# A Report from the State Domestic Violence Fatality Review Team



# Presented by:

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

#### Presented to:

Governor Charlie Baker; Lieutenant Governor Karyn Polito; 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

December 06, 2019

#### I. A Letter from the Chair

The Massachusetts State Domestic Violence Fatality Review Team presents its annual report for 2018.

This year brought some transitions to the State Domestic Violence Fatality Review Team: Tammy Mello, the previous Chair of the Team left her position in December of 2017, and I was appointed as the new Chair in early summer of 2018. I am honored to join this crucial initiative and continue this important work.

This year, our focus was on defining our philosophy and process for case reviews. We built off of a previously crafted mission statement, core values, and guiding principles to carry us into our review sessions. Additionally, we developed sample documents to help guide local review teams as we build their capacity in hosting their own review sessions. The Team continues to review exclusively intimate partner-related fatalities, which are a subset of overall domestic violence related homicides. We also continue to carry out the "no blame and no shame" philosophy, fostering opportunities to learn without fear.

We present our recommendations in Section VI of this report. In 2018, there were 15 domestic violence homicide incidents, resulting in 15 domestic violence homicide victims and 4 perpetrator suicides or deaths. The need for our Team remains urgent; there is still much work to be done.

Moving forward, the Team anticipates continuing our work in 2019 with the current process of comprehensive case review sessions across the Commonwealth. Members would like to thank Governor Baker, Lt. Governor Polito, and the Governor's Council to Address Sexual Assault and Domestic Violence for their support throughout this process. We would also like to thank the Massachusetts District Attorneys Association, along with the Commonwealth's dedicated District Attorneys and staff who have held review sessions and offered to host review sessions in the near future.

As we look to next year and the years ahead, we are heartened by the progress of the "RESPECTfully" statewide public awareness and prevention campaign, initiated by Lt. Governor Polito in May of 2019. This effort, along with the efforts of social workers, law enforcement, local courts, and others on the ground moves us closer to a future where the tragedy of domestic violence homicide will be a thing of the past.

Sincerely,

Kelly Dwyer

Chair, State Domestic Violence Fatality Review Team

# II. Membership

# **Standing Members**

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

Shara Benedetti, Acting General Counsel, Massachusetts Parole Board

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

Dr. Mindy Hull, Chief Medical Examiner, Office of the Chief Medical Examiner

Deborah Mendoza-Lochrie, Chief Policy Officer, 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 John Lannon, Division of Investigative Services, Massachusetts State Police

Dianne Fasano, Office of Probation

Liam Lowney, Executive Director, MA Office for Victim Assistance

Diane 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 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."

Per the CJE Opinion, the State Fatality Review Team is currently working with the Trial Court and the Family & Probate Court to name designees who can act in the limited consulting capacity outlined above.

#### III. Dedication

The Massachusetts Domestic Violence State Fatality Review Team dedicates the annual report to the 15 victims killed in Massachusetts in 2018 as a result of domestic violence, and to victims and survivors of domestic violence everywhere.

# IV. 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.

<sup>&</sup>lt;sup>1</sup> http://www.mass.gov/courts/case-legal-res/ethics-opinions/judicial-ethics-opinions/cje-2014-4.html

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."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.

<sup>&</sup>lt;sup>2</sup> https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter260

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."

The State Fatality Review Team was organized over the summer of 2018. Members held meetings and had the first review of the year under the new Chair in early fall of 2018 and continued to schedule reviews for early 2019 in order to deliver a robust annual report.

# V. 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 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.

<sup>&</sup>lt;sup>3</sup> https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter260

#### **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 can only meaningfully review three cases per year, as members have opted to take a deep dive into a smaller number of cases instead of a cursory review of all fatalities. The National Domestic Violence Fatality Review Initiative (NDVFRI) demonstrates, however, that recommendations from a handful of meticulous case reviews can yield far-reaching implications for reducing Massachusetts' domestic violence fatalities in the future.

During review sessions, members have embraced the "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 these deaths. Rather, members will seek to identify systemic failures stemming from shortfalls and inefficiencies in local and state responses and then recommend appropriate solutions.

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

#### THE REVIEW PROCESS

Each review session took place in the county where the crime was committed and involved a Local Review Team chaired by the District Attorney with jurisdiction over the case. In conjunction with the State Team, the Local Team requested all available information and connected with relevant parties. This included consultation with law enforcement, as well as gathering criminal histories, medical records, autopsy reports, and other case history. The aim is to gather as much background information as possible to paint an accurate portrait of the victim, perpetrator, and those that knew them.

In the week prior to assembling, the host local review chair created a timeline of events from all gathered information and shared this with team members. This exercise was 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. Once assembled, the members continued to refine the timeline until they had exhausted all available information.

At the conclusion of each session, members identified a number of practical recommendations and corresponding objectives that are measurable over time. These criteria enable the State Team to monitor progress of its recommendations and ultimately measure success.

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.

# VI. Findings and Recommendations from the Fatality Review Sessions

In 2018 and early 2019, the State Team partnered with various counties across the Commonwealth to review cases that involved homicide by intimate partners. Members collaborated with the District Attorney of the jurisdiction, and their staff, to assemble a Local Review Team and the necessary materials to complete each review. The review sessions each lasted a full day at the respective District Attorney's Offices.

Below are the recommendations provided by the State Review Team based on in-depth, comprehensive fatality review sessions.

1. 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, the Executive Office of Education, and the State Domestic Violence Fatality Review Team, should create community booklets with various community resources for each county in Massachusetts and determine where the community resources booklet should be located for ongoing reviews and updates.

Through its work, the State Team identified a need for publication and dissemination of community resources. Members saw a trend of neither victim nor perpetrator accessing any or very minimal resources for support prior to a homicide. Additionally, there must be consideration of the ability to safely distribute the booklet without indicating the possibility that individuals receiving the information are reaching out to Sexual Assault - Domestic Violence (SADV) organizations. The booklet should be inclusive of all resources within the county that constituents may utilize and should indicate how the resources are accessed, including anonymous access.

2. The Trial Courts, in consultation with the Family and Probate Courts, the Executive Office of Public Safety, the Municipal Police Training Committee, the Parole Board, the Probation De-

partment, the Department of Children and Families, the Department of Public Health (specifically Supervised Visitation Programs), and the MA Office for Victims Assistance, should create a process, to include notification of involved parties, for when the exchange of children is court-ordered outside of the guardians' family due to history or alleged history of violence between guardians.

Another issue that continues to be identified during reviews is that of court-ordered exchange of children in public settings, such as the local police departments, where those settings are not informed of a history of domestic violence. This poses a genuine safety concern for all parties involved, including establishments identified unknowingly for such exchanges. These establishments, commonly local police departments, only view these exchanges by chance and do not know the underlying circumstances to assist in facilitating a safe exchange. It is imperative that a plan and process be put in place for the family to exchange children safely. The above identified agencies should determine the appropriate process for setting the safe exchange, notifying all involved, and identifying the entity leading the process.

#### VII. Data on 2018 Domestic Violence Related Fatalities

Jane Doe, Inc. is the Massachusetts statewide coalition against sexual and domestic violence. The organization publishes an annual overview of domestic violence homicides in Massachusetts. The 2018 overview is included in Appendix A.

According to Jane Doe, Inc. there were 15 domestic violence homicide incidents, resulting in 15 domestic violence homicide victims and 4 perpetrator suicides or deaths. This is a decrease from 2017, where there were 24 domestic violence homicide incidents, resulting in 19 domestic violence homicide victims and 9 domestic violence perpetrator suicides or deaths. Although we hope to see a continued decrease with each coming year on the number of domestic violence homicides, even one is one too many.

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

### VIII. Looking Ahead to 2019

Unfortunately, there is still a need for the State Domestic Violence Team. As we continue to review cases for 2019, members will select cases at random under the following topics: one case that did

not have prior contact with the criminal justice system, one that did, and one 'outlier case' that involves an underserved population of victims, such as immigrants, elders, teens, members of the LGBTQ community, or persons with disabilities.

The Team will continue to look for particular identifiers to ensure that chosen cases do not all look the same. For example, identifiers could include: children in the home, use of a firearm, high profile perpetrators and/or victims, open probate and criminal issues, and murder/suicide.

# IX. Appendices

A. Jane Doe, Inc. Domestic Violence Homicides in Massachusetts Year to Date 2018

# Appendix A



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						
# of DV Homicide Incidents	15	WHO ARE THESE DV HOMICIDE VICTIMS?				
		Female DV Victims	14			
4 of DV Housiside Vietims	15	Male DV Victims	0			
# of DV Homicide Victims	15	DV Perpetrators (except when killed by police)	0			
# of DV Perpetrator Suicides or Deaths^	4	Female Associated with DV Victim	0			
Total DV Deaths	19	Male Associated with DV Victim	1			
Male DV Homicide Perpetrators	15	Children Associated with DV Victim	0			
Female DV Homicide Perpetrators	0	Family (non-IPV)	0			
		Bystanders (includes police)	0			

Details Domestic Violence Homicides in Massachusetts January 1, 2018 through YTD 2018						
DATE	HOMICIDE VIC- TIM	AGE	ALLEGED HOMICIDE PERPETRATOR (relationship)	AGE	CITY/ COUNTY	LOCATION/ method
1/5/2018	Christa Leigh Steele- Knudslien	42	Mark Steele-Knudslien Current male spouse	47	North Adams, Berkshire	Home/ Stabbing/ Blunt Trauma
1/22/2018	Janice Houston	65	Jeffrey Houston (S) Current male spouse	68	Montgomery, Hampden	Home/ Shooting
2/10/2018	Olivia Bergstrom	20	Benjamin Walsh Current Male Partner	24	Needham, Norfolk	Home/ Stabbing
2/23/2018	Kimberly Lockett	43	Terry Lockett Current male spouse	41	Springfield, Hampden	Home/ Stabbing
3/26/2018	Luz Acevedo	47	Miguel A. Castillo Current male spouse	55	Lynn, Essex	Home/ Blunt Trauma

4/13/2018	Kassedi Clark	24	Michael S. Boulais Fomer Male Partner	32	Hinsdale, Berkshire	Home/ Shooting
4/21/2018	Wendi Rose Da- vidson	49	Brian Chevalier Former Male Spouse	51	North Andover, Essex	Strangulation
5/12/2018	Bethgy Cator	26	Renardo Williams Acquaintance	24	Brockton, Plym- outh	Shooting
5/28/18	Yesinia Torres	28	Joel Monegro Current male spouse	32	Lawrence, Essex	Stabbing
6/25/2018	Dolores Chisholm	79	Robert Chisholm (S) Current male spouse	78	West Boylston, Worcester	Outdoors/ Shooting (Note: potentially sui- cide pact)
6/29/18	Janet Kastberg	60	Jonathan Kastberg Current male spouse	75	Holland, Hampden	Home/
8/9/2018	Maddilyn Burgess	28	Gyrth Rutan (S) Current male partner	34	Sturbridge, Worcester	Perpetrator's Home/ Blunt Force Trauma
9/24/2018	Shana Warner	48	Alan Warner Current spouse (estranged)	47	Marshfield, Plymouth	Home/ TBD
11/19/2018	Lodimira DosSantos	23	Jose M. DosSantos (S) Former male partner	32	Jamaica Plain, Suffolk	Home/ Shooting
12/19/2018	Ersilia Cataldo Matarazzo	50	Emilio Matarazzo Current spouse (estranged)	55	Everett, Middlesex	Parent's Home/ Shooting

#### 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

#### **IDI 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.