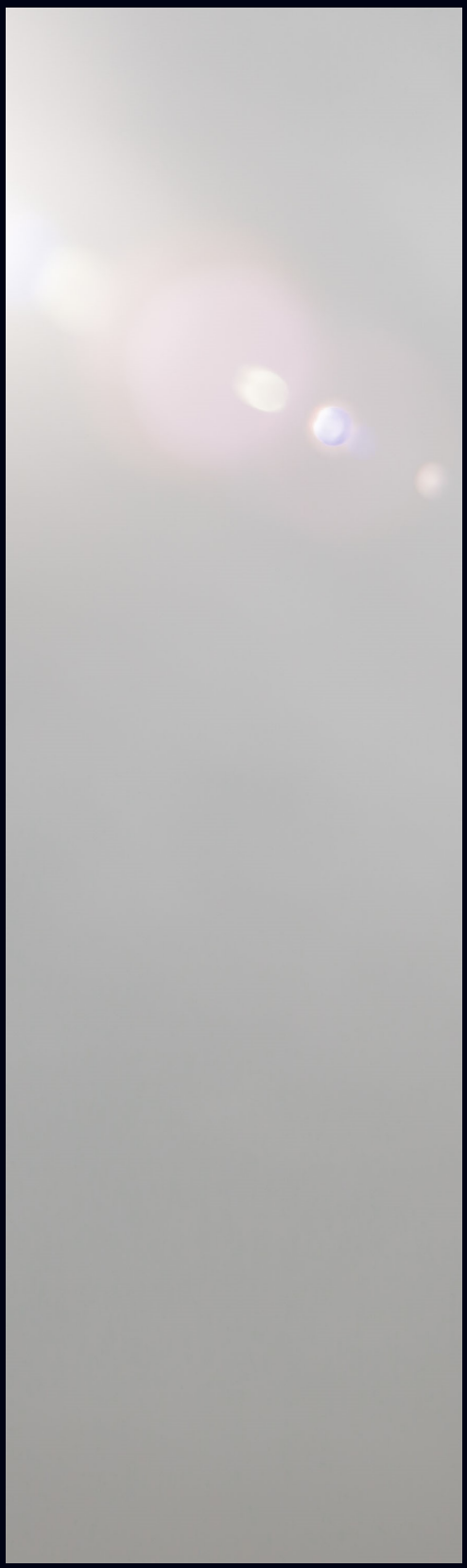

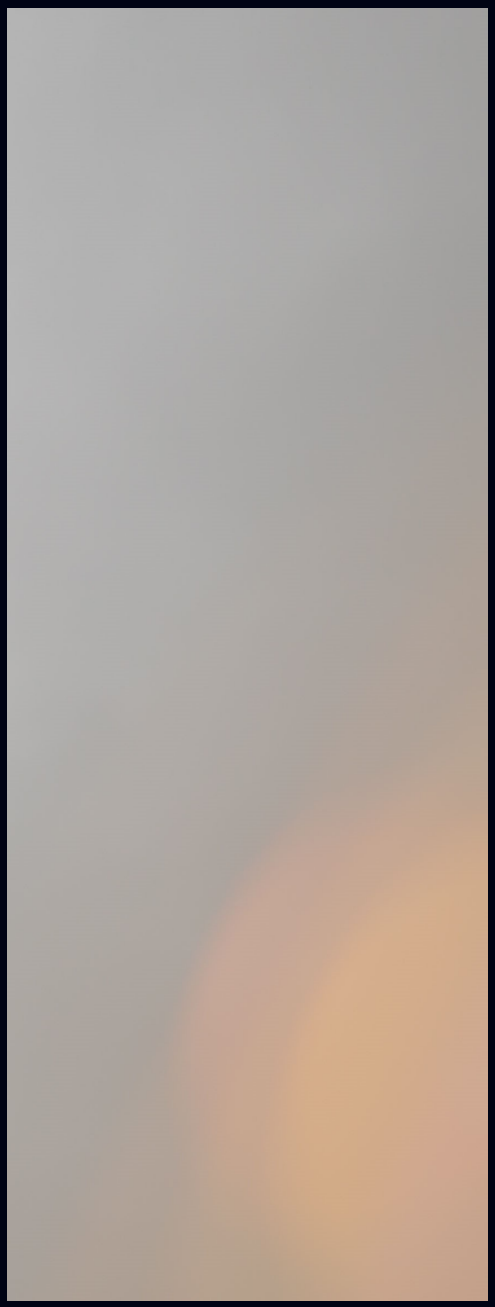

Fourth Judicial District
Domestic Fatality Review Team

2019 Annual Report

20th Year of Review, 10 Year Case Analysis & Achievements

Project Chair:

Referee Mary Madden
Minnesota Fourth Judicial District

2019 Local & Community Partners:

Bloomington City Attorney's Office
Community Volunteers
Eden Prairie Police Department
Hamline University
Minneapolis City Attorney's Office
Minneapolis Police Department
Paradigm Counseling
South Lake Minnetonka Police Department
The Advocates for Human Rights

2018 County & State Partners:

Minnesota Fourth Judicial District Court
Minnesota Fourth Judicial District Court Administration
Hennepin County Adult Representation Services
Hennepin County Attorney's Office
Hennepin County Domestic Abuse Service Center
Hennepin County Community Corrections & Rehabilitation
Hennepin County Family Court Services
Hennepin County Child Protection
Hennepin County Medical Examiner
Hennepin County Public Defender's Office
Hennepin County Sheriff's Office

This report is a product of:

Fourth Judicial District Domestic Fatality Review Team

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In This Report

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 is 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.

Guiding Standards

The perpetrator is solely responsible for the homicide.

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

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

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

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.

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.

The Review Team attempts to reach consensus on every opportunity for intervention.

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

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

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

Acknowledgements

The Mary Madden, 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;

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; and

The following professionals who shared their expertise and perspective with the Team in 2019:
Dr. Stacy Lincoln Casper
Dr. Sean Fields
Katie Holmgren MA, LPCC
Kirstin Matteo
Dr. Samantha Scott

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. These Opportunities for Intervention are developed based on findings from the review of specific cases of domestic homicide that have occurred in the Fourth Judicial District. Out of respect for the privacy of the victims and their families, identifying details have been removed. By design, the Fourth Judicial District Domestic Fatality Review Team process focuses on a few specific cases each year. This opens the door to in-depth examination of all the facts of those cases from the varied perspectives of Team members.

Members of the Team examine the case chronologies and then, as a group, make observations about specific elements of the case. Sometimes the observations assist in identifying the context of the crime. Other times, they illuminate a clear missed opportunity to avoid the homicide. From these observations, the Team identifies Opportunities for Intervention that directly correspond to the observations yet are general enough to apply to agencies throughout our community.

In 2019, the Team reviewed four cases. From these reviews, the Team developed Opportunities for Intervention that include: changes to legislation to require domestic violence programming for people convicted of violating a Domestic Abuse No Contact Order (DANCO), incorporation of review hearings in family court to follow progress on mental health services ordered for parents and/or children to ensure compliance and assess appropriateness of original programming ordered, and enhanced procedures at well-baby checks– to include questions for partners and/or family members- to screen for changes to behavior that may indicate symptoms of post-partum depression or psychosis. The full list of Opportunities for Intervention begins on page 9.

This reports contains the Opportunities of Intervention created from cases reviewed in 2019 but also marks the twentieth year of Review Team work and includes a ten year case analysis of the 38 cases and 44 deaths reviewed from 2010 through 2019. A similar retrospective analysis of the first ten years is available at our website in the 2010 Annual Report. For both of these case analyses, we assessed 49 unique factors of each case with an eye toward trends and commonalities in the cases reviewed which now total 78 since the Team's start. Factors include: general demographics, history of chemical dependency, family of origin information, CPS history, history of domestic violence, contributing factors in the homicide, type of weapon used, time of day, and location of the homicide. This information begins on page 11.

Finally, we have included highlights of the changes that have occurred through direct actions of Team members or that correspond with Opportunities for Intervention introduced by the Team in the past ten years. Join us in celebrating these important achievements beginning on page 14.

The Review Team hopes that the information in this report will prompt active interest in these cases and changes to policy and practice that may help to prevent future homicides. 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, including the creation of more Teams in the region, continues to be a goal of the Review Team.

The Work of the Team

The Team is able achieve its goal and purpose through the structured and deliberative review of volumes of information from multiple sources and the active collaboration between the multi-disciplinary members who are willing to engage in the process with honesty, humility, and curiosity. The Team holds the privileged and unique position of being the only group to information spanning a person's lifetime. The Opportunities for Intervention that the Team develops are, by extension, fully contextualized within the lives and experiences of the people involved in the case. The Team uses the following process in reviewing each case:

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. Letting time pass after the incident allows some of the emotion and tension of those members who may have had direct involvement in the case to dissipate and creates an environment for more open and honest discussion. The Project Director uses information provided by Violence Free Minnesota's Intimate Partner Homicide Report, homicide records from the Hennepin County Medical Examiner's Office, news reports, and recommendations from group members to determine which cases to review.

The Case Review

After a case is selected for Team review, the Project Director sends requests for agencies to provide documents and reviews the information. If the perpetrator was prosecuted for the crime, police and prosecution files typically provide the first source of information and identify other agencies that may have records important 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 involved people prior to the homicide are all examples of additional data sources used in reviews.

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.

This chronology is sent to Review Team members prior to the case review meeting, and each source document used is sent to two team members for review- one member from the agency that provided the information and one who has an outside perspective.

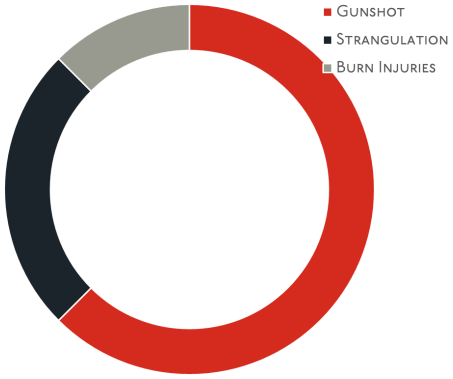
Each Review Team meeting begins with members signing a confidentiality agreement. At the meeting, individuals who reviewed the case report their findings. The Team then develops a series of observations related to the case. Small groups of Team members use these observations to identify opportunities for intervention that may have prevented the homicide. The Team records key issues, observations and Opportunities for Intervention related to each case. These deidentified and universalized Opportunities for Intervention become the work product of the Team. Most cases take two to three months to review.

Homicide Data

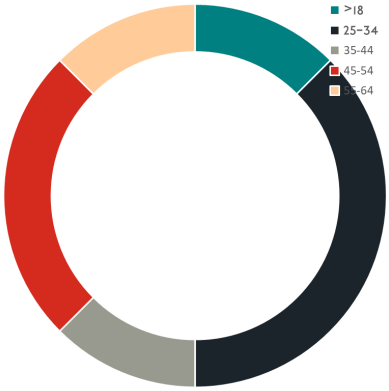
We review cases of domestic homicide– homicides related to domestic abuse which is defined as a pattern of physical, emotional, psychological, sexual and/or stalking behaviors that occur within intimate or family relationships between spouses, individuals in dating relationships, former partners and parents and children. Occasionally the Team reviews homicides that occurred in the context of domestic violence but in which the victim of the homicide is not the primary victim of the abuse.

In 2017, at least **25** people were killed in domestic homicides in Minnesota. **8** of these deaths occurred in Hennepin County and we reviewed **3** of these cases in 2019.

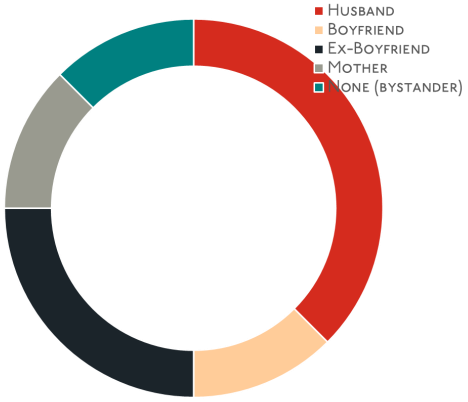
Cause of Death 2017



Age of Victim 2017

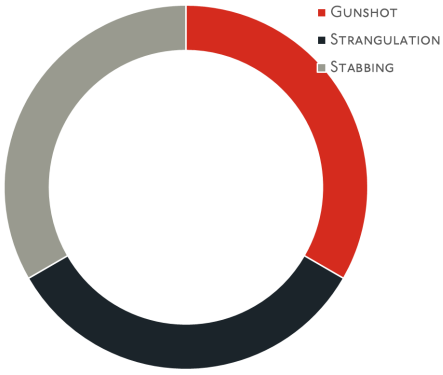


Relationship of Perpetrator 2017

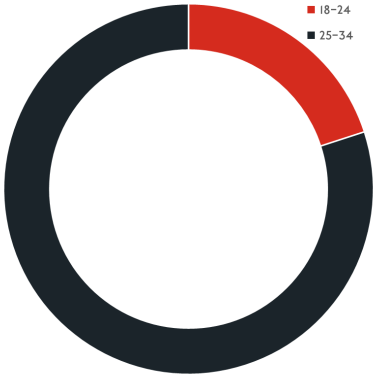


In 2018, at least **14** people were killed in domestic homicides in Minnesota. **3** of these deaths occurred in Hennepin County and we reviewed **1** of these cases in 2019.

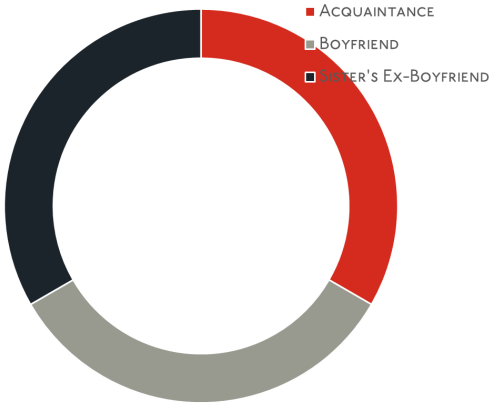
Cause of Death 2018



Age of Victim 2018



Relationship of Perpetrator 2018



Presence of Risk Factors

It is not possible to accurately predict when a perpetrator of domestic violence may kill the victim of abuse. However, researchers have identified 20 factors that are often present in cases of domestic homicide. The Fourth Judicial District Domestic Fatality Review Team notes the presence of risk factors in the reviewed cases because increasing public awareness of risk factors for homicide is an Opportunity for Intervention.

Risk Factors– 2019	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	
Perpetrator had access to a gun.	X		X	X
Victim had attempted to leave the abuser.	X		X	X
Perpetrator was unemployed.	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 perpetrator.	n/a	n/a		n/a
Perpetrator sexually assaulted victim.	X			
Perpetrator had a history of substance abuse.	X		X	X
Perpetrator had previously strangled victim.	X			
Perpetrator attempted to control most or all of victim's activities.	X	X		
Violent and constant jealousy.	X			
Perpetrator was violent to victim during pregnancy.	n/a	n/a		n/a
Perpetrator threatened to commit suicide.	X	X	X	
Victim believed perpetrator would kill him/her.	X			X
Perpetrator exhibited stalking behavior.	X	X		X
Perpetrator with significant history of violence.	X			X
Victim had contact with a domestic violence advocate. (this is a protective factor)	X			

2019 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 increase the likelihood that situations similar to those seen in the case will be identified and intervened upon. 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.

Legislation

The Team has identified two related areas of legislative change that could improve early intervention and prevention of future domestic violence.

- Modify legislation to require **mandatory** Pre-Sentence Investigations for domestic abuse related offenses, including DANCO violations, to better assess the risk factors and treatment needs.
- Move to require that domestic abuse programming be ordered for domestic abuse related offenses including DANCO violations.

Court Administration/Criminal Court

- Offer judicial education opportunities on specific areas of treatment programming to include the philosophy and evidence supporting the program, what a person ordered to the programming can expect to experience, and what outcomes can be reasonably expected for someone who successful completes the program so that Judicial Officers can order the most appropriate intervention.
- Encourage understanding of the differences between domestic violence programming and anger management and encourage Judicial Officers to order domestic violence programming, which is statutorily defined, for cases in which domestic violence is present.

Family Court /Family Court Services

The Team identified opportunities for staff and judicial officers involved in family court cases to build knowledge and expertise about therapeutic programming options, expectations, and how to assess efficacy. Responsiveness to family needs can be further enhanced by the availability of Guardians ad Litem to be used in case as needed.

- Encourage use of only specially trained and experienced family and child therapists in highly contested cases custody cases.
- Incorporate review hearings to follow progress on mental health services ordered for parents and/or children to ensure compliance and assess appropriateness of original programming ordered.
- Offer regular education for any staff involved in, or responding to, assessment processes on the potential adjunctive therapy options that may be more effective in addressing underlying trauma diagnoses.
- Expand resources to allow for discretionary appointment of Guardians ad Litem on any case that may benefit from those observation/services regardless of status of child protection involvement.

Law Enforcement

In the cases reviewed during 2019, the Team identified two areas in which the conveyance of critical information can be missed based on practices that are more likely to be completed based on gender assumptions.

- Practice uniformity across genders in law enforcement referrals to advocacy groups when domestic abuse reports are made, event when the reported victim does not want further law enforcement investigation,
- Practice uniformity across genders in administering lethality assessment upon a reported victim of domestic abuse at advocacy and law enforcement agencies,
- To ensure accuracy and relevant information, request interpreter when working with individuals who are not completely fluent English speakers in both law enforcement and avoid using children, even adult children, as interpreters.

Medical

- Consider expanding intervention and assessment when patient presents with prior or repeated history of sexual assault.
- Similarly, consider policy changes in requiring review and mental health intervention, rather than simply adding to medical record, when a patient seeks emergency care with high-frequency but, ultimately, without the presence of the presenting complaint.
- Request interpreter when working with individuals who are not fluent English speakers in the medical environments. Avoid using children, even adult children, as interpreters.
- Develop social work intervention for patients who choose alcohol over medically necessary interventions like medication.
- Refer to chemical health evaluation when patient reports alcohol use to doctor when there for depression issues.
- Develop screening questions for changes to behavior that may indicate symptoms of post-partum depression or psychosis and other concerning patterns that can be administered to the partner after birth of child and at subsequent well-child check-ups.

Case Review 2010-2019

The Domestic Fatality Review Team was formed in 1999. The Team's 2010 Annual Report contains our initial 10 year retrospective case analysis and can be found on our website. At that time, the Team had reviewed 40 cases of domestic homicide with a total of 43 victims of homicide. To aid that process, and with an eye toward trends and commonalities, we developed a list of 49 factors which included general demographics, history of chemical dependency, family of origin information, CPS history, history of domestic violence, contributing factors in the homicide, type of weapon used, time of day, and location of the homicide. During the past year, with the assistance of Kirstin Matteo, we replicated this analysis for the ten years of cases reviewed from 2010 through 2019.

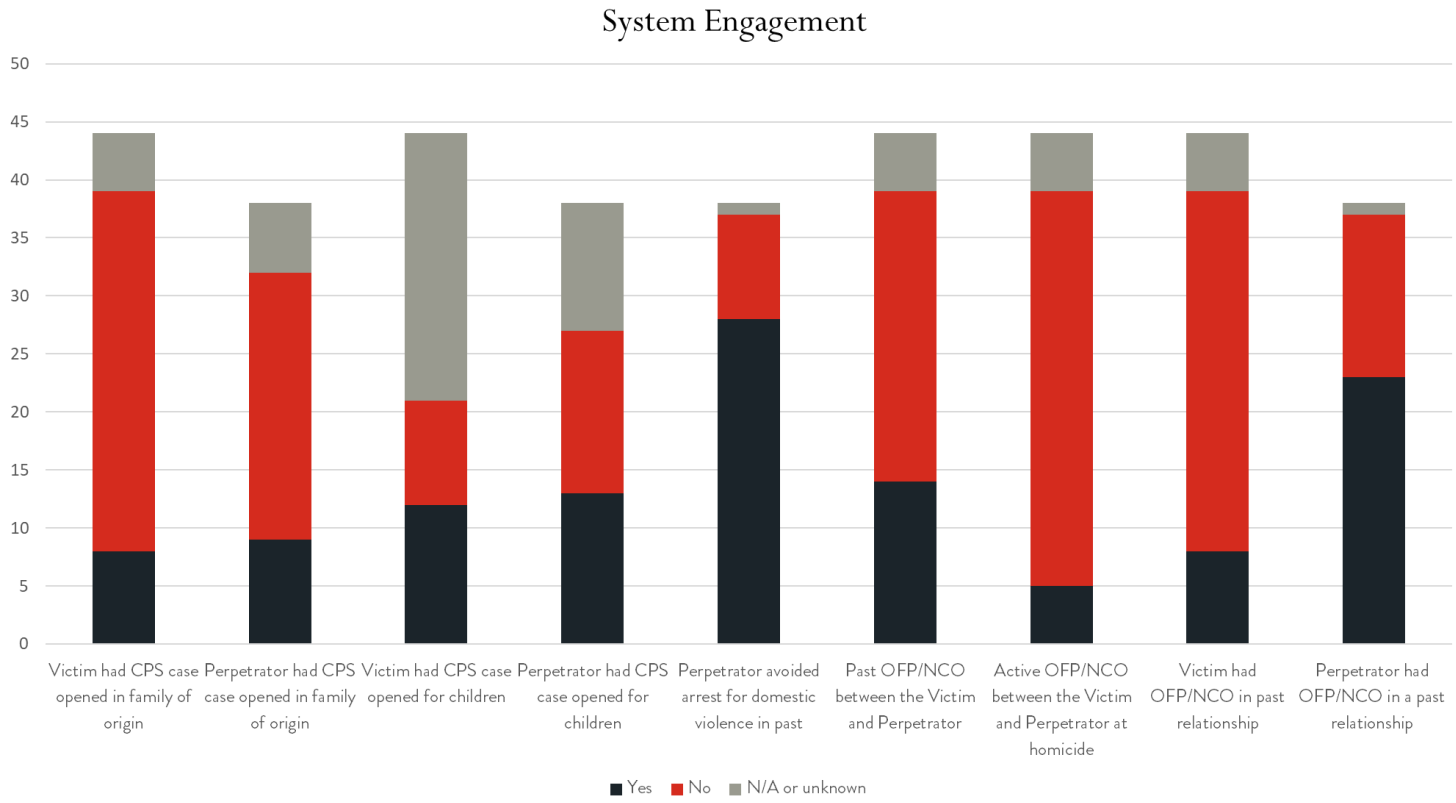
During the last decade, the Team has reviewed 38 cases of domestic homicide and a total of 44 victims of homicide. In the cases where bystanders or children were killed rather than the targeted victim, we included the targeted victim's information rather than the information of the actual homicide victim. As a Team that serves the Fourth Judicial District, we attempt to review as many cases as possible that occur within our geographic boundaries. The Team has reviewed 72% of the cases that have occurred from 2006 to 2018 . There are three common reasons that cases are not reviewed: the case was a homicide/suicide with no history of system interaction, despite the relationship between the perpetrator and victim falling within the definition of a domestic upon further research, the homicide was not in the pattern of domestic abuse (mental health, accident, etc), or the Team is waiting for the case to be closed to further prosecution before reviewing.

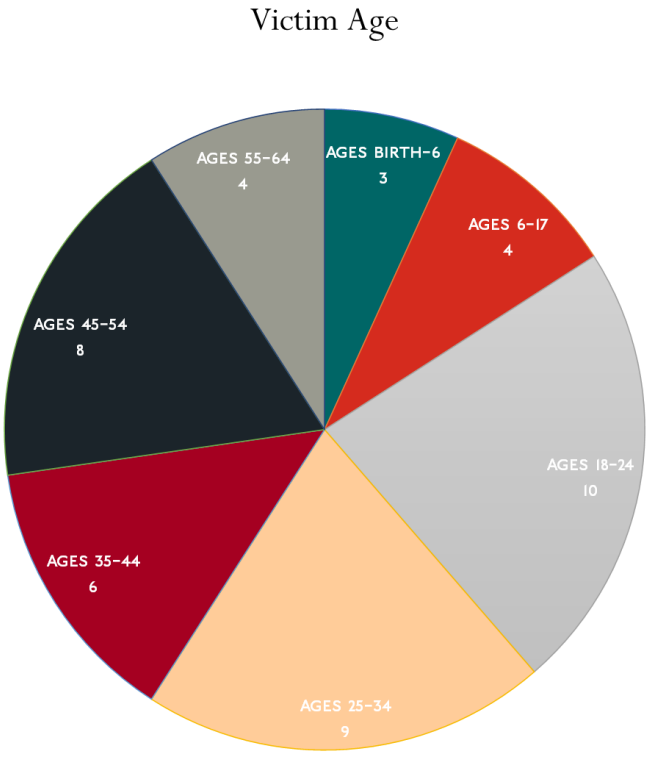
During the last ten years, the Team has reviewed:

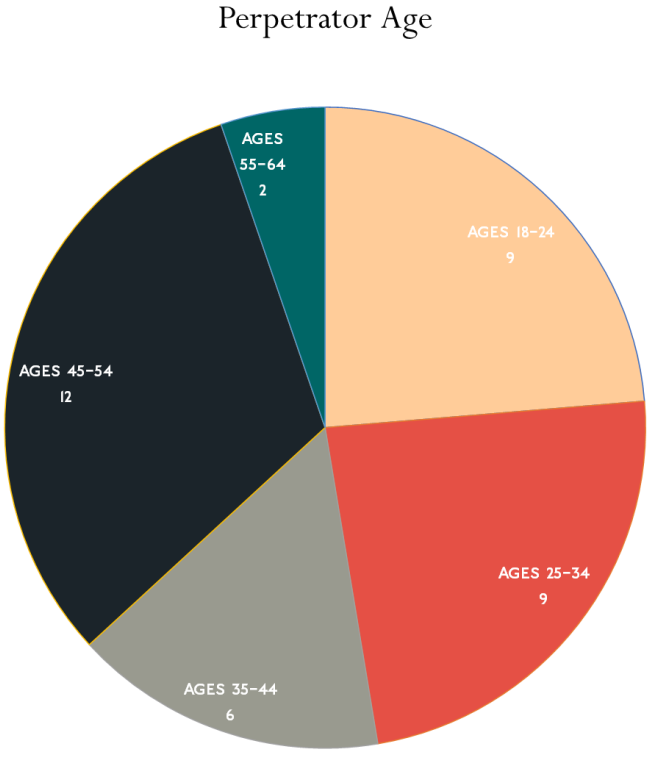
- Five cases that were murder/suicides with a single victim killed prior to the perpetrator's suicide
- Two cases in which there were multiple victims killed prior to the perpetrator's suicide
- Four cases in which there were multiple victims but the perpetrator survived
- A total of seven child deaths, three of whom were killed within the context of the abuse of one of the parents by the other and four of whom were the intended victim of the perpetrator
- One near-death case and, due to privacy concerns, the information about this person is not included in the case composition data

The following pages include visual representations of more case elements.

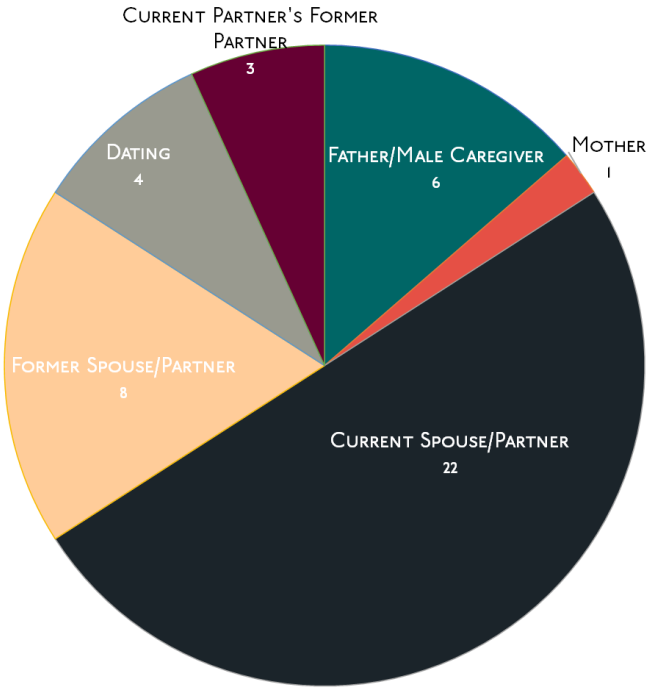
Case Composition 2010-2019



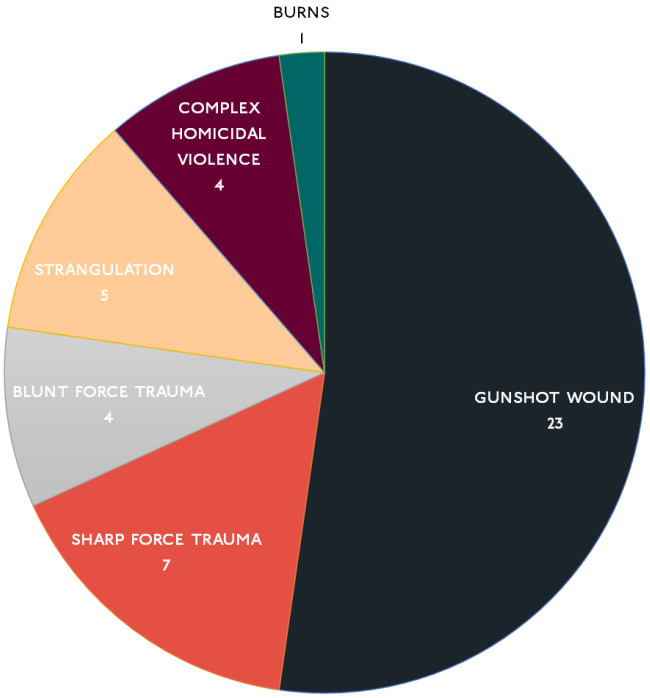




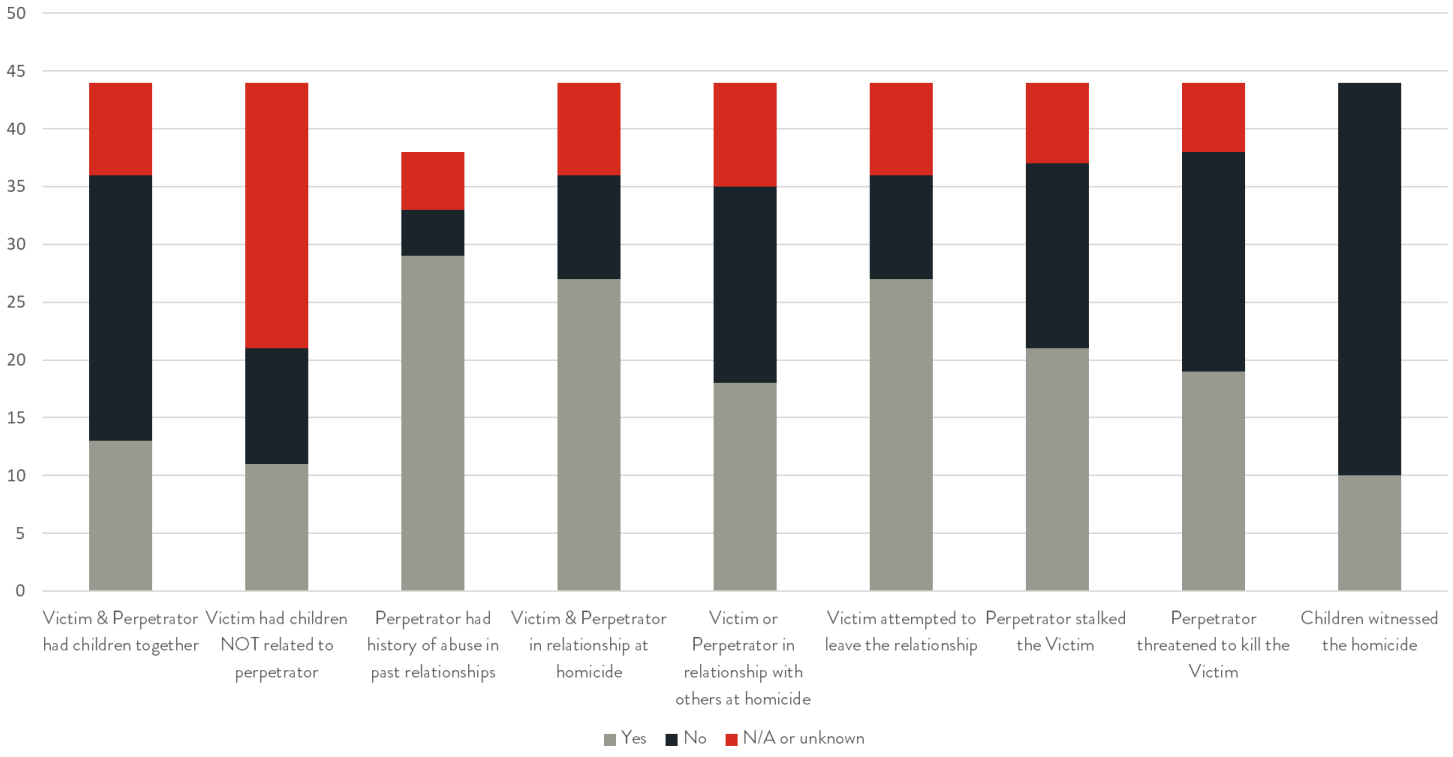
Perpetrator Relationship to Victim



Cause of Death



Situational Factors



2010-2019 Achievements

The Review Team is a part of a larger movement toward a societal shift with respect to domestic violence. The Opportunities for Intervention from our past reports have already resulted in significant changes within many organizations, both inside and outside the collaborative. These changes take many forms. Some are part of formal initiatives; many occur as a result of Review Team members going back to their respective organizations with knowledge gained through direct involvement in the review process and implementing more appropriate and responsive practices and procedures. Since many in the group are senior members within their respective organizations, they have the clout to implement these needed changes. Throughout its history the Review Team members have also participated in a variety of policy-making forums related to domestic violence. Many of these organizations work together on a variety of critical issues to stem the tide of domestic violence.

A recent survey of current and past Team members showed that there have been changes to policy and practice that align with 84 of the 191 directly system related Opportunities for Intervention developed from 2010-2018 and occurred after they were highlighted in Team annual reports. The Team developed an additional 19 Opportunities for Intervention that were aimed at general awareness raising efforts and not included in the survey. While we can not claim credit for the encouraging progress on this front, we think it is important to celebrate these positive changes and noted some below.

All Annual Reports and Opportunities for Intervention are available on the Team's website where you can also see the surveys completed by current and former Team members– www.amatterolifeanddeath.org

Hennepin County Community Correction & Rehabilitation

Procedural guidelines for probation discharge now includes a review of the client's file in MNCIS.

All relevant documents, treatment progress, chronological notes, and other pertinent information, including agent contact information is processed and sent along to the receiving agency for probation transfers between counties or states as part of the process within the transfer module. Transfers are allowed 45 day window to accept, and agents communicate with the transferring agent who continues to supervise until the case is formally accepted by the receiving agency.

In cases where there is a presumption that the sentence will include prison time, more agents have begun including alternative recommendations, for community supervision with conditions, if the Court were to chose to place the client on probation, and depart from the sentencing guidelines. Given the recent research on sentencing disparities, especially in terms of race, the frequency of both dispositional and durational departure have increased.

Policy now indicates that if a domestic violence offenses occur while a person is on probation, and they are sentenced on an different crime, probation officers and supervised release officers have the ability to include domestic

violence related programming in their case planning.

HCCC&R has assigned a resource coordinator to reach out to community agencies and gather details and explanations of their programming goals and missions, including providing information and updates on regular basis or as requested of client's progress. This resource list of programs and details of the programming is available to all agents.

Child Protection

The Intake Department now has the ability to make referrals directly to Parental Support Outreach Program (PSOP) which offers supportive services for families.

Child Protection has engaged the services of CornerHouse and Domestic Abuse Project for therapeutic trauma intervention with child witnesses of violence.

Investigators are screening for domestic violence in cases and making referrals to advocacy and domestic abuse programming for the adults in the family as appropriate even when child protection does not open a case.

Prosecutors

Some City Attorney's Offices have adopted language in their prosecution plans that disfavor the use of a Continuance without Prosecution in domestic abuse related cases.

Strangulation cases are being identified and investigated more and reviewed by the county attorney's office more frequently, though they continue to be difficult to prove without the use of more sophisticated evidence gathering techniques like Alternative Light Source photography and, therefore, rarely lead to convictions.

Many prosecutors have adopted a practice of referring cases to advocates when there is a defendant who appears to also be a victim of domestic abuse based on the reports and regardless of offense . Similarly, defense attorneys are alerted and encouraged to make referrals for domestic abuse services.

Law Enforcement

There has been a noted increase in the use of a standardized risk assessment tool by police officers investigating domestic violence incidents.

Hennepin County Sheriff's Office carry permitting process includes comprehensive checks of court records, including cases that are in progress with no disposition, before the issuance of a permit.

There has been a shift toward legitimizing electronic threats. Many officers are including transcribed threats from social media or texts in reports and courts are becoming more accepting of text/social media printouts as exhibits.

More third-party witnesses are interviewed by officers responding to domestic violence calls, including friends or family who may have been contacted by the victim during or after the assault for their statements/information. .

It is now best practice for officers to record the question and answers in the statement of the victim and gather

relevant evidence- including photographs of the scene and injuries and names and contact information for witnesses – while on the scene rather than relying on the domestic violence victim to complete and submit a written statement after the conclusion of the police call.

Advocacy Providers

Safety planning and resource referrals have become part of any Advocacy-related meeting, including assessing for risk and meeting people where they are at in determining best safety options. This might include Orders for Protection, conducting the Danger Assessment instrument, exploring support networks, or safety planning specific to the situation (staying, leaving, work safety, technology). Many organizations, like Domestic Abuse Service Center, are putting measures into place that are more culturally responsive to the populations that they are serving. The courts are also now offering emailed Order For Protection courtesy copies in an effort to increase access.

Court

The Criminal Court Bench is increasingly aware of the need to use plain language when explaining conditions and ensuring that the people involved in the case leave the courtroom with papers that explain what has happened and what is expected of them. No Contact Orders and Domestic Abuse No Contact Orders, specifically, are explained in more detail.

Family Court Services

All Early Neutral Evaluation (ENE) providers must complete 40-hour family mediation training and ENE-specific program that includes several hours of domestic violence training.

Family Court Services has engaged in extensive training on Intimate Partner Violence and how to assess its impact on children, parenting dynamics, and proposed custody arrangements.

The intake process has been refined in the past five years to better identify cases of domestic violence and ensure that parents' participation can be accomplished in a safe and productive manner, or be referred for a more appropriate service, such as a custody evaluation.

Mental Health Providers

There has been an increase in both availability of training for, and awareness of, domestic violence among mental health professionals. This has begun to include information on aspects or features common in domestic violence that are not necessarily overt instances of physical violence.

2019 Members

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Director
Justice for Families/OVW

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Supervisor–
Seward Neighborhood Probation
Community Corrections &
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** Member of Advisory Board ** Resigned the Team in 2019 ‡ Joined Team in 2019*

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