

REPORT TO THE LEGISLATURE

MONTANA DOMESTIC VIOLENCE FATALITY REVIEW COMMISSION

JANUARY 2005

PAGE 6 - Third of Ten Commission Recommendations:

Improve/increase supervision of those convicted of PFMA, either through compliance officers or misdemeanor probation officers, in order to ensure that all aspects of the sentence are carried out.

PAGE 9 - LIST OF DOMESTIC VIOLENCE DEATHS SINCE 2000

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January 2005

Fellow Montanans:

It is with tremendous satisfaction that the Montana Domestic Violence Fatality Review Commission brings forth its first summary report. Created by HB 116 and authorized by the 2003 legislature, the Commission is charged with reviewing homicides across the state resulting from intimate partner violence. The Commission is required to report its findings and recommendations every two years, coinciding with new legislative sessions.

The Commission undertakes two reviews per year. This report describes how the Commission does its work, summarizes trends identified through the first four reviews and contains forms and documents to be used in implementing the Commission's recommendations. It provides a broad overview of who the Commission is, its purpose and its work thus far.

Unfortunately, the need for the Commission has not lessened in the past two years. Twelve individuals died in the homicides reviewed in this report. Since 2000, at least 10 additional domestic violence deaths have occurred. The ultimate goal of the Commission's work, to reduce that number, remains urgent.

The Commission is extremely grateful to the Montana legislature for the opportunity to undertake this important work. We are also indebted to Attorney General Mike McGrath for his ongoing support and direction.

Sincerely,

Matthew Dale, Coordinator  
Montana Domestic Violence Fatality Review Commission

**MONTANA DOMESTIC VIOLENCE FATALITY REVIEW COMMISSION  
MEMBERS**

<b>Name</b>	<b>Position</b>	<b>Organization</b>	<b>City</b>
Deb Bakke	Victim Witness Advocate	Friendship Center	Helena
Ali Bovington	Assistant Attorney General	Department of Justice	Helena
Beki Brandborg	Team Facilitator	Mediator	Helena
John Buttram	Licensed Professional Counselor	Batterer's TX Program	Kalispell
Matthew Dale	Team Coordinator	Office of Victim Services	Helena
Bryan Fischer	Police Officer	Helena Police Department	Helena
Connie Harvey	DPHHS Social Worker	Children & Family Services Div.	Billings
Warren Hiebert	Chaplain	Gallatin Co. Sheriff's Dept.	Bozeman
Wally Jewell	Justice of the Peace	Justice Court	Helena
Joan McCracken	Sexual Assault Nurse Examiner	Retired	Billings
Alison Paul	Attorney	MT Legal Services	Helena
Gary Perry	Senator	MT Legislature	Manhattan
Joseph Rich	Medical Director	Yellowstone Boys & Girls Ranch	Billings
Mel Rutherford	Probation Officer	Blackfeet Tribe	Browning
Stu Stadler	District Judge	State of MT	Kalispell
Judy Wang	Prosecutor	City of Missoula	Missoula
Cindy Weese	Executive Director	YWCA	Missoula

## MDVFRC REVIEW TIMELINE

- The commission selects the review community based on a number of factors.
- The review site is approved by the attorney general.
- The team coordinator attends a family violence council meeting in the host community in order to explain the process and answer questions.
- The process of gathering information begins; law enforcement, victim services, courts, medical examiner, etc. are contacted. As appropriate, individuals within those systems are interviewed re: their experience with victim or offender. Records and interview notes are sent to the team coordinator. Those individuals interviewed are invited to attend the review.
- Family members, close friends, coworkers, ministers, teachers, etc., are interviewed. Interview notes are passed on to the team coordinator.
- The commission coordinator disseminates accumulated information to members (Electronically or through the mail).
- Day one of the review process: a timeline is constructed identifying key events in the lives of the victim and perpetrator and their contacts with a variety of professionals/services (3 hours).
- Day two: community members who have been involved in the accumulation of information for the review join the commission to evaluate the timeline and provide any additional information they might have. Those attending the review read and sign a confidentiality agreement. Additions and corrections are made to the timeline (3.5 hours). Following a break for lunch, the commission discusses trends and recommendations learned from this review. Tentative dates and locations for the next review are identified (2 hours).
- The commission coordinator retrieves all written information at the end of the review and transports it back to Helena to be shredded.
- A summary of the review is transcribed by the facilitator and circulated to commission members. This document is the only written record of the review; it is not made public.

The 2003 Montana legislature passed HB 116 creating the Montana Domestic Violence Fatality Review Commission. The commission has completed four reviews since May 2003. The legislation mandates this biannual report from the commission to the legislature, the attorney general, the governor and the chief justice of the Montana Supreme Court outlining its findings and recommendations.

All of the domestic violence deaths reviewed for this report occurred in the past four years, were perpetrated by men and involved multiple victims. All involved a firearm as the murder weapon. Two of the incidents were homicide/suicides; the other two took the lives of the killer, his spouse and their children. All told, 12 individuals died in these four incidents. In two of the incidents, in addition to the shootings, the perpetrator also attempted to burn down the house.

It should be noted that the Commission reviews only a fraction of the family violence deaths in Montana each year. Since the passage of HB 116 in 2003, at least 25 people have died in domestic violence homicides, including the 12 mentioned above. Since 2000, our state has averaged more than seven family violence deaths per year, which should be considered a *minimum* figure. It seems likely that additional deaths that are not easily recognized as domestic violence deaths (suicides, drug overdoses, mercy killings, etc.) would push the figure even higher.

Equally important is the recognition that the individuals killed in the reviewed incidents were young, active and vibrant, cut down in the prime of their lives. The average age of the adult victims was 31, 39 for perpetrators (also deceased in these four incidents). The murdered children ranged in age from 3-7. A fifth child was left an orphan at the age of 12.

One of the victims had finished high school as a teenage mom and had recently started college. Another was named an Indian Princess by her high school peers. A third was known throughout her community as a highly talented musician. Most were lifelong Montana residents. At the time of their deaths, each of the women had made a decision to leave their violent relationship. In every case reviewed, the women were killed at the point their partner truly believed they were ending the relationship.

For the most part, the perpetrators were not well known to law enforcement. Only one had a criminal history involving firearms. Two of the four purchased the murder weapon only days before using it and the other two used borrowed weapons. In two cases, law enforcement had never been called to the home previous to the homicide. All four men were employed, in positions ranging from construction to the financial industry to a ranch hand. They were from diverse ethnic backgrounds.

The Commission is guided by a "no blame/no shame" philosophy. The goal of a fatality review is not to identify an individual or agency as responsible for the deaths. These are complex cases, involving a number of professionals and variables. It is simply not true that any one action, or inaction in and of itself resulted in the tragedy. At the same time, none of the individuals involved with the family would consider the deaths an acceptable conclusion. These deaths traumatize not only those affiliated with the family but the community as well. By reviewing the deaths, it is hoped that the Commission will identify gaps or inadequacies in the social service

system that might be addressed in order to prevent future family violence deaths. The attachments to this report are specific, concrete steps in that direction.

In a majority of cases, the Commission was warmly welcomed to the review community. Information requested was provided quickly and cooperation by agency employees was excellent. Whenever possible, the team coordinator attended a local family violence council meeting previous to the review itself to explain the process and answer questions. Equally important, Commission members made initial contact with their peers in the review community in order to help reduce suspicion and increase access to information. Having judges speak with other judges, victim advocates talk with their colleagues, law enforcement converse among themselves, and so on, has been a key aspect in the Commission's success. Interviews with these professionals augment their paper reports and improve the review process. These individuals are also invited to sit in on the actual review. Attendance at reviews by those invited has been good, although it is hoped that even more invitees will participate in future reviews. So far representatives from law enforcement, child protective services, victim advocacy, county, city and private attorneys and shelter personnel have participated.

Family members are not invited to the review itself, but parents, siblings, surviving children and former spouses of both the victim and the offender are interviewed prior to the review. When possible, friends, neighbors, coworkers, ministers and other concerned persons are also interviewed. Their memories and descriptions broaden and deepen the review process. Montana's fatality review team is alone in the nation in going to this extent to include input from family members and has received national attention for this aspect of their work. From the outset, Commission members have been dedicated to having reviews move beyond a purely statistical exercise. The team endeavors to understand each of the victims as unique individuals. Each of the victims had a life outside of the tragedy; the team is committed to making the reviews as well rounded as possible.

The Commission undertakes only two reviews per year. This is fewer than most states, and it allows for the in-depth work required for each review. Again, the goal of domestic violence fatality reviews is to identify gaps in current systems and propose solutions that will result in fewer lives lost. Montana's Commission has achieved success in its first two years of operation. Over the next two years, we look forward to ongoing work with all those committed to reducing family violence across our state.

Please direct questions, comments or suggestions about this report or the MDVFRC to Matthew Dale, 406-444-1907 or [madale@state.mt.us](mailto:madale@state.mt.us). Additional information (and downloadable versions of the attached forms) is available at <http://www.doj.state.mt.us/victims/default.asp>.

### **Trends identified by the Commission:**

- Firearms were used in each of the deaths reviewed.
- The homicides all took place after the offender was convinced the victim was ending the relationship permanently.
- In all cases, the homicides were the last in a series of controlling behaviors exercised by the batterer.
- The homicides occurred across the state, in families of varied socioeconomic levels.

### **Commission recommendations include:**

- Vigorous enforcement of state and federal firearm statutes for those convicted of Partner and Family Member Assault (PFMA).
- Close the technology gap that limits the ability of courts to track prior offenses (for enhancement) and to exchange electronic records with one another.
- Improve/increase supervision of those convicted of PFMA, either through compliance officers or misdemeanor probation officers, in order to ensure that all aspects of the sentence are carried out.
- Restrict communication between the offender and the victim during incarceration.
- Make “no contact” orders between the victim and offender automatic with a PFMA arrest.
- Hold arraignments for those arrested for PFMA later in the day, in order to allow time for an advocate to contact the victim before the offender is released.
- Provide domestic violence referral information to victims who ask to have a restraining order or PFMA charge rescinded.
- Disseminate the model “Victim Notification of Inmate Release” form statewide.
- Increase the use of “lethality assessments” by courts, law enforcement, victim advocates and all professionals who interact with victims and batterers.
- Extend the “sunset” date of HB 116 from December 31, 2006 for another two years.

# **MONTANA DOMESTIC VIOLENCE FATALITY REVIEW COMMISSION**

## **Mission**

The Montana Domestic Violence Fatality Review Commission (MDVFRC) is a multi-disciplinary group of experts who study domestic violence homicides in a positive, independent, confidential and culturally sensitive manner, and make recommendations – without blame – for systems and societal change.

## **Vision Statements**

Because we are committed to partner and family safety, the MDVFRC, in partnership with the local community, will achieve:

1. Systemic change: Domestic violence interventions occur early, often and successfully. Individuals communicate openly and effectively across boundaries.
2. Societal change: Communities are educated about and understand why domestic violence occurs and become involved in its reduction.

## **Guiding Principles**

1. We offer each other support and compassion.
2. We conduct the Review in a positive manner with sensitivity and compassion.
3. We acknowledge, respect and learn from the expertise and wisdom of all who participate in the Review.
4. We work in honor of the victim and the victim's family.
5. We are committed to confidentiality.
6. We avoid accusations or faultfinding.
7. We operate in a professional manner.
8. We share responsibilities and the workload.

## DV HOMICIDES SINCE 2000

(As of 12/9/04)

Last Name	First Name	Fatality Location	Age	Date Of Death	Type Of Death
Vanderpool	Eugenia	Lockwood	32	02/15/00	Homicide / Suicide
Miller	Leanne	Bozeman	42	06/03/00	Homicide / Shot By Officer
Brekke	Bonita	Bozeman	51	01/11/01	Homicide / Suicide
Williams	Bonnie	Lockwood	33	2/19/01	Homicide
Baarson	Kim	Butte	39	03/06/01	Homicide / Suicide
Vancleave	Emily	Billings	22	04/17/01	Homicide / Suicide
Mosure	Michelle	Billings	23	11/19/01	Homicide / Suicide + 2 Kids
Rasmussen	Noelle	Butte	23	04/13/02	Homicide / Suicide
Newman	Cathy	Frenchtown	51	05/15/03	Homicide / Suicide
Flying	Sheila	Conrad	30	05/22/03	Homicide / Suicide
McDonald	Jessica	Great Falls	32	07/01/03	Homicide / Suicide + 2 Kids
Erickson	Mindie Jo	Bozeman	33	09/10/03	Homicide / Suicide
Zumsteg	Deborah	Billings	41	03/01/04	Homicide / Suicide
Macdonald	Virginia	Missoula	Mid-40s	04/29/04	Homicide / Suicide
Chenoweth	Aleasha	Plains	24	07/19/04	Homicide
Yetman	Labecca	Hamilton	35	08/30/04	Homicide
Hackney	Stephen	Lolo	38	11/26/04	Homicide
McKinnon	Gina	Marion	40	12/01/04	Homicide / Suicide

**MONTANA FATALITY REVIEW COMMISSION  
CONFIDENTIALITY AGREEMENT**

1. The effectiveness of the work of the Domestic Violence Fatality Review Team is conditioned upon the confidentiality of the review process and the information shared. I agree that all discussions and information obtained in the review process will remain strictly confidential and will not be used for any purpose outside this review process. Communications, oral and written, and documents relating to this review shall remain confidential and not subject to disclosure.
2. I may speak with a review participant about the substance of the meeting without violating this agreement, provided that the discussion and information shared is not communicated in any way with non-participants.
3. I will notify the Fatality Review Team coordinator if I am subpoenaed or court ordered for information in my capacity as a member of the Fatality Review Team.
4. Any public presentation of case illustrations by our Team coordinator or another authorized Team member will have all identifying characteristics removed.
5. I agree to return all information received during the review process to the Team coordinator at the conclusion of each review.
6. A designated Team member shall report evidence of an additional offense, separate from the homicide reviewed, to a law enforcement agency with jurisdiction over the offense. Filing a report with a law enforcement agency concerning this evidence does not violate this agreement.
7. The identities of individual local Team participants will not be disclosed without the written authorization of the participant.
8. I will not divulge the views or work of the Team to the media, except as authorized by the Team.
9. I understand that violation of this agreement may result in my removal from the review Team and a civil penalty of not more than \$500.

**SIGNATURE**

**AGENCY**

**DATE**

\_\_\_\_\_  
\_\_\_\_\_

**DETENTION CENTER  
VICTIM NOTIFICATION OF INMATE RELEASE**

**INMATE'S NAME:** \_\_\_\_\_

**VICTIM'S NAME:** \_\_\_\_\_

**VICTIM TELEPHONE #:** \_\_\_\_\_

**VICTIM PHYSICAL ADDRESS:** \_\_\_\_\_

\_\_\_\_\_

**OTHER INFORMATION:** \_\_\_\_\_

\_\_\_\_\_

**TELEPHONE BLOCKED:**

**VICTIM NOTIFIED OF PENDING RELEASE:**

**1st Attempt to Contact:** no answer

**2nd Attempt to Contact:** no answer

**3rd Attempt to Contact:** no answer

**DISPATCH NOTIFIED OF NO CONTACT:**

**INMATE RELEASED:**

Date	Time	Officer
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ADDITIONAL NAMES AND INFORMATION ARE TO BE PLACED ON ADDITIONAL PAGES

Prior to release of the inmate, the Detention Center Staff will attempt to contact the authorized person listed above by telephone. If the person does not have a telephone or is unable to be contacted via telephone, the Detention Center Staff will notify the arresting agency, via the dispatch center, of the pending release so that the agency may make personal contact with the victim.

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## DANGER ASSESSMENT

Jacquelyn C. Campbell, PhD, RN

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Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

(If any of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

- \_\_\_\_\_ 1. Has the physical violence increased in severity or frequency over the past year?
- \_\_\_\_\_ 2. Does he own a gun?
- \_\_\_\_\_ 3. Have you left him after living together during the past year?
- \_\_\_\_\_ 3a. (If you have never lived with him, check here \_\_\_\_\_)
- \_\_\_\_\_ 4. Is he unemployed?
- \_\_\_\_\_ 5. Has he ever used a weapon against you or threatened you with a lethal weapon?  
(If yes, was the weapon a gun? \_\_\_\_\_)
- \_\_\_\_\_ 6. Does he threaten to kill you?
- \_\_\_\_\_ 7. Has he avoided being arrested for domestic violence?
- \_\_\_\_\_ 8. Do you have a child that is not his?
- \_\_\_\_\_ 9. Has he ever forced you to have sex when you did not wish to do so?
- \_\_\_\_\_ 10. Does he ever try to choke you?
- \_\_\_\_\_ 11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
- \_\_\_\_\_ 12. Is he an alcoholic or problem drinker?
- \_\_\_\_\_ 13. Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: \_\_\_\_\_)
- \_\_\_\_\_ 14. Is he violently and constantly jealous of you? (For instance, does he say, "If I can't have you, no one can.")
- \_\_\_\_\_ 15. Does he follow or spy on you, leave threatening notes or messages on answering \_\_\_\_\_ machine, destroy your property, or call you when you don't want him to?
- \_\_\_\_\_ 16. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: \_\_\_\_\_)
- \_\_\_\_\_ 17. Have you ever threatened or tried to commit suicide?
- \_\_\_\_\_ 18. Has he ever threatened or tried to commit suicide?
- \_\_\_\_\_ 19. Does he threaten to harm your children?
- \_\_\_\_\_ 20. Do you believe he is capable of killing you?
- \_\_\_\_\_ Total "Yes" Answers

**Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.**