THE BALTIMORE CITY DOMESTIC VIOLENCE FATALITY REVIEW TEAM (BCDVFRT)

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2012 RECOMMENDATIONS

The mission of the Baltimore City Domestic Violence Fatality Review Team (BCDVFRT) is to reduce domestic violence-related fatalities and near fatalities through systemic multi-disciplinary review of domestic violence fatalities and near fatalities in Baltimore City; through interdisciplinary training and community based prevention education; and through data-driven recommendations for legislation and public policy.

In the past year, the BCDVFRT continued to review domestic violence related homicides and near homicides as part of our ongoing mission to identify systemic flaws. Many of the issues which surfaced in these cases were identified in previous years, but have yet to be fully addressed. As a consequence, the BCDVFRT plans to continue working through workgroups dedicated to refining its recommendations to address specific ongoing system problems. In addition, the BCDVFRT identified six new issues, and agreed upon the following recommendations.

1. IMPROVE SYSTEM RESPONSE TO CHILDREN WHO WITNESS FATAL ABUSE OF A PARENT

Problem: Since the BCDVFRT began meeting, it has reviewed cases with children who witnessed one or both of their parents being killed or almost killed as a result of domestic violence. The impact of witnessing the crime is immense and their lives are changed forever. Not only do these children deal with trauma and grief, they also must deal with practical consequences centered around who they will live with and where. These surviving children were separated from friends, schools, and possessions. For several it meant the end of some family relationships. Others had to cope with visits to prison or no contact with the perpetrator/parent. Others were subjected to custody disputes between maternal and paternal relatives. When one parent kills the other, the child may live with the shame of being the child of a killer or the guilt of not being able to prevent the killing. Traumatized and bereaved, these children must struggle to find a new life. Over the course of reviews, we have seen children who witness this event end up incarcerated for later committing serious crimes themselves or lost to systems of care or help.

Recommendation: Create a protocol which will identify and develop an appropriate response to children whose parent(s) have been killed as a result of domestic violence. This protocol should be implemented in conjunction with the school system where those children will be systematically identified and an appropriate response given. The BCDVFRT and DVCC will invite a representative of the school system as well as other relevant stakeholders to join them to address this issue.

2. INCREASE SCREENING AND INTERVENTION FOR DOMESTIC VIOLENCE BEFORE, DURING AND AFTER PREGNANCY

Problem: Homicide is the leading cause of pregnancy-associated death in Maryland; the majority of these deaths are perpetrated by a current or former intimate partner[1]. During 2012 the BCDVFRT reviewed a case in which a mother was shot and killed by her boyfriend within 12 months of giving birth to their child. During her most recent pregnancy, medical staff did not complete a domestic violence screen during her prenatal visits or during her hospital stay for her delivery. Many of the known domestic violence risk factors were present in her reproductive health history.

Recommendation: Increase screening and intervention for domestic violence before, during and after pregnancy. Research has shown that screening for domestic violence during pregnancy along with appropriate intervention can reduce domestic violence during pregnancy[2] –a risk factor for poor pregnancy outcomes[3].

As recommended by the 2012 American College of Obstetricians and Gynecologists (ACOG) Committee Opinion on "Intimate Partner Violence (IPV)", obstetric assessment for IPV should ideally occur at the first prenatal visit, each trimester and postpartum[4]. The following measures would improve IPV assessment of pregnant women: 1) Education of pregnant women and obstetric providers about IPV. Provider education should include physicians, nurses, nurse midwives, social workers and others who may be in contact with pregnant women as well as health professional students in school and training; 2) Counseling and referral to appropriate resources of women who either self-identify as IPV victims or those with risk factors who deny domestic violence; 3) Dissemination of user-friendly tools to health care providers for IPV assessment; and 4) Pre-conception and inter-conception IPV assessment targeted at service sites where reproductive-aged women are seen (family planning, STI, Healthy Start, home visiting, WIC, substance abuse treatment sites).

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[1] Cheng, D and Horon I. Intimate Partner Homicide Among Pregnant and Postpartum Women. Obstetrics and Gynecology, June 2010; vol.115:1181-6.

[2] Kiely M, et al. An Integrated Intervention to Reduce Intimate Partner Violence in Pregnancy. Obstetrics and Gynecology, February 2010; vol. 115:273-83.

[3] Shah PS and Shah J. Maternal Exposure to Domestic Violence and Pregnancy and Birth Outcomes: A Systematic Review and Meta-analysis. Journal of Women's Health. October 2010; vol 19:2017-31.

[4] Intimate Partner Violence. Committee Opinion No. 518. American College of Obstetricians and Gynecologists. Obstetrics and Gynecology, February 2012; vol.119:412-

3. ENCOURAGE PEDIATRIC PROVIDERS TO ROUTINELY SCREEN THEIR PATIENTS AND THEIR PATIENTS' CAREGIVERS FOR FIREARM OWNERSHIP

Problem: The FBI Crime in the United States Report from 2010 places Maryland as one of the top four states in the United States for per capita firearm-related homicides.[5] Easy access to firearms is a consistent theme in cases reviewed by the BCDVFRT. In one recently reviewed case of an adolescent who shot and killed his partner with a firearm, the offender told us that he first had access to his grandfather's gun at age fourteen. The American Academy of Pediatrics Committee on Injury and Poison Prevention found that firearm availability significantly increases children's risk of firearm-related injury and death. In addition, many firearm-related homicides occur impulsively during conflict, and the majority of homicides committed by juveniles involve firearms.[6]

The American Academy of Pediatrics states that "the most reliable and effective measure to prevent firearm-related injuries to children and adolescents is the absence of guns in homes and communities," and emphasizes the important role pediatricians play in screening for and counseling about firearm ownership.[7] In addition, strong evidence supports the idea that the counseling provided by pediatricians leads to higher rates of safe firearm storage.[8]

Recommendation: Pediatric medical providers should screen all adolescents and their caregivers for firearm ownership. If firearms are present, pediatric medical providers should counsel adolescents and caregivers about the risks of firearm ownership and, if families refuse to remove firearms, about safe storage.

4. "FLAG" MEDICAL CHARTS TO ALERT HEALTH CARE PROVIDERS OF PATIENTS WHO HAVE BEEN DOMESTIC VIOLENCE IDENTIFIED

Problem: In one case the team reviewed, the medical record of the deceased victim revealed that she had been identified in a hospital Emergency Department as a domestic violence victim; yet the same patient was not identified as a domestic violence victim on a subsequent visit, even though she sought medical services as the result of an assault. During the second visit the patient was not screened for domestic violence. She arrived at the Emergency Department with her abusive partner and no efforts were made to determine whether it was safe for her to leave with him.

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[5] United States Department of Justice, Federal Bureau of Investigation. Crime in the United States, 2010, retrieved September 7, 2012 from http://www.fbi.gov/about-us/cjis/urc/crime-inthe-u.s.us/2010/crime-in the u.s.-2010

[6] Firearm-related injuries affecting the pediatric population. Committee on Injury and Poison Prevention American Academy of Pediatrics. Pediatrics 2000; 105:885-95

[7] Policy statement- role of the pediatrician in youth violence prevention. Committee on Injury, Violence and Poison Prevention. Pediatrics 2009; 124: 393-402.

[8] Grossman DC, Cummings P, Koepsell TD, Marshall J, D'Ambrosio L, Thompson RS, Mack C. Firearm safety counseling in pediatric primary care pediatrics: a randomized, controlled trial. Pediatrics 2000; 106:22-6.

Recommendation: Health care facilities should institute a confidential, internal system of "flagging" the charts of patients who have been identified as victims of domestic violence so that they may receive more intensive screening, appropriate intervention, confidential treatment, documentation and links to needed services at the hospital and to allow for intervention and services as needed on any subsequent visits.

5. HOSPITAL-BASED INTERVENTION AND SAFE DISCHARGE – RESPOND TO THE NEEDS OF DOMESTIC VIOLENCE VICTIMS WHO HAVE SUBSTANCE ABUSE ISSUES

Problem: In one case reviewed, the victim was intoxicated when she presented at an Emergency Department for treatment of abuse-related injuries. Hospital staff was unable to assess the patient for domestic violence because of her level of intoxication. Instead, she was treated and discharged with her companion who, the hospital may have been unaware, was her abusive partner.

Recommendation: In cases where the patient is intoxicated or otherwise temporarily impaired, the facility should hold the patient until staff can complete domestic violence screening and offer appropriate intervention. Substance abuse is pervasive in Baltimore City and many domestic violence victims in the City self-medicate to cope with their abuse. It is important for Emergency Departments to complete domestic violence screening even if it means holding the patient until they are no longer impaired and the provider is able to conduct the screening. When a patient is medically ready for discharge from a hospital, health care providers should consider the clinical, functional, and social aspects of the situation to which the patient will be released. Hospitals regularly identify a discharge plan for patients that assesses for adequate medical provisions, accessibility, necessary utilities, family or community support, potential suicide risks, as well as for potential abuse in juvenile patients. In many cases the facility must delay discharge until staff can identify an adequate environment for release. Similarly, hospitals should delay discharge of domestic violence victims until they are able to develop an adequate discharge plan.

6. THE DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES SHOULD SCREEN INMATES FOR A HISTORY OF DOMESTIC VIOLENCE AND OFFER ABUSER INTERVENTION PROGRAMS

Problem: Throughout the cases the team has reviewed, we have interviewed inmates who have been convicted of domestic crimes and those who were themselves victims of family violence. In addition, we are aware that some inmates who were convicted of non-domestic violence crimes were also involved in abusive relationships. At least one inmate we interviewed believed that he would benefit from an Abuser Intervention Program but was not able to enroll in one prior to his release from incarceration. The inmate had been incarcerated for more than ten years before his scheduled release.

Recommendation: The Department of Public Safety and Correctional Services should screen and assess inmates for a history of domestic violence. This should include those inmates who are incarcerated for domestic violence related crimes, inmates who were abused as children or

who witnessed abuse between their parents, and inmates who were abusive to their intimate partners even if they are incarcerated for unrelated crimes. Where a history of domestic violence is identified, the Department of Public Safety and Correctional Services should offer an abuser intervention program as a part of an inmate's case planning and re-entry programming.

UPDATES ON PAST RECOMMENDATIONS

PROGRESS TOWARD IMPLEMENTATION OF PAST RECOMMENDATIONS

2007 – 1

BETTER EVIDENCE FOR PROSECUTION

The first issue identified in 2007 was that the Baltimore City State's Attorney's Office Felony Family Violence Division (FFVD) was hampered in its efforts to successfully prosecute felony domestic violence cases because police collected little admissible evidence. The BCDVFRT recommended the creation of a centralized, specialized unit of domestic violence detectives within the Baltimore Police Department (BPD). Begun in 2008, the Family Crimes Unit (FCU) is comprised of detectives who receive specialized training in felony level investigations, as well as issues unique to family violence cases.

Update: In 2012, the SAO merged the FFVD with the Sex Offense Division into what is now the Special Victims' Unit and will continue the existing protocol with FCU. The FCU and the Special Victims Unit work closely as a team on the investigation and prosecution of very serious domestic violence cases. Outcomes in "first responder" cases have dramatically improved. Current sentences for domestic violence offenders in serious cases average over five times higher than those obtained prior to the creation of the FCU. The number of stets and nol prosses has been reduced to less than half their previous rates. However, the most important statistic concerns the dramatic decrease in the number of domestic violence related homicides since the implementation of this recommendation. In 2007, Baltimore City reported 13 domestic violence related homicides. In 2008, the number rose slightly to 14. Since the beginning of 2009, there has been a sharp drop in domestic violence related homicides. In 2009, 5 victims died as a result of domestic violence. There were six victims in both 2010 and 2011. In 2012, there have been six victims as of October 1, 2012.

2007 – 3

ACCESS TO SERVICES

Another problem identified in the 2007 report concerned the large number of victims of fatal domestic violence who never accessed potentially life-saving services. In an effort to decrease domestic violence related homicides by increasing access to services, the BCDVFRT recommended that police administer the lethality assessment screen to victims of domestic violence. In 2009, the BPD, in conjunction with the House of Ruth Maryland (HRM), applied for and received funding to begin a lethality assessment pilot project. The protocol required that when the police respond to a domestic violence call where they believed a crime had been

committed, the officer would administer the lethality assessment screen with the victim. The screen and a copy of the police report are delivered to the HRM within 24 hours. HRM staff attempt to contact the victim within 24 hours and offer that person services

Update: In 2011, the BPD and the HRM received a federal GTEAP grant to allow the partners to begin to implement the program city-wide. The project began in the Northern and Northeastern districts. During the fall of 2010, it expanded into the Southern District. During 2012, it expanded into the Southwestern and Eastern districts. The partners plan to expand into the Southeastern District on October 1, 2012 and expect to go city-wide in 2013.

The program has been very successful. From November 2009 through August 2012, the HRM received 7013 lethality assessment screens, has reached 3247 (46.3%) victims, and has enrolled 1042 (32%) of them in HRM services.

2007 – 4

TIMELY SERVICE OF WARRANTS

The last problem identified in the 2007 report was the tremendous backlog of unserved warrants. In 2008, the BPD created a specialized Warrant Squad dedicated to serving domestic violence arrest warrants.

Update: In 2011, the squad served a total of 2883 domestic violence warrants. To date in 2012, the squad has served 1830 domestic violence warrants, compared to 2007 during the same period last year. The warrant squad has gone through several changes this year but BPD is confident that there will be an increase in service of warrants next year.

2008 – 1

RECOGNIZE AND RESPOND TO THE DANGERS OF STRANGULATION

As we noted in 2008, many professionals working with victims of domestic violence are unaware of the seriousness of strangulation. Strangulation, often incorrectly called "choking," is a significant risk factor for a subsequent fatality and is a weighted item in Dr. Jacquelyn Campbell's lethality assessment. By itself, strangulation can cause serious injury or death, even in the absence of visible, external injuries.

Update: The BCDVFRT continues to support its 2008 recommendation for domestic violence advocates to secure legislation which would classify strangulation as either a first-degree assault or a separate felony. In 2012, domestic violence advocates supported legislation that would have made it easier to prosecute the crime of strangulation as first degree assault by more clearly describing the prohibited acts. While the bill again passed unanimously in the Senate, it was never voted on in the House Judiciary Committee. It is anticipated a bill will be introduced again in the 2013 legislative session.

2008 – 2

FACILITATE PROVISION OF MEDICAL CARE TO DOMESTIC VIOLENCE VICTIMS WHO SUSTAIN INJURY

In our 2008 recommendations, we noted that victims often do not seek medical treatment for injuries sustained in domestic violence incidents. When police are first responders, they may not recognize the gravity of the injury and that the victim requires medical treatment and observation (as with victims of strangulation or abdominal trauma while pregnant), and may not actively encourage or facilitate transfer for medical care.

Update: Since the implementation of the FFVU (now the Special Victims' Unit) and the expansion of the Mercy SAFE program's forensic evaluation of domestic injuries as well as sexual assault, we have seen a marked increase in the number of injured domestic violence victims who are transported directly to Mercy Medical Center for medical clearance and evidence documentation. The BPD Academy's basic training and annual in-service trainings includes information on medical issues, treatment options and the dangers of strangulation. The Academy instructors continue to be trained by Mercy's forensic program.

2008– 3

IMPROVE SCREENING FOR DOMESTIC VIOLENCE IN HEALTH CARE SETTING

In 2008, the BCDVFRT noted that despite a mandate that all hospitals have protocols to assess for domestic violence, hospital medical charts that were reviewed had no documentation of domestic violence screening. We recommended that resources for the evaluation and counseling of domestic violence cases should be aggregated in one place and training be available for medical providers on violence assessment.

Update: In 2012, the Department of Health and Mental Hygiene (DHMH) created a website (www.dhmh.maryland.gov/ivp/), "Intimate Partner Violence (IPV): A Guide for Health Care Providers" to educate health care providers about domestic violence. The website contains information clinicians need for domestic violence assessment and intervention. All local domestic violence organizations are listed as well as other national and state resources.

In addition, under the Affordable Care Act (ACA) beginning on August 1, 2012, all new and non-grandfathered health plans must cover screening and counseling of domestic violence, and plans cannot require cost sharing or deductibles for these services. The Congressional intent under ACA was that screening and assessing for domestic violence be considered a primary prevention or early intervention service

2008 – 6

CHANGE ATTITUDES ABOUT DOMESTIC VIOLENCE

In our reviews, we have heard that victims do not view themselves as victims because they do not understand the dynamics of a healthy relationship. In 2008, the BCDVFRT recommended

creating a collaborative relationship with school systems and public health, social services and domestic violence experts to utilize an already existing Maryland curriculum to ensure that schools and staff are educated and trained to teach about the dynamics of dating and intimate partner abuse and healthy relationships.

Update: In 2011, the Baltimore City Health Department's Office of Youth Violence Prevention received a five year grant to implement the Dating Matters Initiative which will fund twelve Baltimore City middle schools for a healthy relationships curriculum. The Criminal Justice Coordinating Council submitted a letter in support of the initiative to promote healthy relationships and prevent teen dating violence. The DVCC is monitoring the progress of the Dating Matters Initiative and exploring other options for outreach to youth. The HRM currently offers the HRM Teen Initiative, which provides an eight session school curriculum geared to 10th graders addressing a range of healthy relationships, from friendships to intimate partners. Outreach is also made through HRM's teen website www.youlovemeyoulovemenot.com as well as a Facebook page to better reach the intended audience.

2009 – 3

CREATE A SYSTEMATIC TRACKING MECHANISM FOR DOMESTIC VIOLENCE VIOLATIONS OF PROBATION WITHIN THE DIVISION OF PAROLE AND PROBATION

In both the 2007 and 2008 reports, we expressed concern regarding the results of violation of probation (VOP) hearings in domestic violence cases. We had repeatedly reviewed cases in which domestic violence offenders were placed on probation, violated the terms of the probation, and received no consequence for the violation other than continued probation. In one case, the special condition which the defendant refused to satisfy was simply eliminated by the judge. Each of these probations was terminated only after the probationer murdered his victim.

Believing that this sent the wrong message to offenders and left victims vulnerable to further violence, we recommended establishing a system for tracking domestic violence VOP cases. A workgroup was established to create a systematic tracking mechanism for domestic violence probation cases.

In 2009, we recommended that the Division of Parole and Probation's new Offender Case Management System (OCMS) include a section which collects and stores data regarding the results of VOP hearings. The Secretary of the Department of Public Safety and Correctional Services and the head of the Division of Parole and Probation agreed to assist in the implementation of this recommendation.

Update: Currently the DPSCS Community Supervision Support Department and the DPSCS Chief Information Officer are adding a field to fill in sentencing information in OCMS if an offender's probation is revoked at a violation hearing. This will allow DPSCS to see how much jail time was imposed. Currently, agents can see if a probationer is continued under supervision, if the case is closed, or if the probation/parole was revoked.

2010 – 1

CREATE RESOURCES FOR MEN WHO SEEK TO PREVENT VIOLENCE IN INTIMATE RELATIONSHIPS

In 2010, the BCDVFRT identified that there were scant resources available for men who could benefit from help prior to an act of domestic violence or for men who wanted to persuade an abusive friend or family member to stop battering. Men seeking this type of assistance have no place to turn for advice or assistance. Although domestic violence is often viewed as a "women's issue," we interviewed several men in the course of our case review process who suggested that services need to be developed for men who are interested in taking an active role in addressing domestic violence or who are experiencing their own relationship stress. We recommended that resources must be developed to assist men who want to avoid domestic violence in their own relationships, or to address it appropriately when the relationships of friends or family members become violent.

Update: In 2012, the HRM created a video, "Nobody Ever Earned It," directed at encouraging abusive men to enroll in counseling services. The video is currently on YouTube. The HRM also created a low literacy brochure as a way to inform readers with limited reading skills.

The Open Society Fellowship Award announced last year was ultimately declined. HRM's abuser intervention program does not have the staff or financial resources to pursue this mentoring project at this time. The program continues to conduct outreach and engagement work on a limited basis with community programs working with men (e.g., Center for Urban Families' Responsible Fatherhood Program, Christopher's Place Employment Academy, and Historic East Baltimore's Community Action Coalition). The program also continues to accept non-court ordered participants at a reduced fee rate.

2010 – 2

SEEK PARTNERSHIPS WITH CLERGY

Another 2010 recommendation was that the BCDVFRT create a subcommittee to explore developing partnerships with the faith-based community since many domestic violence victims and perpetrators reach out to clergy for advice and support. However, many clergy members are not trained on the dynamics of domestic violence or the need for safety planning. In one case the team reviewed, a pastor encouraged a victim to stay in an abusive marriage, resulting in fatal consequences.

Update: In 2012, the DVCC formed a workgroup to increase community awareness about domestic violence and to offer outreach to the faith-based community. Chaired by Judges Karen Friedman and David Young, the workgroup has representatives from the Mayor's Office, the Governor's Office, the Baltimore Police Department, community advocates, victim service providers, and members of the clergy from numerous denominations. The workgroup seeks to partner with the clergy to heighten awareness of domestic violence and to educate citizens about the impact of domestic violence on the community. It will also provide

community members with information and resources to assist those who are victims of domestic violence.

2010 – 3

IMPROVE DOMESTIC VIOLENCE SERVICE PROVIDERS' OUTREACH TO VICTIMS BY DEVELOPING EFFECTIVE, MODERN COMMUNICATION STRATEGIES

In 2010, the BCDVFRT recommended that agencies that offer support and services to victims of domestic violence should begin to advertise with alternative social media sources such as cable TV, Facebook, You Tube, and other computer sites. After interviewing victims and family members we discovered that while most domestic violence agencies publicize their services by means of flyers, brochures and print media, many domestic violence victims either do not or cannot read this material. These victims were far more likely to be engaged with electronic media.

The Team also recommended that hospitals and health clinics provide information on closed circuit televisions in waiting rooms and information regarding domestic violence and available services must be visible where victims, witnesses and perpetrators are likely to go, e.g. hair and nail salons, barbershops, and neighborhood shops.

Update: The HRM has four distinct Facebook pages, including one specifically designed for teens. Each Facebook page is written to educate its followers about the various services that the agency provides. In addition, the HRM has a twitter account which it uses to distribute information about various agency activities and the Teen Initiative also has a Twitter account and a Pinterest account.

2010 – 4

INCLUDE SCREENING FOR DOMESTIC VIOLENCE IN HEALTH CLINIC SCREENS AND DURING TREATMENT FOR SEXUALLY TRANSMITTED DISEASES

A fourth problem identified in 2010 was that many victims of domestic violence do not access potentially life-saving services because they do not realize that their violent relationships are "abusive". In an effort to encourage screening for domestic violence in many kinds of settings that women use, we recommended that health clinics should include a screen for domestic violence whenever screening and treatment is done for sexually transmitted diseases (STDs). If health clinic personnel were to screen, record, and provide referrals, victims might be more likely to take advantage of domestic violence services.

Update: Free services for STD screening and treatment are available at local health departments throughout the state. Because the peak incidence of STDs occurs among women 15-24 years of age, the federally subsidized family planning programs also routinely screens all women under 25 years of age and provide treatment for STDs in their local health department programs. The Maryland Family Planning guidelines include a clinical guideline about

domestic violence assessment. In 2012, clinical providers who attended the annual Reproductive Health Update heard a presentation about domestic violence. Similarly, a presentation about domestic violence was given in June 2012 at the annual Maryland Sexually Transmitted Infections Update. These presentations educated Maryland health care providers about the co-morbidity of domestic violence and STDs. Additionally, educational materials have been ordered and re-stocked so that by the end of 2012 all family planning and STD clinic sites in Baltimore City (the jurisdiction with the highest incidence of STDs) have information and resources about domestic violence for patients. It is anticipated that women who use these clinic sites will be able to see information about domestic violence displayed in the clinic setting and also be able to access information privately in examining rooms and bathrooms.

2010 – 5

ENACT LEGISLATION CREATING ENHANCED PENALTIES FOR CRIMES INVOLVING DOMESTIC VIOLENCE COMMITTED IN THE PRESENCE OF A CHILD

The final problem we discussed in 2010 was our continued concern about the effects of domestic violence on children in the household. We repeatedly observed that these children were subsequently more likely to be known to the Department of Social Services, the Juvenile Court and ultimately the criminal justice system. Perpetrators also reported witnessing domestic violence as a child. As a consequence, we learned that when an act of domestic violence is perpetrated in the presence of a child, the adult victim is not the only one who suffers. The children who witness the violence, as well as the community which must live with the consequences of that violence, are also victimized. The criminal penalties for these acts should reflect the damage which is done to the children who witness the violence and the community which must address it. One appropriate means of expressing the community's outrage over this crime, as well as its concern for the victims, is a law which provides enhanced penalties for crimes involving domestic violence perpetrated within the sight or hearing of a child.

Update: Delegate Luiz Simmons introduced House Bill 664 in the 2012 legislative session. This bill would have prohibited a person from committing a crime of violence when the person knows or reasonably should know that a minor is present. HB 664 passed in the House Judiciary Committee and was amended and passed by the Senate Judicial Proceedings Committee but it never made it out of the conference committee. It is anticipated that the bill will be introduced again in the 2013 legislative session.

COMPLETED RECOMMENDATIONS

2008 – 4

IMPROVE FORENSIC MEDICAL DOCUMENTATION FOR DOMESTIC VIOLENCE INJURIES

Our 2008 recommendations identified a problem that medical documentation of injuries often does not adequately support later prosecution of domestic violence cases. The Mercy Sexual

Assault Forensic Examiner's Program, with the aid of the Mercy Family Violence Response Program, developed an Intimate Partner Violence Forensic Evidence Standard Kit (IPV Kit), modeled on the state's accepted SAFE Kit, to thoroughly and expertly document domestic violence injuries and evidence.

Update: Completed and ongoing

2008 – 5

ASSESS CHILDREN EXPOSED TO FATAL AND NEAR FATAL ABUSE OF A PARENT

Both our 2007 and 2008 recommendations reflected our growing concern with the extremely negative consequences children face as a result of living in violent homes. In our case reviews, we repeatedly observed that these children were known to the Department of Social Services (DSS), the Juvenile Court and ultimately the criminal justice system.

Update: In July 2010, the HRM received funding from the Fund for Change to work with the BPD, the Baltimore City SAO, the Baltimore City DSS and hospital-based trauma specialists to develop and implement a model protocol to protect and support children affected by domestic violence involving fatality or near fatality of one or more parents. After numerous meetings of this BCDVFRT workgroup, the protocol was completed and fully executed in January 2012. With this new protocol, the Baltimore Police Department, the Baltimore Office of the State's Attorney, the Baltimore City Department of Social Services, and the House of Ruth Maryland are prepared and coordinated to immediately respond to these children and provide the necessary services and support.

2009 – 2

INCREASE AWARENESS OF HUMAN BITES AS A FORM OF DOMESTIC VIOLENCE

In 2009, the BCDVFRT discussed that although biting has been referenced in the literature as a form of domestic and sexual violence, there is little knowledge regarding the prevalence of this form of abuse, or its significance as a precursor to escalated or even lethal violence. Because biting is not usually included on lists of examples of domestic violence, victims may not recognize it as a form of domestic violence. We recommended specifically (1) Include human bites on medical screens for domestic violence; (2) Educate medical providers regarding the evaluation and documentation of bite wounds; and (3) Revise the Petition for a Protective Order to include biting as an example of domestic violence. In 2010, the Maryland Department of Health and Mental Hygiene included biting as a type of abuse in their 2010 women's health screening cards. In 2011, biting was added to the revised Protective Order petition on the list of types of abuse.

Completed in 2011

2011 – 1

ENCOURAGE THE DIVISION OF PAROLE AND PROBATION TO DEVELOP A SYSTEMATIC PROTOCOL TO ENSURE THAT THE PROPER AGENT RECEIVES CORRESPONDENCE

In more than one case that we reviewed, a probation agent did not receive correspondence alerting the agent that the probationer had violated his probation or that a warrant had been issued. In cases reviewed this occurred because the original probation agent retired, resigned, or was reassigned. This resulted in the probationer not being sanctioned for the violation or arrested for the warrant. We recommended that the Division of Parole and Probation should develop a systematic way for correspondence (mail, fax, email, etc.) to get to the appropriate agent, in light of the fact that the office inevitably experiences turnover in personnel.

Update: Completed in 2012

RECOMMENDATIONS YET TO BE ADDRESSED

2007 – 2

FAMILY JUSTICE CENTER

A 2007 recommendation was for the creation of a Family Justice Center (FJC) in Baltimore City. At that time a BCDVFRT workgroup met to develop a blueprint for a FJC, and to seek funding for this enterprise. The group was not able to obtain funding and no progress has been made on this recommendation.

2009 – 1

CREATE AN ENHANCED RESPONSE PROTOCOL FOR IDENTIFYING AND RESPONDING TO VICTIMS IN HIGHLY LETHAL RELATIONSHIPS

Our 2009 recommendations stated that one of the most important services advocates provide to victims of domestic violence is safety planning. This is the time the advocate discusses with the victim the precautions she can take to attempt to protect herself from further abuse. It is a time to assess her level of danger and identify safety options. If the victim is prepared when violence occurs, she is more likely to respond quickly and avoid additional injury. However, in some cases, traditional safety planning techniques were insufficient to protect certain victims who were in extremely lethal relationships. We recommended the creation of an enhanced response protocol involving a high danger safety plan that incorporates safety precautions appropriate for victims who are at the highest risk of being murdered.

Update: The HRM applied to the Fund for Change to enable HRM to collaborate with members of the BCDVFRT and Maryland domestic violence service providers to create a high danger safety plan that incorporates safety precautions appropriate for victims who are at the highest risk for being murdered. The proposal was not funded.