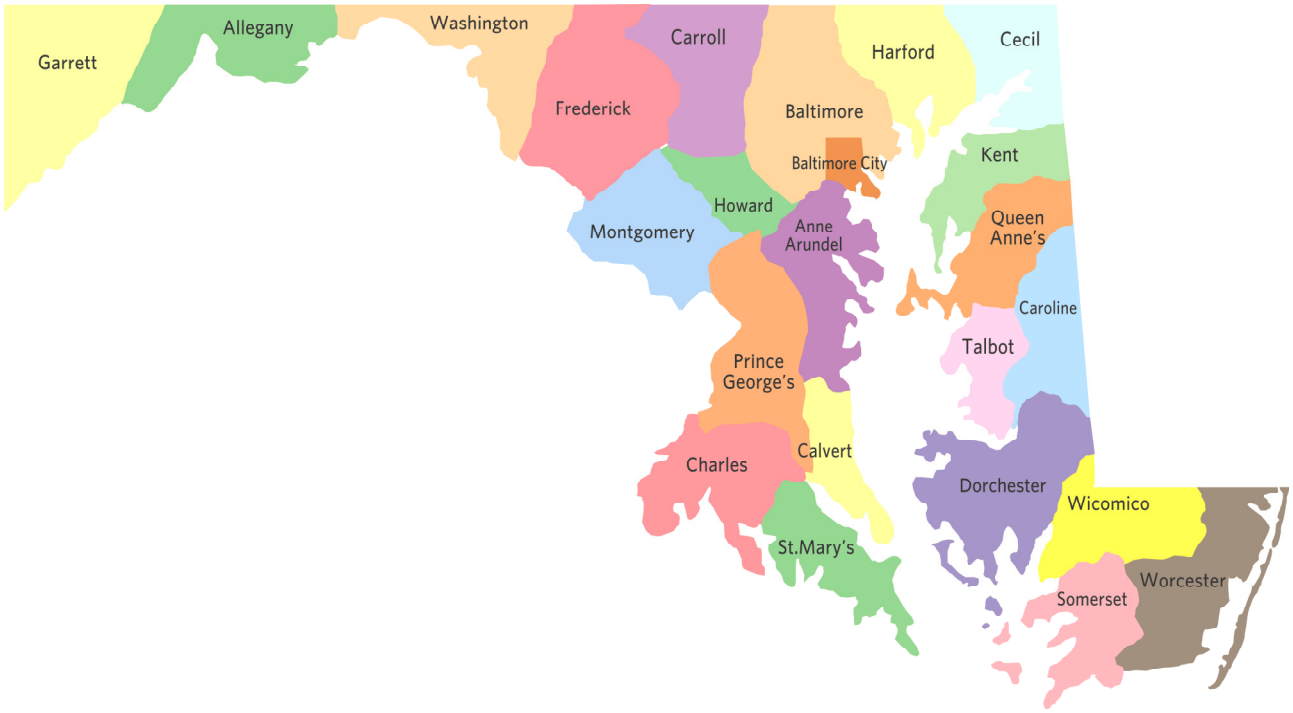
Maryland Network Against Domestic Violence



Taking a Closer Look:

Domestic Violence Fatality Review

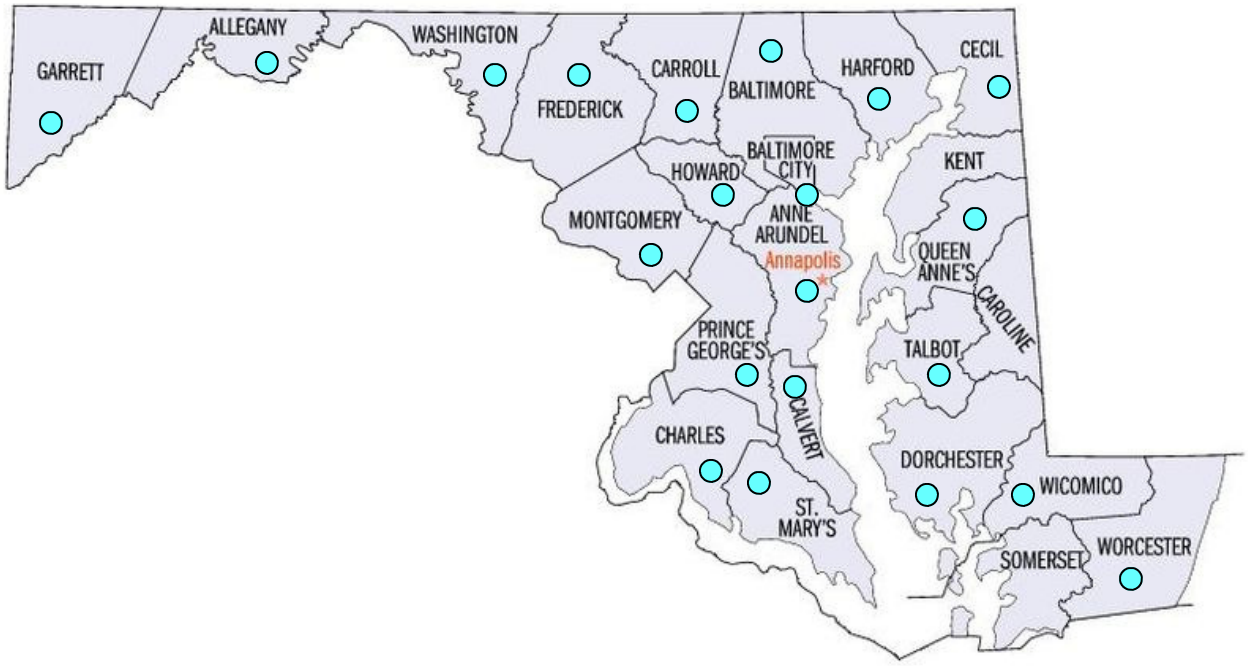
Statewide Report

2009

Table of Contents

I. Acknowledgements

The 2009 Domestic Violence Fatality Review Statewide Report is the product of the combined expertise of Domestic Violence Fatality Review Teams throughout the state. Such a report is meant to establish an understanding of the scope and magnitude of domestic violence and to highlight trends, patterns, and recommendations. We extend gratitude to the DVFRT team members who brought their interest, years of experience, commitment, and perspective to the meetings. A special thanks to the family members and friends of homicide victims who were willing to share the story of their loved ones and to the survivors of the near fatality incidents who allowed us to learn from their experiences.



Indicates active teams

II. Executive Summary

The Maryland Network Against Domestic Violence (MNADV) presents its first statewide Domestic Violence Fatality Review Team (DVFRT) Report entitled: *Taking a Closer Look.* This document represents a collection of county DVFRT findings and recommendations. This tool can be used to guide local and state agencies, funders, nonprofits, and policy makers with their strategic planning and legislative advocacy.

The cases reviewed reveal some important information about patterns and how communities and systems respond to domestic violence. These findings offer insight into critical issues and can be used to create better systems, policies, and procedures to decrease domestic violence-related homicides.

The Report is not strictly for providers in the field of domestic violence. Domestic violence is a community issue that spreads far beyond the parameters of shelters, police stations, law offices, and emergency departments. This Report can be a catalyst for discussion at staff meetings and planning sessions with boards of directors. Judges, advocates, police officers, funders, friends, family, mental health clinicians, and addictions counselors should be encouraged to read it as well. This document represents issues that have important statewide application.

Taking a Closer Look discusses the history of the Domestic Violence Fatality Review Team formation, followed by guiding principles, and methodology. The last part of the Report discusses key findings and statewide recommendations, both of which are contained in this Summary. Summaries of some pertinent research follow in the Appendix and can be used to aid in the understanding of the recommendations. This research should also be used to strengthen grant proposals and drive discussions and planning. Admittedly, while the Report is a reflection of limited county findings, many domestic violence fatality review teams are still molding and developing. As they grow, the breadth and depth of their recommendations will expand. The Maryland Network Against Domestic Violence acknowledges that the teams are at different stages of development and all are taking initiatives to make their teams and review processes richer. We hope that by "taking a closer look," the reader will learn from the recommendations, work to expand programming, and decrease service gaps for the benefit of victims of domestic violence and their families.

Key Findings:

Fatality review teams report that victims continue to under-utilize domestic violence services as well as refuse to seek medical attention after an incident of domestic violence occurs. Some victims never sought a protective order, or their order was inactive at the time of their death. In addition to the involvement of alcohol in fatalities, children are witnessing domestic violence in the home and often go unnoticed.

Teams also determined there is a need for training on issues such as strangulation, human bite wound identification, and the Lethality Assessment Program. First responders play a particularly crucial role by impacting whether or not an individual seeks services beyond initial contact. Teams are encouraging standardized evidence collection methods to ensure a uniform statewide standard of care for victims, which will raise the bar for holding abusers accountable. Teams feel that an active domestic violence unit within police departments or a set of specially trained officers in each county is a step toward this approach.

Systemwide Recommendations:

1. Increase awareness of the importance of strangulation as a risk factor in predicting a victim's risk for being killed by providing trainings on strangulation.

2. Increase the number of medical evaluations for victims of strangulation by creating a statewide protocol standard for evidence collection and medical response to strangulation victims.

3. Increase the likelihood of domestic violence assessment within the health care setting by implementing training and continuing education courses to health care professionals.

4. Improve forensic medical documentation for domestic violence injuries.

5. Increase access to resources and assessment tools by health care professionals throughout the state by establishing an information clearinghouse.

6. Implement existing protocol screening and evaluation of victims of domestic violence throughout all health care facilities.

7. Increase the availability of mental health services immediately following a homicide by establishing a system where crisis intervention is available on the scene of a homicide for surviving loved ones.

8. Create a system that would allow very limited information about emergency petitions (EPs) to be accessed by law enforcement and parole and probation agents.

9. Increase victim awareness of and access to medical treatment for injuries immediately following a domestic assault by creating and implementing a protocol for law enforcement that would encourage victims to seek immediate medical treatment.

10. Increase victim access to officers specially trained in domestic violence by establishing a domestic violence unit or a set of specially trained officers in each sheriff's office and law enforcement municipality.

11. Increase victim safety and abuser accountability after a domestic violence incident where the abuser was arrested by using the Lethality Assessment Program Screen to assist in decisions regarding the setting of bond.

12. Foster active, consistent, and ongoing communication between detention centers, the Division of Parole and Probation, sheriff's offices and state's attorney's offices regarding firearms and protective orders.

13. Establish a system for tracking and implementing penalties for domestic violence Violation of Probation (VOP) cases.

14. Continue trainings on the Lethality Assessment Program.

15. Alert high level commanders at military installations of the growing trend of domestic violence incidents when military personnel return from overseas.

16. Increase high danger victims' access to domestic violence services by establishing a protocol for following up with victims referred through the Lethality Assessment Program.

17. Create an enhanced response protocol and safety planning mechanism for identifying and responding to victims in highly lethal relationships.

18. Expand Lethality Assessment Program participants to involve the county departments of social services including child protective service workers, county detention centers, county departments of health, hospital emergency departments and related medical personnel, as well as other service providers.

19. Enact legislation to amend the first degree assault statute to include strangulation or create a felony statute prohibiting acts of strangulation.

III. History and Background

A fatality review team was established by the Maryland Network Against Domestic Violence (MNADV) and Anne Arundel County in 2003, followed by Calvert County in 2004. Both teams were voluntary, operated without protection of the law, and the information for their reviews could only be taken from public records and interviews. Both teams supported the MNADV's efforts to support legislation enabling the establishment of Domestic Violence Fatality Review Teams.

Legislation initiated in 2005 by the MNADV was modeled after the Maryland Child Fatality Review Statute and sponsored by Delegate Theodore Sophocleus of Anne Arundel County. The MNADV provided leadership and advocacy for the legislation. Legislation passed unanimously in both houses, was signed on April 26, 2005, and became effective on July 1, 2005.

In 2006, the MNADV developed a model protocol and start-up kit for use by those jurisdictions seeking to organize a fatality review team. The protocol and kit may be used at the jurisdictions' discretion. The MNADV also provides support and technical assistance.

Review Teams

Anne Arundel County
Established October, 2003

Calvert County
Established October, 2004

Montgomery County
Established November, 2005

Baltimore City
Established January, 2006

Queen Anne's County
Established April, 2006

Baltimore County
Established May, 2006

Prince George's County
Established May, 2006

Washington County
Established June, 2006

Frederick County
Established October, 2006

Garrett County
Established May, 2007

St. Mary's County
Established May, 2007

Allegany County
Established May, 2007

Harford County
Established August, 2007

Howard County
Established November, 2007

Worcester County
Established November, 2007

Cecil County
Established December, 2007

Dorchester County
Established September, 2008

Carroll County
Established September, 2008

Charles County
Established December, 2008

Wicomico County
Established September, 2009

Talbot County
Established December, 2009

IV. Legislation and The Law

HB 741 "Local Domestic Violence Fatality Review Teams" was signed into law by Governor Robert Ehrlich on April 26, 2005, effective July 1, 2005. The legislation enabled counties to establish domestic violence fatality review teams, making Maryland the twenty-first state that passed legislation regarding domestic violence fatality review. The domestic violence fatality review legislation is based on the Child Fatality Review Statute under Title 5, Subtitle 7, entitled "Child Fatality Review Teams," of the General Health Article established by SB 464 during the 1999 legislative session.

The Law:

The legislation is codified under Title 4, Subtitle 7, entitled "Local Domestic Violence Fatality Review Teams" of the Family Law Article.

FL§ 4-701:	Defines domestic violence (DV) as being between "intimate partners."
FL§ 4-702:	Authorizes establishment of team and organizing agencies.
FL§ 4-703:	Sets out membership.
FL§ 4-704:	Establishes: Purpose—to prevent deaths. Method of operation—creation of protocol and review of DV fatalities and near fatalities. Scope of review—number and type of cases for review.
FL§ 4-705:	Authorizes mandatory access to records.
FL§ 4-706:	Authorizes closed meetings when discussing cases.
FL§ 4-707:	Authorizes confidentiality and protection from civil and criminal proceedings.
CJ 5-637.1:	Allows for protection from liability.

Overview of Local Domestic Violence Fatality Review Teams

Family Law § 4-701: Definitions.

"Domestic violence," for purposes of fatality review, covers cases in which the involved parties were or had been "intimate" partners. Therefore, the definition does not include family relationships such as father-son, brother-brother, etc.

FL§ 4-702: Authorization.

This section authorizes the establishment of a team, and designates which agency heads have the authority to organize a team.

FL§ 4-703: Membership.

This section sets out the "persons, organizations, agencies, and areas of expertise" from which membership of the team shall be drawn, but provides that the members shall be drawn "as available." The MNADV believes the listed entities must be given the opportunity to join the team but considers the phrase "as available," to be subject to broad interpretation for agencies or organizations which, after being given the opportunity, do not choose to participate.

This section also provides for the appointment of "any other person necessary to the work of the team, recommended by the local team."

FL§ 4-704: Purpose (A), Method of Operation (B), and Scope of Review (C).

The purpose portion of this section sets forth how the team intends to prevent domestic violence deaths.

The method of operation portion of the section specifies the establishment of a protocol, reviews of "fatalities and cases of serious physical injury related to domestic violence that have occurred in the county," meeting as a team to review cases, and preparing reports "that include recommendations." This section authorizes the review not only of deaths related to domestic violence, both homicides and suicides, but also to what might be termed "near fatalities," as specified by the term "cases of serious physical injury."

The term "cases of serious physical injury," taken specifically from CR 3-201, means a physical injury that "creates a substantial risk of death, or causes permanent or serious disfigurement, loss of function of any bodily member or organ, or impairment of the function of any bodily member or organ." The term "serious physical injury" is the legal term that most

closely identifies the term "near fatality" that Anne Arundel and Calvert used in their protocols. Additionally, the section provides for the review of any fatality "related to domestic violence." This language includes the deaths of third parties. For example, during a domestic assault between a husband and wife, their child is killed. That would be considered a fatality "related to domestic violence."

The scope of the review portion designates which fatalities a team may review, but that the team "shall determine the number and types of cases the team will review." This latter provision means that a team is not required to review every domestic violence fatality that may have occurred, particularly if there is good cause not to review a fatality, such as the filing of a civil suit arising from the criminal case.

FL§ 4-705: Access to Information and Records.

This section provides for mandatory access to information and records, "on request of the chair and as necessary to carry out the local team's purpose and duties," by providers of medical care, by state or local government agencies, and by social services agencies "that provided services to the person or the person's family." The law does not give subpoena power to the chair and does not provide a specific compliance mechanism.

FL§ 4-706: Meetings.

This section provides that meetings "shall be closed to the public . . . when the local team is discussing individual cases," and that information that identifies a deceased person, a family member, or perpetrator, or information regarding the involvement of an agency, organization or person with a deceased person "may not be disclosed during a public meeting." Violation of the section is a misdemeanor punishable by fine or imprisonment.

FL§ 4-707: Confidentiality.

This section provides that all information and records acquired by the team is confidential and free from disclosure, and provides that members "may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting."

CJ 5-637.1

This section in the Courts and Judicial Proceeding Article, which was part of the legislation creating domestic violence fatality review teams, provides that any member who acts in good faith within the scope of the team's jurisdiction "is not civilly liable for any action as a member of the (team) or for giving information to, participating in, or contribution to the function of the (team)."

V. National Domestic Violence Fatality Review Initiative: Guiding Principles

Maryland has built its foundation of Domestic Violence Fatality Review based upon these Guiding Principles and Themes.

*Taken from the National Domestic Violence Fatality Review Guiding Principles (www.ndvfri.org retrieved August 29, 2009).

National Guiding Principles and Themes

- **Ethics, Confidentiality and Respect** for all those who conduct or are involved in the death review process.

- Discussions of **Philosophy** are central to the death review as are concerns that agencies and individuals be accountable for their actions. Balancing no blame and shame with the notion of **Accountability** is another theme that underscores death review work.

- Domestic violence fatality review requires a paradigm shift from a **Culture of Blame to a Culture of Safety** in which deaths are reviewed through a lens of preventative accountability. With vigor, trust, honesty and candor, communities can establish reliable systems that value accountability, honesty and systemic improvement, which should be the focus rather than denial, blame and personalizing the review.

- It is important to remember that it is the batterer and the batterer's violent behavior that causes the death. The batterer is ultimately responsible. Review philosophies that point the finger at agencies, or seek to blame and shame individual agency personnel, are counterproductive. At the same time, agencies that work with perpetrators and victims of domestic violence may have opportunities to prevent these deaths. The failure to prevent deaths through inaction, negligence, malfeasance, corruption, the inability to better coordinate service delivery, and so on, must be examined in order to improve system response to future domestic violence incidents. It is essential that review teams gather information to **Make Informed Decisions** about how to introduce changes to prevent domestic violence.

- Review teams should work with a philosophy of **Kindness and Concern**, a philosophy that respects the rights of surviving family members and the victims, but with a philosophy that recognizes that better agency coordination can save lives. It is important to keep the no blame and shame philosophy at the center of the review, while still realizing the need for agency accountability. Issues relating to culture ought to permeate all workshops, presentations, mock reviews and so on. If we only identify those aspects of culture that appear to cut across domestic violence homicides, then we may obscure the idiosyncrasies of particular cultures and particularly the role of history. We need to weigh carefully the role of culture in domestic violence deaths. Our experiences in researching homicides in different cultures are that there are similarities but also important differences. Another key issue is whether we are actually seeing the effects of culture, or the effects of poverty. Some would argue it is impossible to separate these two issues. Of course, another important issue is whether the dynamics of gender and arguments regarding power and control are

applicable in different cultures and same-sex killings.

- Teams should **Confront a Range of Deaths** as being traceable to domestic violence. Here we include phenomena, such as suicide, accidents, HIV deaths, deaths of prostitutes (sex workers, depending upon your politics), the killing of men by women, the deaths of children, and so on. Some have been working on resurrecting old cases and using child witnesses to reconstruct cases now perceived to have been homicides, etc. There are many more deaths traceable to violence against women than at first meet the eye. We should emphasize those deaths and the value of exploring them.

- While teams may never know if the review process "works," it is important to **Document System Changes** that are implemented and try to reflect upon the impact of these changes.

- **Trust and Collaboration** are crucial to conducting death reviews. Building trust involves individuals and agencies negotiating ideological difference.

Taken from the National Domestic Violence Fatality Review Guiding Principles (www.ndvfri.org retrieved August 29, 2009).

VI. Goals and Objectives of Domestic Violence Fatality Review Teams

The Primary Purpose of Domestic Violence Fatality Review is to Prevent Deaths Related to Domestic Violence by:

- **Promoting** a coordinated community response among agencies that provide services related to domestic violence.
- **Identifying** gaps in service and developing an understanding of the causes that result in deaths related to domestic violence and,
- **Recommending** changes, plans, and actions to improve:
  - Coordination related to domestic violence among member agencies
  - The response to domestic violence by individual member agencies, and
  - State and local laws, policies and practices.

Selected Mission Statements from Local DVFRTs:

- To evaluate and better comprehend deaths or near death situations related to intimate partner violence.
- To reduce domestic violence related fatalities and near fatalities through systemic multidisciplinary review of domestic violence fatalities and near fatalities.
- 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.
- 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.
- To identify systemic issues and missed opportunities for intervention in homicide and near homicide cases.

VII. Methodology

Selection of Cases for Review

Introduction. The review process begins with the selection of cases for review. Since one case review usually carries over into multiple meetings and many teams meet quarterly, the focus is on the quality, rather than the quantity, of case reviews. Teams use one of two methods to select cases.

Selection by Case Screening Committee (CSC). Some teams, primarily because of the number of cases that match the DVFRT scope of review, use a case screening committee to identify those cases. The case screening committee usually meets about four weeks before the scheduled DVFRT meeting to determine which cases from a specified time period should be reviewed. The committee determines which cases qualify for review: homicides, suicides, and cases of serious physical injury.

Selection by Full Team. Teams not using a CSC obtain eligible cases from their prosecutor and/or law enforcement representative and decide as a full team during a review session which cases they will next review.

Any member of the DVFRT may request to the chairperson that a particular case be reviewed even if the CSC decided not to review the case. The full team makes the final decision whether to review the case.

Records Review. After the team or committee determines which cases will be reviewed, the chairperson submits the victims' names and other basic identifying information to the team's members at least three weeks prior to the DVFRT review, so that the members may research agency/organization files to determine what, if any, records and/or other information they may have on the victims.

Gathering Information

By request of the chair, the DVFRT shall be provided, by law, with access to information and records for medical, dental and mental health care and 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. DVFRT members "access" this information via review meetings.

Teams can also request records and information from agencies/organizations that are not participating team members. The release of medical records is covered by HIPAA, and local teams work with the health facilities in their counties on an individual basis to seek the release of records. Teams do not have the power to enforce the release of information.

Interviews

Either the team or the case screening committee determines, before or during the course of a review, whether any family or non-family members have any information useful to the case review. If so, the team or committee appoints members to contact them and determine whether interviews are appropriate. The team or committee will usually assign interviews to team members who are domestic violence counselors or advocates by profession.

Interviews with family or friends must be viewed by the team with great sensitivity, compassion, awareness, and caution. Decisions to interview or not to interview are made on individual basis with as much information as possible. The team or committee may choose not to interview certain informed family members, friends, or other individuals if they believe that such contact may be counterproductive or harmful in any way. Interviewers may recommend the appearance of an interviewed person before the full team. However, whether the interviewed person appears or not, the interviewer will report on the interview to the team.

Recommendations

Based on case review findings, teams recommend actions for the purpose of preventing deaths related to domestic violence:

- To improve services, coordination of services, and investigations among and within member agencies and the system as a whole;
- For agencies to implement recommended changes; and
- On needed changes to state and local law, policy, and practice to prevent deaths related to domestic violence.

With each case that is reviewed, the chairperson instructs each member 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 member provides a report of what, if any, action was taken concerning the recommendation(s).

In addition to setting forth current recommendations, the annual report describes the status of prior recommendations and reports on those current recommendations on which action has already been taken. Teams do not permit recommendations to go unresolved.

Annual Report

Each team prepares an annual report in order to provide information to the public and persons or agencies and organizations that can have influence in having its recommendations enacted. The report may not, by law, ascribe findings and recommendations to particular cases. If circumstances are described, they may not be attributed by name to the cases reflected by the circumstances or described in a manner that would readily permit the identification of an individual.

The annual report is a public document that is used as a vehicle to promote social change. It can be distributed to a broad audience including: member agencies/organizations; county and municipal governments; county representatives; legislators other elected officials; county media outlets; non-member agencies that may have an interest in particular recommendations; and other entities that have oversight concerning victim matters, in particular, the Maryland Governor's Office of Crime Control and Prevention, the Governor's Family Violence Council, the Maryland Health Care Coalition Against Domestic Violence, and the National Domestic Violence Fatality Review Initiative. The team may distribute its report to any agency, organization, or individual whom it believes can have a constructive effect on its recommendations. Additionally, families of victims whose cases were reviewed may also receive a copy.

VIII. Key Findings and Concerns

Overview of Prevalent Issues

- **Prior Services**
  Some reports indicated that victims had no prior contact with domestic violence service providers before their death and some reports indicated that victims who had contact with domestic violence service providers did not follow through with any services.

- **Children**
  The majority of the review teams reported that children were witnesses to domestic abuse in the home. Teams have growing concerns that children who have witnessed abuse in the home often engage in unacceptable and destructive behaviors that result in their involvement in the criminal justice system, juvenile court, and the department of social services.

- **Criminal Justice Involvement**
  Cases reviewed found that victims rarely sought a protective order, or if they had, an order was not active at the time of their death. While enhanced and client-specific safety planning may or may not include seeking a domestic violence protective order, linking clients with services that can provide information about options available will help them to make an informed decision.

  Cases reviewed also highlighted repeated incidents where a domestic violence offender was placed on probation, violated the terms of probation, and received no penalty for their violation outside of continued probation. One county learned the firearm later used by an abuser in the murder of his partner was the same firearm the Division of Parole and Probation had previously requested from the offender in a written letter. The offender did not receive the letter because he was serving a jail sentence and the detention center was unaware of his obligation to surrender the weapon upon his release.

- **Trainings**
  Several review teams indicated the lack of training on such crucial issues as strangulation, human bite wound identification, and lethality assessment, all of which can significantly impact whether or not a victim chooses to seek domestic violence services, and whether or not proper evidence is collected to influence prosecution.

- **Seeking Medical Treatment**
  Several teams discovered that victims minimized the need for medical care following an assault and often chose to decline medical treatment on-site when an ambulance was called. First responders were not trained in recognizing the need for immediate medical attention for victims when serious, non-visible injuries were present and, consequently, were unable to convey this urgency to the victim.

- **Domestic Violence Units**
  Teams believe that an active domestic violence unit within police departments or a set of specialized officers in each police municipality provides victims with access to an officer trained in the dynamics of domestic violence. For those counties or jurisdictions unable to establish a domestic violence unit due to lack of resources or size, consideration should be given to having a set of officers specially trained in domestic violence. This will ensure victims will not be required to retell their story to an officer each time the police become involved. Giving victims this exclusive access may change victims' image of law enforcement and increase the number of victims who are more willing to seek services.

- **Standardizing Evidence Collection**
  Teams believe that a more uniform approach to evidence collection may assist in successful prosecution and a better coordinated response across disciplines throughout the state. This will also lead to a consistent, standardized approach to abuser account-ability and a standard of care for victims.

IX. Statewide Recommendations

Healthcare Providers

1. **Increase awareness of the importance of strangulation as a risk factor in predicting a victim's risk for being killed by providing trainings on strangulation.**

   Trainings should educate the criminal justice community, law enforcement, medical professionals, and domestic violence advocates on the seriousness of strangulation as a risk factor in predicting a victim's risk for being killed. Research shows that women who experience strangulation as a form of physical abuse in intimate relationships are at higher risk for increasingly severe and ongoing intimate partner violence. Emphasis should be placed on the importance of recognizing non-visible indicators of strangulation since injuries from strangulation are not easily visible. If professionals are better aware of the seriousness of strangulation and its signs and symptoms, more cases can be triaged appropriately and victims can receive the medical care needed.

2. **Increase the number of medical evaluations for victims of strangulation by creating a statewide protocol standard for evidence collection and medical response to strangulation victims.**

   Often, only a cursory history or physical examination is given when victims present at the hospital after an incident of strangulation. Standardization of evidence collection can ensure accountability from the health care provider to the victim and can aid in establishing the urgency resulting from the dangers of strangulation. Statewide uniform responses to strangulation can hold abusers more accountable. Additionally, a standardized protocol may impact or influence an amendment to the definition of "serious physical injury" in the Criminal Law Article, Section 3-201(c) or may lead to the enactment of a felony statute (similar to the Idaho statute) prohibiting acts of strangulation in family violence cases deeming the act a felony.

3. Increase the likelihood of domestic violence assessment within the health care setting by implementing training and continuing education courses to health care professionals in their training and in their practice.

The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO) mandates all hospitals have protocols to assess for domestic violence. Despite this mandate, many medical charts lack documentation of such screenings. Numerous physicians report a lack of confidence in their ability to inquire about or complete domestic violence screenings. The Maryland Health Care Coalition Against Domestic Violence has developed a protocol for screening victims of domestic violence within the health care setting and the Maryland Network Against Domestic Violence (MNADV) has developed a Lethality Assessment Program screening protocol. These protocols, in conjunction with resources available from the Family Violence Prevention Fund, can be used for trainings to build confidence and competence among health care professionals in the assessment of domestic violence victims.

4. Improve forensic medical documentation for domestic violence injuries.

Insufficient or unintelligible medical documentation of injuries to victims negatively impacts the prosecution of domestic violence cases. Currently, Mercy Medical Center (Baltimore, MD) uses an Intimate Partner Violence Forensic Evidence Standard Kit (IPV Kit) modeled and developed after the state's accepted Sexual Assault Forensic Examiner (SAFE) Kit with the input of both law enforcement and prosecutors. Using the kit enables properly trained medical personnel to record or preserve evidence, document clinical findings, document abuse history and the victim's account of how injuries were sustained, and photograph evidence. Mercy's Internal Review Board approved an outcome study of the Kits, examining the differences in court outcomes (verdicts and sentences) between cases that used the IPV Kit and cases that had random or scant medical documentation. Too few cases are available to make a sufficient quantitative analysis at this time. Mercy will continue to conduct the outcomes study with the goal of providing both qualitative and quantitative feedback.

5. Increase access to resources and assessment tools by health care professionals throughout the state by establishing an information clearinghouse.

Resources should include screening tools, safety assessments, confidentiality rules, Maryland reporting mandates, forensic evidence requirements, coding for documentation and reimbursement, and local referral sources.

6. **Implement existing protocol screening and evaluation of victims of domestic violence throughout all health care facilities.**

The Maryland Network Against Domestic Violence created and implemented a protocol for implementing the Lethality Assessment Program in the hospital setting. The Maryland Health Care Coalition Against Domestic Violence created a Toolkit for hospitals and health care providers to respond more effectively to domestic violence victims. Hospitals should consider utilizing these existing resources.

Criminal Justice System

7. **Increase the availability of mental health services immediately following a homicide by establishing a system where crisis intervention is available on the scene of a homicide for surviving loved ones.**

Victims and families can use immediate support from counselors after a critical incident to help in providing linkages to resources within the community. While the crisis intervention specialists need not be affiliated with domestic violence programs, they are still an integral part of the coordinated community response to domestic violence. Some law enforcement municipalities and county health departments employ a model that allows for this specific intervention. Providing this service can help in supporting families transition out of crisis.

8. **Create a system that would allow very limited information about emergency petitions (EPs) to be accessed by law enforcement and parole and probation agents.**

Law enforcement is concerned about service calls for domestic incidents and the possible return of weapons when there has been a recent Emergency Petition (defined as a mental health intervention, usually initiated by police or mental health counselor/social worker requiring a client to receive a psychiatric evaluation at the hospital). Parole and probation agents are not always aware of existing emergency petitions unless the individual petitioned chooses to disclose this information. Knowledge of the existence of such petitions could increase the safety of officers and victims.

9. Increase victim awareness of and access to medical treatment for injuries immediately following a domestic assault by creating and implementing a protocol for law enforcement that would encourage victims to seek immediate medical treatment.

Historically, victims have declined medical treatment for injuries sustained in a domestic violence assault. Law enforcement may not understand the depth of medical issues involved, due to lack of training or from making the assumption that only visible injuries equate to the necessity for medical treatment. First responders, such as law enforcement, should receive training on injuries from domestic assaults that may have delayed manifestation or hidden effects and should develop a protocol that actively encourages victims to seek treatment. The protocol should also include a process for addressing victims who refuse treatment—educating them on the possible dangerous and lethal effects of strangulation. Currently, the Baltimore City Police Department General Order G-11 dealing with domestic violence states under "Required Action" that officers are to "Take appropriate measures at the scene but not limited to: rendering or obtaining medical attention, affecting arrest or obtaining a warrant." Perhaps other law enforcement jurisdictions or first responders should implement such an order or establish a similar protocol.

10. Increase victim access to officers specially trained in domestic violence by establishing a domestic violence unit or a set of specially trained officers in each sheriff's office and law enforcement municipality.

Establishing a domestic violence unit, or a set of specially trained officers to work with victims and their families gives victims access to a specific officer or a core group of officers who are highly trained in the dynamics of domestic violence. This will ensure victims will not be required to retell their story to an officer each time the police become involved as the officers in the domestic violence unit will be familiar with the victims' case histories. Giving victims this exclusive access may change victims' image of law enforcement and increase the number of victims who are more willing to seek services.

11. Increase victim safety and abuser accountability after a domestic violence incident where the abuser was arrested by using the Lethality Assessment Program Screen to assist in decisions regarding the setting of bond.

The Lethality Assessment Program Screen should be flagged for the courts to take into consideration when setting bond.

12. Foster active, consistent, and ongoing communication between detention centers, the Division of Parole and Probation, sheriff's offices and state's attorney's offices regarding firearms and protective orders.

One team discovered a gap in communication between the detention center, Parole and Probation officers, and the sheriff's office after an abuser used a firearm in the murder of his partner. The individual was convicted of a felony and, as a result, was not permitted to possess the handgun; he was still serving his jail sentence when Parole and Probation sent a letter to the home stating the firearm must be surrendered. The individual was released and the detention center was unaware of his obligation to surrender his firearm.

One county discussed the lack of a procedure for the Division of Parole and Probation to be informed when a protective order has been filed against an abuser on supervised probation.

Notifying the state's attorney's office regarding each felony conviction alerts Parole and Probation officers to offenders who cannot legally possess a firearm.

13. Establish a system for tracking and implementing penalties for domestic violence Violation of Probation (VOP) cases.

Several cases reviewed uncovered the fact that domestic violence offenders were on probation, violated the terms of the probation, and received no penalty. In one case, the special condition a defendant refused to satisfy was eliminated by the judge. Establishing a system to track cases will help to determine if these cases are isolated incidences or if there is a systemic issue that needs to be addressed. These efforts may also reduce a victim's vulnerability to future violence.

14. Continue trainings on the Lethality Assessment Program.

Training on the Lethality Assessment Program increases the likelihood that victims will seek services from a domestic violence program.

15. Alert high level commanders at military installations of the growing trend of domestic violence incidents when military personnel return from overseas.

One team's case review revealed "post traumatic stress disorder" as a factor in the commission of domestic violence. Additionally, there were some reports of abuse from military spouses that were not criminally prosecuted.

Domestic Violence Service Providers

16. Increase high danger victims' access to domestic violence services by establishing a protocol for following up with victims referred through the Lethality Assessment Program.

Records have shown that high risk victims do not follow through on seeking services. After the domestic violence agency receives information about a person who has screened in at high risk, protocols should be established for following up with clients whether or not they initially chose to speak with a hotline counselor. Follow-ups that are completed the same day or within 24 hours may aid in encouraging clients to seek services. Including the police in home visits may serve as an effective follow-up method. Agencies should consult their guidelines for speaking with a client by telephone as well as any other resources that the Maryland Network Against Domestic Violence has to offer. Guidelines for follow-up home visits are in the process of being finalized by the MNADV.

17. Create an enhanced response protocol and safety planning mechanism for identifying and responding to victims in highly lethal relationships.

One of the most important services provided to victims is safety planning. Some DVFRTs feel that traditional or basic safety planning has not sufficiently protected or assisted victims in very lethal relationships. Enhanced and creative client-specific safety planning should include the use of Dr. Jacquelyn Campbell's Danger Assessment and scoring tool, as well as any information regarding the abuser's criminal history, possession of weapons and prior threat to use, and gang activity. Other aggressive responses may include "swapping" high risk clients from one domestic violence shelter to another.

18. Expand Lethality Assessment Program participants to involve the county departments of social services including child protective service workers, county detention centers, county departments of health, hospital emergency departments and related medical personnel, as well as other service providers.

Teams learned that the Lethality Assessment Program can be useful to community workers other than law enforcement and domestic violence programs. This expansion takes an aggressive approach to engage clients in using domestic violence services. It also builds more awareness in the community about domestic violence programs and initiatives to combat domestic abuse.

Legislation

19. Enact legislation to amend the first degree assault statute to include strangulation or create a felony statute prohibiting acts of strangulation.

Work to amend the definition of "serious physical injury" found in Criminal Law Article, Section 3-201(c) to add strangulation to the definition of first degree assault or enact a distinct statute similar to an Idaho statute, which prohibits acts of strangulation in family violence cases and creates a felony crime of strangulation.

X. Appendix

A. List of DVFRT Chairpersons and Coordinators

B. Individuals Killed as a Result of Domestic Violence: July 2007 — June 2008

C. Individuals Who Died as a Result of Domestic Violence: FY 2004 — FY 2009

D. Research Articles

E. National Domestic Violence Fatality Review (DVFRT) Resources

List of DVFRT Chairpersons and Coordinators

1. Allegany County

Chairperson:	David Goad, Sheriff dgoad@allconet.org
Vice Chairperson:	Richard Paulman, Department of Social Services dpaulman@dhr.state.md.us
Coordinator:	Shantrella York, Family Crisis Resource Center syork@allconet.org

2. Anne Arundel County

Chairperson:	Anastasia Prigge, State's Attorney's Office sapriq84@aacounty.org
Vice Chairperson:	Sarah Kling, State's Attorney's Office saklin01@aacounty.org

3. Baltimore City

Chairperson:	Dorothy Lennig, House of Ruth dlennig@hruthmd.org
Vice Chairperson:	Julie Drake, State's Attorney's Office jdrake@sattorney.org
Coordinators:	Kimberly Barranco, Criminal Justice Coordinating Committee kbarranco@baltimorecitycjcc.org
	Angela Sobol, Criminal Justice Coordinating Committee asobol@baltimorecitycjcc.org

4. Baltimore County

Chairperson:	Marci Van De Mark, Assistant Director, DSS mvandema@dhr.state.md.us
Vice chairperson:	Rosalyn Branson, Executive Director, TurnAround rbranson@turnaroundinc.org

5. Calvert County

Chairperson:	Jennifer Morton, State's Attorney's Office mortonjl@co.cal.md.us
Vice Chairperson:	Janet Scott, Crisis Intervention Center, Health Department jscott@dhmh.state.md.us

6. Carroll County

Coordinator:	Cheryl Powers, Family and Children's Services of Central MD cpowers@fcsmd.org

7. Cecil County

Chairperson:	Gary Pierce, Family Violence Council Coordinator gpierce@dhr.state.md.us
Vice Chairperson:	Chief Chip Peterson, Rising Sun Police Department rspd@zoominternet.net

8. Charles County

Chairperson:	Tony Covington, Assistant State's Attorney covingtt@charlescounty.org
Vice Chairperson:	Sergeant Steve Salvas, Charles County Sheriff's Office salvass@ccso.us
Coordinator:	Rosemary Raiman, Center for Abused Persons rosemaryraiman@verizon.net

9. Dorchester County

Chairperson:	Bill Jones, State's Attorney wjones@docogo.net
Vice Chairperson:	Bill McConnell, Director, Department of Social Services bmcdonne@dhr.state.md.us
Coordinator:	Patti Dickerson, State's Attorney's Office pdickerson@docogonet.com

10. Frederick County

Chairperson:	Mary Howser, Heartly House Clinical.dir@heartlyhouse.org
Vice Chairperson:	Lieutenant Ted Nee, Frederick County Sheriff's Office tnee@fredco-md.net

11. Garrett County

Coordinator:	Lisa Thayer Welch, State's Attorney statesattorney@garrettcounty.org

12. Harford County

Chairperson:	Steve Lentowski, Director of Student Services, Public Schools Steve.lentowski@hcps.org
Vice Chairperson:	Robert McCord, County Government Attorney rsmccord@harfordcountymd.gov
Coordinator:	Stephanie McAtee, Clinical Director, SARC smcatee@sarc-maryland.org

13. Howard County

Co-Chairperson:	Devora Pontell, Assistant State's Attorney dpontell@howardcountymd.gov
Co-Chairperson:	Vacant

14. Montgomery County

Chairperson:	Laura Chase, State's Attorney's Office Laura.chase@montgomerycountymd.gov
Vice Chairperson:	Hannah Sassoon, Sheriff's Office Hannah.sassoon@montgomerycountymd.gov

15. Prince George's County

Chairperson:	Judy Wolfer, House of Ruth jwolfer@hruthmd.org
Vice Chairperson:	Ann Wagner-Stewart, Assistant State's Attorney alstewart@co.pg.md.us
Coordinator:	Bethany Bordeaux, Sheriff's Office bmbordeaux@co.pg.md.us

16. Queen Anne's County

Chairperson:	Vacant
Vice Chairperson:	Ron Russum, Mid-Shore Council on Family Violence ron@mscfv.org
Coordinator:	Michelle Mayoral, State's Attorney's Office mmayoral@qac.org

17. St. Mary's County

Co-Chairperson:	Ella Mae Russell, Director, Department of Social Services erussel@dhr.state.md.us
Co-Chairperson:	Timothy Cameron, Sheriff Tim.cameron@co.saint-marys.md.us

18. Talbot County

Coordinator:	Ellen Grunden, Deputy State's Attorney ebg@goeaston.net

19. Washington County

Chairperson:	Vicki Sadehvandi, Executive Director, CASA Casa.incorp@myactv.net
Vice-Chairperson:	Vacant
Coordinator:	Anne Martin, CASA Anne.martin@myactv.net

20. Wicomico County

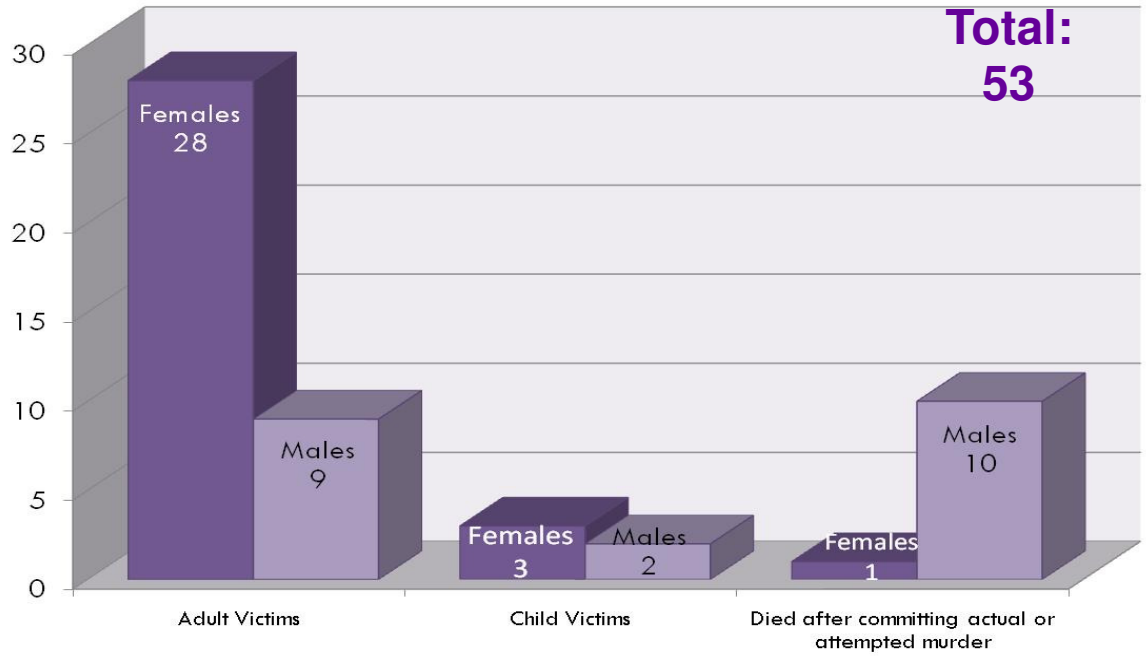
Coordinator:	Michele Hughes, Executive Director, Life Crisis Center mhughes@lifecrisiscenter.org

21. Worcester County

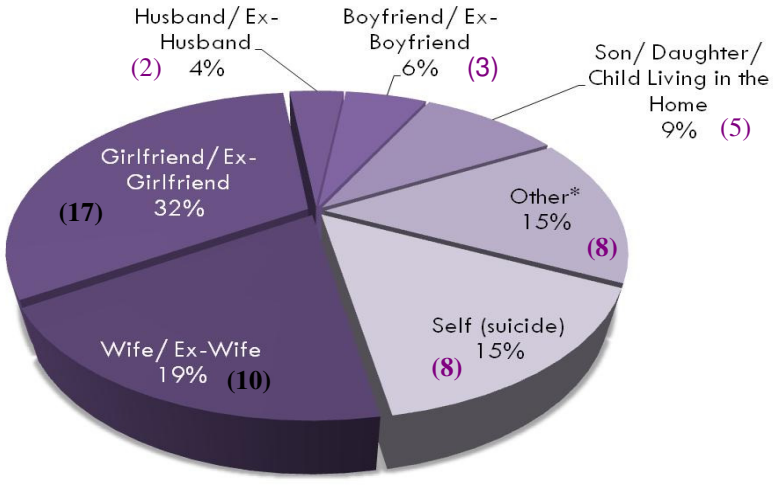
Chairperson:	Joel Todd, State's Attorney jtodd@co.worcester.md.us
Vice Chairperson:	Marty Pusey, Health Department martyp@dhmh.state.md.us
Coordinator:	David Baker, Health Department davidb@dhmh.state.md.us

Individuals Killed as a Result of Domestic Violence: July 1, 2008 – June 30, 2009

Killed as a Result of Domestic Violence

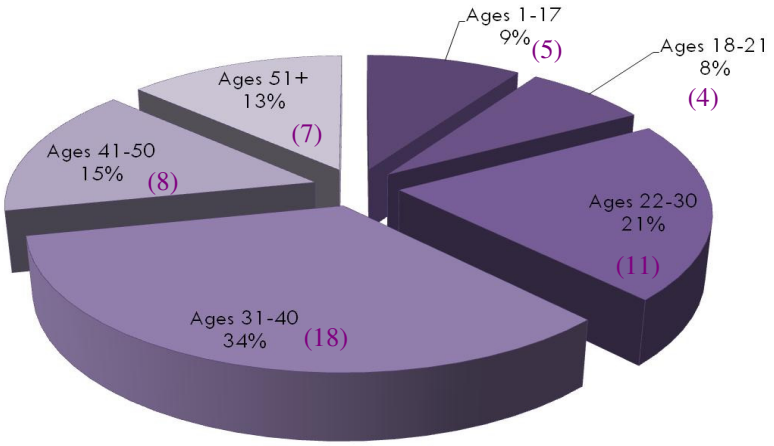


Relationship of Victim to Offender

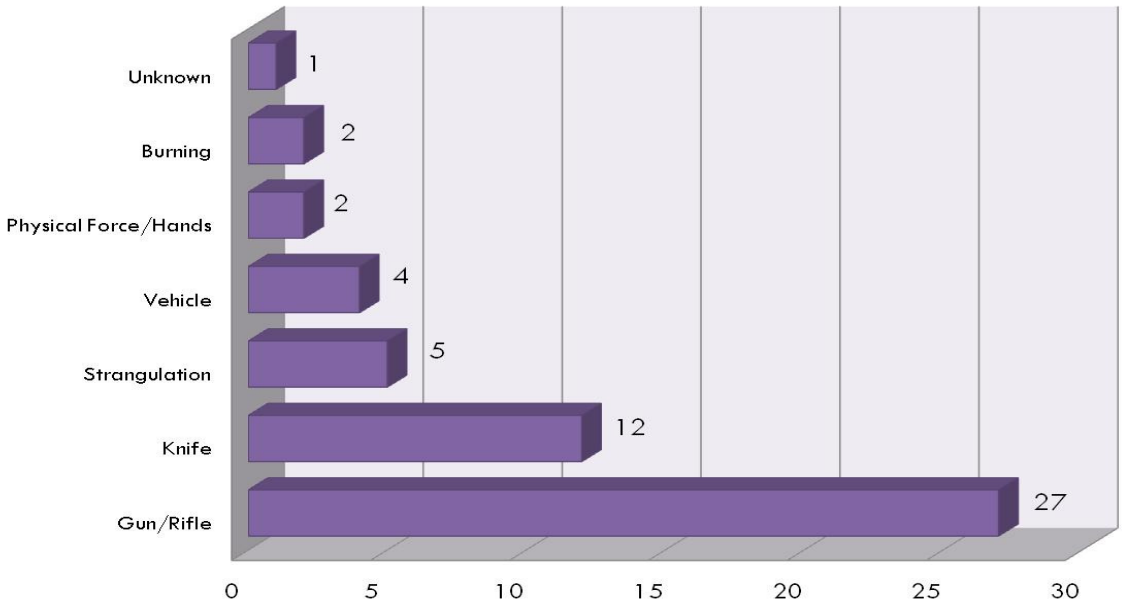


* 1 man killed by police; 3 men killed by their partner in self-defense; 3 men killed by their current partner's ex; and 1 man killed by his ex's current partner.

Age of Individuals



Method of Death



Individuals who Died as a Result of Domestic Violence: FY 2003 - FY 2009

County	7/1/08 - 6/30/09	7/1/07- 6/30/08	7/1/06 - 6/30/07	7/1/05 - 6/30/06	7/1/04 - 6/30/05	7/1/03 - 6/30/04	7/1/02 - 6/30/03
Allegany	1	0	0	0	0	0	0
Anne Arundel	3	0	2	8	9	8	13
Baltimore City	10	22	7	15	14	16	18
Baltimore	12	11	8	10	12	14	14
Calvert	0	4	0	1	1	1	3
Caroline	0	0	0	0	0	0	0
Carroll	0	0	1	0	0	1	4
Cecil	2	1	2	1	3	3	0
Charles	1	2	0	2	2	1	3
Dorchester	0	3	1	0	2	1	0
Frederick	5	11	5	2	1	0	7
Garrett	0	0	0	0	1	0	0
Harford	4	0	1	1	1	1	1
Howard	0	0	0	0	1	1	2
Kent	0	0	0	0	0	0	0
Montgomery	2	5	5	7	5	11	9
Prince George's	8	11	13	13	9	7	8
Queen Anne's	0	0	0	0	0	0	0
St. Mary's	2	1	3	1	3	2	3
Talbot	0	2	0	0	2	2	1
Washington	3	2	1	0	2	0	1
Somerset	0	0	0	0	2	0	2
Wicomico	0	0	2	2			
Worcester	0	0	1	0			
Total	**53**	**75**	**52**	**63**	**70**	**69**	**89**

Research Articles

Healthcare Providers

Elliott, L., Nerney, M., Jones, T., & Friedman, P.D., (2002). Barriers to Screening for Domestic Violence. *Journal of General Intern Medicine.* 117, 112-118.

The study examined physicians' reasons and perceptions associated with low screening rates for domestic violence victims. Six hundred surveys (from names in the American Medical Association Masterfile) were sent to each of the following disciplines: general internists, family practitioners, obstetrics and gynecology and emergency room physicians. At a fifty-three percent response rate, eighty-one percent of respondents felt they had a responsibility to address domestic violence but only 27% felt confident enough to address it. Respondents' perceived barriers to screening included feelings of insufficient resources to serve victims of domestic violence (45%) and thoughts that asking about domestic violence would make patients angry (33%). Those respondents who did ask about domestic violence noted it in the patient's chart (76%) and gave them community resources (80%).

Krasnoff, M., & Moscati, R., (2002). Domestic Violence Screening and Referral Can Be Effective. *Annals of Emergency Medicine.* 40(5) 485-492.

Hospital personnel attempted to connect victims of domestic violence with a domestic violence service provider after meeting with a volunteer domestic violence advocate in the emergency room. Researchers defined domestic violence as physical abuse and attempted linking victims to services between July 1, 1997 and December 31, 1999. Patients were asked three screening questions and if they triggered the protocol, a packet was completed by hospital personnel. The "packet" consisted of a patient resource form, body maps and consent to be photographed. Volunteer advocates spoke with the victim regarding safety planning and asked about follow-up services. If they agreed to follow-up, a case manager contacted them within 24 to 48 hours after their hospital visit. Case managers then developed a "Case Plan" with victims and assisted them with meeting their goals.

Rhodes, K.V., Lauderdale, D.S., He, T., Howes, D.S., & Levinson, W., (2002). "Between Me and the Computer": Increased Detection of Intimate Partner Violence Using a Computer Questionnaire. *Annals of Emergency Medicine.* 40 (4), 476-484.

This study proposed that a computer-based health risk assessment given in the emergency department may improve disclosure of domestic violence. Previous studies indicated domestic violence prevalence rates drop when assessments were completed by physicians and nurses in a busy emergency department. An intimate partner violence computer screening tool was made available to patients for completion in an urban university emergency department. The questionnaire was on a fifth grade reading level and was available by touch screen. During the controlled trial, 248 patients used the computer based assessment and 222 were questioned using the normal hospital methods and protocols. Results showed that 83 of the 248 computer screened patients indicated a positive screen — meaning they had experienced emotional or physical abuse by a current partner. Only one patient disclosed emotional or physical abuse by a current partner when questioned using the traditional protocol or questioning methods.

Strangulation

Glass, N., Laughon, K., Campbell, J., Block, C.R., Hanson, G., Sharpe, P.W., & Taliaferro, E., (2008). Non-fatal Strangulation is an important risk factor for Homicide of Women. *The Journal of Emergency Medicine.* 35 (3), 329-335.

This study emphasizes the need to screen for non-fatal strangulation in victims of domestic violence who present in the emergency department. Using Dr. Jacquelyn Campbell's Danger Assessment, researchers identified risk factors for intimate partner homicide during an 11 city case control study. Three hundred and ten homicide cases were reviewed,194 attempted homicide cases were reviewed and 3637 women were interviewed by phone to find if they were ever abused. Data analyses showed that women who were killed or nearly killed had a higher probability of strangulation history compared to the women who were in the "abused" category. Additionally, Danger Assessment scores were much higher for these women.

McClane, G.E., Strack, G.B., & Hawley, D., (2001). A Review of 300 Attempted Strangulation Cases Part II: Clinical Evaluation of the Surviving Victim. *The Journal of Emergency Medicine.* 21(3) 311-315.

This article discusses concerns about victims of domestic violence who present at the emergency room with physical complaints after a domestic assault. These patients only receive a physical exam and provide a cursory history. Fifty percent of the strangulation cases previously studied indicated no signs of visible injury to the neck and 35% showed "minor" injuries. Researchers are concerned that patients may not receive proper treatment if visible injuries are not present. Researchers suggest that protocols should include a menu of tests including: nasal x-rays, soft tissue x-rays, pulse oximetry and chest x-rays. They also suggest victims who disclose an incident of strangulation be admitted to the hospital for further observation of breathing, circulation and vital signs. Also, those victims who decline to be admitted should not be easily dismissed but educated about the potential progressive dangerousness and lethal outcomes of their assault.

Strack, G., McClane, G.E., Hawley, D., (2001). A Review of 300 Attempted Strangulation Cases Part I: Criminal Legal Issues. *The Journal of Emergency Medicine.* 21(3) 303-309.

This study of 300 attempted strangulation cases was prompted by two teenage deaths due to domestic violence. Researchers set out to find the type of evidence that can be obtained by law enforcement for use in felony and misdemeanor prosecution to corroborate that a victim has been strangled. The first death was of a 17 year old female who was stabbed to death by her former boyfriend just a week after she called 9-1-1 to report an incident of choking. Once police arrived at the scene, the female recanted and her injuries were fading. Six months later, a 16 year old pregnant female and mother of an 18 month old was found strangled to death and set on fire in a dirt field by her 18 year old former boyfriend. This study highlights the need for further training on strangulation for law enforcement and the necessity of victims seeking medical attention. While only 5% of the victims in the cases examined sought medical help within 48 hours of their assault, the documentation of the injuries was more comprehensive — which can aid in prosecution.

Wilbur, L., Higley, M., Hatfield, J., Surprenant, Z., Taliaferreo, E., Smith, D., & Paolo, A., (2001). Survey Results of women who have been Strangled while in an Abusive Relationship. *The Journal of Emergency Medicine.* 21 (3) 297-302.

This study evaluated strangulation as a method of domestic violence, medical symptoms experienced after strangulation, and treatment of victims in the health care setting after the report of strangulation. Sixty-two participants were surveyed from three sites: Parkland Health and Hospital System, a domestic violence shelter in Dallas, and a domestic violence shelter in Los Angeles. Of the participants, 42 women, over the age of 18 and previously or currently in a domestic violence relationship, reported an incidence of strangulation. Thirty-nine reported substance abuse as a factor during the attack. Twelve women sought medical help and two women were hospitalized as a result of the assault. Other analyses of the data revealed that victims were in the relationship about 5.2 years before being strangled (on average) and about 3.1 years before other methods of physical abuse occurred (on average). Eighty-seven percent of abusers had previously threatened to kill their victim and 70% of the victims thought they would die from the strangulation incident.

Law Enforcement

Balenovich, J., Grossi, E., & Hughes, T., (2007). Toward a Balanced Approach: Defining Police Roles in Responding to Domestic Violence. *American Journal of Criminal Justice.* 33, 19-31.

Researchers discuss focus group results of officers' views of themselves when responding to domestic violence. In 1998, a mid-size law enforcement agency redefined their approach to domestic violence to make offenders more accountable and to provide more extensive services to victims of domestic violence. Their new approach included providing domestic violence awareness and training, and placing a team composed of a police detective, victim advocate, and a representative from Parole and Probation in each police district. After conducting focus groups about officers' feelings regarding their perceived roles, responses were divided into three roles: strict enforcer, service officer, and integrated investigator. Those viewing themselves as strict enforcers felt their purpose was to deal with the legal issues of the domestic violence call — they were to only complete their criminal investigation.

Officers viewing themselves as service officers thought exploring the social services issues was their primary focus and the domestic violence investigation was secondary. Integrated officers viewed themselves as understanding of domestic violence issues, and thought using both investigative and social worker techniques together were the best fit. Researchers propose there is a benefit to the integrated investigator approach that involves officers having a more balanced view of the dynamics of domestic violence. Additionally, they are more involved with the issues of domestic violence which can lead to them resolving domestic violence calls more efficiently.

Bledsoe, L.K., (2006). Impact of Coordinated Response to Intimate Partner Violence on Offender Accountability. *Journal of Aggression, Maltreatment & Trauma.* 13(1) 109-129.

Researchers discuss the impact of Police Domestic Violence Units on offender accountability. During the time of the study (August 1, 1999 to July 31, 2000), the Domestic Violence Unit made 35% of intimate partner arrests in comparison to the 1.6% of intimate partner arrests made by police officers not in the Domestic Violence Unit. Additionally, the Domestic Violence Unit had a slightly higher number of convictions in comparison to convictions from patrol officers; not guilty findings were also slightly higher for officers from the DV unit as well. Of the total arrests made by the DV unit, 39.3% or 149 were classified as felony arrests in comparison to 17.6% or 123 felony arrests made by patrol officers. Arrests made by the Domestic Violence Unit resulted in longer jail sentences, and longer time on probation compared to non-domestic violence unit cases (96.92 days compared to 20.68 days, respectively). Time on probation was longer for those cases handled by the DV unit compared to patrol officers was 97.15 days compared to 60.90 days, respectively.

Frattaroli, S., & Teret, S.P., (2006). Understanding and Informing Policy Implementation: A Case Study of the Domestic Violence Provision of the Maryland Gun Violence Act. *Evaluation Review.* 30, 347-360.

The Maryland Gun Violence Act became a law in 1996 and authorized courts to order an abuser to surrender their firearm when a civil protective order is in place. Additionally, the law gives law enforcement the authority to remove guns when responding to a domestic violence incident. One urban, two suburban and one rural locality were selected as study sites to inform researchers about the gun violence act. Three types of data were collected:

information from semi-structured interviews with key informants, field notes from observations of protective order hearings, and information from documents related to implementing the gun law.

When discussing the policy regarding firearm removal, interviewees felt the law was unclear regarding returning removed guns and removing firearms. While officers will act in the best interest of the victim's safety, interviewees described situations where it was unclear in how to apply the law and return guns. Researchers suggested that the Attorney General may be able to provide direction on what to do or how to handle instances where an officer doesn't observe the firearm but is informed by the witness or victim that one exists.

Domestic Violence Service Providers

Edleson, J.L., Mbilinyi, L.F., Beeman, S.K., Hagemeister, A.K., (2003). How Children are Involved in Adult Domestic Violence: Results from a Four-City Telephone Survey. *Journal of Interpersonal Violence.* 18, 18-32.

Researchers conducted voluntary, anonymous telephone interviews focusing on children's responses to domestic violence. Fifty-two percent of interviewees stated that children yelled occasionally from another room during an argument. Fifty-three percent yelled occasionally while in the same room during an incident, 21% called for help during abuse and 23% of children became involved in the abusive incident.

Payne, B., Carmody, D.C., Pilchta, S., Vacdecar-Burdin, T., (2007). Domestic Violence Training Policies: Influence on Participation in Training and Awareness of Abuse. *Affilia.* 22, 292-301.

This study sought out whether the presence of domestic violence training policies in social services units influences client participation in domestic violence programs. Surveys were mailed to supervisors of domestic violence programs throughout Virginia and supervisors of social work programs at 122 social work agencies asking questions about domestic violence, the training of domestic violence and any existing policies around training. Researchers received a 92% response rate. Surveys indicated that 62% of respondents were responsible for more than one program and 55% of the agencies served clients from rural areas while 28% served mixed areas and 11% served urban areas. The programs had a median of seven full time social workers and served a median of 400 clients per year. Researchers found that the

level of knowledge was higher in agencies with domestic violence training policies. Those that did not require or encourage training needed more training than its counterparts. As a result of the study, a policy change was implemented at the Department of Social Services that required minimum standards of training be established to provide educational programs that train workers in the field of child and adult protective services in local departments and community based domestic violence programs. The policy change also included that training and education opportunities on effective collaboration be provided to all staff of local departments and community-based domestic violence programs.

National Domestic Violence Fatality Review (DVFRT) Resources

Books:

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

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

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

Articles:

Editorial, "Promoting Patient Safety by Preventing Medical Error," *Journal of the American Medical Association,* 1998, 280(16),1444-1447.

Gawande, A. (1999). "When Doctors Make Mistakes," *The New Yorker,* Feb. 1, 1999.

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

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

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

***Those in bold contain the most extensive information on fatality review.**

For further information or assistance please contact:

Maryland Network Against Domestic Violence

6911 Laurel-Bowie Road
Bowie, MD 20715

(301) 352-4574

(301) 809-0422 (Fax)

info@mnadv.org

www.mnadv.org

The Domestic Violence Fatality Review Statewide Report was written by Fatima N. Burns and edited by Michaele Cohen, Karen Hartz, and Dave Sargent.