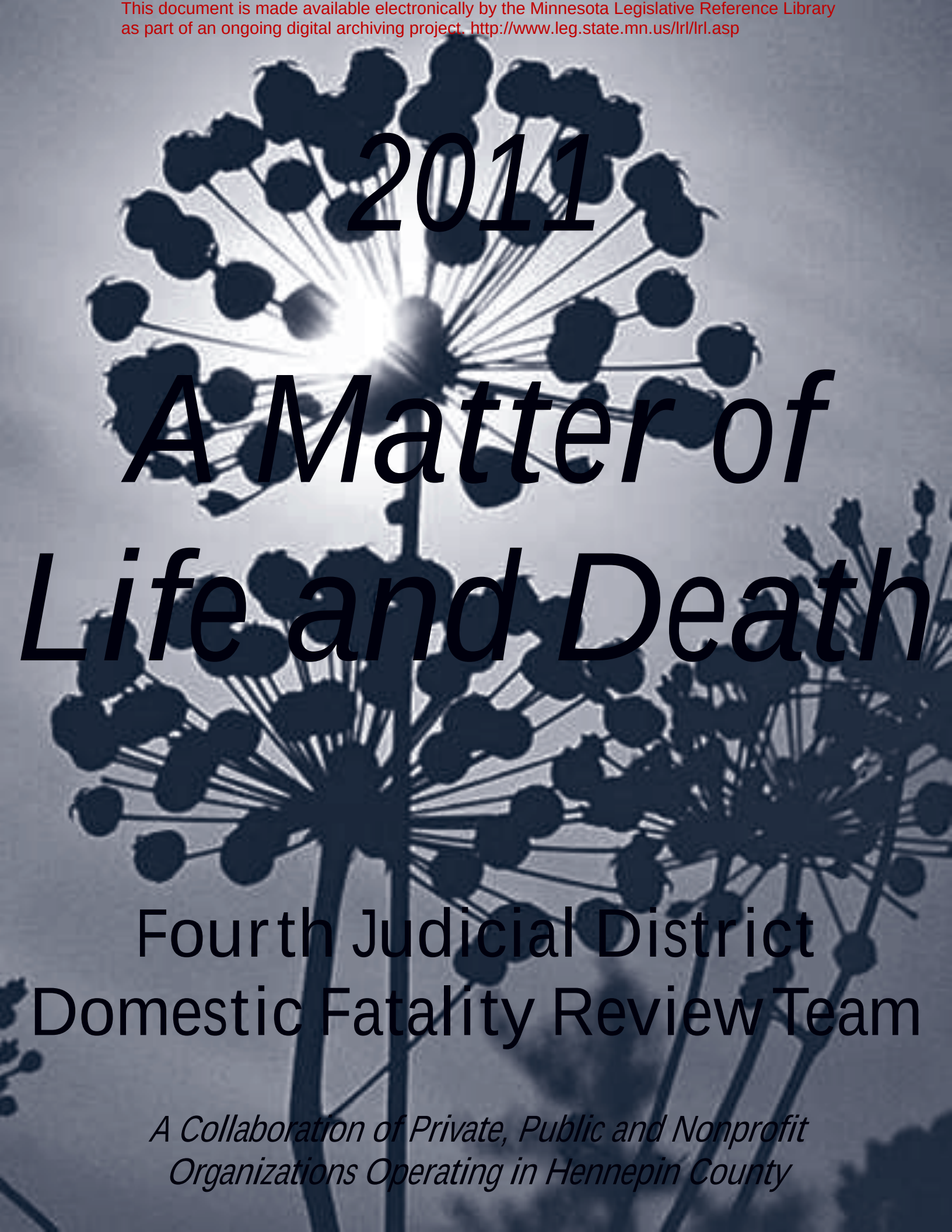

2011

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

2011 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
General Mills
Minneapolis City Attorney's Office
Minneapolis Police Department
Minnetonka City Attorney's Office
Mound Police Department
Outfront Minnesota

2011 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

For more information please contact:

The Honorable Gina Brandt
Minnesota Fourth Judicial District
Project Chair
612-348-5049
or
Deena Anders
Project Director
651-263-2901

www.amatteroflifeanddeath.org

Table of Contents

Appendices

Acknowledgments

The Honorable Gina Brandt, Project Chair, gratefully acknowledges the supporters and members of the Fourth Judicial District Domestic Fatality Review Team:

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

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

The Review Team and Advisory Board members who give their time generously, work tirelessly and share their experience and wisdom in the review of each case.

Bethany Dorfe, Team Volunteer Extraordinaire, for her continued exceptional support and general awesomeness.

The leaders of partner organizations who willingly commit staff time to the Team and encourage changes in procedures based on the Team's findings. By doing so, these leaders send a clear message to the justice system and the community about the importance of addressing domestic violence.

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

The Office of the Hennepin County Medical Examiner for providing space for the Team meetings.

The Domestic Abuse Service Center for the use of space for Advisory Board meetings.

And those who donated their time to present information to the Team:
Marna Anderson, WATCH
Detective Becker, Brooklyn Center Police Department
Dr. John Clarke, CART
Sgt. Bruce Folkens, Minneapolis Police Department
Pastor Alika Galloway, Northside Women's Space/Kwanzaa Community Church
Commander Gannon, Brooklyn Center Police Department
Gretchen Gray-Larson, Hennepin County Attorney's Office
Elizabeth Hogan, Hennepin County Public Defender's Office
Sgt. Scott Larson, Minneapolis Police Department
Referee Patrick Meade, Civil Mental Health Court
Dr. Steven Olson, Fairview University Medical Center
Ann Remington, Hennepin County Public Defender's Office
Liz Richards, Minnesota Coalition for Battered Women
Jennifer Swick, People Serving People

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 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.

The Team has the privilege of assessing multiple elements in the lives of those involved in homicide. The members of the Team are often the only people who have looked a the full scope of a person's involvement with social service, community and criminal justice organizations throughout their lifetime. The allows the Team a unique perspective and enhances the ability to develop relevant and informed Opportunities for Intervention.

In 2011, the Team reviewed four cases. In two 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. In a third case, the homicide victim was not the person against whom most of the domestic violence had occurred, instead the pattern of abusive and violent behavior was most easily seen in an earlier relationship. Three of the cases involved a boyfriend killing his girlfriend and one a husband killing his wife. Children were present, and sustained injuries, in two of 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 12.

The Review Team hopes that the information in this report will prompt active interest in improving system response to domestic violence 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:

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 2011.

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

2010

Of 15 women, seven children and two men killed in domestic homicides in Minnesota, four died in Hennepin County and the Fatality Review Team has reviewed three in 2011.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Complex Homicidal Violence	19	Female	Boyfriend
Stabbed	42	Female	Husband
Stabbed	56	Female	Husband
Gunshot	28	Female	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
Victim had attempted to leave the abuser	X	X	X	
Perpetrator was unemployed	X	X	X	
Perpetrator had previously used a weapon to threaten or harm victim	X		X	
Perpetrator had threatened to kill the victim	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		X	
Perpetrator had a history of substance abuse	X	X	X	X
Perpetrator had previously strangled victim			X	
Perpetrator attempted to control most or all of victim's activities				
Violent and constant jealousy	X		X	
Perpetrator was violent to victim during her pregnancy				
Perpetrator threatened to commit suicide	X		X	
Victim believed perpetrator would kill her				
Perpetrator exhibited stalking behavior	X			
Perpetrator with significant history of violence	X	X	X	X
Victim had contact with a domestic violence advocate	X		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

2011 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

With the practice of treating each alleged criminal act as a unique incident, the pattern of domestic violence can be difficult to illuminate in the criminal justice system. This is further exacerbated when the crime committed by an abuser is a property crime or breaking and entering, rather than the more recognizable physical assault. ***Designate damage to property and disorderly conduct charge that are domestic abuse related as such to allow the system to recognize when the alleged crime occurred within the context of abuse.***

When a person applies for an Order for Protection and the respondent to the Order is not served with the papers or fails to appear at the hearing, the person filing for the Order may be required to attend multiple scheduled hearings, even when the respondent continues to fail to appear, before any permanent Order might be granted. This represents a barrier to safety and an added stress on the victim of domestic violence. ***Establish a committee, possibly though an existing entity like the FVCC, to develop a process to allow petitioners to be granted a 2 year OFP for basic relief (including on behalf of children) without the necessity of multiple court appearances when respondent has avoided service of the Order or has failed to appear at hearings.***

Opportunities for Employers

Domestic violence is not contained only in the home and victims of domestic violence are often harassed at work or miss work as a result of injuries. For this reason, ***every employer should have a protocol for providing information, education, referrals and work-related safety planning for employees (both permanent and contract) who receive threats or harassment while at work.***

Opportunities for Criminal Justice Response to Domestic Violence

Courts

The court process can be very confusing and misunderstanding court orders or instructions can have significant consequences for victim of the crime. ***We encourage the court staff and members of the bench to use every opportunity***

to describe how the court process works and explain common legal language to victim and involved family members. This should include a clear explanation of the difference between Domestic Abuse No Contact Orders (DANCO), No Contact orders and probation condition and who to notify if the defendant violates these orders.

Finally, since a DANCO or No Contact order may mean that the defendant will need to find different housing, they should be given a list of shelters and resources at the time the order is made.

The Team reviewed a case in 2011 that had overlap with the Civil Mental Health Court. Through observations on the case, the Team was able to identify opportunities for enhanced assessment for domestic violence in that setting. *Specifically, that a tool to screen for domestic violence and lethality be integrated into Civil Mental Health Court procedures.*

The Team also encourages the *development of accountability procedures and practices for Continuance For Dismissals and other outcomes in Civil Mental Health Court, with particular attention paid to individuals who fail to follow conditions issued by the Court or fail to take prescribed medications and miss follow-up appointments with medical professionals or case workers. Further, that a protocol to stringently monitor compliance with psychotropic drugs be developed and implemented.*

Child Support Workers

Negotiating difficult issues like child support can be extremely stressful and in cases where the person being asked to provide the support has been abusive in the past, dangerous. *Develop a protocol for educating child support workers regarding the dynamics of domestic violence, how to ensure that petitioners receive and understand information about safety planning, and how to make referrals for community resources if domestic violence is a concern.*

Law Enforcement

Stalking behavior often occurs in conjunction with domestic violence. It is a difficult crime to identify and to prove in court so it is very important that *advocates and law enforcement officers offer education to victims of stalking on how to keep records of the stalker's behavior, like a log of stalking activities, in order to support stalking charges.*

Many of the cases the Team reviews cross city, county and jurisdictional lines. Critical information about past domestic violence related behavior can be lost when it does not rise to the level of criminal charges and occurs in a different jurisdiction. Therefore, *a centralized clearinghouse where law enforcement could deposit and retrieve reports of domestic abuse related behaviors on a given perpetrator, regardless of the jurisdiction in which it occurred, would be beneficial* to enhancing the safety of victims of domestic violence and holding abusers accountable for their behavior.

Access to firearms is an identified lethality indicated and our State laws forbid felons and those with an active Order for Protection against them from possessing firearms. These *existing prohibitions on firearm possession should be universally enforced and law enforcement officers, those who must enforce the laws, should be offered regular education on the relevant statutes and processes for seizing a firearm.*

Adult Community Corrections & Rehabilitation

In many of the cases the Team reviews, the perpetrator has had a history of domestic violence and involvement with the criminal justice system, though not necessarily related to the domestic violence, so the risk factors are sometimes missed. *Consider prior crimes of violence or felonies as additional risk factors in making danger assessments about individuals to inform risk planning.*

Many probation officers receive reports when their client has contact with local law enforcement. They are able to use this information to assess the client's adherence to probation conditions and take appropriate actions. Having access to this information from around the state, through *the creation of an automated probation officer alert system from MNCIS, would further enhance the ability of probation officers to hold their clients accountable.* In the meantime,

a standard practice of reviewing the client's MNCIS file on a quarterly basis and as part of any discharge procedure can create added assurances that all court and probation conditions are being met. Finally, *probation officers should not recommend discharge of probation if the assessable conditions of probation have not been met.*

If allegations of domestic violence are made against a person on probation, that person's probation officer should review the allegation and make referrals for programming as appropriate, regardless of whether the crime for which they are on probation is domestic violence related. To encourage this response, *Community Corrections and Rehabilitation can provide universal training for probation officers across specialties on dynamics of domestic violence, available resources and how they can best support their clients to succeed in probation.*

Orders for Protection can be issued in the absence of criminal findings so there exists some concern about imposing any sanctions, beyond the stay away order itself, on the respondent. However, in several cases the Team has reviewed, the perpetrator had multiple Orders for Protection filed against them, often by different petitioners. For this reason, the Team *sees a potential benefit to conducting a formal risk assessment on a respondent after the second Order for Protection petition is filed, and that, if appropriate, the respondent be referred for intervention services to address the target behaviors.*

Juvenile Community Corrections & Rehabilitation

When the Team reviews juvenile probation and court files on the perpetrators in the cases, it is not uncommon to find crimes of assault against peers or family members. *Consider developing a protocol to assess juveniles who are on probation for interpersonal violence for domestic violence indicators. If the domestic violence indicators are present the probation officer may offer appropriate referrals to intervention services. Probation officers might also offer resources and referrals for interested family members as appropriate.*

Opportunities for Human Service Response to Domestic Violence

Child Protection Services

In one of the cases that the Team reviewed, a person involved had multiple out-of-home placements. It was unclear how successfully these placements sites addressed the issues in the person's life beyond basic needs. It would be helpful to *complete case audits of sites for out-of-home placements for juveniles to ensure compliance and effective service provision.*

Opportunities for Other Mandated Reporters or Helping Professionals

In both 2010 and 2011 the Team reviewed cases in which the daycare provider had knowledge of the domestic violence occurring in the home and, in one case, of threats made by the perpetrator to kill the victim. Daycare providers, teachers, healthcare providers, youth program staff and other helping professionals may be among the first, and sometimes the only, people outside of the family who know about the violence in occurring at home. Again this year, *we encourage 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. Further, daycare providers and other licensed care providers should receive training about the dynamics of domestic violence and available resources as part of their licensing process.*

Opportunities for Public Response to Domestic Violence

In nearly every case the Team reviews, there is an Opportunity for Intervention to increase awareness about domestic violence in the general public. In the cases the Team reviews, there is often a person who knew about the domestic violence but either did not know how to help, did not know about lethality indicators, or did not realize that the domestic violence could result in homicide. This year the Team encourages the *creation of a public services campaign aimed at teaching people who know that a friend or loved one is being abused about how to call for help, report a crime, and what safety planning and advocacy services that are available in our community.*

2011 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 eight 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, are able to share their knowledge and skills as part of larger initiative to change policy or practice. Some examples of these efforts are highlighted below.

- In 2011, the Minneapolis City Attorney's Office, Minneapolis Police Department Family Violence Unit and Domestic Abuse Project (DAP) expanded their long-term partnership in an innovative new direction. Several times each week, a police officer assigned to the Domestic Assault Unit and an advocate from DAP visit victims of domestic violence for whom a Domestic Abuse No Contact Order (DANCO) has been issued by the court. This this collaborative has expanded services even further with the addition of advocate and investigator teams that follow up on Gone on Arrival police calls and attempt to enforce Domestic Abuse No Contact Orders (DANCOs).

- A group of professionals in the criminal justice system, including several members of the Fatality Review Team representing the Minneapolis Police Department, Domestic Abuse Project advocates, Hennepin County Community Corrections and Rehabilitation, Minneapolis City Attorney's Office, Hennepin County Attorney's Office, has formed to develop a pilot project to explore ways that the agencies working in the criminal justice system can best support the courts in enforcing existing federal and state laws that prohibit gun ownership in cases of domestic violence and Orders for Protection.

- In May 2011, the Chiefs of Police in Brooklyn Center and Brooklyn Park formed a community conversation that has evolved into the Brooklyn Park/Brooklyn Center Domestic Violence Systems Council and the Community Council. Members of the community are joined by city and county prosecutors, judges, advocates, probation officers, court administration and law enforcement professionals on these councils with the ultimate goal of effort to improve the response of community members and systems to domestic violence in Brooklyn Center and Brooklyn Park. These Councils share several members with the Fatality Review Team.

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

these cases and provide immunity to those who spoke openly to the Fatality Review Team about case information.

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

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

As other judicial districts begin to consider starting fatality review teams, the Fourth Judicial District Domestic Fatality Review Team formalized its practices and processes in preparing to provide technical assistance to new and forming teams. 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 resulted from this effort was 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 better 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 greatly benefits 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 the work.

The 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.

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.

Review Team Members

Ellen Abbott, J.D.
Mediator/Attorney
Community Volunteer

Kristine Arneson*
Minneapolis Police Inspector, 1st Precinct
Minneapolis Police Department

Angela Bailey, J.D.**
Assistant Public Defender, Juvenile Division
Hennepin County Public Defender

Jeanette Boerner, J.D.*
Assistant Public Defender, Adult Division
Hennepin County Public Defender's Office

Bernie Bogenreif
Detective
Hennepin County Sheriff's Office

The Honorable Gina Brandt, Project Chair *
District Court Judge
Fourth Judicial District

Mary Ann Campbell
Career Probation Officer– Adult Division
Hennepin County Community Corrections & Rehabilitation

Anna Crabb, J.D.
Assistant City Attorney
Minnetonka City Attorney's Office

Katheryn Cranbrook, Psy.D., LP**
Senior Clinical Forensic Psychologist
Hennepin County 4th Judicial District Court

Liz Cutter
Assistant County Attorney, Adult Division
Hennepin County Attorney's Office

Marcus Erickson
Commander
Brooklyn Park Police Department

Sue Fite*
Legal Services Specialist Supervisor
Hennepin County Domestic Abuse Service Center

Mike Gephart*
Program Manager- Adult Field Services
Hennepin County Community Corrections & Rehabilitation

Anne Gilmore, L.I.C.S.W.**
Senior Social Worker
Domestic Violence Program Coordinator
Hennepin County Medical Center

Nancy Halverson, J.D.
Corrections Unit Supervisor
Hennepin County Community Corrections & Rehabilitation

Michelle Hatcher, J.D.**
Assistant County Attorney, Juvenile Division
Hennepin County Attorney's Office

Appendix C

Captain Amelia Huffman**
Criminal Investigations Division Commander
Minneapolis Police Department

Michelle Jacobson, J.D.*
Supervising Attorney
Minneapolis City Attorney's Office

Deirdre Keys
Stalking Program Coordinator
Battered Women's Legal Advocacy Project

Nicole Kralik‡
Assistant Public Defender
Hennepin County Public Defender's Office

Jim Kurtz**
Chief of Police
Mound Police Department

Brenda Langfellow**
Criminal Court Operations Manager
Fourth Judicial District Court Administration

Mike Maas
Career Probation Officer– EJJ/Juvenile Division
Hennepin County Community Corrections & Rehabilitation

Dave Mathews, Psy.D., L.I.C.S.W.*
CEO/One T
Community Volunteer

Timothy Mulrooney
Referee
Fourth Judicial District Court

Keshini Ratnayake‡
Assistant Public Defender
Hennepin County Public Defender's Office

The Honorable Jeannice Reding
Project Vice-Chair*
District Court Judge
Fourth Judicial District Court

Jay Samson‡
Global Security Manager, General Mills
Community Volunteer

Karen Shannon**
Project Manager
Office of Student Attendance
Minneapolis Public Schools

Connie Sponsler-Garcia
Training & Technical Assistance Manager
Battered Women's Justice Project

Carol Tellett
Family Court Services
Fourth Judicial District

Pheng Thao
Community Programs Director
Asian Women United of Minnesota

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

Rebecca Waggoner
Anti-Violence Program Manager
Outfront Minnesota

* Member of Advisory Board
** Resigned the Team in 2011
‡ Joined Team in 2011

Fourth Judicial District Domestic Fatality Review Team

Project Chair:
The Honorable Gina Brandt
Minnesota Fourth Judicial District

Deena Anders, Project Director
651-263-2901
deena@amatteroflifeanddeath.org
www.amatteroflifeanddeath.org