

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

February 10, 2017

I. A Letter from the Chair

Citizens of the Commonwealth:

The Massachusetts State Domestic Violence Fatality Review Team presents its annual report for 2016.

We began our second year by building upon the technical assistance and training that we conducted at the end of 2015. 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) to construct a robust seminar centered on national best practices. The day-long training included a comprehensive overview of fatality review procedures and protocols, followed by a mock case review.

Joining the State Review Team for the seminar were District Attorneys and Assistant District Attorneys from all eleven offices across the Commonwealth. The DAs' Offices are charged with chairing Local Fatality Review Teams for case reviews. We were fortunate to welcome back Matthew Dale, the Executive Director of the Montana State Fatality Review Commission, as a co-facilitator, along with Chief Jerald Monahan from Prescott, Arizona. Mr. Dale led our previous technical assistance session last year, and Chief Monahan chairs the Yavapai DV Fatality Review Team in Arizona. Both serve as consultants with the NDFVRI. They have been instrumental in launching our State Review Team.

Similar to best practices by review teams, members worked to outline our philosophy and process for case reviews. We crafted our mission statement, defined core values, and set forth guiding principles for our review sessions. The Team opted to review only intimate partner related fatalities, a subset of overall domestic violence related homicides. The Team has adopted a "no blame and no shame" philosophy, which fosters opportunities for learning and also guides many national fatality review teams.

Our report in 2015 identified 23 domestic violence incidents resulting in 18 domestic violence homicides and eight perpetrator suicides or deaths. This year, there were 18 incidents resulting in 14 homicide victims and nine perpetrator suicides or deaths. Members worked with local District Attorneys and law enforcement agencies to gather additional information on these incidents and create a set of data.

Moving forward, the State Review Team anticipates conducting three regional case review sessions in 2017 across the Commonwealth. We are eager to apply the knowledge we have gained these past 18 months and help identify methods for decreasing the number of domestic violence fatalities across the Commonwealth.

Sincerely,

Tammy Mello
Chair, State Domestic Violence Fatality Review Team

II. Membership

Standing 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, Office of the Chief Medical Examiner*

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

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

Dianne Fasano, *Office of Probation*

Liam Lowney, *Executive Director, 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 docu-

ments that list committee members and on all reports and recommendations the committee makes.”¹

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

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 opera-

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

tion 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.

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. The Team issued its first annual report in January of 2016.

² <https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter260>

³ Ibid.

IV. Technical Assistance and Mock Case Review

Through consultation with Lieutenant Governor Karyn Polito and the Governor's Council to Address Sexual Assault and Domestic Violence, the State Fatality Review Team sought technical assistance and training from the National Domestic Violence Fatality Review Initiative in 2015. NDVFRI Director, Dr. Neil Websdale, was eager to help Massachusetts establish its first State Team, and his organization funded on-site technical assistance with Matthew Dale – the Executive Director of the Montana Office of Victim Services and Director of the Montana State Fatality Review Commission.

Mr. Dale joined the Team in Boston for a half-day of training on Thursday, December 10, 2015. He shared his experiences in managing the Montana State Team for the past decade, focusing on how his team's methods and procedures have evolved during that time. Mr. Dale's Montana Team is now recognized nationally for its best practices in the review of domestic violence fatalities.

This year, the State Fatality Review Team sought to build upon the December training with a full-day seminar on March 15, 2016. The NDVRI funded a comprehensive overview of fatality review procedures and protocols, followed by a mock case review. Matthew Dale joined the Team again as co-facilitator along with Chief Jerald Monahan from Prescott, Arizona. Chief Monahan chairs the Yavapai DV Fatality Review Team in Arizona. Members also invited District Attorneys and Assistant District Attorneys from across the Commonwealth, as the DAs are charged with chairing the Local Fatality Review Teams for case reviews. Representatives from all 11 District Attorneys' Offices attended the seminar.

Mr. Dale began the training with an in-depth look at the Montana review process that has garnered national attention. He walked attendees through the Commission's mission, its philosophy, guiding principles, and process. Mr. Dale alerted members to the pitfalls his Commission encountered in its formative years and highlighted methods to overcome common issues that inevitably arise. In addition, he emphasized the importance of protocols, guidelines, and training prior to the commencement of any reviews.

Chief Monahan discussed the importance of law enforcement to the review process and on effective means for officers on review teams to work with local authorities to retrieve case information and assist with interviews. Chief Monahan also reminded attendees of the threats that officers face in responding to DV calls, highlighting the murder of rookie police officer Tyler Stewart of Flagstaff, Arizona. Officer Stewart, just 24 years old, was answering a domestic violence call when the suspect produced a concealed weapon and killed the officer on the front porch. The officer's body-worn camera captured the tragedy.

For the second half of the training, Mr. Dale and Chief Monahan led attendees through a full mock case review. Members were presented with a real case from the Boston area. They were asked to review the case materials, reconstruct a timeline of events, and identify potential breakdowns in the system that may have led to the fatality. Throughout the review, both Mr. Dale and Chief Monahan stressed the

importance of a “no blame, no shame” approach. Members were not there to single out a specific individual or agency as being at fault, but to identify gaps and inadequacies in the systemic response.

Members were also reminded that many victims have no contact, or limited contact, with state or local agencies. Similarly, many perpetrators have no prior, or limited, criminal histories. Often, it is not until these horrific crimes are committed that the full picture emerges.

V. Philosophy and Process

Throughout the Team’s training and consultation with NDVFRI, members were advised to craft a clear Mission Statement, along with identifying Core Values and Guiding Principles to lead the Team through the fatality review process. All three documents are to be reviewed and read aloud at the start of all fatality review sessions. They provide a template for decision making throughout the review objectives goals.

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 three to five 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 those who were involved.

Once assembled, the group will create a timeline of events from all of the gathered information. This exercise is designed to expose strengths and weaknesses in the system, get a better understanding of relationship dynamics and help the team understand the circumstances leading up to the fatality. Members will keep refining the timeline until they have exhausted all available information.

The State and Local Teams operate under strict confidentiality. Sensitive information is not distributed ahead of review sessions and all information is destroyed immediately following the case review.

At the conclusion of each session, Members will then identify a number of practical recommendations and corresponding objectives that adhere to the “SMART” criteria popularized by famed management guru Peter Drucker⁴. Each objective must be:

- Specific
- Measurable
- Achievable
- Relevant
- Trackable

Only through objectives meeting these criteria will the State Team be able to monitor the progress of its recommendations and ultimately measure success.

Upon completion of the review, all materials, reports and timelines used and created in the meeting are shredded. The team will only leave with recommendations.

VI. Background Data Form

In preparation for case reviews, the State Fatality Review Team researched various background data and incident fact finder forms utilized by state and local fatality review teams across the country. The

⁴ Drucker, Peter. *The Practice of Management*. Harper Collins, 2006. Print

Team wanted to customize a form that could be used by Local Review teams in the Commonwealth to gather background case information ahead of review sessions.

Members drafted a comprehensive form, covering law enforcement information, decedent and perpetrator backgrounds, and child involvement. The form also seeks to capture information on the relationship between the perpetrator and the victim(s). The background includes behavior prior to the incident, DV history, court involvement, and services and programs sought prior to the fatality.

Each section of the draft form also includes a list of relative risk factors. As the information is gathered, members can flag certain areas they feel warrant closer review.

The risk factors include:

A) Incident Information

- Strangulation
- Lethal Weapon
- Sexual Assault
- Drugs
- Pregnancy
- Suicide

B) Child Involvement

- Children Present
- Decedent Has A Child That Is Not The Perpetrator's

C) Perpetrator Information

- Perpetrator Unemployed
- Decedent Left Perpetrator After They Lived Together During The Past Year

D) Behavior Prior to Incident

- Evidence Of Prior Verbal Or Emotional Abuse
- Use of Illegal Drugs
- Alcoholic / Problem Drinker
- Control of Daily Life
- Violently/ Constantly Jealous
- Follows or Spies
- Frequency Of Family Violence In The Past Six Months
- Prior Family Violence (Including Pets)

E) No Contact Orders

- History of Violation Restraining Orders

The State Fatality Review Team is still finalizing the final version of the form. However, they will have a completed version ahead of the first case reviews in early 2017.

VII. Data on 2016 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 2016 Overview is included in Appendix A.

The State Team gathered additional data on each fatality from local district attorneys and created graphs to create a visual representation of the type of weapons or methods used in DV-related homicides and suicides, the geographic breakdown by county, and the age of the victims. See Appendix B.

VIII. Looking Ahead to 2017

Unfortunately, the need for the State Fatality Review Team has not diminished this past year. According to Jane Doe Inc., there were 18 separate episodes of domestic violence related homicides in Massachusetts in 2016, resulting in 23 deaths (see Appendix A).

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, and members are eager to review cases in the upcoming year.

Beginning in January of 2017, the State Fatality Review Team will adhere to the following goals:

- Hold three case review sessions across the Commonwealth
- Consult quarterly with Matthew Dale and Dr. Websdale at the NDVFRI on progress
- Consult monthly with the State Fatality Review Team Working Group within the Governor's Council to Address Sexual Assault and Domestic Violence
- Conduct additional training and technical assistance sessions as needed

Members will aim to select one case that did not have prior contact with the criminal justice system, one that did have contact, and one 'outlier case' that involves an underserved population of victims, such as immigrants, the elderly, teenagers, LGBTQ individuals, or persons with disabilities .

The Team will also look for certain 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.

Additionally, at the Team is considering increasing its membership. Best practices indicate the Team could benefit from including the following governmental entities, non-profit organizations, and community stakeholders:

- A Legal Advocate
- A Counselor from a Batterer's Treatment Program
- A Licensed Social Worker from the Montana DCF equivalent
- A Member from the Faith Community
- A Member from the Judiciary
- A Member of the Legislature
- A Member from the Health Care Industry
- A Sexual Assault Nurse Examiner
- A Representative from the Greater Boston Legal Services equivalent
- A Representative from a Community Non-profit Program with an interest in curbing incidence of Domestic Violence

The State Team looks forward to publishing the results of our case reviews, data gathering, and accompanying recommendations in our 2017 annual report.

IX. Appendices

- A. Jane Doe Domestic Violence Homicides in Massachusetts Year to Date 2016 (PDF)
- B. Data on 2016 Domestic Violence Related Fatalities

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 Year to Date 2016			
		WHO ARE THESE DV HOMICIDE VICTIMS?	
		# of DV Homicide Incidents	18
		Male DV Victims	1
# of DV Homicide Victims	14	DV Perpetrators	1
# of DV Perpetrator Suicides or Deaths^	9	Female Associated with DV Victim	0
		Male Associated with DV Victim	1
Total DV Deaths	23	Children Associated with DV Victim	1
Male DV Homicide Perpetrators	13	Family (non-IPV)	0
Female DV Homicide Perpetrators	1	Bystanders (includes police)	0

Details Domestic Violence Homicides in Massachusetts January 1, 2016 through YTD 2016

DATE	HOMICIDE VICTIM	AGE	ALLEGED HOMICIDE PERPETRATOR <i>(relationship)</i>	AGE	CITY/ COUNTY	LOCATION/ method
1/16/2016	Jeannine O'Connor	51	Kevin O'Connor (S) Current male spouse	51	Waltham, Middlesex	Home/ Shooting
1/26/2016	Elisete Benevides	51	Gelcino Souza Oliveira (S) Former male partner	50	Peabody, Essex	Home/ Stabbing
1/27/2016	Julie A. Meede	34	Martin McDonald Estranged male spouse	35	Norton, Bristol	Home/ Stabbing
1/29/2016			Randolph McClain (D) Former male partner	33	Lynn, Essex	Home/ Shooting by police
2/9/2016	John Williams	70	John Witty Former male partner of DVHV's female partner	70	Wareham, Plymouth	Home/ Shooting & Stabbing
2/15/2016	Colleen Russell	36	Kenneth Manning Former male partner	35	Malden, Middlesex	Home/ Sharp Force Injuries
3/24/2016			Robert L. Dussourd (D)	44	Braintree, Norfolk	Outside / Shooting by police
4/5/2016	Renee Berbert	45	Peter Doherty(D) Current male spouse	52	West Springfield, Hampden	Home/ Victim: Stabbing Perpetrator: Shooting by police
4/13/2016	Kelly Sugarman	36	Michael Sugarman Current male spouse	42	Grafton, Worcester	Home/ Shooting
4/29/2016			Antonio Gonzalez (D)	23	Lawrence, Essex	Home/ Shooting by police
6/14/2016	Rosa Goncalves	53	Antonio Cardoso (S) Current male partner	61	Brockton, Plymouth	Home/ Strangulation (TBD)
6/24/2016	Jermaine Good	43	Rogers Jordan Friend of former female partner of DVHV	51	Boston, Suffolk	Home/ Shoting
7/3/2016	Sabrina DaSilva	19	Walter DaSilva Former male spouse of DVH victim's mother	45	New Bedford, Bristol	/Shooting
8/1/2016	Carmela Saunders	48	Douglas Steeves	50	Salem, Essex	Home/ Strangulation
8/6/2016			Francesco Cenca (S) Current male partner	44	Wilmington, Middlesex	Home/ Stabbing

Details Domestic Violence Homicides in Massachusetts January 1, 2016 through YTD 2016 continued						
DATE	HOMICIDE VICTIM	AGE	ALLEGED HOMICIDE PERPETRATOR (relationship)	AGE	CITY/ COUNTY	LOCATION/ method
8/26/2016	Rebecca Griffin	51	John Griffin (S) Former male spouse	55	Ashby, Middlesex	Home/ Stabbing
9/12/2016	Wanda Rosa	29	Emilio De La Rosa Former male partner	32	Methuen, Essex	Home/ TBD
10/6/2017	Male, Name not yet released	TBD	Female, name not yet released Current female spouse	36	Boston, Suffolk	Home/ Stabbing

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. See next page for key explanations.

(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

Beginning in 2005 Jane Doe Inc. reconsidered its definition of domestic violence homicide and used the new definition in identifying all incidents that occurred in 2003 and subsequent years. The definition was modified in order 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).

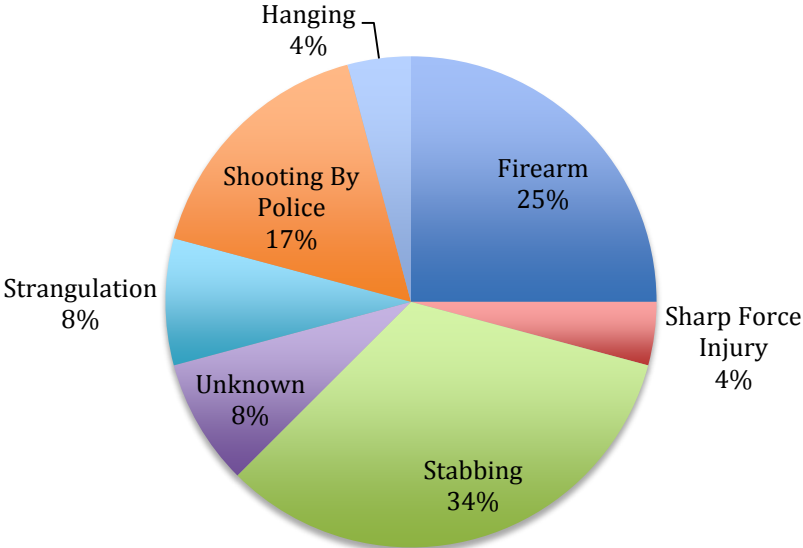
Furthermore, in order to meet our goal of capturing the full picture of deaths due to domestic violence, we have also included the deaths of perpetrators, whether by suicide, police or self-defense by the victim. To the extent that information is available, we also add to this list domestic violence homicides that have a Massachusetts connection (e.g. perpetrator suicide and out of state). This list may be edited over time to reflect any new information that comes to light about these domestic violence homicides.

APPENDIX B

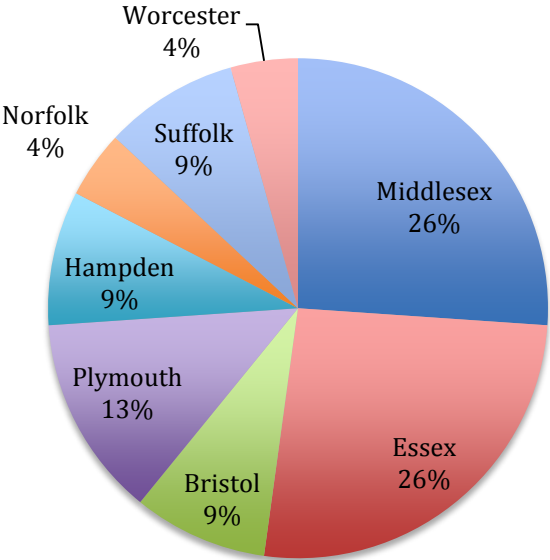
Massachusetts Domestic Violence Homicides and Suicide Data 2016

LAST NAME	FIRST NAME	FATALITY LOCATION	AGE	DATE OF DEATH	TYPE OF DEATH	WEAPON	COUNTY
O'Connor	Jeannine	Home	51	1/16/16	Homicide	Firearm	Middlesex
O'Connor	Kevin	Home	51	1/16/16	Suicide	Firearm	Middlesex
Benecides	Elisete	Home	51	1/26/16	Homicide	Knife	Essex
Souza Oliveria	Gelcino	Home	50	1/26/16	Suicide	Unknown	Essex
Meede	Julie	Home	34	1/27/16	Homicide	Knife	Bristol
McClain	Randolph	Home	33	1/29/16	Homicide	Shooting by Police	Essex
William	John	Home	70	2/9/16	Homicide	Firearm/Knife	Plymouth
Russell	Colleen	Home	36	2/15/16	Homicide	Knife	Middlesex
Dussourd	Robert	Outside	44	3/24/16	Homicide	Shooting by Police	Norfolk
Berbert	Renee	Home	45	4/5/16	Homicide	Knife	Hampden
Doherty	Peter	Home	52	4/5/16	Homicide	Shooting by Police	Hampden
Sugarman	Kelly	Home	36	4/13/16	Homicide	Firearm	Worcester
Gonzales	Antonio	Home	23	4/29/16	Homicide	Shooting By Police	Essex
Goncalves	Rosa	Home	53	6/14/16	Homicide	Strangulation	Plymouth
Cardoso	Antonio	Home	61	6/14/16	Suicide	Hung	Plymouth
Good	Jermaine	Home	43	6/24/16	Homicide	Firearm	Suffolk
DaSilva	Sabrina	Home	19	7/3/16	Homicide	Firearm	Bristol
Sanders	Carmela	Home	48	8/1/16	Homicide	Strangulation	Essex
Cenca	Francesco	Home	44	8/6/16	Homicide	Stabbing	Middlesex
Griffin	Rebecca	Home	51	8/26/16	Homicide	Stabbing	Middlesex
Griffin	John	Home	55	8/26/16	Suicide	Sharp Force Injury	Middlesex
Rosa	Wanda	Home	29	9/12/16	Homicide	Unknown	Essex
Collin	Edwards	Home	37	10/7/16	Homicide	Knife	Suffolk

Massachusetts Domestic Violence Homicides and Suicide Data 2016

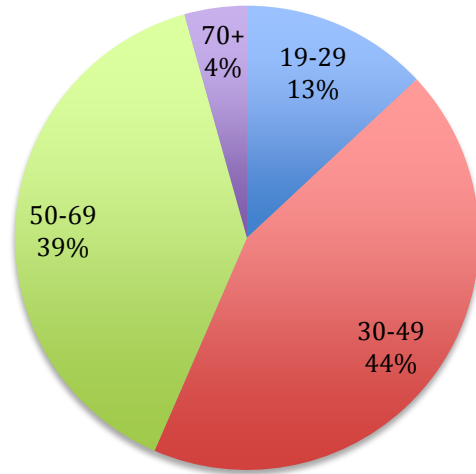


Weapon or Method Used in Domestic Violence Homicides and Suicides



Counties in Massachusetts Where Domestic Violence Homicides and Suicides Occurred

Massachusetts Domestic Violence Homicides and Suicide Data 2016



**Ages of Domestic Violence
Homicides and Suicides
Victims**