Howard County Domestic Violence Fatality Review Team
Howard County, Maryland

2021 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 inactive. 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, and the Team continues to meet quarterly to review DV related fatalities and near fatalities that have occurred in the County.

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 affect 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 over the past year a case involving a near-fatality. The review of the background of the perpetrator specifically resulted in the Team identifying areas of concern that might be addressed in the community. The HCDVFRT has identified two (2) issues and has agreed upon the following recommendations to address these issues.

1. **Improve communication between agencies to ensure compliance with Abuser Intervention Program Referrals and Requirements**

   **Identified Problem:**

   Offenders are often referred to or court ordered to attend an Abuser Intervention Program as a result of their criminal domestic violence case. Often referrals are made, but the referring agency must follow up with the program to ensure compliance and completion. In many cases it is not known until late in the probation or the stet period that offenders are not compliant with the AIP program. The concern is by not addressing the non-compliance earlier, the offenders are not receiving the necessary counseling and therefore victims are not being provided with the most protection and assistance possible.

   **Recommendations:**

   Increase the communication between partner agencies, specifically the AIP programs, the Division of Parole and Probation, and the State’s Attorney’s Office, regarding an offenders’ compliance with the AIP program.

   Work to create a database or some other shared electronic system where all partners have access and can see up-to-date information on all offenders in the AIP programs. This would relieve the AIP from the burden of sending out regular compliance letters and make it easier for P&P and SAO to keep track of offenders referred to AIP.

2. **Bringing ACES education and training to schools and community to include creation of an additional screening tool for children and streamlined referrals to counseling.**

   **Identified Problem:**

   Adverse Childhood Experiences (ACES) have been recognized by the American Academy of Pediatrics and the Center for Disease Control (CDC) as creating long term negative effects in children. Although they have been identified for some time, there is limited training on identification of ACES and limited resources to address the needs of these children. Physical and emotional violence in the home are identified ACES, as are drug and alcohol use, all of which we see in many domestic violence cases. A method to identify these children early on through the school and community would allow an earlier intervention.
Recommendation:

Develop a standardized training for teachers, educators, school counselors, nurses, and others in the school environment to identify ACES in their students. Expand this training to include those who come into regular contact with children, including coaches, bus drivers, librarians and police.

Prepare a screening tool that could be used by all identified parties and create a streamlined reporting process to assist in reporting identified children for assistance.

Develop a method by which the identified students would be quickly referred to a school counselor for support.

An identified resource – Creating Social Emotional Learning (SEL) Supportive School Environments. Presentation at the 2022 Child and School Counseling Summit held February 11-13, 2022

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Progress Report on 2019 Goals

The Team had a recurring recommendation to create a State-wide DVFRT. After many months planning with a very active working group, MNADV agreed to sponsor a state-wide Recommendations implementation team. The first meeting of the Team was in October 2021.

Continued Goals of DVFRT

The Team has the ongoing goal of following through with Recommendations from previous years, as well as including new participants in our working group as new issues arise during our discussions.

The Team will continue to participate in learning opportunities when new or novel issues arise.