SONOMA COUNTY

DEATH REVIEW

TEAM

1998 FINAL REPORT

TEAM MEMBERSHIP

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

LINDA ABRAHAMS
YWCA

BARBARA BRANAGAN, RN, NP
DEPARTMENT OF HEALTH SERVICES

DR. DEANE DEFONTES
PETALUMA HEALTH CENTER

DR. THOMAS GILL
FORENSIC MEDICAL GROUP

DET. SGT. ROY GOURLEY
SONOMA COUNTY SHERIFF'S DEPARTMENT
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SARAH JENNINGS, LCSW
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TONI NOVAK
SONOMA COUNTY LEGAL SERVICES FOUNDATION

DET. SGT. ERNESTO OLIVARES
SANTA ROSA POLICE DEPARTMENT

BRAD STEVENS
REDWOOD CHILDREN'S CENTER

DET. SGT. RICHARD SWEETING
SONOMA COUNTY SHERIFF'S DEPARTMENT

Domestic Violence Death Review Team
1998 Final Report
Gregory J. Jacobs, Chair

The Sonoma County Domestic Violence Death Review Team, established December 12, 1996, continued to meet every two months throughout 1998. The Team followed its 1998 work plan which included examining domestic violence-related deaths, as well as sponsoring a training event. The Team evaluated three cases as listed in the caseload description. The cases were examined according to the purposes of the Team as stated in the Team Protocol. (The Team reviewed four cases in 1997.)

It should be noted that 1998 was the first full year of operation for the Sonoma County Domestic Violence Court, established by the Sonoma County Board of Supervisors in November of 1997. As stated in the 1997 Domestic Violence Death Review Team Report, "it remained to be seen whether or not the establishment of the court would have an impact on domestic violence in the County."

Prior to the establishment of the Domestic Violence Court in November of 1997, law enforcement agencies were submitting an average of 325 cases per month to the District Attorney's Office for review for filing of criminal charges. That average dropped by 20% immediately after the Domestic Violence Court was implemented. According to statistics kept by the Sonoma County District Attorney, 1998 saw a decline in the number of cases presented to the District Attorney's Office for charging. As of the last four months, the number of cases submitted to the District Attorney's Office has averaged approximately 200 cases per month. This is a substantial decline. As previously stated, the number of domestic violence deaths in Sonoma County declined from four cases in 1997 to three cases in 1998. Although it is not a statistically significant decline, it is noteworthy in conjunction with the above drop in number of cases submitted to the District Attorney's Office.

The Sonoma County Sheriff's Department reports that its statistics show that it is also investigating fewer cases involving actual injury. The Sheriff's Department compared their 1997 statistics to 1998 and noted a 19% reduction in felony and misdemeanor domestic violence cases. The Sheriff's Department is very aware that although reported domestic violence is decreasing, which is a positive indicator, they are unable to statistically calculate the unreported cases of domestic violence.

The Domestic Violence Court Program requires rigorous investigative procedures by law enforcement, early filing of charges, and submission of police reports with Polaroid photos of any injuries, to the Domestic Violence Court Judge. The District Attorney's Office also provides domestic violence counselors, one of whom is bilingual, to make contact with victims in person,

by phone, or by mail at or before the actual filing of charges. Because of the immediate and thorough approach by law enforcement to domestic violence, the increased advocacy and counseling, the developed partnerships with the YWCA and other non-profits, the coordination of county departments, and the increased prevention and education programs, it is possible that these have lead to a reduction in the number of domestic violence incidents involving injury and death.

The Domestic Violence Death Review Team sponsored a conference on October 1, 1998, at a Santa Rosa Memorial Hospital facility. The Conference featured Dr. Daniel Sonkin, a leading practitioner and author regarding Domestic Violence. Dr. Sonkin gave a presentation regarding domestic violence and how to assess for lethality in relationships. There was full attendance at the lecture, which included representatives of County Department of Human Services, County Probation Department, YWCA, various law enforcement agencies, Sonoma County Public Health, local children's counseling programs, Sonoma County Mental Health Department, Sonoma County Orenda Center and others involved in the field of domestic violence in Sonoma County. The conference was deemed to be a success, and plans are in the making for a follow-up conference in 1999.

The Sonoma County Board of Supervisors reviewed the Death Review Team 1997 Final Report at a Supervisors Board meeting on October 27, 1998. The Team and its report was reviewed favorably by the Board of Supervisors. As stated at that time, the Team will continue to discuss any domestic violence related deaths in Sonoma County, not only to review the way County agencies dealt with the death, but to determine if improvements can be made in community efforts to prevent and intervene in domestic violence situations. The Team will also continue to sponsor educational programs for all county agencies which deal with domestic violence.

1998 Case Summaries

Case 1: Homicide/Attempted Suicide. A 30-year-old Caucasian female beaten, stabbed and possibly tortured by 24-year-old Caucasian live-in boy friend. He had previous felony conviction for bank robbery. Both had a high school education. Descendent was employed, accused was not; neither had children. Her blood alcohol level was 0.07 at the time of death. After the murder, he drove a pick-up off a cliff. When found, his blood alcohol level was 0.01. He is currently in jail charged with homicide. Investigated by Santa Rosa Police Department.

Case 2: Manslaughter. Following a custody altercation, a 26-year-old female was found dead at the bottom of the steps at the home of her ex-husband, age 25. The cause of death was a broken neck and spinal separation. Decedent and accused were separated for 4 years and divorced for 1 year. Previous contact with law enforcement included an argument between accused current girl friend and ex-wife at the police station. Decedent had also contacted police for custody violations. Child Protective Services had been contacted concerning their 6-year-old daughter. Accused had 3 misdemeanors for vandalism and bombing. Decedent and accused both Caucasian, employed, and high school graduates. She had attended college. Accused is on bail awaiting trial. Investigated by Sebastopol Police Department.

Case 3: Double homicide/Suicide. Eighteen-year-old wife bludgeoned to death and 3-week-old son asphyxiated by 19-year-old husband on 12/20. Husband dove under a semi-truck in Alameda County on 12/21 and died. Homicides occurred in family apartment. Both mother and father had a history of alcohol use and some drug experimentation. He had a history of use and sale of methamphetamines and had been arrested previously for minor theft and throwing a brick. Coroner's report revealed he had a positive toxicology screen. Decedent was Caucasian, suspect was African American. Both spoke English. They had been having financial problems. Investigated by Petaluma Police Department.

	1997	1998
Age:		
Average age of victim	31 years	25 years
Average age of perpetrator	43 years	23 years
Age of children killed	14 years	3 weeks
Gender:		
Victim	4 females and 1 male	3 females and 1 male
Perpetrator	4 males	3 males
Sexual orientation:		
Victim	4 straight, 1 gay	3 straight (+ 1 infant)
Perpetrator	3 straight, 1 gay	3 straight
Race:		
Victim	4 Caucasian and 1 Hispanic	3 Caucasian, 1 biracial
Perpetrator	3 Caucasian and 1 Hispanic	2 Caucasian, 1 African American
Location of deaths:	5 in family home 1 in neighbor's home 1 in boyfriend's home (in another county)	3 in family home 1 in ex-husband's home 1 on freeway
Weapons:	4 guns, 1 kitchen knife	Hands, kitchen knife, vase

RECOMMENDATIONS

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

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

For training and technical assistance on issues of family violence, the Domestic Violence Action Committee should oversee a review of available cultural resources, including a list of individuals considered knowledgeable regarding various cultural groups living in Sonoma County. These could include personnel within member departments, and from other public and private agencies, schools, churches, or the community at large.

In two of the three cases we reviewed, the victims were very young women and their partners were apparently heavy drug users. It is recommended that more information be provided to young people regarding lethality factors (through efforts like the DOVE Project and the YWCA). The link between drug abuse and lethality will be explored in these informational efforts.

Police checklists for investigation of domestic violence homicides include a review of health provider contacts by the victim, including prenatal care, routine health care screenings, and treatment for health problems, to determine if the victim ever disclosed domestic violence or fear of domestic violence.

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

A list of domestic violence counseling resources be developed for use by courts and mediators when recommending counseling to parties when domestic violence is an issue in Family Law Court proceedings, whether criminal charges are pending or not.

Prevention education about violent relationships and advocacy be available to teens in violent families or dating relationships.

1999 WORK PLAN OF DEATH REVIEW TEAM

- The Death Review Team will provide a final report at the end of each calendar year and make appropriate recommendations aimed at the prevention of domestic violence-related deaths.
- Hold bimonthly meetings to review cases of domestic violence homicide and suicide and to identify areas of need in the system.
- Make recommendations to the Sonoma County Violence Action Committee regarding needs in the system, as well as specific institutions or agencies as identified in case reviews.
- Provide case data on an annual basis to the Domestic Violence Action Committee and the Department of Health Services.
- Participate in training events for law enforcement, probation, courts, health and mental health, and community service providers.
- Review lethality assessment instruments and sponsor presentations by experts in domestic violence.
- Work with the Domestic Violence Action Committee to identify multicultural resources in the community and provide information about resources to law enforcement.
- Identify issues that may help in the prevention of domestic violence in the community.

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

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.

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.