Howard County Domestic Violence Fatality Review Team
Howard County, Maryland

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2015 ANNUAL REPORT

History

The Howard County Fatality Review Team (HCDVFRT) was originally established in November of 2007 and operated through April of 2012 at which time the group became in-active. In part this inactivity was due to a lack of DV related fatalities to review and due in part to an erroneous belief that cases could not be reviewed until all appellate action was exhausted. Staff changes at the State's Attorney's Office, as well as the Domestic Violence Center resulted in the re-establishment of the group in April of 2013. In recent years, there have been few domestic violence related fatalities in the County, therefore the HCDVFRT opted to focus on a recent non-reviewed DV near-homicide that occurred in 2010.

Purpose

The mission of the Howard County Domestic Violence Fatality Review Team (HCDVFRT) is to attempt to reduce domestic violence, specifically domestic related fatalities and near fatalities in our County through a multi-disciplinary review of our response to domestic violence in our community. The goal is to utilize a multi-disciplinary model to address training and community based prevention programs, as well as to effect systemic change to our community's response to domestic violence.

Authorization

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. Below are the citations for specific aspects of the authorization:

- 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**.**

Membership

The HCDVFRT is made up of a multidisciplinary group of professionals whose role in the community may contribute to a better understanding of the factors that influenced the occurrence of a domestic violence fatality or near fatality and whose agency, organization or governmental department has the ability to influence or change the response protocol in hope of preventing future deaths or injury. Please see attached roster for a full listing of HCDVFRT members and agencies represented.

Methodology

Selection of cases for review by the HCDVFRT ("Team")

The review process begins with the selection of cases for review. The Team discussed potential cases that fit the criteria that were set at our first meeting: domestic homicides, domestic suicides and domestic cases involving serious injury. After the selection of a case, the co-chair provides the names of the victim and the perpetrator, as well as all identifying information to

all of the team members. The Team members will then use the information to research their agency's files for any pertinent information.

Information gathering

The team will gather all pertinent information from their agency's files and submit the information to the chair of the Team. The Team is permitted by law to review confidential files for the purposes of reviewing the cases selected. The Team is permitted to request records from organization's that do not have participating team members. The Team may also request medical records for the victim through an agreement with the local hospitals.

Interviews

The Team during its initial review may decide that there are individuals that it would be beneficial to interview during the screening process. If the decision is made, the Team will contact the individuals by letter and request an interview. The interviews will be assigned to team members who have training in interviewing victims and witnesses.

Review Process

Prior to each meeting, the Team members are given a to-do list of items to complete prior to the next scheduled meeting. At the meeting, the members will present the materials they were asked to locate and may be questioned about the materials or procedures by Team members. Many items are asked to be submitted prior to the meeting so an assigned member of the Team can compile a Case Timeline for each case reviewed. The timeline is discussed at the meeting and the members discuss any areas where they believe the process might have been changed to better the outcome. The members continue to brainstorm solutions to the identified problems.

Recommendations

During the review process of a case, the Team compiles a list of "Identified Problems" and works to create "Recommendations" to address the problem. The members of the Team who are associated with the agency being discussed will participate in the discussion and help draft a potential solution. These solutions are then presented to the appropriate person in the agency and the member will report back what, if any, actions were taken on the Team's recommendations.

Annual Report

The Team prepares an annual report with the purpose of providing information to the public and persons, agencies or organizations and community groups that may have an influence on enacting the proposed recommendations.

Recommendations

The HCDVFRT reviewed in totality over the past year one domestic related near-homicide that occurred in our community in 2010 with the purpose of identifying systemic issues that might be addressed and corrected. The HCDVFRT has identified two (2) issues and has agreed upon the following recommendations to address these issues.

1. Promote education of elderly population about DV and available resources in the community.

Identified Problem:

There is a lack of assessable information and minimal education available for the elderly population on elder domestic violence. There exists an identifiable gap due to a generational issue related to domestic violence; including a difference of thought process amongst that population. Elderly domestic violence victims present unique barriers such as generational attitudes towards domestic violence, health issues, religious mores, fixed income that are not addressed with traditional domestic violence education and programming.

Recommendations:

Increase resources available to the senior population on issues of domestic violence. The Team arranged to have pamphlets and domestic violence information available at the Office of Aging 50+ Expo that was held this year in Howard County.

Create collaboration between the Office of Aging, Department of Social Services and HopeWorks to provide existing posters, pamphlets and pocket cards at Senior Centers and other identified areas.

Collaborate with the Maryland Network Against Domestic Violence to create elder specific domestic violence materials.

Provide the available materials in public locations such as the District Courthouse in Howard County. Pamphlets have been displayed in the lobby of the Office of the State's Attorney-District Court.

Continue education of Howard County Police patrol officers to identify the signs of domestic violence, including financial and emotional control, in the elderly population and to help provide resources to those individuals.

Progress Report:

The team arranged to have pamphlets and domestic violence information available at the Office of Aging 50+ Expo that was held this year in Howard County. We will continue to make sure this literature is available at next year's Expo.

Pamphlets have been displayed in the lobby of the Office of the State's Attorney-District Court to provide additional information and resources specific to elder domestic violence issues.

2. **Promote education of medical personal about screening and referrals -possibly targeting medical conferences, medical schools, and physicians that serve the delay population.**

Identified Problem:

Health care providers in our community that specialize in serving the elderly population may have a lack of knowledge on how health and mental health issues complicate domestic violence issues. Specifically, how a patient with dementia or Alzheimer's may become aggressive with family members creating a domestic violence situation for the caregiver. Health care providers are under no obligation to discuss an elderly patients mental health issues with family members or informal caregivers.

In the case we reviewed, the defendant was under treatment by a physician for a variety of issues, including dementia. The victim initially went with him to the doctor but she stopped when her comments about his health resulted in an increase of verbal abuse in the home. The victim further provided information regarding the dementia and the defendant driving and getting lost. The doctor did not follow through with the patient or Motor Vehicle Administration which resulted in the defendant getting into an accident and injuring the victim. Although the victim never reported any domestic violence to the doctor, the doctor did not ask about any escalation of violence at home. The doctor did comment to the victim that if there was violence that she should call the police. This demonstrates a recognition that there was a potential for violence but there were no resources provided to the victim/caregiver.

Recommendations:

Increase educational opportunities for doctors and nurses in regards domestic violence issues and elder abuse issues. Our review shows that no education exists for these health care providers in Maryland.

Coordinate with Howard County General Hospital to include domestic violence as part of their continuing education requirement for health care providers.

Collaborate with the Maryland Health Care Coalition to provide resources on domestic violence and opportunities for training and continued education for health care providers.

Progress Report:

The Team is still in a planning phase for this Recommendation and has not yet made the connections necessary to support a collaboration with the Maryland Health Care Coalition or Howard County General Hospital.

Progress Report on 2014 Goals

The Caretaker Manual prepared by DVFRT for distribution to families who become caretakers of children due to domestic violence is in the final approval stage at the Howard County Police Department and is being reviewed by the Office of Law. The goal is that it will be ready for use this year.

Continued Goals of DVFRT

The Team has the ongoing goal of following through with our 2013, 2014 and 2015 Recommendations, as well as including new participants in our working group as new issues arise during our discussions.