Domestic Violence Homicides in Multnomah County 2004-2006 Report and Recommendations

December 31, 2007

Prepared for and approved for release by the
Multnomah County Domestic Violence Fatality Review Team

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Multnomah County Domestic Violence Fatality Review Team
Report and Recommendations

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The mission of the Multnomah County Domestic Violence Fatality Review Team and Process is to improve our community's response to domestic violence and to reduce the number of fatalities related to domestic violence.

This report provides information about domestic violence homicides over the past three years, the fatality review process, and recommendations resulting from in-depth review of a sample of fatalities. The recommendations are intended to provide the community with information on how we can better intervene in high risk domestic violence cases.

The Family Violence Coordinating Council extends thanks to friends, co-workers, family members and organizations that provided information for each review, making this detailed examination possible, and enriching the Team's understanding of how we can work together to prevent such sad and tragic outcomes in the future.

I. Domestic Violence Fatalities

Domestic violence remains one of the greatest risks to life and safety in Multnomah County. In the past three years (2004-2006), 32 people died in 28 domestic violence-related incidents. In 2006, domestic violence homicides accounted for 30% of all murders in the county, and half of all murders of women. In that year, domestic violence was the single largest cause of homicide.

Domestic violence-related homicides for 2004 through 2006 are listed on the following pages. The 30 deaths included one incident in which a mother and her two children were killed, four cases where a person killed another in a DV-related incident and then committed suicide.

- The victims ranged in age from 5 to 66 years old; the perpetrators were 22 to 63 years old.
- Sixteen men/boys and 13 women/girls were killed.
- Eighteen of the perpetrators were male and two were female.
- Ten of the victims were former or current wives or girl-friends.
- Five victims were other family members (sister, father, brother-in-law, brother), and three were the children or parent of the girl-friend who was also killed.

Perpetrators used a variety of weapons: eight used firearms, five stabbed the victim, three used hands, feet or a blunt instrument, two strangled the victim and one burned the victim. All of the murder-suicides were accomplished with a firearm.

II. Domestic Violence Fatality Review Team (DVFRT)

The DVFRT is authorized by the Legislature (ORS 418.712 through 418.718, Appendix A). To a large extent, membership of the DVFRT is determined by statute, and includes: domestic violence victim services, medical personnel, county health department staff, the District Attorney's Office, Gresham Police, Portland Police, Legal Aid Services of Oregon, Oregon Department of Human Services, Department of Community Justice, Multnomah County Sheriff's Office, Judge, court administrator, batterer intervention program, the medical examiner, Department of County Human Services, and the Multnomah County Family Violence Coordinating Council and the Local Public Safety Coordinating Council.

The Multnomah County DVFRT initiated a process to review local domestic violence fatalities in fall of 2006. The purpose of these multidisciplinary reviews is to examine the events leading to a particular domestic violence fatality, with a goal of learning how a fatality could have be prevented in similar cases in the future. The DVFRT followed protocols developed and approved in May of 2006, and amended in May 2006 that met the standards of the Oregon Revised Statutes passed in 2005. These statutes authorized and set standards for domestic violence fatality reviews and protected the confidentiality of participants in the reviews. Appendix B provides the time line for the reviews of the two homicides that were conducted to develop the following recommendations.

The fatality review process is organized by the Multnomah County Family Violence Coordinating Council (FVCC) staff and the Public Safety Coordinating Council. This process is based on the willing participation and open dialogue among members of diverse agencies, including law enforcement, criminal justice, medical and human services, as well as domestic violence advocates. Participating agencies and their representatives are all committed to reviewing the facts of each case, and learning from these tragedies to improve the response to domestic violence by established systems and by the community. The respectful manner of all members participating in this difficult process has facilitated finding opportunities to make progress. Deep thanks are also given to all the family members, friends and coworkers who provided information for the review process.

The Team will convene in 2007 and 2008 to review two more homicides and to track the implementation of recommendations contained in this report.

III. Multnomah County Domestic Violence-Related Fatalities

2004-2006

2004

Bill Hartse, 41, January, Corbett, was shot and killed by his ex-girl-friend, Vicky Kavanagh, who then shot herself.

Linda Bullock, 50, January, Portland, was shot by her husband, David Bullock, 54, who then shot himself after the shooting. Linda survived the incident.

Jose Angel Padilla, 22, January, Portland, was killed by Portland police when he threatened to kill his girlfriend he was holding at knifepoint. Padilla had a history of domestic violence.

Deborah Spriggins, 52, May, Portland, was killed by her boyfriend Matthew Roy Greer Jr., 52. She died of blunt force head trauma.

Letitia Bracamontes Rodrigues, 31, June, Portland, was found dead in her apartment. She had been stabbed multiple times. Police have identified her boyfriend, as a suspect, but believe he has left the area.

Kim, Hun, 57, June, Gresham, was stabbed to death by brother-in law Dong Ok Suh, 45. He was found guilty but insane.

Julia Wilson, 47, and Shirley Wilson (Julia's mother), 66, December, Portland, were killed by Mark A. Litkie. Julia Wilson died of 14 stab wounds, and her mother was burned alive. Police say Litkie killed his ex-girlfriend when he learned through an e-mail she received that she planned to travel to California to visit a childhood sweetheart.

2005

Diane McGrail, 46, February, Portland, was strangled to death by her brother, Paul Miller Guenther, 44. She died of asphyxiation from ligature strangulation.

Ronald Riebling, JR, 40, March, Portland, was killed by a Portland Police Officer after a 3-hour standoff in which he held his ex-girlfriend's children hostage.

Derriel James Johnson, 52, April, Portland, was killed by his sister, Gloria Johnson, 47. He died of two gunshot wounds to the chest. Police suspect the shooting was the result of an ongoing dispute.

Duane H. Chandler, 33, April, Gresham, was killed by Mitch Schoonover, 22. He died of an assault rifle shot to the face. Chandler was helping Schoonover's girlfriend move her belongings from the home she shared with Schoonover.

Kim Visathep, 40, May, Portland, was shot and killed by her husband, Victor Seth Chayanam, 54, who then committed suicide. The couple was going through a divorce.

Gabriel Thomas Gefre, Jr., 50, July, Portland, died from a blow to the head. His son punched Gefre who fell during an argument. The Multnomah County district attorney's office chose not to file charges against the son because he was acting in self defense.

Stacey Lynn Shapleigh, 40, July, Portland, was shot by her husband, Robert Charles Mikus, 43, who then killed himself.

Jessica Nicole Koon, 24, July, Gresham, was beaten to death by her boyfriend Christopher J. Jones, 23.

Ismael Santos, 33, October, Portland, was found inside a residence in SW Portland with a stab wound to the chest. Police issued an arrest warrant for Santo's brother-in-law, Juan Marcelo Joaquin, 40. Police said that jealousy between family members played a role in the stabbing.

2006

Jennifer Crawford, 34, February, Portland, was shot by her husband Gary Crawford, 48, who then committed suicide.

Soupaphane Homsombath, 24, and two children, 6 and 8 years old, March, Portland, were killed by her boyfriend Somkhith Soulinho, 31, who was the younger brother of Soupaphane's ex-husband. Somkhith shot his girlfriend and her son, stabbed her five-year-old daughter and shot himself.

Claudia Rhone, 54, May, Portland, was stabbed to death by her ex-boyfriend, Gilberto Pedroso, 63.

Jerry Lloyd Goins, 37, July, Portland, shot himself during police intervention outside his girlfriend's office.

Timothy Gripp, 36, July, Portland, was killed by his domestic partner, Jeff Rodgers, 50.

Susan Kuhnhausen, 51, September, Portland, killed Edward Dalton Haffey, 59, who had been hired to kill her by her estranged husband, Michael Kuhnhausen, 58. He has pled guilty and sentenced to 10 years

IV. Recommendations from 2006/07 Reviews

The Oregon Statute sets limit on the information that can be released following a review: only recommendations can be publicly distributed. The following list of recommendations does not fully encompass the learning and discussions held at the review meetings, nor the dire circumstances of the victims of these homicides. Yet, each of the recommendations addresses a strategy identified in a review to prevent future fatalities in our community.

Recommendations are presented in two areas: public awareness and education; and system improvements. Clearly there is overlap in some of these arenas.

A. Public Awareness and Education

In each of the cases we reviewed, the victim had contact with friends, family members, co-workers or others who were aware of the abuse prior to the fatality. The following recommendations are intended to increase the possibility that community members will be able to identify and more appropriately respond to domestic violence.

1. Improve ability to recognize high-risk domestic violence perpetrators.

- Develop an information campaign about the risk factors that indicate a high potential for lethal violence, what actions victims, family, friends or co-workers can take when these indicators are present, and resources available. Information should be distributed to a variety of individuals and organizations that have contact with victims: churches, attorneys, health workers, mental health workers, employers, or schools.

2. Communicate options to all domestic violence victims.

- Develop a flyer or card to give information and referrals to a domestic violence victim when police respond to a call, even if there is no arrest or follow-up. The flyer or card should include information about what is abuse, resources available and how to access those resources, and potential next steps that the criminal justice system might take to assist in providing safety for the victim.

3. Educate the general public.

- Increase the efforts of the Family Violence Coordinating Council Speakers' Bureau and victim advocacy organizations to provide information to community or civic groups, businesses and others.

4. Increase violence prevention for youth.

- Develop and implement an inter-personal violence education and prevention curriculum for youth in schools. Address issues that affect youth directly: bullying, controlling or jealous behavior, and coercive versus equal relationships and safety planning.

- Encourage school-based health clinics, SUN schools and other services for school-aged children, to focus more on prevention of dating and relationship violence in schools, beginning in middle school. Develop a process for referring youth who show signs of abuse to appropriate resources.

5. Education at the workplace.

- Encourage domestic violence training at the workplace, specifically about how to ask if a co-worker needs help, what resources are available for victims and how to develop a safety plan. Utilize and expand existing resources, such as the Multnomah County web-based training and training already being done by domestic violence victim services providers, including the FVCC.

6. Outreach to potential victims.

- Seek funding for in-home follow-up for people released from jail who are suspected of being domestic violence victims, e.g. a system similar to the Adapt Nurse program that visits pregnant inmates after release.
- Explore links to non-traditional reporters for leads on potential victims of domestic violence (like the "Gatekeepers" program for elders), and provide outreach to those identified.
- Improve the ability of the medical community to assess for and link potential domestic violence victims with services while still in the medical setting.

B. System Improvements

In addition to providing the public with information and resources for response, the Team also identified ways in which the domestic violence response system (criminal justice, victim services, health care and others) could make improvements. Most of the following recommendations were suggested by and identified as doable by the agency that would be responsible for implementing them.

1. Improve connections between community advocacy and formal systems.

- Improve communication, cooperation and cross-training between victim advocates and the criminal justice system. Increase resources so that victim services agencies have the capacity to respond to referrals from criminal justice agencies.

2. Improve knowledge in legal & judicial systems about domestic violence, services available and referral options.

- Provide education, technical assistance and training for all in the criminal justice system who may have contact with victims of

domestic violence, so that individuals have the knowledge and resources to link victims with victim services agencies or other appropriate resources. The Team prioritized training that qualifies for Continuing Legal Education (CLE) for civil and criminal attorneys so that more attorneys know the resources available for clients and victims.

3. Increase the capacity of hospital staff to respond effectively on-site to victims of domestic violence.

- Increase the capacity of hospital staff to respond effectively on-site to victims of domestic violence. Develop a mechanism so that hospital staff have access to the Restraining Order (RO) database (LEDS). Train hospital staff to research the database in cases of suspected domestic violence, to assist them to develop safety plans with the victims, report violations of restraining orders, assure safety of health care workers on-site and connect the victim to the hospital social worker, needed legal services or other victim advocacy services while the victim is still on-site.
- Train health care workers on predictors of DV homicide/fatalities, and strategies to prevent a fatal outcome.
- Reinvigorate Health Care Systems United, which includes the County Health Department, local health providers and DV agencies, to examine how health systems can better help DV victims. Seek funds for staffing.

4. Improve connections among law enforcement agencies.

- Fund a Regional Domestic Violence Response Team (RDVRT) program to develop protocols and appropriate inter-agency agreements to assure seamless enforcement of laws and other batterer accountability strategies across county and state lines.
- Advocate for a Criminal Justice Information System (CJIS) so agencies can better share information across systems, regardless of the jurisdiction.
- Work with the Oregon Association of Community Corrections Directors (AOCCD) to create a workgroup on DV offender supervision that would develop statewide policy on training, risk assessment and communication; include victim advocates on this workgroup.
- Support aggressive warrant enforcement for priority high-risk cases, and track results of this effort.
- Improve inter-county and inter-state communication on DV cases. Develop interagency agreements to help facilitate the sharing of documents and other information between jurisdictions.

5. Improve services for domestic violence victims who have contact with the Courts, including Community Courts and Drug Courts.

- Convene a process to look for a new way to provide prevention and intervention to victims who are charged with misdemeanor level crimes dealt with by the Courts, especially prostitution.
- Provide further education to Deputy DA's, defense bar and community corrections officers (probation/parole) in the region about the link between drug use, prostitution and domestic violence. Develop mechanisms for linking drug abusers or prostitutes who are also victims of domestic violence to services.
- Assure that Court judicial officers, referees and other staff have training on domestic violence, and regularly updated information on services available for DV victims and where to make referrals.

6. Reduce gun availability.

- Better utilize existing state and federal laws that limit gun access to convicted domestic violence offenders and restraining order respondents, in order to reduce availability of handguns in DV households, and thus reduce the likelihood that the gun will be used for a homicide.

7. Improve pet care options for victims.

- Work with Humane Society and Multnomah County Animal Control to develop a pet care program, and to advertise those in existence locally, so that pet care is available to assist victims in leaving dangerous situations.

For additional information about the DVFRT process and resources available in Multnomah County, contact:

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Appendix A – Oregon Revised Statutes

DOMESTIC VIOLENCE FATALITY REVIEW TEAMS

418.712 Definitions for ORS 418.714 and 418.718. As used in ORS 418.714 and 418.718, "domestic violence fatality" means a fatality in which:

(1) The deceased was the victim of a homicide committed by a current or former spouse, fiancé, fiancée or dating partner;

(2) The deceased was the victim of a suicide and there is evidence that the suicide is related to previous domestic violence;

(3) The deceased was the perpetrator of the homicide of a current or former spouse, fiancé, fiancée or dating partner and the perpetrator also died in the course of the domestic violence incident;

(4) The deceased was a child who died in the course of a domestic violence incident in which either a parent of the child or the perpetrator also died;

(5) The deceased was a current or former spouse, fiancé, fiancée or dating partner of the current or former spouse, fiancé, fiancée or dating partner of the perpetrator; or

(6) The deceased was a person 18 years of age or older not otherwise described in this section and was the victim of a homicide related to domestic violence. [2005 c.547 §1]

Note: 418.712 to 418.718 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 418 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

418.714 Domestic violence fatality review teams. (1) A local domestic violence coordinating council recognized by the local public safety coordinating council or by the governing body of the county may establish a multidisciplinary domestic violence fatality review team to assist local organizations and agencies in identifying and reviewing domestic violence fatalities. When no local domestic violence coordinating council exists, a similar interdisciplinary group may establish the fatality review team.

(2) The purpose of a fatality review team is to review domestic violence fatalities and make recommendations to prevent domestic violence fatalities by:

(a) Improving communication between public and private organizations and agencies;

(b) Determining the number of domestic violence fatalities occurring in the team's county and the factors associated with those fatalities;

(c) Identifying ways in which community response might have intervened to prevent a fatality;

(d) Providing accurate information about domestic violence to the community; and

(e) Generating recommendations for improving community response to and prevention of domestic violence.

(3) A fatality review team shall include but is not limited to the following members, if available:

(a) Domestic violence program service staff or other advocates for battered women;

(b) Medical personnel with expertise in the field of domestic violence;

(c) Local health department staff;

(d) The local district attorney or the district attorney's designees;

(e) Law enforcement personnel;

(f) Civil legal services attorneys;

(g) Protective services workers;

(h) Community corrections professionals;

(i) Judges, court administrators or their representatives;

(j) Perpetrator treatment providers;

(k) A survivor of domestic violence; and

(l) Medical examiners or other experts in the field of forensic pathology.

(4) Other individuals may, with the unanimous consent of the team, be included in a fatality review team on an ad hoc basis. The team, by unanimous consent, may decide the extent to which the individual may participate as a full member of the team for a particular review.

(5) Upon formation and before reviewing its first case, a fatality review team shall adopt a written protocol for review of domestic violence fatalities. The protocol must be designed to facilitate communication among organizations and agencies involved in domestic violence cases so that incidents of domestic violence and domestic violence fatalities are identified and prevented. The protocol shall define procedures for case review and preservation of confidentiality, and shall identify team members.

(6) Consistent with recommendations provided by the statewide interdisciplinary team under ORS 418.718, a local fatality review team shall provide the statewide team with information regarding domestic violence fatalities.

(7) To ensure consistent and uniform results, fatality review teams may collect and summarize data to show the statistical occurrence of domestic violence fatalities in the team's county.

(8) Each organization or agency represented on a fatality review team may share with other members of the team information concerning the victim who is the subject of the review. Any information shared between team members is confidential.

(9) An individual who is a member of an organization or agency that is represented on a fatality review team is not required to disclose information. The intent of this section and ORS 418.718 is to allow the voluntary disclosure of information.

(10) An oral or written communication or a document related to a domestic violence fatality review that is shared within or produced by a fatality review team is confidential, not subject to disclosure and not discoverable by a third party. An oral or written communication or a document provided by a third party to a fatality review team is confidential, not subject to disclosure and not discoverable by a third party. All information and records acquired by a team in the exercise of its duties are confidential and may be disclosed only as necessary to carry out the purposes of the fatality review. However, recommendations of a team upon the completion of a review may be disclosed without personal identifiers at the discretion of two-thirds of the members of the team.

(11) Information, documents and records otherwise available from other sources are not immune from discovery or introduction into evidence solely because the information, documents or records were presented to or reviewed by a fatality review team.

(12) ORS 192.610 to 192.690 do not apply to meetings of a fatality review team.

(13) Each fatality review team shall develop written agreements signed by member organizations and agencies that specify the organizations' and agencies' understanding of and agreement with the principles outlined in this section. [2005 c.547 §2]

Note: See note under 418.712.

418.715 [1961 c.621 §§2,5; repealed by 1989 c.786 §13]

418.718 Statewide team. (1) The Department of Human Services may form a statewide interdisciplinary team to meet twice a year to review domestic violence fatality cases, identify domestic violence trends, make recommendations and take actions involving statewide issues.

(2) The statewide interdisciplinary team may recommend specific cases to a local multidisciplinary domestic violence fatality review team for review under ORS 418.714.

(3) The statewide interdisciplinary team shall provide recommendations to local fatality review teams in the development of protocols. The recommendations must be designed to facilitate communication among organizations and agencies involved in domestic violence fatality cases so that incidents of domestic violence and fatalities related to domestic violence are identified and prevented. The recommendations must include procedures relevant for both urban and rural counties. [2005 c.547 §3]

Appendix B – Review Process

The two reviews conducted in 2006-07 followed the following process:

- In May, 2006, the Team met, approved protocols and identified the first fatality to review. The list of potential cases was provided by the Multnomah County Family Violence Coordinating Council (FVCC) staff and the DA's Office.
- From June through August, staff to the FVCC gathered information relating to the case that was chosen for the first review, including case files and interviews with family, friends or co-workers of the deceased and the perpetrator.
- In September 2006, the Team met and reviewed the information gathered, developed a timeline of the relationship and of the events prior to the fatality, and, based on the information presented, generate a list of recommended steps that could be taken to prevent future homicides.
- In November 2006, the Team met again and prioritized those recommendations, based on two criteria: what steps appeared to have the most potential to improve the outcome for victims in similar situations (i.e., most likely to save a victim's life) and which were most doable given available resources.
- In June 2007, the Team met twice to review a second case based on case file information and interviews with family, friends or co-workers. The Team generated a timeline of the relationship and of the events prior to the fatality, developed a list of recommendations, and discussed strategies/leadership for potential implementation.
- *In September 2007, the Team met to review a final version of recommendations for both cases and this report, and voted to (release/ not release the recommendations).*

Appendix C – Domestic Violence Fatality Review Team Members

Convened by:

The Honorable Dale Koch, Presiding Judge Multnomah County Circuit Court
Commissioner Lisa Naito, Chair, Multnomah County Public Safety Coordinating Council, and
Chiquita Rollins, Multnomah County Domestic Violence Coordinator and staff to Multnomah County Family Violence Coordinating Council

Team Meetings Facilitated by:

Kamala, Bremer

Team Member Organizations and Representatives:

Catholic Charities' El Programa Hispano - Project UNICA,
Gloria Wiggins,
Choices DVIP,
Christine Crowe,
Circuit Court,
The Honorable Jean Maurer, Judge
Tracey Cordes, Interim Court Administrator
Doug, Bray Court Administrator
Department of Community Justice,
Scott Taylor, Director
Carl Goodman
Jeremiah Stromberg
Desarrollo Integral de la Familia,
Rosemary Alston
Gresham Police Department,
Dale Cummins
Tony Cobb,
David Lerwick
Metropolitan Public Defenders,
Nathalie Darcy,
County Domestic Violence Coordinator' Office and staff to Multnomah County Family Violence Coordinating Council
Joslyn Baker
Annie Neal
Multnomah County Attorney
Patrick Henry
Multnomah County District Attorney's Office
Helen Smith
Rod Underhill
Jeff Howes
Amy Holmes-Hehn
Multnomah County Health Department,
Julie Goodrich
Multnomah County Legal Aid,
Leslie Kay, Director
Julia Olsen
Multnomah County Public Safety Coordinating Council,
Judy Shiprack,
Carol Wessinger,
Multnomah County Sheriff Office,
Bernie Giusto, Sheriff
Tim Moore,
Bobbi Luna,
Monte Reiser,

Garr Nielsen,
Sean Christian,
Multnomah Department of County Human Services,
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Karl Brimner,
Oregon Dept of Human Services,
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Oregon State Medical Examiner,
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Portland Police Bureau,
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John Eckhart
Cliff Madison
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Bryan Steed
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Teri Lorenzen
Volunteers of America Home Free,
Kris Billhardt