

State Domestic Violence Fatality Review Team



2025 ANNUAL REPORT

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Presented by:

State Domestic Violence Fatality Review Team; Executive Office of Public Safety and Security

Presented to:

Governor Maura Healey; Lieutenant Governor Kim Driscoll; 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

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Dedication

This report is dedicated to the memory of those who lost their lives to domestic violence. Each name represents someone whose life was cut short by preventable tragedy. We honor their memory by committing ourselves to the work of prevention, survivor support, and perpetrator accountability.

We also dedicate this work to the survivors who carry the weight of trauma and loss, and to the children who have witnessed or experienced domestic violence. Your resilience inspires our continued efforts to create safer communities where all people can live free from fear and violence.

May this report serve as a catalyst for meaningful change and a testament to lives that mattered and continue to matter.

Acknowledgment

This report would not have been possible without the contributions of many dedicated individuals and organizations committed to ending domestic violence across Massachusetts.

We extend our heartfelt gratitude to the domestic violence advocates, law enforcement officers, prosecutors, medical professionals, community partners, and state agencies who shared their expertise, data, and insights for the reviews conducted in 2025. Your frontline work and willingness to collaborate have been essential in understanding the scope and nature of the fatalities reviewed.

We would like to give special thanks to Anjeza Xhemollari, the State Team, and the Local District Attorney's Offices for leading the 2025 domestic violence fatality reviews. Your commitment to this process is evident and pays tribute to those we have lost while protecting those who remain at risk.

Thank you.

Notes from the Chair

As we close another year of the State Domestic Violence Fatality Review Team's work, I am reminded that behind every case that we examine lies a preventable tragedy and a community forever changed. This year our team reviewed several fatalities across the state, each one representing not just a statistic, but a life lost and a family and community left to grapple with the aftermath.

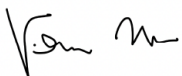
Our fatality review process is difficult work. It requires us to look unflinchingly at system gaps, missed opportunities, and complex dynamics that too often culminate in lethal violence. Yet this work is also necessary and hopeful—because understanding how and why these deaths occurred is the first critical step in preventing future tragedies.

This year, several themes emerged from our reviews that require our attention and action. We observed recurring patterns in crisis, judicial response and funding. These highlight both the challenges we face and the opportunities available to strengthen our system and save lives. The recommendations developed as a result of the review process are born from our collective analysis and represent actionable steps toward a safer future for survivors. I urge stakeholders at every level—from legislators and agency leaders to frontline advocates and community members—to carefully consider these recommendations and work together to implement them.

As we look toward the coming year, I am hopeful. Hopeful because I see increased awareness and collaboration. Hopeful because I witness the courage of survivors. Hopeful because dedicated advocates continue to innovate and improve their response. And hopeful because communities are beginning to understand that domestic violence is not a private matter but a public health crisis that requires our collective action.

To those we have lost: we remember you. To those working to prevent future tragedies: thank you. To those experiencing violence: we see you, and support is available.

Sincerely,



Vilma Uribe
Chair, State Domestic Violence Fatality Review Team
Executive Director, Governor's Council to Address Sexual Assault, Domestic Violence, and Human Trafficking

Membership

State Team

Chair Vilma Uribe, Governor's Council to Address Sexual Assault, Domestic Violence, and Human Trafficking

Andrea Joy Campbell, Attorney General, Office of the Attorney General

Anna Holding, Office of the Attorney General (Designee)

Dr. Mindy Hull, Office of the Chief Medical Examiner

Deborah Mendoza-Lochrie, Office of the Chief Medical Examiner (Designee)

Middlesex District Attorney Marian Ryan, Massachusetts District Attorneys Association

Megan McGovern, Middlesex District Attorney's Office (Designee)

Colonel Geoffrey Noble, Massachusetts State Police

Major Geoffrey Boutwell, Massachusetts State Police (Designee)

Dianne Fasano, Office of Probation

Corinn Crowninshield, Office of Probation (Designee)

Liam Lowney, MA Office for Victim Assistance

TBD, Retired Trial Court Judge

State Partners

Anjeza Xhemollari, Executive Office of Public Safety and Security

Kaitlyn O'Leary, Massachusetts Parole Board

Sue English Lachowetz, Department of Children and Families

Crystal Jackson, Department of Transitional Assistance

Arielle Mullaney, Executive Office of Public Safety and Security

Roles and Responsibilities

State Team

The State Domestic Violence 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. The purpose of the State Team is to decrease preventable domestic violence fatalities. To achieve its purpose, the State Team conducts comprehensive analyses of domestic violence fatalities, examining the causes, frequency, and circumstances surrounding these incidents, including murder-suicides, in collaboration with Local Teams. Based on these reviews, the team provides recommendations to the Governor and Legislature regarding essential modifications to existing laws, policies, and practices to prevent domestic violence fatalities.

Responsibilities

Protocols and Operational Rules

- Create model investigative and data collection protocols for local review teams.
- Establish rules and procedures for state and local review teams, including the use of confidentiality agreements.

Review Fatalities

- Annually review at least three domestic violence fatalities across the state
- Assign selected cases to local review teams for investigation and reporting
- Review reports from local review teams
- Analyze community, public, and private agency involvement with victims and perpetrators

Training and Support

- Share relevant information with local review teams, law enforcement, and domestic violence service providers to protect victims.
- Train local review teams on data collection, confidentiality, and investigative protocols
- Provide training and written materials to assist local review teams

Reporting

- Provide findings and recommendations in annual written reports to the Governor and Legislature

Local Review Team

Membership

Composed of at least the following members:

- Local District Attorney who serves as chair
- Medical examiner or pathologist
- Chief of police
- Probation officer
- Non-profit legal services provider for domestic violence victims
- Direct service provider for domestic violence victims
- Additional experts on an ad hoc basis

Functions

- Coordinate the collection of information on fatalities assigned to it for review
- Promote cooperation and coordination between agencies responding to fatalities and providing services to victims or victims' family members
- Understand the causes and incidence of domestic violence fatalities
- Advise the state review team on potential policy and practice improvements

Responsibilities

- Review and implement the fatality review protocol established by the State Team.
- Sign and execute a confidentiality agreement to protect sensitive information.
- Collect, maintain, and provide confidential data as the state review team requires for fatality case reviews.
- In collaboration with the State Team, conduct thorough reviews of individual fatality cases, utilizing established protocols.
- Recommend strategies to enhance coordination and collaboration between regional agencies and service providers.
- Provide relevant information to law enforcement or other agencies to support the protection of domestic violence victims and the accountability of perpetrators.

Philosophy and Process

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

Mission Statement

The State Team provides strategic leadership for and conducts collaborative, multi-disciplinary reviews of domestic violence-related fatalities with local review teams to better understand the dynamics of such deaths and develop recommendations to prevent and reduce the number of domestic violence deaths across the state.

Core Values

The State Team conducts in-depth reviews of intimate partner homicides and related fatalities annually, collaborating with Local Teams to ensure a comprehensive examination.

The review team operates under a "no blame, no shame" philosophy. This approach allows the State Team to conduct impartial investigations without casting blame on individuals or agencies involved in the fatalities being examined. Instead, the focus is on identifying systemic failures within local and state response systems that may have contributed to these tragic events.

The team aims to identify systemic issues and develop practical solutions to prevent future fatalities. These solutions may include public awareness campaigns, education initiatives, and community empowerment programs.

By fostering collaboration and a nonjudgmental environment, the team strives to gain a comprehensive understanding of the challenges involved and ultimately improve overall safety outcomes.

Recommendations are de-identified and provided in general terms to maintain confidentiality for those involved in each case.

The Review Process

Each review session takes place in the county where the crime was committed and involves a Local Team chaired by the District Attorney with jurisdiction over the case.

In conjunction with the State Team, the Local Team requests all available information and connects with relevant parties. This includes consulting with law enforcement and gathering criminal histories, medical records, autopsy reports, and other case histories. The aim is to gather as much background information as possible to accurately portray the victim, perpetrator, and those who knew the individuals who lost their lives.

Before the review, the local review chair creates a timeline of events from all gathered information and shares this with team members during the discussion. 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 outcomes, and help the review

team understand the circumstances leading up to the fatality. Once the review team convenes, the members continue to refine the timeline until they have exhausted all available information.

After each session, members identify practical recommendations and measurable objectives. The State Team monitors the progress and measures the success of any recommendations ultimately implemented.

The State and Local Teams operate under strict confidentiality. All materials, reports, and timelines used and created during meetings are not part of the public record.

Data

National Incident-Based Reporting System Data

The National Incident-Based Reporting System (NIBRS) collects detailed data on crimes reported to police, including offense types and victim and offender characteristics. NIBRS collects demographic data on victims of crimes, including:

- **Sex of Victim:** This data element categorizes victims as male, female, or unknown.
- **Race of Victim:** This data element categorizes victims into specific racial categories, including White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, or Unknown.
- **Ethnicity of Victim:** This optional data element categorizes victims as Hispanic or Latino, Not Hispanic or Latino, or Unknown.
- **Resident Status of Victim:** This optional data element indicates whether the victim was a resident or nonresident of the jurisdiction where the crime occurred, not their immigration or citizenship status.

It is important to note that NIBRS data may only partially capture the experiences of LGBTQIA+ and communities of color due to limitations in data collection and reporting practices.¹ These groups may face unique forms of victimization and discrimination that may not be adequately reflected in current data collection methods.

¹ The acronym LGBTQIA+ represents a diverse range of gender and sexual identities, including lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual, as well as those identities yet to be fully defined.

Massachusetts NIBRS Data

The data below outlines domestic violence-related charges in Massachusetts from 2020 to 2024. These offenses pertain to individuals such as spouses, intimate partners, children, and other family members. Aggravated assault charges include assault and battery with a dangerous weapon, strangulation, and assault on a pregnant woman. Note that these figures reflect the total number of offenses, not the number of arrests.

In 2024, there were **26,297** domestic violence incidents reported to law enforcement in Massachusetts.

Domestic Violence Incident Data (NIBRS 2024)

Incident Date	Murder And Non-Negligent Manslaughter	Kidnapping/Abduction	Aggravated Assault	Simple Assault	Intimidation
2020	21	290	5,690	16,026	3,347
2021	18	341	5,739	16,400	3,531
2022	28	299	6,102	16,760	3,498
2023	26	308	6,072	16,566	3,147
2024	31	309	6,025	16,532	3,400

Domestic violence-related crime rates declined in several categories in 2024:

- **Aggravated Assault:** 0.77%
- **Simple Assault:** 0.21%

Domestic violence-related crime rates increased in several categories in 2024:

- **Murder and Non-negligent Manslaughter:** 19.23%
- **Kidnapping/Abduction:** 0.32%
- **Intimidation:** 8.04%

While we have seen declines in some categories, these rates underscore the need for improved prevention programming and continued survivor support.

The Complexities of Domestic Violence Data

Data analysis and fatality reviews are essential tools for unraveling the complexities of domestic violence fatalities. While data analysis can provide a quantitative overview of trends and patterns, it

often falls short of capturing the nuanced dynamics of domestic violence. Law enforcement data, frequently focused on isolated incidents, provides limited information on the broader context of abuse, including, but not limited to, economic control, emotional abuse, and coercive control. Limited information sharing across jurisdictions and a lack of connection between multiple incidents involving the same parties limit the insights that can be gleaned from these data. These issues often hinder a comprehensive understanding of the factors leading to domestic violence fatalities.

In-depth domestic violence fatality reviews can complement data analysis by delving into the specific circumstances of each case. These reviews can identify missed opportunities for intervention, uncover patterns in system responses, and reveal barriers that prevent victims from seeking help. This qualitative approach allows for a more comprehensive understanding of the factors contributing to lethal violence, including economic factors, cultural barriers, and the impact on children and communities.

By combining detailed data analysis of domestic violence fatalities with in-depth reviews of individual cases, the State Team develops a comprehensive understanding of the factors contributing to these tragic events across the state. This integrated approach informs the evidence-based recommendations presented in this document.

Recommendations

In 2025, we carried out multiple detailed domestic fatality reviews throughout the year, working with designated District Attorneys and their local community partners. Below are the recommendations created by the State Team in collaboration with the Local Teams. We present these to the Governor and Legislature to help prevent and decrease domestic violence deaths.

R1: Crisis Response Team Integration

Consider piloting a Domestic Violence Crisis Emergency Response Team (DVCERT) to work alongside existing High-Risk Teams (HRTs) for consistent, case-by-case management of complex high-risk cases.

DVCERTs and HRTs play distinct yet complementary roles in domestic violence intervention. DVCERTs are rapid-response teams that provide immediate support and emergency safety planning after incidents, while HRTs offer ongoing case management and coordinated safety planning. Together, they create a comprehensive care continuum, with DVCERTs identifying urgent cases that need HRT-level coordination for long-term support.

To protect legal integrity and victim safety, we recommend that the advocacy agency on the DVCERT function as an independent service provider separate from the prosecution team,

supported by strictly partitioned files and case management systems. Communication between parties should be limited to high-level status updates rather than narrative statements from advocacy sessions.

R2: Fatality Review Team Membership Expansion

Amend statutes to expand and formalize the State Domestic Violence Fatality Review Team's membership, ensuring multidisciplinary expertise and legislative accountability through additional members appointed by the chair.

Recommended additions include: Executive Office of Health and Human Services (EOHHS) agencies—Department of Public Health (DPH) (including SANE and Intimate Partner Abuse Education Programs), Department of Mental Health (DMH), and Bureau of Substance Addiction Services (BSAS); Department of Children and Families (DCF) (including the Domestic Violence Unit); Department of Transitional Assistance (DTA) (including the Domestic Violence Unit); and Massachusetts Parole Board (Victim Services Unit). Public safety representation should include the Massachusetts Chiefs of Police Association and judiciary stakeholders.

R3: Survivor Education on Judicial Privilege

Ensure Survivors are properly educated on all of their rights throughout their case, including their right to assert any privilege. This education will enable them to make informed decisions and understand all available options, resources, and potential implications—such as the implications of asserting marital privilege.

R4: Increased and Stable Funding

For FY26 GAA, a \$7 million cut was made to the DPH Line 4513-1136. This reduction threatened the stability of domestic and sexual violence programs statewide, including the loss of shelter beds, prevention efforts, and direct services. In December 2025, the Healey-Driscoll Administration announced a plan to restore the cuts to direct services. The State Domestic Violence Fatality Review Team respectfully recommends that the Legislature not only provide stable and adequate funding but also an increase to annual legislative appropriations for Sexual and Domestic Violence programs to meet demonstrated needs for victim support, shelter, and prevention.

Looking Forward: 2026

As recommended in previous reports, we look forward to working with the legislature to implement recommendation two from the [2024 State Team Report](#).

The goals are to address two issues regarding membership limitations and record-sharing limitations that need to be addressed to conduct effective reviews, as outlined below.

- **Membership Limitations:** The current law, MGL Chapter 6A, Section 18N, limits the participation of necessary state agencies and community stakeholders on the State Team, impacting the review process and information collection.
- **Recommendation:** In 2017, 2023, and 2024 the State Team recommended reviewing and amending the current law to address membership limitations.
- **Record Sharing Limitations:** The current law, MGL Chapter 6A, Section 18N, also limits the ability to directly access relevant information from state agencies such as DTA and DCF, medical institutions, and others.
 - **Recommendation:** To address this challenge, as highlighted in previous years, we recommend updating the current law to address record-sharing challenges

Appendix

2014 Establishing Legislative Language

Section 18N: State domestic violence fatality review team; membership; purpose; powers and duties; local review teams; provision of information to review team; confidentiality

Section 18N. (a) As used in this subsection, the following words shall have the following meanings:–

"Domestic violence", the abuse of a family or household member, as defined in section 1 of chapter 209A.

"Fatality", any death resulting from an incident of domestic violence or attempted domestic violence, including the death of an individual who was not a family or household member of the perpetrator's.

"Local review team", a local domestic violence fatality review team established pursuant to subsection (c).

"State review team", the state domestic violence fatality review team established pursuant to subsection (b).

"Team", either the local review team or the state review team.

(b) There shall be a state domestic violence fatality review team within the executive office of public safety and security. Members of the state review team shall be subject to criminal offender record checks to be conducted by the colonel of the state police. All members shall serve without compensation for their duties associated with membership on the state team. All members shall be immune from any liability resulting from the execution of their duties.

The state review team shall consist of the following members: the secretary of public safety or a designee employed by the executive office of public safety and security who shall serve as chair; the attorney general or a designee employed by the office of the attorney general; the chief medical examiner or a designee employed by the office of the chief medical examiner; a member selected by the Massachusetts District Attorneys Association; the colonel of the state police or a designee employed by the department of state police; the commissioner of probation or a designee employed by the office of probation; the chief justice of the trial court or a designee; the chief justice of the family and probate court or a designee; and 1 member selected by the Massachusetts office of victim assistance, who shall be employed by the office.

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 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

(c) If the state team selects a case for review, a local team shall be assembled to participate in the review. Members of a local review team shall be subject to criminal offender record checks to be conducted by the district attorney of the district. All members shall serve without compensation. All members shall be immune from any liability resulting from the execution of their duties.

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.

(d) At the request of the local district attorney, the local review team shall be immediately provided with: (1) information and records relevant to the cause of the fatality, including those of the perpetrator or any other party involved with the fatality maintained by providers of medical or other care, treatment or services, including dental and mental health and behavioral care; (2) information and records relevant to the cause of the fatality or any party involved with the fatality maintained by any state, county or local government agency including, but not limited to, birth certificates, medical examiner investigative data, incident reports, parole and probation records and law enforcement's data post-disposition; provided, that certain law enforcement records may be exempted by the local district attorney; (3) information and records of any provider of social services, including the department of children and families and non-profit agencies, related to the victim or victim's family or any party involved with the fatality, including the perpetrator, that the local team deems relevant to the review; and (4) demographic information relevant to the victim and the victim's immediate family or any party involved with the fatality, including, but not limited to, address, age, race, country of origin, gender and economic status. The district attorney may enforce this subsection by seeking an order of the superior court.

(e) Any privilege or restriction on disclosure established pursuant to chapter 66A, section 70 of chapter 111, section 11 of chapter 111B, section 18 of 111E, chapter 112, chapter 123 or sections 20B, 20J, 20K or 20M of chapter 233 or any other law relating to confidential communications which would otherwise be held by the victim of a fatality or protect records and information directly related to such victim shall not prohibit the disclosure of such records or information, as it

directly relates to that victim, to the chair of the state review team or a local review team. Any privilege or restriction on disclosure pursuant to the aforementioned statutes, or any other law relating to confidential communications not directly related to the victim of a fatality shall remain in effect; provided, however, that such privilege or restriction may be waived, in writing, by the person holding it, for the limited purposes of disclosure to the state review team or a local review team. Any information considered confidential pursuant to the aforementioned statutes received by the chair of the state review team or a local review team may be submitted for a team's review upon the determination of that team's chair that the review of the information is necessary. The chair shall ensure that no information submitted for a team's review is disseminated to parties outside the team. Under no circumstances shall any member of a team violate the confidentiality provisions set forth in the aforementioned statutes.

Except as necessary to carry out a team's purpose and duties, members of a team and persons attending a team meeting shall not disclose any information relating to the team's business.

Team meetings shall be closed to the public. Information and records acquired by a team pursuant to this section shall be confidential, shall not be considered public records, as defined in clause twenty-sixth of section 7 of chapter 4, shall be exempt from disclosure pursuant to chapter 66 and may only be disclosed as necessary to carry out a team's duties and purposes. All such records shall be maintained by the chair of the team.

Statistical compilations of data which do not contain any information that would permit the identification of any person may be disclosed to the public.

(f) Members of a team, persons attending a team meeting and persons who present information to a team may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a team meeting.

(g) Information, documents and records of a team shall not be subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding; provided, however, that information, documents and records otherwise available from any other source shall not be immune from subpoena, discovery or introduction into evidence through these sources solely because they were presented during proceedings of a team or are maintained by a team.

2014 CJE Opinion No.2014-4

After the Committee on Judicial Ethics issued this opinion, the Massachusetts Supreme Judicial Court adopted a revised Code of Judicial Conduct. Because this opinion was rendered under a prior version of the Code, a judge should not rely on it without contacting the Committee on Judicial Ethics.

2022 Update to Legislative Language

[Section 18N of chapter 6A](#), as appearing in the 2022 Official Edition, is hereby amended by striking out, in lines 30 and 31, the words "the chief justice of the trial court or a designee" and inserting in place thereof the following words:- a retired judge of the trial court to be appointed by the Governor.