

## **The Houston/Harris County Adult Violent Death Review Team**

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## **The Houston/Harris County Adult Violent Death Review Team**



In the late 1990's the Harris County Domestic Violence Coordinating Council, a 501-C-3 organization committed to the prevention of domestic violence, began to discuss the formation of a domestic violence death review team.

Agencies were recruited to participate, information was gathered from different state review teams; and the work of a number of child abuse death review teams was examined.

During meetings it became clear that confidentiality and immunity were issues. The team decided they would not be able to continue until protective legislation was in place.

## Legislation Passed

- 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.
- In 2002, the Death Review Team began meeting again, but was not yet formalized. Most of the members had changed, but we had the preliminary work well underway. **The primary question at this stage was, “Can this work be realized?”**

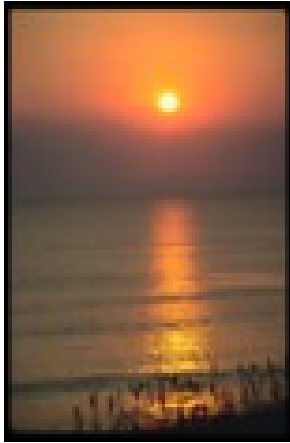


## A Partnership Between the Harris County Domestic Violence Coordinating Council and Harris County Public Health & Environmental Services (HCPHES)



- After the legislation was passed, the HCPHES Injury Surveillance Program also began to investigate the possibility of forming an adult fatality review team.
- In 2002, the HCPHES made contact with HCDVCC Death Review Team.
- Thus began collaboration between the two entities, resulting in the formation of the Houston/Harris County Adult Violent Death Review Team.

## Beginning the “Work”



- In 2002, we began working to create the death review team structure, developing policies and procedures, and searching for possible funding sources.
- We recognized there was a need to develop relationships with the Harris County Commissioners, the Medical Examiner's Office, and a host of others to share in this work.

## What Are Our Goals?

- To conduct formal, confidential, and systematic evaluation and analyses of adjudicated cases of family violence occurring in Houston and Harris County, focusing on the flow of each case through the various agencies in the system to identify areas of improvement or strengthening of agency contacts and interagency response.
- To evaluate policies, protocols and practices to identify gaps in service within agencies and the community.
- To build a database for analysis of aggregate population of deceased persons and perpetrators.
- To disseminate information on prevention strategies through an annual quantitative and qualitative report to the AVDRT, HCDVCC, and as required to the Texas Department of Protective and Regulatory Services and to the community at large.
- To promote cooperation, communication, and coordination among agencies involved in responding to unexpected deaths.
- To develop an understanding of the causes and incidence of deaths caused by family violence in the counties in which the review team is located.
- To advise the legislature, appropriate state agencies, and local law enforcement agencies on changes to law, policy, or practice that will reduce the number of violent deaths.

## Making the “Work” Visible

- In 2003, we completed policies and procedures and we began to carry out case reviews. During this time we acknowledged that we needed a review process. We decided to visit the long-established Houston/Harris County Child Fatality Review Team to learn about reviews. We also contacted other state review teams to ask questions and seek guidance.

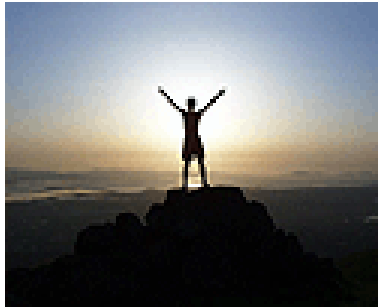


## Striving for Designation

- Throughout 2003, decision-making and growth continued to be a large part of our work.
- In May 2003, an elder abuse fatality review team was formed within the Harris County Hospital District. This team became known as the Elder Abuse Fatality Review Team (EFFORT). We began to coordinate a partnership with EFFORT.
- Decision making: What type of cases will we review? Who do we want to develop cooperative working agreements with?
- Petitioned Harris County Commissioner's Court for designated review team status under Chapter 672 of the Texas Health and Safety Code.



## Designation



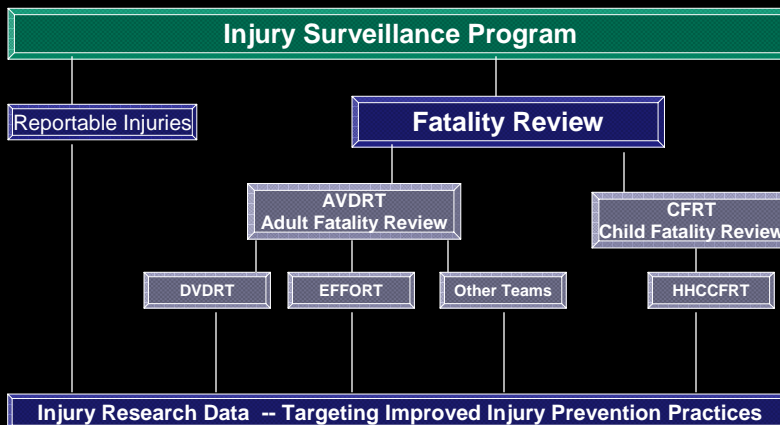
- In August 2003, the AVDRT was designated as the official Harris County fatality review team.
- Subsequently, the Domestic Violence Death Review Team (DVDRT) was formed as a subcommittee of the AVDRT.
- **The DVDRT Charge:** review family violence-related homicides.

## DVDRT Progress

- September 2003: The DVDRT began official case reviews.
- Review of cases continued through 2004 while the DVDRT continued to develop working relationships with other agencies.
- In August of 2004 we learned that we received a State Funded 421 Criminal Justice Planning Grant
- September 2004 – The AVDRT completed its first report.



## Injury Surveillance Program Organizational Structure



### Houston/Harris County Domestic Violence Death Review Team Member Agencies

**Harris County**

- Domestic Violence Coordinating Council
- Public Health & Environmental Services
- District Attorney's Office, Victim Witness Division & FCLD
- 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
- Aid to Victims of Domestic Abuse, AVDA-BIPP
- Shalom Bayit
- The Bridge Over Troubled Waters
- Memorial Hermann Healthcare System, Forensic Nursing Services
- Prevent International Parental Child Abduction



## Member Responsibilities



- Each member provides the team with information from their records, serves as a liaison to their professional counterparts, provides definitions of their profession's terminology, interprets the procedures and policies of their agency, and explains the legal responsibilities or limitations of their profession.
- Team members may designate another representative of their agency to replace them at meetings they are unable to attend.

## How is a Review Conducted?

- Confidentiality
- Members do not take notes.
- Records sharing – through use of DVDRT Case Report Form
- Order of Case Review
  - Law Enforcement Agency
  - District Attorney's Office
  - Medical Examiner's Office
  - CPS
  - Other agencies
- Identification of gaps in the community
- Missing information will roll over to the next DVDRT meeting.

## Referrals for Survivors

- Referrals for appropriate services are an opportunity for the team to assess and address an immediate need. The team member professionally associated with the agency that is providing or knowledgeable about the service usually handles referrals.
- Any team member may assist with making a referral. The team discusses which agency will handle the referral.



## First Report Completed

### Preliminary Findings:

- The majority of the homicide victims in the 13 reviewed cases (54%) were Black females.
- One case involving a Hispanic male victim was reviewed.
- Women in their thirties comprised 46% of the victims but the ages ranged from 20's to 80's.
- Five fatal GSW's. Other causes of death included blunt force trauma caused by beating and kicking, stabbing, and manual strangulation.
- Two murder/suicides involving the death of children under 17 years of age.
- Six victims were married to their perpetrators at the time of death.



## What We Learned 2003-2004

- We speak a different language.
- Women are not seeking shelter.
- Despite previous incidents of violence, women are not seeking Protective Orders.
- There is a need for broader community involvement in the larger council (HCDVCC), i.e. clergy, defense attorneys, chemical dependency counselors.

## Second Report Completed

### Preliminary Findings

- A total of 20 cases were reviewed in 2005-2006. Victims ranged in age from 17 to 77 y.o.
- Perpetrators age range from 18 to 69 y.o.
- Thirteen (13) victims were females, seven (7) were male.
- Race/Ethnicity – 9 victims were White, 5 were African American, 3 were Hispanic
- Twelve (12) fatal GSW's. Five (5) fatal knife wounds, two (2) blunt force trauma (hammer, pipe), one (1) manual strangulation.
- Nine (9) victims were married to the perpetrator at the time of their death, two (2) were ex-spouses and one (1) same sex relationship.
- Half (10) of the victims had a history of filing police reports.
- None of the victims were found to have filed for a protective order.

## What We Learned 2005-2006

- Victims are not going to shelters.
- Victims are not seeking protective orders.
- Co-workers know a lot, but don't know how to help.
- Family members, friends know of abuse, but are unsure as to where to turn for help.
- There is a need for broader community involvement in the larger council (HCDVCC), i.e. clergy, defense attorneys, chemical dependency counselors.

## Recommendations

- Improve access to domestic violence service providers.
- Promote knowledge in the community that every citizen is obligated to report suspected child abuse.
- Insure that all hospital Social Workers have adequate domestic violence service provider (resources) information for distribution to victims.
- Training Family and Protective Services workers and private therapists to recognize signs of domestic violence and make appropriate referrals.
- Review what kind of interaction probation officers have with parolees and probationers in possible domestic violence situations.
- Involve psychological services personnel from area school districts in the review process, when appropriate.
- Stop or reduce harassing telephone calls placed by inmates in area correctional facilities.

## Case Scenarios

- The decedent was a 78 y.o. female who was strangled and suffocated by her husband of 54 years. There had been no previous reports of domestic violence. The victim had a history of leg and hip problems which may have been violence related. The defendant was sentenced to 8 years and fined \$10,000.
- The decedent was a 24 y.o. female who was stabbed approximately 46 times by her boyfriend. The couple did not live together but did have a 2 y.o. daughter. There was a long history of violence by the boyfriend toward the victim including threats against the victim's family members. The defendant was sentenced to life.
- The decedent was a 20 y.o. female who was shot in the head after having told her boyfriend that she wanted a separation. The boyfriend had a long history of criminal behavior including physical abuse of previous girlfriends. The couple had a 3 month old child together. The victim was found dead in her bathroom by a friend concerned about her safety. The defendant was sentenced to 40 years.

## Case Scenarios (Cont.)

- The decedent was a male in his 50's who died from a gunshot wound to his back, by his son. The family had a long history of mental health issues, including schizophrenia, bipolar disorder, and emotional breakdowns. There was also a history of alcohol and drug abuse. The son repeatedly beat his father on many occasions in front of other witnesses. The defendant was sentenced to 35 years.
- The decedent was a male in his late 50's with multiple gunshot wounds to the face, chin, neck, chest and arms. The defendant was the victim's cousin, whose criminal history included a previous murder, as well as numerous offenses in Texas, Louisiana and Florida. The defendant was sentenced to life.