Multnomah County Domestic Violence Fatality Review Team

Fall 2015 Findings & Recommendations

This report is a product of the Multnomah County Domestic Violence Fatality Review Team, a collaboration of private, public and nonprofit organizations.

Written by the Multnomah County Domestic Violence Coordination Office
Portland, OR

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Please contact Allison Wilson with the DV Coordination Office at: Allison.wilson@multco.us or 503-988-6634 with any questions.

Since 2005 the Multnomah County Domestic Violence Fatality Review Team has been conducting multi-disciplinary, systemic examinations of intimate partner homicides in our County, with the goal of preventing future deaths by identifying risk factors associated with homicides; improving community responses to domestic violence; increasing public awareness and identifying strategies to prevent domestic violence; and fostering communication across public and private agencies that intervene in domestic violence. The team comes together for this purpose with a deep sense of respect for those who have lost their lives to domestic violence, and their community of loved ones who are left behind after their death. It is our shared perspective that these tragic incidents are not only heartbreaking losses to be mourned, but are also important moments for us to reflect on the opportunities they provide to us, to learn and change how we work in Multnomah County to prevent and respond to intimate partner violence.

The case selected for the Fall 2015 review was the first time that our team has reviewed a case involving a victim and perpetrator from the elder/vulnerable adult community. This case was selected in part to support a new effort towards establishing an Elder/Vulnerable Adult Fatality Review team being established.

This case was unique in that the victim & perpetrator both grew up and spent most of their early adulthood living on the East Coast. Much of the family history was preserved through their daughter's ability to recount oral history passed on to her through her mother and father. The victim in this case was raised by an adoptive family in Brooklyn, NY, having little contact with her siblings until her later teens and young adulthood. She was a highly educated woman, refuting the gender roles of the time and completing both her bachelor & master's degrees in American Literature and joining the Army for service during WWII. The perpetrator in this case was also a military veteran, serving throughout WWII as a Belly Gunner for the Air Force. After meeting post-WWII in Washington DC the couple married and remained living on the East Coast with their only child until 1979 when the family moved to Oregon.

Per family history there was ongoing verbal and emotional abuse throughout the relationship, including regular threats from the perpetrator to kill the victim, who was highly isolated inside the home to the point that she did not possess a photo ID for the duration of her life. At various times in their relationship the perpetrator would move out of the family home, giving opportunity for their daughter to gain independence and break out of the traditional gender roles that were absolute in the relationship of the victim/perpetrator. As both victim and perpetrator aged the perpetrator became the primary caregiver for the victim who was suffering from a variety of health needs. Despite many offers there were only a few in-home care services provided, mostly due to the perpetrator's declination of these services and staunch belief that only he could care properly for the victim and her advancing health needs. There is little documentation from health care providers regarding inappropriate statements made by the perpetrator on the few occasions that the victim was seen for care outside of the home, leading to an increasing amount of isolation in her later years. Neither victim nor perpetrator participated in social activities outside of the home which limited access to resources for the victim.

The victim was shot and killed in her bedroom in the home she had shared with perpetrator since 1979. The perpetrator committed suicide in the same room shortly after. This case was largely referred to as a "mercy killing" or "suicide pact" which was highly refuted by family and the information that was provided to our team during this review.

Elder/Vulnerable Adult Fatality Review Committee

In Multnomah County alone in 2014 there were approximately 619,000 adults over the age of 65 and people with disabilities who may be vulnerable to abuse. This same year Adult Protective Services (APS) screened 32,966 reports of possible abuse, neglect or self neglect. Of the 13,993 referrals that were screened in for investigation, 9,198 allegations were investigated for older adults and people with physical disabilities living in the community, and 2,538 adults were determined to have been abused. There were 2,483 assessments for possible self neglect, of which 540 adults were determined to be self-neglecting. Out of the 4,364 allegations for older adults and people with physical disabilities living in a licensed facility setting, 1,000 adults were deterimined to have been abused. Since 2010 over 50,000 Oregonians turned 65 each year, and will continue to for the next 10 years. Over the next 5 years (through 2020) this will add nearly 300,000 older adults to Oregon's population over the age of 65.

In a comprehensive review of literature published from 2000–2010, lifetime prevalence of any type of intimate partner violence (IPV) against adult women with disabilities was found to be 26–90%. Lifetime prevalence of IPV against adult men with disabilities was found to be 28.7–86.7%. It was concluded that, over the course of their lives, IPV occurs at disproportionate and elevated rates among men and women with disabilities.[1]

Elder Death Review Teams (EDRT) focus on deaths of elders where suspicions about the role or abuse or neglect in the elders' deaths exist. Teams may be convened by the Medical Examiner, Coroner, District Attorney, or another public entity. Some teams meet to determine the feasibility of prosecution, others focus only on systemic issues raised by the cases. Team membership typically consists of public agencies involved in the investigation of elder abuse cases, and may also include geriatricians, psychologists, and forensic experts.[2]

Currently in Oregon, and specifically in Multnomah County, there is not jurisdiction provided allowing for an EDRT to be formed with privacy protections in place similar to that of the Domestic Violence Fatality Review Team or a Child Abuse Fatality Review Team. With the increasing number of Multnomah County residents aging into our senior population every year there is increased need for oversight and detailed review of the systems in place to prevent and protect one of our most vulnerable populations.

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[1] http://www.ncea.aoa.gov/Library/Data/index.aspx#population
[2] National Center on Elder Abuse; www.ncea.aoa.gov

Recommendations

1.1 Multnomah County should establish a workgroup of interested parties to research established EDRTs in other states/counties and to begin laying out the formal steps needed towards formation of an EDRT in Multnomah County, including the design of a bill to be presented during the February 2016 Legislative session.

Multnomah County Domestic Violence Fatality Review team members who have been identified to assist in moving this recommendation forward are Allison Wilson and Annie Neal. Additionally, ad hoc members who participated in this review and are identified to assist in moving this recommendation forward are Judge Katherine Tennyson, Ellen Klem, Wendy Hillman and Judge Amy Holmes-Hehn.

Caregiver Supports/Systems

In the Merriam-Webster dictionary a caregiver is defined as a person who gives help and protection to someone (such as a child, an old person, or someone who is sick) and/or a person who provides direct care (as for children, elderly people, or the chronically ill)[3]. In Oregon we define a caregiver as anyone who provides assistance to another person so that person can maintain an independent lifestyle. This can include family members & other informal caregivers as well as medical and social service professionals.

In order to be a successful caregiver there are many factors that need to be considered for both the care provider, as well as for the person being provided the care. It is a difficult and not only physically, but emotionally, draining situation to find ones self in and during this review it was identified that stronger caregiver support systems could have been helpful in alleviating some of the emotional stress and caregiving duties in this circumstance.

Multiple times the perpetrator was offered various options for more intensive in-home assistance, the possibility of looking into assisted living for the victim, or having family take on more of the caregiving duties on certain days and each time these offers were declined. Whether from a sense of “duty and obligation”, concern around financial ability to afford services, or a need for power and control over the victim and what was happening in her life, it was clear that addtitional supports were needed.

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[3] http://beta.merriam-webster.com/dictionary/caregiver

Recommendations

1.1 An assessment tool should be created to assess for a family's ability to recognize vulnerabilities of themselves and their elder family members. This tool would be used when screening families for in-home services, by in-home service providers to assess family ability to provide care (and the sustainability of said care), and finally would be used when identifying appropriate family members who are interested in becoming care providers for elder family members and loved ones.

1.2 Family care providers are currently not expected to complete training before beginning their role with their loved one/family member outside of completing a mandatory background check. A 40 hour training should be developed and provided to those interested in acting as care providers in home for family members and loved ones who are elderly or vulnerable adults. Washington State has a current model that may aide in directing Oregon's development of this training.

1.3 Mandatory reporting requirements and consequences for lack of following through as a mandatory reporter should be evaluated for improvement and/or modification. Potential recommendations may be considered and developed following this initial analysis.

Multnomah County Domestic Violence Fatality Review team members who have been identified to assist in moving these recommendations forward are Allison Wilson and Annie Neal. Additionally, ad hoc members who participated in this review and are identified to assist in moving these recommendations forward are Wendy Hillman, Joe Easton, and Lee Girard.

Community Education & Outreach/Public Awareness Campaigns

One in ten Americans age 60+ experiences abuse each year, and many experience it in multiple forms.[4] While some states have moved progressively toward campaigning to raise awareness of Elder Abuse, it is still believed to be underreported and largely misunderstood. Raising public awareness to these issues not only provides additional resources to survivors but enables our County to become fully invested and involved in building a safe and sustainable community for everyone who chooses to call Multnomah County home.

[4] http://www.centeronelderabuse.org

Recommendations

1.1 The upcoming launch of the “No More” campaign is set for April 2016 in Multnomah County and will be targeting raising awareness around ending domestic violence and sexual assault. Messaging around abuse of elders & vulnerable adults should be incorporated into this campaign and future public awareness efforts around similar topics.

1.2 In our community there are a variety of people who could act as “gatekeepers” to services and information for the elderly and vulnerable adult population outside of traditional service providers. Additional outreach for training and awareness raising campaigns should be spread more broadly and outside of traditional service providers in order to reach a wider audience.

1.3 Incorporate a CORE component of domestic violence into standard training for those service providers/professionals who are already working with the elder/vulnerable adult population.

Multnomah County Domestic Violence Fatality Review team members who have been identified to assist in moving these recommendations forward are Allison Wilson and Annie Neal. Additionally, ad hoc members who participated in this review and are identified to assist in moving these recommendations forward are Shannon Rose and Samantha Naliboff.

Multnomah County DVFRT Members

The Multnomah County Domestic Violence Fatality Review Team is comprised of members from various public, private, and non-profit agencies who come together in the effort of applying a multi-disciplinary lens to domestic violence homicides that occur in our county. This team is a highly dedicated group of individuals who goes about their task with a deep sense of respect for the lives that have been lost, the families and community members directly affected by these tragedies, and the abiding hope that this work will make a direct impact in changing the way we address domestic violence in Multnomah County.

Agency	Member
Abuse Recovery Ministry & Services	Stacey Womack
Oregon Department of Justice	Erin Greenawald
Legal Aid Services	Julia Olsen/Pam Haan
Local Public Safety Coordinating Council	Abbey Stamp
Metropolitan Public Defenders	Lane Borg
Multnomah County Circuit Court	Judge Patrick Henry
Multnomah County Circuit Court*	Judge Maureen McKnight
Multnomah County Circuit Court*	Judge Nan Waller
Multnomah County Commissioner*	Loretta Smith, District 2
Multnomah County District Attorney's Office	Traci Anderson
Multnomah County District Attorney's Office	Charles Sparks
Multnomah County Health Department	Sonja Miller
Department of Community Justice	Sandra Rorick
Department of Community Justice	Andrew Altman
Department of Community Justice	Laura Ritchie
Department of Juvenile Justice	Deena Corso
Domestic Violence Coordination Office	Annie Neal
Domestic Violence Coordination Office	Allison Wilson
Domestic Violence Enhanced Response Team	Becky Bangs
Multnomah County Sheriff's Office	Tim Moore
Oregon DHS-Child Welfare	Jennifer Bren
Oregon DHS-Child Welfare	John Richmond
Oregon DHS-Self Sufficiency	Linda Pursell
Gateway Center	Martha Strawn-Morris
Portland Police Bureau	Sgnt. Ron Mason
Raphael House	Emmy Ritter
VOA Home Free	Kris Billhardt

*2014-2016 Co-chairs

With additional thanks to ad-hoc Members for Fall 2015 Review:

Wendy Hillman, ADVSD
Lee Girard, ADVSD
Joe Easton, ADVSD
Shannon Rose, DVCO
Ellen Klem, Dept. of Justice
Sgnt. Tim Musgrave, PPB Elder Crimes
Judge Amy Holmes-Hehn, Multnomah County Circuit Court
Judge Katherine Tennyson, Multnomah County Circuit Court
Dr. Maureen Nash, Providence Elder Place
Samantha Naliboff, Volunteers of America Home Free