A Report from the State Domestic Violence Fatality Review Team

The State Domestic Violence Fatality Review Team
and the 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

2023
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I. Dedication

The Massachusetts Domestic Violence State Fatality Review Team dedicates the 2023 annual report to those who’ve died in Massachusetts because of domestic violence or occurring within the context of domestic violence, and to the victims, survivors, and surviving families of domestic violence everywhere.
II. Acknowledgment
The Massachusetts State Domestic Violence Fatality Review Team Members would like to thank Governor Healey and Lt. Governor Driscoll for their commitment to supporting domestic violence, sexual assault, and human trafficking survivors across the Commonwealth. In April, the Healey-Driscoll Administration launched the Governor’s Council to Address Sexual Assault, Domestic Violence, and Human Trafficking (Council) and added several new members/voices to the Council, bringing in additional perspectives and ideas. Governor Healey also named Lt. Governor Driscoll as Chair of the Council and established six subcommittees with identified focus areas: Assessment and Response; Economic Mobility; Early Interventions of Children and Youth; Housing Stability; Human Trafficking; and Veteran/Military Families.

We would also like to thank the Massachusetts District Attorneys Association, along with the Commonwealth’s District Attorneys and staff who continue to dedicate their time and efforts to facilitate review sessions. Last, but certainly not least, we would like to thank the local community partners who have participated in local reviews each year. Without their support and contributions to these review sessions, our work would not be possible.

III. Executive Summary
The Massachusetts State Domestic Violence Fatality Review Team (“State Team”) presents its annual report for the calendar year 2023. The State Team aims to address the problem of domestic violence and to seek solutions to reduce the number of domestic violence incidents in Massachusetts. The fatality review process creates recommendations for both community-level and systemic-level changes across Massachusetts. The focus is on strengthening prevention efforts and improving responses to prevent domestic violence and related fatalities in the future.

In 2023, the Chair, and the Executive Office of Public Safety and Security (EOPSS) Coordinator worked with the technical team to create the State Team’s first [website](#) on mass.gov. The decision was made due to the ongoing requests for reports or information within reports filed starting in 2015 and the need to centralize that information for easier access by the public. The website includes each report filed since 2015, the appointed State Team membership, as well as the legislative language that formed the State Team and fatality review process.

Unfortunately, the need for the State Team remains, and there is still more work to be done. Since enactment of the State Domestic Violence Fatality Review in 2015, we have developed the review process and learned a great deal over the years. The State Team, in partnership with Local Teams, have developed and revised several items involving the review process including the purpose, mission
statement, policies, procedures, and memberships for both the State and Local Teams. We have also brought in nationally recognized trainers for professional development and to assist in developing our own processes. Though we have accomplished a lot, we are also significantly limited due to both the current structure of the team as well as the information we are able to access and assess for each review. This is explored deeper in our recommendations section. We present our recommendation in Section VII of this report.

We also included Massachusetts data in Section VIII of this report, provided by the National Incident-Based Reporting System (NIBRS). The inclusion of data is intended to improve our understanding of the context of domestic violence in Massachusetts. It is important to note that as information and investigations emerge, the number of domestic violence-related incidences may change and may not be reflected in this report after publication.

IV. Membership

MEMBERS

Chair Kelly Dwyer, Executive Director, Governor’s Council to Address Sexual Assault, Domestic Violence, and Human Trafficking

Joy Cambell, Attorney General, Office of the Attorney General

Nicole Poirier, Assistant Attorney General, Office of the Attorney General (Designee)

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

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

Middlesex District Attorney Marian Ryan, Massachusetts District Attorneys Association

Megan McGovern, Assistant District Attorney, Middlesex District Attorney’s Office (Designee)

Interim Colonel John Mawn Jr., Massachusetts State Police

Detective Captain Michael Farley, Massachusetts State Police (Designee)

Dianne Fasano, Office of Probation

Corinn Crowninshield, Office of Probation (Designee)

Liam Lowney, Executive Director, MA 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 the 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 Team despite being named in the 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 Team is currently working with the Trial Court and the Family and Probate Court to name designees who can act in the limited consulting capacity outlined above.

It is important to note and acknowledge key additional State Agencies/Individuals that continue to assist and support the State Team and the identified District Attorney's Office both prior to and during review sessions in gathering allowable information and documentation to ensure information is accessible. These State Agencies/individuals include:

Anjeza Xhemollari, Coordinator, Executive Office of Public Safety and Security

Keara Kelley, Counsel II, Massachusetts Parole Board

Sue Englaish Lachowetz, Domestic Violence Supervisor, Department of Children and Families

Crystal Jackson, Domestic Violence Unit Director, Department of Transitional Assistance

Arielle Mullaney, State Team Counsel, Executive Office of Public Safety and Security

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

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

“The purpose of the state team shall be to decrease the incidence of domestic violence fatalities by: (i) developing an understanding of the causes and incidence of domestic violence fatalities and domestic violence murder-suicides and the circumstances surrounding them; and (ii) advising the governor and the general court by recommending changes in law, policy and practice designed to prevent domestic violence fatalities. The state review team, in conjunction with any local review teams, shall develop a report to be sent to the clerks of the house and senate, the house and senate committees on ways and means, the joint committee on children, families and persons with disabilities, the joint committee on public safety and homeland security, and the joint committee on the judiciary. The report shall be issued not later than December 31 of each year.

To achieve its purpose, the state review team shall: (1) develop model investigative and data collection protocols for local review teams; (2) annually review incidents of fatalities within the commonwealth and assign at least 3 reviews, selected at random, to a local review team for investigation and report; provided, that no review shall be assigned unless it is approved by a majority vote of the state review team and all criminal proceedings, including appeals, related to the fatality are complete; (3) provide information to local review teams, law enforcement agencies and domestic violence service providers for the purpose of protecting victims of domestic violence; (4) provide training and written materials to local review teams to assist them in carrying out their duties; (5) review reports from local review teams; (6) analyze community, public and private agency involvement with victims and perpetrators of domestic violence and their families prior to and subsequent to fatalities; (7) develop a protocol for the collection of data regarding fatalities and provide training to local review teams on the protocol, which shall include protocol and training on the issues of confidentiality of records, victims’ identities and any personally identifying data; (8) develop and implement rules and
procedures necessary for its own operation and the operation of local review teams, which shall include the use of confidentiality agreements for both the state and local review teams; and (9) provide the governor and the general 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 Team assigns cases to Local 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

2 https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter260
the purposes of the protection of victims of domestic violence and for the accountability of perpetrators.\(^3\)

The State Team convened in early 2023. Members held meetings and partnered with several District Attorney Offices, supporting the preparation, coordination, and execution of reviews to deliver the 2023 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 Review 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—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 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. The Team reviews 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 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. This includes identifying when there are needs related to public

\(^3\) https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter260
awareness and education. Additionally, 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 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 local review chair created a timeline of events from all gathered information and shared this with team members as a part of the discussion. 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 outcomes, 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 practical recommendations and corresponding objectives that are measurable over time. The state team monitors the progress and measures the success of any recommendations which are 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.

VI. Findings and Recommendations from the Fatality Review Sessions

In 2023 we conducted several reviews throughout the year in partnership with identified District Attorneys and their local community partners. Reviews were held either in person or fully remote. Below are the recommendations for 2023.

1. Development and/or enhancement of statewide public awareness and education relative to identification of and resources for domestic violence.
Over the years the fatality reviews have regularly brought to light the need for public awareness and education regarding domestic violence. This is not limited to identifying the behaviors or red flags, but also the resources available to victims and loved ones, as well as resources to offenders wanting to change their behavior. In 2018, Massachusetts launched its first statewide awareness campaign since over 20 years ago. RESPECTfully is aimed at youth to encourage building healthy relationships. This campaign was designed to identify concerning behaviors, connect individuals with resources, and ultimately prevent violence from occurring is the desired goal. In 2020, the decision to create more of a directed impact with youth, Massachusetts launched the Healthy Relationships Grant Program. This program awarded funds to five programs across the state to work with youth and youth serving organizations to educate and encourage youth on building healthy relationships. The hope with this program is to reach more youth and young people across the Commonwealth, and hopefully prevent any violence from ever happening. We are grateful for the support from both the Governor’s Office and Legislature for these programs, however, it is evident that more needs to be done. It is our recommendation to explore whether these programs should be expanded, or new programs need to be created to reach more people across the Commonwealth.

2. Review the current law, Chapter 260, Section 18N, and recommend filing legislation for certain technical amendments.

In 2017, the State Team recommended filing legislation for certain technical amendments relative to record sharing and membership outlined in its authorizing statute – MGL ch6A 18N. The previous recommendation stated that current law does not allow for all records pertaining to the perpetrator from certain state agencies. Additionally, the same limitations have occurred regarding record sharing of medical documents which include but are not limited to emergency rooms within hospitals or mental health information. Members believe this oversight have left them at a disadvantage during reviews. Additionally, members believe the legislation limits participation of necessary state agency representation as appointments on the State Team to support the review process and information collection. The State Team recommends reviewing current language within the law to correct these limitations.

VII. Data

As we have stated in previous years, data can be an incredibly useful tool in determining areas of need, identifying possible trends, and responding accordingly, as well as measuring successes. To date, the State Team has been unable to take a deep dive into the data metrics here in Massachusetts for several reasons. There are a variety of ways to obtain data related to intimate partner violence (IPV) and homicides such as law enforcement, friends and family, local programs,
and online statewide tools such as the Trial Courts, and even nationally through agencies such as
the Centers for Disease Control (CDC). This includes information being broken down into categories
such as incident type, weapons used, location, and identifying populations disproportionately
impacted. It is the hope in the coming years the State Team will take a deeper dive into
Massachusetts based statistics and data related to IPV and related homicides to assess where
challenges and opportunities arise. This includes determining outputs, what sites to pull in
information from, and what we are hoping to understand from the information. In the meantime,
we continue to pull together data from relative Massachusetts sources included in this report and in
years past.

We have included data from the FBI’s National Incident-Based Reporting System (NIBRS) which
became the national standard for law enforcement crime data reporting in the United States in
January of 2021. NIBRS reflects types of crimes addressed by law enforcement and as demonstrated
within this report includes types of offenses within Massachusetts. Below is a chart from NIBRS
which includes calendar years (CY) 2020, 2021, and 2022 for the total number of domestic violence
related charges across Massachusetts. Domestic violence related offenses include those which
involve a spouse, ex-spouse, intimate partner, ex-partner, child, stepchild, grandchild, sibling,
stepsibling, parent, stepparent, grandparent, in-law, and other family member. Charges such as
assault and battery with a dangerous weapon, strangulation, and assault and battery on a pregnant
woman are included in the aggravated assault totals. These numbers represent total number of
offenses, not total number of arrests across Massachusetts. Comparing 2020-2022, in 2022 we have
unfortunately seen a dramatic increase within all categories except for kidnapping and intimidation,
however, both only show very slight decreases. These rates continue to demonstrate the need for
improved prevention programming as well as continued survivor supports.

<table>
<thead>
<tr>
<th>Incident Date</th>
<th>Murder and Non-negligent Manslaughter</th>
<th>Kidnapping/Abduction</th>
<th>Aggravated Assault</th>
<th>Simple Assault</th>
<th>Intimidation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>21</td>
<td>290</td>
<td>5,690</td>
<td>16,026</td>
<td>3,347</td>
</tr>
<tr>
<td>2021</td>
<td>18</td>
<td>341</td>
<td>5,739</td>
<td>16,400</td>
<td>3,531</td>
</tr>
<tr>
<td>2022</td>
<td>28</td>
<td>299</td>
<td>6,102</td>
<td>16,760</td>
<td>3,498</td>
</tr>
</tbody>
</table>

The success of the State Team will ultimately be measured by our ability to identify opportunities
for prevention and education, improve systems responses, and identify replicable best practices
that increase safety for victims and hold offenders accountable.
VIII. Looking Ahead: 2024

Looking ahead to 2024 will bring opportunity for fresh perspectives on the continued development of the fatality review team and process. As always, the State Team has identified and secured the partnering District Attorney Offices and will continue to review cases to assist in determining recommendations each year with the goal of ending the cycle of violence.

A NOTE FROM THE CHAIR:

The 2023 report is my final report as the State Fatality Review Team Chair. It is my hope that the next Chair for the State Team will continue to bring in training from National experts, continue to develop the infrastructure to expand reviews to include voices of family, friends, and colleagues by way of interviews, and continue to build independence of local review teams. Over the years it has been evident that the reviews have been limiting due to several reasons which include the constraints of conducting reviews of murder/suicide with no previous encounters, limitations on information and/or record sharing by certain agencies, and the infrastructure not yet fully built to include interviewing family, friends, and colleagues. Not having a full view of individuals involved is extremely limiting and does not provide us with full context and understanding of opportunities potentially missed. This is a combination of the State Team just needing more time to develop the infrastructure of reviews and/or the need for a full time or even part time administrative support dedicated to the work, providing the ability for that person to streamline the build out of the infrastructure. Thank you for entrusting me with the responsibility of leading the Fatality Review Team over the years.

- Kelly Dwyer, Chair Executive Director, Governor’s Council to Address Sexual Assault, Domestic Violence, and Human Trafficking