



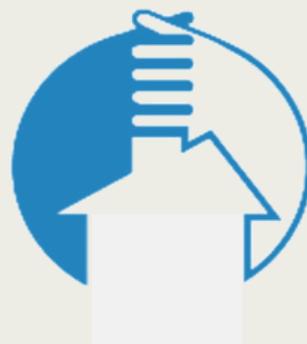
Domestic Violence *Fatality Review*



STATEWIDE ANNUAL REPORT

**Turning Tragedy
into Change**

2012



Maryland Network Against Domestic Violence



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ACKNOWLEDGEMENTS



The Maryland Network Against Domestic Violence (MNADV)'s **2012 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 250 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, as well as local DVFRT reports, may be viewed at the following web address: www.mnadv.org

EXECUTIVE SUMMARY



The **Maryland Network Against Domestic Violence (MNADV)** presents its second 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 provides system-wide recommendations. 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 MNADV acknowledges that the teams are at different stages of development and all are taking initiatives to make their teams and review processes richer. 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.

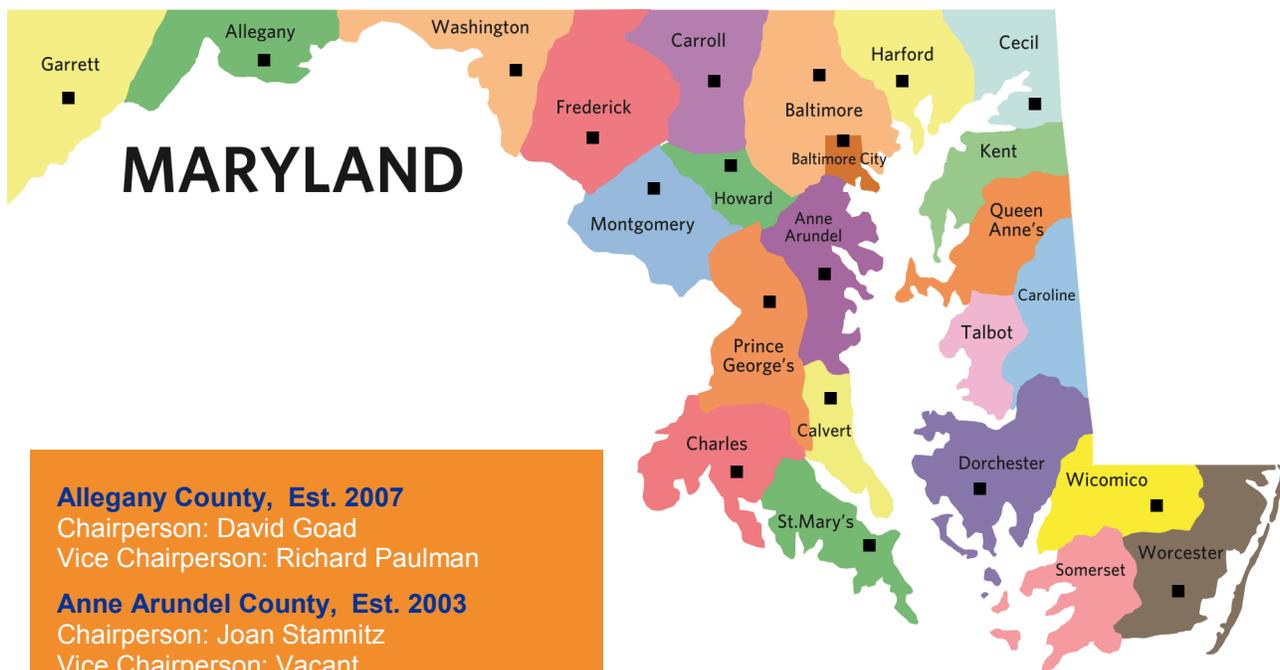
FL§ 4-707: Confidentiality.

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 Stammitz
Vice Chairperson: Vacant

Baltimore City, Est. 2006

Chairperson: Dorothy Lennig
Vice Chairperson: Lt. Rhonda McCoy

Baltimore County, Est. 2006

Chairperson: Marci Van De Mark
Vice Chairperson: Rosalyn Branson

Calvert County, Est. 2004

Chairperson: Sergeant 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 McConnell

Frederick County, Est. 2006

Co-Chairpersons: Michelle Pentony and
Theresa Heigel

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-Chairperson: JoAnna Miller
Co-Chairperson: Luanne McKenna

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-Chairperson: Ella Mae Russell
Co-Chairperson: Sheriff Timothy Cameron

Washington County, Est. 2006

Chairperson: Vicki Sadehvandi
Vice-Chairperson: Melissa Bartles

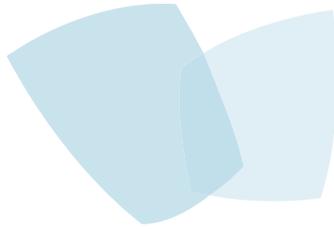
Wicomico County, Est. 2009

Chairperson: Joel Todd
Vice-Chairperson: Michelle Hughes

Worcester County, Est. 2007

Chairperson: Marty Pusey
Vice Chairperson: Bridgette Saulsbury

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

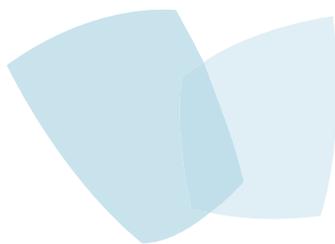
By request of the DVFRT chair, the team is granted, by law, access to team members' critical information, reports, and records relevant to the victim and the perpetrator. Teams can also request records and information from agencies that are not participating team members. The release of medical records 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.

OF THE 25 WOMEN WHO WERE MURDERED BETWEEN JULY 1, 2010, AND JUNE 30, 2011, ALL 25 WERE KILLED BY THEIR CURRENT OR FORMER HUSBANDS OR BOYFRIENDS.

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 prepares 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, 2010, AND JUNE 30, 2011,
43 MARYLANDERS DIED AS A RESULT OF
INTIMATE PARTNER-RELATED DOMESTIC VIOLENCE.**

FINDINGS AND RECOMMENDATIONS

HIGHLIGHTS

Baltimore City

Community Supervision (formerly Division of Parole and Probation)

- 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.

Charles County

Lethality Assessment Program, Centralized Information and Confidentiality

- Train and implement the Lethality Assessment Program (LAP) in all local police departments.
- Ensure local police departments forward all Lethality Screens for domestic violence calls, regardless of identified risk level, to the Center for Abused Persons (CAP) within a specified time frame (immediately for all high-danger cases and within ten days for non-high danger cases).
- Identify the appropriate service agency to serve as the collection point for all domestic violence information, possibly CAP.
- Identify the barriers to sharing information that exist within each agency (e.g., Department of Social Services, Charles County Sheriff's Office, court system, etc.) and determine how to identify and overcome barriers with regard to victim confidentiality.

OF THE 43 INTIMATE PARTNER-RELATED FATALITIES BETWEEN 2010 AND 2011, 54% WERE KILLED WITH GUNS.

FINDINGS AND RECOMMENDATIONS



Harford County

Plea Bargains, Workplace Violence Committee, Safehaven for Pets, Clergy and Health Care Professionals' Training

- Ensure that the State's Attorney's Office educates victims on plea bargains and involves Community Supervision in information sharing.
- Establish a Workplace Violence Committee in the hospital to proactively assess staff for domestic violence and provide assistance as needed in all hospital units.
- Expand the current SARC (Safety•Awareness•Resources•Change) Safehaven for Pets program to all clients of SARC.
- Educate clergy to improve their response when working with victims of domestic violence.
- Educate health care professionals, specifically nurses at local hospitals, to screen, identify and document domestic violence.

St. Mary's County

Training, Education and Multi-Agency Support

- Provide further training and education to advocates, court personnel, and judges about the need for emergency family maintenance and the abuse of financial control by domestic violence offenders.
- Educate and train hospital staff on signs of depression, chronic health problems, domestic violence, and financial abuse experienced by victims.
- Provide multi-agency, on-going support services to surviving family members, including occupational, vocational, and housing assistance.

FINDINGS AND RECOMMENDATIONS

Prince George's County

Supplemental Report, Domestic Violence Unit, Interim Protective Orders and Faith-based Communities

- Require all law enforcement agencies to complete the Domestic Intervention Supplemental Report for every domestic violence call for service.
- Evaluate the effectiveness of the Domestic Violence Unit in the Prince George's County Sheriff's Office.
- Examine victim follow-through on protective orders and criminal prosecution after contact with a domestic violence advocate from the Sheriff's Office.
- Expand the specialized Domestic Violence Unit of the Sheriff's Office to all districts, or a new district each year, after assessing the effectiveness of specialized intervention.
- Provide more in-depth, regular training for all court commissioners on domestic violence, as well as the legal requirements for the issuance of interim protective orders.
- Ensure that all applications for interim protective orders that are denied by a Court Commissioner are reviewed promptly by supervisory staff and a member of the judiciary to determine if the proper legal standard has been applied.
- Develop a video, in English and Spanish, about the process of obtaining an interim protective order as well as available resources and options for victims and show the video in court commissioners' offices.
- Require enhanced supervision for domestic violence and sexual assault cases.
- Assist domestic violence programs to establish close relationships with faith-based communities.
- Enable faith-based communities to provide domestic violence information and support within their services and study curricula.

**BETWEEN JULY 1, 2010, AND JUNE 30, 2011, OVER
25,000 PROTECTIVE ORDERS WERE FILED IN
MARYLAND DISTRICT COURTS.**

STATEWIDE RECOMMENDATIONS

This section highlights specific recommendations that have policy and systemic applications for the entire state.

Community Supervision (formerly the Division of Parole and Probation)

1. Improve communications within the Division of Parole and Probation to ensure that information and correspondence is delivered to the appropriate agent to reduce problems related to turnover in personnel.
2. Require enhanced supervision for domestic violence cases. Parole and Probation agents should be notified of the entry of any protective orders or peace orders against the offender and consider the entry of such an order to be a violation of the terms of parole/probation (i.e., consider the entry of such an order to be a violation of the terms of parole/probation).
3. Implement a policy that requires active supervision for every case involving domestic violence.

The Judiciary

1. In sentencing in criminal cases, where a history of domestic violence is evident, specify in the parole/probation order that issuance of a final protective order or peace order shall be considered a violation of probation or parole.
2. Ensure that all applications for interim protective orders that are denied by a court commissioner are reviewed promptly by supervisory staff as well as a member of the judiciary to insure that the proper legal standard has been applied.
3. Strengthen follow-up with the respondent to ensure the court's expectations to attend anger management or an abuser intervention program have been met and report progress back to the court.

Inform appropriate agencies that a referral has been made to them by the court (e.g., the abuser was referred to a fatherhood program for anger management).

Clarify the wording on the protective order or provide a reference in the judges' bench book that differentiates "anger management" from "abuser intervention" so the appropriate program referral is made.

STATEWIDE RECOMMENDATIONS



Victim Needs

1. Create a protocol for Maryland domestic violence programs to “swap” clients who are at the most risk. A resident of one county might be much safer in a shelter in another county. An enhanced response protocol would include a high danger safety plan, incorporating safety precautions appropriate for victims who are at the highest risk of being murdered. This recommendation would require development of a memorandum of understanding among the comprehensive domestic violence programs in Maryland.
2. Have an established funding resource to assist those victims fleeing from their homes due to imminent danger. The fund could be modeled after a program in State’s Attorneys’ offices that provides emergency assistance to victims of crimes.

POSITIVE RESULTS FROM THE 2009 DVFRT STATEWIDE REPORT 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.

In response to this recommendation, the MNADV established a pilot project in Calvert County that provided three different types of trainings on strangulation. The MNADV offered these trainings to law enforcement, prosecutors, hospital health care professionals, and program advocates. The three training sessions covered each discipline's role and responsibility in: 1) recognizing specific medical signs and symptoms of strangulation; 2) knowing what questions to ask; 3) seeking immediate medical care for and forensic examinations of victims; and 4) conducting thorough investigations that elicit the high quality documentation.

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.



Baltimore County and Calvert County created Strangulation Response Teams, which include model protocols. Audrey Bergin, manager of the DOVE Program at Northwest Hospital in Baltimore County, helped to develop the first model Emergency Room protocol in Baltimore County along with partners in the police department and State's Attorneys' office. The MNADV facilitated the establishment of a second project in Calvert County. Three levels of training were instituted for this project. As the training coordinator of the

Baltimore County Strangulation Response Team, Audrey provided an orientation/training session for the Calvert County pilot. Secondly, the first training session was provided to about 80 stakeholders and trainers from the Calvert County Sheriff's Office and the Maryland State Police, Prince Frederick Barrack by the Calvert County Strangulation Response Team and other state presenters. Thirdly, a number of roll call sessions were provided by the Strangulation Response Team. Adoption of the model protocol and experience from the two pilot projects will help to standardize the model as a statewide protocol and facilitate implementation in additional counties.

POSITIVE RESULTS FROM THE 2009 DVFRT STATEWIDE REPORT RECOMMENDATIONS

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 Health Care Coalition created a manual to train hospital staff on domestic violence and encourage them to establish hospital-based domestic violence programs: *The Health Care Response to Domestic Violence: An Advocacy-Based Manual for Hospitals, Facilities, and Providers*. Seven hospitals have now established hospital-based domestic violence programs in Maryland: Anne Arundel Medical Center, Sinai Hospital, Northwest Hospital, Mercy Medical Center, Prince George's Hospital Center, Greater Baltimore Medical Center, and Meritus Medical Center.



The Maryland Health Care Coalition Against Domestic Violence, in conjunction with the MNADV, has also provided dozens of training sessions to hundreds of health care providers and hospital-based health care professionals all over the state. Trainings include effective tools and skills to identify, screen, treat, document, and refer victims of domestic violence to local domestic violence service providers. These updated trainings have improved universal screening and identification of victims. In addition to general training for health care providers, the Health Care Coalition offers training sessions on specific topics related to domestic violence and health care, educational seminars for health care professionals, forums for hospital-based domestic violence program staff, and periodic statewide conferences.

Additionally, the MNADV's Lethality Assessment Program-The Maryland Model has been adapted for hospitals and is currently implemented in six hospitals in Maryland: Frederick Memorial Hospital, Atlantic General Hospital, Northwest Hospital, Prince George's Hospital Center, Peninsula Regional Medical Center, and Bon Secours Baltimore Health System. The MNADV is working with two additional hospital to implement the LAP: Meritus Medical Center and Western Maryland Regional Medical Center.

POSITIVE RESULTS FROM THE 2009 DVFRT STATEWIDE REPORT RECOMMENDATIONS

4. Improve forensic medical documentation for domestic violence injuries.

Currently, Mercy Medical Center in Baltimore, one of the original hospital-based domestic violence programs, 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 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.



The Interpersonal Violence and Abuse Program (IVAP) at Meritus Medical Center in Hagerstown, another one of the seven hospital-based domestic violence programs in Maryland, is developing a "forensic documentation" program that will be implemented shortly. Additionally, the MNADV partnered with the Maryland Coalition Against Sexual Assault (MCASA) to provide training for the Maryland Forensic Nurses Examiner's (FNE) Certification.

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

The Health Care Coalition and MNADV websites provide a wealth of information for health care professionals. The Health Care Coalition also offers a variety of informative brochures for patients and providers, available by download and in hard copies. Additionally, the Health Care Coalition manual, *The Health Care Response to Domestic Violence: An Advocacy-based Manual for Hospitals, Facilities, and Providers*, offers information, tools, and resources for the health care provider. The Health Care Coalition and the MNADV also provide information through training and technical assistance to health care professionals throughout the state.

POSITIVE RESULTS FROM THE 2009 DVFRT STATEWIDE REPORT RECOMMENDATIONS

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

The Health Care Coalition manual, *The Health Care Response to Domestic Violence: An Advocacy-based Manual for Hospitals, Facilities, and Providers*, provided information and tools for the establishment of two new hospital-based domestic violence programs at Prince George's Hospital Center and Meritus Medical Center in Hagerstown.



The MNADV modified its LAP health care training, created a standardized protocol for hospital implementation of the LAP, and developed a readiness checklist and hospital expectations for hospitals interested in implementing the LAP. Eight hospitals in Maryland will be implementing the LAP by 2013.

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 a link 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.

Unfortunately, no additional funding has been made available to establish or expand these services. This continues to be an unmet need.

POSITIVE RESULTS FROM THE 2009 DVFRT STATEWIDE REPORT RECOMMENDATIONS

- 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.

This recommendation has not been addressed.

- 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.**

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 including, but not limited to: rendering or obtaining medical attention, affecting arrest or obtaining a warrant.”

In Baltimore County and Calvert County, Strangulation Response Teams are trained to recognize strangulation indicators and to promote medical identification, treatment, and documentation. This can assist in the investigation and prosecution of offenders for strangulation, which is a significant predictor of high danger and lethality.

The MNADV’s multiple regional trainings in 2011 on the identification of predominant aggressors also included information about the handling of victim injuries.

POSITIVE RESULTS FROM THE 2009 DVFRT STATEWIDE REPORT RECOMMENDATIONS

- 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.**

Specialized domestic violence units are currently established in nine jurisdictions: Anne Arundel, Baltimore, Carroll, Charles, Harford, Howard, Montgomery, and Prince George's Counties, and Baltimore City. Calvert, St. Mary's and Washington Counties have dedicated domestic violence officers. The St. Mary's County DVFRT developed a collaborative domestic violence unit, which includes the State's Attorney's Office and the Sheriff's Office. The unit incorporates the Domestic Violence Coordinator from the St. Mary's Sheriff's Office, the Assistant State's Attorney who handles domestic violence cases, and victim advocates.



- 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.**

Prosecutors in at least three counties are now using the LAP 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.**

Effective communication among agencies continues to be a challenge and deserves on-going attention. However, a Multi-Agency Lead Case Review Team created in St. Mary's County provides a model for other jurisdictions to follow. The Team meets monthly and consists of law enforcement, prosecutors, advocates, counselors, and social service case workers. High lethality cases are reviewed and discussed to ensure victims are receiving assistance from all available resources.

POSITIVE RESULTS FROM THE 2009 DVFRT STATEWIDE REPORT RECOMMENDATIONS

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

No system has been established yet to track these cases.

14. Continue trainings on the Lethality Assessment Program.

LAP trainings, technical assistance, monitoring and data collection continues. 100% of all Maryland law enforcement agencies are now participating in the implementation of the LAP. A re-training packet is sent annually to law enforcement agencies, including: 1) a 50-minute in-service training; and 2) a 3-minute roll call training. As previously noted, the LAP is being implemented in several Maryland hospitals, and training has been provided to faith-based groups and other human service agency staff. Additional best-practices have also been developed, including specialized hotline guidelines, law enforcement and advocate follow-ups with victims, screening of victims at temporary protective order hearings, strangulation assessment, and multi-disciplinary offender management.

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

This issue is being addressed at the national level and has received media attention.

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.

All of the twenty comprehensive domestic violence programs are now doing follow-ups with high-risk victims identified through the LAP. Some follow-ups are done by a law enforcement/advocate team that visits high danger victims and other follow-ups are provided by telephone or only by advocates.

POSITIVE RESULTS FROM THE 2009 DVFRT STATEWIDE REPORT RECOMMENDATIONS

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

The MNADV has encouraged domestic violence programs to conduct LAP screening during victim-initiated calls. Several programs are already doing this and the data is captured in the statewide LAP report. Many programs also utilize Dr. Jacquelyn Campbell's longer Danger Assessment and scoring tool when working with victims who go into services. The MNADV is currently planning a Danger Assessment training in 2013 to enhance the skills of service providers using this tool. The MNADV's emphasis on trauma-informed advocacy and the exploration of improved program standards should also enhance program providers' effectiveness in responding to high danger victims.

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.

As a result of MNADV and local domestic violence program training, the LAP is currently being implemented by two county departments of social services in Carroll and Harford counties, eight hospitals, the Carroll County Head Start program, and the Carroll County Health Department. The process of expanding the LAP to additional agencies is on-going and will continue.

Legislation

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

This legislation was introduced in the Maryland General Assembly in both 2011 and 2012 but failed to receive a favorable report in the House Judiciary Committee. The bills were supported by the Maryland State's Attorney's Association and supportive testimony was provided by prosecutors, health care professionals, domestic violence and legal advocates, and survivors.