Statewide Domestic Violence Fatality Review Team

OVERVIEW

Case Reviews, Findings, and Recommendations

In **January 2011** the statewide Domestic Violence Fatality Review Team (DVFRT), originally authorized by statute in 2005, began to take shape. For over a year after initial meetings, the Team recruited a multi-disciplinary membership and drafted its protocol. The mission of the DVFRT is to improve the coordinated statewide response to and prevention of domestic violence and domestic violence fatalities around the state. The DVFRT is guided by this mission statement, as well as by the statutory mandates, and the core principles and values outlined in the Team's protocol.[1] This document outlines the Team's case reviews and resulting recommendations.

April/May, 2012: The first case the Team reviewed involved an adult male perpetrator and adult female victim. The parties had been married for a considerable amount of time. They lived in a small, coastal town. Each had adult children from previous marriages. In legal terms, both the perpetrator and the victim were considered "elderly." Family members, acquaintances, and community members reported knowing or having heard that the perpetrator had engaged in abusive behavior toward the victim prior to her death, however law enforcement was never previously involved with either party. The perpetrator used a firearm to kill the victim and himself and then set the couple's house on fire.

In early 2013, in its first report to the legislature, the Team offered the following findings and recommendations based on the first case review:

ISSUE	RECOMMENDATION
Senior services and cultural competency around the elderly population	1) Domestic violence multi-disciplinary teams in each county whose members should include adult protection service workers 2) Improved awareness around suicidality in the elderly population
Impact of childhood trauma	1) Awareness and additional research surrounding effects of childhood trauma 2) Improved trauma-informed services and intervention
Opportunities of health care to interact with victims and perpetrators of domestic violence	1) Education of medical care providers around domestic violence issues including safety planning.
Inadequate and inaccurate media coverage	1) Improved and accurate media reporting on domestic violence to promote public

[1] For a copy of the Team's Protocol, or more information on the Team, generally, please email Erin Greenawald at erin.greenawald@doj.state.or.us

	awareness
Limitation of access for victims to obtain a Family Abuse Prevention (FAPA) order	1) Increased accessibility to FAPA ("Restraining Order") processes (24-hour) to facilitate victim separation from violence and increased protection.
Lack of shelter and housing for diverse-needs populations (homeless, domestic and sexual violence survivors, families)	1) Access to emergency and transitional housing to meet diversity of community needs.

2013

May, 2013: Due to inclement weather, the Team reviewed only one case in 2013. The case involved a victim and a perpetrator who were in an intimate relationship and were living together in a central/eastern Oregon town at the time of the murder-suicide. Both were in their twenties and members of one of Oregon's nine Tribal Nations. The couple had one young child together. The victim had three children from a previous relationship. The victim's previous relationship also involved domestic violence. The perpetrator had been exposed to domestic violence during his youth, as well. The perpetrator killed the victim by shooting her. He then shot and killed himself. The couple's eight-month old baby was in the room when the murder-suicide occurred.

2014

May, 2014: The case involved a victim and perpetrator who had been in an intimate relationship but were separated and living apart at the time of the murder. The murder happened in a small southern Oregon town. Both parties were in their twenties. The couple had one young child together. The victim had another young child who did not live with her. Both the victim and perpetrator had significant drug and alcohol issues and there was a history of domestic violence in the relationship. The victim had filled out a restraining order petition close in time to her death but had not filed it with the court. The perpetrator killed the victim by stabbing her. He ultimately fled but was caught by police. The couple's 11-month old baby was in the apartment when the murder occurred.

- In late 2014, the Team submitted to the legislature its biennial report, "Executive Summary," which offered four key findings identified in the two cases reviewed by the Team since its last report in January, 2013.The findings were: children exposed to domestic violence, civil protection orders, points of intervention, and improving community awareness and promoting cultural change.
- In early 2015, the Team submitted a report to the legislature on Family Abuse Protection Orders, "Report and Recommendations on Improving the Efficacy of Oregon's Family Abuse Prevention Act (FAPA) Order."[2]

[2] For copies of either the "Executive Report," or "Report and Recommendations on Improving the Efficacy of Oregon's Family Abuse Prevention Act (FAPA) Order" please email erin.greenawald@doj.state.or.us

December, 2014: The Team reviewed its second case of 2014 in December. This case involved a married couple, nearing retirement age. The couple had no children together. The female victim had one living adult son who lived 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.

2015

April, 2015: The first case the Team reviewed in 2015 involved a familicide[3]. 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.

November/December, 2015: 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.

In its annual letter to the Attorney General and the Directors of the Oregon Health Authority and Department of Human Services, the Team offered the following nine recommendations from the three most recent case reviews:

FINDINGS	RECOMMENDATIONS
1. There is a need to prevent domestic violence offenders from access to or possession of firearms.	The DVFRT recommends that: A. Oregon's lawmakers continue to build upon the firearms restrictions placed on domestic violence offenders; 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.
2. There is a need to enhance community corrections supervision of domestic violence offenders.	The DVFRT recommends that: A. The minimum number of hours of domestic

[3] Familicide 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

	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.	<u>The DVFRT recommends that:</u> 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	<u>The DVFRT recommends that:</u> A. DHS' DV Council create 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 is expanded to include an advanced domestic violence course.
5. There is a need to improve domestic violence education for students and professionals	<u>The DVFRT recommends that:</u> A. Domestic violence training is required for all: K-12 teachers and counselors; lawyers and judges; 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	<u>The DVFRT recommends that:</u> 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 which victims/survivors attend.
7. There is a need to improve long-term post-incident assistance to victims' family	<u>The DVFRT recommends that:</u> 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 the victims' family in fatality cases.
8. There is a need to improve media coverage of domestic violence and domestic violence fatalities	<u>The DVFRT recommends that:</u> 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 its response to the needs of domestic violence victims and survivors	<u>The DVFRT recommends that:</u> A. The DVFRT develop a proposal for working with Oregon's faith communities to enhance their effectiveness in preventing and responding to domestic violence.

The DVFRT is currently working on selecting cases for its reviews in **2016**.