Domestic Violence *Fatality Review*

STATEWIDE REPORT

Turning Tragedy into Change

2013

Maryland Network Against Domestic Violence

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EXECUTIVE SUMMARY

The **Maryland Network Against Domestic Violence (MNADV)** presents its third statewide Domestic Violence Fatality Review Team (DVFRT) Report entitled: ***Turning Tragedy into Change***. This document represents a collection of county DVFRT findings and recommendations that offer insight into critical issues and can be used to create better systems, policies, and procedures to decrease domestic violence-related homicides. It can be used to guide local and state agencies, funders, nonprofits, and policy makers with their strategic planning and legislative advocacy.

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, legal representation, and emergency departments. This Report can be a catalyst for discussion at staff meetings and planning sessions with boards of directors, and for legislators, judges, advocates, police officers, funders, friends, family, mental health clinicians, addictions counselors and other community stakeholders. This document represents issues that have important statewide applications.

Turning Tragedy into Change discusses the purpose and authorization of the DVFRTs, identifies the local teams, followed by the methodology utilized in reviewing cases and creating recommendations statewide. The Report also identifies key findings and recommendations specific to the local teams and that in some cases have statewide application. This Report was developed in the hope that local teams and other professionals will learn from the recommendations, work to expand programming, and decrease service gaps for the benefit of victims of domestic violence and their families, all in the effort of "turning tragedy into change."

PURPOSE

The domestic violence fatality review process takes a broad look at domestic violence-related fatalities, viewing these deaths and near-deaths in a larger context rather than as isolated events. By focusing on the victims' and the deceased families' contact with and access to frontline intervention services and the quality of the services they received prior to the death, the DVFRTs can determine where failures, gaps, and barriers in the service delivery system occurred or where improvements can be made. They can then make recommendations to improve access to community services and interventions, as well as influence positive policy and legislative change in order to prevent future fatalities and combat domestic violence.

In Maryland, unlike in many states where there is one designated DVFRT, each county and Baltimore City is authorized to establish its own team. This recognizes that local jurisdictions must develop criminal justice and service provision strategies for dealing with domestic violence that are tailored to meet the needs of their local agencies, police, and individuals in their communities.

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;
- **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; and
- **Influencing** the adoption of the recommended changes, plans, and actions.

AUTHORIZATION

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," established by SB 464 during the 1999 legislative session.

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.

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.

AUTHORIZATION

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." All the enumerated participants are encouraged to join the team but, ultimately, agencies and organizations have the right to choose whether or not 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 "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."

AUTHORIZATION

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." 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 or a case pending appeal.

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 associated with a deceased person "may not be disclosed during a public meeting." Violation of the section is a misdemeanor punishable by fine or imprisonment.

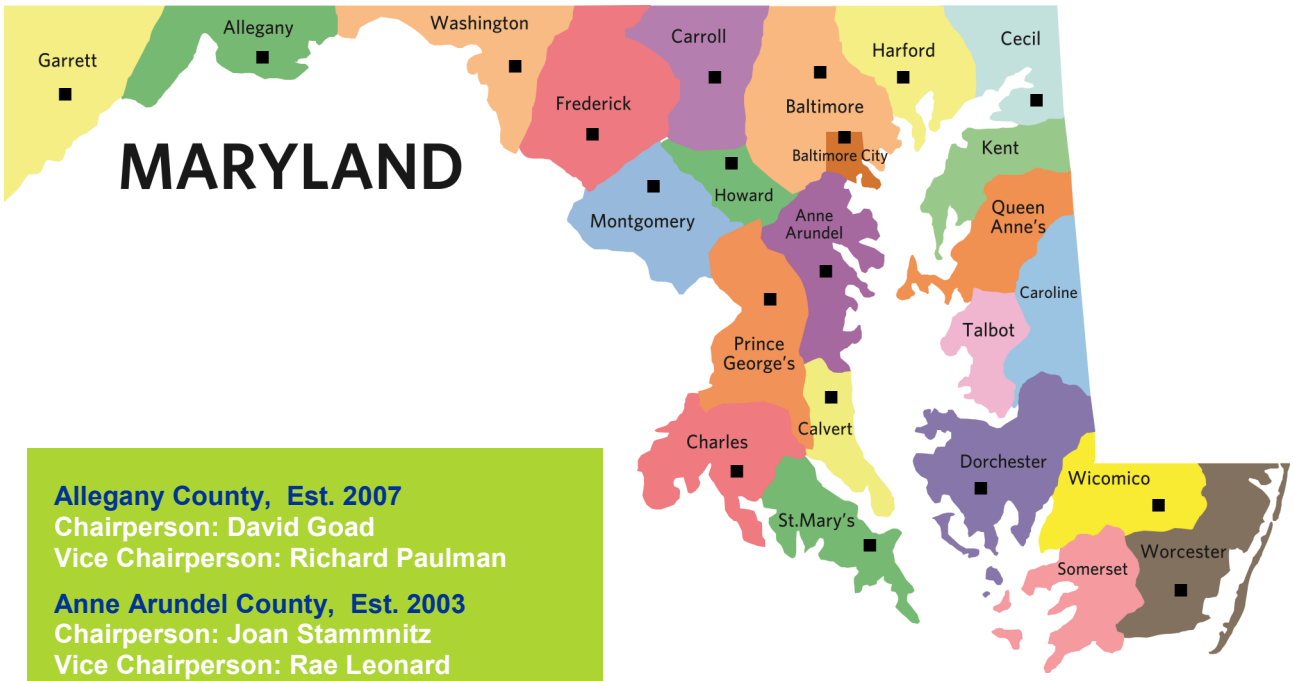
FL§ 4-707: Confidentiality.

This section provides that all information and records acquired by the team are 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)."

DOMESTIC VIOLENCE FATALITY REVIEW TEAMS*



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

Anne Arundel County, Est. 2003
Chairperson: Joan Stammnitz
Vice Chairperson: Rae Leonard

Baltimore City, Est. 2006
Chairperson: Dorothy Lennig
Vice Chairperson: Lt. Rhonda McCoy

Baltimore County, Est. 2006
Chairperson: Audrey Bergin
Vice Chairperson: Jill Savage

Calvert County, Est. 2004
Chairperson: D/Sgt. Timothy Fridman
Vice Chairperson: Vacant

Carroll County, Est. 2008
Chairperson: Connie Sgarlata
Vice Chairperson: Chief Jeff Spaulding

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

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

Dorchester County, Est. 2008
Chairperson: Bill Jones
Vice Chairperson: Bill McDonnell

Frederick County, Est. 2006
Co-Chairpersons: Michelle Pentony &
Theresa Hiegel

Garrett County, Est. 2007
Coordinator: Lisa Thayer Welch
Vice Chairperson: Brenda LeMay

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

Howard County, Est. 2007
Co-Chairpersons: Amy Hott &
Jennifer Pollitt-Hill

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

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

Washington County, Est. 2006
Chairperson: Vicki Sadehvandi
Vice-Chairperson: Melissa Bartles

Wicomico County, Est. 2009
Chairperson: Joel Todd
Vice-Chairperson: Michele Hughes

Worcester County, Est. 2007
Chairperson: Marty Pusey
Vice Chairperson: Bridgette Saulsbury

**As of September 2013*

MARYLAND DOMESTIC VIOLENCE FATALITY REVIEW COUNCIL

Maryland has 19 domestic violence fatality review teams based on an empowerment model.[1] All 19 teams are county-based. As such, they are decentralized and do not have a central supervising or organizing body. By agreement with local teams, the MNADV coordinates and assists teams to provide them with statewide connection. Under the guidance of the MNADV, the local teams formed the Maryland Domestic Violence Fatality Review Council (MDVFRC). Its membership is comprised of chairs, co-chairs, vice chairs and coordinators of all the local county teams.

The MDVFRC meets annually to discuss issues of statewide applicability and to provide training and guidance on local team processes. The Council met on September 19, 2013 and twelve of the nineteen teams were in attendance. This year's meeting featured a presentation by the Baltimore City Domestic Violence Fatality Review Team on its recommendation to improve the system response to children who witness fatal abuse of a parent. Other discussions revolved around specific recommendations that teams had made and new ways to engage local teams in creating systemic change.

[1]Kelly A. Watt and Nicole E. Allen, *Domestic Violence Fatality Review Teams: Critical Tensions and Promising Practices,* University of Illinois at Urbana-Champaign.

METHODOLOGY

Selection of Cases for Review

The review process begins with the selection of cases for review. Some DVFRTs use a case screening committee to identify those cases. The committee determines which cases qualify for review: homicides, suicides, and cases of serious physical injury. Teams not using a case screening committee 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. 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 so that they may research their agency files to determine what, if any, records and/or other information they may have on the victims. Other DVFRTs use a team consensus selection process guided generally by the State's Attorney's Office, law enforcement or other individual team members.

Gathering Information

By request of the DVFRT chair, the team is granted, by law, access to team members' critical information, reports, and records relevant to the victim and the perpetrator. Teams can also request records and information from agencies 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.

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 often assign interviews to team members who are domestic violence counselors or advocates by profession. Interviews with family or friends are conducted with great sensitivity, compassion, awareness, and caution. 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. Some interviewees may be asked to address the DVFRT. In near fatality cases, the surviving victim may be invited to address the DVFRT as part of the case review.

METHODOLOGY

Recommendations

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 and recommendation to the agency head with a request for consideration and action. At subsequent meetings, the member provides a report of what, if any, action was taken concerning the recommendation.

Annual Report

Each team can prepare an annual report in order to provide information to the public and persons, agencies, or 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, identified 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 and other elected officials; county media outlets; non-member agencies that may have an interest in particular recommendations; and other entities that are concerned with victim issues, including the 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.

BETWEEN JULY 1, 2011, AND JUNE 30, 2012, 49 MARYLANDERS DIED AS A RESULT OF INTIMATE PARTNER-RELATED DOMESTIC VIOLENCE.

RECOMMENDATIONS

CHILDREN

Children Witnessing Fatal Abuse of a Parent

Recommendation: Create a protocol which will identify and develop an appropriate response to children whose parent(s) have been killed as a result of domestic violence. This protocol should be implemented in conjunction with the school system where those children will be systematically identified and an appropriate response provided. *(Baltimore City, 2012)*

Assessing Information and Referrals for Victims Utilizing Visitation Centers

Recommendation: To display literature in the supervised visitation center so that parents who are victims of domestic violence can access information and referrals without disclosing that they are a victim of domestic violence. *(Harford County, 2012)*

Amending the Penalty for Criminal Law Article, §4-104 (c)

Recommendation: Amend the penalty in Criminal Law Article, §4-104 (c), Annotated Code of Maryland, which prohibits a child from having access to firearms, to include a potential period of incarceration. The current penalty carries the potential of only a $1,000 fine. *(Wicomico County, 2013)*

OF THE 49 INTIMATE PARTNER-RELATED FATALITIES BETWEEN 2011 AND 2012, 12 WERE SUICIDES PRECEDED BY AN ACTUAL OR ATTEMPTED MURDER OF AN INTIMATE PARTNER.

RECOMMENDATIONS

HEALTH CARE

Screening and Intervention for Domestic Violence Before, During and After Pregnancy

Recommendation: Increase screening and intervention for domestic violence before, during and after pregnancy. *(Baltimore City, 2012)*

Screening Pediatric Patients and Patient Caregivers for Firearm Ownership

Recommendation: For pediatric medical providers to screen adolescents and their caregivers for firearms ownership. If firearms are present, pediatric medical providers should counsel adolescents and caregivers about the risks of firearm ownership and, if families decline to remove firearms, about safe storage. *(Baltimore City, 2012)*

Alerting Health Care Providers of Patients/Victims of Domestic Violence

Recommendation: For health care facilities to institute a confidential, internal system of "flagging" charts of patients who have been identified as victims of domestic violence. Such flagging will promote more intensive screening, appropriate intervention, confidential treatment, documentation and links to needed services at the hospital during current and subsequent visits. *(Baltimore City, 2012)*

Addressing Substance Abuse Issues Related to Domestic Violence

Recommendation: For Emergency Departments to delay discharge of patients who are victims of domestic violence and are intoxicated or otherwise temporarily impaired until they are able to complete domestic violence screening and develop an adequate discharge plan. *(Baltimore City, 2012)*

Assessing for Domestic Violence and Lethality in Health Departments

Recommendation: To assess for domestic violence and lethality at the addictions program through the local health department. *(Harford County, 2012)*

RECOMMENDATIONS

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

Screening Prison Inmates for a History of Domestic Violence

Recommendation: For the Department of Public Safety and Correctional Services to screen and assess inmates for a history of domestic violence. The screening should include those inmates who are incarcerated for domestic violence related crimes, inmates who were abused as children or who witnessed abuse between their parents, and inmates who were abusive to their intimate partners even if they are incarcerated for unrelated crimes. *(Baltimore City, 2012)*

Offering Prison Inmates Access to Abuser Intervention Programs

Recommendation: For the Department of Public Safety and Correctional Services, where a history of domestic violence is identified, to offer an abuser intervention program as a part of an inmate's case planning and re-entry programming. *(Baltimore City, 2012)*

PRIVACY AND CONFIDENTIALITY

Training of DVFRTs in Privacy Laws

Recommendation: For review teams to devote time to dialogue and receive training on state and federal privacy laws. This training should explore ethical and legal ways to address barriers caused by privacy laws and to discuss potential legislative remedies. *(Wicomico County, 2012)*

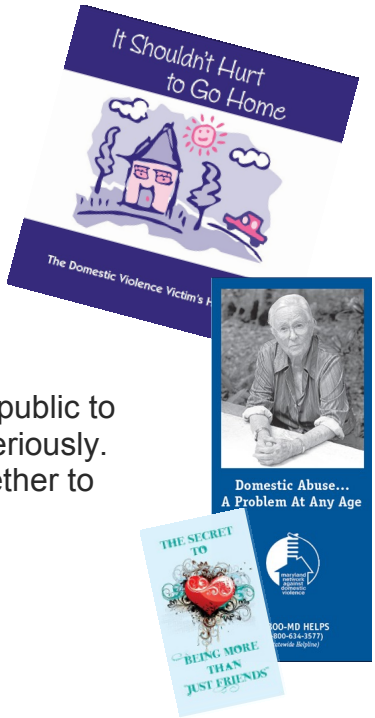
Providing an Exception to the Exchange of Information in Mental Health Cases

Recommendation: Develop an exception to the privacy laws so that mental health multi-disciplinary teams are permitted to exchange information. *(Wicomico County, 2012)*

RECOMMENDATIONS

PUBLIC AWARENESS

Increasing Public Awareness of Domestic Violence



Recommendation: Disseminate domestic violence literature to apartment complexes to educate residents about domestic violence and what to do if domestic violence is suspected. *(Cecil County, 2012)*

Producing Public Service Messages about Domestic Violence

Recommendation: For the State to encourage the general public to assume that threats of domestic violence should be taken seriously. Local teams and crisis centers should consider working together to produce a public service announcement or program. *(Wicomico County, 2012)*

OF THE 49 INTIMATE PARTNER-RELATED FATALITIES BETWEEN 2011 AND 2012, 57% WERE KILLED WITH GUNS.

POSITIVE RESULTS FROM LOCAL DVFRT RECOMMENDATIONS

Establish a Workplace Violence Committee in the hospital to proactively assess staff for domestic violence and provide assistance as needed in all hospital units.

The Harford Memorial Hospital:

- established a Workplace Violence Committee in 2012;
- provided job placement assistance to permit employees who are victims of domestic violence to transfer to different units or hospitals; and
- proactively assesses staff for signs of domestic violence. *(Harford County, 2012)*

Educate health care professionals, specifically nurses at local hospitals, to screen, identify and document domestic violence.

In February 2013, SARC provided training to Harford Memorial Hospital's Workplace Violence Committee on compassion and domestic violence education and assessment. *(Harford County, 2012)*

Expand the current SARC Safehaven for Pets program to all clients of SARC.

The Safehaven for Pets program was extended to all clients of SARC, not just residential clients. *(Harford County, 2012)*

Increase awareness of human bites as a form of domestic violence.

The Maryland Department of Health and Mental Hygiene included biting as a type of abuse on their women's health screening cards. Biting has been added to the revised Protective Order petition on the list of types of abuse. *(Baltimore City, 2012)*

Assess children exposed to fatal and near fatal abuse of a parent.

A model protocol was completed in January 2012. With this protocol, Baltimore's Police Department, Office of the State's Attorney, Department of Social Services, and House of Ruth Maryland immediately responds to children exposed to fatal and near fatal abuse of a parent and provides necessary services and support. *(Baltimore City, 2012)*

Train and implement the Lethality Assessment Program (LAP) in all local police departments.

All patrol and domestic violence unit officers have been trained. New officers are trained in the academy and then again by the Charles County Sheriff's Office Domestic Violence Unit supervisor the week they start on the road. *(Charles County, 2012)*

Ensure local police departments forward all Lethality Screens for domestic violence calls, regardless of identified risk level, to the local domestic violence program (Center for Abused Person [CAP]) within a specified time frame.

All high danger screens are forwarded to CAP immediately and all non-high danger screens are forwarded within 30 days. Additionally, the Charles County Sheriff's Office (CCSO) Domestic Violence Unit supervisor and LAP contact personally deliver copies of all lethality screens to CAP once a month. This enables the CCSO and CAP to compare received screens and to ensure that all screens, and thus all victims, are accounted for. Compliance with the LAP phone protocols are monitored and followed up with by the CCSO Domestic Violence Unit. *(Charles County, 2012)*

Identify the appropriate service agency to serve as the collection point for all domestic violence information.

The Charles County State's Attorney's Office (SAO) was identified as the appropriate agency. The SAO Domestic Violence Unit has been put in place to serve all reported victims and to serve as the collection point. The SAO Domestic Violence Coordinator will "collect, communicate and coordinate appropriately." *(Charles County, 2012)*

Community Supervision should develop a more effective, systematic way for correspondence (i.e., mail, fax, or email) to be delivered to the appropriate agent in order to address problems resulting from the turnover in personnel.

This recommendation was implemented by the Department of Public Safety and Correctional Services (DPSCS) in 2012. The Department of Public Safety and Correctional Services clerical staff or supervisor checks the Offender Case Management System to see who each case is reassigned to when an agent leaves or is reassigned. When a report is received, DPSCS emails the new agent and forwards the information. DPSCS is also notifying domestic violence programs when there is an agent change. *(Baltimore City, 2012)*

ACKNOWLEDGEMENTS

The Maryland Network Against Domestic Violence (MNADV)'s ***2013 Domestic Violence Fatality Review Statewide Report*** highlights trends, patterns and recommendations from local, county-based Domestic Violence Fatality Review Teams throughout Maryland. This report is made possible by the support and dedication of more than 200 community leaders who bring their interest, years of experience, commitment, and perspectives to serve on these local teams. These individuals recognize that the death or near-death of a victim of domestic violence is a community problem and their work acknowledges the scope and magnitude of domestic violence in the state.

Domestic Violence Fatality Review Team (DVFRT) members honor the lives of victims by summarizing identified gaps in services and providing recommendations for enhancing agency responses to victims of domestic violence. We thank them for using their professional expertise to work toward preventing future deaths in Maryland. Without their participation, this report would not be possible.

Questions concerning this report should be directed to:

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This report may be viewed: www.mnadv.org