



**THE BALTIMORE CITY DOMESTIC VIOLENCE
FATALITY REVIEW TEAM (BCDVFRT)**
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2013 RECOMMENDATIONS

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The mission of the Baltimore City Domestic Violence Fatality Review Team (BCDVFRT or Team) 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 two new issues, and agreed upon the following recommendations. Throughout this report, domestic violence and intimate partner violence (IPV) are used interchangeably.

1. REQUIRE HEALTH CARE PROVIDERS TO SCREEN FOR DOMESTIC VIOLENCE BY MAKING IPV QUESTIONS REQUIRED FIELDS IN ELECTRONIC CHARTS AND REQUIRING THAT THE ELECTRONIC RECORD AUTOMATICALLY REPOPULATE POSITIVE IPV SCREENS ON SUBSEQUENT VISITS

Problem: In 2008, despite a mandate that all hospitals have protocols to assess for domestic violence, we reviewed cases where the hospital medical charts had no documentation of domestic violence screening. Since then, we have issued five recommendations concerning screening by health care providers. This year we reviewed a case where the Team was unable to determine if the victim had been screened properly at her obstetrician visit because the questions in her medical record were left blank. As discussed in past years, screening and assessment is the first step in the best practice response to IPV victims who are medical patients, followed by proper treatment, documentation, resource linkage and an advocate response.

Recommendation: As many health care facilities are converting to electronic medical charts, they have the opportunity to make the IPV screening questions “required fields,” so that the health care provider cannot advance to the next section of the chart unless the screen is completed. Required fields for IPV screening questions should be obligatory at least in emergency departments and for all comprehensive visits of females of reproductive ages, including visits for substance use, sexually transmitted diseases, depression, and visits during pregnancy and postpartum. In addition, once a medical professional records a positive response in a domestic violence screening field in the electronic medical chart, that field should automatically repopulate as a positive screen on subsequent visits. With the new electronic records, some medical facilities make records electronically accessible to the patient. As a safety measure, the domestic violence questions should not be included in these accessible records.

2. EXPAND, ENHANCE, AND STANDARDIZE THE TRAINING PROVIDED TO ALL PERSONS WORKING IN CORRECTIONAL FACILITIES SO THAT THEY CAN BETTER RECOGNIZE AND IDENTIFY THE CHARACTERISTICS OF DOMESTIC VIOLENCE ABUSERS.

Problem: This year during one of our reviews, we found that the victim was an employee of a contractor for the Department of Public Safety and Correctional Services (DPSCS). It appears she met her abuser while he was incarcerated and continued the relationship after he was released from custody. Ultimately, this led to an abusive relationship. The Team reviewed the training provided to employees of DPSCS’s outside vendors and found that it varied from region to region. For example, the training provided for these employees in one region lasts one day and does not appear to include a module concerning fraternization with inmates, while in another region the training is two days and does include a module about fraternization. The DVFRT believes that education and training is one of the best ways to combat domestic violence.

Recommendation: Expand, enhance, and standardize the training provided to all DPSCS employees and vendors’ employees who have contact with inmates, offenders, or defendants. The expanded training should include a segment about the dynamics of domestic violence so that employees will better understand the characteristics of abusers. This training could be in conjunction with current fraternization in the workplace modules.

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. (In 2012, the SAO merged the FFVD with the Sex Offense Division into what is now the Special Victims' Unit (SVU).) 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: The SVU is currently working with BPD to create short video segments which will be played at roll calls. The purpose of these video segments is to train patrol officers about how to maximize the quality of the evidence they collect during domestic violence calls and thereby increase the number of successful prosecutions in these cases. Some of the SVU recommendations are: take pictures of the victim to document injuries; take pictures of the crime scene to corroborate a fight or struggle; and make sure the Domestic Incident Report is completely filled out, especially the handwritten, signed statement by the victim. This kind of evidence collection will increase the SAO's ability to successfully prosecute the case even when the victim recants or is uncooperative.

However, the Team is concerned about this year's increase in the number of domestic violence related homicides. This 2007 recommendation was implemented in 2008. In 2007, Baltimore City reported 13 domestic violence-related homicides. In 2008, the number rose slightly to 14. In 2009, there was a significant decrease in domestic violence-related homicides to five. There were six domestic violence homicides in both 2010 and 2011. In 2012, there were nine domestic violence homicides and, as of September 9, 2013, there have been ten.

Unlike previous years where domestic homicide victims reported prior incidents of domestic violence to the criminal justice system, five of the 2013 homicide victims had no reported contact with the judicial system or law enforcement in Maryland. As we see the rise in incidents of domestic violence homicides, we are reminded of just how important it is from a law enforcement and prosecution standpoint to aggressively investigate, charge, and prosecute every legally viable incident of violence between intimate partners. With successful prosecutions of misdemeanor, felony and non-fatal incidents of violence, hopefully we can curb the incidence of fatalities.

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 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 HRM within 24 hours. HRM staff attempt to contact the victim within 24 hours and offer that person services

Update: As of July 2013, the lethality assessment project has expanded into all nine police districts. The program has been very successful. From November 2009 through August 2013, HRM has received 11,336 screens and reached 5,376 people (47%), enrolling 1794 (34%) 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: The Warrant Squad successfully served a total of 2883 domestic warrants in 2011. From January 1 to August 31, 2012, the squad and patrol officers served a total of 1,896 domestic violence warrants. During the same period in 2013, the squad and patrol officers only served 1,662 domestic violence warrants. This is a 12% decrease. The warrant squad continued to experience several organizational changes that have decreased service numbers. BPD is currently exploring new initiatives aimed at increasing service numbers.

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 2013, a strangulation bill was introduced by a member of the House of Delegates but it was never voted on.

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 may not actively encourage or facilitate transfer for medical care.

Update: In 2013, the BPD Academy's basic training and annual in-service trainings continue to include information on medical issues, treatment options and the dangers of strangulation. Mercy Medical Center personnel continue to provide training to Academy instructors.

2008– 3

IMPROVE SCREENING FOR DOMESTIC VIOLENCE IN HEALTH CARE SETTINGS

In 2008, the BCDVFRT noted that, despite a mandate that all hospitals have protocols to assess for domestic violence, the Team found hospital medical charts that had no documentation of domestic violence screening. We recommended that medical facilities aggregate their resources for the evaluation and counseling of domestic violence cases and that they offer training for medical providers on violence assessment.

Update: A Maryland IPV Task Force was established in the fall of 2012 at the Department of Health and Mental Hygiene (DHMH). Members included clinician representatives from the fields of emergency medicine, obstetrics and gynecology, psychiatry, pediatrics, family practice, internal medicine, nurse midwifery, social work and nursing. A simple IPV assessment tool was adapted from evidence-based screens. The tool was open for public comments from December 2012 until January 2013. Comments from practitioners and national experts were extremely positive. The Task Force agreed to promote use of the assessment tool within their respective specialties. The Maryland IPV Task Force assessment tool has been cited as a public health model for other states. In 2014, a training module for medical students, ob/gyn residents and faculty at Johns Hopkins University School of Medicine will be piloted. In addition, please see our first recommendation for 2013.

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 school personnel are educated and trained to teach about the dynamics of dating and intimate partner abuse and healthy relationships.

Update: In 2011, the Criminal Justice Coordinating Council supported the Baltimore City Health Department's Office of Youth Violence Prevention's award of a five year grant to implement the Dating Matters Initiative. The goal of this initiative is to implement a curriculum to promote healthy relationships and prevent teen dating violence. In June 2013, nine middle schools implemented the student curriculum; three middle schools are scheduled to implement a curriculum for parents. The Dating Matters Initiative has also held three community events to raise awareness about teen dating violence. The Domestic Violence Coordinating Council (DVCC) is monitoring the progress of the Dating Matters Initiative and exploring other options for outreach to youth.

Unfortunately, in 2012, HRM ended its 14-year Teen Initiative. After many years of aggressive outreach to the Baltimore City School system, HRM determined that the effort required did not result in enough successful engagement with schools to justify the continued use of the agency's limited financial and personnel resources. HRM remains committed to the prevention strategy of outreach to youth. The agency continues to provide educational and engaging trainings by well-trained and informed staff to schools upon request, but these presentations have been folded into a menu of services offered by HRM's Training Institute.

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 Maryland Network Against Domestic Violence (MNADV) applied for funding to address this recommendation. If funded, MNADV will convene a team of domestic violence advocates who will develop an enhanced response protocol for high danger cases and statewide protocols for high risk safety planning and following up with high risk victims.

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 about the results of violation of probation (VOP) hearings in domestic violence cases. The Team had repeatedly reviewed cases in which domestic violence offenders were placed on probation, violated the terms of their 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: In order to examine the trends in outcomes for domestic violence offenders who violate their probation, Baltimore City DV Stat has created a subcommittee of stakeholders who will guide and inform the VOP inquiry. More specifically, the subcommittee will attempt to illustrate how, and to what extent, offenders are held accountable for their probation violations, and how this ultimately affects recidivism. The subcommittee, and DV Stat as a whole, will then use this information to inform and guide policy discussions.

2010 – 1

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

In 2010, the BCDVFRT identified that there were few resources available for men who might not follow through on an act of domestic violence if they received appropriate intervention or for men who wanted to persuade an abusive friend or family member to stop battering. Men who seek this type of support 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. As a result, we recommended developing resources to assist men who want to avoid domestic violence in their own relationships, or who want to address it appropriately when the relationships of friends or family members become violent.

Update: No new update from 2012.

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 Domestic Violence Coordinating Council (DVCC) formed a workgroup to increase community awareness about domestic violence and to offer outreach to the faith-

based community. In 2013, the Governor's Office of Community Initiatives and the Mayor's Office of Neighborhoods assumed coordination of the workgroup. Judges Karen Friedman and David Young chair the Interfaith Domestic Violence Initiative Committee, which has representatives from the Mayor's Office, the Governor's Office, community advocates, victim service providers, and members of the clergy from numerous denominations. The Committee has asked clergy from every congregation of every faith in Baltimore City to join together against domestic violence during Domestic Violence Awareness and Prevention Month. The group held a very well attended breakfast in May 2013 for faith-based leaders to kick-off the initiative. An interfaith dialogue was held on October 1, 2013 to share different religious perspectives on the issue of domestic violence and to provide information and resources in anticipation of the weekend of October 25-27, 2013 when Baltimore faith leaders will address domestic violence in their congregations.

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 internet sites. Interviews with victims and family members revealed that many victims either do not or cannot read the variety of flyers, brochures and print media that most domestic violence agencies utilize. 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. We also recommended that 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 One Love Foundation was created by Sharon Love, mother of Yeardley Love, after her daughter was murdered by a boyfriend. The Foundation created the "Be 1 for Change" campaign which was launched in the fall of 2012. "Be 1 for Change" is a signature program for the One Love Foundation, with the goal of combating relationship violence throughout the United States. It includes their new app and an educational program that will be accessible online for community agencies, educational institutions, and even individuals, to talk about being a responsible bystander in instances of intimate partner violence. It allows family and friends of the victim to conduct a threat assessment of the couple as a way to encourage them to reach out to the victim. This long-term initiative will continue to develop over the next several years in partnership with the Michael and Kim Ward Foundation and Johns Hopkins University.

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 they screen and treat patients 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: Maryland was one of six states funded from the Office of Women’s Health for “Project Connect: A Coordinated Public Health Initiative to Prevent and Respond to Violence Against Women.” This 3-year grant, begun January 2013, will be used to integrate IPV assessment into the Title X Family Planning Program, a program that sees approximately 75,000 women per year.

In addition, the STD program at the Maryland Department of Health and Mental Hygiene (DHMH) made an official commitment to integrate IPV assessment at all their sites using the Maryland IPV Task Force assessment tool. DHMH will offer training in 2014 and pilot the assessment protocol at several sites.

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. Many perpetrators also reported witnessing domestic violence as children. 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: During the 2013 General Assembly, Delegate Simmons and Senator Zirkin introduced a bill which would have prohibited a person from committing a crime of violence when the person knows or reasonably should know that a minor is present. The House and the Senate both amended the bill and passed it, but each house passed it with different amendments. The conference committee was able to come to an agreement late on the last night of the session, but the bill was never brought up for a vote.

2012 – 1

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

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 this crime is immense and the child's life is changed forever. Traumatized and bereaved, these children must struggle to find a new life. Over the course of our reviews, we have seen children who witness this event and ultimately are incarcerated for later committing serious crimes themselves or who are lost to systems of care or help. In 2012, we recommended working in conjunction with the school system to 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.

Update: In 2012, the Governor's Family Violence Council (FVC) created a work group to focus on the issue of domestic violence in the presence of a child. The work group was divided into two subgroups, one of which is examining gaps and best practices in schools. The school-based effort is focusing on how the state school system identifies and responds to children who witness domestic violence. The work group also is examining who provides services to children and how services are provided. Additionally, the group is learning about the training needs of school staff. In July 2013, the FVC voted unanimously to continue addressing this issue during FY 14.

2012 - 2

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

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 Throughout this report, we have identified cases where medical staff did not complete a domestic violence screen during a victim's prenatal visits or during her hospital stay for her delivery. In 2012, we recommended increased screening and intervention for domestic violence before, during and after pregnancy.

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

Update: In FY 14, DHMH received a grant to promote IPV screening among obstetrician/gynecologists. The grant provides funding for trainings which promote evidence-based domestic violence screening tools coupled with interventions for those who screen positive for domestic violence. The Johns Hopkins University School of Medicine will pilot this project. In addition, DHMH will develop educational modules for medical students and residents. The American College of Obstetricians and Gynecologists is overseeing the project. They will encourage the creation of partnerships between clinicians and local domestic violence organizations, including House of Ruth Maryland, TurnAround, and the Family Crisis Center in Baltimore County.

2012 - 3

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

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.² In 2012, the Team recommended that 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.

Update: The Maryland Hospital Association (MHA) has agreed to distribute the BCDVFRT's Recommendations, highlighting the medical-related recommendations, to all Maryland hospitals through their e-mail contacts. As part of this outreach effort, the Maryland Health Care Coalition Against Domestic Violence will offer training and support to any institution that is interested in adopting any of the recommendations.

2012 - 4

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

Another 2012 recommendation was that 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.

² Firearm-related injuries affecting the pediatric population. Committee on Injury and Poison Prevention American Academy of Pediatrics. Pediatrics 2000; 105:885-95

Update: See 2012 – 3 above. In addition, one of this year’s recommendations is for the new electronic medical records to pre-populate a positive domestic violence screen on subsequent visits.

2012 - 5

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

In cases where a patient is intoxicated or otherwise temporarily impaired, medical facilities 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 self-medicate as a way to cope with their abuse. In 2012 we recommended that Emergency Departments complete domestic violence screening even if it means holding the patient until s/he is 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 create 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.

Update: See 2012 – 3 above.

2012 - 6

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

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. In 2012, the Team recommended that the Department of Public Safety and Correctional Services (DPSCS) 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.

Update: DPSCS generally screens and assesses inmates for a history of domestic violence. Although our recommendation suggested assessment and screening of 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, DPSCS is only screening inmates who are incarcerated for domestic violence or who have been abusive to an intimate partner. They are not screening inmates who were abused as children or who witnessed abuse between their parents. The initial screening is completed by the Case Management Department. If an offender is identified as a domestic violence offender, the case is referred to the Social Work Department which conducts a more detailed assessment. The social work staff uses the Duluth model as their assessment tool and their treatment model. Offenders found eligible and suitable for domestic violence services receive programming per the reentry initiative prior to release. Not all inmates offered treatment wish to participate, and DPSCS does not force them to attend because they believe that would be detrimental to the group dynamics for those who do want to participate. If an inmate is found to be a domestic violence offender, a note is placed in his/her file which is used to classify the inmate for purposes of parole supervision upon his/her release.

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. Since we made this recommendation, there have been two *Frye-Reed* challenges (2010 and 2013) made in Baltimore courts about the validity and acceptability of forensic evidence obtained through the use of an Alternative Light Source (ALS). The ALS shows injury and bruising often invisible to the naked eye. In both cases, the ALS findings were admitted into evidence under the challenges to the *Frye-Reed* test as accepted in the scientific community. The ALS has become a significant tool in the IPV Kit documentation, particularly in strangulation cases in which there may be no visible bruising. Overcoming the *Frye-Reed* challenges paves the way for future admissibility of these findings.

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. The HRM, the BPD, the Baltimore City SAO, the Baltimore City DSS and hospital-based trauma specialists developed

and implemented a model protocol to protect and support children affected by domestic violence involving fatality or near fatality of one or both parents.

Update: Completed in 2012 and ongoing.

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.

Update: 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.