2010

A Matter of Life and Death

Fourth Judicial District Domestic Fatality Review Team

A Collaboration of Private, Public and Nonprofit Organizations Operating in Hennepin County

Project Chair:

The Honorable Gina Brandt
Minnesota Fourth Judicial District

2010 Community Partners:

Asian Women United of Minnesota
Battered Women's Justice Project
Battered Women's Legal Advocacy Project
Brooklyn Park Police Department
Community Volunteers
Domestic Abuse Project
Minneapolis City Attorney's Office
Minneapolis Police Department
Minneapolis Public Schools
Minnetonka City Attorney's Office
Mound Police Department
Outfront Minnesota

2010 County and State Partners:

Minnesota Fourth Judicial District Court
Hennepin County Attorney's Office
Hennepin County Community Corrections & Rehabilitation
Hennepin County Family Court Services
Hennepin County Human Services
Hennepin County Medical Center
Hennepin County Medical Examiner
Hennepin County Public Defender's Office
Hennepin County Sheriff

This report is a product of:

Fourth Judicial District Domestic Fatality Review Team

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The Hennepin County Board of Commissioners, whose financial contribution makes the continued work of the Team possible.

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Executive Summary

The goal of this report is to share the work of the Fourth Judicial District Domestic Fatality Review Team and the Opportunities for Intervention identified by the Team. Our Opportunities for Intervention are designed to capture the points relevant to our audience in a manner that encourages safety for victims of domestic violence and accountability for abusers. Out of respect for the privacy of the victims and their families, identifying details have been removed. Also included in this report are facts about the domestic homicide rate in Hennepin County and Minnesota during the years in which these cases occurred to assist readers in putting the case information in context.

By design, the Fourth Judicial District Domestic Fatality Review Team process focuses on a few specific cases each year. This opens the door to in-depth examination of all the facts of those cases from the varied perspectives of Team members. Members of the Team examine the case chronologies and then, as a group, make observations about specific elements of the case. Sometimes the observations assist in identifying the context of the crime. Other times, they illuminate a clear missed opportunity to avoid the homicide. From these observations, the Team identifies Opportunities for Intervention that directly correspond to the observations yet are general enough to apply to agencies throughout our community.

In 2010, the Team reviewed four cases. Three of the cases involved very young perpetrators and victims, including one in which a young woman murdered her boyfriend. The fourth case provided the Team an opportunity to examine the Early Neutral Evaluation process recently implemented through Family Court Services. In three of the cases, multiple lethality/risk factors were present in the months and weeks leading up to the homicide, and you can see, on page 8, a detailed summary of the lethality/risk factors the Team identifies and those present in the cases.

This report also sets out to highlight the excellent efforts of Team members and participating agencies in incorporating the findings of the Fourth Judicial District Domestic Fatality Review Team and making changes to policy and procedure. Similarly, we acknowledge the good work of other organizations that help to ensure safety for victims of domestic violence and hold abusers accountable. You can read more about these efforts on page 14.

This year, with the assistance of a Robina Fellow, Keith Miller, we had the opportunity to analyze the cases the Team has reviewed in its ten year history. We developed 49 unique factors with an eye toward trends, commonalities and factors in the 40 cases reviewed during this time. Factors include: general demographics, history of chemical dependency, family of origin information, CPS history, history of domestic violence, contributing factors in the homicide, type of weapon used, time of day and location of the homicide. We have also compiled data on all the domestic homicides in Hennepin County during the same years as the cases the Team has reviewed. This information helps to put the cases in context. This information begins on page 15.

Finally, we have included highlights of the changes that have occurred as a result of the work of the Team or Team members in the past ten years. Join us in celebrating these important achievements on pages 21-24.

The Review Team hopes that the information in this report will prompt active interest in these cases. Agencies are encouraged to take advantage of the Opportunities for Intervention identified by the report. Support for domestic fatality prevention in Minnesota's 87 counties continues to be a goal of the Review Team.

Guiding Standards

The perpetrator is solely responsible for the homicide.

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

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

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

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

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

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

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

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

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

Instead, this report focuses on areas that need improvement.

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

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

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

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

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

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

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

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

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

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

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

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

Homicide Data

For the purposes of the Fourth Judicial District Domestic Fatality Review Team, domestic abuse is defined as a pattern of physical, emotional, psychological, sexual and/or stalking behaviors that occur within intimate or family relationships between spouses, individuals in dating relationships, former partners and against parents by children. This pattern of behavior is used by the abuser to establish and maintain control over the victim. The Review Team examined four domestic homicide cases in 2010. The Team only reviews cases in which more than a year has passed since the homicide and the case is closed to further prosecution. The following information includes all domestic homicides in Hennepin County in those years as well as the cause of death, age and gender of the victim and the relationship of the perpetrator to the victim:

2006

Of 20 women and nine men killed in domestic homicides in Minnesota, seven died in Hennepin County and the Fatality Review Team has reviewed two in 2010.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot	59	Female	Estranged Husband
Gunshot	28	Female	Ex-Boyfriend
Gunshot	66	Female	Husband
Stabbed	20	Male	Girlfriend
Stabbed	36	Male	Girlfriend
Stabbed	22	Male	Girlfriend
Gunshot	20	Female	Ex-Boyfriend

2007

Of 22 women, one child and three men killed in domestic homicides in Minnesota, 10 died in Hennepin County and the Fatality Review Team has reviewed one in 2010.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot	20	Female	Ex-boyfriend
Strangulation	18	Female	Boyfriend
Gunshot	59	Female	Ex-husband
Stabbed	24	Female	Ex-boyfriend
Blunt Trauma	32	Female	Husband
Stabbed	45	Female	Brother
Gunshot	24	Female	Acquaintance
Stabbed	48	Female	Acquaintance
Gunshot	33	Female	Husband
Gunshot	18	Male	Girlfriend's Ex-Boyfriend

2008

Of 22 women, one child and two men killed in domestic homicides in Minnesota, eight died in Hennepin County and the Fatality Review Team has reviewed one in 2010.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot	15	Female	Sexual Partner
Blunt Trauma	41	Female	Husband
Gunshot	28	Female	Ex-boyfriend
Gunshot	28	Female	Estranged Husband
Strangulation	51	Female	Boyfriend
Blunt Trauma	15	Female	Unknown
Gunshot	44	Female	Ex-Boyfriend
Stabbed	38	Male	Boyfriend

Presence of Risk Factors

It is not possible to accurately predict when a perpetrator of domestic violence may kill the victim of abuse. However, researchers* have identified approximately 20 factors – from unemployment and substance abuse to death threats and access to guns – that are often present in cases of domestic homicide. The Fourth Judicial District Domestic Fatality Review Team notes the presence of risk factors in the reviewed cases and spotlights raising public awareness of risk factors for homicide as an opportunity for intervention.

Potential Predictors of Homicide	Case 1	Case 2	Case 3	Case 4
The violence had increased in severity and frequency during the year prior to the homicide.	X	X	X	X
Perpetrator had access to a gun	X	X	X	
Victim had attempted to leave the abuser	X	X	X	X
Perpetrator was unemployed	X	X	X	
Perpetrator had previously used a weapon to threaten or harm victim	X	X	X	X
Perpetrator had threatened to kill the victim	X	X	X	
Perpetrator had previously avoided arrest for domestic violence	X		X	X
Victim had children not biologically related to the perpetrator.				
Perpetrator sexually assaulted victim			X	
Perpetrator had a history of substance abuse	X	X		X
Perpetrator had previously strangled victim	X	X	X	
Perpetrator attempted to control most or all of victim's activities	X		X	
Violent and constant jealousy	X	X	X	X
Perpetrator was violent to victim during her pregnancy	X			
Perpetrator threatened to commit suicide	X			
Victim believed perpetrator would kill her	X		X	
Perpetrator exhibited stalking behavior	X		X	
Perpetrator with significant history of violence	X	X	X	X
Victim had contact with a domestic violence advocate		X		

*For more information about the research on risk factors for domestic homicide, look for Campbell, J.C, Assessing Risk Factors for Intimate Partner Homicide in the NIJ Journal, Issue 250, available here: http://www.ncjrs.gov/pdffiles1/jr000250e.pdf . The Danger Assessment is available at: http://www.dangerassessment.org

Adoption of By-Laws

In 2009, Senator Warren Limmer and Representative Michael Paymar introduced legislation to make permanent the data access that is essential to the work of the Fatality Review Team and to expand the opportunity to create fatality review teams in all judicial districts in Minnesota. These bills were adopted by the legislature and are now Statute 611A.203.

As other judicial districts begin to consider starting fatality review teams, the Fourth Judicial District Domestic Fatality Review Team is working to formalize our practices and record our processes and preparing to provide technical assistance to new and forming teams. As part of this effort, the Advisory Board modified an earlier draft charter used by the Team and in January 2011 the Team adopted its first By-Laws.

One of the most noticeable changes that has resulted from this effort is the name of the Team. Instead of A Matter of Life and Death: Hennepin Domestic Fatality Review Team A Collaboration of Private, Public and Nonprofit Organizations Operating in Hennepin County, the Team is now officially named Fourth Judicial District Domestic Fatality Review Team which we feel best defines both the scope and geographic focus of the Team.

The By-Laws also set the length of service on the Team to two-year terms and limit the number of terms that one can serve to three consecutive with the option of rejoining after a year off. The Team has greatly benefited from having long time members who maintain an organizational memory but also thrives on the ideas and perspective newer members are able to bring to the process. This structure of term limits allows the Team to maintain both components in our work.

The Team strives to balance the highly confidential nature of our work with our commitment to understanding all aspects of the cases we review. To support this, the By-Laws define when and how visitors may participate in the Team meetings. Whether they are invited to a meeting as a content expert, as a professional who worked with either the victim or perpetrator in the case being reviewed or members of organizations working to develop fatality review teams in their community, they must adhere to the confidentiality agreement that each member and any visitor signs at every meeting.

Further, the new By-Laws reflect the expressed desire of Team members to have a greater influence on the adoption of policies and practices based on the Opportunities for Intervention developed by the Team. The By-Laws allow for the creation of topical subcommittees to work on the implementation of Opportunities for Intervention. This will be a complement to the working groups of the Fourth Judicial District Family Violence Coordinating Committee which incorporate relevant Opportunities for Intervention from the Review Team into their annual work plans.

2010 Opportunities

The Review Team examines cases of domestic homicide and the lives of those involved, looking for points where a change in the practice of various agencies or individuals might have changed the outcome of the case. Review Team members examine the case chronologies and make observations about elements of the case. Sometimes the observations assist in identifying the context of the crime, other times they illuminate a clear missed opportunity to avoid the homicide. From these observations, the Team identifies Opportunities for Intervention that correspond to the observations.

This resulting information is focused on specific actions, or Opportunities for Intervention, that agencies could initiate in order to ensure that the incident seen in the case will not be repeated. These Opportunities for Intervention are not limited to agencies that commonly have interactions with the victim or perpetrator prior to the homicide, like law enforcement or advocacy, but include agencies or groups that may serve as a source of information about domestic violence, risk factors of domestic homicide or make referrals to intervention services. The Opportunities are organized into categories to assist the reader in identifying potential areas of focus. **The Review Team recommends that all agencies refer clients to a domestic violence advocacy agency for safety planning, lethality/risk assessment and other services when domestic violence indicators are present.**

Opportunities for Legislative or Policy-Making Organizations

- Require all law enforcement agencies to maintain a formal relationship with a domestic violence intervention agency to provide independent advocacy support and services to victims of domestic violence.

Opportunities for Academic Researchers

- Include the use of violence and abuse unrestrained by the presence of witnesses as a factor in lethality assessment.

Opportunities to Increase Access to Data

- Provide prosecutors and police ready access to comprehensive felony level juvenile records for purposes of enhancement and accurate risk assessment.
- Allocate funding for the return of the Hennepin County Data Sharing Project for Hennepin County agencies.
- Include issued Harassment Restraining Orders and Orders For Protection information in the publicly viewable area of MNCIS.

Opportunities for Criminal Justice Response to Domestic Violence

Courts

- Refer all domestic violence offenders to Hennepin County Community Corrections & Rehabilitation rather than plac-

ing them on probation to the court. Community Corrections & Rehabilitation has the capacity for closer supervision, effective risk assessment and referral to appropriate intervention services.

- Screen for domestic violence whenever there is court action involving assaultive behavior regardless of the relationship between the perpetrator and victim. The Bench Card, developed by the Supreme Court Gender Fairness Implementation Committee, is an example of the type of screening tool that can be used.
- Develop best practices encouraging Courts to regularly impose sanctions on parties who file lawsuits determined to have been intended to perpetrate harassment or abuse. More severe sanctions should be imposed for domestic abuse related cases.

Family Court

- Increase screening of the Early Neutral Evaluation cases at intake for domestic violence related issues, including modifying the pre-Initial Case Management questionnaire to ask parties if they are afraid of the other party and perform individual intakes regarding Early Neutral Evaluation process to ensue that domestic violence victims are fully informed about the process prior to participation. Emphasize that Early Neutral Evaluation is voluntary and parties can withdraw at any time.
- Train all Early Neutral Evaluation evaluators to identify language and behaviors associated with domestic violence and battering and develop a protocol to refer parties for appropriate services while maintain neutrality.
- Early Neutral Evaluation evaluators should make it a best practice to be knowledgeable and informed of any and all information available on the parties involved in the process before beginning the process.
- Put a protocol in place so that statements about threatening behavior on the part of one of the partners, in any setting, should prompt further questioning and/or evaluation by the person interviewing the victims.
- Encourage Judicial Officers to err on the side of not allowing a parent against whom there are allegations of domestic violence from making parenting time exchanges at the victim's home.
- Encourage Judicial Officers to ask about domestic violence at Initial Case Management hearing, particularly in cases where the parties are unrepresented.

Juvenile Court

- Judicial Officers and Community Corrections and Rehabilitation staff must ensure that all programming and assessments ordered as a condition of probation have been completed prior to considering a discharge from probation.
- In cases related to a violent crime, the strong preference is for an in-person review hearing rather than an administrative dismissals.
- When hearing multiple charges at the same time, Judicial Officers must address each charge separately in order to ensure that the consequences of each act are not minimized for the sake of judicial efficiency.

Prosecutors

- Prioritize interventions and charging involving violations of Orders for Protection, witness tampering and harassment

of victims in domestic violence cases that occur at or near the courthouse.

- Take electronic threats– those received through text, email, voicemail and social media sites- as seriously as handwritten or verbal threats.
- To enhance victim safety, include a timeline for eliminating the use of Continuance Without a Plea (CWOP) for domestic violence cases in all Prosecution plans.

Law Enforcement

- Develop a policy to regularly conduct warrant checks when responding to domestic violence related calls and serving Orders for Protection.
- Rather than relying on the domestic violence victim to complete and submit a written statement after the conclusion of the police call, officers must be trained on the best practice model of recording the question and answer statement of the victim and gathering relevant evidence- including photographs of the scene and injuries and names and contact information for witnesses– while on the scene.
- Law enforcement officers must be provided the tools needed to connect the victim to an on-call advocate while at the scene of a domestic violence call, including a department cell phone and ready access to a language translation service.

Community Corrections & Rehabilitation

- Assess risk presented by and the needs of juvenile offenders on a regular basis, to build upon the findings of the Youth Level of Services Inventory (YLSI) and with a focus on potential level of trauma. Modify the structure of the case plan to specifically address the newest assessment finding.
- Include the lethality/domestic violence risk assessment as part of Pre-Sentence Investigation recommendations.

Emergency Communications/Dispatch

- Incorporate questions about prior incidents into 911 operator scripts on domestic violence calls.

Minnesota Department of Corrections

- Provide a parenting needs assessment upon intake to a state facility and encourage inmate to utilize programming that addresses the identified needs while incarcerated. A similar assessment can be used during release planning to ensure the inmate has the skills necessary to parent minor children upon release as well as access to community resources to support positive parenting skills.
- Develop domestic violence intervention and healthy relationships programming for correctional facilities targeted toward the needs of the newer inmate as well as those who are preparing for reentry. Do not limit access to these services to those who are incarcerated specifically for domestic violence related offenses.

Opportunities for Human Service Response to Domestic Violence

- Ensure training on signs of domestic violence, lethality indicators and methods of safety planning for all human ser-

vice workers who have direct contact with potential victims of violence. This will allow a human services staff person who has contact with a domestic abuse victim, or a person who may be a victim of violence, to immediately initiate safety planning and risk assessment processes.

- Always refer clients reporting sexual abuse to developmentally appropriate support services without judging the validity of the report.

Child Protection Services

- Provide ongoing and more frequent assessment of mental health needs for children receiving child protection services due to abuse/neglect incidents and ensure follow-through on recommended treatment services for the children.
- Immediately address, through assessment and counseling, the impact of grief and abandonment on the children who have experienced family violence.
- Develop a consistent response to truancy, including a more comprehensive look at attendance from year to year and training first responders on how to identify and report educational neglect.

Opportunities for Enhanced Education

- Add healthy relationship, domestic violence and chemical dependency education and resource components to health classes and include evidence of that knowledge in state learning standards.
- Opportunities to report domestic abuse should be available and publicized in school districts in a systematic, age-appropriate and confidential manner.

Opportunities for Other Mandated Reporters or Helping Professionals

- Provide protocol and training for mandated reporters, like daycare providers, to identify and report suspicious or concerning statements made by parents or children regarding domestic violence or threats of harm.

Opportunities to Address Cultural Issues in Domestic Violence Cases

- Develop a public outreach campaign targeting leaders in Minnesota regarding domestic violence to clearly define what domestic violence is, to encourage interaction with agencies that offer helping services and to build understanding of and confidence in the US legal system's ability to assist victims of domestic violence.

Opportunities for Public Response to Domestic Violence

- Support community education efforts to increase domestic violence awareness and knowledge of lethality risks, including targeted messages to bystanders and friends who witness, suspect and/or are aware of domestic violence, encouraging them to intervene in safe ways.

2010 Achievements

A benefit of the current structure is the change-making work that has organically developed from the process of case reviews within the Fourth Judicial District Domestic Fatality Review Team. Since all the Team members are in some way connected to community, justice or government systems that serve those who may become the perpetrator or victim of a domestic homicide, each member also brings a unique perspective on ways in which their agency's work can prevent homicide. The trusting relationships Team members build with each other often enhance their ability to work within their organization and the broader community with more creativity and a clearer understanding of how various system components can be utilized to address the factors that can lead to domestic homicide.

The Domestic Fatality Review Team has published seven previous reports in which we have identified recommendations for changes to system procedures that increase safety for victims and hold perpetrators accountable. After each of the reports, we collect information about changes that were made in response to Opportunities for Intervention identified by the Team. Additionally, some members of the Review Team, having identified a better way to keep victims safe and hold abusers accountable through case reviews, have taken the initiative to make more immediate changes within their organization. Some examples of these efforts are highlighted below.

- In 2010, the Minneapolis City Attorney's Office, Minneapolis Police Department Family Violence Unit, Domestic Abuse Project, Asian Women United and Casa de Esperanza expanded their long-term collaboration to include Hennepin County Community Corrections and Rehabilitation. The collaborative has developed a list of Domestic Repeat Offenders and probation officers, advocates, police, an assistant city attorney and a paralegal meet regularly to monitor the cases and ensure that the victims of these offenders have a connection with an advocate. In 2011, this collaborative will expand services even further with the addition of advocate and investigator teams that will follow up on Gone on Arrival police calls and attempt to enforce Domestic Abuse No Contact Orders (DANCOs).

- In 2008, the Minneapolis City Attorney's Office (MCAO) and Police Department launched a pilot project to improve the City's response to domestic violence cases. The Pilot had two goals (1) to increase the conviction rate on misdemeanor domestic violence cases and (2) to decrease recidivism by domestic violence offenders. The pilot proved successful and was expanded citywide as the new Minneapolis misdemeanor domestic violence investigation protocol. The implementation of the protocol has enabled the MCAO's conviction rate for domestic violence cases to rise from 54% to 72% since its implementation. The City Attorney's Office and Police Department both have had members on the Fatality Review Team and based many of the new protocols established in Minneapolis on lessons learned and Opportunities for Intervention identified by the Fatality Review Team.

- Dr. Dave Mathews, a member of the Fatality Review Team since 2003, has launched an initiative to provide trauma assessment for children whose families are involved in the court system. Through his experience reviewing cases with the Team, he was able to identify a gap in services for child witnesses of domestic violence that the Mosaic Project: A Minnesota Child, Youth and Family Mental Health Trauma Assessment Initiative is meant, in part, to close by bringing the child's perspective to be considered in family court matters, provide recommendations for ongoing mental health care and increase the parents' understanding of how a child is responding to traumatic incidents.

- Hennepin County Community Corrections & Rehabilitation has expanded its usage of the Domestic Violence Screening Instrument– Revised (DVSI-R) to all domestic related felony cases. Previously its use had been limited to domestic related misdemeanor cases.

10 Years Case Analysis

The Domestic Fatality Review Team has, in its ten years of existence, reviewed 40 cases of domestic homicide and a total of 43 victims of homicide. With the assistance of Keith Miller, a recent University of Minnesota Law School graduate who served the Team as a Robina Fellow, we analyzed the cases with an eye toward trends and commonalities. We developed a list of 49 factors which included general demographics, history of chemical dependency, family of origin information, CPS history, history of domestic violence, contributing factors in the homicide, type of weapon used, time of day and location of the homicide. In the three cases where bystanders were killed rather than the targeted victim, we included the targeted victim's information. We also excluded the two child murders. Interesting findings include:

- 67% of the victims of homicide in the cases reviewed had previously attempted to leave the relationship.
- 78% had lived with their murderer.
- In 61% of the cases the Team reviewed, the frequency and/or severity of domestic assault incidents had increased in the period of time before the homicide.
- 58% of the perpetrators had access to a firearm.
- 50% of the perpetrators had a known history of chemical abuse.
- 72% of the perpetrators had exhibited extreme jealousy prior to the homicide.
- 50% of the victims died from gunshot wounds and 33% were stabbed to death.
- The cases were split almost equally between 47% of the couples currently in a relationship and 44% of those whose relationship had ended.
- 67% of the victims/perpetrators were involved with partner agencies at some point prior to the homicide.
- 75% of the victims had shared their fears with others and had sought help to remain safe.

*Case Composition**

Type of Case	Number Reviewed by Fatality Review Team 2000-2010	Number Occurred in Hennepin County in Years Reviewed**
Homicide/Suicide	3	7
Domestic Violence Victim as Perpetrator	1	1
Same Sex Domestic Violence	2	4
Intended Victim Survived- Bystander Killed	3	4
Multiple Victims	4	5
Child Targeted to Terrorize DV Victim Parent	2	4
Child/Sibling/Family Member as Perpetrator	1	7
Immigrant Involved	10	21
Female Perpetrator	1	3
Perpetrator Younger than 22***	7	14

* Not all reviewed cases are on this list, some did not fit within these criteria.
**Cases have been drawn from homicides that occurred between 1996 and 2008.
*** In these cases there is often a significant juvenile record of violent behavior and less of an adult record of violent behavior.

10 Year Fatality Overview

1996

Of 22 women, six children and two men killed in domestic homicides in Minnesota, 13 died in Hennepin County and the Fatality Review Team has reviewed three during its 10 year history.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot	22	Female	Ex-Boyfriend
Gunshot	32	Female	Friend
Gunshot	39	Female	Ex-Husband
Gunshot	41	Female	Husband
Gunshot	16	Female	Host Father
Gunshot	43	Male	Neighbor/Friend
Strangulation	20	Female	Boyfriend
Stabbed	42	Female	Daughter's Ex-Boyfriend
Stabbed	9	Male	Sister's Ex-Boyfriend
Stabbed	13	Male	Friend's Sister's Ex-Boyfriend
Strangulation	30	Female	Boyfriend
Gunshot	22	Female	Boyfriend
Gunshot	18 months	Female	Mother's Boyfriend

1997

Of 17 women, one man and two children killed in domestic homicides in Minnesota, seven died in Hennepin County and the Fatality Review Team has reviewed four during its 10 year history.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot Wounds	34	Female	Estranged Husband
Stabbed	28	Female	Live-in Boyfriend
Gunshot Wounds	23	Female	Ex-boyfriend
Gunshot Wounds	19	Female	Stalker
Gunshot Wounds	48	Female	Ex-husband
Gunshot Wounds	17	Female	Ex-boyfriend
Gunshot Wounds	35	Male	Acquaintance's Ex-Boyfriend

1998

Of 20 women and three children killed in domestic homicides in Minnesota, four died in Hennepin County and the Fatality Review Team has reviewed two during its 10 year history.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot Wounds	28	Female	Estranged Husband
Asphyxiated	13	Female	Acquaintance
Stabbed	83	Female	Acquaintance
Gunshot Wounds	34	Female	Boyfriend

1999

Of 23 women and nine children killed in domestic homicides in Minnesota, six died in Hennepin County and the Fatality Review Team has reviewed three during its 10 year history.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Stabbed	17	Female	Ex-boyfriend
Strangulation	18	Female	Acquaintance
Strangulation	37	Female	Live-In Boyfriend
Blunt Trauma	23	Female	Husband
Blunt Trauma	4 months	Male	Father
Strangulation	8	Female	Guardian's Boyfriend

2000

Of 40 women, one man and four children killed in domestic homicides in Minnesota, eight died in Hennepin County and the Fatality Review Team has reviewed four during its 10 year history.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Stabbed	27	Female	Boyfriend
Multiple Homicidal Violence	32	Female	Husband
Blunt Trauma	76	Female	Acquaintance
Stabbed	38	Female	Boyfriend
Stabbed	37	Female	Boyfriend
Gunshot	42	Female	Son
Gunshot	41	Female	Husband
Gunshot	31	Female	Husband

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot	39	Female	Boyfriend
Gunshot	26	Female	Acquaintance
Stabbed	30	Female	Husband
Stabbed	89	Female	Granddaughter's Boyfriend
Stabbed	89	Male	Granddaughter's Boyfriend
Blunt Trauma	42	Female	Boyfriend
Blunt Trauma	80	Female	Husband
Stabbed	68	Female	Son
Stabbed	58	Male	Son
Multiple Homicidal Violence	39	Female	Acquaintance
Gunshot	24	Female	Acquaintance
Blunt Trauma	41	Female	Unknown
Blunt Trauma	37	Female	Husband
Asphyxiation	52	Female	Son
Gunshot	10	Female	Father

2001

Of 34 women, two men and one child killed in domestic homicides in Minnesota, 15 died in Hennepin County and the Fatality Review Team has reviewed four during its 10 year history.

2002

Of 17 women and three children killed in domestic homicides in Minnesota, seven died in Hennepin County and the Fatality Review Team has reviewed three during its 10 year history.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Strangulation	21	Female	Boyfriend
Stabbed	30	Female	Ex-boyfriend
Stabbed	22	Female	Ex-boyfriend
Gunshot	50	Female	Husband
Gunshot	20	Female	Boyfriend
Gunshot	45	Female	Ex-Boyfriend
Gunshot	45	Male	Ex-Boyfriend

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Stabbed	27	Female	Boyfriend
Stabbed	23	Female	Boyfriend
Gunshot	42	Female	Ex-boyfriend
Gunshot	41	Female	Boyfriend
Gunshot	57	Female	Son
Gunshot	26	Female	Female Roommate
Gunshot	48	Male	Neighbor

2003

Of 14 women and two men killed in domestic homicides in Minnesota, seven died in Hennepin County and the Fatality Review Team has reviewed four during its 10 year history.

2004

Of 13 women, three children and two men killed in domestic homicides in Minnesota, sevenoccurred in Hennepin County and the Fatality Review Team has reviewed five during its 10 year history.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Stabbed	47	Female	Husband
Stabbed	21	Female	Estranged Husband
Gunshot	32	Female	Boyfriend
Stabbed	26	Female	Ex-boyfriend
Stabbed	61	Male	Granddaughter's Ex-Boyfriend
Stabbed	44	Female	Daughter's Ex-Boyfriend
Stabbed	48	Male	Girlfriend's Ex-Boyfriend

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Stabbed	22	Female	Fiancé
Overdose	15	Female	Boyfriend
Gunshot	27	Female	Boyfriend
Gunshot	49	Female	Husband
Gunshot	72	Female	Husband
Stabbed	25	Female	Boyfriend
Gunshot	43	Female	Boyfriend
Blunt Trauma	23	Female	Husband

2005

Of 26 women and two men killed in domestic homicides in Minnesota, eight died in Hennepin County and the Fatality Review Team has reviewed four during its 10 year history.

2006

Of 20 women and nine men killed in domestic homicides in Minnesota, seven died in Hennepin County and the Fatality Review Team has reviewed three during its 10 year history.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot	59	Female	Estranged Husband
Gunshot	28	Female	Ex-Boyfriend
Gunshot	66	Female	Husband
Stabbed	20	Male	Girlfriend
Stabbed	36	Male	Girlfriend
Stabbed	22	Male	Girlfriend
Gunshot	20	Female	Ex-Boyfriend

2007

Of 22 women, one child and three men killed in domestic homicides in Minnesota, 10 died in Hennepin County and the Fatality Review Team has reviewed four during its 10 year history.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot	20	Female	Ex-boyfriend
Strangulation	18	Female	Boyfriend
Gunshot	59	Female	Ex-husband
Stabbed	24	Female	Ex-boyfriend
Blunt Trauma	32	Female	Husband
Stabbed	45	Female	Brother
Gunshot	24	Female	Acquaintance
Stabbed	48	Female	Acquaintance
Gunshot	33	Female	Husband
Gunshot	18	Male	Girlfriend's Ex-Boyfriend

2008

Of 22 women, one child and two men killed in domestic homicides in Minnesota, eight died in Hennepin County and the Fatality Review Team has reviewed one during its 10 year history.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot	15	Female	Sexual Partner
Blunt Trauma	41	Female	Husband
Gunshot	28	Female	Ex-boyfriend
Gunshot	28	Female	Estranged Husband
Strangulation	51	Female	Boyfriend
Blunt Trauma	15	Female	Unknown
Gunshot	44	Female	Ex-Boyfriend
Stabbed	38	Male	Boyfriend

10 Year Achievements

The Review Team is a part of a larger movement towards a societal shift with respect to domestic violence. The Opportunities for Intervention from our past reports have already resulted in significant changes within many organizations, both inside and outside the collaborative. These changes take many forms. Some are part of formal initiatives; many occur as a result of Review Team members going back to their respective organizations with knowledge gained through direct involvement in the review process and implementing more appropriate and responsive practices and procedures. Since many in the group are senior members within their respective organizations, they have the clout to implement these needed changes.

Throughout its history the Review Team members have also participated in a variety of policy-making forums related to domestic violence, including the Hennepin County Family Violence Coordinating Council, the Sheila Wellstone Institute, Minnesota Advocates for Human Rights, The Battered Women's Justice Coalition, Domestic Court Steering Committee and Minnesota Coalition for Battered Women. Many of these organizations work together on a variety of critical issues to stem the tide of domestic violence. While we do not take full credit for the encouraging progress on this front, we think it is important to highlight improvements that have occurred since the formation of the Team.

City Attorney Offices

- Minneapolis City Attorney's Office (MCAO) actively and aggressively refers cases to the Hennepin County Attorney's Office when tab charged with misdemeanor offenses, but where facts may support a felony level offense.
- Through legislative lobbying efforts of the MCAO, the Minnesota State Legislature passed a law that doubled the amount of time police have to arrest defendants who flee the scene of misdemeanor domestic violence cases from 12 to 24 hours.
- MCAO asks every domestic violence victim for the name of a trusted contact who they can contact if they can't reach the victim directly.
- MCAO streamlined the felony referral process to the Hennepin County Attorney's Office by placing an attorney in the Family Violence Unit of the Minneapolis Police Department.
- MCAO reviews all felony level investigations completed by the police, which do not rise to the level of felony charges, to determine if misdemeanor charges are warranted, or if more investigation is needed to support felony level charge
- MCAO publishes a Probable Cause Felony Enhancement List for the county jail that identifies people who, if arrested on a misdemeanor charge, can be booked on a felony charge.
- MCAO provided police training to all Minneapolis police officers regarding "gone on arrival" procedures and how those cases are reviewed and potentially prosecuted, on domestic assault investigation, report writing, dynamics of domestic violence cases and laws pertaining to domestic violence cases.

- MCAO provided training to all Minneapolis 911 operators and dispatchers regarding dynamics of domestic assault, laws and system responses to domestic violence.
- The Minnetonka City Attorney's Office incorporates the Opportunities for Intervention identified by the Team into their annual agency goals.

Committees & Collaborations

- The Review Team identified strangulation as a significant lethality factor in our 2002 and 2004 reports. In 2005, the Minnesota Legislature passed a law making strangulation during domestic abuse a felony offense.
- The Family Violence Coordinating Council is now using the opportunities for intervention from past Review Team reports as a foundation for building its annual subcommittee work plans.
- The Minnetonka City Attorney and police department collaborated to implement recommendations published by the Fatality Review Team; a shift from primary aggressor analysis to predominant aggressor analysis, the adoption of protocols requiring a speedy review of domestic assault police reports by a City Attorney for Gone on Arrival calls and the creation of a referral process to ensure that every documented incident of domestic violence is prosecuted at the appropriate level of severity.
- The Hennepin County Family Violence Coordinating Council Criminal Committee formed a work group to study police, prosecutor and advocacy response to Gone On Arrival (GOA) cases. The GOA Best Practices Workgroup was formed in response to the recommendation of the Fourth Judicial District Domestic Fatality Review Team and Battered Women's Justice Project to develop consistent GOA practices and encourage investigations of domestic cases. The GOA Best Practices Workgroup has just released their findings, Best Practices and Procedures for Police Departments with Regard to the Handling of Domestic Violence Gone on Arrival Cases.
- Minneapolis' Misdemeanor Domestic Assault Investigation Pilot, a collaboration project of the Minneapolis City Attorney's Office and the Minneapolis Police Department, which began on February 1, 2008 in the city's 5th Precinct, expanded to the 3rd Precinct on February 1, 2009 and will expand to the other Minneapolis precincts by the end of 2009. During the first three quarters of the pilot project, the conviction rate for cases occurring in the 5th Precinct rose 23% from 54.4% in 2007 to 77.5% after the introduction of the protocol.
- In 2008, Hennepin County Community Corrections and Rehabilitation formed a group of employees who visit a variety of treatment facilities to which they refer clients to conduct audits of the services. This addresses the underlying concern in a 2007 Opportunity for Intervention: Criminal justice should beware of automatically referring to the least restrictive and lowest cost treatment options for sex offender services, domestic violence intervention services or chemical dependency treatment as they may not be the most effective.

Fourth Judicial District Court

- Fourth Judicial District established the dedicated Domestic Court which hears all adult domestic violence related criminal cases occurring in Minneapolis.
- Informed Judges about factors relevant to bail determination including threats of suicide and violence threats on dates close to the time protection orders are served.

Hennepin County Attorney's Office

- Hennepin County Attorney's Office Domestic Abuse Service Center (DASC) reviews all cases in which the perpetrator is "gone on arrival" within 24 hours.
- Hennepin County Attorney's Office initiated a national research on prosecution of strangulation cases.
- Provides training on protocols for interviewing children and referrals to child protection.
- Assigned advocate to work with children in domestic abuse cases.
- Conducted police training on rights of custodial and non-custodial parents.

Hennepin County Community Corrections & Rehabilitation

- Implemented Domestic Violence Screening Inventory (DVSI) within the Community Corrections & Rehabilitation Department to determine the level of supervision services being afforded to defendants post-conviction.
- Modified their existing Pre-Sentence Investigation (PSI) reports to better reflect dynamics of domestic abuse.
- Permits advocates to sit in on Probation Officer's interviews with victims.
- Hennepin County Community Corrections and Rehabilitation developed a pilot position (now expanded to three permanent) with a caseload of probationers with felony-level domestic assault. Previously, misdemeanor-level domestic assault offender had specialized probation officers while felony-level domestic assault offenders were supervised by a general felony probation officer. This pilot position offers the opportunity for more rigorous, specialized supervision by a probation officer who is trained and experienced in domestic violence issues.
- Beginning in 2009, Hennepin County Community Corrections and Rehabilitation implemented a domestic abuse screening tool in the felony-level Pre-Sentence Investigation. This screening process had previously been used during misdemeanor Pre-Sentence Investigation and provides judges, prosecutors and probation officers with the information they need to make well-informed decisions.

Hennepin County Medical Center

- Initiated training on domestic violence for Emergency Department Faculty and Residents.
- Instituted intake interview screening of domestic violence.

Law Enforcement

- The Brooklyn Park Police Department has undertaken an internal system audit on the handling and outcome of domestic calls.
- Minneapolis Police Department has adopted a protocol to check for a Domestic Assault No Contact Order or Order for Protection on every domestic call.
- The Hennepin County Jail has revised its policies and procedures for notifying victims when a perpetrator is being released from custody.

Minneapolis Public Schools

- Minneapolis Public Schools developed a policy and procedure for staff, parents and students that have an Order for Protection.
- Minneapolis Public Schools now screens for domestic violence as part of the newly-implemented Knock and Talk school attendance protocol, which provides for visits to homes of truant children.

The Review Team also commends efforts to improve the outcomes in cases of domestic violence and changes to policy and practice that further those efforts. Below are several changes that occurred in the past decade:

- A recent legislative modification to the Order for Protection statute brought to light the absence of criminal court Domestic Abuse No Contact Orders (DANCOs) in the police database, the CJIS. This database, which police use to access information from their squad cars, contained information about Orders for Protection but it did not contain No Contact Orders made by the court as a condition of release. A workgroup was formed to determine how to make DANCO information accessible in CJIS. As a result of the working group findings, DANCOs issued after December 16, 2008, are viewable by police in the CJIS database.
- The bail schedule for misdemeanor domestic assault cases has doubled from $1,200 to $2,400.
- The Domestic Violence Risk Assessment Bench Guide, created by the Supreme Court Gender Fairness Implementation Committee, has been distributed to judges and referees throughout the state of Minnesota.
- Mound Police Department conducts a Lethality/Risk Assessment with victims at the scene of domestic assaults.
- In an effort to enforce the Federal and State ban on firearm possession by people convicted of domestic assault, the Fourth Judicial District explicitly included the firearm ban on the Domestic Sentencing Order form.
- HCMC is providing specialized training on domestic violence to Registered Nurses working nights in the Emergency Department.
- In 2010, Minnesota State Legislature voted to increase bail maximums on domestic cases to $10,000 for misdemeanors and $30,000 for gross misdemeanor.

Project History

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

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

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

Enthusiasm for the project was high from the outset. Consequently the Advisory Board spent very little time on the feasibility study and soon began laying out the framework for the project to be established in the Fourth Judicial District. It began with an extensive research effort to gather information from jurisdictions that had already implemented fatality review teams, gaining extremely valuable information in this process. Many jurisdictions stressed the importance of having enabling legislation to create the project and to lay the framework for the project to go forward with multiagency participation. This would assist in creating a non-blaming environment and help to assure the neutral review of cases.

During the process of developing the proposed legislation, the Advisory Board assembled a larger Planning Committee comprised of 34 members representing private, public and nonprofit agencies and organizations to gain a variety of perspectives on particular topics and to develop broader support for the project. The Planning Committee worked pri-

marily on establishing a definition of domestic homicide and on identifying who should be represented on the Review Team. Once critical decisions had been made about participation and structure, the existing Advisory Board worked with Senate counsel to put together legislation that would create and fund the project. The legislation also included important data privacy and immunity provisions that would enable the project to gain access to confidential records related to these cases and provide immunity to those who spoke openly to the Fatality Review Team about case information.

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

The Advisory Board returned to the legislature during the 2000 session to pursue the data privacy and immunity provisions. The legislation passed and was signed by the Governor. It became effective on August 1, 2000. In 2004, the State Legislature granted an extension to these provisions until June 2006. In 2006, the Team was granted another extension, this time to December 2008. In 2009, the legislature made permanent the data access that enables the work of the Team and extended the opportunity to develop a Fatality Review Team to all Judicial Districts in Minnesota with Statute 611A.203.

Fourth Judicial District Domestic Fatality Review Team

Purpose

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

Goal

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.

Structure & Processes

The Review Team Structure

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

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

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

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

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

Case Selection

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

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

The Case Review

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

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

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

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

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

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Fourth Judicial District Domestic Fatality Review Team

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