MONTANA DEPARTMENT OF JUSTICE
DIVISION OF CRIMINAL INVESTIGATION

JANUARY 2025

# MONTANA DOMESTIC VIOLENCE FATALITY REVIEW COMMISION REPORT FOR 2025

Report to the 69th Regular Session Legislature

# TABLE OF CONTENTS

# REPORT TO THE 2025 LEGISLATURE

The Montana Domestic Violence Fatality Review Commission (MDVFR) was created by the 2003 Montana legislature. The Native American fatality review team was added in 2014. Among other things, the Legislature mandates dissemination of this biennial report 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 carefully selected fraction of the family violence deaths in Montana each year. The team uses its limited time and resources to review only cases related to intimate partner homicides (IPH). Other groups, such as Montana's Fetal Infant Child Mortality Review, Suicide Mortality Review and the Montana Department of Justice Child and Family Ombudsman fatality review teams gather information on other types of familial deaths. The MDVFR Commission closely monitors all intimate partner homicides in Montana, but with its limited scope for reviews and multidisciplinary experts volunteering their time, the commission carefully chooses cases for full review. Since 2000, when the Department of Justice began tracking these events, approximately 286 Montanans have died in family violence homicides through December 2024.

Due to organizational changes, fatality reviews have not been conducted since 2023. However, the creation and hiring of the new Domestic Violence Program Coordinator position within Office of Victim Services will remedy this.

# 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 governmental authority as responsible for the deaths. Rather, these are complex cases, involving a number of individuals and variables. Domestic violence fatalities are simply not caused by any one action – or inaction – by any one person or actor. In fact, we find that many of the victims had limited, if any, contact with the "system." Oftentimes, persons who die in domestic violence incidents tragically do not seek shelter, or contact law enforcement, family services, or victim witness advocates. And they often die without having sought or obtained an order of protection. Similarly, most of the perpetrators do not have extensive criminal histories or involvement with law enforcement or the criminal justice system.

That many of these deaths are preceded by relative social isolation makes their occurrence all the more tragic. Domestic violence homicides traumatize not only those close to the family but entire communities. Reviewing the murders and working with local community members, the State and Native American fatality review teams seek to identify gaps and inadequacies in the response to domestic violence (DV) at the local, state, and federal levels. The goal is to prevent future deaths by identifying obstacles and trends and by making recommendations for improvements in policy and practices. Clearly, there is more work to do. The recommendations in this report are intended to take specific, concrete steps in that direction.

Montana's fatality review teams have chosen an "inch wide, mile deep" approach to reviewing these deaths, undertaking two reviews per year, per team. In each case the teams review all available information including:

- law enforcement reports
- criminal histories
- medical and autopsy records
- presentence investigations
- newspaper stories
- 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. The team holds monthly virtual meetings to share information and create a timeline of events leading up to the deaths. The timeline illuminates involvement with law

enforcement and family services leading up to the deaths. The timeline illuminates involvement with law enforcement, family services, domestic violence advocates and other local and state authorities or services, as well as missed opportunities, things that worked well and gaps in services.

Then the entire team [see page 4] travels to the community where the homicide(s) took place. Once there, criminal justice community members who worked with the decedent's family are invited to participate in the review and improve the timeline. Everyone attending the review is required to sign the same confidentiality agreement because confidentiality is foundational to open communication, developing trust, and a thorough and efficacious review process. 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 the fatality review, which is to introduce and highlight changes that increase victim and community safety and perpetrator accountability.

The assembled group is multidisciplinary as set forth by statute to include representatives from state departments, private organizations, and Montana Indian tribes; medical and mental health care providers; law enforcement, the judiciary; the state bar of Montana; a member of the legislature and other concerned citizens. It provides the opportunity for individuals who seldom work with one another, or have traditional biases to proceed toward the common goal of understanding and preventing domestic violence deaths. While the reviews generate many more recommendations than what is published in the report, the team works to synthesize those recommendations into action items that will create local and statewide improvements which are low-cost and capable of being promptly implemented. While our teams are committed to finding ways to fulfill our mission without significant monetary investments, we believe all our recommendations merit serious consideration. This report's recommendations appear on page 5.

# REVIEWS

The two statewide reviews in 2023 inform this report's trends and recommendations. This document, through its posting on the DOJ website, serves as the teams' vehicle for highlighting new ideas, best practices, and creative solutions identified around the state, as effective tools in combating domestic violence deaths.

In 2023, the Commission reviewed two IPH events. One utilizing the state team, and one utilizing the Native American team. One of these events was perpetrated by a female, the other by a male. Choice of weapon in one event was a vehicle, alongside a firearm, which correlates with an almost 50% increase in vehicles used as weapons in DV homicides over the last 5 years. Lack of stable and affordable housing, childhood trauma or neglect, drug and/or alcohol dependency, and unfinished education was prevalent in both reviews. In the state review we found the parties involved had little or no contact with service providers. A total of 6 surviving children were left without one or both parents due to these 2 events, including 1 child who was a witness to the homicide

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 seek to reduce the number of families and communities traumatized by these deaths.

No reviews were conducted in 2024 due to organizational changes within the Division of Criminal Investigation. A new Domestic Violence Program Coordinator position was created in 2025 to oversee the Commission and Reviews. This position is housed within DCI's Office of Victim Services and work is being completed to fully staff vacant commission seats, with reviews resuming in 2026.

# DVFR TIMELINE

1. The Commission selects the review community based on several 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 the victim(s) or offender.

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 the members.

6. Monthly virtual meetings are conducted and a timeline identifying key events in the lives of the victim and perpetrator and their contacts with a variety of professionals begins to take shape.

7. Day One of the review process: The members travel to the community in which the domestic violence fatality occurred. Community members who have been involved in the accumulation of the information for the review (excepting family members) join the Commission to evaluate the timeline and provide any additional information they might have to contribute. Those attending the review read and sign a confidentiality agreement. Additions and corrections are made to the timeline. Next, the Commission, along with the community members, discuss trends and recommendations based on the review of this case.

8. Day Two: Commission members refine the list of trends and recommendations and discuss implementation strategies. The Commission explores next case options and tentative dates and locations.

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

10. Transcription of the Trends and Recommendations are circulated to the members for final input and accuracy. This document is the only written record of the review. All electronic files are deleted.

11. Every two years a report is generated.

# MDVFR COMMISSION MEMBERS

| Name | Position | Organization | Term Expiration |
|---|---|---|---|
| Amy Regier | Legislator | MT House of Representative | 2026 |
| Connie Harvey | Therapist | Self-Employed | 2026 |
| Dan Murphy | Retired LE Officer | Building Blue, LLC | 2026 |
| Jen Murphy | Tribal Liason | Building Blue, LLC | 2026 |
| Kate Croft | Victim Advocate | Domestic and Sexual Violence Services | 2026 |
| Dawn Bryant | Registered Nurse | Norther Cheyenne Service Unit | 2028 |
| Dr Jackson Bunch | Professor/Criminology | University of Montana | 2028 |
| Dr Julie Kelso | Psychiatrist | Riverstone Health | 2028 |
| Monique Voigt | Attorney | MT Legal Services Assoc. | 2028 |
| Nathan Griesse | Detective | Missoula Police Department | 2028 |
| Selene Koepke | Deputy Attorney General | Montana Dept. of Justice | 2028 |
| Alex Beal | Justice Court Judge | Missoula Justice Court | 2029 |
| Brittany Williams | Prosecutor | Missoula County Attorney | 2029 |
| Cory Purves | Probation Officer | Montana Dept. of Corrections | 2029 |
| DawnDee Hoffman | Crime Victim Compensation Examiner | MT Dept. of Justice | 2029 |
| Justice Rod Souza | District Court Judge | Yellowstone District Court | 2029 |
| Elise Landles | Team Coordinator | MT Dept. of Justice | NA |

# Trends

**The following are trends identified from the two reviews conducted in 2023, as well as data collected form 2022-2024**

**31% Of homicides from 2022-2024 were perpetrated by individuals age 50 or above**

51% of all IPH from 2022-2024 included a gun

**Lack of affordable or stable housing was a factor in both cases reviewed**

Unfinished education was prevalent in both cases reviewed

**Childhood trauma and generational abuse (physical and sexual) continue to be significant factors of intimate partner violence**

Substance abuse continues to be a commonality among incidents of IPH violence

**Patterns of abuse in prior relationships were not addressed and continued in future relationships in both cases reviewed**

**Both cases took place in more rural areas which led to a sense of isolation and/or lack of services**

# Recommendations

## Statewide

**Implement mandatory usage of the Arizona Intimate Partner Risk Assessment Instrument System (APRAIS) on DV related calls for service. Train the APRAIS model at District, Courts of Limited Jurisdiction and Tribal Court Conferences.**

Expand the Montana Child Sexual Assault Response Team (MCSART) to include children who are exposed to or are victims of DV. Surviving children of IPH to qualify for the John H. Chafee Foster Care program.

**Train or develop task forces in larger jurisdictions to prosecute felony firearm violations, especially firearm possession (MCA 45-8-313).**

Introduce a uniform case management system for district court cases.

**Revamp MCA 45-5-09 to make no contact presumed and automatic until parties are seen by a judge. Update statutory language to mirror language used in orders of protections so restrictions and rules are clear. Increase penalties for violating an order of protection.**

Create a statewide accessible family resource center. Introduce social and emotional learning, including healthy relationship models to school curriculum.

**Train county attorneys on ways to utilize and encourage usage of Guardians Ad Litem.**

# Recomendations

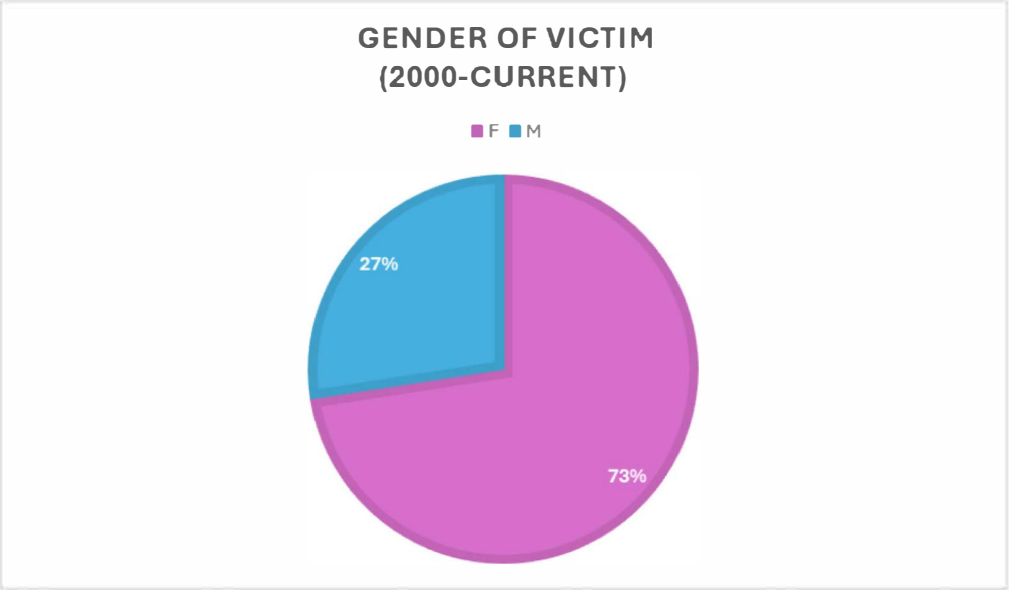
## Native American Domestic Violence Fatality Review/Tribal Recommendations

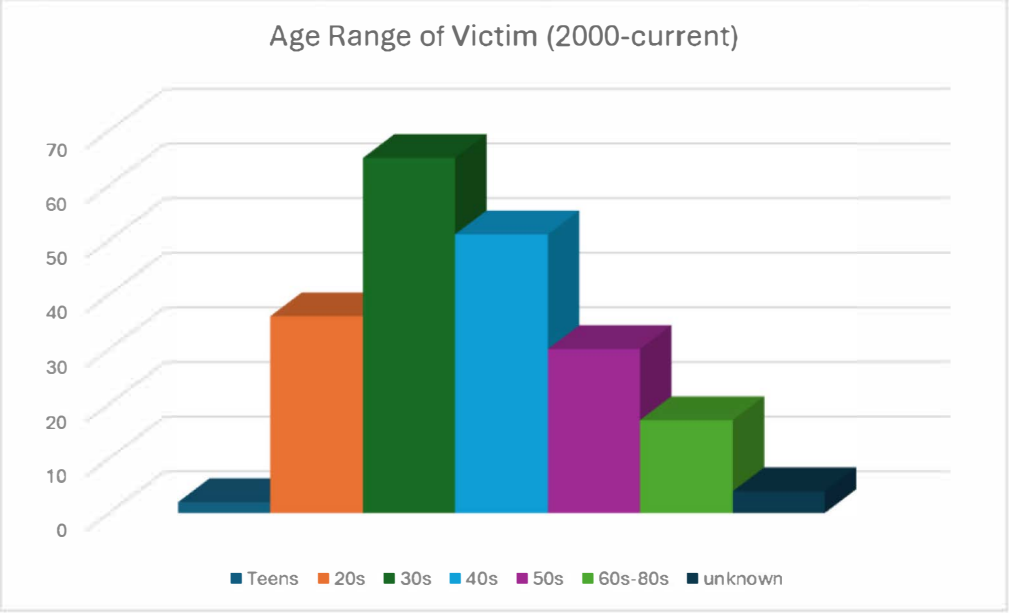
**Amendment of tribal codes to have default arrest in DV situations like MCA 46-6-311**

Funding to reintroduce or create Head Start programs in native communities, especially investing in cultural aspects and family services (look at Hummingbird Nest program in WA)

**Invest in Community Health Aide Programs (CHAP)**

# IPH DATA 2000-2024



# IPH DATA 2000-2024