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2013

A Matter of Life and Death

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

Project Chair:

The Honorable Gina Brandt
Minnesota Fourth Judicial District

2013 Community Partners:

Battered Women's Justice Project
Battered Women's Legal Advocacy Project
Brooklyn Park Police Department
Community Volunteers
Domestic Abuse Project
Minneapolis City Attorney's Office
Minneapolis Police Department
Minnetonka City Attorney's Office
Outfront Minnesota

2013 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 Child Protection
Hennepin County Medical Center
Hennepin County Medical Examiner
Hennepin County Public Defender's Office
Hennepin County Sheriff

This report is a product of:

Fourth Judicial District Domestic Fatality Review Team

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The 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;

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;

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Executive Summary

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 may, in a similar situation in the future, result in a more positive outcome. 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 and individuals 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 or individual 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.

This year, as a result of the unusual aspects present in the cases reviewed, the Opportunities for Intervention are organized in a manner to encourage an enhanced coordinated community response to domestic abuse. Research has repeatedly shown that consistent awareness of, and response to, domestic violence from every supportive entity that may interact with a victim or perpetrator – church, work, friends, helping agencies, law enforcement, and advocacy– is what works to protect against domestic homicide. Our community established a coordinated community response, among the first in the nation, during the 1980s. The Opportunities for Intervention are meant to build from, and reinvigorate, this network of policies, practices, and inter-agency relationships and to expand the partnerships that make up the community of responders by educating other sectors on domestic violence and how they can intervene effectively.

In the *Sharing Information* section, the Opportunities for Intervention include the creation of a statewide database to share arrests, police calls, and Gone on Arrival police reports that would serve the need of law enforcement and probation to properly assess the risk that the perpetrator poses to the victim and to the interveners, and a standard NATIONAL information sharing method for child protection cases so that states in which the family is now residing can access ALL the information contained within the case file of the state in which the case was previously held. *Developing a Consistent and Effective Response Statewide* calls for the use of a uniform Lethality Assessment tool in every law enforcement agency in the state and that the validated tool be combined with a protocol for police to put victims DIRECTLY in contact with an advocate, and a plan for what other intervention must be available post arrest. Finally, *Fully Funding Initiatives* highlights the way that financial restraints and competing priorities can undermine the effective execution of best practice responses to domestic violence and asks that sustained funding for the tools and training necessary to adequately address domestic violence and prevent domestic homicide be provided to law enforcement agencies.

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.

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 that are often present in cases of domestic homicide. The Fourth Judicial District Domestic Fatality Review Team notes the presence of risk factors in the reviewed cases because public awareness of risk factors for homicide is an opportunity for intervention.

Potential Predictors of Homicide	Case 1	Case 2	Case 3	Case 4	Case 5
The violence had increased in severity and frequency during the year prior to the homicide.		X	X	X	X
Perpetrator had access to a gun.	X		X	X	
Victim had attempted to leave the abuser.	X	X	X	X	X
Perpetrator was unemployed.		X	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		X
Perpetrator had previously avoided arrest for domestic violence.		X	X		
Victim had children not biologically related to the perpe-trator.		X			X
Perpetrator sexually assaulted victim.					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.	X		X	X	X
Violent and constant jealousy.	X		X	X	X
Perpetrator was violent to victim during her pregnancy.					X
Perpetrator threatened to commit suicide.	X		X		
Victim believed perpetrator would kill her.					
Perpetrator exhibited stalking behavior.	X	X	X		
Perpetrator with significant history of violence.		X	X	X	X
Victim had contact with a domestic violence advocate. (this is a protective factor)					

*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

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. Occasionally the Team reviews homicides that occurred in the context of domestic violence but in which the victim is not the primary victim of the abuse. The Review Team examined six domestic homicide cases in 2013 and pursued Opportunities for Intervention in five of those cases. 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:

In **2008,** 22 women, one child, and two men were killed in domestic homicides in the State of Minnesota. Eight of those homicides occurred in Hennepin County. The Fatality Review Team reviewed one of the cases in 2013.

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

In **2011,** 23 women, four children, and two men were killed in domestic homicides in the State of Minnesota. Eight of those homicides occurred in Hennepin County. The Fatality Review Team reviewed three of the cases in 2013.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Strangulation	45	Female	Boyfriend
Blunt Force Trauma	34	Female	Husband
Gunshot	20	Female	Former Boyfriend
Gunshot	21	Male	Girlfriend's Former Boy-friend
Gunshot	27	Male	Friend's Estranged Husband
Strangulation	40	Female	Boyfriend
Stabbing	58	Female	Husband
Stabbing	38	Female	Husband

In **2012,** 15 women, and three men were killed in domestic homicides in the State of Minnesota. Seven of those homicides occurred in Hennepin County. The Fatality Review Team reviewed two of the cases in 2013.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot	32	Female	Boyfriend
Gunshot	45	Female	Estranged Husband
Blunt Trauma	42	Female	Former Boyfriend
Gunshot	26	Female	Boyfriend
Gunshot	27	Female	Acquaintance
Stabbing	43	Female	Boyfriend
Gunshot	42	Male	Former Girlfriend

2013 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.

This year, as a result of the unusual aspects present in the cases reviewed, the Opportunities for Intervention are organized in a manner to encourage an enhanced coordinated community response to domestic abuse. Research has repeatedly shown that consistent awareness of, and response to, domestic violence from every supportive entity that may interact with a victim or perpetrator – church, work, friends, helping agencies, law enforcement, and advocacy– is what works to protect against domestic homicide. Our community established a coordinated community response, among the first in the nation, during the 1980s. The Opportunities for Intervention are meant to build from, and reinvigorate, this network of policies, practices, and inter-agency relationships and to expand the partnerships that make up the community of responders by educating other sectors on domestic violence and how they can intervene effectively.

SHARING INFORMATION

In many of the cases the Team reviews, a move across the river from St. Paul to Minneapolis, or even from Minneapolis to a suburb within the same county, could effectively erase a person's record of police interaction because information was not available between the jurisdictions. The statewide adoption of MNCIS, the Minnesota State Courts database on charges and convictions has gone far to established a source of shared information. However, information about arrests that do not lead to charges, Gone on Arrivals, or police calls are still held, largely, within the information systems of the jurisdiction where the event occurred. Because domestic violence is a patterned crime, and because an increase in frequency and severity of domestic assaults is a known lethality factor, ***the creation of a statewide database to share arrests, police calls, and Gone on Arrival police reports would serve the need of law enforcement and probation to properly assess the risk that the perpetrator poses to the victim and to the interveners***. Further, this information can be used by advocates to help the victim accurately assess risk of lethality and create effective safety plans and to provide similar services to victims after multiple calls, reports, or allegations of domestic violence in which no arrests or charges are made.

Much of the time of the Fatality Review Team members is spent trying to determine who in each system being analyzed had what information about which incident, when they did or did not have the information, and

whether or not they could have even, legally, acquired it. Often the result of the inquiry is that everyone acted in the correct manner to protect the private information of the individuals involved. However, sometimes, the gap in valuable knowledge seems to be, instead, a holdover from a time when intra-agency information sharing was less technologically feasible. Diligent employees within agencies have often figured out appropriate, if arduous, ways to work around the barriers, but ***having a standard NATIONAL information sharing method for child protection cases so that states in which the family is now residing can access ALL the information contained within the case file of the state in which the case was previously held could greatly improve the outcomes for children and families involved in that system***.

DEVELOPING A CONSISTENT AND EFFECTIVE RESPONSE STATEWIDE

At this time, some police departments in Minnesota have adopted their own lethality and risk assessment tools and many have a relationship with a domestic violence service provider to which they refer victims of domestic crimes. Ideally, ***every law enforcement organization in the state would use the same lethality assessment tool at the scene of the crime***. However, simply training every law enforcement officer to ask the same three, or four, or six, or nineteen questions is not sufficient to preventing severe injury or homicide. ***Assessing for lethality must combine a validated tool for law enforcement, a protocol for police to put victims DIRECTLY in contact with an advocate, and a plan for what other intervention must be available post arrest.***

Because contact with a domestic violence advocate has been found to be a protective factor for victims of domestic violence, ***we encourage each police department in the state to have a policies and procedures that connect a victims of domestic violence with an advocate at the scene of the crime or as quickly thereafter as is feasible. Further, to ensure that this is occurring and having a meaningful effect, police reports should include an indication that this has occurred.***

Ensuring that judicial officers have adequate information about a defendant's potential for lethality may improve outcomes for victims of domestic violence. ***Important information about defendant lethality could be attained during a pretrial evaluation that incorporated a validated domestic violence risk assessment tool, like the DVSI-R or ODARA, and included questions that specifically address current access to firearms.***

ACKNOWLEDGING AND PROVIDING INTERVENTION FOR THE BROADER EFFECTS OF VIOLENCE & ABUSE

The effects of domestic violence are vast and extend beyond the person who is the primary victim to the children who grow up witnessing it, to friends, co-workers and family members who are unsure of how to intervene, to caring professionals who work to keep victims safe, to law enforcement and criminal justice professionals. This year, our cases included scenarios with a number of bystanders who were deeply affected by the domestic violence. The Opportunities for Intervention address the experiences of various group affected by those experiences.

Law enforcement officers deal with matters of life and death in the course of each day. Some of the calls to which they respond can have more lasting impact and the officers deserve to have support in processing their experiences. ***We encourage all law enforcement departments to incentivize the use of easily accessible critical incident debriefings services for any officer who witnesses suicides or homicides***. At this time, debriefing services are available through the Minneapolis Police Department and the Metro Critical Incident Stress Management Team (www.metrocism.org).

So often in case reviews in which either the perpetrator or victim had severe mental health issues, there is evidence of family members and friends who had long sought help for the person exhibiting the symptoms but had not succeeded in finding adequate resources for treatment or any guidance for themselves through the system. There are groups that are expert in assisting people experiencing mental health symptoms, and their family or friends, to navigate the complicated hospitalization, intervention, aftercare, social work, and case management systems. ***When law enforcement, religious leaders, or medical professionals receive inquiries from friends or family members regarding mental health commitment or concerned that their loved one has become a threat to self or others, provide crisis response information for organizations like National Alliance on Mental Illness (NAMI)- 888-626-4435, COPE in Hennepin County- 612-596-1223, or Mental Health Crisis Alliance in Ramsey, Dakota & Washington Counties- 651-266-7900 .***

KNOWING THE WARNING SIGNS AND INFORMING OTHERS

An excellent result of the focus on domestic homicide is the shared understanding of what factors indicate an increased risk of lethality (this is outlined in detail on page 7). This understanding allows for targeted, intensive intervention. However, those who know and recognize the lethality factors tend to imagine that everyone shares their knowledge and those who don't know them feel like domestic homicide is an unpredictable tragedy. If you are reading this report, you have the knowledge and expertise to make at least rudimentary assessments of risk in situations you encounter. Others can too, if they just know what to look for:

- ***Make regular education on the dynamics of domestic violence, lethality, and current laws providing relief to victims of domestic violence in lease obligations a requirement of the licensing/permitting for landlords.***
- ***Include information about technology stalking, and physical stalking, and methods to address it when issuing Orders for Protection, Harassment Restraining Orders, or other protective orders in Civil or Criminal Court.***
- ***REQUIRE that mental health professionals receive regular continuing education on Mandated Reporting, Reporting Threats to Self and Others, Homicidal Ideations, and Duty to Warn, especially as these topics relate to domestic violence, in order to maintain their license to practice.***
- ***Provide education on dynamics of domestic violence, lethality risk factors, and treatment options to all victims and family members who live in the home in cases where sexual abuse or domestic violence is identified so that each person can have the understanding they need to be safe.***

USING YOUR ROLE IN THE SYSTEM TO ENHANCE SAFETY & INTERVENTION

The feedback we most often receive from fellow Team members is that participating in the process of domestic homicide review changes the way they look at cases in their work life. This shift in perspective is powerful tool in creating practices that enhance safety for victims and hold perpetrators accountable for the abuse. We invite you to consider small ways you might modify your client interaction to do the same.

This year, the following Opportunities for Intervention came out of the cases reviewed:

- ***Prosecutors can make it a practice to look up the victimization history of the identified victim in assigned cases and look for possible crimes that may be related to domestic violence (i.e. theft, burglary, damage to property). This will give the prosecutor a sense of the pattern of abuse that may be occurring and, if it appears that the person is a victim of domestic violence, the prosecutor may make a direct referral to an advocacy agency to assist the victim in safety planning.***
- ***Judges, Referees, and staff from court administration can ensure that all petitioners for Orders for Protection are given a direct referral to a specific domestic violence advocate, rather than a general referral to a help line.***
- ***Child Protection Investigators and Case Managers can view all new child protection cases holistically, consider-***

ing past "founded" and "unfounded" child protection reports on file during intake to provide context for the case being considered. This will offer some perspective on the experiences of the children and family involved and may inform the course of intervention.

FULLY FUNDING INITIATIVES

Sometimes the barriers to implementing best practices in various responses to domestic violence are not the result of internal resistance or a lack of information. Sometimes it is just a financial reality that the best practice requires resources that are not available. In a recent Team discussion about why a law enforcement agency did not include photographs of injuries with police reports, it was revealed that there is not enough money to provide an adequate number of cameras or smart phones for the officers to follow the procedure. ***Sustained funding for the tools and training necessary to adequately address domestic violence and prevent domestic homicide must be provided to law enforcement agencies.***

LEVERAGING COMMUNITY PARTNERSHIPS

Schools

- ***Educate K-12 students about healthy relationships and conflict resolution skills.***
- ***Ensure that a system exists to share Independent Education Plans for students across both schools and districts so that intervention services can be consistent and uninterrupted, especially for highly-mobile students.***
- ***Allow school medical personnel, with the approval of the parent as needed, to work with prescribing physicians to provide medications to a child in the school setting if there is a history of the medication being administered irregularly or times when the medication was not administered at all.***

Employers

- ***Encourage employers to establish policies, protocols, and training to identify and report risk factors associated with an employee's mental health issues and the potential for violence.***
- ***Create employee environment where employees feel comfortable to report situations in which they felt concern for their own safety or the safety of another because of the behavior of a fellow employee.***
- ***Use Employee Assistance Programs to disseminate regular information about the red flags of domestic violence, how to get help if you're experiencing it or intervene if you think someone else may be, what emotional and psychological abuse looks like, and what lethality factors are– particularly access to firearms.***

SETTING REASONABLE EXPECTATIONS FOR CLIENTS WHO HAVE MULTIPLE SYSTEM INTERACTION AND ARE IN TRANSITION

Effectively sharing information across schools, agencies, and jurisdictions, goes far in establishing a safety net for victims and perpetrators of domestic violence. Other important aspects of effective intervention, however, are access and relevance. Very often people who are seeking services for domestic violence at shelters and intervention programs in our community are also involved with the criminal justice system, child protection, various mandated therapeutic and educational services, have unstable housing and no personal means of transportation, and very few monetary resources. This means that fulfilling all that is required of them is especially challenging. The move to decentralize services in Hennepin County is the sort of effort that can lead to greater accessibility and is consistent with the Opportunity identified to ***develop more social service and community-based services outside the immediate city centers, to provide assistance with transportation (like bus passes) for clients who are required to complete services as victims of domestic abuse or court-ordered services intervention services for perpetrators, as well as for chemical dependency groups, court appearances, and probation meeting.***

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 had routinely created chronologies of cases involving chronic domestic abusers and published those chronologies in a 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 Non-profit 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.

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

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District Court Judge
Fourth Judicial District Court

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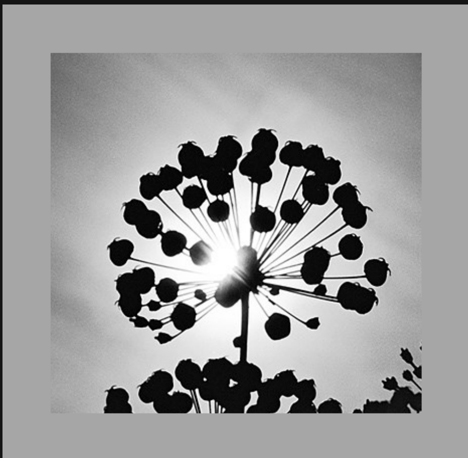
* Member of Advisory Board
** Resigned the Team in 2013
‡ Joined Team in 2013



Fourth Judicial District Domestic Fatality Review Team

Project Chair:
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