# 2023 Annual Report

Minnesota Fourth Judicial District
Domestic Fatality Review Team

## Project Chair:

The Honorable Michael Burns
Minnesota Fourth Judicial District

## 2023 Local & Community Partners:

Bloomington City Attorney's Office
Brooklyn Center Police Department
Cornerstone
Domestic Abuse Project
Eden Prairie Police Department
Hurd Law PLLC
Maple Grove Police Department
Minneapolis City Attorney's Office
Minnetonka Police Department
Missions Inc. Home Free Shelter
Standpoint

## 2023 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 Health & Human Services
Hennepin County Law, Safety and Justice
Hennepin County Medical Examiner
Hennepin County Psychological Services
Hennepin County Public Defender's Office
Minnesota Department of Health
Minnesota Fourth Judicial District Court Administration
Minnesota Fourth Judicial District Court Criminal, Family & Juvenile Divisions
Minnesota Fourth Judicial District Court Research
University of Minnesota Twin Cities School of Social Work

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## This report is a product of:

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

*Cover Art by Chloe Stella; Visual & Editorial Designer, 2023.*

# Domestic Fatality Review Team 2023 Annual Report

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# Acknowledgements

**Together, The Honorable Michael Burns- Project Chair, and Makenzie Nolan- Project Director, would like to extend their deepest gratitude on behalf of Minnesota's Fourth Judicial District Domestic Fatality Review Team by acknowledging community partners and guest presenters who supported the work of the Team over the course of 2023.**

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;

Members of the Team who selflessly offer their time and professional expertise in the review of each case;

Local law enforcement agencies across Hennepin County with dedicated Domestic Abuse Response Teams (DART) that operate with specialized training to help domestic abuse victims and are critical to local prevention and intervention efforts;

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

The parents of a beautiful soul and victim of domestic homicide, who willingly met with members of the Advisory Board to provide deeply personal and privileged information to aid in the Team's case review for 2023;

**The following professionals and content experts who joined the Team in 2023 to present information pertinent to each case review:**

Andrew Baker, M.D.; Chief Hennepin County Medical Examiner

Erica Coy; Former Detective with Eden Prairie Police Department

Lorren Jackson, M.D.; Assistant Hennepin County Medical Examiner

Shawn Wilson; Department Administrator at Hennepin County Medical Examiner

Stephanie Magnuson; Presentence Investigations at HCCCR

Grant Smith; Seargent at Maple Grove Police Department

# Prevention & Support Services for Domestic Violence

## Important Note from the Domestic Fatality Review Team

*It is the Team's belief that to disrupt future domestic fatalities and address an alarming increase in domestic homicides committed across the State of Minnesota in 2023, this work requires something of everyone, and it calls on our shared humanity.*

*To this point, it is important to preface that anyone can become a witness to an active domestic dispute, an innocent bystander, and/or a victim of intimate partner violence. It can also happen to those closest to you— friends, family, neighbors, co-workers, peers in faith circles etc. It can happen to absolutely anyone and it can happen behind closed doors. Help break the silence around intimate partner violence by doing* ***YOUR*** *part to help spread awareness.*

***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

Available 24/7, 365 days a year, the National Domestic Violence Hotline provides essential tools and support services to help survivors of domestic violence get connected to highly trained, expert advocates for free, confidential, and compassionate support, crisis intervention information, education, and referral services in over 200 languages. The National Domestic Violence Hotline can be reached by calling: 1-800-799-7233 (TTY 1-800-787-3224); SMS by texting: "START" to 88788; or through live chat on their website.

## The National Deaf Domestic Violence Hotline

The Deaf Hotline is a 24/7 national hotline that is ASL accessible for people experiencing abuse who identify as Deaf, DeafBlind, or Hard of Hearing. Individuals can access safety planning, crisis intervention, and emotional support through videophone calls and by phone with connection to an interpreter at: 1-855-812-1001; or through email submission using their website.

## Minnesota Day One Crisis Hotline

Day One is a statewide network that serves victims and survivors of general crime, domestic violence, human trafficking, and sexual violence. Day One hosts the Minnesota Day One Crisis Line and connects individuals seeking safety and resources to service agencies statewide by phone: 1-866-223-1111; SMS by texting: 612-399-9995; email: safety@dayoneservices.org; or through live chat on their website.

## Hennepin County Domestic Abuse Service Center

The Domestic Abuse Service Center (DASC) offers support services and safety planning for victims of domestic violence which includes advocacy, filing Orders for Protections, legal consultation and representation from pro-bono attorneys, and connection to the Hennepin County Attorney prosecution team. All services can be accessed by calling: 612-348-5073; or by visiting the Domestic Abuse Service Center located on the lower level of the Hennepin County Government Center (LL0650) at 300 South Sixth Street Minneapolis, Minnesota 55487. DASC hours of operation can be found on their website.

***Additional national and statewide victim support resources, safety planning, and enrollment information for Safe at Home Minnesota can be accessed by visiting the Office of the Minnesota Secretary of State website.***

# About the Domestic Fatality Review Team

The Minnesota 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 community.

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, which are homicides related to domestic violence. Domestic abuse, also called "domestic violence" or "intimate partner violence," can be defined as a pattern of behavior in any relationship that is used to gain or maintain power and control over another. Domestic abuse is defined by the United Nations to include physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound someone. Domestic abuse can happen to anyone of any race, age, sexual orientation, religion, or gender. It can occur within a range of relationships and affects people of all socioeconomic backgrounds and education levels.

## Purpose:

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

## Goal:

The goal of Team 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 violence.

## Advisory Board:

The Advisory Board represents a group of elected members who have served on the Team for a minimum of 6 months, are recommended by an existing Advisory Board member, and receive approval from the Board Chair. As the governing body of the Fourth Judicial District Domestic Fatality Review Team, the Advisory Board is responsible for adhering to Minnesota State Statutes and Team Bylaws, and appointing members to the Domestic Fatality Review Team. The Advisory Board generally meets bi-monthly or on an *ad hoc* basis throughout each review year. The Advisory Board is tasked with upholding the Team's Code of Ethics, and ensuring that the Team operates in a respectful, professional, and confidential manner that adheres to data practices and Team Meeting Guidelines.

## Team Members:

The Team includes professionals in select roles, often operating within the system, who are most likely to overlap with perpetrators and victims of domestic violence. 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 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, Team members would gather and conduct monthly in-person meetings for each case under review. In 2020, the work of the Team moved to a virtual platform following the Covid-19 Global Pandemic. Since then, the Team has continued to hold virtual monthly meetings and in 2023 welcomed more than 6 guests and content experts to present information to the Team in a virtual setting. Unlike recent years, the Team and Advisory Board came together to close out 2023 with an in-person meeting which included a presentation by Chief Hennepin County Medical Examiner and an in-depth tour of the Hennepin County Medical Examiner's Office.

## 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 and any appellate process 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 its assumptions.
- Many incidents that reflect exemplary or best-practice responses to domestic violence, both inside and outside the justice system, are not included.
- The Team appreciates that several of the agencies who 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 identified Opportunity for Intervention.
- We will never know if an Opportunity for Intervention 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 achieves its goal and purpose through the intentional and meticulous review of each domestic homicide case. With its multi-disciplinary lens, the Team engages in a collaborative review process using 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 an individual's lifetime. The Opportunities for Intervention developed by the Team are, by extension, fully contextualized within the lives and experiences of the people involved in each case. The Team uses 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 Reports, homicide records from the Hennepin County Medical Examiner, 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 on which cases to review. 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. If a case includes 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 limit exposure to secondary trauma and emotional distress experienced by members who may have had direct involvement in a case.

## The Case Review Process

After a case is selected for the Team's review, the Project Director sends requests for agencies to provide documents. 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.

To begin each case, the Project Director compiles all available information to create a chronology of a case that narrates 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. A copy of the case chronology is sent to Team members prior to the first case review meeting. Each Team member is responsible for completing a confidentiality agreement prior to beginning a new case. The first meeting and introduction to a new case begins with a clinical presentation on autopsy findings and toxicology results from the Hennepin County Medical Examiner. 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 and can help substantiate source documents reviewed by the Team. As part of the Team's review process and meeting structure, 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 month, Team members take turns reviewing and presenting source documents. A series of observations are made by the Team in relation to each source document and the systemic responses. These observations are used to identify Opportunities for Intervention that may have impacted the outcome of a case and/or could aid in the prevention of future domestic homicides. The Team records key issues, observations, and Opportunities for Intervention related to each case, all of which are considered in the composition of each annual report.

# 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 by year. The Team's case selection process for 2023 was largely dependent on what was available to the Team—in no particular order—and included an extended case review that was carried over by the Team from 2022.

The Team will select 2-4 cases in a calendar year and will review one case at a time. Because the Team only convenes once a month, the case review process occurs over the course of several months. Homicide cases can take the Team 3-6 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 and thorough documentation is compiled for the domestic homicide under review, a designated confidential case chronology is created and distributed to each Team member; signaling the case is ready to be reviewed by the Team. Members of the Team often begin each case review by independently examining the confidential case chronology 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 for each case. 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.

In 2023, the Team reviewed 2 homicide cases that occurred in 2016 and 2020, both of which are documented in this report through the Presence of Risk Factors, 2016 and 2020 Minnesota Domestic Homicide Data, and corresponding Opportunities for Intervention identified by the Team. All 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 and can be referenced beginning on page 18**.** Out of respect for the privacy of the victims and their families, all identifying information has been removed.

The Domestic Fatality Review Team hopes that the information in this report will prompt active changes to policy and practice that may help to prevent future domestic homicides. Agencies across municipal jurisdictions and state government are encouraged to take advantage of the Opportunities for Intervention identified by the report.

Regional support for domestic fatality prevention efforts across Minnesota's remaining 86 counties continues to be a goal of Minnesota's Fourth Judicial District Domestic 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 "lethality factors" that are often present in cases of domestic homicide. The Domestic Fatality Review Team notes the presence of risk factors in their review of each case, because increasing the public's awareness on risk factors for domestic homicide is an identified Opportunity for Intervention in itself.

| **Risk Factors: 2023** | **Case 1** | **Case 2** |
|---|---|---|
| The violence had increased in severity and frequency during the year prior to the homicide. | | **X** |
| Perpetrator had access to a gun. | **X** | |
| Victim had attempted to leave the abuser. | **X** | **X** |
| Perpetrator was unemployed and/or experienced temporary unemployment. | | **X** |
| Perpetrator had previously used a weapon to threaten or harm victim. | | |
| Perpetrator had threatened to kill the victim. | | **X** |
| Perpetrator had previously avoided arrest for domestic violence. | | **X** |
| Victim had children not biologically related to the perpetrator. | | |
| Perpetrator sexually assaulted victim. | | **X** |
| Perpetrator had a history of substance abuse. | **X** | **X** |
| Perpetrator had previously strangled victim. | | **X** |
| Perpetrator attempted to control most or all of the victim's activities. | **X** | **X** |
| Violent and constant jealousy. | **X** | **X** |
| Perpetrator was violent to victim during pregnancy. | **NA** | **X** |
| Perpetrator threatened to commit suicide. | **X** | **X** |
| Victim believed perpetrator would kill him/her. | | |
| Perpetrator exhibited stalking behavior. | **X** | **X** |
| Perpetrator with significant history of violence. | | **X** |
| Victim had contact with a domestic violence advocate. | | **X** |

# Domestic Homicide Data

The Team's 2023 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 that year. This report only includes data detailing domestic homicides that occurred in 2016 and 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 as research conducted by the Team.

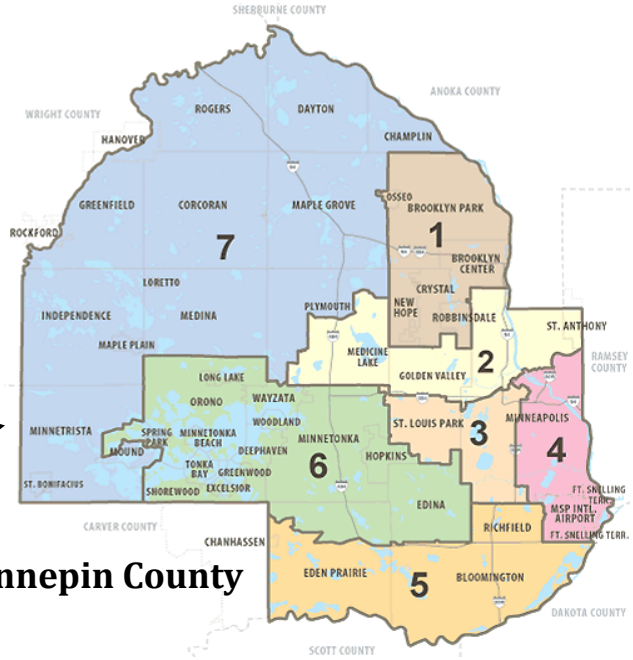
## Population

Minnesota's Fourth Judicial District includes only Hennepin County which is the state's largest trial court with 63 judges, 12 referees, and 582 staff who process approximately 40% of all cases filed in the state.

Hennepin County is located on the cultural, spiritual, and indigenous homeland of the Dakota Oyate (Dakota Nation) and is 1 of 87 counties in the State of Minnesota. Hennepin County has the largest population density of any county in the State of Minnesota, and is home to an estimated 1.2 million people, according to the United States Census Bureau. Hennepin County's total land area equates to only 554.0 square miles making it the 60th largest county in Minnesota by geographic area, and is bordered by Anoka County, Wright County, Dakota County, Carver County, Ramsey County, Sherburne County, and Scott County.

Hennepin County contains 45 cities, 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, and Woodland.

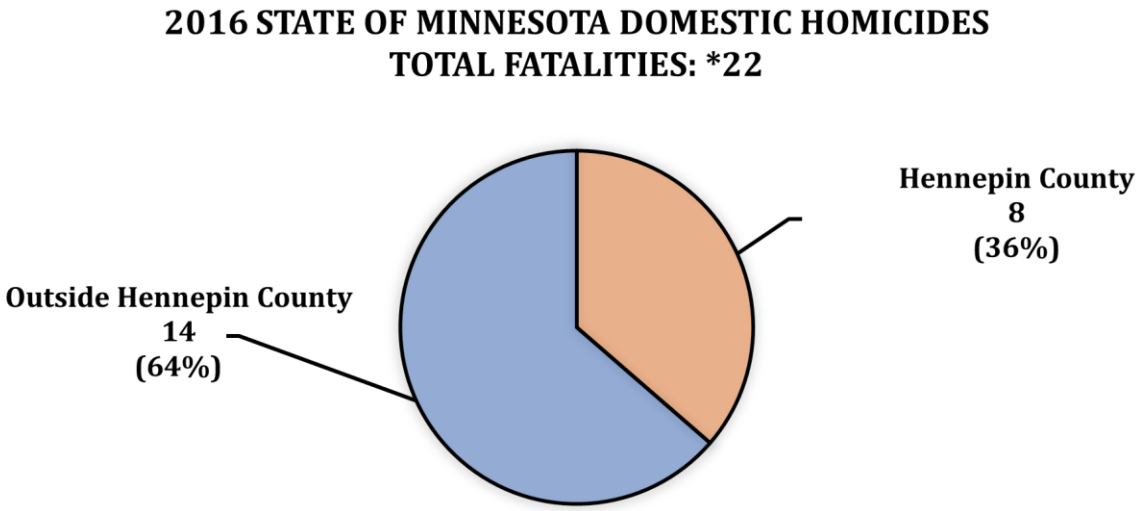
**Minnesota Fourth Judicial District**




**Hennepin County**

## 2016 Domestic Homicide Data

In 2016, at least 22 Minnesotans were killed due to violence resulting from domestic abuse. **A total of 8 domestic homicides were recorded in Hennepin County** (Brooklyn Park [1], Eden Prairie [2], Minneapolis [4], and Plymouth [1]); and 14 domestic homicides were recorded as occurring outside of Hennepin County (Apple Valley [1], Bemidji [1], Coon Rapids [1], Cottage Grove [1], Faribault [1], Good Thunder [1], Hastings [1], Isle [1], Lewiston [1], Mahnomen [1], Mankato [1], Ramsey [1], Wadena [1], and Woodbury [1]).

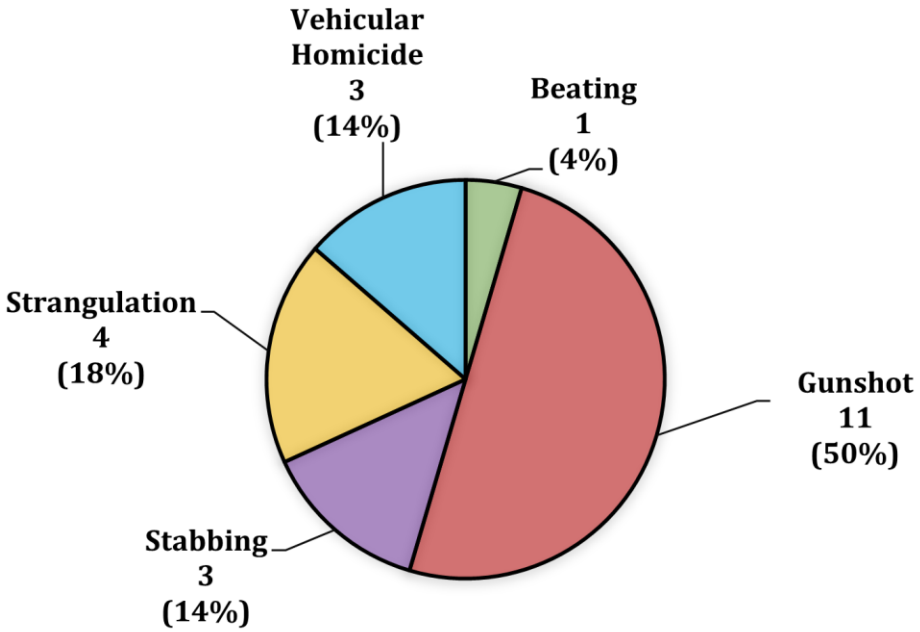



Of the 22 domestic homicides reported in the State of Minnesota in 2016, at least 19 of the victims identified as women and at least 5 were from Hennepin County. Additionally, at least 1 of the 22 victims was pregnant (*this case was later classified as a double homicide and contributed to the total count of 22 fatalities in Minnesota); and 1 victim was identified as a vulnerable adult. At least 8 of the 22 victims of domestic homicide were parents and/or had children, and at least 1 of those victims resided within Hennepin County.

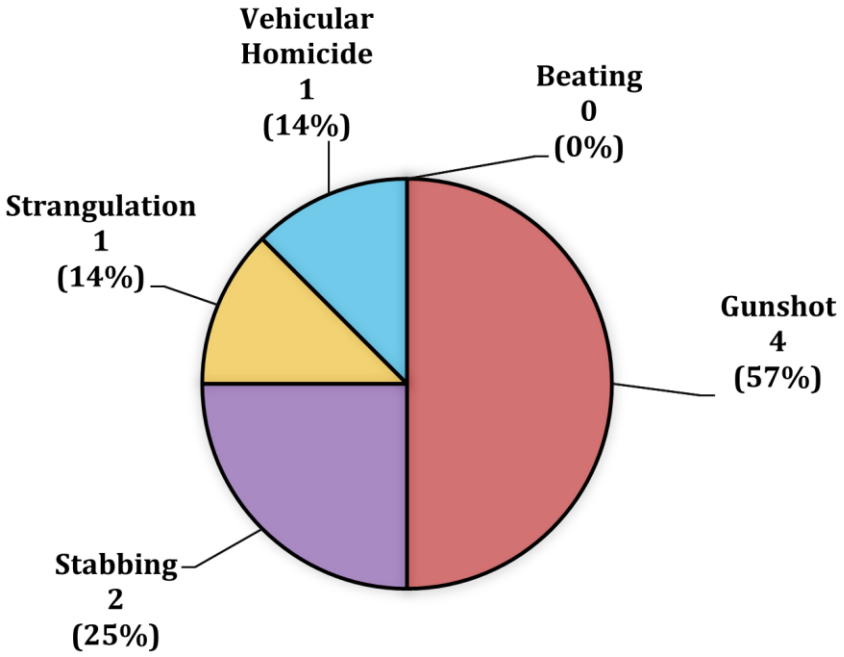
In 2016 domestic homicides left at least 19 people in the state without a parent; at least 2 of those impacted were from Hennepin County. Data outlining the specific cause of death for each victim of domestic homicide in 2016 can be reviewed on page 13. *It should be noted that the 2 victims in the double homicide case (referenced above) are both included under the same cause of death category in the state and county 2016 domestic homicide data sets. The primary cause of death in this case is categorized by the way in which maternal injuries were inflicted by the perpetrator.*

Homicide-suicides accounted for at least 54% of the homicide cases reported in 2016, with a total of 12 perpetrators committing suicide; 3 of which occurred in Hennepin County. Although homicide-suicides are not uncommon, the number recorded in 2016 is significant.

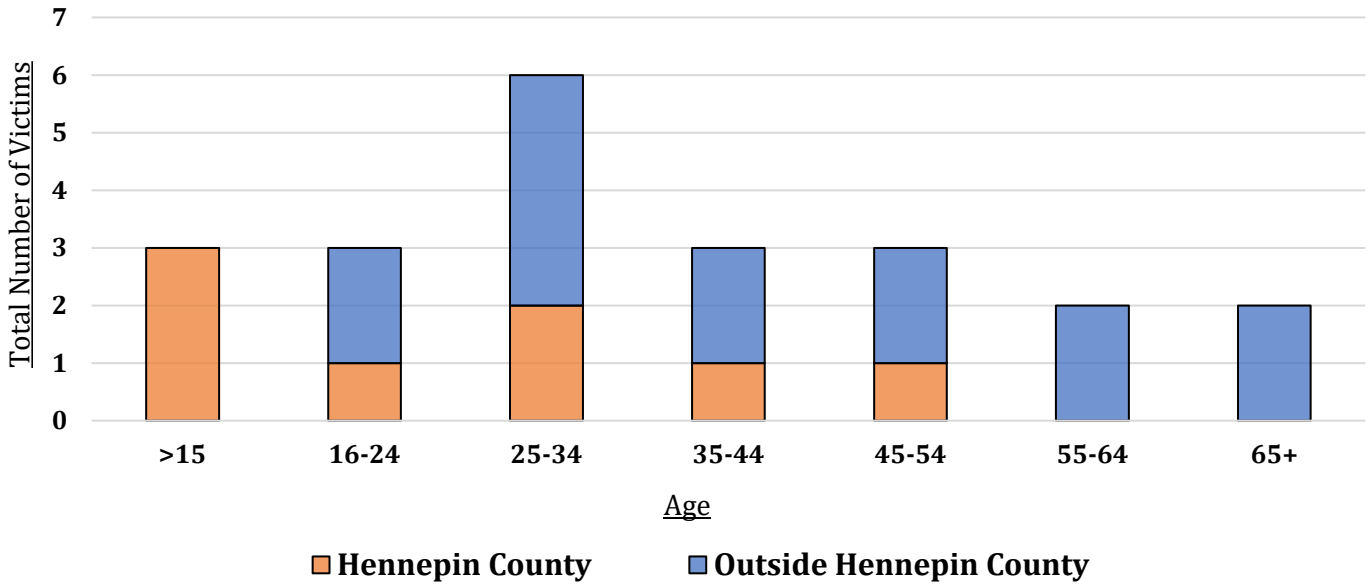
## 2016 STATE OF MINNESOTA DOMESTIC HOMICIDES CAUSE OF DEATH



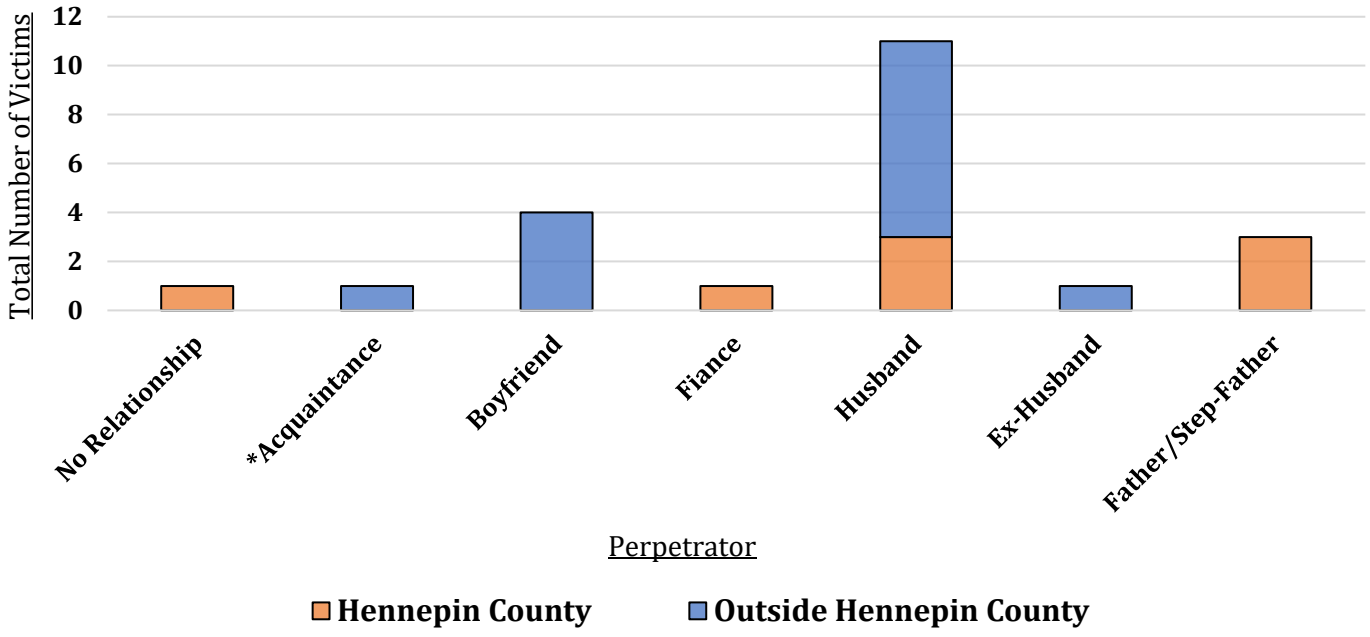

## 2016 HENNEPIN COUNTY DOMESTIC HOMICIDES CAUSE OF DEATH



# 2016 STATE OF MINNESOTA DOMESTIC HOMICIDES
# AGE OF VICTIMS



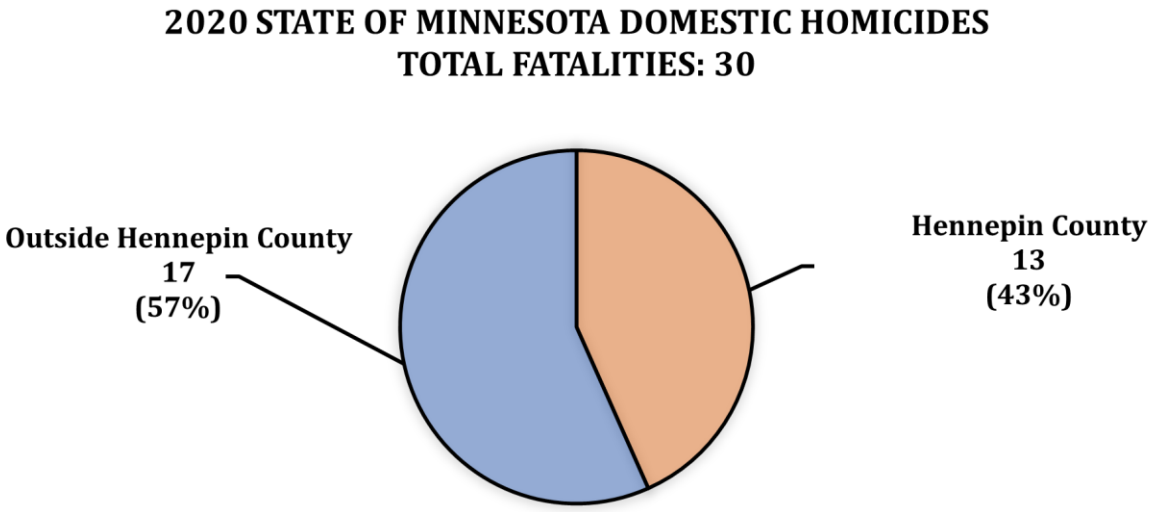

# 2016 STATE OF MINNESOTA DOMESTIC HOMICIDES
# VICTIM & PERPETRATOR RELATIONS




*"Acquaintance" is used to loosely describe domestic relationships where the victim knew (or was familiar with) the perpetrator through a third party, relative, or friend. These relationship dynamics were unique to each case, and not commonly reprepresented. The perpetrator relation referenced is an uncomfirmed casual or brief relation.*

## 2020 Domestic Homicide Data

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], and 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], and St. Paul [6]).

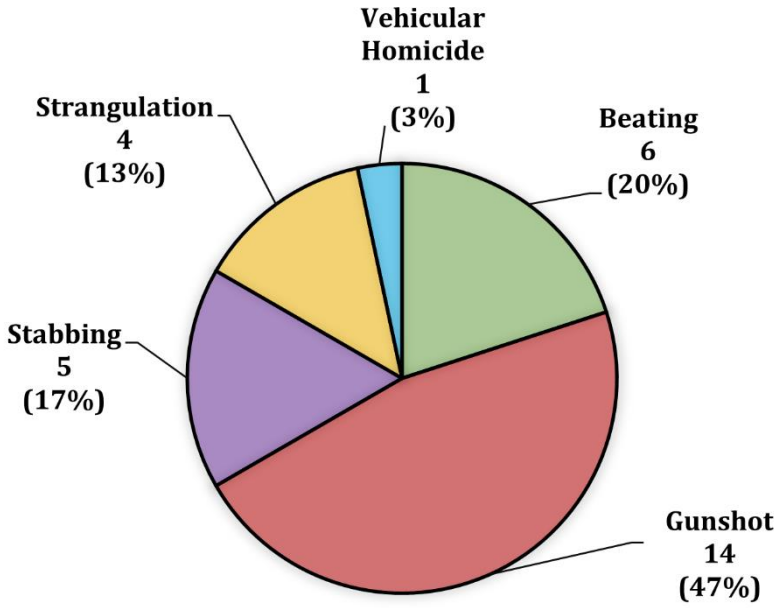



Of the 30 total domestic homicides reported in the State of Minnesota in 2020, at least 22 of the victims identified as women and at least 10 were from Hennepin County. Additionally, at least 4 of the 30 victims in the state were pregnant (Cloquet [1], Rochester [1], St. Paul [1], and Minneapolis [1]), and at least 1 of the 30 fatalities was the result of premature birth in Hennepin County. 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.

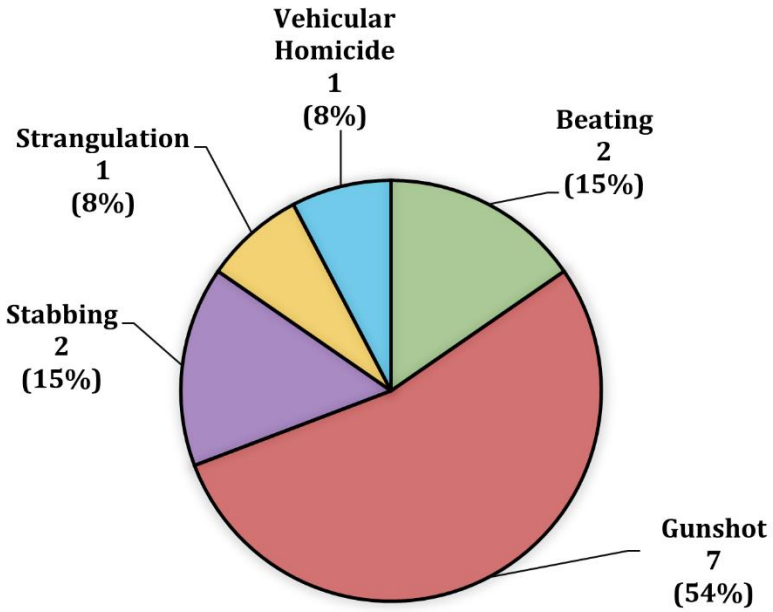
In 2020 domestic homicides left at least 20 people in the state without a parent; at least 7 of those impacted were from Hennepin County. Data outlining the specific cause of death for each victim of domestic homicide in 2020 can be reviewed on page 16.

Homicide-suicides accounted for at least 16% of the homicide cases reported in 2020, with a total of 5 perpetrators committing suicide; 2 of which occurred in Hennepin County. Of these 2 cases, one perpetrator committed suicide while in jail after their conviction and the other committed suicide after being charged. There were at least 2 additional cases—one being in Hennepin County—of attempted suicide where the perpetrator survived. This number is not as statistically significant compared to the rate of homicide-suicides that occurred in 2016.

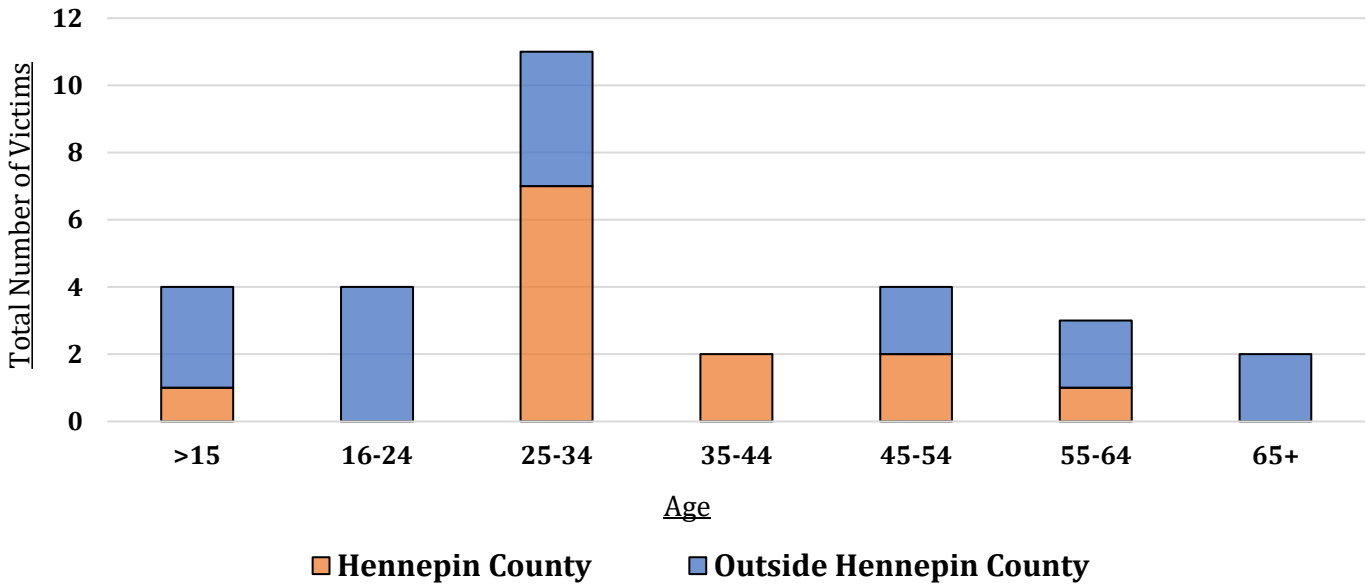
## 2020 STATE OF MINNESOTA DOMESTIC HOMICIDES CAUSE OF DEATH



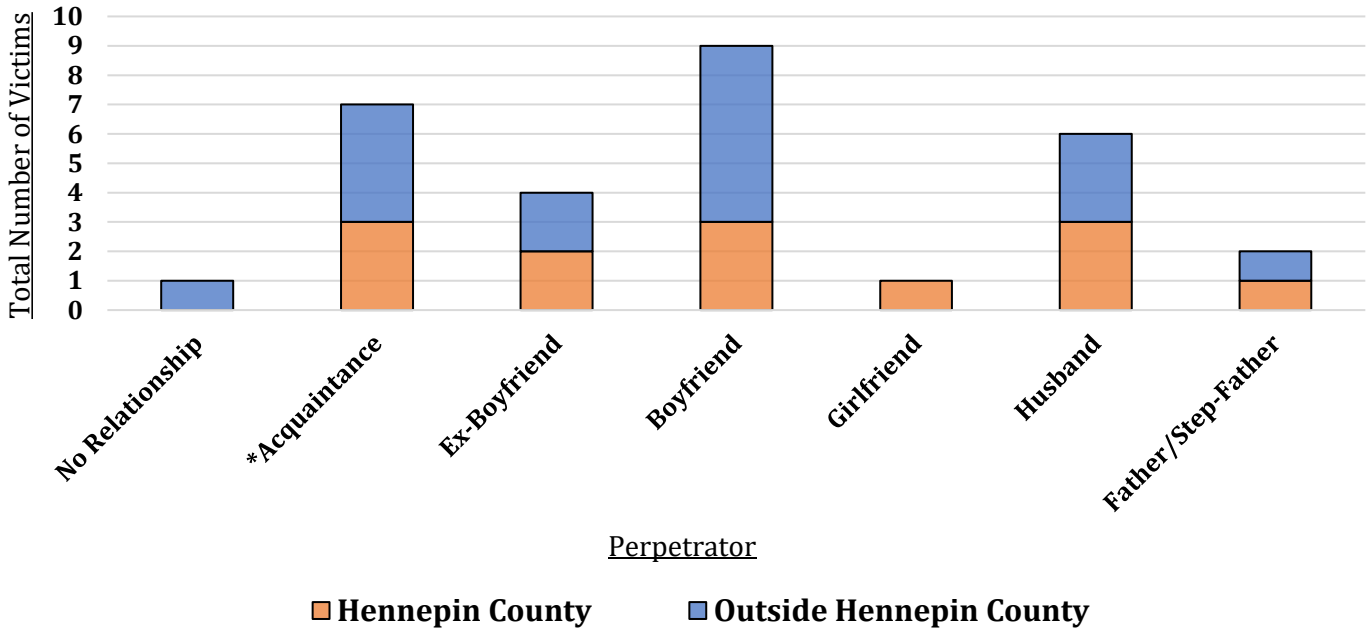

## 2020 HENNEPIN COUNTY DOMESTIC HOMICIDES CAUSE OF DEATH



# 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) the perpetrator through a third party, relative, or friend. These relationship dynamics were unique to each case, and not commonly reprepresented. 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.*

# 2023 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, to identify intervention and prevention efforts. Although we will never know if an intervention identified could have prevented any of the deaths cited from 2016 and 2020 in this report, the goal of the Team is to offer opportunities where a change in practice by various agencies or individuals may have impacted 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 based on numerous risk factors observed by the Team, as well as overlapping and thematic patterns that are pulled from the totality of cases reviewed in 2023.

The goal of each annual report is to help raise awareness and strengthen the public's response and identification of domestic violence by highlighting each Opportunity 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. Each Opportunity for Intervention identified by the Team can support proactive prevention strategies and standard operating directives that can be implemented and applied to daily practice and processes across *all systems that interface and engage with people*.

The Domestic Fatality Review Team's Opportunities for Intervention should be considered by all agencies, organizations, and communities across the Hennepin County area and its 45 cities.

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 across state, county, and city lines.

Each of the 2023 Opportunities for Intervention have been divided into 5 categories to assist the reader and identify potential areas of focus for system intervention. The 5 categories cited in this report include: 1. *Early Education: Critical Prevention Measures to Disrupt the Cycle of Violence* with reference to Accessing Higher Education, Faith Based Education and Organized Religion; 2. *Addressing Language & Accessibility Barriers: Improving Public Engagement*; 3. *Child Protective Services (CPS): Reviewing Processes & Creating Measures for Accountability*; 4. *Civil Protective Orders: Reviewing Processes & Measures for Accountability*; and 5. *Protecting Victims' Assets from Perpetrator Abuse & Exploitation*. **The full list of Opportunities for Intervention can be found on pages 19-23.**

## 1. Early Education: Critical Prevention Measures to Disrupt the Cycle of Violence

The Team's Opportunities for Intervention signify a need for prevention strategies that touch each age and stage of life, and this often begins with our youth and education systems. Educators have a unique and evolving role that often goes beyond teaching academic curriculums with ever-present and impeding public health and safety concerns becoming part of educators' daily reality.

Educators operate within one of the most intimate familial systems placing them in close proximity to students' families, parenting dynamics, peer-to-peer relationships, and knowledge of each student's home life, especially when it percolates into the classroom through concerning social behaviors, academic performance, and physical appearance. Teachers can often be the first to detect when something is "off" with a student and can witness the interplay of [unhealthy] dating dynamics or modeled behavior between students. Because of this intimate exposure to students' livelihood, educators can serve as lifeline and offer a critical point of intervention in disrupting the cycle of violence. The Team identified the following Opportunities for Intervention:

- Educate school staff (teachers and counselors) on the complexities surrounding domestic and sexual violence and referral/support options for students.

- Provide schools with age-appropriate language and opportunities for intervention when children exhibit violent or combative social behaviors.

- Raise awareness through a state-led curriculum that details objective healthy and unhealthy relationship characteristics through a variety of formats, beginning with early education pre-K through 12th grade, and continuing through post-secondary education.

- Develop legislation to educate youth and young adults on the signs of domestic and sexual violence, including the building blocks of consent and bystander intervention accessible to every student.
    - Could be integrated within existing health classes and include guest presentations and partnerships with local advocates.
    - Utilize social media outlets and QR codes to improve consistent and accessible messaging in public spaces.

## Accessing Higher Education

- Add a requirement within Licensed Marriage and Family Therapist (LMFT) certification that mandates successful completion of domestic violence education and offer additional trainings/courses as part of continuing education and career development. This should be encouraged for anyone who has contact with this potential population or is working towards other advanced certifications like Social Work.

## Faith Based Education & Organized Religion

- Extend resources and engage faith leaders in tailored education modules that help identify and address signs of domestic violence and silent abuse issues that occur between spouses within the sanctity of marriage as defined by each faith.

- Encourage collaboration with community advocacy groups to address the stigma and cultural norms that may determine gender roles, religious requirements, and beliefs of what abuse looks like and how people can use their place of worship to get help.

## 2. Addressing Language & Accessibility Barriers: Improving Public Engagement

The Team views public engagement as a necessary part of prevention work that can help reduce cases of domestic fatalities. Like the Opportunity for Intervention cited above, providing equitable access to education through information sharing is paramount. To best serve the general public, the Team would like to emphasize that all service providers who work or engage with perpetrators and victims of domestic violence must actively work to reduce language and communication barriers that exist across systems. This includes closing the gap between standards of practice that exist across state, county, and city agencies and assessing how each system interacts with people from all language backgrounds and with the Deaf, DeafBlind, and Hard of Hearing community.

Failure to meet communities where they are can have devastating consequences and further isolates victims of domestic violence. The Team has unfortunately observed the impact this can have on the quality and quantity of information available to law enforcement and other systems involved in the early investigation of domestic fatalities. It can be detrimental to individuals most intimately involved in a case (families, friends, faith communities, members of different cultural groups, immigrants, and individuals with disabilities etc.) are not provided or offered interpreters. The Team has identified the following Opportunities for Intervention:

- Request interpreters and/or exhaust all available resources to ensure adequate language access for all investigative and system involvement with families who use English as a second language.

- Create a statewide hotline number specific to domestic violence resources that allows people to call and have any language and ASL interpretation services available, modeled after the statewide Mental Health Hotline number.

- Provide education regarding a variety of cultural and generational norms and why some things are no longer socially acceptable or will aid in an individual's holistic wellness.

- Include "Domestic Violence 101" presentations at housing conferences for hotels, apartment managers, and other housing ventures in a variety of languages, including ASL, to provide coaching on resident safety; improvement of building security— "Safe at Home" applications (available through the Office of the Minnesota Secretary of State), maintaining confidentiality, and how to help when suspecting someone is not safe at home.

## 3. Child Protective Services (CPS): Reviewing Processes & Measures for Accountability

Victims of domestic violence and their families must overcome tremendous obstacles to leave abusive situations. There are many reasons that can lead a victim and their family to relocate, and while each case is unique, the Team has observed common themes across households. For example, a family may move to a different city, county, or state to get away from the perpetrator of domestic violence and avoid further abuse; to remove their children from an unsafe environment; to avoid further system involvement; and/or regain unrestricted access to their children if Child Protective Services (CPS) and/or Juvenile Court has become involved. For the latter, often this means CPS has opened an investigation, and depending on the circumstances, children could be temporarily removed from a parent or guardian's custody due to (but not limited to) a minor being in imminent danger, evidence of abuse and/or neglect to a minor, or the perpetrator and victim live together increasing the risk of lethality or serious harm for all who reside in the household.

These factors observed by the Team can impact the outcome of a case. The Team identified an Opportunity for Intervention that specifically applies to CPS processes when working with families with indicators of domestic violence present, and who move between state lines. Although CPS cases can be sent to another state via an interstate compact- an agreement between states on the placement and supervision of children and their family; often the state of the family's origin will keep jurisdiction of a case, and the receiving state will provide services. This is largely dependent on another state's system, mandates, and general accountability to the people they serve. Sometimes families move undetected, or a case is not transferred. The goal of this Opportunity for Intervention is not to further penalize victims and their families, but rather to highlight additional opportunities for improving victim and child safety from a perpetrator of abuse through the following Opportunities for Intervention:

- When "failure to protect" is determined, CPS must assess barriers that could prevent a victim/family from fleeing abuse and connect victims/families to appropriate resources. This could include help to alleviate barriers that make it difficult for victims to flee abusive relationships such as financial dependence, lack of access to adequate housing, and fear children will be removed when reporting instances of domestic violence.
    - Create inter-state notification requirements for open CPS cases (similar to inter-state compact for adoption cases).

- Create accountability measures for the perpetrator by ensuring CPS engages victims/families in safety planning and as part of conditional release.
    - Establish a CPS requirement that perpetrators alleged of committing domestic violence must go through programming.

## 4. Civil Protective Orders: Reviewing Processes & Measures for Accountability

In Minnesota, "Civil Protective Orders" include Orders for Protection; Harassment Restraining Orders; and Extreme Risk Protection Orders, which go into effect January 1, 2024. Victims of domestic violence will often file an Order for Protection against their abuser to receive protection ordered by the court and enforceable by law. If granted by the court, protective orders can include: no contact provisions; exclusions from a home or other locations frequented by a victim; exclusion from the victim's place of employment; temporary child custody and/or parenting time; temporary supports; and/or possession of a pet or companion animal. In cases of domestic homicide reviewed by the Team, system documentation of each civil protective order issued is essential for enforcement, public safety, and the prevention of domestic fatalities.

Under both state and federal law, individuals convicted of domestic assault, and/or against whom a civil protective order has been issued, may be restricted from possessing firearms or ammunition for a period of time following the conviction or issuance of the order. This is critically important information that can help reduce the risk of gun violence and use of deadly force against first responders, or members of law enforcement, when responding to domestic calls. With this in mind, the Team identified the following Opportunities for Intervention:

- Create a statewide and nationwide database using National Crime Information Center (NCIC) to allow systems at all levels to access up-to-date information regarding protective orders filed on all protected persons, and flag individuals prohibited from possessing firearms and/or ammunition.
    - Facilitate statewide collaboration to help improve public safety and ensure individuals moving across state lines who pose significant safety risks are more easily identifiable.

- Create a system in which protective orders can be attached to a state issued driver's license and filed in each local jurisdiction where an individual lives and/or works.
    - Ensure domestic violence advocates are available to victims in every Police Department or Sheriff's Department in the assigned county.
    - Provide necessary funding for the technological and administrative infrastructures required across Minnesota Department of Public Safety's Driver and Vehicle Services, and support implementation.

## 5. Protecting Victims' Assets from Perpetrator Abuse & Exploitation

Based on the Team's review of cases from 2016 and 2020, the Team identified an Opportunity for Intervention that is specific to honoring a victim's autonomy and personhood after a domestic homicide is committed by their spouse or next of kin beneficiary. In 2016, 50% of all domestic homicides committed in Minnesota were committed by a victim's spouse, compared to 20% of domestic homicides in 2020. Following a victim's death, the right to control the deceased human body, including the location and conditions of final disposition, will often remain with the perpetrator or spouse, unless otherwise directed in writing (a will or other legal document) prior to a victim's death, pursuant to Minnesota State Statute 149A.80, subdivision 1. This Opportunity for Intervention would relinquish a perpetrator's "ownership" and control by identifying ways in which the system can honor the victim, their autonomy from control, and the wishes of a victim's family.

The goal of this Opportunity for Intervention is to eliminate the process of the Hennepin County Medical Examiner obtaining consent and/or an order to conduct an autopsy to determine the formal cause of death. This process impedes a victim's autonomy and final freedom of control from their abuser. This process can also compound the emotional and physical distress shouldered by the family of the victim. To honor the dignity and personhood of victims of domestic homicide, the Team identified the following Opportunities for Intervention:

- Review current legislation, policies, and opportunities for a victim's family to gain rights when a domestic homicide has occurred, and the perpetrator is the victim's spouse or next of kin beneficiary.

- Provide a victim's family with the opportunity to petition the court for rights (i.e. to the victim's body, property, accounts, etc.) when an intimate partner is charged with causing the death. Consider allowing prosecutors to assist by providing information a family is entitled to seek relief based on a criminal case being filed.

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