2022 Annual Report

Minnesota Fourth Judicial District
Domestic Fatality Review Team

Project Chair:

Referee Mary Madden
Minnesota Fourth Judicial District

2022 Local & Community Partners:

Bloomington City Attorney's Office
Cornerstone
Eden Prairie Police Department
Hurd Law, PLLC
Minneapolis City Attorney's Office
Minneapolis Police Department
The Advocates for Human Rights

2022 County & State Partners:

Hennepin County Adult Representation Services
Hennepin County Attorney's Office
Hennepin County Child Protection
Hennepin County Community Corrections & Rehabilitation (HCCCR)
Hennepin County Domestic Abuse Service Center
Hennepin County Family Mediation and Evaluation
Hennepin County Juvenile Prosecution Division
Hennepin County Law, Safety, and Justice
Hennepin County Medical Examiner
Hennepin County Public Defender's Office
Hennepin County Psychological Services
Hennepin County Public Defender's Office
Minnesota Fourth Judicial District Court

For more information please contact:

Makenzie Nolan, Project Director
Makenzie Nolan LLC
Makenzienolan@outlook.com | 952-288-8711

This Report is a product of:

Minnesota Fourth Judicial District Domestic Fatality Review Team
www.amatteroflifeanddeath.org

Domestic Fatality Review Team 2022 Annual Report

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Acknowledgements

Together, Mary Madden- Project Chair, and Makenzie Nolan- Project Director, would like to acknowledge members and supporters of Minnesota's Fourth Judicial District Domestic Fatality Review Team:

The Hennepin County Law, Safety, and Justice Department who manages the contract;

The agencies and individuals who promptly and generously provide documents and information critical to case reviews;

The leaders of partner organizations who willingly commit staff time to the Team and encourage changes and procedures based on the Team's findings;

Members of the Advisory Board who oversee the work and membership of the Team;

The members of the Team who give their time generously and offer their professional expertise in the review of each case;

The friends and family members of homicide victims who share memories of their loved ones and reflect on the tragedy of their deaths;

The following professionals and content experts who joined the Team in 2022 to present information pertinent to each case review:

Deena Anders; Former Domestic Fatality Review Team Project Director

Dr. Andrew Baker; Chief Hennepin County Medical Examiner

About the Domestic Fatality Review Team

The Fourth Judicial District Domestic Fatality Review Team is a collaboration of private, public, and non-profit organizations and citizen volunteers from throughout Hennepin County. The Domestic Fatality Review Team was created to improve policies and procedures to better address domestic violence in our county.

The work of the Fourth Judicial District Domestic Fatality Review Team is protected under Minnesota State Statute, Section 611A. 203; which outlines the Domestic Fatality Review Team's purpose, the definition of domestic violence death, criteria for Team membership, terms of data practice and confidentiality, Team immunity, and our Team's process for evaluation and reporting.

The Domestic Fatality Review Team reviews cases of domestic homicide; homicides that are related to domestic abuse. Domestic abuse is defined as a pattern of physical, emotional, psychological, sexual, and/or stalking behaviors that occur within intimate or family relationships. It includes relationship dynamics between spouses, dating relationships, former and current partners, relatives, as well as parents and children. Occasionally the Team reviews homicides where the victim of the homicide is not the primary victim of the abuse.

Purpose:

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

Goal:

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

Advisory Board:

The Advisory Board represents a group of elected members who have served on the Team for a minimum of 6 months, and are recommended by an existing Advisory Board member with the approval of the Board Chair. As the governing body of the Fourth Judicial District Domestic Fatality Review Team, the Advisory Board is responsible for adhering to the Minnesota State Statute and Team Bylaws, and is charged with appointing members to the Domestic Fatality Review Team. The Advisory Board generally meets bi-monthly. The Advisory Board is tasked with upholding the Team's Code of Ethics; ensuring that the Team operates in a respectful, professional, and confidential manner that adheres to data practices and Team Meeting Guidelines. In 2022, the Advisory Board appointed a new Project Director to oversee the work of the Team, and met monthly.

Team Members:

The Team includes professionals in select roles, often embedded within the system, who are most likely to overlap with perpetrators and victims of domestic abuse. Our members reflect leadership from civic organizations, criminal and civil attorneys and Judicial Officers, probation, law enforcement, mental health professionals, and advocates from across Hennepin County and its respective 45 cities. The Team also strives to have community representatives or members from community organizations with a wide array of backgrounds, who bring knowledge and perspective apart from the professional "systems" vantage point.

Meeting Structure:

Historically, all Team members would gather and conduct monthly in-person meetings for each domestic homicide under review. Occasionally (and on a case-by-case basis), content experts from various departments and agencies were also invited to present information that would aid in the Team's review. In 2022, although the work of the Team continued to operate utilizing a virtual meeting platform— a model first adopted by the Team in 2021 as a result of the Covid-19 Global Pandemic; the Team was able to integrate virtual guest presentations into their formalized review process and meeting structure.

Guiding Standards:

- The perpetrator is solely responsible for the homicide.
- Every finding in this report is prompted by details of specific homicides.
- The Team only selects cases in which prosecution is completed.
- Findings are based primarily on information contained within official reports and records regarding the individual's involved in the homicide before and after the crime.
- The 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.
- The Team appreciates that several of the agencies that had contact with some of the perpetrators or victims in the cases reviewed, have made changes to procedures and protocols since these homicides occurred.
- The Team attempts to reach consensus on every Opportunity for Intervention.
- We will never know if the interventions identified could have prevented any of the deaths cited in this report.
- The Team operates with a high level of trust rooted in confidentiality and immunity from liability among committed participants.
- The Team does not conduct statistical analysis and does not review a statistically significant number of cases.

The Review Process

The Team is able to achieve its goal and purpose through the intentional and meticulous review of each domestic homicide case. Using a multi-disciplinary lens, the members of the Team engage in a collaborative review process that uses the professional expertise and lived experience of each Team member.

The Team approaches this work with a willingness to engage in the review process with honesty, humility, integrity, and curiosity. The Team also recognizes its unique and privileged position with access to information that extends across a person's lifetime. The Opportunities for Intervention that the Team develops are, by extension, fully contextualized within the lives and experiences of the people involved in each case. The Team utilizes the following processes in the review of each case:

Case Selection

The Project Director uses information provided by Violence Free Minnesota's Intimate Partner Homicide Report, homicide records from the Hennepin County Medical Examiner's Office, news reports, and recommendations from Team members to determine which cases to review. A list of cases is then compiled and brought to the Advisory Board for a final vote. Once consensus is reached by the Advisory Board, and it is confirmed that the case is closed to further prosecution, the case is then reviewed by the Team. In circumstances where a case may include a homicide/suicide where no criminal prosecution takes place, the Team waits at least one year before the case is considered for review. Allowing 1-2 years to pass between an incident and the Team's review can also help alleviate some of the emotion and tension experienced by members who may have had direct involvement in the case.

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. If the perpetrator was prosecuted for the crime, law enforcement and prosecution files typically serve as the first source(s) of information, and can often lead to the identification of other agencies with records related to the case. Relevant records from Child Protection, mental health providers, probation, advocacy organizations, courts, and input from family members, friends, and professionals who worked with the perpetrator and/or victim prior to the homicide, are all examples of additional data sources used in the Team's review process.

The Project Director compiles all of the available information to create a chronology of the case that narrates the life events of both the victim and perpetrator. Names of law enforcement, prosecutors, social workers, doctors, or other professionals involved in the case are not used. This chronology is then sent to Team members prior to the case review meeting. As part of the Team's review process, each source document that is used to develop the case chronology is assigned for review by two Team members; one member from the agency or similar agency that provided the information, and another member with an outside perspective. Each Team member is also responsible for completing a confidentiality agreement at the beginning of each new case. At Team meetings, the members who reviewed source documents report their impressions, and a series of observations are made in relation to the case and the systemic responses. These observations are then used to identify Opportunities for Intervention that may have prevented the homicide. The Team records key issues, observations, and Opportunities for Intervention related to each case.

Executive Summary

By design, the Domestic Fatality Review Team only reviews cases in which prosecution is completed. Cases reviewed by the Team will often vary in range by year, however, in 2022 the Team reviewed homicide cases that occurred within the same year. The Team's case selection process for 2022 was largely dependent on what was available to the Team, and were in no particular order.

Each year the Team will select anywhere between 2-4 cases, and reviews one case at a time. Because the Team only convenes once a month, each case review occurs over the course of several months. Homicide cases can take the Team anywhere between 3-5 months/meetings to complete. It is important to note that the number of cases reviewed by the Team, and the timeline in which they are reviewed, also depends on the amount of information that is available for the Team to complete an in-depth examination and gathering of facts. This leaves room for exception, and is determined on a case-by-case basis with oversight from the Advisory Board.

Once information is compiled for each homicide, and a case is ready to be reviewed by the Team, a designated confidential case chronology is created and distributed to each Team member. Members of the Team often begin each case review by independently examining the confidential case chronology, which is provided in advance of Team meetings. Each confidential case chronology establishes a working timeline that includes the following information for both the perpetrator and victim: date of birth, major life events, contacts with various systems, the date of the domestic homicide, and events preceding the domestic homicide. This document serves as a primary reference point for members, and is utilized for the duration of the Team's review. It also helps the Team make observations on specific elements of a case. Sometimes the observations assist in identifying the context of the crime. Other times, the Team's observations can illuminate a clear missed opportunity to avoid the domestic homicide. From these observations, the Team identifies and creates Opportunities for Intervention that directly correspond to facts or patterns observed by the Team.

The goal of the 2022 Annual Report is to share the work of Minnesota's Fourth Judicial District Domestic Fatality Review Team and highlight the Opportunities for Intervention that have been identified by the Team. The Opportunities for Intervention included in this report were developed based on findings from specific cases of domestic homicides that occurred in Hennepin County's Fourth Judicial District.

In 2022, the Team reviewed 3 homicide cases that were reported in 2020. The Team completed 2 out of the 3 case reviews, both of which are documented in this report through the Presence of Risk Factors, 2020 Minnesota Domestic Homicide Data, and corresponding Opportunities for Intervention identified by the Team. The third case remains under review by the Team, and will be included in the 2023 Annual Report. Out of respect for the privacy of the victims and their families, identifying details have been removed.

Expanding the 2022 Case Review Process

For each homicide case reviewed by the Team in 2022, the Team would begin its review with a clinical presentation on the autopsy findings and toxicology results by Chief Hennepin County Medical Examiner-Dr. Andrew Baker. This is an essential part of the Team's review process, as it helps decipher the cause and manner of each victim's death through an objective and scientific lens.

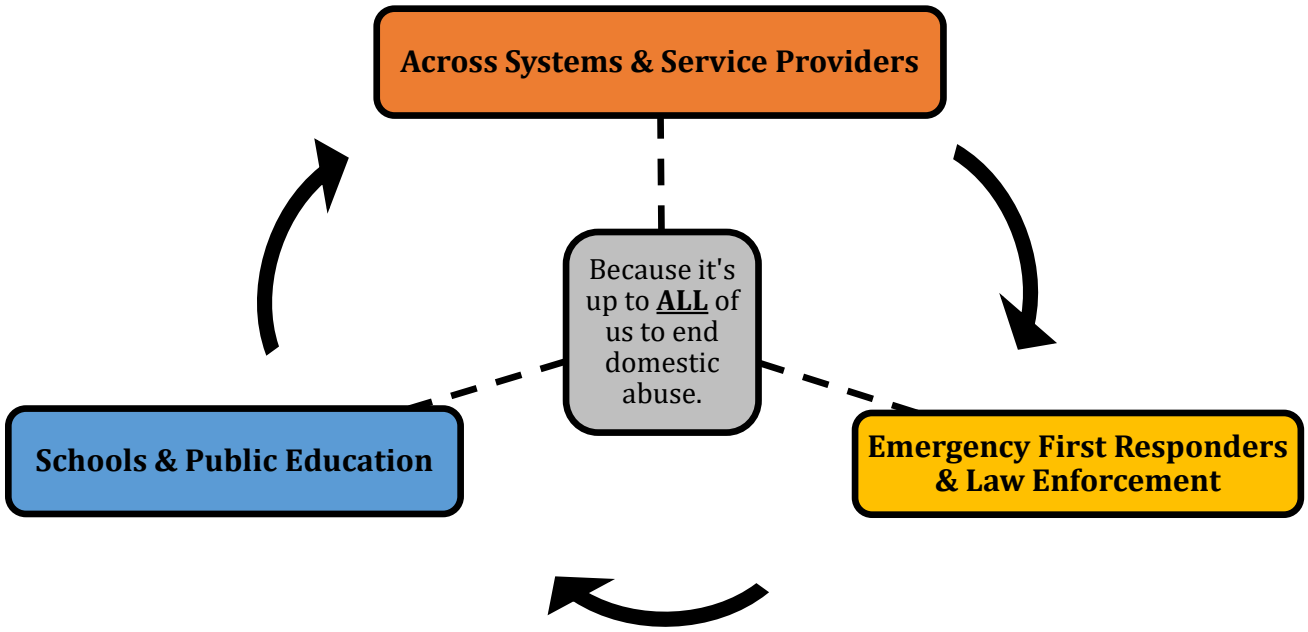
Understanding the Data

The Team's 2022 Annual Report is not meant to reflect homicide data that is congruent with the reporting year. Rather, it documents the year in which each homicide case under review took place, and offers corresponding data for each year.

Since the Team reviewed 3 different cases from 2020, the report will only include data detailing domestic homicides that occurred in 2020 across the state of Minnesota and Hennepin County area. All data included in this report has been collected using public data sources and does not constitute research conducted by the Team.

Applying the Team's Opportunities for Intervention across Systems

From each case review, the Team developed Opportunities for Intervention that identify a need for a more robust cross-sectoral approach that seeks to connect Minnesotans across state, county, and city lines; in a shared effort to prevent domestic homicides before they occur. Prevention efforts and Opportunities for Intervention have been divided into 3 categories of system engagement which include:



From our Team to **YOU**, we hope that the information in this report will prompt active changes to policy and practice that may help to prevent future domestic homicides. **Agencies are encouraged to take advantage of the Opportunities for Intervention identified in this report, beginning on page 14**. Support for domestic fatality prevention in Minnesota's 87 counties, including the creation of more Domestic Fatality Review Teams in the region, continues to be a goal of the Fourth Judicial District Fatality Review Team.

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 20 factors 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 because increasing public awareness of risk factors for homicide is an Opportunity for Intervention in itself.

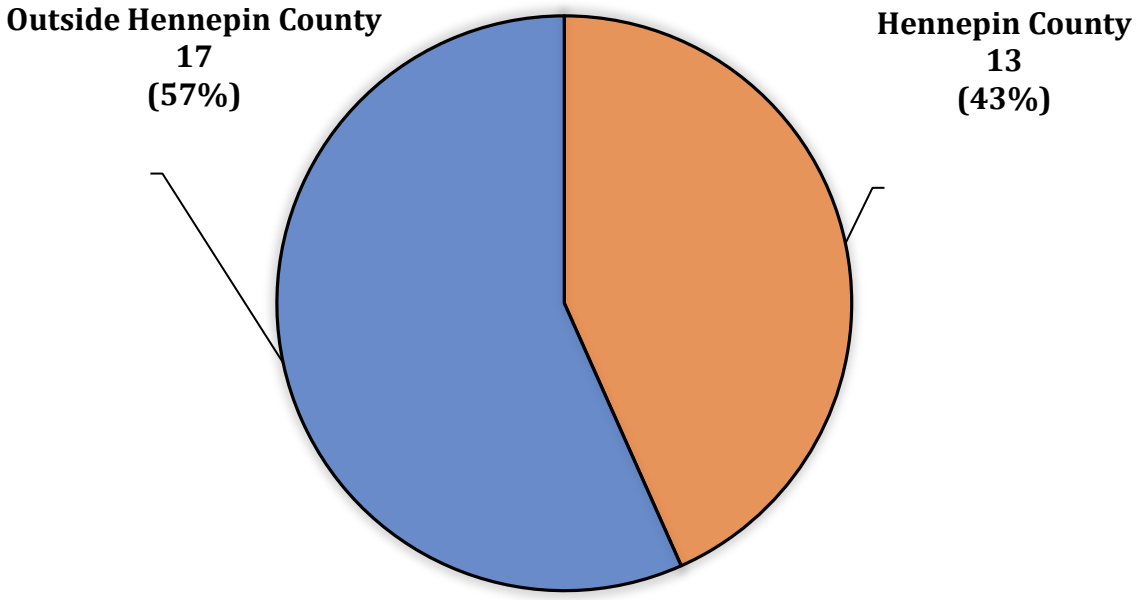
Risk Factors: 2022	**Case 1**	**Case 2**
The violence had increased in severity and frequency during the year prior to the homicide.	**X**	**X**
Perpetrator had access to a gun.		**X**
Victim had attempted to leave the abuser.		**X**
Perpetrator was unemployed.	**X**	**X**
Perpetrator had previously used a weapon to threaten or harm victim.		**X**
Perpetrator had threatened to kill the victim.		
Perpetrator had previously avoided arrest for domestic violence.	**X**	**X**
Victim had children not biologically related to the perpetrator.		
Perpetrator sexually assaulted victim.		
Perpetrator had a history of substance abuse.	**X**	**X**
Perpetrator had previously strangled victim.		
Perpetrator attempted to control most or all of the victim's activities.		
Violent and constant jealousy.	**X**	
Perpetrator was violent to victim during pregnancy.	**N/A**	
Perpetrator threatened to commit suicide.		
Victim believed perpetrator would kill him/her.		
Perpetrator exhibited stalking behavior.	**X**	
Perpetrator with significant history of violence.	**X**	
Victim had contact with a domestic violence advocate.		**X**

2020 Domestic Homicide Data

In 2022, the Domestic Fatality Review Team completed a total of 2 domestic homicide case reviews that took place in 2020. These 2 cases were reported in Hennepin County, which is 1 of 87 counties represented in the state of Minnesota that contains 45 cities. In 2020, at least 30 Minnesotans were killed due to violence resulting from domestic abuse. **A total of 13 domestic homicides were recorded in Hennepin County** (Bloomington [2], Crystal [1], Maple Grove [3], Minneapolis [7]); and 17 domestic homicides were recorded as occurring outside of Hennepin County (Ashby [1], Austin [1], Blaine [1], Cloquet [2], Dakota [1], Grand Lake Township [1], Ham Lake [1], Moorhead [1], Rochester [2], St. Paul [6]).

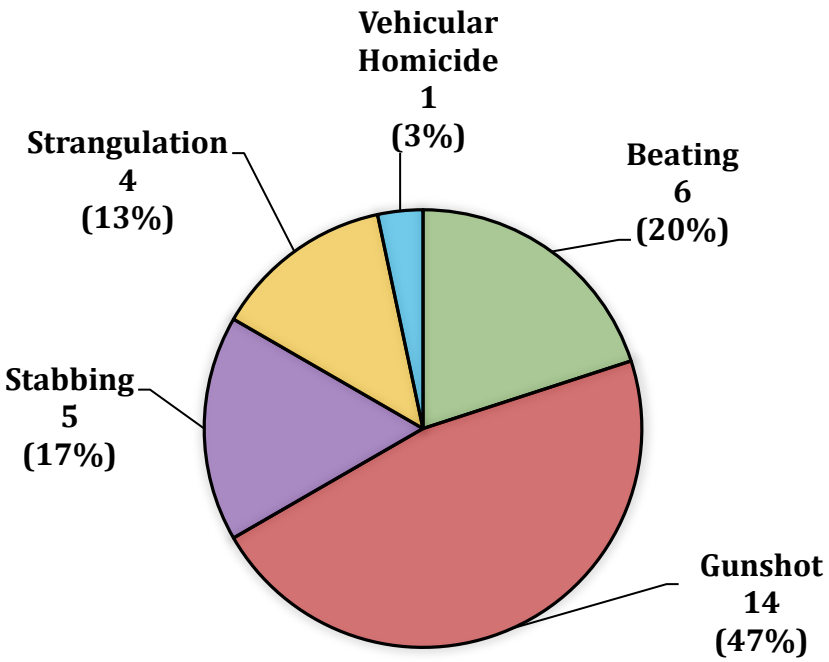
2020 STATE OF MINNESOTA DOMESTIC HOMICIDES

TOTAL FATALITIES: 30

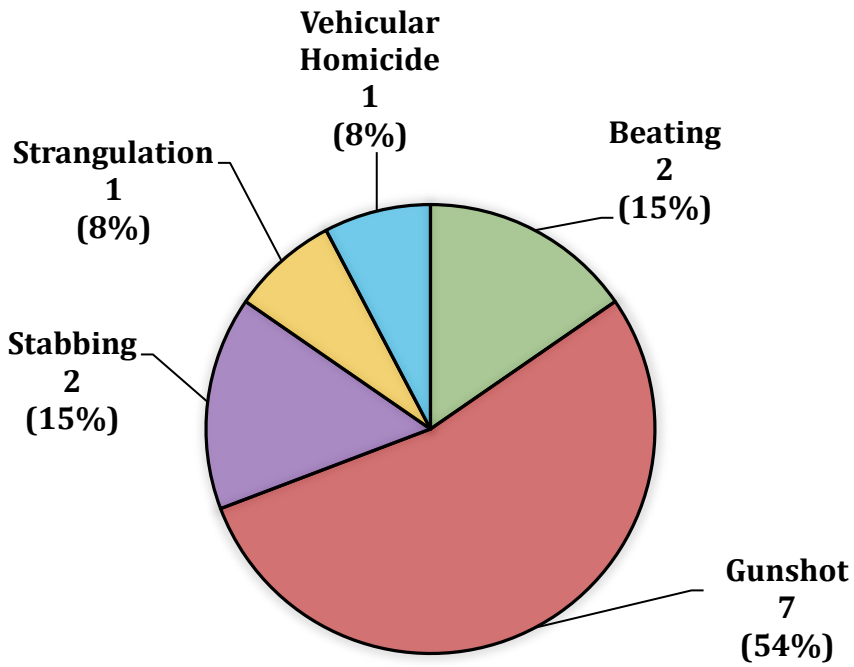


Of the 30 total domestic homicides reported in the state of Minnesota in 2020, at least 22 of the victims identified as women; at least 10 were from Hennepin County. Additionally, at least 4 of the 30 victims in the state were pregnant (Cloquet [1], Rochester [1], St. Paul [1], Minneapolis [1]), and at least 1 of the 30 fatalities was the result of premature birth in Hennepin County. In the state of Minnesota, at least 10 of the 30 victims of domestic homicide were parents and/or had children, and at least 5 of those victims resided within Hennepin County. In 2020 domestic homicides left at least 20 people in the state without a parent; at least 7 of those impacted were from Hennepin County. Data outlining the specific cause of death for each victim of domestic homicide in 2020 can be reviewed on page 12.

2020 STATE OF MINNESOTA DOMESTIC HOMICIDES
CAUSE OF DEATH

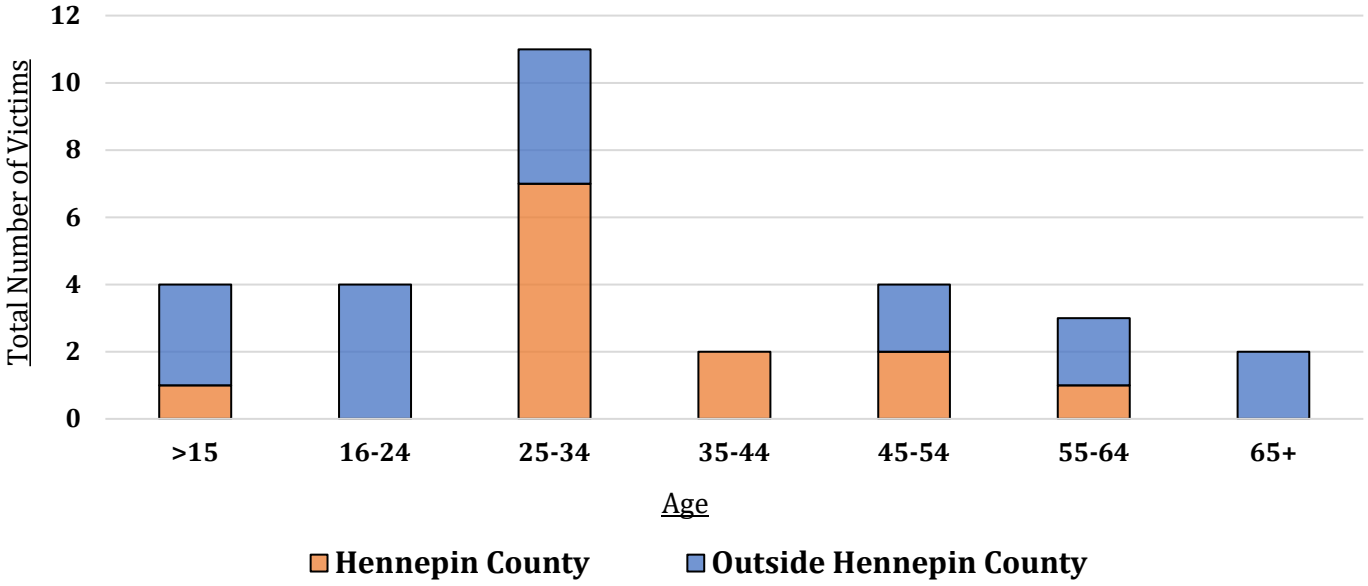


2020 HENNEPIN COUNTY DOMESTIC HOMICIDES
CAUSE OF DEATH

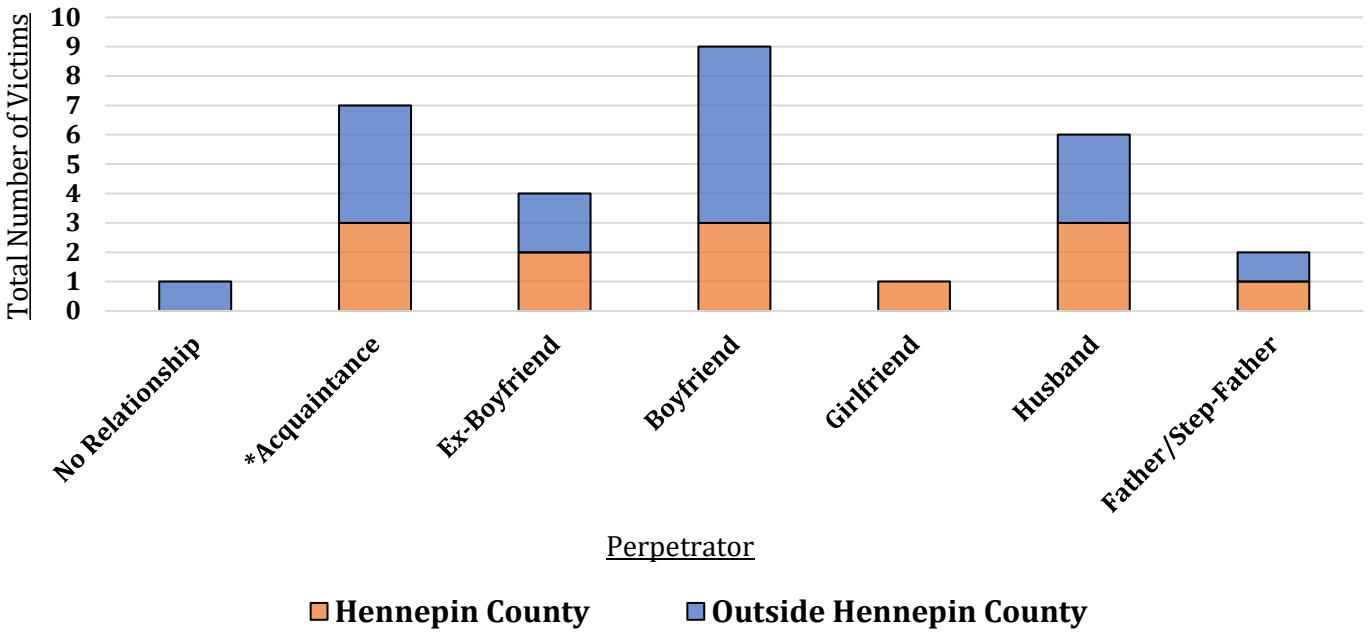


Domestic fatalities resulting from gun violence were the leading cause of death in both the state of Minnesota and Hennepin County area in 2020. At least 10 of the 14 gunshot victims in the state were women, with 5 being from Hennepin County. Of the 14 gunshot victims, the average age of death was ~33 years old in the state of Minnesota, and ~28 years old in Hennepin County.

2020 STATE OF MINNESOTA DOMESTIC HOMICIDES
AGE OF VICTIMS



2020 STATE OF MINNESOTA DOMESTIC HOMICIDES
VICTIM & PERPETRATOR RELATIONS



**Acquaintance is used to loosely describe domestic relationships where the victim knew (or was familiar with) their perpetrator through a third party, relative, or friend. These relationship dynamics were unique to each case, and not commonly represented. The perpetrator relations include: a sibling's ex-boyfriend, an ex-partner's current boyfriend, a parent's ex-partner, a friend's boyfriend, and a casual date.*

2022 Opportunities for Intervention

The Fourth Judicial District Domestic Fatality Review Team examines cases of domestic homicide occurring in Hennepin County, and the lives of those involved, in order to identify intervention and prevention efforts. Although we will never know if the interventions identified could have prevented any of the deaths cited from 2020 in this report; our goal is to offer opportunities where a change in practice by various agencies or individuals, might have changed the outcome of the case and/or could aid in the prevention of future domestic homicides. For each domestic homicide reviewed by the Team, observations about the cause and manner of each victim's death are documented and help guide the creation of Opportunities for Intervention.

These Opportunities for Intervention are not limited to agencies that commonly have interactions with victims or perpetrators prior to a homicide, such as law enforcement or advocacy, but also include agencies or groups that may offer educational information about domestic violence, help to mitigate risk factors of domestic homicide, and/or make referrals to intervention services. Our Team's 2022 review champions a collaborative and cross-sector approach in the prevention of domestic homicides and increasing intervention efforts in cases of domestic abuse.

The Domestic Fatality Review Team's Opportunities for Intervention should be considered by all agencies, organizations, and communities across the Hennepin County area, which includes: Bloomington, Brooklyn Center, Brooklyn Park, Champlin, Chanhassen, Corcoran, Crystal, Dayton, Deephaven, Eden Prairie, Edina, Excelsior, Golden Valley, Greenfield, Greenwood, Hanover, Hopkins, Independence, Long Lake, Loretto, Maple Grove, Maple Plain, Medicine Lake, Medina, Minneapolis, Minnetonka, Minnetonka Beach, Minnetrista, Mound, New Hope, Orono, Osseo, Plymouth, Richfield, Robbinsdale, Rockford, Rogers, St. Anthony, St. Bonifacius, St. Louis Park, Shorewood, Spring Park, Tonka Bay, Wayzata, Woodland. The Team also encourages the state of Minnesota, and the remaining 86 counties represented across the state, to view each opportunity as part of a larger statewide effort to end domestic violence fatalities.

Opportunities for Intervention have been divided into 3 categories of system engagement which includes: Across Systems and Service Providers, Schools and Public Education, and Emergency First Responders and Law Enforcement. With consideration of the important role Emergency First Responders and Law Enforcement have in their response and exposure to cases of domestic violence, the Team expanded on additional Opportunities for Intervention across this system, identified in this report and category 3. This includes but is not limited to: improving victim services, identifying opportunities for prevention through engagement and outreach, reviewing chemical health and mental health protocols, and expanding documentation involving weapons or firearms.

The Domestic Fatality Review Team recommends that ALL agencies refer individuals experiencing domestic abuse to a domestic violence advocacy agency for safety planning, lethality/risk assessments, and other services when domestic violence indicators are present.

The National Domestic Violence Hotline is available 24/7/365 and can be reached by calling: 800-799-7233; or through SMS by texting: "START" to 88788.

1. Across Systems & Service Providers:

- Develop a system for collaborating with other agencies (prosecutors, law enforcement, domestic violence organizations, advocate, probation, etc.) so information is shared more efficiently across systems, and efforts are not duplicated.
- Strengthen a network of resources, available providers, and referral options that can be used by a broad range of professionals when and if a client discloses past or present physical/sexual abuse.
- Involve community agencies as partners in education and intervention efforts.

2. Schools & Public Education:

- Create gender-expansive informational brochures that include resources and support groups for men who identify as victims of domestic violence; create awareness that men can also be the victims of domestic abuse.
- Connect with high school counselors to create opportunities for students and families to access psychological evaluations if patterns of violence, prolonged substance use, and other high-risk behaviors impact an adolescent's ability to thrive in a social and educational setting.
- Review/increase/improve substance use education in schools and for parents of school-aged children.

3. Emergency First Responders & Law Enforcement:

➢ **Victim Services**

- Require law enforcement officers, deputies, and agents to follow-up on domestic assault cases within 24 to 48 hours of the reported incident.
- Institute a verification as part of the incident report or lethality assessment to confirm that advocates have received notice of domestic incidents.
- Contact Safe Place with victim information and make a referral from the scene. Ensure there is a process to include this step in every case involving domestic violence.
- Remove law enforcement from follow-up assignments if they: are the respondent in a pending Order for Protection petition, have had an Order for Protection entered against them, or have pending domestic assault charges or domestic assault convictions.
- Review current domestic violence screening practices across law enforcement agencies to ensure they are gender inclusive, and improve law enforcement identification of domestic violence victims in response to calls not specifically coded as a domestic.
- Review current practices on who is provided resources (a blue card) as an identified domestic violence victim.

3. Emergency First Responders & Law Enforcement (continued):

- **Prevention through Engagement and Outreach:**
    - Increase embedded social workers in all law enforcement agencies across Hennepin County to expand outreach efforts that engage high-risk individuals with frequent law enforcement contact. This could include individuals in domestic situations or with frequent livability or theft offenses. Explore statewide options.

- **Chemical Health & Mental Health Protocol:**
    - Separate parties with more than 1 law enforcement contact (or call for service) occurring within a 2-hour time period if alcohol, drugs, or domestic violence is involved.
    - Encourage law enforcement to re-examine their policies regarding their response to individuals who are under the influence of a substance.
    - Offer detox, or other alternatives, that connect intoxicated individuals with: a safe family member, hospital, detox/treatment center, crisis center, etc.; based on law enforcement training and experience.
    - Reassess civil commitment procedures to determine when an individual is a danger to themselves and/or others.
    - Conduct additional specialized assessments, screenings, and/or testing if an individual self-reports medical or mental health issues unverified by records.

- **Documentation Involving Weapons or Firearms**
    - Create a standardized protocol for law enforcement to verify whether an individual, with whom they have contact in a domestic call, is prohibited from possessing or having access to firearms or ammunition.
    - Ensure a "flag" automatically appears for prohibited individuals when law enforcement runs identifications through DMV/CAPRS/PIMS.
    - Run a background check through dispatch on direct parties involved in assault-related incidents where firearms are reported and/or present, to determine whether a party is ineligible to possess a firearm.
    - Mandate law enforcement to report and submit cases involving contact with individuals prohibited from possessing or accessing firearms or ammunition (who are in violation), to the appropriate charging authority.

Advisory Board Members 2022

Board Chair
Referee Mary Madden*
Judicial Officer
Minnesota Fourth Judicial District Court

Vice Board Chair
Honorable Michael Burns
Judicial Officer
Minnesota Fourth Judicial District Court

Valerie Estrada*
Corrections Unit Supervisor
HCCCR

Bethany Hurd, JD**
Attorney
Hurd Law, PLLC

Jennifer Prax, MA
Family Mediation and Evaluation
Hennepin County Family Court Services

Andrew Reiland II, JD**
Supervising Attorney
Hennepin County Public Defender's Office

Lindsay Siolka, JD*
Supervising Attorney
Hennepin County Public Defender's Office

Gretchen Zettler, JD*
Assistant City Attorney
Minneapolis City Attorney's Office

[*] Resigned from the Board in 2022

[**] Joined the Board in 2022

Domestic Fatality Review Team Members 2022

Daryl Alkire, JD
Former Justice for Families Project Director
Minnesota Fourth Judicial District Court

Pamela Bensen**
Probation Supervisor
HCCCR

Jackie Braun-Lewis
Head of Analytics
Hennepin County Law, Safety and Justice

Honorable Michael Burns
Judicial Officer
Minnesota Fourth Judicial District Court

Zak Chesson
Family Mediation and Evaluation
Hennepin County Family Court Services

Erica Coy
Detective
Eden Prairie Police Department

Theresa Dykoschak, JD*
Pro Bono Counsel
The Advocates for Human Rights

Valerie Estrada*
Corrections Unit Supervisor
HCCCR

Tara Ferguson Lopez, JD
Senior Assistant County Attorney
Hennepin County Attorney's Office

Bethany Hurd, JD
Attorney
Hurd Law, PLLC

Kimberly Johnson**
Investigating Juvenile Probation Officer
HCCR

Amanda Keuseman**
Legal Advocate
Cornerstone

Atif Khan, JD*
Attorney
Hennepin County Public Defender's Office

Audrey Liquard, JD**
Attorney
Hennepin County Juvenile Prosecution Division

Siri Lokensgard*
Legal Service Specialist
Domestic Abuse Service Center

Referee Mary Madden*
Judicial Officer
Minnesota Fourth Judicial District Court

Heather Magnuson, JD
Assistant City Attorney
Bloomington City Attorney's Office

Kim Mammedaty, JD
Senior Assistant County Attorney
Hennepin County Attorney's Office

Nathan Messmer*
Probation Officer
HCCCR Northside Domestic Violence Unit

Joe Mitchell, JD
Attorney
Hennepin County Adult Representation Services

Domestic Fatality Review Team Members 2022

Laura Nolen, JD**
Attorney
Hennepin County Public Defender's Office

Briana Perry, JD**
Attorney
Hennepin County Public Defender's Office

Andrew Reiland II, JD**
Supervising Attorney
Hennepin County Public Defender's Office

Cecelia Rude*
Domestic Violence Community Navigator
Minneapolis Police Department

Lindsay Siolka, JD*
Supervising Attorney
Hennepin County Public Defender's Office

Samantha Scott, PhD*
Forensic Psychologist
Hennepin County Psychological Services

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