

Remembering and Responding

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Maryland Domestic Violence Fatality Review Newsletter

Why Fatality Review?

The Will to Do Better...

At a time when we can tout that 16 domestic violence fatality review teams have organized, we close out the year 2007 with the saddest of events. On December 20th a 31-year old Washington County woman was stabbed to death by her boyfriend. During the incident, the responding officer was fatally shot by the assailant, who was later wounded by police in a shootout after he fled the scene. The assailant was under a protective order at the time. The murders of Alison Munson and Officer Christopher Nicholson of the Smithsburg Police Department were the 64th and 65th intimate partner-related fatalities of the year and occurred at a time when the question is still being asked: "Why do we need a domestic violence fatality review team?" As we should with every victim who is killed and every law enforcement officer who is killed serving victims, today we owe it to the memory of Ms. Munson and Officer Nicholson to try to prevent these kinds of tragedies. We can do this by making the system work better for the victims it serves and for the officers who implement it. The question is perhaps not "can we make the system better?" but "do we have the *will* to make the system better?"



A "System of Accountability"



On November 29-30, 2007, six representatives from Maryland attended a regional conference in Princeton, NJ. The focus was on examining how to conduct near fatality reviews. Keynote speakers were Dr. Jacquelyn Campbell of The Johns Hopkins University and a member of the Baltimore DVFRT, and Dr. Neil Websdale, co-coordinator of the national fatality review effort. During his address, Dr. Websdale noted that the largely unfunded expansion of fatality review across the country over the last 10 years has been "astronomical" and speaks to the value of this kind of multi-disciplinary coordination in addressing domestic violence. As a response to our opening question of "why fatality review?" he noted that the fatality review process has put a "system of accountability" in place.

Quarterly Newsletter

This newsletter is a product of the Maryland Domestic Violence Fatality Review Council. The Council provides support for DVFRTs, encourages jurisdictions to consider establishing a team, discusses relevant issues, and offers recommendations for change. The Council consists of the chairpersons, vice-chairs, and other representatives of Maryland review teams, and is assisted by the MNADV.



Maryland Review Teams

Anne Arundel County
Operating since October 2003
David Cordle, Chairperson

Calvert County
Operating since 2004
Jennifer Morton, Chairperson

Montgomery County
Operating since 2005
Laura Chase, Chairperson

Baltimore City
Operating since 2006
Dorothy Lennig, Chairperson

Queen Anne's County
Operating since January 2006
Frank Kratovil, Chairperson

Baltimore County
Operating since May 2006
Marcy Van De Mark, Coordinator

Prince George's County
Operating since May 2006
Patricia Smoot, Chairperson

Washington County
Operating since June 2006
Col. Doug Mullendore, Coordinator

Frederick County
Operating since October 2006
Mary Howser, Coordinator

Garrett County
Operating since June 2007
Lisa Thayer Welch, Coordinator

St. Mary's County
Operating since May 2007
Ella Mae Russell, Coordinator

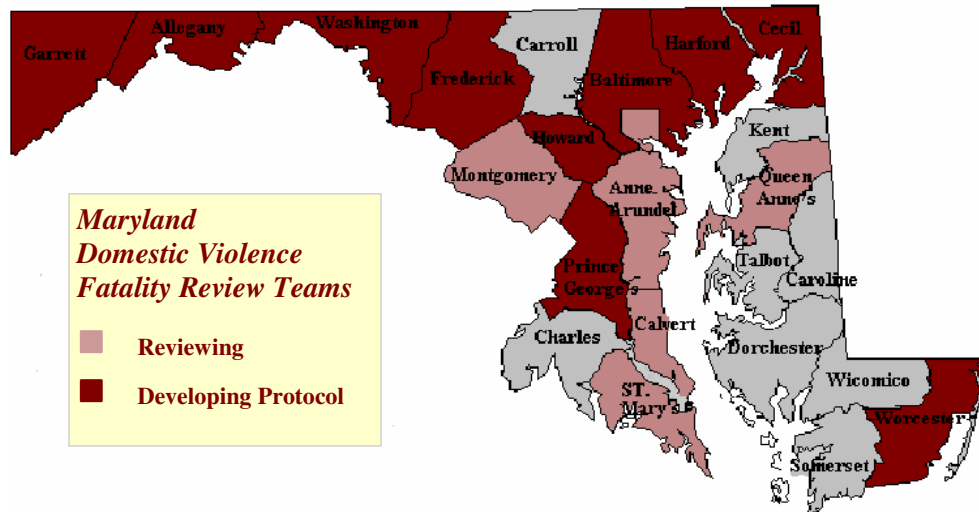
Allegany County
Operating since May 2007
Michele Beaulieu, Coordinator

Harford County
Operating since August 2007
Joe Cassilly, Coordinator

Howard County
Operating since November 2007
Devora Pontell and Sergeant Steve Martin, Co-Chairpersons

Worcester County
Operating since November 2007
Joel Todd, Coordinator

Cecil County
Operating since December 2007
Gary Pierce, Coordinator



Some Issues for Team Discussions

Survivors of domestic violence on teams.

This has been an ongoing discussion. The MNADV, following Dr. Neil Websdale's lead, has advocated this position, and most teams seem to espouse the idea. However, there are few survivors represented on teams.

Clergy on teams.

We have also talked about having members of the clergy on teams. Two recent studies found that 97% of victims considered religion a significant aspect of their lives and that nearly half had had contact with a pastor regarding their abuse, while only 2% had contact with a domestic violence provider.

Victim focus groups.

Want to know how "good" your recommendations are? Have a focus group of victims provide you with feedback.



Giving the victim a voice.

Try to include family interviews in your reviews. 90% of families want to tell their deceased family member's story and they have a lot to tell. For example, while the system had records on 27% of deceased victims, in an overwhelming 70% of the cases, family members were aware of the abuse the victim endured. Another example: system records existed for only 10% of deceased stalking victims while family members in 87% of the cases knew the victim had been stalked.



Post Assessments.

Lethality assessment is growing as a practice in Maryland. Consider doing a post assessment to learn whether or not a lethality assessment would have been predictive.

What Is Your Team's Value to the System?

Though we are making strides as a state in moving fatality review *along*, we need to ask ourselves if we are truly moving *forward*. The fatality review team process presents us with a somewhat unique situation. As members of a team we have the opportunity to bring about social change in our own county through a true coordinated community response.

What power, if used appropriately! Simply organizing and meeting just to say you have a team is not only a waste of everyone's valuable time, but sells the community—particularly victims of the community—short. Teams should gather with a clear view of the shared power they hold and the responsibility they have undertaken. They need to ask themselves what is being gained from the case reviews and what has been learned. Are the resulting findings being used effectively to improve upon the way the system responds to victims?



We are beginning to move more broadly into a new phase where teams, especially those with review experience, will begin to observe how much or how little value they bring to the system. Their value will be influenced by the following factors: Are they making significant recommendations? Are they seeing their recommendations come to fruition? Are they being assertive in having their recommendations considered and implemented? Remember, it's easy to start a team; it's hard to maintain a team; and harder still to maintain an *effective* one.



Developing Your Team's Protocol in a Timely Manner

The law requires teams to develop a protocol. Most teams are in that phase now and using the model protocol as a guide. Most are comfortable with the model because it covers a team's operating process reasonably well. We encourage teams to develop their protocol quickly in order to get to the business of reviewing cases. Developing the protocol over a protracted period can become an impediment to the team's objective of reviewing cases. Some suggestions:

- **Create** a subcommittee of 4-6 team members.
- **Appoint** a drafter.
- **Complete** the task within a very short period of time—perhaps one month.
- **Do homework!** Have the subcommittee members read the protocol ahead of time and be ready with initial comments at the first meeting.
- **Don't wordsmith** the model. Either accept or change the concepts conveyed in each section.
- **Draft changes promptly** in order to meet your deadline.
- **Focus** on completing the protocol. Agree to make additional changes once the team becomes fully operational. You will already have the foundation in place.



Fatality Review Status in Md.

Sixteen teams are organized in Maryland. However, the system of accountability cannot begin to work until teams are actually reviewing cases and making change. Six of our 16 teams are currently reviewing cases. Two suggested objectives for the coming year:

Objective 1: The remaining 10 teams will begin reviewing cases.

Objective 2: Each of the six reviewing teams will accomplish at least one element of systemic change.

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