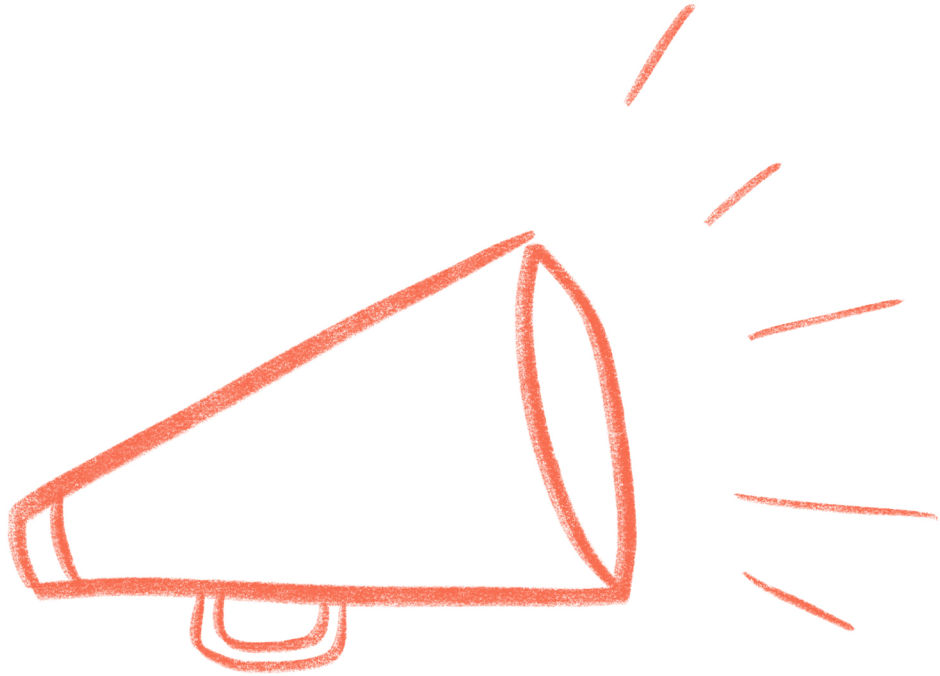


VOICES AGAINST VIOLENCE

The 12th Biennial Report of the Maine Domestic Abuse Homicide Review Panel





Dedicated to those who have raised their voices against domestic violence by actively supporting someone, reporting abuse to law enforcement, testifying in court, appearing in legislative hearings and have otherwise been outspoken advocates for themselves and others.



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The Consequences

Mama was right,
I've heard it a hundred times.
He's hurt you once
He'll do it again.

I did not listen,
Now I suffer the consequences.
I wish a hundred times,
I could go back to that night.

I cried the next day,
For I had a black eye.
I should have listened to mama,
Now I suffer the consequences.

How much longer can this go on,
It's all up to you, she's always said.

So I finally stand up to him.
Now he's put away,
I have surely suffered the consequences.
I should have listened to mama,
For now it is too late,
Because I am already dead.

By: Amy Theriault, date unknown

Thank you to the family of Amy Theriault, who gave permission to include this poem in the report. Amy was killed by her intimate partner in 2014.

Foreword by Maine Attorney General Janet T. Mills

“If you see something, say something,” is what the Department of Homeland Security tells us every day. I suggest the same motto should apply to domestic violence. When you see a person suffering from abuse, talk with them, reassure them, and offer nonjudgmental support.

There are many numbers and statistics in this report, but none more disturbing as this: Nearly half of all the homicides in our state were acts of domestic violence.

Often when we are faced with trying to solve or make sense of issues that seem senseless or unsolvable, we become overwhelmed and we do nothing. Upon hearing the news of yet another domestic violence homicide, we pause for a moment, feel sad and then feel grateful that our own lives are not impacted. Then we return to our daily business –hoping or expecting that someone else has the answers.

The findings in this report illustrate the suffering of real people at the hands of their abusers. The powerful and chilling poem by Amy Theriault (found on the page preceding this) shines a light on her feelings of helplessness and expresses the feeling of shame and responsibility she felt, that somehow by staying with her abuser, she did not fix the abusive situation.

One of the Panel’s observations is that public perception of a victim’s role and responsibility sometimes hinders the victim’s ability and willingness to report abuse, to testify, or to leave the relationship. This perception further complicates the prosecution and conviction of perpetrators of abuse because jurors may hold the victim responsible for choices made by the perpetrator. It is NEVER the victim’s fault or responsibility to fix the situation; it is the abuser’s choice and responsibility to stop the behavior.

We each have a role in contributing to or helping to change public perception. So here’s how each of us can help:

- Let survivors know that it’s not their fault.
- Change the words we use and challenge others who use “victim-blaming” language. Victim-blaming only serves to reinforce what the perpetrator is already saying--that it’s the victim’s fault they abuse.
- Hold abusers accountable for their actions. Abuse is not caused by a person’s “anger issues” or “too much stress” or the fact that “he was just drunk.”
- Reframe the question of “why does the victim stay?” to “why does the perpetrator abuse?”
- If you have a friend or co-worker who is afraid of their partner or who is being hurt, offer your support and refer them to the 24-hour toll-free hotline 1-866-834-HELP

Remember, when you see something, say something.

My thanks to the dedicated members of the Domestic Abuse Homicide Review Panel, including retiring Augusta Police Chief Robert Gregoire and former DHHS Director of Violence Prevention Holly Stover, for the time, experience and insights they have contributed to the endless work of preventing domestic violence in our lifetimes. They are saving lives.

Introduction by Panel Chair

Lisa J. Marchese, Deputy Attorney General

I am proud to introduce to you *Voices against Violence*, the 12th Report of the Maine Domestic Abuse Homicide Review Panel. The Homicide Review Panel is a multi-disciplinary group of professionals who meet monthly to retrospectively review resolved domestic abuse homicide cases as well as serious injury domestic abuse cases to make recommendations to state and local agencies for improving systems related to protecting victims and holding offenders accountable. The 12th biennial report celebrates those people who have used the power of their voices against domestic violence. As a homicide prosecutor for 21 years and Chair of the Panel for the past 18 years, I have seen the impact and power of a person's voice. Whether it is the victim who decides to testify against her abuser in court or the neighbor who calls law enforcement to report hearing abuse or the surviving family member who articulates to the court the impact their loved one's homicide has had upon their life and the life of their family or the brave survivor who stands before a legislative committee to voice why a law needs to be changed. It takes courage and strength to become involved and raise a voice against domestic violence. This report celebrates those individuals who have used their voices to speak out against domestic violence. Too often we hear a person say that they wished they had called the police or wished they had provided support to a victim or wished they had used their voice for change. Over the years the Panel has repeatedly encouraged and recommended that victims, family members, friends, bystanders and community members report domestic abuse to law enforcement. We again make this recommendation in *Voices against Violence*. We make this recommendation because the Panel has reviewed cases when a voice to end abuse has made a difference between life and death. Voices truly matter.

During this past biennial, the Panel has also reviewed resolved serious injury cases. These cases represent a departure from the practice of reviewing closed homicide cases. When a victim is seriously injured as a result of an intimate partner's abuse, and survives, there is much to be learned directly from the victim. These case reviews have provided invaluable insight to the members of the Panel. Not only have we learned more information about the perpetrators' history and tactics but also more about how different systems responded to both victims and perpetrators. Hearing from the victims directly has provided a more practical picture of changes that can/should be made and how we can better help victims of domestic violence and hold offenders accountable. As Attorney General Janet Mills recently wrote to the Health and Human Services Committee of the Legislature, "The Panel's charge is not simply to point out the problems facing our state. They also work to identify solutions."

Voices against Violence represents the collaboration of dedicated Panel members who work together to synthesize the information gathered during the cases reviews which result in the compiled data that lead to the observations and recommendations found in this report. In June of 2017, long time Panel Coordinator Susan Fuller retired. Susan's dedication and commitment to ending domestic abuse and domestic abuse homicides was unwavering. She shepherded the Panel through 3 reports and her voice remains with the Panel. We thank Susan for all her contributions and wish her all the best in her retirement. Susan's daughter, Sophie Corinne Sarno has provided artwork for this report as well as the 3 prior reports. Sophie has captured the title of the report in her artwork that is compelling and powerful.

Upon Susan's retirement, Laura Gallant Mintzer was hired to fulfill the Panel Coordinator position. Laura came to the Panel with years of experience as a victim advocate, most recently as an advocate in homicide cases in the Attorney General's office. Laura and Kate Faragher Houghton worked collaboratively to produce *Voices Against Violence*. Kate was the first Panel Coordinator and is a violence prevention consultant who has volunteered countless hours to the Panel. Kate has decades of experience working in domestic violence prevention and her thoughtful, articulate voice can be heard throughout this report. Thank you, Laura and Kate. A special thank you also to Professor Nancy Fishwick, Assistant United States Attorney Margaret Groban, Director of Victim Services of the Maine Department of Corrections, and Francine Stark, Executive Director of the Maine Coalition to End Domestic Violence, for your hard work in producing this report.

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**required by enabling legislation*

Acknowledgments:

The Panel would like to thank the following former members for their contributions:

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Panel Description

By law, effective October 1, 1997, the Maine Legislature charged the Maine Commission on Domestic and Sexual Abuse with the task of establishing a Domestic Abuse Homicide Review 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 systems for protecting persons from domestic and sexual 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 and sexual abuse." 19-A M.R.S. §4013(4). See Appendix A for the complete language of the Panel's enabling legislation.

The Maine Domestic Abuse Homicide Review Panel meets on a monthly basis to review and discuss domestic abuse homicide cases. The Panel Coordinator works with the prosecutor and/or the lead detective to present to the multi-disciplinary Panel detailed data about the homicide, information about the relationship of the parties, and any relevant events leading up to the homicide.

The Panel reviews these cases in order to identify potential trends in domestic abuse and recommend systemic changes that could prevent future deaths from occurring in Maine. The Panel plays a significant role in the prevention and intervention work that is occurring in Maine by gathering opinions, analysis, and expertise from a variety of professional disciplines across the state.

Mission Statement

The mission of the Maine Domestic Abuse Homicide Review Panel is to engage in collaborative, multidisciplinary case reviews of domestic abuse-related homicides for the purpose of developing recommendations for state and local government and other public and private entities in order to improve coordinated community responses to protect people from domestic abuse.

Summary of Case Data

Introduction

This biennial report addresses the fatality reviews completed by the Maine Domestic Abuse Homicide Review Panel in 2016 and 2017. The Panel reviews domestic abuse homicide cases after sentencing or acquittal, and domestic abuse homicide-suicide cases after investigations are complete. This report includes selected cases that occurred from 2012 to 2016.

The cases reviewed by the Panel include “intimate partner homicides” as well as “intrafamilial homicides.” Intimate partner homicide involves the killing of a current or former intimate partner or spouse. Intrafamilial homicide refers to the killing of a parent, child, sibling or other family member by a family member. The Panel makes every effort to review all intimate partner homicides and as many intrafamilial homicides as possible.

In keeping with national best practices regarding the review of domestic abuse deaths, from time to time the Panel also reviews “serious injury” domestic abuse cases. The occasional domestic abuse serious injury cases reviewed by the Panel are presented after disposition. Much may be learned from cases when victims survive.

During this two-year report cycle, perpetrators committed sixteen homicides in 2016, seven of which the Maine Department of Public Safety categorized as “domestic” homicides, and offenders committed twenty-one homicides in 2017, nine of which were categorized as domestic homicides. Together, the sixteen domestic homicides accounted for 43% of Maine’s total homicides in those two years. Homicide lists from the Maine Department of Public Safety may be found in the appendices to this report.

According to the Violence Policy Center’s recent study, “When Men Murder Women: An Analysis of 2015 Homicide Data,” Maine ranked 44th in the nation for single male offender and single female victim homicides.

See <http://www.vpc.org/studies/wmmw2017.pdf>

Number and Nature of Homicide and Serious Injury Cases Reviewed

During 2016 and 2017, the Panel reviewed fifteen cases involving domestic abuse. Of the cases reviewed, twelve were classified as domestic abuse homicide cases and three were classified as serious injury review cases. These cases occurred between 2012 and 2016. One homicide and two serious injury cases occurred in 2016. Three homicide cases occurred in 2015. Three homicide cases occurred in 2014. One serious injury case took place from 2013 to 2014. Three homicide cases occurred in 2013. Two homicide cases occurred in 2012.

The cases involved fifteen perpetrators and twenty victims. Seven of the fifteen perpetrators committed intimate partner homicides. Three of the fifteen perpetrators committed intimate partner serious injuries. Five of the fifteen perpetrators committed intrafamilial homicides. In addition, three of the seven perpetrators who committed intimate partner homicides also went on to commit intrafamilial homicides.

Perpetrators killed seventeen victims, and seriously injured three victims. Two of the fifteen perpetrators committed triple homicide—each of these perpetrators killed his girlfriend, one perpetrator killed his girlfriend's two children, and the other perpetrator killed two bystanders related to the girlfriend he also killed.

Of note, there were two victims who are not included in the data for this report. They were connected to a domestic abuse serious injury case that was reviewed by the Panel. The perpetrator in this case seriously injured a person connected to his former intimate partner whom he abused, and killed a person not known to the domestic abuse victim, in a connected incident.

Children

The Panel continues to review cases when perpetrators of domestic violence have a devastating and lasting effect on children. In the cases reviewed, the fifteen perpetrators directly impacted twenty known children under the age of 18. Some perpetrators committed abuse in more than one category below.

- Four of the fifteen perpetrators killed five children
 - Two fathers killed their infant sons.
 - One mother killed her young daughter.
 - One perpetrator killed two children after they saw him kill their mother.
- Three of the fifteen perpetrators impacted six children by killing their mothers. Three of these six children witnessed the killing of their mothers, including two who were then killed themselves.
- Four of the fifteen perpetrators abused their children or their intimate partners' children prior to the homicide.
- Nine of the fifteen perpetrators exposed children to abuse against an adult.

In addition to the perpetrator abuse described above, children were further impacted in the following ways:

- Two children were impacted by their fathers committing suicide.
- Five children were impacted by the incarceration of their father.
- One child was impacted because the child's mother lost custody of the child.

In addition, adult children were also impacted by abuse. In the cases reviewed by the Panel, a father killed his adult son, a father killed his adult daughter, and an adult grandson killed his grandmother.

For surviving children of domestic violence homicides, the killing, suicide or incarceration of their parents is traumatic and profound.

Futures without Violence and the National Child Traumatic Stress Network have published helpful information and resources on children impacted by domestic violence.

See <http://www.nctsn.org/content/resources>

Gender of the Parties and Relationship of the Perpetrators to the Victims

The cases the Panel reviewed involved fifteen perpetrators. Of these, fourteen were male and one was female.

The cases involved twenty victims, which included fifteen female victims and five male victims.

- One husband killed his wife
 - The perpetrator also killed his adult son
- One husband seriously injured his wife
- Five boyfriends killed their girlfriends
 - One girlfriend was pregnant
 - Two of the boyfriends each also killed two other people
 - One killed his girlfriend's two children
 - One killed two bystanders related to his girlfriend
- One boyfriend killed his former girlfriend
- Two boyfriends seriously injured their girlfriends
 - One of the boyfriends also killed a bystander and seriously injured another bystander related to his girlfriend
- Two fathers killed their sons
- One father killed his daughter
- One mother killed her daughter
- One grandson killed his grandmother

Change in Relationship Status

Research and cases the Panel reviews continue to show that leaving an abusive relationship can be a dangerous time due to the escalation of control tactics by perpetrators. **Twelve of the fifteen** cases reviewed involved the homicide or serious injury following a change in the status of the relationship between the parties. **Nine** of these twelve cases involved intimate partner homicide in which the relationship between the perpetrator and victim was ending or had recently ended. **Three** of these twelve cases involved intrafamilial violence – two of these perpetrators were facing a change in living situation, and the third was facing a shared custody situation and losing full access to the child victim.

Note: The data collected reflects former relationships and those that are not considered former. In this report, "former" refers to relationships that ended for a period of time prior to the homicide or serious injury. Relationships that ended or were ending within a day of the homicide or serious injury, or where the parties were still living together, are considered to not be "former" in the data for this report.

Ages of the Parties

Victims ranged from ages 3 months old to 75 years old.

Perpetrators ranged from ages 18 years old to 71 years old.

For the fifteen perpetrators in the cases reviewed:

Seven of the ten perpetrators who committed intimate partner homicide or serious injuries were between the ages of 25-45. Six of the eight perpetrators who committed intrafamilial homicides were under the age of 30. Two of the perpetrators of intimate partner violence went on to commit intrafamilial homicide, so were counted in both categories.

For the twenty victims in the cases reviewed:

Eight of the ten victims of intimate partner violence were under the age of 40. This includes victims of intimate partner homicide and serious injury.

Community/Services Involvement with Parties

In the fifteen cases reviewed, perpetrators and victims were involved with several different community services. The following list reflects only the information available to the Panel, and in some cases, the perpetrators and victims were involved in multiple services:

- In three cases, the victim was working with a community domestic violence organization.
- Seven cases included information of active or very recent involvement with healthcare providers.
- In two cases, perpetrators had been involved with some type of behavioral health counseling or sought behavioral health intervention.
- In four cases, parties were involved with substance abuse programs: one victim and four perpetrators were currently engaged in, or had previously been engaged in, substance abuse treatment.
- In five cases, the parties were involved with the Maine Department of Health and Human Services, Child Protective Services.
- In eight cases, the parties were actively involved with the legal system or had been in the past, i.e. filing for divorce, child custody orders, obtaining Protection From Abuse Orders, involving law enforcement, or otherwise in the criminal justice system.

- Six perpetrators had prior criminal convictions and had been served with Protection From Abuse Orders.
 - One of these perpetrators was also involved in a family matters court case for child custody.
 - Two perpetrators had previous interactions with law enforcement for criminal investigations.
 - Three victims had filed for Protection From Abuse Orders and attended court hearings—two Protection From Abuse Orders were active against perpetrators, and one Order was no longer active against the perpetrator.
- In two cases, the perpetrator was ordered to complete a Batterers Intervention Program, either as part of the current case or in a previous criminal case.

Actions Taken by Family Members, Friends or Neighbors

In eleven cases, victims’ family members, friends or co-workers were aware of the perpetrators’ abusive behavior.

Table 1 shows actions taken by family members or friends in response to perpetrators’ abusive behavior. Individuals may have taken more than one action. Not all case records indicated that family members or friends took action.

Actions Taken by Family Members and/or Friends	Referred the victim to a community domestic violence organization	Called 911	Reported concerns for child safety to Child Protective Services	Neighbors checked on well-being of the victim	Supported victim during incident or break up	Family knew about and confiscated weapons	Attempted to connect perpetrator with community services
Number of Cases	4	1	1	5	5	0	3

Table 1

Method of Homicide or Serious Injury

As depicted in Chart 1, and as reflected in every prior report of this Panel, perpetrators most commonly used firearms to commit domestic abuse homicides. The graph below illustrates the percentage of each method used to commit homicide or serious injury.

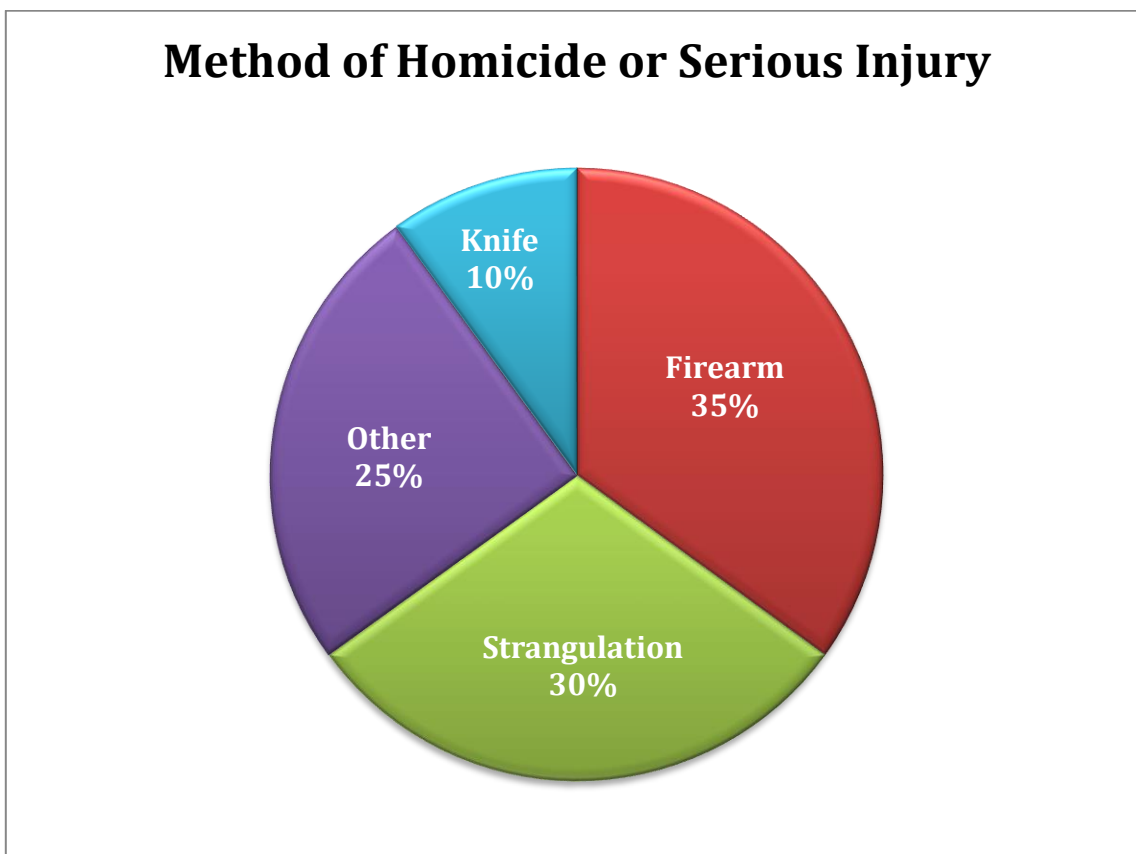


Chart 1

Firearm

Five of the fifteen perpetrators in the cases reviewed used firearms to kill seven victims. One of these perpetrators also stabbed the victim with a knife and so is also mentioned in that section below. This perpetrator is designated in Chart 1 as using a firearm only.

Strangulation

Four of the fifteen perpetrators used strangulation to seriously injure or kill six victims.

Knife

Two perpetrators used knives to injure or kill two victims. One more perpetrator used both a knife and a firearm to kill the victim. This perpetrator is counted in that section above and is designated in Chart 1 as using a firearm only.

Other Methods

Five of the fifteen perpetrators used other methods to kill five victims. Two perpetrators used their hands to kill two victims. One perpetrator used multiple objects to kill the victim. One perpetrator used an automobile to kill the victim. One perpetrator used suffocation to kill the victim.

Status of Perpetrators Who Committed Homicides

The status of the thirteen perpetrators who killed the victims is as follows:

- Nine perpetrators were prosecuted and ultimately incarcerated:
 - Five perpetrators were found guilty of murder after trials and their sentences ranged from 37 years to life in prison.
 - Two perpetrators pled guilty to murder and their sentences ranged from 45 years to life in prison.
 - Two perpetrators were convicted of manslaughter—one pled guilty and the other was convicted after trial. One was sentenced to 12 years (with all but 4.5 years suspended, plus 4 years of probation). The other was sentenced to 30 years in prison (with all but 15 years suspended, plus 4 years of probation).

Of note, two perpetrators who were convicted of murder were also charged with Gross Sexual Assault. One perpetrator was convicted of Gross Sexual Assault. The other case of Gross Sexual Assault was dismissed as part of a plea agreement.

- Three perpetrators committed suicide after committing homicide.
- One perpetrator was killed by law enforcement. The Maine Office of the Attorney General determined that this death was legally justified.

The Existence of Protection From Abuse (PFA) Orders

No Protection From Abuse Orders were in place against any of the perpetrators who committed homicide. In all three of the serious injury cases, the perpetrators were subject to PFA Orders at the time of the offenses.

Perpetrator Tactics Prior to the Homicide or Serious Injury Incident: Suicidality, Stalking, Strangulation, Sexual Assault, and Serial Battering

In the Panel's 11th report, it noted the prevalence of suicidality, stalking, and strangulation in the intimate partner homicide cases reviewed. This year, the Panel adds sexual assault and serial battering to this list. Sexual assault is an umbrella term for any type of sexual activity committed by one person without the consent of the other. It involves the use of threats, force, or any other form of coercion or intimidation, and includes sexual contact with a person who is unable to give consent. Serial battering involves perpetrators who abuse multiple intimate partners over time. The Panel continues to review cases in which serial batterers eventually commit homicide. The Panel associates sexual assault and serial battering, and all of the high-risk behaviors in this section, with intimate partner homicide.

The Panel also reviews intrafamilial homicides, and intimate partner homicides that also involve intrafamilial homicides or serious injuries. The dynamics in these cases often look different than intimate partner homicide cases, and the Panel is careful to avoid trend language due to the lower number of these types of cases reviewed. This said, the Panel has observed some similar tactics by perpetrators committing both kinds of homicides, and observes that perpetrators of intrafamilial homicide who use the tactics described below may pose threats to other family members as well.

In the cases reviewed, prior to the homicides and serious injury incidents, perpetrators used high-risk tactics that included, but were not limited to, the following:

Suicidality – The Panel continues to review cases in which the perpetrator displayed signs of suicidality prior to the homicide, often committing suicide after committing homicide. Suicidality is a sign of increased danger to victims of domestic abuse as well as to perpetrators themselves. Research and the Panel's case reviews reinforce that suicidality is strongly linked to homicidality as listed below:

Nine of the fifteen perpetrators exhibited suicidality either prior to or after committing serious injury or homicide

Three of the nine perpetrators killed or seriously injured their intimate partners or family members and then went on to commit suicide.

Two of the nine perpetrators attempted to commit suicide after killing their intimate partners or family members.

Three of the nine perpetrators exhibited signs of suicidal ideation, threats or previous suicide attempts prior to killing or seriously injuring their intimate partners or family members, but did not commit or attempt to commit suicide after committing the offense.

One perpetrator pointed a firearm at law enforcement officers and was shot and killed by law enforcement; the Maine Office of the Attorney General determined this death was legally justified.

Stalking - Stalking an intimate partner is a dangerous and prevalent tactic of relentless abusers. In **eight of the fifteen** cases reviewed, perpetrators stalked or monitored the victims prior to committing homicide or serious injury. Significantly, this accounted for 80% of the intimate partner cases reviewed by the Panel.

Strangulation – **Two of the fifteen** perpetrators used strangulation to kill four victims. **Two of the fifteen** perpetrators used strangulation to seriously injure a victim. It is crucial for survivors, first responders, and bystanders to recognize the prevalence and extremely dangerous effects of strangulation. Strangulation is a life-threatening and often repeated tactic of domestic violence. Often the tactic of strangulation is incorrectly referred to as “choking.” Choking is an internal obstruction of the airway. Maine’s statute defines strangulation as “intentional impeding of the breathing or circulation of the blood of another person by applying pressure on the person’s throat or neck.”

See [17-A M.R.S. §208](#)

**“I choked her to death... like six minutes. It took forever
and I couldn’t stop”**

– perpetrator during an interview with law enforcement

Sexual Assault – **Four of the fifteen** perpetrators sexually abused the victims. Two of the perpetrators who committed homicide also sexually assaulted the victims before killing them. Also of note is that multiple perpetrators had a history of sexual abuse against previous partners or other victims—this is not reflected in the numbers for this section as they did not involve victims in the index crimes.

Serial Battering – **Eight of the fifteen** perpetrators abused at least one former intimate partner or family member. While battering always involves a pattern of behaviors over time, serial battering refers to perpetrators who take abuse to the level of predation, creating immense cumulative harm.

The Panel continues to observe additional repeated perpetrator tactics in the cases reviewed and notes them here:

Physical Abuse – Twelve of the fifteen perpetrators physically abused the victims prior to the homicides or serious injury.

Emotional/Verbal Abuse – Thirteen of the fifteen perpetrators used emotional and/or verbal abuse as coercive and controlling tactics in the relationships with the victims prior to the homicides or serious injury.

Firearm acquisition – Eight of the fifteen perpetrators had access to or owned firearms. Four of the fifteen perpetrators used a gun to kill their intimate partners or family members. Of those four perpetrators, one purchased the gun used to kill the victim the same day of the homicide; one took the gun from the victim's home and used it in the commission of the homicide; one already owned the firearm used to kill the victims; and investigators were unable to determine how the other perpetrator obtained the gun used to kill the victims.

Previous Homicidal Threats – Six of the fifteen perpetrators previously threatened homicide. This includes threats made to kill the victims in the cases reviewed and threats to kill others.

Isolation – Five of the fifteen perpetrators isolated the victims from family, friends, and other support networks as a tactic of power and control. This includes incidents when perpetrators kidnapped their intimate partners.

Observations & Recommendations

The Panel continues its tradition of making observations and recommendations to various systems and organizations based on its analysis of the domestic abuse homicide and serious injury cases reviewed for this biennial report.

The Panel reiterates some of its previous recommendations and identifies many new ones. Recommendations that have been recognized and implemented are indicated with checkmarks and details of the progress-to-date are noted in italics.

Of particular concern to the Panel in this report is a lack of resources observed in several areas of Maine's coordinated community response to domestic violence. In multiple cases reviewed in this two year period, the Panel noted the lack of, and strongly recommends addressing the need for, the following systemic supports for those at risk for, and impacted by, domestic violence:

- Specialized domestic violence investigators
- Specialized domestic violence probation officers
- Public Health Nurses

Identification and Management of High-Risk Offenders

Observations:

- The Panel observes that law enforcement agencies in Franklin County have instituted a practice whereby officers from each agency meet regularly with a representative from the Maine Department of Health and Human services and the Maine Department of Corrections – Probation and Parole. At these meetings, the group takes a close look at individuals who are returning to Franklin County from incarceration and have exhibited high risk behaviors that indicate a likelihood of recidivism. These individuals may have committed domestic violence-related crimes, and/or other crimes. During these meetings, officers share information about the individual's criminal history, current location in the county, and any other pertinent information to support focused attention on those individuals by all the agencies. This group meets every three weeks and shares updated information regarding the individuals with all area law enforcement agencies.

- The Panel further observes that similar models exist around the country, such as in High Point, NC, where law enforcement agencies have instituted a “focused deterrence” system that involves leveled interventions with offenders to decrease violent crimes, including domestic violence. The “High Point Model” has resulted in a 56% decrease in violent crime in over the 20 years they have been using this system. For more information, see <http://www.bwjp.org/resource-center/resource-results/north-carolina-offender-focused-deterrence.html>
- The Panel observes that risk assessment tools can provide validated, evidenced-based information to victims and others about the danger presented by offenders. The Panel recognizes the potential benefits of using risk assessment tools to enhance offender accountability efforts and victim safety strategies. Risk assessment tools are more reliable than professional judgment and experience and create a common language regarding risk across systems in the coordinated community response to domestic violence. Risk assessment tools can provide valuable information about which offenders are at high risk for re-assault, or for committing homicide. Risk assessment tools provide another lens for victims to view their situations, offenders, and themselves. The Panel reviews many cases in which it is not clear whether the victims identified themselves as being in danger.
- The Panel observes that the Ontario Domestic Assault Risk Assessment (ODARA) is one tool of many in a criminal domestic violence investigation. ODARA is a validated, research-based risk assessment tool that indicates the likelihood that a person who has already committed an assault on a current/former domestic or dating partner in a heterosexual relationship will do so again in the future. The Panel observes that ODARA is only validated for use following arrests for domestic violence assault, domestic violence criminal threatening with a dangerous weapon or any other crime involving a violent incident including physical contact or a credible threat of death with a weapon made in the presence of the victim. ODARA is not validated for use following arrests for repeated violations of protective orders, or other crimes, unless the elements described above exist, even though a violation of condition of release such as PFA Order conditions or probation conditions is one of the items on ODARA. In addition, ODARA is only validated for use in heterosexual intimate partnerships with a male or female arrestee; other familial relationships, or other intimate partnerships are not eligible. Finally, in some cases, the risk to a person can be increasing, even without threats or physical violence being present. ODARA, while a useful tool that is being used statewide by trained first responders, is validated to predict recidivism; it does not predict all the avenues of danger the offender presents to a victim.

- The Panel observes that Jacqueline Campbell's Danger Assessment is a risk assessment tool that is validated to assess lethality. The Danger Assessment is intended for use by domestic violence advocates as well as healthcare providers and is intended to inform safety planning with victims. Many community-based advocates in Maine are currently certified to use this Assessment, and the Maine Coalition to End Domestic Violence has plans for statewide certification of advocates in the administration of the Danger Assessment in 2018.
- The Panel observes the effectiveness of High-Risk Response Teams (HRRTs). These teams are composed of representatives from the criminal justice system and advocates who are responding to particular domestic violence offenders. Generally, HRRTs consist of domestic violence resource center advocates, law enforcement, prosecutors, and victim witness advocates. The team may also include probation officers, jail staff, and/or pre-trial case managers. HRRT meetings may be convened on a regular schedule or on an as needed basis, when a case is flagged as high risk. Each team determines the process for identifying the cases to be reviewed, taking into consideration risk and/or dangerousness assessments and other factors. Because confidential information is discussed, these meetings have a restricted attendance list. These meetings are subject to the Maine statutes regarding confidentiality and information sharing.
- The Panel observes that strategies in place to protect victims of high-risk offenders, such as electronic monitoring designated by an HRRT, can increase a victim's sense of safety and increase offender accountability. For example, even a false alarm on an electronic monitoring device with several officers responding will demonstrate a consistent and elevated response to both the victim and offender.
- The Panel observes that a lack of funding and infrastructure exists for meaningful, successful electronic monitoring in the State. Currently, the areas using electronic monitoring systems for domestic violence offenders are not operating with consistency. Issues include lack of funding as well as implementation problems. There is currently no funding mechanism to pay for court-ordered electronic monitoring if the offender is unable to pay. Different counties that have electronic monitoring programs administer them differently and have varied practices in how best to notify law enforcement and victims of potential violations, the locations of exclusion zones, and what specifically should trigger the alarms.

Recommendation:

- The Panel recommends that law enforcement agencies throughout Maine consider organizing community risk meetings similar to the Franklin County model as a way to streamline information-gathering and sharing, and focus limited law enforcement resources on offenders who may be high risk for committing additional criminal activity. This offender-focused practice would create increased supervision/checks on domestic abusers and other criminals in communities that may not have specialized supervision such as domestic violence probation officers or domestic violence investigators, and would help focus law enforcement attention where it is most needed.
- The Panel recommends that following widespread advocate certification on the Danger Assessment, law enforcement officers, prosecutors, judges, and other criminal justice partners in Maine receive training and information about the Danger Assessment instrument, as it will be a helpful tool in predicting lethality in domestic abuse cases and will add to the common language and understanding of risk assessment across multiple systems.

Firearms

Observations:

- The Panel continues to observe that firearms in the hands of domestic abusers are dangerous. Removing firearms can enhance safety and minimize dangerousness.
- The Panel observes that offenders may be prohibited from possessing firearms in a variety of ways. A Protection From Abuse Order may explicitly prohibit a defendant from possessing firearms. Previous criminal convictions may also result in a person being prohibited from possessing firearms.
- The Panel observes that when a Protection From Abuse Order is granted, the individual subject to the Order becomes a “prohibited person,” who is disqualified from purchasing, owning, and possessing firearms. Once the Protection From Abuse Order is recorded in the National Instant Criminal Background Check System (NICS), a person who seeks to purchase a firearm from a Federal Firearms Licensee (FFL) should receive from NICS a denial for this firearm transfer, based on the entry of the disqualifying order.

- The Panel recognizes the gap existing between the number of prohibited offenders and the enforcement of these prohibitions.
- The Panel further observes that FFLs are not mandated to sell firearms to anyone when warning signs are present, even if the purchaser passes a background check. FFLs have the discretion to sell or not sell to any person.
- The Panel observes that Maine’s temporary involuntary commitment procedures, known as “blue paper” laws, do not include firearm prohibitions. Only a court-ordered commitment issued under Maine’s “white paper” laws, which afford both a hearing and an opportunity to be heard, prohibits firearm possession.
- The Panel observes that law enforcement officers always have the authority to request the voluntary surrender of firearms by individuals, even in situations when no arrest is made.

Recommendations:

- The Panel recommends that whenever concern exists for the safety of a victim of domestic violence, friends and family can report concerns to law enforcement and encourage the victim and the abuser to surrender guns from the house. If a firearm is turned over to a non-prohibited third party, it is best practice for the third party to sign an acknowledgment form documenting the responsibility to keep firearms away from prohibited persons.

Law Enforcement

Observations:

- The Panel observes that law enforcement officers conducting death investigations are not always required to engage in debriefings after a case. However, debriefings are offered regularly and can help investigators to process any effects of trauma. The Panel observes the importance of critical incident stress debriefing for first responders to homicides and supports debriefing and individual counseling requirements for law enforcement officers who respond to these traumatic incidents.
- The Panel observes that when bail conditions are imposed on domestic violence offenders, those bail conditions are not readily available to view by law enforcement agencies outside of Maine.

- The Panel observes that within the criminal justice system, contact between an abuser and victim that is seen or documented as "consensual" or "non-threatening" is sometimes minimized and not considered to be dangerous even in instances when a domestic violence offender is in violation of a court order to have no contact with a victim. It is dangerous to minimize this conduct. Maine law requires a mandatory arrest by law enforcement officers for violations of Protection From Abuse Orders, see [19-A M.R.S. §4012](#).
- The Panel observes that in cases in which law enforcement officers do incomplete investigations, or do not finish investigative reports, prosecutors' ability to hold offenders accountable is compromised, and victims are left in unsafe situations and with poor perceptions of the criminal justice system.
- The Panel observes that sexual violence remains a minimized aspect of domestic violence homicide investigations in some cases. At times this may be evident by investigative documentation that refers to a perpetrator "having sex" with a victim whom the perpetrator has incapacitated, at other times it is a lack of specific questioning of perpetrators and others by investigators about sexual violence within an intimate partnership.
- The Panel has reviewed multiple cases involving young men who were domestic violence offenders, abusing their young, female intimate partners both physically and sexually. In these cases, the young women became pregnant early in the relationship. The Panel observes the hidden nature of sexual abuse, which was revealed by the victims in these cases only after the completion of trials for the homicides of the children of these couples by the fathers. The Panel recognizes that in cases like this, victims may not receive referrals to support them with their experiences of sexual violence.
- The Panel observes that there are many benefits to the community when Maine State Police detectives, as well as technical and forensic teams, support local law enforcement through a homicide investigation.
- The Panel observes that in communities where law enforcement officers take a community policing approach with residents, residents may be more likely to reach out and inform law enforcement officers when they have information about serious incidents such as homicides.

- The Panel observes that there may be inconsistency in law enforcement officers' practices of making mandated reports to the Maine Department of Health and Human Services – Child Protective Services. This may be due to the assumption that a supervisor has already made the report, or they may wait to make a report later.

Recommendations:

- The Panel recommends that law enforcement officers, including homicide detectives, routinely include questions about strangulation in all domestic abuse investigations, including homicide investigations.
- Frequently, victims of domestic violence homicide have not worked with a community domestic violence organization prior to the homicide. Therefore, the Panel recommends that law enforcement officers and investigators who respond to domestic violence-related calls should provide victims of domestic abuse with information and referrals to community domestic violence organizations, during their primary and any subsequent interviews and follow ups. Law enforcement officers should always document these referrals, including repeat referrals, in their investigative reports.
- The Panel further recommends that law enforcement officers, including homicide detectives, provide information and referrals for community domestic violence organizations to surviving family members of domestic abuse homicide victims.
- The Panel further recommends that, when appropriate, law enforcement officers refer non-offending parents in child homicide cases to the local community domestic violence organizations, regardless of whether they are still in relationships with the homicide perpetrators.
- The Panel recommends that law enforcement officers make a report to the Maine Department of Health and Human Services – Child Protective Services when a child is in the home at the time of a domestic violence assault, regardless of whether the child is in the room when the incident occurs.
- The Panel recommends that law enforcement agencies create a checks and balances system within their records management systems to ensure that mandated reports to the Maine Department of Health and Human Services – Child Protective Services are made whenever required by law.

- The Panel recommends that investigating law enforcement officers routinely ask victims of domestic violence about experiences with sexual assault, make additional referrals to sexual assault service providers when appropriate, and document these referrals in their investigative reports.
- The Panel recommends that documentation of domestic violence homicides include careful articulation of sexually violent behaviors and related crimes.
- The Panel recommends that the Department of Public Safety and the Courts investigate the feasibility of notifying law enforcement agencies outside of Maine of the existence of active bail conditions in criminal cases originating in Maine.

Prosecution

Observations:

- The Panel observes that a pattern of guilty pleas and “low level” violations of Protection From Abuse Orders and other court orders may in itself be an indication of manipulation and dangerousness, not dependent on whether the individual behaviors or violations were extreme or violent.
- The Panel observes that Deferred Dispositions create situations in which offenders go unsupervised. The Panel also observes that in some cases, Deferred Dispositions represent the highest level of accountability possible given the circumstances of some cases.
- The Panel observes that prosecutor case documentation at times has characterized domestic violence offender behavior as stemming from “loss of control” or “anger/rage.”
- The Panel observes that when a domestic abuser repeatedly violates a condition of bail or a protective order condition of no contact with the victim(s), the appropriate crime to investigate and charge may be stalking.
- The Panel observes that surviving family members may not be privy to all information regarding a homicide investigation during the time of the investigation and prosecution, due to restrictions in the criminal justice process. The Panel recognizes especially in small, close-knit communities where information (accurate or not) may travel quickly following a homicide, family members experience difficult impacts from a lack of clear information.

- The Panel recognizes the benefits to prosecution of victim witness advocates and specialized domestic violence investigators, particularly as cases linger and take extensive time and energy of victims. The likelihood of successful prosecution is greatly enhanced if a victim witness advocate and/or domestic violence investigator establishes a relationship with the victim. They are also able to link victims with available resources and services in their area.
- The Panel observes that a victim's perception of safety, case resolution and confidence in the criminal justice system in general, all directly impact the victim's likelihood of participating in a prosecution. A victim's confidence in the system is damaged when the defendant is represented by an attorney who has committed domestic violence. The community's perceptions could be similarly impacted.
- The Panel observes that a defense attorney's representation of a defendant in a criminal domestic violence case in which the defense attorney represented the victim in previous legal matters results in the possibility that the attorney possesses adverse and prejudicial information about the victim from that prior representation. This results in the defense attorney having an inappropriate means to defend the perpetrator that potentially places the victim at a higher risk of danger.
- The Panel observes that when victims of domestic violence provide testimony that reveals indicators of impaired cognitive functioning, due to strangulation or traumatic brain injury for example, the effects of trauma are not taken into account, and victims of these crimes may be deemed inappropriately to be "changing their story" or providing "inconsistent statements," impacting their credibility as witnesses.
- The Panel observes that jurors are the conscience of the community as well as a reflection of the community's cultural beliefs. The Panel recognizes that community members may be impacted by mythology and misunderstanding about domestic violence, perpetrator tactics, and victim behaviors and decision making. For example, community members may believe that victims can end abuse by simply leaving an abusive relationship, or may see abuse as merely "problems in a relationship" for which both people are equally responsible. Once in a juror role, community members who hold these beliefs may be more likely to find victim behaviors confusing, unreasonable, or lacking credibility. Victim behaviors are most often caused by pressure, threats and violence by the perpetrator. A coordinated community response to domestic violence must include effecting a cultural change toward understanding the dynamics of

domestic violence, so that community members who become jurors have accurate information about the dynamics of domestic violence.

- The Panel observes that in some domestic violence cases, it is difficult for prosecutors to convict domestic violence offenders at jury trials despite overwhelming evidence of guilt. The Panel observes that this may be true even with victim testimony and audio recordings of abusive incidents. Due to the common misperception that victims falsely report abuse or “allow the abuse to happen,” domestic violence victims frequently face a court process that may be difficult and unsatisfying.

“The victim was equally guilty for sticking around for the abuse.”

– statement from a juror

“I worry that [the victim] could set another man up.”

– statement from a juror

- The Panel observes that *Voir Dire* is an opportunity for attorneys to screen potential jurors regarding their understanding of the dynamics of domestic violence. *Voir Dire* is an individual examination of jurors to determine whether there are any reasons why they should not be sworn.
- The Panel observes that expert testimony may be helpful in some cases to provide education to finders of fact regarding the dynamics and impacts of domestic violence, as well as offender and victim behavior. In the absence of expert testimony, it largely falls to victims of domestic violence to amplify the dynamics and impacts. The Panel recognizes that mythology and misunderstandings about domestic violence often overtake the victims’ realities and result in victims being seen by fact finders (judge or jury) as lacking credibility.
- The Panel observes that when the coordinated community response to domestic violence fails to hold perpetrators of these crimes accountable, and victims feel compelled to go into hiding for their own protection, first responders, service providers, and the criminal justice system lose the opportunity to obtain justice and to provide ongoing supports and services.

Recommendations:

- The Panel recommends that prosecutors request interstate criminal history information for defendants in all domestic violence-related cases, including those charged with violating conditions of bail or protection orders.
- The Panel recommends that prosecutors obtain the original complaint and affidavit filed with the court for a Protection From Abuse or Protection from Harassment Order when charging a violation of the order.
- The Panel recommends that in cases in which victims do not provide testimony, prosecutors use other evidence, such as testimony from domestic violence investigators, testimony from eye witnesses, physical evidence and photographs, and/or expert testimony, to support the case.
- Recognizing that supervision of an offender to assure compliance with Deferred Disposition restrictions may be the best way to hold the offender accountable, and Deferred Disposition does not include such supervision of the offender, the Panel recommends the extremely careful use of Deferred Disposition for any offense beyond the first offense.
- While there are differing views on whether Deferred Dispositions are appropriate in domestic violence cases, at a minimum the Panel recommends that the Ontario Domestic Assault Risk Assessment (ODARA) be consistently considered by prosecutors when determining the appropriateness of Deferred Disposition for domestic violence-related crimes that are eligible for the ODARA.
- The Panel recommends that prosecutors move away from describing domestic violence offender behavior as a “loss of control” or “anger/rage” in case/court documentation, as this does not accurately reflect the domestic violence dynamic. Instead, the Panel recommends that prosecutors use language reflecting the established understanding of domestic violence as offenders’ seeking to “coerce” and maintain “power and control” over victims.
- The Panel recommends that prosecutors actively consider applying a stalking charge when a domestic abuser repeatedly violates a condition of bail or a protective order of no contact with the victim(s).

- The Panel recommends that prosecutors and victim witness advocates at the District Attorneys' Offices and the Maine Office of the Attorney General consistently and repeatedly provide referrals to victims of domestic violence crimes for support, safety planning and advocacy services from the community domestic violence organizations. In the case of a homicide, surviving family members should also be referred to community domestic violence organizations for support and advocacy services.
- The Panel recommends that prosecutors and victim witness advocates utilize all avenues available to regularly and consistently keep victims, and in cases of homicide, surviving family members, informed about the status, timeline, and progress of prosecution. Education about the criminal process may also help surviving family members through this very painful time.
- The Panel recommends that any situation in which a criminal defense attorney representing a defendant in a domestic violence case has previously represented the victim in prior legal matters result in a consultation with the Maine Board of Bar Overseers to determine if a conflict of interest under the Bar Rules has occurred.
- The Panel recommends that attorneys utilize expert witnesses to assist fact finders in understanding the dynamics and impacts of domestic violence, as well as perpetrator behaviors and victim behaviors. In addition, the Panel notes the importance and availability of healthcare professionals to testify as expert witnesses regarding the dynamics and impacts of domestic violence non-fatal strangulation. Currently in Maine, a limited number of experts are available for all of these purposes, and attorneys can contact the Maine Coalition to End Domestic Violence for assistance linking with these experts.
- The Panel recommends that when a person is convicted of a crime of domestic violence prohibiting him/her from owning or possessing a firearm, that the prosecuting office notify the appropriate law enforcement agency as soon as possible with information about the conviction and a request to follow up with the prohibited person regarding firearm possession. If firearms are surrendered and the person transfers the firearms to a third party, law enforcement should communicate to the third party his/her responsibility not to return the firearms to the prohibited person. This should be documented in the investigative report. If possible, the third party should sign an acknowledgement of this responsibility.

Judicial Branch

Observations:

- The Panel observes that ongoing domestic violence education for the Judiciary provides judges an increased understanding about the domestic violence dynamic and emerging knowledge about many aspects of domestic violence. This education, while not affecting a judge's application of the law, does impact the courtroom experience for offenders and victims overall, and can positively impact offenders' sense of accountability and victims' sense of safety throughout the courtroom experience.
- The Panel observes that the court system does not currently provide translated documents to defendants who are not primarily English speaking.
- The Panel observes that the court system does not currently provide interpreter/translator services to victims or families who are not parties to the proceeding.
- The Panel observes that victims of domestic violence often experience long wait times for trial and wish for more information about the court process than they receive. Similarly, in homicide cases, surviving family members may experience long periods of time between a homicide and case resolution with not as much information as they wish for. The Panel observes that Through These Doors, formerly Family Crisis Services, of Cumberland County completed a study with survivors regarding the length of trial and information shared, and learned that victims feel safer when they are informed and an active part of the criminal justice process.
- The Panel observes the pain caused to a homicide victim's family when an offender does not address the court directly in a sentencing hearing and instead faces the victim's family and places responsibility for the homicide on the victim.
- The Panel observes that restitution in criminal cases is only meaningfully available to victims whose perpetrators have the means to pay restitution.
- The Panel observes that funds available to surviving family members through the Victim's Compensation Fund are limited to \$15,000, and may not meet all the needs of the family.

- The Panel observes that a Protection From Abuse Order is effective as soon as the judge has signed it. The defendant cannot be prosecuted for violating the Order, however, until receiving actual notice of the Order, or until the Order is served on the defendant. The Panel observes that confusion exists in the community about when a Protection From Abuse Order takes effect relative to service and recommends that the court system add information regarding Protection From Abuse Orders taking effect regardless of service into the next revision of the Protection From Abuse Order booklet provided by the courts:
http://www.courts.maine.gov/reports_pubs/pubs/hanbooks_guides/pa_ph/pa-ph-guide.pdf

Recommendations:

- The Panel recommends that the Judicial Branch develop options to allow for a more timely response by the court to domestic violence criminal cases.
- The Panel recommends that in cases when a defendant presents in court on an initial appearance for a domestic violence-related charge, including violating a protective order or bail conditions and enters a guilty plea, the Court or prosecuting office should consider continuing the matter for sentencing. This would allow the prosecuting office time to collect important information about the defendant's prior history, to notify the victim regarding the substance of the plea, and to allow the victim time to participate in the sentencing process.

The Panel applauds the State of Maine Judicial Branch for its willingness to conduct reviews of serious injury domestic violence cases that have occurred. The Panel adopts the recommendations within the Judicial Branch Report dated March 3, 2017. The Panel recognizes and reinforces recommendations the Judicial Branch has already implemented from the report.

The Panel applauds the State of Maine Judicial Branch for its leadership in statewide implementation of the Ontario Domestic Assault Risk Assessment beginning in January 2015. This initiative involved new legislation and training of every law enforcement officer and bail commissioner in the state in order to affect an increased consideration of risk during investigations, bail setting, and other aspects of decision making in the criminal justice system.

Corrections

Observations:

- The Panel observes that domestic violence offenders often attempt to “fly under the radar” when on probation or while incarcerated. Due to their manipulative natures, they may be courteous and placating, with a goal of receiving as little supervision as possible. One dangerous outcome of these behaviors could be that domestic violence offenders become eligible for work release, furloughs, and home confinement, which are opportunities for them to access, harm and/or manipulate those whom they victimized.
- The Panel observes that the Maine Department of Corrections (MDOC) employs approximately 75 probation officers and supervises approximately 6,000 probationers. The probation population continues to rise without additional supervision resources. Given these numbers, the likelihood is that some domestic violence offenders may not be getting the most effective supervision.

Recommendations:

- The Panel recommends that the Maine Legislature and the MDOC review law and policy related to furlough/early release to examine whether both may be improved to better move toward the goal of accountability for domestic abusers. At a minimum, the MDOC should continue to ensure that low-security furloughs/home confinement does not create additional risks for victims when offenders are in the same communities. Timely notification to victims of furloughs/home confinement/early release, should be considered in this process.
- The Panel recommends that probation officers statewide receive regular annual training and education about the dynamics of domestic violence and supervising domestic violence offenders, including the importance of enforcing conditions regarding Batterer Intervention Programs.

MCEDV provided training to all MDOC Probation and Parole Officers as well as probation administrators statewide in March 2018.

- The Panel recommends that the MDOC support specialized Domestic Violence Probation Officer positions in each region of Maine in Adult Community Corrections. These probation officers would have both specialized caseloads including supervision of high-risk offenders and would receive specialized training in working with domestic violence offenders.

Public Awareness

Media -

Observations:

- The Panel observes that media outlets continue to report murder-suicides without a domestic violence designation. This minimizes the domestic violence present in the act of killing an intimate partner or other family or household member.

Recommendation:

- The Panel recommends that the media be attentive to the representation of domestic violence murder-suicides when reporting. These cases should be recognized and named as being domestic violence-related.

Bystanders -

Observations:

- The Panel observes that it is appropriate for victims and/or their family or friends to call law enforcement for assistance when someone is leaving an abusive partner or for assistance in safely removing an abusive family or household member from the home.
- The Panel observes that some offenders withdraw and isolate themselves from others prior to committing homicide. This behavior should be a sign to friends, family members, co-workers, and others that this may be a time of elevated risk.
- The Panel observes that escaping an abusive partner is difficult and dangerous for victims of domestic violence, due to offenders' ongoing tactics of coercive control. Bystanders including family, friends, co-workers, school community members, etc., can better assist victims by listening to them and referring them to community domestic violence organizations for advocacy and safety planning services. Bystanders also help those affected by abuse by recognizing that leaving an abusive partner may escalate rather than minimize risks – particularly in the short term. Victims often must engage in creative problem solving and safety planning in order to safely escape abusive partners.
- The Panel observes a cultural reluctance to reporting the suspected abuse of children or dependent/incapacitated adults to the Maine Department of Health and Human Services – Child Protective Services for investigation: a desire to

avoid conflict; an assumption that someone else already made the report; apprehension about reporting something with few facts; or a belief that nothing will be done if a report is made. For many, the reluctance to report suspicions may stem from fear that the report will cause a disruption for a family unnecessarily if, in fact, there is no abuse or neglect. These ideas and lack of action, however, all contribute to a culture in which abuse and neglect can thrive.

Recommendations:

- The Panel continues to review disturbing cases in which homicide defendants share details about their crimes with family members or friends, and no call to law enforcement is made, even when crimes are posted on social media or otherwise made public. The Panel recommends that community members call law enforcement whenever they believe someone is committing or has committed domestic abuse, including homicide.

“I would have no problem killing them all.”

– Statement by perpetrator to co-worker weeks before killing three people

“Maybe I should just kill her.”

– Statement by perpetrator to a family member before killing his intimate partner

- The Panel recommends initiatives to encourage members of the public to report concerns about the health and welfare of children and incapacitated/dependent adults to the Maine Department of Health and Human Services – Child Protective Services or Adult Protective Services.

Employers –

Observations:

- The Panel observes that non-disclosure agreements between abusers and their employers prevent employers from disclosing abusive acts to future employers. This allows abusers to continue to perpetrate abusive and violent behavior without consequence or accountability.
- The Panel observes that no law exists to require potential and current employees of a school district to notify their employer if they have been convicted of a crime(s) prior to or during employment.

Recommendations:

- The Panel continues to observe that many victims and perpetrators are employed at the time of domestic violence homicides, and co-workers were aware of difficulties and/or dangers in the relationship. The Panel recommends that public, private, and nonprofit sector employers, including schools (pre-K through graduate level) and healthcare facilities, across the state prioritize the creation of a comprehensive workplace response to domestic violence. Policies and protocols can be tailored to fit the size and structure of every workplace. The Maine Coalition to End Domestic Violence is an employer's resource for collaboration, training, and policy consultation regarding domestic violence and the workplace.
- The Panel recommends that school districts be vigilant in responding to any criminal activity by employees. The Panel recommends that in education settings, background checks made during hiring, transfer, or promotion processes include additional research by the school/employer to determine the specific nature of any crimes of violence committed by an applicant.
- The Panel recommends that school districts, in concert with the Maine Department of Education, require school employees to notify the district if they have been convicted of a crime(s) prior to, or during, employment, and the nature of the crime(s).

Children

Observations:

- The Panel continues to observe in the cases reviewed that childhood experiences such as homelessness, exposure to domestic violence, and substance abuse in the home, exist in the backgrounds of individuals who commit domestic violence homicide.
- The Panel observes that if one child in a home is at known risk of child sexual abuse/sexual assault, other children in the home may be at similar risk.
- The Panel observes that for those responding to homicides of children, including but not limited to law enforcement officers, prosecutors, and victim witness advocates, personal and professional impacts experienced may differ from other types of homicide cases.

- The Panel observes the importance of early childhood interventions to counteract the effects of exposure to domestic violence and support resiliency in children. These interventions especially implicate education systems, healthcare providers, social service providers, and community domestic violence organizations.
- The Panel observes that enrollment in the Women, Infants, and Children (WIC) Program can be an opportunity to assess risks to an infant and provide resources to assist with unmet family needs. For example, a nutritionist could assess a child who is failing to thrive. This may also present an opportunity for a family to gain access to resources and referrals to community domestic violence organizations.
- The Panel observes that the Maine Coalition to End Domestic Violence resource centers provide direct services to children, although this currently happens in a limited way through advocates connecting with children whose parents are attending support group, or are in shelter or Transitional Housing Programs. The Maine Coalition to End Domestic Violence recognizes this is a critical gap and seeks to connect with children of all ages.

Recommendations:

- The Panel recommends the ongoing continued provision of prevention and education services for children and adolescents focusing on information about healthy and unhealthy behavior in relationships.
- The Panel recommends that a sexual medical forensic exam on child homicide victims be performed routinely as part of the evidence collection process during an autopsy. This will not only yield information about the child homicide victims' experiences but will be protective of other surviving children.
- The Panel recommends that those responding to homicides of children, including but not limited to law enforcement officers, prosecutors, and victim witness advocates, recognize that these cases can impact them differently than other types of homicide cases. Seeking support can avoid these cases creating an undue burden on responders personally or professionally. The Panel recognizes that peer and supervisory supports exist for all of these professionals and reminds professionals who are government employees that Human Resources, the Employee Assistance Program, and community domestic violence organizations are available to help when needed.

Maine Department of Health and Human Services

(DHHS)

Observations:

- The Panel observes that DHHS intake process tools currently assess for the presence of indicators of high-risk offenders – including but not limited to the use of non-fatal strangulation, strangulation during pregnancy, threats to kill, stalking behaviors, suicidality, sexual assault, and serial battering.
- The Panel observes that DHHS investigations often include interviews with law enforcement, schools, and childcare providers, but it is not routine for investigators to interview neighbors or household members.
- The Panel observes that mandated reporters in licensed positions are required to take mandated reporter training every 4 years. Mandated reporting laws often change, resulting in mandated reporters not being familiar with those changes. For online training and information about mandated reporting in Maine, see: <http://www.maine.gov/dhhs/ocfs/mandated-reporters.shtml>

Recommendations:

- The Panel recommends that DHHS review its intake process and identify additional training that could be provided to intake workers regarding the identification and documentation of high-risk offenders who use tactics including but not limited to non-fatal strangulation, strangulation during pregnancy, threats to kill, stalking behaviors, suicidality, sexual assault, and serial battering.
- The Panel recommends that DHHS - Child Protective Services personnel conducting investigations into suspected child abuse or neglect interview all household members and consider interviewing neighbors that may have had an opportunity to observe the family. This may provide pertinent information into an investigation that can help guide safety planning with the family, as well as documentation of facts and circumstances that may not otherwise present themselves.

- The Panel recommends that DHHS provide ongoing training regarding mandated reporting to all agencies providing direct care or other services to children, such as law enforcement, healthcare providers, domestic violence resources center staff, and other community services. The training should be provided on an ongoing basis and updated whenever the mandated reporting law changes. The Maine Department of Health and Human Services provides online information about mandated reporting, and training is available:
<http://www.maine.gov/dhhs/ocfs/mandated-reporters.shtml>

Maine Coalition to End Domestic Violence (MCEDV)

Observation:

- The Panel observes the need for linguistically appropriate visual resources providing information about community domestic violence organizations, to be posted in adult education program locations. This is especially important in areas in Maine with concentrated immigrant and refugee community members for whom English is not their first language.

Recommendation:

- The Panel recommends that MCEDV provide multilingual visual resources to adult education programs that regularly offer services to immigrant, refugee, and other non-English speaking community members. These resources should be designed for posting in public spaces and should include information about available domestic violence services.

The Panel observes that for many immigrant and refugee survivors of domestic violence, a powerful culture of silence exists in their countries of origin and within their new cultural communities. Language access issues, a lack of understanding of laws and law enforcement, and other barriers may create situations in which community members and first responders or service providers do not connect. The Panel applauds the significant and groundbreaking services that the Immigrant Resource Center of Maine, one of the domestic violence resource centers of the Maine Coalition to End Domestic Violence, provides to immigrant and refugee victims of domestic violence, including culturally and linguistically appropriate services. The Immigrant Resource Center also provides cultural brokerage services to the entire immigrant and refugee community as well as first responders, service providers, and the criminal justice system. The Immigrant Resource Center has made changes very quickly within the immigrant communities in Lewiston/Auburn, the greater Portland area, and statewide, to create services for New Mainers.

The Panel applauds the Maine Coalition to End Domestic Violence for its series of *Take Action Maine* public service announcements, which feature survivors and encourage viewers to make the call to a domestic violence resource center and access services for themselves or someone they care about. The series can be viewed at: www.MCEDV.org/media

The Panel applauds the advocates at the domestic violence resource centers of the Maine Coalition to End Domestic Violence for helping victims plan for their safety in response to the risks presented by offenders, and for supporting and informing victims about what they may face when accessing services or seeking relief from the criminal justice system.

Healthcare

Observations:

- The Panel continues to review cases in which medical records reveal missed opportunities for intervention by professionals in the healthcare system with victims and perpetrators of domestic violence. The 2016 Homicide Review Panel Report outlined comprehensive strategies for universal education and screening in the healthcare setting. The Panel renews its observation that healthcare is a crucial system in the coordinated community response to domestic violence. Conversations between healthcare providers and patients that include information and dialogue have the best potential for reaching victims and offenders with the message that domestic violence is a public health concern, while providing accurate information and making referrals to community domestic violence organizations. Providing universal education and screening for domestic violence would establish a framework for healthcare providers to name the behaviors, explain the negative health outcomes to patients, and connect patients to supportive resources in the community.
- The Panel observes that domestic violence tactics often include sexual abuse, and therefore, universal education and screening for domestic violence in healthcare settings should include information, conversation, and referrals regarding sexual violence.
- The Panel observes the prevalence of domestic violence/abuse across the lifespan, including abuse in later life.
- The Panel observes that universal education and screening for patients about domestic violence should include asking questions about committing abuse.
- The Panel observes that universal education and screening regarding domestic violence in the healthcare setting will require training for providers. One critical aspect of this training would be preparing providers to respond to patients of widely varying cultural and experiential backgrounds. Cultural competency in diverse communities must include a focus on patients' individual circumstances, such as prior trauma from their country of origin, and limited English proficiency, for example.

- The Panel observes that victims of domestic violence often experience short-term and long-term effects of traumatic brain injury from a single blow, or multiple blows, to the head. However, record reviews indicate that victims were not evaluated for mild traumatic brain injury and for post-concussion syndrome during health care visits.
- The Panel observes that offenders who use non-fatal strangulation against victims may inflict a range of serious health problems. It is critical that healthcare providers who are aware of a patient experiencing an incident of strangulation, or who receive a patient report of neck pain, or a diagnosis of thyroiditis, follow up specifically to assess and treat patient symptoms and conditions that could be related to non-fatal strangulation. In addition to treating the patient's health needs, this provides another point of overall intervention regarding domestic violence.
- The Panel observes that, although medical resources about thyroiditis mention neck trauma as a possible cause, they do not currently include information about non-fatal strangulation as a possible cause of the neck trauma.
- The Panel observes that healthcare providers are in a position to observe behaviors by parents or caregivers of new babies that may be considered inappropriate, concerning, or cause medical providers to believe the baby may be at risk of abuse or neglect by the parent(s) and/or caregivers.
- The Panel observes that some healthcare professionals may be reluctant to report their observations of inadequate parent/child bonding or inappropriate parental behaviors that might indicate child abuse and neglect. Healthcare professionals may be concerned about reporting to Child Protective Services if they do not believe they have sufficient facts to support their suspicions or that they would be violating HIPAA laws. However, under mandated reporter laws, healthcare professionals must make these reports, regardless of these concerns. Mandated reporters are required to "immediately report or cause a report to be made to the Department of Health and Human Services when the person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred." See [22 M.R.S §4011-A\(1\)](#).

- The Panel observes that if a statement is made to a Maine Department of Health and Human Services – Child Protective Services caseworker regarding possible abuse or neglect of a child, and those statements are second-hand, they may not be admissible in a Child Protection or criminal case in the court system. It is important for healthcare professionals to support statements made to Child Protective Services caseworkers with written documentation in medical records that can be produced for court.
- The Panel observes that Public Health Nurses provide a much-needed focus on home and community environments. For support with high-risk families, doctors rely on hospital social work departments and caseworkers, who in turn rely on Public Health Nurses to assess new parents' homes and to provide home-based services to families. The Panel observes that the lack of sustained funding for Public Health Nurses has severely limited the availability of Public Health Nurses in Maine. In the absence of Public Health Nurses providing information, education, and referrals, high-risk families with infants who may be experiencing domestic violence go largely unobserved and unsupported.
- The Panel observes that in multiple cases reviewed, a father who killed his infant child was the person primarily responsible for care of the child and demonstrated great frustration when his baby cried. Those around that father reported his frustration and responded to it by limiting his time alone with the baby prior to the homicide. The Panel recognizes that hospitals around the state make available to parents-to-be or new parents a video resource called "The Period of Purple Crying." The video and accompanying resources educate parents-to-be about the higher levels of crying by infants during their first six months of life and offer strategies to parents to manage their own responses to their babies' extensive crying and keep their babies safe. Information provided includes information about the lethality of violent, forceful shaking of babies (see www.purplecrying.info). The videos are available through local child abuse and neglect (CAN) prevention councils and the Maine Children's Trust.
- The Panel observes that there may be cases when an infant dies from traumatic injuries caused by another person and that some injuries or behaviors in that case may have been observed but not documented or reported by healthcare professionals.

Recommendations:

- The Panel recommends that healthcare facilities implement a comprehensive universal education and screening approach to domestic violence. This would include private screening of all patients for abusive behavior as well as experiences of abuse, treating patients for all healthcare consequences of abuse, and providing information and referrals to patients. This approach encourages conversations with all patients and supportive intervention when any red flags present, regardless of whether screening has occurred at all, and regardless of whether screening resulted in a negative response. No authentic responses to questions about abuse can be anticipated, however, if the professional has the conversation or asks screening questions in the presence of the patient's partner, child, or other persons accompanying the patient.
- The Panel further recommends that, during health care encounters, health care providers routinely consider the short and long-term health effects of domestic violence on one's health (emotional, psychological and physical effects) as a possible underlying cause of a wide variety of symptoms and illness conditions. For example, suicidality, depression, anxiety, trouble sleeping, and chronic pain may all be the result of abuse.
- The Panel recommends that universal education and screening about domestic violence in healthcare settings include information and conversation about abuse and violence in its many forms including intimate partner violence, abuse in later life, and intergenerational abuse (abuse by an adult child or grandchild against a parent or grandparent). Screening for abuse in later life should include taking a social history of a patient about stresses in the home, with whom the patient lives and spends time, and exploratory questions about potential physical, emotional and financial abuse or exploitation.
- The Panel recommends that healthcare providers in Emergency Departments, as well as primary care settings, consistently and proactively assess the effects of concussions through standardized cognitive assessment tools. For any facility or physician who cannot provide this assessment, the Panel recommends referring the patient to someone who can.
- The Panel recommends that due to the high numbers of domestic violence offenders who use non-fatal strangulation, and the high lethality of non-fatal strangulation as a tactic of abuse, providers who treat patients for thyroiditis should consider non-fatal strangulation as a possible cause and include this in their assessment and treatment of patients.

- The Panel recommends that healthcare providers consistently evaluate and document the relationship between new parents and infants, in an anticipatory evaluation process to assess strengths and deficits in a family expected to care for a new baby at home. This process should identify potential points of intervention prior to the baby being born.
- The Panel recommends that healthcare organizations have a system of checks and balances in place so that when healthcare providers have concerns of possible abuse or neglect by new parents of infants, that those concerns, in fact, result in a mandated report to the Maine Department of Health and Human Services – Child Protective Services, as required by law. See [22 M.R.S §4011-A\(1\)](#).
- As an additional support to families who are high risk, the Panel recommends that the Maine Legislature re-employ and sustain a cadre of Public Health Nurses and visiting nurses across the state. These positions are crucial to collaborate on assessments, help with resource management, and provide enhanced services to Maine families. Public Health Nurses are in a position to identify persons at risk of domestic violence and providing referrals to community-based services as appropriate. See [22 M.R.S §1963](#).

The Maine State Legislature passed LD 1108, An Act to Restore public Health Nursing Services, in 2017.

- The Panel recommends that every new parent receive from healthcare providers and/or the Maine Department of Health and Human Services, the video “The Period of Purple Crying” for viewing at home or in the hospital, in addition to a detailed explanation from a parent educator or medical professional about the specific dangers of shaking babies, and that the parents’ receipt of this video and information be documented by the distributing organization. In addition to the educational materials supporting parents and children during a time of vulnerability, an important benefit of medical documentation of the provision of this resource includes this documentation being evidence in court that parents were previously aware of the dangers of shaking babies, prior to an incident in which a parent kills a child by shaking him/her. This evidence may make the difference in greater charges sought.

- The Panel recommends that all healthcare providers and mandated reporters keep detailed documentation of any injuries, observed behaviors, and statements made that could be suggestive of child abuse or neglect as part of a patient’s medical records.
- The Panel recommends that in cases of missed “sentinel injuries” or any other observations of potential child abuse or neglect that were not documented or reported, an internal review and assessment of the case be initiated in the healthcare setting to identify any opportunities to improve care. Sentinel injuries are injuries that, due to their very nature, indicate harm was committed. For example, bruising on a non-mobile child would be considered a sentinel injury.
- The Panel recommends that hospitals systematically conduct reviews of all infant deaths, regardless of whether the conditions leading up to the death occurred prior to, or after, being seen in a hospital, to determine if protocol and laws were followed or if any other actions may have led to a different outcome for the child.

Behavioral Health

Observations:

- The Panel observes that substance abuse is often a coping mechanism for early trauma.
- The Panel observes that, prior to the homicide, some perpetrators in the cases reviewed were involved with behavioral health providers whose treatments were not supported by critical background information from collateral sources.

Recommendations:

- The Panel recommends that behavioral health practitioners follow sentinel events – injuries that by their very nature indicate their cause, such as external harm – with debriefs as a matter of consistent practice. Behavioral health providers benefit from debriefing and engaging in a root cause analysis or after action review to see how systems responded to the patient/client and how they could be improved. Behavioral health providers who worked with domestic violence offenders prior to sentinel events have the opportunity to reevaluate their treatment to identify gaps and improvements.

- The Panel recommends that behavioral health practitioners consistently screen clients who are experiencing delusions of any kind, for firearm possession and/or firearms in the home, so they can engage in safety planning, which may include surrender of firearms.
- The Panel recommends that its biennial report be circulated at each publication to behavioral health service providers.
- The Panel recommends that behavioral health practitioners take a careful social history of patients that includes legal history, relationships, firearm possession, history of violence and/or assaultive behavior, addiction issues, and mental illness. A social history also includes obtaining releases of information for prior records, prior therapeutic relationships, and releases to talk with family members. Developing a treatment plan based on these factors must include follow-up with patients. If patients possess firearms or have easy access to firearms, practitioners should specifically engage in safety planning around firearms with patients.

Appendix A: Enabling Legislation

Title 19-A M.R.S. §4013(4)

4. Domestic Abuse Homicide Review Panel. The commission [Maine Commission on Domestic and Sexual Abuse] shall establish the Domestic Abuse Homicide Review Panel, referred to in this subsection as the "Panel," to review the deaths of persons who are killed by family or household member as defined by section 4002.

- A. The chair of the commission shall appoint members of the Panel who have experience in providing services to victims of domestic and sexual abuse and shall include at least the following: the Chief Medical Examiner, a physician, a nurse, a law enforcement officer, the Commissioner of Health and Human Services, the Commissioner of Corrections, the Commissioner of Public Safety, a judge as assigned by the Chief Justice of the Supreme Court, a representative of the Maine Prosecutors Association, an assistant attorney general responsible for the prosecution of homicide cases designated by the Attorney General, an assistant attorney general handling child protection cases designated by the Attorney General, a victim witness advocate, a mental health service provider, a facilitator of a certified batterers' intervention program under section 4014 and 3 persons designated by a statewide coalition for family crisis services. Members who are not state officials serve a 2-year term without compensation, except that of those initially appointed by the chair, ½ must be appointed for a one-year term.
- B. The Panel shall recommend to state and local agencies methods of improving the system for protecting persons from domestic and sexual abuse, including modification of laws, rules, policies and procedures following completion of adjudication.
- C. The Panel shall collect and compile data related to domestic and sexual abuse, including data relating to deaths resulting from domestic abuse when the victim was pregnant at the time of the death.
- D. In any case subject to review by the Panel, upon oral or written request of the Panel, any person that possesses information or records that are necessary and relevant to a homicide review shall as soon as practicable provide the Panel with the information and records. Persons disclosing or providing information or records upon the request of the Panel are not criminally or civilly liable for disclosing or providing information or records in compliance with this paragraph.
- E. The proceedings and records of the Panel are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The commission shall disclose conclusions of the review Panel upon request, but may not disclose information records or data that are otherwise classified as confidential.

The commission shall submit a report on the panel's activities, conclusions and recommendation to the joint standing committee of the Legislature having jurisdiction over judiciary matters by January 30, 2002 and biennially thereafter.

Appendix B: Definition of Domestic Abuse

Maine statute Title 19-A M.R.S. §4002(1) defines domestic abuse as:

1. Abuse. "Abuse" means the occurrence of the following acts between family or household members or dating partners or by a family or household member or dating partner upon a minor child of a family or household member or dating partner:

A. Attempting to cause or causing bodily injury or offensive physical contact, including sexual assaults under Title 17-A, chapter 11, except that contact as described in Title 17-A, section 106, subsection 1 is excluded from this definition;

B. Attempting to place or placing another in fear of bodily injury through any course of conduct, including, but not limited to, threatening, harassing or tormenting behavior;

C. Compelling a person by force, threat of force or intimidation to engage in conduct from which the person has a right or privilege to abstain or to abstain from conduct in which the person has a right to engage;

D. Knowingly restricting substantially the movements of another person without that person's consent or other lawful authority by:

- 1) Removing that person from that person's residence, place of business or school;
- 2) Moving that person a substantial distance from the vicinity where that person was found; or
- 3) Confining that person for a substantial period either in the place where the restriction commences or in a place to which that person has been moved;

E. Communicating to a person a threat to commit, or to cause to be committed, a crime of violence dangerous to human life against the person to whom the communication is made or another, and the natural and probable consequence of the threat, whether or not that consequence in fact occurs, is to place the person to whom the threat is communicated, or the person against whom the threat is made, in reasonable fear that the crime will be committed; or

F. Repeatedly and without reasonable cause:

- 1) Following the plaintiff; or
- 2) Being at or in the vicinity of the plaintiff's home, school, business or place of employment.

Appendix C: New Maine Laws Domestic and Sexual Abuse related 2016-2018

2016

Chapter 394 - LD 1114

An Act Regarding Sexual Exploitation of Children

http://legislature.maine.gov/legis/bills/bills_127th/chapters/PUBLIC394.asp

Chapter 407 - LD 622

An Act to Require Training of Mandated Reporters under the Child Abuse Laws

http://legislature.maine.gov/legis/bills/bills_127th/chapters/PUBLIC407.asp

Chapter 410 - LD 1487

An Act to Amend the Laws on Protection from Abuse, Protection from Harassment and Unauthorized Dissemination of Certain Private Images

http://legislature.maine.gov/legis/bills/bills_127th/chapters/PUBLIC410.asp

Chapter 436 - LD 1639

An Act to Implement the Recommendations of the Intergovernmental Pretrial Justice Reform Task Force

http://legislature.maine.gov/legis/bills/bills_127th/chapters/PUBLIC436.asp

Chapter 443 - LD 1531

An Act to Protect Victims of Human Trafficking

http://legislature.maine.gov/legis/bills/bills_127th/chapters/PUBLIC443.asp

Chapter 497 - LD 1689

An Act to Protect Children from Possible Sexual, Physical and Emotional Abuse by Persons Who Have Been Convicted of Crimes

http://legislature.maine.gov/legis/bills/bills_127th/chapters/PUBLIC497.asp

Chapter 509 - LD 1540

An Act to Protect All Students in Elementary or Secondary Schools from Sexual Assault by School Officials

http://legislature.maine.gov/legis/bills/bills_127th/chapters/PUBLIC509.asp

2017

Chapter 65 – LD 138

An Act to Amend the Laws Governing the Sex Offender Registry

<http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0057&item=3&snum=128>

Chapter 66 – LD 511

An Act to Amend the Laws Governing Domestic Violence and Preconviction Bail

http://legislature.maine.gov/legis/bills/bills_128th/chapters/PUBLIC66.asp

Chapter 105 – LD 814

An Act Regarding Court Orders for Completion of a Batterers’ Intervention Program in Domestic Violence Cases

<http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0259&item=3&snum=128>

Chapter 128 – LD 1221

An Act to Clarify and Amend Certain Provisions of Law Regarding Victim Services

<http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0412&item=3&snum=128>

Chapter 135 – LD 1261

An Act to Protect Children from Sex Trafficking

http://legislature.maine.gov/legis/bills/bills_128th/chapters/PUBLIC135.asp

Chapter 156 – LD 1219

An Act to Amend the Laws Governing Forensic Examination Kits

<http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0410&item=3&snum=128>

Chapter 300 – LD 654

An Act to Amend the Laws Governing Certain Sexual Offenses

http://legislature.maine.gov/legis/bills/bills_128th/chapters/PUBLIC300.asp

Chapter 294 – LD 848

An Act to Support Law Enforcement Officers and First Responders Diagnosed with Post-Traumatic Stress Disorder

http://www.mainelegislature.org/legis/bills/bills_128th/chapters/PUBLIC294.asp

Chapter 81 – LD 350

An Act to Repeal Certain Requirements Concerning the Sale/Purchase of Firearms

http://legislature.maine.gov/legis/bills/bills_128th/chapters/PUBLIC81.asp

Chapter 227—LD 1332

An Act to Prohibit Possession of Black Powder and Muzzle-loading Firearms by Certain Persons

<http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP0926&item=3&snm=128>

Chapter 312 - LD 1108

An Act to Restore Public Health Nursing Services

<https://legislature.maine.gov/legis/bills/getPDF.asp?paper=SP0362&item=5&snm=128>

2018

Chapter 374 —LD 449

An Act to Add Domestic Violence against the Victim as an Aggravating Factor in Sentencing for Murder

<http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0151&item=3&snm=128>

Chapter 416 - LD 1740

An Act Regarding Criminal Forced Labor, Aggravated Criminal Forced Labor, Sex Trafficking and Human Trafficking

<http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0639&item=3&snm=128>

Chapter 386 - LD 1705

An Act to Strengthen Crime Victims' Rights

<http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP1185&item=3&snm=128>

Chapter 336 - LD 1728

An Act to Amend Maine Criminal Code Sentencing Provisions Relating To Increased Sentencing Class Based on Multiple Prior Convictions for Certain Violent or Sexual Crimes

<http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0627&item=3&snm=128>

Chapter 397 - LD 1838

An Act to Include in the Crime of Harassment by Telephone or by Electronic Communication Device the Distribution of Certain Photographic Images and Videos

<http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0690&item=3&snm=128>

Appendix D: “What to Do if You Suspect Someone is Being Abused” - www.mcedv.org

You’ve learned that your co-worker, friend, neighbor, or relative is being abused at home. What can you do to help?

Inform yourself. Gather all the information you can about domestic violence. This website is a great place to start; pay attention to the “Other Resources” sections to connect with further reliable sources of information.

Call the helpline. The eight Domestic Violence Resource Centers of the Maine Coalition to End Domestic Violence not only offer victims safety, but also provide advocacy, support, and other needed services. Victim’s advocates can be an excellent source of support for both you and the person you want to help. Do not call a project for an abused person. Call to educate yourself and find out how to be most supportive and helpful to someone who is being abused. “People have an absolute right to be free of bodily harm,” said Phyl Rubinstein, nationally recognized domestic violence expert formerly at the University of New England. “We must act on that belief.”

Ask the question... And believe the answer. Often, people experiencing abuse are experiencing isolation and control. They are frequently told that no one really cares what happens to them, or that no one will believe them. By asking them about their experience, without judgment or agenda, you are sending the message that you do care.

Initiating this conversation can be difficult. Some tips to help:

Tell what you see	"I noticed a bruise on your arm..."
Express concern	"I am worried about you."
Show support	"No one deserves to be hurt."
Refer them for help	"I have the phone number to..."

If your friend begins to talk about the abuse:

Just Listen: Listening can be one of the best ways to help. Don't imagine you will be the one person to "save" your friend. Instead, recognize that it takes a lot of strength and courage to live with an abusive partner, and understand your role as a support person.

Keep it Confidential: Don't tell other people that they may not want or be ready to tell. If there is a direct threat of violence, tell them that you both need to tell someone right away.

Provide Information, Not Advice: Give them the phone number to the MCEdV Helpline (1.866.834.HELP) or other local resources. Be careful about giving advice. They know best how to judge the risks they face.

Be There and Be Patient: Coping with abuse takes time. Your friend may not do what you expect them to do when you expect them to do it. If you think it is your responsibility to fix the problems, you may end up feeling frustrated. Instead, focus on building trust, and be patient.

Appendix E: Maine Coalition to End Domestic Violence Resource Centers



MCEDV.

The Maine Coalition
to End Domestic Violence

Help is just a call away.

24 Hour • Toll Free • Confidential

1-866-834-HELP (4357)

Maine Telecommunications Relay Service:
1-800-437-1220



MCEDV MEMBERS:

AROOSTOOK

Hope and Justice Project

PENOBSCOT & PISCATAQUIS

Partners for Peace

KENNEBEC & SOMERSET

Family Violence Project

HANCOCK & WASHINGTON

Next Step Domestic Violence Project

**ANDROSCOGGIN,
FRANKLIN & OXFORD**

Safe Voices

**KNOX, LINCOLN,
SAGADAHOC & WALDO**

New Hope for Women

CUMBERLAND

Through These Doors

YORK

Caring Unlimited

CULTURALLY SPECIFIC SERVICES

Immigrant Resource Center of Maine

mcedv.org

 **MCEDV MEMBERS**

Aroostook County
Hope and Justice Project
www.hopeandjusticeproject.org
P.O. Box 148, Presque Isle, ME 04769
Admin: 207-764-2977 Helpline: 1-800-439-2323

Penobscot & Piscataquis Counties
Partners for Peace
www.partnersforpeaceme.org
P.O. Box 653, Bangor, ME 04402
Admin: 207-945-5102 Helpline: 1-800-863-9909

Kennebec & Somerset Counties
Family Violence Project
www.familyviolenceproject.org
P.O. Box 304, Augusta, ME 04332
Admin: 207-623-8637 Helpline: 1-877-890-7788

Cumberland County
Through These Doors
www.familycrisis.org
P.O. Box 704, Portland, ME 04104
Admin: 207-767-4952 Helpline: 1-800-537-6066

Hancock & Washington Counties
Next Step Domestic Violence Project
www.nextstepdvproject.org
P.O. Box 1466, Ellsworth, ME 04605
Admin: 207-667-0176 Helpline: 1-800-315-5579

Androscoggin, Franklin & Oxford Counties
Safe Voices
www.safevoices.org
P.O. Box 713, Auburn, ME 04212
Admin: 207-795-6744 Helpline: 1-800-559-2927

Knox, Lincoln, Sagadahoc & Waldo Counties
New Hope for Women
www.newhopeforwomen.org
P.O. Box A, Rockland, ME 04841-0733
Admin: 207-594-2128 Helpline: 1-800-522-3304

York County
Caring Unlimited
www.caring-unlimited.org
P.O. Box 590, Sanford, ME 04073
Admin: 207-490-3227 Helpline: 1-800-239-7298

Serving Refugee and Immigrant Communities
Through Culturally and Linguistically Sensitive Services
Immigrant Resource Center of Maine
www.ircofmaine.org
PO Box 397 Lewiston, ME 04243
207-753-0061



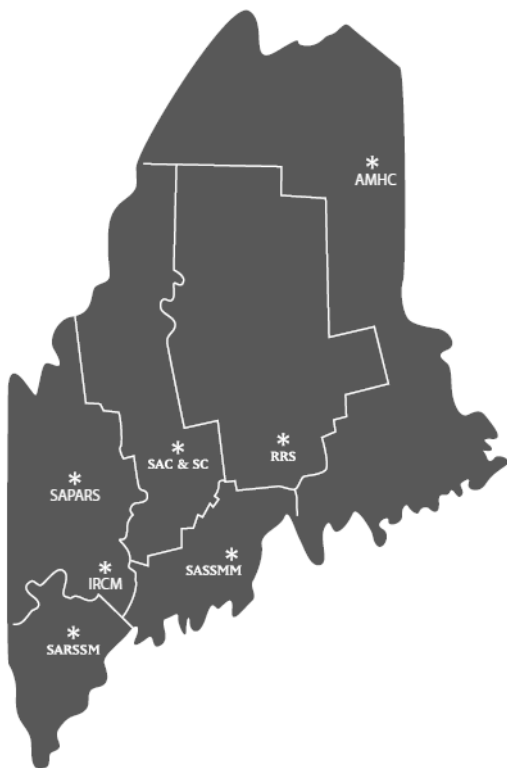
**The Maine Coalition
to End Domestic Violence**

Connecting people,
creating frameworks for change.
mcedv.org

Appendix F: Maine Coalition Against Sexual Assault Member Centers

mecasa MAINE COALITION AGAINST SEXUAL ASSAULT

info@mecasa.org | mecasa.org
207-626-0034



STATEWIDE SEXUAL ASSAULT HELPLINE

Text/Call: 1-800-871-7741

Chat: mecasa.org

Text & chat help: Monday-Friday, 8 am - 5 pm

Phone help: 24/7

Free. Private.

MAINE'S SEXUAL ASSAULT SUPPORT CENTERS

AMHC Sexual Assault Services (AMHC)

Serving Aroostook, Hancock, & Washington Counties •
amhcsexualassaultservices.org

Immigrant Resource Center of Maine

Serving Androscoggin & Cumberland Counties • ircofmaine.org

Rape Response Services (RRS)

Serving Penobscot & Piscataquis Counties • rronline.org

Sexual Assault Prevention & Response Services (SAPARS)

Serving Androscoggin, Oxford & Franklin Counties and the towns of
Bridgton & Harrison • sapars.org

Sexual Assault Crisis & Support Center (SAC & SC)

Serving Kennebec & Somerset Counties • silentnomore.org

Sexual Assault Response Services of Southern Maine (SARSSM)

Serving Cumberland & York Counties • sarsonline.org

Sexual Assault Support Services of Midcoast Maine (SASSMM)

Serving Eastern Cumberland, Sagadahoc, Knox, Waldo & Lincoln
Counties • sassmm.org

Appendix G: Wabanaki Women's Coalition Domestic and Sexual Violence Advocacy Centers

~ Increasing the capacity of tribal communities to respond to domestic and sexual violence ~

www.WabanakiWomensCoalition.org
 Jane Root, Executive Director
 207.763.3478
 Donna Brown, Outreach Coordinator
 207.322.6604

Micmac Domestic and Sexual
Violence Advocacy Center

Maliseet Domestic and
Sexual Violence
Advocacy Center

Passamaquoddy Indian
Township Domestic and
Sexual Violence
Advocacy Center

Penobscot Nation
Domestic and Sexual
Violence Advocacy
Center

Passamaquoddy
Peaceful Relations
Domestic and Sexual
Violence Advocacy Center

Wabanaki Women's Coalition
Member Domestic and Sexual Violence Advocacy Centers

Aroostook Band of Micmacs, Domestic and Sexual Violence Advocacy Center
 7 Northern Road, Presque Isle, ME 04769
 Office: 207.760.0570 Hotline: 207.551.3639

Houlton Band of Maliseets, Domestic and Sexual Violence Advocacy Center
 690 Foxcroft Road, Houlton, ME 04730
 Office: 207.532.3000 Hotline: 207.532.6401

Pleasant Point Passamaquoddy, Passamaquoddy Peaceful Relations Domestic & Sexual Violence Advocacy Center
 P O Box 343, Perry, ME 04467
 Office: 207.853.0092 Toll Free Hotline: 877.853.2613

Indian Township Passamaquoddy, Domestic and Sexual Violence Advocacy Center
 P O Box 301, Princeton, ME 04668
 Office: 207.796.6106 Hotline: 207.214.1917

Penobscot Indian Nation, Domestic and Sexual Violence Advocacy Center
 12 Wabanaki Way, Indian Island, ME 04468
 Office: 207.817.3164 Ext 4 Hotline: 207.631.4886

Appendix H: Maine Certified Batter Intervention Programs

<http://www.maine.gov/corrections/VictimServices/BatIntervent.htm>

Androscoggin, Franklin, & Oxford Counties:

Alternatives to Abuse (Safe Voices; BIP Coordinator: Angela Desrochers)
(male program) (female program)
PO Box 713, Auburn, ME 04212
Tel: 207-795-6744

Aroostook County:

Northern New England Community Resource Center
(male program) Director: Charles Moody

Choices (female program) Director: Desiree Chasse
P.O. Box 164, Houlton, ME 04730
Tel: 207-694-3066

Cumberland County:

A Different Choice (male program) Director: Ellen Ridley
P.O. Box 6413, Scarborough, ME 04070-6413
Tel: 207-318-2313

Opportunity for Change (male program) Director: Mary Campbell
Suite 140, 222 St. John St, Portland, ME 04102

Cumberland & Sagadahoc Counties:

Choices - The Men's Group (male program) Director: Mary O'Leary
14 Maine St., Brunswick, ME 04011
Tel: 207-240-4846 Tel: 207-373-1140

Hancock County:

Choice V (male program) Supervisor: Astor Gillis

Turning Points (female program) Directors: Astor Gillis & Angie Butler
59 Franklin St., B, Ellsworth, ME 04605
Tel: 207-667-2730

Kennebec & Somerset Counties:

Menswork (male program) Director: Jon Heath
P.O. Box 304, Augusta, ME 04332-0304
Tel: 207-620-8494

Respect ME (female program) Director: Robert Rogers

Knox, Lincoln & Waldo Counties:

Choices – The Men’s Group (male program) Director: Mary O’Leary

14 Maine St., Brunswick, ME 04011

Tel: 207-240-4846 Tel: 207-373-1140

Time for Change (female program)

93 Park St, Rockland, ME 04841

Tel: 207-594-0270

Penobscot County:

Penobscot County Batterers’ Intervention Program

(male program) Director Kathryn Maietta

One Cumberland Place, Suite 104, Bangor, ME 04402

Tel: 207-217-6588 Fax: 207-217-6587

Piscataquis County:

DV Classes for Men (male program) Director: Betty Carolin

Charlotte White Counseling Center

572 Bangor Rd., Dover-Foxcroft, ME 04426

Tel: 888-564-2499 Annex: 207-564-7106 Fax: 207-564-8137

Washington County:

Alternatives to Abuse (female program) Director: Dorothy Martel

P.O. Box 1466, Ellsworth, ME 04605

Tel: 207-667-0176

York County:

Violence No More (male program) Director: Martin Burgess

110 Saco Falls Way, Suite 425, Biddeford, ME 04005

Tel: 207-283-8574

Caring Unlimited (female program) Director: Cynthia Peoples

P.O. Box 590, Sanford, ME 04073

Tel: 207-490-3227

Appendix I: Electronic Monitoring Subcommittee Report 2017

Maine Commission on Domestic and Sexual Abuse

Electronic Monitoring Subcommittee Report, October 2017

1. Data: Use of ELMO by County in 2016

County	2016 DV ELMO cases	Model	Company
Androscoggin	0		
Aroostook	5	AC Community Corrections	STOP LLC
Cumberland	18	Pretrial Services	Sentinel
Franklin	0		
Hancock	10	Sheriff's Office	Stop LLC
Kennebec	0	DA's Office	Stop LLC
Knox	0		
Lincoln	7	Sheriff's Office	Stop LLC
Oxford	0		
Penobscot	0		
Piscataquis	0		
Sagadahoc	5	Sheriff's Office	Stop LLC
Somerset	5	Sheriff's Office	Stop LLC
Waldo	9	Sheriff's Office	Stop LLC
Washington	0		
York	0		
Tribal Courts	0		
Probation	None in 2016: 3 DV, 4 sex offenders, prior years	Probation	Stop LLC, 1 Sentinel

2. Report from Research and Judicial Branch IPV Conference Panel presentation

349 people (judges and lawyers) attended the Intimate Partner Violence sessions organized by the Maine Judicial Branch as part of the 2017 Maine Bar Association meeting. The only Maine presentation was a panel on Electronic Monitoring, for which a Best Practices fact and data sheet was prepared (see Appendix A). It

became clear from the presentations (and data gathering for the chart above) that the infrastructure supporting the programs is under-resourced, depending largely on local contact people (Pretrial, Sheriff's or DA's Office) who are available 24/7 to coordinate responses. While admirable, the group did not believe this was a sustainable model.

3. Companies/models in Maine

The Committee discussed trying to develop a chart to compare and contrast services provided by the two companies who are offering services in Maine. But given that STOP LLC appears to have individual agreements with each jurisdiction in which they work, such a chart does not seem to be practical. For example, victim notification is not even a part of some of the programs, where only a Sheriff's Office coordinator and dispatch are notified of a breach by the monitoring company.

There appear to be four models in Maine, if Probation is counted separately. In the chart, the "Model" column identifies where the Electronic Monitoring project is based. The majority of the programs in operation in Maine are based in the Sheriffs' Offices, with one in the prosecutor's office, and one at Maine Pretrial Services. Only the Cumberland County model that uses Maine Pretrial Services and the Sentinel Company offers victims the opportunity to carry a mobile device. Victims in Cumberland County have reported being well supported, and high satisfaction with the program.

4. "Best Practices"

The subcommittee decided that with the current variety of programs and models in Maine, and the small group of participants in the subcommittee, it would not be possible to create a list of "best practices." Instead, the report to the Commission will consist of the ELMO data and fact sheet created for the Judicial Branch panel, and a checklist of questions that should be addressed before any jurisdiction attempts to implement an electronic monitoring program for Domestic Violence and Sexual Assault cases.

5. Statewide Recommendations- LD 1183:

LD 1183 is the bill that proposes funding for infrastructure for a statewide electronic monitoring program. The bill was carried over to the second session, but the hurdle remains regarding where such a program would be based: Office of the Attorney General, Maine Pretrial Services, or Maine Sheriffs' Association. The subcommittee members discussed whether LD 1183 could be a mechanism to provide/support DV Investigators in each prosecutorial district who would have

responsibility for the Electronic Monitoring programs, as well as coordinating victim notification when an offender is released from jail, in addition to their investigative duties.

Questions to Resolve Before Implementing an Electronic Monitoring Program:

The following are a list of questions and issues that should be considered before any jurisdiction implements an electronic monitoring program for domestic violence and sexual assault offenders.

System issues and challenges:

- Eligibility criteria
- Contract with Monitoring Company
- Funding, including for indigent offenders, and fee rates
- Capacity
- Sustainability of the model
- Stage of court process: pre-trial and/or post-conviction
If pre-trial only, victims should be prepared for transition
- Information flow for alerts: victim, dispatch, supervising agency
- Training for law enforcement officers
 - o How to respond to various types of alerts
 - o How to prepare violation reports
 - o Determine information flow: dispatch, patrol, supervisors
- Training for prosecutors on the system and eligible participants
- Expert testimony for trial
- Procedures for terminating participation in the program

Basic Procedures:

ELECTRONIC MONITORING ENROLLMENT FOR DEFENDANTS CHARGED WITH DOMESTIC VIOLENCE

1. Complete Intake Screening, Risk Assessment & ODARA

The defendant must fall within agency guidelines, a decision based on information gathering. A Pretrial Risk Assessment and an ODARA assessment should be conducted. Defendants who are appropriate for the electronic monitoring program are scored as medium/high level risk.

2. Complete Financial Worksheet & Questionnaire

Completing a Financial Worksheet helps determine if the defendant is able to pay for the electronic monitoring program. This required payment should be a sliding scale fee

based on the defendant's monthly income and is payable daily, weekly or bi-weekly through money order, credit/debit card or online. The financial questionnaire should help to establish profile information of the defendant's current financial situation. Utilization of available funding sources should be considered to offset the cost of monitoring.

3. Coordinate a Victim Safety Plan with System Partners

System partners should include the District Attorney's Office, Victim Witness Advocates, local Domestic Violence Resource Center, Law Enforcement Agencies (including Dispatch/Communications), Probation and Jail Staff. Comprehensive coordination allows for the gathering of the most accurate victim information to establish exclusion/mobile zones and to determine if the victim would like to carry a mobile device (where available). The coordination also allows for timely and accurate information flow to the victim.

4. Enroll Defendant/Alleged Victim into the Monitoring System

Enrollment includes assigning devices, inputting profile information and creating exclusion zones/schedules. Exclusion zone maps, victim information and administrator contact information should all be included in a "monitoring packet" that can be disseminated to local law enforcement and dispatch centers prior to a defendant's release on electronic monitoring. Address issues/information flow for exclusion zones in a jurisdiction outside the county.

5. Review & Sign Electronic Monitoring Agreement

Prior to release, an electronic monitoring agreement should be reviewed with the defendant. Components of this agreement include providing proper maintenance to the electronic monitoring equipment, geographic prohibitions, payment instruction, charging instruction, reporting instruction and potential consequences for violations that occur.

6. Coordinate & Arrange Device Placement & Release From Jail

Once release/bail conditions are approved by the court, program administrator notifies/coordinates with Jail staff to place the device on the defendant prior to being released. Additional notification/coordination with family, friends or acquaintances of the defendant should be arranged if a cash bail component is required for release.

7. Release Notification

When prepared for release, all documentation is sent out to corresponding Law Enforcement Agencies, Dispatch Centers and all other System Partners. These documents include:

- Law Enforcement Notification Form
- Electronic Monitoring Supervision Contract
- Bail Conditions provided by the Court of jurisdiction
- Electronic Monitoring Program Fact Sheet

8. **Alert Notification**

Alerts received can include: Exclusion Zone violation, Mobile Zone violation (if the company offers this service), Buffer Zone violation, Tamper, No Location/Communication, and Low Battery. All alerts except Low Battery alerts should be sent directly to local dispatch centers, or a point person who can quickly send law enforcement to respond. The victims should also be notified immediately by the company. Initial low battery alert notifications are sent out to the supervising agency, to be followed up by law enforcement only if the device stops sending location information due to low/dead battery. Protocols for responding to alerts should be carefully devised with the company, supervising agency, law enforcement (including PSAP/communications agents), and victim service agencies.

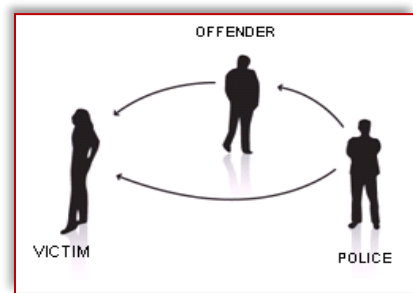
Electronic Monitoring Victim Notification Questions:

1. Does your multidisciplinary team have a clear process or policies to define roles and responsibilities for victim contact and notification?
 - a. Has the team determined the agency or point person for victim contact through the duration of electronic monitoring?
2. How do team members of the multidisciplinary team communicate information to one another in reference to:
 - a. Defendant's Monitoring and conditions
 - b. Enforcement of violations
 - c. Victim notification and safety planning
3. Has the Victim been notified that monitoring is being considered as part of pre-trial bail?
4. Has the Victim been contacted in reference to input for restrictions? (Example: inclusion/exclusion zones, buffer zones, curfew etc.)
 - a. Do the restrictions of monitoring enhance victim safety?
 - b. Do the other Bail conditions enhance victim safety?

5. Are there exemplary conditions that need to be considered when establishing restrictions to defendant? (For Example)
 - a. Is the victim's address confidential? Do any of the defendant's exclusion zones unintentionally release this information?
 - b. Are there specific concerns about kidnapping/abuse of children? Should their schools be excluded?
6. Has the Victim been informed about how electronic monitoring operates:
 - a. How the equipment works?
 - b. How monitoring occurs?
 - c. Action if there is a violation?
 - d. How they will be notified of violations or change in status?
 - e. Limitations of electronic monitoring, i.e., that it cannot guarantee victim safety
7. Who does the victim call to receive or share information?
 - a. If there is a violation
 - b. If they have concerns
 - c. If they have questions about status or program
8. Is there an option for the victim to carry a device?
 - a. Who is responsible for assisting with acquiring device?
 - b. Has there been a discussion about capabilities/restrictions of a victim carried device?
 - c. Are they informed about how to maintain device? (Charging etc.)
9. Is the victim referred to victim services for safety planning and support?
 - a. District Attorney's Office Victim/Witness Assistant?
 - b. Domestic Violence Resource Center?
 - c. Sexual Assault Resource Center?
10. Who is responsible for notifying the victim if there is a safety concern or violation?
11. What is the timeline for victim notification?
 - a. Is it timely?
 - b. Does it enhance safety?
 - c. Is it sustainable?

Appendix A: Electronic Monitoring Best Practices Fact Sheet 2017

- **Domestic Violence Electronic Monitoring and Victim Notification:** Pretrial electronic monitoring programs for medium to high-risk domestic violence offenders are distinctly different from those that offer post-conviction home confinement options for low-risk offenders.



- **MDT:** A dedicated, multidisciplinary team with clearly defined roles and responsibilities, and layered, consistent protocols are

essential to a successful domestic violence electronic monitoring project; planning, education, and ongoing communication are key. The team should include: prosecutors and victim witness assistants, domestic violence resource center advocates, law enforcement including DV investigators, communications/dispatch representatives, pretrial services case managers, probation officers, and jail intake staff.

- **Victim Participation:** A GPS monitoring program “should be victim-centered and have victim safety as its core goal.”¹
- **Program Eligibility:** Appropriate candidates are those determined to be medium to medium-high risk using validated risk assessment tools. “High-risk defendants who are not currently deemed appropriate for bail should not be considered as candidates for GPS monitoring... In addition, low risk individuals are not appropriate as there may be negative effects for over scrutiny of low risk individuals.” ²
- **PFA vs. Criminal Justice System:** The required multidisciplinary teams and infrastructure exist only in the criminal justice system, an infrastructure not available in the protection from abuse process in the civil system; however, as soon as a protection order is violated, the case moves into the criminal justice system and the offender becomes eligible for electronic monitoring when released into the community.
- **Response:** Every element must be in place with clear roles before the program starts, from protocols covering appropriate response to alerts (violation of exclusion zones, tamper alerts, low battery/no location alerts) to funding and decisions about who has access to the data. All stakeholders should be educated about the importance of appropriate, timely response and consequences for violations. Victim notification and law enforcement response to an exclusion zone or tamper alert violation must be immediate.
- **Risk Management:** Electronic Monitoring is an important risk management tool, which is a critical component of Maine’s focus on risk assessment and our High Risk Response Teams. Victims report feeling more connected to the court process and safer when electronic monitoring is in place. Research shows more victim participation in cases where the offender is monitored pretrial, and lower recidivism post-program.

¹ Final Report: Governor’s Task Force to Reduce Domestic Violence Through Technology, 2012, p. 16.

² Final Report: Governor’s Task Force to Reduce Domestic Violence Through Technology, 2012, p. 16.

➤ **What the technology can do:**

- GPS monitoring is an effective tool that can augment pretrial case managers' or corrections staff ability to supervise offenders released to the community under certain conditions (including no contact with the victim)
- GPS can enhance victim safety, and provide notification to the victim about offender location
- GPS can increase the information available to communications officers and law enforcement responding to alerts
- GPS can be used to document potential violations of conditions of release
- GPS can be used as an effective alternative sanction for certain offender populations while also reducing the cost of housing them in a jail and/or correctional facility

➤ **What the technology cannot do:**

- While GPS monitoring is a useful tool in community supervision, it cannot ensure compliance
- GPS devices cannot track, locate, and communicate accurately without being able to constantly communicate with both the GPS Network and Cellular Communications network
- GPS tracking devices require a daily charge; without being charged, the device cannot reliably track and locate
- GPS tracking devices provide data that cannot be used effectively without having someone to interpret the data and immediately respond to that information

2016 Maine Data:

County	2016 DV ELMO cases	Model	Company
Androscoggin	0		
Aroostook	5	AC Community Corrections	STOP LLC
Cumberland	18	Pretrial Services	Sentinel
Franklin	0		
Hancock	10	Sheriff's Office	Stop LLC
Kennebec	0	DA's Office	Stop LLC
Knox	0		
Lincoln	7	Sheriff's Office	Stop LLC
Oxford	0		
Penobscot	0		
Piscataquis	0		
Sagadahoc	5	Sheriff's Office	Stop LLC
Somerset	5	Sheriff's Office	Stop LLC
Waldo	9	Sheriff's Office	Stop LLC
Washington	0		
York	0		
Tribal Courts	0		
Probation	3 DV, 4 sex offenders	Probation	Stop LLC, 1 Sentinel

Appendix J: Maine's Homicides for 2016

MAINE'S 16 HOMICIDES FOR 2016

(MURDER-MANSLAUGHTER)

Compiled by the Maine Department of Public Safety
Steve McCausland, Public Information Officer

1/11 FAIRFIELD – newborn boy dies on December 30 and body is discovered inside garage on 1/11. Baby's mother – Kayla Stewart, 20, is charged with murder and manslaughter **DOMESTIC**

1/14 WINDHAM – Alicia Gaston, 34, is shot to death inside her home. Her husband, Noah Gaston, 34, is charged with murder. **DOMESTIC**

3/5 SEBAGO – Charles Cross, 66, is shot and killed in the driveway of his home. A friend, David Pinkham, 67, is charged with murder.

3/15 PORTLAND – David Anderson, 36, is shot to death inside an apartment on Gilman St. Portland Police are investigating

4/9 ST ALBANS – Randy Erving, 53, is shot to death at his home. His nephew, Jeremy Erving, 24, is charged with murder.

6/1 WILTON – Michael Reis, 24, is shot to death outside the home of Timothy Danforth, 24, of Wilton. Danforth is indicted for murder and manslaughter in August.

6/10 LIMINGTON – Douglas Flint, 55, is killed at his home with a machete. His neighbor, Bruce Akers, 57, is charged with murder

7/21 PRESQUE ISLE – Leo Corriveau, 86, is strangled outside his home. A friend, Robert Craig, 80, is charged with murder.

8/15 FALMOUTH – Roger Nelsen, 67, dies from stab wounds. His longtime room-mate, Kenneth Briggs, 27, is charged with murder. **DOMESTIC**

8/25 FAIRFIELD – Valerie Tieman, 34, shot to death at her home and buried in the yard. Her husband, Luc Tieman, 32, charged with murder. **DOMESTIC**

9/26 BIDDEFORD – Jonathan Methot, 30, shot to death in apartment. Timothy Ortiz, 20, from Brooklyn, NY charged with murder. **DRUGS**

10/15 SHERMAN – Douglas Morin, 31, found dead in a car on a remote road. Three people from MA have been charged with murder – Marcus Asante, 20, Darin Goulding, 27, and Tia Ludwick, 23. **DRUGS**

10/31 WINTHROP – Antonio and Alice Balcer, both 47, are stabbed to death inside their home. Their 17 year old son, Andrew Balcer, is charged with two counts of murder. **DOUBLE HOMICIDE – BOTH DOMESTIC**

11/27 NAPLES – Richard Diekema, 55, is shot and killed inside his home by Norman Strobel, 59, who is later killed by Cumberland deputies in a confrontation. Earlier Strobel had wounded a man inside a home in Casco.

12/8 HEBRON – Claire Randall, 27, is shot and killed inside her family's home by her father – Daniel Randall, 56, who shoots and kills himself. **MURDER-SUICIDE - DOMESTIC**

2016 SUMMARY

**7 OF THE 16 HOMICIDES WERE DOMESTIC,
AT LEAST TWO HOMICIDES WERE DRUG RELATED,
9 INVOLVED GUNS, AND FOUR VICTIMS WERE STABBED**

Appendix K: Maine's Homicides for 2017

MAINE'S 21 HOMICIDES FOR 2017

(MURDER-MANSLAUGHTER)

Compiled by the Maine Department of Public Safety
Steve McCausland, Public Information Officer

1/12 TROY Jaxson Hopkins, 7 weeks old, beaten to death at his home. His mother, Miranda Hopkins, 32, indicted for manslaughter. **DOMESTIC**

2/8 WALDO Edwin Littlefield, 43, stabbed to death at a home of a friend. Victoria Scott, 24, is indicted for manslaughter in May.

2/9 RICHMOND Malcolm Linton, 76, beaten inside his home and later dies at a hospital. His son, Kurt Linton, 54, charged with manslaughter. **DOMESTIC**

2/22 ACTON Scott Weyland, 42, stabbed to death outside his home. His ex-wife, Kandee Weyland, 46, charged with murder. **DOMESTIC**

2/28 PORTLAND Bryan Garcia, 35, found dead in car along Chadwick St. Portland Police investigating.

4/2 BURNHAM Joyce Wood, 72, dies of a heart attack after her home was entered by an intruder. Tara Shibles, 36, is indicted for manslaughter in May.

4/16 BANGOR Terrance Durel, 36, is shot to death along Ohio St. Antoinne Bethea, 40, is charged with murder.

6/17 WEST GARDINER James Haskell, 41, shot to death outside of a home. The homeowner, Derrick Dupont, 26, indicted for murder and manslaughter in August

7/5 MADISON Lori Hayden, 52; Dustin Tuttle, 25; & Mike Spaulding shot and killed at their homes by Carroll Tuttle, 51, who is shot and killed by Somerset deputies. **TRIPLE HOMICIDE, TWO ARE DOMESTIC**, as Hayden was Tuttle's wife and Dustin was their son.

7/11 JAY Wendy Douglass, 51, found beaten to death at her home, Her longtime boyfriend, James Sweeney, 56, charged with murder. **DOMESTIC**

7/19 CHERRYFIELD Sally Shaw, 55, found dead along Route 193. Arrested in NY and charged with murder are Carine Reeves, 37 & Quaneysha Greeley, 19. **DOMESTIC**

9/10 PORTLAND Sunai Thomas Yamada, 54, found dead off Temple St. Portland Police investigating.

10/18 BUCKSPORT Kloe Hawksley, 2, dies at her home. State Police detectives announce the death is a homicide in late December.

10/28 WHITNEYVILLE Wayne Foss, 48, found dead inside his burned out mobile home. State Police are investigating.

10/28 HEBRON Karen Wrentzel, 34, shot to death by a deer hunter on first day of hunting season on land that she owned. Robert Trundy, 38, is charged with manslaughter.

11/8 WISCASSET Kendall Chick, 4, dies from a number of injuries. Her caregiver, Shawna Gatto, 43, charged with murder . **DOMESTIC**

11/9 MANCHESTER Kimberly Shue is shot and killed by her husband, Clyde Shue, 82, who shoots and kills himself inside their home. **MURDER SUICIDE - DOMESTIC**

11/17 CARIBOU Jean Bragdon, 44, dies following a fight with another man in Caribou October 30. Jonathan Limary, 22, is indicted for manslaughter in January.

12/19 MILLINOCKET Wayne Lapierre, 59, shot to death following a home invasion. His wife is wounded. State Police issue murder arrest warrants for two North Carolina men – Christopher Murray, 38, and Tony Locklear, 43. Murray is arrested in NC and Locklear remains at-large.