

# Contra Costa County Domestic Violence Death Review Team 2010 - 2019 Report

The Contra Costa County **Domestic Violence Death Review Team dedicates this** report to the victims, children and family members who have lost their lives due to domestic violence; and to survivors, families and those impacted by domestic violence everywhere.

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### Mission

To reduce and prevent future domestic violence related deaths by utilizing a systematic, confidential, multi-agency review process to identify domestic violence related deaths and potential system gaps in order to develop strategies, policies and procedures to improve Contra Costa County's response to domestic violence.

### Goals

- Identify domestic violence related deaths by collecting, analyzing and interpreting Contra Costa County homicide and suicide data.
- Conduct intensive examinations of selected victims and suspects by focusing on any contact the individuals may have had with the judicial system, mental health services and/or other social service programs. \*Careful examination of the homicides and the information collected will assist with public education, identifying risk factors, developing prevention measures and intervention strategies, and improving the coordination of efforts among service providers.
- Work to increase safety for victims and accountability for suspects by promoting cooperation and communication among agencies providing direct services to victims or perpetrators of domestic violence.
- 4 Identify patterns in domestic violence related deaths and gaps in services to formulate recommendations for collaboration on domestic violence prevention, investigation and intervention.

## **Guiding Principles**

We conduct the reviews in a positive manner with sensitivity and compassion.

We are committed to confidentiality.

We work in honor of the victim and the victim's family.

We acknowledge, respect and learn from the expertise and wisdom of all who participate in the reviews.

We avoid accusations or faultfinding.

We share responsibilities, the workload and are active participants in the reviews.

# Members of the Domestic Violence Death Review Team

Natalie Oleas, JD	Alexandra Madsen	Amy E Yakaitis, MD
DVDRT Coordinator	The Alliance to End Abuse	Women's Health Physician
The Alliance to End Abuse	Contra Costa County Employment and	Kaiser Permanente
Contra Costa County Employment and Human Services	Human Services	
Ashley Palomino	Beth Armentano	Captain David Hartman
Crisis Line & Community Services Manager STAND! For Families Free of Violence	Epidemiology, Planning and Evaluation Unit Contra Costa Public Health	Contra Costa County Sheriff's Office Coroner's Division
Erin Everett, Esq.	Sergeant James Normandin	Sergeant James Stenger
Family Law	Contra Costa County Sheriff's	Homicide Unit
Bay Area Legal Aid	Office Coroner's Division	Antioch Police Department
Jill Henderson, Esq.	Sergeant Kristopher Tong	Sergeant Laurie Bailey
Deputy District Attorney	Special Victims Unit	Homicide Unit
Domestic Violence & Elder Abuse	Richmond Police Department	Contra Costa County Office of the Sheriff
Contra Costa District Attorney's Office		
Sergeant Matthew Cain	Marie Scannell, PhD, MFT	Mary Staunton, MD
Patrol Unit	Forensic Mental Health	Psychiatrist
Concord Police Department	Contra Costa Health Services	Kaiser Permanente
Nicole Gremillion, MSW	Reina Sandoval-Beverly	Shanette Richardson
Central County Operations	Director of Client Services	Adult Probation
Division Manager	STAND! For Families Free of	Domestic Violence Unit
Children & Family Services	Violence	Contra Costa County Probation Department
Shannon Mahoney	Susun Kim, Esq.	Tara M Godoy, BSN RN CFN
Victim Assistance Program Manager	Executive Director	Forensic Nurse
Contra Costa District Attorney's Office	Contra Costa Family Justice Center	
Sergeant Todd Orlando	Veronica Boutelle, MS, AMFT	Detective Zechariah Matis
Special Victims Unit	Victim Services Program Manager	Special Victims Unit
Brentwood Police Department	Community Violence Solutions	Antioch Police Department 2

# HISTORY OF THE DOMESTIC VIOLENCE DEATH REVIEW TEAM IN CONTRA COSTA COUNTY

n 1994, the Contra Costa County Superior Court convened the Advisory Council Against Domestic Violence, which authorized the formation of a Domestic Violence Death Review Team (DVDRT) within the county. In 1995, California Senate Bill 1230 resulted in the creation of California Penal Code Sections 11163.3-11163.6, authorizing the formation of county -wide interagency death review teams to examine homicides and suicides related to domestic violence. DVDRTs were established to ensure that incidents of domestic violence and abuse are recognized and that agency/system involvement with homicide and suicide victims are systematically studied.

In 1998, Contra Costa Health Services, in partnership with the Contra Costa Office of the Sheriff, established the Contra Costa Domestic Violence Death Review Team. Case reviews began in August 1999. The DVDRT's first report was published in November 2000 and the team continued to review cases until 2005.1

In 2019, the Alliance to End Abuse, housed within Contra Costa County's Employment and Human Services Department, restarted the DVDRT. The DVDRT consists of a cross-section of organizations and disciplines in Contra Costa County that interact with domestic violence victims, offenders, their family members and other interested third parties. DVDRT must be diverse, and members are selected based on organization affiliation, position in the organization, access to

confidential information and whether they have expert level status. Each member is an active participant within DVDRT. The DVDRT may decide to recruit additional members to assure the team has the collective expertise needed to carry out its mission.

In 2020, the DVDRT conducted in-depth reviews of two domestic violence related deaths that occurred within Contra Costa County. The number of meetings was limited due to COVID-19 meeting restrictions. The DVDRT also collected aggregate data on all the domestic violence related homicides and suicides within Contra Costa County from 2010 - 2019. De-identified aggregate data will be annually shared with the public in the form of a Domestic Violence Death Review Report. The report will include recommendations from the DVDRT on ways to prevent future domestic violence homicides.

Throughout the
State of
California, there
are 17 counties
with active
Domestic
Violence Death
Review Teams

### **CASE REVIEW PROCESS**

DVDRT meets in-person on a quarterly basis to identify and conduct an in-depth review of deaths that appear to be related to domestic violence and classify those deaths as such under California Penal Code Section 11163.6. This definition includes family violence within the domestic violence spectrum.<sup>2</sup> Suicides related to domestic violence are also reviewed.

Cases selected for review are provided by the Contra Costa County Sheriff's Office Coroner's Division, the Contra Costa County District Attorney's Office and the appropriate law enforcement agencies. Cases that are actively being adjudicated are not reviewed by DVDRT.

Due to the number of domestic violence related deaths per year, in-depth discussions of every case are not possible. A sub-committee selects the cases that are reviewed in-depth. To have a comprehensive discussion about the case, DVDRT focuses on one case per meeting.

During the meeting, DVDRT discusses the history of each selected case, what interactions the victim and suspect had with the judicial system, mental health services and/or other social service programs. DVDRT reviews the events leading up to the death(s) and conducts intensive analyses to identify patterns in domestic violence related deaths and gaps in services to formulate recommendations for collaboration on domestic violence prevention, intervention and investigation.

In 2020, DVDRT held two in-depth case reviews. The DVDRT anticipates completing three in-depth case reviews in 2021.

### COVID-19

In January 2020, DVDRT began in-person case reviews. In March of 2020, the county placed restrictions on large, in-person gatherings due to the threat of COVID-19. In response to this "shelter-in-place" order, the scheduled April 2020 in-person case review was cancelled. As county-wide restrictions extended into the summer, DVDRT grew concerned that in-person case reviews would not be able to continue until 2021.

With the support and technical assistance of the National Domestic Violence Fatality Review Initiative, the DVDRT adjusted and held its first virtual case review in July 2020. This is the first domestic violence death review case known to have been held virtually in the United States.

### **SUMMARY OF FINDINGS**

- Between 2010 and 2019, there were 86 domestic violence related homicides or suicides in Contra Costa County. 72 were domestic violence related homicides and 14 were domestic violence related suicides.
- Of the 86 victims, law enforcement identified 39 as female and 47 as male.
- Domestic violence related homicides made up 11% of the total number of homicides within Contra Costa County between 2010-2019.
- The five cities with the highest rates of domestic violence homicide and suicide were Antioch (12), Richmond (12), Pittsburg (11), San Pablo (7) and Walnut Creek (7).
- 2011, 2015 and 2019 had the highest rates of domestic violence related deaths; 12 deaths in each year.
- Current or former dating partners were the most frequent type of relationship between the victim and suspect.
- Gun shot wounds made up the most frequent cause of death (63%).
- Attempting to leave a domestic violence relationship is the most dangerous time for victims.
- Domestic violence affects people regardless of age, race, gender, immigration status or the city one lives in.

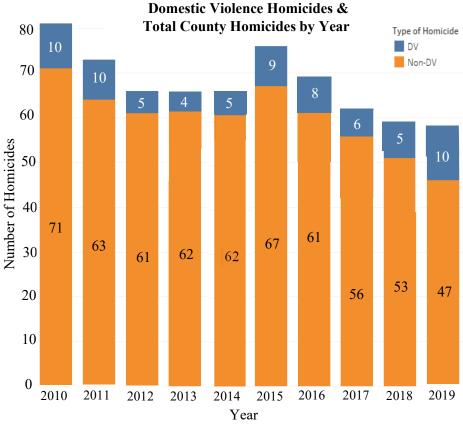
- Team recommendations:
  - Funding needs to be directed towards the development and implementation of danger assessments and in custody, in-person intervention services.
  - 2 Children who have experienced the loss of a parent due to a homicide or suicide related to domestic violence should immediately be connected to supportive services.
  - 3 Law enforcement agencies should have a protocol in place to support the mental health needs of personnel dealing with homicide or suicide calls.
  - 4 Strengthen community awareness around the Domestic Violence Restraining Order process by providing training for agencies that work with individuals requesting DVROs frequently.
- Current county projects reducing the risk of domestic violence homicide include:
  - Domestic Violence Multidisciplinary Team
  - Lethality Assessment Program
  - Strangulation Task Force
- In Contra Costa County, there are resources available for domestic violence victims:
  - STAND! For Families Free of Violence
    - www.standffov.org
  - Family Justice Center www.familyjustice.org
  - Narika <u>www.narika.org</u>
  - The Latina Center www.thelatinacenter.org

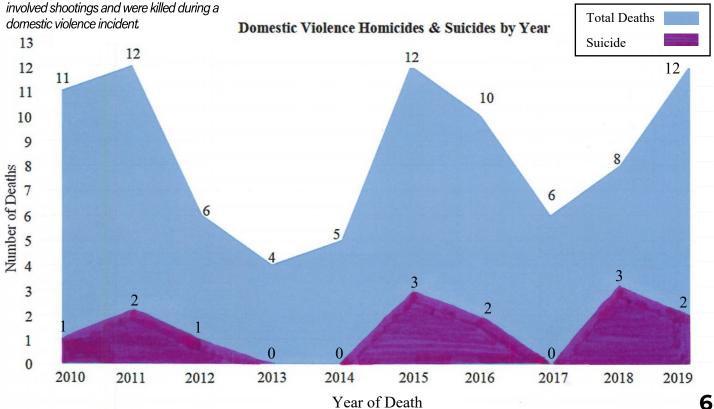
Between 2010 and 2019, there were 86 domestic violence related homicides or suicides in Contra Costa County. 72 (84%) were domestic violence related homicides and 14 (16%) were domestic violence related suicides.

When comparing the county's total homicide data to the domestic violence homicide data, domestic violence related homicides made up 11% of the total number of homicides within Contra Costa County between 2010-2019.

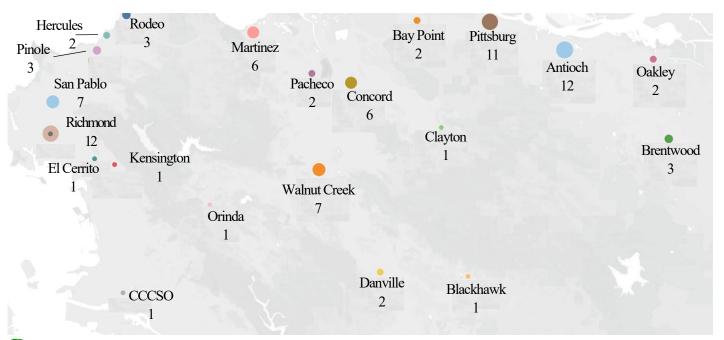
Contra Costa County had the least domestic violence related homicides in 2013, making up 6% of the total homicides that year. 2010, 2011 and 2019 saw the highest rate of domestic violence related homicides, making up 12%, 14% and 18% of the total homicides in the county respectively.

\*Note: Three of the homicide victims were officer

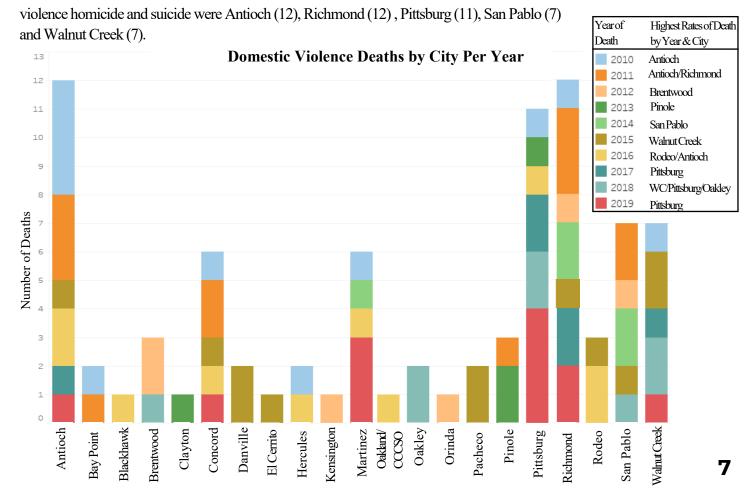




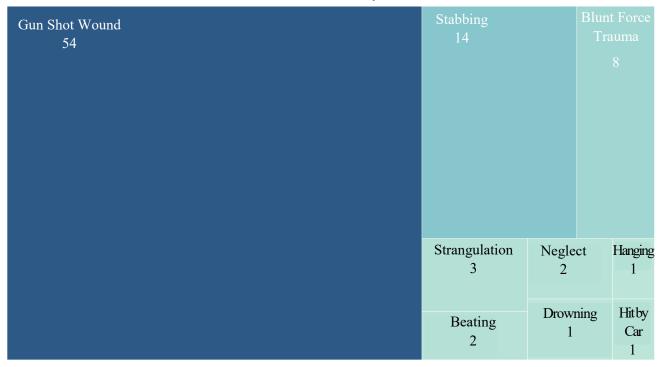
### Domestic Violence Deaths by City Between 2010 - 2019



Domestic violence deaths occur throughout Contra Costa County. The five cities with the highest rates of domestic

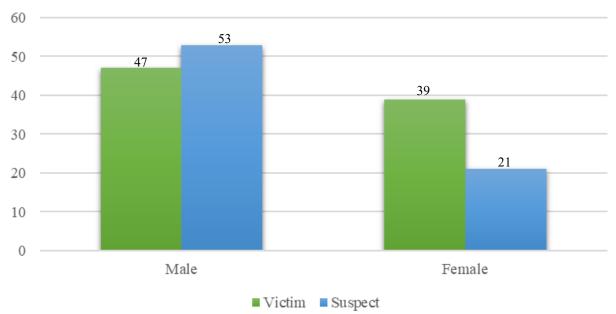






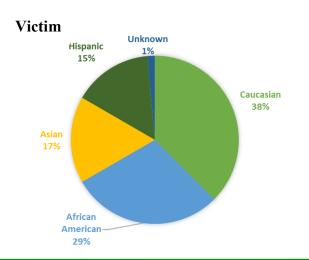
The leading cause of domestic violence homicide and suicide was by gun shot wound. Gun shot wounds made up 63% of the overall causes of death. Stabbings were also frequent causes of death (16%), followed by blunt force trauma (9%). Of the 86 victims, law enforcement identified 39 as female and 47 as male. Of the 47 male victims, 14 were killed by females (30%). Of the 39 female victims, 34 were killed by males (87%).

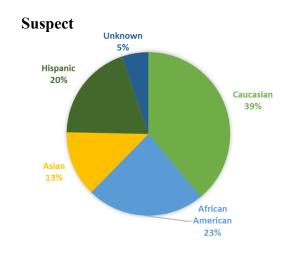
### Domestic Violence Homicides and Suicides by Sex of Victim - Suspect\*



<sup>\*</sup> The sex of the victims and suspects were identified by law enforcement. Three of the deaths were officer involved shootings. The gender of the officers is unknown.

### **Domestic Violence Homicides by Race of Victim and Suspect**





### **Agency Connections**

- STAND! For Families Free of Violence receives roughly 10,000 calls to their hotline annually.
- Since opening in 2015, the Contra Costa Family Justice Center has assisted 1,802 survivors of domestic violence and their families.
- 1 victim completed a LAP Screening and screened as High Danger prior to their death.
- Victim or Suspect connected to a victims' services agency prior to the death.

STAND! - 3 Family Justice Center - 1

### Suspect's Relationship to Victim

<b>Current Dating Partner</b>	15
Former Dating Partner	12
Current Spouse	11
Victim's Child	10
Romantic Rival	9
Victim's Sibling	5
Victim's Parent	2
Victim's Grandchild	1
Victim's Relative	1
Victim's In-Law	1

### **Victim & Suspect Court Interaction**

 Domestic Violence Restraining Orders (DVRO)\*

> Active DVRO Against Suspect - 3 Active DVRO Against Victim - 1 Previous DVRO Against Suspect - 5 Previous DVRO Against Victim - 1

Divorce Filings
 Victim Filed for Divorce Against Suspect - 2
 Suspect Filed for Divorce Against Victim - 1

### Law Enforcement Data

- Between 2010-2019, there were 32,489 domestic violence related calls placed to the 26 law enforcement agencies in Contra Costa County. This is an average of 3,200 calls per year. 3
- Contra Costa District Attorney's Office Domestic Violence Unit 2019 Case Data

Misdemeanor - Cases Reviewed: 2,442

Cases Filed: 400 (16%)

Felony - Cases Reviewed: 598

Cases Filed: 233 (39%)

<sup>\*</sup> Includes all active or former DVROs against the victim or suspect filed by any party.

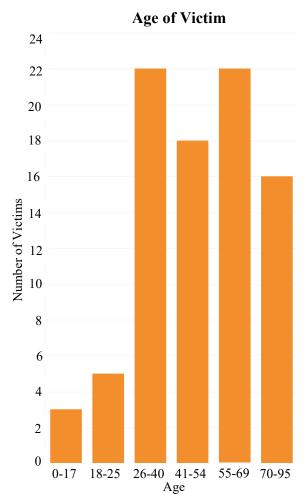
### **Probation History of Homicide Suspect\***

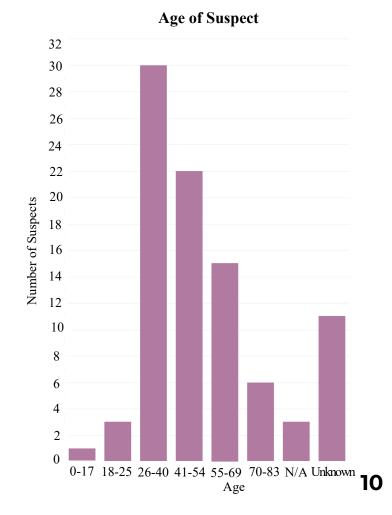
### **Probation History of Homicide Victim\***

Year	DV Related	Manslaughter or Attempted Murder	Other Violent Offense	Percentage of Total Suspects That Year	Year	DV Related	Manslaughter or Attempted Murder	Other Violent Offense	Percentage of Total Victims That Year
2019	1	1	1	30%	2019	1	0	1	20%
2018	0	0	0	-	2018	0	0	1	20%
2017	0	1	1	20%	2017	0	0	0	-
2016	0	0	3	30%	2016	0	0	0	-
2015	0	0	0	-	2015	0	0	0	-
2014	0	0	2	20%	2014	0	0	1	20%
2013	0	0	1	10%	2013	0	0	0	-
2012	0	0	1	10%	2012	0	0	0	-
2011	2	1	1	40%	2011	0	0	2	20%
2010	1	0	2	30%	2010	0	0	2	20%

\*Only includes violent offenses.

None of the suspects or victims participated in Contra Costa's Mandatory Domestic Violence Court.





# CURRENT PROJECTS REDUCING THE RISK OF DOMESTIC VIOLENCE HOMICIDE

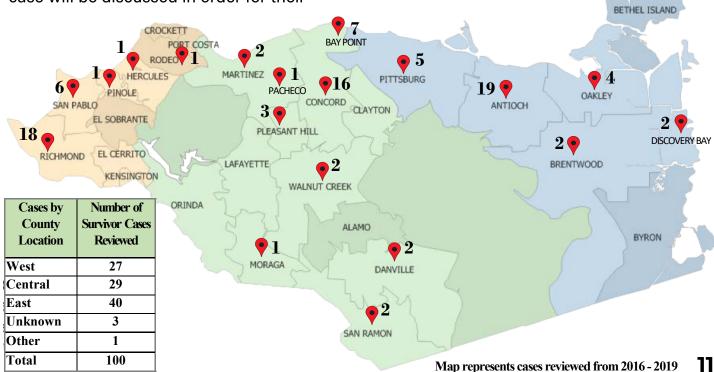
# DOMESTIC VIOLENCE MULTIDISCIPLINARY TEAM

In March 2016, the Contra Costa Family
Justice Center, in partnership with the
Alliance to End Abuse, convened the
county's first Domestic Violence
Multidisciplinary Team (DV MDT) meeting
to review and help create a plan for high
risk or "complex" cases of domestic
violence within Contra Costa County. The
meetings are comprised of representatives
from county agencies, law enforcement
and service providers. DV MDT reviews
cases on a monthly basis. Case
nominations come from any of the
above-mentioned agencies.

A survivor must consent to their case being reviewed by the DV MDT. Survivors must be aware of the MDT, its purpose, membership, when it meets and that their case will be discussed in order for their case to eligible. Survivors must also work with their nominating service provider to identify 1-5 goals for themselves which are then presented to the MDT to help connect the survivor to services.

In 2018, California passed AB 998, which protects the confidential nature of domestic violence and human trafficking MDTs. The bill allows members of these MDTs to share, only with one another, information and records that may be confidential but are relevant to the prevention, identification, management, or treatment of those crimes when doing so serves the victim's interest.<sup>4</sup>

From 2016 - 2019, the DV MDT reviewed 100 high-risk or complex domestic violence cases. Survivors were connected to 251 MDT partners. Of the cases closed for review, an average of 60% of goals set by survivors were achieved.



### **CURRENT PROJECTS CONTINUED**

### **Lethality Assessment Program (LAP)**

The Lethality Assessment Program (LAP) is an innovative strategy to prevent domestic violence homicides and serious injuries. LAP was created by Dr. Jacquelyn Campbell, of The Johns Hopkins University School of Nursing, and the Maryland Network Against Domestic Violence (MNADV) in 2005. It provides an effective method for identifying victims of domestic violence who are at the highest risk of being seriously injured or killed by their intimate partners.<sup>5</sup>

In 2015, Contra Costa County's Alliance to End Abuse, and its project partners, were selected as one of four sites nationally for the Department of Justice's Office on Violence Against Women (OVW), Domestic Violence Homicide Prevention Demonstration Initiative (DVHP) to implement the LAP program. Five county agencies administered the pilot from 2015 -2020 including STAND! For Families Free of Violence, Richmond Police Department, Concord Police Department, Brentwood Police Department and The Alliance to End Abuse.

In 2019, Walnut Creek and San Ramon Police Departments additionally began implementing the LAP due to the success of the pilot.

LAP has three main components; an instrument, a response, and a coordinated partnership with a domestic violence service agency and law enforcement. The instrument is an 11-question evidence-based screening tool administered by law enforcement when responding to a domestic violence incident. The response and coordination at the scene allows an officer to call STAND! For Families Free of Violence and places the victim on a call with a domestic violence advocate at that moment, linking them to immediate and differentiated services within 48 - 72 hours.

D	DOMESTIC VIOLENCE LETHA SCREEN FOR FIRST RESPOND		8
	Date:	Case #:	
	Offender:		
tios di	not answer any of the questions.		
o any	of Questions #1-3 automatically triggers the prot-	ocol referra	l.
da me	apon against you or threatened you with a weapon	i? DYes	ΠNo
l to kil	you or your children?	DYes	DNo
ght tr	to kill you?	ΠYe	s DN

Of the victims screened
between January and June of
2020, 66% were high danger
and were immediately
connected to supportive
services.\*

Between January - June of

2020, 647 LAP screens were

conducted by law

enforcement and STAND! For

Families Free of Violence .\*

\* Note: LAP data from 2015-2019 is not available.

### **CURRENT PROJECTS CONTINUED**

### **Strangulation Task Force**

Strangulation is one of the best predictors for the subsequent homicide of victims of domestic violence.<sup>6</sup> When comparing domestic violence homicide victims to that of living victims who had previously been strangled by their partners, the study found that prior non-fatal strangulation was associated with greater than seven-fold odds (7.48) of the victim becoming a completed homicide.<sup>7</sup>

In response to the severity of strangulation in domestic violence cases, California passed SB 40 in 2018. SB 40 "additionally require[s] law enforcement [responding to a domestic violence incident] to include a statement informing the victim that strangulation may cause internal injuries and encouraging the victim to seek medical attention."8

In January of 2019, the Contra Costa County Strangulation Task Force was created as a response to the lethal implications of strangulation for domestic violence victims. The Task Force is a multi-agency team with representatives from domestic violence agencies, law enforcement and healthcare agencies which meets on an ongoing basis.

Strangulation Advisement Card Created by the Task Force

### Goals

- Help implement SB 40 by developing protocols, creating tools and conducting training around strangulation.
- 2 Raise awareness around strangulation and the services available for victims of strangulation.

### **2019 Achievements**

- ✓ Developed county-wide protocols related to the implementation of SB 40 which have been adopted by the 26 law enforcement agencies within Contra Costa County including the Strangulation Advisement Card and the law enforcement form PC 13700, both of which were uploaded into ARIES;
- ✓ Updated the Contra Costa County Police Chiefs' Association Law Enforcement Protocol: Domestic Violence and Children Exposed to Domestic Violence to include language around strangulation, stalking, LGBTQ+ identified victims and human trafficking; and
- ✓ Trained law enforcement, healthcare professionals and victim advocates on the county's updated strangulation protocols.

### LAW ENFORCEMENT STRANGULATION ADVISEMENT TO VICTIM

- After a strangulation assault, you can experience internal injuries with a delayed onset of symptoms, usually within 72 hours. These internal injuries can be <u>serious or fatal</u>.
- Stay with someone you trust for the first 24 hours and have them monitor your signs and symptoms.
- Seek medical attention or call 911 if you have any of the following symptoms: difficulty breathing, trouble swallowing, swelling to your neck, pain to your throat, hoarseness or voice changes, blurred vision, continuous or severe headaches, seizures, vomiting or persistent cough.
- The cost of your medical care may be covered by your state's victim compensation fund. An advocate can give you more information.

"As a law enforcement officer, I have a duty to warn you that strangulation is serious and can cause internal injuries, brain damage and/or delayed health consequences such as strokes, thyroid issues, miscarriage and/or death. Research shows that if you are strangled even one time, you are 750% more likely to be killed by your partner. I strongly encourage you to seek immediate medical attention at an emergency department and ask for support from an advocate."

### **SIGNS SYMPTOMS** YOUR SIGNS Scratch marks Ligature marks • Voice changes Behavioral changes Signs/Symptoms: Pinpoint red Fingemail Swallowing Vision Changes spots impressions Involuntary urination changes Date: - On eyes Cuts/ or defecation Neck pain - On scalp/face Signs/Symptoms: abrasions Nausea/vomiting • Hearing changes Bruising Bloody/ Breathing changes Date: Swollen tongue/ broken nose

# DOMESTIC VIOLENCE DEATH REVIEW TEAM RECOMMENDATIONS

Funding needs to be directed towards the development and implementation of danger assessments and in custody, in-person intervention services.

Danger Assessments: Of the 86 homicide/ suicide victims, only one had completed a danger assessment (LAP). The LAP has shown promise as an intervention that reduces subsequent violence and homicide, while increasing the likelihood victims will seek help.9 Currently, the LAP is utilized by five law enforcement agencies within Contra Costa County as well as STAND! For Families Free of Violence. In 2018, SB 1331 was passed by the California state legislature which requires law enforcement trainings to include procedures and techniques for assessing lethality or signs of lethal violence in domestic violence situations. 10

As LAP is already utilized by several law enforcement agencies within the county and will be expanded in 2021, the goal is to have as many of the 26 law enforcement agencies administering this uniform danger assessment and connecting victims to services as possible. To sustain and expand LAP throughout the county, funding provided by the county and law enforcement is critical. This funding will assist with program implementation, training and the ongoing differentiated service delivery model between STAND! and law enforcement.

Mental Health Support for Incarcerated Individuals: Of the ten years reviewed by DVDRT, data showed that an average of 19% of the domestic violence homicide suspects had violent probation histories prior to the murders. This includes prior domestic violence

convictions, attempted murder or murder convictions, or convictions for other violent offenses. One in-depth case reviewed by DVDRT exemplified the importance of creating a space for domestic violence counseling or survivor support groups for suspects where such programs have not existed previously. The mental health support recommended should not be confused with Batterer Intervention Programs (BIP) classes, which are mandated by the court, but rather domestic violence counseling or survivor support groups for survivors who are incarcerated. In the case reviewed, the suspect in the case had been the victim in previous domestic abuse incidents.

According to the ACLU, nearly 60% of people in women's prison nation-wide, and as many as 94% of some women's prison populations, have a history of physical or sexual abuse before being incarcerated.<sup>11</sup> For men who have been violent with their female intimate partners, traumatic violent experiences in childhood, such as physical and sexual abuse, frequently led to school problems, misuse of substances, and arrests for a spectrum of crimes. 12 13 As there is a high correlation between childhood trauma, such as experiencing family violence, and those who are incarcerated, it follows that individuals within the criminal justice system should receive mental health support to address the past traumas they have experienced. Receiving mental health support would potentially reduce recidivism rates of domestic violence and prevent future homicides.

Women's Nonviolence Program (Batterer Intervention Program): In one case reviewed by DVDRT, the victim was a male who had been killed by his female partner. Of the 86 domestic violence deaths in Contra Costa

### **TEAM RECOMMENDATIONS CONTINUED**

between 2010 and 2019, there were 21 female suspects (24% of the homicide suspects).

Currently, the county is running a male nonviolence program (Batterer Intervention Program) for those who are incarcerated, but there is not an equivalent nonviolence group offered for incarcerated females. As females made up almost a quarter of the domestic violence homicide suspects, it follows that there should be nonviolence programs offered to female incarcerated populations as well.

2 Children who have experienced the loss of a parent due to a homicide or suicide related to domestic violence should immediately be connected to supportive services.

Currently, law enforcement is not required to file a mandated report to Children and Family Services (CFS) when children are not present at the time of the parent's domestic violence related death, whether it be a homicide or suicide. Nor is a mandated report required when there is a homicide and subsequent suicide between both parents and the children are not present. Given the trauma experienced by children with the sudden and violent loss of one (or both) parents, DVDRT recommends law enforcement notify CFS immediately to ensure the children and their surviving guardians are connected to the proper supportive services. These services would allow children to cope with their loss.

DVDRT also recommends that when children are present during a domestic violence related death, they are interviewed at the Children's Interview Center (CIC). One case reviewed by

DVDRT was a domestic violence incident which led to a suicide. The victim's children were present when the death occurred and were interviewed by police. Being interviewed at the CIC provides specialized services to children who are the victims or witnesses of a crime. The CIC conducts child forensic interviews, non-acute forensic medical examinations, provides advocacy services, parent education and access to therapy. This would allow children and their families to be connected to the necessary resources needed to process the death.

3 Law enforcement agencies should have a protocol in place to support the mental health needs of personnel dealing with homicide or suicide calls.

During the in-depth case discussions, DVDRT realized that law enforcement is not always given time or the resources necessary to process their emotional trauma from working on a homicide or suicide call. "Police officers undergo extensive training that prepares them to keep communities safe and ensure that citizens abide by the law. Although this training does prepare them for the things that they face on the job, it doesn't necessarily prepare them for the tragedies that they encounter or how to deal with the aftermath. It is next to impossible to train someone to be prepared psychologically for some of the tragedies that they will see on the job."15

The public expects law enforcement to respond to each incident in a trauma-informed manner. But if they have not been given the resources necessary to process their own trauma of working a homicide or suicide incident, then their behavior, approach and trauma-informed response to future incidents could be hampered.

### **TEAM RECOMMENDATIONS CONTINUED**

Conversely, when fire departments respond to a homicide incident, those who responded are given time to process the incident and de-brief with their team, supervisors or trained mental health professionals.

While mental training isn't really achievable, bringing awareness to police officer's mental health can allow for more attention and extra care to be given. It is important that police officers rely on open communication with their superiors to ensure that these concerns are addressed and don't go ignored. Ultimately, this could be a disservice to the police officers, their colleagues and even citizens. Open communication about mental health will allow for all parties to remain safe. Peer support groups have also shown great promise within police departments. Due to the trauma experienced by law enforcement in working on homicide and suicide cases, DVDRT recommends all 26 law enforcement agencies within the county have an established protocol in place for mental health supportive services for their personnel.

4 Strengthen community awareness around the Domestic Violence Restraining Order process by providing training for agencies that work with individuals requesting DVROs frequently.

During the in-depth case reviews, DVDRT noticed that of the victims who had interactions with county agencies or advocacy systems prior to their death, there was a lack of uniformity and training around the Domestic Violence Restraining Order (DVRO) process. This was particularly noticeable for service providers who interact with domestic

violence victims most frequently. These service providers included court personnel and CFS social workers.

DVDRT recommends strengthening community awareness around the DVRO process. For instance, court personnel such as mediators and facilitators frequently interact with domestic violence victims when they file DVROs, but do not receive training on domestic violence related resources available within the county. As the most dangerous time for a domestic violence victim is when they are trying to leave the relationship, it is critical for those explaining the DVRO process to understand this heightened level of risk.

CFS social workers also recommend a parent going through domestic violence get a DVRO to protect themselves and their children, but have limited knowledge of the legal process, when to encourage a survivor to get a DVRO and the steps involved in obtaining a DVRO. By training court personnel and CFS social workers on DVROs and domestic violence resources within the county, awareness around the DVRO process and domestic violence county services will increase.

### **WORKS CITED**

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