Greetings,

Pursuant to the DVFRT’s protocol and authorizing statutes, the Team is providing this annual update regarding the DVFRT’s work in 2014-2015.

Domestic Violence in Oregon

December was one of the deadliest months in Oregon in 2015 related to domestic violence. In that one month, eight Oregonians in five different counties lost their lives in six separate domestic violence incidents.

On December 11th, in Deschutes County, Rebekah Gomes, 24, was shot and killed by her estranged boyfriend.

On December 24th, in Lane County, Edda “Sue” Kimberling, 65, was shot and killed by her husband who then shot and killed himself.

On December 26th, in Douglas County, a man, 53, shot his girlfriend, who survived, before he shot and killed himself.

On December 26th, in Marion County, Joseph DiMatteo, 69, was shot and killed by his wife.

On December 29th, in Hood River County, Wendy Hildreth, 48, was bludgeoned to death by her estranged husband, who then shot and killed himself.

For purposes of tracking deaths, the Criminal Justice System (CJS) and its community partners define “domestic violence” to also include family relationships outside of the intimate partner context. The Oregon Health Authority (OHA) keeps statistics related to deaths in the intimate partner violence (IPV) context. OHA’s definition of IPV is narrower than the one used by CJS and its partners, resulting in data disparities.
On December 29th, in Lane County, Jack Harvey Youngblood, 80, was killed by his adult stepson.

In addition to the December deaths, our state bore the loss of another 38 Oregonians due to domestic violence in 2015. Those who died include:

- 22 intimate partner victims
- 10 non-intimate partner victims
- 11 perpetrators
- 2 police-involved deaths.

In total in 2015, there were 46 deaths in 37 separate incidents in thirteen Oregon counties related to domestic violence. These numbers represent an increase over the prior year; in 2014 there were 40 deaths in 28 separate incidents in 14 Oregon counties.

These numbers, whether 40 or 46, 28 or 37, are discouraging, disheartening, and tragic. As we try to comprehend what these figures mean, it is vitally important for all of us to remember that these numbers are more than just numbers—they represent real people. There were 86 real people who died due to domestic violence in the last two years—real people who had families, friends, neighbors, and communities who loved them and are, almost certainly, still reeling from the profound loss every day.

Statewide Domestic Violence Fatality Review Team

The Domestic Violence Fatality Review Team (DVFRT), through its review process, endeavors to remember the people who have died due to domestic violence, as well as those who continue to grieve them; the DVFRT’s case reviews are informed by our respect for all involved and done in a manner sensitive to all people, living or dead.

As we noted in our “2012 Report to the Legislature,” “[t]he goal of each review is to be as thorough, in-depth, and insightful as possible. Toward this goal, the DVFRT attempts to obtain and review as much information as is available about the involved parties, their relationship, and life circumstances leading up to and including the fatality incident...[t]his type of review allows for not only a deeper understanding of the particular fatality we are reviewing, it also provides for a broader and more textured consideration of Intimate Partner Violence, generally.”

The in-depth nature of the review process limits the number of fatalities that the DVFRT is able to review each year. Since 2012, the DVFRT has reviewed six cases. This letter will briefly address the cases reviewed in 2014 and 2015 and offer the Team’s findings and recommendations based on those case reviews.

“In addition to the deaths, there were individuals who were injured in these fatal incidents. There were six attempted murders among the 37 domestic violence incidents.

The Domestic Violence Fatality Review Team Protocols are available on the Oregon Coalition Against Domestic and Sexual Violence (OCADSV) website: www.ocadsv.org/our-work/dv-fatality-review.

Case Reviews

Due to inclement weather, the Team was able to review only one case in 2014. That case involved a married couple nearing retirement age. The couple had no children together. The female victim had one living adult son who resided in another state. At the time of the victim’s murder, the couple was living together in the mid-Willamette Valley. There was no history of physical violence, but there were other examples of how the perpetrator may have maintained control over the victim. The male perpetrator killed the victim by strangulation/ asphyxiation. The perpetrator is in prison.

The Team reviewed two cases in 2015. The first case involved a familicide. At the time of the murder, the female victim and the male perpetrator, her husband, had been separated and living apart in a rural, western Oregon county. The couple had two children, a son (elementary age) and a daughter (middle school age). There was a long history of domestic violence in the relationship, perpetrated by the husband on the wife, though none of the abuse was formally reported until shortly before the murders. The perpetrator shot and killed his wife and their children before shooting and killing himself.

The second case reviewed in 2015 involved a married couple living together in a southern Oregon coastal community. The male perpetrator had a long history of domestic violence (with the victim and with others) as well as other criminal activity. He was involved with a local government agency at the time of the murder. The female victim was born with a physical disability and suffered from other physical ailments. She was not formally engaged with local services at the time of the murder. The couple was involved in the local faith community. The perpetrator shot and killed the victim. The perpetrator is in prison.

Through multiple days of intense examination and thoughtful discussion of police reports, photographs, court records, interviews, and DVFRT-member provided information, the Team, in these case reviews, identified dozens of critical issues and potential areas for system improvement. Recognizing the limitations of time, funding, and resource capacity, the Team has synthesized its observations and offers the following nine findings and attendant recommendations:

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<th>Findings</th>
<th>Recommendations</th>
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<td>1. There is a need to prevent domestic violence offenders from access to or possession of firearms.</td>
<td>The DVFRT recommends that:</td>
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<td>A. Oregon’s lawmakers continue to build upon the firearms restrictions placed on domestic violence offenders;</td>
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<td>B. Policies in local jurisdictions regarding protection and no-contact orders are implemented to restrict access to firearms by domestic violence offenders and those subject to protection and no-contact orders.</td>
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5The first meeting of every review, out of respect for the parties, their families, and the participating local agencies, is held in the location where the fatality occurred. The second meeting occurs approximately two weeks later and is usually held in Portland or Salem.

6Familicide is the murder of family members by another family member. In other words, familicide is a multiple-victim homicide in which the killer’s spouse or partner and one or more children are killed. https://en.wiktionary.org/wiki/familicide
Findings Cont.

2. There is a need to enhance community corrections supervision of domestic violence offenders.

Recommendations Cont.

The DVFRT recommends that:

A. The minimum number of hours of domestic violence training at the community correction officer basic academy is increased;

B. A mandatory annual continuing education unit requirement for community corrections officers is implemented to include domestic violence training facilitated by the Family Violence Supervision Network;

C. County community corrections offices adopt an established policy or protocol regarding the supervision of domestic violence offenders which should include the use of a risk assessment tool;

D. Advocates are incorporated in the supervision of domestic violence cases.

3. There is a need to improve access to resources for victims and survivors, especially those with special or unique needs.

The DVFRT recommends that:

A. OCADSV make inquiries of domestic violence advocacy agencies regarding accessibility, crisis placement availability, and ADA compliance for dissemination of information to sister agencies;

B. Multi-disciplinary teams in each county are encouraged to expand membership to include Aging and Persons with Disabilities workers.

4. There is a need to determine DHS services, points of intervention, and gaps.

The DVFRT recommends that:

A. DHS’s DV Council creates a committee to review program protocols, applications, personnel training, and resources to determine how helpful and/or accessible the available resources are for victims;

B. The quality and consistency of domestic violence training for all DHS workers is improved and expanded to include an advanced domestic violence course.
Findings Cont.

5. There is a need to improve domestic violence education for students and professionals.

Recommendations Cont.

The DVFRT recommends that:

A. Domestic violence training is required for all K-12 teachers and counselors, lawyers and judges, and landlords/property management company employees;

B. Advocate training is expanded to include safety planning for “victims in transition.” This could be included in the 40-hour advocate training;

C. All undergraduate students in their first year at an Oregon institution of higher education receive information about domestic violence.

6. There is a need to promote trauma-informed courtrooms and proceedings for victims and survivors.

The DVFRT recommends that:

A. In coordination with recommendation number five, all judges, court staff, and court administrators receive training on creating trauma-informed environments in family court, restraining order, stalking order, EPPDAPA, and other proceedings that victims/survivors attend.

7. There is a need to improve long-term post-incident assistance to victims’ families.

The DVFRT recommends that:

A. Multi-Disciplinary Team (MDT) or Major Crime Team (MCT) protocol(s) include a System Navigator position responsible for acting as a point of contact with victims’ families in fatality cases.

8. There is a need to improve media coverage of domestic violence and domestic violence fatalities.

The DVFRT recommends that:

A. The DVFRT identify a media/PR professional to participate as a member of the DVFRT;

B. The DVFRT invite a member of the media to participate in a portion of a review/interim meeting;

C. The DVFRT send reports to members of the media.
9. There is a need to collaborate with Oregon’s faith community to enhance response to the needs of domestic violence victims and survivors.

The DVFRT recommends that:

A. The DVFRT develop a proposal for working with Oregon’s faith communities to enhance their effectiveness in preventing and responding to domestic violence.

Fatality Review Team: Impact and Future

In late 2014 and early 2015, the Team submitted its biennial report on our ongoing work to the Oregon Legislature. The report was submitted in two parts: the first part was the “Executive Summary” and the second part was the “Report and Recommendations on Improving the Efficacy of Oregon’s Family Abuse Prevention Act (FAPA) Order.” At least two of the recommendations in the report were reflected in recent legislative changes. Oregon legislators also referenced the DVFRT’s report throughout last year’s legislative session. That is to say, the DVFRT’s work is being noticed, relied upon, and is making a difference.

Of course, this work cannot be accomplished without the dedicated and diligent work of the Team’s membership. All participants volunteer multiple days of their time, and for some, at their own financial expense, each year to this group. We are extremely proud of the efforts the Team has made and grateful for the agencies which allow employees to participate, spending valuable time away from their respective offices. However, we are acutely aware that our ability to do more, or even continue the work, is threatened by lack of funding. Currently, the Team is an unfunded, all-volunteer, workhorse of a group, held together by a common aspiration that we can do better by those affected by domestic violence. We are inspired to continue based on a desire to effect change, prevent and/or decrease domestic violence-related deaths, and improve the lives of domestic violence victims and survivors.

Notwithstanding the financial and other challenges, the Team is determined to continue our efforts in 2016. We are encouraged that the Team’s energies have resulted in some forward progress. To be sure, any accomplishments are a testament to and in honor of the real people involved in the cases we have been privileged to review.

7The Team recommended that Oregon enact an Emergency Protection Order. HB 2776, enacting an Emergency Protective Order in domestic violence situations, became effective January 1, 2016. Likewise, the Team recommended that Restraining Order violations become a crime. SB 3, which became effective January 1, 2016, makes certain Restraining Order violations a crime (as opposed to a contempt adjudication).
In closing, we would like to thank each of you for your support through participation of your agency representatives on the DVFRT. If you have any questions or comments, please do not hesitate to contact me directly.

Erin Greenawald, Co-Chair, DVFRT
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C: Senate Committee Chairs and Vice-Chairs
   House Committee Chairs and Vice-Chairs