SONOMA COUNTY

DEATH REVIEW

TEAM

1999 FINAL REPORT

TEAM MEMBERSHIP

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SONOMA COUNTY SHERIFF'S DEPARTMENT

Domestic Violence Death Review Team
1999 Final Report
Gregory J. Jacobs, Chairman

The Sonoma County Domestic Violence Death Review Team, established December 12, 1996, continued to meet every two months throughout 1999. The Team followed its 1999 work plan, which included examining domestic violence-related death. The Team evaluated two 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 and three cases in 1998.)

As stated in the 1998 Final Report, the first full year of operation for the Sonoma County Domestic Violence Court was 1998. This Court had been established by the Sonoma County Board of Supervisors in November of 1997. I note that in my 1998 Final Report that it was too soon to tell whether or not efforts by law enforcement and the courts of Sonoma County would have any significant impact on the incidence of domestic violence in Sonoma County.

For the past two years, however, the number of domestic violence cases submitted to the District Attorney's Office declined. 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. In 1999, the District Attorney's Office reviewed approximately 200 cases per month, which was the same as 1998. As previously stated, the number of domestic violence cases reviewed by the Domestic Violence Death Review Team declined from four cases in 1997, to three cases in 1998, to two cases in 1999. (See attached Exhibit "A.") Although it is not a statistically significant decline, it is noteworthy in conjunction with the drop in the number of cases submitted to the District Attorney's Office.

In addition the Sonoma County Sheriff's Office reported in 1999 that from 1997 to 1998, there was a 19% reduction in the number of domestic violence crime reports. Reports of domestic violence, domestic violence-related calls to law enforcement, and emergency protective orders all decreased in 1999. However, the number of calls to the YWCA has remained steady, around 2,500 from 1996 through 1999. This may reflect: 1) people are afraid to call law enforcement for fear of being arrested as the co-aggressor, a result of the recent mandatory arrest policy; 2) the victim, who is often financially dependent on the perpetrator, may fear income loss if the perpetrator is arrested; 3) people are more aware of domestic violence and the services available and call for help more often; and, 4) the interventions of Domestic Violence Court and other efforts have actually reduced the incidence of physical injury. Given the complicated social circumstances of domestic violence, the actual incidence remains unknown.

Two local Domestic Violence training opportunities were offered during the year On June 3rd and 4th, 1999, the Sonoma County Sheriff's Department, the District Attorney's Office,

and the Probation Department hosted a Domestic Violence Conference at the Hilton Hotel in Santa Rosa. One of the experts invited to address this conference stated that if there is a decline in domestic violence reports there may be a corresponding decline in child abuse reported. The possible reason for this is: if women who are usually the caretakers of young children are victimized less frequently or not at all in domestic violence situations, they will be more able to care for and protect their children from neglect and/or physical abuse. In that regard, the Sonoma County District Attorney's Office noted a decline in child physical abuse cases reported to it by law enforcement agencies during the months of January to October, 1999. (See attached Exhibit "B.") Another local training opportunity was hosted by the Sonoma County YWCA which presented training materials regarding human violence and animal cruelty. The theme of that presentation stressed the importance of local government officials (i.e., animal control officers, police officers, etc.) to note any evidence of family violence seen in the course of their regular duties. Please see graph attached.

As stated previously, the Domestic Violence Court Program continues in Sonoma County. In addition law enforcement continues to follow protocol established by the County Law Enforcement Chiefs Association as well as individual department protocols, which call for intensive investigation of domestic violence. Grants continue to fund Domestic Violence Advocates for the YWCA, the Sheriff, the Santa Rosa Police Department, and the Sonoma County District Attorney's Office.

As required by the State Office of Criminal Justice Planning, a Child Abuse Investigative Protocol for Sonoma County is being created. The request for such a protocol was directed to four core "county agencies": Child Protective Services, the Sonoma County Law Enforcement Chief's Association, and the Public Health Department. A committee, formed from these four agencies to create the Protocol, is calling for closer collaboration among themselves. One portion of the Child Abuse Investigation Protocol will include a section, which directs law enforcement and other county agencies to be aware of the possibility that in investigating a domestic violence case that there may well be possible child abuse occurring. It is well established that children often suffer injury in the course of domestic violence incidents, either direct physical injury or indirect psychological trauma from witnessing the violence between their adult caretakers. This subject matter is one which will be pursued in subsequent meetings of the Child Abuse Protocol Committee as well as the County Domestic Violence Action Committee. An effort will be made to ask that, when investigating domestic violence cases, law enforcement officials advise the children's adult caretakers that domestic violence may have a destructive impact on the children within the household where the domestic violence occurs.

In October of 1999, members of the Death Review Team presented information of domestic violence to the Board of Supervisors. In addition to declaring October as "Domestic Violence Awareness Month," the Board acknowledged the progress that diverse agencies have made in responding to domestic violence and the health consequences of domestic violence, especially the effects on children.

RECOMMENDATIONS

The members of the Sonoma County Domestic Violence Death Review Team recommend the following:

1. That 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.

2. That law enforcement officers responding to domestic violence ask the parties about children in the home. Children in homes where domestic violence occurs should have advocacy and counseling available to them.

3. That Batterer's Programs address the effects of domestic violence on children.

4. That the Domestic Violence Action Committee should oversee a review of available mental health resources, including resources for low income patients and invite participation by the mental health community in the Domestic Violence Action Committee.

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

6. That police checklists for investigation of domestic violence homicides should be provided by the District Attorney's Office in cooperation with the Sonoma County Law Enforcement Chief's Association. The checklist should include a review of health provider contacts by the victim, including pre-natal care, routine health care screenings, and treatment for health problems, to determine if the victim ever disclosed domestic violence or fear of domestic violence.

7. That coordination and communication with the Elder Abuse Council regarding issues of domestic violence involving the elderly be inproved.

8. That a list of domestic violence counseling resources be developed for use by the 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.

SONOMA COUNTY DEATH REVIEW TEAM
2000 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:

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

2) 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.

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

4) Promote awareness of the effects of domestic violence on children.

5) Encourage law enforcement agencies to educate parents and provide written information on domestic violence and child abuse.

6) Promote domestic violence education in schools and the workplace.

Sonoma County District Attorney's Office

Child Abuse Cases Reviewed

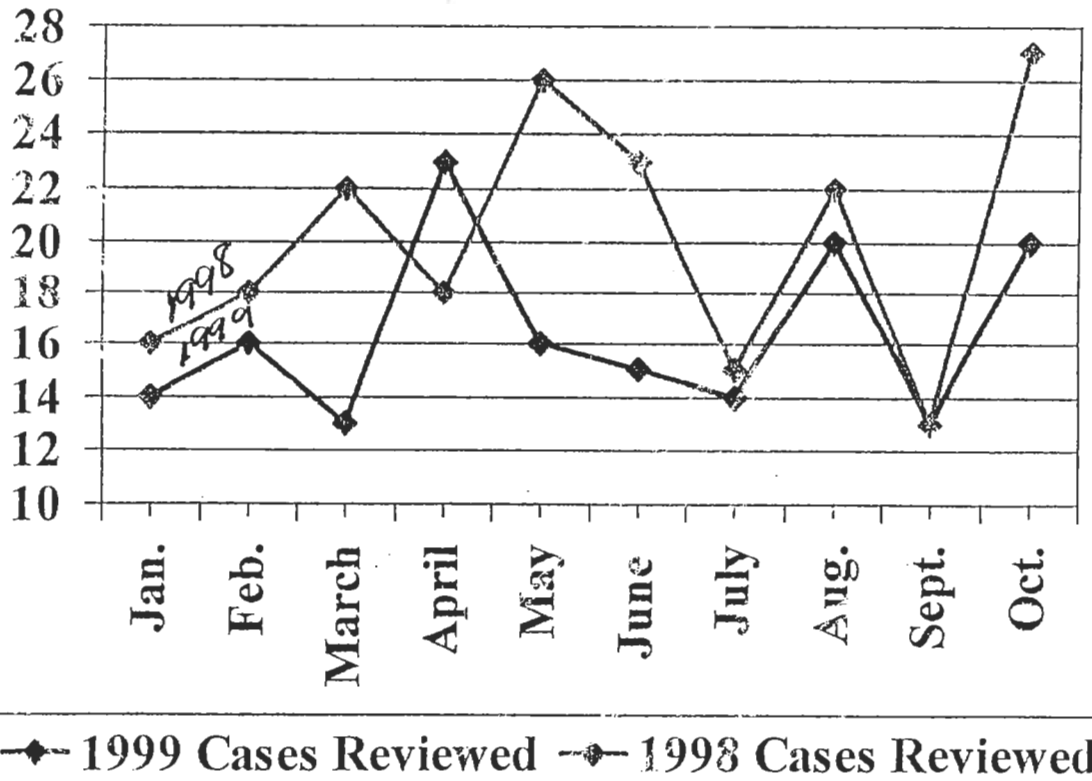

Exhibit "A"

1999 Case Summaries

3/99: A woman from Mendocino county was transported to Sonoma County for organ transplant. She died in Sonoma County as a result of the domestic violence in Mendocino. No investigation was done.

Case 1: **Homicide.** A 70-year-old Japanese female was beaten with a claw hammer and suffocated in the couple's mobile home. The couple had met through a dating service and lived together for two months. The suspect, an 86-year-old male, had filed a police report three days before her death, accusing her of forgery and theft. He was quoted as saying, "She has a gambling problem, and I'll break her of it if I have to take a baseball bat to her head." He had previous misdemeanor contact with the police. His education level was unknown; he was a retired Merchant Marine with an engineering education. They had no children together. Neither had alcohol in their blood. He is in County jail. Investigated by the Rohnert Park Police Department.

Case 2: **Homicide/Suicide.** A 45-year-old wife was shot to death by her 43-year-old husband on 5/6/99. Husband then shot himself. Suicide notes and letters were found. Wife had long history of illnesses -- real and imagined -- and convinced the husband she was terminally ill with liver disease. He believed she was dying and could not afford the medical treatment and medications. Her autopsy showed no signs of liver disease. She had numerous prescribed medications and had seen several doctors and alternative healers. She had been diagnosed as obsessive and a hypochondriac. They had been married 20 years and had no children. They were Hispanic and spoke English. There was no known previous domestic violence incidence or alcohol use. Investigated by Santa Rosa Police Department.

	1997	1998	1999
Age:			
Average age of victim	31 years	25 years	57 years
Average age of perpetrator	43 years	23 years	65 years
Age of children killed	14 years	3 weeks	None
Gender (F=females; M=males):			
Victim	4 F, 1 M	3 F, 1 M	2 F
Perpetrator	4 M	3 M	2 M
Sexual Orientation (S=straight; G=Gay):			
Victim	4 S, 1 G	3 S (+ 1 infant)	2 S
Perpetrator	3 S, 1 G	3 S	2 S
Race (AA=African American, B=biracial, C= Caucasian, H=Hispanic, J=Japanese):			
Victim	4C, 1H	1B, 3C	1 H, 1 J
Perpetrator	3C, 1H	1AA, 2C	1 C, 1 H
Location of deaths:	5, family home 1, neighbor's home 1, boyfriend's home (in another county)	3, family home 1, ex-husband's home 1, on freeway	3, family home
Weapons:	4 guns, 1 kitchen knife	hands, kitchen knife, vase	1 hammer, 1 gun

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

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

STATUTORY AUTHORIZATION:

n 1995, Sections 11163.3, 11163.4, 11163.5 were added to the Penal Code authorizing counties o establish interagency domestic violence death review teams to assist local agencies in dentifying 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 eam. The meetings will review all new cases since the previous meeting, plus any cases held ver for further review or analysis.

PROCEDURES:

The representative from the Sonoma County Coroner's Office will compile a packet for each neeting, which will include an agenda listing all new cases of domestic violence deaths for the ime period under review. The packet will include the death certificate on each new case and vill 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 vhat information is available on the adult or family. That information will be brought by the eam member to the next meeting for discussion. The agency files and records will be not be nailed to the team or the team members, and are not reproduced for central files.

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

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.

jes/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.