

STATE OF MAINE



Maine Commission on Domestic Abuse

THIRD REPORT OF THE HOMICIDE REVIEW PANEL

Report to the Joint Standing Committee on Judiciary

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Domestic Violence Homicide Review Panel Annual Report

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ENABLING LEGISLATION

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

PANEL MEMBERSHIP

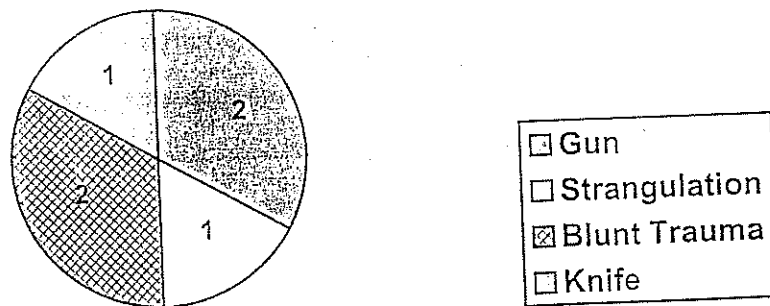
The chair of the commission appoints members of the panel who have experience providing services to victims of domestic abuse. Members shall include at least the following: the Chief Medical Examiner, a physician, a nurse, a law enforcement officer, the Commissioner of Human Services, the Commissioner of Corrections, the Commissioner of Public Safety, a judge assigned by the Chief Justice of the Supreme Judicial Court, a representative of the Maine Prosecutors Association, an Assistant Attorney General handling child protection cases, a victim witness advocate, a mental health service provider, a facilitator of a certified batterers' intervention program, and three individuals designated by a statewide coalition for family crisis services.

The panel meets on a monthly basis, except during the summer. Cases are pre-selected so that material can be gathered ahead of time and each case takes one to two months for a full review. The case review begins with a report by the investigating officer and the Asst. Attorney General Homicide Prosecutor. Other panel members report on information from the agency or discipline they represent as it relates to the case. Sometimes, other individuals, such as family members, friends, educators, or other providers are asked to come before the panel to offer their perspective about the case. This information can be helpful in providing insights into the case that may not be apparent from the written materials. Once the information is reviewed, the panel takes a systems approach in making recommendations on how this homicide might have been prevented.

CASE SUMMARIES

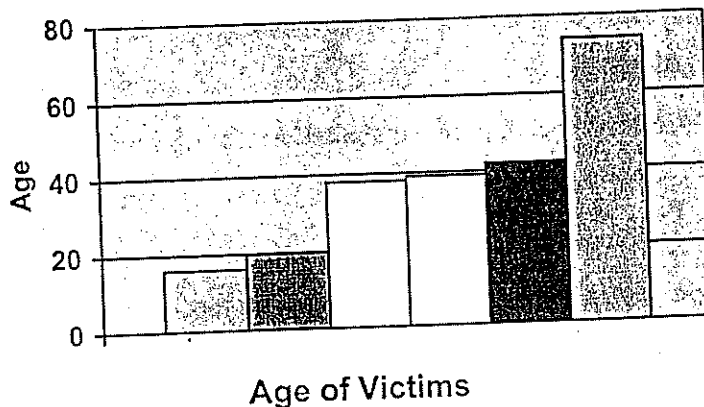
The panel reviewed six domestic violence homicide cases during 2000. The cases reviewed included one homicide that occurred in 1997, three in 1998, and two in 1999. Because the panel does not have the ability to review all cases occurring within a particular calendar year, cases are selected to assure some diversity of geography, circumstances and include those cases that a committee consisting of an Assistant Attorney General within the homicide unit, the Medical Examiner's office, an Asst. District Attorney and the chair of the commission select as being most representative. Additionally, one criterion is that the case was completed, either that there was no prosecution (as in cases where the perpetrator committed suicide) or that a trial or plea had occurred.

In two of the six cases, the murder weapon was a gun. In one case a high-powered rifle and in the other a 44 Magnum were used. Other mechanisms of death included strangulation, blunt trauma and stabbing with a knife. Figure A below shows the methods of death implemented in the six homicides that were reviewed.



Cause of Death.

The victims ranged in age from 16 to 74 and were all female.



The relationships between the victim and the perpetrator were varied, both in type and length of relationship. This was the first time the Panel reviewed a homicide involving a stepfather/stepdaughter relationship. This case also was part of a double homicide that included another victim, which was not domestic related. In another case, the perpetrator served as a caregiver to the victim who became dependent because of health problems. The relationships are depicted as follows:

- One marital relationship
- One long-standing co-habitation, recently separated
- Two prior romantic relationships
- One current romantic relationship
- One Step-parent/Step-child relationship

Length of relationship ranged from a few months to 57 years. Two cases had relationships that were six months or less; 2 cases had relationships between 1 ½ - 2 years; and, 2 cases had long-term relationships of 19 and 57 years.

All of the perpetrators are men. Two of the perpetrators committed suicide. Four perpetrators either pled or were convicted with the following dispositions:

- One pled to Murder and was sentenced to 45 years
- Two were convicted of Murder and sentenced to 35 years
- One was convicted of murder and aggravated assault and received a life sentence

CHILDREN

It is important to pay particular attention to the children affected by domestic violence homicides. Four of the six victims had children. In two of the cases, the children were minors and in the other two cases, the children were adults. Exposure to domestic violence has far-reaching consequences for children. Of the cases reviewed in 2000, four minor children were left without a parent and are left with the effects of witnessing domestic violence in their homes. In one case, the victim's three minor children were present when their father killed their mother and then killed himself. In two of the cases, the victims were children and were still living at home. One victim was still a child and the other young victim was making plans for future with plans of attending college. Both of these two young victims left siblings, who have had to deal with their loss. Whether as a witness or a victim of domestic violence, the impact of domestic violence is devastating to children.

USE OF SERVICES/INTERVENTIONS

In two of the six cases, the victims had contacted the domestic violence program, which is part of the Maine Coalition to End Domestic Violence.

MEDICAL/MENTAL HEALTH INTERVENTIONS

Contact with the medical community occurred in three of the six cases with the Emergency Room and /or physicians. In three of the six cases, victims had been in contact with mental health providers. One victim had seen many doctors and had numerous prescriptions for medication. In one case, the mental health provider received significant information from the perpetrator that should have raised concerns about public safety. Substance abuse was an issue in all of the relationships.

POLICE INTERVENTION / CRIMINAL CONVICTIONS

In every case, there had been contact with the police. Five of the six perpetrators had a prior criminal record and three of the six had prior violent crime convictions.

PROTECTION FROM ABUSE

Only one case had a Protection from Abuse order, which was in effect at the time of the homicide and was a temporary one. In one case, a friend of the victim had received a Protection from Harassment Order to keep the perpetrator away.

PUBLIC AWARENESS

In all of the cases that were reviewed there was some element of public awareness. Three of the women were employed and co-workers were aware of these women's abusive relationships. These women often went to work bruised and/or distressed. In one case, an employer was aware and initiated a policy that the perpetrator was not to have contact with the victim, who was also an employee. Co-workers, who were aware, often would get involved to varying degrees by encouraging the victim to leave the relationship to offering assistance upon leaving. Family, friends and/or neighbors were aware of the abuse that was occurring in five of the relationships. In one case, although the perpetrator was known to have violent tendencies, no one predicted that this victim would be his target. One of the women was homeless, but her community was aware of the violence. In another case, a victim's situation was considered by some as a "mercy" killing because of her age and medical condition.

RECOMMENDATIONS:

This year the Panel's recommendations have been targeted to specific sectors within state government and other stakeholders to improve the response to domestic violence within and among the agencies that deal with domestic violence through public policy development and systems improvements. It is our plan to report on the status of these recommendations as part of the next annual report.

LABOR

1. Information on domestic violence awareness, prevention and intervention needs to be available as a resource for small businesses. Many times employers and co-workers see the symptoms of domestic violence, but do not know how to intervene. This may be due to lack of resources or just a lack of information on how to address the problem. The recent initiative of the Governor's Office and the Maine Coalition to End Domestic Violence, Maine Employers Against Domestic Violence, can play a role in addressing this gap by encouraging both small and large employers in the State of Maine to disseminate information to employees about domestic violence prevention and intervention strategies.

HEALTH

2. Information on teen dating violence needs to be available where teens are likely to go for other information, especially at health care clinics where teens go for information on health issues and birth control. The Panel recommends that the Bureau of Health – Division of Maternal & Child Health coordinate efforts to provide information on teen dating violence at these places.
3. Three major recommendations for the medical/health field are:
 - a. Domestic violence screening as a part of patient in-take;
 - b. Discharge planning follow-up; and
 - c. Communication among medical personnel regarding medication to avoid over-medication that may mask signs of domestic violence.

It is clear that often the only possible intervention point that a victim may have is through a contact with the medical community. The contact may be totally unrelated to the domestic violence issue or domestic violence may be an underlying cause for the medical contact. If routine screening occurs, and if domestic violence is discovered access to remedies and services at that time should be provided.

CORRECTIONS

4. Programs for women in correctional facilities should focus on domestic violence issues including:
 - a. Screening for domestic violence in county jails.
 - b. Programs integrated with parent issues.
5. Probation with intensive supervision to ensure offender accountability.
6. Domestic Violence Probation Officers who have a reasonable caseload and are available in every region of the state to ensure offender accountability.

LEGISLATIVE

7. Modification to existing laws to ensure forfeiture of guns used in the commission of a crime.
8. Support legislation to require Pre-Sentence Investigations for the third domestic violence conviction.
9. Legislation to allow the court to remove any weapon from the defendant as part of interim or emergency relief under the Protection From Abuse Act.

JUDICIAL & PROSECUTORIAL

10. The next Sentencing Institute should address the issue domestic violence particularly as in relates to the issue of sentences imposed for violations of probation, crimes of violence, and Protection from Abuse Orders.

11. Prosecutors should recommend that a Pre-Sentence Investigations (PSI) should include a dangerousness assessment be completed for all third offense domestic violence cases.
12. The State Forensic Service should work in conjunction with Batterers Intervention Programs and the Maine Coalition to End Domestic Violence to develop and train on domestic violence dangerousness assessment.

PUBLIC SAFETY

13. Examine the issue of guns used in domestic violence and other gun related crimes.
14. Research and develop model policies on the following:
 - a. Removal of guns in circumstances of domestic violence, particularly when a Protection From Abuse order has been ordered.
 - b. Having two officers present when the victim's belongings are being retrieved, to the extent possible.
 - c. Not having the victim and the perpetrator present at the same location when personal property is being retrieved.
15. Cases should be reviewed by a Domestic Violence Coordinator to assess whether the case was handled appropriately.
16. The issue of safety of children should be addressed in every police policy.

MAINE COALITION TO END DOMESTIC VIOLENCE

17. Resources and training for domestic violence advocates for improved communication with law enforcement and the courts.
18. Identify barriers and explore cultural sensitivity that prevents women from utilizing services.

HUMAN SERVICES

19. Public awareness and education, to include:

- a. Cross-disciplinary training with homeless, medical and mental health providers; and,
- b. Public education including a media campaign to address the issue of awareness of domestic violence, the resources available and the importance of safety planning.

MAINE STATE HOUSING

20. Continue to address the need for housing options for domestic violence victims and their families to include transitional housing and shelters.

CONCLUSION

Into its third year of reviewing cases, the Homicide Review Panel has further refined the process of looking at cases with a broad perspective offered by the multi-disciplinary panel. In this year's cases, the panel was able to direct its recommendations to particular stakeholders within state government or the community that have a role in working with victims of domestic violence. These recommendations can then be used by the designated agency for action. Most of the agencies have a representative on the panel, which is critical to providing insight into the existing practices and making suggestions for improving the system. One of the recommendations is to broaden the panel, by including representatives from the education profession. A representative from the Department of Education and from the Maine Principal's Association will be provide that link in addressing the issue of domestic violence in children who are witnesses and victims themselves.