



*Calvert County,
Maryland*

2008

Domestic Violence Fatality Review Team

Annual Report

CALVERT COUNTY, MARYLAND
DOMESTIC VIOLENCE FATALITY REVIEW TEAM
ANNUAL REPORT
2008

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, Sharon 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:

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

In addition, in response to the findings contained in the 2005 Annual Report that substance abuse was a factor in three out of the six cases reviewed, Calvert Substance Abuse Services joined the Team in 2006.

- ***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 least 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.

Location of the homicide, near fatality, or suicide:

- ▶ The homicide-suicide occurred outside the residence where the wife had moved to after she separated from her husband.
- ▶ The suicide took place in the male's residence.

Means or weapons used:

- ▶ The homicide-suicide involved a firearm.
- ▶ The suicide involved setting himself on fire.

Substance abuse as a factor:

- ▶ Alcohol was a factor in 1 out of the cases reviewed.

Impact on the families and community:

- ▶ Two other individuals and children were present inside the home at the time of the homicide-suicide.

Demographics:

- ▶ The one homicide victim was female; the two suicides were male.
- ▶ The homicide victim and perpetrator were Caucasian.
- ▶ The suicide was African American.

PART V. FINDINGS AND RECOMMENDATIONS

Carefully examining each of the two 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.

Below is a summary of each of the cases reviewed and the findings and recommendations of the Team:

CASE #1: Homicide-Suicide. Wife (age 31); husband (age 33)

Time line of Events:

7/2/07	Foreclosure proceedings initiated on home
7/23/07	Sentenced in a possession with intent to distribute and driving under the influence case - 4 years suspend all but one year at the Calvert County Detention Center
January 2008	Home detention is authorized
1/2/08	Parole and probation sends husband a letter that he had to turn over or transfer his handgun because of the felony conviction
3/1/08	Husband is granted home detention
4/23/08	Wife moves into friends home due to reported physical abuse from husband; friend reports that abuse has been ongoing for years

*friend also later reports that wife had been seeing her ex boyfriend for several weeks

*ex boyfriend reports that wife would tell him that husband would beat her up and he had observed wife with bruise on her neck and a swollen eye; wife never reported because she didn't want to deal with the court and was afraid of husband

*friend further reports husband had been driving by the residence at different times since wife moved in

Husband reports to jail personnel and his employer that wife moved out and that they were having marital problems; husband is advised to seek counseling

4/28/08

Wife talks to personnel at jail and denies there is any physical abuse, reports they were having problems and husband was seeing other women

Husband finds out wife and ex-boyfriend are dating about 2 weeks before the shooting per ex-boyfriend

Husband threatened to shoot ex-boyfriend and wife per ex-boyfriend

5/2/08

Wife files for divorce

5/6/08

Summons Issued for husband in divorce case
*a check with the clerk's office on 8/14/08 reveals no return of service - but see note below

5/13/08 6:12 a.m.

Husband leaves residence to work

5/13/08 1:03 p.m.

Husband returns home early from work
(finished job early per employer)

5/13/08 2:30 p.m.

Friend reports that wife served husband at his house with the divorce papers.
Wife reported to friend that husband sat on her and begged her not to leave him

5/13/08 9:51 p.m. Husband leaves home when he's not supposed to; parked vehicle about 2000 feet from residence where wife was staying; empty handgun magazine found laying on passenger side floorboard

5/13/08 10:24 p.m. Shootings occur - husband shoots wife then short distance away, shoots self.

*No prior calls for service for domestics at either address

Findings and Recommendations:

The husband was a convicted felon and legally could not possess the handgun that he used to commit the offense. The husband was serving an active jail sentence for a felony drug case at the Calvert County Detention Center but had been released on home detention. The Division of Parole and Probation had sent the husband a letter that he had to turn over his handgun because of the felony conviction, however, because the husband was still serving a jail sentence he was not under the supervision of Parole and Probation at the time of the incident. The Calvert County Detention Center was not aware of the letter sent to the husband prior to his release on home detention.

Immediately in response to this incident, the agencies involved made changes to address the gaps in the process. The Division of Parole and Probation now sends a copy of the letter regarding surrendering firearms to the Calvert County Detention Center and the Calvert County Sheriff's Office. In addition, the State's Attorney's Office notifies the Calvert County Sheriff's Office of each felony conviction so they are immediately aware that the offender cannot legally possess a regulated firearm. Also, the Calvert County Detention Center joined the DVFRT in 2008.

The Team also noted that although friends and those who knew the couple were aware of domestic violence and escalating behavior on the part of the husband, neither the victim nor any of her friends sought intervention from any agencies prior to the incident. In fact, the wife was contacted by Detention Center personnel and specifically asked about domestic violence and she denied there was any physical abuse. Friends reported that the wife never reported any of the abuse because she did not want to deal with the court system and was afraid of her husband. The Team again discussed the need to increase community awareness about the problem of domestic violence and the services available within the community.

Finally, the Team discussed the need for counseling and services to be made available to witnesses to the incident, especially where children are involved. It was suggested that law enforcement who responds could notify CIC who could have counselors respond to the scene, if needed.

CASE #2: Suicide (Male, age 51)

Time line of Events:

Case #2 Suicide: Male (Age 51)

3/26/07 Female applies for Protective Order against male
 reports threats to kill but also states just verbal abuse under
 “describe all past injuries”

4/2/07 Protective order dismissed at female’s request

5/9/08 Male appears in court for a violation of probation hearing for failure to
 pay restitution (1991 Assault with Intent to Murder conviction - male
 victim). Probation is extended 5 years for purposes of paying restitution.

6/19/08 1 a.m. Ambulance sent to male’s apartment for sick or injured person,
 female transported to hospital - domestic assault by male, victim reports
 she was strangled by male.

 While police are at the hospital interviewing female, male sets the
 residence and himself on fire, he later dies at the hospital from his injuries.

Findings and Recommendations:

The Team noted that the female victim of the assault had filed for a Protective Order in 2007. The male was on probation at the time for a non-domestic violence related offense. The Division of Parole and Probation observed that had the Division been aware of the Protective Order being sought in 2007 and that there were potential domestic violence related issues with the offender being supervised, they could have increased supervision of the offender. Currently, there is no procedure in place for the Division to be informed that a Protective Order has been applied for and/or obtained against an offender who is on supervised probation. The Team discussed and recommended instituting a procedure whereby Parole and Probation would be notified when Protective Orders are sought against an offender who is on supervised probation. The Team had discussions with the judges in Circuit and District Court and the judges agreed to ask Petitioner’s and Respondent’s if the Respondent in the Protective Order is on supervised probation and, if so, to forward a copy of the Protective Order to the Division of Parole and Probation so supervision could be increased.

PART VI. CONCLUSION

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. Most of the recommendations made during the 2008 Case Review have already been put in place by agencies during the 2008 year.

One of the key areas that continues to predominate the case review findings is that victims have not sought services prior to the event, indicating a need to increase education among victims and community members about the services that are available. The Team will continue to look for ways to increase awareness within the community of the problem of domestic violence and the available programs and agencies available to assist victims of domestic violence.

Respectfully submitted,

Jennifer L. Morton

Chair

Calvert County Domestic Violence Fatality Review
Team

CALVERT COUNTY



APPENDICES

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| Appendix 1 | Membership Roster |
| Appendix 2 | Calvert County Protocol for Domestic Violence Fatality Reviews |
| Appendix 3 | Md. Ann. Code, Family Law, § 4-701, <i>et. seq.</i> |
| Appendix 4 | Domestic Violence Lethality Screen for First Responders |
| Appendix 5 | Danger Assessment |
| Appendix 6 | Lethality Assessment Protocol for Maryland First Responders |
| Appendix 7 | <i>Reading the Signs</i>, Quarterly Newsletter for Participants in the MNADV'S Lethality Assessment Program for First Responders |
| Appendix 8 | Calvert County DVFRT Brochure |
| Appendix 9 | <i>Remembering and Responding</i>, Maryland Domestic Violence Fatality Review Newsletter |