



## DEDICATED TO THE VICTIMS OF DOMESTIC ABUSE HOMICIDE IN MAINE

20 YEAR LOOKBACK

1998 - 2020

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# FOREWORD BY MAINE ATTORNEY GENERAL AARON M. FREY

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I would like to begin by thanking the dedicated members of the Homicide Review Panel on the 13<sup>th</sup> Biennial report – **A 20 Year Lookback**. This retrospective analysis from the last 20 years is informative and encouraging.

As a former legislator and defense attorney and the current Attorney General, I have seen first-hand the impact that people who commit domestic abuse have on their families. I have seen children left parentless because a husband kills his wife and is then arrested and the serial batterer who loses his job because he has spent so much time in jail or the woman who wants to get a protection from abuse order to protect herself and her family yet is overwhelmed by the entire process. As the conversation about domestic violence evolves, the **20 Year Lookback** is representative of progress made and challenges that remain.

As the 13<sup>th</sup> Biennial report goes to print, the world has been in a pandemic for a year. We must face the realities that the pandemic has impacted all budgets. It is critical, however, that Maine prioritize funding for domestic and sexual violence prevention and intervention. People who commit domestic and sexual violence have a societal and economic impact on all of us. Continued funding for victims' services must be realized to keep the momentum going forward.

I would like to take this opportunity to highlight some of the more impactful legislative changes that are a direct result of the work of the Panel, some of which I had the honor to support while I was a legislator.

- In the 10<sup>th</sup> Biennial report (2014), the Panel recommended training for criminal justice professionals on the difference between Certified Batterer Intervention Programs (CBIPs) and anger management programs or domestic abuse counseling. In 2016, by order of the legislature, LD 150 resolved the Maine Commission on Domestic and Sexual Abuse to review pretrial and post-conviction use of CBIPs. In 2017, LD 814 formalized in statute that CBIPs are the appropriate and effective community intervention in cases involving domestic abuse, not anger management or counseling. In addition, LD 814 requires the Courts to articulate on the record the court's reasoning when CBIPs are not ordered in certain domestic violence crimes.
- The Panel has repeatedly reviewed cases in which children have lost both parents because of homicide-suicide or lost one parent to homicide while the other parent has been incarcerated for the crime. In 2003, in response to a Panel recommendation, the Maine legislature passed a law that required Maine Department of Health and Human Services to



perform an emergency assessment in the event of a homicide, for the purposes of temporarily placing children with a relative or other responsible person. (*See* 22 MRS §4023 (8)).

- In multiple case reviews, the Panel observed the need for additional funding and enhanced services for public health nursing across the state for high-risk families. In 2017, the Maine State Legislature passed LD 1108 – An Act to Restore Public Health Nursing Services.
- In the 9<sup>th</sup> Biennial report (2012), the Panel recommended that licensed, registered and certified mental health practitioners receive training in domestic violence. In 2013, LD 1238, An Act to Improve Professional Training for Licensed Mental Health Clinicians was enacted into law.

These legislative changes are representative of just a few improvements in laws, policy and practice attributable to the work of the Homicide Review Panel. The **20 Year Lookback** represents hard work and dedication by a team of people who are committed to saving lives. I thank you all.

# INTRODUCTION BY PANEL CHAIR

## LISA J. MARCHESE, DEPUTY ATTORNEY GENERAL

For the past 23 years, the Maine Domestic Abuse Homicide Review Panel has met monthly to retrospectively review cases of intimate partner and intrafamilial homicide. The 13<sup>th</sup> Biennial report is entitled simply **A 20 Year Lookback** and is dedicated to the victims of domestic abuse homicide in Maine 1998-2020. In recognition of the Panel's twenty years of biennial reviews, this report reflects new recommendations that are presented in summary form and by system, in the context of previous years' recommendations.

In the past 20 years, the Panel has made recommendations that have resulted in legislative and system changes with the goal of keeping victims safe and holding offenders accountable. The Panel has also made repeated recommendations that have not yet resulted in change. While it is discouraging to see that some themes emerge over multiple years with no systemic change in policy and practice, the Panel remains hopeful that this report will focus the appropriate decision makers on the barriers that prevent victims from being safe. Throughout this report you will see reference to Maine's Coordinated Community Response (CCR) to domestic violence. In 2021, we know that keeping victims safe and holding defendants accountable is not the responsibility of a single entity. It is the Criminal and Civil Justice Systems working with DHHS and Healthcare and the greater Community of family, friends and co-workers that will ultimately result in true change.

It has been my honor and privilege to Chair the Homicide Review Panel for the past 20 years. The work that has led to the **20 Year Lookback** is nothing short of extraordinary. The 13<sup>th</sup> Biennial report is by far the most in-depth and reflective analysis of domestic violence homicides that has been done in this state. This report would not have been possible without the time and commitment of Francine Garland Stark, Executive Director of the Maine Coalition to End Domestic Violence and Kate Faragher Houghton, Violence Prevention Consultant and Former Panel Coordinator, both of whom recognized the value of coalescing 20-years' worth of data collection, observations, and recommendations into a single report. Thank you, Francine and Kate. Thank you also to Stacie Bourassa, Project Coordinator at the Attorney General's Office who spent hours compiling and creating the dynamic data presentation and entire format for the report and Yvonne Borelli-Chace, Panel Coordinator who devoted countless hours to ensuring the report reflected the views of the Panel. Thank you also to Panel members Polly Campbell, Alice Clifford, Nancy Fishwick, Jennifer Fiske, Rebecca Hobbs and Bobbi Johnson for their many contributions. Lastly, this report would not be possible without the dedication of the members of the entire Panel who honor the lives of the victims at every meeting. Some Panel members have dedicated their time to Panel meetings and reports for the past 20 years. I am proud and humbled to be a part of this important work.

# CURRENT MEMBERSHIP

## MAINE DOMESTIC ABUSE HOMICIDE REVIEW PANEL

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*Panel Chair:*

**Lisa Marchese\***

Deputy Attorney General  
Chief, Criminal Division  
Office of the Attorney General

*Panel Assistant:*

**Stacie Bourassa**

Coordinator, Civil Rights Team Project  
Office of the Attorney General

**Debra Baeder Ph.D., ABPP – Forensic\***

Chief Forensic Psychologist  
State Forensic Service  
Clinical Director, Office of Behavioral Health

**Elsie-Kay Banks, MA, D-ABMDI, LSW\***

Medicolegal Death Investigator  
Office of Chief Medical Examiner

**Lisa R. Bogue**

Assistant Attorney General  
Office of the Attorney General,  
Criminal Division

**Eric Brown, MD\***

Eastern Maine Medical Center  
Family Medicine Residency

**Polly Campbell, RN, BS, BA\***

Clinical Director, ANE SANE Program  
School of Nursing and Population Health  
University of New England

**Hon. Deborah P. Cashman\***

Judge, Maine District Court, Portland

**Alice Clifford, Asst. District Attorney\***

Penobscot County District Attorney's Office

**Kate Faragher Houghton, JD**

Violence Prevention Consultant  
Former Panel Coordinator

**Sarah Firth**

Director of HR and Compliance  
Maine Coalition Against Sexual Assault

*Panel Coordinator:*

**Yvonne M. Borelli-Chace, Esq.**

Research Assistant  
Office of the Attorney General

**Nancy Fishwick, PhD, RN, FNP\***

Associate Professor (adjunct)  
University of Maine School of Nursing

**Jennifer Fiske**

Detective, Major Crimes Unit North  
Maine State Police

**Renee Fournier**

Victim Advocate, Attorney General's Office  
Criminal Division/Homicide Unit

**Aaron M. Frey**

Attorney General  
Office of the Attorney General

**Francine Garland Stark\***

Executive Director  
Maine Coalition to End Domestic Violence

**Courtney Goodwin, Esq.\***

Assistant Attorney General  
Child Protection Division  
Office of the Attorney General

**Margaret S. Groban**

Assistant United States Attorney  
U.S. Attorney's Office

**Rebecca Hobbs\***

Facilitator  
Certified Batterer Intervention Program  
Executive Director  
Through These Doors

**Ellie Hutchinson\***

Community and Legal Advocate  
New Hope for Women

**Bobbi Johnson, LMSW\***

Associate Director, Child Welfare Services  
Office of Child and Family Services  
Dept. of Health and Human Services

*Continued to page five.*

**Chief Jared J. Mills\***  
Augusta Police Department

**Lindsay Moon\***  
Legal Services Coordinator  
Next Step Domestic Violence Project

**Tessa Mosher\***  
Director, Office of Victim Services  
Maine Department of Corrections

**David St. Laurent**  
Lieutenant Detective  
Franklin County Sheriff's Office

**Michael Sauschuck\***  
Commissioner  
Department of Public Safety

**Joanna Stokinger\***  
Victim Advocate, Attorney General's Office  
Criminal Division/Homicide Unit

*\*Required by enabling legislation*

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

**Michelle Cram**  
Victim Advocate, Attorney General's Office  
Criminal Division/Homicide Unit

**Destie Hohman Sprague**  
Former Associate Director  
Maine Coalition Against Sexual Assault

**Laura Mintzer**  
Former Panel Coordinator

**John Morris\***  
Commissioner  
Department of Public Safety

**Peter Panagore**  
Reverend

**S. Taylor Slemmer, M.A., F-ABMDI**  
Medicolegal Death Investigator  
Office of Chief Medical Examiner

**Hon. Susan A. Sparaco**  
Chief Judge of the Maine District Court

**Hon. Valerie Stanfill**  
Judge, Maine District Court  
Judicial Branch

The Panel would also like to acknowledge Jane Monaghan of wojane design + advertising for the commemorative report cover art, as well as Kelly O'Connor, System Advocacy and Training Coordinator for MCEDV. Kelly's assistance with the data portion of the 20 year lookback was integral to the process of specifically examining the separate categories of intimate partner and intrafamilial homicide, making it possible for the Panel to provide such an in-depth review of the two types of domestic abuse homicide in Maine.

# ABOUT

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## PANEL DESCRIPTION

By law, effective October 1, 1997, the Maine Legislature charged the Maine Commission on Domestic and Sexual Abuse with the task of establishing a Domestic Abuse Homicide Review Panel to "review the deaths of persons who are killed by family or household members." The legislation mandated that the Panel "recommend to state and local agencies methods of improving the systems for protecting persons from domestic and sexual abuse including modifications of laws, rules, policies, and procedures following completion of adjudication." The Panel was further mandated "to collect and compile data related to domestic and sexual abuse." 19-A M.R.S. §4013(4). See [Appendix A](#) for the complete language of the Panel's enabling legislation.

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

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

## MISSION STATEMENT

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



# SUMMARY OF CASE DATA

## 13<sup>TH</sup> BIENNIAL REVIEW PERIOD

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### Introduction

This biennial report addresses the fatality reviews completed by the Maine Domestic Abuse Homicide Review Panel since 2018. The Panel reviews domestic abuse homicide cases after sentencing or acquittal, and domestic abuse homicide-suicide cases after investigations are complete.

During the period established for this review, the Panel reviewed nineteen cases involving domestic abuse, which occurred from 2014 to 2019. Of the cases, eighteen were classified as domestic abuse homicide cases and one was classified as a suicide preceded by prolonged intimate partner violence. A total of twenty perpetrators in the cases reviewed were responsible for twenty-one victims of domestic abuse homicide, one suicide, and one victim of serious injury who was a bystander.

In the current biennial review period, the following homicides occurred in Maine:

- In 2018, nineteen perpetrators committed twenty homicides, nine of which the Department of Public Safety categorized as domestic abuse homicides.
- In 2019, nineteen perpetrators committed twenty-two homicides, nine of which were categorized as domestic abuse homicides.

**Together, these eighteen domestic abuse homicides accounted for nearly 43% of Maine’s total homicides during this two year period.** Homicide lists from the Maine Department of Public Safety may be found in [Appendix B](#) of this report.

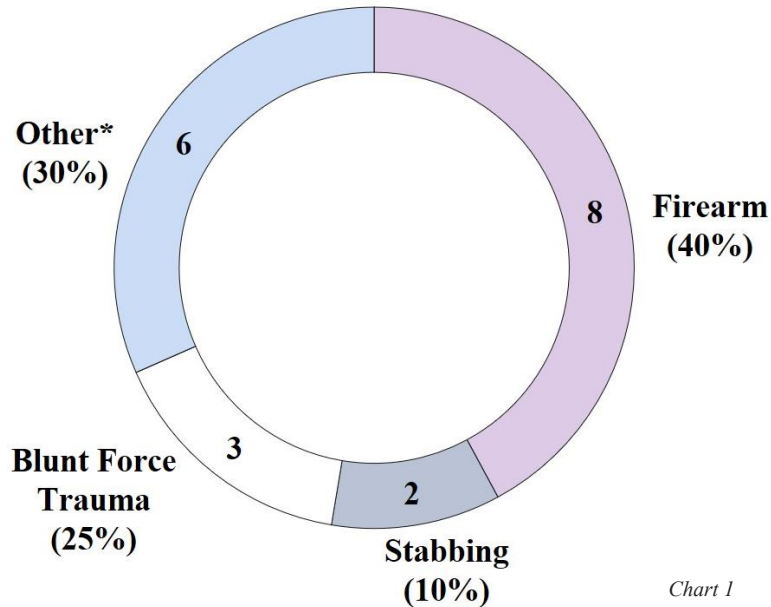
According to the Violence Policy Center’s recent study, “When Men Murder Women: An Analysis of 2018 Homicide Data,” Maine ranked 24<sup>th</sup> in the nation for single male offender and single female victim homicides. See: <https://vpc.org/studies/wmmw/2020.pdf>



## 2020 Biennial Review Cases: Domestic Abuse Homicide Data

(All data used throughout this report has been rounded to the nearest whole percent)

### Method of Homicide by 19 Perpetrators



### TRENDING DATA:

*As depicted in Chart 1, and as reflected in every prior report of this Panel, perpetrators most commonly used firearms to commit domestic abuse homicides.*



*Of the 19\*\* perpetrators of homicide responsible in the cases reviewed by the Panel:*

*8 of 20 perpetrators used a firearm to kill 10 victims and seriously injure 1 other*

*3 of 20 used blunt force trauma/objects to murder 3 victims*

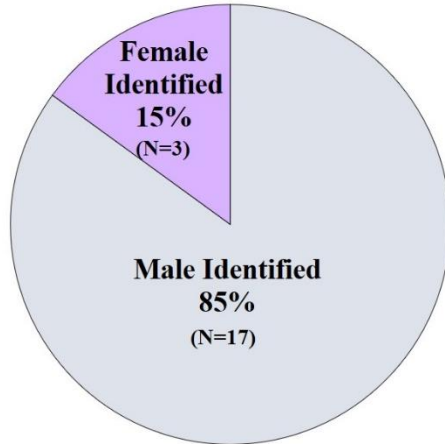
*2 used knives to kill 3 victims*

*\*6 of the 20 perpetrators used other methods to kill 6 victims; 4 used their hands to kill 4 victims, of these 3 also used objects; 1 asphyxiated his victim; and 1 used a pair of scissors to stab and kill his victim*

*\*\* (1 perpetrator, who is not reflected in this chart, committed years of abuse against the victim who died by suicide)*

## 2020 Biennial Review Cases: Domestic Abuse Homicide Data

**20 Domestic Abuse Homicide  
Offenders by Gender**



**22 Domestic Abuse Homicide  
Victims by Gender**

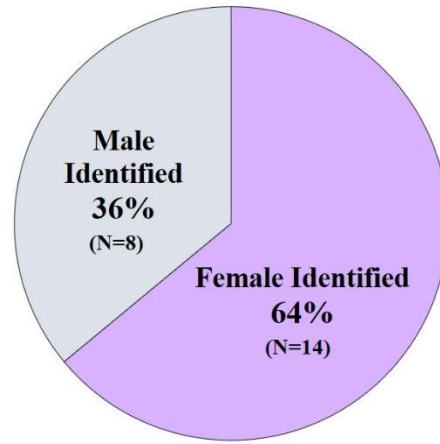
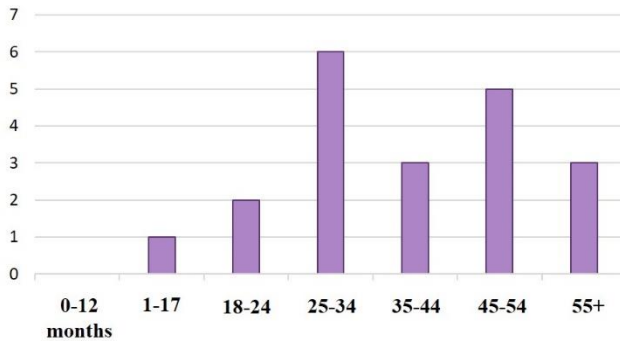
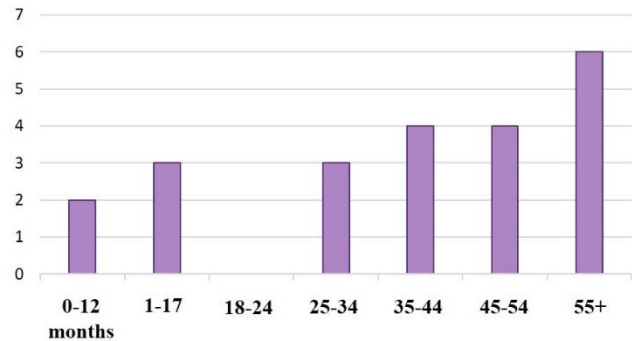


Chart 2

**20 Domestic Abuse Homicide  
Offenders by Age**



**22 Domestic Abuse Homicide  
Victims by Age**



Graph 1

The ages of the 20 perpetrators ranged from 17 years to 82 years old.

*\*One of the perpetrators of intimate partner homicide also committed intrafamilial homicide, and is detailed in both categories below*

**8 of the 11** perpetrators who committed intimate partner homicide were **between the ages of 25-54**.

**All 10 of the perpetrators** who committed intrafamilial homicides were under the age of 55, and **half were under the age of 35**.

For the 22 homicide victims and 1 victim of serious injury in the cases reviewed, ages of the parties ranged from 7 weeks to 78 years old.

*\*Serious injury not included in above data set*

**6 victims** were **55 or older**, **12 victims** were **under the age 40**, and **5 victims** were just **10 years of age or younger**.

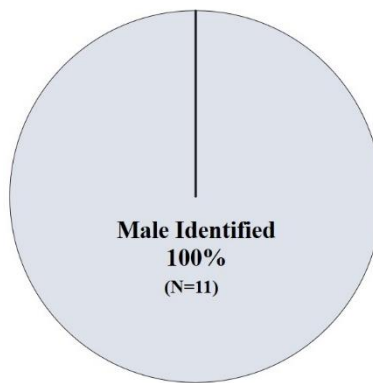


## 2020 Biennial Review Cases: Intimate Partner and Intrafamilial Homicide Data

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

The cases reviewed during this two-year period involved a total of eleven perpetrators and twelve victims of intimate partner homicide, and one related serious injury. These included ten female and two male victims of homicide, plus one male serious injury victim: nine men killed their current or former female intimate partners, of these, one father killed his female partner, his adult son, a neighbor, and then seriously injured another neighbor; one man killed his live-in male partner; one female victim died by suicide after prolonged exposure to intimate partner violence. *100% of perpetrators of intimate partner homicide during this review period were male.*

**11 Intimate Partner Homicide Offenders by Gender**



**12 Intimate Partner Homicide Victims by Gender**

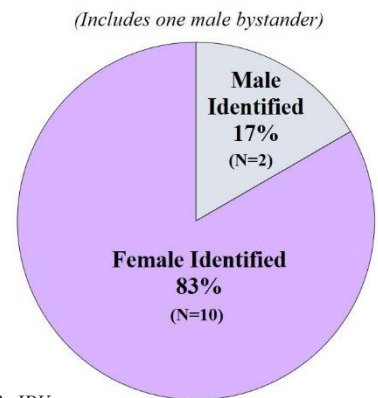
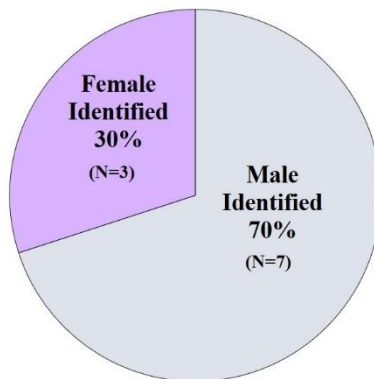


Chart 3- IPV

There were an additional nine perpetrators responsible for the ten victims in total of intrafamilial homicide. These included four female and six male homicide victims: two fathers killed their infant sons; one son killed both of his parents; one adult son killed his father; one adult grandson killed his grandmother; one stepfather and mother killed their daughter; one mother killed her infant son; and one step-grandmother killed her granddaughter.

**10 Intrafamilial Homicide Offenders by Gender**



**10 Intrafamilial Homicide Victims by Gender**

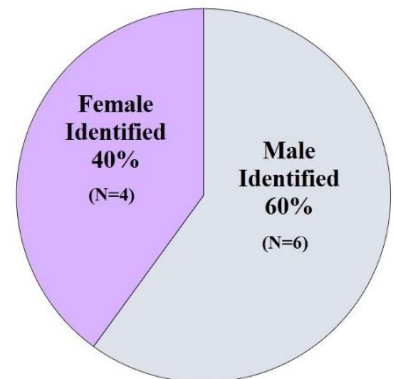


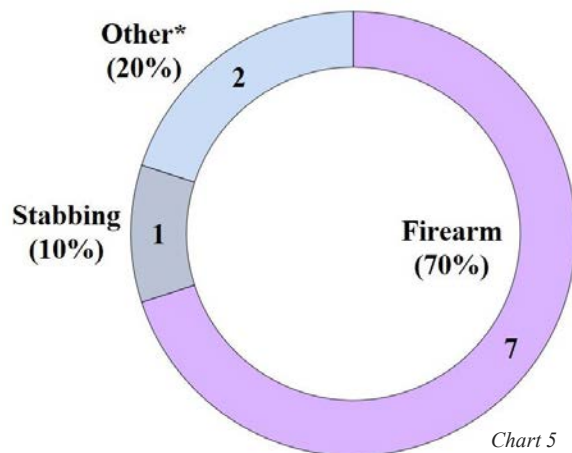
Chart 4- IFV

## 2020 Biennial Review Cases: Intimate Partner Homicide Data

Of the nineteen cases reviewed by the Panel, eleven involved intimate partner homicide. Nine men killed their current or former female intimate partners, and of these, one man also killed an additional bystander and seriously injured another. One man killed his male intimate partner, and one man abused his female intimate partner who died by suicide.

### Method of Intimate Partner Homicide by Perpetrator

(Includes cases with multiple victims)



### Of these 11\* IPV homicides:

7 perpetrators **killed 8 victims using a firearm**

1 perpetrator **killed a victim with a knife**

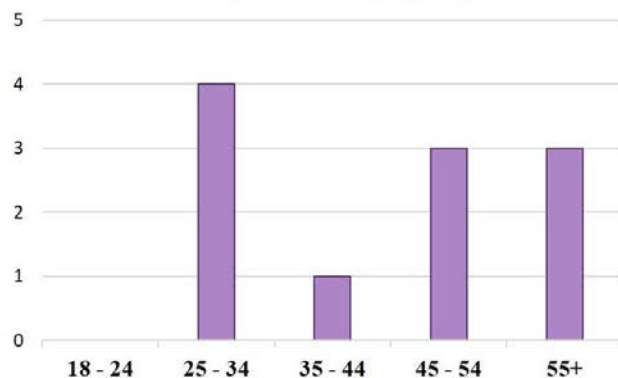
\*2 perpetrators **used other objects to kill 2 victims** (scissors, baseball bat)

(1 perpetrator, who is not reflected in this chart, committed years of abuse against the victim who died by suicide)

### TRENDING DATA:

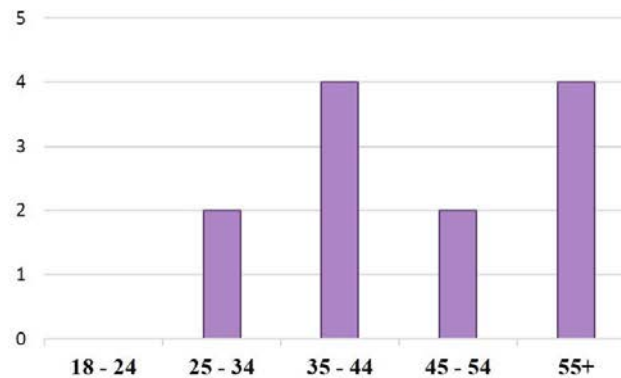
**Perpetrators most commonly use firearms to commit intimate partner violence homicide in Maine.**

### 11 Intimate Partner Homicide Offenders by Age



The ages of the perpetrators in these cases ranged from 27 to 82 years old.

### 12 Intimate Partner Homicide Victims by Age



Graph 2

The ages of the victims ranged from 30 to 67 years old.

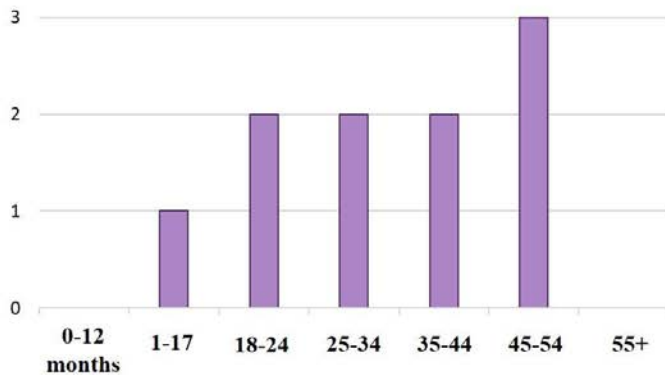
**6 of the victims were under the age of 40.**



## 2020 Biennial Review Cases: Intrafamilial Homicide Data

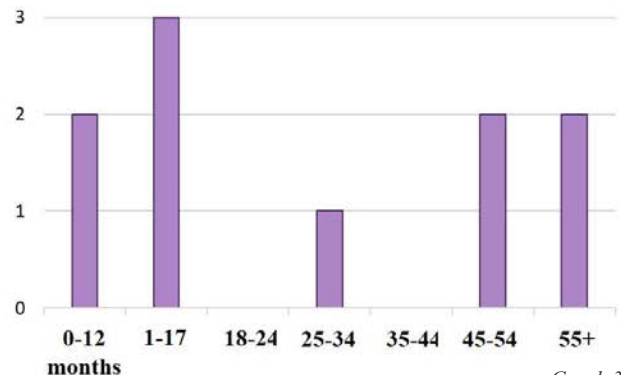
The Panel reviewed nine cases involving people who killed family members other than intimate partners. In these cases, ten perpetrators killed ten people. One case involved two perpetrators, and one case involved both intrafamilial and intimate partner homicide, and so that perpetrator is represented in both data sets.

**10 Intrafamilial Homicide Offenders by Age**



The ages of the perpetrators in these cases ranged from **17 to 54 years old**.

**10 Intrafamilial Homicide Victims by Age**



Graph 3

The ages of the victims of IFV homicide ranged from **7 weeks to 78 years old**.

**TRENDING DATA:**

*In the context of intrafamilial homicide, perpetrators of all ages place children and older adults at greatest risk.*

**Method of Intrafamilial Homicide By Perpetrator**

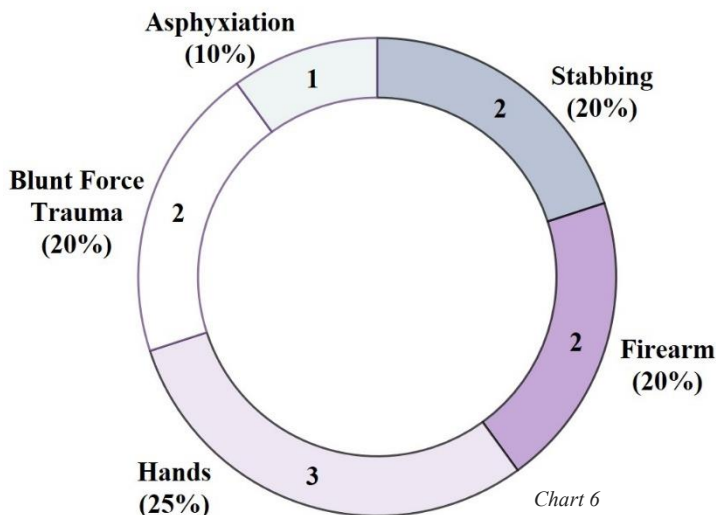


Chart 6

**Of these 10 IFV homicides:**

- 4 perpetrators used their hands to kill 3 victims*
- 2 perpetrators killed 2 victims using a firearm*
- 1 perpetrator used a knife to kill 2 victims*
- 2 perpetrators killed 2 victims by blunt force trauma*
- 1 perpetrator asphyxiated 1 victim*

## 2020 Biennial Review Cases: Children

### Impacts of Offenders on Children

*Offenders have devastating and lasting impacts on children. **People who commit abuse and violence do not see children as people with equal value**, as evidenced by the cases reviewed in which twenty perpetrators directly changed the lives of twenty-three children under the age of 18. The Panel reviewed five cases when children were directly murdered by their family members. In addition, multiple cases involved offenders who otherwise subjected children to domestic abuse and trauma. (Some perpetrators committed abuse in more than one category.)*

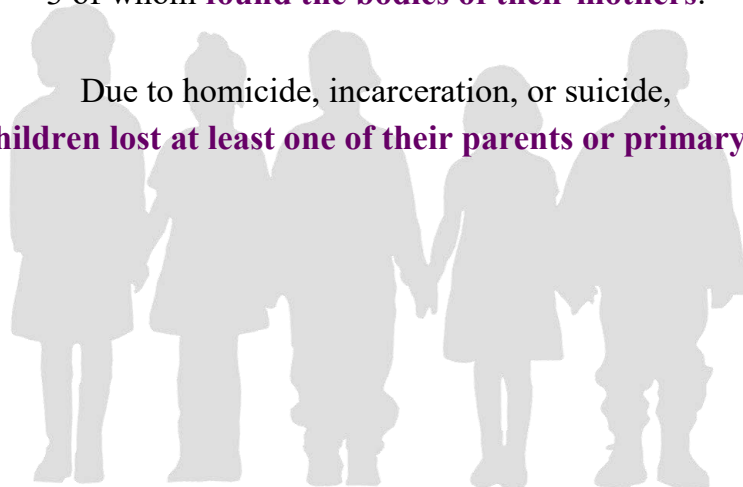
5 of the 20 perpetrators **ended the lives of 5 children**.

9 perpetrators **directly abused children** in their care.

5 of the 20 perpetrators killed women who were **mothers to 10 children**.

**10 surviving children were home** at the time a homicide occurred,  
3 of whom **found the bodies of their mothers**.

Due to homicide, incarceration, or suicide,  
**16 minor children lost at least one of their parents or primary caregivers.**



Futures without Violence and the National Child Traumatic Stress Network have published helpful information and resources on children impacted by domestic violence. See <http://www.nctsn.org/content/resources>

## 2020 Biennial Review Cases: Involvement with Community

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

<b>Community/Service Involvement with Parties by Intimate Partner Homicide (IPV) &amp; Intrafamilial Homicide (IFV)</b>		
	<b>IPV</b>	<b>IFV</b>
Working with Community-Based Advocacy Organization <sup>1</sup>	2	0
DHHS involvement (active or prior)* <i>*Record of 4 mandated reports having been made</i>	3	6
Treatment of Substance Use Disorder (active or prior)	1	2
Protection from Abuse Order	0	0

Table 1

## 2020 Biennial Review Cases: Status of Perpetrators

<b>Status of 20 Perpetrators Who Committed Homicide by Intimate Partner Homicide (IPV) &amp; Intrafamilial Homicide (IFV)</b>		
	<b>IPV</b>	<b>IFV</b>
Found guilty and incarcerated <i>(5 years federally to 55 state)</i>	6	7
Suicide after committing homicide	5	1
Killed by law enforcement/legally justified	1	0

Table 2

<sup>1</sup> “Community-based advocacy organizations” include the Maine Coalition to End Domestic Violence (MCEDV), the Wabanaki Women’s Coalition (WWC), and the Maine Coalition Against Sexual Assault (MECASA) and all of their member programs, including the Immigrant Resource Center of Maine.



## CONNECTING THEMES:

### Family Members, Friends, Neighbors, & Co-Workers

In fourteen of the nineteen cases reviewed by the Panel, family, friends or co-workers were aware of domestic abuse occurring in the relationship of the perpetrator and the victim. In the cases reviewed, friends and family of the victims tried to assist victims by talking with them about Protection from Abuse Orders, calling police, encouraging or helping them to move out, assisting the victim with retrieving belongings, and following up with the victim after witnessing abuse.

**Key relationships in a victim's life can be a source of support and assistance in situations of abuse.** The family, friends and co-workers of a victim can play an important role in preventing the abuse and death of victims. The Panel recognizes that people who are abusive may also present risks to those who help victims. The Panel emphasizes that **anyone who is aware of a person who is committing abuse against a current or former intimate partner or family member can contact a community-based advocacy organization for support and resources to safely help victims.** In addition, encouraging victims of abuse to contact community-based advocacy organizations could help break their isolation, connect them with safety planning services, and potentially save their lives.

## Perpetrator Tactics Prior to the Homicide

Domestic abuse is a pattern of behavior over time, not isolated incidents of physical or sexual violence. Perpetrators of domestic abuse use an array of coercive behaviors to assert and maintain power and control over their intimate partners, children, and family members. These behaviors are intentional and designed to enforce compliance through fear, based on the perpetrators' beliefs that they have the right to limit the human and civil rights of their intimate partners, children, and family members.



DOMESTIC ABUSE INTERVENTION PROJECT  
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*The Power and Control Wheel is a diagram that includes examples of the tactics that people who commit domestic abuse and violence use against their current/former intimate partners. Created in 1984 by domestic abuse survivors, this tool is used worldwide to support and/or educate individuals, communities, and professionals across many fields. The Wheel is available in multiple languages and has been adapted culturally as well. A powerful outreach tool, the Wheel validates the common experiences of victims/ survivors, provides a framework for exploring the tactics used by those who are abusive, and informs safety strategizing with advocates and other professionals.*

*The center of the Wheel is labeled Power and Control, naming the result of and intention behind the tactics in the spokes and rim. The rim of the Wheel represents physical and sexual violence, the threat or presence of which frames and enables the other tactics named in the spokes.*



## **The Prevalence of Suicidality, Stalking, Strangulation, Sexual Abuse, and Serial Battering**

In this and all past reports, the Panel has observed several dangerous and prevalent tactics employed by perpetrators of homicide. The Panel recommends that all people and systems who are concerned about or respond to perpetrators and/or victims of domestic abuse and violence identify these tactics as abusive and lift this information to support interventions and safety measures. Many of these tactics are recognized as crimes in Maine. In the cases reviewed, prior to the homicides and the case in which the victim died by suicide, perpetrators frequently used five high-risk tactics: suicidality, stalking, strangulation, sexual abuse, and serial battering.

The Panel recognizes that people often commit abuse that is unreported or undocumented. The Panel's information about tactics used in these cases is limited to the documentation available, which while instructive and in many cases extensive, may not capture the full scope of the abuse and violence. The perpetrator tactics described in this section are those apparent from the documentation.

- 1) **Suicidality** – The Panel continues to review cases in which the perpetrator displayed signs of suicidality prior to the homicide, often dying by suicide after committing homicide. In the cases reviewed in the last biennium, 35% (7 of 20) of the perpetrators died by suicide after killing an intimate partner or family member. Perpetrators' suicidality is a consistent sign of lethal danger to victims of domestic abuse and to the perpetrators themselves. The Panel's biennial review periods reinforce that suicidality is strongly linked to homicidality, with an average of 50% and as many as 69% (9<sup>th</sup> HRP report, p. 13) of perpetrators exhibiting suicidal behavior prior to attempting or committing homicide. In all professional sectors, any protocols and training regarding responses to domestic abuse and violence should address the connection between suicidal ideation and homicide. The Panel encourages every community member to identify the increased risk to victims when people committing abuse are suicidal, and reach out for assistance with these dangerous situations.
- 2) **Stalking** – Stalking an intimate partner is a dangerous and prevalent tactic of abusers and a powerful form of coercive control. In the cases reviewed in the last two years, 30% (6 of 20) of the perpetrators stalked the victims prior to committing homicide. In past reports, the Panel has observed that at least 50% of the perpetrators stalked their victims prior to committing homicide. While dangerous and prevalent, the Panel observes that stalking is often overlooked or minimized by people surrounding the perpetrator and victim. The emergence of extensively available and easy-to-use technology has given people who commit abuse heightened ability to control, monitor, and track victims. The Panel observes that people who commit stalking use social media to maintain a presence in the victims' lives, to share shaming images, to harass and intimidate, and create false narratives about themselves and the victims. People who manipulate through social media may further isolate victims away from other people, including service providers. Email and texting are also prevalent forms of misusing technology to commit abuse including stalking. The Panel has reviewed cases involving extensive and public stalking prior to homicides that was not reported, investigated, or prosecuted.

- 3) **Non-Fatal Strangulation** – Maine law defines strangulation as “impeding the breathing or circulation of the blood of another person by intentionally, knowingly or recklessly applying pressure on the person’s throat or neck” (17-A M.R.S. §208(C)). Beginning with its 10<sup>th</sup> report in 2014, the Panel has observed that at least 25% of the perpetrators non-fatally strangled the victims prior to committing the homicides. Women who experience non-fatal strangulation are 750% more likely to be killed. This remains true for the Panel’s current biennial review period in which 25% (5 of 20) of the perpetrators committed non-fatal strangulation against the victims prior to the homicides. It is crucial for survivors, first responders, and bystanders to recognize the prevalence and extremely dangerous effects of non-fatal strangulation, a life-threatening and often repeated tactic of domestic violence.
- 4) **Sexual Abuse** – Sexual abuse is a common tactic of coercive control used by perpetrators of domestic abuse and violence to assert ongoing dominance over victims. In this biennium, 20% (4 of 20) of the perpetrators were known to have sexually abused the victims. In its 12<sup>th</sup> report, the Panel observed that 27% of the perpetrators had sexually assaulted the victims during their relationships before killing them, and multiple perpetrators of homicide in that two years of cases had histories of sexual abuse against previous intimate partners.
- 5) **Serial Battering** – Serial battering refers to perpetrators who commit domestic abuse and violence successively against multiple intimate partners, creating immense cumulative harm. In the Panel’s most recent biennial review period, 15% (3 of 20) of the perpetrators committed serial battering. In its 12<sup>th</sup> report, the Panel observed that 53% of the homicide perpetrators had a history of abusing intimate partners or family members.

The Panel recommends that all system professionals engage in regular opportunities to educate themselves and refresh their understanding of the dynamics and appropriate responses in high risk domestic violence cases, including known lethality factors and suicide concerns. In high risk cases in which professionals are involved but not attuned to potential dangers, victims become even more vulnerable and perpetrators are empowered.

### **Additional Perpetrator Tactics**

The Panel continues to observe additional repeated perpetrator tactics prior to the homicides in the cases reviewed, reflective of the tactics on the Power and Control Wheel. The Panel notes them here with the cumulative prevalence among cases reviewed in the Panel’s last three reports, when the Panel began to note these tactics:

**Physical Abuse** – At least 69% of the perpetrators physically abused the victims prior to the homicides. 75% (15 of 20) of perpetrators physically abused the victims in the cases from the current biennium.

**Emotional/Verbal Abuse** – At least 76% of the perpetrators used emotional and/or verbal abuse as coercive and controlling tactics in the relationships with the victims prior to the homicides. 70% (14 of 20) of perpetrators in current biennium cases emotionally/verbally abused the victims.

**Previous Threats to Kill** – At least 50% of the perpetrators previously threatened homicide. This includes threats made to kill the victims in the cases reviewed as well as threats to kill others associated with the victims. 55% (11 of 20) of the perpetrators in current biennium cases previously threatened homicide.

**Isolation and Jealousy** – At least 43% of the perpetrators isolated the victims from family, friends, and other support networks. This includes incidents when perpetrators kidnapped their intimate partners. 50% (10 of 20) of the perpetrators in current biennium cases isolated the victims in this way.

### **Increasing Perpetrator Accountability: Key Areas**

In the time the Panel has been reviewing Maine homicide cases, it has raised two significant areas of concern in case after case. These areas arise from the choices and behaviors of the people who commit domestic abuse related homicides. The Panel observes that individuals and professional systems struggle to intervene effectively in these areas, and collectively fail to protect victims from the people who kill them.

#### **Firearms**

**In the Panel's 20 years of biennial reviews, people who commit domestic abuse related homicide have used firearms more than any other method to kill.** In current biennium cases, 40% (8 of 20) of perpetrators used firearms and 60% (12 of 20) had legal access to or owned firearms.

In cases when the perpetrator was prohibited from possessing firearms, the Panel has frequently observed gaps in the enforcement of civil Firearms Relinquishment Orders that accompany qualifying Protection from Abuse Orders, as well as enforcement of laws that otherwise prohibit persons from owning or possessing firearms. The Panel observes that removing firearms from dangerous individuals and/or people known to be legally prohibited from possessing firearms can enhance safety and minimize the risk of injuries and lethality. The Panel has repeatedly and continues to recommend:

- Consistent and effective enforcement of Firearms Relinquishment Orders granted with Protection from Abuse Orders.
- Development of statewide policies and procedures to ensure the relinquishment of firearms to law enforcement by persons legally prohibited from possessing them. This should include that when a person is released from a jail or correctional facility with conditions of release that prohibit the use or possession of firearms or other dangerous weapons, upon their release, they be notified/reminded of the condition and that it be asked and documented if they have any weapons/firearms that must be removed/relinquished. The Panel notes that a multi-disciplinary subcommittee of the Maine Commission on Domestic and Sexual Abuse is currently engaged in this work, advancing the Panel's recommendations in past reports.

- Recognition by everyone – bystanders and all professional disciplines – of the significant connection among suicide, homicide, and firearms, and the importance of involving law enforcement to secure or remove firearms to prevent tragedy. Maine’s “Yellow Flag Law” (34-B M.R.S. §3862-A) provides a mechanism for temporarily removing firearms and other dangerous weapons from persons who are medically assessed to be at substantial risk in the foreseeable future of committing serious physical harm to themselves or others. Following the medical assessment, a judge determines whether a removal of firearms is warranted.
- In its current review period, the Panel noted that victims of domestic violence may acquire firearms to assist in their personal protection due to risks from a person who commits domestic abuse and violence against them. The Panel recommends that bystanders who receive disclosures from victims of domestic violence, or otherwise become aware that victims acquire firearms, should be aware that the presence of firearms may lead to increased danger for victims. The Panel encourages bystanders to assist victims in contacting community-based advocacy organizations to explore high risk safety planning in situations when victims are so afraid that they have acquired firearms for their protection.

## Collusion

The Panel has consistently observed how people who commit abuse seek collusion from others in the community, including in the professional sectors interacting with them. The goal of perpetrators is to avoid accountability for their abusive actions. Collusion here refers to the unfortunate and dangerous spectrum of responses from bystanders and professionals who: fail to identify abusive tactics; minimize the effects of abuse; mischaracterize domestic violence as “mutual” conflict or discord; agree with the abusive person that their abusive behaviors are justified; and/or support the abusive person’s belief that the abuse only “happens” because of the behaviors and characteristics of the victim.

One measure of collusion is how people in victims’ lives, even when well-meaning and concerned for victims’ safety, typically focus on the decisions and actions of victims, rather than the behaviors and choices of the people committing abuse. People around the victim may hope and/or believe that a change in the victim’s choices will stop the abuse and violence. This mistakenly implies that it is the victim’s presence and behaviors that cause the abuse in the first place. The Panel has reviewed post-trial surveys of jurors and observed the impact of this focus on victims’ actions manifesting in jurors’ reluctance to convict those who have committed egregious violence; jurors focused instead on the question of why the victim was still in relationship with the perpetrator when the crime(s) occurred. **The Panel observes that while victims can and do take action to try to stop the abuse and keep themselves and their children safe, ultimately, the abusive behaviors – up to and including homicide – are the sole responsibility of those who perpetrate the harm.**

The Panel observes that after homicides, bystanders may come forward to say they did not observe the perpetrator’s violence and aggression or did not understand the level of risk. Domestic abuse and violence involve methods of ongoing manipulation against a victim. The tactics of

manipulation, minimizing, denying or blaming, may result in bystanders not believing victims and instead supporting the person committing abuse.

The challenge for all professionals and bystanders is to avoid aligning with perpetrators of domestic abuse and violence. The Panel observes that when people accept justifications for abusive and violent behavior that deny abuse happened, minimize the harm done, and blame the victim for causing the abuse or failing to stop it by better protecting themselves, this is collusion with the perpetrator.

*“In order to escape accountability for his crimes, the perpetrator does everything in his power to promote forgetting. Secrecy and silence are the perpetrator’s first line of defense. If secrecy fails, the perpetrator attacks the credibility of his victim. If he cannot silence her absolutely, he tries to make sure that no one listens. To this end, he marshals an impressive array of arguments, from the most blatant denial to the most sophisticated and elegant rationalization. After every atrocity one can expect to hear the same predictable apologies: it never happened; the victim lies; the victim exaggerates; the victim brought it upon herself; and in any case it is time to forget the past and move on. The more powerful the perpetrator, the greater is his prerogative to name and define reality, and the more completely his arguments prevail.”*

— *Judith Lewis Herman, Trauma and Recovery: The Aftermath of Violence - From Domestic Abuse to Political Terror*



# **OBSERVATIONS & RECOMMENDATIONS**

The Panel established the tradition of making observations and recommendations to various systems and organizations based on its analysis of the domestic abuse homicide cases reviewed for each report. Marking 20 years of biennial reviews, the Panel has chosen in this report to bring focus to recurring themes of observations and recommendations from its twelve previous reports related to public services and institutions, professional disciplines, and the community.

## **Summary of Observations:**

The process of reviewing domestic violence homicides is instructive because it provides for in-depth, retrospective review and analysis of the lives of victims and perpetrators following homicides. The Panel recognizes that most domestic violence offenders do not ultimately commit homicide and that – fortunately – there are far more survivors of domestic abuse and violence than victims of domestic violence homicide. Maine has made progress; however, there is more to be done. The Panel observes the need for everyone to learn to recognize the dynamics of domestic abuse, how to support accountability for someone committing abuse, how to be helpful to a victim, and what resources are available to each of us. This fundamental approach applies to people in their personal and professional spheres.

In the Panel's reports over these 20 years, several observations are consistently apparent:

1. People close to the victim – family, friends, neighbors, coworkers – have been aware of the abuse and concerned about what might happen, but unaware and unsure of how to be helpful.
2. Professionals who interacted with the offender and/or victim prior to the homicide did not follow the best practices and/or policies of their disciplines intended to ensure that they identify abusive individuals and initiate appropriate interventions to prevent further harm, including failure to:
  - a. Ask about/screen/investigate fully for domestic abuse;
  - b. Refer to appropriate community-based advocacy organizations;
  - c. Make legally mandated reports to Child or Adult Protective Services; and/or
  - d. Document the above.
3. Perpetrators of domestic violence homicides have frequently:
  - a. Threatened to commit suicide and/or homicide;
  - b. Used the methods of strangulation and stalking to harm their victims;
  - c. Exposed their children or stepchildren to violence and verbal abuse against their mothers and subjected the children to abuse and neglect;
  - d. Been charged with domestic violence related crimes prior to the homicide;
  - e. Received sentences for previous crimes that did not prohibit them from possessing firearms (as the initial charges would have done) and did not require Certified Batterer Intervention Program completion.

4. Adult victims of domestic violence homicides have typically:
  - a. Not sought assistance from community-based advocacy organizations;
  - b. Not obtained Protection from Abuse Orders;
  - c. Told someone that they were afraid the abuser would kill them.
  
5. Child victims of domestic violence homicides have typically:
  - a. Been subjected to generational, severe, and ongoing physical and verbal abuse in a context of isolation and neglect;
  - b. Experienced intense pressure not to disclose their experiences, due to consequences to them and their families;
  - c. Had their suffering and injuries go unnoticed and/or unacknowledged by their extended families and the professionals with whom they had contact;
  - d. Not received age-appropriate and child-centered assessments and interventions by the professionals with whom they had contact;
  - e. Had no access to trauma-informed intervention programs when they survive domestic abuse, including the homicide of a parent or other family member.
  
6. Older adult victims of domestic violence homicides have often been caregivers or companions to those who kill them:
  - a. Their adult children who have untreated chronic mental illness, substance use, or personality disorders. In these cases, the older adult victims:
    - i. Have sought but been unable to obtain behavioral health and other services to replace themselves as caregivers;
    - ii. Have been reluctant to involve the criminal justice system;
    - iii. Have been reluctant to obtain Protection from Abuse Orders.
  - b. Their spouses of many years. In these cases:
    - i. Isolation and resulting lack of available information have led others including family, friends, and the media to be unsure whether to characterize the homicide/suicide as a “pact” at end of life, or a result of the perpetrator’s position of power and control over his wife;
    - ii. The perpetrators, in all the Panel’s reviews of this type of case, have been men.

## **Summary of Recommendations:**

The Panel’s recommendations from the most recent biennial review period mirror many of those brought forward in past reports. In recognition of the Panel’s twenty years of biennial reviews, new recommendations are presented in summary form and by system, in the context of our previous years’ recommendations.

Overall, the Panel recommends sustained and expanded efforts to maintain and expand Maine’s Coordinated Community Response (CCR) to domestic violence. “Coordinated Community Response” refers to an interconnected and multidisciplinary approach to ending domestic violence by enhancing abuser accountability and supporting victim safety. Since the early 1990s, CCR efforts have been nationally funded and supported with training and technical assistance to enhance prevention and intervention strategies. CCR work involves the criminal and civil justice systems,

community-based advocacy organizations, healthcare and behavioral health organizations, faith communities, child welfare organizations, Certified Batterer Intervention Programs, schools, government agencies, and many others. CCR efforts focus on facilitating new connections and strengthening existing relationships, and may take the shape of task forces, CCR teams, and high-risk response teams. One desired outcome is a strong mutual understanding of the roles of various agencies and systems. Another outcome is an overall higher understanding of the dynamics of domestic abuse and violence, that results in less successful manipulation of systems by perpetrators who consistently seek collusion from others.

An effective CCR creates and maintains interagency, coordinated approaches to the larger issue of domestic violence as well as to individual cases. CCR teams and response protocols establish a coherent process, helping to ensure that victims receive consistent, comprehensive services and referrals, and offenders are held accountable across all parts of their community involved. Methods used by CCR teams may include development of CCR risk assessment and management protocols, internal information-sharing and training, community awareness and prevention campaigns, case reviews, and management of high risk cases by multidisciplinary teams. The coordination of all agencies through a sustained, involved CCR has been demonstrated to have a positive impact on victim safety and offender accountability.

The Panel is a part of Maine's CCR, as a statewide fatality review team that brings together a multidisciplinary group of people to review cases and identify strategies to prevent homicides. After 20 years of biennial reviews in a rapidly changing world, the Panel remains committed to its mission of identifying gaps in prevention and intervention and bringing attention to those for improvement of all communities, organizations and systems in Maine.

### **The Criminal and Civil Justice Systems**

Through its 20 years of reports, the Panel has recognized gaps in the legal system and has recommended improvements to the law, policy and practice that structure the work of law enforcement officers, prosecutors, judges, corrections/probation officers, and advocates. The Panel observes that significant efforts have strengthened the justice system participation in the Coordinated Community Response and its response overall to perpetrators and victims of domestic abuse and violence. However, the Panel has consistently seen the effectiveness of these systems fail when individuals or agencies do not adhere to best practices for their disciplines. Because the Coordinated Community Response is centered on the criminal and civil justice systems to increase offender accountability and enhance victim safety, the Panel often directs many of its recommendations to these systems.

In past reports and now also including the cases that were part of its most recent biennial review period, the Panel has repeatedly recommended the following areas of improvement for Maine's criminal and civil justice systems:

#### ***Law Enforcement***

- Ensure access by all law enforcement agencies to specially trained Domestic Violence Investigators located either within the Offices of the District Attorney or law enforcement

agencies to support thorough evidence collection and investigative follow up in domestic violence cases. Domestic Violence Investigators are currently available in several agencies and regions of the state to consult and inform development of additional programs. The Panel recognizes that establishing permanent funding for these positions is challenging, but such specialization is an essential component of homicide prevention.

- Follow the best practices for law enforcement response to domestic violence related incidents. These are embodied in the Maine Criminal Justice Academy (MCJA) mandatory minimum standards, the Maine Chiefs of Police Association (MCOPA) model policy, and training through the Maine Criminal Justice Academy. When officers do not follow best practices, it may have the impact of empowering perpetrators and making victims more vulnerable to abuse. The Panel particularly recommends that officers maintain vigilance after repeated calls for service regarding the same couple or family, as this indicates high risk. **The current MCJA standards, MCOPA policy, and Best Practices Card for Law Enforcement Response to Domestic Violence are all included in [Appendix C](#).**
- Include questions about non-fatal strangulation in all interviews with victims, at every call for service, no matter the initial impression of whether an assault has occurred. The prevalence and dangerousness of offenders who use non-fatal strangulation requires this.
- Increase training, focus, and law enforcement attention on high risk offenders, including when investigating incidents over time involving the same people. Repeat calls for service indicates higher risk, not less. Identify high risk offenders through the Ontario Domestic Assault Risk Assessment (ODARA) and consideration of other known lethality indicators (strangulation, sexual abuse, suicidality, stalking, serial battering, threats to kill, etc.). Local CCR efforts including task forces, high risk response teams, and specialized interagency training enhance and support risk assessment and management. Individuals, organizations and systems can connect with the community-based advocacy organization in their area to learn what CCR efforts are underway and how to support and/or participate in these initiatives.
- Refer victims of intimate partner violence and intrafamilial violence to the services of the community-based advocacy organizations and document this in investigative reports, as required under 19-A M.R.S. §4012(6)(C) and MCJA Policy 3, standard #15. The Panel notes the importance of making these referrals in cases that lack evidence to support probable cause to make an arrest.
- Provide information to victims of intimate partner violence and intrafamilial violence about Protection from Abuse Orders and document this in investigative reports, as required under 19-A M.R.S. §4012(6)(C) and MCJA Policy 3, standard #14. The Panel notes the importance of making these referrals in cases that lack evidence to support probable cause to make an arrest.
- Share investigative reports with domestic violence/sexual assault advocates for the purposes of safety planning with victims, pursuant to 16 M.R.S. §806.

- In cases where perpetrators cross state lines to commit crimes involving domestic violence or other crimes, a victim of domestic violence is reported missing, or the perpetrator possessed a firearm illegally, law enforcement agencies should consider involving the FBI and/or the U.S. Attorney's Office in the investigation and prosecution.
- Conduct internal agency reviews required by MCJA Policy 3, Standard #23\* whenever a domestic violence offender commits homicide or harm resulting in serious injury during the time a permanent Protection from Abuse Order is in effect or when there was past agency involvement with the people involved. As required, include a domestic violence advocate in this review process, and provide the reports on these reviews to the Maine Office of the Attorney General for inclusion in the Panel's case reviews.
- Add training about officer and agency responsibilities related to domestic violence to required training for new police chiefs statewide.
- Engage in training and critical incident debriefing to address vicarious/secondary trauma and compassion fatigue. Responding to domestic violence incidents over a career may have a cumulative effect, as may repeat calls for service involving the same people. Responding to serious injury cases and homicides may be especially traumatic.

*\*The policy states: Requirement that an agency review its compliance with all applicable provisions of this policy in the event that a victim of domestic violence who resided in the agency's jurisdiction is killed or seriously injured during the time that any temporary or permanent Protection from Abuse Order was in effect or if there had been past agency involvement related to interactions between the perpetrator and the victim. The review shall be conducted in consultation with a domestic violence advocate as defined in 16 M.R.S. §53-B(1)(A) and a sworn law enforcement officer designated or trained as a domestic violence investigator. A report of such review must be kept on file by the agency. In any case where one or more victims are killed, a copy of the report shall be forwarded to the Maine Domestic Abuse Homicide Review Panel through the Office of the Attorney General.*

### ***Prosecution***

- Participate in Coordinated Community Response efforts statewide and locally including task forces, high risk response teams, and specialized interagency training.
- Implement practices that account for the likelihood that many victims will not see it as safe to actively support prosecutions:
  - Center prosecution on evidence other than victim testimony.
  - Train law enforcement to investigate cases on the assumption that victim testimony will not be available.
- Communicate regularly with victims about the status, timeline, and progress of prosecution through ongoing contacts by prosecutors, victim witness advocates and/or trial assistants.
- Increase prosecution attention on high risk offenders, including when prosecuting repeat cases involving the same people. Repeat crimes indicate higher risk, not less. Identify high

risk offenders through the Ontario Domestic Assault Risk Assessment (ODARA) and consideration of other known lethality indicators (strangulation, sexual abuse, suicidality, stalking, serial battering, threats to kill, etc.).

- Charge stalking when a person repeatedly violates conditions of release or violates protective orders by contacting the victim.
- Use ODARA as one of the considerations in determining whether to use deferred disposition.
- When reducing charges and accepting pleas, consider the impact on subsequent charge enhancements and on the defendants' status regarding prohibitions to possess firearms. Consider whether the person's demonstrated course of conduct warrants those consequences.
- Address domestic violence specifically at sentencing, and involve a Pre-Sentence Investigation for a third offense, to include a dangerousness assessment. Consider a continuance before sentencing repeat offenders, to support complete information gathering, including victim input.
- Notify the appropriate law enforcement agency when a person is convicted of a crime of domestic violence that prohibits them from owning or possessing a firearm, to support relinquishment.
- Recommend Certified Batterer Intervention Programs in deferred dispositions and/or sentences as the appropriate and effective community intervention in cases involving domestic violence (17-A M.R.S. §1501(9), 17-A M.R.S. §1807(4)), rather than anger management programs or counseling, including in cases involving a child death that occurs in the context of domestic violence.
- Engage in training and critical incident debriefing to address vicarious/secondary trauma and compassion fatigue. Prosecuting domestic violence cases over a career may have a cumulative effect, as may repeat cases involving the same people. Responding to serious injury cases and homicides may be especially traumatic.

### ***Judiciary (including Bail Commissioners)***

- Participate in CCR efforts statewide and locally, including task forces and specialized interagency training for judges, guardians ad litem, and bail commissioners.
- Establish conditions on Protection from Abuse Order defendants and take an active role in determining the appropriateness of criminal sentences proposed by counsel, to align justice system remedies with Maine's statute indicating that a Certified Batterer Intervention Program (CBIP) is the appropriate and effective community intervention in cases involving domestic violence (17-A M.R.S. §1501(9), 17-A M.R.S. §1807(4)), rather than anger management programs or counseling.



- Support statewide implementation of the ODARA and integrate ODARA scores into bail commissioner and judicial decision making.
- Address the lack of ability for bail conditions to be easily and immediately discoverable by law enforcement officials in Maine and across state lines. This applies to people who commit abuse out of state and come into Maine, and to people whose bail conditions originate in Maine and they travel out of state.
- Enhance the timeliness of criminal cases coming to court.
- Clarify communication by judges and court clerks to victims about the differences among types of protective orders and other legal remedies that may be available.
- Provide a standard cover sheet to all family matter paperwork and Protection from Abuse Order complaint paperwork that provides information about community domestic violence organizations, legal assistance and law enforcement.
- Organize Protection from Abuse Order dockets to enable community-based domestic violence organization advocates to be available to plaintiffs, and rely on the work of these advocates to support docket flow, work with parties on protective order negotiations and agreements, and support victims who are completing paperwork and/or appearing in court.
- Recognize that Protection from Abuse Order complaints may not make immediately apparent the overall level of risk a defendant presents to a plaintiff.
- Connect plaintiffs with community-based domestic violence organization advocates prior to dismissing Protection from Abuse Orders.

***Corrections (Maine Department of Corrections – Probation)***

- Permanently fund specially trained Domestic Violence Probation Officers statewide to propel effective supervision of people who commit domestic violence and continue to seek control over victims through direct contact, claims of homelessness, and pressure on the victims to reunite. People who are victims of domestic abuse and violence and are on probation for related or unrelated crimes also benefit from specialized Domestic Violence Probation Officers who can respond effectively to risks these probationers face.
- Participate in Coordinated Community Response efforts statewide and locally including task forces, high risk response teams and specialized interagency training.
- Train probation officers statewide regarding domestic abuse and violence.
- Support statewide implementation of the ODARA and integrate ODARA scores into probation supervision practices and information management systems.

- Provide timely notification and communication to victims regarding the furlough and/or release of offenders, as well as safety planning in those circumstances.
- Link probation information and status to METRO<sup>2</sup> for electronic access by law enforcement officers in real time.

### ***Private Bar Attorneys (Criminal Defense and Civil)***

The Panel’s recommendations in this area largely seek to address the high prevalence of victims of domestic violence who are unrepresented or underrepresented in Protection from Abuse Order and/or criminal domestic violence related cases. In addition, the Panel has repeatedly observed the common occurrence in civil and criminal cases of court orders that direct people who commit abuse to participate in anger management programs or counseling rather than the appropriate intervention of Certified Batterer Intervention Programs.

- Explore through the Maine State Bar Association potential models for a mandated pro bono requirement for all members and develop a standard of practice related to representing parties with domestic violence related criminal or Protection from Abuse Order histories.
- Explore through the Maine Commission on Domestic and Sexual Abuse issues of access to civil-legal representation for victims of abuse, especially in rural or remote areas.
- Encourage attorneys through the Family Law Section of the Maine State Bar Association to address clients’ safety issues during initial screenings in divorce cases. Develop guidelines and training for screening/standard assessment questions.
- Be aware of Maine’s statute indicating that a Certified Batterer Intervention Program (CBIP) is the appropriate and effective community intervention in cases involving domestic violence (17-A M.R.S. §1501(9), 17-A M.R.S. §1807(4)), rather than anger management programs or counseling. Anger management and counseling are also less likely to reduce recidivism.

### ***Protection from Abuse (PFA) Orders***

The Panel’s recommendation regarding PFA Orders reflects the fact that most cases reviewed over the past 20 years involved no PFA Orders, notable because this is one of the primary civil remedies in place to protect victims of domestic violence.

- Community members and all professionals working within systems in the Coordinated Community Response to domestic violence should become informed about PFA Orders. Individuals, communities, and systems must then commit to providing information about PFA Orders as a consistent part of their personal and/or professional approach, practice, and/or policy when responding to people who are victims of domestic violence. PFA

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<sup>2</sup> METRO stands for Maine Telecommunication and Radio Operations, and is the message switching system of the Maine Department of Public Safety.

Orders are free, are available on a while-you-wait basis during court business hours, and constrain the defendant from committing further abuse or else be subject to mandatory arrest or contempt of court, depending on the violation.

## **Health and Behavioral Health Care**

### ***Health Care Professionals***

In each of its reports, the Panel has observed significant gaps in the health care system. Medical professionals on the Panel reviewed the medical records of perpetrators and victims and rarely found evidence of any screening for domestic abuse and violence. Often the only intervention point that a victim may have is through a contact with the medical community. The contact may be unrelated to domestic violence, or domestic violence may be an underlying cause for the contact. If routine screening occurs, and if domestic violence is disclosed, access to community services and remedies should be provided at that time.

Conversations between health care providers and patients that include information and dialog about abuse within family and intimate relationships have the best potential for reaching victims and offenders with the message that domestic violence is a public health concern. For these conversations to be effective, health care providers and other health care staff require special knowledge and skills, including how to pose sensitive questions, engage in culturally sensitive communication, and in provision of brief interventions and referrals to community-based advocacy organizations. Acquisition of fundamental knowledge and skills should begin during professional preparation programs; periodic education should continue in the health care setting using a variety of strategies.

In its 11<sup>th</sup> report in 2016, the Panel observed:

*“Unfortunately, the healthcare system is one of the weakest links in Maine’s efforts to provide a coordinated community response to domestic abuse.”*

In its 11<sup>th</sup> report, the Panel included extensive information for health care providers, including observations and recommendations specific to brain injury and strangulation, observing the prevalence of these injuries but lack of healthcare intervention observed in the documentation of the cases reviewed.

In each of its reports, the Panel’s recommendations to healthcare providers have reinforced the following practices:

- Adopt evidence-based instruments to screen patients (including children, teens, and older adults) at each healthcare encounter privately and regularly, and especially during pregnancy, for experiences of physical abuse and/or coercive, controlling behavior in their intimate and familial relationships. Universal screening (asking all patients about abuse at each health care encounter) is endorsed by leading medical and nursing organizations. Based on research evidence, the U.S. Preventive Services Task Force recommends that “clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services” (2018). The

screening instrument needs to be included in the electronic health record in a way that is easily accessible to the staff person who is posing the questions and responding to the patient's response to questions. In addition, the questions must be asked again at regular intervals rather than carrying forward the patient's prior responses to all future encounters.

- Appreciate that the focus of screening is less on victims disclosing abuse, and more on providing information to all patients that help is available in many forms, from many systems, when patients are ready to access services.
- Recognize that suicidal ideation by people who commit abuse is strongly linked with homicidal ideation, and ensure that assessments of patients with mental illness and/or presenting with suicidal ideation include questions regarding:
  - Domestic abuse and lethality toward other people;
  - Harm to self;
  - Possession of or access to firearms; and
  - Consent to include information from family members in the assessment to provide a more complete picture of the potential risks posed to self and others.
- Consider possible domestic abuse as the underlying cause of a myriad of symptoms such as headache, abdominal and pelvic pain, sleep disorder, or changes in mood and behavior. These symptoms are more subtle than are overt indicators of physical injury and thus require maintaining a high index of suspicion for domestic abuse in all health care encounters.
- Integrate questions regarding head trauma and post head trauma, signs of post-concussion syndrome with assessment of cognitive/emotional impairment, as well as questions about strangulation during a violent episode.
- Recognize that the postpartum period can be a difficult and/or dangerous time for a family, both in homes with or without people who commit abuse. New mothers may experience physical effects that go undiagnosed and untreated and the risk of harm or injury to children may be elevated. The Panel recommends collaboration with Public Health Nursing to ensure follow up, including home visits to families with newborns.
- If self-harm is reported by a patient or the patient's caregivers, providers should maintain a high index of suspicion of abuse and must ask age appropriate, patient-centric questions in order to ensure that the reported self-harm is not actually abuse inflicted by others.
- For each patient, it is imperative that whenever a new provider comes on board, the provider review the case with a fresh set of eyes and a fresh perspective, and with the understanding that historical case information is sometimes outdated and/or inadequate.
- Document in the medical record, recognizing its potential importance as evidence in court:
  - That screening was completed;
  - Any patient statements;
  - Photographs or documentation on body diagrams and other evidence of injuries;

- Referrals provided; and
- Mandatory reports made to the Maine Department of Health and Human Services as appropriate.
- Hospitals and all medical practices should:
  - Obtain training from a local community-based advocacy organization;
  - Collaborate with the Maine Coalition to End Domestic Violence and/or local community-based advocacy organization in the development and implementation of workplace policies to address domestic violence in the workplace; and
  - Establish referral practices to connect patients and employees affected by domestic abuse and violence with community-based advocacy organization services.
- Develop and implement comprehensive domestic violence educational programs in collaboration with the Maine Coalition to End Domestic Violence, which prepare members of the health care team including nurses, nurse practitioners, physicians, physician assistants as well as support staff such as certified medical assistants and certified nursing assistants. On-site staff education should be conducted on a regular basis for new staff and as a refresher and update for existing health care staff members. This education should at a minimum include the following critical issues:
  - Foundational education about domestic violence;
  - The myriad of ways in which victims and perpetrators may present in any health care setting;
  - The need for routine universal screening and appropriate referrals;
  - Non-fatal strangulation and head injury signs and symptoms, and care and appropriate treatment; and
  - Mandated reporting of child and incapacitated/dependent adult abuse.

### ***Licensed Behavioral Health Professionals***

In its work over 20 years, the Panel has reviewed many cases in which perpetrators and/or victims of domestic violence turned to behavioral health professionals for individual counseling and/or couples or marriage counseling. The Panel has observed inconsistent responses from behavioral health professionals who work with victims, in that some would focus on responding to common symptoms such as anxiety or depression, while others would provide support and referrals specifically related to domestic abuse. Likewise, some behavioral health professionals might work effectively with perpetrators of abuse, while others appear to miss signs of escalating danger to victims and/or the perpetrators themselves.

Informed in part by the observations and recommendations of the Panel in its reports over the previous decade, in 2013 the legislature enacted “An Act to Improve Professional Training for Licensed Mental Health Clinicians” (PL 2013 c. 262), including Psychologists (32 M.R.S. §3831(2), Social workers (32 M.R.S. §7053(1)) and licensed clinical professional counselors (32 M.R.S. §13858(2)). These laws require training about intimate partner and family violence for all licensed behavioral health professionals for licensing and renewals as of 2020.

The Panel's biennial reviews over 20 years have exposed a significant systemic gap in services for people living with severe mental illness. Intrafamilial homicides in which adult children kill their parents or caregivers often occur in circumstances when parents or other caregivers feel both unable and afraid to provide ongoing support for the affected person. However, there are insufficient resources for residential or community-based intensive support to provide an alternative.

The Panel observes the unrealistic expectations on law enforcement and the criminal justice system to address the actions of individuals experiencing behavioral health issues and the need for sufficient behavioral health supports and interventions separate from and earlier than interventions by the criminal justice system.

The Panel recognizes the need for more accessible and expanded residential and community-based treatments. Every effort should be made at the state level to maintain/augment the gains made by Medicaid Expansion, even in the face of future budget shortfalls. The Panel observes that funding and services to address behavioral health concerns were severely cut in years past. A lack of services can lead to people suffering from untreated behavioral health concerns and potential harm to those around them.

The Panel observes that behavioral health providers, and healthcare providers in general, often do not recognize intrafamilial conflicts as possible issues involving domestic violence. Failing to recognize domestic violence as a contributor to family dysfunction/conflict could increase the risk of a deadly outcome. The Panel observes the need for referrals to community-based advocacy organizations for families who are experiencing domestic violence.

In each of its reports, the Panel's messages to behavioral health professionals have reinforced the following recommendations:

- Include in any behavioral health assessments:
  - Screening for domestic abuse and violence;
  - Screening regarding possession of or access to firearms; and
  - Questions regarding consent to include information from family members in the assessment to provide a more complete picture of the potential risks posed to self and others.
- Recognize that suicidal ideation by people who commit abuse is strongly linked with homicidal ideation, and ensure that assessments of patients with mental illness and/or presenting with suicidal ideation include questions regarding:
  - Domestic abuse and lethality toward other people;
  - Harm to self;
  - Possession of or access to firearms; and
  - Consent to include information from family members in the assessment to provide a more complete picture of the potential risks posed to self and others.
- Recognize that intrafamilial conflicts may be indicators of domestic violence.



- Recognize that anger management is not the appropriate intervention for perpetrators of domestic violence and refer these patients/clients to Certified Batterer Intervention Programs.
- Develop robust community-based behavioral health services for both crisis intervention and long-term support as a critical need and essential component of intrafamilial homicide prevention.
- Behavioral health agencies and individual practitioners should:
  - Document in the case record:
    - That screening was completed;
    - Referrals provided; and
    - Mandatory reports made to the Maine Department of Health and Human Services as appropriate.
  - Obtain trauma-informed training from the Maine Coalition to End Domestic Violence and/or local community-based advocacy organization to become better equipped to observe and recognize patterns in patients who exhibit violent and or self-harming behavior;
  - Collaborate with the Maine Coalition to End Domestic Violence and/or local community-based advocacy organization in the development and implementation of workplace policies to address domestic violence in the workplace; and
  - Establish referral practices to connect clients and employees affected by domestic abuse and violence with community-based advocacy organization services.

In the current review period, the Panel observed that there is an ongoing lack of availability and continuity of care with respect to behavioral health services in rural and underserved areas. Therefore, behavioral health services are commonly handled by a primary care provider. This lack of access to specialized behavioral health treatment may pose challenges and risks to both the provider and the patient, particularly in cases of high/greater need. Therefore, the Panel recommends:

- Thorough evaluation and follow-up for patients reporting or presenting with psychotic thoughts and behaviors, or other complex mental health issues. These patients require immediate treatment and referral to an appropriate specialized provider (if seen by primary care provider). The primary care provider, in partnership with patient when possible, should seek consultation with a specialized provider, either in person or via telehealth services. In addition, thorough narrative notes should be taken, and questions asked regarding harm to others and access to weapons.
- Use of telehealth be encouraged and expanded statewide. These services will be particularly useful in rural and underserved areas. Protocols should be developed to safely address privacy issues and the inherent risk to victims of domestic violence when accessing telehealth services (i.e. given the power and control dynamics present in interpersonal relationships suffering from domestic violence, the challenge of ensuring that telehealth evaluations are private and confidential is especially important).

## **Maine Department of Health and Human Services (DHHS): Child Protection, Adult Protection, and Public Health Systems**

DHHS' role in the Coordinated Community Response to domestic violence addressed in the Panel's reports spans child welfare, adult protection, and public health. DHHS policy addresses the assessment of domestic violence in families. The Panel has reviewed cases in which DHHS responded to reports of child abuse and neglect, and/or that child homicides occurred, in the context of intimate partner violence or intrafamilial violence. The Panel has also observed in intimate partner violence homicides and intrafamilial homicides a continued gap in reporting - both by those who are statutorily required to report as well as others in the community - when children are at risk or being harmed by a family member. When reports are made, a thorough investigation becomes crucial as no other responding system is charged so essentially with protecting the welfare of children. In cases involving the homicide or homicide-suicide of older adults, the Panel has often encountered a lack of information about the context prior to the homicide and no indicators that the circumstances would warrant a report to Adult Protective Services or other interventions relating to family violence.

### ***Child Protection Services (CPS)***

The Panel has observed in homicide cases involving children a lack of mandatory reports to Child Protection Services by those who should have done so. In addition, in cases when reports were made, DHHS investigations have been incomplete. In the current biennium and past reports, the Panel has recommended that DHHS:

- Implement strategies to address training needs, caseload challenges, and access to adequate supervision for CPS staff. This will ensure that reports of suspected child abuse and neglect are thoroughly investigated, and appropriate and effective interventions can be implemented for both the children and adults affected.
- Sustain the Child Protective Liaison collaboration between the Office of Child and Family Services and Maine Coalition to End Domestic Violence. This program supports community-based domestic violence organization advocates partnering with child welfare caseworkers throughout the state. Advocates provide consultation and case specific support to address the complexities of ensuring child safety while minimizing risk and danger to the non-offending parent. Advocates also are beneficial to families and provide support and assistance to the non-offending parent.
- In cases when a child loses a parent(s) and/or sibling(s) to homicide or homicide-suicide, and especially if children have witnessed a homicide or discovered the body, that Child Protective Services act quickly to assess the needs of the child. It is imperative that CPS immediately identify a plan for the safest and appropriate placement and services for surviving children.
- Develop and update training for all legally mandated reporters, as laws change and vigilance declines.

During this biennial review period, the Office of Child and Family Services provided the following summary of internal work and improvements for this report after the homicides of children that were reviewed by the Panel:

### ***FROM THE OFFICE OF CHILD & FAMILY SERVICES (OCFS)***

In the span of three months, from December 2017 to February 2018, the Office of Child and Family Services (OCFS) responded to the deaths of two children as a result of abuse and neglect inflicted by their caregiver(s). OCFS had prior involvement with both children and upon learning of their deaths immediately sought to review the previous interactions between child welfare staff and these children/families. This included both a macro (system-level) review and micro review which looked at the specific case decisions in each previous involvement. As a result of these reviews OCFS undertook a number of changes. Among them:

- *Modifications to the Alternative Response Program (ARP) which required a new report to the Department when a family failed to engage in ARP services.*
- *Changes to OCFS' system for tracking reports of abuse and neglect to ensure each new report is documented separately in the Maine Automated Child Welfare Information System (MACWIS).*
- *Implementation of a case review toolkit for supervisors as they work with caseworkers. This toolkit is meant to strengthen high quality, consistent casework practice and increase oversight and organization of supervisory practice.*
- *Discontinuing out-of-home safety plans to ensure proper oversight (both by the Department and the Courts) when a child cannot remain safely in their home.*
- *Procurement of clinical support services for staff.*
- *Securing Legislative approval for additional staff and studying Maine-specific workload for caseworkers to ensure adequate staffing based on current caseloads.*
- *Sought and was granted access to confidential criminal history information, including interstate information, resulting in the creation of a dedicated Background Check Unit within OCFS.*
- *Guidance to all staff regarding requirements for case closure.*
- *Engagement with the Muskie School of Public Service at the Univ. of Southern Maine to review and update OCFS' policies and explore innovative and more effective means of delivering training to staff.*
- *Development and implementation of a new Investigation Policy and Structured Decision Making tools in the child welfare investigation process to ensure staff have guidance and support as they make decisions regarding the outcome of an investigation.*
- *Delivering Motivational Interviewing training to all child welfare caseworkers and supervisors.*

In addition, OCFS has focused considerable efforts over the last few years on ensuring transparency throughout its various program areas, including child welfare. This includes the publication of a regularly updated data dashboard which provides information on key child welfare metrics, a regular COVID-19 data report that includes data from all aspects of the child welfare system, and various ad-hoc public reports. OCFS is dedicated to transparency in all aspects of its work, regardless of whether it reflects successes or areas in need of improvement. All of these changes and initiatives were undertaken to improve the safety of children that become involved with child welfare and ensure that OCFS staff

have the tools and support they need in order to successfully respond to reports of alleged abuse and/or neglect. It is OCFS' hope that these changes will prevent similar tragedies in the future. OCFS remains committed to working toward a future where all Maine children and families are safe, stable, healthy and happy.

### ***Adult Protection Services / Older Adults***

Beginning with its 2008 Report, the Panel has made recommendations regarding cases involving older adults. In cases of intimate partner homicide, the perpetrators and victims have often been married for a long time. In cases when the victims of intrafamilial homicide are older adults, the perpetrators are typically adult children or adult grandchildren, often with significant behavioral health issues. The Panel notes that most often the older adult victims of homicide are not incapacitated or dependent, thus outside the statutory mandate of Adult Protective Services. The Panel further observes the reluctance of these families to ask for assistance from public agencies as they are concerned about the potential legal consequences to their children/grandchildren. The Panel's reports have continued to recommend that:

- Those providing services for older adults obtain training from community-based advocacy organizations to recognize and respond to intimate partner and intrafamilial violence. This is especially important for those who provide services in older adults' homes or in residential institutions and could engage in screening.
- Housing, social services, and home healthcare be expanded to support the needs of older adults and families, including assistance for parents who are full time care providers for their adult children, or grandparents who are full time care providers for their young or adult grandchildren.

### ***Public Health Nursing***

For the past decade, the Panel has observed the lack of resources for Public Health Nursing and recommended the restoration and expansion of these essential services, particularly for new parents. In cases of intrafamilial homicide involving infants, the Panel observed a lack of follow-up in the homes of new parents, a role historically filled by Public Health Nurses. Public Health Nurses provide information and support to families, are mandated reporters of child abuse and neglect, and can be a key link between families and other community services.

The Panel observes that the Maine Legislature enacted legislation to restore public health nursing services (22 M.R.S. §1964).

### **Community: Bystanders, Media, Advocacy Organizations, and Batterer Intervention**

#### ***Bystanders/Concerned 3<sup>rd</sup> Parties: Family, Friends, Neighbors, Employers, Schools, and Faith Communities***

Beginning with its first report in 2000, the Panel has observed that in a “number of cases...with hindsight, people were not surprised by the events.” Often, people were concerned about abuse but

felt helpless to do anything. The Panel has continuously observed the fundamental resources and support available to victims of domestic abuse and to the people who are concerned about them.

The Panel made these recommendations in its first and subsequent reports:

- Anyone who is concerned about someone who may be experiencing or perpetrating domestic abuse can call a community-based advocacy organization for help in strategizing ways to effectively help.
- Encourage a victim of abuse to contact a community-based advocacy organization to help break their isolation, connect them with safety planning services, and potentially save their lives. Advocates are experts at safety planning, including in anticipation of, during, or after a separation, when perpetrators are likely to escalate their control tactics.
- Inform a victim of abuse about the option of seeking a civil Protection from Abuse (PFA) Order from District Court. PFA Orders may be a useful part of a victim's safety plan. It is free to file a complaint for a PFA Order, and victims can do this during the court's business hours. PFA Orders constrain the person who is committing abuse and can provide a measure of accountability for a defendant who violates conditions of the Order and becomes subject to arrest or contempt of court, depending on the violation.
- Anyone seeing or hearing dangerous behavior should call law enforcement, and, when the victim is a child or incapacitated/dependent adult, make a report to Child or Adult Protective Services. It is important to keep in mind that reports to DHHS are cumulative, so even a seemingly lower risk concern could become the tipping point towards a life-saving intervention.
- Take seriously any reports of abuse and avoid minimization, particularly when those reports include any reference to suicide or homicide. Identify and act upon the connection between suicidality and homicidality by seeking emergency intervention by law enforcement.
- Lack of resources to access quality childcare, healthcare, housing, transportation, and other essential services contribute to the ability of perpetrators of abuse to maintain their positions of control, contributing to victims' sense of helplessness. Public officials, employers, and policy makers all have roles in making these resources available and known to those who need them.
- Schools should partner with community-based advocacy organizations:
  - To provide youth-focused education regarding domestic abuse and dating violence; and
  - To develop and implement workplace domestic violence policies for schools/districts.

- Community groups and faith communities should seek consultation and training from community-based advocacy organizations to better prepare themselves to prevent and respond to domestic abuse and violence.
- Employers should engage with community-based advocacy organizations for assistance in developing and implementing workplace responses to domestic violence. Developing a policy statement, training supervisors and managers, and rolling out a policy to employees creates the necessary structure to engage in workplace safety planning with employees who are victims, to link employees with community-based advocacy organizations and other resources, and to provide assistance and intervention to employees who commit domestic violence.

### ***Media***

In the current and past biennial review periods, the Panel recommends that news media take care not to minimize abuse or shift responsibility for abuse and violence by editorializing about victims or perpetrators when reporting on domestic violence incidents. Denigrating descriptions of victims may appear to be a justification of a perpetrator's use of violence. Positive character reports about a perpetrator not related to the violence may obfuscate the dynamics and impacts of the abuse and violence. Domestic violence, by its nature, involves manipulation and secrecy, so bystanders' lack of recognition of abuse, for example, should be expected and reported through that lens.

***Community-based advocacy organizations: the Maine Coalition to End Domestic Violence (MCEDV), the Wabanaki Women's Coalition (WWC), the Maine Coalition Against Sexual Assault (MECASA), and all of their member programs including the Immigrant Resource Center of Maine***

The Panel, in all its reports over these 20 years, recommends that professionals and community members in contact with offenders and victims make referrals to the community-based advocacy organizations. ***Contact information for these organizations is available as [Appendix D](#).*** The Panel notes that victims of homicide have rarely accessed these services, and all too often records from law enforcement officers, healthcare/behavioral health providers, and other system records and materials available in case reviews do not include documentation that referrals were ever made. Referrals are an immediate way for all Mainers to assist victims of abuse and violence.

Advocates at these organizations are available 24/7 through helplines and during the day for designated walk-in hours. Community-based advocacy organizations provide a range of services designed to help individuals and communities through safety planning, advocacy, and ongoing support. These organizations provide consultation and a wide range of training programs to assist individuals and institutions in shaping their responses to both perpetrators and victims. Since its inception, the Panel has recommended that all professional disciplines collaborate with these organizations to establish and implement referral policies and procedures.

The Panel has recommended that these community-based advocacy organizations expand their outreach efforts to ensure that services are accessible and known to all who need them.



### ***Certified Batterer Intervention Programs (CBIPs)***

The Panel has reviewed very few cases in which the homicide perpetrator was ordered to complete a Certified Batterer Intervention Program (CBIP). The Panel has repeatedly observed the prevalence of perpetrators of domestic violence being inappropriately required to attend anger management programs or counseling rather than CBIPs. CBIPs address victims' wishes that people who commit domestic abuse and violence recognize the impact of their behavior, stop the abuse and violence, and improve the well-being of their partners and children<sup>3</sup>. CBIPs provide people who are abusive an opportunity to recognize and change their abusive behavior, while providing the criminal justice system with an appropriate education mechanism that can both increase public safety and minimize the incarceration of offenders. (See *"Pretrial and Post-Conviction Use of Batterer Intervention Programs," Report to Maine's Joint Standing Committee on Criminal Justice and Public Safety Pursuant to L.D. 150, Prepared by the Maine Commission on Domestic and Sexual Abuse, February 2016, p. 2.*)

Maine law recognizes CBIPs "as the appropriate effective community intervention" in domestic violence related cases. Judges must make findings on the record that justify a disposition that does not include a CBIP, and a disposition that requires anger management. The effectiveness of Maine's directive regarding CBIPs depends both on the Coordinated Community Response, and on "swift and certain" sanctions for non-compliance by people who commit abuse. (See [Chapter 105 Public Law](#) *Maine 128<sup>th</sup> Legislature*, and *"Pretrial and Post-Conviction Use of Batterer Intervention Programs," p. 5.*)

### **Considerations and Recommendations for All Systems**

Through its two decades of biennial reviews, the Panel has identified several considerations and themes common to all community and professional systems. These relate to the difficulties inherent in witnessing and responding to perpetrators and victims of domestic violence. The Panel's observations and recommendations in this area include:

- Research indicates that nearly everyone knows people who perpetrate domestic violence, and nearly everyone knows people who have been victimized. The experiences and impacts are widespread, making it critical to reflect on possible changes to personal approach and professional protocol when a tragedy has occurred. In the cases of community systems, this should take the shape of institutionalized case review, once the emergency has passed, that reflects on met or failed expectations of policy and practice.
- Community members in the lives of victims and perpetrators, such as family, friends, neighbors, co-workers and others, may benefit from seeking ongoing support and guidance from advocates at community-based advocacy organizations. It is not easy to know how to safely respond to victims and perpetrators, given the risks perpetrators may present to anyone who tries to help. Without support, people often choose to distance themselves from the situation, leaving victims more isolated and vulnerable, and perpetrators

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<sup>3</sup> MCEDV released "[Initial Findings on the Effectiveness of Maine's Certified Batterer Intervention Programs](#)" in January 2021 (pursuant to P.L. Chapter 341 section 1), a report on the status of these programs, including the results of a survivor impact survey regarding the effectiveness of CBIP, beginning on page 23.

empowered. Accessing support can increase a community member's knowledge and fortitude to intervene in safe and effective ways.

- Language access for victims, offenders, and family members is imperative to ensure meaningful, timely, and informed access to and participation in all community services and public institutions. The Panel observes, as one example, that family members of homicide victims who do not speak English as their first language may need interpreter services in order to have meaningful victim input to and understanding of the criminal justice process in a homicide prosecution.
- Fidelity to best practices, grounded in knowledge that people who commit domestic abuse and violence create traumatic experiences for victims. Frame responses to victims around the awareness that victims will be impacted in both significant and everyday ways regarding how they perceive themselves, others, and what perpetrators have done.
- Recognize that witnessing people commit abuse, supporting victims who experience the consequences of abuse, responding professionally to perpetrators and victims, being present at scenes of domestic violence incidents, investigating cases, and prosecuting crimes, all can cause secondary/vicarious trauma or “compassion fatigue” over time. People in these roles may become emotionally and physically overwhelmed by the circumstances of domestic violence, particularly when responding to homicides.
- Support and training for first responders and other professionals regarding self-care and professional practices shore up effective responses over time. The effect of burnout and hopelessness can translate into minimizing the risks victims face when they are with dangerous and/or homicidal perpetrators. First responders and other professionals must guard against desensitization due to the cumulative effect of responding to victims and perpetrators, and/or to responding repeatedly to the same people. Repeat offenders are an increased risk, so vigilance over time is critical.
- Routinely engaging in critical incident stress debriefing by responders (law enforcement, Child Protective Services workers, Emergency Medical Technicians, etc.) is an important restorative practice that should address all of the above considerations.

*Pages 42 – 46 provide a data summary of domestic abuse homicides in Maine that were reviewed by the Domestic Abuse Homicide Review Panel between 2000-2019.*

# 20 YEAR LOOKBACK DATA: 2000-2019

## Introduction:

The following 20 year analysis of domestic abuse homicides in Maine includes cases that occurred between the years of 2000-2019 and that were examined by the Domestic Abuse Homicide Review Panel. The initial domestic abuse homicide data includes both intimate partner (IPV) and intrafamilial homicides (IFV), and then each category is examined in separate detail.

In recent years, the Panel has made it a practice to review more cases involving intrafamilial homicide than in prior years. However, the total number of domestic abuse homicide victims in Maine is not represented in the following data. Cases that have yet to be adjudicated have also been omitted from this report, as well as cases reviewed that involved harm exclusively to the perpetrator.

There were a total of 202 domestic abuse homicide victims in Maine between 2000-2019. **This 20 year lookback represents 147 of these victims based on cases reviewed by the Panel, and 129 of their perpetrators.** Of these, there were a total of 95 perpetrators of IPV with a total of 101 victims, and 41 perpetrators of IFV with a total of 46 victims. There were 12 perpetrators, all male, who committed multiple domestic homicides and were responsible for the deaths of 32 intimate partner and intrafamilial victims. Perpetrators who committed both IPV and IFV are represented in both specific data examinations to follow.

**% of Victims of Intimate Partner vs. Intrafamilial Homicide**

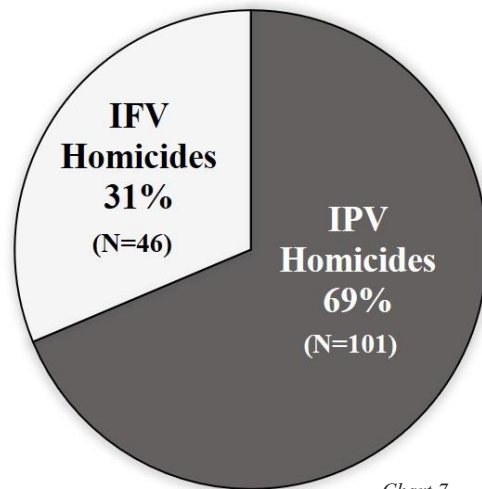


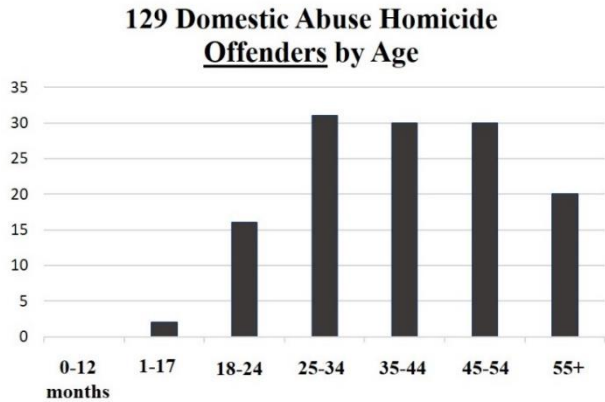
Chart 7

 **2000**  
**2019**

*Of all homicides in Maine from 2000 through 2019, 48% have been categorized by the Dept. of Public Safety as domestic abuse homicides.*

# 20 YEAR LOOKBACK: 2000-2019

## *Trends in Domestic Abuse Homicide Cases Reviewed by the Panel*



Graph 4

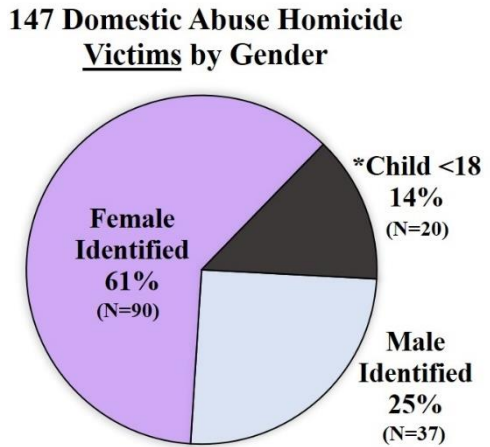
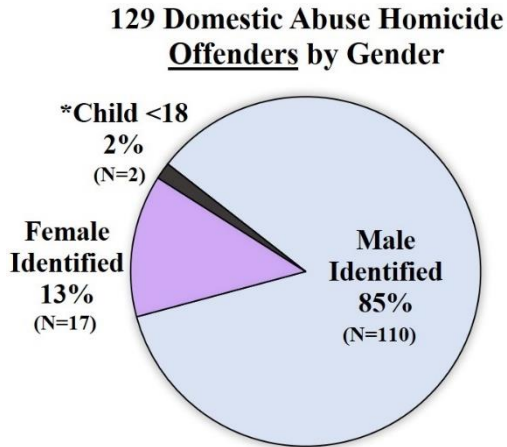


Chart 8

*\*Children under 18 years of age not separated by gender in the above data set*

### Method of Domestic Abuse Homicide by 129 Offenders

*(N=136; 5 perpetrators used multiple methods of homicide and each are represented below)*

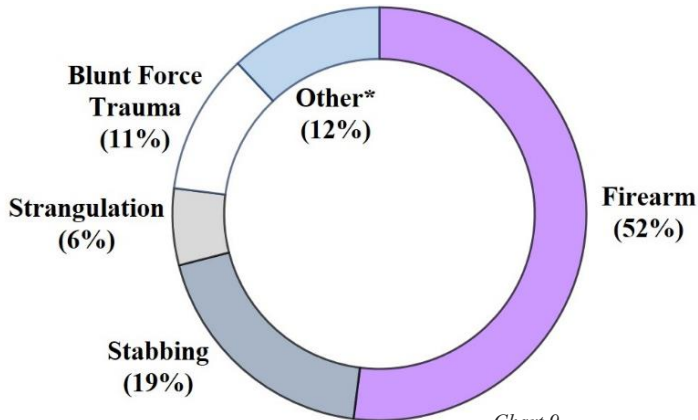


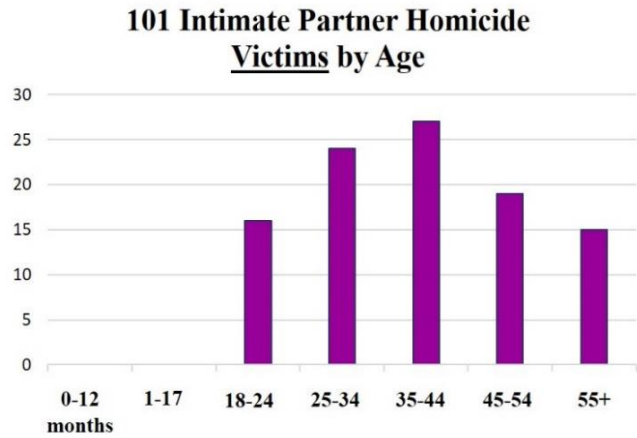
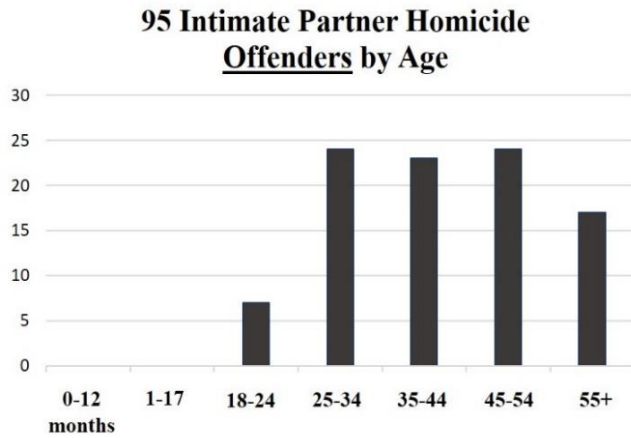
Chart 9

*\*Other category detailed ahead in intimate partner and intrafamilial homicide data*

*Overall, and consistent with national data, males committed the majority of domestic abuse homicides, and the majority used firearms.*

## 20 YEAR LOOKBACK: 2000-2019

### *Trends in Intimate Partner Homicide Cases Reviewed by the Panel*



**95 Intimate Partner Homicide Offenders by Gender**

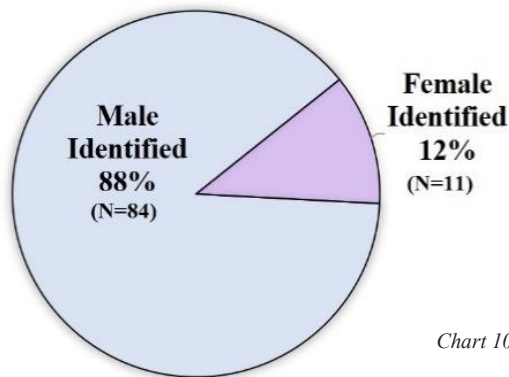
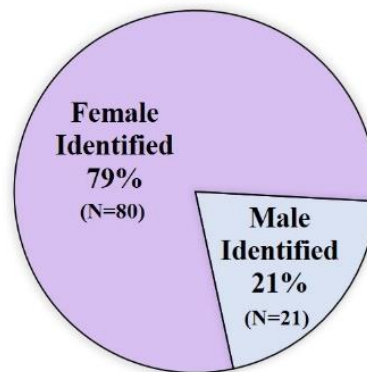


Chart 10

**101 Intimate Partner Homicide Victims by Gender**



#### Relationship of 101 Intimate Partner Homicide Victims to Offenders

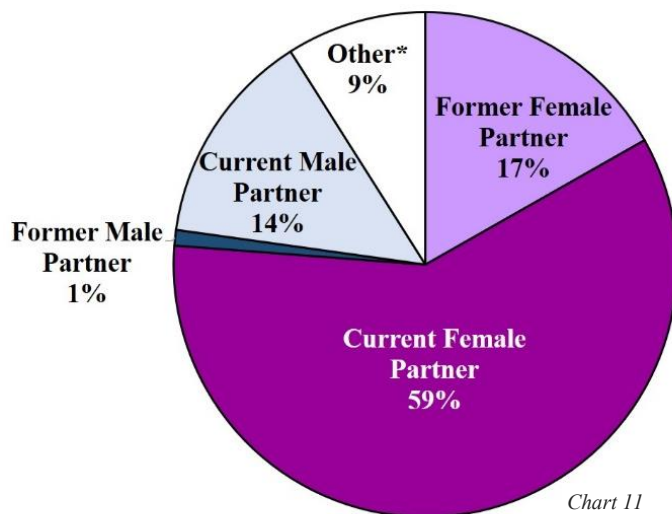


Chart 11

*People who commit domestic abuse and violence may escalate tactics to homicide when partners take steps to end the relationships.*

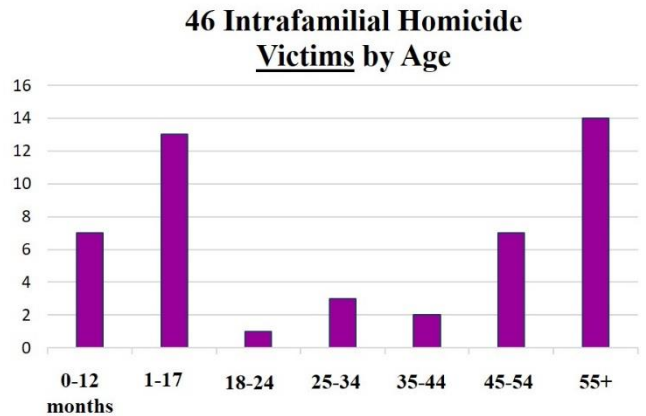
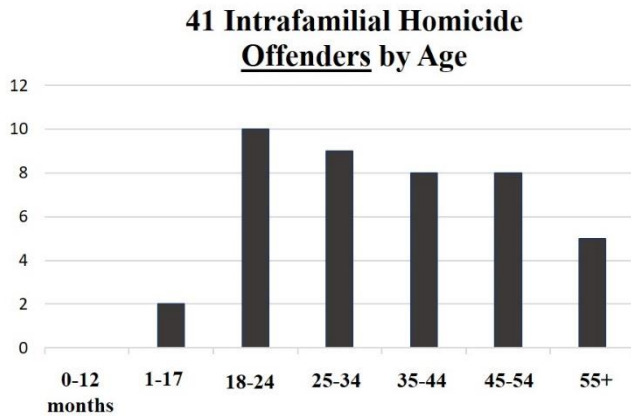
2000 2019

*The majority of IPV cases involved males killing their female intimate partners.*

*\*\*Includes family, friends, bystanders, and current partners of intimate partner homicide victims*

# 20 YEAR LOOKBACK: 2000-2019

## *Trends in Intrafamilial Homicide Cases Reviewed by the Panel*

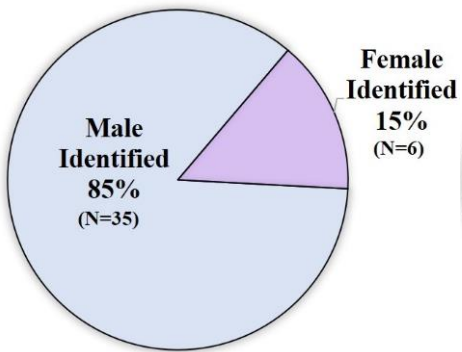


Graph 6

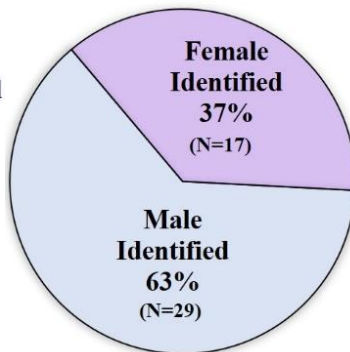
20 victims <18

9 victims 65+

**41 Intrafamilial Homicide Offenders by Gender**



**46 Intrafamilial Homicide Victims by Gender**



*The majority of people who committed intrafamilial homicide targeted minors and older adults. 20 victims were under the age of 18, and nine victims were age 65+.*

### Relationship of 46 Intrafamilial Homicide Victims to Offenders

*(1 victim was killed by both a biological and non-biological parent and is duplicated below)*

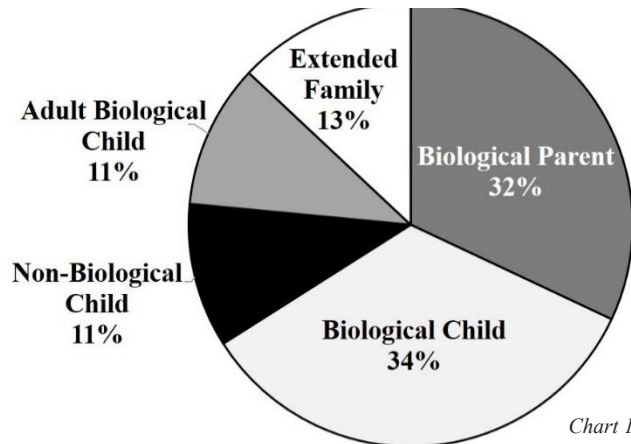


Chart 13

2000 2019

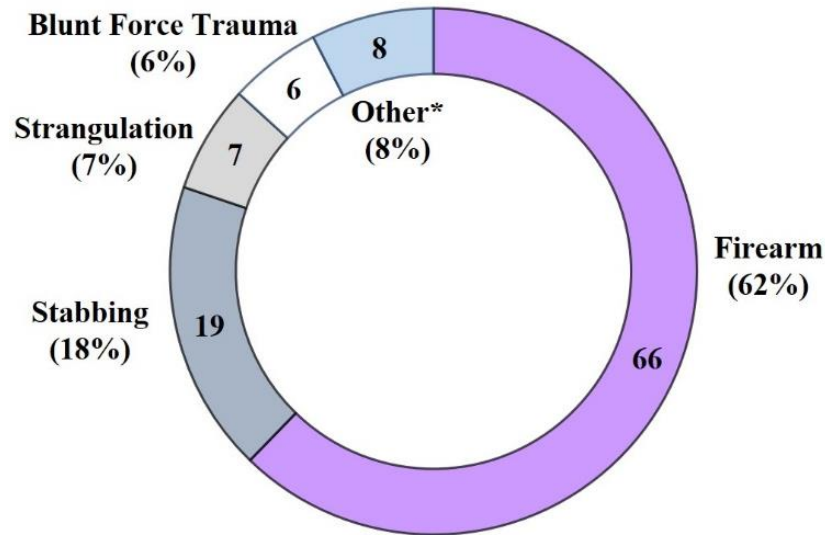
*The majority of IFV homicides were committed by males against other males. 26 male perpetrators killed a total of 29 male victims. Overall, 35 male perpetrators were responsible for the deaths of 41 IFV victims.*



## 20 YEAR LOOKBACK: 2000-2019

### Method of Intimate Partner Homicide by 95 Offenders

(N=106; 4 perpetrators used multiple methods of homicide and each are represented below)



\*Includes perpetrator use of fire, suffocation, hands, objects, and death by suicide after prolonged exposure to domestic violence

2000
2019

*In 20 years of case reviews, the majority of perpetrators of domestic abuse homicides used firearms to kill the victims.*

### Method of Intrafamilial Homicide by 41 Perpetrators

(N=42; 1 perpetrator used multiple methods of homicide and each are represented below)

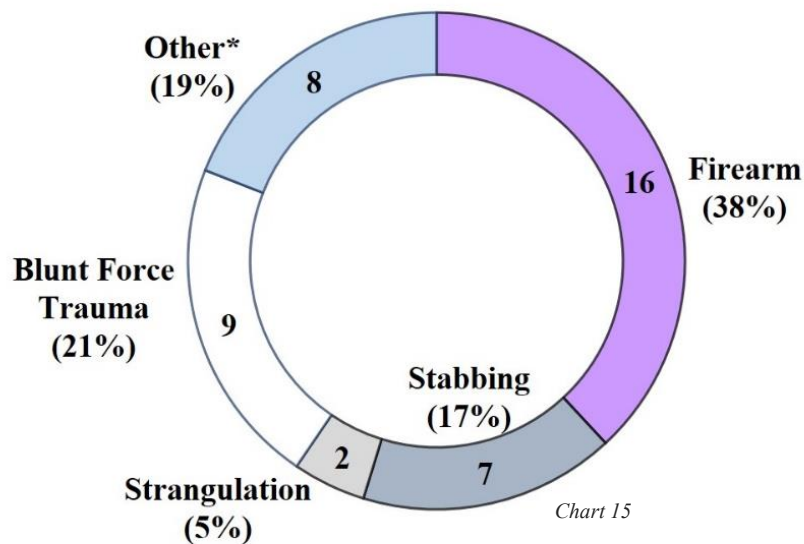


Chart 15

\*Includes use of hands, objects, fire, suffocation, and intentional poisoning with medicine

## **APPENDIX A: ENABLING LEGISLATION**

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Title 19-A M.R.S. §4013(4)

4. Domestic Abuse Homicide Review Panel. The commission [Maine Commission on Domestic and Sexual Abuse] shall establish the Domestic Abuse Homicide Review Panel, referred to in this subsection as the “Panel,” to review the deaths of persons who are killed by family or household member as defined by section 4002.
  - A. The chair of the commission shall appoint members of the Panel who have experience in providing services to victims of domestic and sexual abuse and shall include at least the following: the Chief Medical Examiner, a physician, a nurse, a law enforcement officer, the Commissioner of Health and Human Services, the Commissioner of Corrections, the Commissioner of Public Safety, a judge as assigned by the Chief Justice of the Supreme Court, a representative of the Maine Prosecutors Association, an assistant attorney general responsible for the prosecution of homicide cases designated by the Attorney General, an assistant attorney general handling child protection cases designated by the Attorney General, a victim-witness advocate, a mental health service provider, a facilitator of a certified batterers’ intervention program under section 4014 and 3 persons designated by a statewide coalition for family crisis services. Members who are not state officials serve a 2-year term without compensation, except that of those initially appointed by the chair, ½ must be appointed for a one-year term.
  - B. The Panel shall recommend to state and local agencies methods of improving the system for protecting persons from domestic and sexual abuse, including modification of laws, rules, policies and procedures following completion of adjudication.
  - C. The Panel shall collect and compile data related to domestic and sexual abuse, including data relating to deaths resulting from domestic abuse when the victim was pregnant at the time of the death.
  - D. In any case subject to review by the Panel, upon oral or written request of the Panel, any person that possesses information or records that are necessary and relevant to a homicide review shall as soon as practicable provide the Panel with the information and records. Persons disclosing or providing information or records upon the request of the Panel are not criminally or civilly liable for disclosing or providing information or records in compliance with this paragraph.
  - E. The proceedings and records of the Panel are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The commission shall disclose conclusions of the review Panel upon request, but may not disclose information records or data that are otherwise classified as confidential.

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

# APPENDIX B: MAINE'S HOMICIDES

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## MAINE'S HOMICIDES 2018

### (MURDER-MANSLAUGHTER)

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

*Updated 12/28/18*

**1/7 PORTLAND** Sokha Khuon, 36, shot to death inside her home. Her longtime partner, Anthony Leng, 40, is charged with murder. **DOMESTIC**

**1/9 TEMPLE** Michelle Masse, 59, shot to death inside her home. Her husband, Thomas Massie, 60, then shoots and kills himself. **MURDER-SUICIDE - DOMESTIC**

**1/10 BANGOR** Israel Lewis, 51, shot to death inside his apartment. Frank Daly, 29, is charged with murder.

**1/17 BRIDGEWATER** Paul Hilenski, 79, shot to death inside his home. James Peaslee, 37, is charged with murder.

**2/25 STOCKTON SPRINGS** Marissa Kennedy, 10, beaten to death inside her home. Her parents- Julio Carrillo, 55, and Sharon Carrillo, 33, are charged with murder. **DOMESTIC**

**2/26 BOWDOINHAM** Beulah "Marie" Sylvester, 55, beaten to death inside her home. Her grandson, Dominic Sylvester, 16, charged with murder. **DOMESTIC**

**3/28 BANGOR** Michael Bridges, 43, and Desiree York, 36, died while trapped inside a box truck that is set afire downtown. John De St. Croix, 25, is charged with two counts of murder.

**3/31 NORRIDGEWOCK** Marie Lancaster-Hale, 58, is shot and killed inside her home by her husband, William Hale, 62, who shoots and kills himself. **MURDER-SUICIDE - DOMESTIC**

**4/22 LITCHFIELD** Kimberly Mironovas, 47, stabbed and strangled inside her home. Three teenage boys are charged with her death, including her son. Lukas Mironovas, 15 and William Smith, 15, are charged with murder and 13 year old Thomas Severance is charged with conspiracy to commit murder. **DOMESTIC**

**4/25 NORRIDGEWOCK** Somerset Deputy Sheriff Eugene Cole, 61, is shot and killed in an encounter with a local man, who later steals his police cruiser. John Williams, 29, is

arrested after a four-day manhunt and charged with murder.

**5/31 BAR HARBOR** Mikaela Conley, 19, is killed in downtown wooded area. Jalique Keene, 21, arrested and charged with murder.

**6/24 WARREN** Dana Bartlett, 28, dies at the Bolduc Unit of the Maine State Prison, where he is an inmate. State Police investigating.

**6/26 PORTLAND** Jack Wilson, 45, is shot along a street in the Bayside area. He dies from his wound on July 3. Tyrese Collins, 18, charged with murder on July 7.

**7/12 HAMPDEN** Renee Clark, 49, is shot to death inside her home. Her brother-in-law who also lives in the house, Phillip Clark, 55, is charged with murder. **DOMESTIC**

**7/15 LEWISTON** Kimberly Dobbie, 48, is stabbed to death along a downtown street. Albert Flick, 76, is charged with murder.

**11/11 BANGOR** Jason Moody, 40, beaten and found along a city street. He died on November 13. Donald Galleck, 29, charged with murder.

**11/25 FORT KENT** Daren Charette, 49, shot to death inside an apartment house. State Police investigating.

**12/12 HARTFORD** Ana Cordeiro, 41, dies inside her home. Her longtime boyfriend, Rondon Athayde, 46, is charged with murder. **DOMESTIC**

**12/15 RICHMOND** Niomi Mello, 37, shot to death inside her home by her longtime boyfriend, Kirk Alexander, 46, who shoots and kills himself. **MURDER-SUICIDE - DOMESTIC**

## **MAINE'S HOMICIDES 2019**

### **(MURDER-MANSLAUGHTER)**

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

*Updated 12/30/19*

**1/2 PARIS** Heather Bickford and Dana Hill, both 31, are shot to death inside a downtown apartment. Mark Penley, 49, is charged with two counts of murder. Penley is the former boyfriend of Bickford. **DOMESTIC**

**1/14 CLIFTON** Kary Dill, 35, shot to death inside her home. Her long term boyfriend, Dwight Osgood Jr., 37, charged with murder. **DOMESTIC**

**2/21 OWLS HEAD** Helen Carver, 83, is beaten to death inside her home. Sarah Richards, 37, is charged with murder. Richards had been hired by Carver to shovel snow.

**3/15 SWANVILLE** Shane Sauer, 26, shot to death outside a cabin. Austin McDevitt, 22, is charged with murder. The two men were dating the same woman.

**3/16 PORTLAND** Isahak Muse, 22, shot to death inside a home on Milton St. Mark Cardilli, 24, charged with murder. He is the brother of the victim's girlfriend.

**3/17 PORTLAND** Patricia Grassi, 59, strangled inside a Cumberland Ave. apartment. Her boyfriend, Gregory Vance, 61, is charged with murder. **DOMESTIC**

**3/17 PRESQUE ISLE** Quinten Leavitt, 14 months old, is shot to death by his father, who shoots and kills himself. Father is Matthew Leavitt, 35, and shooting takes place inside their home. **MURDER-SUICIDE - DOMESTIC**

**3/19 OLD ORCHARD BEACH** William Popplewell, 65, is beaten and stabbed to death inside his apartment. His roommate, Dustan Bentley, 30, is charged with murder.

**3/19 GARDINER** Autumn Bryant, 44, shot and killed by her estranged husband, Kenneth Bryant, 48, at a home in Gardiner where she had been staying. **MURDER-SUICIDE - DOMESTIC**

**5/11 LEBANON** Allison Parker, 30, shot and killed by her long-term boyfriend, Thomas Doyon, who shoots and kills himself at their home. **MURDER-SUICIDE - DOMESTIC**

**7/19 WATERBORO** Christal Denis, 45, shot and killed by her husband, Christopher Denis, 45, who shoots and kills himself at their home. **MURDER-SUICIDE - DOMESTIC**

**7/27 AUBURN** Jean Fournier, 41, shot to death in the Wal Mart parking lot. Gage Dalphonse, 21, charged with murder.

**8/3 PORTLAND** Rodney Cleveland, 63, beaten and dies six weeks later at the hospital. Everett Meserve, 62, a neighbor, is charged with murder.

**8/12 CASTLE HILL** Roger Ellis, 51, and Allen Curtis, 25, shot to death inside Ellis' pickup on Route 227. Bobby Nightingale, 38, indicted on two counts of murder October 17

**8/31 LEEDS** Nadi Hagi Mohamed, 31, found shot to death along a woods road in Leeds. State Police investigating.

**10/11 RICHMOND** Andrew Sherman, 48, found dead inside his home. State Police investigating.

**10/22 WATERVILLE** Melissa Sousa, 29, shot to death inside her home. Her longtime boyfriend, Nicholas Lovejoy, 28, is charged with murder. **DOMESTIC**

**11/1 BANGOR** Berton Conley, 59, dies following the discovery of a small fire inside his home. Two men - Joseph Johnson, 30, and Cote Choneska, 39, are charged with murder on December 4 by Bangor Police.

**11/11 AUGUSTA** Loryn McCollett, 30, is stabbed to death inside the apartment she shares with her boyfriend, Eric Ryan, 30, who then shoots and kills himself. **MURDER-SUICIDE - DOMESTIC**

**12/15 SCARBOROUGH** James Pearson, 82, stabbed to death in the front yard of his home. Quinton Hanna, 22, charged with murder.

# APPENDIX C:

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## Maine Criminal Justice Academy Board of Trustees Minimum Standards, Policy 3

### DOMESTIC VIOLENCE POLICY

**Date Board Adopted: 03/08/2019**      **Effective Date: 11/01/2019**

The agency must have a written policy to address Domestic Violence, to include, at a minimum, provisions for the following:

1. A policy statement that recognizes domestic violence as a serious crime against the individual and society.
2. Officers are responsible for being familiar with the applicable statutes in 15 M.R.S. Chapter 12A; 19-A M.R.S. Chapter 101; 17-A M.R.S. §15 and the applicable chapters in the Maine Law Enforcement Officer's Manual.
3. Definitions of abuse, predominant aggressor, predominant aggressor analysis, self-defense, domestic violence crimes, family or household members, risk assessment, strangulation and domestic violence advocate.
4. Emergency Communication Specialist (ECS) procedures regarding the receipt and response to a complaint. These procedures must include: receipt and prioritization of the call; information to be elicited from the caller; exigencies of situation; "excited utterances;" consulting agency and available court records pertinent to either party; and possibility of a back-up unit. (19-A M.R.S. §4012 (2)).
5. Complaint response procedure must include: receipt of the call; tactical approach to the call; initial contact; situation control process, on-scene investigation and enforcement action; and post-incident follow-up with the victim.
6. Agency responsibilities and procedures when a complaint involves a law enforcement officer, a family member of a law enforcement officer or any employee of a law enforcement agency. This must include an investigative follow-up and review by the administration that is consistent with these standards.
7. Agency responsibilities and procedures when any member of the law enforcement agency shows signs of experiencing or perpetrating domestic violence. This must include an investigative follow-up and review by the administration that is consistent with these standards.



8. Responsibility of an officer to determine who may be the predominant aggressor by investigating for probable cause, self-defense, and/or other factors, and take the appropriate enforcement action against that person.
9. Circumstances under which arrest is mandatory. (19-A M.R.S. §4012 (5) & (6) (D)).
10. Circumstances under which a warrantless arrest may occur (17-A M.R.S. §15).
11. Procedures for the administration of a validated, evidence based domestic violence risk assessment recommended by the Maine Commission on Domestic and Sexual Abuse, such as the Ontario Domestic Assault Risk Assessment (ODARA) and the conveyance of the results of that assessment to the bail commissioner, if appropriate, and the district attorney for the county in which the domestic violence occurred. (25 M.R.S. §2803-B (1) (5)).
12. Responsibilities of an officer when an arrest is not authorized.
13. Responsibility of a responding officer to remain at the scene to protect the safety of persons in danger and to obtain medical assistance, if necessary. (19-A M.R.S. §4012 (6) (A) & (B)).
14. Responsibility of an officer to provide written instructions to a victim concerning the victim's right to obtain a Protection From Abuse Order and the procedures involved. This must include a mechanism for language access services if the victim is limited English proficient. (19-A M.R.S. §4012 (6) (C)).
15. Responsibility of an officer to provide the victim with information about the local domestic violence resource center and/or relevant culturally specific domestic violence organization.
16. A reporting process for detailed documentation of the incident and any charges. This report must include ATN/CTN numbers.
17. Procedures to ensure expeditious service of both temporary and permanent Protection From Abuse Orders issued under 19-A M.R.S. §4006 and §4007. (25 M.R.S. §2803-B (1-D)(4)). This includes entering service information into the METRO system without unnecessary delay.
18. Recognition that a person who obtains a Protection From Abuse Order cannot violate the order regardless of any action taken by that person; a Protection From Abuse Order only constrains the defendant. (19-A M.R.S. §4001 (6) & §4007 (7) & (8)).
19. Must enforce validated Protection From Abuse Orders from other states and tribal courts under the authority of the federal Full Faith and Credit Clause.

20. Procedures to ensure that a victim receives notification of the defendant's release on bail. (25 M.R.S. §2803-B (1) (D) & 17-A M.R.S §1175-A).
21. Procedures for the collection of information regarding the defendant that includes the defendant's previous history of domestic violence, the parties' relationship, whether the commission of a crime included the use of strangulation as defined in 17-A M.R.S. §208(1) (C), sexual assault offenses as defined in 17-A Chapter 11 offenses, stalking as defined in 17-A M.R.S. §21-C, current or past suicidality of the defendant, the name of the victim, and a process to relay this information to a bail commissioner before a bail determination is made. (25 M.R.S. §2803-B (1) (2)).
22. Procedures for the safe retrieval of personal property belonging to the victim or the defendant that includes identification of a possible neutral location for retrieval, the presence of at least one law enforcement officer during the retrieval, and providing the option of at least 24 hours' notice to each party prior to the retrieval. (25 M.R.S. §2803-B (1) (3)).
23. Requirement that an agency review its compliance with all applicable provisions of this policy in the event that a victim of domestic violence who resided in the agency's jurisdiction is killed or seriously injured during the time that any temporary or permanent Protection From Abuse Order (PFA) was in effect or if there had been past agency involvement related to interactions between the perpetrator and the victim. The review shall be conducted in consultation with a domestic violence advocate as defined in 16 M.R.S. §53-B(1)(A) and a sworn law enforcement officer designated or trained as a domestic violence investigator. A report of such review must be kept on file by the agency. In any case where one or more victims are killed, a copy of the report shall be forwarded to the Domestic Violence Homicide Review Panel through the Office of the Attorney General.
24. A provision that any agency, as permitted by 16 M.R.S. §804(4) and subject to the conditions of that section may provide a copy of the incident report or intelligence or investigative information to a domestic violence advocate as defined in 16 M.R.S. §53-B(1).
25. Officers must abide by their agency policy as it applies to all standards of the Maine Criminal Justice Academy Board of Trustees.

Note: Any violation of these standards may result in action by the Board of Trustees.

# MAINE CHIEFS OF POLICE ASSOCIATION MODEL POLICY

	Effective Date <b>02/04/2020</b>	Number <b>1-3</b>
Subject <b>Domestic Violence</b>		
Distribution <b>All Personnel</b>	Amends/Supersedes <b>1-3</b> dated 11/01/19	

## I. Purpose

The purpose of this policy is to provide a consistent process for responding to domestic violence and to prescribe a preliminary course of action that officers should take in response to domestic violence incidents.

## II. Policy     ***BOT 3-1 MLEAP 7-10***

This agency maintains that the nature and seriousness of crimes committed between family or household members are not mitigated solely because of the relationships or living arrangements of those involved. It is the policy of this agency that domestic violence be treated with the same consideration as violence in any other enforcement context.

It is also the policy of this agency that officers take steps to properly investigate, identify predominant aggressors, and combine the use of appropriate community services with enforcement of the law in an effort to: (1) break the cycle of domestic violence by preventing future incidents or reducing the frequency and/or seriousness of such incidents, (2) protect victims of domestic violence and provide them with support, and (3) promote officer safety when dealing with domestic violence situations.

This agency also recognizes that no one is immune from incidents of domestic violence, including law enforcement. As part of this policy, this agency will take a proactive approach when dealing with any domestic violence committed by agency employees.

Given this is a statutorily mandated policy; officers must abide by this agency's policy as it applies to all standards of the Maine Criminal Justice Academy Board of Trustees. ***BOT 3-25***

## III. Definitions   ***BOT 3-3***

**Adult:** Means any person 18 years of age or older or a person under 18 years of age who is emancipated pursuant to 15 M.R.S. §3506-A.

**Abuse:** Means the occurrence of the following acts between family or household members or dating partners or by a family or household member or dating partner upon a minor child of a family or household member:

1. Attempting to cause or causing bodily injury or offensive physical contact, including sexual assaults under Title 17-A, chapter 11, except that contact as described in 17-A M.R.S. §106(1), (physical force by persons with special responsibilities) is excluded from this definition.
2. Attempting to place or placing another in fear of bodily injury through any course of conduct including, but not limited to, threatening, harassing or tormenting behavior.
3. Compelling a person by force, threat of force or intimidation to engage in conduct from which the person has a right or privilege to abstain or to abstain from conduct in which the person has a right to engage.
4. Knowingly restricting substantially, the movements of another person without that person's consent or other lawful authority by:

- a. Removing that person from that person's residence, place of business or school;
  - b. Moving that person, a substantial distance from the vicinity where that person was found; or
  - c. Confining that person for a substantial period either in the place where the restriction commences or in a place to which that person has been moved.
5. Communicating to a person a threat to commit, or to cause to be committed, a crime of violence dangerous to human life against the person to whom the communication is made or another, and the natural and probable consequence of the threat, whether or not that consequence in fact occurs, is to place the person to whom the threat is communicated, or the person against whom the threat is made, in reasonable fear that the crime will be committed; or
6. Repeatedly and without reasonable cause:
- a. Following the plaintiff; or
  - b. Being at or in the vicinity of the plaintiff's home, school, business or place of employment.

Confidential Communications: Means all information, whether written or oral, transmitted between a victim and a domestic violence advocate in the course of the working relationship. Confidential communications includes, but is not limited to, information received or given by the advocate in the course of the working relationship, advice, records, reports, notes, memoranda, working papers, electronic communications, case files, history and statistical data, including name, date of birth and social security number, that personally identify the victim.

Dating Partners: Means individuals currently or formerly involved in dating each other, whether or not the individuals are or were sexual partners.

Domestic Partners: Means two unmarried adults who are domiciled together under long term arrangements that evidence a commitment to remain responsible indefinitely for each other's welfare.

Domestic Violence Crimes: Means crimes of domestic violence assault; domestic violence aggravated assault; domestic violence elevated aggravated assault, domestic violence elevated aggravated assault on pregnant person; domestic violence criminal threatening; domestic violence terrorizing; domestic violence stalking and; domestic violence reckless conduct.

Domestic Violence Advocate: Means an employee of or volunteer for a nongovernmental program for victims of domestic violence who:

1. Has undergone at least 30 hours of training; and
2. As a primary function with the program supports and provides safety planning services to victims, supervises employees or volunteers who perform that function or administers the program.
3. Domestic Violence Advocates include those who work or volunteer at the member domestic violence resource centers of the Maine Coalition to End Domestic Violence, and the member advocacy centers of the Wabanaki Women's Coalition.

Family or Household Members: Means spouses or domestic partners or former spouses or former domestic partners, individuals presently or formerly living together as spouses, natural parents of the same child, adult household members related by consanguinity or affinity (blood or marriage) or minor children of a household member when the offender is an adult household member. Holding oneself out to be a spouse shall not be necessary to constitute "living as spouses." For purposes of this subsection, "domestic partners" has the same meaning as in 18-A M.R.S. §1-201(10-A).

Law Enforcement Agency Employee: Means all sworn and non-sworn members of this agency.

Predominant Aggressor: Means the person most responsible for the violence, uses the higher level of violence, has an established history of violence in the relationship, and who represents the more serious present threat of violence, when one or both parties have committed some sort of violence towards each other.

Predominant Aggressor Analysis: Method in which used by an officer to identify a predominant aggressor. (See Appendix #3)

Risk Assessment: Means a procedure whereby we measure some characteristics of a person or situation and then use that information to predict the likelihood of some negative event, i.e. re-abuse for example, as measured by re-arrest.

Self-defense: Means a person is justified in using a reasonable degree of physical force upon another person in order to defend the person or a third party from what the person reasonably believes to be the imminent use of unlawful force. See 17-A M.R.S. §108.

Strangulation: Means impeding the breathing or circulation of the blood of another person by intentionally, knowingly or recklessly applying pressure on the person's throat or neck. See 17-A M.R.S. §208(1)(C).

#### **IV. Procedures**

##### **A. General *BOT 3-2***

Law enforcement officers are responsible for being familiar with the applicable statutes of 15 M.R.S. Chapter 12-A, Chapter 101 of Title 19-A M.R.S. Chapter 101, and 17-A M.R.S §15 and the applicable chapters of the Maine Law Enforcement Officer's Manual (L.E.O.M.).

##### **B. Emergency Communication Specialist (ECS) Responsibilities *BOT 3-4***

The ECS who receives a domestic violence call can provide the responding officers with vital information that could save the victim's and/or officer's life. The ECS shall give a domestic violence call the same priority as any other life-threatening call and shall, whenever possible, dispatch at least two officers to every incident.

1. In addition to information normally gathered, an effort should be made to determine and relay the following information to responding officers, but not limited to:
  - a. Whether the suspect is present and, if not, the suspect's description and possible whereabouts.
  - b. Whether weapons are involved.
  - c. Whether the offender is under the influence of drugs or alcohol.
  - d. Whether children are present.
  - e. Whether a current protective order, bail conditions, and/or probation conditions are in effect.
  - f. Complaint history at that location.
  - g. Whether medical attention is needed.
  - h. Any ""excited utterances"" made by the caller.
  - i. Any agency or court record or risk assessment pertinent to either party.
2. The ECS should attempt to keep the caller on the telephone as long as possible and should tell the caller that help is on the way and when the caller can expect officers to arrive and should relay ongoing information provided by the caller to the responding officers.

3. The ECS shall NOT cancel the law enforcement response to a domestic violence complaint based solely on a follow-up call from the residence requesting such cancellation. However, the ECS shall advise the responding officers of the request.
  4. The ECS shall ensure that officers at the scene of an incident of violence or violation of an order of protection are informed of a recorded prior incident of violence involving the abused party and can verify the effective dates and terms of a recorded order of protection.
  5. If the call involves, or appears to involve, a law enforcement officer or other employee of a law enforcement agency, the ECS shall immediately notify the employee's supervisor, regardless of the involved employee's jurisdiction.
- C. Initial Officer Response **BOT 3-5**
1. The officer should avoid the use of sirens and emergency lights in the vicinity of the scene of the incident. Officers should be alert to and note persons encountered while approaching the scene. If possible, an officer should question any potential witnesses to the incident.
  2. The officer should not park the police vehicle directly in front of the residence of the disturbance. The officer should be alert for assailants leaving the scene and for the employment of weapons from doors, windows, or nearby vehicles.
  3. The officer should consider the surroundings before knocking on the door, and listen and look in any nearby window to obtain additional information about the situation (layout of house, number of people involved, weapons).
  4. Officers must be concerned for their own safety as well as the victim's. Minimize the possibility of injury, stand on the side of the door when knocking. The unexpected may occur when the door opens.
  5. If the incident involves a law enforcement officer or other employee of a law enforcement agency as the suspect, refer to additional initial officer response protocols below in section J of this policy.
- D. Complaint Investigation **BOT 3-8**
- Upon arriving to a domestic violence call, officers shall:
1. Identify oneself as an officer by name, explain the law enforcement presence, and request entry into the home. If the complainant is in the home, ask to see the complainant. If the person who called the police is someone other than the subject of the call, the officer should not reveal the caller's name.
  2. Restore order by gaining control of the situation, in particular by securing the suspect and controlling the suspect's movement and ability to interact visually or verbally with others at the scene.
  3. Take control of all weapons used or threatened to be used in the crime.
  4. Assess the need for medical attention and call for medical assistance, if needed. In cases involving non-fatal strangulation, always call Emergency Medical Services to examine the victim, regardless of whether visible injury exists.
  5. If any of the parties are Limited English Proficient, officers should arrange for interpretation services.
  6. Interview all parties, to include children, neighbors, and other witnesses, separately.

7. Process the crime scene.
8. In cases when one or both parties have committed some kind of violence against the other, utilize the predominant aggressor analysis by 1) establishing that probable cause exists that a crime has occurred, 2) actively investigating whether any party used self-defense, and 3) determining who is the overall predominant aggressor in the relationship. This is the person who poses the most past/present/future risk to the other, who uses an overall pattern of coercive, controlling tactics, and the person who places the other in fear. These steps in the analysis should be completed in order. Officers should consult the Predominant Aggressor Decision tree (Appendix 1) when utilizing the analysis. This analysis is to be used in making arrest decisions.
9. Collect and record evidence and, where appropriate, take color photos of injuries and property damage.
10. If the offender has left the scene and a crime has been committed, officers will:
  - a. Conduct a search of the immediate area.
  - b. Obtain information from victims and witnesses as to where the offender might be.
  - c. Officers are encouraged to make a warrantless arrest when the offender is found or write an affidavit for an arrest warrant and arrest the offender.
11. If probable cause does not exist to make an arrest for violation of any domestic violence crime, officers must indicate in the agency incident report the reason for such.
12. In-custody arrest is mandatory when an officer has probable cause to believe that a violation of a court-approved consent agreement or protection order has occurred, or if a domestic violence aggravated assault, a domestic violence elevated aggravated assault (17-A M.R.S. §208-, or domestic violence elevated assault on a pregnant person has occurred, pursuant to 19-A M.R.S. §4012(5). **BOT 3-9**
13. A warrantless arrest is authorized if an officer has probable cause to believe that a person violated an order issued pursuant to 15 M.R.S. §321(6). Furthermore, when an officer has reason to believe that a family or household member has been abused, the officer shall immediately use all reasonable means to prevent further abuse, which may include arresting the abusing party with or without a warrant pursuant to 19-A M.R.S. §4012(6)(D) and Title 17-A, §15.. **BOT 3-10**
14. A warrantless arrest is also authorized if an officer has probable cause to believe a person has committed or is committing any crime listed in 17-A M.R.S. § 15.
15. Officers must make a good-faith effort to complete a validated, evidence-based domestic violence risk assessment, currently the Ontario Domestic Abuse Risk Assessment (ODARA) (see Appendix 2), on the offender:
  - a. ODARA is used In any case involving a male or female arrested for: domestic violence assault; domestic violence aggravated assault; domestic violence elevated aggravated assault; domestic violence elevated aggravated assault on pregnant person; domestic violence criminal threatening with a dangerous weapon; and/or domestic violence terrorizing when the circumstances include:
    - a. An act of violence involving physical contact with the victim or;
    - b. A credible threat of death with a weapon in hand made in the presence of the victim.



- b. ODARA is validated for use in heterosexual intimate or dating partnerships only; it is not yet validated for use in same sex intimate partnerships; not validated for cases involving other family or household member relationships.
  - c. In addition to completing the ODARA score sheet, the officer should document in the narrative of the investigative report the specific facts and circumstances that support the scoring of the ODARA.
  - d. The officer must provide the ODARA results with the Bail Commissioner, see 19-A M.R.S. §4012(6).
  - e. The officer must provide a copy of the ODARA to the Office of the District Attorney for the county in which the abuse took place, see 19-A M.R.S. §4012. At a minimum, the officer must ensure that a copy of the ODARA assessment is included in the case file for provision to the District Attorney's Office.
  - f. The officer should attach the ODARA scoresheet to the incident report and also provide details about the sources of information and scoring of each ODARA item in the report narrative.
16. Complete appropriate offense or incident reports and include, if possible and at a minimum, the following:
- a. Time of dispatch, time on the way to the call, and time of arrival.
  - b. Description of the scene and the appearance and demeanor of the parties.
  - c. Excited utterances/present sense impressions from the parties or witnesses.
  - d. The officer's own observations of injury, people, and the scene.
  - e. Each person's description of the relationship of the parties.
  - f. Photographs.
  - g. Any other physical evidence, including digital/technology.
  - h. Names, ages, addresses, phone numbers of witnesses (including children and neighbors).
  - i. Written statements.
  - j. The three-step analysis when making the predominant aggressor determination.
  - k. Whether an arrest was made.
  - l. Details about the validated, evidence-based domestic violence risk assessment (Ontario Domestic Assault Risk Assessment), including the sources of information for each item and the score, if an arrest is made for an eligible crime and an eligible relationship exists.
  - m. Details about medical intervention if any.
  - n. Request for medical records.
  - o. Note all existing Protection From Abuse Orders, bail conditions, and probation conditions.
  - p. Information and referrals provided to the victim, including Protection From Abuse Order information if no order already exists, and contact information for the domestic violence resource centers of the Maine Coalition to End Domestic Violence and the advocacy centers of the Wabanaki Women's Coalition.
  - q. ATN and CTN numbers when necessary.
  - r. Current contact information for the victim or another person who knows where to contact the victim.
  - s. SBI and Triple-I.
17. The agency may provide a copy of the incident report or information to an advocate at a domestic violence or sexual assault center, pursuant to 16 M.R.S. §806(3).

E. Bail Commissioner Information Form **BOT 3-21**

1. Officers should make a good faith effort to complete the Bail Commissioner Information Form (see Appendix 3). The form includes:
  - a. The officer's name, agency, incident number, ATN and CTN numbers.
  - b. The pending charges with statutory cites and class of the pending crimes charged.
  - c. The defendant's name, DOB, address(es), phone numbers, place of employment, physical description and location of arrest.
  - d. The victim's name, DOB, relationship to the defendant, phone numbers and the victim's address only if it is clear the defendant already knows where the victim lives.
  - e. Maine SBI, NCIC Triple III (if appropriate), MV history information and any other history.
  - f. Failing to Appear, Protection for Abuse/Harassment Orders or Other Bail Conditions information.
  - g. When appropriate, the validated, evidence-based domestic violence risk assessment (ODARA) score.
  - h. Whether the incident included the use of strangulation.
  - i. Other information to include, but not limited to the presence/use/threat of weapons, threats to kill self/others/pets, alcohol or drug use, if the victim is pregnant, or if there was a recent separation.

F. On Scene Assistance to Victims and Dependents **BOT 3-12, 3-13, 3-14, 3-15**

Maine law provides that whenever an officer has reason to believe that a family or household member has been abused, the officer shall immediately use all reasonable means to prevent further violence. The LEO shall assist the victims of domestic violence in the following manner:

1. If any of the parties are Limited English Proficient, officers should arrange for interpretation services
2. Advise all parties about the criminal nature of domestic violence, its potential for escalation, and that help is available.
3. Remain on the scene as long as there is a reasonable belief that there is a danger to the physical safety of that person without the presence of an officer, including, but not limited to, staying in the dwelling unit.
4. Assist that person in obtaining medical treatment necessitated by an assault, including driving the victim to the emergency room of the nearest hospital.
5. Give that person immediate and adequate written notice of rights, which shall include information summarizing the procedures and relief available to victims of violence. This includes information about Protection From Abuse Orders and contact information for local domestic violence resource centers of the Maine Coalition to End Domestic Violence and the advocacy centers of the Wabanaki Women's Coalition.
6. In circumstances in which it is necessary for the victim to temporarily leave the residence, officers should offer the victim assistance in locating lodging with family, friends, public accommodations, or a domestic violence shelter/safe home.

G. Victim Notification, see 17-A M.R.S. §1175-A **BOT 3-20**

1. For victim notification to be possible by a jail, the officer must provide current victim contact information to the jail to which the defendant is delivered.
2. In a case of a crime involving domestic violence, a jail shall notify a victim of a defendant's release on pre-conviction bail as soon as possible but no later than one hour after the defendant's release. If the defendant is released on bail before being delivered to a jail, the arresting officer shall notify the victim as provided in this section.
3. Victim notification must be made by a telephone call directly to the victim. If the jail has not succeeded in contacting the victim after the jail has exercised due diligence in attempting to contact the victim, notification of the defendant's release must be made to this agency.
4. This agency shall make a reasonable attempt to notify the victim of the defendant's release. All notification attempts will be logged.
5. Notification to a minor victim must be made to an adult who is the victim's parent or legal guardian.

#### H. Law Enforcement Officer Follow-up

Officers assigned to domestic violence follow-up, accompanied by a back-up officer if reasonably available, shall contact the victim within 48 hours of all domestic violence incidents whether an arrest was made or not. In doing so, the officer can:

1. Check on the safety and well-being of the victim.
2. Ensure adherence with bail conditions, protection orders, and any other court orders. If violations are found, the officer should determine the nature of bail and court orders in that they are subject to change and, if there is a violation, arrest the offender.
3. Further advise the victim of information about Protection From Abuse Orders and advocacy programs.
4. Collect statements or other evidence.
5. Take follow-up photographs of any injuries from the original incident, if warranted.
6. Check social media outlets or other forms of digital technology in order to determine if any misuse of technology and/or stalking is occurring.
7. The officer shall complete a supplemental report regarding each follow-up visit and will ensure that it is attached to the original paperwork for the Office of the District Attorney. The officer will also ensure that the Office of the District Attorney receives any additional photographs or other evidence obtained as a result of the follow-up visit.
8. If the officer is unable to contact the victim within 48 hours, the officer will contact their supervisor who will make alternative arrangements to ensure that reasonable efforts to contact the victim continue.

#### I. Property Retrieval ***BOT 3-22***

Officers shall assist the retrieving individual in obtaining the safe retrieval of the personal property belonging to the victim/defendant by using the following procedures:

1. Officers shall make reasonable efforts to ensure a property retrieval has not already occurred. The officer shall then contact each party to determine a convenient time for

the retrieving individual to obtain personal belongings, if possible, giving the victim the option of at least 24 hours' notice.

2. When possible, meet the retrieving individual at a pre-determined neutral location, with at least one officer.
3. Identify any language, cultural, or other barriers to assistance and safety and provide referrals to community-based advocacy organizations.
4. Determine what personal belongings are to be obtained. These should be limited to clothing, children's clothing, toiletry items, and other reasonable personal belongings.
5. In a "keep the peace" retrieval for additional property, the officer shall review any court order provided detailing the property to be retrieved. The retrieving individual may not remove property unless specifically designated in the order unless both parties confirm the agreement. If any property is in dispute and possession is not designated in the order, the officer may not allow the retrieving individual to remove the property. The officer may refer the parties to the court for resolution of the matter.
6. The officer should keep the retrieving individual at a safe distance until it can be determined that the other person is not present.
7. Once the officer determines the other person is not present, then the retrieving individual can be accompanied into the location in order to obtain personal belongings.
8. The officer shall accompany the retrieving individual throughout the entire retrieval.
9. If it is determined the other person is at the location and violating any bail conditions or protective order stipulations, the officer shall arrest that person for the violation.
10. If it is determined other person is at the location and there is a "no contact" provisions in place, the officer shall attempt to have that person leave prior to the retrieving individual retrieving personal items.
11. The officer shall check the existence of any order or conviction that prohibits possession of firearms from the retrieving individual. The officer shall not allow firearms or ammunition retrieval by any prohibited person.
12. Advise the victim(s) in writing of the availability of Temporary Protection from Abuse Orders and where they can be obtained. This information can be obtained from the local domestic violence resource center. The officer shall also advise the victim(s) that transportation is available to a court or person authorized to issue such Protection from Abuse Orders.

J. Procedures Involving a Law Enforcement Agency Employee ***BOT 3-6, 3-7***

This agency also recognizes that no one is immune from incidents of domestic violence, including law enforcement. As part of this policy, this agency will take a proactive approach when responding to any domestic violence committed by agency employees. Incidents of domestic violence involving agency employees shall be investigated utilizing both the procedures outlined above in this policy, and the following procedures and considerations:

1. Agency Responsibilities

- a. This agency shall, either in response to observed warning signs or at the request of an officer or a member of an agency employee’s family, provide non-punitive avenues of assistance to employees, their partners, and other family members to mitigate potential acts of domestic violence.
  - b. This agency shall identify a procedure for making confidential referrals to counseling services, either internally or in collaboration with existing community services that have specific expertise in domestic violence.
  - c. Information learned by the CLEP about an employee’s conduct relating to the commission of domestic abuse, which could include criminal conduct, being a defendant in a temporary or permanent protective order in any jurisdiction, or other conduct reportable to the Maine Criminal Justice Academy under 25 M.R.S. §2806-A & §2807 shall be investigated both criminally and administratively as outlined in Model Policy 1-10 Investigation of Employee Misconduct.
  - d. Following a domestic violence incident, the agency shall designate a member of the command staff to act as a principal contact for the victim. The assigned contact officer will:
    - a. Keep the victim apprised of the case throughout the adjudication process.
    - b. Inform the victim of confidentiality policies and their limitations, and ensure that confidentiality is maintained throughout the case.
  - e. When responding to a domestic violence incident involving a law enforcement officer or other law enforcement agency employee from another jurisdiction, all law enforcement personnel shall follow the same procedures that are to be followed in responding to a domestic abuse complaint involving an employee from their own agency. The agency shall provide written notification to the CLEO in the suspect’s jurisdiction in a timely manner, and if possible within 24 hours.
  - f. 25 M.R.S. §2807 requires the Chief Law Enforcement Officer (CLEO) of an agency to notify the Director of the Maine Criminal Justice Academy within 30 days when an officer employed by that agency is convicted of a crime or violation or engages in conduct that could result in suspension or revocation of the individual’s certification.
    - i. In practice, this could include for example, a domestic violence related arrest, or being the defendant in a temporary or permanent Protection From Abuse Order.
    - ii. This could also include other conduct not resulting in an arrest, charge or conviction that would constitute engaging in conduct that is prohibited or penalized by state law as murder or a Class A, Class B, Class C or Class D crime or by any provision of Title 17-A, chapter 15, 19, 25, 29, 31, 35, 41 or 45, as per 25 M.R.S. §2806-A(5)(F).
2. Supervisor Responsibilities
- a. Supervisors shall be cognizant of and document all behavior, on-duty or off-duty, in which employees may be exhibiting signs of possible domestic violence related problems, including increased use of force during arrests, alcohol and/or drug abuse, increase in “controlling” behaviors, stalking activity, citizen and fellow officer complaints of unwarranted aggression and verbal abuse,

inappropriate aggression towards animals, and on-duty or off-duty injuries. Off-duty related problems and injuries would include problems as a victim or a suspect.

- b. Supervisors shall immediately make their ranking supervisor aware of any and all such behavior.
- c. The CLEO shall be informed of such circumstances or concerns in a timely manner through the chain of command, and if possible within 24 hours.
- d. Whenever an agency employee is arrested, the supervisor shall relieve the employee of any agency-issued weapons provided that the weapons can be legally obtained. The supervisor shall inquire whether the victim wants any weapons removed from the home for safekeeping by the agency and thereafter remove such weapons provided that such removal is accomplished legally.
- e. In the event that an incident involves the CLEO of the agency or the agency of another jurisdiction, the supervisor shall immediately notify the individual who has direct oversight for the CLEO.

### 3. Responding Law Enforcement Officer Responsibilities

- a. Investigating officers follow all procedures outlined in this policy, in addition to the procedures and considerations in this section.
- b. Upon arrival on the scene of a domestic violence call or incident involving a law enforcement officer or other employee of a law enforcement agency, the primary officer shall immediately notify dispatch, and notify or request notification of a supervisor of higher rank than the involved officer. The ranking officer should report to the scene, regardless of the involved officer's jurisdiction.
- c. Responding officers shall be aware of the heightened risk that a suspect who is a law enforcement officer will likely possess firearms, other weapons, physical combat training, or all three.
- d. Officers should be aware that the suspect might attempt to make emotional appeals to responding officers.
- e. In cases involving a suspect who is a law enforcement officer or other employee of a law enforcement agency, responding officers must respond to the victim in a way that assures the victim that their case will be investigated and handled thoroughly and professionally, without regard for the suspect's employment as a law enforcement officer.
- f. Responding officers shall seek out and preserve secondary sources of information and supplemental evidence, in order to ensure that coercion and tampering is not being attempted or committed, and in order to support the case in the event that the victim may discontinue involvement in the case for safety or other reasons.

### 4. Law Enforcement Employees Responsibilities

- a. Agency employees are encouraged and entitled to seek confidential assistance from the agency to prevent a problem from escalating to the level of criminal conduct against a family or household member.
- b. Agency employees with definite knowledge of violence and/or violence involving fellow employees must report such information in a timely manner to their supervisor. Failure to do so will subject the employee to disciplinary action.
- c. All employees shall be aware of possible witness or victim intimidation, coercion or tampering. Whenever an employee suspects this is occurring, the employee shall prepare a written report and immediately deliver it to the investigator in charge of the case.

- d. Employees who are the subject of a criminal investigation, protective order related to domestic violence, regardless of jurisdiction, are required to report themselves to the CLEO and provide notice of the court dates, times, appearances, and proceedings in a timely manner.

K. Protection Orders **BOT 3-9, 3-17, 3-19**

1. General
2. Arrest is mandatory if there is probable cause to believe that a violation of a court-approved Protection Order or a consent agreement has occurred, pursuant to 19-A M.R.S. §4012(5).
3. Once a Protection From Abuse Order has been issued, whether temporary or permanent, officers shall place a high priority on service of the Protection Order, or any modification of such order. The order must be served on the individual, by delivering a copy to the individual personally.
4. If the individual refuses to receive any Protection Order, the officer shall leave the Protection Order in the immediate presence of the individual and advise the individual of the content of the Protection Order, the fact that the individual has been officially served, and the consequences of a violation of the Protection Order.
5. Officers will document all Protection Order services and/or attempts, articulating the circumstances surrounding the service/attempt of the Protection Order. Once service has been made, the serving agency shall ensure the service information is entered into the METRO System without delay and the return of service is sent to the court.
6. Uniform Full Faith and Credit Clause: Officers shall expeditiously enforce valid Protection Orders from other States and Tribal Courts. Officers shall verify the validity of the protection orders prior to enforcing them.
7. Violation of a Protection Order **BOT 3-18**

A person commits the offense of “Violation of a Protection Order” if:

- a. A District Court has issued a Protection Order, Temporary Protection Order, or any modification of such an order against a person, and that person violates that order;
  - b. The defendant received prior actual notice of the order or consent agreement, which may be by physical service of the order or notice other than service in hand, pursuant to 19-A M.R.S. §4011(1); and
  - c. That person knowingly violated any condition of the Order.
  - d. Officers must recognize that a person who obtains a Protection From Abuse Order cannot violate the order regardless of any action taken by the person or the defendant; the order only constrains the defendant.
8. Enforcement of a Violation of a Protection Order  
Pursuant to 19-A M.R.S. §4012(5), in-custody arrest is mandatory for any violation of a protective order.

L. Agency Follow Up if Victim is Seriously Injured or Killed **BOT 3-23**

The Chief Law Enforcement Officer (CLEO) of this agency shall cause to have this policy reviewed, and document the agency’s compliance with policy, in the event that a victim of domestic violence who resided in this agency’s jurisdiction is killed or seriously injured during the time that any temporary or permanent Protection from Abuse order (PFA) was in effect or there had been past agency involvement related to interactions between the perpetrator and the victim. The review shall be conducted in consultation



with a domestic violence advocate as defined in 16 M.R.S. §53-B(1)(A) and a sworn law enforcement officer designated or trained as a domestic violence investigator. A report shall be prepared and kept on file with the agency.

In any case where one or more victims are killed, a copy of the report shall be forwarded to the Maine Domestic Abuse Homicide Review Panel through the Maine Office of the Attorney General.

PER ORDER OF: \_\_\_\_\_  
Chief Executive Officer

**\*\*\*ADVISORY\*\*\***

This Maine Chiefs of Police Association model policy is provided to assist your agency in the development of your own policies. All policies mandated by statute contained herein meet the standards as prescribed by the Board of Trustees of the Maine Criminal Justice Academy. Prior to implementation, it is recommended to review this model policy and incorporate any changes that will make it unique to your agency. The watermark may be removed by going to page layout, click on watermark, and click on remove watermark.

**\*\*\* DISCLAIMER\*\*\***

This model policy should not be construed as a creation of a higher legal standard of safety or care in an evidentiary sense with respect to third party claims. Violations of this policy will only form the basis for administrative sanctions by the individual law enforcement agency and/or the Board of Trustees of the Maine Criminal Justice Academy. This policy does not hold the Maine Chiefs of Police Association, its employees or its members liable for any third-party claims and is not intended for use in any civil actions. Any questions regarding the policy can be directed to the MCOA Policy Committee.

- Chief Jason Moen, [jmoen@auburnmaine.gov](mailto:jmoen@auburnmaine.gov) Chairperson
- Chief Doug Bracy [dbracy@yorkpolice.org](mailto:dbracy@yorkpolice.org)
- Chief Jack Peck [jpeck@FarmingtonPD.org](mailto:jpeck@FarmingtonPD.org)
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- Major Chris Cloutier [chris.cloutier@maine.gov](mailto:chris.cloutier@maine.gov)
- Detective Peter Lizanecz [peter.lizanecz@maine.gov](mailto:peter.lizanecz@maine.gov)

# Domestic Violence Response: Best Practices for Law Enforcement Officers in Maine



## I. INITIAL RESPONSE

- A. Secure the scene and restore order
- B. Locate parties upon arrival and *separate them*
- C. Secure all weapons
- D. Assess medical needs of parties
- E. **Note excited utterances**—exact words by all parties including children, and all parties' emotional and physical condition

## II. AT-SCENE INVESTIGATION

### A. Interviews—recording preferred

#### 1. Victim and Suspect

- a. Provide language services to those with Limited English Proficiency and avoid using family members to interpret for each other
- b. Interview parties out of sight and sound of each other, if possible
- c. Interview twice to test consistency of statements—determine what occurred with detailed description of the crime(s)
- d. **Determine history of abuse**—include convictions, arrests, time in jail, undocumented/unreported abuse
- e. Seek additional details about the context of the relationship – Ongoing stalking behaviors, misuse of technology to enhance abusive tactics, any non-criminal dynamics of coercive control observed at the scene or heard in interviews.
- f. In all cases involving Domestic Violence Assault or threatening with a weapon, gather information to complete the 13 **ODARA** items:
  - i. Prior domestic incident of assault in a law enforcement or criminal record
  - ii. Prior non-domestic incident of assault in a law enforcement or criminal record
  - iii. Prior custodial sentence of 30 days or more
  - iv. Failure on prior conditional release
  - v. Threat to harm or kill at the index assault
  - vi. Confinement of the victim at the index assault
  - vii. Victim concern about future assaults
  - viii. More than one child
  - ix. Victim's biological child from a previous partner
  - x. Prior violent incident against a non-domestic victim
  - xi. Two or more indicators of substance abuse
  - xii. Assault on the index victim while pregnant
  - xiii. Barriers to victim support
- g. Due to prevalence and lethality of strangulation, ask about it and look for signs and symptoms in all cases, especially when the suspect has committed any other form of Domestic Violence Assault
- h. Check NCIC for warrants and Protection From Abuse Orders

#### 2. Children (in the home, even if not present at the scene)

- a. Names and dates of birth
- b. Current/historical abuse that the children have witnessed
- c. Talk to children about their safety

#### 3. Other witnesses at the scene

- a. Family    b. Friends    c. Neighbors    d. Others with knowledge

### B. Make the predominant aggressor determination

1. **Actively investigate the possibility of self-defense by either party**
2. Note the relative strength of each party
3. Note the nature and severity of any injuries—look for self defense injuries
4. Determine credibility and ability
5. Determine the history of abuse and likelihood of future harm

### C. Obtain written statements at the scene—do not leave affidavits to be filled out later

1. **Record or document suspect's statement**

2. Record or document victim's statement
3. Determine where suspect lived previously—to locate priors and determine felon status (side 2)
4. Obtain name/contact info. of someone who always knows how to reach victim

**D. Collect and Preserve All Relevant Evidence**

1. **Photograph the crime scene**
  - a. All parties including children to show injury and demeanor—for use at bail hearings, trial, sentencing
  - b. Property damage
2. Collect technology-based evidence (texts, e-mails, telephone records, social-networking, hardware, etc.)
3. Seize weapons used
4. Collect damaged property
5. Collect other pertinent physical evidence—hair, blood, torn clothing, etc.

**E. Possible actions at the scene**

1. **Arrest**
2. Serve trespass/harassment notice
3. Transport for medical attention
4. Obtain medical release from victim
5. Complete jail phone block form with victim
6. Provide referral information for PFA/PFH Order
7. Provide referral information for local domestic violence resource center, sexual assault support center, and/or batterers intervention program
8. Complete the ODARA
9. Remain on the scene until believing all parties will be physically safe

**III. REPORT WRITING CHECKLIST**

- A. Note who called law enforcement
- B. Note the names, dates of birth, and relationship between parties—note elder abuse and gay/lesbian/bisexual/transgender
- C. Note the times of the incident, arrival, and statements—for excited utterance purposes
- D. **Describe the scene/all crimes**
- E. Describe injuries, medical attention, and emotional states of parties
- F. Note the use of weapons
- G. Note liquor/drug use
- H. Note bail status and conditions, probation status and conditions, and PFA/PFH Order status and conditions
- I. Victim and suspect statements
- J. Note primary language spoken by victim and suspect
- K. Information from children and other witnesses
- L. Photographs and other relevant evidence
- M. Probable cause determination for each arrested party
- N. Attach criminal records checks—SBI, Triple-I
- O. Attach ODARA Item Summary score sheet

**IV. FOLLOW-UP**

**A. Bail**

1. **Give bail commissioner detailed information** including victim's name, date of birth, address and phone number, exact relationship to offender, history of domestic abuse, any probation, bail, or PFA Order conditions, and ODARA results
  2. Ask for appropriate bail conditions—for example: no contact direct or indirect with the victim, no returning to residence, no possession/consumption of liquor or drugs, no possession of firearms
- B. Notify victim upon receiving information from correctional facility re: suspect's release
  - C. Advise local domestic violence investigator of the case
  - D. Collect 911 recording and other recorded evidence
  - E. Follow-up with victim and take additional photographs of injuries
  - F. Interview and obtain written statements from EMTs—including run sheets—and communications officers/dispatchers
  - G. Obtain medical records and ER photographs
  - H. Deliver victim consent form to domestic violence resource center for follow-up contact
  - I. Refer to other domestic violence services in Maine including Wabanaki Tribes of Maine Domestic Violence and Sexual Assault Services, and/or culturally specific services for members of Somali or Sudanese populations
  - J. Refer to victim-witness advocate for follow-up contact
  - K. Report to DHHS—Child or Adult Protective Services
  - L. Refer to State of Maine Address Confidentiality Program
  - M. Follow up with Office of District Attorney and Office of U.S. Attorney for federal prosecution

*This Best Practices Card was originally created by "Peace In Our Families" and endorsed by the following groups: Maine Chiefs of Police Association, Maine Coalition Against Sexual Assault, Maine Coalition to End Domestic Violence, Maine Commission on Domestic and Sexual Abuse, Maine Prosecutors Association, Maine Sheriffs Association, Maine State Police, Office of the Attorney General, Office of the U.S. Attorney. The template for this card is available from the Maine Coalition to End Domestic Violence—revised 3/14*

# APPENDIX D: RESOURCES



## MCEDV.

The Maine Coalition  
to End Domestic Violence

Help is just a call away.

24 Hour • Toll Free • Confidential

**1-866-834-HELP (4357)**

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



### MCEDV MEMBERS:

#### AROOSTOOK

*Hope and Justice Project*

#### PENOBSCOT & PISCATAQUIS

*Partners for Peace*

#### KENNEBEC & SOMERSET

*Family Violence Project*

#### HANCOCK & WASHINGTON

*Next Step Domestic Violence Project*

#### ANDROSCOGGIN, FRANKLIN & OXFORD

*Safe Voices*

#### KNOX, LINCOLN, SAGADAHOC & WALDO

*New Hope for Women*

#### CUMBERLAND

*Through These Doors*

#### YORK

*Caring Unlimited*

#### CULTURALLY SPECIFIC SERVICES

*Immigrant Resource Center of Maine*

[mcedv.org](http://mcedv.org)



 **MCEdV MEMBERS**

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

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

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

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

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

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

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

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

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

**Member Programs of the Wabanaki Women's Coalition**

**Tribal Domestic & Sexual Violence Coalition**  
www.wabanakiwomenscoalition.org

**Aroostook Band of Micmacs  
Domestic & Sexual Violence Advocacy Center**  
www.micmac-nsn.gov  
7 Northern Rd., Presque Isle, ME 04769  
Admin: 207-760-0570 Hotline: 207-551-3639

**Houlton Band of Maliseets  
Domestic & Sexual Violence Advocacy Center**  
www.maliseets.com  
690 Foxcroft Rd., Houlton, ME 04730  
Admin: 207-532-3000 Hotline: 207-532-6401

**Pleasant Point Passamaquoddy  
Peaceful Relations Domestic & Sexual  
Violence Advocacy Center**  
www.wabanaki.com  
P.O. Box 343, Perry, ME 04467  
Admin: 207-853-0092 Hotline: 1-877-853-2613

**Penobscot Indian Nation  
Domestic & Sexual Violence Advocacy Center**  
www.penobscotnation.org  
2 Down St., Indian Island ME, 04468  
Admin: 207-817-3164 x2 Hotline: 207-631-4886

**Indian Township Passamaquoddy  
Domestic & Sexual Violence Advocacy Center**  
P.O. Box 301, Princeton, ME 04668  
Admin: 207-796-6106 Hotline: 207-214-1917

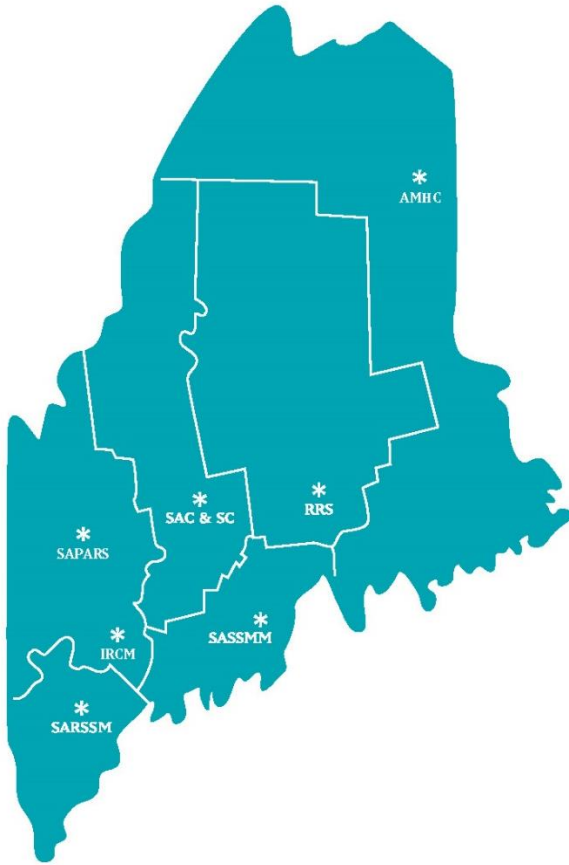
**The Maine Coalition  
to End Domestic Violence**

Connecting people,  
creating frameworks for change.  
mcedv.org

# mecasa

MAINE COALITION AGAINST  
SEXUAL ASSAULT

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



## STATEWIDE SEXUAL ASSAULT HELPLINE

**Text/Call: 1-800-871-7741**

**Chat: [mecasa.org](https://mecasa.org)**

**Text & chat help: Monday-Wednesday, 10 am - 8 pm**

**& Thursday-Friday, 12 pm - 8 pm**

**Phone help: 24/7**

**Free. Private.**

## MAINE'S SEXUAL ASSAULT SUPPORT CENTERS

### AMHC Sexual Assault Services (AMHC)

Serving Aroostook, Hancock, & Washington Counties •  
[amhcsexualassaultservices.org](https://amhcsexualassaultservices.org)

### Immigrant Resource Center of Maine

Serving Androscoggin & Cumberland Counties • [ircofmaine.org](https://ircofmaine.org)

### Rape Response Services (RRS)

Serving Penobscot & Piscataquis Counties • [rrsonline.org](https://rrsonline.org)

### Sexual Assault Prevention & Response Services (SAPARS)

Serving Androscoggin, Oxford & Franklin Counties and the towns of  
Bridgton & Harrison • [sapars.org](https://sapars.org)

### Sexual Assault Crisis & Support Center (SAC & SC)

Serving Kennebec & Somerset Counties • [silentnomore.org](https://silentnomore.org)

### Sexual Assault Response Services of Southern Maine (SARSSM)

Serving Cumberland & York Counties • [sarsonline.org](https://sarsonline.org)

### Sexual Assault Support Services of Midcoast Maine (SASSMM)

Serving Eastern Cumberland, Sagadahoc, Knox, Waldo & Lincoln  
Counties • [sassmm.org](https://sassmm.org)

## MORE SEXUAL VIOLENCE SERVICES

Wabanaki Women's Coalition • [wabanakiwomenscoalition.org](https://wabanakiwomenscoalition.org)  
207-763-3478

Aroostook Band of Micmacs, Domestic & Sexual Violence  
Advocacy Center • 207-551-3639

Houlton Band of Maliseets, Domestic & Sexual Violence  
Advocacy Center • 207-532-6401

Indian Township Passamaquoddy, Domestic & Sexual  
Violence Advocacy Center • 207-214-1917

Passamaquoddy Peaceful Relations • 1-877-853-2613

Penobscot Indian Nation, Domestic & Sexual Violence  
Advocacy Center • 207-631-4886

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



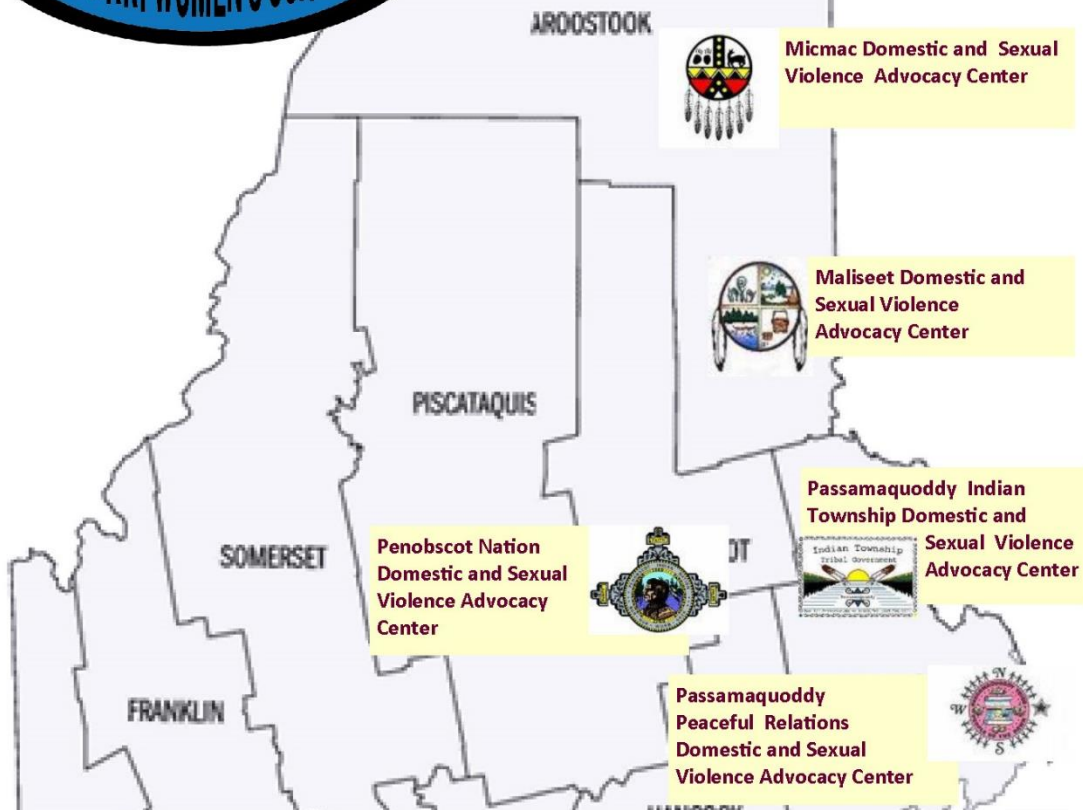
[www.WabanakiWomensCoalition.org](http://www.WabanakiWomensCoalition.org)

Jane Root, Executive Director


207.763.3478


Donna Brown, Outreach Coordinator


207.322.6604





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

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

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

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

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

 **Penobscot Indian Nation**, Domestic and Sexual Violence Advocacy Center  
23 Wabanaki Way, Indian Island, ME 04468  
Office: 207.817.7448 Hotline: 207.631.4886