

Houston/Harris County Adult Violent Death Review Team

2004 Report

***A presentation of findings from meetings of the
Domestic Violence Death Review Team
and the
Elder Abuse Fatality Review Team***



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References Cited in Text

1. Hoyert DL, Kochanek KD, Murphy SI. Deaths: final data for 1997. *Natl Vital Stat Rep.* 1999;47:28-37.
2. Grisso JA, Schwartz DF, Hirschinger N, et al. Violent injuries among women in an urban area. *N Engl J Med.* 1999;341:1899-905.
3. Puzone CA. National trends in intimate partner homicide. United States 1976-95. *Violence Against Women.* 2000;6:409-26.
4. Greenfeld LA, Rand MR, Craven D. et al. Violence by intimates: *Bureau of Justice Statistics Fact-Book* Washington, DC: US Department of Justice (Publication NCJ-167237); 1998.
5. Rennison M, Welchans S. (U.S. Department of Justice). Intimate partner violence. *Bureau of Justice Statistics special report*; May 2000.
6. National Center for Injury Prevention and Control. *Costs of Intimate Partner Violence Against Women in the United States.* Atlanta (GA): Centers for Disease Control and Prevention; 2003.

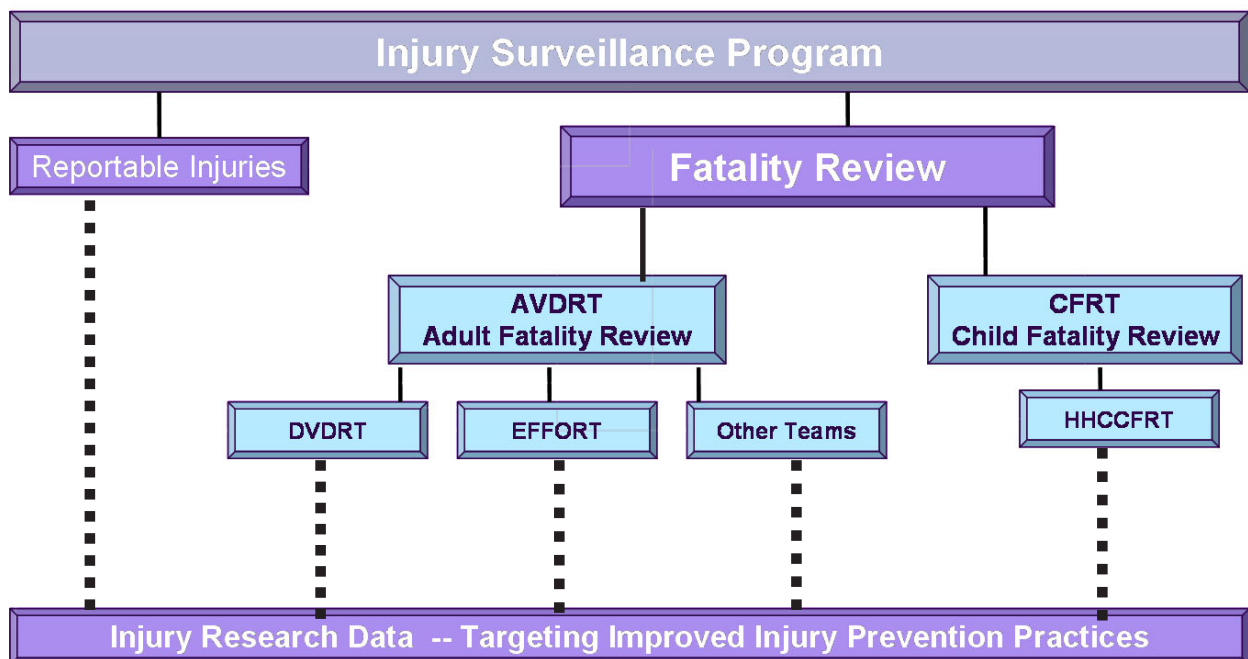
Harris County Public Health & Environmental Services Fatality Review Program

A Public Health Injury Prevention Initiative

The Injury Surveillance Program at Harris County Public Health & Environmental Services (HCPHES) collects data, maintains records, and provides statistical reports on deaths and certain injuries recorded in Harris County. The HCPHES Fatality Review Program is a major component of the Injury Surveillance Program and is composed of a Child Fatality Review Section and an Adult Fatality Review Section.

The vision of the HCPHES Injury Surveillance Program has been to develop multi-faceted death review teams that would gather information on all forms of injury death in Harris County. This information would then be used in the public health arena to lower the incidence of injury both in the local community and in other urban counties across the nation. There are two fatality review teams operating within the Adult Fatality Review Section under Chapter 672 of the Texas Health and Safety Code, the Domestic Violence Death Review Team (DVDRT) and the Elder Abuse Fatality Review Team (EFFORT). The DVDRT meets monthly to review adjudicated homicide cases in which the death occurred during a family violence incident within Houston/Harris County. EFFORT also meets on a monthly basis and reviews cases of individuals over 55 years of age who may have died of neglect or abuse within Houston/Harris County.

HCPHES Injury Surveillance Program Organizational Structure





Introduction

There were 808 violent deaths (homicides and suicides) reported in Houston and Harris County for the year 2002. That number, along with demographic information such as age, sex, and race or ethnicity of the victims, is easily obtained from the records of the Harris County Medical Examiner's Office. Demographic information on the perpetrators can sometimes be accessed through other agencies, such as the Harris County District Attorney's Office. But the answers to other questions are not readily available from one or two sources. For example:

- How many of those who were killed by a family member or an intimate partner had taken out a protective order against the perpetrator? How many had never taken out a protective order despite repeated previous attacks?
- What proportion of homicide victims had a history of substance abuse? How many victims were intoxicated when they were killed?
- What proportion of suicide victims had previously attempted suicide and wound up in an emergency department at a local hospital? Did they receive any medical or psychological follow-up treatment? What type of weapon was used in the majority of suicide deaths? Where did the victim get the weapon?
- How many times had the caregivers of a deceased elderly or disabled individual previously been reported to Adult Protective Services for possible neglect or abuse? Did the deceased previously exhibit signs of self-neglect to neighbors, family, or friends? What resources were available and accessible to this person in life?

The answers to most of these questions have been collected and are available in disparate records because of the meticulous investigative work of medical examiners, district attorneys, law enforcement agencies, adult and children's protective services, physicians who treated the victim in life, and social work agencies where the deceased may once have requested or received services. This type of information builds an important picture of the circumstances surrounding violent and otherwise unexpected deaths so that trends can be identified:

- In risk and the effectiveness of public health prevention strategies
- In access to legal services and the enforcement of crime interventions
- In emergency room procedure and care and in the services provided by community-based organizations.

This picture is specific to Houston and Harris County issues and yet it can be compared to pictures from other communities so that ideas and innovations can be measured and shared. But the information cannot be accessed in any one place without a collaborative effort between all of these agencies and the subsequent publication of a multi-agency report to the community.

Domestic Violence Death Review Team (DVDRT)

Homicide is one of the leading causes of premature death for women in the United States¹ and the leading cause of death for African-American women aged 15-34 years.² Whereas only 3% to 6% of male homicide victims are killed by an intimate partner³, 30% to 55% of female victims are killed by an intimate partner.⁴ Despite widespread efforts to decrease intimate partner violence (IPV), and a steady decrease in the rate of murders by intimate partners where the victim is male, there has been little improvement in intimate partner murder rates where the victim is female. Studies have found that 65% to 80% of intimate partner murder victims were previously abused by the partner who killed them.⁵ IPV against women costs the United States an estimated 5.8 billion dollars per year.⁶

According to the Texas Department of Public Safety, one family violence incident is reported to a law enforcement agency in Harris County on the average of every 20 minutes, and there were nearly 48,000 family violence incidents reported in Houston and Harris County in 2001. Furthermore, an estimated 250,000 women residents of Harris County are living in violent situations. A 2001 study conducted by researchers from the University of Texas Health Science Center in a primarily Hispanic Houston neighborhood discovered a prevalence of domestic violence (20%) that is significantly higher than the national rate of 10.5-17.3%. The children of these underserved families also had excess odds of poorer overall emotional health.

One Family in Harris County: (case not reviewed by DVDRT)

Julie, age 10, was at a friend's house when her mother was beaten and stabbed to death. Julie heard sirens and ran home. Paul and Mark, ages two and six, were in their bedroom, where they had been carried by their father and the door had been locked. They listened as their mother screamed for help. Mark squeezed through the bedroom window and ran outside to find his older sister, Julie. Julie and Mark arrived back at the house to watch their father purposely cut himself with the same knife used to stab their mother and listened to him explain to the police minutes later how he was hurt defending himself from his wife. Six months later, none of the children had received counseling. Julie stopped playing soccer and associating with friends. Mark began to hit and kick other children at school, and Paul had stopped talking and refuses to leave his grandmother's side. When asked if the young mother of three had sought help prior to the murder, the grandmother explains that her daughter was afraid the abuse would worsen if she told anyone. Despite three pregnancies and multiple trips to the clinic with the children for common childhood illnesses, the grandmother does not think her daughter was ever questioned about abuse. Yes, the police had been called to the house but the father always promised to change. No, the murdered mother had never gone to a shelter because she did not want to disturb life for her three children. The grandmother looks up from her chair to the photograph of her daughter on the mantel and asks, "How can you prevent this from happening to other families?" The question then becomes: How do Houston and Harris County prevent these premature deaths?



A Partnership Between the Harris County Domestic Violence Coordinating Council and Harris County Public Health & Environmental Services

The Harris County Domestic Violence Coordinating Council (HCDVCC) held its first formal meeting of community leaders working in the field of domestic violence in April of 1996. The continuing mission of the HCDVCC is to develop and implement a Harris County community wide plan to end domestic violence. In order to accomplish this mission, the HCDVCC has identified the following goals:

- Develop cooperation and coordination among all the participants who serve domestic violence victims.
- Evaluate the current institutional response to domestic violence in order to develop and maintain a community protocol handbook.
- Identify additional service needs in the community and work to fill those needs.
- Educate the public about domestic violence policies and available resources.
- Strengthen and coordinate interventions and prevention efforts.
- Encourage efficient use of community resources and simplify and increase access to services.

In the late 1990s HCDVCC members began to discuss the formation of a Domestic Violence Death Review Team. A subcommittee of members was formed that included representatives from law enforcement agencies, the Harris County District Attorney's Office, and domestic violence service providers. This group began unofficial review of a small number of completely adjudicated domestic violence-related homicide cases.

In 2001 the Texas Legislature passed Senate Bill 515, amending Chapter 672 of the Texas Health and Safety Code to allow for the formation of adult fatality review teams in Texas counties. Following this legislation, the Harris County Public Health & Environmental Services Injury Surveillance Program began to investigate the possibility of forming an adult fatality review team. As a part of the planning process, HCPHES made contact with the HCDVCC Death Review Team. Thus began a collaboration between the two entities that resulted in the formation of the Houston/Harris County Adult Violent Death Review Team (AVDRT). The AVDRT was designated as the official Harris County fatality review team in August of 2003. Subsequently, the Domestic Violence Death Review Team was formed as a subcommittee of the AVDRT with the specific charge of reviewing family violence-related homicides.



DVDRT Progress

The DVDRT began official case reviews in September of 2003 and has completed 13 reviews of homicides that occurred in 2002 and 2003. These cases were selected for review by date of occurrence and adjudication status. Information gathered from these cases forms the beginning of a comprehensive database that will include all adjudicated family violence cases filed in Harris County from 2002 forward. Subsequent DVDRT reports will contain a statistical picture of the incidence and circumstances of family violence in Houston and Harris County through analysis of a larger number of cases.

Summary of Preliminary Findings

- The majority of the homicide victims in these 13 cases (54%) were Black females. Only one case involving a male victim has been reviewed to date and this individual was of Hispanic ethnicity.
- Women in their thirties comprised 46% of the victims but the ages ranged from 20's to 80's.
- There were five fatal gunshot wounds. Other causes of death included blunt force trauma caused by beating and kicking, stabbing, and manual strangulation.
- Two of the cases were murder/suicides and both of those cases also involved the death of children under the age of 17 years.
- Six victims were married to the perpetrator at the time of their death. In five of the cases, there had been documented prior family violence but none of the 13 victims had a protective order in place at the time of the fatal incident and there was no evidence to show that any had accessed women's center or victim's assistance services.

DVDRT Needs and Recommendations

- Implement a recently funded grant to provide for a staff person/bilingual interviewer at HCPHES to assist with the collection of data regarding domestic violence homicides.
- Develop a sensitive yet efficient system to interview family members of victims.
- Identify positives and negatives about services available for victims of family violence and use this information to impact the quantity, quality, and accessibility of services in Houston and Harris County.
- Educate agencies or service providers on assistance to victims of family violence, especially targeting those agencies which do not typically screen for this issue. Examples include private physicians, clergy, parole officers, school counselors, and employers.
- Partner with the American Bar Association to increase attorney knowledge and awareness of family violence, enabling attorneys to provide enhanced assistance to their clients who may be living in a dangerous home situation.

Elder Abuse Fatality Review Team (EFFORT)

Over the last 10 years, elder abuse has become recognized as one of the most pressing public health issues in the United States. Reports to Adult Protective Services have increased by 150% since 1986, paired with only a 10% increase in the elder population. Historically there has been a lack of routine assessment of elder patients for abuse at either the doctor's office level or in emergency departments. There have also been few population based studies of the problem and most of these are not directly comparable. In 1997 the Baylor College of Medicine Geriatrics Program at the Harris County Hospital District began a collaboration with the Texas Department of Family and Protective Services, Adult Protective Services Division to form the Texas Elder Abuse and Mistreatment Institute (TEAM). TEAM is composed of an inpatient unit for abused or neglected elders, a research component that studies outcomes of treated elder patients, and an educational branch that sends third-year medical students attending Baylor College of Medicine on Adult Protective Services investigations. The TEAM Institute has treated over 700 Harris County residents suffering from elder mistreatment since 1997.

The Houston/Harris County Texas Elder Abuse Fatality Review Team (EFFORT) was formed in May 2003 with support from the American Bar Association. EFFORT is comprised of representatives from TEAM, the Harris County Medical Examiner's Office, the Harris County Hospital District, the Harris County District Attorney's Office (Prosecution and Victim's services), the Harris County Department of Public Health and Environmental Services, the Houston Area Women's Center, and the Houston Police Department.

The Texas Health and Safety Code, Chapter 672, Adult Fatality Review and Investigation Section are the legal authority under which EFFORT operates. The Health and Safety Code forms the basis from which EFFORT derives its policies and procedures. EFFORT is a subcommittee of the Houston/Harris County Adult Fatality Review Team (known as AVDRT), which was designated the official Harris County adult death review team by Harris County Commissioners Court in August of 2003. The AVDRT is administered through a collaborative agreement between Harris County Public Health and Environmental Services and the Harris County Domestic Violence Coordinating Council. Membership in EFFORT is through invitation; all institutions and organizations belonging to EFFORT sign a memorandum of agreement with the Harris County Public Health and Environmental Services Adult Fatality Review Program. Per statute, all members must have expertise in elder mistreatment issues.



EFFORT Mission Statement

The mission of the Harris County Elder Abuse Fatality Review Team is to strive for justice for all elder and vulnerable adult citizens who die as a result of interpersonal violence and/or neglect.

EFFORT Purpose Statement

The purpose of the Harris County Elder Abuse Fatality Review Team is to decrease the incidence of preventable deaths of elder and vulnerable adults caused by interpersonal violence and/or neglect. EFFORT promotes cooperation, communication and coordination among agencies involved in responding to elder and vulnerable adult deaths. EFFORT reviews cases to develop an understanding of the physical and systemic circumstances of such adult deaths in Harris County. EFFORT makes recommendations to the County Commissioner, appropriate state agencies and local law enforcement agencies on changes to law, policy, and practice that will reduce the number of elder and vulnerable adult deaths caused by abuse and neglect.

EFFORT Progress

EFFORT began comprehensive case review in 2003. As of October 5, 2004, EFFORT has reviewed the circumstances surrounding seven cases of unexpected death of elder and vulnerable adult individuals. Below is a summary of three of the seven cases reviewed by EFFORT.

The decedent was an 84 year-old male brought to the emergency department with large open decubitus ulcers revealing exposed metal hardware from healed joint replacement surgery. He weighed 120 pounds, was emaciated and dehydrated, and was covered with feces and urine. He lived in his own home with his children, who had control of his finances. Two prior reports had been made to Adult Protective Services regarding his situation. The likely cause of death was sepsis due to fecal matter in his wounds.

The decedent was a 56 year-old mentally retarded male found unresponsive in his sister's car in a retail store parking lot. The sister was the primary caregiver and both siblings were homeless.

The decedent was a 64 year-old male who had been discharged from the hospital into an unlicensed personal care home. Previous to hospital admission he was reported to have been hitchhiking from Austin, and he was ambulatory when he left the hospital. He had no family. The decedent had severe contractures of the upper and lower extremities; weight was 112 pounds on a 71-inch frame. He was suffering from congestive heart failure, sepsis, and severe malnutrition. The case was investigated by the Houston Police Department.

Through examination of the circumstances surrounding the seven cases, EFFORT has identified the following needs and recommendations.

Needs and Recommendations

1. Strengthen the lines of communication among agencies and organizations:

- Develop a system modeled on the reporting requirements of Child Protective Services to determine if there had been prior reports to Adult Protective Services concerning abuse or neglect of elder or vulnerable individuals who die unexpectedly.

2. Increase and strengthen our educational efforts:

- To educate clinicians, forensic pathologists, and other health professionals, about the subtle signs of mistreatment and the physiological changes in the frail elder that are different from their younger counterparts. To reinforce the legal obligation that health professionals have in reporting elder mistreatment and suspicious deaths.
- To educate the public about mistreatment of vulnerable adults in general, their responsibility for reporting, and the reporting avenues available to them. A particular need is to increase awareness of the societal imperative to recognize the magnitude of the problem and the difficulties associated with identifying, investigating and prosecuting suspicious deaths.
- To educate law makers, government and public officials and members of the criminal justice system about the increasing magnitude of mistreatment in our community, and the need for more rigorous action and increased funding to combat the problem.

3. Create community action boards to address the recommendations of elder fatality review teams. These boards could advocate for funds to implement review team recommendations and to sustain review team efforts.

It is difficult to determine how many older Americans are victims of elder abuse, in its various manifestations. It has been estimated that from 500,000 to 5 million older Americans are abused every year. Elder abuse is even more difficult to detect than child abuse since the social isolation of some elderly persons may increase both the risk of abuse and neglect, and the ability for outsiders to detect it. The problem of proving abuse relates to the view held by many that injuries to the elderly are most likely a consequence of the aging process and not abuse. There is an unspoken “burden of proof” placed upon elders to convince society they could, in fact, have suffered abuse rather than injuries and declining functions related to the natural aging process. The state of clinical science concerning elder abuse in the year 2000 has been compared to the clinical knowledge of child abuse in the 1960s. Sen. John Breaux, Aging Committee Chairman, from the Executive Summary of the white paper released in May 2002 on the history of elder abuse, neglect and exploitation in the United States.

Houston/Harris County Domestic Violence Review Team Member Agencies

Harris County Domestic Violence Coordinating Council
Harris County Public Health & Environmental Services
Harris County District Attorney's Office Family Criminal Law Division
Harris County District Attorney's Office Victim Witness Program
Harris County Medical Examiner's Office
Northwest Assistance Ministries Family Violence Center
Houston Police Department Family Violence Unit
Harris County Sheriff's Office Victim Services Unit
Humble Police Department
Texas Woman's University
Texas Department of Family and Protective Services
Crisis Intervention of Houston, Inc.
Aid to Victims of Domestic Abuse Battering Intervention and Prevention Program
Texas Commission on Access to Justice
Shalom Bayit
The Bridge Over Troubled Waters
Memorial Hermann Healthcare System Forensic Nursing Services
Prevent International Parental Child Abduction

Houston/Harris County Elder Abuse Fatality Review Team Member Agencies

Texas Elder Abuse and Mistreatment Institute
Harris County Hospital District
Harris County Medical Examiner's Office
Harris County District Attorney's Office, Prosecution and Victim's Services
Houston Police Department
Harris County Public Health & Environmental Services
Houston Area Women's Center

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of this report are actual victims or associated with the subject matter. These
individuals are photography models from images provided by www.photos.com.*

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