

Baltimore County Domestic Violence Fatality Review Team

Annual Report FY2014



Table of Contents

Executive Summary.....2

Purpose3

DVFRT Procedures.....3

History of Baltimore County’s DVFRT & FY14.....4

List of Member Agencies & Consultants.....5

Statistical Information on Baltimore County IPH from FY14.....6

July 1, 2013 – June 30, 2014.....7

FY14 Findings & Recommendations – Case 7.....8

Acknowledgements.....13

References.....14

Executive Summary

Domestic Violence Fatality Review Teams (DVFRTs) review intimate partner abuse related fatalities and near fatalities to gain an understanding of the history of the relationship, dynamics, interventions and coordinated community response. Using a multi-agency, multi-disciplinary approach findings and recommendations are developed to help impact future victims positively.

Baltimore County's DVFRT was developed in collaboration with Baltimore County's Department of Social Services, Police Department and State's Attorney's Office in 2006, after legislation was passed in Maryland in 2005 allowing the establishment of teams. Under the leadership of the Department of Social Services, and with guidance from Maryland Network Against Domestic Violence, operational protocols were developed and the team began reviewing cases in 2008.

Originally led by Chairperson Marci van de Mark of the Department of Social Services, and Vice-Chairperson Rosalyn Branson from TurnAround, Inc., a new Chair and Vice Chairperson were elected in 2013. In FY14, the DVFRT reviewed one homicide-suicide, and developed findings and recommendations related to Abuser Intervention Programs, coordinated responses between victim and abuser services, the Victim Notification System (VINE), and police intervention.

It is our hope that this report provides insight and ideas to improve negative outcomes of intimate partner abuse in the future.



Audrey Bergin, MPH, MA
Chairperson



Jill Savage, JD
Vice-Chairperson

Purpose

The first official domestic violence fatality review is thought to have taken place in the 1990's in California, following a homicide-suicide that occurred in front of a school with teachers and students witnessing. The main goal is to gather information and review deaths and near deaths related to intimate partner abuse, in order to make improvements to services, interventions, and policies (Jaffe, Dawson, Campbell, 2013; Wilson, Websdale, 2006).

The mission of Baltimore County's Domestic Violence Fatality Review Team (DVFR) "is to prevent deaths and serious injury related to and to remember those who have died as a result of domestic violence. To achieve its mission, the team will review a person's life and death and make recommendations to strengthen the community's response to victims of domestic violence" (Baltimore County Domestic Violence Fatality Review Team, 2007, p. 2).

DVFR Procedures

DVFRs are multi-agency, multi-disciplinary groups, which seek to decrease intimate partner homicides (IPHs). Use of a multi-disciplinary approach promotes partnerships and collaborations while seeking to save lives by preventing IPHs, and avert the suffering of surviving family members. Teams may review aggregate data from their community, or conduct in-depth reviews of single cases (Wilson, Websdale, 2006). For individual cases, team members go back to their respective agency to see if they were involved with either the victim or perpetrator. Team members may also attempt to identify key people involved with the victim or perpetrator to interview for more information.

Using this information, a timeline is created showing major events in the case. The team seeks to identify “missed opportunities or gaps in services that may have occurred when attempting to protect victims and/or children as well as strategies for perpetrator intervention that may have been overlooked” (Jaffe, Dawson, Campbell, 2013, p.140).

History of Baltimore County’s DVFRT& FY14

Baltimore County’s DVFRT began in 2006, and has conducted a total of seven full case reviews. In July 2013 a new Chairperson and Vice-Chairperson were instated. Since that time, new members were added to the team including representatives from The Women’s Law Center, CHANA, House of Ruth Legal Clinic, and public health researchers. Furthermore, participating agencies were asked to provide a primary and secondary member to ensure attendance. (See full list of agencies and consultants in next section.)

Moreover, a change was made from quarterly meetings to monthly meetings. The quarterly meetings are larger meetings that all agencies are expected to attend. The monthly meetings are optional and have different themes or focus, for example, orientation for new members, case screening meeting in which cases are selected, and meetings to review details of the time line in a selected case. During FY14, there were a combined eight quarterly and monthly meetings held, and one murder-suicide case was reviewed in-depth.

List of Member Agencies & Consultants

Baltimore County's DVFR consists of representatives from:

- ❖ Baltimore County Department of Corrections
 - ❖ Baltimore County Department of Health and Human Services (Department of Health, and Department of Social Services)
 - ❖ Baltimore County Police Department
 - ❖ Baltimore County Office of State's Attorney
 - ❖ Baltimore County Sherriff's Office
 - ❖ CHANA
 - ❖ Community Members
 - ❖ Department of Juvenile Services
 - ❖ Department of Public Safety and Correctional Services
 - ❖ Faith-based Community Representation
 - ❖ Family & Children's Services
 - ❖ Family Crisis Center
 - ❖ Greater Baltimore Medical Center
 - ❖ House of Ruth, Maryland
 - ❖ Northwest Hospital
 - ❖ Researchers
 - ❖ Turnaround, Inc.
 - ❖ Women's Law Center of Maryland, Inc.
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Statistical Information on Baltimore County IPH from FY2014

One of the main challenges to examining intimate partner homicide (IPH) is how homicides are determined to be IPHs, and how and where they are tracked. For example, law enforcement may be bound by specific criteria of what constitutes an IPH. Murders and suicides may be tracked in different categories and not linked together (Galta, Olsen, Wik, 2010). As a result of this lack of a standardized approach to surveillance, a variety of sources are used to gather information, however, many cases are missed this way (Biroscak, Smith and Post, 2006).

The Liaison of Baltimore County Police Department's Domestic Violence Unit receives a brief synopsis on all homicides occurring in the county. When the relationship between the victim and perpetrator is known, it is included in the summary. Since the synopsis is cursory, news reports are examined and the Homicide Unit is consulted to see if more detail can be gleaned. The following information was pulled from Baltimore County Police Department, news reports, as well as Maryland Network Against Domestic Violence.

Between July 1, 2013 and June 30, 2014, there were a total of 10 deaths occurring in eight domestic violence related incidents of violence. There was one other death which occurred in this time period, which is still under investigation.

Eight deaths were victims of intimate partner homicide, and two deaths were perpetrators who committed suicide after the homicide. There was additionally one other suicide by a male partner after an attempted homicide. 60% of the victims were female, which is consistent with findings across the country and in research, demonstrating the majority of victims are female. 90% of the perpetrators were male, which is also consistent with other

findings (U.S. Department of Justice, 2013; Nicolaidis, Curry, Ulrich, Sharps, McFarlane, Campbell, Gary, Laughon, Glass, Campbell, 2003). In 25% of the homicides the male perpetrator committed suicide after the homicide, which is consistent with findings in the U.S. (Sillito and Salari, 2011). A more detailed review of deaths follows:

July 1, 2013 – June 30, 2014

During fiscal year 2014, there were 10 deaths attributed to intimate partner homicide, including associated suicides by perpetrators after the homicide. Details break down as follows:

Victims	Perpetrators
6 Females	9 Male
2 Males	
Ages 28-78	Ages 30-81
Average age 43	Average age 48
	2 perpetrators committed suicide after the homicide

Relationship of perpetrator to victim

4 Husband
 1 Boyfriend
 1 Father of child (killed new boyfriend)
 1 Girlfriend & 3 friends of hers

Method

4 Firearms	1 Physical force	1 Knife
1 Strangled	1 Unknown	

FY14 Findings & Recommendations - Case 7

The seventh case reviewed by the DVFRT was a homicide-suicide. The victim was married to the perpetrator for just over a year. There was one unreported incident of domestic violence immediately following the wedding that included strangulation, and one police involved assault nine months later. The perpetrator was charged with second-degree assault. The victim received a protective order against the perpetrator, separated from him, filed for divorce, and was planning on testifying against him at court six months later. The perpetrator was court ordered to Abuser Intervention Program (AIP), and was attending the weekly group up until his death. On the day of the trial, the perpetrator killed the victim as she was putting her child in the car, to go to court. The perpetrator fled the scene and went to a friend's house. The next day, police located him, and as they approached the apartment where he was staying, he killed himself.

There were several known risk factors for lethality noted in this case, including: threats to kill, threats with a weapon, separation, children fathered by another man, strangulation, and the victim thinking the perpetrator might kill her. Researchers have found these factors to be significantly associated with homicide (Campbell, Webster, Koziol-McLain, Block, Campbell, Curry, Gary, Glass, McFarlane, Sachs, Sharps, Ulrich, Wilt, Manganello, Xu, Schollenberger, Frye, Laughon, 2003; Nicolaidis et al, 2003).

Finding #1 - AIPs

Abuser Intervention Programs (AIPs) are in a good position to gather information about the offender, assess the offender for risk factors related to potential for committing re-assault, homicide, or homicide-suicide, and collaborate with victim services to monitor victim safety and offender behavior.

Recommendations:

- ❖ The Services Providers Subcommittee of the Domestic Violence Coordinating Committee (DVCC) should review topics related to AIP in order to develop consistency and recommend best practices among the agencies. (E.g., intake, danger assessment, curriculum, notes, absences, and facilitators.)
- ❖ When a referral is sent from DSS/FVU DVRP to an agency, the police report and LAP should be attached.
- ❖ Baltimore County AIPs should attend MAIC and the Service Providers Subcommittee of the Domestic Violence Coordinating Committee (DVCC) regularly.
- ❖ A formal evaluation should be conducted in Maryland on AIPs, to determine effectiveness of these groups.

Finding #2 – Communication between AIP and Victim Services

Communication between AIP and victim services is essential to holding the perpetrators accountable and keeping victims safe.

Recommendations:

- ❖ When a known risk factor (such as reconciliation or divorce) is raised in AIP, this should trigger a “safety check” with the victim conducted by victim services.
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- ❖ If abuser is talking about reconciling with victim, this information should be discussed with the team. If the victim is not considering reconciling, the team needs to decide how the information will be addressed with the offender and victim.

Finding #3 - Victim Services & Coordinated Response

There are certain known risks for a victim, such as court proceedings, including both criminal and civil actions such as divorce or custody. Victim services should pay special attention to these times. Furthermore, numerous agencies contacting a victim may be overwhelming. A victim may already be connected with a supportive professional; however, that professional may need “technical assistance,” or a “consultant” to assist them with the domestic violence.

Recommendations:

- ❖ Recognizing court as a high-risk time for homicide, shelter should be offered prior to court hearings. If the victim declines, alternate housing/transportation arrangements should be urged on the day of court to alter the victim’s “normal routine” about which the perpetrator may be aware.
 - ❖ All victim services should assess the victim’s involvement with other services and inform them that many people may be calling them to check on their safety.
 - ❖ Task the victim service agencies to coordinate their outreach efforts so as to not “overwhelm” the victim while still ensuring she is getting the services she might need and desire.
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- ❖ Schedule a training by police and prosecutor for victim advocates, to help provide a better understanding of the legal system and process.
- ❖ Service providers should find out if the victim has a primary supportive professional, such as a therapist. If they do, advise the client that technical assistance can be offered to the professional as opposed to taking over services.
- ❖ A High Risk Team Model should be implemented in Baltimore County, perhaps using the model developed by Jeanne Geiger Crisis.

Findings #4 – VINE Notification

Victims should be notified when the perpetrator is released from jail. Victims may think they are registered with VINE; however, they may only be registered with VINE PO (or vice versa). The jail has a system for notifying victims of release of a defendant, but they do not always have the victim's name and contact information.

- ❖ Brochures, created by GOCCP, for VINE should be simplified and review the difference between VINE and VINE PO.
 - ❖ Add a prompt to VINE registration website to register for both VINE and VINE PO. (E.g., "You are now registered for VINE. Would you like to register for VINE PO now? Click here.")
 - ❖ Have the VINE and VINE PO link embedded into case search, the jail/prison system, and other websites victims may access.
 - ❖ Victim services should advise victims to contact Baltimore County Department of Corrections, Records Office at 410-512-3422 and provide contact information for notification of release.
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Finding #5 – Police Intervention

When a respondent to a Protective Order returns to the home to pick up belongings, this can be re-traumatizing and harassing for the victim and children.

Homicide detectives may suggest therapy to the family of a homicide victim.

911 operators handle calls from domestic violence victims, and may be supportive of a distraught victim.

Recommendations:

- ❖ Before the police accompany the perpetrator to get his belongings, there should be a phone call to the victim first to alert her and give her time to prepare. (E.g., have the kids leave; have a support person with her.)
 - ❖ Determine if a time limit can be made for the perpetrator to pick up belongings. (E.g., you have one week to pick up your belongings, absent extraordinary circumstances.)
 - ❖ Conduct training for all homicide detectives on effectively encouraging therapy to surviving family members. The Service Providers Subcommittee of the DVCC should further discuss a process for connecting the surviving family members and children to services. (E.g., using the DVC and advocate home visit or other best practices.)
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