THE BALTIMORE CITY DOMESTIC VIOLENCE FATALITY REVIEW TEAM (BCDVFRT)

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2016 RECOMMENDATIONS

The mission of the Baltimore City Domestic Violence Fatality Review Team (BCDVFRT or Team) is to reduce domestic violence-related fatalities and near fatalities through systemic multi-disciplinary review of domestic violence fatalities and near fatalities in Baltimore City; through interdisciplinary training and community based prevention education; and through data-driven recommendations for legislation and public policy.

In the past year, the BCDVFRT continued to review domestic violence-related homicides and near homicides as part of our ongoing mission to identify systemic flaws. Many of the issues which surfaced in these cases were identified in previous years, but have yet to be fully addressed. As a consequence, the BCDVFRT plans to continue working through workgroups dedicated to refining its recommendations to address specific ongoing system problems. In addition, the BCDVFRT identified three new issues, and agreed upon the following recommendations. Throughout this report, domestic violence and intimate partner violence (IPV) are used inter-changeably.

NEW RECOMMENDATIONS

VICTIM NOTIFICATION BY COURT COMMISSIONERS

Problem: This year the Team reviewed a case where the defendant was arrested, appeared before a district court commissioner for an initial appearance, and was released on his own recognizance. The defendant left the commissioner's office, returned to the victim and killed her. As we examined the court commissioners' protocol, we found that there is no mechanism for the commissioners to notify the victim of the outcome of the initial appearance hearing.

Recommendation: Create a mechanism for the victim to receive notice of the outcome of the initial appearance hearing. The victim should receive notification of whether the defendant is held or released and, most importantly, what, if any, special conditions of release exist, including any stay away order.

Notification should be available to the victim whether the defendant is held or released. This will allow the victim to take protective measures such as leaving the home, asking someone to stay with them, going to a shelter, etc.

TRAUMATIC BRAIN INJURY

Problem: This year, the Team reviewed a case where the abuser punched the victim in the head. The Team recognized a growing body of evidence related to traumatic brain injury (TBI) and IPV victimization. TBI is defined as an injury to the brain which is caused by an external physical force. Physical abuse, particularly incidences of strangulation and assaults to the head or neck with objects or against other surfaces, can result in mild, moderate or severe injuries and temporary or permanent impairment of cognitive, physical, and psychosocial functions. [1] Victims of repeated physical abuse by an intimate partner are therefore at particular risk of sustaining traumatic brain injuries. [2] A 2003 study revealed that 30% of domestic violence survivors reported experiencing a loss of consciousness at least once, 67% of whom reported long term difficulties in functioning that were potentially related to a brain injury. [3] Individuals with TBI frequently experience impaired cognitive functioning. The impact of brain injuries and subsequent impaired cognitive functioning on victims of domestic violence can present unique challenges to achieving lives free of abuse, including a reduced capacity to remember and communicate critical information to law enforcement officials, attorneys and judges about abuse and to make informed decisions related to safety, health and parenting matters. [4]

Recommendation: Encourage the Baltimore Police Department (BPD) and domestic violence service providers to train police officers and staff in recognizing indicators of TBI and understanding the unique challenges of serving victims of IPV who may have experienced TBI. Police officers who act as first responders can encourage and assist victims in accessing critical medical treatment for a variety of injuries, including those related to the brain. Mercy Medical Center currently provides training to Police Academy Officers on IPV related injuries and can enhance its curriculum to include content on TBI.

SPECIALIZED TRAINING FOR POLICE AND DOMESTIC VIOLENCE SERVICE PROVIDERS ABOUT THE BEST WAY TO DEAL WITH DOMESTIC VIOLENCE VICTIMS WHO ARE USING DRUGS OR ALCOHOL

Problem: As identified in prior recommendations, substance abuse is pervasive in Baltimore City and many domestic violence victims self-medicate with drugs and/or alcohol as a way of coping with their abuse. The Team reviewed a case this year where the victim was a substance abuser and that issue presented challenges for the BPD and service providers.

Recommendation: Create a specialized training for both BPD and domestic violence service providers to address the unique challenges they face when dealing with a victim with substance abuse issues. Convene a work group with representatives from BPD Education and Training, substance abuse experts, the DVFRT, and professors/presenters, to create and review the curriculum. During the review process, make sure the training is relevant, contains scenario-based exercises, is taught by qualified personnel (submit to Maryland Police and Correctional Training Commissions for an approval number), and make sure all information concerning

training is regularly recorded and securely maintained. Use an evaluation method at the conclusion of each training session.

UPDATES ON PAST RECOMMENDATIONS

PROGRESS TOWARD IMPLEMENTATION OF PAST RECOMMENDATIONS

2007 – 1

BETTER EVIDENCE FOR PROSECUTION

The first issue identified in 2007 was that the Baltimore City State's Attorney's Office Felony Family Violence Division (FFVD) was hampered in its efforts to successfully prosecute felony domestic violence cases because police collected little admissible evidence. (In 2012, the Baltimore City State's Attorney's Office (SAO) merged the FFVD with the Sex Offense Division into what is now the Special Victims' Unit (SVU).) The BCDVFRT recommended the creation of a centralized, specialized unit of domestic violence detectives within the BPD. Begun in 2008, the Family Crimes Unit (FCU) is comprised of detectives who receive specialized training in felony level investigations, as well as issues unique to family violence cases.

Update

1. **Photographic Evidence**

BPD collects two types of photographic evidence. In some cases, patrol officers who respond to the crime scene take photographs with cellular phones (either their departmentally issued "Pocket Cops" or their personal cell phones). Officers are directed to email these photographs to an email address within the police department (DV@baltimorepolice.org or dvphotos@baltimorepolice.org), which then forwards the emails and photographs to the State's Attorney's Office. During the past year, SVU and BPD continued to use this system, which works well as long as the correct identification number is on the photographs. Every email and two copies of the attached photographs are printed, which helps streamline the SAO's responsibilities to provide discovery. Additionally the SAO routinely searches these emails and shares them with House of Ruth and the Women's Law Center, upon request, in order to strengthen Protective Order cases, which often are pursued simultaneously to criminal charges.

In other cases, Crime Lab Technicians takes photographs of crime scenes and victims' injuries. These are readily available to prosecutors in a timely manner. BPD officers who respond to a call determine whether to take photographs themselves or whether to call the Crime Lab. Alternatively, if a FCU detective or detective from another BPD division assumes responsibility for the case, that individual may determine the process to collect evidence and photographs.

2. **Recorded Statements at the Crime Scene-Felony Domestic Violence Investigations by FCU**

SVU prosecutors continue to encourage recording statements of victims and witnesses as early as possible. These statements are generated when a FCU detective is involved in the initial or follow-up investigation of a case. These recordings exist for both District and Circuit court cases.

This year, the BPD has also begun using body worn cameras. The officers who respond to crime scenes while wearing this equipment often capture the initial report from victims, as well as their physical appearance and demeanor. This evidence is invaluable in court, both at trial and in putting the SAO in a better positon during charging and plea bargaining of cases. The SAO has a team dedicated solely to identifying and matching body worn camera footage to individual criminal cases. As time passes and this evidence is tested in pretrial hearings and in trial, the SAO will have a better sense of how frequently it plays into the prosecution of domestic violence cases.

3. **911 Calls**

SVU prosecutors receive 911 recordings from BPD in electronic form. However, in order to match the calls to the case the identification number must be on the recording or the Assistant State's Attorney (ASA) must listen to the tape to try to identify it. In an effort to solve this problem, the screening ASAs in SVU have changed how they maintain their case intake databases to include the BPD-assigned central complaint (CC) number. SVU anticipates that adding this information should significantly increase the ability to identify recordings produced by BPD and match them back to the proper case files.

4. **Jail Calls**

Department of Public Safety and Correctional Services has changed the vendor that tracks inmates' calls from jail, which utilizes different technology than the previous vendor. As a result, SVU prosecutors are now able to easily search for a defendant's calls from jail, despite a defendant using another inmate's identification number. Detectives and SAO law clerks are able to utilize jail calls to identify witnesses who have knowledge about the contents of the calls if that content generates new charges. SVU is continuing to explore options to use jail calls to prove existing cases and to curtail witness tampering and intimidation.

5. **Medical Records**

The SAO has worked with local hospitals and encouraged them to make victims' medical records available within a shorter time frame, either by sending them to the office directly or by uploading the records to a secure online server. Johns Hopkins Hospital has already implemented the uploading process.

The SAO's ability to request medical records in a timely fashion affects how quickly the hospitals can provide them. The SVU has worked to improve its access to the original police incident report, by referencing the domestic violence supplemental reports which are emailed

on a daily basis as part of the lethality project with House of Ruth. This has greatly reduced the turnaround time for the SAO to make its initial records requests to hospitals.

6. **Working with Victim-Witnesses**

The SAO recently assigned a victim witness advocate to the Circuit Court SVU who follows through with victims and witnesses for the duration of a case. In addition, the SAO uses social work interns to maintain regular contact with domestic violence victims and offer them collateral services such as safety planning and trial accompaniment. In the District Court SAO office, a social worker was added to the team and social work interns provide follow-up and victim contact during the academic year. The social worker assigned to the District Court is also piloting a new approach: to have the interns do more "vertical follow-up" with victims whose cases continue past one court date or whose cases transfer to the Circuit Court as a result of jury trial prayers. The SAO continues to expand victim witness services to better support crime victims and assist ASAs in developing the best cases possible.

2007 – 2

FAMILY JUSTICE CENTER

A 2007 recommendation was for the creation of a Family Justice Center (FJC) in Baltimore City. At that time a BCDVFRT workgroup met to develop a blueprint for a FJC and to seek funding for this enterprise. The group was not able to obtain funding.

Update: As reported last year, the Governor's Family Violence Council (FVC) created a Best Practices for Family Justice Centers workgroup. In April 2016, the workgroup held a focus group to obtain input from the victim community and determine how systems within a Family Justice Center would be used and where the best places to put family justice centers would be. Because of the small number of focus group participants, members of the workgroup suggested conducting a second focus group. In addition, members of the workgroup toured the Center for Survivor Agency and Justice facility in Scranton, PA, which is similar to a FJC but focuses on economic empowerment for victims. During the coming year, the workgroup hopes to conduct a needs assessment to determine which victims' needs are the most important and what resources are needed throughout the state.

2007 – 3

ACCESS TO SERVICES

Another problem identified in the 2007 report concerned the large number of victims of fatal domestic violence who never accessed potentially life-saving services. In an effort to decrease domestic violence-related homicides by increasing access to services, the BCDVFRT recommended that police administer the lethality assessment screen to victims of domestic violence. In 2009, the BPD, in conjunction with the House of Ruth Maryland (HRM), began a lethality assessment project (LAP). The protocol required that when the police respond to a domestic violence call where they believe a crime had been committed, the officer would administer the lethality assessment screen with the victim. The screen and a copy of the police report are delivered to HRM within 24 hours. HRM staff attempt to contact the victim within 24 hours and offer that person services

Update: Currently, LAP operates in all nine police districts. The program has been very successful. From November 2009 through July 2016, HRM has received 23,542 lethality assessment screens and reached 10,885 people (46%), enrolling 3,312 (35%) of them in HRM services. During the year from August 1, 2015 through July 31, 2016, HRM received 4,623 assessment screens.

2007 – 4

TIMELY SERVICE OF WARRANTS

The last problem identified in the 2007 report was the tremendous backlog of unserved warrants. In 2008, the BPD created a specialized warrant squad dedicated to serving domestic violence arrest warrants.

Update: The Warrant Apprehension Task Force maintains a Domestic Violence Squad. The squad focuses on felony and priority warrants based on the perpetrator's propensity for violence. The squad also focuses its efforts on apprehending individuals deemed an extreme danger to victims and others. The squad treats calls from FCU requesting immediate apprehension of suspects as a high priority. As a result of these efforts, felony warrant apprehension has increased; however overall warrant service has decreased from September 1, 2015 to August 31, 2016. There were a total of 2083 new domestic violence warrants issued for service, and the Domestic Violence Warrant Squad and patrol officers served 1491 warrants.

2008 – 1

RECOGNIZE AND RESPOND TO THE DANGERS OF STRANGULATION

In 2008, we noted that many professionals who work with victims of domestic violence were unaware of the seriousness of strangulation. Strangulation, often incorrectly called "choking," is a significant risk factor for a subsequent fatality and is a weighted item in the lethality assessment. By itself, strangulation can cause serious injury or death, even in the absence of visible, external injuries.

Update: The BCDVFRT continues to support its 2008 recommendation for domestic violence advocates to secure legislation which would classify strangulation as either a first-degree assault or a separate felony. In 2016, the Maryland State's Attorneys Association and the domestic violence advocates again decided not to ask a member of the General Assembly to introduce a bill regarding strangulation because they did not believe it would have any different outcome than the bills introduced during the last several sessions.

2008 – 2

FACILITATE PROVISION OF MEDICAL CARE TO DOMESTIC VIOLENCE VICTIMS WHO SUSTAIN INJURY

In our 2008 recommendations, we noted that victims often do not seek medical treatment for injuries sustained in domestic violence incidents. When police are first responders, they may not recognize the gravity of the injury and that the victim requires medical treatment, and may not actively encourage or facilitate transfer for medical care.

Update: Mercy Medical Center continues it training initiative with the BPD Training Academy which now includes pertinent information to share with victims on financial support from the Maryland Criminal Injuries Compensation Board.

2008– 3

IMPROVE SCREENING FOR DOMESTIC VIOLENCE IN HEALTH CARE SETTINGS

In 2008, the BCDVFRT noted that, despite a mandate that all hospitals have protocols to assess for domestic violence, the Team found hospital medical charts that had no documentation of domestic violence screening. We recommended that medical facilities aggregate their resources for the evaluation and counseling of domestic violence cases and that they offer training for medical providers on violence assessment.

Update: DHMH Maternal and Child Health Bureau maintains an Intimate Partner Violence (IPV) website which includes a health care provider toolkit to assist providers in the assessment and referral of patients experiencing IPV. The website also provides listings of IPV programs in Maryland by jurisdiction, as well as local and national hotlines. The web site is accessible at http://phpa.dhmh.maryland.gov/mch/Pages/IPV.aspx

2008 – 6

CHANGE ATTITUDES ABOUT DOMESTIC VIOLENCE

In our reviews, we have heard that victims do not view themselves as victims because they do not understand the dynamics of a healthy relationship. In 2008, the BCDVFRT recommended creating a collaborative relationship with school systems and public health, social services and domestic violence experts to utilize an already-existing Maryland curriculum to ensure that school personnel are educated and trained to teach about the dynamics of dating and intimate partner abuse and healthy relationships.

Update: In 2011, the Criminal Justice Coordinating Council supported the Baltimore City Health Department's Office of Youth Violence Prevention's award of a five year grant to implement the Dating Matters Initiative. The goal is to develop, implement, and evaluate a comprehensive curriculum in Baltimore City Public Schools to promote respectful, nonviolent dating relationships and decrease emotional, physical, and sexual dating violence.

Dating Matters has been implemented in eleven Baltimore City Public Schools (BCPS). Seven schools implemented the evidence-based program, Safe Dates, with 8th grade students only. Four schools implemented evidence-based and CDC-developed curricula with students in the 6th -8th grades. During the 2015-2016 academic school year, 682 students were reached through curricula implementation, and 47 parents were served. Successes of the program include increasing the number of educators trained through Vetoviolence (online violence education tools); training additional implementers to deliver student curricula; strengthening school partnerships; making progress on policy enhancement; and completing 100% student/parent implementation. Forty-eight Youth Ambassadors were trained and over 570 tool kits were distributed at Youth Ambassador events. Twelve community events were held; and approximately 61 students attended each event.

The Baltimore City Health Department reviewed and provided recommendations on the development of the Wellness, Nutrition and Physical Activity Policy including the administrative regulation, implementation and monitoring of the support services. In 2015, Baltimore City Public Schools included relationship abuse as a code violation in its Code of Conduct. All schools will provide skill-based education to promote healthy relationships and implement evidence-based violence prevention strategies through a continuum of services, beginning with comprehensive health education and through the provision of student support services. Student support services will be provided through a collaborative effort between BCPS, BCHD and other community behavioral health agencies/organizations.

The Baltimore City Health Department was recently awarded a grant to implement the Dating Matters curriculum in high schools over the next five years.

2009 – 1

CREATE AN ENHANCED RESPONSE PROTOCOL FOR IDENTIFYING AND RESPONDING TO VICTIMS IN HIGHLY LETHAL RELATIONSHIPS

Our 2009 recommendations stated that one of the most important services advocates provide to victims of domestic violence is safety planning. This is the time the advocate discusses with the victim the precautions she can take to attempt to protect herself from further abuse. It is a time to assess her level of danger and identify safety options. If the victim is prepared when violence occurs, she is more likely to respond quickly and avoid additional injury. However, in some cases, traditional safety planning techniques were insufficient to protect certain victims who were in extremely lethal relationships. We recommended the creation of an enhanced response protocol involving a high danger safety plan that incorporates safety precautions appropriate for victims who are at the highest risk of being murdered.

Update: As we reported last year, in 2014, the Maryland Network Against Domestic Violence (MNADV) convened a team of domestic violence advocates to develop an enhanced response protocol for high danger cases and statewide protocols for high risk safety planning and following up with high risk victims. The team created a High-Danger Safety Planning Protocol, Resource Manual, and PowerPoint. While this protocol provides important safety planning training and resources for domestic violence advocates, it does not establish a

different safety planning protocol to specifically address people in extremely lethal relationships. One of the proposals the BCDVFRT strongly urged was that Maryland shelters create a protocol for "swapping" clients who are at the greatest risk. For example, a Baltimore City resident might be much safer in a shelter in Carroll County. This would require development of a protocol or memorandum of understanding among various domestic violence shelters in Maryland.

2009 – 3

CREATE A SYSTEMATIC TRACKING MECHANISM FOR DOMESTIC VIOLENCE VIOLATIONS OF PROBATION WITHIN THE DIVISION OF PAROLE AND PROBATION

In both the 2007 and 2008 reports, we expressed concern about the results of violation of probation (VOP) hearings in domestic violence cases. The Team had repeatedly reviewed cases in which domestic violence offenders were placed on probation, violated the terms of their probation, and received no consequence for the violation other than continued probation. In one case, the special condition which the defendant refused to satisfy was simply eliminated by the judge. Each of these probations was terminated only after the probationer murdered his victim.

Believing that this sent the wrong message to offenders and left victims vulnerable to further violence, we recommended establishing a system for tracking domestic violence VOP cases. A workgroup was established to create a systematic tracking mechanism for domestic violence probation cases.

In 2009, we recommended that the Division of Parole and Probation's new Offender Case Management System (OCMS) include a section which collects and stores data regarding the results of VOP hearings. The Secretary of the Department of Public Safety and Correctional Services and the head of the Division of Parole and Probation agreed to assist in the implementation of this recommendation.

Update: DPSCS agreed to revise OCMS to begin to capture many of the specific data points that the group requested. The business requirements have been completed and approved. The project is on hold waiting for funding approval.

No new update for this year.

2010 – 1

CREATE RESOURCES FOR MEN WHO SEEK TO PREVENT VIOLENCE IN INTIMATE RELATIONSHIPS

In 2010, the BCDVFRT identified that there were few resources available for men who might not follow through on an act of domestic violence if they received appropriate intervention or for men who wanted to persuade an abusive friend or family member to stop battering. Men who seek this type of support have no place to turn for advice or assistance. Although domestic violence is often viewed as a "women's issue," we interviewed several men in the course of our case review process who suggested that services need to be developed for men who are interested in taking an active role in addressing domestic violence or who are experiencing their own relationship stress. As a result, we recommended developing resources to assist men who want to avoid domestic violence in their own relationships, or who want to address it appropriately when the relationships of friends or family members become violent.

Update: House of Ruth Maryland (HRM) launched the "Man Up" initiative in the fall of 2014. The "Man Up" initiative continues to meet monthly and works to engage men in an effort to end intimate partner violence. This year the group focused on completing its listening session project to hear from men about barriers to and ideas for addressing domestic violence in the community. Preliminary findings from these sessions show that men are aware that domestic violence is an issue in their community that needs to be addressed, but they are unclear about what steps they can take to help victims while not jeopardizing their own safety. The most consistent suggestion shared in the sessions is that any attempt to engage men should include offers of free food. The final qualitative data is being reviewed this fall and will be used to inform the group's strategy for material development, information sharing and community engagement.

2010 – 2

SEEK PARTNERSHIPS WITH CLERGY

Another 2010 recommendation was that the BCDVFRT create a subcommittee to explore developing partnerships with the faith-based community since many domestic violence victims and perpetrators reach out to clergy for advice and support. However, many clergy members are not trained on the dynamics of domestic violence or the need for safety planning. In one case the team reviewed, a pastor encouraged a victim to stay in an abusive marriage, resulting in fatal consequences.

Update: This year marks the 4th Annual Interfaith Dialogue and Training Session on November 9, 2016, in Annapolis, Maryland. Major Sabrina Tapp-Harper, vice-chair of the BCDVFRT, became a member of the Interfaith DV Coalition Committee this past year and has been attending the monthly meetings along with CJCC Executive Director Kimberly Barranco. The Chairperson of this committee, Judge Karen Friedman, and the committee members continue to discuss ways to address clergy of all faiths within the community through training and support as it relates to their role in dealing with abusers and those abused in domestic violence matters.

2010 – 3

IMPROVE DOMESTIC VIOLENCE SERVICE PROVIDERS' OUTREACH TO VICTIMS BY DEVELOPING EFFECTIVE, MODERN COMMUNICATION STRATEGIES

In 2010, the BCDVFRT recommended that agencies that offer support and services to victims of domestic violence should begin to advertise with alternative social media sources such as cable TV, Facebook, You Tube, and other internet sites. Interviews with victims and family members revealed that many victims either do not or cannot read the variety of flyers, brochures and print media that most domestic violence agencies utilize. These victims were far more likely to be engaged with electronic media.

The Team also recommended that hospitals and health clinics provide information on closed circuit televisions in waiting rooms. We also recommended that information regarding domestic violence and available services must be visible where victims, witnesses and perpetrators are likely to go, e.g. hair and nail salons, barbershops, and neighborhood shops.

Update: Johns Hopkins University researchers (Dr. Glass and colleagues) developed MyPlan, a safety decision aid smartphone application and website for women experiencing abuse and their concerned friends and family. The application allows the user to answer questions on the Danger Assessment (DA) for themselves or a friend/family member and then provides immediate feedback through a graphic with the user's or loved one's DA score and level of danger in the relationship with personalized messages about safety. The DA score and risk factors are then combined with the safety priorities of users to develop a tailored safety action plan with links to resources. MyPlan will be released in English and Spanish in Fall 2016.

2012 – 1

IMPROVE SYSTEM RESPONSE TO CHILDREN WHO WITNESS FATAL ABUSE OF A PARENT

Since the BCDVFRT began meeting, it has reviewed cases with children who witnessed one or both of their parents being killed or almost killed as a result of domestic violence. The impact of witnessing this crime is immense and the child's life is changed forever. Traumatized and bereaved, these children must struggle to find a new life. Over the course of our reviews, we have seen children who witness this event and ultimately are incarcerated for later committing serious crimes themselves or who are lost to systems of care or help. In 2012, we recommended working in conjunction with the school system to 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.

Update: Beginning in FY 13, the Governor's Family Violence Council (FVC) has had a workgroup focused on the issue of domestic violence in the presence of a child. The workgroup divided into two subcommittees, the Criminal Justice Subcommittee and the Schools Subcommittee. This year, the workgroup's brochure "Fighting in the Home: Is Your Child Being Affected?" was finalized. Once funds have been secured for printing and

dissemination costs, brochures will be distributed to victim service agencies. The Governor's Office of Crime Control and Prevention (GOCCP) will also work with the Maryland State Department of Education in an effort to have the brochures disseminated in schools and libraries in Maryland.

The Criminal Justice Workgroup scheduled a meeting with law enforcement officers in various jurisdictions throughout Maryland in an effort to continue a protocol to reduce inadvertently causing additional trauma to children exposed to domestic violence during police intervention. The University of Maryland School of Social Work agreed to videotape different scenarios about how police should interact with children when they arrive at the crime scene and children are present. House of Ruth has a partnership with Towson University to do filming. The House of Ruth and the School of Social Work will work together on this.

2012 - 2

INCREASE SCREENING AND INTERVENTION FOR DOMESTIC VIOLENCE BEFORE, DURING AND AFTER PREGNANCY

Homicide is the leading cause of pregnancy-associated death in Maryland; the majority of these deaths are perpetrated by a current or former intimate partner.[5] Throughout this report, we have identified cases where medical staff did not complete a domestic violence screen during a victim's prenatal visits or during her hospital stay for her delivery. In 2012, we recommended increased screening and intervention for domestic violence before, during and after pregnancy.

Update: Approximately 8,800 women deliver babies in Baltimore City each year, about 55% of which are supported by Medicaid and receive care coordination services from HealthCare Access Maryland (HCAM). HCAM screens all successfully outreached pregnant women for IPV and refers women screening positive to House of Ruth and Turn Around. Pregnant women who screen positive also automatically qualify for home visiting. Home visiting programs, which now serve approximately 1,700 pregnant women and families of children up to age 2 in Baltimore City, screen for IPV at intake, 36 weeks pregnant, and 12 months postpartum. Starting October 1, 2016, home visiting programs federally funded by the Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiative will be required to use a validated screener. The Maryland Department of Health and Mental Hygiene has selected the Relationship Assessment Tool for use by all Maryland programs and is hosting training on IPV and the tool in September 2016.

2012 - 4

"FLAG" MEDICAL CHARTS TO ALERT HEALTH CARE PROVIDERS OF PATIENTS WHO HAVE BEEN DOMESTIC VIOLENCE IDENTIFIED

Another 2012 recommendation was that health care facilities should institute a confidential, internal system of "flagging" the charts of patients who have been identified as victims of domestic violence so that they may receive more intensive screening, appropriate intervention,

confidential treatment, documentation and links to needed services at the hospital and to allow for intervention and services as needed on any subsequent visits.

Update: As costs to institute system-wide changes to electronic medical records systems continue to be a challenge, flagging continues to occur on a case by case basis at hospitals including Mercy Medical Center. The Team acknowledges that revisions to the medical chart are linked to each organization's electronic medical record and may be complicated and cost-prohibitive. At the appropriate time for health care facilities to make changes to the electronic medical record, we urge them to include this change.

2012 – 5

HOSPITAL-BASED INTERVENTION AND SAFE DISCHARGE – RESPOND TO THE NEEDS OF DOMESTIC VIOLENCE VICTIMS WHO HAVE SUBSTANCE ABUSE ISSUES

In cases where a patient is intoxicated or otherwise temporarily impaired, medical facilities should hold the patient until staff can complete domestic violence screening and offer appropriate intervention. Substance abuse is pervasive in Baltimore City and many domestic violence victims self-medicate as a way to cope with their abuse. In 2012 we recommended that Emergency Departments complete domestic violence screening even if it means holding the patient until s/he is no longer impaired and the provider is able to conduct the screening. When a patient is medically ready for discharge from a hospital, health care providers should consider the clinical, functional, and social aspects of the situation to which the patient will be released. Hospitals regularly create a discharge plan for patients that assesses for adequate medical provisions, accessibility, necessary utilities, family or community support, potential suicide risks, as well as for potential abuse in juvenile patients. In many cases the facility must delay discharge until staff can identify an adequate environment for release. Similarly, hospitals should delay discharge of domestic violence victims until they are able to develop an adequate discharge plan.

Update: The Maryland Health Care Coalition Against Domestic Violence hosted the Maryland Network Against Domestic Violence's day-long symposium, *The Co-Occurrence of Substance Use, Domestic Violence, and Trauma in Health Care Settings*, on May 20, 2016. The keynote speaker, Jessica M. Peirce, Ph.D., Associate Professor in the Johns Hopkins University Department of Psychiatry and Behavioral Sciences, addressed the particular challenges that the health care community faces in responding to domestic violence victims who may be using drugs or alcohol. There were fifty-five attendees drawn from various health care and domestic violence service provider facilities. As follow-up to the Maryland Network's efforts, three Baltimore-area hospitals that have dedicated domestic violence response programs received staff training specific to domestic violence and substance use. Advocates in these programs are better prepared to do in-depth screening and facilitate safe discharge.

The Maryland Health Care Coalition Against Domestic Violence will continue to address ways to educate and encourage health care providers in improving safety for victims who use

substances. For instance, guidance on proper domestic violence screening, which includes guaranteeing that the victim is sober enough to comprehend the questions, is an essential part of all Coalition outreach. As well, the Coalition reinforces that hospitals have an obligation to ensure safe discharge, which may include postponing domestic violence screening until appropriate to determine if safety is established. The Coalition will examine whether there are other best practices to suggest for policy guidelines.

Finally, given the added complexity of working with IPV victims who also abuse drugs and/or alcohol, multi-disciplinary partnerships can be highly beneficial and effective. At Mercy Medical Center, all patients served in the Emergency Department are screened for substance abuse. The hospital's Family Violence Response Program (MFVRP) staff often work alongside in-house substance abuse counselors known as Peer Recovery Coaches. The SBIRT program (Screening, Brief Intervention, Referral to Treatment), a statewide health care initiative launched in 2013, encourages health care professionals and patients to address alcohol and drug abuse during medical visits. SBIRT Peer Recovery Coaches conduct in-house follow up visits with patients who screen positive for substance abuse and with patient consent, will facilitate linkage to community based treatment programs. The SBIRT program (www.marylandsbirt.org/about/) currently operates in three Baltimore City hospitals (Harbor Hospital, Bon Secours Hospital and Mercy Medical Center. Mercy's Family Violence Response and SBIRT programs often work together when patients present with co-occurring issues of IPV and substance abuse to ensure all patient needs are met, including a safe discharge.

2012 - 6

THE DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES SHOULD SCREEN INMATES FOR A HISTORY OF DOMESTIC VIOLENCE AND OFFER ABUSER INTERVENTION PROGRAMS

Throughout the cases the Team has reviewed, we have interviewed inmates who have been convicted of domestic crimes and those who were themselves victims of family violence. In addition, we are aware that some inmates who were convicted of non-domestic violence crimes were also involved in abusive relationships. In 2012, the Team recommended that the Department of Public Safety and Correctional Services (DPSCS) should screen and assess inmates for a history of domestic violence. This 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.

Update: The Department of Public Safety and Correctional Services screens inmates for a history of domestic violence and offers abuser intervention programming. Upon entering into the institution an inmate's case manager, assigned as a part of the offender assessment, determines whether an inmate has a pattern of domestic violence offenses by reviewing the inmate's record or self-report. If it is determined by verified sources such as criminal history documents and inmate self-report that an offender has a pattern of domestic violence behavior, the case management specialist places a domestic violence code on the inmate's record in

OCMS. The social work staff pulls records with domestic violence alerts, completes assessments, and recruits inmates for domestic violence programming if needed.

2013 - 1

REQUIRE HEALTH CARE PROVIDERS TO SCREEN FOR DOMESTIC VIOLENCE BY MAKING IPV QUESTIONS REQUIRED FIELDS IN ELECTRONIC CHARTS AND REQUIRING THAT THE ELECTRONIC RECORD AUTOMATICALLY REPOPULATE POSITIVE IPV SCREENS ON SUBSEQUENT VISITS

Throughout the work of the Team, we have reviewed cases where the hospital medical charts had no documentation of domestic violence screening. Screening and assessment is the first step in the best practice response to IPV victims who are medical patients, followed by proper treatment, documentation, resource linkage and an advocate response. In 2013, we recommended that as health care facilities convert to electronic medical charts, they make the IPV screening questions "required fields," so that the health care provider cannot advance to the next section of the chart unless the screen is completed. In addition, once a medical professional records a positive response in a domestic violence screening field in the electronic medical chart, that field should automatically repopulate as a positive screen on subsequent visits.

Update: No new update for 2016

2013 - 2

EXPAND, ENHANCE, AND STANDARDIZE THE TRAINING PROVIDED TO ALL PERSONS WORKING IN CORRECTIONAL FACILITIES SO THAT THEY CAN BETTER RECOGNIZE AND IDENTIFY THE CHARACTERISICS OF DOMESTIC VIOLENCE ABUSERS

In 2013, the Team discovered during a case review that the training provided to employees of DPSCS's outside vendors varied from region to region. The Team recommended that an expanded, enhanced, and standardized domestic violence training be provided to all DPSCS employees and vendors' employees who have contact with inmates, offenders, or defendants.

Update: On August 3 and 4, 2016, the Maryland Department of Public Safety and Correctional Services and The Maryland Network Against Domestic Violence held an all-day mandatory domestic violence training for agents of domestic violence offenders and their supervisors. The objectives of the training were: review of intimate partner violence dynamics and challenges probation/parole agents may face; understanding how lethality factors indicate increased danger for victims; best practices with working with intimate partner violence offenders; domestic violence resources for effective treatment referrals; and implementation of trauma-informed practices for working with victims of intimate partner violence.

2014 - 1

SHIFT THE COMMUNITY'S AWARENESS AND UNDERSTANDING OF HOW INTERVENTION BY A BYSTANDER WHO WITNESSES OR SUSPECTS DOMESTIC VIOLENCE CAN MAKE A DIFFERENCE

In 2014, the Team recommended creating outreach efforts to inform the community how to intervene when they know or suspect domestic violence is occurring. This effort creates awareness about the issue and gives bystanders the tools and resources to intervene.

Update: House of Ruth Maryland's "Man Up" initiative is focused on developing an emergency palm card creating three steps anyone in the community can take if they witness an act of domestic violence. The group is also working on a training module that its members can offer to others in the community. The final data from the initiative's listening sessions will be reviewed this fall and used to inform material development.

2014 - 2

CREATE INTERVENTION STRATEGIES FOR POLICE RESPONDING TO ESCALATING DOMESTIC DISPUTE CASES

In 2014, the Team reviewed a case where the parties had an extensive history of domestic disputes. A domestic dispute is when the police respond to a domestic call but determine that no crime has been committed. In domestic dispute cases, the police do not provide all of the domestic violence interventions and services that they would provide to a domestic violence victim. The Team recommended that BPD should create a strategy for responding to repeat and escalating domestic dispute calls. This might include home visits, friendly knock-and-talks, or providing the victim with domestic violence information and referrals as a way to de-escalate the situation and prevent it from turning into a domestic violence crime or homicide.

Update: No update in 2016

2015-1

ENCOURAGE WORKPLACES TO TRAIN THEIR EMPLOYEES TO IDENTIFY AND RESPOND TO DOMESTIC VIOLENCE

In 2015, the Team recognized the critical role employers can play in identifying, protecting, and responding to employees who experience intimate partner violence. Research shows that 21% of American employees self-identified as a victim of domestic violence and it is estimated that 75% of victims face stalking and harassment from intimate partners while at work. [6]As a result, the Team recommended that employers should create a workplace culture that ensures employees are well informed about domestic violence.

Update: House of Ruth Maryland (HRM) partnered with Futures Without Violence, a national technical assistance provider, to develop a workshop for human resource

professionals, managers and other supervising staff to understand their legal responsibility to respond to domestic violence in the workplace, resources available, and ways to increase the likelihood that victims would disclose to employers and those employers would respond in a helpful way. That workshop has been offered across Maryland since 2013 to various audiences. In the past year, HRM partnered with Maryland's Department of Health & Mental Hygiene to provide the workshop to state employees in Baltimore, Washington and Talbot Counties. HRM, Turnaround and St. Ambrose House also partnered with University of Maryland St. Joseph Medical Center to participate in a pilot project with Futures Without Violence to address domestic violence, sexual assault and stalking in the workplace. St. Joseph Hospital was one of four demonstration sites where materials and trainings were customized for and delivered to agency staff at every level of the organization.

2015 - 2

CREATE A TRAINING MODULE/CURRICULUM/PROGRAM TO PROVIDE GUIDANCE/SUPPORT FOR YOUNG MEN AFTER A BREAK UP

In 2015, the Team acknowledged that many of the programs and interventions about dating violence focus on providing support, education, and services to young women, yet the Team reviewed cases which suggest that young men frequently commit acts of violence against a partner during or after a relationship break-up and there are few resources for young men. The Team acknowledged that ending a relationship is hard on both young men and women. We recommended that intervention programs also need to target young men who have been traumatized or have a personal history of exposure to violence and abuse, as these men might be more likely to abuse a current or former intimate partner. Often young men learn at an early age that acts of violence are accepted, tolerated behavior.

Update: No update in 2016

2015 - 3

ENCOURAGE THE BALTIMORE POLICE DEPARTMENT TO RECOGNIZE THE IMPACT OF TRAUMA ON POLICE AND PROVIDE MENTAL HEALTH SERVICES TO OFFICERS THAT ARE TRULY CONFIDENTIAL AND ENCOURAGE THEM TO REACH OUT TO NATIONAL POLICE ORGANIZATIONS FOR BEST PRACTICES

In 2015, the Team also recognized the impact of trauma, stress and fatigue on police and the barriers some officers experienced in obtaining mental health services. This secondary traumatic stress (or vicarious trauma) can lead to compassion fatigue and burnout. In addition, some officers face significant stigma when they recognize they are having their own symptoms of burnout or compassion fatigue or secondary traumatic stress. The Team encouraged BPD to train police officers and other first responders in trauma informed care, a service model which recognizes the impact of trauma on victims and those who work with victims and that integrates knowledge about trauma into policies, procedures and practices.

The Team also encouraged BPD to create options for staff to receive confidential mental health services, and reach out to national police organizations such as the National Organization of Black Law Enforcement (NOBLE) and the International Association of Chiefs of Police (IACP) for best practices.

Update: The Baltimore Police Department currently has a contract with Interdynamics Counseling to offer mental health services to its members. This agency provides confidential counseling and assessments for officers as needed. Officers may make contact with the agency at freewill and at no charge to them. Supervisors may also make contact with the medical unit within BPD for referrals if they see that an officer may benefit from services. BPD also uses Crisis Intervention Team, which consists of trained members of local and adjoining police departments. The team members are trained in providing immediate crisis counselling and support services to officers who experience trauma related to their duties. The team also recognizes the needs of officers and offers additional services as deemed necessary. During the 2015 In Service Training, all officers received a block of instruction on suicide prevention and recognizing the signs and symptoms of stress and depression.

2015 - 4

ENCOURAGE BALTIMORE CITY SCHOOL NURSES TO BE TRAINED IN IDENTIFYING AND DEALING WITH TRAUMA, DOMESTIC VIOLENCE, SEXUAL ASSAULT, SEXUALLY TRANSMITTED DISEASES AND BIRTH CONTROL WITH STUDENTS AS APPROPRIATE

Throughout the course of our reviews, the Team has seen that adolescents involved as perpetrators and victims often have repeated exposure to traumatic events in their homes and neighborhoods, including seeing adults in their home hit each other, being physically or sexually abused themselves, as well as witnessing shootings, stabbings, violent robberies or seeing dead bodies in their neighborhood. Cumulative exposure to traumatic life events can result in post-traumatic stress disorder, which may manifest in both overt and subtle ways such as poor scholastic performance, aggressive behavior, and hypervigilance to one's surroundings (anticipating attack even when there is none coming) and physical symptoms like stomach pains and trouble sleeping. For adolescents, school may be one of the most stable and safe places in their lives. In 2015, the Team recommended that school nurses be trained on recognizing and dealing with symptoms of exposure to stress, trauma and abuse.

Update: While staff at DHMH acknowledge the importance of this training, no progress has been made in 2016. In August 2016, all Baltimore City School Health staff, including all nurses and aides, received trauma-informed care training. In February 2016, all staff were trained on sexual assaults and intimate violence, referrals, mandatory reporting, and Mercy Medical Center's bmoresafe program. In addition, all staff have been trained in human trafficking, needs of incarcerated minors, and reproductive health issues, including administration of contraceptives including Nexplanon.

COMPLETED RECOMMENDATIONS

2008 – 4

IMPROVE FORENSIC MEDICAL DOCUMENTATION FOR DOMESTIC VIOLENCE INJURIES

Our 2008 recommendations identified a problem that medical documentation of injuries often does not adequately support later prosecution of domestic violence cases. The Mercy Sexual Assault Forensic Examiner's Program, with the aid of the Mercy Family Violence Response Program, developed an Intimate Partner Violence Forensic Evidence Standard Kit (IPV Kit), modeled on the state's accepted SAFE Kit, to thoroughly and expertly document domestic violence injuries and evidence.

Update: Completed and ongoing. Since we made this recommendation, there have been two *Frye-Reed* challenges (2010 and 2013) made in Baltimore courts about the validity and acceptability of forensic evidence obtained through the use of an Alternative Light Source (ALS). The ALS shows injury and bruising often invisible to the naked eye. In both cases, the ALS findings were admitted into evidence under the challenges to the *Frye-Reed* test as accepted in the scientific community. The ALS has become a significant tool in the IPV Kit documentation, particularly in strangulation cases in which there may be no visible bruising. Currently the Special Victim's Unit and other prosecutors use ALS evidence routinely in court without further legal challenges as the Circuit Court and defense counsel have come to accept such evidence. The ALS evidence is proving extremely helpful in cases where the injury happened many days and even weeks before and can document internal injury to the neck and other areas long after the outward bruising or marks have faded. Police now routinely take children who are suspected victims of child abuse and victims of sexual and domestic violence to hospitals that have ALS capabilities, thus improving a prosecutor's arsenal of evidence.

2008 – 5

ASSESS CHILDREN EXPOSED TO FATAL AND NEAR FATAL ABUSE OF A PARENT

Both our 2007 and 2008 recommendations reflected our growing concern with the extremely negative consequences children face as a result of living in violent homes. In our case reviews, we repeatedly observed that these children were known to the Department of Social Services (DSS), the Juvenile Court and ultimately the criminal justice system. The HRM, the BPD, the Baltimore City SAO, the Baltimore City DSS and hospital-based trauma specialists developed and implemented a model protocol to protect and support children affected by domestic violence involving fatality or near fatality of one or both parents.

Update: Completed in 2012 and ongoing.

2009 – 2

INCREASE AWARENESS OF HUMAN BITES AS A FORM OF DOMESTIC VIOLENCE

In 2009, the BCDVFRT discussed that although biting has been referenced in the literature as a form of domestic and sexual violence, there is little knowledge regarding the prevalence of this form of abuse, or its significance as a precursor to escalated or even lethal violence. Because biting is not usually included on lists of examples of domestic violence, victims may not recognize it as a form of domestic violence. We recommended specifically: (1) Include human bites on medical screens for domestic violence; (2) Educate medical providers regarding the evaluation and documentation of bite wounds; and (3) Revise the Petition for a Protective Order to include biting as an example of domestic violence. In 2010, the Maryland Department of Health and Mental Hygiene included biting as a type of abuse in their 2010 women's health screening cards. In 2011, biting was added to the revised Protective Order petition on the list of types of abuse.

Update: Completed in 2011

2010 – 4

INCLUDE SCREENING FOR DOMESTIC VIOLENCE IN HEALTH CLINIC SCREENS AND DURING TREATMENT FOR SEXUALLY TRANSMITTED DISEASES

A fourth problem identified in 2010 was that many victims of domestic violence do not access potentially life-saving services because they do not realize that their violent relationships are "abusive." In an effort to encourage screening for domestic violence in many kinds of settings that women use, we recommended that health clinics should include a screen for domestic violence whenever they screen and treat patients for sexually transmitted diseases (STDs). If health clinic personnel were to screen, record, and provide referrals, victims might be more likely to take advantage of domestic violence services.

Update: As reported last year, Maryland was one of six states funded by the Office of Women's Health for "Project Connect: A Coordinated Public Health Initiative to Prevent and Respond to Violence Against Women." This three-year grant, begun January 2013, is being used to integrate IPV assessment into the Title X Family Planning Program, a program that sees approximately 75,000 women per year.

In addition, the STD program at the Maryland Department of Health and Mental Hygiene (DHMH) made an official commitment to integrate IPV assessment at all of their sites using the Maryland IPV Task Force assessment tool. During 2014, staff at DHMH has made regular presentations about IPV assessment at the STD annual meetings and conducted two webinars for the STD clinical program. The Project Connect Leadership team also recently recruited members from the STD program at DHMH. Ongoing trainings will facilitate IPV assessment by STD clinic staff.

2010 – 5

ENACT LEGISLATION CREATING ENHANCED PENALTIES FOR CRIMES INVOLVING DOMESTIC VIOLENCE COMMITTED IN THE PRESENCE OF A CHILD

The final problem we discussed in 2010 was our continued concern about the effects of domestic violence on children in the household. We repeatedly observed that these children were subsequently more likely to be known to the Department of Social Services, the Juvenile Court and ultimately the criminal justice system. Many perpetrators also reported witnessing domestic violence as children. As a consequence, we learned that when an act of domestic violence is perpetrated in the presence of a child, the adult victim is not the only one who suffers. The children who witness the violence, as well as the community which must live with the consequences of that violence, are also victimized. The criminal penalties for these acts should reflect the damage which is done to the children who witness the violence and the community which must address it. One appropriate means of expressing the community's outrage over this crime, as well as its concern for the victims, is a law which provides enhanced penalties for crimes involving domestic violence perpetrated within the sight or hearing of a child.

Update: **Completed in 2014**

2011 – 1

ENCOURAGE THE DIVISION OF PAROLE AND PROBATION TO DEVELOP A SYSTEMATIC PROTOCOL TO ENSURE THAT THE PROPER AGENT RECEIVES CORRESPONDENCE

In more than one case that we reviewed, a probation agent did not receive correspondence alerting the agent that the probationer had violated his probation or that a warrant had been issued. In cases reviewed this occurred because the original probation agent retired, resigned, or was reassigned. This resulted in the probationer not being sanctioned for the violation or arrested for the warrant. We recommended that the Division of Parole and Probation should develop a systematic way for correspondence (mail, fax, email, etc.) to get to the appropriate agent, in light of the fact that the office inevitably experiences turnover in personnel.

Update: Completed in 2012

2012 - 3

ENCOURAGE PEDIATRIC PROVIDERS TO ROUTINELY SCREEN THEIR PATIENTS AND THEIR PATIENTS' CAREGIVERS FOR FIREARM OWNERSHIP

The American Academy of Pediatrics Committee on Injury and Poison Prevention found that firearm availability significantly increases children's risk of firearm-related injury and death. In addition, many firearm-related homicides occur impulsively during conflict, and the majority of homicides committed by juveniles involve firearms.[7] In 2012, the Team recommended that pediatric medical providers should screen all adolescents and their caregivers for firearm ownership. If firearms are present, pediatric medical providers should counsel adolescents and caregivers about the risks of firearm ownership and, if families refuse to remove firearms, about safe storage.

Update: **Completed in 2014**

As reported last year, in 2014, the American Congress of Obstetricians and Gynecologists issued a policy statement to recommend IPV assessment and "periodic injury prevention evaluation and counseling regarding firearms." The Team considers this recommendation as complete.

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[1] Murray, Christine E., et al. "Practice Update: What Professionals Who Are Not Brain Injury Specialists Need to Know About Intimate Partner Violence–Related Traumatic Brain Injury." Trauma, Violence, & Abuse (2015): 1524838015584364.

[2] Dawodu, S.T. (2015, Sept. 22). Traumatic Brain Injury (TBI) - Definition and Pathophysiology, http://emedicine.medscape.com/article/326510-overview.

[3] Corrigan, J. D., Wolfe, M., Mysiw, W. J., Jackson, R. D., & Bogner, J. A. (2003). Early identification of mild traumatic brain injury in female victims of domestic violence. American journal of obstetrics and gynecology, 188(5), S71-S76.

[4] Monahan, K., & O'Leary, K. D. (1999). Head injury and battered women: an initial inquiry. Health & Social Work, 24(4), 269-278.

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