The Commonwealth of Massachusetts
Executive Office of Public Safety and Security
One Ashburton Place, Room 2133
Boston, Massachusetts 02108
Tel: (617) 727-7775
TTY Tel: (617) 727-6618
Fax: (617) 727-4764
www.mass.gov/eopss

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lt. Governor

DANIEL BENNETT
Secretary

8/30/18
3:48pm

August 29, 2018

The Honorable William F. Welch
Clerk of the Senate
State House, Room 335
Boston, MA 02133

The Honorable Steven T. James
Clerk of the House
State House, Room 145
Boston, MA 02133

Dear Mr. Welch and Mr. James:

Pursuant to Section 4 of Chapter 260 of the Acts of 2014, please find a Report from the State Fatality Domestic Violence Review Team (2018) enclosed with this letter.

We hope you find this information helpful. Please let us know if we may be of further assistance.

Sincerely,

David Bennett

Daniel Bennett
Secretary of Public Safety and Security

Encl.
2018 Report

cc: House Committee on Ways and Means
Senate Committee on Ways and Means
Joint Committee on Children, Families and Persons with Disabilities
Joint Committee on Public Safety and Homeland Security
Joint Committee on the Judiciary

A Report from the State Domestic Violence Fatality Review Team

June 23, 2018

I. A Letter from the Chair

Citizens of the Commonwealth:

The Massachusetts State Domestic Violence Fatality Review Team presents its annual report for 2017.

The State Team took a major step forward this past year, making the leap from the comprehensive training seminars and mock review sessions of 2016 to holding our first ever fatality reviews across the state.

In accordance with our mission statement, core values, and guiding principles, the Team opted to review only intimate partner related fatalities, a subset of overall domestic violence related homicides. We selected two cases involving murder and suicide through different District Attorneys' Offices. Local teams were assembled by the DAs who then met with the State Team to conduct the case review sessions. As always, Members strictly adhered to our "no blame and no shame" philosophy – a national best practice that fosters opportunities for learning and guides many state and local fatality review teams.

We present our findings and recommendations from the review sessions in Section V of this report. While we hope that these findings and recommendations can have a positive impact on reducing the incidence of domestic violence related deaths in the Commonwealth, we know there is still much work to be done. 2016 saw 18 domestic violence incidents resulting in 14 domestic violence homicides and nine (9) perpetrator suicides or deaths. Sadly, 2017 was worse – with 24 incidents resulting in 19 homicide victims and nine perpetrator suicides or deaths. The need for our Team is real and it is urgent.

For 2018, we are planning three deep and comprehensive fatality review sessions that are both geographically and demographically different than this past year. The Team hopes to have reviewed one case from each county within the next four years.

Members would like to thank Governor Baker, Lieutenant Governor Polito, and the Governor's Council to Address Sexual and Domestic Violence for their leadership and support throughout the process. We would also like to thank the MA District Attorneys Association, along with the Commonwealth's dedicated District Attorneys and staff who have held review sessions this year and offered to host local review sessions in the near future.

Sincerely,

Tammy Mello
Chair, State Domestic Violence Fatality Review Team

II. Membership

State Team Members

Tammy Mello, *Executive Director of the Governor's Council to Address Sexual Assault and Domestic Violence, Executive Office of Public Safety and Security (Chair)*

Jennifer Snook, *Assistant Attorney General, Office of the Attorney General*

Henry M. Nields, MD, PhD, *Chief Medical Examiner (Ret.), Office of the Chief Medical Examiner*

Mindy Hull, MD, *Chief Medical Examiner, Office of the Chief Medical Examiner*

Middlesex District Attorney Marian Ryan, *Massachusetts District Attorneys Association*

MaryBeth Long, *General Counsel, Office of Middlesex District Attorney Marian Ryan*

Major Joseph Duggan, *Division of Investigative Services, Massachusetts State Police*

Dianne Fasano, *Deputy Commissioner for Field Services, Massachusetts Probation Service/Office of the Commissioner of Probation*

Liam Lowney, *Executive Director, Massachusetts Office for Victim Assistance*

Dianne Coffey, *Director of Victim Services, Massachusetts Office for Victim Assistance*

Chief Justice of the Trial Court or a designee*

Chief Justice of the Family and Probate Court or a designee*

*In accordance with Committee on Judicial Ethics (CJE) Opinion No. 2014-4, "Serving on Statutory Commissions", dated December 10, 2014, Judges are not permitted to serve on the State Fatality Review team despite being named in statute:

> *"The Code also does not permit you to serve on the domestic violence state review team, St. 2014, c. 260, § 4, because its clear focus and unbalanced make-up could convey the impression that domestic violence victims have a special position of influence with the judiciary and that the judiciary is aligned with the interests of law enforcement and the prosecution.*
>
> *You may, however, consult with the Juvenile Life Sentence Commission and the domestic violence state review team pursuant to Section 4C(1) on discrete matters that concern the business of the courts as long as you make your limited participation clear in the reports and any records these commissions produce.*
>
> *Additionally, the Code does not prohibit you from appointing non-judge employees of the judiciary to serve on any of these commissions as your designees. Those designees cannot have more powers than*

you. Although the Committee cannot render advice to non-judges, the Committee instructs you to inform your designees that the Code's limitations on your participation also apply to the designees and that these limitations should be clearly disclosed on all documents that list committee members and on all reports and recommendations the committee makes."[1]

III. Background

The State Fatality Review Team was created by Chapter 260 of the Acts of 2014, *An Act Relative to Domestic Violence*. Chapter 260 was passed unanimously by the Legislature and signed into law on August 8, 2014.

Section 4 of Chapter 260 outlines the Team's roles and responsibilities:

> *"The purpose of the state team shall be to decrease the incidence of domestic violence fatalities by: (i) developing an understanding of the causes and incidence of domestic violence fatalities and domestic violence murder-suicides and the circumstances surrounding them; and (ii) advising the governor and the general court by recommending changes in law, policy and practice designed to prevent domestic violence fatalities. The state review team, in conjunction with any local review teams, shall develop a report to be sent to the clerks of the house and senate, the house and senate committees on ways and means, the joint committee on children, families and persons with disabilities, the joint committee on public safety and homeland security, and the joint committee on the judiciary. The report shall be issued not later than December 31 of each year.*
>
> *To achieve its purpose, the state review team shall: (1) develop model investigative and data collection protocols for local review teams; (2) annually review incidents of fatalities within the commonwealth and assign at least 3 reviews, selected at random, to a local review team for investigation and report; provided, that no review shall be assigned unless it is approved by a majority vote of the state review team and all criminal proceedings, including appeals, related to the fatality are complete; (3) provide information to local review teams, law enforcement agencies and domestic violence service providers for the purpose of protecting victims of domestic violence; (4) provide training and written materials to local review teams to assist them in carrying out their duties; (5) review reports from local review teams; (6) analyze community, public and private agency involvement with victims and perpetrators of domestic violence and their families prior to and subsequent to fatalities; (7) develop a protocol for the collection of data regarding fatalities and provide training to local review teams on the protocol, which shall include protocol and training on the issues of confidentiality of records, victims' identities and any personally identifying data; (8) develop and implement rules and procedures necessary for its own operation and the operation of local review teams, which shall include the use of confidentiality agreements for both the state and local review teams; and (9) provide the governor and the general*

[1] http://www.mass.gov/courts/case-legal-res/ethics-opinions/judicial-ethics-opinions/cje-2014-4.html

court with annual written reports, subject to any applicable confidentiality restrictions, which shall include, but not be limited to, the state team's findings and recommendations."[2]

In selecting cases for review, the State Review Team assigns cases to Local Review Teams. Per Section 4 of Chapter 260:

> *"Each local review team shall be chaired by the local district attorney and shall be comprised of at least the following members, who shall be appointed by the district attorney and who shall reside or work within the district: a medical examiner or pathologist; a chief of police; a probation officer; a member with experience providing non-profit legal services to victims of domestic violence; a member with experience in the delivery of direct services to victims of domestic violence; and any other person with expertise or information relevant to an individual case who may attend meetings on an ad hoc basis, including, but not limited to, local or state law enforcement officers, local providers of social services, providers of community based domestic violence, rape and sexual assault shelter and support services, hospital representatives, medical specialists or subspecialists, teachers, family or friends of a victim and persons recommended by the state review team.*
>
> *The purpose of each local review team shall be to decrease the incidence of preventable domestic violence fatalities by: (i) coordinating the collection of information on fatalities assigned to it for review; (ii) promoting cooperation and coordination between agencies responding to fatalities and providing services to victims or victims' family members; (iii) developing an understanding of the causes and incidence of domestic violence fatalities within its area; and (iv) advising the state review team on changes in law, policy or practice which may affect domestic violence fatalities.*
>
> *To achieve its purpose, each local review team shall, subject to assignment by the state review team: (1) review, establish and implement model protocols from the state review team; (2) execute a confidentiality agreement; (3) review individual fatalities using the established protocol; (4) recommend methods of improving coordination of services between agencies and service providers in its area; (5) collect, maintain and provide confidential data as required by the state review team; and (6) provide law enforcement or other agencies with information for the purposes of the protection of victims of domestic violence and for the accountability of perpetrators."*[3]

The State Fatality Review Team organized over the summer of 2015. Members held meetings and initial training with the NDVRI later that fall.

Through consultation with Lieutenant Governor Karyn Polito and the Governor's Council to Address Sexual Assault and Domestic Violence, the State Review Team collaborated with the National Domestic Violence Fatality Review Initiative (NDVFRI) in 2016 to construct a robust seminar centered on national best practices. The day-long training included a comprehensive overview of fatality review procedures and proto-

[2] https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter260
[3] Ibid.

cols, followed by mock case reviews. Joining the State Review Team for the seminar were District Attorneys and Assistant District Attorneys from all eleven offices across the Commonwealth.

IV. Philosophy and Process

Throughout the Team's training and consultation with the National DV Fatality Review Initiative (NDVFRI), members crafted a clear Mission Statement and identified Core Values and Guiding Principles to lead the Team through the fatality review process.

The Statement, Values, Process are reviewed and read aloud at the start of all fatality review sessions. They provide a template for decision making throughout the review.

MISSION STATEMENT

The Massachusetts State Domestic Violence Fatality Team provides strategic leadership for, and conducts collaborative, multi-disciplinary reviews of domestic violence related fatalities with local review teams in an effort to better understand the dynamics of such deaths and develop recommendations—without blame—for creative and effective strategies to reduce the number of domestic violence deaths in the Commonwealth.

CORE VALUES

It would be a daunting task to review all of the domestic and family violence deaths in Massachusetts each year. Accordingly, the State Team decided to take a similar approach to Montana and other states – focusing its time and resources on reviewing only "intimate partner" homicides and related fatalities.

Even then, the Team is only able to review two to three cases per year, as members have opted to delve deeply into a smaller number of cases versus a cursory review of all fatalities. The NDVFRI demonstrates, however, that the recommendations from a handful of meticulous case reviews should yield far-reaching implications for reducing Massachusetts' domestic violence fatalities in the future.

For the review sessions, members have opted for the same "no blame and no shame" philosophy that guides many national fatality review teams. The State Fatality Review Team is not looking to single out individuals or agencies as bearing responsibility for the deaths. Rather, members will seek to identify systemic failures stemming from shortfalls and inefficiencies in the local and state responses and then recommend the appropriate solutions.

In addition, the reviews will help to identify needs related to public awareness and education. For example, in 2010, Baltimore, Maryland's team made a recommendation on increasing resources for men's engagement work, and in 2014 recommended creation of an outreach program to work with communities on bystander interventions. Team recommendations are to be issued in general terms so as not to infringe upon the confidentiality of those involved in each case.

THE REVIEW PROCESS

Each review session will take place in the county where the crime was committed and involve a Local Review Team chaired by the District Attorney with jurisdiction over the case. In conjunction with the State Team, the Local Team will request all available information and connect with relevant parties. Relevant information includes consultation with law enforcement, as well as gathering criminal histories, medical records, autopsy reports, and other case history. The Teams will also attempt to speak with family members, friends, colleagues, teachers, advocates and other individuals close to the victims and perpetrators. The idea is to gather as much background information as possible to paint an accurate portrait of the family and those that knew them.

About a week prior to assembling, the host local review chair will create a timeline of events from all of the gathered information and share with team members. This exercise is designed to expose strengths and weaknesses in the system, get a better understanding of relationship dynamics, understand who the formal and informal support networks were and what they knew, determine any history of help-seeking and offender accountability and the impact of both, and help the team understand the circumstances leading up to the fatality.

At the conclusion of each session, Members will then identify a number of practical recommendations and corresponding objectives that can be measured over time. These criteria allow the State Team to monitor the progress of its recommendations and ultimately measure success.

The State and Local Teams operate under strict confidentiality. Upon completion of the review, all materials, reports and timelines used and created in the meeting are shredded. The state team Chair will keep the recommendations for inclusion in the annual report.

V. Recommendations from Fatality Review Sessions

In 2017, The State Team unanimously selected two cases for review from different counties in the Commonwealth. Both cases involved murder and suicide by the perpetrator. Members worked with District Attorney of jurisdiction, and his or her staff, to assemble a Local Review Team and the necessary materials to complete each case review. The review sessions each lasted a full day at the respective DA's Offices.

The State Fatality Review Team offers the following recommendations from the two in-depth fatality review sessions held this past year:

1. **The State Team recommends filing legislation for certain technical amendments relative to record sharing and membership outlined in its authorizing statute – M.G.L. ch.6A §18N.**

   Current law allows for record sharing related to the victim, but they do not allow for those related to the perpetrator in all cases. Language allowing the Chair of the State Team to review records related to the perpetrator was omitted from subsection (e). In the two cases that were reviewed, the

Chair could not access and review records related to the perpetrator that were held by certain state agencies. Members believe this left them at a disadvantage when reviewing cases. The Team recommends correcting this oversight to allow access to all records related to the perpetrator.

2. **The State Team recommends filing legislation adding two new members to the State Fatality Review Team.**

   In completing their review sessions this past year, Members felt that the addition of the following two seats would be beneficial to the State Team: (1) A Representative from a Community Non-profit Program with expertise in perpetrators of intimate partner violence and risk assessment, and (2) The Commissioner of the Massachusetts Department of Public Health or a designee.

3. **The Massachusetts Department of Public Health, in consultation with the Executive Office of Public Safety and Security, the Executive Office of Health and Human Services, and the State Domestic Violence Fatality Review Team, should create a public service announcement campaign on domestic violence awareness targeted towards family, close acquaintances, and bystanders to help identify the signs of abusive behavior.**

   Through its work, the State Team found a real need for public service announcements emphasizing the dangers and risks that victims face even when physical violence is not evident or apparent. The campaign should highlight and include recommended courses of action and available resources for concerned family members, close acquaintances, and bystanders who witness troubling behavior or identify certain warning signs of an abusive relationship.

4. **The Massachusetts Department of Public Health, in consultation with the Executive Office of Public Safety and Security, the Executive Office of Health and Human Services, and the State Domestic Violence Fatality Review Team, should explore options for creating a community-based training program on domestic violence awareness. The program should be targeted towards family, close acquaintances, and bystanders to help identify the signs of abusive behavior and highlight available resources.**

   In reviewing cases, the State Team identified the need for a community training program (similar to the "Mental Health First Aid" model) that helps family, close acquaintances, and bystanders identify, understand, and respond to the signs of abusive behavior.

5. **The State Review Team should confidentially share any feedback from review sessions relative to state agencies with the appropriate agency leadership. This includes noted achievements as well as areas needing improvement.**

The State Team operates in accordance with its "no blame and no shame" philosophy. Members are not looking to publicly single out certain individuals or agencies. However, the Team believes it has the responsibility to share feedback on any areas where agencies have made progress and/or may need improvement. Members feel it is just as important to report on the successes as it is any potential shortcomings they may encounter during a case review. In many instances, potential issues identified in past cases have already been remedied through recent legislation or changes to administrative policies. The Team especially wants to note such areas where progress has been made.

VI. Data on 2017 Domestic Violence Related Fatalities

Jane Doe, Inc. is the Massachusetts statewide coalition against sexual assault and domestic violence. The organization publishes an annual overview of domestic violence homicides in Massachusetts. The 2017 Overview is included in Appendix A.

According to Jane Doe Inc., there were 24 separate episodes of domestic violence related homicides in Massachusetts in 2017, resulting in 19 homicide victims and 9 perpetrator suicides or deaths.

The success of the State Review Team will ultimately be measured by our ability to both identify opportunities to improve system and community response to domestic violence, identify opportunities for prevention and education, as well as identify replicable best practices that increase safety for victims and hold offenders accountable. The need is urgent.

VII. Appendices

A. Jane Doe Domestic Violence Homicides in Massachusetts Year to Date 2017

Appendix A

Jane Doe Inc.
The Massachusetts Coalition Against Sexual Assault and Domestic Violence

Please refer to JDI's definition of domestic violence homicide to provide context for these different categories and the information provided here.

Overview of Domestic Violence Homicides in Massachusetts Year to Date 2017			WHO ARE THESE DV HOMICIDE VICTIMS?	
# of DV Homicide Incidents	24		Female DV Victims	14
# of DV Homicide Victims	19		Male DV Victims	4
# of DV Perpetrator Suicides or Deaths^	9		DV Perpetrators (except when killed by police)	0
Total DV Deaths	28		Female Associated with DV Victim	0
Male DV Homicide Perpetrators	16		Male Associated with DV Victim	0
Female DV Homicide Perpetrators	3		Children Associated with DV Victim	1
			Family (non-IPV)	0
			Bystanders (includes police)	0

Details Domestic Violence Homicides in Massachusetts January 1, 2017 through YTD 2017

DATE	HOMICIDE VICTIM	AGE	ALLEGED HOMICIDE PERPETRATOR *(relationship)*	AGE	CITY/ COUNTY	LOCATION/ method
1/9/2017	**Eugenia Gomes Monteiro**	30	**Matias Andrade** *(S)* *Former male partner*	38	*Brockton, Plymouth*	*Home/ Shooting*
1/22/2017	**Maria Morton**	32	**Tony Ventura** *Current male partner*	32	*Lawrence, Essex*	*Home/ Strangulation*
2/28/2017	**Mary J. Fratantonio**	35	**Christopher S. Fratantonio** *Current male spouse*	36	*Cotuit, Barnstable*	*Home/ Stabbing*
4/16/2017	**Aracelys Valdez Deleon**	40	**Luis Rodriguez** *Former male partner*	24	*Lawrence, Essex*	*Public space/ Shooting*
4/30/2017	**Brenda Hatheway**	43	**Joseph Kenadek** *Current male partner*	51	*Webster, Worcester*	*Home/ TBD (possibly blunt force trauma and drug overdose)*
5/11/2017	**Nicole White**	44	**Ross Elliot (S)** *Current male partner*	51	*Lowell, Middlesex*	*Home/ Shooting*
5/22/2017	**Kristina Reis**	36	**Scott Rego** *Current male partner*	26	*Fall River, Bristol*	*Home/ Stabbing*
5/23/2017			**Kelly Pastrana** *(S)* *Current male partner*	38	*Chelsea, Suffolk*	*Home/ Shooting by police and Thermal Injuries from Fire*
6/21/2017	**Leah Penny**	31	**Ryan Power** *Current male partner*	32	*Malden, Middlesex*	*Home/ Strangulation*
6/21/2017	**Scott Benoit**	52	**Kirsten Smith** *Current female partner (potential dv victim)*	53	*Brockton, Plymouth*	*Home/ Stabbing*
7/1/2017			**Antonio Goncalves** (S) *Current male spouse*	47	*Brockton, Plymouth*	*Near home/ Hanging*
7/5/2017	**Amanda J. Glover**	48	**Lewis Starkey III** *Current male partner*	53	*Wendell, Franklin*	*Home/ Shooting*
7/8/2017			**Austin Reeves (S)** *Former male partner*	26	*Hingham, Plymouth*	*Home/ Shooting*
7/9/2017	**Corrinna L. Santiago**	42	**James P. Vaillancourt** *Current male partner*	49	*Leominster, Worcester*	*Home/ Strangulation*

Details Domestic Violence Homicides in Massachusetts January 1, 2017 through YTD 2017						
DATE	**HOMICIDE VICTIM**	**AGE**	**ALLEGED HOMICIDE PERPETRATOR** *(relationship)*	**AGE**	**CITY/ COUNTY**	**LOCATION/ method**
7/14/2017 (approx.)	**Joseph Shaw**	*44*	**Kathryn Podgurski** *Current female partner*	*33*	*Brockton, Plymouth*	*Home/ Stabbing*
7/23/2017	**Sonia Rios**	*42*	**Jose Cortes** *Current male partner*	*58*	*Leominster, Worcester*	*Home/ Stabbing*
7/23/2017			**Walter Lynde (D)** *Current male partner*	*49*	*East Brookfield, Worcester*	*Home/ Shooting by police*
7/24/2017	**Celeste Kordana**	*39*	**John Kordana (S)**	*51*	*Pittsfield, Berkshire*	*Home/ Blunt Trauma*
7/27/2017	**David Carlson**	*53*	**Brayan Flores** *Former male partner*	*28*	*Worcester, Worcester*	*Home/ Blunt Trauma*
8/19/2017	**Michele Clarke**	*33*	**Cornel Bell (uses multiple aliases)** *Former male partner*	*44*	*Weymouth, Norfolk*	*Home/ Sharp trauma injuries*
9/1/2017			**Daniel Gillis (D)** *Current male partner*	*36*	*Pittsfield, Berkshire*	*Home/ Shooting by police Context unclear*
9/17/2017	**Juan Roman**	*45*	**Zaishary Gonzalez** *Former female partner*	*23*	*New Bedford, Bristol*	*Home/ Stabbing*
9/21/2017	**Anthony Scaccia**	*6*	**William Scaccia (S)** *Current male spouse of child's mother*	*49*	*Foxboro, Norfolk*	*Home/ Shooting*
9/23/2017	**Vanessa MacCormack**	*30*	**Andrew MacCormack** *Current male spouse*	*29*	*Revere, Suffolk*	*Home/ Blunt trauma and asphyxiation*

TRACKING THESE CASES UNTIL MORE INFORMATION IS AVAILABLE:

Details Domestic Violence Homicides in Massachusetts January 1, 2017 through YTD 2017						
Around 3/2/2017	**Joanne Ringer**	*39*	**Charles Reidy** *(S)* *Current male spouse*	*42*	*Clarksburg/ Berkshire*	*Unknown/ Unknown (have not found Joanne's body so no official charges)*
4/10/2017	**Delilah Santiago**	*18*	**Robert Santiago**	*19*	*Springfield, Hampden*	*Home/ Shooting Relationship not confirmed*

KEY:

^ This list includes all cases of domestic violence related deaths including dv perpetrator suicide or death with or without either murder or attempted murder of dv victim as long as suicide occurred in the context of a relationship with domestic violence. In these cases, there will be no name listed under "homicide victim" and explains why the total number of incidents does not always equal the total number of perpetrators.
(S) – indicates suicide
(D) – indicates other cause of domestic violence homicide perpetrator death, including being killed by dv victim in self-defense and suicide by police
(A) – attempted suicide by domestic violence homicide perpetrator
(DVV) – indicates that domestic violence victim committed the murder

JDI Definition of Domestic Violence Homicide – see next page

JDI Definition of Domestic Violence Homicide

JDI's definition of domestic violence homicide aims to capture the full picture and context of domestic violence homicides. Homicides are considered domestic violence related if:

- the homicide victim and perpetrator were current or former spouses or intimate partners, adults or teens with a child in common, or adults or teens in a current or former dating relationship
- the homicide victim was a bystander or intervened in an attempted domestic violence homicide and was killed (including friends, family members, new intimate partners, law enforcement officers or other professionals attempting to assist the victim of domestic violence, roommates and co-workers)
- the motive for the murder was reported to have included jealousy, in the context of an intimate partner or dating relationship, or
- a relationship existed between the homicide perpetrator and adult or teen victim that could be defined as exhibiting a pattern of power and control (including family or household members and caregivers).

We also include the deaths of perpetrators, whether by suicide, police or self-defense by the victim to demonstrate the broad impact of domestic violence. This list may be edited over time to reflect any new information that comes to light about these domestic violence homicide incidents.