SONOMA COUNTY

DEATH REVIEW

TEAM

1997 FINAL REPORT

TEAM MEMBERSHIP

ASSISTANT DISTRICT ATTORNEY GREG JACOBS, CHAIR
DISTRICT ATTORNEY'S OFFICE

DR. BRIAN PETERSON
FORENSIC MEDICAL GROUP

DR. DEANE DEFONTES
PETALUMA HEALTH CENTER

BARBARA BRANAGAN, RN, NP
DEPARTMENT OF HEALTH SERVICES

CHERYLE RUTHERFORD-KELLY, MSW
YWCA

DETECTIVE STACEY CAMARA
SANTA ROSA POLICE DEPARTMENT

DETECTIVE CURT LOWE
SONOMA COUNTY SHERIFF'S DEPARTMENT
CORONER'S OFFICE

TONI NOVAK
SONOMA COUNTY LEGAL SERVICES FOUNDATION

SERGEANT RICHARD SWEETING
SONOMA COUNTY SHERIFF'S DEPARTMENT

SARAH JENNINGS, LCSW
KAISER MEDICAL CENTER

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REDWOOD CHILDREN'S CENTER

DOMESTIC VIOLENCE DEATH REVIEW TEAM

Final Report

Gregory J. Jacobs, Chairman

The Sonoma County Domestic Violence Death Review Team met for the first time on December 12, 1996. The concept of the Domestic Violence Death Review Team finds its origins in the successful model of Child Death Review Teams, which have been established in the past five years, and whose legislative foundation is found in the Penal Code, section 11166.7.

The Sonoma County Child Death Review Team studies all deaths of children of the age of 18 and under in Sonoma County and determines cause of death. The Team's particular emphasis is to ensure that no child's death in Sonoma County goes unexamined, to reduce the possibility that the death was the result of a criminal act or negligence. Other goals of the Child Death Review Team are to determine if County medical and law enforcement officials are investigating child deaths adequately. There is also an emphasis on encouraging the prevention of child deaths in the County, not only by criminal acts, but by accidental and negligent acts. For example, the Child Death Review Team has recommended public education regarding water safety, and teen suicide.

With this model as a guide, the Sonoma County Domestic Violence Death Review Team was formed. In 1996, Penal Code section 11163.3, authorized the formation of such teams in California. By statute, these teams are to involve individuals from various disciplines within the County who meet in a confidential setting and professionally discuss domestic violence related deaths.

Since its inception, the Domestic Violence Death Review Team has been meeting every two months. One of the first things that the Team did was draft a Domestic Violence Death Review Team Protocol. The Sonoma County Child Death Review Team Protocol was used as a reference. During 1997, the Protocol was adopted. All participants on the Team have agreed that any discussions during the Team meetings remain confidential. It should be noted that confidentiality is ensured by the Penal Code Statute providing for the establishment of death review teams.

During 1997, the Death Review Team did discuss several cases listed in the caseload description. These cases were examined according to the purposes of the Team as stated in the Protocol. The Team also used the Los Angeles County Domestic Violence Death Review Team policies as a guide. The Protocol provided a guideline for the Team to examine the facts of the cases that came to the attention of the Team during the year. The Team also established a data form which would be used to record various pertinent statistics about each case.

The Team evaluated each case involving a domestic violence related death to determine the cause of death; to review resources for appropriate services at the scene of the domestic

lence death, and discuss patterns of evidence indicating factors which might provide for the diction of lethal situation(s) involving perpetrators and victims. The Team also examined es to determine if improvement in individual agencies' response and/or if improvement ween agencies was needed. The Team has evaluated the cases that have been examined this t year to develop recommendations.

One of the early determinations by the Death Review Team was that the Coroner's fice, which is part of the Sheriff's Department, would bring to us reports of death which may olve domestic violence; whether it be suicide, homicide or accidental death. This would be e source of information about domestic violence related deaths within the county. Besides the roner, other agencies involved in the Domestic Violence Death Review Team are the Sheriff's partment; the Santa Rosa Police Department; Department of Human Services; Department of alth Services; the District Attorney; the Sonoma County YWCA; the Sonoma County Medical sociation; Kaiser Hospital; Sonoma County Legal Services Foundation; and the County hologist. Each representative from each of these agencies participating in the Death Review am may bring to the attention of the Team any domestic violence related death. Law orcement agencies have been willing to provide us with reports and an oral presentation upon uest.

During the year, the Chair, Gregory J. Jacobs, Assistant District Attorney, used a legal rm to survey all law enforcement agencies in the County to examine what their domestic lence investigation protocols. A document was compiled comparing each agency. The Chair n notified each of the law enforcement agencies regarding their protocols and made gestions to improve them. The Chair also discussed this survey at the Sonoma County Law forcement Chief's Association meetings. The Chair concluded that all the agencies had more n adequate protocols for investigating domestic violence deaths. The need is not necessarily raft or to construct additional investigative protocols, but to ensure each agency's personnel, l particularly investigating officers, receive training on how to carry out the formal protocols. should be noted that in 1997, the Sonoma County Sheriff's Department put on two county- le domestic violence training sessions for each agency in the County.

The Team decided it would operate independently of any other agency or commission. eral Team members are also on the County Domestic Violence Action Committee. D.V.A.C. a large Committee involving Courts, law enforcement, advocacy, public health, shelters, and er agencies which deal with domestic violence issues. However, because the Team operates ler rules of confidentiality, the Team can only share statistics and general recommendations l findings with D.V.A.C.

It should also be noted that in November, 1997, the Sonoma County Domestic Violence art began operations. All misdemeanor domestic violence cases are initially sent to this Court ich is presided over by Judge Robert P. Dale. There is an experienced District Attorney, blic Defender and Probation staff assigned to the Court. The Death Review Team is aware of Court and is interested in its impact on domestic violence in Sonoma County. The court has y been in operation for four months. Whether it substantially reduces incidences of domestic lence is of great interest, but remains to be seen.

DOMESTIC VIOLENCE DEATH REVIEW TEAM PROTOCOL

FOR

SONOMA COUNTY

PURPOSE:

The purpose of the Domestic Violence Death Review Team is to reduce or eliminate the incidence of domestic violence through these goals:

1. Establish the means to determine with accuracy the number of homicides and suicides related to domestic violence.
2. Review resources for appropriate services at the scene of a homicide or suicide.
3. Analyze patterns common to abusers and victims for possible identification as lethality assessment indicators.
4. Develop systematic analysis of selected cases as they are handled by various agencies, and determine if improvement in individual agency response and interagency cooperation is needed.
5 Develop recommendations for policies and protocols for community prevention and intervention initiatives that reduce and eradicate the incidence of domestic violence.

MEMBERSHIP:

In order to carry out the above-stated purpose, the Team will be composed of representatives of agencies operating within Sonoma County. Agencies are requested to maintain an individual representative for at least one year to ensure continuity. The agencies represented on an ongoing basis are:

Sonoma County Coroner
Sonoma County Sheriff's Department
Santa Rosa City Police Department
Sonoma County Department of Human Services
Sonoma County Department of Health Services
Sonoma County District Attorney
Sonoma County YWCA
Sonoma County Medical Association
Psychiatrist/Psychologist/M.F.C.C.
County Pathologist

In addition to these standing members, other agencies and individuals may be invited to attend

team meetings when, after an initial review, the team feels that they: 1) may have direct information about a case; 2) may be mentioned in a pertinent manner in case records from a standing team agency; or 3) may have particular subject expertise which may enhance the overall review.

STATUTORY AUTHORIZATION:

In 1995, Sections 11163.3, 11163.4, 11163.5 were added to the Penal Code authorizing counties to establish interagency domestic violence death review teams to assist local agencies in identifying and reviewing domestic violence deaths.

TARGET POPULATION:

The target population for case review is all adult deaths caused by or related to "Domestic Violence" as defined in Penal Code Section 13700 who die in Sonoma County. The team will consider cases for adults who are not residents of the county if they die within county limits. Team members or agencies may also request that additional cases be reviewed which have particular interest to an agency or which remain suspicious and unresolved.

MEETINGS:

Regular meetings of the team will be held routinely on set dates to be determined annually by the team. The meetings will review all new cases since the previous meeting, plus any cases held over for further review or analysis.

PROCEDURES:

The representative from the Sonoma County Coroner's Office will compile a packet for each meeting, which will include an agenda listing all new cases of domestic violence deaths for the time period under review. The packet will include the death certificate on each new case and will be sent to each team member one (1) week prior to the meeting.

Each team member is then responsible for reviewing his/her internal agency records to determine what information is available on the adult or family. That information will be brought by the team member to the next meeting for discussion. The agency files and records will be not be mailed to the team or the team members, and are not reproduced for central files.

If team members wish to bring up names of additional cases, they can bring them up at the meetings.

Team members will bring their agency records on each case where agency information is available. If a team member cannot attend the meeting, he/she may choose another team member or an agency substitute to bring records to share with the team.

A chairperson, chosen by the team, will introduce each case and lead the discussion in order to

complete all reviews in a timely fashion. The team may openly discuss all relevant case data on site during the meeting. Case Data will be documented by a designated committee member on the case log form (see attachment B). No other written minutes of the meetings will be maintained. Recommendation for action will be communicated to agency representatives at the time of the meeting or by the Chair to absent members following the meeting. Recommendations will be offered verbally unless the team requests a written format.

Following the meeting, the agenda and shared copies of death certificates are destroyed on closed cases. The data for the case logs is entered into the data system without names, and the forms are then destroyed by the Chair.

In the event that a case has yet to progress sufficiently to provide a conclusion at the meeting, it will be rescheduled and team members may hold that death certificate until the following meeting. If there is only one remaining, time-specific piece of data, the case will be rescheduled for the meeting following receipt of the data. If it is on-going, it will be placed on successive agendas until resolved. At any time, a team member may request that a case be reconsidered.

CONFIDENTIALITY:

The statute provides that all oral or written communications or documents shared within or produced by the team is confidential and not subject to disclosure and not discoverable by a third party. In addition, an oral or written communication or document provided by a third party to the team or between a third party and the team is confidential and not subject to disclosure or discoverable by a third party. The exception to this confidentiality protection applies to recommendations developed by the team which a majority of the members vote to disclose.

EVALUATION:

Data will be compiled on a one (1) year basis to provide a on-going record of the team's activities and to provide a statistical base for other agencies and records. The data base will, at a minimum, provide an overview of the domestic violence deaths in the county. It will include all the data indicated on the case log form (Attachment B) which will be used for automation.

In addition, in keeping with the goals of the team, there may be additional reports or system recommendations which emerge as a result of the data analysis. The team reserves the option to issue separate reports and policy recommendations.

If other agencies, researchers or individuals wish to have access to any data or records, they must make a written request to the team stating the need, specific data requested, purpose of the data and the data needed. The team will consider any requests on an individual basis.

es/sw

Attachment A

MEMORANDUM OF UNDERSTANDING
FOR
SONOMA COUNTY DOMESTIC VIOLENCE DEATH REVIEW TEAM

The following agencies do hereby agree to participate in and work cooperatively to implement the Sonoma County Domestic Violence Death Review Team. Implementation will include providing an ongoing representative to participate as a member of the team and providing the necessary case data to support its operations, as described in the attached protocol.

The agencies agree to operate in good faith to fulfill their duties and carry out the responsibilities as delineated.

The agreement commenced January 1, 1997, and may be reviewed and revised at the request of any party hereto upon thirty (30) day written notice. Notice of revision or termination of the Memorandum of Agreement will be sent to all parties of this Agreement.

JAMES PICCININI, Sheriff
Sonoma County Sheriff's Office

J. MICHAEL MULLINS, District Attorney
Sonoma County District Attorney's Office

MICHAEL DUNBAUGH, Chief
Santa Rosa Police Department

MARK KOSTIELNEY
Director of Dept. of Health Services

DIANE EDWARDS
Director of Human Services

ROBERT SCHULTZ, M.D.
Physician -in-Chief
Kaiser Medical Center

CHERYL RUTHERFORD-KELLY
Program Director

APPROVED AS TO FORM:

Deputy County Counsel

Chief's Association

ing against a parolee. *(Added by Stats.1993, c. 992 (A.B.1652), § 11.)*

§ 11163.3. Domestic violence; interagency death review teams; autopsy protocol; reporting procedures; confidentiality; disclosure

(a) A county may establish an interagency domestic violence death review team to assist local agencies in identifying and reviewing domestic violence deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases. Interagency domestic violence death review teams have been used successfully to ensure that incidents of domestic violence and abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for community prevention and intervention initiatives to reduce and eradicate the incidence of domestic violence.

(b) For purposes of this section, "abuse" has the meaning set forth in Section 6203 of the Family Code and "domestic violence" has the meaning set forth in Section 621 of the Family Code.

(c) A county may develop a protocol that may be used as a guideline to assist coroners and other persons who perform autopsies on domestic violence victims in the identification of domestic violence, in the determination of whether domestic violence contributed to death or whether domestic violence had occurred prior to death, but was not the actual cause of death, and in the proper written reporting procedures for domestic violence, including the designation of the cause and mode of death.

(d) County domestic violence death review teams shall be comprised of, but not limited to, the following:

(1) Experts in the field of forensic pathology.

(2) Medical personnel with expertise in domestic violence abuse.

(3) Coroners and medical examiners.

(4) Criminologists.

(5) District attorneys and city attorneys.

(6) Domestic violence shelter service staff and battered women's advocates.

(7) Law enforcement personnel.

(8) Representatives of local agencies that are involved with domestic violence abuse reporting.

(9) County health department staff who deal with domestic violence victims' health issues.

(10) Representatives of local child abuse agencies.

(11) Local professional associations of persons described in paragraphs (1) to (10), inclusive.

(e) An oral or written communication or a document shared within or produced by a domestic violence death review team related to a domestic violence death review is confidential and not subject to disclosure or discoverable by a third party. An oral or written communication or a document provided by a third party to a domestic violence death review team, or between a third party and a domestic violence death review team, is confidential and not subject to disclosure or discoverable by a third party. Notwithstanding the foregoing, recommendations of a domestic violence death review team upon the completion of a review may be disclosed at the discretion of a majority of the members of the domestic violence death review team. *(Added by Stats.1995, c. 710 (S.B.1230), § 1.)*

§ 11163.4. Domestic violence; death review teams; design protocol

Subject to available funding, the Attorney General, working with the state domestic violence coalition, shall develop a protocol for the development and implementation of interagency domestic violence death review teams for use by counties, which shall include relevant procedures for both urban and rural counties. The protocol shall be designed to facilitate communication among persons who perform autopsies and the various persons and agencies involved in domestic violence cases so that incidents of domestic violence and deaths related to domestic violence are recognized and surviving nonoffending family and household members and domestic partners receive the appropriate services. *(Added by Stats. 1995, c. 710 (S.B.1230), § 2.)*

§ 11163.5. Domestic violence; death review teams; Department of Justice responsibilities; cooperating departments; authorized activities; directory

(a) The purpose of this section is to coordinate and integrate state and local efforts to address fatal domestic violence, and to create a body of information to prevent domestic violence deaths.

(b)(1) The Department of Justice is hereby authorized to carry out the purpose of this section with the cooperation of the State Department of Social Services, the State Department of Health Services, the California State Coroner's Association, the County Welfare Directors Association, and the state domestic violence coalition.

(2) The Department of Justice, after consulting with the agencies and organizations specified in paragraph (1), may consult with other representatives of other agencies and private organizations to accomplish the purpose of this section.

(c) To accomplish the purpose of this section, the Department of Justice and agencies and organizations involved may engage in the following activities:

(1) Collect, analyze, and interpret state and local data on domestic violence death in an annual report to be available upon request. The report may contain, but need not be limited to, information provided by state agencies and the county domestic violence death review teams for the preceding year.

(2) Develop a state and local data base on domestic violence deaths.

(A) The state data may include the Department of Justice statistics, the State Department of Health Services Vital Statistics, and information obtained by other relevant state agencies.

(B) The Department of Justice, in consultation with the agencies and organizations specified in paragraph (1) of subdivision (b), may develop a model minimal local data set and request data from local teams for inclusion in the annual report.

(3) Distribute a copy of the report to public officials in the state who deal with domestic violence issues and to those agencies responsible for domestic violence death review investigation in each county.

(d) The Department of Justice may direct the creation of a statewide domestic violence death review team directory, which shall contain the names of the members of the agencies and private organizations participating under this section, the members of local domestic violence death review teams, and the local liaisons to those teams. The department may maintain and update the directory annually.

County of Sonoma

DOMESTIC VIOLENCE DEATH REVIEW
CASE LOG

Case ID #_____ Presenting Agency_____Review Date ___/___/___

Case Status: ☐ Open ☐ Closed ☐ Investigation Time: ___months

(PLEASE CIRCLE ANSWERS BELOW)

INFO. NEEDED	DECEASED	SUSPECT
1. *Sex*	Female Male	Female Male
2. *Date of Birth*	___/___/___ Age ___Years	___/___/___ Age ___Years
3. *Ethnicity*	*(see key below)* 1 2 3 4 5 6 7 Other:_____	*(see key below)* 1 2 3 4 5 6 7 Other:_____
4. *Address at Death*	_____ _____ _____	_____ _____ _____
5. *Marital Status*	Sgl M D Sep W ___Years in relationship	Sgl M D Sep W ___Years in relationship
6. *Living Arrangement*	_____ _____ _____	_____ _____ _____
7. *Previous contact with agencies*	Shelter CPS LE Court Health Other_____	Shelter CPS LE Court Health Other_____
8. *Age(s) of children in home*	0-5 yrs. 6-10 yrs. >10 yrs.	0-5 yrs. 6-10 yrs. >10 yrs.
9. *Education level*	6 yrs. 8 yrs. 12 yrs. >13 yrs.	6 yrs. 8 yrs. 12 yrs. >13 yrs.
10. *Country of birth/Yrs. in USA*	USA Other:_____/___Yrs. In USA	USA Other:_____/___Yrs. in USA
11. *Language spoken*	English Spanish Other:_____	English Spanish Other:_____
12. *Criminal record*	DV Felony Misdemeanor	DV Felony Misdemeanor
13. *Possession of firearms*	Yes No	Yes No
14. *Employed?* *Income:*	Yes No <$10,000 $10,-20, $20,-30, $30,-40, >$40,000	Yes No <$10,000 $10,-20, $20,-30, $30,-40, >$40,000
15. *Previous DV interventions*	_____ _____	_____ _____
16. *Drug/ETOH history*	_____ _____	_____ _____
17. *Previous health intervention*	_____ _____	_____ _____
18. *Other*	_____ _____	_____ _____
File Info.	Place of death:_____ Date of death: ___/___/___Autopsy date: ___/___/___ Cause of death_____ *(see key below)*	Current address:_____ _____ Access to children: Yes No

COMMENTS/PREVENTION STRATEGY: _____

_____

_____

Ethnicity: White = 1; Hispanic = 2; Black = 3; Asian = 4; Native American = 5; Philipino = 6; Pac Islander = 7

Cause of Death: Accident = 1; Suicide = 2; Homicide = 3; Natural Causes = 4; Pending = 5; Not Determined = 6

CONFIDENTIALITY AGREEMENT

DOMESTIC VIOLENCE
DEATH REVIEW COMMITTEE

I, as a member of the Domestic Violence Death Review Committee **agree to keep confidential all** information discussed at the death review meetings. I also **agree to return all** outside case information received in the meeting involving decedents to the Chairperson of the Death Review Committee upon my resignation from the committee.

_____ _____

DATED Printed Name

_____

Signature

SONOMA COUNTY DEATH REVIEW TEAM
CASE SUMMARIES

Case #1: Homicide/Suicide:
Previous contact with law enforcement for domestic violence. Husband shot wife and self in family home. Two teen children present. Deceased husband 40 years old, deceased wife, 39 years old. Both from El Salvador, Spanish speaking. (1996)

Case #2: Homicide:
Two past contacts with law enforcement after drinking and arguing, one for civil standby. Two previous visits to emergency room, one on date of previous altercation. Gay men living and working together for 10 years. Decedent stabbed at home. Both born in U.S. and age 36. Trial pending. (1997)

Case #3: Double Homicide/Suicide:
Numerous contacts with law enforcement for domestic violence, including a restraining order. Record of child molestation by family member not living in home. Daughter living at shelter prior to deaths. Guns present in home. Husband in counseling unrelated to family violence. The 40-year-old husband/father shot 39-year-old wife at family home, 14-year-old daughter at neighbor's home, and himself at family home. All Caucasian and English speaking. (1997)

Case #4: Homicide:
Previous contact with law enforcement and courts for domestic violence in several counties, including Sonoma. Guns in home. A 54-year-old male shot 25-year-old girlfriend in his home outside Sonoma County. Couple had infant son who probably witnessed the crime. Child abandoned by father when fleeing the crime. All Caucasian. Extradition pending. (1997)

Two cases were submitted but not reviewed. In the first, a police officer, responding to a domestic violence incident in 1969, was shot by the husband. The officer died as a result of complications in 1997. In the second case, a police officer responding to a domestic violence related complaint, shot and killed the husband.

SONOMA COUNTY DEATH REVIEW TEAM RECOMMENDATIONS FOR 1997

We the members of the Sonoma County Domestic Violence Death Review Team recommend as follows:

- All law enforcement, prosecution, court personnel and mandated domestic violence reporters should be trained on domestic violence, including the cycle of violence, risk assessment, and cultural factors (including same sex) represented in Sonoma County.

- These agencies should also develop cultural resources and a list of individuals knowledgeable about various cultural groups for training and technical assistance as needed on issues of family violence, including personnel within their own departments, and from other public and private agencies, schools, churches, or the community at large.

- If a household has multiple reported instances of domestic violence, police departments will monitor these situations for possible further intervention.

- The presence of guns in the home, and their eventual use, was noted in two of four cases. The District Attorney and law enforcement agencies should take full advantage of existing laws, including the use of search warrants, to remove guns from any person alleged to have perpetrated domestic violence. Petitions to destroy these weapons according to PC 12028..5 shall be filed.

- Training on the dynamics of domestic violence should be provided for the mental health and counseling community, including the importance of reporting clients who make threats against each other, according to the Tarasoff ruling.

- The courts and mediators should consider recommending counseling to both parties when domestic violence restraining orders are filed in Family Law Court, whether criminal charges are pending or not.

- In three of the four cases reviewed, children were present when the domestic violence death occurred. Advocacy and therapy need to be available to minors who witness parental domestic violence.

- Advocacy and therapy services should be available to teens in violent dating relationships.

SONOMA COUNTY DEATH REVIEW TEAM
1998 WORK PLAN

The purpose of the Sonoma County Domestic Violence Death Review Team is to evaluate policies and practices used by agencies and individuals in working with the victim and perpetrator in violent relationships. The Team will examine murders, suicides and accidental deaths caused as a result of domestic violence and determine if other services or better services may have prevented the ultimate death of the individual. The Team will also provide a final report at the end of the year, and will make appropriate recommendations aimed at the cessation of murder in domestic violence cases.

The above will be accomplished by:

- Holding bimonthly meetings to review cases of domestic violence, homicide and suicide, and to identify areas of need in the system.

- Making recommendations to the Sonoma County Domestic Violence Action Committee regarding needs in the system, as well as specific institutions or agencies as identified in case reviews.

- Providing case data on an annual basis to the Domestic Violence Coordinating Committee and the Health Services Department.

- Participating in training events for law enforcement probation, courts, health and mental health, and community service providers.

- Reviewing lethality assessment instruments and sponsoring presentations by experts in batterers' diagnoses and treatment.

- Identifying multicultural resources in the community and providing a list of these resource people to law enforcement.

- Identifying issues related to professional standards for intervention and treatment of families suffering family violence.