Project Chair:

The Honorable Daniel Mabley
Minnesota Fourth Judicial District

Community Partners:

Academy on Violence and Abuse
Bloomington Police Department
Community Volunteers
CornerHouse
Domestic Abuse Project
HomeFree Programs
Minneapolis City Attorney's Office
Minneapolis Police Department
Minneapolis Public Schools
Minnesota Advocates for Human Rights
Minnetonka City Attorney's Office
Outfront Minnesota
Sojourner Project, Inc.

County and State Partners:

Fourth Judicial District Court
Fourth Judicial District Public Defender
Hennepin County Attorney
Hennepin County Community Corrections
Hennepin County Human Services
Hennepin County Medical Center
Hennepin County Medical Examiner
Hennepin County Sheriff

This report is a product of:

A Matter of Life and Death: The Domestic Fatality Review Team
A Collaboration of Private, Public and Nonprofit
Organizations Operating in Hennepin County

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Acknowledgments

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The friends and family members of the homicide victims who share their thoughts and memories about their loved ones and the tragedy of their death.

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Executive Summary

Through its detailed review of individual cases, the Fatality Review Team seeks to identify opportunities for changes in practice that could prevent future domestic homicides. In three of the four cases reviewed in 2007, there was evidence that enhanced paths of communication between systems in which the perpetrator or victim was involved might have contributed to avoiding the homicide. Within this report, each opportunity for intervention has been placed into one of three broad themes: Closing the Gaps, Facilitating Effective Transitions and Enhancing Understanding. Within these themes, there are opportunities that address practice changes for law enforcement, the judiciary, the media, community service professionals and the general public.

By design, the Fatality Review Team process focuses on a few specific cases. This permits in-depth examination of all the facts of those cases from the varied perspectives of the Team members. Team members examine the case chronologies and then, as a group, make observations about elements of the case. Sometimes the observations assist in identifying the context of the crime. Other times, they illuminate a clear missed opportunity to avoid the homicide. From these observations, the Team identifies opportunities for intervention that directly correspond to the observation and to the case.

These opportunities for intervention are specific to the cases reviewed. However, sometimes themes emerge from the information provided by this rigorous analysis of individual cases. Such is the case in 2007, when, in three of the four cases reviewed, the Team identified situations in which the safety of the victim might have been enhanced by better communication among the systems in which the perpetrator or victim was involved.

The goal of this report is to share the work of the Hennepin Domestic Fatality Review Team and the opportunities for intervention identified by the Team in a manner that respects the privacy of the victims and their families. Identifying details have been removed and the opportunities have been designed to capture the points relevant to our audience in a manner that globally encourages enhanced safety for victims of domestic violence and accountability for abusers. Additionally, this report contains facts about the domestic homicide rate in Hennepin County and Minnesota during the years in which these cases occurred along with potential risk factors for domestic homicide to assist the reader in putting the case information in context.

	Law Enforcement	Criminal Justice	Mental Health & Medical Providers	Medical Examiner	Media	Community Service Professionals	Employers	Community Members
Closing the Gaps								
Interagency Information Sharing Pg. 8	X	X	X	X				
Justice System Oversight of Probation Violations Pg. 9		X				X		
Addressing Known Risk Behavior Pg. 9	X	X				X	X	
Facilitating Effective Transitions								
Facilitating Effective Transitions Pg. 10		X	X			X		
Enhancing Understanding								
Media Pg. 11					X	X		
Employers Pg. 12	X						X	
Community Members Pg. 12				X		X		X

Domestic Abuse Overview

For the purpose of the Hennepin Domestic Fatality Review Team, domestic abuse describes a pattern of physical, emotional, psychological, sexual and/or stalking behaviors that occur within intimate or family relationships including spouses, individuals in dating relationships and former partners and against parents by children. This pattern of behavior is used to establish and maintain control by the abuser over the victim.

Domestic Abuse & Fatality Statistics

National

- Approximately 1.3 million women and 835,000 men are physically assaulted by an intimate partner annually in the United States. (U.S. DOJ, *Full Report of the Prevalence, Incidence, and Consequences of Intimate Partner Violence Against Women,* 2000)
- Access to firearms yields a more than five-fold increase in risk of intimate partner homicide when considering other factors of abuse, according to a recent study, suggesting that abusers who possess guns tend to inflict the most severe abuse on their partners. (Jacquelyn C. Campbell et al., *Risk Factors For Femicide in Abusive Relationships: Results From A Multi-Site Case Control Study ,* 2003)
- 76% of femicide victims had been stalked by the person who killed them. (Stalking Resource Center, *Stalking Fact Sheet)*
- 61% of stalkers made unwanted phone calls; 33% sent or left unwanted letters or items; 29% vandalized property; and 9% killed or threatened to kill a family pet. (Stalking Resource Center, *Stalking Fact Sheet)*

Minnesota

- Twenty women and twelve children were murdered in Minnesota in 2006 as the result of domestic violence or child abuse. (Minnesota Coalition for Battered Women, *2006 Femicide Report,* 2006)
- One of every three homeless women in Minnesota is homeless at least in part due to domestic violence. (Wilder Research Center, 2003)
- In 2004, 998 Minnesotans received emergency department or in-hospital care for domestic violence related injuries. 97% of the victims were women. (Minnesota Department of Health, Violence and Prevention Unit, 2006)
- About 25% of 6th and 9th graders in Minnesota reported that they had been physically abused by an adult living in the household. Similar percentages of students reported that someone in their household had been the victim of domestic violence. (*Minnesota Student Survey,* 2004)

Hennepin County & City of Minneapolis

- In 2007 there were 18,460 calls to 911 in Minneapolis that were domestic related. Of those calls, 1873 resulted in arrests. (Minneapolis Police Department Emergency Communications)
- According to Hennepin County, 2,458 OFPs were filed in 2006 and preliminary numbers indicate that there were 2,312 filed in 2007. (Hennepin County Information Department)
- Three women and four children were murdered in Hennepin County in 2006 as the result of domestic violence or child abuse. (Minnesota Coalition for Battered Women, *2006 Femicide Report,* 2006)

The Review Team reviewed four domestic homicide cases in 2007. The homicides were from 2003, 2004 and 2005. Following is information on all the homicides in Hennepin County in those years as well as the cause of death, age and gender of the victim and the relationship of the perpetrator to the victim:

Cause of Death	Age of Victim	Gender of Victim	Relationship of Perpetrator to Victim
Gunshot	48	Male	Neighbor
Gunshot	57	Female	Son
Multiple Stab Wounds	27	Female	Ex-Boyfriend
Multiple Stab Wounds	23	Female	Boyfriend
Gunshot	42	Female	Estranged Partner
Gunshot	41	Female	Boyfriend

2003

Of 16 domestic homicides in Minnesota, 6 domestic homicides were committed in Hennepin County

Hennepin County Domestic Homicide Data from 2003, 2004 & 2005

2004

Of 16 domestic homicides in Minnesota, 6 domestic homicides were committed in Hennepin County

Cause of Death	Age of Victim	Gender of Victim	Relationship of Perpetrator to Victim
Multiple Stab Wounds	47	Female	Husband
Multiple Stab Wounds	21	Female	Estranged Husband
Gunshot	32	Female	Boyfriend
Multiple Stab Wounds	26	Female	Ex-Boyfriend
Multiple Stab Wounds	44	Female	Daughter's Ex-Boyfriend
Multiple Stab Wounds	61	Male	Granddaughter's Ex-Boyfriend

2005

Of 19 domestic homicides in Minnesota, 7 domestic homicides were committed in Hennepin County

Cause of Death	Age of Victim	Gender of Victim	Relationship of Perpetrator to Victim
Gunshot	72	Female	Husband
Gunshot	27	Female	Boyfriend
Gunshot	49	Female	Husband
Multiple Stab Wounds	22	Female	Fiancé
Gunshot	43	Female	Boyfriend
Homicidal Violence	23	Female	Husband
Multiple Stab Wounds	25	Female	Boyfriend

Potential Risk Factors for Domestic Homicide

It is not possible to accurately predict when a perpetrator of domestic violence may kill the victim of abuse. However, researchers have identified approximately 20 factors, from unemployment and substance abuse to death threats and access to guns, that are often present in cases of domestic homicide. This research has been used to develop the Dangerousness Assessment, a free tool with calendar and questionnaire components, that can be used in many settings with victims of domestic violence. The Dangerousness Assessment helps to clarify the frequency and severity of the abuse and allows the victim to identify behaviors or actions that may indicate an increased risk of homicide.

Potential Predictors of Homicide by Abuser	Case #1	Case #2	Case #3	Case #4
Victim Has Attempted to Leave the Abuser		X		X
Perpetrator Threatened to Kill the Victim	X			X
Access to Firearms	X			X
Perpetrator With Significant History of Violence	X	X		X
Use or Threats of Use of a Weapon Against Victim	X			X
Substance Abuse	X	X		X
Violent and Constant Jealousy			X	X
Stalking Behavior		X	X	X

To access the Dangerousness Assessment, the information for interpreting results and resources go to: www.dangerousnessassessment.org.
For more information about the research on risk factors for domestic homicide, look for Campbell, J.C, Assessing Risk Factors for Intimate Partner Homicide in the NIJ Journal, Issue 250, available here: http://www.ncjrs.gov/pdffiles1/jr000250e.pdf.

Guiding Standards for Case Review and Reporting

The perpetrator is solely responsible for the homicide.

The Review Team recognizes that the responsibility for the homicide rests with the person who committed the crime. That said, we also recognize that agencies and individuals can sometimes improve how they handle and respond to cases of domestic violence prior to the homicide.

Every finding in this report is prompted by details of specific homicides.

Many Review Team members have extensive experience with domestic assault cases. Consequently, it is tempting to draw on that broader experience, which may or may not be relevant when making findings in the review of a specific murder. The Review Team thus established a procedure to guarantee that all findings are based only on the specific cases reviewed.

The Review Team only reviews cases in which prosecution is completed.

All prosecution must have been completed before cases are reviewed. In addition to allowing all participants to discuss cases freely, the passage of time also allows some of the emotion and tension surrounding them to dissipate, generating more openness and honesty during the review process.

Findings are based primarily on information contained within official reports and records regarding the individuals involved in the homicide before and after the crime.

Whenever possible, information is supplemented by interviews with friends, family members, or services providers associated with the case. The findings of the Review Team are limited to the availability of information reported by these sources.

The Review Team occasionally uses the words "appear" or "apparent" when it believes certain actions may have occurred but cannot locate specific details in the documents or interviews to support our assumptions.

Many incidents that reflect exemplary responses to domestic violence, both inside and outside the justice system, are not included.

Instead, this report focuses on areas that need improvement.

The Review Team appreciates that several of the agencies that had contact with some of the perpetrators or victims in the cases reviewed have made or are making changes to procedures and protocols since these homicides occurred.

However, the observations included in this report are based on our review of actual case histories and what was in place at the time of the homicide.

The Review Team attempts to reach consensus on every recommended intervention.

While every recommendation is fully discussed by the Review Team, not every recommendation is supported by every member. The Review Team represents a wide variety of positions and complete consensus is not always obtainable.

We will never know if the recommended interventions could have prevented any of the deaths cited in this report.

We do know, in most instances, that the response to the danger in the relationship could have been improved.

The Review Team operates with a high a level of trust rooted in confidentiality and immunity from liability among committed participants.

This process fosters honest introspection about policies, procedures, and criminal justice system responsiveness.

The Review Team does not conduct statistical analysis and does not review a statistically significant number of cases.

Actual numbers, not percentages, are used to ensure that analyses are not misleading.

The findings should not, alone, be used to assess risk in other cases.

Cases with similar scenarios will not necessarily result in the same outcome. However, the findings do address situations of potential danger for victims.

Opportunities for Intervention

For seven years, members of the Fatality Review Team have examined cases of domestic homicide and the lives of those involved, looking for points where a change in the practice of various agencies or individuals might have changed the outcome of the case. Fatality Review Team members examine the case chronologies and then, as a group, make observations about elements of the case. Sometimes the observations assist in identifying the context of the crime, other times they illuminate a clear missed opportunity to avoid the homicide. From these observations the team identifies opportunities for intervention that directly correspond to the observation and to the case. This resulting information is focused on specific actions that agencies could initiate in order to ensure that the discrete incident seen in the case will not be repeated.

The benefit of tying all opportunities for intervention and recommendations directly to events of the case is the legitimacy such rigor creates. Conversely, the focused nature of the resulting information makes generalization of the recommendations for action challenging because they are often dwarfed by the larger context and complex interconnections of the community in which each victim, family and perpetrator exists. The structure of the Team process does not often allow for the illumination of the connections between agencies or places where these connections are weak or absent.

As the discussions of the Team members have advanced, it is these connections, the intricacies of system and community interaction, that most frequently emerge as areas of focus. However, the fact that these connections are inherently complex and larger than a specific incident in a specific case means that the opportunities to address broader modifications are rare. Fortunately, the four cases the Fatality Review Team examined in 2007 have provided exactly such opportunities. In all but one case reviewed, there was evidence that enhanced paths of communication between systems in which the perpetrator or victim was involved could have contributed to avoiding the homicide. The structure of the opportunities for intervention remain the same, they are each linked directly to a case. The structure of this report, however, places each opportunity for intervention into one of three broad themes: Closing the Gaps, Facilitating Effective Transitions and Enhancing Understanding. Within these themes, there are opportunities that address practice changes for law enforcement, the judiciary, the media, community service professionals, medical and mental health providers and the general public.

Closing the Gaps

A little more than thirty years ago, our society began to recognize domestic violence as a crime. As such, the issue shifted from the private to the public spheres. Since that time, communities and systems have struggled to effectively incorporate this understanding into policy and to make safety for victims of violence paramount and accountability for perpetrators a matter of course.

We have made great strides, some through increased public awareness, others through changes in public policy, but there remains more we can do. We must build on the success of individual units within the larger system, whether judicial, governmental or community-based, by ensuring that they are able to communicate and collaborate easily in cases where they share clients.

Interagency Information Sharing

1. Every law enforcement agency should establish a protocol for determining the existence of an active Order for Protection or Domestic Abuse No Contact Order on every domestic assault call.*
2. Hospitals should have access to and be able to consider all previous records related to mental health.
3. There is a need for a comprehensive assessment and delivery system of mental health services for juveniles and adolescents.
4. When both mental health problems and criminal behavior are present, both legal avenues should be pursued, but in a coordinated fashion.
5. Jurisdictions should cooperate, collaborate and provide increased information sharing to assure aggressive prosecution of domestic violence and sexual assault cases involving multiple jurisdictions.
6. Neither the Medical Examiner's Office nor funeral homes have a process for notifying the Department of Motor Vehicles of a person's death. The State systems need to share data to minimize risk of identity theft or other unlawful use of the vital records of the deceased.

* Please see page 13 to learn more about a pilot project in place to addresses this issue.

Justice System Oversight of Probation Violations

1. Probation officers and the courts should work more closely together to hold probationers accountable when situations arise that may represent a violation to the conditions of their probation.
2. Criminal justice should beware of automatically referring to the least restrictive and lowest cost treatment options for sex offender services, domestic violence intervention services or chemical dependency treatment as they may not be the most effective.
3. Probation officers should apply consistent and accountability-based supervision that independently verifies compliance with all conditions of probation.
4. Courts should order batterers' intervention or other appropriate treatments in Order for Protection cases and should enforce those orders.

Addressing Known Risk Behavior

1. In addition to responding to the immediate situation, any professional who comes in contact with a person for whom threats or acts of violence are ongoing should make an effort to assess the situation for the major risk factors for homicide and inform those against whom the threats are made of the increased risk of death when these factors are present.
2. Consider statutory language to highlight particular vulnerability to sexual assault of people used in prostitution.
3. When there is a pattern of a perpetrator targeting victims who are among groups that are traditionally less likely to report crimes or be viewed as good witnesses, there should be a system response that aggressively pursues prosecution.
4. Because threats of homicide indicate an increased likelihood of homicide by perpetrators of domestic violence, police should refer all death threats in domestic cases for investigation.
5. Stalking behavior is indicative of an increased risk of death for victims of domestic violence. Stalking should be recognized and treated with the same gravity as other precursors of homicide.

Facilitating Effective Transitions

Through our case reviews, we have found that the homicide is rarely the perpetrator's first involvement with the justice system, community agencies or government services. In fact, we more often find that the perpetrator has experienced, at some point, a rapid shift from deep involvement in a system— mental health, sex crimes treatment and/or prison— to an almost complete disconnection from any community resources.

Research has shown that the period prior to a conclusion of services presents an opportunity for the creation of a transition plan. Such a plan helps the person returning to the community or ceasing regular services to develop an inventory of their existing resources, from tangible elements, such as housing or employment prospects, to the less tangible elements, such as family relationships and emotional support networks. Additionally, the process of transition planning allows a person to identify areas of challenge, such as maintaining medical or mental health services, and to make a connection with community service providers who will assist them meeting their needs.

Equally important is regular assessment of the efficacy of the various services to which people are referred. Those who assist in transition planning or referral to services must be aware of the quality of the services available. Ideally, they would research effective services and keep up to date on information about best practices in the field.

1. When a juvenile is admitted to a treatment program, the treatment plan should include plans for transition once the juvenile reaches age of majority.
2. Once a juvenile is placed in a facility, funding should be provided to ensure that he/she can remain in that placement until completion of the program.
3. Treatment professionals should work with insurance and government agencies to maintain continuity of care until treatment is completed.
4. Prior to discharge from a long-term treatment facility, all involved parties and agencies should collaborate to construct a comprehensive discharge and transition plan. The facility should identify other agencies that have had relevant contact with the patient and include them in developing the discharge and transition plans.
5. Criminal justice should beware of automatically referring to the least restrictive and lowest cost treatment options for sex offender services, domestic violence intervention services or chemical dependency treatment as they may not be the most effective.
6. Funders should be aware of the methods of treatment used by the non-profit agencies that they support and whether those methods reflect best practices in the treatment field.

Enhancing Understanding

Domestic violence is a complex, often confusing, phenomenon. When it is present in a person's life, they can sometimes behave in a manner that appears counter to their own best interests. It is important that professionals develop a sophisticated understanding of domestic violence. This is especially important when that person has the potential to greatly affect the life of a person experiencing abuse, as is the case for law enforcement personnel, guardians ad litem and judicial officers, or the understanding of a larger group, as is the case for media professionals, public policy leaders or respected members of the community. There must be an enhanced understanding about domestic violence among people in all the systems to which a victim, perpetrator or witness to domestic violence may connect.

Media

1. Media should develop ethical standards and guidelines for reporting about domestic violence.
2. There should be an increase in awareness and training for reporters and news organizations about how to report on domestic violence homicides. Specifically that:
    - by using language, like *dispute* or *argument*, to describe homicidal domestic violence, they are downplaying the dangers that domestic violence poses to thousands of people in their audience. How they report on and name the violence makes a significant impact on the perceptions of the general public as well as those who are experiencing the violence.
    - by treating the homicide as an anomaly, an occurrence with no preamble, they fail to educate on the typical patterns of violence. Families in which domestic violence occurs often make an effort to hide the violence and appear normal but the homicide is rarely the first time evidence of the violence has existed. Domestic violence is prevalent in all communities and an estimated one in three women will be a victim of domestic violence in her lifetime.
3. Public relations or communication staff at community agencies or county agencies should be trained on how to pitch or respond to stories about domestic violence homicide.

Employers

The face of the workforce is changing in our community. Specifically, more people are employed by temporary agencies and, as a result, the duty of the employer to ensure a safe work environment, versus the duty of the contracting job site to do so, often appears unclear. Ultimately, the employer, the temporary agency, is legally responsible for maintaining a safe work environment for employees, but when someone is at risk for becoming a victim of domestic violence or homicide, every person and organization has a role to play.

1. Employers should take affirmative action to assist employees who are experiencing domestic violence.
2. When an employer is threatened through the threats to their employee, the employer should contact the police.

Note: By law, employers cannot take negative action against an employee because of that employee's experience of domestic violence.

Community Members

1. More efforts should be made to educate agencies and individuals to recognize the connection between suicide threats/attempts and homicides.
2. Professional law enforcement, medical or mental health providers should educate people about the heightened danger that having weapons in the home presents, especially in cases of domestic violence or family members who threaten to harm themselves or others.
3. Community agencies and mental health service providers must make an effort to be more accessible and to ensure that those who may benefit from their services know that they exist.
4. There should be an increased public awareness about the role that coercive and controlling behavior plays in domestic violence and abuse.

The Importance of Continued Case Review

A benefit of the current structure and a key argument for the continuation of the team is the change-making work that has organically developed from the process of case reviews within the Hennepin Domestic Fatality Review Team. Since all the members of the team are in some way connected to community, justice or government systems that serve those who may become the perpetrator or victim of a domestic homicide, each member also brings a unique perspective on ways in which their agency's work can prevent homicide.

The Domestic Fatality Review Team has published four reports in which we have made recommendations for changes to system procedures that increase safety for victims and hold perpetrators accountable. After each of the reports, we collected feedback from agency leaders and documented changes that were made in response to Team recommendations. Additionally, some members of the Review Team , having identified a better way to keep victims safe and hold abusers accountable, have taken the initiative to make more immediate changes within their organization.

An example of the type of systems change engendered, in part, by the Domestic Fatality Review Team's previous reports is Minneapolis' Misdemeanor Domestic Assault Investigation Pilot, a collaborative project of the Minneapolis City Attorney's Office and the Minneapolis Police Department, which will begin on February 1, 2008. As a part of the pilot project, officers in Minneapolis' 5th Precinct will be given special training in the dynamics of domestic abuse and in handling domestic assault related calls. Officers will then be asked to complete a more in-depth initial investigation for misdemeanor domestic assault cases, including interviewing defendants and asking victims some preliminary risk assessment questions. Also as a part of this Pilot, based on a recommendation of the Domestic Fatality Review Team in this year's report, officers will be instructed to check for the existence of Orders for Protection or Domestic Abuse No Contact Orders on every domestic related call. Both the City Attorney's Office and the Police Department hope that this increased emphasis on misdemeanor level domestic assault related cases will increase the successful prosecution of those cases and will ultimately reduce the number of repeat or serious domestic assault offenses occurring in Minneapolis.

Hennepin County Fatality Review Project History

The Fatality Review process in Hennepin County began in 1998 when WATCH, a nonprofit court monitoring organization, received a planning grant from the Minnesota Department of Children, Families and Learning. As part of its work, WATCH routinely creates chronologies of cases involving chronic domestic abusers and publishes them in its newsletter. While creating chronologies, WATCH often became aware of missed opportunities for holding abusers accountable. The organization felt strongly that, in the vast majority of cases, these opportunities were not missed because of carelessness or disinterest on the part of the individuals handling the cases. Instead, many opportunities were missed because adequate and accurate information was not available at critical decision points and because the sheer volume of domestic abuse cases created significant pressure to resolve them quickly, oftentimes forcing an outcome that was less than ideal.

While attending a National District Attorneys Conference in 1997, a WATCH staff member learned about a movement to conduct Domestic Fatality Reviews, a movement that was gaining interest nationwide and that appeared to address many of the organization's concerns about the many places where chronic abusers could slip through the cracks of the justice system. When WATCH learned about the availability of planning funds from the Minnesota Department of Children, Families and Learning, it applied for, and soon after received, a $25,000 planning grant to determine the potential for establishing such a project in Hennepin County.

If representatives from the justice system and community agencies determined that such an effort was feasible, the grant called for an organization that would lay the foundation for the project. Upon receipt of funding, WATCH put together an Advisory Board of representatives from the primary public and private agencies that handle domestic violence cases. The Advisory Board included representatives from District Court, City and County Attorney, Police, Public Defender, Probation and Victim Advocacy Services, meeting up to four times a month.

Enthusiasm for the project was high from the outset. Consequently the Advisory Board spent very little time on the feasibility study and soon began laying out the framework for the project to be established in Hennepin County. It began with an extensive research effort to gather information from jurisdictions that had already

implemented fatality review teams, gaining extremely valuable information in this process. Many jurisdictions stressed the importance of having enabling legislation to create the project and to lay the framework for the project to go forward with multiagency participation. This would assist in creating a non-blaming environment and help to assure the neutral review of cases.

During the process of developing the proposed legislation, the Advisory Board assembled a larger Planning Committee comprised of 34 members representing private, public and nonprofit agencies and organizations to gain a variety of perspectives on particular topics and to develop broader support for the project. The Planning Committee worked primarily on establishing a definition of domestic homicide and on identifying who should be represented on the Review Team. Once critical decisions had been made about participation and structure, the existing Advisory Board worked with Senate counsel to put together legislation that would create and fund the project. The legislation also included important data privacy and immunity provisions that would enable the project to gain access to confidential records related to these cases and provide immunity to those who spoke openly to the Fatality Review Team about case information.

A proposal to create and fund the pilot passed during the 1999 session. However, for technical reasons the data privacy and immunity provisions were taken out of the enabling legislation. This language was critical to the success of the project, since many agencies were interested in providing information to facilitate the fatality review process but were not able to do so under existing statutes without suffering significant penalties.

The Advisory Board returned to the legislature during the 2000 session to pursue the data privacy and immunity provisions. The legislation passed and was signed by the Governor. It became effective on August 1, 2000. In 2004 the State Legislature granted an extension to these provisions until June 2006. In 2006, the Team was granted another extension, this time to December 2008.

Hennepin Domestic Fatality Review Team
Purpose and Goal

The purpose of the Hennepin County Domestic Fatality Review Team is to examine deaths resulting from domestic violence in order to identify the circumstances that led to the homicide(s).

The goal is to discover factors that will prompt improved identification, intervention and prevention efforts in similar cases. It's important to emphasize that the purpose is not to place blame for the death, but rather to actively improve all systems that serve persons involved with domestic abuse.

Team Structure and Processes

The Review Team Structure

The enabling Legislation requires that the Hennepin Domestic Fatality Review Team have up to 35 members and include representatives from the following organizations or professions:

- The Medical Examiner;
- A Judicial Court Officer (Judge or referee);
- A County and City Attorney and a public defender;
- The County Sheriff and a peace officer;
- A representative from family court services and the Department of Corrections;
- A physician familiar with domestic violence issues;
- A representative from district court administration and DASC;
- A public citizen representative or a representative from a civic organization;
- A mental health professional; and
- Domestic violence advocates or shelter workers (3 positions)

The Team also has representatives from community organizations and citizen volunteers.

Review Team members are appointed by the District IV Chief Judge and serve three year terms of service. There is one paid staff person who supports the Team in the role of Project Coordinator.

The Review Team is governed by the Advisory Board, which is also the policy-making and strategic oversight body. The Advisory Board is made up of members of the Review Team with at least six months of experience. The Chair of the Review Team leads the Advisory Board and appoints Advisory Board members for three year terms.

Case Selection

The Fatality Review Team reviews only cases which are closed to any further prosecution. In addition, all cases - such as a homicide/suicide where no criminal prosecution would take place - are at least one year old when they were reviewed. This policy is based on the advice of several jurisdictions that were already well versed in the review process. In their experience, letting time pass after the incident allowed some of the emotion and tension to dissipate, thus allowing for more open and honest discussion during case reviews.

A sub-committee of the Advisory Board uses information provided by the Minnesota Coalition for Battered Women's Femicide Report and homicide records from the Hennepin County Medical Examiner's Office to determine which cases to review. The committee selects a mix of cases that differ from one another based on race, location of the homicide and gender of the perpetrator.

The Case Review

After a case is selected for Team review, the Project Coordinator sends requests for agencies to provide documents and reviews the information. Police and prosecution files typically provide the bulk of the information and identify other agencies that may have records that are important in reviewing the case.

The Project Coordinator reviews the records to develop a chronology of the case. The chronology is a step by step account of lives of the victim and perpetrator, their relationship, incidents of domestic violence, events that occurred immediately prior to the homicide and the homicide itself. Names of police, prosecutors, social workers, doctors, or other professionals involved in the case are not used.

A designated person from the Team contacts members of the family of the victim, and when appropriate, the perpetrator, to inform them that the Review Team is reviewing the case and to see if they are willing and interested in providing information and reflections on the case.

This chronology is sent to Review Team members prior to the case review meeting, and documents from the police records, prosecution records and, typically, medical records are sent to members of the team. Two team members are assigned to review each of these records, one member from the agency that provided the information and one who has an outside perspective.

Each Review Team meeting begins with members signing a confidentiality agreement. At the meeting, individuals who reviewed the case report their findings. The Team then develops a series of observations related to the case. Small groups of Team members use these observations to identify opportunities for intervention that may have prevented the homicide. The small groups then present their findings to the full Review Team, which discusses the issues and opportunities. The Review Team records key issues, observations and opportunities for intervention related to each case for later publication.

Review Team Members

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Hennepin County Public Defender

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Assistant Medical Examiner
Hennepin County Medical Examiner

Anna Crabb
Assistant City Attorney
Minnetonka City Attorney's Office

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Senior Clinical Forensic Psychologist
Hennepin County 4th Judicial District Court

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Technical Assistance Consultant
Community Volunteer

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CornerHouse Interagency

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Community Program Manager
Sojourner Project, Inc.

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Manager
Hennepin County Domestic Abuse Service Center

Mike Gephart*
Corrections Unit Supervisor
Hennepin County Adult Field Services

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Senior Social Worker
Domestic Violence Program Coordinator
Hennepin County Medical Center

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Corrections Unit Supervisor
Hennepin County Community Corrections

Jacquelyn Hauser
Executive Director
Academy on Violence and Abuse

Liz Hughes, J.D. **
Assistant Public Defender
Hennepin County Public Defender

Hani Hussein**
Multicultural Project: Somali Community
Hennepin County Multicultural Services

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Minneapolis City Attorney's Office,
Family Violence Unit

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Judicial Officer-Magistrate
4th Judicial District Court

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Attorney with Ameriprise Financial
Community Volunteer

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Detective
Hennepin County Sheriff's Department

Rebecca Waggoner-Kloek‡
Anti-Violence Program Manager
Outfront Minnesota

Laura Landis‡
Advocacy Supervisor
HomeFree Programs

John Laux
Chief of Police
Bloomington Police Department

Daniel Mabley, Project Chair*
District Court Judge
4th Judicial District Court

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Director of Therapy
Domestic Abuse Project

Jahmal Mattson
Career Probation Officer
Hennepin County Community Corrections

Laura Nelson, J.D.**
Staff Attorney
Minnesota Advocates for Human Rights

Kathryn Quaintance**
District Court Judge
4th Judicial District Court

Tim Reardon**
The Reardon Group

Karen Shannon
Project Manager
Office of Student Attendance
Minneapolis Public Schools

Dr. Jon Thompson ‡
Assistant Medical Examiner
Hennepin County Medical Examiner

Margaret Thunder
Child Protection Program Manager,
Hennepin County Child Protection Investigations Unit

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Managing Attorney
Hennepin County Domestic Abuse Service Center

Mandy Wienke
Office Specialist, Principal
Sheriff s Department Records Unit

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** Resigned from the Review Team in 2007