Calvert County, Maryland

2005

Domestic Violence Fatality Review Team

Annual Report

CALVERT COUNTY, MARYLAND

DOMESTIC VIOLENCE FATALITY REVIEW TEAM

ANNUAL REPORT

2005

PART I. EXECUTIVE SUMMARY

- ***INTRODUCTION***

The Maryland Network Against Domestic Violence (MNADV) obtained a VAWA grant for the 2003-2004 grant year to establish a Domestic Violence Fatality Review Team (DVFRT) in Anne Arundel County. In May 2004 the Director of the Crisis Intervention Center of the Calvert County Health Department, Sharron Bickel, approached the MNADV with an offer to establish a DVFRT in Calvert County. She indicated that she thought the support for domestic violence fatality review existed and wanted to begin the process. The MNADV and Ms. Bickel identified agencies and organizations who come in contact with victims and/or perpetrators of domestic violence and who would be approached to serve on the Calvert County DVFRT.

On October 25, 2004, the Calvert County DVFRT met, under the guidance of the team consultant from the MNADV, to begin the process of reviewing and revising a draft protocol supplied by the MNADV, based on its experience with the Anne Arundel County DVFRT.

- ***PURPOSE AND GOALS OF THE DOMESTIC VIOLENCE FATALITY REVIEW TEAM***

The purpose of the Domestic Violence Fatality Review Team is to bring together a multi-disciplinary team to review domestic violence cases which resulted in deaths or near-deaths and examine the events that lead up to the fatality or assault.

The goals of the DVFRT are to reduce the rate of domestic violence related deaths and assaults in Calvert County, to identify possible gaps in services provided to victims of domestic violence, to make non-accusatory recommendations to improve interventions and programs in the future, to improve agency response to victims of domestic violence, and to educate the victims, their families, the community and the perpetrators about domestic violence.

MISSION STATEMENT

The mission of the Calvert County Domestic Violence Fatality Review Team (DVFRT) is to reduce the incidence of domestic violence, to prevent the occurrence of domestic violence fatalities, and to improve the quality of life for victims of domestic violence and their families. The team will pursue its mission of committing itself to discover the antecedent causes of domestic violence fatalities or near fatalities, such as identifying gaps in service, by seeking to improve the coordinated community response to domestic violence, by holding abusers accountable for their actions, by recommending improvements in the criminal justice and civil systems that serve victims of abuse, by educating county institutions and citizens about domestic abuse, and by seeking to ensure compliance with its recommendations. In carrying out its mission of heightened community response, the Calvert County Domestic Violence Fatality Review Team hopes to free victims of domestic abuse and their families from the cycle of violence and empower them to pursue their lives without the control that is the stigma of abuse.

- ***PURPOSE OF ANNUAL REPORT***

Domestic violence is defined as a pattern of behavior used to establish power and control over another family member or intimate partner using fear and intimidation, often including the threat or use of violence. The purpose of the Annual Report is to give an overview of those domestic violence cases resulting in death or near-death and record the Team's findings and recommendations.

Part II. Team and Protocol Development

- ***TEAM MEMBERSHIP STRUCTURE***

The DVFRT was designed as a multi-disciplinary team which calls upon information provided by its members to review deaths and near deaths in domestic violence situations. Each agency agrees to provide two people, one primary representative and one alternate, to attend meetings, review cases and assist in formulating recommendations.

The MNADV entered into a memorandum of understanding with The Crisis Intervention Center, who assumed "lead agency" status, and the following agencies:

- Calvert County Department of Social Services
- Calvert County Domestic Violence Coordinating Council
- Calvert County Health Department, Crisis Intervention Center (lead agency)
- Calvert County Sheriff's Office
- Calvert County State's Attorney's Office
- Calvert Memorial Hospital
- Maryland Division of Parole and Probation
- Maryland State Police
- Naval Criminal Investigative Service
- Safe Harbor Shelter
- Southern Maryland Center For Family Advocacy

- ***PROTOCOL DEVELOPMENT***

The MNADV provided the Calvert County Team with "start up" binders which included a packet of materials such as examples of letters addressing administrative processes, sample agendas and minutes, reference information with the draft and a protocol (with the appendices included). The Calvert Team, with the MNADV's assistance used the drafted protocol as a starting point and spent several laborious months modifying and refining it to meet the unique needs of Calvert County.

The protocol was finalized and approved by the Team in March 2005.

A copy of the Calvert County Protocol can be found in Appendix 2 of this document.

PART III. SCOPE OF REVIEWS

- ***CASE SCREENING COMMITTEE***

The protocol allows any team member to attend Case Screening Committee (CSC) meetings but mandates attendance by the DVFRT Chairperson, the Assistant State's Attorney, and the Calvert Investigative Team (which is represented by the Calvert County Sheriff's Office and Maryland State Police).

When the CSC meets, the Calvert Investigative Team (CIT) will present all homicide, suicide, and near-fatal cases to the committee so that the committee can examine the cases to determine which cases meet the criteria for domestic violence involvement and should be reviewed.

In determining which cases to review, the Protocol requires that the Case Screening Committee (CSC) meet at lease four weeks prior to a scheduled DVFRT meeting. The Chairman will then submit the victims and offenders names to the Team members so that the representatives, who are responsible for reviewing the records of their agency, can identify any information related to domestic violence about the parties.

PART IV. OVERVIEW OF 2005 REVIEW

- ***INTRODUCTION***

After each case was presented by the Case Screening Committee and reviewed by the DVFRT, the Team made recommendations based on information provided during the review. The Team members believe that these recommendations can be useful in implementing effective prevention strategies.

- ***2005 REVIEWS***

The Calvert County DVFRT reviewed 6 cases of domestic violence homicides, suicides, and near-fatal attacks which occurred between 2000 and 2005. Because all of the cases were presented and initially reviewed in 2005 the six were included in the 2005Aannual Report. The cases included:

Case # 1	Near death-stabbing	Husband (age 43)/Wife (age 33) Female victim
Case # 2	Near death-shooting	Husband (age 81)/Wife (age 82) Female victim
Case # 3	Near death-shooting	Husband (age 52)/Wife (age 33) Female victim
Case # 4	Suicide	Husband (age 38)/Wife (age 36) Female victim
o Case # 5	Suicide	Husband (age 00)/Wife (age 00) Female victim
o Case # 6	Homicide	Girlfriend (age 49)/Boyfriend (age 51) Male victim

- ***STATISTICAL BREAKDOWN***

As noted above, the Calvert County Domestic Violence Fatality Review Team reviewed six cases including one homicide, two suicides, and three near fatal assaults in 2005. As this is the first year of reviewing domestic violence deaths/near-deaths, the Team did not believe that it had enough information to perform a formal statistical analysis. However, the following is a summary of interesting facts:

Relationship between victims and perpetrator:

- All of the couples were involved in heterosexual relationships.
- Five of the 6 couples were married at the time of the incident.
- Four of the 6 couples were separated at the time of the incident.
- One couple was married and living together at the time of the incident.
- One of the 6 had an intimate relationship but never actually lived together.

Prior domestic violence reports, arrests, or protective orders:

- In five out of the 6 cases reviewed the victim had suffered prior domestic violence at the hands of the perpetrator resulting in either arrest or orders of protection, being issued.
- Four of the 6 cases reviewed had protective orders in place at the time of the incident.

Prior threats:

- Five of the perpetrators made threats against their victims prior to the incident.
- The Team found was not able to determine whether there was prior domestic violence involvement with one couple.

Points of contact with professional intervention prior to the assault (other than law enforcement):

- One victim had contact with health care professionals within the year preceding the event.
- None of the victims had contact with a domestic violence counseling provider or shelter.
- One of the cases reviewed had prior involvement with Child Protective Services.

Location of the homicide, near fatality, or suicide:

- The assault or suicide took place at the home of the victim in 4 of the 6 cases reviewed.
- The assault took place at the home of a relative of the victim in 1 of the 6 cases reviewed.
- One suicide took place in a public place.

Means or weapons used:

- Firearms were used in three of the assaults, resulting in one homicide and 2 near-deaths.
- A knife, acquired at the residence, was used in one near fatal stabbing.
- One suicide was committed by hanging, one by shooting.

Substance abuse as a factor:

- Substance abuse was a factor in 3 out of the 6 cases reviewed.
- Dementia and/or prescription medication was a factor in one case.

Impact on the families and community:

- Four of the six cases had children living in the home at the time of the incident.
- One child found her father after the suicide.

Age range of victims and perpetrators:

- Because of the small sample being reviewed and the fact that the ages varied to such a wide extent, there was little statistical benefit in examining the ages of the perpetrators. For informational purposes, the youngest offender was 38 and the oldest was 81. The youngest victim was 33 and the oldest was 82.
- It might be noteworthy, at some point, to include the information that there was a difference of more than 10 years between victim and perpetrator in two cases, and jealousy was a contributing factor.

Demographics:

- Five of the victims were female, one homicide victim was a male.
- Four of the six victims and perpetrators were African American, two were Caucasians.
- Both of the suicides (which did not include harm to the victim) were Caucasian.

PART V. FINDINGS AND RECOMMENDATIONS

Carefully examining each of the six cases, the Team was interested in what, if any, services the victim had sought prior to the incident. Had she or any family members made contact with a domestic violence advocacy group? We wanted to know whether, and how often, the police had been called to the residence and what was the disposition of the call. Had the victim applied for, been granted, and followed through with an order of protection? How many times had she sought relief through the courts? Had the offender ever violated a protective order? Had the offender ever been ordered to Abuser Intervention Program services? If so, had he completed? Had the victim ever been hospitalized because of an unexplained injury, and if so, had hospital personnel reported their concerns to the proper authorities? Was the Department of Social Services ever concerned with the welfare of the children in the family? Had any action been taken? In the months we spent reviewing the cases, the Team tried to identify trends that would be useful in preventing future deaths or violent assaults. We also examined any information uncovered during the review that might be specific to rural Calvert County and its population.

Agencies are encouraged to examine the recommendations carefully and communicate with the Team regarding the feasibility of implementing or improving suggested services to victims. Next year's Annual Report will detail the outcome of each of this year's recommendations.

The following are the findings and recommendations of the Team:

FINDING #1: **In four of the cases, orders of protection were ignored by the offender at the time of the assault. In one instance the offender was reported to have approached the victim in the hallway outside the courtroom after the order was issued.**

Recommendation: Discussion with the Court and with other agencies to strengthen compliance of the order of protection by the victim and the perpetrator.

Comment: The victim is sometimes the one to make contact with the offender when a protective order is in place.

Recommendation: Vigorously enforce penalties for offenders who violate orders of protection.

Recommendation: Initiate frequent, specific in-service training for law enforcement agencies on orders of protection.

Recommendation: Encourage advocates to do an educational piece with victims to discourage contact with the perpetrator.

•

FINDING #2: **Several offenders had a history of domestic violence and had multiple protective orders.**

Recommendation: To provide intense advocacy to victims of domestic violence for an extended period of time.

Recommendation: That the victim advocate make periodic calls to the victim, and when possible, a more personal contact.

Comment: Victim advocates are helpful to victims in going through the court process but for many going to court is only the first step in getting away from the abuser.

Recommendation: Encourage training in lethality assessment for Court Commissioners who may be first responders to domestic violence situations.

•

FINDING #3: **In some cases, the offender cannot be found to be served an order of protection or there is a lapse in time between when the order is issued and when it is served.**

Recommendation: To support the Sheriff's Office's efforts to increase the number of deputies to be more in proportion with the population of the county.

•

FINDING #4: **Alcohol or substance abuse was a factor in three of the six cases.**

Recommendation: To improve communication between agencies providing offender and substance abuse services by developing an institutional protocol which would address coordinating services.

Comment: Currently coordinated services are addressed on an informal basis.

Recommendation: That the AIP attempt to secure a co-facilitator who has credentials as a substance abuse counselor.

Recommendation: To encourage membership of the Calvert County Substance Abuse in the DVFRT.

•

FINDING #5: **Two of the offenders had completed Abuser Intervention Program (AIP) and committed further offences against the same victim.**

Recommendation: That the AIP administer a risk assessment to attempt to identify the most violent offenders at intake.

Recommendation: That the AIP offer intensified services to those whose score indicated a high level of aggression.

Comment: Research shows that 8% of offenders are involved in 85% of the recidivism (Chris Murphy, PhD, University of Maryland, Baltimore County). This assessment will be administered in an attempt to identify this 8%.

Recommendation: That the AIP administer an exit inventory when the offender completes the AIP.

Recommendation: That the AIP "red flag" abusers who have been identified by the risk assessment as being especially dangerous and notify the victim. The AIP coordinator will advise the State's Attorney's Office and the Office of Parole and Probation that the offender has been "red flagged".

Action: The AIP adopted this policy in December, 2005 following the recommendation of the Team.

Recommendation: That the Sheriff's Office, Maryland State Police, State's Attorney's Office and Victim Advocates implement the Domestic Violence Lethality Assessment (DVLA) program for first responders (See Appendix 6 for DVLA protocol)

Action: The State's Attorney's Office recently began implementing the DVLA program.

The Calvert County Sheriff's Office will begin administering the Lethality Screening on May 15, 2006.

•

FINDING #6: **None of the victims sought services prior to the event even though there was a history of domestic violence in the relationship.**

Recommendation: That the Sheriff's Office, Maryland State Police, State's Attorney's Office and Victim Advocates implement the Domestic Violence Lethality Assessment (DVLA) program for first responders (See Appendix 6 for DVLA protocol)

Action: The State's Attorney's Office recently began implementing the DVLA program.

The Calvert County Sheriff's Office will begin administering the Lethality Screening on May 15, 2006.

Recommendation: That Crisis Intervention Center re-instate the practice of calling victims in 911 calls for the purpose of educating them about victim services.

Recommendation: That all police agencies and first responders distribute packets with information about victim domestic violence services when Dispatched on a domestic violence call.

•

FINDING #7: **In one case, dementia or impaired judgment, due to taking prescribed medication, played a significant role in a near death shooting. It was reported that the offender may have told hospital personnel that he did not intend on leaving this life without his wife (paraphrased).**

Recommendation: That Hospital staff receive training in domestic abuse among elders and the possible increased risk due to dementia.

Recommendation: That a protocol be developed to warn authorities when threats have been made by a patient suffering from dementia.

•

FINDING #8: **In one case the domestic violence may have been minimized by the victim's church.**

Recommendation: To educate clergy about domestic violence.

Action: Members of the Calvert Investigative Team, Crisis Intervention Center and the State's Attorney's office are spearheading a workshop on domestic violence for the Calvert County Clergy.

PART VI. CONCLUSION

The single greatest concern identified by the Team members was that in spite of the number of orders of protection that were in place at the time of the offense, or the number of victims who had prior orders of protection issued or those who had prior service agency involvement, these fatalities, near fatalities, and suicides occurred. It may be that the prevention of domestic violence homicides lies in prior intervention with the victim by means of increased community awareness, collaborations of county and community based organizations, and intense advocacy. Family members of the victims are often aware of, and sometimes brought into, the violence but do not call for intervention. Concerned family and community members must know what they can do and what services are available to help victims. It is the sincere hope of the Calvert County Fatality Review Team that this report will be instrumental in some recommendations being adopted resulting in changes in the way the community responds to family violence.

In conclusion, the key intervention recommendations resulting from the DVFRT meeting were to:

- Encourage AIP programs to offer intensified services for violent offenders.
- Improve communication between Law Enforcement, State's Attorney's Office, Parole and Probation, substance abuse programs, and victim advocacy groups.
- Encourage membership of the Calvert County Substance Abuse in the DVFRT.
- Encourage hospital staff to receive training in domestic violence among the elderly and the possible increased risk due to dementia.
- Educate the community about agencies/programs available to help victims of domestic violence and encourage the community to become proactive in reporting cases. Make pamphlets and brochures available in public places as well as the courthouse and police stations.
- Have advocates make follow-up calls and offer home visits to identified victims of domestic violence who appear to be high risk.
- Enforce penalties for offenders who violate orders of protection
- Initiate frequent in-service trainings to police officers in serving protection orders.
- Encourage training in Lethality Assessment for Court Commissioners and others who may be first responders to domestic violence situations.
- Educate clergy about domestic violence. (The Calvert Investigative Team, The State's Attorney's Office and Crisis Intervention Center are spearheading a workshop inviting the Calvert County Clergy Council).

Respectfully submitted,

Janet R. Scott, LCSW-C
Chair
Calvert County Domestic Violence Fatality Review Team

CALVERT COUNTY

APPENDICES

Appendix 1	**Membership Roster**
Appendix 2	**Calvert County Protocol for Domestic Violence Fatality Reviews**
Appendix 3	**Maryland Legislation, HB 741**
Appendix 4	**Domestic Violence Lethality Screen for First Responders**
Appendix 5	**Danger Assessment**
Appendix 6	**Lethality Assessment Protocol for Maryland First Responders**
Appendix 7	***Reading the Signs*, Quarterly Newsletter for Participants in the MNADV'S Lethality Assessment Program for First Responders**
Appendix 8	**Calvert County DVFRT Brochure**
Appendix 9	***Remembering and Responding*, Maryland Domestic Violence Fatality Review Newsletter**