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Second Report of the Homicide Review Panel, 2000

Office of the Maine Attorney General

Maine Commission on Domestic Abuse

SECOND REPORT OF THE HOMICIDE REVIEW PANEL

Maine Commission on Domestic Abuse

Report to the Judiciary Committee - January 1, 2000

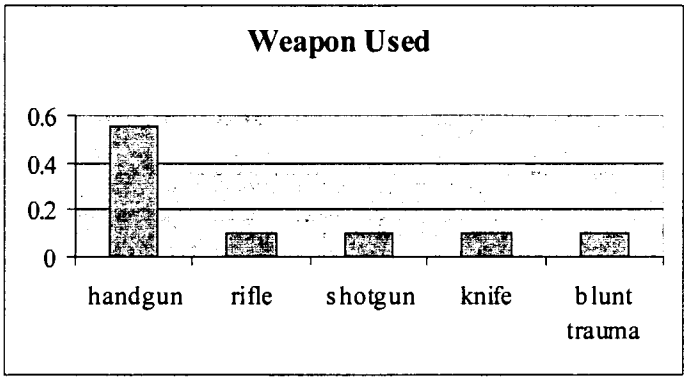
By law effective October 1, 1997, the Legislature charged the Maine Domestic Abuse Commission (hereinafter "commission") with the task of establishing a homicide review panel (hereinafter "panel") to "review the deaths of persons who are killed by family or household members." The legislation mandated that the panel "recommend to state and local agencies methods of improving the system for protecting persons from domestic abuse including modifications of laws, rules, policies and procedures following completion of adjudication. The panel was further mandated "to collect and compile data related to domestic abuse." 19A M.R.S.A. §4014.

In its first report to the Legislature in January of 1999 the panel reported that it had reviewed an insufficient number of cases to make any credible findings or recommendations and made one recommendation to the Legislature - to fund staff to support the panel. A bill to provide for a staff person for the Commission and panel was proposed and the Legislature ultimately passed legislation creating a clerical position. The law creating that position was subsequently vetoed by the Governor. The absence of staff continues to limit the number of cases and the level of review that the panel can accomplish.

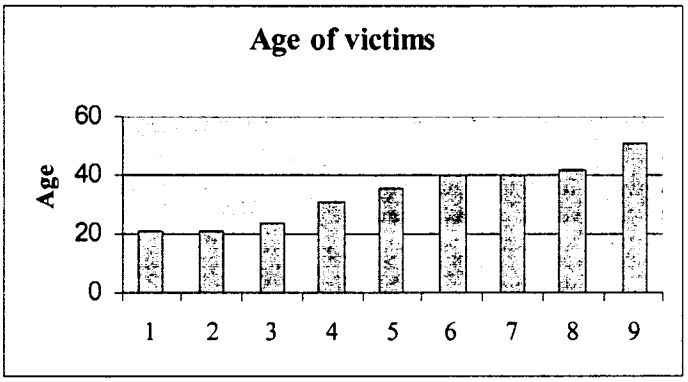
The panel has reviewed nine cases to date.

Five of the cases reviewed occurred in 1998 or 1999, the remaining four occurred between 1992 and 1996. Because the panel does not have the ability to review all cases occurring within a certain time frame, cases were selected to assure some diversity of geography, circumstances and included those cases that a committee consisting of an Assistant Attorney General within the homicide unit, the Medical Examiner's office and the chair of the commission selected as being most representative. Additionally, one criterion was that the case was completed, either that there was no prosecution (as in cases where the perpetrator committed suicide) or that a trial or plea and sentencing had occurred. One case included three victims, a woman and her two children who were killed by her husband and father of the children. Although it is important to acknowledge that the children were also victims, the homicides are reported as one case for purposes of data collection.

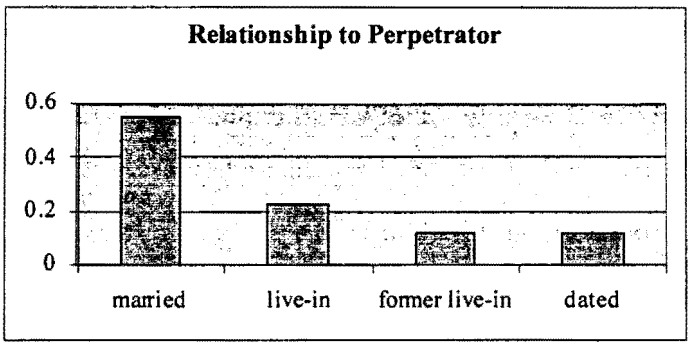
In seven of the nine cases, the murder weapon was a gun - in one case a rifle, another a shotgun and in five cases a handgun. In one case, the victim was stabbed and in one case, the cause of death was blunt injury to the face with aspiration of blood and fracture of the hyoid bone and larynx.



The victims (excluding the two children, a 5-year-old girl and a 2-year-old boy) ranged in age from 21 to 51 and were all female.



Five victims were married to the perpetrator at the time of the homicide - three of these had recently separated and two others had discussed and planned a separation in the immediate future. Two victims were living in a romantic relationship with the perpetrator at the time of the homicide. One victim had lived with the perpetrator in the past but had been separated for several months. One victim had dated the perpetrator but had never lived with him.



There is a range of length of each of the relationships with the shortest being 4 years and the longest being 22 years. All of the perpetrators are men. Six of the perpetrators committed suicide and died subsequent to the homicide. Three perpetrators were prosecuted and convicted and the dispositions are as follows:

· Plea to manslaughter - sentenced to 12 years with 6 years probation

· Plea to manslaughter - sentenced to 40 years

· Convicted of murder and aggravated assault - sentenced to 50 years

CHILDREN

It is important to pay particular attention to the children affected by domestic violence homicides. As noted previously, two children, a 5-year-old girl and a 2-year-old boy were murdered with their mother, shot in the chest by their father. In another case, two children, ages 1 and 2 were in the home when their mother was killed. It is believed that the 2 year old girl may have witnessed her mother after the homicide because she will not allow people to lie down with their eyes closed. In one case, the estranged father saw his 9-year-old daughter to the school bus before murdering her mother. In two cases, the children found the bodies of the victims. In two cases, the victims had no minor children and in one case, the victim had no children.

USE OF SERVICES/INTERVENTIONS

In only two of the nine cases, the victims had contacted the domestic violence program, which is part of the Maine Coalition to End Domestic Violence. In one case, we were aware of a referral made by a mental health provider but there is no identified contact with the program.

MEDICAL/MENTAL HEALTH INTERVENTIONS

In four of the nine cases, the panel obtained medical or Emergency Room records that indicated an opportunity to screen for domestic violence and an opportunity to intervene or refer to services. In two cases, the victims had numerous visits to the ER for injuries that were related to the abuse being perpetrated. In two other cases, the perpetrator was seen in the hospital with an incident that can now be seen as a "red flag" for domestic abuse and could have been screened. In six of the nine cases one or both of the parties had or were receiving some mental health counseling.

POLICE INTERVENTION

In three of the nine cases, there had been no prior contact with the police. In four cases, the police had been called to the home for a domestic violence incident with the victim. Two cases involved reported assaults to children or stepchildren. One case involved an extensive police and court record, including several convictions for assault on the victim. The perpetrator was previously convicted of three counts of theft, three counts of burglary, manslaughter, five previous assaults (most involving the same victim), four counts of revocation of probation. Two charges of assault and criminal trespass were filed two months before the homicide and were pending at the time of the crime. Sentences for previous assaults ranged from 90 days with all but 9 days suspended for the first offense to 9 months for the fifth charge one year before the homicide. Within the period between those two assault convictions, the perpetrator's probation was revoked four times.

In one case, it was reported that the police were called to the home on several occasions but there was no indication of any action by police and in fact, no records were available for review.

PROTECTION FROM ABUSE

In two cases the victims had filed and obtained a temporary order of Protection. In one case, the PFA order was dismissed because the victim failed to appear at the final hearing. In the other case, the order had lapsed before the homicide.

PUBLIC AWARENESS

As the panel reviewed these cases, it was instructive to note the number of cases where, with hindsight, people were not surprised by the events. In two cases, all of the professionals involved realized that the danger was there but felt helpless to do anything. In several cases, family and friends either describe controlling and abusive behavior or noted fears expressed by the victim. In two cases, people were aware of death threats made by the perpetrator to the victim.

RECOMMENDATIONS:

1) The panel continues to recommend that the Legislature fund a staff position. The time required to review cases, contact witnesses, follow-up to obtain records from courts, hospitals, mental health providers, law enforcement officials and to report to the panel and to the legislature requires the service of a half-time professional with knowledge of domestic violence issues and the skills required to fulfill these tasks. This position is more than a clerical position and the panel will continue to be hampered in its efforts until this position is funded.

2) In several cases, there were people who suspected abuse or knew of tensions or conflicts but were not aware of the abuse. In still other cases family, friends and co-workers who encouraged separation wondered if they could have done something different. A public awareness campaign describing the signs of abuse with suggestions as to how to support someone who is in an abusive relationship along with suggestions for resources and safety planning for someone who is about to leave an abusive relationship. In only two of the nine cases reviewed had the victim contacted the battered women's project in her area. In one other case the victim had received information about the program but had not made contact. Public awareness should include information about programs that provide support to victims of domestic abuse.

3) A coordinated community response is essential. Police, prosecutors, judges and probation officers must be provided with information about prior incidents of abuse in order to hold abusers accountable for their actions. Other critical aspects of this response include training for police officers and prosecutors to reflect the need to pursue domestic abuse cases in the absence of a cooperative victim. Training on the use of 911 tapes and hearsay exceptions as well as improved evidence collection and interviewing techniques should continue to be provided statewide. A focus on sentencing practices in cases of domestic abuse cases should be addressed by the courts. Finally, a coordinated community response must include prevention efforts such as school based programs teaching young people about the nature of abuse and the value of healthy relationships.

4) In many cases, the parties had come to the attention of hospital personnel, school officials and mental health providers. Training for these individuals on the dynamics of domestic abuse, on appropriate and inappropriate interventions and on services that are available in the community are critical for those people who see victims of domestic abuse every day.

Appendix A

MAINE HOMICIDE REVIEW PANEL

James Ferland - Chief Medical Examiner's Office

Dr. Eric Brown, EMMC, Family Practice Residency, Bangor - physician

Emmy Hunt, R.N., MSN, Maine Medical Center, Portland – nurse

Chief Edward Googins, South Portland PD - law enforcement officer

Sherriff Mark Westrum, Sagadahoc County - alternate

Phyllis Merriam - Department of Human Services

Denise Giles – Department of Corrections

Major Charles Love, Lt. Anne Schaad, Det. Michael Sperry – Department of Public Safety

Hon. Vendean Vafiades, Maine District Court

Alice Clifford, Asst. District Attorney, Bangor - Maine Prosecutor's Association

Linda Holdsworth, Asst. District Attorney, Alfred - alternate

Assistant Attorney General Lisa Marchese (criminal division)

Assistant Attorney General Janice Stuver (handling child protection cases)

Mary Ferrar, Attorney General's Office - Victim/Witness Advocate

Lesley Devoe, LCSW, Rockland – a mental health service provider

Kathryn Maietta, LCSW, Acadia Hospital, facilitator of a certified batterers' intervention program

3 persons designated by the Maine Coalition to End Domestic Violence

Carol Perkins, Abused Women's Advocacy Project, Lewiston

Lois Reckitt, Family Crisis Services, Portland

Andrea Itkin, New Hope for Women, Rockland

Alternates

Donna Baietti, Battered Women's Project, Presque Isle

Karen Coy, Womancare, Dover-Foxcroft

Francine Stark, Spruce Run, Bangor

Marie Tessier, Journalism professor, University of Maine

Anita St. Onge, Esq., Edmund S. Muskie School of Public Service, Chair, Maine Domestic Abuse Commission

Appendix B

DEVELOPING CASE REVIEW PROTOCOLS

Maine Domestic Abuse Homicide Review Panel

Loren Andrews ◆ Field Practicum ◆ April, 1998

In January of 1998, my Field Instructor presented me with the opportunity to provide assistance to the Maine Commission on Domestic Abuse and the newly-created Domestic Abuse Homicide Review Panel. Although reluctant to sway from clinical opportunities at the time, I was intrigued by the work of these organizations and the possibility of learning new and different issues related to domestic violence. Even in my clinical work thus far, I have not confronted many situations where domestic violence has been a dominant theme in a person's experience.

As I perceived it, my role in this setting was to provide staff support to both groups that may include research, writing, and evaluation. Thus far, I have attended three meetings of both the Commission and the Panel, which meet on the same day and include many of the same members. Eventually, I was asked to conduct research into how other states implemented domestic abuse fatality review panels, and, specifically, how they established case protocols.

Background

In a sense, the Commission on Domestic Abuse is the parent organization to the Homicide Review Panel. In fact, legislation passed last year establishing the Review Panel was included in the existing law that enabled the creation of the Commission. The Commission was established in 1995 by the Legislature, and its membership includes individuals from around the state who have either been involved in providing services to victims of domestic violence or are a part of the law enforcement, legal, and medical communities that address the needs of these same victims.

In 1997, individuals involved with the Commission endeavored to establish a fatality review panel. These individuals realized that, much like the Multi-disciplinary Child Death and Serious Injury Review Panel that already exists in Maine, victims of domestic violence deserve the attention of professionals in various fields to determine how the system — from service providers to law enforcement — responds to a victim's situation (if at all) and what changes could be recommended to prevent such murders in the future.

It is important to note that domestic abuse and homicide are integrally related. A recent report indicated that deaths related to domestic violence averaged 37% of all murders from 1985 to 1989,

and the average rose to 51% of all murders from 1990 to 1995, peaking at 69% in 1993 (Maine Coalition for Family Crisis Services). Thus, with these statistics supporting the need to review fatalities related to domestic violence, language was adopted in Maine law that established Maine's Domestic Violence Homicide Review Panel (see Appendix A). As one can see from this language, it clearly dictates what organizations will be represented on the panel, reinforcing the significance of a multi-disciplinary approach to the issue.

As Bowman (1997) stressed, multi-disciplinary death review teams are essential and collaborative efforts between legal, judicial, health, and advocacy groups. She wrote, "By creating overlapping circles of inquiry, opportunities for systems improvement can be more clearly identified" (p. 83). She added that according to the National Council of Juvenile and Family Court Judges, the goal of death review teams is to determine the causes that led to a death and identify what early intervention and prevention efforts should be made in similar cases. In materials obtained from the Washington State Domestic Violence Fatality Review Project, it is stressed that effective case reviews expose gaps in the system that demonstrate where improvements can be made in the response community and highlight areas where cooperation and communication can be enhanced.

I was fortunate to attend the organizational meeting of the Review Panel in January, 1998, and observe the vision of its members for this important project. The largest issue to emerge from this and subsequent meetings was how best to review cases. In other words, what is the appropriate protocol for case review, including where to obtain necessary information, whom to contact for appropriate information, how to disseminate that information to panel members, and whom to include in testimonials before the panel? Addressing and resolving these issues will enable the Panel to fulfill its vital mission.

Case Review Protocols

To help ascertain answers to these questions about case review protocols, I gathered information from various sources and contacted several individuals in other states who have experience with

fatality review panels[1]. For instance, Bowman (1997) indicated that all persons representing agencies sitting on a fatality review panel should follow a uniform procedure for reviewing their agency's involvement in a case. She further wrote that while a person responsible for the case from each agency should be asked to speak at the meeting itself, any agencies not represented should be asked to provide for the panel a summary of the agency's involvement.

Other considerations Bowman noted include whether or not the panel should summarize the activities of each agency involved in the homicide in a report, and whether or not the group's comments and suggestions should be included in that summary. Furthermore, Bowman suggested that a clear process be established for reporting back to each agency: perhaps the agency's representative should be informed what to communicate, or members of the panel could communicate that information directly, or the chair could send a letter outlining the panel's findings and recommendations.

It is important to note that Maine's homicide review panel is modeled somewhat after the successful Multi-disciplinary Child Death and Serious Review Panel established in the state several years ago. However, the child death review panel has not developed a long list of formal protocol procedures. It merely employs a few simple sequential procedures, which include collecting information, selecting cases for review, and reviewing the confidential material on child abuse fatality and inquiries (see Appendix B).

On the other end of the spectrum of procedural formality, several projects, including the Washington State Domestic Violence Fatality Review Project, perform extensive research with agencies or institutions that had contact with the victim or perpetrator. Project staff create a brief summary presentation of each death for review, summarizing the fatality and circumstances that led to it. Upon review of this information, the panel creates a detailed chronology of the incident and relevant preceding events, and it evaluates and identifies the gaps, training needs, and the points at which collaboration and communication should be strengthened to prevent future fatalities. An

[1] Individuals sent packets of materials describing their fatality review panels; with a few exceptions, most of the information in the following section was obtained from these materials.

important element is recording all of this information into a database which will identify common themes between cases and enhance preventive efforts.

The Washington State Project also gathers a wide range of demographic information, including race, income level, and educational attainment, which helps the program increase the understanding of the barriers to seeking and receiving help, the effectiveness of intervention and accountability, the accessibility of helping resources, and the options that victims of domestic violence have before them. To gather this information, the Project employs a data collection tool, which was created with the input of various individuals involved in these cases, including medical, legal, government, and service provider personnel. This tool asks questions about the context of the abuse and eventual fatality, and it strives to reflect the victim's efforts to find a safe environment as well as the community's ability to maintain the perpetrator's accountability for that violence. In its 23 pages of probing questions, this extensive instrument queries the agencies that were involved, the victim's efforts to end the violence, substance abuse and mental health factors, legal actions, and the involvement of child protective services. It also contains numerous demographic factors relating to the victim. It is comprehensive document that, if adequately completed, would provide an enormous amount of information for panel members to review.

Other projects and committees follow similar procedures, albeit perhaps less comprehensively. For instance, the Denver Domestic Violence Fatality Review Committee collects case information from the following sources: police homicide files, police victim assistant contacts, the coroner's office, the District Attorney's office (for trial information and case histories), prior arrest histories, court probation records, restraining orders, the District Court (for divorce or custody filings), contacts with shelter or domestic violence programs, treatment for substance abuse or domestic violence, contacts with social service or child protection agencies, and interviews with family, friends, co-workers. The Coordinator gathers this information from these various sources and completes a data collection form with relevant information.

Cases to be reviewed are sent to members one week before the meeting, and the members are to review their records for any information they may have on a case. The summary completed by the

Coordinator is presented at the meeting and is discussed and analyzed with the members of the committee. The case summary prepared by the Coordinator typically includes the name and date of birth of the perpetrator and victim, the date and cause of death, a short summary of the incident, a case disposition, and histories of the following areas: relationship and abuse, drug and alcohol abuse, criminal justice records, and mental health issues. It may also include a summary of prior intervention efforts and resources utilized by the victim.

In Hamilton County, Ohio, the Hamilton County Domestic Violence Death Review Panel also employs a data collection form consisting of various demographic and case-specific questions. When a case has been identified for review, the chair sends the following information to panel members: name, address, date of birth, date of death, cause of death, sex, and race. Upon receiving this information, panel members review their agency's records to determine if they had contact with the victim or her or his family; if they have, they bring this information to the review. If they know of other agencies that were involved with the victim in some capacity, that agency's representative is invited to the review. The case is presented by the coroner and is followed by police, medical, and agency reports. Following a discussion of the case, the information is recorded on the data collection form and specific issues are discussed and addressed that arise from the review.

In California, the Shasta County Interagency Domestic Violence Review Team utilizes similar data gathering procedures, which include demographic information on the individuals involved, including criminal history, substance abuse patterns, and how different agencies were involved in the case. It also contains a summary of the behavior related to incident, including information from the "Capital Tactic Scale," which classifies violent acts. Other items include information on substance or alcohol use in the incident, what children or other family members were exposed to violence, what weapons were used, and what interventions may have been attempted to prevent the fatality.

Finally, the Washoe County Domestic Violence Fatality Review Committee in Nevada utilizes data collection forms that are both generated from the case review as well as employed before the

case review to determine demographic information, cause of death and death-related information, information about accident and injury, abuse, and visits to hospitals and clinics.

Implications for Maine's Review Panel

From these accounts of states and localities already involved in fatality reviews, it is evident that case reviews are certainly labor intensive, both for those assembling materials and information and for the members who are asked to review them. Many methodologies or protocols need to be examined for their usefulness and appropriateness for Maine's new Panel.

Before determining what protocols should be adopted for Maine's review process, an initial determination may need to be what staffing resources exist now and may potentially exist in the future to fulfill the panel's expectations and requirements. In other words, are full- or part-time, paid staff critical to accomplishing any one of these steps, especially collecting and summarizing data on each case? The availability of staff time provided to the project will dictate on many levels how much information is gathered and disseminated to Panel members.

Assuming these issues are adequately addressed, I suggest the following are some of the general issues the Panel should consider when adopting its protocols for case review.

- How should members of the panel be asked to contribute to each case? Should they be asked to review their records relative to the case in question? Should they be prepared to summarize them to the Panel?
- Should individuals and agencies not represented on the panel be asked to attend a review of a case in which they were involved? If so, how should they present their findings and data?
- Should staff or others summarize the major aspects of the case, or should Panel members be asked to review the "raw data" themselves?
- Should a data collection form(s) be utilized in either gathering information for the review or summarizing the case after the review? If so, how extensive should they be?
- Will data be collected from consistent sources for each case, such as the Medical Examiner, State Police, etc., so that everyone knows what to expect in each report?

- Similarly, should each case be presented verbally at each meeting in a consistent order, such as the Medical Examiner first, followed by the State Police, and so on?
- When should all relevant information be sent to Panel members? How long do they need to review these sometimes voluminous materials (if they are not summarized) before the Panel meets to discuss the case?
- How should information be transmitted back to agencies involved in a case, especially if that includes (positive or negative) feedback on their performance?

Creating a recognized and accordant list of protocols to these large, important considerations will help the Panel understand its course of action when cases are presented for review.

Conclusion

Regardless of what procedures and protocols Maine's Homicide Review Panel adopts, a central theme of other projects and panels around the county indicates that the process must not become "blame-based." No agency, police department, medical personnel, or others should perceive the Panel's work as accusatory, harmful, or destructive. The review process is designed to address improvements in the various response systems and enhance prevention efforts, and not to place blame anywhere or with anyone.

As Bowman (1997) wrote, it is important that death review teams not become "vicious circles of blame" (p. 94); agencies should not protect themselves or point fingers at other agencies for fatalities. Furthermore, she emphasized, the panel's efforts should not become focused on blaming the victim, or identifying what she should have done differently. The Denver project's materials stress that the goal is to "not to place blame," but to understand the dynamics of domestic violence when death occurs and prevent future fatalities.

Only through a collaborative, open environment where past homicides are reviewed will suggestions and improvements be made that hopefully — in the face of the violence that continues to occur in Maine homes and neighborhoods — will save lives in the future.