Department of Health and Mental Hygiene

Maryland Fatality Reviews
Homicides Among Women and Children

Prepared by the Center for Maternal and Child Health, Family Health Administration

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Introduction

Violent deaths due to homicide among women and children are always associated with enormous trauma and tragedy. Fatality review is a recognized method for understanding the prevalence, risk factors and circumstances surrounding these deaths in order to make recommendations to prevent such deaths in the future. Case review does not seek to place blame or reinvestigate deaths; it seeks to enhance community collaboration and safety.

In Maryland, all fatality review committees are under state statute, ensuring that reviews are conducted and that all information is confidential, immune from liability, and protected from civil and criminal proceedings. Ongoing reviews of deaths, including homicide cases, are conducted by multidisciplinary committees in Maryland for the following populations:

- Child Fatality Review (CFR)
- Domestic Violence Fatality Review (DVFR)
- Maternal Mortality Review (MMR)

It should be noted that the Fetal and Infant Mortality Review (FIMR) does not routinely review homicide cases. Fetal deaths due to homicide are reviewed by MMR as the deaths occur during pregnancy and infant homicides represent <1% of all infant deaths and are reviewed by CFR.

Information about Maryland homicides among women and children is gathered from numerous sources including: Maryland Vital Statistics Administration, Maryland Office of the Chief Medical Examiner, State and local fatality reviews, Maryland Violent Death Reporting System, State and local police agencies, Maryland Network Against Domestic Violence, National MCH Center for Child Death Review, and Maryland Department of Juvenile Systems.

Conducted in the spirit of public health, data about homicides among women and children is presented in this report along with fatality review findings so that future deaths may be prevented.

Definitions

The following definitions were used for this report.

Child abuse: Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm.

Child death rate: number of deaths to children under age 18 per 100,000 children in the same age range

Domestic Violence (DV): Any incident of threatening behavior, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. Intimate partner violence is a type of DV.

Homicide: the killing of one human being by another human being

Homicide rate: number of homicides per 100,000 persons in specified group

Intimate Partner Homicide: Any homicide against a current or former spouse or current or former cohabitant intimate partner. IPV can be committed by a spouse, an ex-spouse, a current or former boyfriend or girlfriend, or a dating partner. This includes same sex relationships. (as defined by the Maryland Uniform Crime Reporting Program)

Intimate partner violence (IPV): physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples. IPV is a type of domestic violence.

Pregnancy-associated death: a death to a woman from any cause while she is pregnant or within one year of termination of pregnancy, regardless of the site or duration of the pregnancy.

Key Findings

From 2005-2009, there were 243 homicide cases among Maryland children ages 0-17 and 333 homicide cases among Maryland women ages 18+. Approximately, three out of every four homicide cases occurred among residents of Baltimore City, Prince George's County and Baltimore County. Homicide rates were highest among residents of Baltimore city, adolescents ages 15-17, and females ages 18-24. Homicide was the 2nd leading cause of death among children ages 1-17 and among women ages 18-24. It was the leading cause of death among women during pregnancy and within one year postpartum.

Fatality review is a recognized method for understanding the prevalence, risk factors and circumstances surrounding the death in order to make recommendations to prevent such deaths in the future. The following recommendations are from state and local reviews of maternal mortality, child fatality, and domestic violence fatality completed during the past five years.

This recommendation has come up multiple years from multiple review teams:

- Establish a state web site to inform health providers about intimate partner violence (IPV) assessment
    - The medical community can play a vital role in helping adolescents and adult women suffering from IPV to stop the cycle of abuse through screening, support, and reviewing available options. Health care providers are often the first professionals seen by women who are abused. The U.S. Department of Health and Human Services (DHHS) has endorsed the Institute of Medicine (IOM) in its recommendation that IPV screening and counseling be a core part of women's health visits. Education about screening tools, safety assessment, confidentiality rules, Maryland reporting mandates, forensic evidence requirements, medical coding, and local referral sources will provide the skills and confidence providers need to routinely assess for IPV. This can be an invaluable asset for hospitals, clinical practices, local health departments, federally qualified health centers, public health sites, home visiting programs, Healthy Start, and all clinicians involved in the care of women.

Other recommendations from fatality reviews:

- Have obstetrical providers routinely assess for intimate partner violence (IPV)
    - homicide was the leading cause of death during pregnancy and postpartum
    - a current or ex- intimate partner was the perpetrator in 56% of these homicides
- Providers who commonly see women should routinely assess for IPV
    - the 1st trimester was the most common time period for intimate partner homicides—before some women have started prenatal care
    - reproductive coercion (partners who do not support women's decision to become pregnant or use contraception) may be a high risk factor for more serious IPV
        - the family planning program is an opportune time to screen for IPV

    - women seen by emergency room providers, testing sites for HIV/sexually transmitted infections, providers of mental health and substance abuse treatment should always assess for IPV
        - the majority of medical charts had no documentation of IPV assessment
- Promote referrals to community domestic violence agencies
    - most women had not benefited from the services of community based domestic violence programs prior to their deaths
        - counseling, residential services, safety planning, legal advice are available
    - the Maryland Lethality Program can identify women at high risk of injury and connect them to a domestic violence program
    - domestic violence programs within hospitals would facilitate IPV assessment and collection of forensic evidence for prosecution
    - collaborate with clergy, military bases, schools to increase sources of referrals
- Facilitate medical care to IPV Victims who sustain injury
    - Many women were not evaluated medically after strangulation despite the serious health consequences associated with it
- Strengthen involvement of the criminal justice and law enforcement system
    - Create a specialized unit in police departments that can be trained in family violence cases and the collection of admissible evidence for prosecution
    - Encourage use of protective orders when appropriate
    - Foster communication between the Division of Parole and Probation, State Attorney's Office, and detention centers
        - When appropriate, alert and update others about violations of parole, issue of warrants, handgun violations, protective orders for violence cases
- Promote education about dealing with the stress of taking care of an infant
    - Abandonment of newborns can be prevented by allowing distressed mothers to use the Safe Haven Program
    - Educate parents and caregivers about dangers of "shaken baby syndrome"
- Improve access to resources for males who wish to prevent violence in intimate relationships
- Enhance support for children exposed to violence
    - Children from abusive households were at risk for poor outcomes (destructive behaviors, mental injury, criminal acts) and need a protocol for accessing appropriate support services

Homicides among Children (<18 years)

Maryland Data

There were 154 child (<18 years of age) homicide cases between 2007-2009. The homicide rate was highest among the oldest age group (ages 15-17) and lowest among 5-9 year olds. Over half (55%) of all homicide victims were 15-17 years old. Among racial and ethnic groups, non-Hispanic Black children accounted for 68% of all homicide victims. Three out of four child homicide victims were male (Table 1).

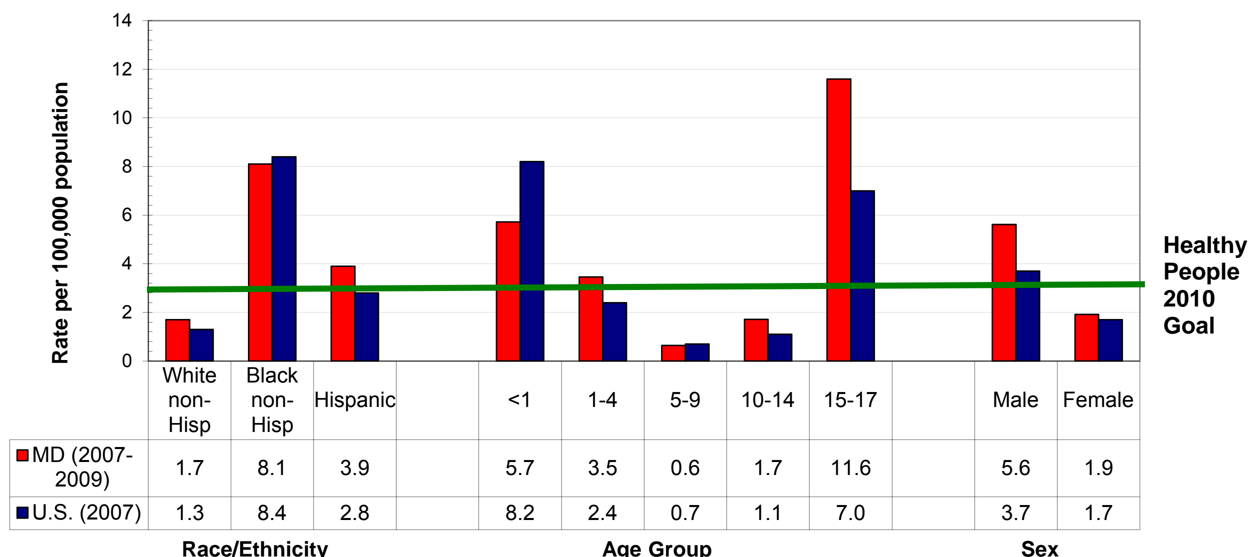
Table 1. Child (0-17 years) Deaths Due to Homicide by Age Group, Race/Ethnicity and Sex, Maryland, 2007-2009

	By Firearm 57%		By Other Means 43%		Total 100%	
	# of Deaths	Rate per 100,000	# of Deaths	Rate per 100,000	# of Deaths	Rate per 100,000
Age Group, years						
<1	1		12	5.3	13	5.7
1-4	2		29	3.2	31	3.5
5-9	3		4		7	0.6
10-14	14	1.3	5	0.5	19	1.7
15-17	68	9.4	16	2.2	84	11.6
Race/Ethnicity						
White, Non-Hisp	16	0.8	18	0.9	34	1.7
Black, Non-Hisp	68	5.3	36	2.8	104	8.1
Asian, Non-Hisp	1				1	
Hispanic	3		12	3.1	15	3.9
Sex						
Male	75	3.6	41	2.0	115	5.6
Female	13	0.7	25	1.3	38	1.9
All	88	2.2	66	1.6	154	3.8

Data Source: MD DHMH, Vital Statistics Administration
Rates based on <5 events in the numerator are not displayed

Maryland's homicide rate in 2007-2009 for children aged 15-17 years was substantially higher than the national rate (Figure 1). The Healthy People 2010 goal for reducing the homicide rate was 3.0 per 100,000 population (all races, gender, ages). In 2009, Maryland's total child mortality rate from homicide (all ages) was 7.8.

Figure 1. Child (0-17) Deaths Due to Homicide, Maryland, 2007-2009, U.S., 2007



Data Sources: MD DHMH, Vital Statistics Administration,
CDC National Center for Injury Prevention and Control,
U.S. Department of Health and Human Services, Healthy People 2010

Table 2. Leading Causes of Death among Children 1-17 by Age Group, Maryland, 2007-2009					
Rank	Cause of Death Number of deaths (% of total in age group)				
	Ages 1-17 years	Ages 1-4 years	Ages 5-9 years	Ages 10-14 years	Ages 15-17 years
1	Accidents 262 (28%)	Accidents 59 (23%)	Accidents 42 (31%)	Accidents 52 (27%)	Accidents 109 (32%)
2	Homicide 141 (15%)	Homicide 31 (12%)	Respiratory Disorders 13 (10%)	Cancer 24 (12%)	Homicide 84 (25%)
3	Cancer 74 (8%)	Congenital Malformations 31 (12%)	Cancer 12 (9%)	Homicide 19 (10%)	Suicide 38 (11%)
Data Source: MD DHMH, Vital Statistics Administration					

Homicide was the second leading cause of death for children (1-17 years) overall, and among the top 3 for all age groups except ages 5-9 (Table 2). The homicide rate among children <1 year of age was the second highest rate among the age groups shown in Figure 1, surpassed only by homicides among older teens. For children < 1 year of age, there were 13 deaths due to homicide which accounted for <1% of all infant deaths (not shown).

Table 3. Child (0-17 years) Homicide Deaths by Suspected Perpetrator, Maryland, 2003-2007		
	Number of Deaths	% of Total Homicides
Total Homicides	238	
Acquaintance	35	14.7
Parent	30	12.6
Other Relative	8	3.4
Parent's Partner	6	2.5
Girlfriend/Boyfriend	2	0.8
Unrelated Caregiver	1	0.4
Stranger	1	0.4
Unknown	155	65.1
Data Source: MD DHMH, MD Violent Death Reporting System		

According to the Maryland Violent Death Reporting System, the suspected perpetrator among child homicide deaths 2003-2007* (the most recent 5-year period available) was a parent, partner of parent, or relative in 18% of cases. However 65% of cases had no known suspect at the time data was collected.

The Maryland Department of Juvenile Services is also involved in reviewing homicide deaths to children and identifying instances involving child abuse.

Maryland CFR teams are now actively entering data into a new electronic child death review registry (National MCH Child Death Review System), from which they can get reports on the details and types of cases that they have reviewed. Data from this registry will provide important information, at the state level, into the causes of child deaths and the recommendations for preventing these deaths.

*The Maryland Violent Death Reporting System (MVDRS) collects data on all violent deaths in Maryland using data from multiple source documents including death certificates, Medical Examiner reports, Police reports and Supplementary Homicide reports. What distinguishes MVDRS data from other data sets is the amount of circumstantial data collected that can help guide violence prevention efforts. One of the objectives of MVDRS is to share information learned from MVDRS with partners, collaborators and the general public through presentations, published manuscripts and reports.

Child Fatality Review

The Child Fatality Review Committee reviews the deaths of children from birth through age 17.

Maryland Statute:	House Bill 705, 2009 Health-General Article, SSSS5-701 and 5-704, Annotated Code of MD
State Team:	Yes
Chair of State Team:	Richard Lichenstein, M.D. (pediatrician)
Coordinated by:	Center for Maternal and Child Health, DHMH,
Members of State Team:	Representatives from offices of state attorney general, chief medical examiner, Department of Human Resources, Department of Health and Mental Hygiene (including Alcohol and Drug Abuse Administration), State Superintendent of Schools, Juvenile Justice, State Police, Vital Records, pediatric medicine, others with interest in child safety
Local Teams:	Yes, all jurisdictions
Members of Local Team:	Representatives from local departments of county health, State's attorney, Social Services, schools, law enforcement, substance abuse, child welfare, child abuse and neglect, mental health, pediatrics
Other:	Collaborates with State Citizen Review Board for Children State Council on Child Abuse and Neglect

Findings from Child Fatality Review

From 2007-2009, there were 154 homicide deaths among children 0-17 years of age. The victim was a male child in three out of every four deaths due to homicide (Table 1). Children in the 15-17 years age group and African American children had the highest incidence of deaths due to homicide. Firearms were responsible for 57% of all deaths due to homicide. For the 15-17 years age group, firearms were responsible for 81% of deaths due to homicide.

The homicide rate among children <1 year of age (5.7 per 100,000 population) was surpassed only by the homicide rate among teens (11.6 per 100,000 population). Even so, there were 13 homicides among infants (age < 1 year) out of 1,780 infant deaths, representing just 0.7% of infant deaths during the three-year period. If only the ages 1-17 years age group is considered, there were 141 homicides that accounted for 15.2% of all deaths and 29.7% of all deaths due to injury.

Annual reports from 2006-2010 from local CFRs were primarily focused on promoting safe infant sleep practices, suicide prevention, and reducing teen motor vehicle collisions.

Maryland's State Child Fatality Review Team (SCFRT) is dedicated to improving the lives of Maryland's children by investigating and analyzing cases of unexpected child deaths. Local teams investigate cases and provide recommendations and, the state team provides training and guidance to effect positive change with the goal of decreasing the number of preventable deaths and injuries. The chair of the state CFR Team, Dr. Lichenstein, recognizes the importance of reviewing homicide cases:

"Violent causes of death to children are among the top 3 causes of death for this population and remain a top priority for the State team. Homicide (child abuse) was the second leading cause of death in children 1-4 years of age, third leading cause for children 10-14 years of age, and second leading cause of death for adolescents 15-17 years of age. In addition suicide was the third leading cause of death for teenagers 15-17 years of age from 2007-2009.

Over the last 3 years we have had specific training to local teams highlighting interventions such as Dr. Carnell Cooper's Baltimore City Violence Prevention Program and this year's annual training meeting focusing on Rob Schmidtt's suicide prevention program in Talbot County. In addition this year we will be also be presenting "An Analysis of Violent Death Trends Using the Maryland Violent Death Reporting System.

The State CFR Team is highly motivated to continue in its efforts to partner with local team initiatives to reduce injuries and fatalities secondary to violence and preexisting state program such as the CHAMP child abuse program. By coordinating efforts we are optimistic in helping our most vulnerable citizens lead healthy and violent free lives."

Richard Lichenstein, M.D., Chair State Child Fatality Review Team, 2011

The following recommendations or actions resulting from LCFR death reviews relating to homicide prevention were focused on the infancy period and older youths.

Recommendations

1) **Increase awareness among young parents about the Maryland Safe Haven Law**

Some mothers, especially teens, who don't have a good support system find parenting to be overwhelming. In the past, there were cases of mothers who were so distressed that they had left their babies at random places without anyone's knowledge. Increasing awareness that there is the Maryland Safe Haven Law where babies can be left with an adult or at a hospital may save some infant lives. The Safe Haven Law does not get much publicity so there is a need to train police officers, school staff, nurses and parents about the law.

2) **Educate parents, caregivers, and home visiting staff about "shaken baby syndrome"**

Abusive head trauma (AHT), also known as shaken baby syndrome (SBS), is the leading cause of death for child abuse cases in the U.S. It is most prevalent among infants less than 6 months of age. Education should be given to all parents prior to leaving the delivery hospital. Continue this education during the first postpartum year, especially targeting fathers. Equally important is education of day care providers. The emergency room clinicians, medical providers, nurses, and home visiting staff should also have continuing education about AHT.

3) **Help keep parents and their children safe from volatile child custody arrangements**

Sharing child custody is a difficult situation when the relationship is complicated by past or current domestic violence. At times, the child's life may be in danger during volatile situations. Designation of a "Safe Hand-Off Center" would create a public setting where the transfer of the care of the child from one parent to the other could take place safely. The Center could also be used for supervised visitation sessions.

4) **Increase background check of foster parents and their household**

Households of foster parents may be unsafe places for children. Although background checks are carried out on the foster parents, sometimes there are changes in the household or visitors that have not been checked for criminal backgrounds. Notification should take place anytime the composition of the household changes.

5) **Promote activities to decrease adolescent violence**

There has been a recent increase in teen violence, especially with firearms. More focus needs to be placed on preventing teen violence. Involve the Parks and Recreation Coaches to help mentor adolescents in nonviolent behavior. Explore methods to decrease gang violence. A video, "Kids, Drugs, Crimes and Consequences" may help facilitate educating teens.

6) **Collaborate more closely with Departments of Social Services and Juvenile Services**

Youths who have problems with school truancy are at higher risk of violent behaviors. The school system can work together with the Department of Juvenile Services to target these children. All

child fatalities indicate a high risk environment and these deaths should be reported to the Department of Social Services especially if there are other children in the household, even if abuse or neglect is not suspected.

7) Educate teens about domestic violence and dating violence

Dating violence is getting more common among teens. Also, they may be living in an abusive household. Have the school system integrate more education about domestic violence. More outreach should be done so that children are knowledgeable about unhealthy relationships and where they can go to get help. Facilitate a conference or event that parents can attend together with their teens to discuss teen dating violence. Increase home visiting for children at-risk of child abuse. Increase education about reporting child abuse to the Department of Social Services (DSS). Family financial stress may increase risk for violence. Involve banks, realtors, mortgage services with education about mental health and referral sources.

8) Promote gun safety

When adults keep guns in their homes, they leave their children susceptible to accidental shooting and even death. Safe firearm storage should be promoted. Explore and publicize the different options of keeping firearms safe in the home.

Homicides among Women (18+ years)

Maryland Data

There were 333 adult (18+ years) female homicide cases during 2005-2009. Among racial and ethnic groups, non-Hispanic Black women accounted for 59% of all homicide victims. The homicide rate among the youngest age group (ages 18-24) and was nearly five times higher than the rate of the 65+ age group (5.1 vs. 1.1). Approximately half of all homicide victims were ages 25-44 years old. See Table 4.

Table4. Female (18+ years) Deaths Due to Homicide by Race/Ethnicity, Maryland, 2005-2009

	By Firearm 49%		By Other Means 51%		Total 100%	
	# of Deaths	Rate per 100,000	# of Deaths	Rate per 100,000	# of Deaths	Rate per 100,000
Race/Ethnicity						
White non-Hispanic	51	0.8	66	1.0	117	1.7
Black non-Hispanic	107	3.2	89	2.7	196	5.9
Asian non-Hispanic	3		4		7	1.2
Other non-Hispanic	0		1		1	
Hispanic	2		10	1.8	12	2.1
Age Group, years						
18-24	42	3.2	26	2.0	68	5.1
25-44	79	2.0	86	2.1	165	4.1
45-64	38	1.0	41	1.1	79	2.0
65+	4		17	0.9	21	1.1
All Races/Ethnicities	163	1.5	170	1.5	333	3.0

Data Source: MD DHMH, Vital Statistics Administration
Rates based on <5 events in the numerator are not displayed

Firearms were the most common method of death. Among the youngest age group (18-24 years), firearms were the weapon used in 62% of deaths—the highest of any age group (Table 4). Firearms were the method of death in only 19% of deaths in the 65+ age group.

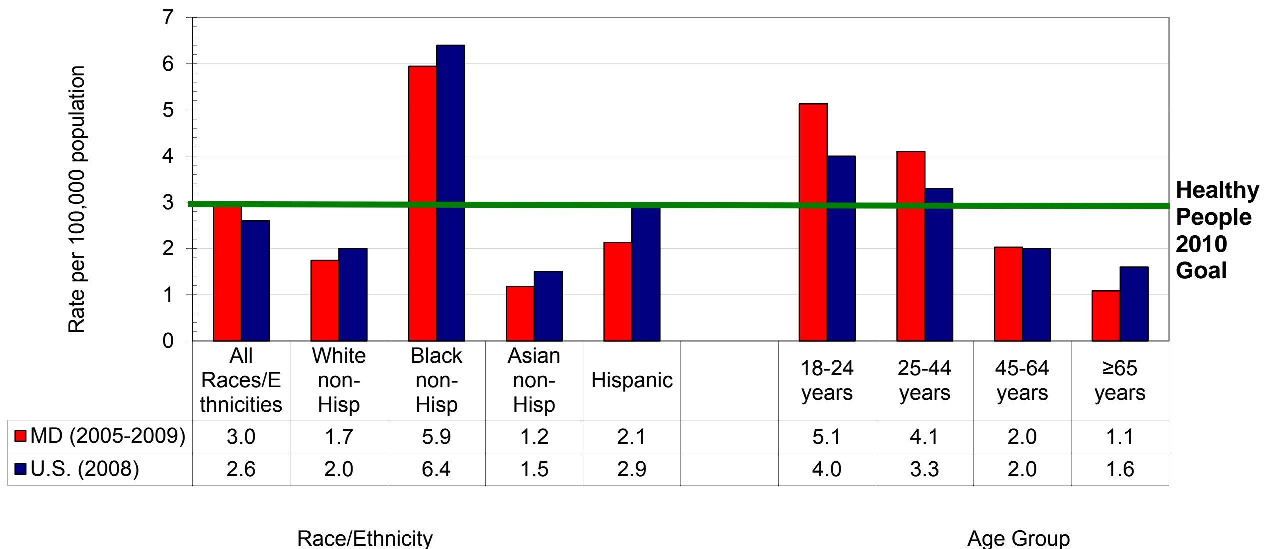
Homicide was the 2nd leading cause of death for females ages 15-24, accounting for 12% of all deaths in that age group. For women ages 25-44, homicide was the 6th leading cause of death, accounting for 4% of all deaths in that age group (Table 5).

Maryland's homicide rate in 2005-2009 for females aged 18-24 and 25-44 years was substantially higher than the national rate (Figure 2).

Table 5. Leading Causes of Death among Females Ages 15-24 and 25-44, Maryland, 2005-2009

Rank	Cause of Death Number of deaths (% of total in age group)	
	Ages 15-24	Ages 25-44
1	Accidents 221 (30.3%)	Cancer 966 (22.0%)
2	Homicide 87 (12.1%)	Heart Disease 549 (12.5%)
3	Suicide 54 (7.5%)	HIV 358 (8.2%)
4	Cancer 50 (6.9%)	Accidents 325 (7.4%)
5	Heart Disease 36 (5.0%)	Suicide 179 (4.1%)
6		Homicide 165 (3.8%)

Leading causes of death shown only if 25 or more deaths in given category
Data Source: MD DHMH, Vital Statistics Administration



	All Races/Ethnicities	White non-Hisp	Black non-Hisp	Asian non-Hisp	Hispanic		18-24 years	25-44 years	45-64 years	≥65 years
MD (2005-2009)	3.0	1.7	5.9	1.2	2.1		5.1	4.1	2.0	1.1
U.S. (2008)	2.6	2.0	6.4	1.5	2.9		4.0	3.3	2.0	1.6

Domestic Violence Fatality Review Team

The Domestic Violence Fatality Review Team (DVFRT) conducts reviews of homicides perpetrated by a current or former intimate partner, including same sex partners. Some review teams also include near-fatalities.

Statute: House Bill 741, 2005
Title 4, Subtitle 7 of the Family Law Article

State Team: No
Chair of State Team: NA

Coordinator of teams: Dave Sargent (retired police officer), consultant and trainer, Maryland Network Against Domestic Violence (MNADV)

Local Teams: Yes, currently in 21 out of 24 Maryland jurisdictions, started 2003

Members of Team: Primarily representatives of DV agencies, law enforcement, state's attorney's office, local health department, health providers, social services, parole and probation, hospitals, judges, clerks of the district and circuit courts, chief medical examiner's office, and survivors of DV.

Table 6. Female (18+ years) Homicide Deaths by Suspected Perpetrator, Maryland, 2003-2007

	Number of Deaths	% of Total
Total Homicides	309	
Current/Ex Partner	106	34.3
Parent	13	4.2
Acquaintance	11	3.6
Stranger	7	2.3
Other Relative	6	1.9
Coworker	1	0.3
Unknown	165	53.4

Data Source: MD DHMH, MD Violent Death Reporting System

Data from the Maryland State Police's Uniform Crime Report shows that 80% (101/126) of the intimate partner homicide victims from 2005-2009 were female. Considering that there were 352 total female homicide cases ages 15+ from 2005-2009, 29% of all female homicide cases were perpetrated by an intimate partner (not shown).

According to the Maryland Violent Death Reporting System (MVDRS), 34% of the suspected perpetrator among female homicide deaths 2003-2007 was a current or former intimate partner. However the suspect was unknown in 53% of cases (Table 10).

Recent data from the Maryland Network Against Domestic Violence revealed that 35% of female homicide cases 7/1/09-6/30-10 were perpetrated by an intimate partner. In contrast 1.4% of male homicide cases were perpetrated by an intimate partner (not shown).

Findings from Domestic Violence Fatality Review Teams

Twenty-one jurisdictions have formed DVFRTs. Sixteen teams are actively reviewing cases and 5 teams are still in the organizational phase. Although Anne Arundel and Calvert counties had started DVFRTs in 2003 and 2004 respectively, legislation in 2005 initiated by the Maryland Network Against Domestic Violence (MNADV) resulted in the formation of many other DVFRTs. MNADV provides support and technical assistance for all the local teams.

Many of the DVFRTs have made recommendations for changes that, based on their review of cases, may prevent future deaths. Some prevalent findings include:

1. **Promote lethality assessment and coordinated safety planning**
   Women at risk of being seriously injured or killed by their intimate partners had not used the potentially life-saving services of a community-based domestic violence program. The Maryland Network Against Domestic Violence developed the Domestic Violence Lethality Assessment Program (LAP). Through a coordinated response to the LAP questionnaire, LAP identifies and immediately connects high risk individuals to the domestic violence service provider in their area. Additionally, women at high risk of danger should develop a safety plan that incorporates safety precautions appropriate for victims at the highest risk of being murdered. Enhancement of the current safety planning techniques may be necessary in some cases where the traditional techniques were not effective.

2. **Increase access to domestic violence services**
   A large number of fatality victims had never accessed services from domestic violence service providers. Research has shown that there is a 60% reduction in risk of severe assault when victims utilize the services of a domestic violence advocacy program and abused women who used community-based domestic violence services are almost never the victim of murder or attempted murder. Women in abusive situations should be encouraged to contact their local DV agency.

3. **Improve collection of evidence by police to prosecute felony domestic violence cases**
   Attorneys were often forced to reduce charges, stet cases or nolle prose cases because of little admissible evidence collected by the police. Creation of a specialized unit within the police department with detectives who are trained in felony level investigations for family violence cases would improve the investigation and prosecution of DV cases. Alternatively, a set of officers can be trained to work with DV victims and their families.

4. **Help DV victims make informed decision about protective orders**
   Victims rarely sought a protective order or let a protective order become inactive. Safety planning should include linking clients with services that can provide information about protective order options and help them make an informed decision.

5. **Foster consistent communication within the Division of Parole and Probation and with state attorney's office, sheriff's offices and detention centers**

Due to the original probation agents' reassignment or retirement, the new probation agents were not aware that the probationer had violated his probation or had a warrant issued against him. The probationer was not sanctioned for violations or arrested for the warrant. Also, an individual serving a felony sentence was released on home detention without the detention center or the probationer ever being aware that Parole and Probation had previously issued a letter to his home requiring the surrender of his handgun. This handgun was subsequently used in the homicide. Thirdly, Parole and Probation are sometimes not aware that a protective order has been issued against a probationer. Increased supervision may be needed in these cases.

6. Enact legislation to enhance penalties for crimes involving DV committed in presence of a child

When an act of DV is perpetrated in the presence of a child, the adult victim is not the only one who suffers. The children who witness violence, as well as the community which must live with the consequences of the violence, are also victimized. Children who witnessed their parent's murder were more likely to be known to the Department of Social Services, the Juvenile Court and ultimately the criminal justice system. Perpetrator also reported witnessing DV as a child. One appropriate means of expressing the community's outrage over this crime, as well as its concern for the victims, is a law which provides enhanced penalties for crimes involving DV perpetrated within the sight or hearing of a child.

7. Enhance support for children exposed to fatal and near fatal abuse of a parent

Case reviews repeatedly revealed that children who were witnesses to their parent's fatality or had been subjected to seeing DV in the home had poor outcomes. They often engaged in unacceptable and destructive behaviors and suffer mental or psychological injury. A protocol should be developed to protect and support children affected by DV. The protocol should ensure that children be evaluated for social or mental health services.

8. Create resources for men who seek to prevent violence in intimate relationships

Although domestic violence is often viewed as a women's issue, several men were interviewed in the case review process who suggested that services need to be developed for men who are interested in taking an active role in addressing DV. More resources need to be developed for men who could benefit from help prior to an act of DV. Other men may serve as mentors to help abusive friends or family members stop battering.

9. Seek partnerships with clergy

Many victims and perpetrators of DV reach out to clergy for advice and support. However many clergy are not trained on the dynamics of DV or the need for safety planning. In one case review, a pastor encouraged a victim to stay in an abusive marriage, resulting in fatal consequences. Extend outreach efforts to faith based organizations for better DV assessment.

10. Increase awareness of DV in military households

Episodes of violence and at least one fatality occurred in households where military personnel had returned from overseas. Post traumatic stress disorder may be a factor in the violence. Outreach to military bases may provide education and referral resources for these circumstances.

11. Facilitate medical care to domestic violence victims who sustain injury

Victims often do not seek medical treatment for injuries sustained in DV incidents. First responders and the victims may not realize the gravity of the injury and may not transfer to a hospital or other health care facility. Hospital based DV programs can help victims be screened, treated and referred. Currently there are six hospital based DV programs in the Baltimore, Prince George's, and Annapolis areas. Expansion of this program to other areas of the state would be of benefit to those women who don't live in the above areas. Use of a standard kit for forensic DV examination such as the one developed by the Mercy Medical Center Family Violence Response Program, would increase proper documentation for legal cases.

12. Increase IPV assessment among the medical community by establishing a state web site with DV assessment tools

Despite a mandate from the Joint Commission that all hospitals have protocols to assess DV, the majority of medical charts lacked documentation of such screening. Numerous physicians report a lack of confidence in their ability to inquire about or complete DV screenings. To increase the likelihood of DV assessment within the health care setting, training and continuing education courses should be made available to clinicians. Also, resources about screening tools, safety assessment, confidentially rules, Maryland reporting mandates, forensic evidence requirements, medical coding for documentation and reimbursement, health conditions associated with DV, and local referral sources should be easy to reference for clinical providers. The web site should be easy to access and updated regularly.

13. Increase awareness of strangulation and biting as a risk factor for severe abuse

Strangulation, often incorrectly termed as "choking", was a significant risk factor for a subsequent fatality, even in the absence of visible external injuries. Legislation to classify strangulation as a first-degree assault or separate felony has been introduced and should be supported to distinguish the seriousness of this method of attack. Trainings targeting first responders, medical providers, law enforcement and the judiciary will help to provide adequate referrals, treatment, and justice for cases of strangulation. Of note, Mercy Medical Center conducts forensic evaluation of strangulation cases and was the 1st hospital in the Baltimore area to utilize an alternative light source (ALS) which is able to identify deep or developing bruising that may not be visible to the naked eye, especially for darker-skinned victims. The ALS has been used as evidence for prosecutors of cases involving strangulation. Victims may not recognize biting as a form of abuse because it is often not included on lists of examples of DV. Several victims had a history of bite wounds. Biting should be included as an example of DV on medical screens for DV and on the Petition for a Protective Order.

14. Include screening for DV during Sexually Transmitted Disease (STD) visits

Many case reviews revealed a history of STD visits among DV homicide victims. One survivor of attempted homicide stated that she would have been receptive to education and assessment about DV during her STD visit. Being diagnosed with an STD may be a pivotal time for women to be proactive about seeking DV services. Outreach is needed to encourage STD providers to assess for DV.

Maternal Mortality Review

The Maternal Mortality Review Committee reviews pregnancy-associated deaths. These are cases of women who have died during pregnancy or within one year of the termination of pregnancy. The pregnancy may be from any cause or site such as a live birth, miscarriage, abortion, stillbirth, resolution of ectopic pregnancy or any other non-viable pregnancy.

Maryland Statute:	House Bill 515, 2000 Health-General Article, SSSS13-1201 et seq., Annotated Code of MD
State Team:	Yes, started 1998
Chair of State Team:	Lillian Blackmon, M.D. (retired neonatologist), chair of Maternal and Child Health subcommittee, MedChi, Maryland Medical Society
Coordinated by:	Center for Maternal and Child Health, DHMH, through MedChi, the Maryland Medical Society
Local Teams:	No
Members of Team:	Primarily health professionals from obstetrics, pediatrics, anesthesiology, public health and other specialists from areas such as substance abuse, mental health, cardiology, and intensive care who are involved with the prenatal and postpartum care of women.

The leading causes of pregnancy-associated deaths were homicide, cardiovascular disorders (including cardiomyopathy) and motor vehicle accidents. These three conditions accounted for 42% of all deaths during pregnancy and within one year postpartum. Other causes of pregnancy-associated deaths were hypertension, hemorrhage, embolism (amniotic fluid and thrombotic), infection, substance abuse, suicide, and other medical disorders such as cancer, asthma and diabetes.

Table 7. Leading Causes of Pregnancy-Associated Death among Women, Maryland, 2005-2009

Rank	Cause of Death	Number (%) of Deaths
1	Homicide	33 (14.7%)
1	Cardiovascular, including cardiomyopathy	33 (14.7%)
3	Motor Vehicle accidents	30 (13.4%)

Data Source: MD DHMH, Vital Statistics Administration

Pregnancy-Associated Homicides

From **1993 to 2010 there were 118 pregnancy-associated homicides** among females ranging in age from 14 to 44. Forty-eight deaths occurred during pregnancy, two occurred after a stillbirth and 68 occurred within a year after a live birth. See Table 12**.**

Table 8. Women Dying as a Result of Pregnancy-Associated Homicide by Perpetrator, Maryland, 1993-2010			
Pregnancy Associated Homicides			
		Known Perpetrator	
	Total* (n=118) % of total	Intimate Partner (n=66) % of total	Non-partner (n=36) % of total
Race			
White	27.1	31.8	22.2
African American	71.2	66.7	75.0
Other	1.6	1.5	2.8
Age (years)			
<25	61.0	60.6	63.9
25-34	32.2	30.3	33.3
35-44	6.8	9.1	2.8
Education (years)			
≤12	80.5	72.7	91.7
>12	17.8	24.2	8.3
Not stated	1.7	3.0	0
Marital status			
Married	20.3	27.3	8.3
Unmarried	78.8	71.2	91.7
Not stated	0.8	1.5	0
Method of injury			
Firearm	60.2	57.6	61.1
Sharp object/stabbing	19.5	21.2	16.7
Strangulation	10.2	12.1	8.3
Blunt object/beating	5.9	4.5	11.1
Other	4.2	4.5	2.8
Timing of Death			
During pregnancy	40.7	48.5	33.3
Postpartum, up to 1 year	59.3	51.5	66.7

*Includes 16 cases with unknown perpetrator
Data Source: MD DHMH Vital Statistics Administration, MD DHMH Office of Chief Medical Examiner, local police departments

Findings from Maternal Mortality Review

Because **homicide was the leading cause of pregnancy-associated deaths,** a review of these 118 homicides was conducted by two members of the MMR committee.

Findings (Table 12):

- Women who were at highest risk for homicide were:
  - African American
  - less than 25 years of age
  - unmarried
- **Firearms accounted for 60% of deaths.**
- A current or former intimate partner was the perpetrator in 56% of pregnancy-associated homicide deaths and a non-partner in 31% of deaths. The perpetrator was not identified in 14% of cases.
  - If the cases in which the victim-offender relationship could not be identified were excluded, **65% of homicides were committed by an intimate partner.**
- Compared to homicides in which the perpetrator was not a partner, a higher percentage of **intimate partner homicides** occurred among women who:
  - were **pregnant** and not postpartum (49% vs. 33%); the **1st trimester was the most common time period for intimate partner homicides.**
  - had completed **more than 12 years of education** (24% vs. 8%), and
  - were **married** (27% vs. 8%).

Recommendations

1. **Increase awareness and assessment of IPV among obstetric providers**

   Intimate partner homicide was more common than other causes of death during pregnancy such as diabetes and hypertension—medical conditions for which screening is done routinely and regularly by prenatal care providers.

   - Obstetrical providers are in the unique position to provide assistance for victims of IPV because of the many opportunities during multiple prenatal visits. The recommendation of the American College of Obstetricians and Gynecologists (ACOG) is that all **pregnant women** have an **assessment for IPV** at:
     - **Initial prenatal visit**
     - **Each trimester of pregnancy**
     - **Postpartum visit**
   - Educational materials about IPV and healthy relationships should be distributed at the same time as IPV assessment and be readily accessible by women. Even if a woman does not disclose IPV, the information can be useful to her or others. Many woman may not disclose IPV the first time they are asked, if ever. **Assessment should be synonymous with education**.
   - Be knowledgeable about Maryland law for reporting IPV [generally reporting is not required]

Activities

a. A 2011 Focus Brief, "Intimate Partner Violence Among Maryland Women Giving Birth 2004-2008" reviewed data from postpartum surveys of the Maryland Pregnancy Risk Assessment Monitoring System (PRAMS) to show the associations of IPV with adverse perinatal health behaviors and outcomes. Other recent PRAMS briefs about cigarette smoking, alcohol use, and depression showed the association between IPV and these unhealthy factors.
b. Information about IPV assessment was inserted into a DHMH 2011 Reference Guide created for Maryland dentists, "Oral Health Care during Pregnancy".
c. IPV assessment will be included for prenatal and postpartum women as part of the Home Visiting and Healthy Start Programs.
    i. A member of the Maryland MMR team participates on a national Department of Health and Human Services initiative to promote both IPV and depression screening during Healthy Start visits.
d. A member of the Maryland MMR is currently drafting a Committee Opinion about Intimate Partner Violence assessment for ACOG. Committee Opinions are documents that become a standard of care for practicing obstetricians and gynecologist. The ACOG Committee Opinions are distributed to every Fellow of ACOG through publication in the journal, Obstetrics and Gynecology. The Opinions are also posted on the ACOG web site.
e. A research article titled, "Intimate-Partner Homicide Among Pregnant and Postpartum Women" was published in June 2010 issue of Obstetrics and Gynecology

2. Increase IPV education and assessment before pregnancy

Intimate partner homicide occurred most commonly during the first three months of pregnancy, often before the initiation of prenatal care.

- **Assessment for IPV should occur before pregnancy**. Health visits for family planning and preconception care should also include IPV assessment and education.
- **Women in an already tumultuous or abusive relationship should not become pregnant in the hopes that having a baby will stop the perpetuation of violence. This can be a fatal mistake.** Violence may start during pregnancy even if there was no abuse before.
- Increase awareness among women and primary care providers that **abuse can have serious health and behavioral consequences.**

Activities

a. The Maryland Title X Family Planning Program was targeted as a site where young women could receive IPV assessment pre-and inter-conceptionally
    i. Clinical guidelines on IPV assessment were added in 2009
    ii. A presentation about intimate partner violence was given at the 2010 Reproductive Health Update (RHU), the annual meeting attended by providers of the Maryland Title X Family Planning Program. A breakout session about IPV assessment will be given at the 2012 RHU.
    iii. Educational materials and referral information will be available for distribution at all clinic sites
    iv. An article in the November 2011 issue of Preventing Chronic Disease, "Optimizing Women's Health in a Title X Family Planning Program" discusses

the benefits of integrating women's health services including IPV assessment into the Maryland family planning program.

b. Information for clinical providers about IPV assessment is planned for placement on the Office of Maternal and Child Health web site.
    i. Include information about Maryland law reporting requirements
    ii. Screening tools, lethality assessment, safety planning
    iii. Referral sources
c. A presentation about IPV assessment is scheduled for the 2012 annual Sexual Transmitted Infections (STI) Update Meeting that is attended by STI clinicians.
d. Health cards for women, created by DHMH, include information about IPV and the hotline domestic violence number.

3. Consider safety planning for women whose pregnancies are unwanted by their partners

Current or ex-partners who expressed strong aversion to the pregnancy were at high risk for violence. Many of these men had no criminal history and in some relationships there was no history of abuse.

Activities

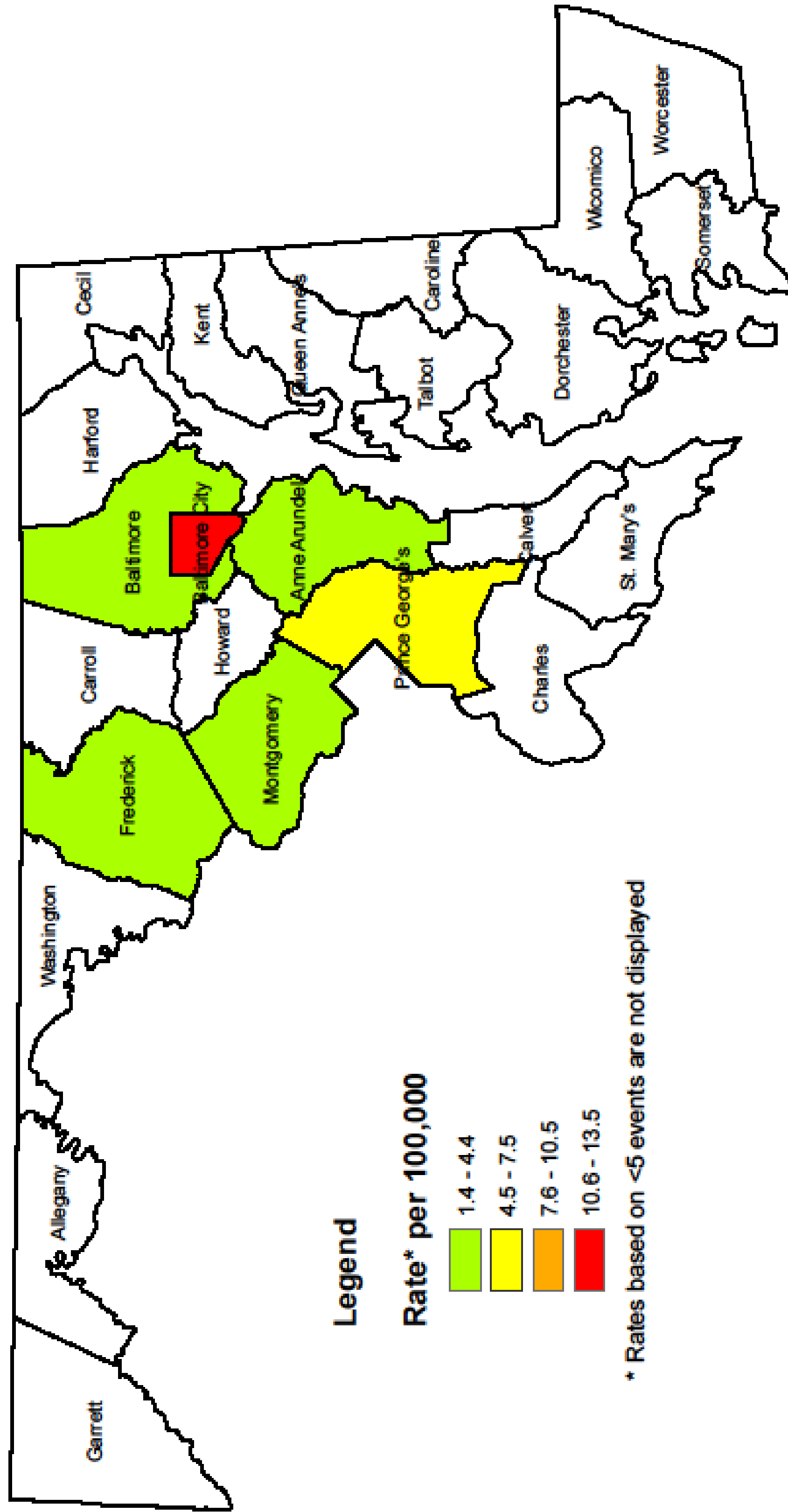
a. Input about reproductive coercion i.e. a partner who is completely unsupportive of the woman's pregnancy decision will be inserted in the national ACOG Committee Opinion about IPV assessment. See 1d.
b. Maryland PRAMS surveys starting with 2012 births will have questions about reproductive coercion. Future PRAMS briefs will analyze this factor. See 1a.
c. Include information about reproductive coercion and referral sources for safety planning in upcoming web site targeted to providers. See 2b.

Appendix A. Homicides among Children by Maryland Jurisdiction

Table 9. Child (0-17) Deaths Due to Homicide by Jurisdiction of Residence, Maryland, 2000-2004, 2005-2009							
Region	*Jurisdiction*	# Deaths- 2000-2004	# Deaths- 2005- 2009	Mortality Rate*- 2000- 2004	Mortality Rate*- 2005-2009	Rate - % Change **	Rates Differ Significantly? ***
Northwest Area	Allegany	0	2				
	Frederick	5	10	1.8	3.5	96.4	No
	Garrett	0	2				
	Washington	3	3				
Baltimore Metro Area	Anne Arundel	9	9	1.4	1.5	2.8	No
	Baltimore	24	23	2.6	2.6	-1.6	No
	Carroll	1	2				
	Harford	4	3				
	Howard	8	4	2.2			
	Baltimore City	150	104	18.6	13.5	-27.2	Yes
National Capital Area	Montgomery	16	16	1.4	1.4	0.2	No
	Prince George's	51	49	4.6	4.6	1.5	No
Southern Area	Calvert	2	2				
	Charles	3	3				
	St. Mary's	2	1				
Eastern Shore	Caroline	1	0				
	Cecil	0	4				
	Dorchester	2	0				
	Kent	0	0				
	Queen Anne's	2	2				
	Somerset	1	1				
	Talbot	0	0				
	Wicomico	6	3	5.6			
	Worcester	1	0				
Maryland - Total		291	243	4.2	3.6	-14.2	No

Data Source: MD DHMH, Vital Statistics Administration
*Rate per 1,000 live births, Rates with <5 events in the numerator are not displayed
** Percent change is based on the exact rates and not the rounded rates presented here.
*** Z Test, $p<0.05$

Table10. Number of Child (0-17) Deaths Due to Homicide by Jurisdiction of Residence and Year, Maryland, 2005-2009							
		Year					Total - 2005-2009
		2005	2006	2007	2008	2009	
Region	*Jurisdiction*						
Northwest Area	Allegany	0	0	0	0	2	2
	Frederick	0	1	4	0	5	10
	Garrett	0	1	0	1	0	2
	Washington	1	0	1	1	0	3
Baltimore Metro Area	Anne Arundel	3	2	0	2	2	9
	Baltimore	5	3	4	8	3	23
	Carroll	0	1	0	0	1	2
	Harford	1	1	1	0	0	3
	Howard	0	0	3	1	0	4
	Baltimore City	11	29	28	22	14	104
National Capital Area	Montgomery	3	3	4	5	1	16
	Prince George's	10	8	10	14	7	49
Southern Area	Calvert	0	0	0	2	0	2
	Charles	0	0	1	0	2	3
	St. Mary's	1	0	0	0	0	1
Eastern Shore	Caroline	0	0	0	0	0	0
	Cecil	0	1	0	2	1	4
	Dorchester	0	0	0	0	0	0
	Kent	0	0	0	0	0	0
	Queen Anne's	1	0	0	1	0	2
	Somerset	1	0	0	0	0	1
	Talbot	0	0	0	0	0	0
	Wicomico	0	2	0	0	1	3
	Worcester	0	0	0	0	0	0
Maryland - Total		37	52	56	59	39	243
Data Source: MD DHMH, Vital Statistics Administration							


Homicide Rates among Children (0-17), Maryland, 2005-2009
Garrett
Allegany
Washington
Frederick
Carroll
Montgomery
Howard
Baltimore
Baltimore City
Harford
Cecil
Anne Arundel
Prince George's
Calvert
Charles
St. Mary's
Kent
Queen Anne's
Caroline
Talbot
Dorchester
Wicomico
Worcester
Somerset
Legend
Rate* per 100,000
1.4 - 4.4
4.5 - 7.5
7.6 - 10.5
10.6 - 13.5
* Rates based on <5 events are not displayed
Data Source: MD DHMH, Vital Statistics Administration

Appendix B. Homicides among Women by Maryland Jurisdiction

Table 11. **Adult Female Homicide Deaths by Jurisdiction of Residence**, Maryland, 2000-2004, 2005-2009

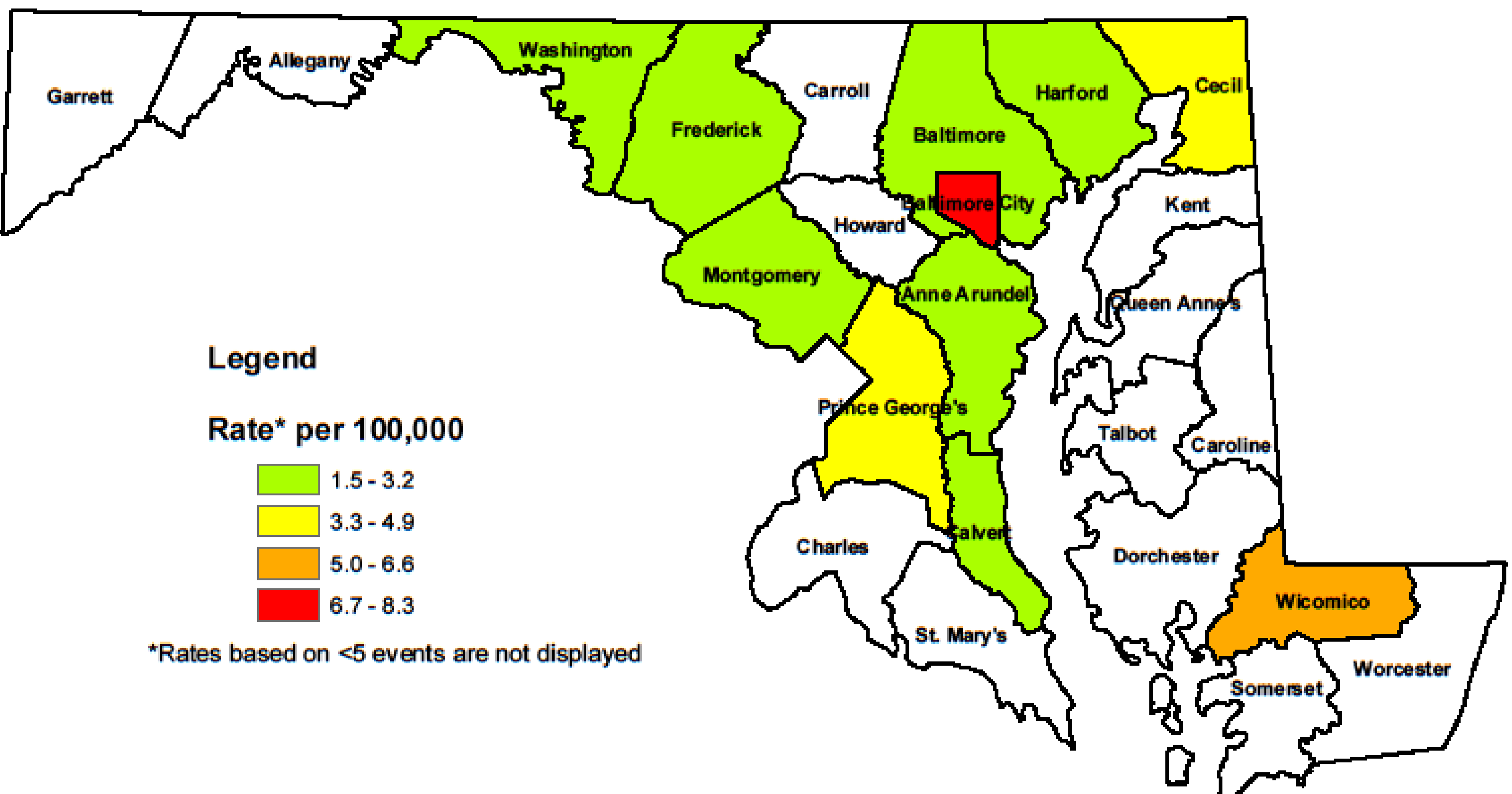
Region	*Jurisdiction*	# Deaths- 2000-2004	# Deaths- 2005-2009	Death Rate*- 2000-2004	Death Rate*- 2005-2009	Rate - % Change **	Rates Differ Significantly? ***
Northwest Area	Allegany	0	2				
	Frederick	6	9	1.5	2.1	37.3	No
	Garrett	2	1				
	Washington	5	5	2.0	1.8	-7.5	No
Baltimore Metro Area	Anne Arundel	21	19	2.2	1.9	-12.9	No
	Baltimore	53	37	3.3	2.3	-32.3	No
	Carroll	5	3	1.7			
	Harford	6	10	1.4	2.1	53.6	No
	Howard	4	3				
	Baltimore City	102	110	7.8	8.3	7.6	No
National Capital Area	Montgomery	46	28	2.6	1.5	-41.8	Yes
	Prince George's	86	71	5.3	4.3	-18.9	No
Southern Area	Calvert	2	5		2.9		
	Charles	17	4	7.1			
	St. Mary's	6	2	3.7			
Eastern Shore	Caroline	2	0				
	Cecil	6	7	3.5	3.6	3.4	No
	Dorchester	4	0				
	Kent	0	0				
	Queen Anne's	2	2				
	Somerset	1	2				
	Talbot	2	2				
	Wicomico	5	10	2.9	5.3	84.8	No
	Worcester	1	1				
Maryland - Total		384	333	3.6	3.0	-17.1	Yes

Data Source: MD DHMH, Vital Statistics Administration
*Rate per 100,000 population, Rates with <5 events in the numerator are not displayed
** Percent change is based on the exact rates and not the rounded rates presented here.
*** Z Test, p<0.05

Table 12. Number of Adult Female Homicide Deaths Due by Jurisdiction of Residence and Year, Maryland, 2005-2009

		Year					Total - 2005-2009
		2005	2006	2007	2008	2009	
Region	*Jurisdiction*						
Northwest Area	Allegany	0	0	0	1	1	2
	Frederick	0	2	3	1	3	9
	Garrett	0	1	0	0	0	1
	Washington	2	1	1	1	0	5
Baltimore Metro Area	Anne Arundel	3	3	4	5	4	19
	Baltimore	12	5	9	8	3	37
	Carroll	0	2	1	0	0	3
	Harford	2	5	0	2	1	10
	Howard	0	0	2	1	0	3
	Baltimore City	23	22	21	26	18	110
National Capital Area	Montgomery	5	6	5	8	4	28
	Prince George's	11	16	20	12	12	71
Southern Area	Calvert	2	0	2	1	0	5
	Charles	0	1	0	3	0	4
	St. Mary's	1	1	0	0	0	2
Eastern Shore	Caroline	0	0	0	0	0	0
	Cecil	2	1	1	2	1	7
	Dorchester	0	0	0	0	0	0
	Kent	0	0	0	0	0	0
	Queen Anne's	0	0	2	0	0	2
	Somerset	1	0	0	1	0	2
	Talbot	1	0	0	1	0	2
	Wicomico	1	3	2	3	1	10
	Worcester	0	0	0	1	0	1
Maryland - Total		66	69	73	77	48	333

Data Source: MD DHMH, Vital Statistics Administration


Homicide Rates among Women (18+ years), Maryland, 2005-2009
Garrett
Allegany
Washington
Frederick
Carroll
Baltimore
Harford
Cecil
Kent
Baltimore City
Howard
Montgomery
Anne Arundel
Queen Anne's
Prince George's
Talbot
Caroline
Charles
Calvert
Dorchester
Wicomico
St. Mary's
Somerset
Worcester
Legend
Rate* per 100,000
1.5 - 3.2
3.3 - 4.9
5.0 - 6.6
6.7 - 8.3
*Rates based on <5 events are not displayed
Data Source: MD DHMH, Vital Statistics Administration