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Executive Summary

In the past 10 years, 262 women in Minnesota have died as a result of domestic violence.[1] Unlike the rates for most other serious crime, which have been decreasing, this number has actually increased in recent years, with a record of 40 deaths in 2000 and 33 in 2001 (the second highest number recorded since 1988 when records began to be kept).

These are extremely troubling statistics which should prompt significant attention, but interestingly, they are not what prompted the Hennepin County Domestic Fatality Review Pilot Project. (Work on the project began in 1998, prior to the record domestic homicide numbers recorded in recent years.) The project began because the professionals who have worked on the various aspects of these cases believe that:

- even one life lost as a result of domestic violence is too many.
- the nature of domestic assaults, with frequent attacks on the same victim (prior to the homicide) presents an opportunity for prevention that isn't present in other types of homicide cases.
- the justice system's response to these cases would benefit greatly by a more collaborative effort.
- the toll that domestic homicides take on society extends far beyond their immediate impact on the victim's family and friends.

The purpose of domestic fatality reviews 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.

A 24-member multi-disciplinary Review Team began reviewing cases on September 29, 2000. It thoroughly examined nine Hennepin County cases involving 13 homicides and three suicides. The Team selected a mix of cases that differed from one another based on race, location of the homicide, and gender of the perpetrator. The three homicide/suicide cases were included because these types of cases make up a significant portion of domestic homicides.

The Team identified five categories which captured its findings in these cases. A brief summary of each category follows. The full report includes more detailed discussion of the findings and the cases, as well as additional opportunities for intervention.

Perpetrator Violence

These sections address the justice system's response to the means and methods perpetrators use to abuse, terrorize and control their victims. Preventive interventions were missed because:

- Perpetrators fled the scene of assaults before police arrived and were not pursued.
- Assaults that would have qualified for felony prosecution were instead identified as misdemeanors and did not receive timely follow-up investigation.

- The perpetrator's complete criminal history was not known to key decision makers.
- Threats to kill and threats with weapons were not treated seriously.

Key opportunities for intervention:

- Routinely make a determined effort to locate known perpetrators who are gone when police arrive (commonly referred to as "gone on arrivals").
- Escalate consequences for repeat acts of domestic abuse.
- Until statewide computerized information becomes available, aggressively seek out criminal history information.
- Increase the attention paid by the justice system to perpetrator's repeated threats to kill.
- Institute a policy wherein any use of a gun or weapon would initiate felony protocol at the scene, and in follow-up investigation.

Situations Involving Children

These sections address the particular issues that surround children's exposure to domestic violence and the use of children by perpetrators to gain power and control over their victims. Preventive interventions were missed because:

- Children were not used often enough as a source of information in domestic assault cases.
- The rights of perpetrators to have access to children — for which they were not an adjudicated parent — were not understood by police and victims.
- Perpetrators used children as hostages to control and terrorize their victims. Victims feared that calls for help may result in the death or permanent disappearance of their child.

Key opportunities for intervention:

- Establish a protocol for assessing and documenting the involvement of children found at the scene of domestic assaults, and for determining whether children may be victims or witnesses.
- Use sites other than victims' homes for visitation and exchange of children.
- Train law enforcement on the rights of adjudicated and non-adjudicated parents.

Justice System Performance

These sections focus on how the justice system assigns resources to address the issue of domestic violence as well as how it responds to the victims of domestic violence. Preventive interventions were missed because:

- Very limited resources were devoted to misdemeanor domestic assault investigation and prosecution when compared to the resources dedicated to investigating and prosecuting the case after the homicide.
- There was a breakdown in the exchange of information and a reduction in the ability to access information when cases crossed jurisdictional lines.

- Victims were aggressively prosecuted for their own offenses without attempts to address their needs as a victim of domestic violence.
- Consequences for violations of protection orders were minimal.

Key opportunities for intervention:

- Bolster the resources devoted to misdemeanor investigation and prosecution.
- Develop a state-wide domestic violence law enforcement initiative which would serve as both a clearinghouse for information and an investigative unit.
- Assess all female offenders to determine if they are victims of domestic abuse.
- Make the safety of the victim and children the primary consideration in determining custody and visitation in Orders for Protection. Limit or deny access to children when necessary.

Treatment and Mental Health Issues

These sections address the complex issues presented when mental health and chemical dependency are intertwined with domestic violence. Preventive interventions were missed because:

- Suicide threats and attempts were not identified as prompting increased risk to the victim.
- The justice system did not hold perpetrators accountable for treatment when chemical dependency issues had been identified as the result of a criminal matter prior to the homicide.

Key opportunities for intervention:

- Recognize that suicide threats are often an antecedent to homicides.
- Establish a task force of psychological service providers, domestic abuse advocates, data privacy specialists, and Review Team members to discuss domestic homicide/suicide cases.
- Consider the issue of chemical dependency as a potential factor in each domestic assault case.

Other Opportunities for Intervention

This category includes two types of opportunities for intervention: Those that need further study (*Treatment Services to Perpetrators*) and those that are not specifically related to case reviews (*Training on Findings of the Review Team* and *Statewide Fatality Review*).

The team could not reach consensus on the extent to which treatment for perpetrators should be used and was successful. It did agree, however, that the current practice for making determinations to send a batterer to treatment had serious shortcomings. It presented several possible opportunities for intervention which it believed would develop greater confidence in the process and would foster more agreement on this topic. They include:

- Rely on a risk assessment and/or psycho-social assessment instead of a plea negotiation process to determine the appropriateness of treatment for batterers.
- Define successful completion of batterer's treatment as no further acts of domestic violence.
- Differentiate the strengths of the various batterer's treatment programs to identify the best program to address each batterer's specific needs.

Also in this category the Team identified ways to use the valuable information uncovered by the Review Team and to use the process to gain a greater understanding of the factors that may lead to enhanced prevention efforts in similar cases. Those opportunities for intervention are:

- Conduct training or information sessions with personnel in the fields of medicine, criminal justice, mental health, education, advocacy and child protection, among others, about the findings and observations of the Review Team.
- Annually conduct at least one fatality review in each judicial district.

Immediate Results

One of the most exciting results of the pilot project was that case reviews prompted an almost immediate effort by Team participants to personally address the issues identified by the reviews. Those responses are detailed in a section entitled *Reasons to Have Hope*, which concludes the report. While major policy and procedural changes are limited in number they are significant for the issues they address and the short time in which they occurred. Nearly every member of the review team has proclaimed a heightened awareness for the scenarios that signal an increased risk to the victims of domestic assault. Review Team members report that they find themselves asking "Is this our next case? What can I do or advise be done to prevent a death?" These are questions the Review Team hopes will be in the minds of key decision makers after reading this report.

The Team also hopes that the information in this report will prompt an increased interest in these cases, an effort by agencies to take advantage of the opportunities for intervention the report identifies, and continued support for this type of retrospection, not only in Hennepin County but statewide. Sometimes a careful look back is the wisest way to move forward.

Preface

Imagine you're an eight-year-old child. You enjoy the same things as other kids your age, particularly riding your bike. But at the end of the day, when your friends put their bikes in the garage, you position yours very carefully in front of the door to your house. And you watch that bike carefully, not for fear that it might be stolen but because it serves as your alarm system. If you return after visiting a friend or relative and the bike isn't in *exactly* the same position, you know that he is there. He is the man who beats your mom and knocks you down when you try to protect her. He is the man who is stealing your freedom and your childhood. Imagine living every day of your life with this level of fear. Imagine being present when your mom is murdered. Imagine its impact on your heart and soul.

Since the fall of 2000 a multi-disciplinary task force, the Hennepin County Domestic Fatality Review Team, has been meeting monthly to sift through the tragic debris left behind after a domestic homicide. It's been a grim task. It's also been enlightening. The Team has worked diligently to make sense of what it has uncovered through a very thorough analysis of these cases. They've learned, however, that it's impossible to make sense out of so many lives needlessly lost because of one human being's need to exert power and control over another. It is possible, however, to identify periods in the family's history where an improved response at a point of intervention by the justice system or others may have prevented the death. The Team's findings are included in this report.

In 2000, according to the Minnesota Coalition for Battered Women, 40 Minnesota women lost their lives as a result of domestic violence — a new state record, when rates for other serious crimes were declining. Last year 33 women died; the second highest total since the Coalition began keeping records in 1988. In the past ten years domestic violence has claimed the lives of 262 women. These are incredibly troubling statistics for which there are no simple answers. Even after careful study, the Review Team cannot guarantee that its findings will ultimately save lives. But there is one thing the Review Team knows for certain:

This is not a crime that happens to someone else, that happens in families that are dysfunctional, that happens only to people who are addicted to drugs and alcohol. Anyone, anywhere, any time can be a victim of domestic violence. A friend helping a friend move out of her home as a result of a failed marriage, a child visiting a friend on a sleep over, a daughter having ever-so-brief a relationship with an unstable suitor and other scenarios too numerous to mention. It can happen to anyone.

Project History

"As a long-time practitioner in the Criminal Justice System, I thought I had a good understanding of the issues that related to my work. I now know that I never truly realized what impact domestic abuse had upon the children who witnessed it and who lived with it. I also know that, because of this, I missed opportunities for intervention in cases in which I was actively trying to provide assistance. This was one of the greatest awakenings in my professional career." Corrections Department Program Manager, Review Team Member

The Fatality Review process in Hennepin County began in 1998 with a planning grant from the Minnesota Department of Children, Families and Learning to WATCH, a nonprofit court monitoring organization. As part of its work, WATCH routinely creates chronologies of cases involving chronic domestic abusers and publishes them in its newsletter. In the process of doing so, it often became aware of many 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 for chronic abusers to 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 justice system and community agencies determined that such an effort was feasible, the grant called for the organization to 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 Board included representatives from District Court, City and County Attorney, Police, Public Defender, Probation and Victim Advocacy Services. The Board has met between two to four times a month since March of 1998. Remarkably, nearly every Board Member has remained with the project since its inception.

Enthusiasm for the project was high from the outset, and consequently the Advisory Board spent very little time on a feasibility study, but instead early on began working to lay 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. The Board gained 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 multi-agency participation. This would assist in creating a non-blaming environment and in help in assuring the neutral review of cases.

During the process of developing the proposed legislation, the Advisory Board assembled a larger Planning Committee — 23 representatives from 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 for 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.

The legislation creating and funding the pilot project 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.

"Working collaboratively and productively with individuals from different areas of the County and other agencies was a wonderful experience and demonstrated clearly the value in making such an effort." Chief Clinical Psychologist, Review Team Member

Review Team Structure

Advisory Board

The Advisory Board for the project began its work in March of 1998. It consisted of nine members plus staff and usually met twice each month. The Advisory Board's work to lay the foundation for the Fatality Review Project included:

- researching the structure and process of Review Teams around the country;
- identifying the appropriate structure for Hennepin County;
- drafting and testifying on behalf of legislation to create and fund the Review Team;
- drafting and testifying on behalf of legislation to address confidentiality and immunity issues;
- recommending, in conjunction with the Family Violence Coordinating Council, potential members for appointment to the Review Team;
- working through, in minute detail, how case reviews would be handled, e.g., how case information would presented in an understandable fashion, who would present it, how to encourage team member participation, how to handle confidential documents, what should be included in orientation sessions, and much more.
- The Advisory Board continued to meet even after the full Review Team was in place. This allowed the Review Team to maximize the time it spent on case reviews without having to address the many administrative matters that accompany a project such as this.

An outline of the respective role of the Advisory Board and the Review Team is included in the Appendix.

Review Team

The Review Team consisted of 23 members, appointed by the Chief Judge of Hennepin County District Court (former Chief Judge, Mabley, and current Chief Judge, Burke) upon the recommendation of the project's Advisory Board and in consultation with the County's Family Violence Coordinating Council and other agencies and individuals knowledgeable in the field of Domestic Violence. The goal in structuring the team was to have multicultural representation and perspective.

The enabling statutory language spelled out a number of agencies that were required to be represented. Others were added in order to increase the level of community involvement. Several domestic abuse advocates who had personal experience with the cases under review were also invited to participate in those case discussions.

"This is the most important project I have been involved with since my appointment to the Minnesota trial court bench." District Court Judge, Review Team Member

The project was supported by two part-time staff: a project director, working half-time; and an administrative assistant, working one-quarter time. In addition, the project was fortunate to have available to it the assistance of a professional facilitator. That expertise was extremely valuable in structuring the case review process and in keeping the Team on track during the review discussions.

Case Selection

Cases reviewed by the Fatality Review Team were closed to any further legal activity including opportunities for appeal. In addition, all cases — such as a homicide/suicide where no criminal prosecution would take place — were at least one year old when they were reviewed. This policy was based on the advice of several jurisdictions which 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.

The Review Team began its effort with three cases chosen randomly by the Advisory Board. When the Team received access to confidential data in August, 2000, it studied over 270 homicide files in the Hennepin County Medical Examiner's Office to determine which may have resulted from domestic violence. Staff prepared a synopsis of all domestic violence homicides A subcommittee of the review team met to examine the records and select cases for review. The committee selected a mix of cases that differed from one another based on race, location of the homicide, and gender of the perpetrator. Three homicide/suicide cases were included since those types of cases make up a significant portion of domestic homicides each year.

Case Review Process

- After a case was selected for review, members of the Advisory Board reviewed case files to identify documents critical to the case analysis. Usually the police and prosecution files provided information sufficient to identify other agencies that may have records that were important in reviewing the case.

- Staff then sent out a request for agencies to provide documents to the Review Team.

- Hennepin County Attorney Victim Witness Advocates attempted to contact the family to let them know about the review process, ask them if they would like to be interviewed, and ask them if they knew of records that would be helpful in the review, particularly records outside of Hennepin County and/or medical records.

- The Advisory Board and staff reviewed the records in order to develop a chronology of the case. This chronology was sent to Review Team members prior to the case review. (This was essential to a meaningful discussion since it was nearly impossible to keep track of the multitude of events and individuals involved in the case without this tool.)

- One month before the review, individual Review Team members were assigned to present agency information about the case at the Review Team meeting. For example, the prosecution representative on the Review Team was assigned to report on the prosecution file. In addition, however, one other member of the Review Team — someone not associated with prosecution — was also asked to review the prosecution records. This gave the Review Team a fresh perspective on the case from someone who was not familiar with the agency's records. (Records were made available to Review Team members through a strict sign-out process. Confidential records were destroyed after the case review process.)

- Each Review Team meeting started with members signing a confidentiality agreement. At the meeting, individuals who reviewed the case reported their findings. The Team then met in small groups relating to the records reviewed, e.g., police, prosecution, medical and others. Small groups looked for missed opportunities for intervention that may have prevented the homicide and made recommendations based on the issues they identified. They also identified successful interventions. The small groups then presented their findings to the full Review Team which discussed the issues and recommendations.

The Review Team identified key issues and recommendations related to each case. It also identified issues that required further investigation. In addition, members were given the opportunity to discuss their personal feelings about the case. This provided a way to address the emotional impact these cases had on the Review Team.

Things to Keep in Mind While Reading this Report

- **The perpetrator is solely responsible for the homicide.** All members of the project recognize that regardless of any improvements that could have been made or may in the future be made by agencies or individuals who have contact with the people involved in these cases, the responsibility for the homicide rests with the person who committed the crime. There is no room in the fatality review process for blaming nor was it an issue during the pilot project. Every individual who participated in this process did so in an effort to learn from the tragedy and to improve the performance of their agency when handling cases of domestic violence.

- **There were many incidents that reflected exemplary responses to domestic violence both inside and outside the justice system.** Since the report is geared toward addressing areas that need improvement, it may appear more negative than was the Team's experience in reviewing the cases.

- **Every finding identified in the report is prompted by a specific homicide case or cases.** Many of the Review Team members had extensive experience with domestic assault cases. Consequently, there was a temptation to draw on that broader experience when identifying the findings. The Team believed, however, that one of its most important functions was to identify the types of issues that are a factor in domestic homicide cases as compared to more general concerns in the area of domestic violence. Therefore it established a procedure to guarantee that all findings are case-based. Those working in the field of domestic violence will not be surprised by many of the findings or opportunities for improvement identified by the Team. The Team hopes, however, that these issues take on greater importance since they are linked to the actual deaths of persons in real cases reviewed.

- **Findings are primarily based on information in official reports and records about the parties before and after the homicide.** Whenever possible, information was supplemented by interviews with surviving friends or family members. The findings of the Review Team are therefore limited to the availability of information reported in and from those sources. The Team occasionally uses the word "appeared" when it believed certain actions may have been taken but could not locate specific details in the documents or interviews to support its assumption. The Team did not consider this process to be a media-type investigation and consequently it did not go to extraordinary means to locate documents.

- **Percentages are not used because the Review Team did not consider a statistically significant number of cases.** Instead, actual numbers are used to make certain the results are not misleading.

- **The findings should not be used as an indicator of lethality.** Much has been written on the subject of lethality assessments — some of which is referenced in the report. Many of the scenarios

which appear in the report will be present in cases that don't become lethal. The Review Team does believe, however that many of the findings are indicators of the level of potential danger to the victim.

- **The Team has identified "opportunities for intervention."** Since this project is based only on cases arising in Hennepin County, this report should be read as suggesting best practices.

- **Case examples may appear in more than one category.** This shows the extent to which the issue exhibits itself as a problem in a variety of ways. It also reflects the complexity of these issues.

- **Perpetrators are referred to with male pronouns.** In eight of the nine cases reviewed, the person who committed the homicide(s) was male. In one case a female victim of domestic violence killed the perpetrator. According to data collected by the Bureau of Justice Statistics, most domestic homicides are committed by males against their female intimate partners. Consequently, the Review Team felt it was appropriate to use male pronouns when referring to batterers and murderers.

- **The oldest of the cases reviewed for this project dates back to 1996.** The Review Team appreciates that several of the agencies involved have made or are in the process of making changes in procedure and protocols since these homicides occurred. However, the observations made are based on review of actual case histories, and the Review Team believes its observations will benefit not only involved Hennepin County agencies in effecting change but others throughout the state and nation who review this report.

- **We will never know if any of these deaths could have been prevented based on the recommended interventions in this report.** We do know, however, that in most instances there could have been an improved response to the danger that existed in the relationship.

Opportunities for Intervention

The Review Team spent many hours digesting the volumes of information generated by each case review. By far the most difficult task was identifying and agreeing upon key categories that would organize the many issues identified in a manner that could be easily read and understood.

Like many complex social issues, matters surrounding domestic violence and the homicides related to it cannot be neatly categorized. Many issues overlap and wind their way in and out of case scenarios. The Team has done its best to structure this section in a way that will assist the reader in understanding the issues identified in the case reviews. Four main categories were identified to capture opportunities for intervention. A fifth category was added to absorb opportunities that did not fit into the other sections. The sections are:

- Perpetrator Violence
- Situations Involving Children
- Justice System Performance
- Treatment and Mental Health Issues
- Other Opportunities for Improvement

Perpetrator Violence

- Perpetrators Gone When Police Arrive
- Correctly Responding to and Documenting the Severity of a Domestic Assault
- Perpetrator's Criminal Histories
- Prior Threats to Kill
- Weapons

The sections in this category address the justice system's response to the means and methods perpetrators use to terrorize, abuse and control their victims.

Perpetrators Gone When Police Arrive

Case Observations

- A perpetrator threatens a victim with a knife and a gun. The victim reports the incident to police the next day. There were no records that indicate that anything was done to locate the suspect.
- A perpetrator is not arrested for assault when he flees the scene. Police have contact with him by phone and know where he is. He commits the homicide while being investigated for this assault.

Findings

When the perpetrator was gone on arrival or when the assault was reported after the fact, there was little documentation that law enforcement agencies attempted to locate the perpetrator. Since there were no follow-up arrests as a result of these calls, the Review Team felt it was unlikely that significant efforts were made to locate the perpetrator. Because opportunities for intervention by the justice system have been largely dependent upon having a perpetrator in custody, failure to find and arrest the perpetrator has made criminal justice intervention unlikely.

Because opportunities for intervention by the justice system have been largely dependent upon having a perpetrator in custody, failure to find and arrest the perpetrator has made criminal justice intervention unlikely.

Opportunities for Intervention

- **Routinely make a determined effort to locate known perpetrators who are gone when police arrive (commonly referred to as "gone on arrivals" or "GOA's").** This would send a message to the perpetrator that he can't "hit and run" and get away with it. It would also let the victim know that she is believed and that her safety is of concern. Efforts to locate should make substantial use of the 12 hours allowed by law for probable cause arrests and should make use of other law enforcement agencies by issuing requests to locate. When probable cause exists, there is no time limit for making an arrest for a violation of an order for protection.

- **Adopt protocols requiring prosecutors to review gone on arrival cases within 24 hours of receiving the police reports.** This would increase the potential for these cases to be charged as crimes.

Discussion

Review Team members directed that the discussion portion of this section reflect the concern and extreme frustration they experienced in reviewing this particular aspect of the case history. In case after case members witnessed examples of perpetrators getting away with

serious assaults because they managed to leave the scene before police arrived. It appeared that some of the assaults, such as the perpetrator smashing the victim's head into a wall leaving blood and hair sticking to the wall and sending the victim to the hospital for lacerations to her face, may have qualified for felony charging.

The Review Team had many unanswered questions about this issue. Are adequate resources available to locate suspects if they are gone on arrival? If law enforcement has been called to the same address on several other occasions, are the police less likely to pursue the suspect? Is it simply human nature to downplay the seriousness of an incident when you are not a witness to it, knowing that ultimately no one was seriously hurt?

. . . considerable efforts should be made to locate perpetrators who are not at the scene when police arrive.

Regardless of the answers to these questions, the Review Team concluded that considerable efforts should be made to locate perpetrators who are not at the scene when police arrive. Not doing so sends a very strong message to both perpetrator and victim. The perpetrator learns — and it appeared from the cases reviewed that certain perpetrators had "learned" this — that he can do whatever he wants to the victim as long as he is gone when police arrive. The victim learns that it is useless to call for help if the perpetrator is gone, that she is not believed and that no one is concerned about her safety. This reduces the likelihood that she will be willing to report future assaults.

Correctly Responding to and Documenting the Severity of a Domestic Assault

Case Observations

- Victims suffer significant injuries, (broken teeth, broken jaw, stitches required for cut lip, and a report of a nose broken with a canoe paddle) yet the seriousness of the cases is often not addressed by police.
- In one case, the investigation is upgraded to a third degree assault only after the victim goes to the hospital and then reports to police that her jaw has been broken which qualifies the assault for felony prosecution.
- In several cases, knives and guns are used, but the cases are treated as misdemeanors.
- Serious threats to the victim, made in the presence of police officers, are not charged as terroristic threats.
- Perpetrators assault victims multiple times, (one case documents 13 prior assaults) yet significant increased consequences are not imposed.
- In at least three assaults on victims prior to the homicide perpetrators attempted to strangle and suffocate them.

Findings

Perpetrators assault victims multiple times, (one case documents 13 prior assaults) yet significant increased consequences are not imposed.

In many of the cases reviewed, the victims were assaulted repeatedly and severely prior to the homicide, including attempts to strangle. The response by the system was inadequate, not recognizing the seriousness of the incidents. Cases that met the criteria for felony charging were not referred for felony charging.

Opportunities for Intervention

- **Escalate consequences for repeat acts of domestic abuse** to underscore the potentially deadly nature of these crimes, and potentially reduce recidivism.

- **Develop a police protocol to thoroughly document the scene of the assault,** including the victim's physical and emotional state, the condition of the home or other location of the assault and the presence of children and other witnesses, to facilitate collection of evidence and allow for prosecution regardless of victim cooperation.

- **Treat delayed reports of domestic violence (i.e. reports of domestic abuse that are presented to police by victims or witnesses after the incident) as seriously as if the incident were happening in the presence of officers.** This would mean that

officers would be more likely to respond to the reported incident consistent with its level of severity.

- **Develop a felony-level protocol to be used in cases where attempted strangulation is alleged** to ensure that these serious offenses, in which the extent of the injury may not be readily apparent, can be appropriately investigated and charged.

- **Have medical personnel thoroughly document the injuries of domestic violence victims (including the nature and extent of injury and the explanation given).** This will increase the likelihood that cases are charged at the appropriate severity level.

- **Encourage the use of medical release forms at the scene and at medical facilities** to help make certain that police and prosecutors have the necessary information for arrests and charging. This would also reduce the likelihood that the perpetrator can interfere with the victim's ability to share information or to sign a release.

- **Reemphasize the importance for police and prosecutors to correctly distinguish between misdemeanor and felony level assaults.** This would facilitate the referral of appropriate cases for felony prosecution.

Discussion

Nearly all of the opportunities for intervention identified by the Review Team in this category relate to the importance of gathering as much information at the scene as possible. Since in some communities there is a significant disparity between investigating misdemeanor and felony cases, the Team believed that calling for felony protocols to be routinely used in certain situations would increase the likelihood that the severity of the offense would be appropriately addressed. This is particularly important when attempts to strangle are alleged since research shows that this type of assault is an indicator of increased risk to the victim. [2]

Perpetrators' Criminal Histories

Case Observations

- A perpetrator's assault charge in another Minnesota county appears to be unavailable to prosecutors making decisions about a current case.
- Several perpetrators have criminal records that apparently are not taken into consideration when decisions are made about their arrest, bail, opportunity to enhance charges, and sentence.

Findings

Judges, probation officers, police officers, charging attorneys and others within the justice system who are required to make instant decisions about how to proceed with a case must frequently do so without access to all available information about the alleged perpetrator. This limits the opportunity to make timely arrests, and appropriate charging and detention decisions.

Opportunities for Intervention

Numerous individuals in numerous agencies are called upon daily to make immediate decisions in domestic abuse cases, any one of which may turn into the next domestic homicide. Each domestic homicide carries enormous implications, not only for the immediate family, but for the community as a whole.

- **Provide real-time access to complete criminal history information about perpetrators including Orders for Protection.** This would enable the justice system to make much more accurate decisions about the level of violence and risk that exists in the relationship. Computerized information systems such as MNCIS and CriMNet would make this possible and should receive strong financial support from policy makers.
- **Until statewide computerized information becomes available, aggressively seek out criminal history information.** Currently this is the only option for obtaining a more complete picture of the level of risk that exists in the relationship. The multijurisdictional task force model described in the section entitled *Cases Involving Multiple Jurisdictions*, would prove extremely useful for this purpose. Also using existing information to the fullest extent would enable decision makers to have a more comprehensive view of these cases.

Discussion

Numerous individuals in numerous agencies are called upon daily to make immediate decisions in domestic abuse cases, any one of which may turn into the next domestic homicide. Each domestic homicide carries enormous implications, not only for the immediate family, but for the community as a whole. The Review Teams believes that a substantial investment in infrastructure is necessary to deliver

sufficient information to decision makers — this could save numerous lives. Consequently, it strongly supports current legislative efforts to develop both MNCIS and CriMNet. Both are statewide integrated information systems — MNCIS for court information and CriMNet for other justice system data — currently in the process of development.

Even if everything goes according to plan in developing these information systems, it will be several years before they are fully implemented. In the meantime, all individuals within the justice system who come into contact with domestic abuse cases must aggressively seek out information that paints a broader picture of these cases. While individual incidents in a few of the cases foreshadowed increasing levels of danger it was only when the Team put the cases into historical context that the "red flags" became obvious.

Prior Threats to Kill

Case Observations

- On ten separate occasions the perpetrator tells the victim he is going to kill her. He carries out the threat on Christmas.
- A victim sets up an elaborate signaling system with the relative who picks her up for work. She does so because the perpetrator has threatened to kill her dozens of times in the preceding days. She is afraid he will be lying in wait for her when she leaves her residence. She is right.

Findings

Victims, and in some cases their children, were repeatedly threatened that they would be killed. The threats occurred before the actual homicide. These victims lived in terror yet did not get a response from the justice system commensurate with their fear or the very real risk presented.

Opportunities for Intervention

- **Increase the attention paid by the justice system to perpetrators' repeated threats to kill.** This would provide an opportunity to address victim safety and offender accountability.

Discussion

In all but one of the nine cases, perpetrators repeatedly threatened to kill their victims and oftentimes the victim's families. Since it didn't appear that justice system treated these cases more seriously as a result of the threats, the Team questioned whether threats to kill were so common in domestic abuse cases that they did not prompt a significant reaction. While no information is available on how often threats to kill are made in nonlethal cases, domestic homicide researcher Neil Websdale notes that in his research on domestic fatalities in Florida, threats to kill the victim emerged as one of the principal antecedents to lethal domestic assaults. [3]

Weapons

Case Observations

- A perpetrator threatens the victim with a knife. The perpetrator is arrested and the knife is inventoried but the case is not referred for felony charges because the victim has no injuries and the knife was not actually "used" by the defendant.
- A victim repeatedly tells police that the perpetrator is threatening to shoot her and that she believes he has a gun. Despite the fact that an Order for Protection is in place it does not appear than an effort was made to locate and remove the perpetrator's weapons. The victim is killed with a handgun.

Eliminating the perpetrator's access to the weapon would also eliminate one of the tools possessed by the perpetrator to control and terrorize the victim and her family.

Findings

Deaths resulted predominantly from gunshot injuries. In six of the nine cases a gun was used to kill the victim(s). In the seventh case a knife was used, in the eighth case a vehicle, and the ninth homicide was the result of strangulation.

Opportunities for Intervention

- **Remove weapons pursuant to an Order for Protection or conditional release order. Also remove weapons when police become aware that weapons are involved in a criminal act** to separate the perpetrator from his murder weapon. Eliminating the perpetrator's access to the weapon would also eliminate one of the tools possessed by the perpetrator to control and terrorize the victim and her family.
- **Institute a policy wherein any use of a gun or weapon would initiate felony protocol at the scene and in follow-up investigation.** This would provide important documentation to support the charges or perhaps support higher level (felony or gross misdemeanor) charges. (Also see section on *Correctly Responding and Documenting the Severity of a Domestic Assault*.)
- **Use the federal law which prohibits persons who are subject to an Order for Protection from possessing a gun** to open more opportunities for prosecution. Or, enact a state law, consistent with the federal law requiring that weapons be surrendered when an Order for Protection is in effect, to make it more likely that a means of routinely seizing weapons is created within state court. Currently, federal authorities are able to prosecute only the most egregious cases of weapons possession.
- **Establish routine court procedures for the review of weapons possession in domestic violence-related cases** to assist in removing weapons from perpetrators.

Discussion

References to weapons were abundant in the cases examined by the Review Team. Members were concerned that there did not appear to be a consistent policy among law enforcement agencies for addressing the presence of a weapon when the weapon was not used in the assault. Confusion appeared to be prompted by how to define "used." The result of the confusion meant that some cases were treated as misdemeanors when they could have qualified for felony prosecution.

In addition, court records did not reflect a routine effort to separate perpetrators from their weapons despite a federal law that makes it illegal to possess a gun after being convicted of domestic assault or during the time the respondent is subject to an Order for Protection.

Several Review Team members recalled being part of committees that discussed the implementation of the federal law when it became effective. Their recollection was that little has been done to make use of the law because law enforcement agencies are neither financed nor equipped to handle the large inventory of weapons they would receive. Many OFP respondents would be entitled to have their weapons returned after the OFP expires. Consequently, law enforcement agencies would need not only space, but staff and a method to inventory and return the weapons to their owners. In addition, because federal prosecutors were not staffed to prosecute the potentially large number of possession violations, perpetrators would have little incentive to turn over their weapons. Furthermore, Hennepin County Family Court allows OFP's to be issued without the respondent admitting guilt as long as he doesn't contest that the order should be put into effect. Making this option available to respondents avoids many contested hearings, which makes the process somewhat easier for the petitioner and saves hundreds of hours of court time. It is likely that requiring the respondent to turn over weapons under this circumstance would lead to a dramatic increase in contested hearings.

Despite the considerable obstacles to removing weapons, Review Team members believed that such efforts may prevent deaths. In three of the six homicides committed with a gun, perpetrators would have been subject to a demand to turn over weapons under federal law.

Situations Involving Children

- Children as Witnesses
- Using Children to Gain Access to Victims

The sections in this category address the particular issues that surround children's exposure to domestic violence and the use of children by perpetrators to gain power and control over their victims.

Children as Witnesses

Case Observations

- Children witnessed homicides in at least three of the nine cases. In one of these cases an unborn child was also murdered. In a fourth case it is believed that the children witnessed the murder but they were too young to describe what they had seen. In a fifth case, children themselves were murdered by the perpetrator.
- Children were actively involved in attempting to protect their mothers, oftentimes calling police, running for help, or attempting to intervene in assaults. In some instances those interventions led to minor, but observable, injuries to the children.
- A shelter's policy to exclude older boys made it difficult for one victim to find emergency shelter for herself and her family.

Findings

In the cases reviewed, children were largely invisible witnesses to and victims of domestic violence. Police reports often did not document their presence and the children were not often called upon by prosecutors to testify to the perpetrator's abuse. It was only *after* the homicide that it became apparent that children were at the scene of domestic assaults that occurred prior to the homicide. It also appeared to the Review Team that very little was done to provide services, particularly psychological services, to the children following the homicide. It is possible that services were provided but were not documented by the agencies working with the children, making it impossible for the Review Team to examine what was done.

Visions of children . . . crawling along the floor with the lights out for fear of being seen through a window by a mother's ex-boyfriend, leaving bicycles "just so" in front of an entry door in order to detect whether the perpetrator had entered the home while they were gone .

Opportunities for Intervention

- **Establish a protocol for assessing and documenting the involvement of children found at the scene of domestic assaults, and determining whether children may be victims or witnesses.** This would assist in the collection of corroborating information and would increase the likelihood that charges against the perpetrator would include separate counts for child victims where appropriate. Such a protocol should take advantage of research in the child abuse area, which indicates that children should be interviewed only once, close in time to the incident, by an interviewer with training in child development to insure maximum reliability of the child's statement.
- **Provide services to child witnesses** such as support at the scene to address fear and trauma, referral to counseling, and safety planning to assist in addressing children's needs.[4] Such services should be developed in consultation with battered women's programs.

Discussion

The cases involving children were haunting. Visions of children attempting to intervene to protect their mother from a perpetrator's assault and in doing so being struck themselves, crawling along the floor with the lights out for fear of being seen through a window by a mother's ex-boyfriend, leaving bicycles "just so" in front of an entry door in order to detect whether the perpetrator had entered the home while they were gone, all painted an extraordinarily troubling picture of the terror that permeates every aspect of these young lives.

As troubling as the scenarios themselves, was the fact that it was not routine to use what the children had seen and experienced as a victim or witness to support action against the perpetrator. In addition, our interviews with surviving family members prompted the Review Team to be concerned about the availability of follow-up services to children who had witnessed such gruesome events. Some family members questioned whether or not the children were getting the best possible care at the placements they were sent to after the homicide. Others documented the hardships involved when older (but still very young) siblings are left to raise their younger siblings while at the same time trying to obtain a college degree. The Review Team found these children's stories very disturbing since none of the documents it obtained contained any information about additional services that were provided to the children or their families once they had been placed in new custodial care after the homicide.

Using Children to Gain Access to Victims

Case Observations

- A perpetrator takes his victim's five-week-old infant after assaulting the victim twice on the same day. While police are at the scene they answer a call from the perpetrator. The perpetrator tells them he will not return the infant unless the victim talks to him. The perpetrator is the non- adjudicated[5] father of the child. Police take no action to locate him or to charge him with kidnapping.
- A perpetrator takes his victim's three month old daughter and refuses to return her. The victim agrees to meet with him in order to get her daughter back. He sexually assaults her.
- A perpetrator tells a friend, "She's had my kid, she's gotta deal with me now."

Findings

Perpetrators frequently use children to control their victims. Several assaults occurred during the pickup or drop-off of a child at the victim's home. In other cases perpetrators took children without the victim's consent and threatened not to return them. Victims allowed perpetrators access to children even when they had no legal right to such access because they were afraid of what would happen if they didn't.

. . . it is very important for law enforcement officers to have a keen understanding of custody and visitation issues, not only for giving accurate advice to victims, but also for reacting appropriately to situations which may qualify as child abductions.

Opportunities for Intervention

- **Use sites other than victim's homes for visitation and exchange of children,** such as visitation centers. This would increase safety and limit children's exposure to violence. Judges and referees should pay particular attention to the safety of the victim and children when issuing Orders for Protection.
- **Conduct classes on visitation, custody, and paternity at shelters to provide another opportunity** to educate victims and reduce their vulnerability.
- **Create brochures (in several languages), describing paternity, custody and visitation rights.** This would decrease victim's susceptibility to manipulation by their abuser by increasing their understanding of their rights, and the perpetrator's rights regarding their children. The brochures should be available at shelters, advocacy programs, emergency rooms, maternity wards and physician's offices.
- **Train law enforcement on the rights of adjudicated and non-adjudicated parents** to enable officers to give accurate advice to victims regarding the perpetrators rights to the child. This would help assure that officers don't inadvertently assist in the manipulation of the victim and also would prepare them to take appropriate action against perpetrators.

Discussion

The number of assaults occurring during visitation indicates the danger such situations present to victims. It was disturbing to observe perpetrators using children like hostages in order to control and terrify their victims. In appeared that victims in these situations were not always aware of the rights they had to keep children from perpetrators who were not adjudicated parents. It became obvious that it is very important for law enforcement officers to have a keen understanding of custody and visitation issues, not only for giving accurate advice to victims, but also for reacting appropriately to situations which may qualify as child abductions. Likewise, judges and referees need to be extremely mindful of the safety issues involved in any order for protection but particularly those involving children.

Justice System Performance

- Justice System Resources
- Cases Involving Multiple Jurisdictions
- Domestic Violence Victims Charged with Crimes
- Orders for Protection

The sections in this category focus on how the justice system assigns resources to address the issue of domestic violence as well as how it responds to the victims of domestic violence.

Justice System Resources

Case Observations

- A perpetrator breaks a victim's jaw three days prior to the homicide. Because the extent of the injury is not apparent, the police treat the case as a misdemeanor, meaning that they don't do a follow-up investigation. Only when the victim calls police, three days later, to tell them her jaw is broken do they upgrade the case for felony investigation. The perpetrator spent those three days terrorizing the victim and her family. He ultimately killed a friend of the victim's sister in an attempt to kill the victim.
- One perpetrator was charged with 10 domestic assault related misdemeanor crimes in Hennepin County over a five year period. The assaults involved two women, one whom he ultimately killed. This is one of several cases that exhibited significant numbers of misdemeanor assaults with little or no indication that those making decisions about how to proceed with arrest, charging, custody and other critical decisions, had a complete picture of of the level of risk posed by the perpetrator.

. . . so much of the information that was gathered after the homicide would have been very helpful to system professionals had it been gathered and used when the perpetrator first appeared in the justice system. . .

Findings

Currently very meager resources are devoted to misdemeanor domestic assault investigation and prosecution when compared to the resources dedicated to investigating and prosecuting the case after the homicide.

Opportunities for Intervention

- **Bolster the resources devoted to misdemeanor investigation and prosecution.** This would increase the opportunity for intervention and prevention by investing justice system resources "up front" i.e., investigating and prosecuting misdemeanor cases, enforcing orders for protection, and preparing thorough defendant pre-sentence investigations, among other things. It would also mean the domestic assault cases would be handled as the potential homicides they are. The first offense is the best opportunity to change the perpetrator's behavior.

Discussion

Having the ability to look at records which reflected a complete, or at least substantial, case history gave Review Team members a powerful perspective on the resources that had been devoted to addressing criminal activity in these cases prior to the homicide. The Team was astonished and saddened to find that so much of the information that was gathered after the homicide would have been very helpful to system professionals had it been gathered and used when the

perpetrator first appeared in the justice system or when the victim first accessed the system by requesting an Order for Protection.

For several years the domestic violence community has noted the need for the justice system to be more aggressive and more thorough during the defendant's and/or victim's first contacts with the court system. Such a change, however, will require significant adjustments within many agencies. With current budgets being slashed, it will be difficult for justice system agencies to maintain their existing level of service, let alone add discretionary preventive efforts. Review Team members believe that's what should be done, however, noting the cost differential between investigating and prosecuting a misdemeanor versus the cost of investigating and prosecuting a homicide. They also noted the cost involved in finding homes for and caring for children who were left without a parent to care for them. And further, the cost to society for these children who often turn to violence and or drug and alcohol abuse as a way to cope with their tragic past.

In 2000 the average court cost[6] for a serious felony, such as homicide, aggravated robbery and criminal sexual conduct, was $1,521.74.[7] The cost for a misdemeanor assault case was $117.39. The cost for a felony homicide trial was $3,125.19 and for a misdemeanor trial, $1,117.39. Aggressively dealing with perpetrator's on their first misdemeanor offense has the potential to save thousands of dollars in court costs alone.

Bolstering the resources devoted to misdemeanor investigation and prosecution would serve another important function. It would create a safety-net when incorrect decisions are made about whether or not a case qualifies for felony prosecution. The thin line between misdemeanor and felony levels of offenses results in vastly differing resources devoted by the justice system to the two levels of offenses. Even very capable law enforcement officers and prosecutors can make the wrong decision about the level of charging. The Review Team observed that victims paid a very high price when that happened.

Cases Involving Multiple Jurisdictions

Case Observations

- A perpetrator arrested in one county is transported to another in response to three traffic bench warrants. Two other counties have requested that the defendant be held if stopped or arrested. However, the defendant is released after appearing and being sentenced on the traffic warrants. He murders the victim the next day.
- A perpetrator who is charged for two domestic assaults against the victim while in a non-metro county does not appear for either case. No warrants for nonappearance are issued. The perpetrator subsequently has contact with metro-area police when he and the victim are arguing over property. Police transport him away from the scene but do not arrest him since there are no warrants outstanding. He murders the victim four days later.
- A perpetrator kidnaps two victims at gunpoint. At the time of the kidnapping the perpetrator indicates the location where he is taking the victims. This location is in a jurisdiction nearby. The police in the jurisdiction where the kidnapping takes place are notified through a call to a non-emergency number that the perpetrator and victims are headed to a new jurisdiction. Law enforcement in the new jurisdiction receive their first information about the case after the homicide occurs.

In seven of the nine cases, the perpetrator had a significant criminal history in one jurisdiction which appeared to be unknown to agencies responding to additional incidents in another jurisdiction.

Findings

In seven of the nine cases, the perpetrator had a significant criminal history in one jurisdiction which appeared to be unknown to agencies responding to additional incidents in another jurisdiction. In addition, when an investigation crossed jurisdictional lines, there were system failures at many levels. Often, the crossing of jurisdictional lines indicated both increased frequency and intensity of violence just prior to a homicide. Thus, the lack of protocols and resulting delays occurred at critical times. This led the Review Team to conclude that when cases cross jurisdictional lines there are frequent breakdowns in the exchange of information, or the ability to easily access information, that result in a less than ideal response to the case. In addition, when looking at active case scenarios (not criminal history), any time a jurisdictional boundary was crossed there was a system failure.

Opportunities for Intervention

- **Develop a state-wide domestic violence law enforcement initiative which would serve as both a clearinghouse for information and an investigative unit.** This would make information on perpetrators readily available to all justice system agencies. Such an initiative could be comprised of representatives from County Sheriff's Departments and the Bureau of Criminal

Apprehension, who would, among other things actively promote the availability of investigative assistance and crime lab resources to areas without specialized domestic assault investigation units. This Task Force would also assist in tracking domestic abusers who commit crimes across jurisdiction and would facilitate the exchange of information with other states. As part of the initiative, sheriffs and county attorneys would conduct in-service training for police detectives on methods of cross-jurisdictional information gathering.

- **Establish a policy for all jurisdictions to routinely issue warrants for nonappearance.** This is an important way to notify law enforcement agencies about criminal activity in other jurisdictions.

Discussion

The Review Team believed that actions taken, particularly by law enforcement agencies, prosecutors, and judges would have been different if those agencies had had immediate access to information about the perpetrator's history in other jurisdictions. Such information may have lead to a more aggressive approach to the case. Decsions that may have been affected include, efforts to locate the perpetrator if he was gone when police arrived, referral for felony prosecution, the amount of bail, offers in plea negotiations, and length of sentence.

The consistency with which warrants for non-appearance are issued also received scrutiny by the Team. In some instances, usually in jurisdictions where the perpetrator appeared to be transient, warrants were not issued when a perpetrator failed to appear for court. The ability for law enforcement to access that information on a routine contact may have led to an intervention that prevented a death.

(See also section entitled *Perpetrators' Criminal Histories.)*

Domestic Violence Victims Charged with Crimes

Case Observations

- A victim who is routinely brutally beaten and terrorized by her perpetrator is charged with two property crimes, offering a forged check and shoplifting. She reports having no food, clothes or diapers for the baby she had in common with the perpetrator. She is aggressively prosecuted.
- A victim is charged with Driving Under the Influence after she drives to a SuperAmerica to report that she has just been assaulted. She serves 20 days in the workhouse for this offense. The perpetrator in this case is charged with 10 domestic assault related offenses over a five year period. For the ten cases combined he is sentenced to 63 days in the Adult Correctional Facility, only 22 of those days are spent in custody, the remainder are on electronic home monitoring with work privileges.

A victim is charged with Driving Under the Influence after she drives to a SuperAmerica to report that she has just been assaulted. She serves 20 days in the workhouse for this offense. The perpetrator in this case is charged with 10 domestic assault related offenses over a five year period.

Findings

In two of the nine cases reviewed, the victims, both women, were charged with crimes during the course of their relationships with the perpetrators. Both women were aggressively prosecuted for their offenses, however, it appeared that the justice system did nothing to address the fact that they were victims of domestic violence.

Opportunities for Intervention

- **Assess all female offenders to determine if they are victims of domestic abuse.** This would provide opportunities for intervention and safety planning for individuals for whom such services are not currently available.
- **Expand domestic violence programming through probation or the workhouse** to create greater opportunities for women whose victimization might otherwise be overlooked by the criminal justice system.
- **Offer many opportunities for women to safely identify themselves as victims of domestic violence.** This could increase the likelihood that women will avail themselves of support services. All government agencies should offer ample opportunities for women to report victimization as should doctor's offices, schools and day care centers.

Discussion

Review Team members who have worked with female offenders noted that many of these women are also victims of domestic violence. They believed that procedures are not currently in place to routinely identify and offer services to these victims. This may be because crimes committed by women are most often nonviolent. Consequently, rather than being under the personal supervision of a probation officer, they are assigned to group reporting or administrative monitoring where they do not receive the type of one-on-one supervision that would be more likely to result in an individual assessment of the factors influencing their lives.

Orders for Protection

Case Observations

- A perpetrator is served with an Order for Protection. He tells his friends and coworkers that as a result his life has been ruined and that he believes he is going to jail. Three days later he murders the petitioner, who is his ex-girlfriend, and then commits suicide.
- A domestic violence victim (of a perpetrator who ultimately murders another victim) receives an Order for Protection and aggressively holds her abuser accountable for violations of the order by reporting to police all of the perpetrator's contact with her. He is charged five times with Violations of an Order for Protection and pleads guilty to three of the charges. In each of the three cases he is placed on electronic home monitoring. He is removed from electronic home monitoring and sentenced to serve 16 days in the Adult Correctional Facility only after he commits a non-domestic disorderly conduct offense.
- An Order for Protection allows the perpetrator to visit his child at his victim's home. He murders his victim while returning the daughter to the home after a visitation. The Order for Protection had expired in this case, although it appears that the victim believed it had been extended.

Findings

An Order for Protection (OFP) does not necessarily confer actual protection to the victim of domestic violence. Orders for Protection were in place at the time of the homicide in three of the nine cases reviewed. The murders in each of these cases took place less than ten days after the perpetrator was served with the OFP. It appeared that the service of the OFP may have been a triggering event in at least two of the three cases. OFP's were in effect at some point in the history of three of the remaining six cases, but had expired at the time of the homicide. Consequences for violations of those OFP's were minimal.

Orders for Protection were in place at the time of the homicide in three of the nine cases reviewed. The murders in each of these cases took place less than ten days after the perpetrator was served with the OFP.

Opportunities for Intervention

- **Treat violations of protection orders seriously.** Make every effort to arrest the perpetrator and increase consequences for each additional offense. This would send a clear message to perpetrators that the court holds accountable those who disregard its orders.
- **Make the safety of the victim and children the primary consideration in determining custody and visitation in OFP's.** Limit or deny access to children when necessary. Whenever possible, use visitation centers to exchange children. This would reduce the victim's exposure to the perpetrator and consequently may reduce her risk. (This opportunity for intervention is also included in the section entitled *Using Children to Gain Access to Victims*.)
- **Encourage advocates and advocacy agencies to remain diligent in notifying victims of the potential for increased risk after the OFP is served.** This was not an issue in the cases reviewed. However, occasionally reemphasizing the importance of routine procedures would help assure that all victims have a heightened awareness of

the need for comprehensive safety planning at the time the OFP is served and the period thereafter.

Discussion

It has become a fairly well-known fact that the most dangerous time for the victim of domestic violence is when she attempts to separate herself from the perpetrator. This was clearly borne out in the cases reviewed by the Team and was a particularly frustrating issue since Team members recognized the importance of the protection order process, but at the same time were confronted with the fact that in some instances it may actually increase the risk to the victim. Since the Team was only looking at homicides, members needed to remind themselves that thousands of Orders for Protection are issued each year that are very effective in achieving their purpose.

Of the issues discussed regarding the OFP process, the Team believed that the most important improvement could come from the seriousness with which violations of Orders for Protection are treated by the justice system. The cases reviewed reflected lenient treatment of repeat violations. The Team also noted that the issue of child visitation created significant risk factors for victims and therefore encourages the court to put victim and child safety consistently first and foremost in visitation decisions. It also believed that keeping perpetrators away from victim's homes by using visitation centers when exchanging children may reduce the risk to the victim as well as reduce the exposure of children to domestic violence.

Finally, the Team believed it should reemphasize the need for impressing upon the victim the potential for increased risk as a result of the Order for Protection. It is important to note that this did not appear to be lacking in the cases reviewed. However, those working with domestic violence victims go through a host of routine procedures each day in order to assure victim safety. The Team believed that for the benefit of those assisting victims with the protection order process, it was important to draw attention to a procedure that is particularly critical to victim safety.

(See also the section entitled *Weapons* for additional issues related to the OFP process.)

Treatment and Mental Health Issues

- Chemical Dependency Issues
- Homicide/Suicide Cases

The sections in this category address the complex issues presented when mental health and chemical dependency are intertwined with domestic violence.

Chemical Dependency

Case Observations

- A perpetrator was using drugs while on electronic home monitoring. The prior year the same perpetrator had three relapses while in a court ordered relapse program.
- A woman was killed within days of telling her husband that he needed to seek residential treatment for his alcoholism in order for her to move back into their home.
- At the time of death in one case, the victim's blood alcohol level was .30, and the defendant's was .22.

Findings

Addiction to drugs and alcohol by the perpetrator and/or the victim, was documented in five of the nine cases reviewed. (Documentation pointed to chemical use in other cases but the extent of use was unclear.) The addiction persisted and was unchecked even when the perpetrator or victim had contact with the criminal justice system for an alcohol or drug related offense. It also persisted when the perpetrator or victim privately sought help from health care professionals.

. . . there may be a correlation between the use of alcohol and drugs and lethal violence.

Opportunities for Intervention

- **Consider the issue of chemical dependency as a factor in each domestic assault case.** This would encourage agencies to increase their level of awareness of the complexities of this problem as it relates to domestic violence.
- **Complete a chemical dependency assessment as part of all domestic assault cases.** This would enable the justice system to better identify and prescribe treatment for offenders.
- **Extending the turnaround time for domestic abuse pre-sentence investigations.** This would allow for more careful assessment of chemical dependency issues.

Discussion

The identification of chemical dependency as a concern in these cases prompted a lengthy debate among Review Team members. Those who worried about including it felt it would promote the uninformed stereotype that domestic violence occurs only among dysfunctional alcoholics and drug addicts. They also felt it would promote the myth that drug and alcohol addiction *causes* domestic violence, when in fact curing a perpetrator's chemical addiction alone will not necessarily stop his propensity to batter.[8] It has been a long and frustrating battle — particularly for domestic abuse advocates — to educate the justice system and the community on these points.

Ultimately however, members agreed to include the observation for the following reasons. First, they were greatly concerned about the justice system's inability to hold perpetrators accountable for treatment when chemical dependency issues had been identified as the result of a criminal matter prior to the homicide. Second, while they knew that chemical abuse didn't cause domestic violence, they believed that there may be a correlation between the use of alcohol and drugs and lethal violence. Third, they observed that drug and alcohol use on the part of the victim inhibits her ability to protect herself from the perpetrator and may in fact increase her dependence on the perpetrator. Lastly, they noted that studies have shown that it is difficult to address domestic abuse issues in treatment unless the therapy also deals with chemical dependency issues.[9] For these reasons, the Review Team believed that effectively addressing the issue of drugs and alcohol in these cases may have saved lives.

Homicide/Suicide

Case Observations

- A perpetrator is admitted to a hospital for suicide evaluation. The murder/suicide occurs less than three weeks later.
- A perpetrator sought help for depression and other mental health issues over a period of several years. He later killed the victim and himself.

Findings

In three of the nine cases reviewed the perpetrator killed the victim and then himself. In one of the three cases, the perpetrator was hospitalized for suicide evaluation less than three weeks prior to the homicide/suicide. In two other cases reviewed, the perpetrators did not kill themselves but made indirect suicide threats prior to killing their victims. While some perpetrators sought help from mental health professionals, mental health and mental illness issues were largely undiagnosed and untreated in perpetrators.

Opportunities for Intervention

. . . mental health and mental illness issues were largely undiagnosed and untreated in perpetrators.

- **Recognize that suicide threats are often an antecedent to homicides.** This would assist justice system professionals, community advocates, mental health professionals, health care professionals and domestic violence victims in determining the level of risk posed by the perpetrator.
- **Establish a task force of psychological service providers, domestic abuse advocates, data privacy specialists, and Review Team members to discuss domestic homicide/suicide cases.** In particular the task force would discuss the appropriateness of developing an assessment tool and protocol to guide professionals when making diagnosis and treatment decisions when dealing with perpetrators of domestic violence.
- **Routinely ask victims of domestic violence about suicide threats by the perpetrator.** This would provide important information for purposes of safety planning for the victim.

Discussion

The discussion of the homicide/suicide cases brought up two important issues for the Review Team: using the threat of suicide as indication of lethality, and the extent to which mental health and mental illness are addressed in perpetrators by both justice system and treatment professionals.

Potential Lethality

In his paper "Lethality Assessment Tools: A Critical Analysis" Neil Websdale states, "The absolute distinction between lethal and non-lethal cases is a false dichotomy; rather there is a range or continuum of violence and entrapment that underspins abusive intimate relationship. Indeed, it would be far more appropriate and useful to employ the term "dangerousness" rather than 'lethality' assessment."[10] He goes on to point out however, that studies conducted by himself and others show that victims are often at increased risk when the perpetrator threatens or attempts suicide. For that reason, and because of the information supported by the case reviews, the Review Team believed that raising the level of awareness about perpetrator suicide would be a helpful intervention tool.

Review Team members believed that suicide threats may actually be taken less seriously by justice system professionals and others in the context of domestic abuse cases than they are in other situations. They hypothesized that this results because many people believe that perpetrators often make empty threats to kill themselves in order to keep their victims in the relationship.

Mental Health and Mental Illness

It's virtually impossible to discuss homicide/suicide cases without addressing the issue of mental health and mental illness on the part of the perpetrator. In two of the three homicide cases examined by the team perpetrators had been treated for mental health issues. No documents related to the perpetrator's mental health were located in the third case.

As in the case of chemical dependency, Review Team members were concerned that mental health and mental illness issues be considered separate from domestic violence, since there is not a cause and effect relationship. Treating mental health and mental illness will not solve battering but it's very difficult to address battering without also addressing issues of mental health and mental illness.

The Review Team had lengthy discussions about psychological services provided to perpetrators and the extent to which those services took into consideration the potential risk to family members. The mental health professionals involved with the Review Team emphasized the importance of developing a trusting relationship with a client and therefore not investigating or second guessing what was being reported to them by the client. However, since homicide/suicide cases are more likely to involve perpetrators with little or no criminal history, but instead a mental health or mental illness history, exploring ways for mental health professionals to prevent homicides in these cases without compromising their relationship with their clients would be particularly beneficial.

Other Opportunities for Intervention

- Treatment Services to Perpetrators
- Training on Findings of Review Team
- Statewide Fatality Review

This section includes two types of opportunities for intervention: One that needs further study and discussion (Services to Perpetrators) and the other, those that are not specific to case observations (Training on Findings of Review Team and Statewide Fatality Review). Because these sections are not specifically case related they do not appear in the same format as those in prior sections.

Treatment Services for Perpetrators

Discussion

Despite several attempts, Review Team members could not reach consensus on this issue. There were nearly as many opinions as there were Team members and they covered the spectrum from using no resources for treatment services since treatment did not work, to providing treatment — along with consequences — for each offense.

The fact that such disparate opinions were so strongly held made a forceful statement about the need to focus attention and hold discussions on this topic.

While members disagreed on the extent to which treatment should be used and was successful there was agreement on one thing: the current practice for making determinations to send a batterer to treatment has serious shortcomings. To address this concern the team concluded that the concept of using treatment to reduce battering needs to be approached differently in order to garner the trust and confidence of those outside the treatment community.

The team believed that the following ideas for changes to existing practice have the potential to develop greater confidence in the process and foster more agreement on this topic.

Possible Opportunities for Intervention

- **Rely on a risk assessment and/or a psycho-social assessment instead of a plea negotiation process** to determine the appropriateness of treatment for batterers. This would ensure that batterer's treatment needs are met.

- **Recognize the important difference between jail time as part of a sentence and expectations to complete treatment as part of probation conditions.** This would allow for the imposition of jail time to be understood in relationship to the violent act itself and treatment to be employed as a corrective means to address the individual's participation in battering behavior instead of being a sanction. One approach should not mitigate the other.

- **Define successful completion of batterer's treatment as no further acts of domestic violence** as opposed to simple completion of a designated number of treatment sessions.

- **Create outcome measures to determine if program participants return to violent behavior.** This would determine whether or not a program is meeting its intended goals and serving as a viable referral option.

- **Tie funding to demonstrated specific outcome expectations.** This would enable funding sources to consider the effectiveness of programs when granting financial assistance.

- **Differentiate the strengths of the various batterers treatment programs to determine which program can best meet the needs of individual participants.** This would help avoid a "one size fits all" approach to treatment and would better enable a triage-type method for treating batterers.

Agency Training on Findings of Review Team

Discussion

Similar to the problems observed by the Review Team when criminal activity crossed jurisdictional boundaries, the Team observed missed opportunities for intervention when several agencies were interacting with the family. This was a challenging area for the Review Team because it was difficult to identify specific opportunities for intervention. To do so would involve understanding the specific policies and procedures of dozens of agencies such as hospitals, mental health clinics, and schools. This was not feasible during the short period of the pilot project.

While the Team generally believed that to identify training as an opportunity for improvement was a compromise, in this area it appeared to be a reasonable option, since the training could be specifically tailored to the interests of each agency.

Opportunity for Intervention

- **Conduct training or information sessions with personnel in the fields of medicine, criminal justice, mental health, education, advocacy and child protection, among others, about the findings and observations of the Review Team.** This would enable the Team to present information that goes beyond that presented in the report and to tailor it specifically to the interests of each agency.

Statewide Review Teams

Discussion

While this project was focused on reviewing cases arising only out of Hennepin County, Team members were very aware of the troubling statewide domestic homicide statistics, and often talked informally about cases from other jurisdictions. Given the enthusiastic commitment to this project by the Hennepin County Team and the benefits they credit to the process, members believed that other jurisdictions would find this to be a valuable process as well. Several Team members expressed their willingness to provide technical assistance to other jurisdictions which are interested in establishing the fatality review process.

Opportunity for Intervention

- **Annually conduct at least one fatality review in each judicial district.** This would add to, and thereby strengthen, the information available about potential opportunities to preventatively intervene in these cases. Such information could play an important role in crafting legislation, establishing funding priorities and developing new ideas to prevent these tragedies.

Reasons to Have Hope

The Review Team is hopeful that this report will inspire many improvements in the way the justice system and others handle cases of domestic violence. However, it can be overwhelming and depressing to review a report of this nature — page after page of tragic case details and lists of changes that need to be made in order for lives to be saved. But there are reasons to have hope. During the short period of the pilot project agencies made changes in policy, procedure and staffing as a direct result of the case reviews. At a minimum such changes will result in improved case management and ultimately may save lives.

"It's not that we didn't see these issues before, it's just that now we see them with a new sense of urgency. The review process focuses attention on what these cases can become." Deputy Minneapolis City Attorney, Review Team Member

One of the most significant improvements came as a result of the Review Team's findings concerning the misclassification of cases at the scene, i.e. identifying cases as misdemeanors that actually met the standard to be prosecuted as felonies. The Deputy Minneapolis City Attorney in charge of the Criminal Division who sat on the Review Team stated, "By the time we got to our third case and saw that each one had involved a misclassification of a case at the scene just prior to the homicide, I was highly motivated to act immediately. I was determined that we were going to fix this now." She worked with the County Attorney representative and the Lieutenant in charge of the Minneapolis Police Family Violence Unit to address the issue. Together they developed a plan to have a City Attorney located within the police department to review all domestic case reports from the previous day for the sole purpose of appropriately classifying them for prosecution. The attorney would work closely with supervisors in the Family Violence Unit to determine how cases should proceed. They sought and received a grant to fund the position, which is now operational.

This is a clear example of the powerful impact of review teams. The misclassification of cases at the scene has concerned those working in the area of domestic violence for some time, but discussion about the issue was often done in the abstract. The review process enabled the Team to distinguish how critical the issue is to victim safety and provided strong documentation for the need to fund an effort to address the problem.

"As a result of my participation on the Review Team I approach the domestic violence victim with much greater concern for her life as well as her overall welfare due to a much greater appreciation for the lethality of domestic violence. " Emergency Room Physician, Review Team Member

The Minneapolis City Attorney's Office has made other changes as a direct result of the Fatality Review Process. One very specific change is that the office asks every victim for the name of a trusted contact, someone they are safe to call if they can't reach the victim directly. This results from cases reviewed in which it was very clear that everyone close to the victim knew what was going on and knew that the risk to the victim was high. The criminal justice system, however, was totally unaware of the dire nature of the case. The City Attorney's Office hopes to use these individuals not only to assist in contacting the victim but also as a source for additional information and evidence to support prosecution.

The office also is focusing more intently on the level of dangerousness presented by domestic assault cases. The Deputy is certain that lives were saved in at least one case that occurred during the period of the pilot project. She states, "It's not that we didn't see these issues before, it's just that now we see them with a new sense of urgency. The review process focuses attention on what these cases can become. I

find myself asking, 'Did I do everything possible to make certain that this case doesn't turn into a fatality?'"

Other Review Team participants have noted changes in their response to domestic violence cases as well. An emergency department physician has tested a different approach in talking with victims of domestic assault who require medical attention. A homicide detective says he is asking more questions and gathering more information at the scene of domestic homicide/suicide cases. Judges on the Team state that they consider the danger of strangulation and suicide threats when setting bail. They also note that they have a heightened awareness to other "red flags" revealed in the cases reviewed. Many Review Team members find themselves asking the question "Is this our next case? What can I do, or advise be done, to prevent a death?" These are questions the Team hopes will be in the minds of key decision makers after reading this report.

Endnotes

[1] Minnesota Coalition for Battered Women, "1989-2001 Femicide Report." www.mcbw.org/femicide, 2001.

[2] The Chicago Women's Health Risk Study examined several thousand non-fatal domestic incidents and 87 domestic homicides. The report indicates that one of the risk factors for the fatal incidents was that they were much more likely to involve the woman being choked. "The Chicago Women's Health Risk Study at a Glance." Illinois Criminal Justice Information Authority, 2000. www.icjia.state.il.us/public/index.cfm

[3] Websdale, Neil. "Lethality Assessment Tools: A Critical Analysis." www.vaw.umn.edu/Vawnet/lethality.htm, 2000.

[4] Several articles on the impact of domestic violence on children can be found at the website for the Minnesota Center Against Violence and Abuse. www.mincava.umn.edu/vaw.asp#A101090300

[5] The term "adjudicated" refers to the establishment of a relationship recognized under the law. The court establishes this relationship in paternity actions brought under Minn. Stat. sec. 257. In addition, the legislature has created a process whereby the parents can sign a "Recognition of Parentage" (ROP) and establish a legal relationship. The ROP can be used to create a support obligation but cannot be used to automatically establish custody and visitation. It does, however, allow a father to start a custody or visitation action without bringing a paternity action to establish his relationship to the child. This is addressed in Minn. Stat. sec. 257.75. If paternity has been recognized under this section, the father may petition for rights of visitation and custody in an independent action under Minn. Stat. sec. 518.156. Custody and visitation cannot be established under an Order for Protection. The respondent is required to file a separate action. www.leg.state.mn.us/leg/statutes.htm

[6] Court costs include salaries for judges, clerks, court reporters, interpreters among other operational costs. They do not include administrative costs such as expenses for managers, supplies, equipment, and facilities. They also do not include the cost for criminal justice professionals such as prosecutors, defense attorneys and probation officers. "2000 Costs of Different Case Types in Hennepin County District Court." June 15, 2001.

[7] Dollar figures in this section come from the Hennepin County District Court Research Department - "2000 Costs of Different Case Types in Hennepin County District Court." June 15, 2001.

[8] Both substance abuse and woman abuse are primary problems which have an important but indirect relationship. Bennett, Larry, Ph.D. "Substance Abuse and Woman Abuse by Male Partners." www.vaw.umn.edu/finaldocuments/Vawnet/substance.htm, 1997.

[9] Ibid

[10] Websdale, Neil. "Lethality Assessment Tools: A Critical Analysis." www.vaw.umn.edu/Vawnet/lethality.htm, 2000.