

*Calvert County,  
Maryland*

*2010*

*Domestic Violence Fatality Review Team*

*Annual Report*

**CALVERT COUNTY, MARYLAND**  
**DOMESTIC VIOLENCE FATALITY REVIEW TEAM**  
**ANNUAL REPORT**  
**2010**

**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. Also, in 2008 the Calvert County Detention Center joined the Team as well as a survivor of domestic violence.

### **• 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 draft 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.

## **PART IV. 2010 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.

#### **• 2010 REVIEWS**

The Calvert County DVFRT reviewed 3 cases in 2010. All three cases were near-fatal attacks. The cases occurred in 2006, 2007 and 2008. The cases included:

- Case # 1 Near-fatal Stabbing. Husband perpetrator (age 51), wife victim (age 51)
- Case # 2 Near-fatal Stabbing. Husband perpetrator (age 33), wife victim (age 33)
- Case # 3 Near-fatal Stabbing. Wife perpetrator (age 47), husband victim (age 55)

#### **• STATISTICAL BREAKDOWN**

As noted above, the Calvert County Domestic Violence Fatality Review Team reviewed three near-fatal attacks in 2010. The following is a summary of interesting facts:

##### ***Relationship between victims and perpetrator:***

- ▶ All of the couples were involved in heterosexual relationships.
- ▶ All of the couples were married at the time of the incident.

##### ***Prior domestic violence reports, arrests, or protective orders:***

- ▶ In one case there was a lengthy history of domestic violence and system involvement. The offender was on probation for a second degree assault involving the same victim at the time of the incident.
- ▶ In one case there was no prior history of domestic violence or system involvement prior to the incident.

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

- ▶ Two of the cases had prior contact with a domestic violence counseling provider or shelter.

***Location of the homicide, near fatality, or suicide:***

- ▶ All of the near-fatalities occurred within the home.

***Means or weapons used:***

- ▶ All three near-fatal attacks involved a knife.

***Substance abuse as a factor:***

- ▶ Alcohol/substance abuse was a factor in 1 of the 3 cases reviewed.

***Impact on the families and community:***

- ▶ In one of the cases reviewed, young children were present and witnessed the incident.

***Demographics:***

- ▶ Two perpetrators were male, one perpetrator was female.
- ▶ One perpetrator was Caucasian, two perpetrators were African American.

## PART V. FINDINGS AND RECOMMENDATIONS

Carefully examining each of the cases reviewed, the Team was interested in what, if any, services the victim had sought prior to the incident. Had the victim 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 the victim 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 the offender completed the program? 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: Near-fatal Stabbing. Husband perpetrator (age 51), wife victim (age 51)**

The parties in the first case reviewed had a lengthy domestic violence history and system involvement, going back to 1994. Seven of the eleven lethality assessment factors were present: the husband was unemployed, had made past suicide attempts, the victim had a child that was not the husband's, the husband had control issues, access to weapons, and had made prior threats to kill the victim with a weapon. The reports of threats by the husband to kill the victim were first reported/documented in 2004. It was noted that the victim applied for an interim protective order four times in 2004 but never received a temporary or final order. Three temporary orders were dismissed at the victim's request. One was dismissed because the victim did not appear in court.

Both the husband and the victim had significant substance abuse and mental health issues. The husband had been referred for abuser intervention counseling but did not attend. The victim was in counseling with the Crisis Intervention Center. The husband was released from the Detention Center on October 7, 2007 after being convicted of two second degree assaults on the victim. The near-fatal stabbing happened on October 20, 2007.

#### ***Findings:***

One of the main findings from this case review was the significance of the near-fatal incident happening within 13 days of the husband's release from the Detention Center. There was discussion about the effects of the offender going to jail and how this may be an escalating factor much like the victim obtaining a protective order.

***Recommendations:***

The Team recommended in high-risk cases that there be a plan in place prior to the offender being released from incarceration to include increased monitoring on probation, home visits, and safety planning for the victim during the immediate time period following the offender's release.

The Domestic Violence Response Team is working together in high risk cases to implement such plans and coordinate them with allied agencies. Currently, when a high risk offender is released from incarceration, notification is made to the State's Attorney's Office, the victim, Crisis Intervention Center, and the Calvert Investigative Team. If the offender is on supervised probation, contact is made with the offender's agent to make them aware this is a high-risk situation. The State's Attorney's office usually notifies the victim in high risk cases upon receiving notice within 30 days of the offenders release. The State's Attorney's office with the assistance of the Crisis Intervention Center and Calvert Investigative Team will meet with the victim prior to the offender's release to go over safety planning and the victim's options.

**CASE #2: Near-fatal Stabbing. Husband perpetrator (age 33),  
wife victim (age 33)**

In the second case that was reviewed, the surviving victim came and spoke with the DVFRT. There was no prior history of domestic violence in the relationship or previous services. About five days before the near-fatal stabbing, the husband physically assaulted the victim for the first time. The incident was not reported and there was not any prior system involvement. The near-fatal stabbing occurred in the presence of two young children, ages 9 and 2.

***Findings:***

Two main findings resulted from this case review. The first was the importance again of responding to children who are witnesses to these types of domestic violence incidents. One of the victim's children was already in counseling prior to the incident. Immediately after the incident, the Calvert County Sheriff's Office contacted the Department of Social Services who responded to the scene. The victim also later placed her other child in counseling. Both children are still in counseling.

The other finding was the importance of the Criminal Injuries Compensation Board (CICB) in these incidents. The victim said that the Board had been a tremendous help. She had significant medical expenses. The husband received a twelve year active incarceration sentence for attempted second degree murder, lost his job and is not in a position to pay restitution for a significant time period. The victim's injuries caused her to lose time from work and undergo five different surgeries. The CICB has reimbursed her for all of her medical and counseling expenses.

***Recommendations:***

The Team recommended that in serious domestic violence incidents where children are present and/or witnesses, follow up must be done by the appropriate agencies to ensure that the victim and family members are educated on the importance of counseling for the children and the available services within the County.

The Team also recommended making sure that victims are aware of the services offered by the Criminal Injuries Compensation Board. Currently, all victims are given a pamphlet by the State's Attorney's Office where there is a pending criminal case about the Criminal Injuries Compensation Board which describes the services offered and contact information.

**CASE #3: Near-fatal Stabbing. Wife perpetrator (age 47), husband victim (55)**

In the third case reviewed, at the time of the incident the perpetrator and the victim were living together, but staying in separate bedrooms. The victim woke up to find the wife in his bed with an object in her hand and the wife started stabbing the victim multiple times. The wife chased the victim from the home. The victim was able to get into a neighbor's home where he called for help. The wife was found back in the marital home and said she attacked victim in self-defense. The wife was later found not criminally responsible for the offense. The wife had previously completed anger management counseling several years before the incident.

***Findings:***

This case will continue under review in 2011. However, one of the findings was the difficulty in addressing offenders who have significant mental health issues, but have not yet committed a crime or are not posing an immediate danger to themselves or others for purposes of an emergency petition and commitment to the hospital for evaluation.

***Recommendations:***

The Team hopes to have further discussions and recommendations on this issue as the review continues in 2011.

## PART V. FIVE YEAR REVIEW

The Calvert DVFRT has been reviewing cases for over five years. As part of the review process this year, the DVFRT examined what findings and recommendations had been made and what changes have been implemented as a result over the past five years.

One of the main findings that has reoccurred over the past five years is the effects of domestic violence on children who have been present and witnessed, or even been victims, of fatal or near-fatal events. One goal that has been put in place is better response to children in crisis situations and in getting counselors to children on the scene of an incident and immediately thereafter. Recommendations have been made to train the officers responding to domestic violence calls to let the counselor know as part of the lethality assessment that children are present so the counselor could discuss with the victim getting the children into services as well. Child Protective Services can also be contacted where the child is put in danger by the situation. State's Attorney Laura Martin has continued to try to work with the school board on educating high school students and parents about teen domestic violence. Finally, as part of the coordinated response now to a fatal or near-fatal incident, follow up is done by the Crisis Intervention Center, Calvert Investigative Team and State's Attorney's Office to make sure the children are getting into much needed counseling.

Another main area of concern has been Protective Orders. The Calvert County Sheriff's Office Sheriff's Office is shortening the time it takes to serve the Orders. The office is processing paperwork for charges when an on-scene arrest is not made and doing a Lethality Assessment when one has not already been done. The Sheriff's Office now has 12 hour shifts for deputies so there is less shuffling of the Protective Order for service between shifts. The office is also keeping detailed service sheets to log the deputies attempts at serving the Protective Order. Also, an advocate is available 24/7 to assist victims with applying for a Protective Order. Violations are being enforced and prosecuted. The Sheriff's Office has taken proactive steps to follow through with obtaining firearms when the temporary and final orders are issued; even accompanying the respondent from the courtroom to the residence to retrieve the firearms, without letting the respondent leave on their own. In cases where the respondent does not appear and a order is issued, the Sheriff's Office is making th effort to contact the respondent directly and secure the firearms.

Another significant achievement over the past five years is both the Calvert County Sheriff's Office and Maryland State Police are conducting lethality assessments when responding to domestic violence incidents and putting victims in touch with a counselor as soon as possible, if not immediately on the scene. In addition, the Calvert County Sheriff's Office has provided a dedicated Domestic Violence investigator. The Crisis Intervention Center has provided a liaison with the Crisis Intervention Center and the Sheriff's Office.

Calvert County has also strengthened the response to domestic violence cases through the formalization of a Domestic Violence Response Team consisting of members of the Crisis Intervention Center, the Calvert Investigative Team and State's Attorney's office. All agencies in the County have established excellent and open communication between all of the representatives involved in responding to domestic violence: law

enforcement, the State's Attorney's Office, Parole and Probation, Crisis Intervention Center, Calvert Substance Abuse Services, Calvert County Detention Center, and victim advocacy groups. In-service training was conducted for deputies to keep them current in handling domestic violence cases and with the changes in the law. Efforts have been made to follow through on court orders, such as bringing offenders back to court and ensuring consequences for offenders who do not participate in anger management or abuser intervention counseling when ordered to by the court.

#### **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. Key findings in this year's reviews continue to illustrate the importance of inter-agency communication and a coordinated community response to domestic violence, especially in high-risk cases. The Team will continue to look for ways to improve agency and community response to domestic violence and increase awareness within the community of the problem of domestic violence and the available programs and agencies available to assist victims.

Respectfully submitted,



Jennifer L. Morton

Chair

Calvert County Domestic Violence Fatality Review  
Team

# CALVERT COUNTY



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# CALVERT COUNTY



DOMESTIC VIOLENCE FATALITY REVIEW TEAM

## ANNUAL REPORT

APPENDIX 1

TEAM MEMBERSHIP

# CALVERT COUNTY

## DOMESTIC VIOLENCE FATALITY REVIEW TEAM

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### TEAM MEMBERSHIP

(2010)

#### **Terri Blazer**

Field Supervisor I  
Division of Parole and Probation  
200 Duke Street, Suite 1100  
Prince Frederick, MD 20678  
443-550-6780 (*office*); 410-535-5696 (*fax*)  
[blazerts@dpscs.state.md.us](mailto:blazerts@dpscs.state.md.us)

#### **Barbara Chambers**

Assistant Manager  
Safe Harbor  
Calvert County Health Department  
P.O. Box 980  
Prince Frederick, MD 20678  
410-257-7225 (*office*); 443-486-4853 (*fax*)  
[calvertshelter@verizon.net](mailto:calvertshelter@verizon.net)

#### **Milton Crump**

Administrator  
Calvert County Detention Center  
P.O. Box 9  
Barstow, Maryland 20610  
410-535-4300 (*office*)  
[crumpmm@co.cal.md.us](mailto:crumpmm@co.cal.md.us)

#### **Judy Evans**

Manager  
Safe Harbor  
Calvert County Health Department  
P.O. Box 980  
Prince Frederick, MD 20678  
410-257-7225 (*office*); 443-486-4853 (*fax*)  
[calvertshelter@verizon.net](mailto:calvertshelter@verizon.net)

**Sgt. Tim Fridman**

Calvert County Sheriff's Office  
30 Church Street  
Prince Frederick, MD 20678  
410-535-1600 ext. 2547; 443-624-1340 (cell)  
[fridmatk@co.cal.md.us](mailto:fridmatk@co.cal.md.us)

**David Gale, Director**

Crisis Intervention Center  
Calvert County Health Department  
975 Solomons Island Road, North  
Prince Frederick, MD 20678  
410-535-1121 (office); 410-414-3962 (fax)  
[dgale@dhmh.state.md.us](mailto:dgale@dhmh.state.md.us)

**Kristy Longfellow**

Victim/Witness Advocate  
Calvert County State's Attorney's Office  
175 Main Street  
Prince Frederick, MD 20678  
410-535-1600, 301-855-1243, ext. 2364 (office); 410-535-2436 (fax)  
[longfeka@co.cal.md.us](mailto:longfeka@co.cal.md.us)

**Laura Martin**

State's Attorney  
Calvert County State's Attorney's Office  
175 Main Street  
Prince Frederick, MD 20678  
410-535-1600, 301-855-1243, ext. 2369 (office); 410-535-2436 (fax)  
[martinll@co.cal.md.us](mailto:martinll@co.cal.md.us)

**John Mitchell**

Calvert Substance Abuse Services  
P.O. Box 1158  
Prince Frederick, MD 20678  
410-535-3079 (office); 410-535-2220 (fax)  
[JMitchell@dhmh.state.md.us](mailto:JMitchell@dhmh.state.md.us)

**Jennifer L. Morton (Chairperson)**

Assistant State's Attorney  
Calvert County State's Attorney's Office  
200 Duke Street  
Prince Frederick, MD 20678  
410-535-1600, 301-855-1243, ext. 2494 (office); 410-535-6459 (fax)  
[mortonjl@co.cal.md.us](mailto:mortonjl@co.cal.md.us)

**Louis Oertly,**

Maryland Network Against Domestic Violence  
6911 Laurel Bowie Road, Suite 309  
Bowie, MD 20715  
301-352-4574 (*office*); 301-809-0422 (*fax*)  
[loertly@comcast.net](mailto:loertly@comcast.net)

**Tracy Palmer, Survivor**

Chesapeake Beach, Maryland 20732  
301-367-7412  
[TLP5001@aol.com](mailto:TLP5001@aol.com)

**Phyllis Poole,**

Law Enforcement Liaison, Crisis Intervention Center  
Calvert County Sheriff's Office  
30 Church Street  
Prince Frederick, MD 20678  
410-535-1600, ext. 2577 (*office*); 410-535-1770 (*fax*); 443-975-4445 (*cell*)  
[poolepr@co.cal.md.us](mailto:poolepr@co.cal.md.us)

**David Sargent**

Consultant  
Maryland Network Against Domestic Violence  
5602 39<sup>th</sup> Avenue  
Hyattsville, MD 20781  
301-927-2714 (*office*); 301-518-0923 (*cell*); 301-927-2051 (*fax*)  
[dmsargent47@msn.com](mailto:dmsargent47@msn.com)

**Janet Scott** (*Vice Chairperson*)

Clinical Director Offenders Programs  
Crisis Intervention Center  
Calvert County Health Department  
975 Solomons Island Road, North  
Prince Frederick, MD 20678  
410-535-1121 (*office*); 410-414-3962 (*fax*); 301-641-0417 (*cell*)  
[circleah@hutaf.com](mailto:circleah@hutaf.com)

# CALVERT COUNTY



DOMESTIC VIOLENCE FATALITY REVIEW TEAM

## ANNUAL REPORT

### APPENDIX 2

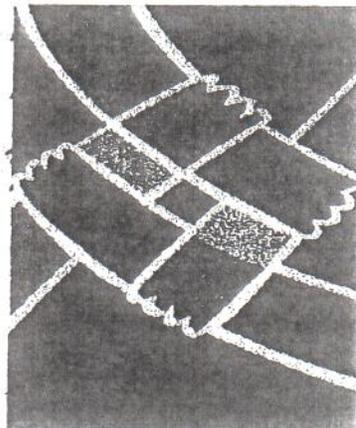
PROTOCOL FOR CONDUCTING  
DOMESTIC VIOLENCE FATALITY REVIEWS

# Calvert County



## Domestic Violence Fatality Review Team

### Protocol for Conducting Domestic Violence Fatality Reviews



March 2005

# Calvert County



## Domestic Violence Fatality Review Team

### Protocol for Conducting Domestic Violence Fatality Reviews

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## 1. 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 by committing itself to find 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 in the manner they should view domestic abuse, and by seeking to ensure compliance with its recommendations. In carrying out its mission of heightened community response, 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.<sup>1</sup>

## 2. Purpose of the Domestic Violence Fatality Review

### a. Primary Purpose

The primary purpose of domestic violence fatality review in Calvert County is to review deaths in which domestic violence has played a role, with the ultimate intent to prevent future fatal occurrences. The review process is aimed at creating a climate in which institutions and individuals in Calvert County will commit themselves to an enhanced response to domestic abuse as a societal evil and a crime, and to victims that they might pursue a better quality of life.

### b. Approach

- (1) Fatality review is intended to be a nonjudgmental, constructive assessment of events preceding a domestic violence fatality and shall not serve as a forum for placing blame on any agency, organization, or individual. It is a prerequisite of the review process that all team representatives keep before them the unalterable fact that fatalities are the underlying responsibility of the perpetrator.<sup>2</sup>
- (2) The review process seeks to enlighten those who are not truly aware of the devastating nature of domestic violence, to give victims a better understanding of the danger that surrounds them and to enable them to plan for their well-being more effectively and with greater circumspection, to improve the awareness, education, sensitivity, caution, proactivity, and communication among coordinated community responders.<sup>3</sup>

### 3. Team Structure

#### a. Authorization for Formation

There is no statutory authorization for the formation of a DVFRT in the State of Maryland. The Calvert DVFRT has been formed under the auspices of the Crisis Intervention Center and through the voluntary participation of the invited agencies and organizations and their respective team representatives. Invitation to participate was extended by the Maryland Network Against Domestic Violence, which was awarded a Violence Against Women grant to establish a DVFRT,<sup>4</sup> and the Crisis Intervention Center, which has assumed leadership of the DVFRT because of its interest in going forward with domestic violence fatality review.

#### b. Lead Agency

1. The "Lead Agency" is that which will oversee the operation of the DVFRT, maintain the Domestic Violence Fatality Review File, and monitor the DVFRT's compliance with its protocol.
2. The lead agency may not influence the case review deliberations of the DVFRT.
3. The lead agency will serve generally as an advisor to the DVFRT, provide a recorder for review meetings, make recommendations to the DVFRT concerning its operations, appoint a supervisor of the Domestic Violence Fatality Review File if the chairperson is not a member of the lead agency, and advise the DVFRT if it fails to comply with its protocol.<sup>5</sup>
4. The Crisis Intervention Center is the lead agency until such time as it would relinquish its position or the DVFRT designates another agency/organization which accepts the position.

#### c. Administration

##### (1) Staffing

Through September 30, 2005, the DVFRT will be staffed by the MNADV. Following that, staffing will be on a voluntary basis by member agencies/organizations, or on a hire basis as funds may become available.

##### (2) Funding

Funding for staff and staff work for the DVFRT will be from the MNADV VAWA grant through September 30, 2005. Following that, the DVFRT will seek funding sources as it determines.<sup>6</sup>

(Team Structure, "Administration" continued)

(3) Address

The DVFRT will be housed in the Crisis Intervention Center, 975 Solomons Island Road, Prince Frederick, MD 20678. Mail should be sent in care of Janet R. Scott, Chair, Domestic Violence Fatality Review Team.<sup>7</sup>

(4) Meeting Sites

Meetings will take place at sites determined by the DVFRT.

d. Membership

(1) Member Agencies/Organizations

The following are the member agencies/organizations of the DVFRT:

- County Sheriff's Office
- Maryland State Police
- County Department of Social Services
- County Health Department Crisis Intervention Center
- County Health Department Safe Harbor Shelter
- Maryland Division of Parole and Probation
- County State's Attorney's Office
- Domestic Violence Coordinating Council
- Calvert Memorial Hospital
- Naval Criminal Investigations Section, Patuxent Naval Air Station
- Southern Maryland Center for Family Advocacy
- Circuit Court
- Survivor(s) of domestic violence<sup>8</sup>

(2) Designation of Primary and Alternate Representatives

Each member agency/organization will designate a primary and alternate representative, if possible. Both the primary representative and the alternate are encouraged to attend DVFRT meetings together.

(3) Appointment of New Member Agencies/Organizations

- (a) Agencies, organizations, or individuals may be added as members by consensus or, barring that, by approval of a simple majority of the voting membership.<sup>9</sup>
- (b) New member agencies/organizations will be asked to sign a letter of agreement that requires the member agency/organization to cooperate with other member agencies/organizations in seeking to fulfill the mission of the DVFRT. However, the DVFRT may invite non-signing members. (See Appendix 1 for Letter of Agreement and Cooperation.<sup>10</sup>)

(Team Structure, "Membership," continued)

**(4) Criterion for Designation of Member Agency/Organization Representatives**

Member agencies/organizations are urged to appoint representatives who have an awareness of domestic violence and a desire to fulfill the mission of the DVFRT.

**e. Leadership**

**(1) Designation of Leadership Positions**

Leadership of the DVFRT will be comprised of a chairperson and vice-chairperson, who will lead meetings in the absence of the chairperson.<sup>11</sup>

**(2) Regular Elections**

- (a) Election of the chairperson and vice chairperson will be by a simple majority of the voting representatives in attendance at the meeting in which a vote is taken.
- (i) One vote is allowed per member agency/organization. Accordingly, two representatives in attendance at a meeting in which an election is held may cast only one vote, with the primary representative serving as the voter. In the absence of the primary representative, the alternate may cast the member agency/organization's vote.
  - (ii) All nominations will be seconded.
  - (iii) All ballots will be recorded in private, unless the DVFRT agrees to a voice vote.
  - (iv) Separate votes for chairperson and vice-chairperson will be taken.
  - (v) The chairperson and vice chairperson will be the primary representative of their agency or organization.
- (b) Representatives may place their own names or the names of another representative in nomination.
- (c) In order to be elected, a representative must be in attendance at the meeting, unless a circumstance acceptable to a simple majority of the voting representatives present at the meeting, is presented.
- (d) In order to serve, elected officers must accept nomination and election and agree to the terms of service.

(Team Structure, "Leadership," continued)

**(3) Interim Elections**

- (a) If an office requires replacement, an interim election will be held.
- (b) Election of interim officers will follow the same procedures as for the election of regular officers.

**(4) Election Schedule**

Regularly scheduled elections will be held every two years during the January meeting of odd years to become effective after the meeting.

**(5) Service**

- (a) Elected officers will serve in their elected capacities as chairperson and vice-chairperson for two years and may be reelected.
- (b) Interim officers will serve until the next regularly scheduled election.

**(6) Removal for Cause**

An elected or appointed representative may be removed from his/her position for cause, upon a vote of three-fourths of the voting representatives.

**f. Case Screening Committee**

In determining which cases match the DVFRT's scope of review, the DVFRT will have a Case Screening Committee, comprised of the chairperson, vice-chairperson, representatives from the County Investigative Team, including the Sheriff's Office, Maryland State Police, and State's Attorney's Office, and any other DVFRT members who wish to participate.<sup>12</sup>

**g. Recorder**

- (1) A staff member from the lead agency will be appointed to serve as recorder of the DVFRT meetings.
- (2) The primary duties of the recorder will be to prepare the minutes during the open part of DVFRT meetings; record notes pertaining to the individual case reviews during the closed part of DVFRT meetings; and to finalize the minutes and notes following the meeting.
- (2) The recorder will sign the Recurrent Confidentiality Agreement at the beginning of each case review meeting to signal his/her agreement to abide by the rules of confidentiality set out for DVFRT members.

(Team Structure, "Recorder," continued)

- (4) If the staff person appointed as recorder is unable to be at a meeting, a representative from the DVFRT may be appointed as a substitute recorder.

#### **h. Records**

##### **(1) Establishment and Designation of File**

- (a) Records initiated by the DVFRT will be maintained and secured by the lead agency in the "Domestic Violence Fatality Review File."
- (b) The file will consist of all records that are generated by the DVFRT and related to the work of the DVFRT such as minutes of meetings, notes concerning reviews, correspondence, completed form letters and agreements, professional articles, journals, and developments concerning domestic violence fatality review.

##### **(2) Maintenance and Supervision of File**

- (a) All records and forms initiated by and related to the DVFRT will be housed in a secure location in the lead agency.
- (b) The Domestic Violence Fatality Review File will be securely maintained under the supervision of a staff member appointed by the head of the lead agency.
  - (i) If the chairperson is a member of the agency, he/she will be the supervisor of the file.
  - (iii) The supervisor of the file, whether the chairperson or a staff member, will sign a "Confidentiality Agreement by File Supervisor." (See *Appendix 2 for Confidentiality Agreement by File Supervisor.*<sup>13</sup>)

##### **(3) Release of File Records**

- (a) No record in the file may be released without the authorization of the chairperson, or vice-chairperson or head of the lead agency in the chairperson's absence when the decision concerning the release cannot reasonably wait until the chairperson's return.
- (b) The officer or agency head releasing the records will require the recipient of the records to sign the "receipt for Records" form, and the two will mutually agree on a date of return that will be noted on the form. (See *Appendix 3 for Receipt for Records.*<sup>14</sup>)

(Team Structure, "Records," continued).

(4) **Retention of File Records**

- (a) Records in this file, except for historical and reference materials, will be retained for three years after the review associated with a particular case. Historical records should be permanently retained. Reference materials may be retained for as long as they remain useful.
- (b) After the three-year period, the records may be destroyed upon the authorization of the chairperson.<sup>15</sup>

(5) **Transfer of File**

If the designated lead agency changes, the Domestic Violence Fatality Review File will be transferred to the new lead agency, which will be responsible for designating a supervisor and secure site for maintenance of the file.

4. **Scope of Reviews**

- a. The DVFRT will review any adult fatality, whether a homicide or suicide involving a victim and/or perpetrator or third parties, or near-fatality, that has domestic violence as an involved factor. Domestic violence, for purposes of a review, is defined as emotional or physical abuse perpetrated by a person against another person with whom the perpetrator has or has had an intimate relationship or with whom the perpetrator resides or has resided.<sup>16</sup>
- b. For a fatality or near-fatality to be reviewable, the criminal case must have been finally adjudicated in the courts and/or the investigation of a suicide must be closed.<sup>17</sup>

5. **Preparation for Meetings**

a. **Gathering Information**

(1) **Case Screening**

- (a) In determining which cases match the DVFRT's scope of review, the DVFRT Case Screening Committee (CSC) will meet at least four weeks before the scheduled meetings of the DVFRT to determine which cases have domestic violence markers and should be reviewed by the DVFRT. All DVFRT representatives will be notified of the date, time, and location of the CSC meeting.

(Preparation for Meetings, "Gathering Information—Case Screening," continued)

- (b) When the Case Screening Committee meets, the County Investigative Team will present all homicide, suicide, and near-fatal cases to the committee so that the committee can examine the cases to determine those which qualify for review by the DVFRT. The committee may also review media and newspaper reports and query the Maryland Network Against Domestic Violence, which tracks domestic fatalities, to be better assured that it has properly reviewed the police cases and included all qualifying cases for the DVFRT review.
- (c) When the committee has determined which cases the DVFRT will review, the chairperson will submit the victims' names to the team representatives, at least three weeks prior to the DVFRT review, so that the representatives may research agency/organization files to determine what, if any, records and/or other information they may have on the victims that can be disclosed to the DVFRT.
- (d) Once cases have been identified, the CSC will seek to determine whether any family or non-family individuals have information beneficial to a case review. If such individuals are identified, the CSC will appoint representatives to contact them and determine whether interviews are appropriate. (Refer to Section 5-d for further information.)
- (e) All decisions of the CSC will be by consensus or, failing that, by a simple majority vote of the appointed representatives and any other participating representatives. The CSC may meet if only two members, including a representative from the County Investigative Team, can be present, in which case all decisions must be unanimous.

(2) **Case-related Materials**

Upon notification by the chairperson of cases that will be reviewed, individual team members will identify records pertinent to the case and will bring to the meeting those records that can be made available for the team review. (See *Appendix 4 for specific case-related materials.*)<sup>18</sup>

(3) **Recognizing Barriers to Obtaining Information**

- (a) There will be barriers to obtaining all the information that the DVFRT needs to make the most informed findings and the most effective recommendations. In a voluntary process, many of the barriers will be more difficult than usual to overcome. However, it is important that the DVFRT recognize what the barriers are in order to overcome them or to move forward to acquire what it can.

(Preparation for Meetings, "Gathering Information—Recognizing Barriers to Obtaining Information," continued)

- (b) The most common barriers are:
- Confidentiality/privilege
  - Statutory restrictions
  - Professional ethical requirements
  - Agency/organization policies
  - Fear of liability or self-incrimination
  - Personal resistance from individuals due to:
    - grief
    - lack of trust
    - invasion of privacy
    - guilt/denial
    - media exposure
  - Missing/incomplete/altered records
  - Inadequate or untrained staff
  - Difficulty in finding information by name or time lapses
  - Lack of subpoena power
  - Lack of releases of information by victims
  - Lack of standardized data collection
  - Lack of standardized number systems
  - Victim-blaming
  - Turf protection
  - Domestic violence issues not recognized or understood
  - Personal relationship of system players
  - Sealing/expunging of records related to domestic violence misdemeanors
  - Sources of information unknown or no longer available.<sup>19</sup>

b. **Case Profile**

A case profile can be developed that includes background, information concerning the involvement of agencies or organizations, related policies and procedures, what services were provided, and what were the results of the various referrals, interventions, encounters, and services. The profile serves as a guide for individual representatives to answer questions and to gather records and information that are relevant to their agency's/organization's aspect of the review, and to prepare themselves for the case review. The following are questions that should be answered in developing a case profile:

(1) **Background**

- What was the nature and history of the violence and abuse between the victim, perpetrator, and children?
- What were the circumstances surrounding the fatality?
- Who knew of suspected family or intimate partner violence, including families, agencies, organizations, and others such as neighbors, friends, and co-workers? How did they know?
- What actions were taken or not taken as a result of those contacts or awareness/suspicions of domestic violence?

(Preparation for Meetings, "Case Profile-Background," continued)

- What information was available to each agency or organization involved in the case?
- Were danger assessments taken, what were the scores, and what actions were taken in light of the scores?
- What was the score of the post-lethality assessment?
- What is the victim's medical/behavioral history?
- What is the perpetrator's medical/behavioral history?
- What is the victim/perpetrator history for substance abuse?

**(2) Agencies Involved**

- Which agencies (to mean any agency, organization, or other institution) had contact with the victim and perpetrator in the case?
- Which agencies had contact with the children, co-workers, and others affected in the case?
- Did any criminal justice or civil agency have contact with the victims or perpetrators? Were there any contacts for assistance and protection (victim, perpetrator, other family members or concerned individuals)? Detail circumstances: 911, hotline, and requests for services.
- What was the extent of involvement (if any) of the parties involved with the legal system and other related community services agencies?
- What interagency communication/collaboration was initiated in response to the case?

**(3) Policies and Procedures**

- What do reviews of various agency policies, procedures, trainings, records, and practices reveal? Are written policies and procedures in place?
- Were all the current written policies and procedures complied with?
- What are the "best practice" procedures? How do these compare with those developed by other communities?
- Are current policies and procedures adequate? If not, how could they be improved?
- Were relevant statutes concerning domestic violence, protective and/or peace orders, stalking, firearms, etc, enforced?

**(4) Services Provided**

- What services were offered/provided/declined?
- When did services and interventions occur?
- What does an event time line tell the team?
- What other services could have been utilized?

*(Preparation for Meetings, "Case Profile," continued)***(5) Outcomes**

- What were the barriers to obtaining services for the victim, perpetrator and children?
- What were institutional barriers, e.g., language and cultural?
- Were statutes a barrier to assistance or prevention?
- What were the barriers to interagency communications?
- Did the enforcement of statutes appear or prove to have created greater risk to the victim, heighten or exacerbate an already dangerous situation, or bring the event to the fatal outcome?
- What specific interventions could have resulted in better outcomes?
- What kind of prevention strategies flow from the interventions identified?
- Were there any other significant recommendations?
- Does the team have all pertinent information it needs to complete a full review?<sup>20</sup>

**c. Time Line.**

The CSC will establish a written time line for each case that will be brought to the team for review. The time line should be prepared on paper large enough for the team to visually refer to as it reviews the case.<sup>21</sup>

**d. Post Danger Assessment**

The CSC or, if interviews are conducted, representatives conducting the interviews will conduct a post Danger Assessment to determine as best as possible after the fact at what level of danger the victim was and what signs existed prior to the fatality. The Danger Assessment will be conducted from the perspective of the CSC or the various individuals giving interviews.<sup>22</sup> (See Appendix 5 for Danger Assessment.)

**e. Involvement of Other Individuals or Entities in the Review Process, Including Surviving Family Members****(1) Determining Significant Persons Associated with the Victim and Who Should Be Interviewed**

- (a) As part of the preparation for the team meeting, the CSC should determine who (individuals, agencies, or organizations) had contact with the involved parties and with significant persons associated with the parties, such as children, other family members, friends, or co-workers; what the extent of the contact was; whether there were any interventions by agencies; and whether there was any interagency communication or collaboration involving the parties.

(Preparation for Meetings, "Involvement of Other Individuals or Entities in the Review Process, Including Surviving Family Members—Determining...Who Should Be Interviewed," continued)

- (b) Individuals designated as persons having information beneficial for a team review will be contacted by the representative assigned by the CSC. The representative will request and, if granted, conduct an interview.
- (c) In the case of non-family members, the representative will consult with the CSC which will determine whether the individual's appearance before the DVFRT would be helpful to the review.
  - (i) If the CSC so determines, the representative will extend an invitation to the individual to appear.
  - (ii) Whether or not the individual appears, the representative who conducted the interview will also report on the interview and his/her assessment of the individual's knowledge about the case, during which time the individual will be excused from the review room.

## (2) Involvement of Family Members

- (a) The involvement in the review process of surviving family members is an important consideration because it is so dynamic and will change with each involved family. Whether or not the family will be involved, the CSC will proceed on several levels.
- (b) The CSC will seek to identify a family member or members who should be contacted. The representative assigned by the CSC will contact the identified member(s) and advise the family member(s) what the DVFRT is and that it will review the circumstances and events leading up to the victim's death. The representative will ask the family member(s) what his/hier thoughts are about the review, ask him/her to discuss it with other family members, if appropriate, and request that the family member or another family member acting on behalf of the family contact the representative to offer the family's views on the matter.

*Note: It is intended that the identification of appropriate family members to contact should be flexible. The CSC or the DVFRT is seeking to identify family members who would offer the DVFRT information that would benefit the review process. If identification of such appropriate family members is obtained through other means, the CSC or the DVFRT should consider that option.*

- (c) If the family is amenable to the process, a request will be made to conduct interviews with various family members whom the CSC has identified as being knowledgeable about the victim's circumstances or who might be recommended by the family member.

*Preparation for Meetings, "Involvement of Other Individuals or Entities in the Review Process, Including Surviving Family Members—Involvement of Family Members," continued)*

- (i) At that time, the representative will explain to the family member the process that will occur, including information about disclosure, and provide the family member with a brochure that explains the DVFRT process. *(See Appendix 6 for CDVFRB Brochure.)*
  - (ii) If approved by the family members who will be interviewed, interviews will be arranged and conducted by the representative.
  - (d) Family members may be invited to participate in the victim's review, if appropriate. The DVFRT representative(s) who interviewed the family members will also provide reports and assessments of their interviews, during which time the family members will be excused from the review room.
  - (e) Following the review a letter will be sent to the family, unless the family requests that no correspondence be sent. The letter will:
    - (i) Advise the family that the review has been completed;
    - (ii) Convey the DVFRT's gratitude for the family's cooperation, if the family was involved in any capacity with the review;
    - (iii) Advise the family that a copy of the annual report will be sent upon request; and
    - (iv) Express the hope that the review of the victim's death will help to reduce domestic violence in the county.
  - (f) The family may also be referred for services, as requested or determined to be necessary or helpful by the DVFRT.<sup>23</sup>
- (3) Interviews and Disclosure Prior to Conducting Interviews**
- (a) Unless the CSC decides otherwise, it will assign interviews to team representatives who are domestic violence counselors or advocates by profession.<sup>24</sup> *(See Appendix 7 for "Guide Questions for Interviews of Victim's Family Members and Other Individuals.")*
  - (b) Interviews will be documented in a form suitable for presentation to the DVFRT.
  - (c) The CSC will also assign an accompanying representative to serve as a witness and to provide his/her interpretation of the interview with the DVFRT during the review of the case.

Preparation for Meetings, "Involvement of Other Individuals or Entities in the Review Process, Including Surviving Family—Interviews and Disclosure Prior to Conducting Interviews," continued)

- (d) Recognizing that such interviews may be an emotional experience for the person giving the interview and may reveal sensitive information, prior to conducting the interview with a family or community member, the representative will inform the person that:
  - (i) The representative will prepare a written report of the interview for presentation to the DVFRT, and should that document ever be subpoenaed or otherwise legally requested, the DVFRT would be required to surrender the requested document; and
  - (ii) Anything the person tells the representative would be disclosable, for example, if the representative were ever subpoenaed to testify in a civil case, if the media obtained information from the DVFRT, or if new information relevant to the criminal investigation of the case or any other case were revealed, or if there were a legal or ethical obligation to disclose.<sup>25</sup>
- (e) Before beginning the interview the representative will:
  - (i) Give a copy of the "Authorization to Give Interview" to the person to read;
  - (ii) Explain the contents of the authorization form for the person, and clarify any information that the person does not clearly understand, and then be satisfied that the person does clearly understand the contents of the authorization form, and
  - (iii) Obtain the signature of the person on the authorization form signifying whether the person wishes to grant or not to grant the interview. If the person declines to grant the interview and does not wish to sign the form, that is the person's prerogative. (See Appendix 8 for "Authorization to Give Interview."<sup>26</sup>)
- f. **Convening of Meetings**
  - (1) The chairperson will convene meetings of the DVFRT in January, April, July, and October. Scheduled meetings may be ~~suspended~~ *canceled* if cases are not available for review or for other good cause, or cases under review may be continued as the team determines.
  - (2) Special sessions of the DVFRT may be convened if the chairperson or individual representatives believe there is a need for the team to meet.

*(Preparation for Meetings, "Convening of Meetings," continued)*

- (3) A need to meet may be based on new information about a case that has already been reviewed that affects the team's findings and/or recommendation, the lack of compliance with the team's recommendations that requires an immediate intervention with the involved agency/organization, or a request of any representative for a reasonable cause.

**g. Confidentiality of Proceedings**

- (1) Especially in a voluntary setting in which the DVFRT exists, it is key to the successful operation of the review process that team member agencies/organizations and representatives are able to have trust in one another. Not all member agencies/organizations and representatives can or should be expected to proceed into a new process with that trust already established or assumed. Accordingly, to build an environment of confidentiality, all member representatives will sign a confidentiality agreement at the outset of their participation in the DVFRT. *(See Appendix 9 for "Confidentiality Agreement by Representative."*<sup>27</sup>)
- (2) To ensure that confidentiality is observed, each team meeting will include an acknowledgment of the confidentiality agreement that each representative signed. The chairperson will thus pass around the same unsigned confidentiality agreement which must be signed by all in attendance. This agreement signed by all in attendance also serves as the attendance roster for that meeting. *(See Appendix 10 for "Recurrent Confidentiality Agreement."*<sup>28</sup>)
- (3) Before proceeding the chairperson will review the signed agreement to ensure that all in attendance have signed the form and will notify the team that all in attendance signed the letter.<sup>29</sup>
- (4) The chairperson will maintain a confidentiality file which will include all originals of the "Confidentiality Agreement by Representative" and the "Recurrent Confidentiality Agreement."
- (5) A breach of confidentiality constitutes cause for removal from the team.<sup>30</sup>

**6. Review Team Meetings**

**a. Rules for Meetings**

- (1) Meetings may not proceed without a quorum. A quorum is constituted when a simple majority of the voting representatives are present.
- (2) Meetings will be called to order and presided over by the chairperson.
- (3) All matters dealing with the actual review of cases, not including information contained in the annual report after it is released, are strictly confidential.

*(Review Team Meetings, "Rules for Meetings," continued)*

- (4) Matters dealing with administrative aspects of the meeting or points of order are not confidential.
- (5) The chairperson may not table or terminate a discussion without consensus, or failing that, without the concurrence of a simple majority of the voting representatives in attendance.

**b. Order of Meetings**

DVFRT meetings will be conducted in the following order:

- (1) Call to order.
- (2) Quorum call.
- (3) Signing of the confidentiality agreement by all representatives in attendance.
- (4) Special reports or presentations.
- (5) New business.
- (6) Old business.
- (7) Follow-up on previous recommendations.
- (8) Case reviews, findings, and recommendations.
- (9) Discussion about release of the annual report (at October meeting).
- (10) Evaluation of the review process.
- (11) Open forum for further discussion, comments, observations, or questions.
- (12) Adjournment.

**c. Conducting the Review****(1) Lead Presentation**

When the chairperson calls for the particular case, the County Investigative Team will serve as the lead presenter of information which the law enforcement agency has concerning the party(ies), contacts, and events immediately leading up to the fatality. The County Investigative Team presenter will tailor his/her presentation to the questions outlined in the "Case Profile."

*(Review Team Meetings, "Conducting the Review," continued)***(2) Review of Available Documents**

The team representatives will then have an opportunity to review available written documents.

**(3) Questions and Discussion**

Representatives will next have the opportunity to discuss and ask questions about the case. Close scrutiny will be given to the background, agencies involved, policies and procedures, services provided, outcomes, and the danger assessments.

**(4) Findings**

Upon completion of the review, the chairperson will ask representatives to offer specific findings. Each finding by the team must be reached by consensus, or, failing that, approval by a simple majority of the voting representatives.

**(5) Recommendations**

Following the discussion of findings, the chairperson will ask for recommendations. Recommendations must be approved by consensus or, not reaching consensus, by a simple majority of the voting representatives.

**(6) Action Concerning Recommendations**

With each case that is reviewed, the chairperson will instruct each representative whose agency was involved in a finding and recommendation to take the particular finding(s) and recommendation(s) to the agency head with a request for consideration and action. At the next meeting, and subsequent meetings, if necessary, the representative will provide a report of what, if any, action was taken concerning the recommendation(s).

**(7) Conclusion of Review**

The review of cases will conclude when the final case has been reviewed and findings and recommendations have been made.

**d. Evaluating the Review Process**

At each meeting, the DVFRT will have a review of its own protocol and review process to determine if changes are necessary to improve the process.

## 7. Annual Report

### a. Annual Report

A written report will be prepared annually for the meetings held during the calendar year and will be disseminated during the first quarter of the following year.

### b. Recording the Team's Findings and Recommendations

- (1) The DVFRT's annual report will not ascribe findings and recommendations to particular cases. While it may cite the names, dates of death, age, method of death, and relationship of the perpetrator, the report will not lay out the individual circumstances of the fatalities. If circumstances are described, they will not be attributed by name to the cases reflected by the circumstances.
- (2) The DVFRT shall make findings concerning significant facts about cases, services, interventions, and events leading up to fatalities.
- (3) The DVFRT shall make recommendations to address needed changes and/or initiatives in such areas as agency responsiveness, agency policy and procedures, services, intervention strategies, the law at the local and state level, community education, and training.

### c. Format

The DVFRT will prepare the final report in the following format:

- (1) An executive summary;
- (2) An overview which provides basic information about the DVFRT meetings: dates, times, locations, attendance by name and agency, and number of cases it reviewed;
- (3) Findings and recommendations;
- (4) Status of prior recommendations;
- (5) Other noteworthy actions taken by the DVFRT; and
- (6) Appendices, which may include aggregate statistical data.<sup>31</sup>

### d. Final Approval

When the report has been drafted, the chairperson will submit the draft to all representatives and the heads of the member agencies. The chairperson will ask the representatives and agency heads to review the draft and to submit amendments that change factual inaccuracies, grammar, and manner of presentation. No substantive changes to the report may be made.

(Annual Report, continued)

**e. Distribution**

- (1) The annual report will be distributed to all member agencies/organizations, county and municipal governments, county representatives, the family of victims whose cases were reviewed who request a copy, county media outlets, and other entities that have oversight concerning victim matters, in particular, the Maryland Governor's Office of Crime Control and Prevention and the National Domestic Violence Fatality Review Initiative.
- (2) The report will also be posted on a website determined by the DVFRT.

**f. Method of Communicating the Final Report**

The chairperson will prepare a cover letter transmitting the annual report.

**8. Appointment and Training of New Team Member Agencies/Organizations and/or Representatives**

**a. Appointment of New Team Member Agencies/Organizations and/or Representatives**

- (1) The appointment of new agencies (including organizations and individuals) to the DVFRT will be based on the recommendation and justification of a voting representative, and a consensus of the voting representatives. If consensus is not reached, a motion must be made by a voting representative and seconded, and approval must be given by a simple majority of the voting representatives present at the meeting.
- (2) The chairperson will invite the newly approved agency, and request the agency head to:
  - (a) Appoint primary and alternate representatives;
  - (b) Sign a "Letter of Agreement and Cooperation"; and
  - (c) Have the representatives sign a "Confidentiality Agreement by Representative."

**b. Training of New Team Member Agencies/Organizations and/or Representatives**

The chairperson will send new member representatives and new representatives from current member agencies a copy of the protocol and training materials developed by the DVFRT, and request the new representatives to review these materials before the next meeting.

## 9. Continuing Education and Training of Team Representatives

- a. The DVFRT will subscribe to the Fatality Review Bulletin published by the National Domestic Violence Fatality Review Initiative.
- b. The DVFRT will seek to send representatives to national or state conferences so that reports can be provided to the DVFRT.
- c. The DVFRT will establish an email group so that the team may make one another aware of new information.
- d. The chairperson will provide updates on articles or pertinent information to representatives.
- e. When meetings are held, if new information has been published, the chairperson or another representative knowledgeable of the information will provide a report to the rest of the team.
- f. With the concurrence of a simple majority of the voting representatives, the chairperson may convene a training session.

## 10. Resigning or Withdrawing from the Team

- a. Primary and alternate representatives may resign from the DVFRT by giving notice to the chairperson. The resigning representative will seek, at the time of his/her resignation, to have a replacement and notify the chairperson of the new representative's name. If a replacement's name is not available, the resigning representative will seek to assure the chairperson that his/her replacement will assume the position of primary representative in time enough to prepare adequately for the DVFRT's next meeting, and that the agency will notify the chairperson of the replacement as soon as practicable.
- b. Any agency, organization, or individual member of the DVFRT may withdraw from the team by notifying the chairperson in writing.

## 11. Media Relations

### a. Establishing a Positive Relationship

Because the media plays an important role in reporting instances of domestic violence and domestic violence fatalities, the DVFRT will seek to establish and maintain a positive working relationship with the media and to provide information to the media that will better inform its coverage and provide a connection to domestic violence advocates and others knowledgeable about domestic violence.<sup>32</sup>

*(Media Relations, continued)***b. How the Media Can Help**

The DVFRT recognizes that the media can aid the team in the fulfillment of its mission by "...publicizing the work products of the team. Very often, teams recommend greater awareness and deeper public understanding of domestic violence, as well as system reforms and additional resources for domestic violence agencies. The media is key to getting the word out and thus promoting needed social change."<sup>33</sup>

**c. Information Exchange**

Accordingly, the DVFRT will proactively offer to the press information it considers to be of a public nature and educational, and will seek information from the media that will enhance the review process generally and specifically.

- (1) The DVFRT will not willingly provide information it would consider too sensitive for public consumption, such as names of family and community members who were intimately involved in aspects of the victim's life that were related to domestic violence, names of victims in the context of events that would tend to unnecessarily identify family or other community members, certain events that would readily and unnecessarily identify the victim and/or family and other community members, information that the DVFRT would not consider educational or would consider detrimental to the well-being of the victim's family.
- (2) Should the press seek information that is of a public nature but that the DVFRT considers too sensitive for public consumption, the chairperson will contact the media and ask it to consider the reasons the DVFRT believes specific information should not be published.
- (3) The above conditions notwithstanding, the DVFRT recognizes that, upon a legal request, it likely will be required to release requested documents.

**d. Public Information Officer**

- (1) The chairperson will serve as the public information officer for the DVFRT.
- (2) All media contacts concerning any aspect of the DVFRT will be referred to the chairperson, or the vice-chairperson in his/her absence.
  - (a) If inquiries are made concerning an individual agency, the chairperson will refer the media to the public information officer of that agency.
  - (b) The chairperson will then notify the agency's public information officer of the referral.

## **Appendices**

1. Letter of Agreement and Cooperation
2. Confidentiality Agreement by File Supervisor
3. Records Receipt
4. Case-Related Materials
5. Danger Assessment
6. CDVVRT Brochure
7. Authorization to Give Interview
8. Guide Questions for Interviews of Victim's Family Members and Other Individuals
9. Confidentiality Agreement by Representative
10. Recurrent Confidentiality Agreement

## Endnotes

1. Sections and subsections that are not endnoted were developed by the DVFRT as part of its protocol development process. The development history of individual sections and subsections is contained in the minutes of the meetings maintained by the lead agency.
2. "Family and Intimate Partner Violence: Fatality Review Team Protocol—Second Edition," Virginia Department of Health, Office of the Chief Medical Examiner, December 2002, p. 2. The DVFRT fashioned Sections 2-a and 2-b after the Virginia "Purpose" statement.
3. "Lethality Assessment Tools: A Critical Analysis," Neil Websdale, VAWnet Applied Research Forum, 2000, pp. 5-7.
4. Violence Against Women Act grant: VAWA-2004-1040.
5. The concept of the "lead agency" was developed before the Anne Arundel County DVFRT development sessions in October 2003 as a means of better insuring the continuity of the team. The lead agency in Anne Arundel was selected by the MNADV because of its interest in the fatality review process. Similarly, the Crisis Intervention Center approached the MNADV about establishing a DVFRT in Calvert, agreed to coordinate the MOU requirements of the grant application process, and agreed to serve as lead agency.
6. Ibid.
7. Since the Crisis Intervention Center currently serves as the lead agency, the mailing address of the DVFRT is the office location.
8. Most of the listed agencies submitted letters of commitment in June 2004 for the VAWA grant application that was awarded to the MNADV for FY 2005. Others were added during the protocol development process between October 2004 and January 2005.  
  
The participation of a survivor or survivors is recommended in "Domestic Violence Fatality Reviews: Recommendations from a National Summit," Louis W. McHardy and Meredith Hofford, p. 7; by Dr. Neil Websdale and Robin Thompson during a seminar they gave to the Anne Arundel county DVFRT on July 12, 2004; and during the national domestic violence fatality review conference in Del Ray, FL, on September 20-21, 2004. The Anne Arundel DVFRT adopted the various recommendations and agreed to bring a survivor onto the team at its first case review team meeting on September 16, 2004. Calvert followed suit upon the establishment of its team in October 2004.
9. The consensus approach was based on "Family and Intimate Partner Violence: Fatality Review Team Protocol—Second Edition," Virginia Department of Health, p. 12. Although the Calvert DVFRT adopted a consensus approach, it decided that the reasonable alternative would be a vote of a simple majority of the voting representatives for all decisions by the team with exceptions as noted in the protocol.

10. The DVFRT "Letter of Agreement and Cooperation" used as a guide the Hamilton County, Ohio, Domestic Violence Death Review Panel letter of agreement, as shown in "Family and Intimate Partner Violence: Fatality Review Team Protocol—Second Edition," Virginia Department of Health, Appendix G, p. 29.
11. See "Domestic Violence Fatality Reviews: Recommendations from a National Summit," Louis W. McHardy and Meredith Hofford, p. 6. The Calvert DVFRT agreed with an MNADV proposal to have a simple leadership structure.
12. In response to Dr. Neil Websdale's remarks during a seminar he and Robin Thompson presented to the Anne Arundel DVFRT on July 12, 2004, that the screening process should be more open, the DVFRT decided to structure the committee through a simple, practical approach: permitting any other representative who wished to attend the committee the authority to do so. The Calvert DVFRT decided to adopt the same approach. However, due to the investigative structure in place in the county, the sheriff's office, state police, and state's attorney's office form what is called the "County Investigative Team." By agreement during the protocol development process, this team will serve as the case-gathering entity for the Case Screening Committee.
13. The "Confidentiality Agreement by File Supervisor," was proposed by the MNADV to the Anne Arundel DVFRT to address a protocol for the position of file supervisor which was created in response to the establishment of the Domestic Violence Fatality Review File, both of which were established as part of the DVFRT development process, January through June 2004. The Calvert DVFRT decided to adopt the form.
15. The Calvert DVFRT wanted to establish a record of the release of documents so that it could track outstanding records. Accordingly, the "Records Receipt" form was created.
15. The three-year designation is to be consistent with the usual Maryland records retention period. The Calvert DVFRT decided to adopted the same retention time frame.
16. This is a broad and generic definition to permit the DVFRT to review cases where the issue of power and control evidences itself.
17. "Domestic Violence Fatality Reviews: Recommendations from a National Summit," Louis W. McHardy and Meredith Hofford, p. 7: "For many reasons, fatality review teams must consider very carefully the disposition of cases to be reviewed. Summit participants grappled with whether to review open cases, i. e., those that had not been fully adjudicated. Generally, participants agreed that for many reasons—confidentiality, discovery, liability, etc.—closed murder cases or open murder/suicide cases were the most appropriate to review."

"Reviewing Domestic Violence Fatalities: Summarizing National Developments," Neil Websdale, Maureen Sheeran, and Byron Johnson, p 45: "Another key issue is whether to review open or closed cases. Research in Florida reveals that reviewing cases pending prosecution is problematic because the state is unwilling or unable to share information that might compromise a conviction." Virginia, for example, under Virginia Code, § 32.1-283.3 (E), requires that "(T)he review of a death shall be delayed until any criminal investigations or prosecutions connected with the death are completed."

18. "Domestic Violence Fatality Reviews: Recommendations from a National Summit," pp. 9 and 10.
19. Ibid., p. 10.
20. "Family and Intimate Partner Violence: Fatality Review Team Protocol—Second Edition," pp. 8 & 9.
21. Ibid., p. 8.
22. Lethality assessment is mentioned in "Family and Intimate Partner Violence: Fatality Review Team Protocol—Second Edition," p. 8. Nevertheless, the Maryland Network Against Domestic Violence is developing a statewide lethality assessment instrument and protocol and is pursuing both lethality assessment and fatality review simultaneously. The "Danger Assessment" is the instrument that has been pioneered by Dr. Jacquelyn Campbell of Johns Hopkins University and has been adopted by the statewide MNADV Lethality Assessment Committee as the instrument of choice for people and institutions who are experienced in domestic violence and have the luxury of time to administer the tool. It is the proper instrument for the Case Screening committee to use, although it must be adapted so that the questions ask the interviewee or other party what they thought the victim was experiencing. The Danger Assessment is thus rendered from the perspective of another party.
23. Though the procedure concerning family involvement was developed independently by the DVFRT, the DVFRT was guided by the work of "Domestic Violence Fatality Reviews: Recommendations from a National Summit," p. 13, and "Family and Intimate Partner Violence: Fatality Review Team Protocol—Second Edition," Appendix K, p. 35, and also by information from Dr. Neil Websdale and Robin Thompson at a seminar they presented to the DVFRT on July 12, 2004, at the YWCA in Arnold, MD.
24. "Family and Intimate Partner Violence: Fatality Review Team Protocol—Second Edition," Appendix K, p. 35, concerning interviews being conducted by team representatives "experienced in crisis intervention or grief counseling." The CDVFRRT, however, decided in its meeting of January 5, 2005, to incorporate an element of flexibility into who should conduct the interviews to provide for occasions when another member or even another individual not on the team would be more appropriate to conduct the interview.
25. "Domestic Violence Fatality Reviews: Recommendations from a National Summit," p. 12: "If, in the course of the review, there is information which may be indicative of a new crime, the team chair is to report it promptly to the most appropriate authority. The team is to decide whether the review should be suspended as a result of these actions."
26. The "Authorization to Grant Interview" was created by the Anne Arundel DVFRT to address concerns about the disclosability of information provided during interviews, as part of its development process, January through June 2004. The Calvert DVFRT adopted the form and amended it and the protocol at its meeting on February 2, 2005, to include the obligation to disclose "legal and ethical" information.

27. The DVFRT "Confidentiality Agreement by Representative" is based on the Washington State Domestic Violence Fatality Review Project "Agreement to Maintain Confidentiality," as shown in "Family and Intimate Partner Violence: Fatality Review Team Protocol—Second Edition," Appendix H, p. 33.
28. The DVFRT "Recurrent Confidentiality Agreement" is based on the Washington State Domestic Violence Fatality Review Project "Agreement to Maintain Confidentiality," as shown in "Family and Intimate Partner Violence: Fatality Review Team Protocol—Second Edition," Appendix H, p. 33.
29. "Family and Intimate Partner Violence: Fatality Review Team Protocol—Second Edition," p. 6. With reference to Appendices G and H, pp. 29 -33, concerning confidentiality agreements.
30. "Domestic Violence Fatality Reviews: Recommendations from a National Summit," p. 12: "Any member who violates confidentiality is to be removed from the committee."
31. The Calvert DVFRT used the "Findings and Recommendations from the Washington State Domestic Violence Fatality Review" as a model, with changes, for its report.
32. See "Covering Domestic Violence: A Guide for Journalists and Other Media Professionals," Washington State Coalition Against Domestic Violence, June 2002, p. 1.
33. Websdale, undated quote.

*Calvert County*



**Domestic Violence Fatality Review Team**

**Protocol  
for  
Conducting  
Domestic Violence Fatality Reviews**

**Appendix 1**

***Letter of Agreement and Cooperation***

*March 2005*

# Calvert County



## Domestic Violence Fatality Review Team

### Letter of Agreement and Cooperation

To the Chairperson and Members of the Calvert County Domestic Violence Fatality Review Team:

I agree that my organization will serve as a full participating and cooperating member of the Calvert County Domestic Violence Fatality Review Team (Review Team).

This agreement means that I will appoint a representative who will serve on the Review Team, will attend and fully participate in all meetings of the Review Team, will prepare for Review Team meetings by reviewing materials forwarded to the representative, and will take to meetings such records that my organization has identified as being pertinent and reviewable by the Review Team. In the event the representative is unable to attend a meeting, I agree that an alternate will also be appointed who will carry out the duties of the representative. I agree that the representative and alternate will have a working knowledge of the dynamics of domestic violence.

I have read the "Protocol for Conducting Domestic Violence Fatality Reviews" and concur in it. I understand the mission and purpose of the Review Team and find them to be consistent with my organization's mission and purpose. Most importantly, I agree with the steps that are taken in the review process to assure the confidentiality of the proceedings, and agree that my representative and alternate will sign the confidentiality agreements drawn up for their purposes and signatures.

I agree to submit written notice to the Chairperson should my agency ever decide to withdraw from the Review Team. Such notice of withdrawal would effectively terminate this agreement.

This agreement becomes effective on the below date. I can request a revision or review of this agreement within 30 days of written notice. Notice of revision of this agreement will be sent to the Chairperson of the Review Team.

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Date: \_\_\_\_\_

*Calvert County*



**Domestic Violence Fatality Review Team**

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**Appendix 2**

***Confidentiality Agreement by File Supervisor***

*March 2005*

# Calvert County



## Domestic Violence Fatality Review Team

### Confidentiality Agreement by File Supervisor

I agree to serve as supervisor of the Domestic Violence Fatality Review File for the Calvert County Domestic Violence Fatality Review Team (DVFRT).

I understand that my assignment as file supervisor requires me to:

- Maintain the Domestic Violence Fatality Review File as outlined in the DVFRT protocol;
- Maintain the file in a secure manner and in a secure location inside the DVFRT lead agency;
- Retain all records generated by the DVFRT and related to the work of the DVFRT such as minutes of meetings, notes concerning reviews, correspondence, completed form letters and agreements, professional articles, journals, and developments concerning domestic violence fatality review.
- Organize the file by categories permitting prompt and efficient record retrieval, with subcategories that permit retrieval by the name of decedents.
- Not to release any record in the file without the authorization of the chairperson, or vice-chairperson or head of the lead agency in the chairperson's absence when the decision concerning the release cannot reasonably wait until the chairperson's return.
- Inspect the file at least once a quarter prior to the next scheduled meeting to ensure the integrity of the file.
- Retain records in the file for three years after the review associated with a particular case, after which time the files related to that particular case may be destroyed. Before destroying any files, however, I understand that I must receive the written authorization of the chairperson, and may only proceed in the manner outlined in the protocol.

I agree to safeguard the Domestic Violence Fatality Review File from unauthorized disclosure. I understand that the only persons who may have access to the file are the chairperson, vice-chairperson, the lead agency head, and myself. A request by any other person, including other representatives of the DVFRT, must be approved by the chairperson, or vice-chairperson or lead agency head in the chairperson's absence when the decision concerning the release cannot reasonably wait until the chairperson's return. I understand and acknowledge that the unauthorized disclosure of confidential records, reports, investigative materials and information may result in civil and criminal liability and removal from my position as supervisor of the Domestic Violence Fatality Review File.

I agree to refrain from representing the views of the DVFRT to the media, and understand and acknowledge that only the chairperson may represent the DVFRT before the media.

Supervisor's Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

Organization \_\_\_\_\_ Date \_\_\_\_\_

My signature represents my endorsement, as the organization head, of this agreement.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Calvert County*



**Domestic Violence Fatality Review Team**

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**Appendix 3**



***Receipt for Records***

*March 2005*

# Calvert County



## Domestic Violence Fatality Review Team

### Receipt for Records

I release for temporary use the following records from the Domestic Violence Fatality Review File:

#### Released by:

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

DVFRT Title: \_\_\_\_\_

#### Return Date

By initialed agreement of the above two parties, the above released records will be returned to the DVFRT chairperson by \_\_\_\_\_ (Date)

Initials of DVFRT Representative: \_\_\_\_\_

Initials of Recipient: \_\_\_\_\_

**Calvert County**



**Domestic Violence Fatality Review Team**

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**Appendix 4**



***Case-Related Materials***

**March 2005**

# Calvert County



## Domestic Violence Fatality Review Team

### Case-Related Materials

- Law enforcement reports, including field reports, investigative and supplemental reports, call history, 911 tapes
- National Crime Information Center (NCIC), Maryland Inter-agency Law Enforcement System (MILES), other criminal history records, *protective and peace orders*
- Court files, including court transcripts of hearings, pleas, and trials, for criminal, civil, family, and juvenile cases
- Mental health records
- Juvenile records
- Adult parole and probation records
- Weapons records
- Shelter/domestic violence provider records
- Court advocate records
- Adult and child protective services records
- Social services records
- Immigration records
- Medical and dental records
- Interviews with perpetrator's former intimate partners
- Information from victim's and perpetrator's families, friends, and co-workers
- Interviews with witnesses and neighbors
- Interviews with medical personnel
- Prosecution records
- Newspaper articles and media stories
- Autopsy reports
- Pre-trial services records
- Abuse intervention services reports
- Landlord or apartment building maintenance and complaint files
- Interviews with security guards
- School records
- Insurance policies
- Records and/or interviews with services such as suicide hotline, child support enforcement, job training programs, legal services
- Animal control reports
- Marriage counseling files
- Interviews with clergy and members of the congregation
- Records and interviews from victim advocates in law enforcement agencies
- Employment records
- Military records
- Adoption records
- Attorney files

*Calvert County*



**Domestic Violence Fatality Review Team**

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**Appendix 5**  
●  
***Danger Assessment***

*March 2005*

# DANGER ASSESSMENT

Jacquelyn C. Campbell, PhD, RN, FAAN

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Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, bums, broken bones, miscarriage
4. Threat to use weapon; head injury, internal injury, permanent injury, miscarriage
5. Use of weapon; wounds from weapon

(If any of the descriptions for the higher number apply, use the higher number.)

Mark Yes or No for each of the following.

("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

Yes	No	
_____	_____	1. Has the physical violence increased in severity or frequency over the past year?
_____	_____	2. Does he own a gun?
_____	_____	3. Have you left him after living together during the past year? 3a. (If have never lived with him, check here _____)
_____	_____	4. Is he unemployed?
_____	_____	5. Has he ever used a weapon against you or threatened you with a lethal weapon? 5a. (If yes, was the weapon a gun? _____)
_____	_____	6. Does he threaten to kill you?
_____	_____	7. Has he avoided being arrested for domestic violence?
_____	_____	8. Do you have a child that is not his?
_____	_____	9. Has he ever forced you to have sex when you did not wish to do so?
_____	_____	10. Does he ever try to choke you?
_____	_____	11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
_____	_____	12. Is he an alcoholic or problem drinker?
_____	_____	13. Does he control most or all of your daily activities? (For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: _____)
_____	_____	14. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
_____	_____	15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: _____)
_____	_____	16. Has he ever threatened or tried to commit suicide?
_____	_____	17. Does he threaten to harm your children?
_____	_____	18. Do you believe he is capable of killing you?
_____	_____	19. Does he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don't want him to?
_____	_____	20. Have you ever threatened or tried to commit suicide?
_____	_____	Total "Yes" Answers

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

**Calvert County**



**Domestic Violence Fatality Review Team**

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**Appendix 6**



**Brochure**

**March 2005**

*Calvert Arundel County*



**Domestic Violence Fatality Review Team**

**Protocol  
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**Appendix 7**



***Authorization to Give Interview***

*March 2005*

# Calvert County



## Domestic Violence Fatality Review Team

### Authorization to Give Interview

A representative of the Calvert County Domestic Violence Fatality Review Team (team) has contacted me to advise me that the team will conduct a review of the death of \_\_\_\_\_ . The representative has explained to me how the team conducts reviews of fatalities or near fatalities related to domestic violence. The representative has explained that the information that will be reviewed will be information that is on the public record or information that it obtains through other sources, such as interviews.

The representative has asked me if I would be willing to provide an interview. The representative has explained that the purpose of the interview is to be able to obtain more information that will help the team better determine the events leading up to the death in order to improve the system's response to domestic violence and to prevent future deaths from occurring. The representative has explained that what I say in the interview will be reported by the representative and may be discussed by the team members as part of the review of the case. The representative explained that team members voluntarily sign an agreement not to discuss information that was part of a case review outside of the confines of the review meeting, except as required by state or federal law.

The representative has also explained to me, however, that any information I provide during the interview could possibly be disclosed and become public knowledge. The representative explained that it is not the team's intention to make the contents of the interview public, but explained that some circumstances could arise where the team could not control the release of the information. The representative offered me some examples, such as:

- In a civil case if a subpoena were issued for information contained in the interview, or
- If the media made a legal request for the interview information,
- If new information were disclosed in the interview that changes the investigation of the case or another case, or
- If there were a legal or ethical obligation to disclose the information.

I understand the information that has been explained to me. I understand that any information I provide in an interview could possibly be disclosed and made public. With that information in mind, I choose:

Not to grant an interview: \_\_\_\_\_  
Signature (not required) (Date)

To grant an interview: \_\_\_\_\_  
Signature (Date)

Representative: \_\_\_\_\_  
Signature (Date)

Witness: \_\_\_\_\_  
Signature (Date)

Calvert County



Domestic Violence Fatality Review Team

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Appendix 8

●  
*Guide Questions for Interviews of  
Victim's Family Members and Other Individuals*

March 2005

# Calvert County



## Domestic Violence Fatality Review Team

### Guide Questions for Interviews of Victim's Family Members and Other Individuals

The following questions serve as a guide to an interviewer of a victim's family members or other individuals who have information beneficial to the domestic violence fatality review process. Many of the questions are taken from the "profile" section of the protocol. They are intended to supplement questions the interviewer may have developed that are pertinent to the particular case, and to provide a full array of potential questions. The interviewer should not feel compelled to ask all the listed questions. The interviewer should ask questions relevant to the particular case and those he or she believes would benefit the review process. The interviewer should reformulate the precise wording of any of the below questions that are used in a manner with which he or she is comfortable and believes will be most understandable to the person being interviewed. Furthermore, through experience, the interviewer should develop a sense of or know when further questioning might be counter-productive.

#### *Questions Concerning Background*

- What was the nature and history of the violence and abuse between the victim, perpetrator, and children?
- Was there a history of violence in the perpetrator's or victim's families?
- What further information can be provided about the victim's and perpetrator's backgrounds? How did they relate personally with others? What were their general demeanor, behavior, and personality? How were they generally viewed by others? Was there anything that stood out or seemed unusual—positive or negative—about any aspects of their personality or behavior?
- What were the circumstances surrounding the fatality?
- What signs were present before the fatality that caused concern?
- Who knew of suspected family or intimate partner violence, including families, agencies, organizations, and others such as neighbors, friends, and co-workers? How did they know? Did the victim ever discuss the violence with anybody?

*(Background Questions, continued)*

- What actions were taken or not taken as a result of those contacts or awareness/suspicions of domestic violence?
- What is the victim's/perpetrator's medical/behavioral history?
- What is the victim's/perpetrator's history of substance abuse?

*Questions Concerning Agency Involvement*

- Which agencies (to mean any agency, organization, or other institution) had contact with the victim and perpetrator in the case?
- Which agencies had contact with the children, co-workers, and others affected in the case?
- Were there any contacts for assistance and protection (victim, perpetrator, other family members or concerned individuals)? Detail circumstances: 911, hotline, and requests for services.
- What was the extent of involvement (if any) of the victim and/or perpetrator with the legal system and other related community services agencies?
- What information was available to agencies involved in the case?
- What interagency communication/collaboration was initiated in response to the case?
- What services were offered/provided/declined?
- When and how frequently did services and interventions occur?
- How responsive were agencies to the domestic violence situation?

*Outcomes—Personal Views of the Person Being Interviewed*

*(Note: Some of the below questions may not be appropriate to ask a person being interviewed. They should only be asked if they clearly relate to the situation and the person seems to have views about them)*

- What were the barriers to obtaining services for the victim, perpetrator and children?
- What were institutional barriers, e.g., language and cultural?
- Were statutes a barrier to assistance or prevention?
- What were the barriers to interagency communications?
- Did the enforcement or non-enforcement of statutes appear or prove to have created greater risk to the victim, heighten or exacerbate an already dangerous situation, or bring the event to the fatal outcome?
- What specific interventions could have resulted in better outcomes?
- What other specific actions, if they had taken place, could have perhaps helped to prevent the fatality from occurring?
- Were there any other significant recommendations?

**Calvert County**



**Domestic Violence Fatality Review Team**

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**Appendix 9**

**Confidentiality Agreement by Representative**

**March 2005**

# Calvert County



## Domestic Violence Fatality Review Team

### Confidentiality Agreement by Representative

I agree to serve as a representative of the Calvert County Domestic Violence Fatality Review Team and to honor a commitment to prepare for, attend, and constructively participate in meetings of the Review Team during my tenure.

I acknowledge that the effectiveness of the fatality review process depends on the quality of trust team members bring to it. I therefore agree that I will not use any material or information obtained during the Review Team meetings for any reason other than that for which it was intended or divulge information discussed during the review of a case, unless such information changes a departmental investigation of the relevant or another case, or for ethical or other obligations.

I further agree to safeguard any records, reports, investigative material, and information I receive from unauthorized disclosure. I will not take any case identifying material from a meeting other than that which originated in the organization I represent. I therefore will not make any copies or otherwise document/record material available in these reviews, including electronically, except for copies of departmental records I take into case review meetings for the purpose of sharing the copies of the records with the other Review Team representatives as part of the review. I understand that I must retrieve all such copies immediately following the case review. I will return all material shared by others at the end of each meeting to the representative of the originating organization.

I understand and acknowledge that the unauthorized disclosure of confidential records, reports, investigative materials and information may result in civil and criminal liability and removal from the Review Team.

Unless specifically authorized to do so by the chairperson, or his/her designee, wherein the chairperson, or his/her designee, sets forth the information and circumstances I may discuss, I agree to refrain from representing the views of the Review Team to the media, and understand and acknowledge that only the chairperson, or his/her designee, may represent the Review Team before the media.

Representative's Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

Organization \_\_\_\_\_ Date \_\_\_\_\_

My signature represents my endorsement, as the organization head, of this agreement.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Calvert County**



**Domestic Violence Fatality Review Team**

**Protocol  
for  
Conducting  
Domestic Violence Fatality Reviews**

**Appendix 10**

***Recurrent Confidentiality Agreement***

**March 2005**

# Calvert County



## Domestic Violence Fatality Review Team

### Recurrent Confidentiality Agreement

Note to Signees: This agreement is being signed by you on the date of the Review Team meeting: \_\_\_\_\_

I agree to serve as a representative of the Calvert County Domestic Violence Fatality Review Team and to honor a commitment to prepare for, attend, and constructively participate in meetings of the Review Team during my tenure.

I acknowledge that the effectiveness of the fatality review process depends on the quality of trust team members bring to it. I therefore agree that I will not use any material or information obtained during the Review Team meetings for any reason other than that for which it was intended.

I further agree to safeguard any records, reports, investigative material, and information I receive from unauthorized disclosure. I will not take any case identifying material from a meeting other than that which originated in the organization I represent. I therefore will not make any copies or otherwise document/record material available in these reviews, including electronically, except for copies of departmental records I take into case review meetings for the purpose of sharing the copies of the records with the other Review Team representatives as part of the review. I understand that I must retrieve all such copies immediately following the case review. I will return all material shared by others at the end of each meeting.

I understand and acknowledge that the unauthorized disclosure of confidential records, reports, investigative materials and information may result in civil and criminal liability and removal from the Review Team.

Unless specifically authorized to do so by the chairperson wherein the chairperson sets forth the information and circumstances I may discuss, I agree to refrain from representing the views of the Review Team to the media, and understand and acknowledge that only the chairperson may represent the Review Team before the media.

	Signature	Printed Name
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____
11.	_____	_____
12.	_____	_____
13.	_____	_____
14.	_____	_____
15.	_____	_____

# CALVERT COUNTY



DOMESTIC VIOLENCE FATALITY REVIEW TEAM

## ANNUAL REPORT

### APPENDIX 3

### LEGISLATION

- (2) the level of stipends for displaced homemakers in job training programs under § 4-607(2) of this subtitle;
- (3) a sliding fee scale, based on ability to pay, for service programs under § 4-607(4) of this subtitle; and
- (4) any other matter that the Secretary finds necessary to carry out the provisions of this subtitle. (An. Code 1957, art. 88A, § 97; 1984, ch. 296, § 2.)

**4-612. Duties of Secretary — Evaluation.**

- a) *In general.* — The Secretary shall:
  - (1) evaluate periodically the effectiveness of the job training, employment, and service programs of the center; and
  - (2) include in the Secretary's annual report to the General Assembly a report on the center and its programs.
- b) *Contents of evaluation and report.* — The evaluation and report shall include:
  - (1) the number of displaced homemakers who participate in job training programs;
  - (2) the number of displaced homemakers who are placed in employment;
  - (3) follow-up information on displaced homemakers who participate in job training programs or who are placed in employment;
  - (4) the number of displaced homemakers who are served by the service programs; and
  - (5) the cost effectiveness of the programs. (An. Code 1957, art. 88A, § 98; 84, ch. 296, § 2.)

**4-613. Powers of Secretary.**

- (a) *Grants.* — The Secretary may make grants to nonprofit agencies or organizations to establish and operate any program of the center.
- (b) *Extension of center or programs.* — The Secretary may establish a multipurpose service center in or extend any program of the center to another area of this State.
- (c) *Delegation of authority.* — The Secretary may delegate any of the authority granted to the Secretary under this subtitle to any agency in the Department of Human Resources that the Secretary considers appropriate. An. Code 1957, art. 88A, §§ 92, 99; 1984, ch. 296, § 2.)

*Subtitle 7. Local Domestic Violence Fatality Review Teams.*

**4-701. Definitions.**

- (a) *In general.* — In this subtitle the following words have the meanings indicated.
  - (b) *Abuse.* — "Abuse" has the meaning stated in § 4-501(b)(1) of this title.
  - (c) *Domestic violence.* — "Domestic violence" means abuse occurring between:
    - (1) current or former spouses or cohabitants;

- (2) persons who have a child in common; or
  - (3) persons currently or formerly involved in a dating relationship.
- (d) *Domestic violence program.* — "Domestic violence program" is a program established in accordance with § 4-515 of this title.

(e) *Local team.* — "Local team" means the multidisciplinary and multiagency domestic violence fatality review team established for a county in accordance with this subtitle.

(f) *Serious physical injury.* — "Serious physical injury" has the meaning stated in § 3-201 of the Criminal Law Article. (2005, ch. 233; 2006, ch. 44, § 6.)

*Editor's note.* — Section 2, ch. 233, Acts 2006, provides that this subtitle shall take effect July 1, 2005.  
 Section 6, ch. 44, Acts 2006, enacted April 7, 2006, pursuant to art. II, § 17(b) of the Maryland Constitution and effective from date of enactment, provides that "the publisher of the Annotated Code of Maryland, in consultation with and subject to the approval of the Department of Legislative Services, at the time of publication of a new supplement, new volume, or replacement volume of the Annotated Code, shall make nonsubstantive corrections to codification, style, capitalization, punctuation, grammar, spelling, and any reference rendered obsolete by an Act of the General Assembly, with no further action required by the General Assembly. The publisher shall adequately describe any such correction in an editor's note following the section affected." Pursuant to § 6 of ch. 44, "of this title" was substituted for "of this article" in (b) and (d).

**§ 4-702. Teams authorized.**

- (a) *Established by county.* — A county is authorized to establish a domestic violence fatality review team.
- (b) *Organizers.* — In a county, the State's Attorney, the head of the primary law enforcement agency, or the director of the domestic violence program may organize a local team. (2006, ch. 233.)

**§ 4-703. Composition of team.**

- (a) *Members.* — The members of a local team shall be drawn from the following persons, organizations, agencies, and areas of expertise, from within the county, as available:
  - (1) domestic violence service providers;
  - (2) law enforcement agencies;
  - (3) the State's Attorney's office;
  - (4) the local health department;
  - (5) the local department of social services;
  - (6) the domestic violence coordinating council;
  - (7) batterer intervention services providers;
  - (8) the Division of Parole and Probation;
  - (9) hospitals;
  - (10) judges of the District Court and circuit courts;
  - (11) clerks of the District Court and circuit courts;
  - (12) the Chief Medical Examiner's office;
  - (13) survivors of domestic violence; and
  - (14) any other person necessary to the work of the local team, recommended by the local team.

- (b) *Designees.* — The members described under subsection (a)(1) through (2) of this section may designate representatives from their departments or offices to represent them on the local team.
- (c) *Chair.* — Each local team shall elect a chair by majority vote from among its members. (2005, ch. 233.)

**4-704. Purpose.**

- (a) *In general.* — The purpose of a local team is to prevent deaths related to domestic violence by:
- (1) promoting cooperation and coordination among agencies involved in:
    - (i) investigating deaths related to domestic violence; or
    - (ii) providing services to victims of domestic violence, abusers, or surviving family members;
  - (2) developing an understanding of the causes and incidence of deaths related to domestic violence in the county; and
  - (3) developing plans for and recommending changes within the agencies whose members represent.
- (b) *Methodology.* — To achieve its purpose, a local team shall:
- (1) establish and implement a protocol for the local team;
  - (2) as provided in subsection (c) of this section, review fatalities and cases of serious physical injury related to domestic violence that have occurred in the county;
  - (3) meet on a regular basis as determined by the local team, at least annually, to:
    - (i) review the status of domestic violence fatality cases in the county;
    - (ii) recommend actions to improve coordination of services and investigations among member agencies; and
    - (iii) recommend actions within the member agencies to prevent deaths related to domestic violence; and
  - (4) provide reports that include recommendations:
    - (i) to improve coordination of services and investigations; and
    - (ii) to implement changes recommended by the local team within member agencies; and
    - (iii) on needed changes to State and local law, policy, and practice to prevent deaths related to domestic violence.
- (c) *Case review.* — (1) In accordance with paragraph (2) of this subsection, a local team shall determine the number and types of cases the team will review.
- (2) A local team may review criminal cases only at the conclusion of the case in trial court or after the investigation of a suicide has been closed. (2005, ch. 233.)

**§ 4-705. Access to information.**

On request of the chair of a local team and as necessary to carry out the local team's purpose and duties under this subtitle, the local team shall be immediately provided:

- (1) with access to information and records by a provider of medical care, including dental and mental health care, regarding a person whose death or serious physical injury is being reviewed by the local team; and
- (2) access to all information and records maintained by any State or local government agency, including birth certificates, law enforcement investigative information, medical examiner investigative information, parole and probation information and records, and information and records of a social services agency that provided services to the person or the person's family. (2005, ch. 233.)

**§ 4-706. Closed and public meetings; violations.**

- (a) *Closed meetings.* — Meetings of a local team shall be closed to the public and not subject to Title 10, Subtitle 5 of the State Government Article when the local team is discussing individual cases.
- (b) *Public meetings.* — Except as provided in subsection (c) of this section, meetings of a local team shall be open to the public and subject to Title 10, Subtitle 5 of the State Government Article when the local team is not discussing individual cases.
- (c) *Confidentiality.* — (1) Information identifying a deceased person, a family member, or an alleged or suspected perpetrator of abuse may not be disclosed during a public meeting.
- (2) Information regarding the involvement of any agency, organization, or person with a deceased person or the person's family may not be disclosed during a public meeting.
- (d) *Requested attendance.* — This section does not prohibit a local team from requesting the attendance at a team meeting of a person who has information relevant to the exercise of the team's purpose and duties under this subtitle.
- (e) *Violations; penalties.* — A violation of this section is a misdemeanor and is punishable by a fine not exceeding \$500 or imprisonment not exceeding 90 days or both. (2005, ch. 233.)

**§ 4-707. Confidentiality.**

- (a) *In general.* — Except as provided in subsections (b) and (c) of this section, all information and records acquired by a local team in the exercise of its purpose and duties under this subtitle:
- (1) are confidential;
  - (2) are exempt from disclosure under Title 10, Subtitle 6 of the State Government Article; and
  - (3) may only be disclosed as necessary to carry out the local team's duties and purposes.
- (b) *Statistics open to public.* — Statistical compilations of data that do not contain any information that would permit the identification of any person to be ascertained are public records.
- (c) *Certain reports deemed public.* — Reports of a local team that do not contain any information that would permit the identification of any person to be ascertained are public information.

(d) *Prohibited disclosures by team members and attendees.* — Except as necessary to carry out a local team's purpose and duties under this subtitle, members of a local team and persons attending a local team meeting may not disclose:

(1) what transpired at a meeting closed to the public under § 4-706 of this subtitle; or

(2) any information the disclosure of which is prohibited by this section. (e) *Team information not available in civil or criminal proceedings; exceptions.* — (1) Except as provided in paragraph (2) of this subsection, members of a local team, persons attending a local team meeting, and persons who present information to a local team may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting.

(2) A person may testify to information obtained independently of the local team or that is public information.

(f) *Protected information, documents, and records.* — (1) Except as provided in paragraph (2) of this subsection, information, documents, and records of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.

(2) Information, documents, and records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were presented during proceedings of a local team or are maintained by a local team.

(g) *Violations; penalties.* — A violation of this section is a misdemeanor and is punishable by a fine not exceeding \$500 or imprisonment not exceeding 90 days or both. (2006, ch. 233.)

*Editor's note.* — See note to § 4-701 of this subtitle.

FAMILY LAW

TITLE 5.  
CHILDREN.

Sec. 5-101.	Definitions.	Sec. 5-323.	Grant of guardianship — Nonconsensual.
	(a) In general.	5-324.	Contents of order.
	(b) Adoptive parent.	5-326.	Effects of order for guardianship.
	(c) Child placement agency.	5-328.	Review hearings.
	(d) Crime of violence.	5-327.	Failed conditional placement during guardianship.
	(e) Department.	5-328.	Termination of guardianship.
	(f) Disability.	5-329, 5-330.	[Reserved].
	<i>Subtitle 1. Definition.</i>	Part III.	Adoption Without Prior Termination of Parental Rights.
	<i>Subtitle 2. Parent and Child.</i>	5-331.	Petition.
5-201.	Scope of subtitle.	5-332.	Parental addresses.
5-202.	Child of void marriage.	5-333.	Notice of filing.
5-203.	Natural guardianship; powers and duties of parent; support obligations of grandparents; award of custody to parent.	5-334.	Order to show cause.
5-204.	Domicile of minor child.	5-336.	Hearing on adoption petition.
5-205.	Right to services and earnings of minor child.	5-336.	Time limits.
5-206.	Right to sue for seduction or wrongful injury of minor child.	5-337.	Considerations.
	<i>Subtitle 3. Guardianship to and Adoption through Local Department.</i>	5-338.	Authority to grant adoption.
	Part I. General Provisions.	5-339.	Consent.
5-301.	Definitions.	5-340.	Dismissal.
	(a) In general.	5-341.	Order for adoption.
	(b) Caretaker.	5-342.	Petition to invalidate.
	(c) Child.	5-343, 5-344.	[Reserved].
	(d) Guardianship.	Part IV.	Adoption After Termination of Parental Rights.
	(e) Identifying information.	5-345.	Petition.
	(f) Parent.	5-346.	Notice of filing.
	(g) Party.	5-347.	Hearing on adoption petition.
5-302.	Scope of subtitle.	5-348.	Time limits.
5-303.	Statement of findings; purposes.	5-349.	Considerations.
5-304.	Relationship with Title 5, Subtitle 5.	5-350.	Authority to grant adoption.
5-305.	Foreign orders.	5-351.	Consent.
5-306.	Faternity.	5-352.	Order for adoption.
5-307.	Appointed counsel.	5-353.	Petition to invalidate.
5-308.	Agreement for postadoption contact.	5-354, 5-355.	[Reserved].
5-309.	Assessment of costs.	Part V.	Access to Records.
5-310.	Appeal.	5-355.	Medical and mental health information.
5-311, 5-312.	[Reserved].	5-357.	Court and department records.
	Part II. Guardianship.	5-358.	Urgently needed medical information.
5-313.	Petition.	5-359.	Vital records.
5-314.	Parental addresses.	5-360.	Access for adoptive parent.
5-315.	Notice of filing.	5-361.	[Reserved].
5-316.	Order to show cause.	Part VI.	Prohibited Acts.
5-317.	Investigations.	5-362.	Prohibited payments.
5-318.	Hearings on guardianship petition.		<i>Subtitle 3A. Private Agency Guardianship and Adoption.</i>
5-319.	Time limits.		Part I. General Provisions.
5-320.	Authority to grant guardianship.		Part I. General Provisions.
5-321.	Consent.		5-3A-01. Definitions.
5-322.	Grant of guardianship — Consensual.		(a) In general.

# CALVERT COUNTY



DOMESTIC VIOLENCE FATALITY REVIEW TEAM

## ANNUAL REPORT

### APPENDIX 4

DOMESTIC VIOLENCE LETHALITY SCREEN FOR  
FIRST RESPONDERS



# DOMESTIC VIOLENCE LETHALITY SCREEN FOR FIRST RESPONDERS



Officer:	Date:	Case #:
Victim:	Offender:	
<input type="checkbox"/> Check here if victim did not answer any of the questions.		
<b>▶ A "Yes" response to any of Questions #1-3 automatically triggers the protocol referral.</b>		
1. Has he/she ever used a weapon against you or threatened you with a weapon?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Ans.
2. Has he/she threatened to kill you or your children?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Ans.
3. Do you think he/she might try to kill you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Ans.
<b>▶ Negative responses to Questions #1-3, but positive responses to at least four of Questions #4-11, trigger the protocol referral.</b>		
4. Does he/she have a gun or can he/she get one easily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Ans.
5. Has he/she ever tried to choke you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Ans.
6. Is he/she violently or constantly jealous or does he/she control most of your daily activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Ans.
7. Have you left him/her or separated after living together or being married?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Ans.
8. Is he/she unemployed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Ans.
9. Has he/she ever tried to kill himself/herself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Ans.
10. Do you have a child that he/she knows is not his/hers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Ans.
11. Does he/she follow or spy on you or leave threatening messages?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Ans.
<b>▶ An officer may trigger the protocol referral, if not already triggered above, as a result of the victim's response to the below question, or whenever the officer believes the victim is in a potentially lethal situation.</b>		
Is there anything else that worries you about your safety? (If "yes") What worries you?		
<b>Check one:</b> <input type="checkbox"/> Victim screened in according to the protocol <input type="checkbox"/> Victim screened in based on the belief of officer <input type="checkbox"/> Victim did not screen in		
If victim screened in: After advising her/him of a high danger assessment, <input type="checkbox"/> Yes <input type="checkbox"/> No did the victim speak with the hotline counselor?		

*Note: The questions above and the criteria for determining the level of risk a person faces is based on the best available research on factors associated with lethal violence by a current or former intimate partner. However, each situation may present unique factors that influence risk for lethal violence that are not captured by this screen. Although most victims who screen "positive" or "high danger" would not be expected to be killed, these victims face much higher risk than that of other victims of intimate partner violence.*

# CALVERT COUNTY



DOMESTIC VIOLENCE FATALITY REVIEW TEAM

## ANNUAL REPORT

### APPENDIX 5

DANGER ASSESSMENT  
Jacqueline C. Campbell, PhD, RN, PAAN

# DANGER ASSESSMENT

Jacquelyn C. Campbell, PhD, RN, FAAN  
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Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones, miscarriage
4. Threat to use weapon; head injury, internal injury, permanent injury, miscarriage
5. Use of weapon; wounds from weapon

(If any of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following.

("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has the physical violence increased in severity or frequency over the past year?
<input type="checkbox"/>	<input type="checkbox"/>	2. Does he own a gun?
<input type="checkbox"/>	<input type="checkbox"/>	3. Have you left him after living together during the past year? 3a. (If have <i>never</i> lived with him, check here <input type="checkbox"/> )
<input type="checkbox"/>	<input type="checkbox"/>	4. Is he unemployed?
<input type="checkbox"/>	<input type="checkbox"/>	5. Has he ever used a weapon against you or threatened you with a lethal weapon? 5a. (If yes, was the weapon a gun? <input type="checkbox"/> )
<input type="checkbox"/>	<input type="checkbox"/>	6. Does he threaten to kill you?
<input type="checkbox"/>	<input type="checkbox"/>	7. Has he avoided being arrested for domestic violence?
<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have a child that is not his?
<input type="checkbox"/>	<input type="checkbox"/>	9. Has he ever forced you to have sex when you did not wish to do so?
<input type="checkbox"/>	<input type="checkbox"/>	10. Does he ever try to choke you?
<input type="checkbox"/>	<input type="checkbox"/>	11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
<input type="checkbox"/>	<input type="checkbox"/>	12. Is he an alcoholic or problem drinker?
<input type="checkbox"/>	<input type="checkbox"/>	13. Does he control most or all of your daily activities? (For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: <input type="checkbox"/> )
<input type="checkbox"/>	<input type="checkbox"/>	14. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: <input type="checkbox"/> )
<input type="checkbox"/>	<input type="checkbox"/>	16. Has he ever threatened or tried to commit suicide?
<input type="checkbox"/>	<input type="checkbox"/>	17. Does he threaten to harm your children?
<input type="checkbox"/>	<input type="checkbox"/>	18. Do you believe he is capable of killing you?
<input type="checkbox"/>	<input type="checkbox"/>	19. Does he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don't want him to?
<input type="checkbox"/>	<input type="checkbox"/>	20. Have you ever threatened or tried to commit suicide?
<input type="checkbox"/>	<input type="checkbox"/>	Total "Yes" Answers

**Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.**

# CALVERT COUNTY



DOMESTIC VIOLENCE FATALITY REVIEW TEAM

## ANNUAL REPORT

### APPENDIX 6

#### DOMESTIC VIOLENCE LETHALITY ASSESSMENT PROTOCOL FOR MARYLAND FIRST RESPONDERS

Developed by the  
Lethality Assessment Committee  
Maryland Network Against Domestic Violence  
2004

Domestic Violence Lethality Assessment Protocol  
for  
Maryland  
First Responders

●  
September 2005

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## Foreword

Under a Violence Against Women Act grant, the Maryland Network Against Domestic Violence (MNADV) has worked in a cooperative venture with agencies and organizations from across the State to develop a model lethality assessment instrument and protocol for Maryland. The objectives were to provide a tool for first responders that would allow them to gauge the level of danger in a particular situation, and to provide them with a protocol that would permit them to respond according to their assessment.

To develop an assessment instrument and protocol, a Lethality Assessment Committee was assembled, comprised of the following members, who, except for the MNADV representatives, all served in a voluntary capacity, through the good offices of their agencies or organizations:

Tracy Bahm	Executive Director Stalking Resource Center--a program of the National Center for Victims of Crime
Jacquelyn Campbell, Ph.D., RN	Associate Dean for Faculty Affairs/Professor School of Nursing Johns Hopkins University
Captain Gregory Carlevaro	Commander, Domestic Violence Unit Harford County Sheriff's Office and Maryland Sheriffs' Association representative
Michael Cogan	Chief, District Court Division Assistant State's Attorney Anne Arundel County
David Cordle	Chief Investigator/Witness Security Program Coordinator State's Attorney Office Anne Arundel County
Lee Goldman	Deputy Director Maryland Police and Correctional Training Commissions
Corporal Jonas Ignatavicius	Domestic Violence Unit Anne Arundel County Police Department
Cara Krulewitch, Ph.D., CNM	Assistant Professor School of Child, Women, and Family Health Nursing University of Maryland--Baltimore
Dorothy Lennig	Director Domestic Violence Legal Clinic House of Ruth, Baltimore
Denise McCain	Executive Director Family Crisis Center Prince George's County
Eugene Morris	Executive Director Abused Persons Program of Montgomery County
Michelle Mueller	Project Manager Maryland Network Against Domestic Violence

*(Foreword, continued)*

David Sargent	Committee Coordinator Maryland Network Against Domestic Violence
Twilah Shipley	Former Acting Director Attorney General's and Lt. Gov.'s Family Violence Council
David R. Thomas	Assistant Director, Domestic Violence Education Program Division of Public Safety Leadership Johns Hopkins University
Daniel Webster, Sc.D., MPH	Associate Professor and Co-Director Center for Gun Policy and Research Johns Hopkins University
Jeanne Yeager	Executive Director Mid-Shore Council on Family Violence

Additionally, the following served as pilot contacts from the three jurisdictions in which the Lethality Screen and Protocol were tested and also served on the LAC:

Janis Harvey	Executive Director YWCA Anne Arundel County
Kate Hall	Former Director, Crisis and Family Support Services YWCA Anne Arundel County
Corporal Jonas Ignatavicius Mary Howser	Anne Arundel County Police Department Clinical Director Heartly House Frederick County
Lieutenant Thomas Chase	Commander, Criminal Investigations Division Frederick Police Department
Stephanie Dalpra	Executive Director Spouse Abuse Resource Center (SARC) Harford County
Susan Fisher	Clinical Director SARC Harford County
Captain Gregory Carlevaro	Harford County Sheriff's Office

The Lethality Assessment Committee developed a "Lethality Screen" for use by first responders, adopted the Danger Assessment by Dr. Jacquelyn Campbell for use by domestic violence professionals in more controlled settings, and drafted a protocol to guide the use of these instruments.

**1.0 Introduction**

**1.1 Issue**

**1.2 Purpose**

**1.3 Goals**

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**1.1 Issue**

**1.1.1 How to Identify and Respond to Situations of Increasing and Potentially Lethal Danger.** Domestic violence situations sometimes move toward the increasing likelihood of further and more serious violence, and sometimes toward the death of the victim, the death of the children or others, and/or the suicidal death of the abuser. Recognizing and responding to this phenomenon is not easy for first responders such as law enforcement officers and domestic violence counselors.

**1.2 Purpose**

**1.2.1 To Improve Response to Victims Generally.** Through the development and adoption of lethality screening instruments and this protocol, we are attempting to continue to improve the way first responders and the community deal with domestic violence in our state. The specter of domestic violence fatalities each year in Maryland commands us to respond to victims with greater understanding and proactivity concerning the danger they confront every day.<sup>1</sup>

**1.2.2 To Respond to High-Danger Situations Specifically.** The protocol seeks to establish a means for Maryland first responders to identify potentially increasingly violent or lethal situations, to assess them, and to offer choices that seek to account for the safety of the victim and her/his children. This process is called "lethality assessment."

**1.2.3 To Improve Cooperation, Communication, and Coordination between Law Enforcement and Service Providers.** It is significant that only 4% of victims of domestic violence homicide were ever in contact with a domestic violence service provider.<sup>2</sup> The lethality screening instrument that is integral to this protocol, and the protocol itself, are designed to respond aggressively to this dysfunctional statistic. However, a successful response depends on the willingness of law enforcement agencies and service providers to work together in different ways. Without cooperation, communication, and coordination, law enforcement agencies and service providers cannot effectively identify victims who are in potentially lethal situations and cannot properly connect them to safety and services. Law enforcement and service providers need to recognize that the safety of victims may best be achieved by their mutual willingness to work together.

*(Introduction, continued)*

### 1.3 Goals

1.3.1 Accordingly, the goals of this protocol are to:

- a. Reduce the danger level for victims;
- b. Reduce domestic-related fatalities;
- c. Cause greater awareness among criminal justice and domestic violence service professionals of increased danger and lethality;<sup>3</sup>
- d. Cause greater consideration among criminal justice and domestic violence service professionals of proactive interventions;
- e. Educate criminal justice and domestic violence service professionals;
- f. Give victims an opportunity “to see themselves, their abusers, and their overall predicaments...” through a “...different lens.”
- g. Enhance cooperation, communication and coordination among criminal justice and domestic violence service professionals.



2.0    **Definition of Domestic Violence**

2.1    **Definition**

2.2    **Explanation of "Intimate Relationship"**

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2.1    **Definition**

2.1.1    **Act of Violence in Intimate Relationship.** Domestic violence occurs when a person commits or attempts to commit one of the following acts against a current or former spouse or a person with whom he/she has, or has had, an intimate relationship:

- a.    An act that causes physical injury,
- b.    An act that places one in fear of physical injury to self or others,
- c.    Sexual assault,
- d.    Property crimes,
- e.    Violation of a protective order,
- f.    False imprisonment,
- g.    Harassment, or
- h.    Stalking.<sup>4</sup>

2.2    **Explanation of "Intimate Relationship"**

2.2.1    An "intimate relationship" is one in which heterosexual or homosexual partners have, or have had, a sexual or emotional relationship.

2.2.2    **Intimate Partners.** Persons involved in an intimate relationship are partners who:

- a.    Are married, separated, or divorced;
- b.    Live or have lived together;
- c.    Have children in common; or
- d.    Date, or have dated, but do not live, or never have lived, together.<sup>5</sup>

### 3.0 Scope of Domestic Violence

#### 3.1 Intimate Partner Homicide

#### 3.2 Scope of Domestic Violence

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### 3.1 Intimate Partner Homicide

#### 3.1.1 Prevalence.

- a. "Femicide, the homicide of women, is the leading cause of death in the United States among young African-American women aged 15 to 45 years and the seventh leading cause of premature death among women overall. American women are killed by intimate partners (husbands, lovers, ex-husbands, or ex-lovers) more often than any other type of perpetrator. Intimate partner homicide accounts for approximately 40% to 50% of US femicides but a relatively small proportion of male homicides (5.9%). The percentage of intimate partner homicides involving male victims decreased between 1976 and 1996, whereas the percentage of female victims increased, from 54% to 72%."<sup>6</sup>

"The majority (67%-80%) of intimate partner homicides involves physical abuse of the female by the male before the murder, no matter which partner is killed. Therefore, one of the major ways to decrease intimate partner homicide is to identify and intervene with battered women at risk."<sup>7</sup>

- b. On average, more than three women are murdered by their husbands or boyfriends in this country every day. In 2000, 1,247 women and 440 men were killed by an intimate partner.<sup>8</sup>

### 3.2 Scope of Domestic Violence

**3.2.1 Most Victims Are Women.** Domestic violence occurs in many relationships. Men and women alike commit crimes of violence against persons with whom they have been intimate. However, the vast majority of victims in domestic cases—85% - 90%—are women.<sup>9</sup>

**3.2.2 Estimates Vary, But in the Millions.** Many studies have examined the scope of domestic violence in the United States. Estimates range from 960,000 incidents of violence against a current or former spouse, boyfriend, or girlfriend per year<sup>10</sup> to three million women who are physically abused by their husband or boyfriend per year.<sup>11</sup>

*(Scope of Domestic Violence, "Scope of Domestic Violence," continued)*

**3.2.3 Prevalence Is Higher Than Most Think.** "The prevalence of domestic violence is higher than most people think. We now estimate that between 700,000 and 1,100,000 women every year seek care at emergency departments for acute injuries incurred from abuse," according to Jacquelyn Campbell, PhD, RN, professor at the Johns Hopkins University School of Nursing and principal investigator of the study. "That estimate does not include the significant numbers of additional women who seek care at emergency departments for indirect symptoms of abuse, such as emotional stress or chronic pain from previous injuries."<sup>12</sup>

**3.2.4 Danger of Domestic Violence.**

Women who are injured during the commission of a violent crime are nearly twice as likely to be injured if the assailant is an intimate, than if the assailant is a stranger; and in about a quarter of the domestic violence cases the victim seeks medical treatment usually for cuts, bruises, black eyes, and similar injuries.<sup>13</sup> In addition, a sizable percentage of persons involved in domestic violence are victims of repeated offenses at the hands of their abusers.<sup>14</sup> The frequency of such occurrences indicates escalating violence and severity and increases the likelihood of such events leading to homicide. The fact that women now report violence perpetrated by an intimate at the same rate as that committed by a stranger highlights the serious nature of assaults by intimates.<sup>15</sup>

**3.2.5 Violence Extends Equal Across the State.** Efforts to serve victims must be uniform and reach out across the state, for the problem of domestic violence extends equally to people living in our cities, suburbs, and rural areas.<sup>16</sup>



#### 4.0 Lethality Assessment

##### 4.1 Introduction

##### 4.2 When to Initiate a Lethality Assessment

##### 4.3 How to Conduct a Lethality Assessment

##### 4.4 Protocol Referral Not Triggered or Victim Does Not Complete the Screen

##### 4.5 High Danger Assessment—Implementation of the Protocol Referral

##### 4.6 Practical Considerations in Administering the Screen

##### 4.7 Domestic Violence Lethality Screen for First Responders—Appendices 1 and 2

##### 4.8 Danger Assessment—Appendices 3 and 4

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#### 4.1 Introduction

In the context of the protocol, lethality assessment for first responders is comprised of conducting a lethality assessment through the use of a screening instrument, contacting the domestic violence hotline when a victim is assessed as being in danger, asking the victim to speak with a hotline counselor, and offering services to the victim as determined by the situation.

#### 4.2 When to Initiate a Lethality Assessment

4.2.1 **Criteria.** The first responder should initiate a lethality assessment when he/she responds to a domestic situation, and

- a. There is reason to believe that an assault or an act that constitutes domestic violence has occurred, whether or not there is an arrest; or
- b. There is a belief or sense on the part of the first responder that once the victim is no longer in the care or presence of the first responder the potential for assault or danger is high;
- c. Repeat calls for service; or
- d. The first responder believes one should be conducted.

#### 4.3 How to Conduct a Lethality Assessment

4.3.1 **Lethality Assessment Form.** The first responder will use the form entitled “Domestic Violence Lethality Screen for First Responders” (referred to as “Lethality Screen”) to ask the victim the lethality assessment questions.

(Lethality Assessment, "How to Conduct a Lethality Assessment," continued)

#### 4.3.2 Lethality Assessment Questions. The lethality assessment questions are as follows

1. Has he/she ever used a weapon against you or threatened you with a weapon?
2. Has he/she threatened to kill you or your children?
3. Do you think he/she might try to kill you?
4. Does he/she have a gun or can he get one easily?
5. Has he/she ever tried to choke you?
6. Is he/she violently or constantly jealous or does he/she control most of your daily activities?
7. Have you left him/her or separated after living together or being married?
8. Is he/she unemployed?
9. Has he/she tried to kill himself?
10. Do you have a child that he/she knows is not his/hers?
11. Does he/she follow or spy on you or leave threatening messages?<sup>17</sup>

4.3.3 **How to Ask the Questions.** The first responder should advise the victim that he/she will ask the victim a short series of questions to help the responder determine how much immediate danger the victim is in. The assessment questions should be in the order they are listed on the form.

4.3.4 **Ask All the Questions.** If time permits, first responders should ask all the questions, even if the victim responds positively to Questions #1 through #3. The more questions to which the victim responds positively, the clearer and more immediate it is that the victim is in danger.

#### 4.3.5 Assessing the Responses

a. After the first responder asks the questions on the Lethality Screen, he/she will handle the information as follows:

- (1) **Yes to Q. #1, #2, or #3 → Referral.** A "yes" or positive response by the victim to any of Questions #1, #2, or #3 reflects a high danger situation and automatically triggers the protocol referral process.
- (2) **Yes to Four of Q. #4-#11 → Referral.** If the victim gives negative responses to Questions #1-#3, but positive responses to at least four of Questions #4-#11, that reflects a high danger situation and triggers the protocol referral.

- b. "No," or negative responses, to all of the assessment questions, or positive responses to no more than three of Questions #4-#11, may still trigger the protocol referral if the first responder believes it is appropriate.
  - (1) A first responder may trigger the protocol referral whenever he/she believes the victim is in a potentially lethal situation.
  - (2) Whenever the victim has responded negatively to all questions or given positive responses to no more than three of Questions #4-#11, the first responder should ask the victim the following question: "Is there anything else that worries you about your safety? (If "yes") What worries you?" The response to the question may help the first responder better determine whether the protocol referral should be triggered.

#### 4.4 Protocol Referral Not Triggered or Victim Does Not Complete the Screen

4.4.1 If the protocol referral is not triggered or the victim does not complete the lethality screen, the first responder will:

- b. **Advise of Dangerous Situation.** Advise the victim that domestic violence is dangerous, and sometimes fatal;
- c. **Advise to Watch for Signs.** Inform the victim to watch for the signs listed in the screen because they may convey to her that she is at increased level of danger;
- d. **Refer to Provider.** Refer the victim to the domestic violence service provider; *and*
- e. **Provide Contact Information.** Provide the victim with the first responder's contact information or contact information of others who may be available during times when the first responder is not, in case the victim wants to talk further or needs help.
- e. **Prepare an incident report.**
  - (a) Record what occurred concerning the screen,
  - (b) Note that the protocol referral process was not triggered,
  - (c) Specify what resources were recommended to the victim, and
  - (d) Explain what, if any, follow-up actions were taken and why.

*(Lethality Assessment, continued)*

#### **4.5 High Danger Assessment—Implementation of the Protocol Referral**

##### **4.5.1 Response by Law Enforcement**

If a high danger assessment is made or the first responder believes it is appropriate, the first responder will implement a protocol referral as follows:

- a. **Advise of Assessment.** Advise the victim that the first responder has conducted an assessment of the victim's situation that has shown that the victim is at an increased level of danger, and that people in the victim's situation have been killed.
- b. **Request by First Responder to Call Hotline.** The first responder will then tell the victim that he/she would like to call the domestic violence hotline to have the victim speak with a counselor.
- c. **If the victim agrees to speak with the counselor,** the first responder will call the domestic violence hotline and advise the counselor that he/she has made a high danger assessment, or believes that the victim is in danger, and would like the counselor to speak with the victim.
  - (1) At the appropriate time during the conversation between the victim and the counselor, the counselor will ask the victim if she/he may speak with the first responder about the situation.
  - (2) The first responder will be guided by his/her discussion with the counselor.
- d. **If the victim initially declines to speak with the counselor,** the first responder will:
  - (1) Tell the victim that the first responder will contact the domestic violence hotline to receive guidance on how to proceed with the situation;
  - (2) Tell the victim that he/she would like the victim to reconsider speaking with the hotline counselor; and
  - (3) After the first responder concludes the conversation with the counselor, ask the victim if she/he has reconsidered and would now like to speak with the counselor.

(Section 4.5.1, *Lethality Assessment, "Implementation of the Protocol Referral—Law Enforcement Response—Victim Declines to Speak with Counselor," continued*)

- e. If the victim continues to decline to speak with the counselor, the first responder will:
- (1) **Repeat Assessment.** Reiterate his/her assessment that the victim is in a dangerous situation;
  - (2) **Advise to Watch for Signs.** Inform the victim to watch for the signs listed in the assessment because they may convey to her that she is at increased level of danger;
  - (3) **Refer to Provider.** Strongly encourage the victim to call the domestic violence service provider and provide the referral information;
  - (4) **Provide First Responder Contact Information.** Provide the victim with the first responder's work phone number or the phone number of others who may be available during times when the first responder is not, in case the victim wants to talk further or needs help;
  - (5) **Review Basic Safety Steps.** Review some basic safety steps and advise the victim not to let her abuser know about these steps because that may provoke the abuser to further violence. Such steps may include any of the following if the first responder believes they are appropriate for the situation:
    - (a) Suggesting that the victim consider filing for a protective/peace order;
    - (b) Advising the victim to consider staying at another location if the abuser has been arrested because the abuser will usually be released from custody in a matter of hours;
    - (c) If the victim wishes to leave the home, advising the victim:
      - (i) To remove necessary documents and items such as birth certificates, social security cards, insurance cards and policies, passports or visas (as applicable), money/credit cards, checkbooks, bankbooks, food stamps, copy of a protective/peace order, vehicle registration, copy of the lease/deed to home, medical and school records, custody papers, power of attorney/will, medications, prescriptions, keys to the home and vehicles, address book, telephone cards, clothes;
      - (ii) That the first responder will either provide or arrange for transportation for the victim, if needed;

(Section 4.5.1-e, *Lethality Assessment, "Implementation of the Protocol Referral—Law Enforcement Response—Victim Declines to Speak with Counselor," continued*)

- (iii) That the domestic violence program can provide shelter and counseling and referral services.
  - (6) **Inform victim about possible follow-up.** Where a law enforcement officer is the first responder, inform the victim that he/she is concerned about the victim's well-being and that other law enforcement officers may be in contact with her; and
  - (7) **Inform domestic violence unit or supervisor.** Where a law enforcement officer is the first responder, notify the agency's domestic violence unit, if one exists, or a supervisor of the high danger assessment and of the victim's wishes, and offer a personal assessment of the victim's situation based on the information that the first responder obtained from the encounter and/or from previous encounters.
    - (a) Based on the information provided by the first responder and/or information known to the domestic violence unit, the unit or supervisor may decide that no follow-up should be made in this particular case or to make contact with the victim and/or abuser.
    - (b) If a decision is made to contact the victim and/or abuser, the unit or a supervisor will devise a plan for contact to better determine the victim's situation and need for further help and the danger posed by the abuser. The potential risks to the victim must be carefully weighed before activating such a plan.
- f. **Assist with Safety Plan.** With permission from the victim and within the responder's capability, assist:
  - (1) The domestic violence program counselor in developing an immediate safety plan, and
  - (2) The victim in carrying out the immediate safety plan; and
- g. **Document.** Prepare a report fully documenting the incident.

#### 4.5.2 Response by the Service Provider—Striving for a Team Approach

##### a. Upon Receipt of a Phone Call from a Law Enforcement Officer.

- (1) Upon being advised by a law enforcement officer that a victim has been assessed as being in high danger, the counselor will speak with the victim if the victim agrees, counsel the victim as appropriate, and determine immediate safety planning measures with the victim.
- (2) If necessary, the counselor will ask the victim if she/he may discuss the victim's situation with the officer in order to coordinate safety plans.
- (3) If it appears to the counselor that she will likely be on the phone with the victim for a lengthy period of time and that the officer's assistance or presence does not seem to be required any longer, the counselor will ask to speak with the officer.
  - (a) The counselor will explain to the officer that his/her assistance or presence or assistance does not seem to be required any longer and that, if the victim agrees, the officer may consider leaving.
  - (b) If the officer chooses to do so, he/she will speak with the victim to assure himself/herself that his/her assistance or presence is no longer required.
  - (c) If the victim agrees, and the officer believes that the situation on the scene is stable and safe and is otherwise a situation where he/she would normally return to service, the officer may return to service after:
    - (i) Providing the victim with his/her work phone number or the phone number of others who may be available during times when the first responder is not, in case the victim wants to talk further or needs help; and
    - (ii) Advising the victim to call 911 if the victim needs emergency assistance.

(Section 4.5.2, Lethality Assessment, "Implementation of the Protocol Referral-Response by the Service Provider," continued)

- b. **Intake.** If a victim who has received a high danger assessment contacts the program either during the initial phone call or by going to the program, the program will:
  - (1) Process the victim according to its administrative intake procedures; and
  - (2) Commit itself to providing enhanced services to victims referred to it as high danger cases and seek to develop or use best practices for helping such victims. Examples of best practices might include guarantees of shelter as long as the victim's situation is urgent, of an internal team approach to safety planning, to provision of resources, and to other options within 24 hours of the program's first business day, of consultation with legal services, if available, of sharing resources across programs; asking clients to sign waivers in the event of their death.
  
- c. **Conduct Danger Assessment.** As part of the administrative intake procedures primarily in cases where the victim has gone to the program for assistance, the counselor will:
  - (1) Administer a Danger Assessment after explaining to the victim why she/he is conducting it;
  - (2) If the counselor believes it helpful or necessary, either advise the victim, to reinforce your counsel that the victim may be in serious danger, that the results of the Danger Assessment confirm the first responder's assessment, or seek to discuss and determine with the victim why the Lethality Screen and Danger Assessment are not consistent; and
  - (3) Advise the victim of the final results of the Danger Assessment and explain the degree of danger that the victim is in.<sup>18</sup>
  
- b. **Team Approach.** If the victim agrees and the counselor believes that it would be a constructive process, a coordinated team approach to securing the victim's safety would begin immediately with the safety planning, and with other agencies/organizations being contacted as necessary for further assistance. Other agencies could include, among others, law enforcement, the state's attorney's office, parole and probation, social services, adult and/or child protective services, mental health services, humane society.

(Section 4.5.2, Lethality Assessment, "Implementation of the Protocol Referral-Response by the Service Provider," continued)

e. **Safety Planning.**

- (1) The entire purpose of identifying victims who are in danger of death and getting them to speak with a counselor on the scene of a domestic call is to help victims obtain services. Once victims are connected to services, the process of securing their lives through safety planning can begin, if and to the extent that they choose.
- (2) A safety plan is an individualized approach victims develop to reduce the risks they and their children face.
  - (a) Safety plans include strategies to reduce the risk of physical violence caused by a batterer and to maintain basic human needs such as income, housing, health care, food, child care, and education for the children.
  - (b) The particulars of each plan vary depending on whether a victim has separated from the batterer, plans to leave, or decides to stay; on what resources are available to her/him; and on the time frame, i.e., does the plan involve an immediately dangerous situation, is it a short-term plan, or is it long term?
  - (c) As a victim's life and circumstances change because of the abuser or by life in general, how the victim copes with these changes is part of a dynamic process that will enable her/him to maintain varying degrees of control over her/his life.<sup>19</sup>

**4.6 Practical Considerations in Administering Screen**

**4.6.1 When an Officer Is Unable to Initiate a Lethality Screen on the Scene or Carry Out the Full Protocol**

- a. **Consider Circumstances.** The first responder must consider the immediate circumstances in determining whether to initiate a Lethality Screen and whether it will be feasible to employ all aspects of the protocol referral process. Such a consideration may sometimes occur when the abuser is present, the victim is inebriated, the victim goes to the hospital, or there is no telephone available.
- b. **Do Not Initiate Screen If Unsafe.** If the circumstances do not permit or the first responder believes that initiation of the Lethality Screen may place the victim in immediate danger if the first responder is not able to assure the victim's immediate safety, the first responder should not initiate the Lethality Screen at that time.

(Section 4.6.1, Lethality Assessment, "Practical Considerations in Administering Screen—Unable to Initiate Lethality Screen," continued)

- c. **Follow-up Cases in Which Screen Is Not Initiated.** If the first responder decides *not is unable* to initiate a Lethality Screen at the scene but believes the victim may be in danger, the first responder should implement as many procedures of the protocol referral as he/she can, and take whatever measures are considered necessary and desirable by the victim. The officer should be in contact with a hotline counselor to discuss the situation to better determine a course of action. The officer, or the agency's domestic violence unit, should consider trying to administer a Lethality Screen at a safe time and location in order to determine the level of danger the particular victim is in.

#### 4.6.2 When the Victim Has No Phone Available

When the victim has no landline phone, the first responder is under no obligation to use his/her own cell phone. However, because the victim is in danger, the first responder should consider this as an option, or consider other possibilities such as using a neighbor's phone. Doing so will enable the victim to be connected with services that may help her/him and will provide the first responder with a practical way to handle the situation.

#### 4.6.3 When the Victim's Landline Phone Is Used

- a. **Clearing the Call to the Hotline.** If you use the victim's landline phone to contact the hotline, you must ensure that you tell the victim to clear the line of the hotline's phone number. For most phones, calling a familiar number after the hotline call, for example, will clear the previous hotline call. Have the victim clear the number while you are on the scene.
- b. **Do Not Use Landline Phones That Record the History of Outgoing Calls.** Some landline phones will maintain a history of outgoing calls which cannot be deleted. Ask the victim whether her phone has that capability. If the victim does not know, do not use that landline phone.
- c. **Do Not Use Victim's Cell Phone.** Do not use the victim's cell phone because call histories cannot be deleted.

*(Lethality Assessment, "Practical Considerations in Administering Screen," continued)*

#### **4.6.4 Use of the Lethality Screen in Cases of Mutual Battery**

In mutual battery cases, usually one of the parties has acted in self-defense. Administering the Lethality Screen to an abuser would enable the abuser to manipulate the protocol referral process and possibly have dangerous repercussions for the real victim. Maryland law expects officers to investigate mutual battery cases with a view toward identifying the primary aggressor. Administering the Lethality Screen challenges officers to properly investigate cases of mutual battery. The Model Domestic Violence Policy for the Maryland Law Enforcement Community advises that "...cases of dual arrest should not be a frequent occurrence."<sup>20</sup> It is highly unlikely that both parties would exhibit the dangerous and controlling factors that comprise the Lethality Screen. Assess the situation very carefully. Be wary of administering Lethality Screens to both parties.

#### **4.7 Domestic Violence Lethality Screen for First Responders—Appendices 1 and 2**

4.7.1 See Appendix 1 for the "Domestic Violence Lethality Screen for First Responders."

4.7.2 See Appendix 2 for the article entitled "Data Supporting a Lethality Risk Reduction Program for Victims of Domestic Violence: A Law Enforcement and Service Provider Collaboration."

#### **4.8 Danger Assessment—Appendices 3 and 4**

4.8.1 See Appendix 3 for the "Danger Assessment."

4.8.2 See Appendix 4 for the article entitled "Assessing Risk Factors for Intimate Partner Homicide."



- 5.0 **Intervention Planning**
  - 5.1 The Goal of Intervention
  - 5.2 Empowering the Victim
  - 5.3 Containing the Abuser
  - 5.4 Interventions Against the Abuser
- 

## **5.1 The Goal of Intervention**

5.1.1 When an assessment is made that a victim is in high danger and needs help, it is important to keep in mind that the abuser is a high danger risk and requires attention. Whether or not the abuser has committed a crime that warrants specific interventions, an intervention plan should be developed concerning the abuser. The goal of intervention planning is to contain the abuser for the purpose of preventing violent acts against the victim or others and providing the victim with a sense of security and empowerment. As with safety planning, interventions should be considered within the framework of containment for the immediate circumstances, the short-term, and the long-term.

## **5.2 Empowering the Victim**

5.2.1 **Three Objectives.** In order to achieve the goal of empowering the victim, three objectives must be met:

- a. To end unwanted control by the abuser.
  - (1) Unwanted control can be gained by using physical, social, emotional, informational, and financial methods.
  - (2) Unwanted control can be gained by direct means or indirectly through the actions, for example, of the courts, schools, or child support system;
- b. To expand the victim's exercise of free choice and activity, and to strengthen her ability to resist and repel the abuser; and
- c. To enhance the victim's support system.

## **5.3 Containing the Abuser**

5.3.1 **Four Objectives.** In order to achieve the goal of containing the abuser, four objectives must be met:

- a. To hold abusers solely and strictly accountable by enforcing the law;
- b. To establish a "legal hold" over the abuser through the allowable actions of the court having to do with bail, pretrial release, probation, and protective/peace orders;

(Section 5.3.1, *Intervention Planning, "Containing the Abuser-Objectives," continued*)

- c. To require restitution to the victim and the community by covering costs related to medical care, shelter, lost work, trauma counseling, court costs, and attorney fees; and
- d. To provide or require attendance in abuser intervention programs.

**5.3.2 Consideration of Actions.** In some cases it will be better for the safety of the victim that no proactive or reactive intervention should be undertaken because such action might escalate the level of danger posed to the victim. Such an action should be a conscious and coordinated decision based on assessments and discussions between the victim and the team of service professionals assisting the victim.

**5.3.3 Required Action to Protect Victim.** In most circumstances, criminal offenses or other actions will have occurred that will require affirmative action on the part of the criminal justice system. In these cases it is critical that the criminal justice professionals and the courts act "to reduce the risks their actions are creating for the victim."

#### **5.4 Interventions Against the Abuser**

**5.4.1 Actions to Contain Abuser.** The following are actions that the criminal justice system, working with the victim, can take to contain the abuser

- a. Law enforcement contacts
- b. "Warn-off" letters from law enforcement or the prosecutor
- c. "Stalk the Stalker" and other surveillance measures
- d. Protective/Peace orders
- e. Arrest and detention for crimes directed against the victim
- f. Arrest and detention for other criminal activity, not related to the victim
- g. Permit revocation
- h. Confiscation of firearms
- i. Bail and other conditions of release, particularly those related to violations of the abuse provision of protective orders
- j. Jail, fines, restitution, including weekend or "parttime" jail sentences
- k. Revocation of probation
- l. Suspended sentences
- m. Supervised probation
- n. Intensive supervision and day reporting
- o. Electronic monitoring and "house arrest"
- p. Psychiatric evaluation and hospitalization/drug and/or alcohol treatment (as conditions of release/probation)
- q. Abuse intervention programs
- r. As a condition of release/probation/suspended sentence and not as an "alternative" to a criminal resolution of a case
- s. Deportation.<sup>21</sup>



**Appendices**

1. Lethality Screen for First Responders
2. "Data Supporting a Lethality Risk Reduction Program for Victims of Domestic Violence: A Law Enforcement and Service Provider Collaboration"
3. Danger Assessment
4. "Assessing Risk Factors for Intimate Partner Homicide"



### Endnotes

1.     The Maryland Network Against Domestic Violence researches various sources, including law enforcement and media accounts, to make as accurate a report as is feasible of domestic violence fatalities in the state. The figures include homicides of victims and abusers, suicides of assailants, and third party homicides. The MNADV publishes an annual statistical report of fatalities that occurred between July of the previous year to June of the current year based on its information-gathering methods. The fatality information is used as part of the MNADV's annual memorial service for victims of domestic violence.
  
2.     *Missed Opportunities for Prevention of Femicide by Health Care Providers*, Jacquelyn Campbell et al., *Preventive Medicine*, 33, pp. 373-380.
  
3.     Subsections 1.3.1-c through -g, including the quote in subsection -f, are taken from *Lethality Assessment Tools: A Critical Analysis*, Neil Websdale, VAWnet Applied Research Forum, 2000, p. 7.
  
4.     *Domestic Violence*, International Association of Chiefs of Police, Training Key #411, 1991. Also,  
  
*Model Domestic Violence Policy for the Maryland Law Enforcement Community*, Maryland Network Against Domestic Violence, March 1998 (rev. April 2004), Section 2.1.1.  
  
Stalking and harassment were added by the Lethality Assessment Committee because they are common to domestic violence and because they are two acts within § 3-1503 of the Courts and Judicial Proceedings Article that permit an individual to obtain a peace order. The other acts listed in this section of the protocol are virtually all covered by the acts enumerated in CJ, § 3-1503. In the 2005 session of the Maryland legislature, stalking was added to the list of acts that constitute "abuse" under FL, § 4-501 (b), which also includes an act that causes physical injury and false imprisonment, and, although not as comprehensively stated as the statute, an act that places one in fear of physical injury and sexual assault (these latter two acts were intended to be broader in scope than the similar abuse provisions which are listed as "an act that places (a person) in fear of imminent serious bodily harm" and "rape or sexual offense under §§ 3-303 through 3-308 of the Criminal Law Article or attempted rape or sexual offense in any degree." Accordingly, the definition in the protocol has several precedents whose definitions are either based one upon the other or are similar.
  
5.     *Model Domestic Violence Policy for the Maryland Law Enforcement Community*, Section 2.2.1-a.
  
6.     *Risk Factors for Femicide in Abusive Relationships: Results from a Multisite Case Control Study*, Jacquelyn C. Campbell, Daniel Webster, et al., *American Journal of Public Health*, Vol. 93, No. 7., July 2003.

7.     Ibid.
8.     *Intimate Partner Violence, 1993-2001*, Bureau of Justice Statistics Crime Data Brief, (Washington, D.C.: U.S. Department of Justice, February 2003).
9.     *Violence between Intimates*, Bureau of Justice Statistics: Selected Findings, (Washington, D.C.: U.S. Department of Justice, November 1994), page 2. "In over 90% of the violence by intimates recorded in NVCS from 1987-1991, the victim was female." Also, *Intimate Partner Violence*, Callie Rennison and Sarah Welchans, BJS: Special Report (Washington, D.C.: U.S. Department of Justice, May 2000), page 1. "About 85% of victimizations by intimate partners in 1998...were against women."
10.    *Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends*, U.S. Department of Justice, March 1998.
11.    *Health Concerns Across a Woman's Lifespan: 1998 Survey of Women's Health*, The Commonwealth Fund, May 1999.
12.    *Hopkins Study Shows High Prevalence of Domestic Violence*, press release, JHMI Office of Communications and Public Affairs, Johns Hopkins University, August 4, 1998.
13.    Ibid., table 14, p. 8. "Women suffering violent victimizations were almost twice as likely to be injured if the offender was an intimate (59%) compared to offenders who were strangers (27%). Women were also more likely to receive injuries requiring medical care if the attacker was an intimate (27%) compared to a stranger (14%)."
14.    *Female Victims of Violent Crime*, table 5, p. 3. "About 1 in 5 women victimized by their spouse or ex-spouse reported that they had been the victim of a series of similar crimes. They had sustained at least three assaults within 6 months of the interview, and the assaults were so similar that they could not remember them distinctly."
15.    Ibid., table 6, page 3. 56% of victimizations by intimates, compared to 57% by strangers, were reported to the police by female victims.
16.    *Violence against Women: A National Crime Victimization Survey Report*, p. 7. "Women living in central cities, suburban areas and rural locations experienced similar rates of violence committed by intimates."
17.    The Lethality Screen for First Responders was developed by the Maryland Network Against Domestic Violence Lethality Assessment Committee between October 2003 and June 2004, field tested between July and August 2004, and evaluated between October and February 2005. The Screen was approved by the Committee at its final meeting on February 23, 2005, with additional changes made in July 2005. See Appendices 1 and 2.
18.    *Assessing Risk Factors for Intimate Partner Homicide*, Jacquelyn C. Campbell, Daniel Webster, et al., NIJ Journal, Issue No. 250, November 2003. Any person wishing to be certified in the use of the Danger Assessment instrument may visit the Dr. Campbell's website: [www.dangerassessment.org](http://www.dangerassessment.org).

19. *Safety Planning with Battered Women: Complex Lives/Difficult Choices*, J. Davies, J. E. Lyon, and D. Monti Catania, Sage Publications, 2001.
20. *Model Domestic Violence Policy for the Maryland Law Enforcement Community*, section 4.4.2-d.
21. *A Guide to Domestic Violence: Risk Assessment, Risk Reduction, and Safety Plan*, "Suspect/Offender-Focused Interventions," Domestic Violence Division, Nashville Metropolitan Police Department, 2003, pages 19-21.

# CALVERT COUNTY

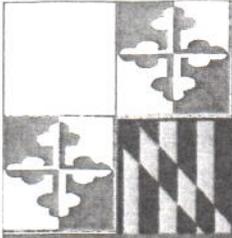


DOMESTIC VIOLENCE FATALITY REVIEW TEAM

## ANNUAL REPORT

### APPENDIX 7

*READING THE SIGNS*



# Reading the Signs

For participants in the MNADV's Lethality Assessment Program

## Westminster Police Department Receives Lethality Assessment Award Second Consecutive Year



With the LAP expanding in Maryland to hospitals, departments of social service, faith communities, and partner agencies in Allegany and Carroll Counties, this year's award takes on even more

significance and meaning. The Westminster Police Department has once again demonstrated that it is, indeed, the best of the best, garnering 70% of the LAP Advisory Board's votes from among five finalists. The WPD continued its success by getting 70% of high risk victims on the phone, with 44% of them going into services. Moreover, they administered more than twice the number of screens that should have been expected.

Congratulations to the other four finalists: **Federalsburg PD, Anne Arundel County PD, Montgomery County PD, and the Easton Barrack of the Maryland State Police.**

Because the LAP is a partnership between law enforcement and local domestic violence programs, we want to highlight **Family and Children's Services of Central Maryland** as an integral part of WPD's success. Improved communications and relationships between LAP partners is a significant by-product of the LAP. Here's a great example of why and how that's happening in Carroll County...



## LAP Wins Celebrating Solutions Award

The Lethality Assessment Program-Maryland Model (LAP) was selected as one of four 2010 national recipients of the prestigious *Celebrating Solutions Award* given annually by the Mary Byron Project. Marcia Roth, Executive Director of the Project, lauded the LAP for its outstanding work. "We received almost 300 applications throughout the United States. Our national review team felt that Maryland's program shows promise in moving beyond crisis management to provide answers every community should use in ending the epidemic crime of domestic violence. It is an outstanding organization and program."

The Mary Byron Project created the *Celebrating Solutions Awards* to showcase and applaud local innovations that demonstrate promise in breaking the cycle of violence. They select programs that can serve as models for the nation and offer \$10,000 cash awards in recognition of their pioneering efforts.

The Mary Byron Project was established in 2000 in memory of the young woman whose tragic murder led to the creation of automated crime victim notification technologies. As a nationally recognized thought leader on domestic violence, the Mary Byron Project cultivates and supports efforts that extend beyond crisis management to attack the root causes of this epidemic and help build safer, healthier communities.



## Carroll County LAP Newsletter

Alexis Arbuthnot, LAP contact for Family and Children's Services of Central Maryland in Carroll County, recently created a newsletter for Carroll County LAP participants. It's called *Lethality Local* and is intended only for the participant audience. Since Alexis frequently makes home visits with officers, deputies, and troopers from all the law enforcement agencies in Carroll County, she thought that another way of communicating LAP information might be to put out a regular newsletter. The newsletter was sent out to all contacts in November, but write Alexis at [arbuthnot@icamd.org](mailto:arbuthnot@icamd.org) to obtain a copy. This is a great communications practice that provides deserved recognition and reporting of activity in the county. We urge you to consider what Alexis has done.

## Lowest Number of Domestic Fatalities since 1987

Since the MNADV began collecting state domestic violence fatality figures in 1987, this past year (July 2009 to June 2010) marked the lowest number of fatalities ever recorded. The annual average since 1987 has been 68. **This past year: 38!** Although we cannot attribute the reduction to the LAP, the trend, and now this low point, since we implemented the LAP, has been downward. In the last four years (since the LAP has been underway with a sizable number of law enforcement agencies) the yearly average has been 54.



The goal of the LAP is to save the lives of domestic violence victims, because we believe that domestic homicides are preventable. With 92% of our law enforcement agencies and all of our domestic violence service providers participating in the LAP, along with some hospitals and others, and now with five full years of experience, we believe the significant decrease in domestic fatalities is a positive sign and should make us all take notice that perhaps the LAP may be having an impact.

## News from Oklahoma

In 2008, The Johns Hopkins University, in collaboration with Arizona State University and the University of Oklahoma Health Sciences Center, received a National Institute of Justice research grant to validate the LAP. The research is being conducted by Dr. Jacquelyn Campbell of JHU, Dr. Jill Messing, ASU, Dr. Janet Sullivan Wilson, OUHSC, Sheryll Brown, Oklahoma State Department of Health, and Beverly Patchell, OUHSC.

The grant works with seven Oklahoma law enforcement agencies and their collaborating domestic violence service providers, including Oklahoma City and Tulsa.



The first phase of the grant obtained in-depth information from more than 330 victims whom law enforcement agencies identified as potentially high risk, but who did not receive the LAP intervention.

The second phase of the research—the LAP implementation—began in November 2010. Another 330 high danger victims who received the LAP intervention will be interviewed to conclude the process. Victims who received the LAP and victims who did not receive the LAP will be compared on their utilization of social services and experiences of violent victimization for approximately 6 months after law enforcement intervention.

**Dave Sargent and Michelle Pentony, for the MNADV**, visited Oklahoma City in August 2009 to train law enforcement officers and service providers and to meet with the entire research team. They continue to consult for the project. We look forward to the outcome of the research and appreciate the scrutiny that the project offers the LAP.

**Maryland Network Against Domestic Violence**  
6911 Laurel Bowie Road; Suite 309; Bowie, MD 20715  
Office: 301.352.4574; Fax: 301.809.0422  
info@mnadv.org; www.mnadv.org

## New Protocols Being Created

We are moving forward with new protocols in four areas:

- Mutual battery cases when the officer cannot determine who the victim is
- When a victim is hospitalized and unable to communicate
- When a victim declines to answer all the screen questions
- For telephone and home-visit follow-ups with High Danger victims

The LAP Advisory Board will meet on March 2, 2011, and will discuss these areas. All Maryland and other state participant contacts will have a chance for input.

## Interesting Read

**Jeanne Yeager**, Executive Director of the Mid-Shore Council on Family Violence and one of the original members of the Lethality Assessment Committee, sent the following book write-up from the American Psychological Association. Although the specific instruments cited in the book are not about the LAP, the LAP fits into the subject matter.



**"Risk Assessment for Domestically Violent Men: Tools for Criminal Justice, Offender Intervention, and Victim Service**, by N. Zoe Hilton, Grant T. Harris and Marnie E. Rice.

*Abstract: From a domestic violence victim's first call to police or visit to a women's shelter, through the offender's bail, sentencing, etc., criminal justice officers and clinicians must make informed decisions about which cases need the most attention as well as ensure targeted provisions are in place to prevent recurrences of violence. [The authors] make a powerful case of using actuarial risk assessments to predict recidivism in male domestic violence offenders....Notably the authors assert that systematically implementing these tools in to public policy will reduce the number of violent assaults on women by their partners."*

ISBN 9781433804663 apa website: [www.apa.org/pubs/books](http://www.apa.org/pubs/books)

# CALVERT COUNTY



DOMESTIC VIOLENCE FATALITY REVIEW TEAM

## ANNUAL REPORT

### APPENDIX 8

*CALVERT COUNTY DVFRT BROCHURE*

What happens to information shared with the team?

All members of the team sign a confidentiality agreement that information shared with the team, by team members or others providing information to the team, will be confidential. Exceptions are information which is already public, or which team members are ethically or legally required to report, such as child abuse.

Who can attend the meetings? Because of the confidential nature of the information being discussed, only team members and individuals invited to present information about a particular case, who have signed confidentiality agreements, may participate.

How does the team publicize its findings and make changes happen? Representatives will take recommendations concerning their agencies back to their agency heads. The team will publish annual reports which will not discuss particular cases, but will list the recommendations the team has agreed upon, concerning "agency responsiveness, agency policy and procedures, services, intervention strategies, the law at the local and state level, community education and training." The report will also include the status of prior recommendations.

### FREQUENTLY ASKED QUESTIONS

Who makes up the domestic violence fatality review team? The CCDVFT is made up of representatives from various agencies, including the State's Attorney's Office, the Sheriff's Office, Maryland State Police, Calvert Memorial Hospital, domestic violence agencies, the Health Department, Social Services, Parole and Probation, the Courts, as well as other knowledgeable individuals, including a survivor of domestic violence.

How does the team identify deaths to review? The team will review any fatality, whether a homicide or suicide, involving a victim and/or perpetrator or third parties, or near-fatality, that has domestic violence as an involved-factor. The team will identify cases through information from law enforcement agencies and the State's Attorney's office.

### OUR PURPOSE

The primary purpose of domestic violence fatality review in Calvert County is to review deaths in which domestic violence has played a role, with the ultimate intent to prevent future occurrences.

The review process is aimed at creating a climate in which institutions and individuals in Calvert County will commit themselves to an enhanced response to domestic violence as a societal evil and a crime, and to victims that they might pursue a better quality of life.

Department of  
women killed in  
by their hus-

## COOPERATION BETWEEN LOCAL AND NETWORK DOMESTIC VIOLENCE CALVERT COUNTY

### DOMESTIC VIOLENCE FATALITY REVIEW IN MARYLAND

Domestic Violence Fatality Review Teams (DVFRTs) have been established in many jurisdictions nationwide to evaluate and better understand domestic homicides. The Maryland Network Against Domestic Violence has worked with Calvert County and Anne Arundel County to establish teams which can serve as models for other jurisdictions in Maryland which would like to work as teams to improve their responses to domestic violence.

By identifying and remedying gaps in services, understanding the circumstances leading up to and resulting from domestic violence-related homicides or suicides, and improving communication between agencies, we hope to prevent future deaths.

**MARYLAND NETWORK AGAINST  
DOMESTIC VIOLENCE**  
(301) 552-4574  
[WWW.MNADV.ORG](http://WWW.MNADV.ORG)

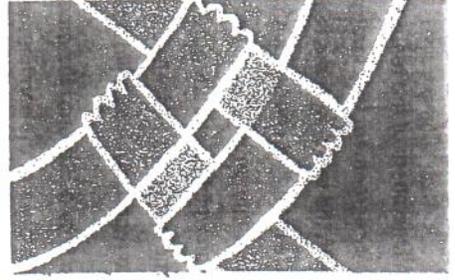
## STATEMENT

### THE MISSION OF THE CALVERT COUNTY DOMESTIC VIOLENCE FATALITY REVIEW TEAM 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.

## CALVERT COUNTY DOMESTIC VIOLENCE FATALITY REVIEW

**A MULTIAGENCY  
PARTNERSHIP TO  
LEARN FROM  
DOMESTIC  
VIOLENCE RELATED  
DEATHS IN CALVERT  
COUNTY**



**CALVERT COUNTY DOMESTIC  
VIOLENCE FATALITY REVIEW TEAM  
CHAIRPERSON**

Deborah L. ...  
Health Department  
... North  
... 20678

CALVERT COUNTY



DOMESTIC VIOLENCE FATALITY REVIEW TEAM

ANNUAL REPORT

APPENDIX 9

*REMEMBERING AND RESPONDING*  
Maryland Domestic Violence Fatality Review Newsletter

# Remembering and Responding

Volume 4 Issue 1  
Spring 2010

## Maryland Domestic Violence Fatality Review Newsletter

### Looking at Fatality Review Through a "Wide-Angled Lens"

We asked Dr. Neil Websdale of the National Domestic Violence Fatality Review Initiative to offer some remarks on the occasion of our first Maryland domestic violence fatality review conference. We requested that he comment specifically on (1) the importance of fatality review, (2) how Maryland teams may be contributing to the overall review effort in the country, and (3) what he hopes our conference will accomplish for our teams.



"Comprehensive, wide-angled lens fatality review is a great means of identifying gaps in systems and community responses to domestic violence cases. The process involves bringing a wide array of concerned people to the table, perhaps with diverse interpretations about the tragedies they are reviewing. This eclecticism is both edgy and progressive and holds great potential for re-thinking how we handle these perplexing cases. Significant recommendations have been implemented and huge improvements made in inter and intra-agency communications because of fatality review. In addition, we have learned more about the part communities play in these cases.

"The meteoric rise of the Maryland teams suggests a profound concern about the seemingly intractable plight of victims and the numerous challenges involved in working with perpetrators. The emergence of 21 teams in a relatively small geographical area over what is a rather short historical time period is unusual and to be commended.

"I hope that the Maryland conference results in deeper, wider angled lens fatality reviews including greater work with surviving families, friends, co-workers and other parties close to victims and perpetrators. I also hope that the conference is able to stir up a discussion among those parties that have differing perspectives on what drives this violence and homicide. We need more dialogue in the domestic violence movement and recent exciting work suggests we are moving in that direction. Part of this discussion involves coming to grips with the large range of deaths and near-deaths caused by, related to or somehow traceable to domestic violence."



### Statewide Fatality Review Conference



On April 6<sup>th</sup>, the Maryland Domestic Violence Fatality Review Council will hold its first-ever statewide conference at Howard County General Hospital in Columbia. The theme for the conference is improving the effectiveness of fatality reviews. The conference will focus on three main aspects:

- How good teams operate
- How to develop and implement recommendations
- How to conduct effective interviews

Our presenters will be local team members. We hope the conference will continue to move our county teams in learning how to become more effective change agents for victims of domestic violence.

We want to thank the **conference steering committee** for their work in organizing the conference:

Mary Howser, Frederick  
Angela Sobol, Baltimore City  
Jennifer Morton, Calvert  
Fatima Burns, MNADV  
Dave Sargent, MNADV

And for assembling our **presenters**:

Julie Drake and Kim Barranco, Baltimore City (*How a Good Team Operates*)  
Jennifer Morton and Janet Scott, Calvert (*Having a Survivor on a Team*)  
Rosemary Raiman, Charles: Colleen Moore and Lauri Richman, Baltimore City (*Interviews*)  
Mary Howser, Frederick (*Recommendations*)  
Ron Russum, Queen Anne (*Reviewing Near Fatalities*)

### Maryland Review Teams

**Allegany County, Est. 2007**  
Chairperson: David Goad  
Vice Chairperson: Richard Paulman

**Anne Arundel County, Est. 2003**  
Chairperson: Anastasia Prigge  
Vice Chairperson: Sarah Kling

**Baltimore City, Est. 2006**  
Chairperson: Dorothy Lennig  
Vice Chairperson: Julie Drake

**Baltimore County, Est. 2006**  
Chairperson: Marci Van De Mark  
Vice Chairperson: Rosalyn Branson

**Calvert County, Est. 2004**  
Chairperson: Jennifer Morton  
Vice Chairperson: Janet Scott

**Carroll County, Est. 2008**  
Coordinator: Cheryl Powers

**Cecil County, Est. 2007**  
Chairperson: Gary Pierce  
Vice Chair: Chief Chip Peterson

**Charles County, Est. 2008**  
Chairperson: Tony Covington  
Vice Chairperson: Sgt. Steve Salvas

**Dorchester County, Est. 2008**  
Chairperson: Bill Jones  
Vice Chairperson: Bill McConnell

**Frederick County, Est. 2006**  
Chairperson: Mary Howser  
Vice Chairperson: Lt. Ted Nee

**Garrett County, Est. 2007**  
Coordinator: Lisa Thayer Welch,

**Harford County, Est. 2007**  
Chairperson: Steve Lentowski  
Vice Chairperson: Robert McCord

**Howard County, Est. 2007**  
Co-Chairperson: Devora Pontell  
Co-Chairperson: Vacant

**Montgomery County, Est. 2005**  
Chairperson: Laura Chase  
Vice Chairperson: Hannah Sassoon

**Prince George's County, Est. 2006**  
Chairperson: Judy Wolfer  
Vice Chairperson: Ann Wagner-Stewart

**Queen Anne's County, Est. 2006**  
Chairperson: Vacant  
Vice Chairperson: Ron Russum

**St. Mary's County, Est. 2007**  
Co-Chairperson: Ella Mae Russell  
Co-Chairperson: Sheriff Timothy Cameron

**Talbot County, Est. 2009**  
Coordinator: Ellen Grunden

**Washington County, Est. 2006**  
Chairperson: Vicki Sadehvandi  
Vice-Chairperson: Vacant

**Wicomico County, Est. 2009**  
Coordinator: Michelle Hughes

**Worcester County, Est. 2007**  
Chairperson: Joel Todd  
Vice Chairperson: Marty Pusey



## National Conference



The National Domestic Violence Fatality Review Initiative (NDVRI) announces its first national conference in five years. The conference is entitled "New Directions in Domestic Violence Fatality Review" and will be held August 16-17, 2010, in Phoenix, AZ. The conference includes mock review activities and topics such as Risk and Danger Assessment, Working with Surviving Family Members, Current/Thorny Issues, Setting Up Domestic Violence Fatality Review Initiatives, Team Membership. The conference, except for travel and lodging, is free to OVW grantees. See the conference flyers for OVW and non-OVW-grantees at <http://www.mnadv.org/fatality.html>.

## Statewide Report

We're pleased to announce the issuance of the first statewide domestic violence fatality review report, based on five 2009 county team reports. The MNADV report focuses on the counties' findings and recommendations and presents them in a unified manner in one document. Our goal is to use the statewide report as a vehicle to cause change on a wider, more systemic stage than what the individual counties might be able to effect, and to assist them in getting their more broadly applicable recommendations achieved. See the report at <http://www.mnadv.org/fatality.html>.

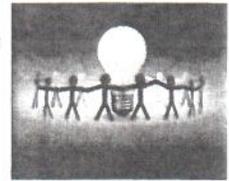


## Recorders Making Their Mark on Their Teams

Every team understands the value of having a good recorder of its proceedings. And good recorders will often put their own stamp on the job they do. One such recorder is **Linda Fenlon** of the Charles County Domestic Violence Fatality Review Team. She has designed a 'minutes' format into three columns: Agenda item, discussion, and action taken or for follow-up. It's a good, effective approach. Take a look at the sample of it at <http://www.mnadv.org/fatality.html>.

## Baltimore City DVFRT—Agent of Change

We have emphasized that unless you can see the domestic violence fatality review team as a legitimate way to change the plight of victims of domestic violence, and unless you treat this responsibility seriously, there is no reason to form and meet as a team. A team that has led the way in Maryland and clearly views itself as an agent of change is the Baltimore City DVFRT. This team is making things happen, creating change. It's what teams should strive for. We have looked to the Baltimore team for the guidance it has provided to a number of teams in the state; they have opened their doors to others who want to observe and have been generous and gracious about that. It has been a wonderful learning experience for other teams, and we believe that those teams, and the way they themselves are engaged in the review process, have benefitted from the mentoring provided by the Baltimore City team. The Baltimore Sun views them as an effective body as well. See the October 16, 2009, editorial at <http://www.baltimoresun.com/news/opinion/editorial/bal-ed.domestic16oct16.0.2525192.story>



## Fatality Review Reading List (Those in bold contain the most extensive information on fatality review)

### Books:

Adams, D. **Why do they kill? Men who murder their intimate partners.** Nashville, TN. Vanderbilt University Press. 2007.

Websdale, N. **Understanding Domestic Homicide.** Northeastern University Press. Boston, MA. 1999.

Websdale, N. **Familicidal Hearts.** Oxford University Press. New York, NY. 2010.

### Articles:

Editorial, "Promoting Patient Safety by Preventing Medical Error," Journal of the American Medical Association, October 28, 1998, Vol 280, Number 16: 1444-1447.

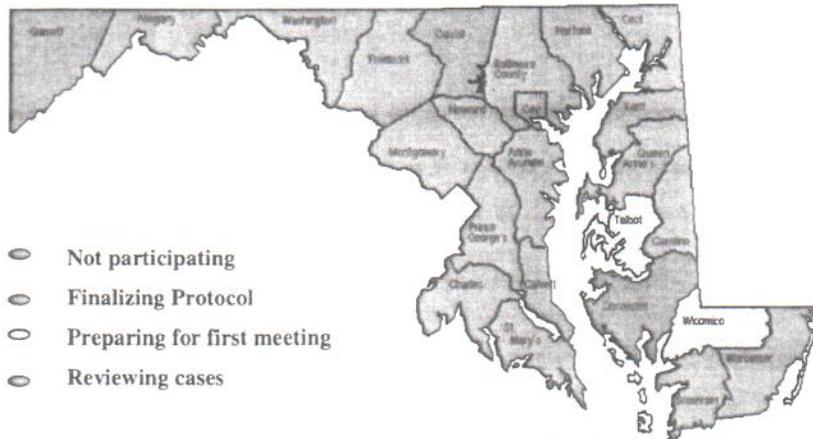
Gawande, Atul. 1999. "When Doctors Make Mistakes," The New Yorker, Feb 1, 1999.

Leape, L.L. "Error in Medicine." Journal of the American Medical Association, 1994, 272: 1851-1857.

Websdale, N. "Reviewing Domestic Violence Deaths." NIJ Special Research Bulletin on Intimate Partner Homicide, 2003.

Websdale, N., Town, M., and Johnson, B. "Domestic Violence Fatality Reviews: From a culture of blame to a culture of safety." Juvenile and Family Court Journal, May 1999: 61-74.

## Maryland Domestic Violence Fatality Review Teams



## Maryland Domestic Violence Fatalities

For the period June 2008 to June 2009, Maryland recorded 53 domestic fatalities. For the second of the last three years, we have recorded the lowest number of fatalities since 1993. 51% of victims were killed by firearms; 26% by stabbing; and 9% by strangulation. For further information go to [http://www.mnadv.org/DV\\_Stats/dv\\_stats.html](http://www.mnadv.org/DV_Stats/dv_stats.html).

## Maryland Network Against Domestic Violence

6911 Laurel Bowie Road,  
Suite 309  
Bowie, MD 20715  
(301) 352-4574  
(301) 809-0422 (Fax)  
[info@mnadv.org](mailto:info@mnadv.org)  
[www.mnadv.org](http://www.mnadv.org)

