

LETHALITY ASSESSMENT PROGRAM REPORT - IN RESPONSE TO HOUSE BILL 1371

DOMESTIC VIOLENCE LETHALITY SCREEN FOR FIRST RESPONDERS		
Officer:	Date:	Case #:
Station:	Offender:	
Check box if victim did not answer any of the questions.		
* A "Yes" response to any of Questions #1-3 automatically triggers the protocol referral.		
1. Has the offender ever used a weapon against you or threatened you with a weapon?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Ass.	
2. Has the offender threatened to kill you or your children?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Ass.	
3. Do you think the offender might try to kill you?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Ass.	
* Response required to Questions #4-7, but positive responses to at least four of Questions #4-7, trigger the protocol referral.		
4. Does the offender have a gun or can he/she get one easily?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Ass.	
5. Has the offender ever tried to choke you?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Ass.	
6. Is the offender violent or constantly anxious or does he/she control most of your life decisions?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Ass.	
7. Have you or the offender or someone else been together or being married?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Ass.	
8. Is the offender employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Ass.	
9. Has he/she ever tried to hurt himself/herself?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Ass.	
10. Do you have a child that the offender knows is not his/hers?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Ass.	
11. Does he/she follow or spy on you or leave threatening messages?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Ass.	
* An officer may trigger the protocol referral, if not already triggered above, as a result of the officer's response to the below question, or whenever the officer believes the victim is in a potentially lethal situation. Is there anything else that worries you about your safety? If "Yes" What worries you?		
Check one: <input type="checkbox"/> Victim assessed in accordance to the protocol <input type="checkbox"/> Victim assessed in based on the field officer <input type="checkbox"/> Victim did not screen in		
If victim screened in: After assigning her/him of a high danger assessment, <input type="checkbox"/> Yes <input type="checkbox"/> No did the victim speak with the hotline counselor?		
<small>Note: The questions above and the criteria for determining the level of risk a person faces is based on the best available research, practice, and common sense. It is not intended to be a perfect predictor of future violence. However, each case is unique and the officer's judgment is critical. Please do not feel that this is a perfect predictor of future violence. The officer's judgment is critical. Please do not feel that this is a perfect predictor of future violence.</small>		
MSP/01/03/16		



MARYLAND POLICE TRAINING AND STANDARDS COMMISSION

DECEMBER, 2016

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The Maryland Police Training and Standards Commission wishes to acknowledge and thank members of the staff of the ***Maryland Network against Domestic Violence*** [MNADV] for their assistance in helping to complete this report to the Maryland General Assembly as required by House Bill 1371. MNADV staff members were able to provide the most up-to-date information on the use of the Lethality Assessment Program in the State of Maryland through their 2015 annual statistics. Likewise, the MNADV staff was helpful in providing background and historical information about the design and development of the Lethality Assessment Program, its screen instrument and the referral protocols currently used by many law enforcement agencies in the State of Maryland as well as information about the use of the Lethality Assessment Program in other states.

In addition, the Commission also extends its thanks to Ms. K. Tracy Yingling, RN, BSN, FNE-A/P, Forensic Services and LAP Coordinator for the Carroll Hospital Center SAFE Program, for her input and professional editing of the “non-fatal strangulation” portion of this Report as well as the Commission’s lesson plan and power point presentation entitled “***Non-fatal Strangulation Investigations***” which will be posted on www.mdle.net in early 2017.

Executive Summary

The Lethality Assessment Protocol:

Intimate partner violence, commonly called domestic violence, is a complex social issue. Police officers are often one of the first formal contacts that abused women make. While police contact may result in victim-survivor safety in the short term, domestic violence victim provider services are best equipped to provide long-term safety options for the victim of intimate partner violence through safety planning, housing assistance and, in some cases, referral to mental health services. This suggests that the ideal response to domestic violence incidents is a coordinated response from law enforcement agencies and victim services providers.

Most police officers have been trained to provide domestic violence victims with information about domestic violence services, but research has shown that only a very small proportion (12.2%) of women access advocacy services after police leave the scene. However, it has been recognized that police officers have a unique and ideal opportunity to intervene with victims at the scene of a domestic violence incident and connect victims to advocacy and safety planning.

In 2000, the Maryland Network against Domestic Violence (MNADV) decided – among other issues – to tackle the problem of domestic homicide in Maryland. The MNADV set the goals of:

1. identifying victims at high risk for homicide by an intimate partner; and
2. creating a plan to assist them in decreasing that risk.

To meet these goals, the MNADV established a statewide multi-disciplinary Lethality Assessment Committee in the fall of 2003 to create a protocol for response to domestic violence in Maryland. The committee included domestic violence victim advocates, police officers, and professionals from other related disciplines including prosecution and probation, as well as researchers from the Johns Hopkins University and the University of Maryland.

Based both on research findings and on practical expertise, the Committee made two important decisions regarding the development of its protocol:

1. the **protocol would be designed for field practitioners** who came into contact with a victim of domestic violence during the course of their work, **focusing on law enforcement officers** who were the practitioners who would most frequently come in contact with domestic violence victims at risk for homicide; and
2. it was important to **create a collaborative intervention between officers and domestic violence advocates** in order to ensure that victims were receiving the services that they needed.

The ultimate goal of the LAP Committee was to develop a field protocol that would identify victims of domestic violence who were at the greatest risk of being killed and encourage them to access domestic violence services.

The Committee worked for two full years creating the Lethality Screen and an accompanying Referral protocol, field-testing it, and gathering feedback from the officers and advocates who had participated in joint field-tests with various law enforcement agencies and victim service providers.

In October 2005, the Lethality Assessment Protocol was introduced and employed for the first time by the Kent County, Maryland Sheriff's Office and the Mid-Shore Council on Family Violence. Its use expanded throughout the State until today nearly 100% of law enforcement agencies that respond to calls for service are LAP co-participants along with 20 domestic violence victim services providers/programs in all 24 state jurisdictions. A number of participants have been employing the LAP in Maryland for more than 8 years.

Between 2006 and 2012, MNADV estimates that law enforcement officers have administered more than 56,000 screens. During that time period, 53% of victims screened at high risk; 57% of those victims spoke with an advocate at the scene; and 31% followed up with the Maryland Network against Domestic Violence.

In addition, based on the latest annual report from the Maryland Network against Domestic Violence, the number of lethality screens completed by law enforcement agencies in Maryland has remained relatively constant over the past 4 years although the total rose 13% in 2015 from the 2014 total. Likewise the number of victims of intimate partner violence who graded as “high-danger” also has remained relatively constant over the past 4 years. However, the number of victims who “did not answer” the screening questions increased by about 600 individuals in 2015 from 2014. The number of victims who spoke to a counselor remained relatively constant from 2014 totals; conversely, the number of victims who entered into some type of provider service increased by 9% to 4.3 victims per day.

In general, it appears that the number of individuals assessed and who graded as being at a “high-danger” risk has remained relatively constant over the past 4 years but the number of victims who have taken advantage of various provider services has risen appreciably in the same time period. This data reinforces the need for first responders to continue to use LAP during response to domestic violence incidents.

Maryland has been acknowledged by the National Institute of Justice and a number of states as the leader in the use of the Lethality Assessment Program.

As of 2015, jurisdictions in 33 other states are implementing the LAP. They are: Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Indiana, Illinois, Kentucky, Michigan, Minnesota, Missouri, Mississippi, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma (where the National Institute of Justice [NIJ] recently finished a study of the LAP), Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.

Model Domestic Violence Policy:

As early as 1997, the law enforcement community in Maryland, represented by Maryland Chiefs of Police Association, the Maryland Sheriffs' Association, the Maryland State Police, and the Baltimore Police Department, in concert with the Maryland Police and Correctional Training Commissions and the Maryland State's Attorneys' Association and the Maryland Network against Domestic Violence (MNADV) developed a model domestic violence policy for the entire Maryland law enforcement community. That model policy was introduced to the Maryland law enforcement community in 1998. Since its introduction that model policy has been reviewed and updated to include the Lethality Assessment Program and the danger/use and investigation of strangulation in domestic violence cases. That model policy is still pertinent today and is available on www.mdle.net to the public and law enforcement agencies.

CONCLUSION:

The Lethality Assessment Protocol (LAP) used by almost all of Maryland’s law enforcement agencies is seen as a national model and has been adopted by over 30 states.

For its part, MNADV maintains an Advisory Council of LAP implementers, researchers and national experts from across the country to advise MNADV about emerging trends in the field of responding to domestic violence and, if necessary, to assist in making any changes to the LAP program. As an example of the Council’s input, members assisted MNADV in drafting a position paper which MNADV has recently published on the use of Body-Worn Cameras during the LAP protocol. Members of MNADV also regularly attend conferences and training sessions devoted to responding to domestic violence. Likewise, they meet with experts in the field of risk assessment at Office on Violence against Women [Department of Justice] sponsored events.

Because of the above, there is no need for the Police Training and Standards Commission to develop a new or different screening and referral protocol.

Non-fatal Strangulation and Domestic Violence:

As regards the “non-fatal strangulation” portion of this Report, research has shown that it is widely believed by domestic violence victim service providers and, now, researchers into domestic violence that strangulation:

- ▶ is one of the most lethal forms of domestic violence:
 - when a victim is strangled, she/he is at the edge of a homicide;
- ▶ is a gendered crime—virtually all perpetrators are men (299/300);
- ▶ is one of the best predictors for the subsequent homicide of victims of domestic violence:
 - victims of prior attempted strangulation are seven times more likely to become homicide victims;
- ▶ is essentially a live demonstration of power and control over another individual’s life or death:
 - the act of strangulation demonstrates to a victim that the perpetrator can end their life whenever he or she chooses:
 - most abusers do not strangle to kill—they strangle to show they **CAN** kill;
- ▶ few victims sought medical treatment within 48 hours of the incident;
- ▶ the lack of external injuries and the lack of medical training among professionals who respond to domestic violence incidents have led to the minimization of this type of violence, exposing the victims to potentially serious health consequences, further violence, and even death;
- ▶ the fact that strangulation often leaves no marks, combined with its terror value, makes it a favorite tactic of experienced batterers;
- ▶ both law enforcement officers and prosecutors overlook symptoms of strangulation and rely too heavily on the visible signs of strangulation, which leads them to miss opportunities for [a] higher level of prosecution and for prevention of more severe victim abuse; non-fatal strangulation assaults may not fit the elements of other serious assaults due to the lack of visible injury;
- ▶ non-visible signs of non-fatal strangulation were often missed or overlooked by law enforcement officials and emergency room doctors, as battered women who have been strangled usually have a broad range of physical complaints but their injuries may not always appear serious;
- ▶ abuse escalates over time, with strangulation typically occurring later as violence progresses in the relationship:
 - threats of death were common among the women who had been strangled;
- ▶ visible injuries are not always present on the skin in homicidal strangulation and suffocation and additional studies are confirming that an offender can strangle someone to death or nearly to death with no visible external injury;

Likewise, research has shown that a number of states have either enacted or are considering enacting separate laws that make strangulation a felony although this effort is not without debate.

CONCLUSION:

The danger of strangulation in domestic violence cases is well documented, with some researchers showing that it is strong indicator of future homicide. Questions about strangulation are a part of the LAP used in Maryland. The training in the administration of the LAP emphasizes that danger.

To reinforce this, the Police Training and Standards Commission is developing a lesson plan on domestic violence related non-fatal strangulation that will be made available to agencies for incorporation into their training in early 2017.

Teri's Story

Early one morning in 2006, Steven Van Keuren broke into the suburban home of his former girlfriend Teri Lee, in Minnesota's Washington County. He shot and killed Lee, a widowed mother of four, and her then boy-friend, Tim Hawkinson. Van Keuren was duly punished. He's serving two consecutive life sentences for the double homicide – but the case continued to gnaw at local authorities.

Van Keuren had no criminal record two months before the September, 2006 shootings. But there were already telltale signs of menacing behavior that authorities had ignored... According to police, in May, "he show[ed] up at her kid's school, they get in an argument and she ends up slamming his hand in her car door because he won't leave her be. That same month, a hockey net went missing from Lee's driveway. On the morning of July 29th beer cans show up in Lee's mailbox, 'part of a pattern that had been going on' " according to police.

Later that same day Van Keuren's behavior escalated, according to police. Armed with knives, he broke into Lee's home and lunged at her. Yet, although Lee testified at a subsequent court hearing that she did not feel safe, Van Keuren was allowed to go free on \$75,000 bail.

Lee's and Hawkinson's deaths "got Washington County thinking about how we can do things differently," [said] Sergeant Randy McAlister of the Cottage Grove, Minnesota Police Department who was one of the first officers at the shooting scene. **One of the key questions: "was it possible to proactively identify those most at risk of being killed by an intimate partner?"**

The county's answer came four years later. In 2010, authorities introduced a domestic violence intervention tool, known as the Lethality Assessment Program (LAP) which was first developed in Maryland...

Would such a program have saved Lee's life? The answer remains uncertain, but McAlister argues that the system in place at the time certainly failed Teri Lee.

According to McAlister, LAP represent[s] a major improvement in guiding law enforcement's ability to detect the potential for domestic abuse or stalking behaviors to escalate into lethal violence. 1

Lisa's Story

"Lisa" was placed in contact with an advocacy organization after a violent attack from her abusive boyfriend. As she was telling the counselor about the history with this partner, she indicated that, although her partner had times when he was angry and violent, **she never considered herself a victim of domestic violence or thought that her partner's behavior was "not normal" until the officer screened her using the Lethality Screen which asked questions about the danger that Lisa was in. Hearing the words from the officer struck a nerve and, for the first time, she decided she was living with an abusive partner.** Lisa decided that she did not want to live in this manner and decided to seek counseling. That was in 2012 and Lisa is safely disengaged from the abuser and continues counseling for herself and her children. 2

LETHALITY ASSESSMENT PROGRAM REPORT - IN RESPONSE TO HOUSE BILL 1371

INTRODUCTION:

House Bill 1371, Strangulation – ***“Lethality Screening Protocol and Training,”*** requires the Maryland Police Training [and Standards] Commission to **“conduct a review of the experience and best practices of other states”** regarding the use of a **“lethality screening protocol and training for law enforcement officers when investigating complaints of domestic violence and assault by strangulation.”** House Bill 1371 also requires the Commission to **“develop a lethality screening protocol and training for law enforcement officers when investigating domestic violence incidents and assault by strangulation.”** The Commission is also required to **submit a report of its findings to the General Assembly by January 1, 2017.** The following pages represent the results of that review and the Commission’s mandated **Report to the General Assembly.**

BACKGROUND/HISTORY of the LETHALITY ASSESSMENT PROGRAM:

SCOPE of the PROBLEM of INTIMATE PARTNER VIOLENCE [DOMESTIC VIOLENCE]:

“It is estimated that 35% of women in the United States will experience some form of intimate partner violence (IPV) in their lifetimes and that 25% of women will experience severe IPV in their lifetimes. Of all violent crimes committed against women in 2010, 22% were perpetrated by a current or former intimate partner. The estimated cost of IPV was \$8.3 billion in 2003 dollars, including costs of medical care, mental health services, loss of productivity, and homicide. This figure excludes funds spent on other social services (e.g., shelter, transitional housing) or the criminal justice response to IPV.

“In addition to the injury suffered by women due to the violence inflicted on them by their partners, women who have experienced IPV are more likely to report chronic illness, disability and physical health problems including gastrointestinal and cardiac symptoms, and gynecological problems associated with forced sex. Further, women who have experienced IPV have high rates of mental health issues. An analysis of U.S. studies found strong associations between IPV and post-traumatic stress disorder, depression, and suicidality, as well as alcohol/drug abuse/dependence. In a more recent global review and analysis, there was a clear association between IPV and suicide attempts and incident depressive symptoms...Women who experience severe IPV [intimate partner violence e.g., being beaten up, assaulted with a weapon] are at greater risk for even poorer physical and mental health outcomes and intimate partner homicide.” ³

THE “PRE-LAP” RESPONSE TO DOMESTIC VIOLENCE:

“Calling the police is one of the most commonly employed help seeking strategies by women in abusive relationships. In published studies, among women NOT seeking help for IPV [intimate partner violence] from the criminal justice or social service systems, between 6.7% and 60% of IPV victims report that the police had been called due to domestic violence. When including women seeking help from the courts, assistance with orders of protection, legal assistance, and/or seeking victim services (e.g., advocacy, shelter), this proportion ranges up to 92%. The proportion of women seeking help from the police significantly increased from 1993-1998 and, when the victim identifies IPV as a crime, domestic violence is reported to the police at rates equal to the reporting of other crimes.

“As the severity or frequency of abuse increases so do calls to the police. Among victims of intimate partner homicide, 56% had called the police in the year before they were killed and 24.5% had an order of protection. Thus, the majority of victims of “femicide” have had contact with the police, yet the police response was unable to save their lives.

Indeed, research is mixed on the deterrent effects of the arrest of perpetrators. When relying on victim self-report, while 74.8% of one sample found contacting law enforcement to be helpful, only 42% of another sample stated that calling the police made the situation better. This wide range of satisfaction may be due to racial/ethnic differences in the samples, differential recruitment strategies, or a difference in the question asked of participants.

“Accessing domestic violence services, such as obtaining counseling or staying at a shelter, occurs much less often. Among samples of women not recruited from shelters or domestic violence service agencies, but generally recruited after coming into contact with the police or seeking an order of protection, **the percent of abused women accessing domestic violence services ranges from 4.8% - 38% and the percent of women accessing shelter services ranges from 3% - 8.9%.** While research has found that accessing domestic violence services and shelter increases as the severity of physical violence increases, **in one study examining homicide, only 4% of the women murdered by their intimate partner had accessed domestic violence shelter or crisis services in the previous year.**

“Women report that contacting a domestic violence service provider and going to a domestic violence shelter are helpful or make the situation better in the majority of cases and shelter services were shown to be most effective in reducing severe and moderate re-assault in one prospective study. **4**

OVERVIEW: LETHALITY ASSESSMENT PROGRAM:

History/Background:

“Intimate partner violence (IPV), also commonly called domestic violence, is a complex social issue...Police officers are often one of the first formal system contacts that abused women make, and the police response is the first step in the criminal justice system process. While police contact can provide accountability for the offender and may attend to victim-survivor safety in the short term, social services are best equipped to provide long-term safety options for the victim-survivor of violence (such as safety planning, housing assistance, mental health services), suggesting **the ideal response to IPV is a coordinated criminal justice and social service response.** **5**

“Calling the police is a commonly employed help-seeking strategy by women in abusive relationships. [Victims of intimate partner homicide were six times more likely to reach out to the police than to domestic violence advocacy or other social service agencies.] **6** **Calls to the police increase as the severity or frequency of abuse increases.** While accessing domestic violence services occurs less often than contacting the police, **women report that contacting a domestic violence service provider and going to a shelter are helpful in the majority of cases and shelter services were shown to be most effective in reducing both severe and moderate re-assault in one prospective study.** **7**

“Police officers face a daunting array of difficulties when attempting to protect victims of IPV. Officers are responsible for intervening in a large number of cases and **it is not always clear if the perpetrator poses a lethal threat to his victim. Even when officers believe it is a high risk case, it may be difficult for them to communicate this information to victims or other actors in the system.**

“**Most police units have been trained to provide IPV victims with information about domestic violence services, but only a small proportion, 12.2% of women, access advocacy services after the police leave the scene.** In spite of increasing coordination between criminal justice agencies and social services in some communities, ongoing coordination is lacking in most. **Although police may have a unique and ideal opportunity to intervene with victims at the scene of the IPV incident and connect them to advocacy and safety planning, no previous research has examined the effects of coordinating police and domestic violence advocacy services to provide immediate safety planning when police are called to the scene of an IPV incident.”** **8**

“**A primary goal of IPV early responders, service providers, and state domestic violence fatality review teams is to identify high risk victims in order to reduce and prevent further IPV injury and homicide, and to ensure the safety of survivors and their children.** Although risk assessment for both IPV re-assault and intimate partner homicide is

available, U.S. law enforcement agencies are not systematically using validated methods for identifying the most dangerous IPV cases. **The use of risk assessment by police officers to tailor their response and educate victims about escalating risk and safety measures may increase victims' protective actions and motivate them to leave their abuser. Women are more likely to remain in an abusive relationship when they are unaware of the resources available and simple assessment and referrals – such as providing safety strategies over the telephone – have been shown to help women in abusive relationships enhance their safety skills.”** 9

THE LETHALITY ASSESSMENT PROGRAM:

Danger Assessment protocol – a Precursor of “LAP”: 10

While conducting research into intimate partner violence and advocacy for domestic violence victims, Dr. Jacquelyn Campbell, the Johns Hopkins University, developed an assessment (screening) tool, now widely known as the Danger Assessment protocol. The Danger Assessment protocol was originally created for use with abused women, in collaboration with domestic violence advocates and health care professionals, and is intended to empower abused women toward decisions of self-care, or protective actions. The Danger Assessment protocol is a **validated** risk assessment instrument that helps determine the level of danger that a woman has of being killed or seriously injured by her intimate partner.

At the time of its introduction and first use, the Danger Assessment protocol was typically administered by an advocate [rather than by a first responder] who interviewed a victim of domestic violence **after** an incident had occurred and been “handled,” asking a series of questions to assess and score her level of risk. Administered by a victim advocate, healthcare professional, or criminal justice practitioner [other than first responder], the advocate attempted to assist the victim in recalling incidents of past abuse with the help of a 12-month calendar; the use of a calendar was intended to help the victim in noting and tracking the dates of abuse and the severity of the abuse. During the screening by the advocate, survivor-victims complete 20 yes/no questions about risk factors present within that past year with the calendar being used to aid the victim in recalling severity and frequency of violent incidents and to avoid minimization of abuse.

Advocates score the survivor-victim's responses to the 20-item assessment using a weighted system to score yes/no responses to risk factors associated with intimate partner violence. Among the 20 risk factors measured were the partner's employment status; gun ownership; drug use; alcoholism; if there were past threats of violence; stalking; and **incidence of choking**. Based on the results of the assessment, the advocate and victim then developed an appropriate safety plan.

The **Danger Assessment protocol is a joint effort between the victim and survey administrator [advocate]**, who may assist the victim in developing a safety plan. This risk assessment is unique in that it is the only risk assessment that **gathers data from only the victim of violence** and is intended specifically to be used in collaboration with the victim of violence to promote safety behaviors.

Through her research Dr. Campbell came to the conclusion that to lessen the frequency and severity of violence inflicted on the victims of intimate partner violence it would be beneficial if first responders who were on-scene were able to assess the potential or likelihood for such future violence and, if warranted, put the victim into immediate contact with a domestic service provider who could help the victim develop a safety plan that could be implemented immediately.

Lethality Assessment Program - Concept Development: 11

In 2000, the Maryland Network against Domestic Violence (MNADV) decided – among other issues – to tackle the problem of domestic homicide in Maryland. In order to do this, the MNADV set the goals of identifying victims at high risk for homicide by an intimate partner and creating a plan to assist them with decreasing that risk. To meet these goals, the MNADV established a statewide multi-disciplinary Lethality Assessment Committee in the fall of 2003 to create a protocol for response to domestic violence in Maryland. The committee included advocates,

police officers, and professionals from other related disciplines including prosecution and probation, as well as three researchers from the Johns Hopkins University and the University of Maryland, including Dr. Jacquelyn Campbell and Dr. Daniel Webster. “Four research findings from Dr. Campbell’s study on intimate partner homicide (Campbell et al., 2003) were utilized as touchstones:

1. nearly half of domestic homicide offenders had been arrested in the year prior to the homicide;
2. women do not access domestic violence services at high rates;
3. there is a significant reduction in risk of severe assault when victims utilize the services of a domestic violence advocacy program; and
4. abused women who used community-based domestic violence services were rarely the victim of murder or attempted murder.” ¹²

Additionally, during research into domestic violence that spanned 25 years, Dr. Campbell, et al. found that:

- 1) only 4% of abused victims had used a domestic violence hotline or shelter within the year prior to being killed by an intimate partner;
- 2) in 50% of domestic violence-related homicides, law enforcement officers had previously responded to a call at the scene; and
- 3) the re-assault of domestic violence victims in high danger was reduced by 60% if they went into shelter. ¹³

“Based both on these research findings and on practice expertise, the committee made two important decisions:

- (1) although the project would be designed for field practitioners who came into contact with a victim of domestic violence during the course of their work, they would **focus on law enforcement, the practitioners who would most frequently come in contact with domestic violence victims at risk for homicide;** and
- (2) it was important to **create a collaborative intervention between officers and domestic violence advocates** in order to ensure that victims were receiving the services that they needed.”

Therefore, the goal of the committee was to develop a field protocol that would identify victims of domestic violence who were at the greatest risk of being killed and encourage them to access domestic violence services. The committee worked for two full years creating the Lethality Screen and an accompanying referral protocol, field-testing it, and gathering feedback from the officers and advocates who had participated in the field-test. In the field test, the pilot protocol was described as “very easy” to “fairly easy” to implement by 84% of officers and 95% of advocates.

Research has shown that “**the cornerstone of domestic violence services is SAFETY PLANNING.** The objectives of safety planning are education and empowerment; it is a process which allows the intimate partner violence victim-survivor to:

- ▶ gain information;
- ▶ assess her/his situation;
- ▶ understand her/his danger;
- ▶ reinforce her/his sense of control;
- ▶ strategize her/his responses; and
- ▶ evaluate outcomes.” ¹⁴

“Lack of awareness regarding available resources and difficulties accessing services are factors associated with remaining in an abusive relationship. Intimate partner violence victims tend to underestimate their risk; however, safety concerns often motivate help-seeking and increasing an IPV victim-survivor’s perception of risk may help encourage protective actions. Research suggests that low cost, **clear, simple assessments and referrals, such as teaching intimate partner violence victims safety strategies over the telephone, can be effective in helping women in abusive relationships enhance their safety skills.**” ¹⁵

LETHALITY ASSESSMENT PROGRAM:

Goals of LAP:

Research has shown that “conducting risk assessment with victims brings fears of her partner into the open and allows her to discuss the issue with an informed professional. In addition, the process also helps the professional gain a better idea of the victim’s degree of risk, what kinds of safeguards are needed, and how assertive the professional needs to be with both the woman and the system in order to get her help. Risk communication – the transfer of information gathered during risk assessment – connects the science and practice of risk assessment. Indeed, some researchers refer to risk assessment instruments as risk communication tools; risk assessments, such as the Danger Assessment and the Lethality Screen, are explicitly focused on the communication of risk from the professional to the victim of IPV or between the criminal justice and social service systems.” **16**

Thus, the two-fold goal of MNADV’s Lethality Assessment Committee came into focus:

- ▶ to develop a tool that could be used to help identify victims of domestic violence who were the most likely to face serious injury or death at the hands of their intimate partners; and
- ▶ to prevent domestic violence homicides, serious injury, and re-assault by encouraging more victims to utilize the support and shelter services of domestic violence programs. **17**

With the **ultimate goal of reducing intimate partner homicides**, the LAP Committee, as a practical matter, decided to:

- (1) develop a **user-friendly field screening instrument to identify those victims of domestic violence in the greatest danger of being killed or seriously injured; and**
- (2) create an accompanying proactive [referral] protocol to **directly [immediately] connect victims to services.** **18**

The screening instrument and referral protocol were intended to be used by first responders at the scene of a police call for service, or by other field practitioners [e.g. medical professionals] who may come into contact with a victim of domestic violence during the course of their workday. The Committee decided to focus the application of the LAP on law enforcement officers as the first primary users. The Committee believed firmly that the effectiveness of the LAP hinged largely on the screening instrument being *evidence-based*, to instill confidence and reliability among practitioners in the product.

“Research suggests that low cost, clear, simple assessments and referrals – such as teaching women safety strategies over the telephone – can be effective in helping women in abusive relationships enhance their safety skills. Women have reported that the use of emergency safety planning strategies are useful, with over half of women reporting that they are helpful or make the situation better. While referral has been shown to increase safety behaviors and decrease violent victimization, it may be more protective to include assessment and case management; the assessment process itself may be a helpful intervention that increases victim awareness of violence levels and safety behaviors. Theoretically, there may be an optimal time for intervention shortly after an abusive episode when women are likely to believe that violence will not cease and are more likely to reach out for help. Women have reported no longer practicing safety behaviors once they feel safer as they want to forget about abusive incidents.” **19**

The Development of the Lethality Assessment Instrument:

The MNADV committee worked for two full years creating the Lethality Screen and an accompanying referral protocol, field-testing it, and gathering feedback from the officers and advocates who participated in the field-test. After the field tests were completed, the pilot LAP screening instrument and referral protocol was described as being “very easy or fairly easy” to implement by 84% of the officers and 95% of the advocates. **20** After a few minor modifications the

lethality assessment screening instrument and referral protocol were prepared for distribution to law enforcement agencies and domestic violence service providers for comment.

In addition, MNADV staff conducted four (4) regional workshops for law enforcement agencies and domestic violence service providers so that MNADV Committee members could explain how the Lethality Assessment was to be used, its benefits and limitations and to answer any user questions. Finally, a training packet and implementation materials, including an in-service training video, were produced and distributed to the law enforcement agencies and domestic violence service providers. **21**

The combination of the screening instrument and the referral protocol, called the Lethality Assessment Program (LAP), was implemented by the Kent County, Maryland Sheriff's Office and the Mid-Shore Council on Family Violence on October 1, 2005." **22**

The LETHALITY ASSESSMENT PROGRAM – HOW IT WORKS:

The **Lethality Assessment Program (LAP)**, as designed and first used in Maryland, is an intervention that **occurs at the scene of an intimate partner violence (IPV) incident in which law enforcement officers and/or other first responders are present. LAP provides an on-scene risk assessment followed by immediate contact with advocacy services for victim-survivors who are judged to be at high risk of being killed by their intimate partners. At the core of LAP is a collaborative partnership between law enforcement agencies and local domestic violence service providers.**

"The Lethality Assessment Program (LAP) is a coordinated response to domestic violence. The LAP uses an intimate partner violence risk assessment/screening (called the Lethality Screen) developed to assist law enforcement officers and/or other first responders in identifying risk for **future violence and homicide at the scene of a domestic violence incident. For victim-survivors at high risk, police departments and local domestic violence agencies collaborate to provide IMMEDIATE telephone advocacy and safety planning."**

The "Lethality SCREEN": **23**

Lethality assessments, as risk assessment/screening tools, have been developed to provide law enforcement officers and other first responders with a **simple and consistent method to measure the level of danger that a victim of intimate partner domestic violence is in given their current situation.** LAP screening consists of a **standard set of questions that are asked of the victim in a specific order; the responses that the victim provides to those questions help indicate the level of danger that the victim believes h/she is currently in.**

The LAP is a two-pronged intervention process that is used by first responders when handling domestic violence incidents. The LAP features:

- 1. a research-based lethality SCREENING instrument; and**
- 2. an accompanying REFERRAL PROTOCOL that provides direction for law enforcement officers, medical personnel [clergy, social workers and others] to initiate appropriate action based on the results of the screening process.**

LAP is intended to identify victims of domestic violence who are at the greatest risk of being killed [or seriously injured] by their intimate partners and is intended to immediately connect them to a domestic violence service provider in their area.

The "program" features a short, 11-question lethality screening instrument/questionnaire called the "Lethality Screen" which is followed, if warranted by the victim's responses, by a response/referral protocol.

The Lethality Screen, which is initiated by the responding officer, is given to the victim at the scene of a domestic violence call for service as soon as control has been restored to the incident. While the on-scene officer ultimately determines whether it is appropriate to use the Lethality Screen, during LAP training officers are urged to use the

Lethality Screen when a past or current intimate relationship is involved and there is a “manifestation of danger” by evidence of at least one of the following criteria:

- (1) the officer believes that an assault or other violent act has occurred whether or not there was probable cause for arrest;
- (2) the officer is concerned for the safety of the victim once they leave the incident scene;
- (3) the officer is responding to a domestic violence call from a victim or at a location where domestic violence had occurred in the past; or
- (4) the officer has a “gut feeling” that the victim is in danger.

Administration of the lethality assessment/screen of 11 questions normally occurs near the end of the responding officer’s investigation and once order has been restored to the scene.

While the lethality screen is typically initiated by law enforcement at the scene of an intimate partner domestic violence call-for-service, **it can also be initiated by other first responders such as hospital staff and other practitioners who come into contact with victims of domestic violence during the course of their primary work.**

Researchers have found that asking questions about the victim’s perception of his/her risk and the risk factors involved in intimate partner violence, in particular closely after an incident has occurred, helps a number of victims of intimate partner violence recognize the dangers of their situation and can often motivate victim-survivors of IPV to take protective actions.

Researchers point out that a lethality assessment/screening is only one of many tools used in domestic violence intervention and that a “lower risk” score on the assessment questions does not necessarily mean that the victim is not in serious danger. Law enforcement officers are trained and encouraged to use other factors in addition to the Lethality Assessment in assessing the potential danger of serious injury to a victim of domestic violence.

“Conducting a lethality screen and contacting a hotline is potentially more beneficial than the more common practice of handing the victim a card or pamphlet that lists domestic violence community resources, phone numbers, and addresses. The phone call to the hotline should be brief and take no more than ten minutes, which should encourage the officer to invest in this program. The presence of an officer can be influential and may persuade the victim to contact victim services or a hotline.” 24



Domestic Violence Lethality Screen For First Responders



Officer:

Date:

Case:

Victim:

Offender:

Check here if victim did not answer any of the questions.

▶ A "Yes" response to any of Questions #1-3 automatically triggers the protocol referral.

- 1. Has he/she ever used a weapon against you or threatened you with a weapon? Yes No Not Ans.
- 2. Has he/she threatened to kill you or your children? Yes No Not Ans.
- 3. Do you think he/she might try to kill you? Yes No Not Ans.

▶ Negative responses to Questions #1-3, but positive responses to at least four of Questions #4-11, trigger the protocol referral.

- 4. Does he/she have a gun or can he/she get one easily? Yes No Not Ans.
- 5. Has he/she ever tried to choke you? Yes No Not Ans.
- 6. Is he/she violently or constantly jealous or does he/she control most of your daily activities? Yes No Not Ans.
- 7. Have you left him/her or separated after living together or being married? Yes No Not Ans.
- 8. Is he/she unemployed? Yes No Not Ans.
- 9. Has he/she ever tried to kill himself/herself? Yes No Not Ans.
- 10. Do you have a child that he/she knows is not his/hers? Yes No Not Ans.
- 11. Does he/she follow or spy on you or leave threatening messages? Yes No Not Ans.

▶ An officer may trigger the protocol referral, if not already triggered above, as a result of the victim's response to the below question, or whenever the officer believes the victim is in a potentially lethal situation.

Is there anything else that worries you about your safety? (if "yes") What worries you?

- Check one: Victim screened in according to the protocol
 Victim screened in based on the belief of officer
 Victim did not screen in

If victim screened in: After advising her/him of a high danger assessment, did the victim speak with the hotline counselor?

- Yes No

Note: The questions above and the criteria for determining the level of risk a person faces is based on the best available research on factors associated with lethal violence by a current or former intimate partner. However, each situation may present unique factors that influence risk for lethal violence that are not captured by this screen. Although most victims who screen "positive" or "high danger" would not be expected to be killed, these victims face much higher risk than that of other victims of intimate partner violence.

The REFERRAL Protocol: 25

Advocates and service providers to domestic violence victims have learned that most IPV victims encountered in domestic violence incidents are different from victims who initiate calls for help to a domestic violence hotline. Victims at the scene of an incident may not be ready to reach out to social services for help or may have not yet even recognized that they are victims of abuse. A hotline worker, therefore, may need to provide more education about domestic violence, provide more information about services, and give more encouragement to access services than they would if a victim had reached out for services on their own. Advocates believe that this moment, at the scene of a volatile call for service with a police officer present and an advocate readily available, may be the best time and opportunity for a victim of domestic violence to act. Throughout the LAP, self-determination and empowerment are the cornerstones of this intervention intended to guide survivors toward decisions of self-care.

The second part of the LAP is the “**REFERRAL Protocol**” which requires a willing partnership between the law enforcement agency and a local domestic violence service provider. If a victim-survivor screens in as being a “high risk” of homicide/serious injury, the officer conveys this assessment of risk to the victim-survivor and informs her/him that individuals in similar situations have been killed by their intimate partner. After informing the victim-survivor of the danger of further violence and injury, the officer informs the victim-survivor that he/she would like to immediately contact the local 24-hour domestic violence hotline. The officer explains to the victim-survivor that the collaborating advocacy organization will provide information to the victim-survivor that will be of immediate help to him/her and requests that the victim-survivor consider speaking with the hotline advocate. **It is the victim’s choice whether or not they want to speak to the hotline worker.**

Maryland’s Lethality Assessment Program is intended to be an intervention that not only provides the victim of intimate partner violence with an opportunity to take advantage of a variety of services provided by domestic violence survivor advocates but also presents an opportunity to educate domestic violence victims about their risk and risk factors within their intimate relationships and empowers them to make a decision of self-care. Speaking to IPV victims about their potential for future severe and fatal violence through the use of a risk assessment tool may raise awareness about risk and risk factors and assist them in identifying the risk within their intimate relationship, whether or not they screen in as high risk.

This educational component may also be helpful for police officers because those who have been educated about risk assessment and risk assessment tools may become more aware of the dynamics of abusive relationships and the risk that domestic violence victims face in those relationships. As such, while particular jurisdictions may choose to provide all victims with the opportunity to speak on the telephone with a hotline counselor, this should be weighed against both the resources needed to provide telephone and in-person intervention (should the victim choose to access services) and the missed opportunity for education about risk factors and risk assessment. **26**

When a victim chooses **NOT to speak with the domestic violence counselor or did not respond to the lethality screening questions the officer/first responder should:**

- advise the victim of the danger involved in their situation; and
- explain to the victim the warning signs of serious injury or death;
- provide the victim with contact information for service providers and law enforcement; and
- follow up with victim through calls or visits as appropriate.

However, the established protocol provides that, regardless of the victim-survivor’s decision, the officer will call the hotline and provide the advocate with basic information about the situation. This may give the victim some time to consider speaking to the hotline worker; therefore, while the officer is on the telephone, the officer will ask the victim if they have reconsidered and would now like to talk to the domestic violence service provider. **If the victim continues to decline to speak to the counselor, the officer no longer pursues his/her effort to put the victim on the phone.** Instead, the hotline worker provides the officer with some immediate safety planning tips for the next 24 hours to share with the victim.

If the victim chooses to speak with the hotline worker, the conversation is brief (no more than 10 minutes) and focused, both because the officer must return to service and because the victim may not be in a position to attend to a great deal of information. Because being on the phone with the victim at the scene of a domestic violence incident is a different type of call for hotline workers, they have also been trained to use special guidelines to communicate with and engage victims in situations where they do not have much time and where the victim may not have come to terms with the seriousness of their situation.

Hotline advocates are specially trained to communicate with and engage victim-survivors in this unique situation where time is limited and where they have just been informed by an officer that they are at high risk of serious injury or even death. Guidelines for hotline advocates stress four main points:

- ▶ gain the victim-survivor's trust;
- ▶ reinforce the information provided by the officer about the danger the victim-survivor is in;
- ▶ educate the victim-survivor and immediately develop a safety plan;
- ▶ actively encourage the victim-survivor to respond to the advocate/domestic service provider for assistance/services.

When the screening instrument indicates that the victim is in "high danger" and chooses to speak with the domestic violence counselor, a victim may decide to:

- **immediately access/enter program services;**
- **immediately develop a safety plan; or**
- **take action at a later time.**

Officers/first responders may assist the victim by:

- arranging or providing transportation to the domestic violence service provider's office or program-services office;
- assisting the counselor with safety planning if asked; and/or
- following up with the victim through calls or visits.

Once a victim enters domestic violence services, an advocate will conduct the more detailed Danger Assessment and will develop a more detailed safety plan based on the victim's specific circumstances.

Research indicates that victims who are immediately connected with domestic violence services are at a reduced risk of domestic violence-related homicide, serious assault and repeat victimization. Research indicates that among victims of domestic violence-related homicide, only 4% had ever accessed DV services.

Through years of experience implementing the LAP, advocates have learned that most victim-survivors encountered during calls from the scene of a domestic violence incident are different from victim-survivors who initiate calls to the hotline for help. Victim-survivors at the scene of an incident may not be ready to accept help from social services or may have not yet even recognized that they are victim-survivors of abuse. The advocate, therefore, may need to provide more education about domestic violence and related services and give more encouragement to access services than they would to a victim-survivor who initiated services on their own. Self-determination and empowerment are the cornerstones of the LAP, an intervention intended to guide victim-survivors toward decisions of self-care. **27**

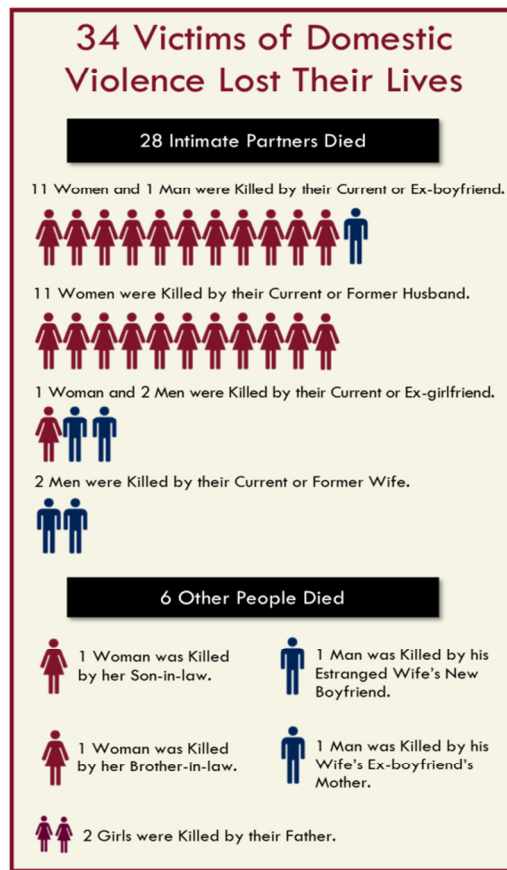
DOMESTIC VIOLENCE IN MARYLAND – STATISTICAL SUMMARY:

The 2014 Uniform Crime Report – “**Crime in Maryland**” published and made available by the Maryland State Police in November 2015 contains data that offers the following snapshot of domestic violence crimes that occurred in Maryland in 2014. That report also helps to explain the change, sometimes a significant one, in several of the domestic violence crime figures relayed by that data.

As is pointed out in the Report:

“In 2012, HB 1146/SB 647 ‘Domestically Related Crimes’ was signed into law to help improve the recording and tracking of domestic violence crimes. Maryland does not have a distinct crime of domestic violence, therefore the new law helps law enforcement, advocates, prosecutors and judges better protect domestic violence victims and set more appropriate conditions for abusers.

To better align with Maryland Law, the Maryland Uniform Crime Reporting Program expanded the definition of domestic violence to include ten (10) additional relationships in calendar year 2013. Prior to 2013, the reported relationships between domestic violence victims and offenders were husband and wife and cohabitant.” 28



In Maryland from July 1, 2014—June 30, 2015

Maryland Network Against Domestic Violence (2016)
4601 Presidents Drive • Suite 370 • Lanham, MD 20706
PH: 301-429-3601 • F: 301-429-3605
Statewide Helpline • 1-800-MD-HELPS

Maryland Domestic Crime Summary: 29

The following domestic violence crime figures, spanning the last five calendar years, indicate that law enforcement officers continue to respond to a significant number of intimate partner violence incidents in the State. Based on this response law enforcement officers, other first responders and domestic violence service providers should continue to use those tools made available to them, including programs such as the Lethality Assessment Program, in their response to crimes of domestic violence.

There were a total of **15,055 domestic violence crimes reported statewide in 2014** as compared to 16,817 crimes in 2013. This represents a 10.5 decrease in the number of domestic crimes in 2013.

VICTIM RELATIONSHIP TO ABUSER					
SPOUSE:	2010	2011	2012	2013 *	2014
Husband	2,064	1,974	1,889	1,866	1,754
Wife	5,233	4,843	4,883	4,761	4,148
CO-HABITANT:					
Heterosexual - Male	2,532	2,727	2,537	2,460	2,257
Heterosexual - Female	7,754	8,261	7,868	7,342	6,514
Homosexual	348	404	438	388	382
TOTAL	17,931	18,209	17,615	16,817 *	15,055

*** NOTE: In 2013, domestic violence data reporting was expanded to include additional relationships and reflect changes in Maryland law. This change explains the increase in the total number of Domestically Related Crimes reported.**

CRIMES					
	2010	2011	2012	2013 *	2014
HOMICIDE	18	23	22	54	67
ASSAULT	16,513	16,846	16,629	25,188	24,485

*** NOTE: In 2013, domestic violence data reporting was expanded to include additional relationships and reflect changes in Maryland law. This change explains the increase in the total number of Domestically Related Crimes reported.**

ASSAULTS					
	2010	2011	2012	2013 *	2014
<u>AGGRAVATED</u>					
GUN	165	141	167	229	214
KNIFE	758	731	715	1,075	1,069
OTHER WEAPON	1,145	1,078	1,036	1,889	1,939
NO WEAPON	1,578	1,067	963	1,567	1,561
<u>NON-AGGRAVATED</u>					
SIMPLE	12,864	13,821	13,384	20,422	19,697
STALKING	3	8	4	6	5
TOTAL	16,513	16,846	16,269	25,188 *	24,485

* **NOTE:** In 2013, domestic violence data reporting was expanded to include additional relationships and reflect changes in Maryland law. This change explains the increase in the total number of Domestically Related Crimes reported.

VICTIMS:

AGE:

Fifty percent (50%) of the victims of domestic violence were between the ages of 25 – 44 years inclusive.

SEX					
	2010	2011	2012	2013 *	2014
FEMALE	13,241	13,360	13,029	19,310	18,760
MALE	4,690	4,849	4,586	8,475	8,482

* **NOTE:** In 2013, domestic violence data reporting was expanded to include additional relationships and reflect changes in Maryland law. This change explains the increase in the total number of Domestically Related Crimes reported.

RACE					
	2010	2011	2012	2013 *	2014
AMERICAN INDIAN	7	7	8	27	20
ASIAN	201	219	167	309	405
BLACK	8,037	8,303	8,102	12,682	12,330
WHITE	9,406	9,427	9,072	14,736	14,455
OTHER	280	253	266	31	32

* **NOTE:** In 2013, domestic violence data reporting was expanded to include additional relationships and reflect changes in Maryland law. This change explains the increase in the total number of Domestically Related Crimes reported.

HOUSE HOLD STATUS					
	2010	2011	2012	2013 *	2014
LIVING TOGETHER	14,543	14,474	13,937	19,516	18,784
NOT LIVING TOGETHER	3,191	3,159	3,252	6,311	7,179
UNKNOWN	197	576	426	1,958	1,279

* **NOTE:** In 2013, domestic violence data reporting was expanded to include additional relationships and reflect changes in Maryland law. This change explains the increase in the total number of Domestically Related Crimes reported.

DOMESTIC VIOLENCE BY COUNTY					
	2010	2011	2012	2013 *	2014
ALLEGANY	367	327	363	529	444
ANNE ARUNDEL	1,394	1,484	1,564	3,287	3,248
BALTIMORE	4,060	4,068	3,755	6,475	6,352
BALTIMORE CITY	3,932	4,161	3,593	3,383	2,799
CALVERT	318	331	297	426	444
CAROLINE	143	153	148	142	116
CARROLL	495	407	346	658	625
CECIL	366	424	354	573	563
CHARLES	618	562	558	1,074	1,027
DORCHESTER	155	163	146	238	204
FREDERICK	619	580	626	1,363	1,418
GARRETT	79	82	99	155	141
HARFORD	595	624	595	959	962
HOWARD	810	856	728	1,925	2,026
KENT	78	66	70	69	45
MONTGOMERY	975	1,054	1,137	1,430	2,203
PRINCE GEORGE'S	937	908	1,238	2,489	2,083
QUEEN ANNE'S	156	131	115	213	170
SAINT MARY'S	564	542	592	815	795
SOMERSET	87	119	88	125	142
TALBOT	117	109	104	98	68
WASHINGTON	294	350	384	318	278
WICOMICO	486	457	474	725	755
WORCESTER	284	243	241	313	334
COUNTY NOT NAMED	0	3	0	8	2

* **NOTE:** In 2013, domestic violence data reporting was expanded to include additional relationships and reflect changes in Maryland law. This change explains the increase in the total number of Domestically Related Crimes reported.

TRAINING IN USE OF LAP:

First Responder – Domestic Violence Service Provider Training:

Using a “train-the-trainer” approach, MNADV staff provided training to first-responders and domestic violence service providers. Because the screening instrument is simple and straightforward the training does not require a great deal of staff time. Typically, the train-the-trainer course takes about four – eight hours to complete. Those being trained as trainers learn about the full program and its processes/protocols on both the law enforcement side and the domestic violence advocate/provider side. Those trained to be trainers were often supervisors/managers, the head of an agency’s Domestic Violence unit, sergeants or field training officers, or administrators (chief operating officers, shelter directors) from the local domestic violence service provider agencies.

Training line-officers in how to conduct their portion of the screening protocol takes between one to two hours for law enforcement officers and domestic violence service providers and advocates. In the many Maryland law enforcement agencies that conduct scenario training as part of entry-level training, recruits complete the LAP screening instrument and practice the follow-up contact protocol during domestic violence response scenarios. In some cases, members of MNADV’s staff participate in entry-level training programs.

Additionally, the Governor’s Office of Crime Control and Prevention provides funding to support training and technical assistance to MNADV to expand the use of LAP to other professional fields in Maryland such as health care and State departments.

Technical Assistance:

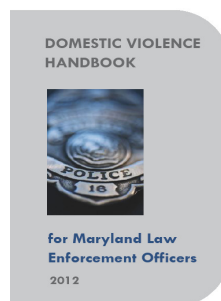
Under a cooperative agreement with the Office on Violence against Women (OVW), the Maryland Network against Domestic Violence (MNADV) provides training and technical assistance to communities across the country to promote or enhance strategies to address homicide prevention and reduce violence against women. Through this program, MNADV provides cost-free, train-the-trainer instruction and technical assistance to teams of community-based domestic violence service programs and partnering law enforcement agencies to implement the LAP in their jurisdictions.

Webinars:

MNADV hosts webinars on a quarterly basis to interested domestic violence service program professionals and law enforcement representatives. One webinar discusses the research behind the development of the LAP, and how/why it works. Another provides an overview of eligibility requirements for cost-free training and technical assistance project, the process of training and implementation, and how to apply.

PUBLICATIONS:

The Maryland Network against Domestic Violence has developed and has available several informational and training publications for law enforcement including:



Maryland Police Training and Standards Training Objectives:

Background:

The following citations from the Code of Maryland Regulations [COMAR] Title 12, Department of Public Safety and Correctional Services, Subtitle 04, Police Training Commission, Chapter 1, Regulations cover, in part, the entry-level training requirements in order for individuals to be certified as law enforcement officers in Maryland.

12.04.01.09

.09 Minimum Standards for Entrance-Level Training for Police Officers:

A. General Requirements.

- (1) An applicant for certification as a police officer shall successfully complete an entrance-level training program approved by the Commission before the Commission may certify the applicant as a police officer.

C. Commission-Required Subject Areas.

- (1) For the Commission to approve an entrance-level training program for police officers, the entrance-level training program shall include the following subject areas:

(a) Organizational principles and law;

(b) Patrol;

(c) Traffic;

(d) Criminal investigation;

(e) Emergency medical care, which shall also provide training in lifesaving techniques, including cardiopulmonary resuscitation (CPR);

(f) Communications;

(g) Report writing and composition;

(h) Crime prevention;

(i) Crisis intervention;

(j) Protective strategies and tactics, including training in the proper level and use of force;

(k) Emergency vehicle operations;

(l) Prisoner processing and security;

(m) Courtroom preparation and testimony;

(n) Health and wellness;

(o) Terrorism and weapons of mass destruction;

(p) Sensitivity to cultural and gender diversity; and

(q) Individuals with physical, intellectual, developmental, and psychiatric disabilities.

- (2) Police officer firearms training and qualification:

(a) May be included in police officer entrance-level training; and

(b) If police officer firearms training and qualification is included in police officer entrance-level training, shall be separately approved by the Commission according to the requirements under COMAR 12.04.02.

D. Commission-Required Performance Objectives.

- (1) **Minimum Performance Objectives.** For the Commission to approve an entrance-level training program for police officers, the entrance-level training program shall include activities to ensure that the applicant for police officer certification has met performance objectives that are:

(a) Composed and sanctioned by the Commission; and

(b) Based on a statewide job task analysis and that address those tasks considered essential for law enforcement officers in Maryland, regardless of law enforcement agency or assignment.

- (2) The Commission shall furnish a copy of the performance objectives upon request by a law enforcement agency, academy, or school.
- (3) The training director of a law enforcement agency, an academy, or a school responsible for police officer entrance-level training shall:
 - (a) Cover the Commission performance objectives during entrance-level training exactly as written by the Commission; and
 - (b) Determine the sequence, content, and duration of training required to cover the Commission's performance objectives.

E. Successful Completion of Commission-Approved Entrance-Level Training.

- (1) The training director of an academy shall conduct testing to verify that an applicant for certification as a police officer has learned or can perform each of the Commission's performance objectives.
- (2) One or more objectives may be addressed by relevant single or multiple demonstrations or questions.
- (3) An applicant for certification as a police officer shall achieve a minimum overall score of 70 percent in each subject area in § C of this regulation. The training director, or a designee, shall maintain accurate records of tests and testing procedures.

Police Entry-Level Objectives

(Effective July 1, 2009)

(Revised Jan 1, 2014)

(Revised Oct. 8, 2014)

(Revised Apr. 20, 2016)

01 – Organizational Principles and Law:

01.07.19 Identify the basic elements of the crime: **domestic violence**.

04 – Criminal Investigation:

04.03.05 Identify resources available to the officer for **handling domestic violence incidents**.

04.05.05 Identify resources available to the victim for **handling domestic violence incidents**.

04.24 Demonstrate the application of an MPCTC approved lethality assessment tool while investigating a domestic violence situation.

06 – Communications:

06.05 Demonstrate interview techniques for person(s) in various situations.

06.05.05 Identify interview techniques when contacting a victim.

06.05.12 Identify special problems to be aware of when interviewing an emotionally shocked person.

09 – Crisis Intervention:

09.01 Identify the duties of a police officer when intervening in an interpersonal conflict.

09.01.01 Describe the methods of intervening in interpersonal conflicts, i.e., sexual offenses (child or adult), hate crimes, violent crimes (including sudden death), **domestic violence** (including child and elder abuse).

09.02 Identify alternative actions an officer has in resolving a conflict situation, i.e., arrest, separate, mediate, refer.

09.03 Identify the basic psychological response of crime victims, i.e., sexual offenses (child or adult), child exploitation, hate crimes, violent crimes (including sudden death), domestic violence (including child and elderly abuse).

09.04 Identify techniques that an officer can use to defuse the crisis stress symptoms of a victim, i.e., of sexual offenses (child or adult) hate crimes, violent crimes (including sudden death), domestic violence (including child and elder abuse).

09.04.01 Describe the basic techniques to defuse a the crisis stress symptoms felt by a victim, i.e., acknowledging victim's ordeal, providing active listening, asking diversionary questions, and explaining options and procedures that will occur.

Start of LAP Implementation in Maryland:

“On October 1, 2005, one law enforcement agency, the Kent County Sheriff’s Office, and their partner domestic violence service provider, Mid-Shore Council on Family Violence, became the first agencies to implement LAP in Maryland. **Today, nearly all Maryland’s law enforcement agencies and domestic violence service providers practice the LAP, including all Maryland State Police barracks. As one Maryland sheriff stated several years after LAP’s initial implementation: "It's what we do!"** 30

AGENCY POLICY AND PROCEDURES INCLUDE LAP:

MODEL DOMESTIC VIOLENCE POLICY:

“Under a grant supported by the Maryland Police and Correctional Training Commissions and the Maryland State’s Attorney’s Association, the Maryland Network against Domestic Violence (MNADV) worked together with the Maryland Chiefs of Police Association, the Maryland Sheriff’s Association, the Maryland State Police and the Baltimore Police Department to develop a model domestic violence policy for the Maryland law enforcement community. Five representatives from the above four law enforcement organizations formed a Policy Development Committee that created a model policy document, ensuring that the document received broad input from various members of the Maryland law enforcement community. In April, 2004 a version of the *Model Domestic Violence Policy for the Maryland Law Enforcement Community* was published and made available to law enforcement agencies throughout Maryland.

While the original model policy was published in 2004, it was updated in 2013 and re-published on www.mdle.net and made available to all law enforcement agencies in Maryland. In the revised edition a section on the use of the Lethality Assessment Program, including a short commentary section on the use of LAP, was added to the original model policy as follows:

Commentary: *In a number of instances the officer responding to a domestic violence call for service is placed in a difficult situation in that he/she will not be able to establish probable cause that a crime has just occurred. Lacking this legal standard to make an arrest, the officer is placed in a situation where he/she is still being asked to take some kind of action to safeguard the well-being of the victim.*

Section 3.7 presents the “Lethality Assessment” as an intervention tool available to officers who respond to domestic violence calls. The “Lethality Assessment Program,” as offered by the Maryland Network against Domestic Violence, is a two-pronged intervention process that features a research-based lethality screening tool and an accompanying protocol referral that provides direction for law enforcement, medical personnel, clergy, social workers and others to initiate appropriate action based on the results of the screening process.

The goal of the Lethality Assessment Program (LAP) is to prevent domestic violence homicides, serious injury and re-assault by encouraging more victims to utilize the support and shelter services of domestic violence programs. By using the Lethality Assessment Screen the responding officer attempts to determine whether the situation with which he/she is dealing has the potential to move toward further and more serious violence, or to death.

The Domestic Violence Lethality Screen for First Responders, provided by MNADV, can be either adopted by agencies that do not have their own screening tool or serve as prototype for agencies wishing to develop their own screening instrument.

While there is no legal requirement that a **Lethality Assessment** be conducted in all domestic violence situations, law enforcement agencies are urged to consider making completion of a **Lethality Assessment** part of their standard operating procedures in response to these calls for service.

Note:

In the original version of the **Lethality Assessment** the question posed in section 3.7.1.B.4.e used the word “choke” instead of the word “strangle.” In this update of the model policy, the question “Has the assailant ever tried to **strangle** you?” has been reworded to reflect current thinking on the difference between the term “choking” [an accident caused by ingesting a foreign object] and “strangling” [an intentional act of violence]. It is recommended that the word “choke” be replaced by the word “strangle” for the reasons cited on page 62 of this model policy.

Model Domestic Violence Policy for the Maryland Law Enforcement Community 31

July 2013 (updated)

[original Model Policy published April, 2004]

3.7.1 Lethality Assessment

The Lethality Assessment Program, as offered by the Maryland Network against Domestic Violence [MNADV], is a lethality screening tool and accompanying referral protocol that provides direction for law enforcement officers to initiate appropriate action based on the results of the screening process when responding to calls for domestic violence. The Domestic Violence Lethality Screen for First Responders provided by MNADV or an agency generated screening tool should be completed by officers responding to domestic violence calls for service involving intimate partners, especially those incident during which a physical assault has occurred.

- A. Upon arrival at the scene of a domestic violence call the responding officer will initially assess the situation to determine who the victim is, whether the victim and assailant have an intimate relationship, whether an assault has taken place and whether there are signs of danger to the well-being and safety of the victim.
- B. If the officer:
 1. determines that a domestic violence assault has occurred;
 2. senses that potential danger to the victim exists;
 3. determines that the names of the parties or the location are repeat names or locations; or,
 4. simply believes a lethal assessment screening should take place he/she will ask the victim to answer a series of questions from the “*Lethality Screen for First Responders*.”
 - a. Has the assailant ever used a weapon against you or threatened you with a weapon?
 - b. Has the assailant threatened to kill you or your children?
 - c. Do you think the assailant might try to kill you?
 - d. Does the assailant have a gun or can he/she get one easily?
 - e. Has the assailant ever tried to **strangle** you?
 - f. Is the assailant violently or constantly jealous or does he/she control most of your daily activities?
 - g. Have you left him/her or separated after living together or being married?
 - h. Is the assailant unemployed?
 - i. Has the assailant ever tried to kill him/herself?
 - j. Do you have a child that the assailant knows is not his/hers?
 - k. Does the assailant follow or spy on you or leave threatening messages?
 - l. Is there anything else that worries you about your safety?
- C. If an officer receives a **YES answer to questions a, b or c** the protocol referral is **automatically** triggered.

- D. If an officer receives NEGATIVE responses to questions “a, b and c” but **at least 4 positive responses to questions “d through l” the protocol referral is triggered.**
- E. If an officer receives a **POSITIVE response to question “a”** or an officer believes the victim is in a potentially lethal situation the **protocol referral is triggered.**
- F. Once the Lethality Assessment is completed the officer shall advise the victim of the results of the screening and, according to the results of the screening as indicated above, explain to the victim that the officer will call the “hotline” in order to contact a counselor. The officer will then request that the victim speak to the counselor who will provide response options to the victim.

If the **victim agrees** to talk to the “hotline” counselor and after the victim does so, the officer will assist the victim in participating in the coordinated safety planning developed between the victim and counselor. If the **victim refuses** to speak to the “hotline” counselor, even after repeated attempts by the officer to convince him/her to do so, the officer shall consult with the counselor in an effort to seek guidance. The officer will then advise the victim of the factors that are predictive of death so that the victim can be on the lookout for them, encourage the victim to contact the domestic violence program, provide the victim with referral information and follow any other established agency protocols designed to address the victim’s safety and well-being.

- G. Once the call for service has been completed, the officer shall complete a **written** report of the incident according to agency reporting procedures including in that report whether a Lethality Assessment was conducted. If none was conducted the reporting officer should note the reason one was not conducted.

SAMPLE – AGENCY DOMESTIC VIOLENCE POLICIES AND PROCEDURES:

The following citations represent a small sample of domestic violence response policies and procedures adopted by Maryland law enforcement agencies. While not all agency policies are the same, as can be noted from the following examples, a number of agencies have adopted either the wording provided by the Maryland Network against Domestic Violence in both its resource and training material or the Model Domestic Violence Policy presented above when outlining the use of the Lethality Assessment Program for their personnel. These policy examples, coming from various law enforcement agencies from across Maryland, indicate the widespread use of LAP in the State.

Maryland State Police 32 Operations Directive OPS. 19.01 [7-1-2014]

.01 Purpose

To provide guidance to troopers who respond to domestic disputes.

.06 Procedures

E. Lethality Screening

1. Troopers will conduct a lethality screening for domestic violence incidents anytime they:
 - a. believe an assault may have occurred;
 - b. sense the victim’s potential for danger is high;
 - c. learn there is a history of domestic calls for service; or
 - d. believe that a lethality screening should be conducted.
2. Troopers conducting lethality screenings will:
 - a. use the Form 246, Domestic Violence Supplemental Report, for the screening;
 - b. advise the victim if the responses meet the threshold for referral as indicated in Section 13 of the Form 246, the factors tend to predict homicide;
 - c. call a domestic violence hotline counselor if the responses meet the threshold or if the trooper believes the victim is in a potentially lethal situation;
 - d. encourage the victim to speak with the counselor;

- e. not jeopardize their safety or the safety of others in order to complete a lethality screening or to call to counselor;
- f. provide full assistance to the victim as outlined in subsection (E), above should the victim choose not to speak with the counselor; and
- g. document the screening in the Incident Report per subsection G below.

G. Documentation

1. Incident Reports will be completed for all for all domestic dispute and domestic violence incidents, regardless of whether a crime occurred and may not be closed as a CAD Incident.
2. In addition to an Incident Report, a Form 246 will be completed for all domestic violence incidents which involve physical injury or assault, regardless of whether an arrest is made.
3. In addition to other required information, troopers responding to domestic violence incidents will document the following in the narrative section of the Incident Report, if applicable:
 - a. if the incident took place in the presence of a child;
 - b. what assistance was offered to the victim;
 - c. if the victim was given a Crime Victims and Witnesses Pamphlet;
 - d. if a Form 246 was completed;
 - e. if a lethality screening was conducted;
 - f. if the required telephone call to a domestic violence counselor was made; and
 - g. if an arrest was not made, an explanation of why the aggressor was not arrested.

FREDERICK (CITY) POLICE DEPARTMENT 33

GENERAL ORDER

Section 5: Special Populations

Order Number: 510

Topic: DOMESTIC VIOLENCE INVESTIGATIONS

Approved: 07/01/11

.01 PURPOSE:

The purpose of this policy is to establish guidelines for handling incidents that involve domestic violence.

.05 DEFINITIONS:

DOMESTIC VIOLENCE LETHALITY SCREEN FOR FIRST RESPONDERS – a questionnaire issued by the Maryland Network Against Domestic Violence.

.35 DOMESTIC VIOLENCE LETHALITY SCREENING:

1. The Maryland Network Against Domestic Violence has developed the “Domestic Violence Lethality Screen for First Responders” form. The purpose of this form is to attempt to identify victims of domestic violence who may ultimately be subsequent lethal victims. As such, the Frederick Police Department will partner with the Heartly House when a “Protocol Referral” is triggered as listed below.
2. The Lethality Screening form consists of a total of eleven (11) questions. A positive response to any of the first three questions, or, four positive responses to questions four through eleven triggers the “Protocol Referral”.
3. Officers assigned to calls for service involving domestic violence, in addition to those duties outlined in this order, will perform the following:
 - A. Conduct an interview with the victim utilizing the “Lethality Screen.” The completed “Lethality Screen” will be attached to the investigative report, regardless of participation or lack thereof of the victim.
 - B. If the responses from the victim indicates the implementation of the protocol referral, the assigned officer will initiate contact from the scene with the Heartly House by dialing 301-662-8800, regardless of whether or not the victim has indicated they wish to speak with a counselor. In the event of a busy signal at this number, contact will be made using 301-639-4284, which is the cellular telephone for the Heartly House.

- C. When contact is made with the Hearty House, the officer will identify himself and agency and advise he is calling in reference to an investigation relevant to the lethality screening.
 - D. When connected with a victim advocate, the officer will apprise them of the investigation information and then offer the phone to the victim in order for the victim to obtain the services of the victim advocate immediately.
 - E. As part of the investigation, request a "Premise History" of the location from Communications. When existent, attach a copy of the premise history to the report.
 - F. FAX a copy of every Lethality Screen, regardless of the results, to the Hearty House at 301-576-3593.
4. In all cases involving current or past intimate partners, such as spouses, ex-spouses, boyfriends, girlfriends, ex-boyfriends, and ex-girlfriends, the investigating officer will conduct a "Domestic Violence Lethality Screen for First Responders" and attach the completed form to the Domestic Violence Report form.
 5. The Lethality Screen will not be completed for calls involving allegations of child abuse and/or vulnerable adult abuse. Instead, the officer responding to such calls will contact the appropriate personnel from the Department of Social Services, who will be responsible for safe and appropriate placement of the alleged victim and other children or vulnerable adults in the household.
 6. The Lethality Screen will not be completed for disputes involving other non-intimate family members, such as parents and children or siblings. The Lethality Screen also does not apply to non-intimate roommate situations.

ANNE ARUNDEL COUNTY POLICE DEPARTMENT 34
DOMESTIC VIOLENCE
INDEX CODE: 1603
EFFECTIVE DATE: 12-05-14

I. DEFINITIONS

E. Lethality Assessment

Lethality Assessment is a way of identifying and assessing a domestic violence victim's potential for being killed.

II. POLICY

The department is committed to reducing the incidence and severity of domestic violence by recognizing it as a significant societal problem, and dealing with it as a serious criminal offense. The department will strive to:

- A. Educate victims as to their legal rights.
- B. Advise victims of the help that is available to them.
- C. Encourage victims to seek legal and social assistance. (et al.)

VI. LETHALITY ASSESSMENT

The department has implemented a Domestic Violence Lethality Screen for First Responders (page 3 of the Domestic Violence Report form.)

The lethality assessment is an instrument and a protocol for first responders that will identify and help victims who would be assessed as being in danger of death. A first responder using a lethality assessment will ask a victim of domestic violence 11 questions that were determined to be critical factors in identifying victims who are in danger of being killed. When an officer is interviewing a victim of domestic violence, after the officer has filled out a domestic violence report, they will initiate the lethality screen of the victim.

- A. The officer will ask the victim 11 yes or no questions. If the victim gives positive responses to any of Questions 1-3, this triggers a protocol referral. If the victim gives negative responses to questions 1-3, but gives positive responses to at least 4 of questions 4-11, this triggers a protocol referral. An officer may also trigger a protocol referral if he/she believes the victim is in a potentially lethal situation.

If the victim gives a positive response to question #9 (“Has he/she ever tried to kill himself/herself?”), the officer will attempt to obtain further information about the prior incident/incidents from the victim. All pertinent information regarding a prior suicide attempt will be communicated to the Booking Officer if an arrest is made, per Index Code 2004.

If the protocol referral is triggered, the officer will advise the victim that the victims in similar situation have been killed and that the officer would like the victim to speak with a domestic violence counselor. The officer will call the domestic violence hotline, advise the counselor of the situation and let the victim speak with the counselor. If the victim refuses to speak with the hotline counselor, the officer is to still call the domestic violence hotline and once again offer a chance for the victim to speak with the counselor.

- B. After the victim has spoken with the counselor or if the victim and officer determine that the officer is no longer required at the scene, the officer will make sure to complete the lethality screen to submit with the domestic violence report.

VII. REPORTING REQUIREMENTS

- A. Cases of domestic violence, including attempts or threats to commit domestic violence, require a written report. The report must articulate the facts of the case and contain as much information as possible under the circumstances concerning what occurred, to include: descriptions of physical evidence, emotional state of victim and suspect, names of witnesses, the age, race, sex, household status, whether or not alcohol/CDS was involved, the relationship of the parties, methods and contributing circumstances of the incident, and any police action taken.
1. Officers must realize that many domestic calls for service may not meet the Warrantless Arrest Criteria, but WILL meet the above department reporting requirements.
 2. In an effort to be as clear as possible in determining which category a specific case falls under, officers should clearly and simply ask the victim if he/she is injured and to describe the injury(s) in detail. This information must be clearly documented in the report whether officers are making a warrantless arrest, applying for charges or documenting a threat.
- B. The Domestic Violence Report form (PD 1603) will be used as the first two pages of the domestic violence report. The reporting officer is responsible for completing both pages of the report; however, attempts should be made to have the victim fill out the body map, victim statement, and sign all the appropriate areas (victim statement **and** body map.) The narrative of the report will be completed **in ARS**.
- C. If a victim is willing to complete the report but is physically unable to do so, the officer will provide assistance and will describe what assistance was provided in completing the report in the narrative of the incident report.
- D. If an incident fits the “Family Violence” criteria and an incident report is required to be written, it is to be titled “Family Violence” and written on a Departmental incident report.
- E. A copy of the Domestic Violence Lethality Screen for First Responders (page 3 of the Domestic Violence Report form, PD 1603) will be submitted with the domestic violence report. This lethality screen must be completed for all cases of domestic violence. The only exception to this reporting requirement is in cases of a dual domestic assault where the officer is unable to determine the primary aggressor. If the officer is able to determine the primary aggressor in the case of a dual domestic assault, the officer may elect to do a lethality assessment on the victim. Officers are advised NOT to perform a dual lethality assessment.
- F. Copies of the domestic violence report will be distributed to the following components:
- * Central Records;
 - * CID;
 - * District Domestic Violence Officer;
 - * Reporting Officer;

NOTE: A written request for a copy of the 911 tape of the Domestic Violence incident should be submitted to the Central Records Manager:

MD Code Family Law, Sec. 4-503 requires that a copy of any incident report filed as a result of a response to a request for assistance under 4-501, be provided to the State Police and to the victim, if the victim so requests. If a victim of domestic violence requests a copy of an incident report filed as a result of a response to a request for assistance, the victim will be referred to Central Records who will accommodate the request. Central Records is responsible for forwarding copies of domestic reports to the State Police.

VIII. DUTIES OF THE DISTRICT DOMESTIC VIOLENCE OFFICER

G. Maintain Lethality Assessment district statistics and forward them to the MNADV.

Cumberland Police Department 35

General Order: 42.2.13 – DOMESTIC VIOLENCE INVESTIGATION

Review Date: January 20, 2016

42.2.13 DOMESTIC VIOLENCE INVESTIGATION

POLICY:

The nature and seriousness of crimes committed between family or household members are not mitigated because of the relationships or living arrangements of those involved. It is the intent of this policy to prescribe courses of action which police officers should take in response to domestic violence that will enforce the law while also serving to intervene and prevent future incidents of violence.

III. RESPONDING OFFICER PROCEDURES:

8. Interview victim and complete *CPD form PT-2 Lethality Assessment Form*.

B. Initiating a lethality assessment

1. In addition to the investigative procedures outlined, the investigating officer will complete the *CPD form PT-2 Domestic Violence Lethality Screen for First Responders* form when he/she responds to a domestic complaint involving intimate partners or incident and one or more of the following conditions exist:

- a. There is reason to believe an assault or an act that constitutes domestic violence has occurred, whether or not there is an arrest.
- b. There is a belief or sense on the part of the investigating officer that once the victim is no longer in the care or presence of the responding officer the potential for assault or danger is high.
- c. Repeated calls for domestic complaints at the same location or involving the same parties.
- d. The investigating officer believes one should be conducted based on his experience, training, and instinct.

2. Lethality Screening Questions

a. The investigating officer should:

- 1) Advise the victim they will be asked a series of questions to help the officer determine the immediate potential for danger to the victim.
- 2) Ask the questions in the order they are listed on the form.
- 3) Ask all the questions in assessing the victim. The more questions the victim responds to positively, the clearer and immediate the potential for danger is to the victim.

3. Assessing the Responses to the Lethality Questions

a. After the responding officer asks the questions on the Lethality Screening, they will handle the information as follows:

- 1) A **single** “yes” or positive response by the victim to questions #1, 2 or 3 reflects a high danger situation and automatically triggers the protocol referral.
- 2) If the victim gives negative responses to questions #1-3, but positive responses to four or more of questions #4 thru 11, reflects a high danger situation and triggers the protocol referral.
- 3) “No” or negative responses to all of the assessment questions, or positive responses to less than four of questions #4 thru 11, may still trigger the referral if the investigating officer believes it is appropriate. The officer should ask the victim the following question; “Is there anything else that worries you about your safety? If yes, what worries you”? The response to the question may aid in your decision.
- 4) Trust your instincts. Use of the domestic violence lethality screen takes into account the “gut factor.” It is flexible and it relies on the investigating officer acting on their instincts. If the victim’s responses does not trigger the referral, but the officer’s “read” of the situation indicates high danger, the officer should trigger the referral.

4. Referral - not triggered

a. If the referral is not triggered or victim does not answer the screening questions, the officer will:

- 1) Advise the victim that domestic violence is dangerous and sometimes fatal.
- 2) Inform the victim to watch for the signs listed in the assessment because they may convey to the victim that they are at an increased level of danger.
- 3) Refer the victim to the Family Crisis Resource Center.
- 4) Provide the victim with the Crime Victims and Witnesses Pamphlet to include the Department’s telephone number, case number, and the officer’s contact information, in case the victim wants to talk further or needs help.

5. Referral – Triggered

a. If a high danger assessment is made or the officer believes it is appropriate, the referral will be implemented as follows:

- 1) Advise the victim that their situation has shown that the victim is at an increased level of danger, and that people in the victim’s situation have been killed or seriously injured.
- 2) Advise the victim that you would like to call the Family Crisis Resource Center and have the victim speak with a counselor.
 - a) If the victim initially declines to speak with the counselor, the first responder will:
 - i. Tell the victim that the officer will contact the domestic violence hotline to receive guidance on how to proceed with the situation;
 - ii. Tell the victim that they would like the victim to reconsider speaking with the hotline counselor; and
 - iii. After the officer concludes the conversation with the counselor, ask the victim if they have reconsidered and would now like to speak with the counselor.

- b) If the victim continues to decline to speak with the counselor, the officer should do the same thing they would do for a victim who did not trigger the referral, including conveying information that the counselor has suggested and going over some safety tips when the victim does not want to leave.
 - c) If the victim agrees to speak with a counselor, the officer will advise the counselor that he has made a high danger assessment, or believes that the victim is in danger, and would like the counselor to speak with the victim.
 - i. Officers will not provide the name of the victim to the counselor without the consent of the victim.
 - ii. At the appropriate time during the conversation between the victim and the counselor, the counselor will ask the victim to speak with the officer about the situation.
 - iii. The officer will then be guided by the discussion with the counselor for further assistance. Officers will provide reasonable assistance to the victim if the victim wants to leave the residence.
- 3) The completed CPD form PT-2 Lethality Assessment will be forwarded to Central Records upon completion.

V. VICTIM ASSISTANCE / CRIME PREVENTION

- A. Many victims of domestic violence feel trapped in violent relationships because they are unaware of the resources available to help them or that domestic violence is a crime. Also, the offenders may have threatened further violence if the victim attempts to leave or seek assistance. Officers are therefore required to provide the following assistance to victims, batterers, and, where appropriate, the children:
- 1. Advise all parties about the criminal nature of family violence, its potential for escalation, and what help is available;
 - 2. Secure medical treatment for victims;
 - 3. Insure the safety of the children;
 - 4. Remain on the scene until satisfied that there is no threat to the victim;
 - 5. Remain on the scene to preserve the peace as one person removes personal property;
 - 6. Provide the victim(s) with referral information for legal or social assistance and support.
 - 7. Complete the *CPD form PT- 2 Lethality Assessment*.

MONTGOMERY COUNTY POLICE DEPARTMENT 36
DOMESTIC VIOLENCE INVESTIGATION

FC No.: 535
 Date: 11-14-08

I. Policy

The department is committed to reducing the incidence and severity of domestic violence by recognizing it as a significant societal problem but dealing with it as a serious criminal offense. The department strives to:

- 1. Educate victims as to their legal rights.
- 2. Advise victims of the help that is available to them.
- 3. Encourage victims to seek legal and social assistance. [et al.]

III. Domestic Violence Complaints

A. When an officer is on the scene of a domestic violence incident, the following steps should be taken:

- 1. Secure the scene for officer safety, victim safety, and evidentiary purposes.**

2. **Conduct a preliminary investigation.** It is imperative that the patrol officer's investigation be as thorough as possible. Victim, witness, and suspect statements should all be included in the investigation. Photographs should be taken whether or not an arrest is made. **Digital photographs will be uploaded to the photographic evidence database prior to the end of the officer's tour of duty.**
3. **Notify proper investigative unit per FC 611, "Follow-Up Investigations."**
4. Complete the MCP 535, "Domestic Violence Supplemental," for all domestic violence **incidents** where an incident report is written.
5. **Complete the MCP 536, "Domestic Violence Lethality Screen," for all domestic violence incidents when an intimate relationship is involved and:**
 - a. **The officer believes an assault has occurred; or**
 - b. **The officer believes the victim faces danger once the officer leaves; or**
 - c. **The parties have been involved in prior domestic violence incidents; or**
 - d. **There have been prior domestic violence incidents at that address; or**
 - e. **The officer simply believes one should be conducted.**
6. **Contact the Abused Persons Program (APP) counselor at (240) 777-4673 to relay high danger lethality assessment findings only. If no one answers, contact the Crisis Center at (240) 777-4000, 24 hours a day. Explain the situation to the counselor and attempt to have the victim speak with the counselor. The APP/Crisis Center is designed to provide the victim with information on shelter, counseling, and safety planning. If the victim refuses to speak with the counselor, document the refusal in the incident report.**
7. Provide an MCP 1107, "Victim/Witness Assistance Information," to the victim in accordance with Family Law Article, Section 4-503.
8. **Forward copies of the MCP 535, the MCP 536, and the incident report to the Domestic Violence Unit (DVU) by the end of the officer's tour of duty.**

WESTMINSTER POLICE DEPARTMENT 37

General Order #: 5-09

DOMESTIC VIOLENCE INVESTIGATION

February 22, 2011

II. POLICY:

The Westminster Police Department recognizes domestic violence situations as serious criminal offenses and responds proactively to all incidents of this nature. Officers responding to domestic incidents will focus on the safety of domestic violence victims and the arrest of domestic violence offenders whenever possible. When evidence of domestic violence is apparent, officers of the Westminster Police Department will use the Lethality Assessment Protocol to assist the victims in how to best protect their own safety.

III. DEFINITIONS:

G. A tool used to identify victims (intimate partners) of domestic violence who are at **highest risk of being killed** or seriously injured by their abusers.

X. WRITTEN REPORTS:

- A. A written report must be prepared for all alleged acts of domestic violence and all verbal domestic disputes, regardless of whether a crime has occurred. **An "NR" (No Report) disposition is not permitted, no matter how little information is obtained from the involved parties.** A (1) Domestic Violence Supplement Form and a (2) Lethality Assessment Form will be completed in all cases of confirmed domestic violence.
- B. The following information should be documented in the written report:
 1. The status of the relationship between the involved parties.
 2. The nature and extent of injuries.
 3. The use of force or weapons.
 4. The use of threatening language or actions.
 5. The nature of the conflict that lead to the violence.
 6. The involved party's history of past violence and police intervention.
 7. The use of alcohol, illicit drugs or medication.

8. Excited utterances by the victim, suspect and witnesses.
9. Temporary location of victim.
10. The names, addresses and phone numbers of witnesses.
11. Any statements made by the victim or witnesses.

NOTE: Items 9-11 above, when documented within a domestic violence report will not be released to any person other than law enforcement agencies or the State's Attorney's Office.

E. INITIATING THE LETHALITY ASSESSMENT PROTOCOL:

1. In addition to the investigative procedures previously outlined, the investigating officer will initiate a Domestic Violence Lethality Screening when he/she responds to (1) a domestic complaint involving intimate partners or (2) a domestic violence incident where one or more of the following conditions exists:
 - a. There is reason to believe an assault or an act that constitutes domestic violence has occurred, whether or not there is an arrest.
 - b. There is a belief or sense on the part of the investigating officer that once the victim is no longer in the care or presence of the responding officer the potential for assault or danger is high.
 - c. Repeated calls for domestic complaints at the same location or involving the same parties.
 - d. There is an alleged Violation of a Protective Order.
 - e. The investigating officer believes an assessment should be conducted based on his/her experience, training and instinct.
2. The investigating officer shall:
 - a. Advise victims that they will be asked a series of questions to help the officer determine the immediate potential for danger to them.
 - b. Ask the questions in the order they are listed on the Domestic Violence Lethality Screen for First Responders.
 - c. Ask all the questions in assessing the victim. The more questions the victim responds to positively, the clearer and more immediate the potential for danger is to the victim.
 - d. The responding officer will then assess the answers and handle the information as follows:
 - i. A single "yes" or positive response by the victim to questions # 1, 2 or 3 reflects a high danger situation and automatically triggers the protocol referral.
 - ii. If the victim gives negative responses to questions #1-3, but positive responses to four or more of questions #4-11, this reflects a higher danger situation and triggers the protocol referral.
 - iii. "No" or negative responses, to all of the assessment questions, or positive responses to less than four of questions #4-11, may still trigger the referral if the investigating officer believes it is appropriate. The officer should ask the victim the following question; "Is there anything else that worries you about your safety? If yes, what worries you"? The response to this question may aid in your decision.
 - iv. Trust your instincts and common sense. Use of the domestic violence lethality screen takes into account the "gut factor." It is flexible and it relies on the investigating officer acting on his/her instincts. If the victim's responses don't trigger the referral, but the officer's "read" of the situation indicates high danger, the officer should initiate the referral.
3. Referral - Not Triggered
If the referral is not triggered or the victim does not answer the screening questions, the officer will:
 - a. Advise the victim that domestic violence is dangerous and sometimes fatal.
 - b. Inform the victim to watch for the signs listed in the assessment because they may convey to the victim that they are at an increased level of danger.

- c. Refer the victim to Family and Children's Services of Central Maryland (Carroll County).
- d. Provide the victim with the Department's telephone number, the case number, and the officer's contact number in case the victim wants to talk further or needs help.

4. Referral - Triggered

If the Lethality Assessment indicates a high danger to the victim **or the officer believes it is appropriate based upon the information known to him/her**, the referral will be implemented as follows:

- a. Advise the victim that the assessment indicates that he/she is at an increased level of danger, and that people in the victim's situation have been killed or seriously injured.
- b. Advise the victim that you would like to call the Domestic Violence Hotline and have the victim speak with a counselor. If the victim initially declines to speak with the counselor, the first responder will:
 - i. Tell the victim that the officer will contact the Domestic Violence Hotline to receive guidance on how to proceed with the situation;
 - ii. Tell the victim that they would like the victim to reconsider speaking with the hotline counselor; and
 - iii. After the officer concludes the conversation with the counselor, ask the victim if they have reconsidered and would now like to speak with the counselor.
- c. If the victim continues to decline to speak with the counselor, the officer should do the same thing he/she would do for a victim who did not trigger the referral, including conveying information that the counselor has suggested and going over some safety tips when the victim does not want to leave.
- d. If the victim agrees to speak with a counselor, the officer will advise the counselor that he/she has made a high danger assessment, or believes that the victim is in danger, and would like the counselor to speak with the victim.
- e. Officers **will not** provide the name of the victim to the counselor without the consent of the victim.
- f. At the appropriate time during the conversation between the victim and the counselor, the counselor will ask the victim to speak with the officer about the situation.
- g. The officer will then be guided by the discussion with the counselor for further assistance. Officers will provide reasonable assistance to the victim if the victim wants to leave the residence.

XI. ASSISTING THE VICTIM:

- A. Officers responding to domestic violence calls, including attempts or threats to commit domestic violence, and on a domestic stand-by, will provide the victim with a copy of the brochure entitled "**CRIME VICTIMS AND WITNESSES: Your Rights and Services.**" Maryland law requires this brochure be given to victims of domestic violence.
Note: The brochures are specific for each county, and contain the appropriate phone numbers and addresses where a victim may get assistance. Supervisors will ensure sufficient copies of the brochure are ordered from the Quartermaster and are available for officers to obtain.
- B. Officers responding to a domestic violence incident will advise victims of the availability of a copy of the report concerning the incident from the office at no cost to them.
- C. Officers will review with the victim his/her rights, to include obtaining an **Interim, Temporary Protective Order** or **Peace Order**.
- D. When requested by the victim, officers will assist in providing transportation to the Court to obtain an order and assist in filing an order or criminal charges. Requests from victims **one (1) or more days** after an incident will be referred to the State's Attorney's Office, Domestic Violence Unit.
- E. Officers will document in the narrative section of the incident report that the victim was given written information on victims' rights and available assistance, and all other assistance offered.
- F. Officers will inquire if the victim wants to leave the residence on a temporary or permanent basis and assist the victim in contacting Family and Children's Services of Central Maryland (Carroll County) or other agencies or individuals to obtain temporary shelter.

XIX. LETHALITY ASSESSMENT REPORTING PROCEDURES:

- A. The Records Section will prepare and forward reports to the Maryland Network against Domestic Violence by the 15th day of the following months:
 - 1. January
 - 2. April
 - 3. July
 - 4. October
- B. The reports shall contain the following information:
 - 1. How many lethality screens were attempted?
 - 2. How many victims were screened in high danger?
 - 3. How many victims were not screened in high danger?
 - 4. How many did not respond to the screening questions?
 - 5. How many screened victims spoke to a counselor?

XX. SUPERVISOR'S ROLE AND RESPONSIBILITIES:

- A. Supervisors will actively monitor their officer's responses to domestic violence cases to ensure compliance with this policy. Supervisors will pay particular attention to problem-solving, dual arrests, report writing and what actions were taken by responding officers to ensure the safety of victims or potential victims.
- B. Supervisors will conduct semi-annual roll-call training on the provisions of this policy in January and July of each year. Documentation of this roll-call training will be forwarded to the Training Division for filing.

IMPACT OF LAP:

Maryland Law Enforcement On-Scene "LAP" Screens:

"In Maryland, 100% of law enforcement agencies that respond to calls for service are LAP participants, including the Maryland State Police, as are all 20 domestic violence programs in all 24 state jurisdictions (D. Sargent, personal communication, May 12, 2014). Some participants have been using the LAP in Maryland for more than 8 years. Between 2006 and 2012, officers have administered more than 56,000 screens. During that time period, 53% of victims screened at high risk with 57% of those talking with the advocate at the scene and 31% following up with the agency (Maryland Network against Domestic Violence [MNADV], 2013). Each year, more agencies have been added, the populations served have increased, and new variations on the protocol have been undertaken. Concerns –such as phone use, officers being on the scene longer, legal discovery of the Lethality Screen by defendants, and liability – have not materialized as problems or have resolved themselves due to the voluntary nature of participation, the effectiveness of the protocol, and officer acceptance of the intervention." 38

Based on the annual statistical reports from the Maryland Network against Domestic Violence, the number of lethality screens completed by law enforcement agencies in Maryland has remained relatively constant over the past 4 years although the total rose 13% in 2015 from the 2014 total. Likewise the number of victims of intimate partner violence who graded as "high-danger" also has remained relatively constant over the past 4 years. However, the number of victims who "did not answer" the screening questions increased by about 600 individuals in 2015 from 2014. The number of victims who spoke to a counselor remained relatively constant from 2014 totals; conversely, the number of victims who entered into some type of provider service increased by 9% to 4.3 victims per day. In general, it appears that the number of individuals assessed and who graded as being at a "high-danger" risk has remained relatively constant over the past 4 years but the number of victims who have taken advantage of various provider services has risen appreciably in the same time period. The data reinforces the need for first responders to continue to use LAP during response to domestic violence incidents. 39

ON-SCENE LAW ENFORCEMENT "LAP" SCREENS						
	Lethality Screens	High-Danger	Non-High Danger	Did not answer	Spoke to Counselor	Went into Services
Total 2015	11,839 (32.4/day)	6,124 (52%)	3,925 (33%)	1,790 (15%)	2,742 (45%) 7.4/day	1,582 (58%) 4.3/day
Total 2014	10,292 (28.2/day)	5,599 (54%)	3,498 (34%)	1,195 (12%)	2,841 (51%) 7.8/day	1,391 (49%) 3.8/day
Total 2013	12,751 (34.93/day)	6,688 (52%)	4,716 (37%)	1,346 (11%)	3,257 (49%) 8.9/day	1,029 (32%) 2.8/day
Total 2012	12,108 (33.2/day)	6,224 (51%)	4,737 (39%)	1,147 (10%)	3,277 (53%) 9/day	925 (28%) 2.5/day

Additionally, MNADV reported the following use of LAP by county for 2015: 40

LETHALITY ASSESSMENT USE BY COUNTY – JANUARY – DECEMBER 2015					
COUNTY	POPULATION	LETHALITY SCREENS	SCREENS PER DAY	SPOKE TO COUNSELOR	WENT TO SERVICE PROVIDER
Allegany	75,000	210	0.58	79	23
Anne Arundel County	538,000	1,695	4.64	444	0
Baltimore County	805,000	2,204	6.04	273	167
Calvert County	89,000	67	0.18	16	1
Caroline County	33,000	41	0.11	1	1
Carroll County	167,000	390	1.07	172	132
Cecil County	101,000	297	0.81	98	34
Charles County	147,000	344	0.94	108	60
Dorchester County	32,500	49	0.13	13	12
Frederick County	233,500	674	1.85	168	140
Garrett County	28,000	66	0.18	20	13
Harford County	245,000	1,031	2.82	142	141
Howard County	287,000	813	2.23	105	156
Kent County	20,000	12	0.03	2	1
Montgomery County	972,000	580	1.59	264	231
Prince George's County	847,000	1,684	4.61	444	298
Queen Anne's County	48,000	144	0.39	25	8
Saint Mary's County	105,000	430	1.18	121	35
Somerset County	26,500	112	0.31	35	18
Talbot County	37,500	72	0.20	23	10
Washington County	144,000	348	0.95	28	0
Wicomico County	99,000	463	1.27	123	79
Worcester County	38,000	113	0.31	38	22
Law Enforcement Agencies (119)	5,118,500	11,839	32.44	2,742	1,582

In a press release generated by MNADV earlier this year to coincide with the publication of its Annual Report, MNADV outlined the impact of the use of its Lethality Assessment Program's on domestic violence deaths and serious injuries in the State.

FOR IMMEDIATE RELEASE

March 16, 2016

Contact: Alicia Bickoff, 301-429-3601 or albickoff@mnadv.org.

**2015 Maryland Lethality Assessment Program (LAP) Annual Report
Continued LAP Expansion Saves Lives in Maryland**

The **2015 Maryland Lethality Assessment Program (LAP) Annual Report**, conducted by the **Maryland Network Against Domestic Violence (MNADV)**, was released this month. The report covers the period January 1 – December 31, 2015. 160 LAP-participating agencies collected and provided data to the MNADV, which documented the life-saving service that law enforcement, domestic violence programs, hospitals and the Department of Human Resources provide through the LAP.

The LAP, created by the MNADV in 2005, is an innovative strategy to prevent domestic violence homicides and serious injuries. It provides an easy and effective method for law enforcement and other community professionals to **identify "High-Danger" victims of domestic violence**, who are at the highest risk of being seriously injured or killed by their intimate partners, and immediately **connect them to the local domestic violence service program**. The LAP is a multi-pronged intervention that uses a standardized, evidence-based lethality assessment instrument and referral protocol to help first responders tailor their response to the unique circumstances of High-Danger victims.

"The LAP has gone from a Maryland innovation and experiment to a practice that is now carried out by thousands of police officers, deputies, troopers, nurses, social workers and domestic violence advocates throughout the state. Over 10 years, more than 12,000 victims, assessed as being in the greatest danger of being killed, have been connected to a domestic violence program for help. These 'High-Danger' victims are being helped to regain control of their own lives, rather than being controlled by their abuser. Because we also see downward trends in homicides related to domestic violence in Maryland, we believe the LAP is making a significant difference in the lives of victims," said Dave Sargent, senior program manager of the Maryland Network Against Domestic Violence (MNADV).

Research on the LAP has demonstrated that High-Danger victims who utilize domestic violence services are safer. The **2015 report** documented that there were **4,796 (56%) High-Danger victims who spoke on the telephone to a hotline advocate** at the scene of a domestic incident, while filing for a protective order, and/or at a hospital or health care facility. **Of those High-Danger victims, 2,729 (57%) accessed the life-saving services of domestic violence programs.** In **2015, 626 more victims came in for services** through all agencies implementing the LAP than in the previous year. This represents an **11% increase** in the percentage of High-Danger victims who chose to participate in domestic violence services.

The report also highlights the **expansion of the LAP in 2015.** This includes the **Department of Human Resources' first full year** of successful LAP implementation. In addition to the nine hospitals already administering the LAP, **three more hospitals/health care facilities** began LAP implementation in partnership with their local domestic violence program: Carroll Hospital Center, Frederick Mental Health Association, and the University of Maryland Charles Regional Hospital.

Domestic violence programs provide critical, life-saving services each day. **The partnership between domestic violence programs and other community practitioners makes a significant difference in the fight to end domestic violence and reduce fatalities in Maryland.**

The 2015 Maryland LAP Report is attached. To access the report online, go to: <http://mnadv.org/lethality/lap-maryland>.

####

NATIONWIDE USE:

Expanding the Use of the Lethality Assessment Program:

Maryland has been acknowledged by the National Institute of Justice and a number of states as the leader in the use of the Lethality Assessment Program. **41**

As of 2015, jurisdictions in 34 states, including Maryland, are implementing the LAP. They are: Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Indiana, Illinois, Kentucky, Michigan, Minnesota, Missouri, Mississippi, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma (where NIJ recently finished a study of the LAP), Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin. **42**

Because time and space do not allow for a complete review of each of the above listed jurisdictions that currently employ Maryland's LAP, five states have been selected as examples of how those jurisdictions have adopted Maryland's model LAP:

- ▶ Connecticut
- ▶ Delaware
- ▶ New Hampshire
- ▶ Pennsylvania
- ▶ Utah

When statistical data regarding the use of LAP was readily available for each state cited in this report, it was included for general information purposes.

CONNECTICUT: **43**

The Lethality Assessment Program (LAP) began in Connecticut on September 15, 2012. The program began as a result of collaboration between Connecticut Coalition against Domestic Violence [CCADV] and the Connecticut Police Officer Standards and Training Council (POSTC). The original pilot program coupled 8 CCADV member domestic violence service provider agencies with 14 Connecticut municipal law enforcement agencies. However, as of September 2016 the program has been expanded to include all of CCADV's 18 member organizations and 86 police departments, including the Connecticut State Police.

Modeled after the LAP first piloted in Maryland in 2005, Connecticut's program employs the same two-pronged intervention process that makes use of a specialized lethality assessment instrument/screen and an accompanying referral protocol. Trained police on the scene of a domestic violence call assess a victim's risk for serious injury or death and can then immediately link those at greatest risk to their local domestic violence advocate for support and safety information.

After the pilot program had been successfully concluded, the Police Officer Standards and Training Council issued its first *advisory* model policy regarding the lethality assessment program [General Notice 14-03] to Connecticut law enforcement agencies in November, 2014. Shortly thereafter, in January, 2015, the Connecticut POST revised and redistributed its original *advisory* model policy that "establishes protocol to implement the use of a domestic violence lethality assessment at domestic violence calls for service." **The Connecticut model policy regarding the use of lethality assessment, for all practical purposes, mirrors the sample Maryland policies presented earlier in this report.** In mid-2015, Connecticut issued a statewide model policy entitled "Police Response to Crimes of Family Violence" and General Notice 14-03 [revised] was to be incorporated into an agency's domestic violence response policy and procedure.

CCADV is currently establishing a website-single access point for all Connecticut law enforcement and domestic violence agencies involved in the Lethality Assessment Program (LAP) to submit their use data. The website will provide an effective and efficient way of collecting data regarding domestic violence screenings performed by law enforcement

and followed up on by domestic violence agencies. The website is password protected and intended only for those agencies and designated staff participating in LAP.

DELAWARE: 44

The Delaware Police Chiefs Council adopted the Maryland model of the Lethality Assessment Protocol in 2010. Data developed through its use is forwarded to the Delaware Criminal Justice Information System (DELJIS) which is the central state agency responsible for the database which comprises the Criminal Justice Information System (CJIS). When the Delaware Police Chiefs Council adopted the LAP in 2010, training was provided throughout the State; the LAP questions were added to the crime report, which became active on November 1, 2010.

During 2013, Delaware’s Criminal Justice Council [CJC] issued a Services-Training-Officers-Prosecution [STOP] sub-grant award to the Capitol Police of Delaware to explore the development of an “Early Warning Communication System”, linking the Capitol Police, prosecutors and the courts, especially the Family Court, to alert the Capitol Police of potentially high-risk cases of domestic violence entering the Court Houses. The Capitol Police initially wanted this system to pull data captured in CJIS, specifically the LAP data. This was the first review on LAP since it started in 2010.

What was discovered from this report was that the LAP was not being performed consistently throughout the State. In fact, during the three years Delaware adopted the LAP, only 40% of the calls that should have screened in for potential lethal situation, were reported. Upon discovering this, the Capitol Police launched a larger training initiative to all local police departments in the use of LAP.

Lethality Assessment Program Calls from Law Enforcement to Shelters (Statewide) November/2010 – 2013					
	Calls from law enforcement	Reports with answers	Total reports	% of calls to shelters	Victims accessing services
2010 *	115	463	1,177	25%	6
2011	896	3,373	8,506	27%	32
2012	837	3,073	8,292	27%	24
2013	633	2,732	6,889	23%	21
TOTAL CALLS	2,481	9,641	24,864	26%	83

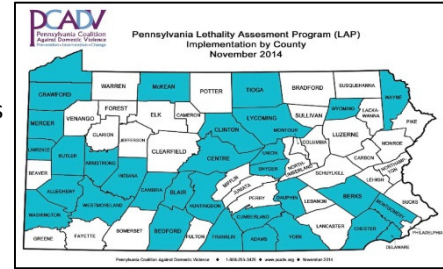
*Only 2 months of reported data

***The Delaware Police Chiefs Council adopted the LAP in 2010. LAP questions were added to the crime reports. LAP went live November 1, 2010.*

PENNSYLVANIA: 45

“In 2012, the Pennsylvania Coalition against Domestic Violence [PCADV] began the initial phase of LAP implementation in communities in 12 Pennsylvania counties, with the goal of expanding this research-driven program to all 67 counties. In Maryland, where LAP is nearly universally applied by law enforcement and domestic violence programs, the homicide rate fell 41 percent. If Pennsylvania can replicate these results, hundreds of lives could be saved.”

PCADV began implementing LAP in late 2012 with 12 counties participating. By the end of the first quarter of 2016, 167 out of 1,200 police departments with 40 domestic violence programs serving 38 counties have implemented LAP. PCADV also is partnering with college police departments to offer LAP screenings on campuses. LAP screening questions are intended to educate younger dating violence victims about unhealthy relationships and how some of those behaviors can be lethal. PCADV added six colleges in Pittsburgh in 2015 for a total of 12 colleges trained on LAP.



To date, the program has been implemented in 24 counties. PCADV’s goal is to install LAP in all of the more than 2,500 municipalities across the state.

“Many communities have taken advantage of federal funding through the Pennsylvania Commission on Crime and Delinquency to address domestic violence and related fatalities. In particular, the **Lethality Assessment and STOP Violence against Women programs** help communities improve responses to victims and enhance enforcement and prosecution. In addition to these **evidence-based strategies**, counties have developed other innovative ways to **safeguard domestic violence victims**.”

Pennsylvania Coalition against Domestic Violence 2015 LAP Use Data					
	# of LAP screens initiated	# of victims screened “high danger”	# of victims speaking to an advocate	# of victims accessing provider services	# of victims seeking provider services <u>without</u> completing LAP
2015	3,351	2,316 (69%)	1,526 (66%)	996 (65% “high danger)	613 victims

Pittsburgh Police Bureau:

In May 2013, the Pittsburgh City Council voted to require that the Pittsburgh Police Bureau adopt the Pittsburgh Police Lethality Assessment Program which is modeled after a highly successfully program in Maryland. During the first year that the Pittsburgh Bureau of Police implemented the program, 70% of the 1,779 screens they conducted were determined to be victims in high danger. 1,003 victims sought the services of the Women’s Center and Shelter following the initial screening. The number of intimate partner homicides in the city of Pittsburgh during the first year of implementation has dropped in half. The Women’s Center and Shelter extended the Lethality Assessment Program to the broader community by developing RUSafe, a free app for Apple or Android that helps users identify if they are in a potentially dangerous situation and connect them to a domestic violence hotline in their area. It also helps individuals to assess the safety of family or friends so they can help to prevent intimate partner or sexual violence from occurring. More than 1,000 people in the Pittsburgh region used RUSafe during the first six months after its release. 46

NEW HAMPSHIRE: 47

In June of 2009, after working with the Maryland Network against Domestic Violence, the New Hampshire Attorney General's Office began a pilot Lethality Assessment Program in Merrimack County, New Hampshire. The Office contracted with a retired police chief to serve as the coordinator and principal trainer for the program. Participating agencies in the pilot program sent a representative to a "train the trainer" class where they received LAP training and LAP accompanying materials and then returned to their respective agencies to train their personnel.

New Hampshire officials found that feedback from the pilot project was very positive. They too found that the additional benefits of the program as an educational tool for both the victims and screeners to help them understand and recognize the potential for danger with intimate partner violence reinforced the benefits of LAP that encouraged victims to take positive action to develop their own safety plan and to access domestic violence resources. Just as Maryland officials had found several years earlier, New Hampshire domestic violence victim advocates found that use of LAP improved collaboration and services provided by first responders, domestic violence programs and other professionals.

In response to the pilot program, efforts were made to implement LAP statewide. To date, many law enforcement agencies, all 14 crisis centers and many prosecuting offices in all 10 counties have attended the LAP "train the trainer" program.

Immediately after the pilot program was completed, the New Hampshire Attorney General's Office adopted the Maryland Lethality Assessment Program (LAP) as a model response for domestic violence cases and strongly recommended its use by all law enforcement agencies statewide. That Office committed itself to continuing to provide additional training, technical assistance and consultation to all law enforcement agencies, crisis centers and prosecuting offices to ensure consistent use of the LAP statewide and to expand the LAP to other professionals who have direct contact with victims of domestic violence.

As a follow-up to the initial implementation of LAP in New Hampshire, the New Hampshire Domestic Fatality Review Committee created the LAP Steering Committee ("Committee"), comprised of representatives from the Attorney General's Office, law enforcement, the courts and advocacy communities, to assist the efforts of implementing the LAP statewide in 2014. The Committee met regularly to assess the status of LAP's use and developed a strategy to move the program forward. They focused primarily on outreach, training, and data collection. To assist these efforts, the Attorney General's Office issued two Memos to Law Enforcement encouraging the use of LAP in law enforcement agencies across the state. Members of the LAP Steering Committee also met with County Attorneys, attended county chief's meetings and provided technical assistance to individual agencies in order to raise awareness about the LAP. The Committee continues to do outreach on the program with Police Chiefs, Court Personnel and other allied professionals. The Committee approved a sample Standard Operating Procedure (SOP) that they have shared with law enforcement agencies. The Committee also created a page on the Attorney General's Office website about the LAP. 48

In the fall of 2014, a workshop on the LAP was also held at the 2015 statewide Partnering for a Future without Violence Conference. Additionally, in 2014 the training offered at the law enforcement recruit academy was revamped to include a lecture based overview of the screening tool and a scenario based training segment. The practical consists of an officer responding to a 911 hang up call. They meet with an alleged victim of domestic violence. Upon investigating the incident they must identify the primary aggressor and obtain sufficient facts to determine if the screening tool would be appropriate. Once that decision is made they then screen the victim and call the advocate on the phone. With the generous help of the AmeriCorps Victim Assistance Program members and advocates from across the state, all full time recruit officers have received the LAP training (approximately 360 officers) during this reporting period.

The LAP Steering Committee decided it was important to collect data from both law enforcement agencies, as well as crisis centers, to get a better picture of how the LAP was working in communities throughout the state. The Committee discussed what data they wanted to collect and created an online data collection tool for law enforcement to report their data on a quarterly basis, effective January 1, 2015. The crisis centers had already been documenting contacts they had with victims as a result of a LAP screen. The Committee worked with the New Hampshire Coalition against

Domestic and Sexual Violence on a mechanism for the getting aggregate crisis center data, also on a quarterly basis. Below is the data that was reported for 2015.

The LAP Steering Committee continues to meet to discuss implementation issues, including outreach to law enforcement agencies that are not currently participating in LAP. One of the goals for 2016 will be to conduct additional trainings. The Committee will explore providing both in person and online training opportunities for law enforcement and advocates. The Committee will also be looking to expand its training capacity by identifying additional LAP trainers throughout the state.

New Hampshire Lethality Assessment Program (LAP) 2015 Data					
2015	Law Enforcement Data				Crisis Center Data
	# of screens initiated	# of screens completed	# of victims screened as "high danger"	# of victims speaking to advocate	# of victims who utilized follow-up services
1st Quarter [52 reporting]	459	275 (60%)	153 (56%)	76 (50%)	61
2nd Quarter [45 reporting]	219	197 (90%)	90 (46%)	49 (54%)	51
3rd Quarter [54 reporting]	280	262 (94%)	158 (60%)	77 (49%)	54
4th Quarter [68 reporting]	265	244 (92%)	139 (57%)	72 (52%)	42
TOTAL	1,223	978 (80%)	540 (55%)	274 (51%)	208

When compared to the Maryland LAP data (*Lethality Assessment Program: Maryland LAP, Maryland Annual Report Summary, January-December, 2015* (<http://mnadv.org/lethality/lap-maryland/>)) New Hampshire's overall percentage of victims screening in as high danger (55%) is slightly higher than what Maryland reported (54% and 52% calendar year 2014 and 2015 respectively). New Hampshire's percentage of victims that spoke to an advocate (51%) was comparable to Maryland's 2014/2015 data (51%/45%).

UTAH: 49

The Utah LAP project provides an example of a LAP project that is in its infant stage of development. The Utah State Legislature has recently awarded the Utah Domestic Violence Coalition (UDVC) funding to provide training and technical assistance to aid communities across the State in promoting or enhancing strategies to address homicide prevention and reduce intimate partner violence using the Lethality Assessment Program—Maryland Model (LAP). Under this program, UDVC can provide cost-free train-the-trainer instruction and technical assistance to community-based victim service providers and partnering law enforcement agencies to implement the Domestic Violence Lethality Assessment Program (LAP) in their jurisdictions.

Eligibility Applicants are limited to:

- Teams of at least one (1) law enforcement agency and at least one (1) community-based domestic violence victim services program serving the same jurisdiction;
- Participating law enforcement agencies and domestic violence victim services programs that have language access policies and procedures in place that comply with Title VI of the Civil Rights Act of 1964 and the Safe Streets Act of 1968 ;
- Participating domestic violence victim services programs that have policies and procedures in place that provide access for individuals with disabilities per the Americans With Disabilities Acts of 1990 and 1991;
- Teams that meet the minimum required criteria for implementing the Lethality Assessment Program—Maryland Model set forth on the accompanying LAP Implementation Readiness Checklist;

Lethality Assessment Program-Maryland Model Implementation Readiness Checklist

This Readiness Checklist sets out the minimum required criteria needed for implementing the Lethality Assessment Program-Maryland Model (LAP).

1. ____ Does your team consist of at least one (1) law enforcement agency and at least one (1) community- based domestic violence victim services program serving the same jurisdiction?
2. ____ Is there a 24/7 domestic violence hotline available for officers to call?
3. ____ Is there a full-service domestic violence victim services program, including shelter, available that will guarantee services for high danger victims?
4. ____ Have you, the participating law enforcement agencies and domestic violence victim services programs, specifically communicated about the LAP, and do you wish to participate as a team in the LAP?
5. ____ Is there an agreement by participating law enforcement agencies and victim services programs to use the Lethality Screen for First Responders, which is in the form of 11 questions that are asked of victims?
6. ____ Is there an agreement by participating law enforcement agencies that their officers will utilize the LAP phone protocol, which consists of using officer’s phones to make the call to the domestic violence hotline from the scene of a domestic call for service?
7. ____ Is there an agreement by participating law enforcement agencies that their officers will encourage high-danger victims to speak on the officer’s phone to the hotline worker from the scene?
8. ____ Is there an agreement by participating domestic violence victim services programs to conduct immediate safety planning with the victim and encourage the victim to access services?
9. ____ Is there an agreement by participating law enforcement agencies that their officers will remain on the scene during the brief 5-10 minute phone conversation the victim has with the hotline worker?

Successful applicants will attend locally conducted LAP train-the-trainer instructional sessions. After attending the training, the trainees will be given up to two months to train their fellow law enforcement officers and program staff as they prepare for implementation of the LAP. After all members have been trained, implementation will begin, which includes collecting and reporting required data to assess each team's effectiveness in implementing the LAP in their jurisdictions. The UDVC will provide technical assistance over the telephone, by e-mail or in person during all phases of this project.

A meeting for law enforcement and victim services program representatives who are policymakers and administrators will be arranged through UDVC's LAP Coordinator. This meeting will explain how the LAP works and will review implementation and administrative provisions. The meeting will be conducted by UDVC's LAP Coordinator and include the local domestic violence victim service provider.

A local law enforcement and a victim services program trainer (trained by the Maryland Network against Domestic Violence), working as a team, will conduct a one-day, six-hour train the-trainer session that must be attended jointly by participating law enforcement agency officers and victim services program staff who will provide in-service training to their officers and staff. This session will be arranged through the appointed team coordinator/point of contact at each agency or organization working jointly with UDVC's LAP Coordinator.

Through either a regular one-hour in-service session or over several roll calls, the newly instructed LAP trainers will conduct in-service training for their officers and victim services program staff within two months of the Train-the-Trainer Session.

Implementation will occur no later than two months after the Train-the-Trainer Session; however, the LAP may be implemented as soon as in-service training has been completed.

LAP statistical data will be collected by law enforcement agencies and victim services programs during implementation for the purpose of providing a LAP statistical report to the Utah Legislature who has provided funding for the expansion of the LAP.

A LAP statistical report will be forwarded monthly from each agency/organization to UDVC by the 10th of the following month. A reporting format will be provided to all jurisdictions.

Research Findings regarding the Use of Risk Assessment Tools:

Domestic Violence Assessment Tools Other than LAP:

"The use of IPV risk assessment within the social service and criminal justice fields is growing, as is scholarly literature devoted to the subject. Within these overburdened systems, the need to determine and treat the most serious cases of IPV has brought about a proliferation of statistical assessments and standardized decision-making tools that allow for allocation of resources where they are most needed. There is a clear need, and growing mandate, for validated systems to assess both risk of re-assault and risk of homicide in IPV cases. At least two entire provinces in Canada as well as some states require some form of risk assessment in IPV cases. It has been suggested that risk assessments be used to inform police, prosecutorial, and judicial responses to domestic violence." 50

Research for this Report indicates that there are several "risk assessment protocols" used by researchers, social scientists, criminologists and mental health professionals who examine domestic violence incidents in an attempt to determine the likelihood of recidivism by domestic partner abusers. **Unlike the Maryland model LAP, these "risk assessment protocols" are intended to be used after an incident by researchers or other academicians who are attempting to forecast future behavior.** While the below listed protocols have a place in the academic world **they are of limited use to first responders who are challenged with determining whether a victim-survivor is at**

immediate risk of further intimate partner violence which may lead to serious injury or death. The below listed protocols are provided for general information only:

Spousal Assault Risk Assessment (SARA) (Kropp, Hart, Webster, & Eaves, 1999)

SARA is a structured professional judgment interview for predicting IPV. It is comprised of 20 items gathered from empirical and clinical literature. All items are scored continuously (0, 1, 2) and tallied for a total score. Although not originally developed as a scale, professional judgment is often superseded by using the total score as a basis for determining risk. **The manual recommends completing this scale after interviewing both the accused perpetrator and victim. The items cover criminal history, psychological functioning, and current social adjustment. Access to correctional and clinical records is needed to complete the assessment.** The SARA covers both dynamic and static risk factors. Its limitations are that it **requires extensive training**, and some items are not associated with recidivism. Kropp and Hart (2000) found high predictive accuracy for the SARA when it was coded from files by researchers. **Accuracy declined when the coding was conducted by police officers in Sweden.**

Domestic Violence Screening Instrument (DVS) (Williams & Houghton, 2004):

The twelve items making up this instrument are primarily related to the offender's criminal history, employment, and treatment participation. It is designed to assess the risk of re-assault. It is often completed by a person affiliated with the probation department and is used to determine the level of supervision the offender requires.

Ontario Domestic Assault Risk Assessment (ODARA) (Hilton, Harris, Rice, Lange, Cormier, & Lines, 2004):

This is a 13-item actuarial scale that is easily rated by police officers or others with access to criminal justice records. Completing this scale **does not require victim participation.** Unlike many of the other scales in which items are based on theory or prior research, this instrument was **developed empirically** using demonstrated relations between predictors and recidivism and combining the information in a way that statistically estimates the likelihood of recidivism. Some of the items are specific to partner relationships (prior IPV confinement of the victim when she was pregnant, victim's children from prior relationships, victim's concern about future assaults), and several items are common to the literature on risk of antisocial behavior in general (prior correctional sentence, failure on conditional release, substance abuse, threats of violence). **It can be completed by clinicians, law enforcement officers, court workers, and other practitioners.**

Psychopathy Checklist – Revised (PCL-R) (Hare, 2003):

The PCL-R is a **20-item structured professional judgment instrument designed to measure psychopathy in clinical, research, and forensic settings.** Although not designed as a risk measure per se, it is one of the most commonly used measures in risk assessment. In the PCL-R's standard administration format, the rater uses a semi-structured interview, records, and other collateral information to obtain as much insight as possible into the personality of the interviewee. This information is then used to assign a score for each item. The PCL-R can also be scored without the interview, based on a file review only. **Use of the PCL-R requires extensive training of mental health professionals.**

Domestic Violence Risk Appraisal Guide (DVRAG) (Hilton, Harris, Rice, Houghton, & Eke, 2008):

This is a 14-item actuarial scale comprised of the original ODARA items. The items are scored categorically and totaled as a continuous variable. Items were scored dichotomously in the original version. The resulting score is combined with the PCL-R score. **Access to criminal history is required, and the assessment needs to be conducted by a highly trained professional.** 51

Evaluation of the [MNADV] Lethality Assessment Program:

“From the outset, the MNADV Lethality Assessment Committee believed it was necessary to maintain data on the performance of the LAP. **Every participating agency voluntarily gathers and reports data to the MNADV; this data**

is then reported back to the participating agencies. In 2012, 100 agencies in Maryland reported doing 12,108 screens. Of those screens, 6,224 (51%) victims were assessed by officers as being at high risk for homicide. Of the victims at high risk, 3,277 (53%) spoke on the phone to a hotline worker. Of those victims that spoke on the phone to a hotline worker, 925 (28%) went into services (MNADV, 2013). This means that they took the concrete action of either going into a shelter or into a domestic violence program for counseling, legal, or other direct services. This is a remarkable number of victims who spoke to the hotline worker and went in for services - credit for this lies directly with officers and advocates.

“The MNADV has kept statistics on domestic violence related fatalities in Maryland since 1987. **Between the years 1987 and 2005, the average annual domestic homicide rate has been 68 fatalities per year. Between July 2007 and June 2012, the number of domestic homicides in one year in Maryland was the lowest recorded at 33. Since July 2007, and during the time that the LAP has been implemented in the state, Maryland has recorded 56, 45, 33, 33 and 37 fatalities for a five year total of 204 domestic fatalities, or an average of 41 fatalities per year.** There have been previous downward trends in the data (e.g., 1989-1992); however, the homicide rate has jumped dramatically after previous downturns. While it is too early to tell whether the pattern of the past 5 years will hold, this is a 34% decrease over 5 years.” **52**

“The LAP has been improved upon in many ways in many jurisdictions. **In Maryland, follow-up with high danger victims has become a virtually integral part of the LAP, with advocate telephone calls or officer-advocate home visits.** The initiation of this practice has caused an increase in the number of victims who go into services. In 2008, 28% of the high risk cases went in for services; in jurisdictions with follow-up, this proportion was 56% in the same year. **Some participating jurisdictions outside of Maryland have begun this practice as well.** The LAP has also extended into other settings and disciplines. **Lethality Screens are being done when petitioners come out of temporary protective order hearings in six Maryland counties and in seven hospitals. In 2012, the high danger rate for screens done with temporary protective order petitioners was 77% and with hospital patients the high danger rate was 68% (MNADV, 2013). This is higher than for screens done at the scene of a domestic violence incident, indicating a much higher level of danger among these particular groups of victims. In addition, high danger petitioners and patients went in for services at a higher rate than those victims from the scene of a domestic violence incident: 38% and 48% respectively (MNADV, 2013).** A protocol has been developed for the faith community, and, in conjunction with the state of Maryland, LAP protocols are being developed for three cabinet-level departments.” **53**

“**The follow-up protocol for Maryland’s lethality assessment program is to re-contact any victim who screened in as “high danger” a day or two after the incident. This follow-up is either by a phone call to a landline or a home visit by both a law enforcement officer and a victim advocate. These visits are unannounced and occur even if the perpetrator is home. According to data from the Maryland program, these follow-up visits have doubled the percentage of victims who use victim services (from 28% to 56%).**” **54**

Research into the predictive validity and effectiveness of the Lethality Assessment program is in its early stages. One such study was conducted in Oklahoma, entitled *“Police Departments’ Use of the Lethality Assessment Program: a Quasi-Experimental Evaluation”* and submitted to the United States Department of Justice in March of 2014. “The purpose of this quasi-experimental research was to examine the effectiveness of the Lethality Assessment Program (LAP). Specifically, [the researchers] **examined the effectiveness of the LAP at:**

- (1) decreasing the frequency and severity of repeat IPV [intimate partner violence]; and**
- (2) increasing the rates of emergency safety planning and help seeking among women who experienced IPV and called the police in a participating jurisdiction during the study time frame (the evaluation aim).**

[The researchers] also **examined:**

- (3) the predictive validity of the Lethality Screen (the validation aim),**
- (4) officers’ implementation of the LAP with the appropriate victims of IPV (the implementation fidelity aim); and**
- (5) victim satisfaction with the police response and the LAP (the victim satisfaction aim).” **55****

“This research study spanned five years and recruitment lasted more than three-and-a-half years. While this was originally intended to be a two year project, many difficulties with start-up, community engagement, changes in police chiefs and management, and recruitment repeatedly delayed the study. Community based interdisciplinary field trial research is complex and requires much communication and time to conduct. Relying on community partners to implement an intervention and recruit participants places a burden on community partners that may be difficult to manage depending on the buy-in and enthusiasm of both management and workers. Using participatory strategies – including reporting the findings of research to community partners – was an important component of engaging community partners over an extended study period. Building an evidence base in criminal justice and social service research requires time, funding, and commitment. The information that emerges, however, has the potential to change the response to IPV and prioritize survivor safety and empowerment within the context of criminal justice intervention.” 56

Participants were seven (7) law enforcement agencies in Oklahoma, including the Oklahoma City Police Department. While time and space precludes a detailed presentation of the research methods used in the Oklahoma study in this report [see: “*Police Department’s Use of the Lethality Assessment Program; a Quasi-Experimental Evaluation*” at www.ncjrs.gov] the researchers did conclude:

“The Lethality Assessment Program – Maryland Model has been operating in Maryland for eight years. Throughout that time, **some data and many case accounts from Maryland and other states that have adopted the protocol provide anecdotal evidence that the Lethality Assessment Program (LAP) “works.”** This report provides the results of a systematic field evaluation and statistical analysis of the impact of the implementation of the Lethality Assessment Program across seven jurisdictions in Oklahoma. 57

“**The preponderance of evidence, albeit in a quasi-experimental design with some important limitations, is that the Lethality Assessment Program was effective in facilitating women at high risk for severe and near lethal violence to talk with a domestic violence advocate at the scene of a police involved domestic violence incident, both increasing survivors’ use of formal and informal protective strategies and decreasing the frequency and / or severity of physical violence.** In other words, both hypotheses of the evaluation aim were supported.

“However, there was **no evidence of decreased presence of intimate partner violence or severe violence, and there was no effect on the utilization of some measured protective strategies.** In addition **there were issues with implementation fidelity, as well as limitations on the predictive validity of the Lethality Screen.** Overall, while this intervention demonstrated effectiveness in this single study in a single state and has important policy and practice implications, **future research is needed to assist in answering additional questions and building the evidence base for the LAP.**

“Given that we found **no negative effects of the LAP** (e.g., there were no protective strategies utilized significantly more by the high violence comparison group and no significant reductions in violence for the comparison group relative to the intervention group), **combined also with the data gathered by the MNADV that suggests that 31% of women who engage in the LAP intervention seek domestic violence services across multiple states, we feel comfortable recommending the Lethality Assessment Program as a collaborative police – social service intervention with an emerging evidence base.** However, given that the only experimental research has been a single study in a single state, **it is premature to label this intervention as “well-established”** per the American Psychological Association Division 12 Task Force Guidelines (1993). As such, **future research should replicate this study in order to garner a stronger evidence base.** Future research should also utilize mixed methods research to examine the differential implementation of the LAP across jurisdictions and survivors and, in particular, whether differential application of the intervention is the result of officer or survivor selection. **Future research should additionally examine whether the implementation of the LAP affects police officer attitudes toward IPV or social service / advocacy organizations.” 58**

“Th[e] LAP is grounded in the idea that the criminal justice and social service responses to intimate partner violence must work in collaboration with one another in order to provide the best intervention

possible in IPV cases. In this model, the criminal justice system provides accountability for the offender while the social service system collaborates with the criminal justice system to provide safety options to the victim. The Lethality Assessment Program uses an IPV risk assessment based on the Danger Assessment and developed for field practitioners or first responders to assist police officers and victims with identifying risk in the intimate relationship. As women tend to underestimate their risk and safety concerns often motivate help seeking, increasing an IPV victim's perception of risk may help encourage protective actions. The LAP is the only intervention that we are aware of to provide immediate telephone advocacy support and safety planning for the victim at the scene of the domestic violence crime. As [a] lack of awareness of community resources is associated with remaining in an abusive relationship, this intervention may provide women with needed information and resources. Finally, because the LAP utilizes existing community agencies and resources, it can be implemented in a large number of jurisdictions and reach a greater number of victims. This research is an exciting first step toward the use of risk assessment tools and evidence based intervention to integrate the criminal justice and social service response to IPV." 59

"...women who participated in the intervention were more satisfied with the police response than women in the high violence comparison group and were likely to report that the advocate was at least somewhat helpful. In addition to providing survivors of IPV with a much needed opportunity to connect with social services, **the LAP attends to the dynamics of an abusive relationship and survivor safety in a way that the traditional police response does not.** The traditional police response (at least since the advent of mandatory arrest) focuses on offender accountability for a single incident of violence. However, physical IPV is often experienced in the context of ongoing power and control within an intimate relationship. **The LAP focuses attention on relationship history, dynamics and lethality (through the use of the Lethality Screen) and engages women with social services in the community that can attend to the diverse needs of survivors.** The LAP is intended to provide women at the scene of a police involved IPV incident with education about their level of risk for lethal and near lethal IPV and an awareness of their options so that they can make decisions that are best for their situation. Previous research has found that a lack of awareness about community resources is associated with remaining in an abusive relationship; as such, this educational component may be particularly important. A collaborative response that provides offender accountability (through criminal justice sanctions) and survivor safety (through social service intervention) makes available a broader scope of intervention and, as such, appears to be more effective (both in terms of survivor outcomes and satisfaction) than the traditional criminal justice response. 60

"Future research should additionally examine police perceptions of the intervention and how the implementation of the LAP affects police officer attitudes toward IPV and IPV survivors, attitudes toward social service / advocacy organizations, and their perceptions of safety and danger when responding to domestic violence calls for service." 61

"The customary role of the police officer [when handling domestic violence incidents] is evolving. Traditionally, the role of the first responder involved restoring order and reducing the likelihood that further violence will occur. Victim assistance often consists of providing the victim with a list of local resources that can lend assistance. Increasingly, however, officers are being asked to perform a more thorough assessment of the danger victims may be facing. There is concern that expanding an officer's role will require more time and, as a result, increase departmental response times to other calls. Therefore, asking an officer to assess dangerousness needs to be carefully structured and targeted to gather needed information in as little time as possible. **Using validated risk-assessment instruments may be helpful in this regard.** When the risk rating is high, **the officer calls a victim assistance hotline and encourages the victim to talk to the hotline operator.** This approach is **designed to help the victim understand the risk she may be facing and directly connect her to resources.** This procedure not only encourages a victim to seek outside help, but has the potential for helping district attorneys press charges against the perpetrator and assist the victim in obtaining a protective order.

"Both first responders and victim services personnel should ideally agree to use the same assessment instrument. Training is required for both groups in order to implement such a program effectively. Each community should

develop protocols for handling these cases that reflect available resources. Issues such as insuring the availability of a hotline worker when an officer calls and the availability of rooms at the shelter need to be addressed. Some shelters reserve beds for victims who call their hotline and need emergency assistance. If a local shelter is full, cooperative agreements need to be in place to help a victim get to a nearby facility.” 62

LAP - ANOTHER POINT OF VIEW:

In keeping with the adage “a good deed never goes unpunished” **it should be pointed out that there have been several criminologists and academicians who have challenged the validity, effectiveness and use of any lethality risk assessment tool, including the LAP, in domestic violence incidents for a variety of reasons.** Several of these questions about the use of lethality assessments were addressed in an article entitled “*Are Domestic Violence Homicides Preventable?*” That article appeared in **The Crime Report**, a multi-media information and networking resource based at John Jay College of Criminal Justice in New York which is published daily online by journalists in New York, Washington and Los Angeles.

Excerpts from that article are presented below in order to offer the reader “another point of view/different perspective” about the use of LAP. [The emphasis added to the article is solely for the benefit of the reader.] 63

Referring to Teri’s Story presented as an introduction to this Report, Jaime Adame, the author writes:

“One of the key questions: **was it possible to proactively identify those most at risk of being killed by an intimate partner?**”

The county’s response came four years later: **in 2010, authorities introduced a domestic violence intervention tool, known as the Lethality Assessment Program (LAP), which involves a structured 11-question interview of domestic violence complainants at the scene of the assault.** The questions are designed to elicit crucial information about the abusive partner, including previous incidents of violence.

According to McAlister, **LAP represented a major improvement in guiding law enforcement’s ability to detect the potential for domestic abuse or stalking behaviors to escalate into lethal violence.** “We’re much more aggressive with these things, (in part) because of the LAP program,” said the officer, who now is part of a team training other officers in the region in the use of the tool.

Similar assessment programs are now in use elsewhere in the country, with efforts to spread the LAP bolstered by federal dollars. Supporters call these assessments critical preventive tools in addressing intimate partner violence, which results in nearly one out of every seven murders according to the Bureau of Justice Statistics.

Skeptics, however, question whether the science exists to back up claims that such intervention efforts can catch many of these cases before they end in death. They also warn that, even as the LAP is rapidly growing in popularity among police and domestic violence victim advocates, some women could be harmed.

Based on the interview, if police identify victims as being at increased risk for homicide, an officer makes an immediate phone call to a trained counselor able to discuss safety concerns with the victim. **Would such a program have saved Lee’s life? The answer remains uncertain, but McAlister argues that the system in place at the time “failed” Teri Lee.**

The introduction of LAP has become part of a more pro-active program of intervention with domestic abuse victims, said McAlister. Now, he says, “we’re watching these people from the moment they’re arrested through the trial process.” Moreover, probation officers armed with results of the lethality evaluation can inform a judge when there is an increased risk that a domestic abuser will commit lethal violence, with the information a factor in setting conditions for release from jail when charges are pending.

According to Tom Adkins, director of Washington County's community corrections, the tool is only one element of a wide-ranging strategy to revamp authorities' response to domestic violence. "It's not about the questions," Adkins said in an interview with *The Crime Report*. "It's about how you coordinate and respond to people you identify as high risk."

Even so, the concept behind the tool itself remains suspect for some researchers.

"You're looking at an increased sense that we can predict outcomes in domestic violence cases, which, to be blunt, I'm not sure that we can," said Neil Websdale, director of the National Domestic Violence Fatality Review Initiative.

The Maryland lethality assessment, she [Dr. Campbell] added, "was never intended to accurately predict who's going to get killed or not, but rather that we can identify cases that are at high risk for either lethal or near-lethal violence."

"To be fair, there is something in these risk assessments that may educate victims of violence, domestic violence and help them make more informed decisions," he [Websdale] said. His experience with fatality reviews examining domestic violence cases, however, leaves him skeptical about using patterns, even if they exist, to create a statistical model predicting risk of death.

When reviewing a murder, "we have all the case materials, we have access to surviving family members, often, and we really dig into the case in great depth," Websdale said. "And these cases are really very, very complicated," adding, **"what the system knows about risk markers in those cases is often limited."** Such reviews don't always lead to answers. **"I come across a lot of cases where there is no prior history of violence, where there are no risk markers, where he just kills,"** Websdale said.

Assessments focus too much on measuring the seriousness of previous violent episodes, according to another researcher, Evan Stark, author of a book about domestic violence called *Coercive Control: How Men Entrap Women in Personal Life*. Instead, **controlling behaviors and assaults not causing physical harm should be viewed as greater warning signs for future serious violence,** Stark said, even pointing to research done by Campbell showing such incidents can be a risk factor leading to homicide. **"Those episodes are significant not because of their severity, which is what the Maryland scale measures to a large extent, but because of their frequency and their duration, and because they have a cumulative effect on the victim,"** Stark said.

To Campbell, it's a given that the LAP will miss a few cases that do end tragically. However, it's built on multiple research studies done at many sites, she said. Much of this research has involved interviews with relatives of homicide victims. **"We do know more than just saying, 'Who knows what's going to happen?'"** she said.

'Narrow Windows'

If it needs a catchier name, call it the "narrow windows" theory of domestic violence. **"What we've learned is that when a police officer shows up at the scene, or a victim shows up in an emergency room, the time to talk with her is then and there,"** said Vice President Joe Biden...Along with U.S. Attorney General Eric Holder, Biden was federal funding for a new demonstration project aimed at reducing domestic violence homicides, with an emphasis on putting in place lethality assessments in more communities. **"What we've learned from the very beginning is there's a very narrow window for most women to have the courage and capacity to say what happened to them,"** Biden said.

Timing is a key concept of the lethality assessment program created in Maryland...After asking the 11 yes/no assessment questions, officers following the protocol inform victims at the scene if their scores indicate a high-risk circumstance. Depending on the assessment, or perhaps just their own judgment, officers call a trained advocate and then hand the phone over to the victim, encouraging a conversation with the advocate to establish a safety plan.

Advocates emphasize the importance of such contacts for victims. “The goal is to get them into services,” said Michael Cohen, executive director of the Maryland Network Against Domestic Violence.

While it may seem like an uncontroversial statement, the protocol shouldn't effectively quash the right of women to make choices for themselves, said Margaret Johnson, an associate professor at the University of Baltimore School of Law and director of the school's Family Law Clinic. “Women are actually predicting their risk all the time,” continued Johnson, who is also one of three co-directors of the law school's Center on Applied Feminism. But Johnson isn't sure if everyone involved with lethality assessment protocols completely grasps this basic premise. While about nine percent of domestic violence victims in Maryland say no to the screening, Johnson is concerned that victims could feel pushed into taking action. She noted that police at the scene represent a “powerful authority” speaking with victims who have likely experienced “some pretty significant trauma.” It's easy for time-pressed police to forego any discussion of pros and cons, Johnson observed.

Stark expressed concern about how police might react when a victim declines to speak to an advocate. “The next time, I'm going to be more reluctant to respond appropriately,” said Stark, describing his worry of how police might perceive such victims.

Johnson, in her academic writing on the topic, emphasizes a concern about liberty. Websdale talked about the uncertainty involved with picking safe choices. “And that's hard to deal with, if you're trying to reassure a woman at the scene that we know best and we're going to recommend that we call the advocate, because I'm not sure we do know best always. “I'm not sure we can guarantee that calling an advocate results in a safer outcome. “It may; it may not.”

Although the Maryland protocol is considered the most popular domestic violence assessment, at least in this country, police agencies elsewhere sometimes establish their own domestic violence risk assessments and protocols. Different tools for instance are in use in Canada and the United Kingdom.

In Tulsa OK, an eight-question assessment adopted last year doesn't involve police making a phone call to domestic violence services. “We always allow the victim to make that phone call for themselves,” said Tulsa Police Sgt. Stephanie Jackson, supervisor of the department's family violence unit.

The department's decision isn't in agreement with the local provider of domestic violence services. “I feel that an important piece of the protocol in Maryland is having the officer actually call the help line during the visit to the home,” said Tracey Lyall, executive director of Tulsa-based Domestic Violence Intervention Services. She cited an oft-repeated statistic, which just happens to be incorrect: “We know that nationwide, only 4 percent of domestic violence homicide victims ever availed themselves of domestic violence services,” Lyall said.

McAlister, in his talk, shared the same finding. The Maryland network recently stated the same finding on its website. *[This citation has since been corrected by MNADV.]*

But the actual study — published in 2001 — only looked at a time period of one year prior to a victim's death at the hands of an intimate partner.

More recently, a report by Georgia domestic violence program officials published last year found that 16 percent of domestic violence homicide victims in the state had contact with domestic violence programs or safe houses within five years of their deaths.

Biden...made it clear how he viewed the demonstration project effort. “This whole idea is to identify women who are most at risk and, hands on, get her to a better place, get her to a different place. Let me make it clear: we believe that this will save lives,” Biden said. “It already has.”

Declining 'Precipitously'

There's another frequently cited statistic that's true, as far as it goes. The Maryland website has noted a 34 percent decrease statewide in intimate partner homicides from July 2007 to June 2012. As McAlister put it in his talk, the rate has dropped off "precipitously".

But a similar percentage decrease can be found from July 2002 to June 2006—before the lethality assessment protocol was in wide use—when all domestic violence deaths (including suicides) decreased by 42 percent. Maryland domestic violence deaths fell from 89 in fiscal year 2003 to 52 in fiscal year 2007. Such deaths then spiked to 75 the next year (a number recently revised to 73). In the 12-month period ending in June 2012, the state tallied 49 deaths resulting from intimate-partner related violence.

With data just in, the number stayed about the same, with 50 deaths from July 2012 to June 2013.

Only beginning in fiscal year 2008 did the Maryland network tally homicides separately from suicides. "I think we've seen a drop. We don't say it's caused by the LAP," Cohen said. In the year ending June 2013, suicide accounted for one out of every six deaths. Excluding suicides, the number of intimate partner homicide victims has now increased the last two years in Maryland. Stated another way, from July 2007 to June 2013, there has been a 25 percent decrease in intimate partner homicides.

Cohen expressed doubt on the accuracy of numbers from earlier years. The Maryland network now has better contacts and more resources to do a more accurate count of intimate partner fatalities, she said.

Even so, "these cases are not always clear cut," Cohen said. Relationships can sometimes be tough to decipher. The network relies on police sources for information about cases. "Sometimes it's hard to know who to include and who not to include," Cohen said.

Many states, but not all, have domestic violence fatality review teams. Websdale leads a group offering support for such initiatives.

The Bureau of Justice Statistics, part of the federal Department of Justice, in 2009 published estimates of intimate partner homicides. In 2007, an estimated 2,340 deaths were tallied. Out of all homicides, intimate partners were responsible for about 14 percent of all deaths. The report also examined trends in homicide from 1993 to 2007, concluding that intimate partner homicides decreased by 29 percent during that time period. "Female victims killed by an intimate partner declined from 2,200 to 1,640 victims, and male intimate partner homicide victims declined from 1,100 to 700 victims," the report states. For the same years, all homicides decreased by 31 percent.

Growing Interest

Nevertheless, interest continues to build in lethality assessments. In Pennsylvania, pressure from local domestic violence advocacy programs has already persuaded 54 police agencies to use the protocol, said Jill Swiontek, staff attorney at the Pennsylvania Coalition Against Domestic Violence. "Our goal is statewide implementation," said Swiontek.

The Maryland network last year began working under a new three-year federal grant to train 40 jurisdictions who apply to learn the protocol. Federal authorities confirmed the grant amount is \$651,191. Separately, the demonstration project has awarded about \$1 million in funding to go to the Maryland network. Sen. Barbara Mikulski, a Maryland Democrat who has called the LAP "a model for the nation," praised the financial commitment to the demonstration project. "This funding will take the Maryland Network Against Domestic Violence's work on lethality assessment nationwide to turn victims into survivors," Mikulski said...This year, the funding for training related to lethality assessments was included in a \$417 million appropriations bill on domestic violence intervention.

In Seattle, police have developed their own assessment tool. Websdale said Phoenix also has developed its own assessment.

But the Maryland protocol seems to be getting the most attention. According to Dave Sargent, senior program manager with the Maryland Network Against Domestic Violence, the protocol is in place with agencies in 32 states [including Maryland], and he estimates that it has spread to more than 500 law enforcement agencies outside of Maryland. That number remains a tiny fraction of the roughly 18,000 law enforcement agencies nationwide, but major cities taking up the Maryland lethality assessments include Kansas City, MO; Dallas and Las Vegas, he said.

Sargent credits a 2007 *Washington Post* article with generating more widespread interest in the state's LAP tool. "We've certainly got a lot of publicity about the program. A number of publications have written about it, so people see that," said Cohen of the Maryland network. She also credited the organization's work with domestic violence victim advocacy groups as part of the reason for the intervention's growing popularity. She didn't mention it, but presentations have been given at national conferences devoted to law enforcement or domestic violence advocacy. "There's been a lot of buzz in the law enforcement community," Cohen added.

Questions about Gathered Information/Data:

What is the Purpose in Gathering Risk Assessment Information?

Another area of concern about the use of Risk Assessment instruments rests in the gathering of information/data when the risk assessment protocol is administered. These concerns have been raised by the Battered Women's Justice Project, a Minneapolis-based resource center on criminal justice responses to intimate partner violence: 64

"Sometimes communities embark on strategies to assess risk without having a clear sense of how the information will be used in practice. If nothing will be done with the information, if no practices change as a result of having risk information, why collect it? It's important to decide what the response will be to the identified risk. Domestic violence victims may share different information with different interveners for a variety of reasons. Interveners should then assess risk on an ongoing basis, accounting for change in the circumstances of victims or offenders. Practices such as monitoring, surveillance, court-ordered services, and swift and certain consequences must interconnect, not only to manage but also to contain dangerous offenders. Ongoing assessment requires information from tools, practitioner expertise, offender history, and the victim's perceptions. It cannot rely on only one information source."

How Will Information Gathered during a Risk Assessment be Used?

Many victims in support groups and focus groups have indicated that they often think of a discussion or interview about risk as "I'm telling you, the practitioner" and **are shocked to find that this information may be shared with many other players: prosecution, defense (and the defendant), the court, probation, and batterers' programming.** The question that arises is "When collecting risk/danger assessment directly from the victim, **it is necessary for a first responder to identify who may have access to the information during the case processing, and afterwards, if it becomes part of the court record.** For some victims of intimate partner violence the questions "**How will the information gathered be used?**" and "**Who will have access to who will have access to the information now and potentially at a later date (prosecutors, defense attorneys, the defendant, child protection, family court practitioners etc.)?**" can be major concerns after the incident has concluded: Officers and/or advocates should consider and be prepared to answer:

- ▶ **Could the information obtained in a lethality assessment be used AGAINST the victim?**
- ▶ **What are the potential ramifications to the victim of sharing this information?**
- ▶ **Does the victim understand that an affirmative answer to some questions may trigger an additional investigation?**
- ▶ **Will the victim be informed about how information will be shared with interagency practitioners?**
- ▶ **Are the results of a lethality assessment available to court personnel during bail hearings if the perpetrator is arrested?**
- ▶ **Are they made available to the court when victims seek protective orders?**
- ▶ **Is a domestic violence risk assessment part of a prosecutorial pre-trial evaluation?**

- ▶ Are risk assessments discoverable [BRADY] material that must be given to a defense attorney and, thus available to the perpetrator?
- ▶ Are they available during post-trial/sentencing procedures?
- ▶ Are the initial risk assessment results and any follow-up assessments available to the public [and media] as public records?
- ▶ Are the results of a risk assessment available to other segments of the criminal justice system such as parole and probation case managers to help determine intervention, field supervision or defendant monitoring programs?
- ▶ Is the information in a risk assessment routinely provided to advocacy groups? What is it used for?

CONCLUSION:

The Lethality Assessment Protocol (LAP) used by almost all of Maryland's law enforcement agencies is seen as a national model and has been adopted by over 30 states.

For its part, MNADV maintains an Advisory Council of LAP implementers, researchers and national experts from across the country to advise MNADV about emerging trends in the field of responding to domestic violence and, if necessary, to assist in making any changes to the LAP program. As an example of the Council's input, members assisted MNADV in drafting a position paper which MNADV has recently published on the use of Body-Worn Cameras during the LAP protocol. Members of MNADV also regularly attend conferences and training sessions devoted to responding to domestic violence. Likewise, they meet with experts in the field of risk assessment at Office on Violence against Women [Department of Justice] sponsored events.

Because of the above, there is no need for the Police Training and Standards Commission to develop a new or different protocol.

“NON-FATAL” STRANGULATION and DOMESTIC VIOLENCE:

Overview:

Research for the second portion of this Report shows that “over the past two decades, there has been increasing attention paid to the problem of strangulation within domestic violence cases among medical professionals, law enforcement, legislators, and researchers. While strangulation was previously recognized primarily as a mode of homicide, investigation of **non-fatal** incidents of strangulation within the context of domestic violence has only recently attracted the attention of policy makers and researchers despite shelter personnel and domestic violence advocates’ longtime awareness of this issue. **When strangulation is used in the context of domestic violence, it is essentially a live demonstration of power and control over another individual’s life or death. The act of strangulation demonstrates to a victim that the perpetrator can end their life whenever he or she chooses.** As strangulation is **typically accompanied by death threats, gasping for breath, loss of consciousness, and can result in a delayed death,** the incidence of strangulation is a critical concern for personnel who respond medically and legally to domestic violence.” **65**

“Today, it is known unequivocally that **strangulation is one of the most lethal forms of domestic violence. When a victim is strangled, she is at the edge of a homicide.** Unconsciousness may occur within seconds and death within minutes.” **66**

“Research also confirms that **the act of placing hands or ligature around a victim’s neck introduces a different level of lethality, rage, and brain injuries than simple assaults such as pushing, punching, kicking, or slapping.**” **67**

“**Strangulation is one of the best predictors for the subsequent homicide of victims of domestic violence.** One study showed that the odds of becoming an attempted homicide victim increased by 700 percent, and the odds of becoming a homicide victim increased by 800 percent for women who had been strangled by their partner. The occurrence of strangulation has been reported in 47–68 percent of women who were being assessed for intimate partner violence and smothering or strangulation has been identified in 25 percent of women killed by an intimate partner.” **68**

“**The lack of external injuries and the lack of medical training among domestic violence professionals have led to the minimization of this type of violence, exposing the victims to potentially serious health consequences, further violence, and even death.**” **69** “... in the legalistic view of physical evidence of crime, many strangulation victims do not meet legal standards of physical injury due to exhibitions of invisible and delayed injuries, and victims may not immediately seek medical care.” **70**

[Non-fatal] “strangulation is ‘one of the most lethal forms of violence’ used by men against their intimate partners. ‘A single traumatic experience of [non-fatal] strangulation. . . [can] instill so much fear’ in a victim that she can ‘get trapped in a pattern of control by the abuser.’ What makes domestic partner non-fatal strangulation even more scary and deadly than other forms of domestic violence is that **women who have been non-fatally strangled by their intimate partners are substantially more likely to be killed by that same partner.** Thus, non-fatal strangulation has become a precursor to death for these victims, and because **non-fatal strangulation is difficult to find, see, and prove, non-fatal strangulation is often undetected by law enforcement officials.**” **71**

“...abuse escalates over time, with strangulation typically occurring later in the progression of violence in the relationship. [In one research study it was found that] **threats of death were common among the women who had been strangled,** with 87% reported being threatened. **The majority experienced physical and verbal abuse in addition to the strangulation** (68%). Threats and co-occurrence of other forms of violence along with strangulation is also evident in more recent studies. For instance, [in a 2014] study of 432 women recruited at the scene of police-involved intimate partner violence incidents, [researchers] found that those who had experienced sexual abuse or forced sex were also more likely to experience strangulation and have their life threatened. **72**

Understanding STRANGULATION:

“Strangulation is one of the most lethal forms of domestic violence. [While] minimal pressure on the neck can cause serious injury... in [some] fatal cases of strangulation, it is possible there may be no external injuries at all.” 73

“Most studies on strangulation do not explicitly offer a simple definition of strangulation; however, there does appear to be a general understanding across fields including criminology, law, forensic science, and medicine as to what constitutes strangulation, though some put more focus on modality [ways in which an individual is strangled] while others focus on mechanism of injury [injuries sustained]... **Of note within the literature is the inconsistent or imprecise use of certain terminology to describe strangulation.” 74**

“Special attention should be paid to vocabulary. While most victims will continue to report they were ‘choked’ or ‘grabbed’ by the neck—and it is important to use words the victim is most comfortable using—responders need to acknowledge the seriousness of the abuse that is actually occurring. ‘Choking’ is accidental. Strangulation is intentional. Choking means having the windpipe blocked entirely or partly by some foreign object, like food. Strangulation means to obstruct the normal breathing of a person. For report writing, the proper term is ‘strangulation.’ Officers should use words such as ‘strangled,’ ‘near-fatal strangulation,’ and ‘non-fatal strangulation’ to describe what happened to the victim. By using the correct terminology, more awareness is brought to the seriousness of the crime that has been committed...Use of the proper terminology will also produce more felony prosecutions. In a recent study conducted in Minnesota, when officers used the word ‘strangulation’ as opposed to ‘choked,’ and described how the victim was strangled, more cases were prosecuted as felonies.” 75

“Strangulation occurs when external pressure is applied to the neck until consciousness is altered. This does not necessarily mean the victim has become completely unconscious; it can mean just lightheadedness. There are **two types of strangulation—manual and ligature. Manual strangulation can be accomplished with one hand, both hands, or another body part (e.g., knee or choke hold). Ligature strangulation is accomplished when a cord-like object is used to apply pressure to the neck.**

“Strangulation is more serious than professionals have realized. Loss of consciousness can occur within external injuries, may take a few hours to be appreciated and delayed death can occur days later.

“Asphyxia occurs when brain cells are deprived of oxygen. This may result from a compromise of respiration—the lungs being deprived of oxygen—or cardiovascular compromise—the brain being deprived of blood flow or from a combination of problems in both systems. Common clinical features—in other words, the symptoms and signs—of asphyxia from any cause, may include pain, anxiety, and altered level of consciousness. Unconsciousness may occur within 10–15 seconds of the application of pressure on the neck.

“Suffocation is the process that halts or impedes respiration. Suffocation can include choking, smothering, and compressive asphyxia.

“Choking is what happens when **an object mechanically blocks the upper airway or windpipe (trachea).** It’s when something gets in the airway and stops airflow *internally*. Choking can occur when food or some other object obstructs the airway and is almost always accidental unless an item is forcibly placed in the mouth [e.g. a gag] and then obstructs the airway. **Choking is often used inappropriately by both individuals who have been strangled and those investigating an incidence of strangulation to describe what has happened when an individual has been strangled.**

“Smothering is a mechanical obstruction of airflow into the nose and mouth (e.g., putting a pillow over the victim’s nose and mouth or a plastic bag over an individual’s head).

“Compressive asphyxia occurs when an assailant puts his body weight on the victim, limiting the expansion of the lungs, which interferes with breathing.” 76

“Generally, ‘strangulation . . . is produced by a constant application of pressure on the neck.’ More specifically, ‘strangulation is defined as a form of asphyxia (lack of oxygen) characterized by closure of the blood vessels and/or air

passages of the neck as a result of external pressure on the neck.' 'Choking can refer to . . . the violent act of strangulation.' Strangulation can be classified into four categories:

- (1) hanging strangulation;
- (2) ligature strangulation;
- (3) manual strangulation; and
- (4) postural strangulation.

"Strangulation by hanging involves the body being 'suspended by a ligature of some sort.' Ligature strangulation, also known as garroting, involves solely applying pressure by the ligature and not the weight of the body. Manual strangulation, also referred to as 'throttling,' involves applying outside pressure by a hand or hands. Postural strangulation occurs 'where the neck is placed over an object and the weight of the body applies pressure to the neck.'" 77

What Happens When an Individual is Strangled?

"The brain needs a continuous supply of oxygen. Without it, brain cells quickly malfunction and die. And brain cells do not regenerate. There are two vital bodily systems that must work perfectly and in unison—the respiratory (breathing) system and the cardiovascular (blood flow) system. Multiple areas of vulnerability exist in both of these systems, and the compromise of a single area can rapidly produce a very bad outcome.

"The inability to get oxygen is one of the most terrifying assaults a person can endure. The body has an automatic reaction to being deprived of oxygen and blood to the brain. It knows it is about to die if it does not change the situation immediately, which leads to escalation of the violence by the victim.

"When an individual is strangled, unconsciousness may occur within seconds and death within minutes. Individuals may lose consciousness by any of the following methods:

- ▶ blocking of the carotid arteries in the neck (depriving the brain of oxygen);
- ▶ blocking of the jugular veins (preventing deoxygenated blood from exiting the brain); or
- ▶ closing off the airway (making breathing impossible).

"Very little pressure on both the carotid arteries and/or veins for 10 seconds is all that is necessary to cause unconsciousness. However, if the pressure is immediately released, consciousness will be regained, usually within 10 seconds. To completely close off the trachea (windpipe), three times as much pressure (33 lbs.) is required. Brain death will occur in 4–5 minutes if strangulation persists.

"...often in non-fatal strangulation cases there are no visible external injuries. The lack of external injuries on a victim and the lack of medical training among domestic violence professionals including law enforcement officers and domestic violence providers, has led to the minimization of this type of violence in the past, exposing victims to potential serious health consequences, further violence, and even death. Not only has strangulation been overlooked in the medical literature, but many states still do not adequately address this violence in their criminal statutes, policies, or responses." 78

MANUAL STRANGULATION during Domestic Violence Incidents:

"Manual strangulation is the most frequent pattern of strangulation assault in intimate partner violence cases. Manual strangulation includes the quintessential mental picture of two people standing, facing each other, where one has hands around the other's throat. While that may happen, it is not the usual mental image that should be conjured in intimate partner violence homicidal strangulation cases. For the most part, these assaults occur in the bedroom, on the bed, with the victim lying down and the assailant on top. It can be with one hand from the front or from behind, two hands from the front or from behind the victim, or often just by placing the forearm across the victim's neck while she is face up on the bed. The forearm can also be used from behind, reaching around the throat. Manual strangulation also includes stepping or kneeling on the victim's throat. In any one posture of victim and assailant, the pattern of defensive injuries that might be made by a struggling victim will depend on the accessible part of the victim's

own body, the accessible or exposed parts of the assailant's body, and whether the assailant has employed some mechanism to chemically or physically restrain the victim prior to the assault." 79

Absence of EXTERNAL Injury:

"Strangulation is one of the most lethal forms of domestic violence. Minimal pressure on the neck can cause serious injury, and even in fatal cases of strangulation, **it is possible there may be no external injuries at all.**" 80

"Visible injuries are not always present on the skin in homicidal strangulation and suffocation." 81

"Studies are confirming that an offender can strangle someone to death or nearly to death with no visible external injury, resulting in professionals viewing such an offense as a minor misdemeanor or no provable crime at all." 82

External skin injuries may or may not be present after a carotid compression. The presence of skin injury produced by the assailant depends on the surface area for application of the force, the texture of the surface against the skin, and the rapidity of loss of consciousness for the victim. The presence of defensive skin injuries on the victim's neck, produced by the victim clawing at a choke hold on the neck, or injuries on the assailant from clawing at the assailant, may or may not be present and depend on circumstances that include body posture, the element of surprise, and even demeanor of the attacker. **In law enforcement demonstration exercises, the person subject to the restraint rarely fights back.** [These types of demonstration are not indicative of what happens in a domestic violence incident.] In demonstrations of lateral vascular neck restraint when trained as deadly force for police agencies and the military, external injuries are seldom present. **With fatal carotid compression, internal injuries are likely in the muscles and perhaps within the vessels, but external injuries are often completely absent even in homicidal assaults.** 83

Injuries Caused by the Assailant:

"Ligature abrasions in suicidal hanging show a definite upward track somewhere around the circumference of the neck, often just behind one ear, proving the direction of force to be head-to-toe. In contrast, ligature strangulation should produce a horizontal band around the neck showing constriction of the skin. While it might be speculatively possible to affect a ligature strangulation assault by lifting the victim up off the floor using only the ligature, this scenario would require a number of conditions, such as victim unconsciousness.

"Manual strangulation can show bruises from the assailant's hands or fingers, sometimes with fingerprints that can be lifted from the surface injuries on the victim's skin. Abrasion of the victim's skin under the chin is common and related to the victim wiggling the chin from side to side in an attempt to get the chin under the stranglehold. Patterned stamp abrasions may be created by a necklace, where the necklace is inside the stranglehold and becomes deeply indented into the skin. **Blunt force impact injuries created by punching or slapping the neck and face sometimes overlie the strangulation injuries.**

"In suffocation, where the mechanism is forcing the mouth and nose closed, there may be incised tooth marks on the inner mucosal surfaces of the upper or lower lips, but these are not generally present in victims who have no teeth. The tooth marks, when present, may be associated with lip swelling. **There may be visible patterned skin abrasion over the nostrils or symmetric abrasions on the upper lip below the nostrils to show that the nose was pinched closed with great force.** If suffocation is done with duct tape, there can be linear abrasions and tape adhesive residue across the face or within the hair." 84

Injuries Caused in Self-Defense (Defensive Injuries) on Victim and Assailant:

"Abrasion of the victim's skin under the chin is common and related to the victim wiggling the chin from side to side against the assailant's hand in an attempt to get the chin under the stranglehold. Patterned curvilinear abrasions made by victim's fingernails are quite common in strangulation cases. The victim will often dig in with the fingernails to try to get fingers under the stranglehold (either manual or ligature), and create scrapes in the neck. The victim may also strike out at the assailant, causing scratches on the face or body of the assailant, which may indicate "defensive injury" in the assault. In the context of an assault taking place on a bed, with both victim and assailant unclothed, and the assailant on

top of the victim, there are many possible locations on the assailant's body for the victim to reach. Finding assailant DNA under the victim's fingernails may be useful in proving identity of a perpetrator." 85

Strangulation and Domestic Violence:

An Overview:

In response to the deaths of two San Diego teenage girls, 17-year old Casondra Stewart and 16-year old Tamara Smith, at the hands of their boyfriends in 1995, the San Diego City Attorney's Office, with the assistance of an emergency room physician, conducted a first of its kind study of 300 **non-fatal** strangulation cases submitted for misdemeanor prosecution in San Diego. The study was conducted to determine the signs and symptoms of attempted **[non-fatal] strangulation.** 86

The study revealed, among other things, that **"police and prosecutors overlook symptoms of strangulation and rely too heavily on the visible signs of strangulation,** which leads them to miss opportunities for [a] higher level prosecution and for prevention of more severe victim abuse. **Non-visible signs of strangulation were often missed or overlooked by law enforcement officials and emergency room doctors, as battered women who have been strangled usually have a broad range of physical complaints but their injuries may not always appear serious.** Thus, victims usually receive only a cursory history and physical examination, if they were even taken to the hospital and seen by a doctor.

The San Diego Study, as well as other later studies of non-fatal strangulation during incidents of domestic violence, has provided law enforcement, prosecutors and domestic violence service providers with the following results:

- ▶ **97% of victims were manually strangled;**
- ▶ **strangulation is a gendered crime**—virtually all perpetrators are men (299/300);
- ▶ **most abusers do not strangle to kill—they strangle to show they can kill:**
 - domestic violence strangulation is **usually about asserting control over the victim**, i.e., showing that the offender has the power of life and death over the victim:
 - ◆ it is **often not about doing serious bodily injury;**
- ▶ the body has an automatic reaction to being deprived of oxygen and blood to the brain. It knows it is about to die if it does not change the situation immediately, which leads to escalation of the violence by the victim;
- ▶ in at least 41% of cases, the attack was witnessed by one or more children;
- ▶ **only 5% of victims sought medical treatment within 48 hours of the incident;**
- ▶ **most strangulation cases, in particular non-fatal strangulation cases, produce minor or no visible injury:**
 - In 50% of cases, officers reported seeing no physical injury when responding to the scene;
 - in 35% of cases the injury was too minor to photograph;
- ▶ **non-fatal strangulation assaults may not fit the elements of other serious assaults due to the lack of visible injury:**
 - studies are confirming that an offender can strangle someone nearly to death with no visible injury, resulting in professionals viewing such an offense as a minor misdemeanor or no provable crime;
- ▶ **jurors expect to see visible injuries:**
 - **the fact that strangulation often leaves no marks, combined with its terror value, makes it a favorite tactic of experienced batterers;**
- ▶ **many victims, however, suffer internal injuries and have documentable symptoms:**
 - victims often suffer major **long-term emotional and physical impacts;**
- ▶ only 15% of cases had a photograph of sufficient quality to be used in court as physical evidence of strangulation;
- ▶ even in fatal strangulation cases, there is often no external evident injury (confirming the findings regarding the seriousness of non-fatal, no-visible-injury strangulation assaults);
- ▶ leading forensic pathologists have now determined that even homicides in strangulation assaults have not been identified at the scene of the crime, leading to poor crime-scene investigation (no photos, interviews, or trace evidence) due to misidentification of the case as a drug overdose;

- ▶ **89% of victims reported a prior history of domestic violence;**
- ▶ **victims of prior attempted strangulation are seven times more likely to become homicide victims:**
 - victims of multiple non-fatal strangulation ‘who had experienced more than one strangulation attack, on separate occasions, by the same abuser, reported neck and throat injuries, neurologic disorders and psychological disorders with increased frequency;
- ▶ **experts across the medical profession now agree that manual or ligature strangulation is “lethal force” and is one of the best predictors of a future homicide in domestic violence cases.** 87

Until the San Diego study had been completed, **law enforcement officers who responded to and investigated domestic violence complaints that included “choking,”** prosecutors who were tasked with presenting those cases in court as well as domestic-violence-victim service providers **lacked appropriate training into all but the most obvious of injuries [e.g. gunshot wounds, stabbing wounds and other visible injuries]** that victims of intimate violence suffered during those incidents. The study revealed that on a regular basis victims had reported being “choked,” and, in many of those cases, there was very little visible injury or evidence to corroborate the “choking” incident. **“The lack of physical evidence caused the criminal justice system to treat many ‘choking’ cases as minor incidents, much like a slap on the face where only redness may appear.”** Because most strangulation victims do not have visible external injuries, **non-fatal strangulation cases are minimized or trivialized by law enforcement, medical, advocacy, and mental health professionals.** 88

Thus, the San Diego study, prompted by the deaths of two teenage intimate-partner-violence victims, became the catalyst that launched an aggressive awareness and education campaign to recruit experts and improve the criminal justice system’s response to the handling of **“choking” cases, which are now referred to as “near-fatal strangulation” cases.** That momentum for specialized training has spread around the country. 89

Research into non-fatal strangulation cases has shown that “strangulation ‘is a common means of domestic violence inflicted upon victims by their perpetrators.” Several recent studies have shown that:

- ▶ 34 percent of abused pregnant women report being “choked;”
- ▶ 47 percent of female domestic violence victims reported being ‘choked;’
- ▶ almost half of all domestic violence homicide victims have experienced at least one episode of strangulation prior to a lethal or near-lethal violent incident;
- ▶ victims of one episode of strangulation are 700 percent more likely to be a victim of attempted homicide by the same partner, and are 800 percent more likely of becoming a homicide victim at the hands of the same partner. 90

Control over the Victim:

“Survivors of non-fatal strangulation have known for years what prosecutors and civil attorneys are only recently learning:

Many domestic violence offenders and rapists do not strangle their partners to kill them; they strangle them to let them know they can kill them—any time they wish. Once victims know this truth, they live under the power and control of their abuser day in and day out. This complex reality creates challenges for prosecutors who have to decide whether to prosecute non-fatal strangulation cases as attempted murders or serious felony assaults.” 91

“Strangulation is also a form of power and control that can have a devastating psychological effect on victims in addition to the potentially fatal outcome, including suicide.”

“Strangulation is a unique crime. It has more in common with sexual assault crimes than basic assault or battery crimes...Domestic violence strangulation is usually about asserting control over the victim, i.e., showing that the offender has the power of life and death over the victim; it’s *not* about doing serious bodily injury (as is required by many statutes). Strangulation is far more cruel, inhumane, and dangerous than merely punching a person (battery). Jurors expect to see visible injuries. But the fact that strangulation often leaves no marks, combined with the terror it causes, makes it a favorite tactic of experienced batterers. Studies are confirming that an

offender can strangle someone to death or nearly to death with no visible external injury, resulting in professionals viewing such an offense as a minor misdemeanor or no provable crime at all. **When an abuser strangles his intimate partner, he is committing a serious criminal offense, often causing permanent brain damage to his victim. He must be held accountable for his conduct through the criminal justice system.” 92**

As the San Diego study showed “...strangulation is a way for an abuser to demonstrate power and control over a victim, as it puts an abuser in a position of power to prey on the person in the relationship who has less power. An abuser uses strangulation to wear down and keep their victims ‘under his or her thumb.’ Some believe that what makes a batterer turn to aggression is feeling disregarded, unimportant, accused, guilty, devalued, disrespected, rejected, powerless, inadequate, or unlovable. Thus, an abuser may strangle a victim to prove to an intimate partner he, the abuser, should be regarded highly, is important, has power, and deserves to be loved.

“Strangulation symbolizes an abuser’s power and control’; ‘the victim is completely overwhelmed . . . vigorously struggles for air, and is at the mercy of the abuser.’ ‘A single traumatic experience of strangulation...[can] instill so much fear’ in a victim that she can ‘get trapped in a pattern of control by the abuser.’ What makes domestic partner non-fatal strangulation more...deadly than other forms of domestic violence is that **women who have been non-fatally strangled by their intimate partners are substantially more likely to be killed by that same partner.** Thus, **non-fatal strangulation has become a precursor to death for these victims, and because non-fatal strangulation is difficult to find, see, and prove, non-fatal strangulation is often undetected by law enforcement officials.” 93**

“Research also argues that **the use of coercive control within abusive relationships is gendered, where women are more vulnerable to these tactics.** A small body of literature has begun to emerge examining strangulation as a mechanism of coercive control that males use over their female intimate partners....Furthermore, **experiencing nonfatal strangulation can have devastating psychological effects. Not only is strangulation a symbol of power and control over the victim’s life or death but being strangled is incredibly painful as well. Following the assault victims report experiencing nightmares, depression, post-traumatic stress disorder, and suicide ideation multiple strangulation attempts on separate occasions are associated with increased frequency of negative symptomology that affects physical and mental health.** Despite the expression of these symptoms few seek medical help after strangulation, and very little research has explicitly investigated the psychological effects of strangulation as a part of abuse.” 94

Strangulation – A Predictor of Future Violence:

“Strangulation is one of the most accurate predictors for the subsequent homicide of victims of domestic violence. One study showed that **‘the odds of becoming an attempted homicide increased by about seven-fold for women who had been strangled by their partner.’** Victims may have no visible injuries, yet—because of underlying brain damage due to the lack of oxygen during the strangulation assault—they may sustain serious internal injuries and **may die days or weeks after the attack. 95**

Studies have also shown that “strangulation is a red flag for serious interpersonal violence. One study asked battered women what made them believe they were in danger. **The majority of women perceiving a great amount of danger mentioned “choking” as a tactic used against them that made them believe their partner might kill them** “Nonfatal strangulation is a risk factor for lethal violence in several studies...These results underscore the need to screen specifically for nonfatal strangulation when assessing abused women.”” 96

Yet, **even given the lethal and predictive nature of these types of assaults, the San Diego Study found that most cases lacked physical evidence or visible injury of strangulation—only 15 percent of the victims had a photograph of sufficient quality to be used in court as physical evidence of strangulation, and no symptoms were documented or reported in 67 percent of the cases. The study found major signs and symptoms of strangulation that corroborated the assaults, but little visible injury. 97**

“Over twenty years ago, physicians working in the area of intimate partner violence realized that victims survive manual strangulation more often than previously thought. Since then, numerous studies and surveys have been conducted to determine the prevalence of strangulation in intimate partner violence.” 98

“...[R]esearch has shown that many of the scales lack content and predictive validity and that there is wide variation between the scales. In their review of 16 clinical domestic violence scales, [some researchers have shown] that physical abuse is heavily focused on in the scales; though, **very few items in the scales address strangulation**. Also, **those that do address strangulation use the term ‘choke’ rather than ‘strangle.’** It is legally important that ‘strangle’ or ‘strangulation’ is used in referring to the violent act, since choking can also describe obstruction by a small object in the throat. **Findings from focus groups and interviews of 17 women in a domestic violence shelter indicate that survivors’ interpretations of choking and strangling differ from the medical definitions. Many participants viewed choking as happening when someone used their hands as the weapon, whereas strangling occurred when another object was used (e.g., rope or belt).** Understanding these and other types of distinctions made by survivors may be critical, since some researchers have suggested that **survivors’ own predictions of risk of severe domestic should be included in prediction instruments ...** Though strangulation is acknowledged as an important risk factor for intimate partner homicide in assessment instruments, a limited body of research underscores the seriousness of strangulation as a potentially lethal form of violence prevalent in the context of domestic violence. Using a case–control design, [researchers, in 2008,] systematically examine[d] strangulation in both attempted and completed femicide records between 1994 and 2000 in 11 cities and showed that prior nonfatal strangulation is an important risk factor for femicide. Specifically, they found that the odds of being killed by an intimate partner were 7.48 times higher for women who had been previously strangled by their abusive partner than those who had not.” 99

Creating an Awareness of the Seriousness of Strangulation:

“...[E]ven when signs or symptoms of strangulation are noticed, they can easily be misidentified as symptoms of other conditions. For example, subconjunctival hemorrhages can be diagnosed as pink eye; voice hoarseness can be attributed to a victim screaming during an argument with her partner; and hyperventilating may be a symptom of numerous pathological conditions secondary to a strangulation attempt. **Thus, it is difficult for law enforcement and medical professionals to detect strangulation, especially when an abuser uses intimidation and control techniques to ensure the victim does not volunteer any information about the strangulation to these professionals.** 100

“...the statistics regarding domestic violence related strangulation are startling. **Ten percent of all violent deaths in the United States are caused by strangulation.** Studies indicate that **‘33% to 47.3% [of] women report that their partner had tried to strangle them in the past year.’** ‘Strangulation is a significant risk factor for attempted or completed homicide of women by their male [partners].’ Recent studies have found that **30-68% of women in abusive relationships have been strangled by their partners at some point in their relationship.** Additionally, **87% of the incidents of non-fatal strangulation were accompanied by death threats.** In fact, in one study, **the odds of becoming a victim of attempted homicide increased by an incredible 800% for women who had been strangled by their partner.** Thus, **victims of domestic violence non-fatal strangulation are much more likely to be eventually killed by their abuser.” 101**

“For many years, medical training to identify domestic violence injuries—including strangulation—for police, prosecutors, and advocates was often overlooked and not included in core training. It wasn’t until the deaths of 17-year old Casondra Stewart and 16-year old Tamara Smith in 1995 that the San Diego criminal justice system first began to understand the lethality and seriousness of ‘choking’ cases. The deaths of these two teenagers were a sobering reminder of the reality of relationship violence, prompting the San Diego City Attorney’s Office to study existing ‘choking’ cases being prosecuted within the office. **The study revealed that on a regular basis victims had reported being ‘choked,’ and, in many of those cases, there was very little visible injury or evidence to corroborate the ‘choking’ incident.** The lack of physical evidence caused the criminal justice system to treat many ‘choking’ cases as minor incidents, much like a slap on the face where only redness may appear. These two horrific deaths ultimately changed the course of history and launched an aggressive awareness and education campaign to recruit experts and improve the criminal justice system’s response to the handling of ‘choking’ cases, which are now referred to as ‘near-fatal strangulation’ cases. **The momentum for specialized training has spread around the country.**

“As a result of those early efforts, **many strangulation cases are now being elevated to felony-level prosecution due to professionals understanding the lethality of strangulation.** Police and prosecutors are using existing statutes or working with legislators **to create new felony legislation.** Doctors, forensic nurses, and domestic violence detectives are being utilized as experts and are testifying in court about strangulation.” 102

“The impact of the San Diego study did not just transform practices at the law enforcement level; **several changes also occurred with respect to the legal response to strangulation in domestic violence cases.** Historically (and presently in a few U.S. states), prosecutors have been forced to try nonfatal strangulation cases under existing statutes, often as assault or battery...**nonfatal strangulation is different and more serious than was previous thought** [and] has resulted in states enacting separate legislation that specifically addresses strangulation in the context of domestic violence and many states have made it a felony offense.” 103

“As of April 2015, 43 states have a statute explicitly addressing adult strangulation in some form, and two states (New Jersey and Ohio) are currently considering legislation to add strangulation statutes. **Of these, 19 states’ strangulation statutes are specific to domestic violence, while most others have in the past decade added strangulation to existing statutes of assault, aggravated assault, attempted murder, or rape statutes...**All of these statutes were added or amended after 2000, so strangulation statutes are a relatively new criminal justice phenomenon; therefore, there has been limited research examining the impact of these laws....In examination of state statutes for this article, at least 39 U.S. states with strangulation-specific language now allow in some way for the prosecution of adult strangulation as a felony as of April 2015, with 19 states specifically referencing domestic violence or household members as victims. The U.S. statutes, on the other hand, are all relatively new and have been developed around the now well-established linkages between domestic violence strangulation and homicide risk.” 104

Current Status of Strangulation Statutes by State: 105

<u>State</u>	<u>Year Amended</u>	<u>Offense Type</u>	<u>Charge Statute</u>	<u>Charge Category</u>
Alabama	2011	Class B Felony	Domestic violence by strangulation or suffocation	Domestic violence
Alaska	2005	Felony assault in the first, second, third degree; misdemeanor fourth degree	Assault	Assault
Arizona	2012	Class 3 Felony; Class 2 Felony if victim is less than 15 years of age	Aggravated assault	Assault
Arkansas	2009	Class D Felony	Aggravated assault on a family or household member	Assault
California	2011	Felony	Domestic violence by strangulation	Domestic violence
Colorado	N/A	Felony	Felony with deadly weapon (hands), Second degree assault, first degree assault, murder	Domestic violence
Connecticut	2007	1 st degree (Class C Felony) 2 nd degree (Class D Felony) 3 rd degree (Class A Misdemeanor)	Strangulation	Domestic violence
Delaware	2010	Felony	Unknown	Domestic violence
Florida	2007	Felony	Domestic battery by strangulation	Domestic Violence
Georgia	2014	Felony	Aggravated assault	Assault
Hawaii	2011	Class C Felony	Abuse of family or household members	Domestic violence; abuse
Idaho	2005	Felony	Attempted strangulation	Domestic violence
Illinois	2009	Class 2 Felony	Aggravated domestic battery	Domestic violence

Indiana	2006	Class D Felony; Level 6 Felony	Strangulation	Battery
Iowa	2012	Misdemeanor, Class D Felony	Domestic abuse assault	Domestic violence; assault
Kansas	2014	Level 6 Felony	Aggravated battery	Battery
Kentucky	N/A	Felony; misdemeanor	Assault	Assault
Louisiana	2007	Up to 3 years in prison	Domestic abuse battery by strangulation	Domestic violence
Maine	2012	Class B crime	Aggravated assault	Assault
Maryland	2014	1 st degree Felony rape, 1 st degree Felony sexual offense	Rape; sexual offense	Rape; sexual offense
Massachusetts	2006	Felony	Attempt to murder	Attempt to murder
Michigan	2013	Felony	Assault by strangulation or suffocation	Assault
Minnesota	2005	Felony	Domestic assault by strangulation	Domestic violence
Mississippi	2010	Subsequent conviction- Felony Aggravated	domestic violence	Domestic violence
Missouri	2000	Class D Felony	Domestic assault	Domestic violence
Montana	N/A	N/A	N/A	N/A
Nebraska	2004	Class 3 Felony; Class 4 Felony	Strangulation	Strangulation
Nevada	2009	Class A, B, and C Felonies	Battery with intent to commit a crime; battery; domestic violence battery	Domestic violence
New Hampshire	2010	Class B Felony	Assault	Assault
New Jersey	N/A	N/A	N/A	N/A
New Mexico	N/A	N/A	N/A	N/A
New York	2010	Misdemeanor; class C and class D Felony	Criminal obstruction of breathing or blood circulation; strangulation	Strangulation
North Carolina	2004	Class H Felony	Assault	Assault
North Dakota	N/A	N/A	N/A	N/A
Ohio	N/A	N/A	Factors to be considered when setting bail; bail schedule; appearance by video conferencing equipment	Bail
Oklahoma	2004	Felony	Domestic abuse by strangulation	Domestic violence
Oregon	2003	Class A misdemeanor; class C Felony	Strangulation	Strangulation
Pennsylvania	1990	Misdemeanor; Felony	Child abuse	Child abuse
Rhode Island	2012	Misdemeanor; Felony	Domestic assault by strangulation; domestic battery by strangulation	Domestic violence
South Carolina	2011	Unknown	Vulnerable adult	Adult protection

South Dakota	2012	Class C Felony	Aggravated assault	Assault
Tennessee	2011	Felony	Aggravated assault	Assault
Texas	2009	first or second degree Felony	Aggravated assault	Assault
Utah	2011	Misdemeanor; Felony	Child abuse	Child abuse
Vermont	2006	Felony	Aggravated assault	Assault
Virginia	2011	Class 6 Felony	Strangulation by another	Strangulation
Washington	2007	Class B Felony	Assault	Assault
West Virginia	2008	Unknown; first degree robbery	Arrest in domestic violence matters; robbery; attempted robbery	Domestic violence; robbery
Wisconsin	2011	Class H Felony	Strangulation and suffocation	Strangulation and Suffocation
Wyoming	2011	Felony	Strangulation of a household member	Domestic violence

“All of these statutes were added or amended after 2000, so strangulation statutes are a relatively new criminal justice phenomenon; therefore, there has been limited research examining the impact of these laws.” 106

NON-FATAL STRANGULATION – CURRENT MARYLAND LAW:

Currently, **non-fatal strangulation** is normally prosecuted, in Maryland, under the Criminal Law Article (CR) §3–203 which states, in part:

- (a) A person may not commit an assault.
- (b) **Except as provided in subsection (c) of this section, a person who violates subsection (a) of this section is guilty of the misdemeanor of assault in the second degree** and on conviction is subject to imprisonment not exceeding 10 years or a fine not exceeding \$2,500 or both.

In addition, in rape cases, **non-fatal strangulation** is subject to prosecution as follows:

CR §3–303 which states, in part:

(a) A person may not:

- (1) **engage in vaginal intercourse with another by force, or the threat of force, without the consent of the other; and**
- (2) (i) employ or display a dangerous weapon, or a physical object that the victim reasonably believes is a dangerous weapon;
 - (ii) **suffocate, strangle, disfigure, or inflict serious physical injury on the victim or another in the course of committing the crime;**
 - (iii) **threaten, or place the victim in fear, that the victim, or an individual known to the victim, imminently will be subject to death, suffocation, strangulation, disfigurement, serious physical injury, or kidnapping;**
 - (iv) commit the crime while aided and abetted by another; or
 - (v) commit the crime in connection with a burglary in the first, second, or third degree.
- (d) **(1) Except as provided in paragraphs (2), (3), and (4) of this subsection, a person who violates subsection (a) of this section is guilty of the felony of rape in the first degree and on conviction is subject to imprisonment not exceeding life.**

(3) A person who violates subsection (a) or (b) of this section is guilty of the felony of rape in the first degree and on conviction is subject to imprisonment not exceeding life without the possibility of parole if the defendant was previously convicted of violating this section or § 3–305 of this subtitle.

(e) If the State intends to seek a sentence of imprisonment for life without the possibility of parole under subsection (d)(2), (3), or (4) of this section, or imprisonment for not less than 25 years under subsection (d)(4) of this section, the State shall notify the person in writing of the State's intention at least 30 days before trial.

CR §3–305 which states, in part:

(a) A person may not:

- (1) **engage in a sexual act with another by force, or the threat of force, without the consent of the other; and**
- (2) (i) **suffocate, strangle, disfigure, or inflict serious physical injury on the victim or another in the course of committing the crime;**
 - (iii) **threaten, or place the victim in fear, that the victim, or an individual known to the victim, imminently will be subject to death, suffocation, strangulation, disfigurement, serious physical injury, or kidnapping;**
 - (iv) commit the crime while aided and abetted by another; or
 - (v) commit the crime in connection with a burglary in the first, second, or third degree.

(d) (1) Except as provided in paragraphs (2), (3), and (4) of this subsection, a person who violates subsection (a) of this section is guilty of the felony of sexual offense in the first degree and on conviction is subject to imprisonment not exceeding life.

(3) A person who violates subsection (a) or (b) of this section is guilty of the felony of sexual offense in the first degree and on conviction is subject to imprisonment not exceeding life without the possibility of parole if the defendant was previously convicted of violating this section or § 3–303 of this subtitle.

(e) If the State intends to seek a sentence of imprisonment for life without the possibility of parole under subsection (d)(2), (3), or (4) of this section, or imprisonment for not less than 25 years under subsection (d)(4) of this section, the State shall notify the person in writing of the State's intention at least 30 days before trial.

During the 2012 session of the Maryland Legislature, two bills (Senate Bill 612 and House Bill 1074) were introduced/cross-filed with one another for passage by the General Assembly. Both bills were intended to expand the crime of felony first degree assault to include the commission of an assault through the application of pressure on the throat or neck of another person that (1) causes a loss of consciousness for any period of time; (2) substantially impedes the normal breathing or circulation of blood; or (3) causes the person to urinate, defecate, or vomit. A violator is subject to the current statutory penalties for felony first degree assault. The bills which were cross-filed failed to pass. 107

ANOTHER POINT OF VIEW:

It needs to be pointed out, however, that **not everyone agrees that a separate law elevating non-fatal strangulation to a felony status should be pursued by legislators.** Those who oppose such a measure do so using the below arguments:

1. allegations of non-fatal strangulation already can, and are, prosecuted under existing statutes dealing with assault and battery; new statutes such as "domestic strangulation" are "superfluous;
2. it is difficult to prove the defendant's intent to inflict "serious bodily injury or harm" in particular when there are no visible injuries and/or victims recant their testimony or refuse to testify in court;
3. "domestic strangulation" laws allow for felony prosecution without objective proof of a victim's injuries;

4. “domestic strangulation” laws give prosecutors too much leverage to obtain guilty pleas for lesser offenses;
5. penalties vary too widely (i.e., 20 years to 1 year of imprisonment);
6. the clarity of the laws, and the specific criteria of who qualifies as a victim under each law is too varied.

To support their arguments opponents of “domestic strangulation” laws cite several of the findings in the previously mentioned San Diego Study noting several of the prosecutor’s problems with pursuing non-fatal strangulation cases:

1. lack of corroboration for strangulation or uncertainty about the primary aggressor led to 25% of the cases being rejected for prosecution;
2. lack of visible injuries [was present] in 50% of cases,
3. an additional 35% of cases [had] injuries too minor for police to effectively photograph;

Additional research indicates that, **“unlike weapon-related assaults, manual strangulation is harder to prosecute as felony assault without some evidence to establish an intent (*mens rea*) to inflict serious injury or death;** however, quality evidence from both researchers and fatality review teams establishing the lethality risks specific to strangulation in domestic violence cases have helped states develop intimate partner violence specific statutes resolving this ambiguity.” **108**

Current Academic Research Results:

Academic “research on criminological aspects of nonfatal strangulation has expanded. **A growing number of research studies show that the use of strangulation is frequent in the context of domestic violence and often experienced multiple times.** Research has also begun establishing the prevalence, risk factors, injuries, and symptoms associated with nonfatal strangulation within abusive relationships. Likewise, efforts have also been made to understand the dynamics and motives behind this gendered form of violence. However, **research on domestic violence strangulation is fraught with methodological issues which make assessing the magnitude of the problem difficult. Comparisons across studies are problematic, because there are great variation[s] in study populations, comparison groups, and a lack of consensus regarding the definition and/or measurement of strangulation.** Also, much of this research has relied on law enforcement, clinical or small shelter samples which may not be representative of those that are not detected or choose not to seek help. Furthermore, controlled studies are scant in the literature focusing on nonfatal strangulation and even when used results may not be generalizable to all victims. For instance, Glass et al.’s (2008) case–control study was limited to urban women making generalizations to women living in other areas problematic. Also, **the majority of studies use self-report data,** which raises concerns about recall. Finally, strangulation is often reported secondary as part of a discussion on various types of physical abuse used within a violent relationship.” **109**

Law Enforcement Response to Non-fatal Strangulation:

“Every day police departments across the country receive a constant stream of 911 domestic violence calls where victims report being threatened, pushed, slapped, kicked, punched, choked, stabbed, or even shot. Some agencies report that as many as 40% of all 911 calls are domestic-violence related. By the time officers respond, victims may already be recanting, minimizing, or simply unaware of the seriousness of their assault, especially if strangulation is involved, in which case the victim may be suffering from anoxic brain injury. Victims may be traumatized by the incident, embarrassed, or afraid of the abuser or the police. **It is imperative that law enforcement first responders be prepared to respond to the challenges of investigating a strangulation case.**” **110**

“One of the challenges for law enforcement officers who respond to calls for intimate partner violence is that this type of crime is happening between people who are (or were) in an intimate relationship. Because of that emotional bond, the fact that they have children together, or because they live in the same house, **officers may have a tendency to downplay what is happening because they may have been to the house before or they may have talked to these individuals before. They also may have had this particular victim recant and minimize prior investigations that they conducted. Officers become very frustrated with this behavior** and while in the past officers may have been tempted

to minimize their response, **that attitude has now been replaced for the most part with a better understanding of why victims of domestic violence may not wholeheartedly agree to leave their violent partner.”** 111 Despite their sometimes frustration, most law enforcement first responders have become better prepared to respond to incidents of intimate partner violence. **In particular, in Maryland, given the extensive use of the Lethality Assessment Program by law enforcement agencies, officers are prepared to make an assessment of the seriousness of a domestic violence incident and the need for the victim to contact and make use of domestic violence victim provider services. In light of increased entry-level and in-service law enforcement training into the dynamics of domestic violence and the use of such protocols as LAP, many officers now believe that they have the opportunity to immediately assist a victim of intimate partner violence in obtaining services that may positively impact the victim.**

Law Enforcement First Responder Initial Response:

Time and space do not allow for a complete presentation in this Report of the steps that a responding officer takes during the investigation into an incident involving non-fatal strangulation whether it is an incident involving intimate partner violence or a sexual assault case. However, this Report will highlight several professionally recognized practices that are being used during these types of investigations. Much of this material can be found in a publication frequently cited in this section of this Report entitled, **“Responding to Strangulation in Alaska: Guidelines for Law Enforcement, Health Care Providers, Advocates and Prosecutors,” Chapter 3 – Investigation of Strangulation Cases – prepared by the Strangulation Training Institute of San Diego, California.** Additionally, the training and experience officers have received from their agency as well as agency policy and procedures also dictate how an officer handles cases of this type. Rather than detail a non-fatal strangulation investigation, the following pages attempt to highlight the investigative steps that are unique to a non-fatal strangulation and which should normally be taken by the responding officer with the primary responsibility for handling that call for service and conducting an investigation.

In some larger agencies, special units/teams have been formed to respond to domestic violence calls where non-fatal strangulation has occurred or is suspected to have occurred. However, in most mid-sized and smaller agencies the first responding officer will be the initial primary investigator in non-fatal strangulation incidents. He/she will often have the responsibility to conduct an investigation and develop a prosecutable case that can be presented to the jurisdiction’s State’s Attorney.

In most cases, unless the victim is critically injured and specialists can be called to the scene, it will be the first responding officer who will conduct the preliminary investigation into an incident involving non-fatal strangulation. When an officer responds to the scene a domestic violence call where “someone is lying on the floor with an open bleeding wound, has been shot, is otherwise seriously injured or is deceased, it is easy for him/her to gauge the seriousness of the situation. However, it is much more **difficult to grasp the significance of the victim’s statement that she was ‘choked,’ especially when the victim is standing without difficulty, talking freely to officers, and has no visible injuries.** To many law enforcement professionals it is just another family disturbance. 112 **Without a basic understanding about the physical and medical effects of strangulation, law enforcement officers may not necessarily view strangulation as one person trying to end another person’s life; they may often view the incident as simply a non-consequential “disturbance” between a couple or a simple assault in which the perpetrator “grabbed” the victim around the neck during a fight.** While to many, it may just be another family disturbance, **it is critical that law enforcement officers have an understanding that an incident involving non-fatal strangulation is not just another assault.** They need to understand, as indicated in current research, that **“strangulation is one of the most accurate predictors for the subsequent homicide of victims of domestic violence.”** 113

In Maryland, **the Lethality Assessment Program has helped to open the door to that realization by requiring the responding officer to ask the question “Has he/she ever tried to choke you?”** with the victim’s answer to it being one of the several triggers that can prompt a referral to provider services. With a basic understanding of non-fatal strangulation, if the victim indicates that his/her intimate partner “choked” him/her during the current event, the responding officer should be prompted to conduct an investigation into the assault as though a weapon had been used to attack the victim.

Unfortunately, while the LAP protocol specifically requires the responding officer to ask the domestic violence victim the question there is no guarantee, for a variety of reasons, that the victim will be willing to answer that question truthfully. And so, it may be critical to the victim's safety that the responding officer widen the breadth of his/her investigation into the incident by further asking the victim if he/she may have previously been subjected to the use or threat of strangulation.

In cases in which an officer responds to a domestic violence incident that includes non-fatal strangulation, a victim's subtle signs and symptoms become very important. Learning how to identify, document, and understand signs and symptoms of non-fatal strangulation is critical to the safety of the victim as well as to the successful prosecution of the criminal case to hold the perpetrator accountable for the attack. "Not all physical violence in domestic violence and intimate partner violence can be identified and rectified in the same manner. Physical violence varies in seriousness, modality, and symptomology. **Strangulation injuries are not easily detected if examining personnel are not trained to question and identify its specific expressions;** first responders and other service providers must be aware of the **seriousness of invisible injuries** and also to be aware of medical services available to help survivors avoid long-term health complications or possible death. Law enforcement, medical professions, and legal professionals are accustomed to securing physical evidence for the conviction of an offender for an alleged assault, but **strangulation typically eludes standard evidence collection methods due to the internal or subtle nature of many strangulation injuries.**" 114

The Physical/Medical Effects of Non-fatal Strangulation:

When law enforcement officers respond to a call for service, they are not expected to be simply "report takers" either by their agencies or by the public. The public expects, and should demand, that they **conduct a thorough, professional investigation of an incident if one is required.** That responsibility entails that **officers be critically observant of the behavior, verbal responses and physical condition of the victim,** the physical state of the crime scene and the conduct and response of the alleged suspect if one is on the scene of the incident. In the case of intimate partner violence involving non-fatal strangulation, training and experience should prepare **law enforcement officers to recognize and professionally appreciate the significance of the most prevalent signs and symptoms of non-fatal strangulation.**

While no one can rightfully expect responding officers to be medically qualified to render professional medical opinions about the victim's physical condition, officers can observe, record and, if warranted, pass on to medical staff significant information about the victim's physical condition and behavior following an incident involving an attack which includes non-fatal strangulation. The following paragraphs provide a summary of symptoms, behaviors and observable injuries that a responding officer should be familiar with when dealing with an intimate partner violence incident involving possible non-fatal strangulation.

Together with other first responders, the **primary officer can:**

- ▶ **visibly detect and document redness, cuts, thumbprints, red marks, and defensive injuries when responding to domestic violence calls;**
- ▶ **screen for invisible symptoms when strangulation is suspected:**
 - confusion;
 - slurred speech;
 - involuntary urination;
 - voice changes;
 - agitation due to hypoxia);
 - be prepared to make referrals to experts (e.g., forensic nurse examiners) if possible.

An officer can also **"learn to screen an individual for strangulation injuries when, for example, a domestic violence victim appears confused or intoxicated, since victims of strangulation may experience loss of consciousness, paralysis, difficulty speaking (sore throat and difficulty swallowing), memory loss, and headaches.** Victims may not only be physically unresponsive or difficult to communicate with, but also [may be] experiencing PTSD symptoms related to the fear of death and/or the shocking reality of the extreme coercive control recently exerted upon them. 115

Victims of strangulation, especially those who are repeatedly strangled by their perpetrator, may acquire Traumatic Brain Injury (TBI) caused by blows to the head, shaking of the brain or Anoxic Brain Injury (AnBI) caused by loss of oxygen to the brain, resulting in irreversible psychological and physical damage. Evidence of unconsciousness includes:

- ▶ loss of memory;
- ▶ lapse in time or location;
- ▶ an unexplained bump on the head; and
- ▶ bowel or bladder incontinence. **116**

Research and experience has shown that a victim of a non-fatal strangulation attack may exhibit one or more of the following behaviors/symptoms:

- ▶ report he/she was standing up one minute, then simply woke up on the floor and didn't know why.
- ▶ **symptoms of hypoxia or asphyxia (a lack of oxygen to the brain) will likely cause the victim to be restless or hostile at the scene;**
- ▶ **may appear to be under the influence of drugs or alcohol, or appear to have stroke-like symptoms;**
- ▶ **problems with memory, inability to concentrate, headaches, anxiety, depression, and/or sleep disorders** caused by temporary or permanent brain injury;
- ▶ **impairment of cognitive, behavioral, neurological, and physical functioning and appear to have a mental health disability which may be symptoms of a TBI or AnBI. 117**

Additionally, **“the victim may be embarrassed or minimize the incident, and she will likely be traumatized from the attack. These factors can dramatically impact how the victim tells her story.** It is common in such situations for the **victim's story to be jumbled or confused.** Early detection and appropriate medical treatment is crucial.” **118**

“The level of injuries and symptoms depends on many different factors including:

- ▶ the method of strangulation;
- ▶ the age and health of the victim;
- ▶ whether the victim struggled to break free;
- ▶ whether the victim was under the influence of alcohol and/or drugs;
- ▶ the size and weight of the perpetrator; and
- ▶ the amount of force used.

“Therefore, it is important to ask the victim a series of questions designed to elicit specific information about her symptoms and internal injuries that are consistent with someone being strangled. **Even when victims exhibit injuries from strangulation, the injuries will likely appear minor and limited to the point at which pressure was applied.** It is important for **trained first responders to look for other signs of injury such as subtle injuries around the eyes, under the eyelids, nose, ears, mouth, neck, shoulders, and upper chest area. If injuries are present, look for redness, scratches, red marks, swelling, bruising, or tiny red spots (petechiae) that arise from increased venous pressure.**” **119**

“The first sign of a traumatic injury to the victim who is reporting that he/she has been strangled [“choked,” had their throat grabbed, etc.] **may begin with symptoms that the victim does not realize are significant. Such victims may not volunteer the information that they are “hurting.”** If the correct questions are asked, first responders may be able to identify a **traumatic injury that is not readily apparent.** Identifying these symptoms may also be an indicator that **the victim needs medical attention** even though he/she is declining it. **Non-fatal strangulation is the type of assault where victims need to be educated about what has happened to them.** To identify internal injuries, first responders should consider asking the following questions:

- ▶ How does your neck feel? Do you feel any pain on movement or touch? Describe it.
- ▶ Do you have pain anywhere else? Describe the pain.
- ▶ Are you having any trouble breathing now? Is your breathing any different than before the incident?
- ▶ Do you have asthma or a history of breathing troubles?
- ▶ Did you experience any visual changes? What did you see? (These are indicators of a lack of oxygenated blood to the brain)

- ▶ How does your throat feel? (Have the victim describe it in his/her own words.)
- ▶ How does it feel to swallow? (Have the victim describe it in his/her own words.)
- ▶ Are you having any drooling problems?
- ▶ Does your voice sound any different since the assault? (Have the victim describe the difference in his/her own words and electronically record his/her voice if possible.)
- ▶ Was there any coughing after the assault? Is the coughing still occurring? (Describe.)
- ▶ How did you feel during and after the assault? Did you feel any dizziness?
- ▶ Did you faint or lose consciousness?" (Describe.)
- ▶ (If the victim lost consciousness) Explain why you believe you were unconscious? (Examples: gap in time; waking up on the floor; bump on head from unknown cause; etc.)
- ▶ Did you lose control of any bodily functions? (e.g. urination or defecation)
- ▶ Is it possible you are pregnant? (How far along? Any problems since the assault?)
- ▶ Did you feel nauseated or vomit? (Describe.)" 120

If strangulation is detected officers "need to document:

- ▶ the modality [method];
- ▶ the duration,
- ▶ the appearance of symptoms,
- ▶ the victim's experience of the event, and
- ▶ threats made to the victim,

that may provide probable cause for an arrest and critical evidence for prosecution." 121

Identification of the *Principal Physical Aggressor*:

When officers arrive at the scene of a domestic violence call, they may find both parties without visible injuries, both parties with visible injuries, or one party with injuries and the other with no visible injuries. **The challenge is determining which party is the principal physical aggressor and who is the true victim.**

In non-fatal strangulation cases, it is more likely that victims will use self-defense to stay alive. Because victims fear for their lives, they may protect themselves by pushing, biting, scratching, or pulling the suspect's hair. Depending on the method of strangulation being used, the suspect may be the only individual with visible injuries.

For example, if the suspect is strangling the victim from behind and using a chokehold, the victim may protect herself by biting the suspect in the arm. If the suspect is manually strangling the victim from the front (face to face), she may push him away, scratch him, or pull his hair.

To identify the **principal physical aggressor**, officers should consider the following factors:

- height/weight of the parties;
- who is fearful of whom;
- details of each party's statement and corroboration of those statements;
- history of domestic violence, assaults, or criminal history;
- use of alcohol or drugs;
- whether either party is subject to a restraining order or on domestic violence probation;
- pattern evidence;
- injuries consistent with each party's reported statement;
- hair, blood, or fiber on the hands, or evidence of epithelia cells after strangulation (fingernail scrapings);
- signs of symptoms of strangulation; and
- signs of offensive/defensive injuries. 122

NON-FATAL STRANGULATION CHECKLIST FOR LAW ENFORCEMENT:

“[M]ore is now known about the signs and symptoms of strangulation. Some of the most common [visible] signs and symptoms of domestic violence strangulation are as follows:

- ▶ voice changes; swallowing changes; breathing changes;
- ▶ mental status changes, including restlessness and combativeness;
- ▶ involuntary urination and defecation;
- ▶ miscarriage;
- ▶ swelling of the neck;
- ▶ visible injuries to the neck, including scratches, abrasions, and scrapes;
- ▶ chin abrasions;
- ▶ ligature marks;
- ▶ petechiae;
- ▶ neurological findings, including facial droop, unilateral weakness, paralysis, or loss of sensation; and

Unfortunately, some of these symptoms are not easily detectable, especially if the victim is not willing to discuss the incident and the injuries do not warrant being taken to a hospital or remaining in a hospital for longer than a few hours. Included among them are:

- ▶ lung injury, pneumonia and pulmonary edema [which] can develop hours after strangulation;
- ▶ subconjunctival hemorrhage;
- ▶ psychiatric symptoms, including memory problems, depression, suicidal ideation, insomnia, night-mares, and anxiety. 123

In the last 15 years, specialized tools have been developed to assist law enforcement with the investigation of non-fatal strangulation cases. These tools include law enforcement brochures, lists of questions that are helpful in identifying and documenting non-fatal strangulation cases, and specialized documentation and checklists. They have been designed to improve the ability of officers to identify and document a non-fatal strangulation case. They are not intended to replace the reports submitted by medical professionals nor are they intended to diagnose any medical condition. They are intended solely as an investigative aid and, when properly used in concert with reports from medical professionals, increase the likelihood of prosecutorial success and perpetrator accountability.

For purposes of this Report, a number of those tools/checklists have been assimilated into the document that appears on the next page. A template such as this can hopefully serve as guide for officers when responding to incidents involving non-fatal strangulation. The questions to be asked of the victim, the observations made and recorded by the responding officer and the care taken to evaluate the victim’s condition and obtain medical evidence can lead to a successful prosecution of the assailant even without the willing cooperation of the victim. **“Successful prosecution of domestic violence cases hinges on the responder’s collection of evidence.** The entire investigation will vary greatly depending on the focus of the case—is the focus on the victim or is it on proving the abuser’s conduct? Generally, **if the victim is the crux of the case, her or his testimony will be the primary evidence obtained. Little effort will be made to identify and collect corroborating evidence...if the entire case focuses on proving the offender’s conduct, the investigation will move beyond the victim’s testimony and lead to a stronger case that is supported by independent corroboration.”** 124

The following sample reference guide in this Report provides a summary of what to look for when seeking to identify visible injuries or symptoms of non-visible [internal] injuries that may have been inflicted on a victim who reports that they have been strangled or is suspected of having been strangled.

NON-LETHAL STRANGULATION ASSESSMENT/REPORT CHECKLIST 125

BEFORE PROCEEDING: OBTAIN MEDICAL ATTENTION FOR THE VICTIM!

- Look for injuries behind the ears; around the face, neck, scalp, chin; inside the mouth; on the jaw; on the eyelids, shoulders, and chest area.
- Look for redness, abrasions, bruises, scratch marks, scrapes, fingernail marks, thumb-print bruising, ligature marks, petechiae (red spots), blood in the white of the eye, swelling, and/or lumps on the neck.
- Do **not** allow the victim to “clean up,” including removing or applying make-up, prior to responding to a medical facility, in particular if a FORENSIC NURSE will be available to conduct an evaluation of the victim. Clean up of any kind will reduce the potential for TOUCH DNA or fingerprints.
- Look for neck swelling (it may not be easy to detect). Ask the victim to look in the mirror to assess any swelling. Take photos of the neck even if you do not see injuries or swelling as they may appear later.
 - ◆ ER nurses have reported using a tape measure to determine neck swelling.
- Injuries may be easily concealed with makeup, long hair, and/or clothing.

REMINDER: A STRANGULATION VICTIM MAY NOT HAVE ANY VISIBLE INJURIES!

NON-VISIBLE/NON-OBSERVABLE INJURIES	VISIBLE/OBSERVABLE INJURIES
<ul style="list-style-type: none"> ● neck pain/swelling ● jaw pain ● scalp pain (from hair pulling) ● sore throat ● difficulty/pain when swallowing ● tongue injury ● vision changes (spots, tunnel vision, flashing lights) ● light headedness ● headache/head “rush” ● ears ringing ● weakness/numbness of arms or legs ● nausea/vomiting ● loss of consciousness (how long?) ● loss of/lapse of memory ● dizziness/fainting or lightheadedness ● change in mental status: <ul style="list-style-type: none"> ◆ disorientation ◆ combativeness ◆ “spaced out” ● shock 	<ul style="list-style-type: none"> ● swelling of neck or face ● redness on neck/throat ● red spots (petichiae) on face/neck due to burst blood vessels ● pulled out/missing hair ● skull fracture/concussion ● unable to/difficulty breathing or hyperventilation ● ptosis (droopy eyelid) ● droopy face ● raspy or hoarse voice due to narrow airway/broken trachea ● coughing ● swollen lips or tongue ● inability to speak ● lip injury ● bruising/hemorrhaging: <ul style="list-style-type: none"> ◆ may be difficult to see on darker skinned victims ● scratch marks/scrapes/abrasions: <ul style="list-style-type: none"> ◆ sometimes made during “defensive” maneuvers by victim ● bloody/broken nose ● fingernail impressions ● red eyes due to burst capillaries in whites of the eyes ● involuntary urination or defecation ● seizure

RECOMMENDATIONS

- When no injuries are apparent and the victim is able and willing, ask the victim to look in a mirror, if available, to obtain her perspective of her current appearance and/or injuries. Ask the victim to point out any differences from her “normal” appearance,
- Remind the victim to notify the officer working on her case if later injuries appear or if she seeks additional medical care:
 - ◆ some bruises/marks may be delayed in developing;

REPORT CONTENTS

GENERAL REPORT INFORMATION

- Is the relationship of the parties identified?
- Is there a valid protection order in place?
- Are the events that took place pre/post strangulation documented?
- Was information about previous incidents (strangulation, domestic/sexual violence, threats, stalking), including frequency, documented?
- Were all witnesses interviewed and documented?
 - ◆ children may be present during non-fatal strangulation incidents;
- Was medical attention provided?
- Is the scene(s) concisely described/diagramed and processed?

NON-FATAL STRANGULATION SPECIFIC INFORMATION

- Has strangulation occurred in the past?
 - ◆ Was it reported to the police?
 - ◆ When? To What agency?
- Identify the exact crime scene - where the strangulation took place, e.g. on bed, on floor, etc., and process it:
 - ◆ multiple crime scenes may need to be processed and evidence identified/secured.
- Was there a struggle between the victim and suspect?
 - ◆ did the victim scratch/hit or otherwise make contact with the suspect by which a transfer of evidence may have occurred?
- What was used to strangle the victim (one hand, two hands, forearm, other body part, ligature, etc.)?
- Were other weapons involved?
- Did the strangulation take place from the front or from behind?
- Was the victim wearing jewelry?
- Was the suspect wearing jewelry? Gloves?
- Is the suspect right or left handed, if known?
- How long did the strangulation last?
 - ◆ Ask the victim to close her eyes and go through the assault with you while you look at your watch to determine the approximate length of time.
- How many times was the victim strangled during this incident?
 - ◆ Multiple strangulations may have occurred during the incident:
 - Were different methods used to strangle the victim during the incident?
- Determine the amount of pressure that the suspect used if manual strangulation was used:
 - ◆ ask the victim to describe on a scale of 1-10 with 10 being the most pressure the perpetrator's grip;
 - ◆ trigger pull = 5 lbs. of pressure; handshake of an average male = 80 lbs. of pressure;
- In an attempt to further determine the perpetrator's grip, ask the victim (one at a time) if during the strangulation she/he could:
 - ◆ scream; ◆ talk; ◆ breathe (intermittently or otherwise)
- Was the victim also smothered?
- Was the victim also shaken while being strangled?
- Was the victim's head pushed into a wall, floor, or other surface? Was there property damage?
- Did the victim attempt to protect themselves?
- What was the emotional state of the victim (what did they report they were thinking and feeling immediately before/after act)?
- Did the suspect say anything to the victim before/while/after the strangulation occurred?
- Did the victim say anything to the suspect before/while/after the strangulation occurred?
- What was the suspect's demeanor before, during and after the incident?
- Did the victim describe what the suspect's face looked like during the incident? (anger, smiling, no expression, etc.)
- Why and how did the suspect stop strangling the victim?
- Are all crimes that co-occurred with the strangulation documented (sexual assault, kidnapping, property damage, etc.)?

Evidence of Non-fatal Strangulation:

Experienced officers are well aware that “**victims of domestic violence may recant, minimize, or even completely change their story by the time the case goes to trial.**” To proceed to trial, prosecutors, therefore, **need evidence that will corroborate the truth of what happened to the victim.** They need to re-create the scene for the judge or jury; they must make the case come back to life. Everyone who reviews the case should feel as if he or she were present when the incident took place. If that happens, it will be the evidence gathered by investigators that tells the truth.

On-scene Evidence:

The following list represents a number of suggested practices by law enforcement investigators experienced in conducting investigations into non-fatal strangulation incidents:

- ▶ photograph and sketch the scene; a sketch can provide a visual of the scene layout, especially the locations of people at the scene, distances, and areas of significance;
- ▶ if an object was used to strangle the victim, locate, photograph, and collect it; if possible, ask the victim where the object came from; (This may indicate intent.)
- ▶ determine if there is blood on the victim, on the walls, or along or at the bottom of the stairs if they are nearby or the victim stated the attack occurred near them; obtain samples of blood for comparison;
- ▶ confiscate the victim’s clothing that is torn or ripped during the incident; (The clothing may support pulling, dragging, of the victim and/or a struggle during the attack)
- ▶ accurately measure the size of the injury or injuries;
- ▶ collect writings or journals by the victim of past similar events;
- ▶ collect any lists of “household rules” created and/or posted by the suspect;
- ▶ identify any property damaged during the incident; (Photograph and collect if there is anything significant)
- ▶ identify any medical treatment recommended or obtained; (Obtain medical/dental release; obtain a copy of the emergency medical services response report.)
- ▶ if the suspect has fled the scene, a critical piece of evidence will be a photograph of the suspect; ask the victim for a recent photo of the suspect and to identify the perpetrator who assaulted her; submit the photograph as evidence; a prosecutor may be able to use the photograph to identify the suspect by questioning the officer who collected it;
- ▶ photograph every visible injury including areas where there is a complaint of pain but no visible injury; when the injury does appear, the initial photograph can corroborate that there was not a pre-existing condition;
- ▶ do **not** allow the victim to “clean up,” including removing or applying make-up, prior to responding to a medical facility, in particular if a FORENSIC NURSE will be available to conduct an evaluation of the victim; clean-up of any kind will reduce the potential for TOUCH DNA or fingerprints;
- ▶ the following photographs of the victim should generally be taken [use a female officer as appropriate]:
 - **Distance photo** — one full-body photograph of the victim from a distance will help identify the victim and the location of the injury.
 - **Close-up photos** — multiple close-up photographs of the face and neck area (front, back, and sides) at different angles will make it easier to see the injuries clearly. Specific areas to photograph include:
 - ◆ surfaces of both ears;
 - ◆ under the chin;
 - ◆ the inner surface of the upper and lower lips;
 - ◆ the soft palate;
 - ◆ the inside of the cheeks;
 - ◆ under the eyelids; and
 - ◆ the eyes (looking up, down, medial, and lateral).

- **Follow-up photos** — taking follow-up photographs of the injury 24, 48, and 72 hours later will document the injuries as they evolve over time and maximize your documentation; it is recommended that officers also take photos of the victim when the injuries have cleared.
- ▶ digital cameras frequently have a video feature; use this feature to capture a raspy voice, difficulty swallowing, coughing, pain exhibited by the victim, and/or drooling;

Medical Evidence:

- ▶ strongly encourage victims to seek medical attention if there is difficulty breathing or swallowing:
 - summon EMS if:
 - (1) the victim requests medical attention;
 - (2) if the officer observes symptoms or injuries that indicate the need for medical attention:
 - ◆ educate the victim about the seriousness of strangulation;
 - (3) if it appears that strangulation has occurred;
 - a victim may have **internal** injuries that later cause complete airway obstruction, even 36 hours after an injury;
 - if EMTs determine a lack of objective symptoms to support internal injury, a medical examination will prove very helpful to assess the victim's health and document any visible injuries and/or symptoms:
 - ◆ medical documentation is persuasive evidence;
- ▶ obtain a medical information release from the victim;
- ▶ obtain hospital/emergency room examination and treatment records; **126**

Use Forensic Nurses during a Non-fatal Strangulation Investigation:

Forensic nurses are medical professionals who have been specially trained to gather evidence using various court-sanctioned techniques. They are **proficient in follow-up examinations, taking photographs, and interpreting medical records**. “Since 1997, the San Diego City Attorney’s Office has worked closely with **forensic nurses to interpret medical records; understand offensive, defensive, accidental, and/or intentional injuries; document follow up injuries; and/or testify in court as experts**. Jurisdictions such as Maricopa, Arizona and Louisville, Kentucky have developed Strangulation Response Teams and have documented tremendous results: higher filing rates; higher convictions; improved sentences; and enhanced victim safety.” **127**

“A clear strength of the emerging literature on nonfatal strangulation is within the growing body of medical research. **Considering the increasing availability of forensic nurses (e.g., Sexual Assault Nurse Examiners (SANE), Sexual Assault Response Teams (SART)) and their present role in sexual assault cases, the extension of this investigative paradigm to include strangulation cases is possible. Many law enforcement agencies already have working relationships with forensic nurses.** Medical screening for strangulation can start with emergency medical personnel and law enforcement officers initially screening and referring a victim for a forensic medical exam at domestic violence scenes. **A forensic nurse examiner can document the symptoms and visible injuries of the victim for legal evidence.** Research clearly demonstrates that **forensic medical documentation can very strongly support the victim, law enforcement officers, and prosecutor in holding an offender legally responsible.**” **128**

Reporting/Documenting Non-fatal Strangulation Incidents:

Special attention should also be paid to the vocabulary used when officers report/document non-fatal strangulation incidents. “While most victims will continue to report they were ‘choked’ or grabbed by the neck—and it is important to use words the victim is most comfortable using— responders need to acknowledge the seriousness of the abuse that is actually occurring. **‘Choking’ is accidental. Strangulation is intentional.** Choking means having the windpipe blocked entirely or partly by some foreign object, like food. Strangulation means to obstruct the normal breathing of a person. **For report writing, the proper term is ‘strangulation.’** Officers should use words such as ‘strangled,’ ‘near-fatal

strangulation,’ and ‘non-fatal strangulation’ to describe what happened to the victim. By using the correct terminology, more awareness is brought to the seriousness of the crime that has been committed. 129

“Simply reporting that a victim was ‘grabbed by her neck and forced into the wall’ does not provide sufficient detail for a prosecutor to walk into a courtroom and prove the case. The prosecutor needs to paint a picture of what took place so jurors can create in their minds an image of exactly what happened. Jurors should feel like they are watching the actual event. To achieve this, investigators need to **detail for prosecutors what took place without offering ‘suggestions’ of what happened to the victim. If an officer asks, “Did he grab you with one hand, or two hands, or his arm?” the victim—who is likely traumatized—may simply select one of the choices offered rather than express in her own words the details of the assault. **Open-ended questions, followed with phrases such as ‘and then what happened?’ or ‘what happened next’ are the best options.”** 130**

“As we gain a deeper understanding of existing strangulation laws and the need for new ones, a special point should be made here. **For many years, medical experts and researchers referred to strangulation assaults as ‘attempted strangulation.’ This represented [an] inadequate understanding of the nature of the assault.** Indeed, even the seminal San Diego Study referred to these assaults as ‘Attempted Strangulation’ cases. **The belief, though unstated in most research, was that strangulation meant death.** And it is no coincidence that **the best medical evidence of strangulation is derived from post mortem examination (autopsy) of the body.** An autopsy affords the ability to examine all of the tissues of the neck, superficial and deep and track the force vector that produced the injuries.

“In living survivors of strangulation, the assessment of the victim/patient is usually limited to superficial examination of the skin. In rare circumstances, if the victim/patient seeks medical attention, the assessment may include two-dimensional shadows by radiography. So, the thinking went, if a victim survived, it must not have been strangulation; it must have only been ‘attempted strangulation.’

“Sadly, this language is still used by some courts, professionals, and even media outlets. The use of ‘Attempted’ should be viewed as incorrect and eliminated from the discussion. Based on the current state of the law and the current research, any intentional effort to apply pressure to the neck in order to impede airflow or blood flow should be viewed as a felony strangulation assault. The perpetrator did not ‘attempt the assault; he/she completed it. If an offender said to a victim that he [she] was going to ‘choke her [him],’ and he [she] lunged for her [him] but was unable to get a strong hold with one or both hands, that this might be an ‘attempted strangulation.’ But **the vast majority of strangulation or suffocation assaults are not ‘attempts.’ They are completed criminal acts and should be prosecuted based on this understanding.**

“The preferred terminology by our national faculty and experts is strangulation or non-fatal strangulation. When unconsciousness, urination, defecation and/or petechiae is/are present, then near-fatal or near-lethal strangulation would be the appropriate terminology as the victim suffered a severe, life-threatening injury.” 131

“Once a victim reports being strangled, the case should be treated as a felony first and a misdemeanor second. If there is evidence to suggest the victim was strangled and her life was threatened, the case should be considered and investigated as if it were an attempted homicide or aggravated assault case. If the case is treated seriously from the time the 911 call is made, everyone involved, including the victim will treat it seriously, as well. A non-fatal strangulation case can be charged as an attempted homicide, felony assault with intent to commit great bodily injury, spousal abuse, and/or false imprisonment.” 132

Follow-up Investigation:

Follow-up investigations of non-fatal strangulation cases will most likely (but not always) be conducted by an agency investigator rather than the officer who first responded to the scene of the domestic violence call. As part of that follow-up investigation the investigator should, at a minimum:

- ▶ **re-photograph** the victim; follow-up photographs taken 2–3 days after the incident can be critical pieces of evidence because they can provide evidence of bruising/other injury that was not visible at the crime-scene or hospital immediately after the assault;

- ▶ **re-interview** the victim/witnesses; victims often give more detailed statements after they have had a chance to calm down and reflect on what occurred; additionally, it will usually become clear during the re-interview of the victim whether the victim will testify at trial willingly or be reluctant to testify against, the abuser; the prosecutor must know the relationship status of the victim when deciding how to proceed at trial;
- ▶ **obtain** medical treatment records, forensic nurse reports, etc.; **133**

Prior History of Domestic Violence Abuse

Whether documented as part of the preliminary investigation by the primary responding officer or added to the case file as part of a follow-up investigation the **perpetrator’s prior history of the domestic violence abuse can be a critical part of the state’s court presentation**. “Prior history of abuse is important for many reasons. It helps professionals assess risk of future violence, establish the pattern of abuse, explain whether there is a credible threat, and document the level of fear. It also helps the prosecutor in charging, sentencing, bail hearings, probation revocation hearings, and for impeachment purposes at trial.” **134**

While history of abuse includes records of documented domestic violence incidents, prior history of abuse may also be substantiated by:

- ▶ a statement by the victim regarding prior admissions and apologies from the defendant, especially those **documented in any texts, e-mail, social media, letters, notes, or cards;**
- ▶ a statement by the victim regarding any **“house rules” for the victim to follow that the abuser may have written and posted/displayed in the house;** and
- ▶ a **victim diary or a log of history of abuse by the defendant;**
- ▶ **defendant’s phone records to show his contact with the victim,** including copies of the recordings of calls from jail;
- ▶ **notes, cards, emails, faxes, and letters from the defendant (including those sent from jail);**
- ▶ statements of family members, including any children in visual or auditory presence of the assault for corroboration of the assault and/or history of the relationship. **135**

Lessons Learned about Non-fatal Strangulation - Summary:

In summary, research for this Report has revealed the following:

General:

- ▶ Non-fatal strangulation is one of the best predictors of the subsequent homicide of victims of domestic violence:
 - women who have been non-fatally strangled by their intimate partners are substantially more likely to be killed by that same partner:
 - victims of prior attempted strangulation are seven times more likely to become homicide victims.
- ▶ The level of abuse escalates over time, with strangulation typically occurring later in the progression of violence in the relationship:
 - strangulation is a red flag for serious interpersonal violence;
 - strangulation introduces a different level of lethality, rage, and brain injuries to an incident than simple assault involving pushing, punching, kicking, or slapping;
 - threats of death were common among the women who had been strangled;
 - the majority experienced other types of physical and verbal abuse in addition to the strangulation;
 - in one major study, 89% of victims reported a prior history of domestic violence;
- ▶ Manual strangulation is the most frequent pattern of strangulation assault in intimate partner violence cases:
 - domestic violence victims often experience strangulation multiple times;
 - abusers use strangulation because it frequently leaves no visible signs of use;

Terminology:

- ▶ there is an inconsistent/imprecise use of certain terminology to describe strangulation **both** in research and in practice:
 - ‘choking’ is accidental; strangulation is intentional;
 - there is an immediate need for clear, standardized definitions and measures of strangulation that can be utilized across, or specific to, a wide variety of fields including criminology, medicine, mental health counseling, and criminal justice;

Facts about Strangulation:

- ▶ most victims of non-fatal strangulation have **not** sought medical treatment within 48 hours of the incident;
- ▶ strangulation is a gendered crime:
 - primarily used by **MALE** abusers;
 - the fact that strangulation often leaves no marks, combined with its terror value, makes it a favorite tactic of experienced batterers;
- ▶ very little pressure on both the carotid arteries and/or veins for 10 seconds is all that is necessary to cause unconsciousness:
 - pressure does not need to be severe as long as it is prolonged, because unconsciousness usually does not occur for several minutes;
 - to completely close off the trachea (windpipe), three times as much pressure (33 lbs.) is required;
 - brain death will occur in 4–5 minutes if strangulation persists;
- ▶ frequently, in **non-fatal strangulation** cases there are no visible external injuries;
 - an offender can strangle someone to death or nearly to death with no visible external injury;
 - **non-fatal strangulation is often undetected by law enforcement officials:**
 - signs of non-fatal strangulation are difficult to find, see, and prove;
 - signs/symptoms of strangulation can easily be misidentified as symptoms of other conditions;
 - even in homicides caused by strangulation there may not be any visible injuries:
 - homicide is determined by autopsy;
- ▶ the lack of **external injuries** and the lack of medical training among professionals dealing with domestic violence have led to the minimization of this type of violence, exposing the victims to potentially serious health consequences, further violence, and even death;

The Psychological Impact of Strangulation on a Victim:

- ▶ domestic violence strangulation is usually about asserting control over the victim, i.e., showing that the offender has the power of life and death over the victim;
 - most abusers do not strangle to kill—they strangle to show they **CAN** kill:
 - strangulation is a live demonstration of power and control over another individual’s life or death;
 - a single traumatic experience of [non-fatal] strangulation can instill so much fear in a victim that she can get trapped in a pattern of control by the abuser;

Criminal Justice System Response:

- ▶ In the past, police and prosecutors have often relied too heavily on the visible signs of strangulation and have overlooked symptoms of strangulation:
 - law enforcement officers often lacked appropriate training into all but the most obvious of injuries [e.g. gunshot wounds, stabbing wounds and other visible injuries] occurring during domestic violence incidents;

- without a basic understanding about the physical and medical effects of strangulation, law enforcement officers did not necessarily view strangulation as one person trying to end another person's life:
 - they may have often viewed the incident as simply a non-consequential "disturbance" between a couple or a simple assault in which the perpetrator "grabbed" the victim around the neck during a fight.
- ▶ with increased training, officers responding to domestic violence incidents are more cognizant of signs of non-fatal strangulation:
 - they are learning how to identify, document, and understand signs and symptoms of non-fatal strangulation and how to investigate and document those signs;
 - training includes understanding both the physical and psychological effects of non-fatal strangulation;
- ▶ police officers may be allowed to testify (as expert witnesses as they do in drug and DWI cases) regarding his/her observations of the victim consistent with the officer's training and experience in the investigation of domestic violence and strangulation cases:
 - laying a foundation regarding the extent of an officer's training, experience, and number of cases investigated is essential;
- ▶ in some (larger) agencies, special units/teams have been formed to respond to domestic violence calls in which serious injury or signs of non-fatal strangulation have occurred or are suspected to have occurred:
 - to develop better coordinated responses for nonfatal strangulation victims within local communities;
- ▶ with the increasing availability of forensic nurses e.g., Sexual Assault Nurse Examiners (SANE), Sexual Assault Response Teams (SART), the extension of this investigative paradigm to include strangulation cases is possible:
 - a number of law enforcement agencies are developing protocols with forensic nurses regarding strangulation cases to utilize the expertise of medical professionals to help victims and support prosecution;

Legal Ramifications:

- ▶ with the increased understanding of strangulation by members of the criminal justice system, many strangulation cases are now being elevated to felony-level prosecution status;
- ▶ nationwide, several changes have occurred with respect to the legal response to strangulation in domestic violence cases:
 - as of April 2015, 43 states have a statute explicitly addressing adult strangulation in some form:
 - 19 states' strangulation statutes are specific to domestic violence;
 - most others have added strangulation to existing statutes of assault, aggravated assault, attempted murder, or rape statutes;
- ▶ not everyone agrees that a separate law elevating non-fatal strangulation to a felony status should be pursued by legislators;

Research Problems:

- ▶ comparisons across studies are problematic, because there are great variations in study populations, comparison groups, and a lack of consensus regarding the definition and/or measurement of strangulation;

Strangulation is a unique crime. Strangulation is far more cruel, inhumane, and dangerous than merely punching a person. The inability to get oxygen is one of the most terrifying assaults a person can endure and the body has an automatic reaction to being deprived of oxygen and blood to the brain. It knows it is about to die if it does not change the situation immediately, which leads to escalation of the violence by the victim. The fact that strangulation often leaves no marks, combined with the terror it causes, makes it a favorite tactic of experienced batterers.

Domestic violence strangulation is usually about asserting control over the victim, i.e., showing that the offender has the power of life and death over the victim; it's *not* about doing serious bodily injury. Survivors of non-fatal strangulation have known for years what prosecutors and civil attorneys are only recently learning:

Many domestic violence offenders and rapists do not strangle their partners to kill them; they strangle them to let them know they can kill them—any time they wish. Once victims know this truth, they live under the power and control of their abuser day in and day out.

While jurors or judges expect to see some injuries, studies are confirming that an offender can strangle someone to death or nearly to death with no visible external injury, resulting in professionals viewing such an offense as a minor misdemeanor or no provable crime at all. When an abuser strangles his intimate partner, he is committing a serious criminal offense, often causing permanent brain damage to his victim. He must be held accountable for his conduct through the criminal justice system.

CONCLUSION:

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The danger of strangulation in domestic violence cases is well documented, with some researchers showing that it is strong indicator of future homicide. Questions about strangulation are a part of the LAP used in Maryland. The training in the administration of the LAP emphasizes that danger.

To reinforce this, the Police Training and Standards Commission will develop a lesson plan on domestic violence related strangulation that will be made available to agencies for incorporation into their training in early 2017.

ENDNOTES – LETHALITY ASSESSMENT PROGRAM

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