weapons.

Law enforcement, the courts, probation, the District Attorney and San Diego City Attorney should continue to seek methods for identifying gun possession, and develop protocols that address the above areas. The DVFRT believes that until there is a unified effort, perpetrators in possession of weapons will continue to be a critical issue.

County of San Diego Domestic Violence Fatality Review Team

Mission

To prevent future deaths from intimate relationship violence by utilizing a systematic, confidential, multi-agency death review process, and to identify system gaps in order to expand effective violence prevention policy and coordinated strategies.

Objectives

- Establish a learning process which brings together public and private agencies to identify their respective roles and potential collaborative opportunities, by working together to prevent domestic violence and, ultimately, death.
- Collect data from various agencies and systems about the victims of domestic violence homicides and suicides, and to evaluate the coordination of systems and the accessibility of services.
- Determine the trends and specific indicators of domestic violence homicides and suicides, to develop policy and program recommendations for future violence prevention programs.
- Increase public awareness and involvement in the prevention and intervention of domestic violence.

ACCOMPLISHMENTS

During 2003, agencies, programs, staff, and the community have benefited from the implementation of recommendations in the DVFRT's first report. Listed below are several of the accomplishments to date:

1. Adult Probation has implemented the Spousal Assault Risk Assessment Guide (SARA) - a lethality assessment tool given to defendants at presentence so that judges, the District Attorney and the defendant's attorney can better assess what the sentence should be.

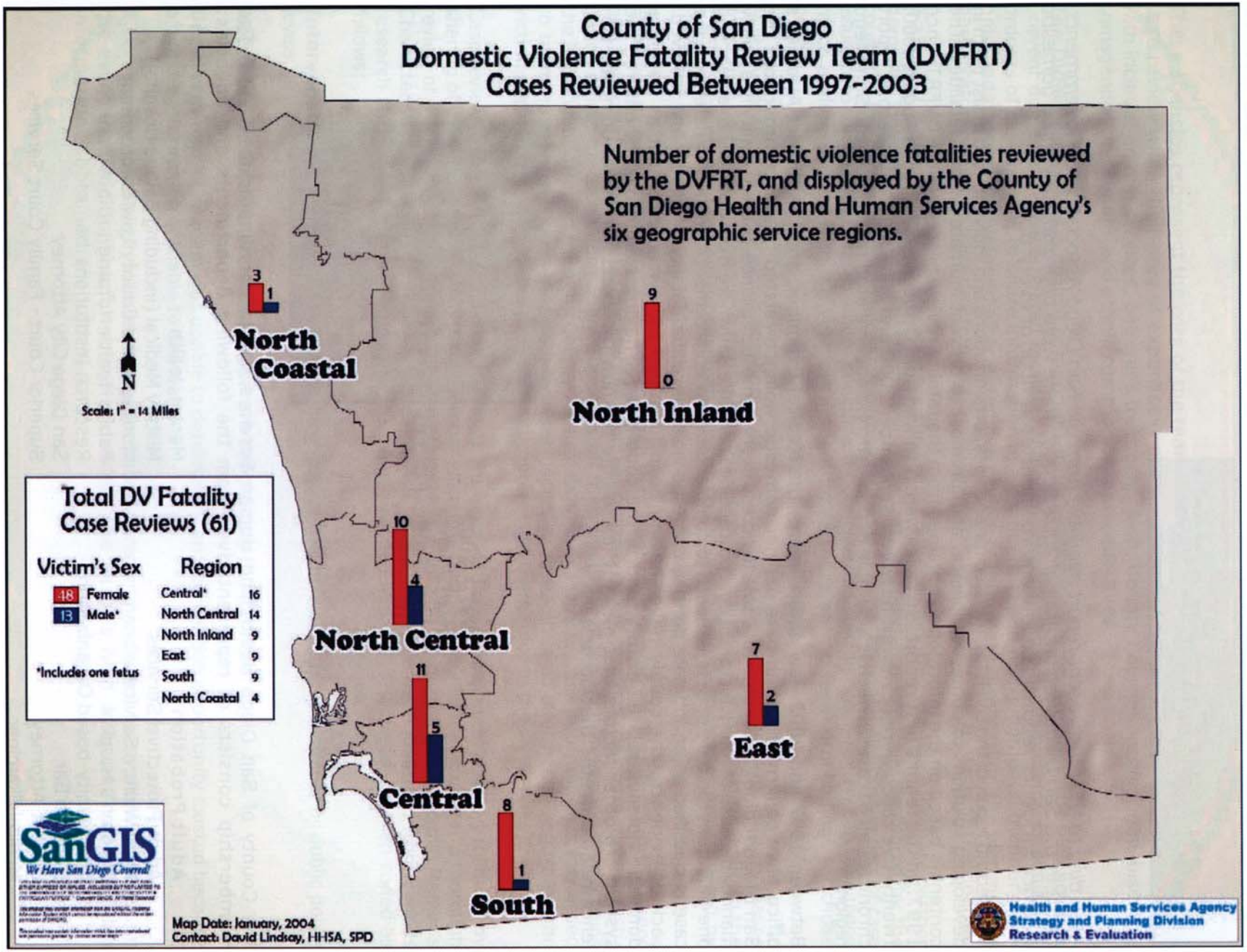
2. Batterer's treatment has created a "Release of Information Form." This form releases information from batterer's treatment programs to the County of San Diego Domestic Violence Fatality Review Team, in the event of the death of the client's partner.

3. Juvenile Probation has implemented a teen relationship violence task force to develop healthy relationship standards for teens involved in relationship violence.

4. DVFRT assisted the County of San Diego HHSA Aging and Independence Services in developing the Elder Death Review Team.

5. Additions to the DVFRT membership - treatment providers, emergency room physician. This has brought new medical expertise to case review.

6. DVFRT participated in the National Domestic Violence Fatality Review Teams Initiatives Conference for the past two years. This has enabled the team to expand case review discussion and develop more concise and comprehensive recommendations.


County of San Diego
Domestic Violence Fatality Review Team (DVFRT)
Cases Reviewed Between 1997-2003
Number of domestic violence fatalities reviewed by the DVFRT, and displayed by the County of San Diego Health and Human Services Agency's six geographic service regions.
North Coastal
3
1
North Inland
9
0
North Central
10
4
East
7
2
Central
11
5
South
8
1
N
Scale: 1" = 14 Miles
Total DV Fatality Case Reviews (61)
Victim's Sex
48 Female
13 Male*
*Includes one fetus
Region
Central* 16
North Central 14
North Inland 9
East 9
South 9
North Coastal 4
SanGIS
We Have San Diego Covered
Map Date: January, 2004
Contact: David Lindsay, HHSA, SPD
Health and Human Services Agency
Strategy and Planning Division
Research & Evaluation

Overview / Case Findings

According to the most recent report available from the San Diego Association of Governments, Crime in the San Diego Region Annual 2002 Report, there were approximately three domestic violence incidents reported to law enforcement each hour of every day.

This second report of the DVFRT is intended for agencies, organizations and individuals to assist them in developing solutions to domestic violence, and foremost to prevent intimate partner fatalities. The content is based on the information obtained from the fatality review process of the DVFRT since 1997. In the team's first report, 36 cases were reviewed from October 1997 through August 2000. Twenty-five cases were reviewed between September 2000 and May 2003. This second report chronicles all 61cases, which is a sample of domestic violence-related fatalities in the San Diego region.

Between 1997 and 2002, law enforcement, the Medical Examiner, and the District Attorney's office have confirmed 84 intimate partner domestic violence-related fatalities throughout the San Diego region. The team is not able to access every domestic violence-related fatality in a timely manner because of many factors. Legal proceedings can take anywhere from one year to a year and one-half, from the date of case issuance to completion. Law enforcement's process to determine if a case is classified as an intimate partner, domestic violence-related fatality is lengthy and involved. Lack of evidence, the couple never having been identified by law enforcement as having a domestic violence-related history, and/or the couple never having sought help or entered the system are other factors that make it impossible to know the exact number of domestic violence-related deaths that occur each year.

1997 - 2002
Intimate Partner
Domestic Violence - Related Fatalities
San Diego County

Year	Total
1997	19
1998	10
1999	15
2000	16
2001	7
2002	17
Total	84

The County of San Diego Health and Human Services Agency coordinates the DVFRT. The membership consists of representatives from the following departments and agencies:

Adult Probation
Adult Protective Services
Child Welfare Services
Children's Hospital
Community-based Organizations
Defense Bar
District Attorney
Medical Examiner
Mental Health
Military Medical (including Balboa Hospital)
Municipal and County Law Enforcement
Public Health Nursing
Research Institutions
San Diego City Attorney
Superior Court - Family Court Services

These agencies represent the core of the team, with additional service providers invited into a case review when their area of expertise is needed. Other entities that the team works closely with include: animal services, batterer's treatment, faith, County Counsel, lesbian, gay, bisexual, transgender, and cultural and ethnic community representatives.

The DVFRT represents a critical component of local efforts to eradicate domestic violence and prevent domestic violence-related fatalities. An open discussion among team members begins the process of case review, to share information in a confidential and non-judgmental manner. Recommendations are developed after extensive review of information regarding the victims and perpetrators, and the identification of the lethality risk factors that led to each of the deaths.

Fatality Review Team Process - The team convenes monthly to review intimate partner domestic violence-related fatalities after the defendant has been convicted and sentenced by the court. The legal proceedings can take anywhere from a year to a year and one-half from the date of case issuance to completion. In cases where concurrent homicide and suicide occur, review can take place much earlier, usually within a year of the deaths, as there are no legal proceedings for those cases.

Military fatality cases in which the homicide or homicide/suicide occurred on military bases must first go through a thorough review by military review boards, prior to being released to the DVFRT. The military review process can take up to two years before the cases are received by the team.

Homicide case information is acquired through the County District Attorney's Office. In the event of a homicide/suicide, the team's law enforcement representative contacts the appropriate investigating officer for case information. Support staff from the Office of Violence Prevention then obtains the Investigative Report from the County Medical Examiner's Office. Case information is forwarded to team members who proceed with their retrospective research of all information regarding the victim, perpetrator, or any individual who had contact with them prior to the fatality(ies).

Case review begins with a synopsis of the death from the lead law enforcement agency, followed by sharing of information from each team member who has specific case information. After a thorough review of the findings, the case is further synthesized by utilizing the team's Investigative Report's Characteristics of Abuse list, which includes 35 risk factors that have been identified from various research studies associated with domestic violence-related lethality. The cases are then coded as follows:

Intervenable - an opportunity existed to intervene at the individual, family, agency or public policy levels.

Not Intervenable - there was no apparent opportunity to intervene.

Undetermined - The team was unable to determine if an intervention opportunity existed because of limited information available to the team.

Risk factors are identified, followed by the formation of recommendations for system changes. In the event that additional information is needed, the case is held over until all available information is obtained.

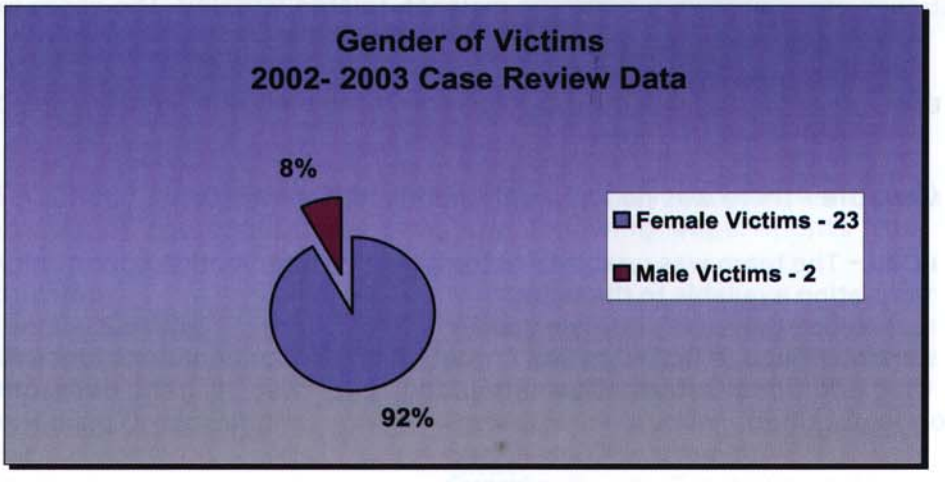
Recent Case Review Changes

In 2002, Dr. Neil Websdale of the National Domestic Violence Fatality Review Initiative was invited to observe the team's case review process. He introduced the team to the concept of developing a timeline and chronology of events to enhance the review process. This has enabled the team to create more accurate and relevant case findings. Additionally, this process has brought to light the complexities of intimate partner violence.

Case Review from 2002 and 2003
25 Cases Chronicled

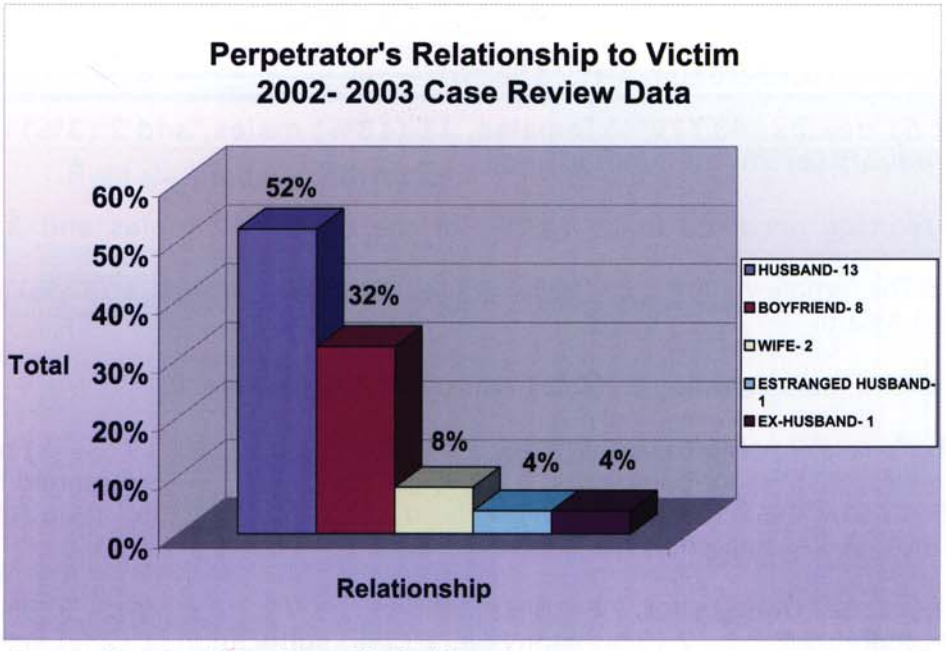
Key findings for the 25 cases reviewed in 2002 and 2003 are summarized below:

- A total of 25 victims: 23 (92%) females and 2 (8%) males.
- Homicide /suicide occurred in ten of the cases.
- Race/ethnicity of the female victims: 16 (70%) White, 6 (26%) Hispanic, and 1 (4%) Black.
- Race/ethnicity of the male victims: White, 2 (100%).
- Perpetrator's relationship to the victims consisted of the following: 13 (52%) husbands, 8 (32%) boyfriends, 2 (8%) wives, 1 (4%) estranged husband and 1 (4%) ex-husband.
- Method used: Firearms 10 (40%), strangulation 4 (16%), stabbings 4 (16%), beaten 3 (12%), suffocation 2 (8%), and 1 (4%) was set on fire. Additionally, 1 (4%) female victim's body has never been recovered.



Source: County of San Diego Medical Examiner n=25

Case Review from 2002 and 2003
25 Cases Chronicled



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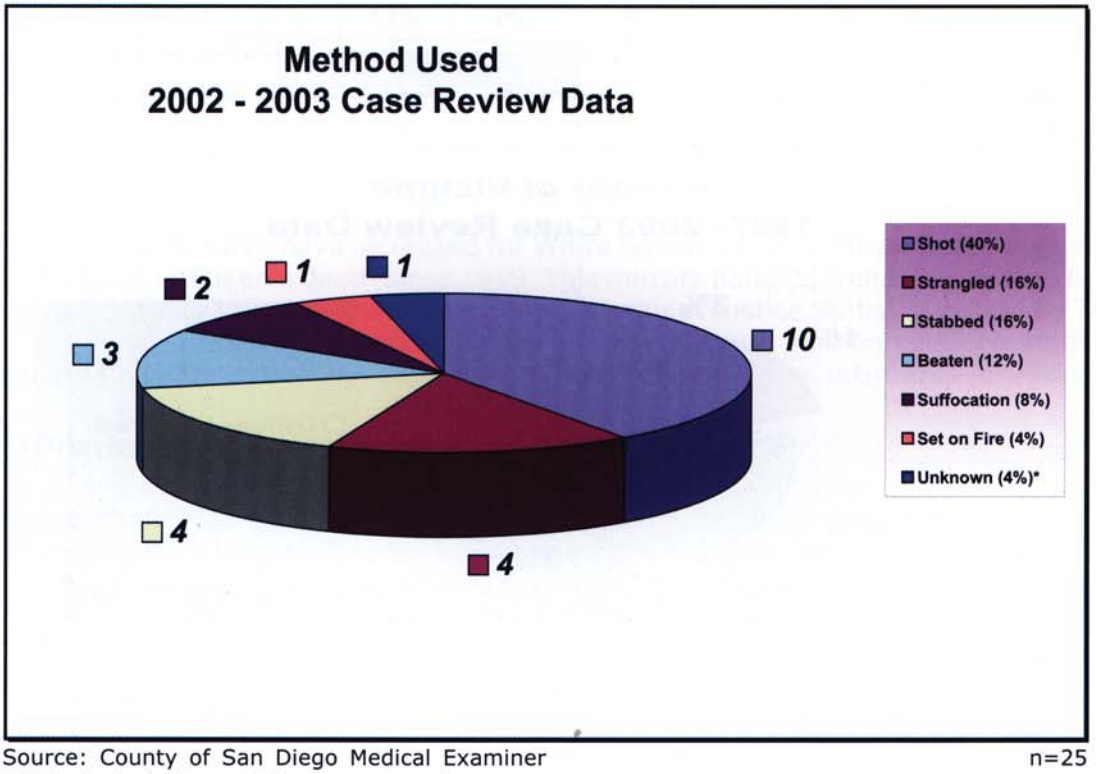
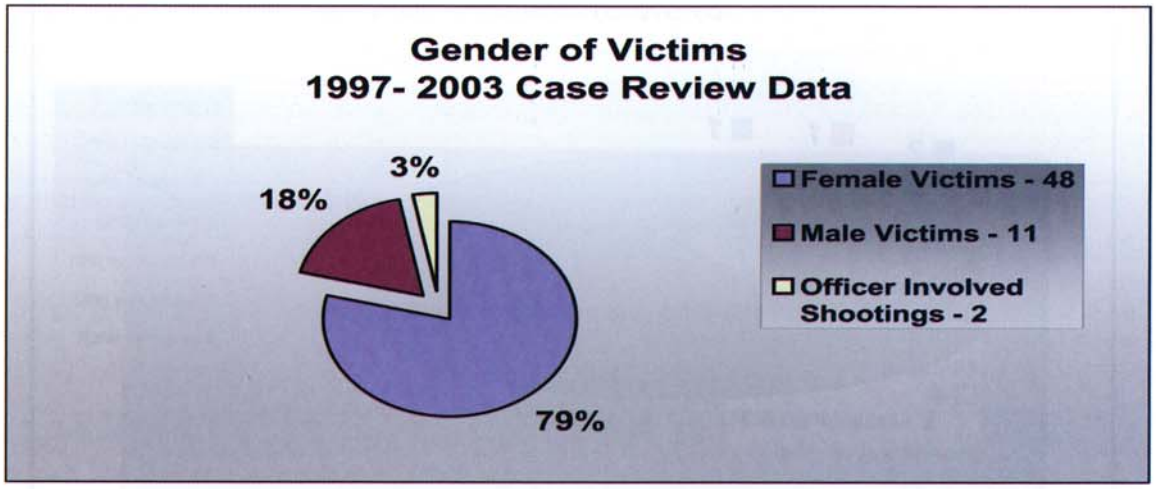


Source: County of San Diego Medical Examiner n=25
*Victim's body has not been recovered.

Case Review from 1997 through 2003
61 Cases Chronicled

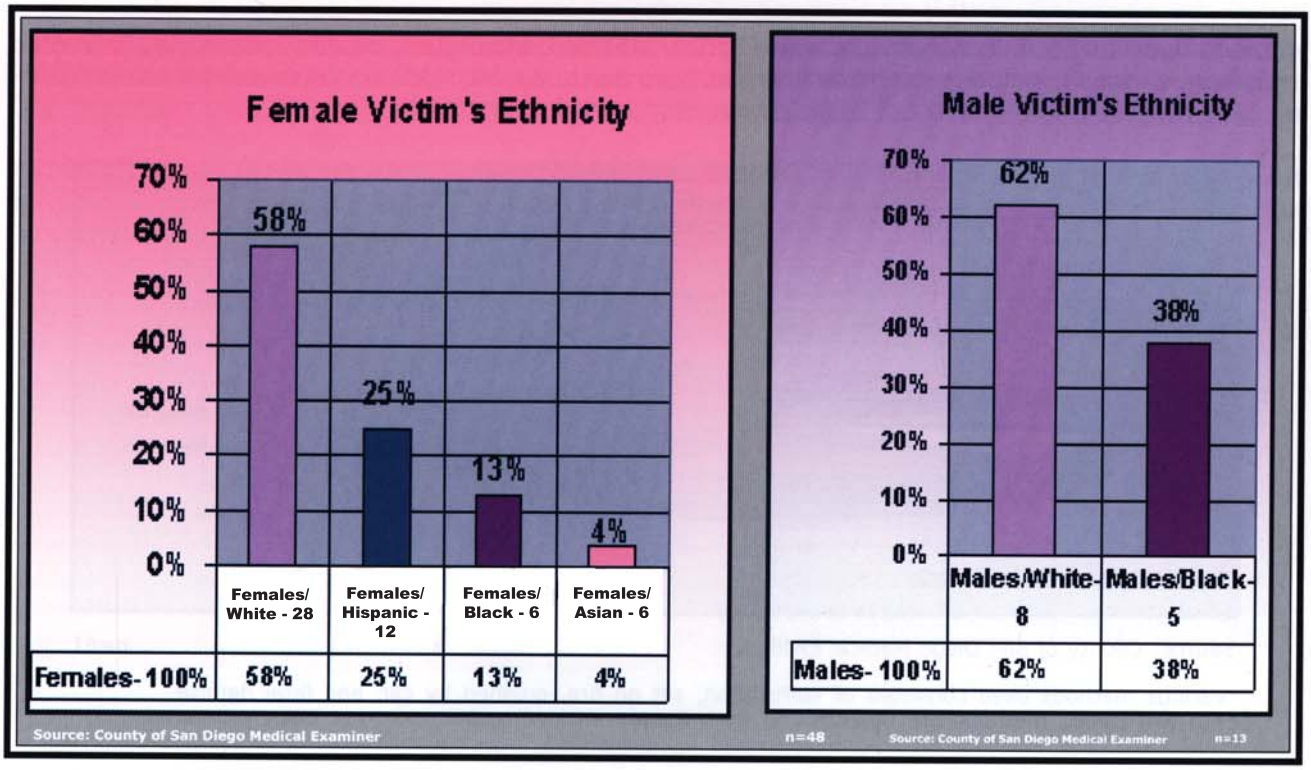
Key findings in the 61 cases are summarized below:

- A total of 61 deaths: 48 (79%) females, 11 (18%) males, and 2 (3%) male deaths from officer-involved shootings.
- Homicide/suicide occurred in 15 (25%) of the cases: 12 males and 3 females.
- Ethnicity of the female victims: 28 (58%) White, 12 (25%) Hispanic, 6 (13%) Black, and 2 (4%) Asian.
- Ethnicity of the male victims: 8 (62%) White and 5 (38%) Black.
- Perpetrator's relationship to the victims: 20 (33%) boyfriends, 19 (31%) husbands, 6 (10%) wives, 5 (8%) ex-boyfriends, 3 (5%) girlfriends, 3 (5%) estranged husbands, 2 (3%) ex-husbands, 2 (3%) officer-involved shootings, 1 (2%) male fetus killed when his mother was beaten by his father.
- Methods used: 27 (44%) shot, 11 (18%) stabbed, 7 (11%) strangled, 5 (8%) beaten, 3 (5%) multiple methods, 2 (3%) asphyxia, 1 (2%) suffocation, 1 (2%) set on fire, 1 (2%) car, 1 (2%) fetal demise, and 2 (3%) methods unknown (bodies have not been recovered).



Source: County of San Diego Medical Examiner n=61

Case Review from 1997 through 2003
61 Cases Chronicled



*Officers responded to two separate domestic disturbance calls. Both reported male perpetrators were shot and killed by officers when they refused to drop their weapons.

Since 1999, the death rates have increased for White females and for Hispanic females. For Black females, there has not been a death since 1999. This mirrors national trends. According to the U.S Department of Justice, Office of Justice Programs, Bureau of Justice Statistics *Homicide Trends in the U.S.: Intimate Homicide*: "Since 1998, the number of white women killed by intimates has increased but not to earlier levels....Black females killed by intimates dropped 53%."

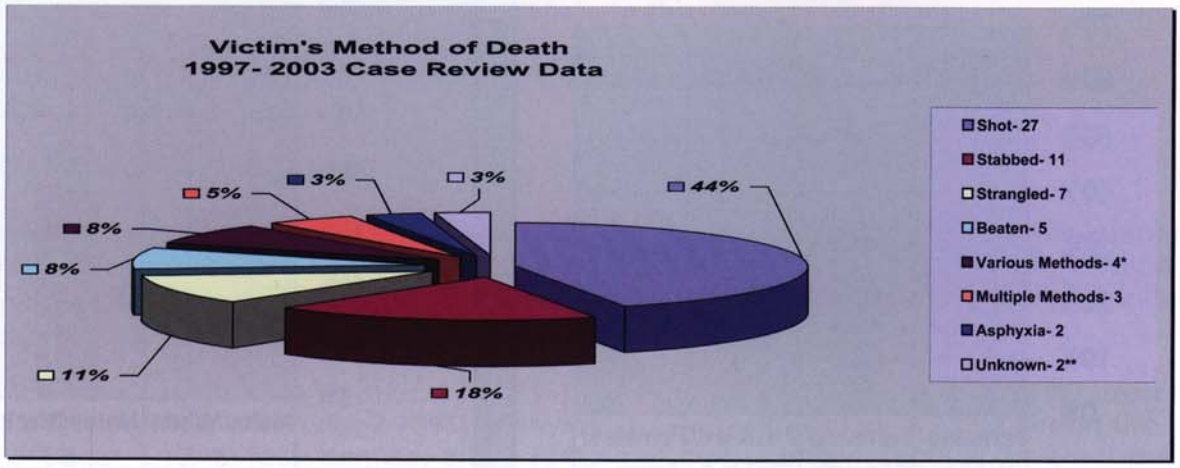
Victim/Perpetrator Relationship

Perpetrators consisted of the following: 20 (33%) boyfriends, 19 (31%) husbands, 6 (10%) wives, 5 (8%) ex-boyfriends, 3 (5%) girlfriends, 3 (5%) estranged husbands, 2 (3%) ex-husbands, 2 (3%) officer-involved shootings, 1 (2%) male fetus killed when his mother was beaten by his father.

Case Review from 1997 through 2003
61 Cases Chronicled

Methods Used by Perpetrators

Methods used in 59 victims' deaths were: shot, stabbed, strangled, beaten, asphyxia, four died each from various methods, and three from multiple methods. Methods are unknown for two remaining cases where bodies have not been recovered.

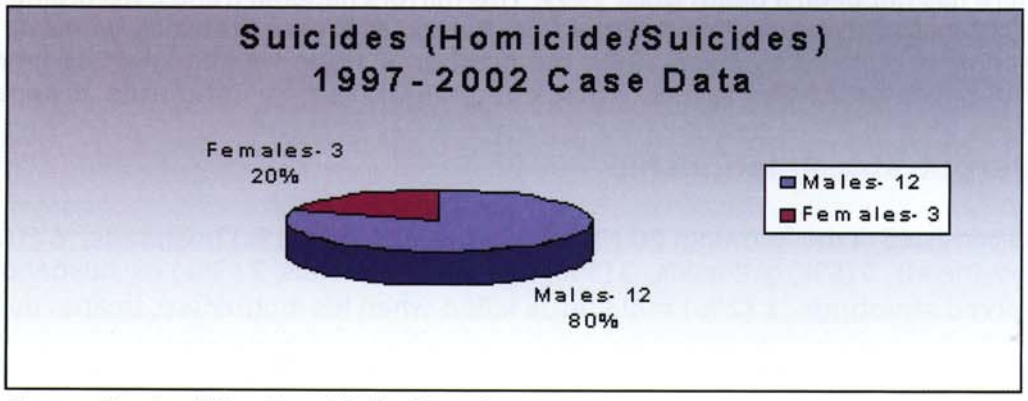


Source: County of San Diego Medical Examiner n=61

*Various methods used consisted of suffocation, set on fire, crushed by car, and fetal demise.
**In two cases, methods are unknown as both female victims' bodies have not been recovered.

Domestic Violence-Related Suicides

Of the 61 cases reviewed, 15 (25%) were classified as homicide/suicide. There were 12 male suicides and 3 female suicides. All suicide victims were identified as perpetrators.



Source: County of San Diego Medical Examiner n=15

All 15 people who committed suicide had numerous risk factors, including: diagnosed mental illness, suicide ideation, alcohol abuse or alcohol and substance abuse issues. Firearms were used in 13 (87%) of the 15 cases.

Case Review from 1997 through 2003
61 Cases Chronicled

Women Who Batter

In nine of the 61 cases reviewed between 1997 and 2003, women were identified as the batterers. In five of the nine cases, law enforcement confirmed that the women were the primary aggressors. The four other cases had mutual battering between the couple.

Additionally, in 26 (43%) of the 61 cases, the victims did not access any services or receive support from the criminal justice system. This finding appears to be consistent with data from the Florida Fatality Review Project: Governor's Research and Policy Model:

> *Women who killed their intimate partners...most had, for whatever reasons, not sought out or received support from criminal justice and other state agencies. Their partners were often obsessively possessive, and a good number of these violent men had threateded to kill them.**

*Neil Websdale, "Domestic Violence Fatality Reviews: From a Culture of Blame to a Culture of Safety" Juvenile and Family Court Journal (Spring 1999):68.

Case Review from 1997 through 2003
61 Cases Chronicled

Children Who Witness the Death(s) of Their Parent(s)

Out of the 61 cases, there were 52 children within the families affected by the death of one or both of their parents.

- Thirty-nine (64%) of the cases had at least one minor child.
- Twelve (23%) of the 52 children witnessed the murder of their parent(s).
- Four (8%) of the children were the first ones to find the victim's body.

The status of children after the death of their parent(s) is of vital concern to the team. Studies indicate that children who witness the homicide of a parent are at greater risk for future psychological and behavioral problems. Violent behavior with peers or in their own intimate relationships may also emerge later in their development, if these children do not receive intervention. In 2003, the DVFRT was able to obtain more information from the Health and Human Services Agency's Child Welfare Services division and the District Attorney's Victim Assistance Program as to the services these children received following the death of their parent(s).

According to the Family Violence Prevention Fund, a national domestic violence prevention advocacy organization based in San Francisco, research shows that early intervention efforts for children exposed to domestic violence are proving effective overall in reducing criminal and delinquent behavior. The factors that these early intervention efforts address are similar to those found to be associated with domestic violence and child abuse. There also appears to be a close correlation between family violence and youth violence.

Case Review from 1997 through 2003
61 Cases Chronicled

Major Risk Factors for Lethality

Major risk factors are those circumstances that are evident in most domestic violence-related fatalities. These factors assist in formulating recommendations, and guide the creation of strategies to prevent future fatalities.

Of the 61 cases reviewed, the team has identified eight major risk factors for lethality, and determined that a history of violence in the relationship (41 [67%] of the cases), and access to firearms (27 [44%]) were the two most common risk factors. Additionally, the more risk factors present in the relationship, the greater the risk of death.

Firearms were used in the deaths of 27 (44%) of the victims. These 27 cases include ten (37%) of the 15 suicides.

MAJOR LETHALITY RISK FACTORS IN ORDER OF OCCURRENCE

67% - History of domestic violence between the couple
44% - Access to firearms
39% - Victim ended relationship prior to death
39% - Alcohol and/or drug abuse in relationship
33% - Mental health issues in relationship
33% - Suicidal issues
25% - Death threats towards victim from perpetrator
16% - Victim obtained restraining order prior to death

No one risk factor alone can be a predictor of fatality. However, when these lethality indicators are present, and as the number of indicators within the relationship increases, the chance of death rises significantly. It is the hope of the DVFRT that those agencies assisting families and individuals experiencing domestic violence will use these risk factors as part of program design and service delivery to prevent future deaths.

Future Focus

Since the DVFRT's inception, team building and trust have been the most important factors in creating cohesiveness among members. This has been achieved to a great extent as the team has coalesced over the past six years. Members who have served on the team for an extended period offer mentoring to new members, and trust develops quickly with the support and encouragement that the team provides. The knowledge gained since the DVFRT began provides a solid foundation for future efforts.

The team has identified four key areas for expansion and enhancement of its review process. The future focus of the DVFRT will include:

- Suicides that have a domestic violence history.
- Near fatalities - victims who survived an attempted murder.
- Follow-up on services provided to the children who have lost their parent(s) to domestic violence-related homicide and/or homicide/suicide.
- Refinement of the case investigative report to be more inclusive of other lethality factors recently identified by researchers in the field of domestic violence, such as attempts to break away from perpetrator, internet stalking, and close surveillance.

The DVFRT is fully committed to finding solutions to prevent domestic violence. It is the team's sincere hope that its findings and recommendations will serve to save lives and further assist in preventing domestic violence.

County of San Diego Domestic Violence Fatality Review Team
Team Membership Roster

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Acting Director
***Rodger G. Lum*, Ph.D**
(Former Agency Director & Chair)
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Co-Chairs:
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Deputy District Attorney
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District Attorney's Office

Linda Wong Kerberg
Assistant Deputy Director
County of San Diego
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Staff Support:
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Team Coordinator
County of San Diego
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Domestic Violence Unit

Liza Boyer, LCSW
Center for Community Solutions
Clinical Services

Patti Chavez-Fallon, LCSW
County of San Diego
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Family Court Services

Kathleen Dully, M.D.
United States Navy
Naval Medical Center
Family Protection Department

Jeannie Ertl, LCSW, BCETS
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Naval Medical Center
Family Protection Department

Shelly Falconer, LCSW
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Children's Mental Health Services

Rose Fox, PHN/Christine Wright, PHN
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Health and Human Services Agency
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Jorge Gonzalez
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Sheriff's Department
Domestic Violence Unit

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