MONTANA DEPARTMENT OF JUSTICE,
OFFICE OF CONSUMER PROTECTION AND VICTIM SERVICES

REPORT TO THE LEGISLATURE:

Montana Domestic Violence Fatality Review Commissions

SEPTEMBER 2015

September 2015

Fellow Montanans:

The state's Domestic Violence Fatality Review Commission has now been in existence a little more than a decade. Progress has been made in keeping victims safe and holding offenders accountable. At the same time, it is clear that we have not achieved the goal of eliminating these tragic deaths.

Our 2013 report identified nine incidents of intimate partner homicide (IPH) resulting in 14 deaths during the previous biennium. Unfortunately, those numbers increased to 12 and 17, respectfully, in the past two years. As a state, we are driven to do better.

A significant step in that direction has been the creation of America's first Native American Domestic Violence Fatality Review Team. Over the years it became clear that elevated rates of IPH involving both Indian perpetrators and victims called for a unique approach in understanding and reducing those deaths. Under the leadership of Attorney General Tim Fox, the Team began its work in the spring of last year and has since completed two reviews. Statistics and lessons learned from those events are included in this legislative report for the first time.

Montana's team has received nationwide and even international attention for our victim-centered reviews and our work with federal and Native American partners. Our hope is to continue to justify that attention by implementing creative and effective strategies in further reducing the number of family violence deaths in our state.

For additional information on the Commission, please call 406-444-1907 or Email madale@mt.gov. Regarding the Native American Team, call 406-444-5803 or Email jeliel@mt.gov.

Sincerely,

Matthew Dale, Coordinator
Domestic Violence Fatality Review Commission

Joan Eliel, Coordinator
Native American Fatality Review Team

Progress has been made in keeping victims safe and holding offenders accountable.

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The Montana Domestic Violence Fatality Review Commission (also referred to as a team) was created by the 2003 Montana legislature. Among other things, the statute mandates this biennial report and its dissemination to the Law and Justice Interim Committee, the attorney general, governor, chief justice of the Montana Supreme Court and the people of Montana.

It should be noted that the Commission reviews only a fraction of the family violence deaths in Montana each year. The group uses its limited time and resources to review only *intimate partner* homicides (IPH). Other groups, such as Montana's Fetal Infant Child Mortality Review and Suicide Mortality Review teams, gather information on other types of familial deaths. Unfortunately, even with our limited scope there are more deaths than the Commission can review each year. Since the passage of House Bill 116 in 2003, at least 144 Montanans have died in family violence homicides. In the past two years, the time frame covered by this report, 12 violent interactions resulted in 17 deaths.

During the past biennium diligent effort created a second Montana team, the nation's first Native American Domestic Violence Fatality Review Team. The need for such a team became clear as the statewide team did its work in Indian Country over the past 10 years. A group of dedicated, experienced professionals was assembled to participate on the team and their first review was conducted in March 2014. A second review took place in November of last year. This is a tremendous victory for our state and the results of those reviews are included in this report for the first time.

Philosophy and Process

A "no blame/no shame" philosophy guides the work of both teams. The purpose 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 individuals and variables. It is simply not true that the tragedy was the result of any one action – or inaction – by any one person or agency. In fact, we find that many of the victims had limited, if any, contact with the "system" – they never sought shelter, did not reach out to a victim witness advocate nor did they have an order of protection. Similarly, the majority of perpetrators do not have extensive criminal histories.

At the same time, no one working with these families would consider any death an acceptable conclusion. Domestic violence homicides traumatize not only those close to the family but entire communities. Reviewing the murders and working with local community members, the teams seek to identify gaps and inadequacies in the response to domestic violence (DV) at the local and statewide levels. The goal is to prevent future deaths. It is clear there is more work to do. The recommendations made in this report are specific, concrete steps in that direction.

Montana's fatality review teams have chosen an "inch wide, mile deep" approach to reviewing these deaths, undertaking only two per year, per team. In each case we review all the information available, including law enforcement reports, criminal histories, medical and autopsy records, presentence investigations, newspaper stories and criminal justice records. Additionally, team members interview family, coworkers, school personnel, friends, shelter staff and all other relevant individuals to learn more about the victim and the perpetrator. Then the entire team [see page 11 and 19] travels to the community in which the homicide(s) took place.

Once there, the group uses all of the collected information to compile a time line of events leading up to the deaths. This exercise illuminates agency involvement, missed opportunities, things that worked well and gaps in services. Community members who worked with the family are invited to in participate in the review and improve the time line. Everyone attending signs the same confidentiality agreement. Local participation expands the knowledge of the team and accelerates changes in the community's protocols for working with families experiencing domestic violence. Focusing our collective efforts at the grassroots level expedites the goal of fatality review, which is to introduce and highlight changes that increase

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victim safety and perpetrator accountability.

At both the local and statewide levels the assembled group is multidisciplinary. It provides the opportunity for individuals who seldom work with one another, or have traditional biases against each other, to proceed toward a common goal. This model has resulted in productive dialogue and created both statewide and inexpensive, quickly implemented community improvements.

Identifying a limited number of practical recommendations, then monitoring their progress, has been a key element in the success of Montana's teams. For instance, of the 10 recommendations in the 2013 report, seven have been achieved in the past two years. The others have been addressed and remain works in progress. This report's recommendations appear on page 9.

2013 and 2014 Reviews

The four statewide and two Native American reviews conducted over the past two years inform this report's trends and recommendations. This report, through its posting on the DOJ website, https://dojmt.gov/victims/domestic-violence-fatality-review-commission/, serves as the teams' vehicle for highlighting new ideas, best practices, and creative solutions identified around the state, or elsewhere in the country, as effective tools in combating domestic violence deaths. Examples of some of these are included at the end of the report in the Guides and Model Forms section.

Our work this biennium, reviewing three homicides, one multiple homicide and two homicide/suicides, taught us a great deal. One of the incidents involved a child of the killer being coerced to participate in the event, a first for the team. Because he was a minor at the time, the local review provided the opportunity to hear from a juvenile probation officer, a discipline we had not heard from before. That element was extremely informative. In another case, team members were able to interview the shooter, learning additional details and hearing his insights as to what might help prevent a similar crime in the future. This perpetrator had killed his girlfriend and her daughter on Christmas Day, adding immeasurably to the grief of the community and surviving family members (This young man committed suicide while in prison, an additional circumstance that has not occurred before.) The remaining reviews involved a military family and two couples who lived together for long periods but never married. One of those killings involved a hostage situation, another new set of events for the team. The Native American reviews included a homicide/suicide where the victim was beaten and the perpetrator committed suicide by hanging and a homicide in which the perpetrator was female. That killing highlights a trend in Native American IPH, in which the perpetrator is predominately female. This differs from statewide and national trends in which the perpetrators are most often male.

At both the local and statewide levels the assembled group is multidisciplinary. It provides the opportunity for individuals who seldom work with one another, or have traditional biases against each other, to proceed toward a common goal.

The teams choose their cases carefully, seeking a wider understanding of IPH in Montana and using innovative approaches to develop new insights. By further refining how law enforcement, victim advocates, social service providers and criminal justice personnel do their jobs, both fatality review teams hope to reduce the number of families and communities traumatized by these deaths.

Positive Results in Indian Country

Montana is also a leader in Indian Country reviews and has received national recognition for its efforts. This process reached its culmination when the nation's first Native American DV fatality review team was created in 2014. The team, underwritten by a federal DOJ grant, consists primarily of Native representatives and their federal partners—BIA, FBI, US Attorney's Office, etc. (See page 19). Their focus is intimate partner homicides in Montana that involve a Native perpetrator and/or victim. They have completed two reviews and their information is included in this report for the first time.

Over the years, Montana's fatality review team has made several positive connections with our

seven Native American reservations, particularly its tribal courts. One very concrete example is the Hope Card, which began on the Crow reservation as the Purple Feather campaign. The statewide fatality review team encouraged the Attorney General's Office to take the idea statewide, which was achieved during Crime Victim Rights Week in April 2010. The Card displays the key elements of an order of protection, including a photo of the perpetrator, on a small, portable plastic card [see example on page 39].

It has been a goal to extend or improve court-based technology to all seven tribal courts and steady progress has been made in that area as well. With the assistance of the same federal grant mentioned above, this biennium saw the last of these courts outfitted with a new or expanded electronic case management system and the capacity to create Hope Cards. Montana was the first state in the country to issue Hope Cards and remains the only state with Indian Country participants.

Over the past two years, Montana's Native team has identified a need for its members to better educate themselves on those factors that make domestic violence in Indian Country different than the rest of the state. To that end, in the near term, the team will focus on educating itself on historical trauma and the effect of concentrated poverty.

National and Statewide Impact

Montana's model of fatality review, including the use of statewide teams, traveling to the community in which the killing occurred, working with local community members and interviewing family members, has been highlighted across the country. Team coordinators have been invited to speak at numerous local, state and national conferences and the teams have been identified as exemplary by the National Domestic Violence Fatality Review Initiative (http://www.ndvfri.org/). Additionally, the Commission was chosen as one of three programs to be recognized nationally for its use of Violence Against Women Act dollars, which are used to pay the group's expenses. The U.S. Department of Justice, Office on Violence Against Women, funded the production of a documentary film highlighting the work of the Commission. The completed film has been seen by hundreds of fatality review team members in the United States and abroad and is an excellent teaching tool. It can be viewed online at http://vimeo.com/15147441 and is also available in DVD form.

While our work is not done by any means, recognition of the efforts by so many Montanans to reduce the amount of IPH encourages us to return to the task until greater success is achieved.

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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:

- **Systemic change:** Domestic violence interventions occur early, often and successfully. Individuals communicate openly and effectively across boundaries.
- **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.

Trends identified by the Commission:

- After several years in which there were no Native American IPH deaths, 2014 brought two. Native Americans remain victims of intimate partner homicide at a disproportionate rate in our state. While constituting approximately 7% of the state's population, they make up 13% of IPH events and 11% of intimate partner victims. As in past Indian Country deaths, both the victim and perpetrator were Native American.
- In non-Native IPH, females are the perpetrator in 22% of the killings. In Native American IPH, females are the killers 58% of the time.
- In non-Native, female perpetrated IPH a knife is used 37% of the time. In Native American IPH a knife is used 86% of the time.
- Firearms are used in 75% of non-Native killings. In reservation communities firearms are used only 25% of the time.
- All Native American IPH have involved both Native victims and perpetrators.
- There have been no Native American familicides.
- Statewide, firearms continue to be the most frequently used weapons.
- Substance abuse, including prescription drugs, was a significant factor in several of the killings.
- Most of IPH deaths this biennium occurred West of Billings. Twenty-seven percent of the deaths took place in the Flathead.
- In the majority of incidents, family, friends and/or coworkers were aware of violence within the home but did not intervene.
- Three of the perpetrators had significant criminal histories.
- These killings resulted in significant trauma to minor children who witnessed the killing or dealt with its immediate aftermath. Resources provided to the children varied tremendously.
- Use of social media/digital technology is becoming much more common in perpetrating coercive control [e.g. cyber stalking]. Additionally, it is being used more and more to solve DV crimes and in the creation of safety plans.

Commission recommendations include:

- Provide regular training to public assistance case managers on the good cause exemption for domestic violence victims, particularly related to child support enforcement.
- Continue the collaboration and joint trainings between Montana's Department of Justice, the Bureau of Indian Affairs, the U.S. Attorney's Office and the MT—WY Tribal Judges Association.
- Expand the state's Crime Victim Compensation Program to increase the reimbursement rate for funeral expenses. The $3,500 figure has not been raised since 1995 and its limitation can place a financial burden on families of those killed in intimate partner homicides.
- Increase the use of trauma-based services among those working with DV victims, perpetrators and children who grow up in violent homes.
- Pass legislation focused on strangulation, either creating a new stand-alone statute or enhancing existing DV statutes.
- Institute a statewide child death review team modeled on the adult death review teams.
- Expand the use of danger/lethality assessments by law enforcement, victim advocates, medical personnel and criminal justice staff.
- Conduct trainings for tribal and non-tribal judges, law enforcement, and health professionals on lethality assessments and domestic violence screenings so those interacting with victims can better assess the risks associated with intimate partner violence. Take steps to educate all Montanans on factors unique to Indian Country in order to better understand how domestic violence is different in Indian Country. Examples include historical trauma, sexual abuse, and concentrated poverty.
- Strengthen Indian Country multi-disciplinary team efforts in staffing and intervening in family violence. Develop culturally appropriate family violence intervention protocols that can be utilized by tribal programs.

Montana Domestic Violence Fatality Review Time Line

1. The Commission selects the review community based on a number of factors. In general, homicides that are more recent, have unique circumstances and are located in communities not previously visited are preferred.

2. The attorney general approves the review site.

3. The process of gathering information begins. Law enforcement, victim services, the courts, medical examiner, etc. are contacted. As appropriate, individuals within those systems are interviewed regarding their experience with victim or offender. Records and interview notes are sent to the team coordinator. Individuals interviewed are invited to attend a portion of the review.

4. Family members, close friends, coworkers, ministers, teachers, etc., are interviewed. Interview notes are passed on to the team coordinator.

5. The Commission coordinator sends all accumulated information to members.

6. Day one of the review process: a time line is constructed identifying key events in the lives of the victim and perpetrator and their contacts with a variety of professionals/ services over time (5 hours).

7. Day two: community members who have been involved in the accumulation of information for the review (excepting family members) join the Commission to evaluate the time line 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 time line (3½ hours). Following a lunch break, the Commission discusses trends and recommendations based on this review. Tentative dates and locations for the next review are identified (2 hours).

8. The Commission coordinator retrieves all written information at the end of the review and transports it back to Helena to be shredded. Members leave the site empty handed.

9. 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.

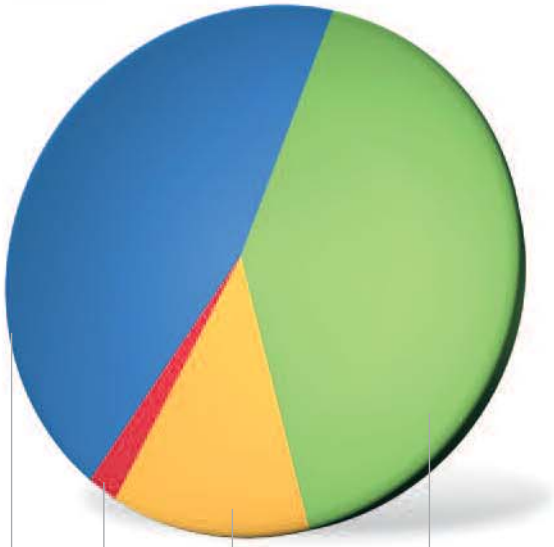
Montana Domestic Violence Fatality Review Commission

NAME	POSITION	ORGANIZATION	CITY
Phoebe Blount	Victim Witness Specialist	FBI	Glasgow
Suzy Boylan	Prosecutor	Missoula County	Missoula
Beki Brandborg	Team Facilitator	Mediator	Helena
John Brown	District Judge	State of Montana	Bozeman
John Buttram	Licensed Professional Counselor	Batterer's Treatment Program	Kalispell
Sarah Corbally	Administrator	Child & Family Services Division	Helena
Matthew Dale	Team Coordinator	Office of Victim Services	Helena
Dan Doyle	Professor	The University of Montana	Missoula
Jenny Eck	Legislator	Montana House of Representatives	Helena
Caroline Fleming	Executive Director	Custer Network Against DV	Miles City
Diana Garrett	Attorney	Montana Legal Services Assoc.	Missoula
Connie Harvey	Therapist	Self-Employed	Lewistown
Warren Hiebert	Chaplain	Gallatin County Sheriff's Dept.	Bozeman
Lee Johnson	Investigator	Division of Criminal Investigation	Bozeman
Dennis Loveless	Judge	City Court	East Helena
Joan McCracken	Sexual Assault Nurse Examiner	Retired	Billings
Chuck Munson	Assistant Attorney General	Department of Justice	Helena
Dan Murphy	Detective	Butte-Silver Bow Law Enforcement	Butte
Martha Rhoades	Psychiatrist	Billings Clinic	Billings
Roxanne Ross	Intelligence Analyst	Division of Criminal Investigation	Helena

Fatalities Associated with Intimate Partner Homicide in Montana since 2000

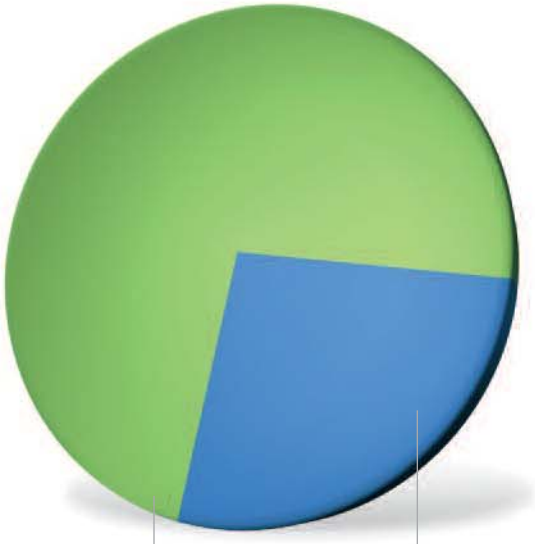
129 deaths as of December 31, 2014 | 86 Intimate Partner Homicide events as of December 31, 2014

Type of Death



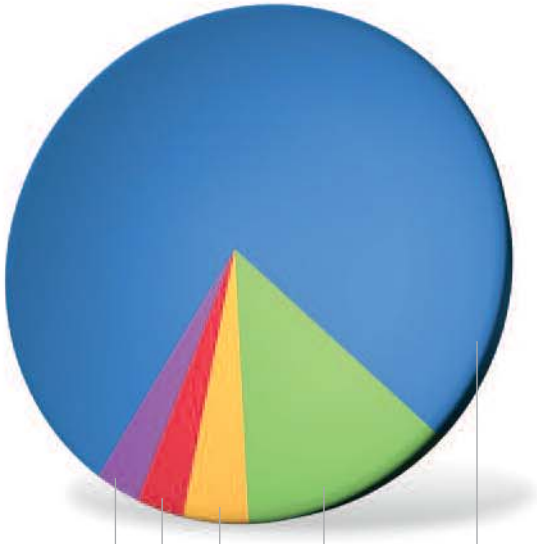
- Homicide 40%
- Familicide.....12%
- Attempted Homicide 2%
- Homicide & Suicide....46%

Perpetrator by Gender



- Female perpetrator 26%
- Male perpetrator 74%

Type of Weapon Used



- Strangulation 4%
- Knife 12%
- Other** 3%
- Beaten 3%
- Firearm 78%

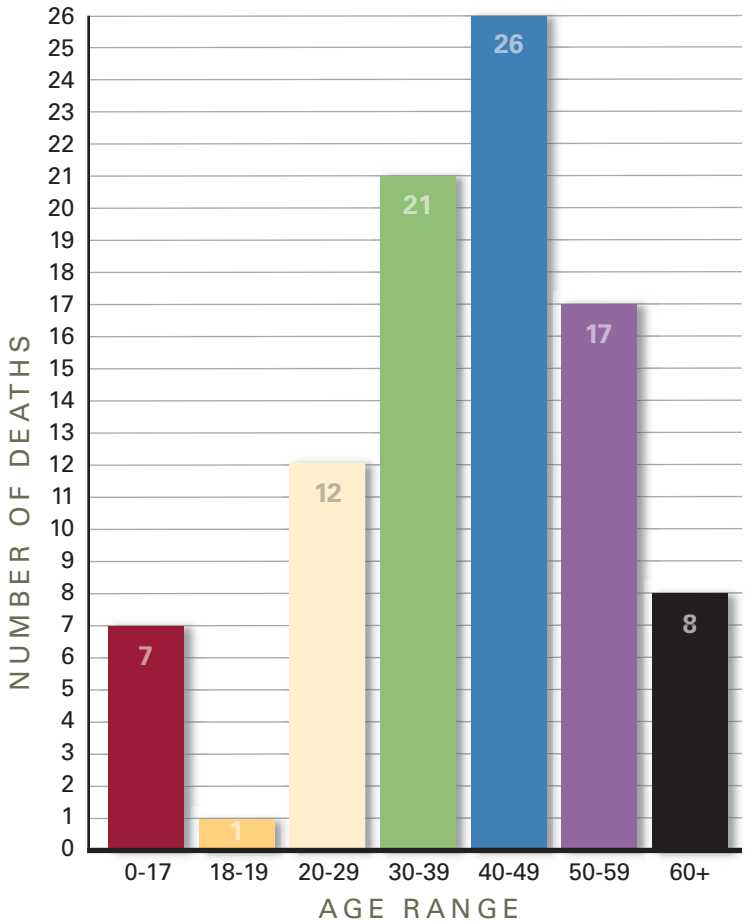
* Other: Run over; hanging; suffocation; pushed off cliff. Fatalities include victims, perpetrators, and children who died in 86 intimate partner homicide events

Data source: Montana Department of Justice; Office of Victim Services.

Fatalities Due to Intimate Partner Homicide in Montana since 2000

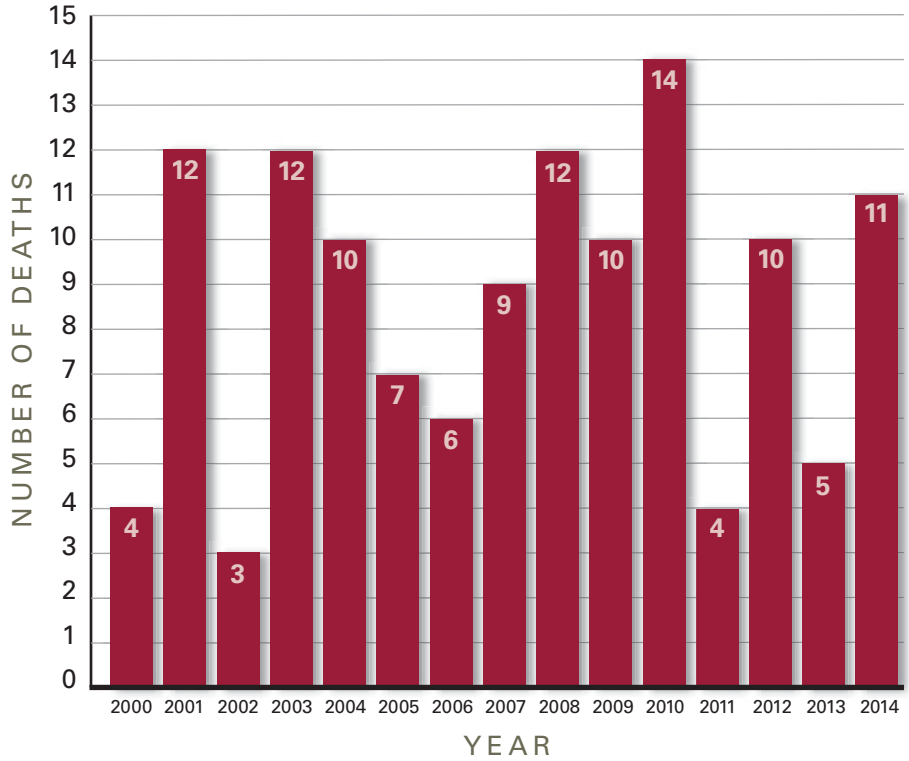
129 deaths as of December 31, 2014 | 86 Intimate Partner Homicide events as of December 31, 2014

Age Range of Intended Victims



Fatalities Associated with Intimate Partner Homicides by Year, 2000–2014

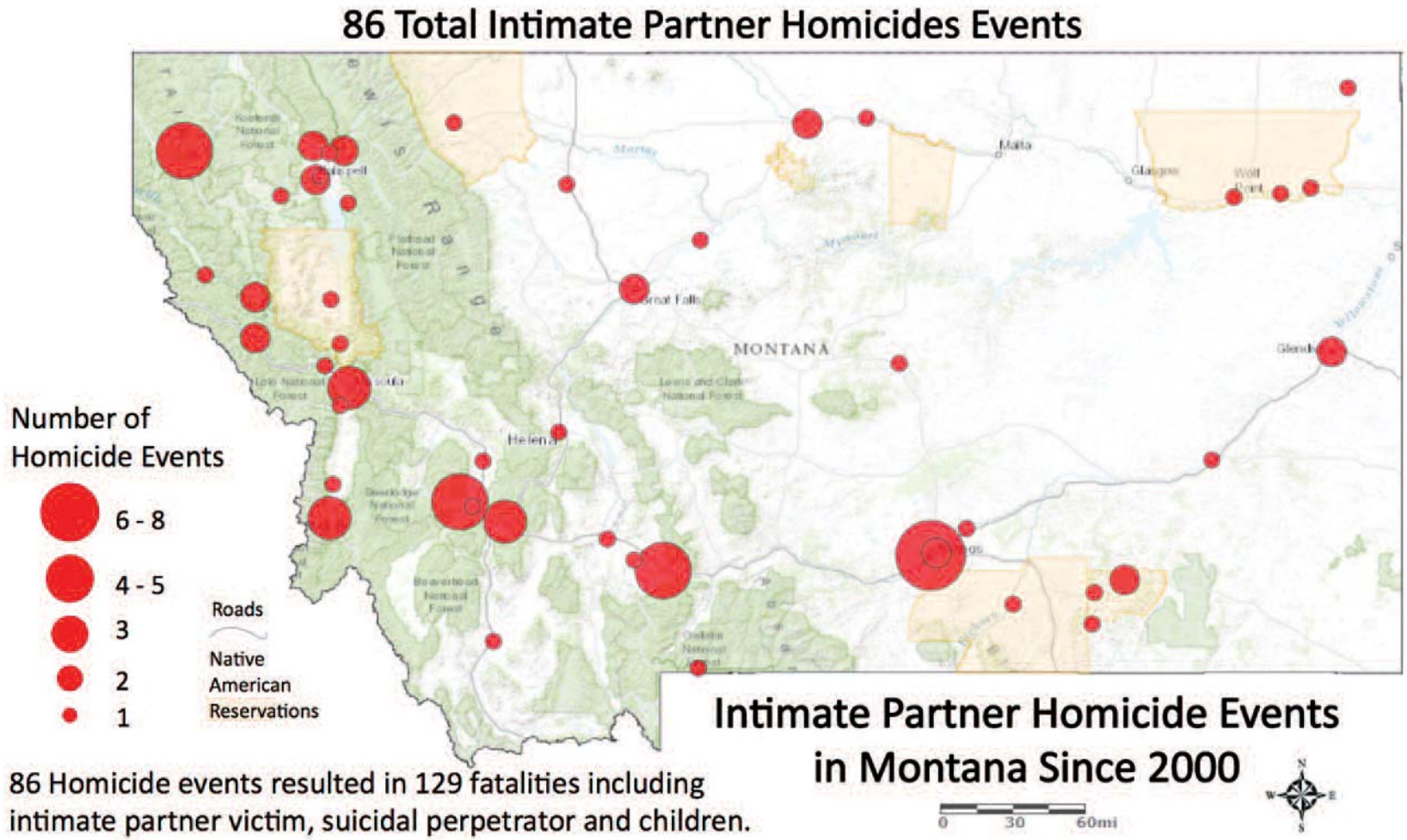
129 deaths as a result of 86 IPH events



Data source: Montana Department of Justice; Office of Victim Services

Intimate Partner Homicide Events Since 2000

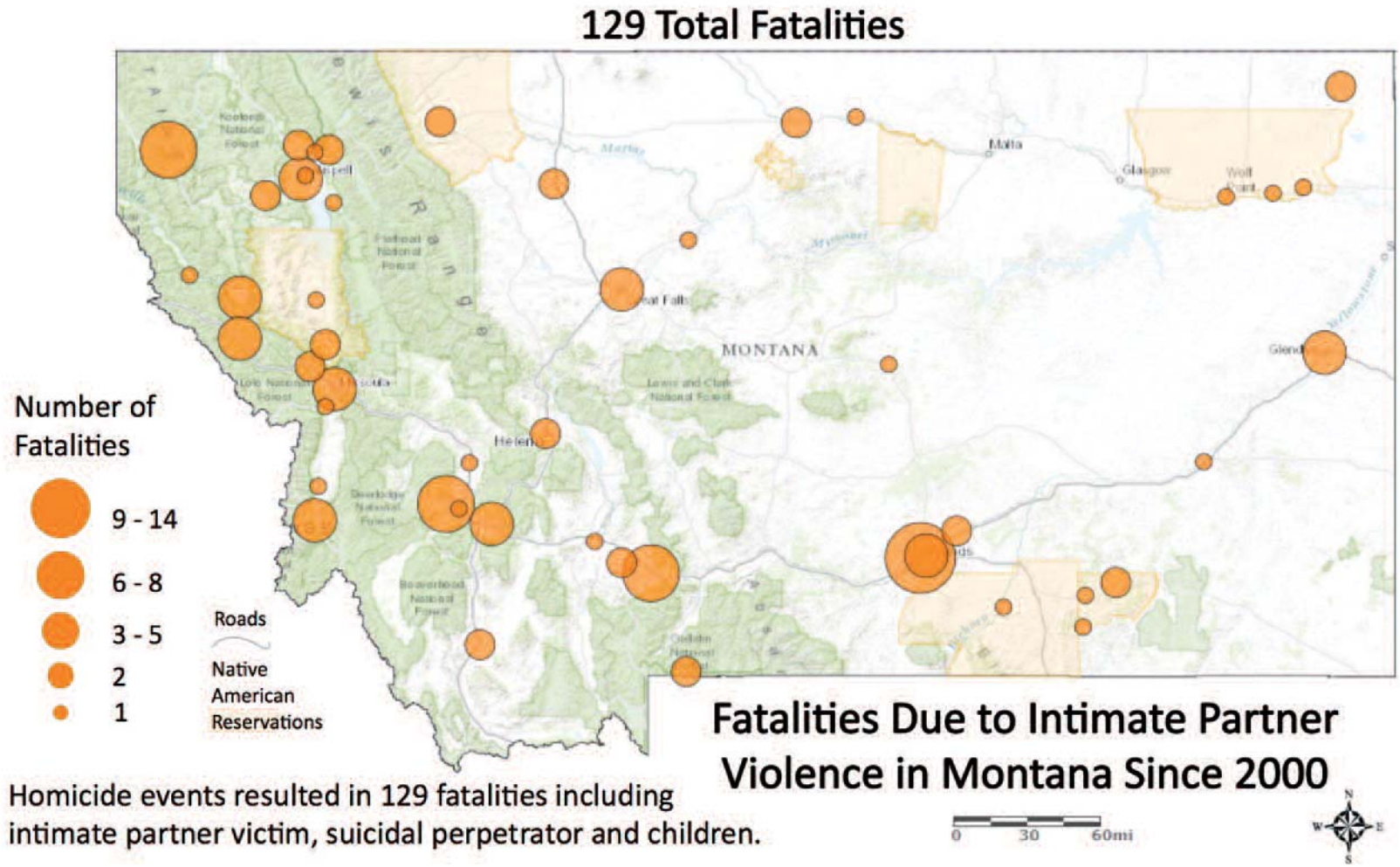
86 Events Resulting in 129 Fatalities as of December 31, 2014



86 Homicide events resulted in 129 fatalities including intimate partner victim, suicidal perpetrator and children.

Intimate Partner Fatalities Since 2000

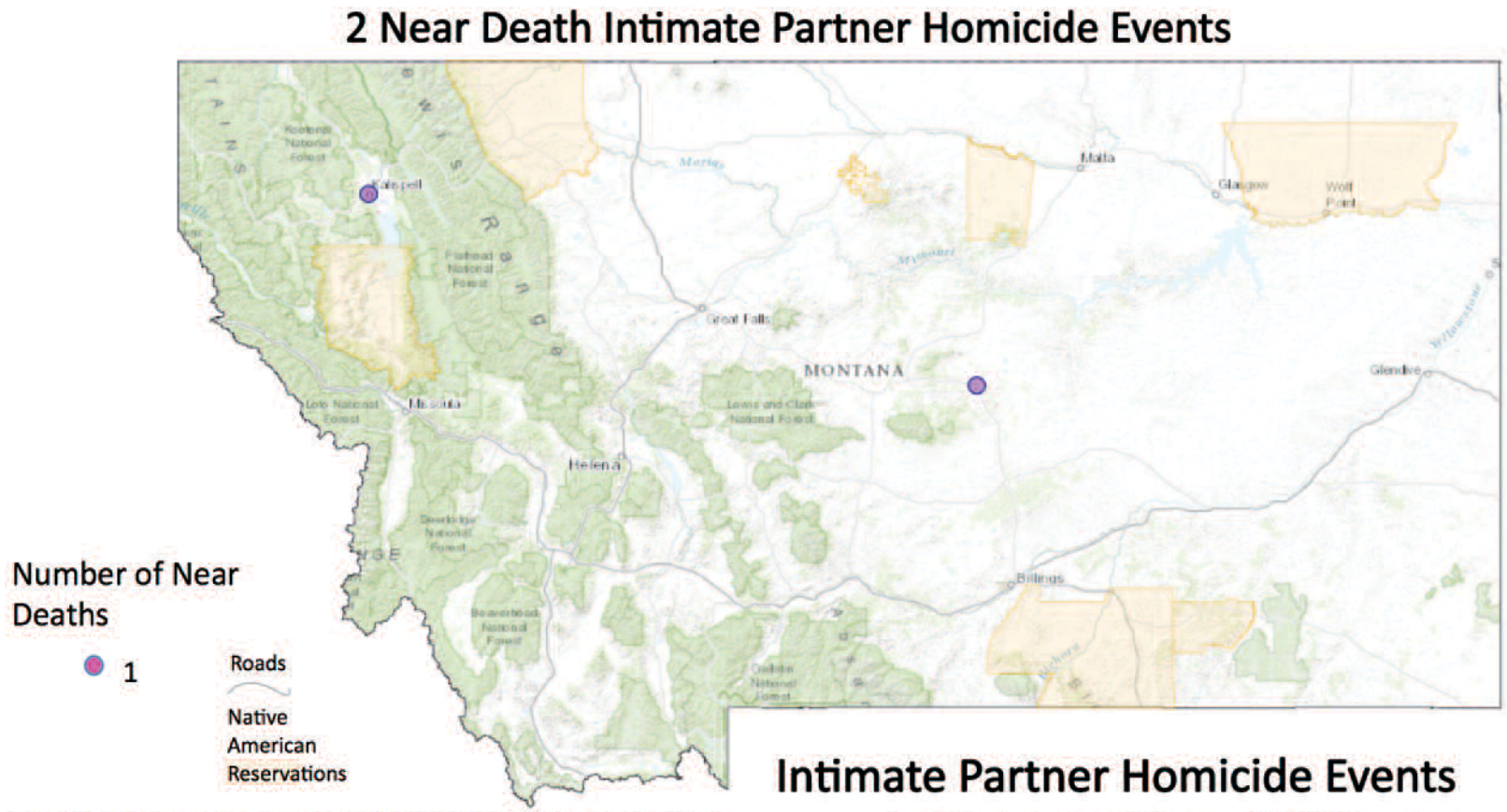
129 Total Fatalities as of December 31, 2014



Homicide events resulted in 129 fatalities including intimate partner victim, suicidal perpetrator and children.

Near Death Intimate Partner Homicide Events Since 2000

129 Total Fatalities as of December 31, 2014



Homicide events resulted in 129 fatalities including intimate partner victim, suicidal perpetrator and children; 2 near deaths

Native American Domestic Violence Fatality Review Team

Native American Domestic Violence Fatality Review Team

Our Mission

The Native American Domestic Violence Fatality Review Team exists to deeply understand what leads to domestic violence fatalities in Montana's Indian Country, and to recommend culturally sensitive, proactive changes to prevent them in the future.

Our Vision Statements

1. Indian Country-specific data is accumulated that educates us about what leads to domestic violence death and what can prevent these deaths in the future.
2. The data is shared with all relevant parties: judges, law enforcement, domestic violence advocates, Tribal leadership, Child Protective Services workers, policy-makers at the state and national level, and communities. It influences their understanding, approaches, and decision making.
3. Both the warning signs leading to death and the best practices to prevent domestic violence deaths are well known in Indian Country by all decision and policy makers.
4. People are open to reporting warning signs and intervening at stages that can prevent deaths.
5. Funding exists to pursue the changes we recommend.
6. Ultimately, there are no domestic violence deaths in Montana's Indian Country.
7. Our approach of studying domestic violence deaths, making recommendations for change, and publicizing those recommendations is a model for Indian Country throughout the United States.

Our Guiding Principles

We agree and are dedicated to the following standards:

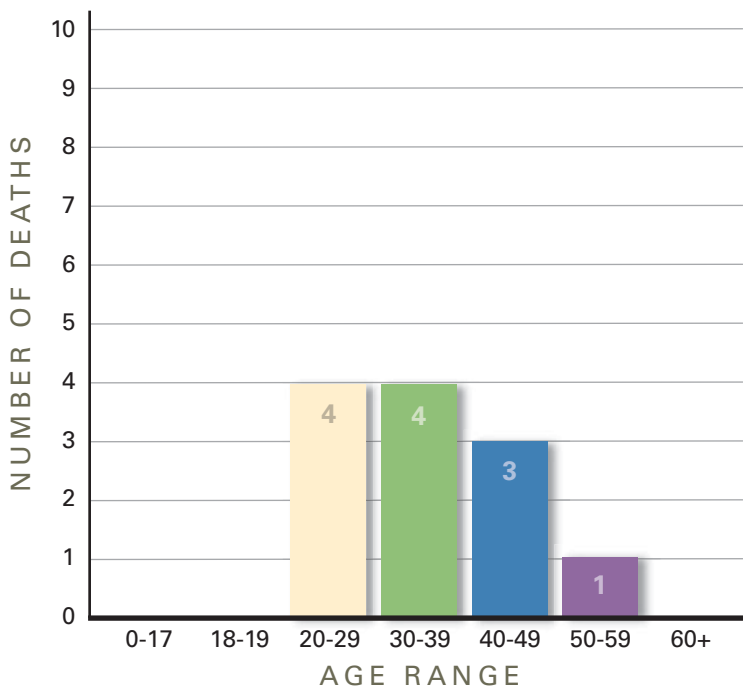
1. We demonstrate our respect for each other by listening carefully and actively. We share the talking time, and avoid talking over one another, having side conversations and making speeches. We actively invite each person's opinion and thoughts and complete honesty.
2. We attend the Reviews with regularity, and are present for the entire process.
3. We respect and honor the victims' lives at all times, and never use any shaming or blaming language. Instead, judgments are made about processes and procedures, and the focus becomes the future and its opportunities.
4. We trust that everyone is doing their best work, giving it their best effort and that they have good intentions in all we do together.
5. We are a team, share the workload, and each do our part to ensure successful review.
6. We honor that some people will be able to do certain kinds of work leading up to the review, and respect when someone cannot participate in a sensitive aspect of the case.
7. Sensitivity to age and gender will be incorporated into interviews, and the best Team members chosen to conduct each one. Gifts will be provided to those we interview.
8. Our focus is on family fatalities related to domestic violence, on or near Reservations.

Native American Domestic Violence Fatality Review Team

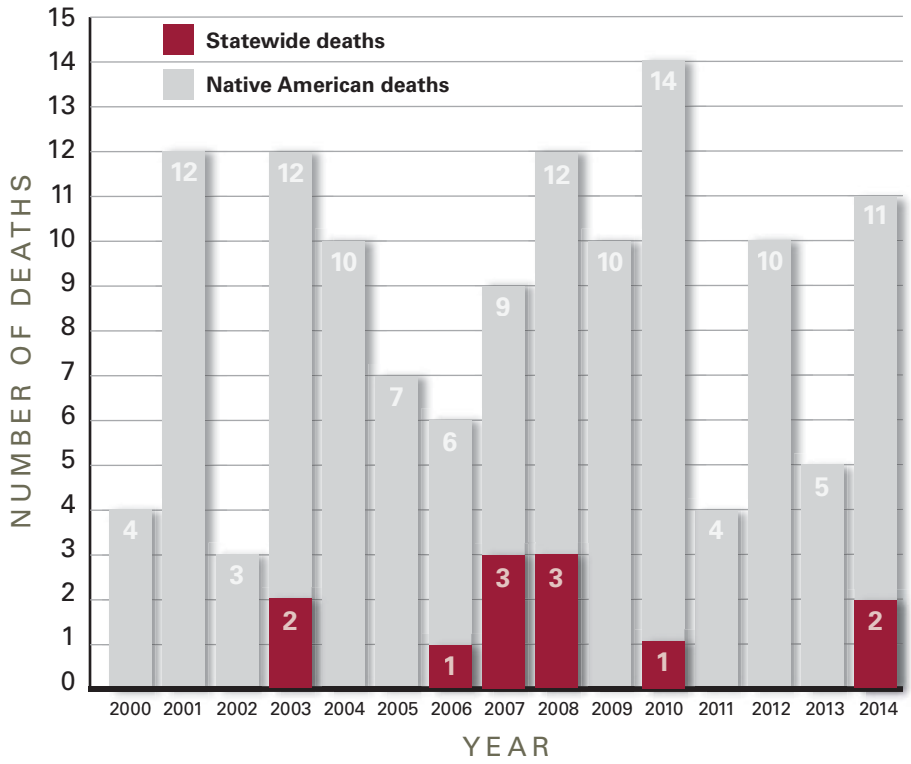
NAME	POSITION	ORGANIZATION	CITY
Beki Brandborg	Team Facilitator	Facilitator	Helena
Carla Lott	Native American Liaison	US Senator Jon Tester	Helena
Charles Robison	State Director and Legal Counsel	US Senator Steve Daines	Helena
Brandon Walter	Special Agent	FBI	Billings
Danna Jackson	AUSA/Tribal Liaison	US Attorney/District of Montana	Helena
Earl Sutherland, Jr.	Medical Director	Big Horn Valley Health Center	Hardin
Georgette Boggio	Former County Attorney	Big Horn County	Hardin
Harlan Trombley	Native American Liaison	Montana Department of Corrections	Great Falls
Joan Eliel	Team Coordinator	Montana Department of Justice-Victim Services	Helena
Kelly McDonald	Tribal Prosecutor	CSK Tribal Court	Pablo
Matthew Dale	Director	Office of Victim Services	Helena
Mistee Rides At The Door	Tribal Liaison	Montana Legal Services	Browning
Richard Jackson	Former Chief Judge	Fort Peck Tribal Courts	Poplar
Roni Rae Brady	Chief Judge	Northern Cheyenne	Lame Deer
Stephanie Iron Shooter	Caring Schools Coordinator	Montana Office of Public Instruction	Billings
Thomas Limberhand	Cultural Advisor/ Advocate	Chippewa Cree DHS	Box Elder
L. Jace Kilsback	Tribal Health Administrator	Northern Cheyenne Tribe	Lame Deer
Eric Barnosky	Regional Administrator	HHS/CFSD	Miles City
Melissa Schlichting	Assistant Attorney General	Indian Law Division	Helena
Trina Wolf Chief	DV Advocacy Coordinator	Chippewa Cree Tribe	Box Elder
Wendy Bremner	BIA Victim Witness Specialist	BIA	Browning
William LeCompte	Asst. Special Agent in Charge	District V MT & WY BIA	Billings
Winona Tanner	Chief Judge	CSK Tribal Court	Pablo

Native American Fatalities Associated with IPH in Montana since 2000

Age Range of Intended Victims



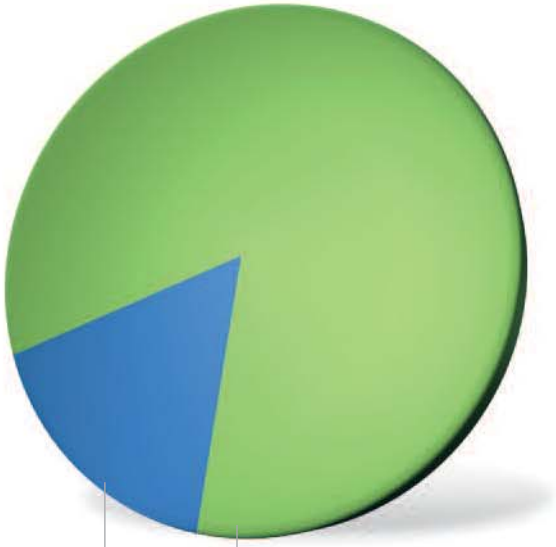
Fatalities Associated with Intimate Partner Homicides by Year, 2000–2014



Data source: Montana Department of Justice; Office of Victim Services

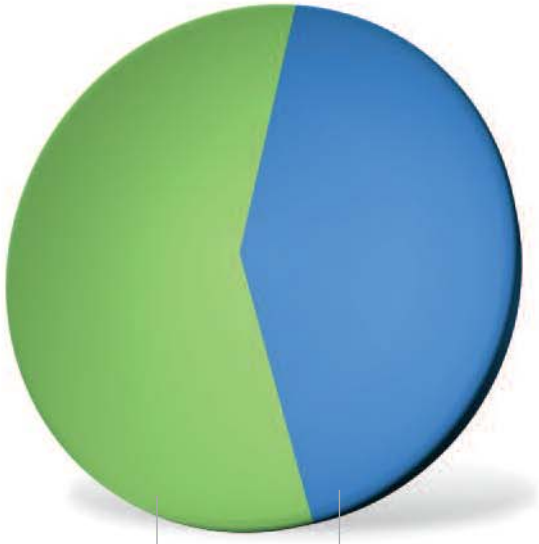
Native American Fatalities Associated with IPH in Montana since 2000

Type of Death



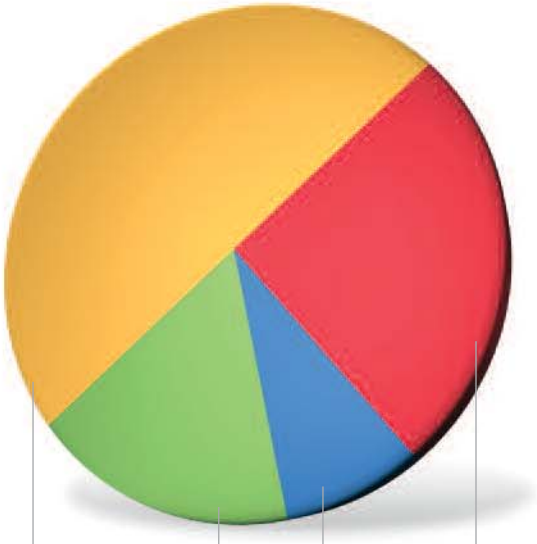
- Homicide 83%
- Familicide 0%
- Homicide & Suicide 17%

Perpetrator by Gender



- Male perpetrator 42%
- Female perpetrator 58%

Type of Weapon Used



- Firearm 25%
- Beaten 8%
- Head injury 17%
- Knife 50%

Data source: Montana Department of Justice; Office of Victim Services.

Native American Intimate Partner Homicide Events Since 2000

129 Fatalities as of December 31, 2014

Homicide events resulted in 129 fatalities including intimate partner victim, suicidal perpetrator and children; 12 which were Native American.

Fatalities associated with Intimate Partner Homicides in Montana

LAST NAME	FIRST NAME	FATALITY LOCATION	AGE	DATE OF DEATH	TYPE OF DEATH	WEAPON
Vanderpool	Eugenia	Lockwood	32	02/15/00	Homicide / Suicide	Firearm
Miller	Leanne	Churchill	42	06/03/00	Homicide / Shot By Officer	Firearm
Brekke	Bonita	Bozeman	51	01/11/01	Homicide / Suicide	Firearm
Williams	Bonnie	Lockwood	33	02/19/01	Homicide	Firearm
Baarson	Kim	Butte	39	03/06/01	Homicide / Suicide	Firearm
Van Cleave	Emily	Billings	22	04/17/01	Homicide / Suicide + 1 Child	Firearm
Mosure	Michelle	Billings	23	11/19/01	Homicide / Suicide + 2 Children	Firearm
Rasmussen	Noelle	Butte	23	04/13/02	Homicide / Suicide	Firearm
Isaacson	Madeline	Libby	90	07/27/02	Homicide	Suffocation
Wolfname, Jr.	Anthony	Busby	28	02/23/03	Homicide	Knife
Newman	Cathy	Frenchtown	51	05/15/03	Homicide / Suicide	Firearm
Flying	Sheila	Conrad	30	05/22/03	Homicide / Suicide	Firearm
McDonald	Jessica	Great Falls	32	07/01/03	Homicide / Suicide + 2 Children	Firearm
Vittetoe	Gina	Anaconda	57	07/14/03	Homicide	Knife
Erickson	Mindie Jo	Bozeman	33	09/10/03	Homicide / Suicide	Firearm
Johnson, Jr.	George	Billings	59	01/04/04	Homicide	Knife
Zumsteg	Deborah	Billings	41	03/01/04	Homicide / Suicide	Knife
MacDonald	Virginia	Missoula	40	04/29/04	Homicide / Suicide	Firearm
Chenoweth	Aleasha	Plains	24	07/19/04	Homicide	Firearm
Yetman	Labecca	Darby	35	08/30/04	Homicide	Firearm
McKinnon	Gina	Marion	40	11/23/04	Homicide / Suicide	Firearm
Hackney	Stephen	Lolo	38	11/26/04	Homicide	Knife
Baird	Donald	Anaconda	53	04/11/05	Homicide	Firearm
Mathison-Pierce	Erikka	Glendive	35	06/10/05	Homicide / Suicide	Firearm
LaRocque	Jill	Great Falls	22	06/25/05	Homicide	Strangulation
Roberson	Will	Missoula	52	07/05/05	Homicide By Hired Killer	Firearm

LAST NAME	FIRST NAME	FATALITY LOCATION	AGE	DATE OF DEATH	TYPE OF DEATH	WEAPON
Thompson	Dawn	Ferndale	36	08/27/05	Homicide	Firearm
Haag	Von Stanley	North Fork	60	11/07/05	Homicide	Firearm
Anderson	Lawrence	Opportunity	45	02/21/06	Homicide	Run over
Vasquez	Joe	Billings	32	04/03/06	Homicide	Knife
Van Holten	JoLynn	Dillon	43	04/12/06	Homicide / Suicide	Firearm
Spotted Bear	Susie	Browning	46	08/13/06	Homicide / Suicide	Kick to head
Eagleman	Donald	Brockton	22	01/01/07	Homicide	Knife
George	Kimberly Ann	St. Xavier	35	02/11/07	Homicide	Head injury
Costanza (James)	Mychel	Billings	50	02/12/07	Homicide	Firearm
Caron	Tarisia	Evergreen	18	05/01/07	Homicide	Firearm
Stout	William	Darby	52	06/10/07	Homicide	Firearm
Whitedirt	Herbie	Lame Deer	41	11/03/07	Homicide	Firearm
Smith	Jody	Hungry Horse	46	12/09/07	Homicide	Firearm
Plough	Robert	Libby	49	12/28/07	Homicide / Suicide	Firearm
Drinkwalter	Seth	Billings	30	02/08/08	Homicide	Knife
Small	Troy	Kirby	35	02/11/08	Homicide	Knife
Calf Boss Ribs	Kimberly	Havre	21	03/15/08	Homicide	Beaten to death
Morin	Lorraine	Columbia Falls	45	03/16/08	Homicide	Firearm
Casey	Susan	Glendive	34	04/12/08	Homicide	Strangulation
Laslo	Alexia	Plains	37	08/09/08	Homicide / Suicide + 1 Child (12)	Firearm
Livingston	Andrew	Grass Range	54	10/03/08	Suicide/Near death	Firearm
Morris	Janeal	Arlee	48	10/25/08	Homicide / Suicide	Firearm
Robinson	Andrew	Wolf Point	37	11/26/08	Homicide	Knife
Bauman	Judi	Great Falls	46	04/18/09	Homicide / Suicide	Strangulation
Updegraff-Winkle	Roni Kay	Bozeman	47	04/23/09	Homicide	Firearm
Brewster	Gayle	Three Forks	53	05/14/09	Homicide	Firearm

LAST NAME	FIRST NAME	FATALITY LOCATION	AGE	DATE OF DEATH	TYPE OF DEATH	WEAPON
Huntley	Sheryl	Thompson Falls	40	07/01/09	Homicide	Firearm
Hoffman, III	Richard	Butte	41	07/27/09	Homicide	Firearm
Hurley	Helen	Great Falls	84	08/04/09	Homicide / Suicide	Firearm
Davidson	Leslie	Fort Benton	50	11/26/09	Homicide	Firearm
Morast	Jason	Billings	27	12/12/09	Homicide	Knife
Rickett	Hazel	Miles City	47	01/08/10	Homicide	Firearm
Olson	Monica	Plentywood	44	01/26/10	Homicide / Suicide	Firearm
Crazy Bull	Charles	Poplar	49	06/26/10	Homicide	Knife
Popham	Connie	Great Falls	59	08/28/10	Homicide / Suicide	Knife/Firearm
Hardgrove	Swanie	Libby	81	08/28/10	Homicide / Suicide	Firearm
Mahoney	Shelly	Great Falls	40	11/11/10	Homicide / Suicide	Firearm
Hurlbert	Jaimie Lynn	Kalispell	35	12/25/10	Homicide + 1 Child (15)	Firearm
Hartwell	Sandra	Anaconda	72	12/31/10	Homicide / Suicide	Firearm
Dube-Woodard	Kelly Jo	Superior	47	05/24/11	Homicide	Strangulation
Gable	Joseph	Helena	48	10/13/11	Homicide + girlfriend	Firearm
Welch	Bryan	Libby	50	12/08/11	Homicide	Firearm
Kinniburgh	Catherine	Libby	55	01/03/12	Homicide/Suicide	Firearm
Roberts	Suzanne Rene	Great Falls	46	02/24/12	Homicide/Suicide	Firearm
Hawkins	Jessica	Hamilton	40	11/13/12	Homicide	Beaten to death
Smith	Alicia Nicole	Bozeman	33	11/19/12	Homicide/Suicide	Firearm
Schowengerdt	Tina	Deer Lodge	66	12/08/12	Homicide	Knife
Salle	Tammy	Anaconda	41	12/23/12	Homicide/Suicide	Knife
Engebretson	Ordean	Whitefish	42	02/02/13	Homicide	Firearm
Yurian	Erica	Worden	22	05/24/13	Homicide/Shot by Officer	Firearm
Johnson	Cody	Kalispell	25	07/07/13	Homicide	Pushed off cliff

LAST NAME	FIRST NAME	FATALITY LOCATION	AGE	DATE OF DEATH	TYPE OF DEATH	WEAPON
Newton	Chad	Whitefish	37	12/30/13*	Homicide	Knife
Schick-Lewis	Holly	Darby	50	01/06/14	Homicide/Suicide	Firearm
Edwards	Thomas	Hungry Horse	71	02/14/14	Homicide	Firearm
Beeman	Dawn	Havre	35	03/23/14	Homicide	Strangulation
Roberts	Debi	Gardiner	59	03/27/14	Homicide/Suicide	Firearm
Lane	Emma Jean	Superior	87	05/27/14	Homicide/Suicide	Firearm
Charlo	RaeLynn	Charlo	29	11/18/14	Homicide	Firearm
Beckman	Brett	Lame Deer	54	11/22/14	Homicide	Knife
Williams	Kaileb	Missoula	20	12/31/14	Shot by officer/near death	Firearm

*Stabbed 11/25/13. Life support removed 12/30/13.

Guides and Model Forms

Possible Reactions to Domestic Violence

Birth to age 5	Ages 6–1	Ages 12–18

▸ Sleep or eating disruptions
▸ Withdrawal or lack of responsiveness
▸ Intense and pronounced separation anxiety
▸ Crying inconsolably
▸ Developmental regression, loss of acquired skills such as toilet training, or reversion to earlier behaviors, such as asking for a bottle again
▸ Intense anxiety, worries, or new fears
▸ Increased aggression or impulsive behavior
▸ Acting out witnessed events in play, such as having one doll hit another doll
	▸ Nightmares, sleep disruptions
	▸ Aggression and difficulty with peer relationships in school
	▸ Difficulty with concentration and task completion in school
	▸ Withdrawal and emotional numbing
	▸ School avoidance or truancy
	▸ Stomachaches, headaches, or other physical complaints
		▸ Antisocial behavior
		▸ School failure
		▸ Impulsive or reckless behavior, such as:
		  ▸ Truancy
		  ▸ Substance abuse
		  ▸ Running away
		  ▸ Involvement in violent or abusive dating relationships
		▸ Depression
		▸ Anxiety
		▸ Withdrawal
		▸ Self-destructive behavior such as cutting

It is important to remember that any of these symptoms can also be associated with other stress, traumas, or developmental disturbances. They should be considered in the context of the child's and family's functioning.

Excerpt from *Domestic Violence and Children: Questions and Answers for Domestic Violence Project Advocates.* Published by the National Child Traumatic Stress Network, November 2010

Firearms and Domestic Violence

- Batterers possessing guns inflict most severe abuse/injury
- Risk of femicide 20 times greater when perpetrator threatened or assaulted battered women with a gun
- Risk of femicide 15 times greater when perpetrator threatened battered women with murder
- Risk of femicide 6 times greater when gun in the house

Excerpt from *Guns and Intimate Partner Violence: Addressing Guns in the Home with Victims and Survivors,* Presented by Jewish Women International, National Alliance to End Domestic Abuse

In 2011, there were 1,707 females murdered by males in single victim/single offender incidents that were submitted to the FBI for its Supplementary Homicide Report.

These key findings from the report, expanded upon in the following sections, dispel many of the myths regarding the nature of lethal violence against females.

- For homicides in which the victim to offender relationship could be identified, 94 percent of female victims (1,509 out of 1,601) were murdered by a male they knew.
- Sixteen times as many females were murdered by a male they knew (1,509 victims) than were killed by male strangers (92 victims).
- For victims who knew their offenders, 61 percent (926) of female homicide victims were wives or intimate acquaintances of their killers.
- There were 264 women shot and killed by either their husband or intimate acquaintance during the course of an argument.
- Nationwide, for homicides in which the weapon could be determined (1,551), more female homicides were committed with firearms (51 percent) than with any other weapon. Knives and other cutting instruments accounted for 20 percent of all female murders, bodily force 14 percent, and murder by blunt object seven percent. Of the homicides committed with firearms, 73 percent were committed with handguns.
- In 87 percent of all incidents where the circumstances could be determined, homicides were not related to the commission of any other felony, such as rape or robbery.

Excerpt from *When Men Murder Women: An Analysis of 2011 Homicide Data Females Murdered by Males in Single Victim/Single Offender Incidents.* Published by Violence Policy Center, September, 2013.

Family Violence Option Facts

What is the Family Violence Option?

The Family Violence Option (FVO) is a special provision for domestic violence survivors who are recipients of Temporary Assistance for Needy Families (TANF). The FVO helps survivors stay safe and become self-sufficient while complying with TANF requirements like child support enforcement and required work activities.

How Can the Family Violence Option (FVO) Help?

Screening and Notification

Under the Family Violence Option, TANF case managers screen and identify survivors of domestic violence. All TANF-eligible applicants receive notification of the FVO through the Universal Notification Form.

Referrals

All TANF participants who disclose that they are experiencing family violence receive a referral to their local domestic violence agency.

Child Support Enforcement

In some cases, domestic violence survivors may be able to get a good cause exemption from child support collection. This exemption is available for survivors who would be in danger if they disclosed their location or attempted to collect child support.

Work Activities

Domestic violence survivors may be able to count domestic violence counseling or other activities necessary for safety or job readiness towards their work activity requirements.

Time Extensions:

TANF participants who are experiencing domestic violence may be able to extend their benefits past the 60-month lifetime timelimit.

MLSA
Montana Legal Services Association

Information Created by: Kelly Hart, Domestic Violence Economic Advocate, Montana Legal Services Association

Emerging Practices: Pilot Project to Increase Strangulation Convictions in Domestic Violence Cases

By Jill Rable, RN, MSN-ED, CPN, SANE-A

The state of Arizona is striving to hold violent people accountable for life-threatening behavior. In an effort to do so, Aggravated Assault by Strangulation 13-1204.B became law as a class 4 felony and was added to the domestic violence statute July 29, 2010. This law defines strangulation as either intentionally or knowingly impeding the normal breathing or circulation of blood of another person by applying pressure to the throat or neck or by obstructing the nose and mouth either manually or through use of an instrument. The statute also requires the presence of a relationship as defined in the Domestic Violence Statute 13-3601; these include being related by blood or through marriage (as in step-family members), current or prior romantic or sexual partnerships, currently or previously cohabitating, sharing children, or when one party is pregnant by the other. Acknowledging the severity of strangulation at the legislative level helps to publicize high-risk behavior and prioritize potentially lethal situations.

Why introduce such specific legislation? When an individual places his or her hands around the neck of another person, it is an act of violence far more dangerous than most physical abuse.

Preventing someone from breathing is a potentially lethal act. Current research suggests that non-lethal strangulation is an important predictor for future lethal violence (1). Understanding the seriousness of strangulation is motivation for the cooperative effort. The common understanding that something more must be done is the rationale for a new approach, but making the adjustments to the laws of domestic violence strangulation is not enough to hold batterers accountable for their crime if there is no proof that strangulation occurred.

Even with this additional legislation in place, a review of strangulation cases filed in the Maricopa County attorney's office between June 1st and November 30th, 2011 found that only 14% of the cases submitted by Chandler and Glendale police department were prosecuted, frustrating law enforcement and advocates who were working to improve the safety of domestic violence victims by holding their batterers accountable. Further investigation found that lack of corroboration was the reason the majority of the cases were turned down by the county attorney's office. This prompted the Maricopa County Attorney's Office to agree to recommendations from law enforcement and advocates to fund the addition of a medical forensic exam for all domestic violence cases with a report of strangulation for a six-month pilot period.

Starting December 1, 2011, the Maricopa County Attorney's Office (MCAO) collaborated with Scottsdale Healthcare Forensic Nurse Examiners and law enforcement in two Phoenix valley cities to provide comprehensive medical forensic

Why Introduce such specific legislation?
Preventing someone from breathing is a lethal act.

examinations to victims of domestic violence. Initially, a six-month trial of Chandler and Glendale Police departments were used to test the development of a protocol for strangulation cases using a forensic nurse examiner.

A new protocol incorporating a forensic nurse response to a valley advocacy center to examine every willing domestic violence strangulation victim was established. A forensic nurse examiner (FNE) was available 24 hours a day, providing quality nursing care and a medical forensic exam that included evidence collection.

The FNE obtained a detailed history, including a description of the present complaints, past medical history regarding interpersonal or domestic violence, and other physical and mental health problems or medical conditions and injuries. The nurse completed thorough head-to-toe physical examinations to identify trauma, measured physcial injuries, documented them on a body map, and described them in detail. In addition, extensive state-of-the art photo documentation accompanied the medical forensic exam report. A seven page medical documentation was completed. The assessment form included a series of detailed clarifying questions about the strangulation incident and was documented for the purpose of medical treatment. The need forevidence collection was determined by the FNE as indicated by the history and assessment of the patient, and if warranted, swabs were collected throughout the examination. While providing care, the forensic nurse also addressed the patient's risk for homicide/suicide and identified social, economic, cultural, and other issues that could impact interventions. The safety of children and other dependents was also addressed in the course of the medical-forensic examination. The FNE reviewed a safety plan with the patient and provided educational materials, and local contacts for resource programs and additional assistance referrals. The safety resources discussed with the patient by the forensic nurse examiner were not meant to be confused with the counseling or advocacy role of a victim advocate.

During the six month pilot project everyone involved in these cases developed a heightened awareness and understanding of the medical and legal complexities of strangulation cases. With the comprehensive strangulation education and training provided to law enforcement, medical personnel and advocates, and with the support of the extensive report completed during a medical forensic exam, the number of domestic violence strangulation cases filed increased from 14% to over 60%. Following this 6-month trial of the strangulation protocol, the Maricopa County attorney's office supported efforts to have medical forensic exams become an integral part of the community response for all victims of domestic violence strangulation cases throughout Maricopa County, and to date, nearly 400 medical forensic strangulation exams have been performed as a part of the strangulation protocol.

Link to statutes:
http://www.bwjp.org/search.html?query=strangulation

This article appeared in the National Domestic Violence Fatality Review Initiative newsletter, Fall 2012.

Billings Gazette Opinion: What we don't know about abuse hurts Montana kids

August 30, 2015

If an adult dies at the hands of a spouse or domestic partner, Montana law provides for a review of the death to glean information that can be used to prevent future domestic violence in our state.

But if a child dies of abuse by a family member or other caregiver, there is no such legal review requirement.

A straight forward plan to fix that discrepancy was proposed to the 2015 Legislature. It would have cost the state nothing. The Montana Division of Child and Family Services explained to the House Judiciary Committee how existing federal child abuse prevention grant money would be redirected to pay the estimated $30,000 annual cost of tracking and having a commission review child abuse deaths in a manner already applied to adult domestic violence deaths for the past decade.

Sarah Corbally, administrator of the division, said the review commission is "desperately needed." Among the nine people testifying in favor of House Bill 309 were representatives of the Montana Medical Association, Montana Association of Churches, the Montana Coalition Against Domestic and Sexual Violence, the Montana Department of Justice, the Great Falls Police Department and providers of children's health services.

No one testified against it.

Then, three weeks later, the Judiciary Committee tabled the bill on a motion of the vice chair, Alan Doane, R-Bloomfield.

So when a Thursday *Gazette* headline said: "Feds warn Montana could lose child abuse program funding," alert readers recalled that the lack of child death information could have been remedied by enacting HB309.

Rep. Kathy Kelker, D-Billings, sponsored the bill. Back in January, a *Gazette* opinion told readers about Kelker's bill and "what Montana can learn from the worst child abuse cases." We know the members of the House Judiciary Committee saw the editorial because Kelker added it to the hearing record on Feb. 4.

The *Gazette* said Kelker's bill should draw bipartisan support. It would give the same level of scrutiny to cases of child homicide as now is given to homicides involving adults. A commission would increase awareness of child abuse and bring together a diverse group of Montanans to recommend child protection system improvements.

Contacted Thursday, Kelker said she is committed to again introducing child abuse legislation.

"It is so apparent that we don't have a good system in place," Kelker said. "Child abuse prevention needs to be a top priority for our state."

A recent Associated Press investigation revealed that Montana is one of few states that doesn't meet federal requirements on publicly disclosing child abuse death information. On Aug. 13, an official from the U.S. Department of Health and Human Services wrote to Montana health officials, warning that the state could lose $120,000 in federal grant money for failing to collect child death data.

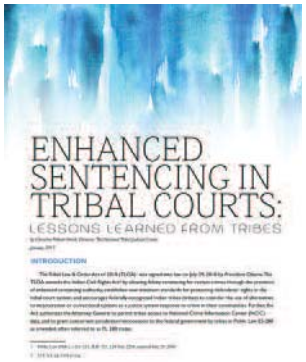
Grant money isn't the main reason to close this information gap. So long as our state fails to collect data and review these terrible cases, neither the public nor Montana child protection, health care and law enforcement professionals will know as much about the problem as they should.

When *Gazette* readers see headlines about babies and children who have been severely or fatally injured by abuse, it's too late to spare those kids. Montana's focus must be on prevention — building up safe, healthy families and supporting a system that helps keep kids safe at home.

The 2017 Legislature should create the commission that the 2015 session tabled. So many of our state lawmakers disdain government, especially the federal government. They must act, not because HHS requires it, but because Montana children deserve to grow up safe.

Enhanced Sentencing in Tribal Courts: Lessons Learned from Tribes

This publication from the National Tribal Judicial Center provides a brief overview of changes under the 2010 Tribal Law and Order Act regarding enhanced sentencing authority in tribal courts. It offers considerations for corrections professionals regarding enhanced sentencing authority in tribal courts and provides tribes with a checklist to help guide discussions around the implementation of the new sentencing authority and other corrections issues. Lastly, this publication provides information on financial resources to fund enhanced sentencing authority implementation.



View/download a copy of this report here: https://www.bja.gov/Publications/TLOA-TribalCtsSentencing.pdf

Futures Without Violence

Hope Cards

The Hope Card allows someone who has been granted an order of protection in one jurisdiction to easily prove it in another jurisdiction.

The Hope Card lets law enforcement know that there is a valid, permanent order of protection in place. In case of a potential violation of an order, a law enforcement officer can refer to the Hope Card for more information.

- A Hope Card is not a substitute for an order of protection.
- The card includes relevant information related to a valid permanent order of protection.
- It is small and durable, and can be easily carried in a wallet, pocket or purse.
- Hope Cards are not issued for temporary orders of protection.

In Montana, Hope Cards are issued by the Crow Tribal Court, Confederated Salish and Kootenai Tribal Court, Northern Cheyenne Tribal Court, Fort Peck Tribal Court, Chippewa-Cree Tribal Court, Fort Belknap Tribal Court, Blackfeet Tribal Court, and the state of Montana. While the cards differ slightly, they must be recognized by law enforcement officers throughout the state.

Features

The Hope Cards issued by the state of Montana contain information about the protected person and the order:

- the protected person's name, birth date, sex, race and height
- the case number listed on the permanent order of protection, the issuing court and county, the date it was issued and any expiration date

The card provides information about the person named in the order, and any children or other individuals who are also protected under the order:

- the respondent's photo, name, birth date, sex, race, eye and hair color, height, weight and any distinguishing features like scars or tattoos
- the names and birth dates of any children or other individuals who are also protected under the order

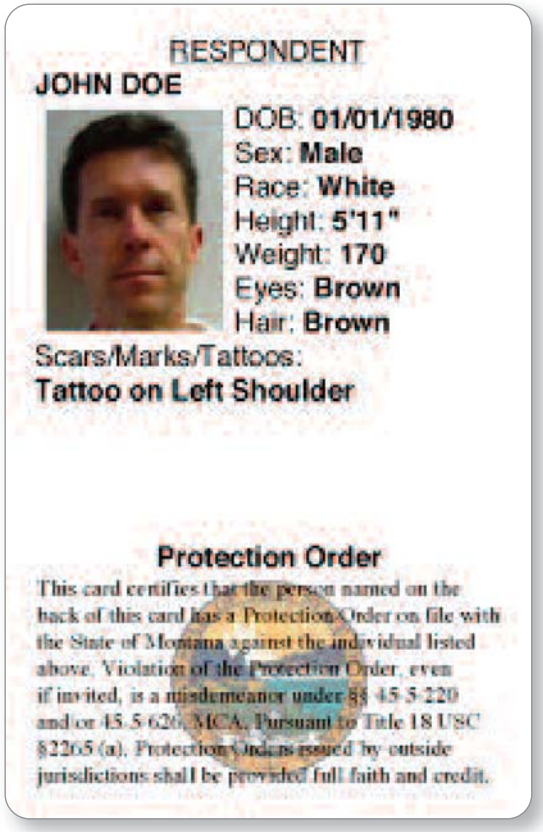
How to Request a Hope Card

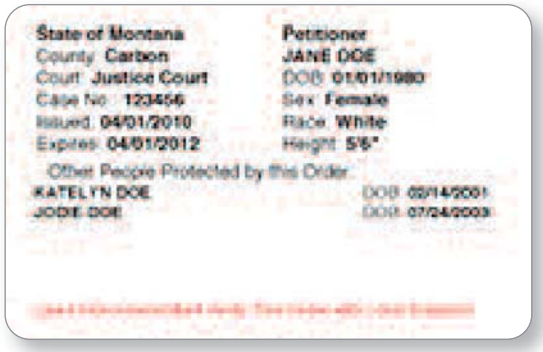
Hope Cards are available to anyone with a valid, permanent order of protection. Cards will also be available for any children or other individuals covered by the order. You may request more than one card per individual if, for example, you wish to provide one to a child's school and another to the child's after-school care program.

Contact

For additional information about the Hope Card program, contact:

Joan Eliel, Hope Card Administrator
Office of Victim Services
(406) 444-5803
E-mail: jeliel@mt.gov





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