A Matter of Life and Death

2016 Annual Report

Fourth Judicial District Domestic Fatality Review Team

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

2016 Annual Report

Project Chair:

The Honorable Fred Karasov
Minnesota Fourth Judicial District

2016 Community Partners:

Battered Women's Legal Advocacy Project
Bloomington City Attorney's Office
Community Volunteers
Domestic Abuse Project
Eden Prairie Police Department
Hamline University
Minneapolis City Attorney's Office
Minneapolis Police Department
South Lake Minnetonka Police Department

2016 County and State Partners:

Minnesota Fourth Judicial District Court
Minnesota Fourth Judicial District Court Administration
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 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 Fred Karasov
Minnesota Fourth Judicial District
Project Chair
612-348-6405
or
Deena Anders
Project Director
651-263-2901

www.amatteroflifeanddeath.org

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Acknowledgments

The Honorable Fred Karasov, 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 those who donated their time to present information to the Team in 2016:
Safia Khan – Minnesota Coalition for Battered Women
Mike Maas– Hennepin County Intensive Supervised Release
The Honorable Anne McKeig– Family Court Enhancement Project
Joan Bibelhausen– Minnesota Lawyers Concerned for Lawyers
Rick Boelter– Hennepin County Sheriff's Office
Kathy Mara– Metro CISM Team
Kjirsten Yahr– Metro CISM Team
- Hennepin County Crime Lab

Executive Summary

The Fourth Judicial District Domestic Fatality Review Team members examine cases of domestic homicide that have occurred within Hennepin County. Each year themes emerge from the cases reviewed, sometimes related to communication processes, other times about the alignment of policies to identified best practices, but a common thread that has been woven through every year and each report is the need for early intervention and public education to end the cycle of violence.

There is a critical and persistent need for attention and resources focused on prevention and early intervention efforts. The Team recognizes the importance of building awareness in the general public about healthy relationships and signs of relationship abuse beyond physical injury. Similarly, after reviewing case after case where the children who witnessed abuse grow up to use abuse, the necessity of trauma-informed healing services delivered by people who understand the dynamics of abuse is clear. These ideas are not controversial but they tend to fall to the end of each report because there is no system partner positioned to champion the implementation efforts.

In government and non-profit sectors, the practices and services that are available closely mirror those for which funding exists. In other words, our community response to domestic violence is dictated by federal funding streams, and those are primarily directed to criminal justice responses and shelter services.

The direction of funding means that domestic abuse is primarily viewed within a criminal justice framework and is focused on physical acts of violence– as defined by the criminal code. The shelter and advocacy structure that provides safety and resources for those who have been abused has also formed around the criminal justice response, with an arrest or 911 call being the entry point for many people into support services, and separation of the parties being the primary mechanism to ensure that safety. This intervention remains a vital component to an effective community response and, additionally, the findings of nearly two decades of homicide review clearly illustrate the need for an expansion of the domestic abuse response into broad reaching prevention education and healing work with children.

Consistent funding for primary prevention is rare. These are the funds that could be used to support Opportunities like public education campaigns that confront the misinformation about domestic abuse and domestic homicide– the assertions that it is and unpredictable tragedy rather than something that happens, on average, a couples times a month in Minnesota– or offer information about the signs and patterns of domestic abuse that are not physical. Typically education and outreach has been conducted by shelter and advocacy programs through small, short-term, funding streams. Similarly, interventions intended to heal are often difficult to access on a long-term basis especially with providers who integrate the dynamics present in families that experience abuse into the healing strategies.

The benefit of raised awareness and a more nuanced understanding of domestic abuse extends to those who are experiencing abuse in their relationship. Too often we review cases where people who were killed experienced coercion, stalking, emotional destruction, and psychological threats, but did not see it as abuse or a lethality risk (page 8) because it was, first, what they grew up seeing as normal in a relationship and, second, not physical violence and often not in the purview of the criminal justice system.

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
The violence had increased in severity and frequency during the year prior to the homicide.	X		
Perpetrator had access to a gun.	X		X
Victim had attempted to leave the abuser.	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	
Perpetrator had previously avoided arrest for domestic violence.	X		X
Victim had children not biologically related to the perpetrator.	X	X	
Perpetrator sexually assaulted victim.			
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	
Violent and constant jealousy.	X	X	
Perpetrator was violent to victim during her pregnancy.			
Perpetrator threatened to commit suicide.			X
Victim believed perpetrator would kill her.			
Perpetrator exhibited stalking behavior.	X		
Perpetrator with significant history of violence.	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 .

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 three domestic homicide cases in 2015 and pursued Opportunities for Intervention in all of those cases. The following information includes all domestic homicides in Hennepin County that occurred in the year from which the cases reviewed by the Team were drawn along with the cause of death, age and gender of the victim and the relationship of the perpetrator to the victim:

In 2013, at least 25 women and 8 men were killed by current or former intimate partners, as well as 5 family members/interveners, in the state of Minnesota. Nine of these homicides occurred in Hennepin County and the Fatality Review Team reviewed one of the cases in 2016.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Blunt Force Trauma	18	Female	Sexual Partner
Blunt Force Trauma	24	Female	Sexual Partner
Gunshot	24	Female	Ex-boyfriend
Gunshot	26	Female	Rejected date
Blunt Force Trauma	46	Female	Boyfriend
Gunshot	26	Female	Husband
Gunshot	21	Male	Sexual Partner
Blunt Force Trauma	58	Male	Girlfriend
Stabbing	48	Male	Wife

In 2015, at least 22 women, 3 men, and 4 children, were killed by current or former intimate partners, as well as 5 family members/interveners, in the state of Minnesota. Ten of these homicides occurred in Hennepin County and the Fatality Review Team reviewed one of these cases in 2016.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot	21	Female	Boyfriend
Strangulation	36	Female	Boyfriend
Gunshot	48	Female	Husband
Gunshot	17	Male	Father
Gunshot	15	Female	Father
Gunshot	14	Female	Father
Gunshot	48	Female	Husband
Gunshot	15	Female	Step-father
Stabbing	48	Female	Husband
Gunshot	25	Female	Boyfriend

2016 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. Below are those Opportunities for Intervention identified in 2016.

Encouraging Healing for Child Witnesses of Domestic Abuse

The use of trauma-informed interview techniques, along with an awareness of typical presentation of children who have witnessed domestic violence, may assist in gleaning more accurate information in child interviews as well as resulting in better care referrals.

- Implement the use of trauma-informed interview techniques and services provision among all system actors that interact with child witnesses of abuse.
- Ensure that each provider, from police officer to physician to attorney to social worker, is educated on how the dynamics of domestic abuse influence the child's experience of the harm witnessed.
- Offer consistent information and tools to parents involved in domestic cases—through the police, courts, probation, and advocacy organizations– to understand the ways that witnessing abuse affects their children, ways that they can help their children heal, and services that can assist them.
- Modify the Department of Education's state Social Studies standards to require Healthy Relationship/ domestic abuse education for K-12 students.
- Enhance ALL school anti-bullying policies to include specific education for school staff and families regarding the underlying factors that may be present for the child using bullying behaviors and how to effectively intervene with both those who are subject to the bullying and those who are accused of it.

Care Providers

- Require regular training for medical and mental health practitioners on the dynamics seen in families experiencing domestic violence and how to integrate questions about those dynamics into existing screening mechanisms. These trainings must include information on existing resources and modes of referral.
- Medical and mental health practitioners may benefit from robust internal protocols on methods and frequency of follow-up with clients who are in active crisis situations.
- Review reasons for lack of progress with clients to better make recommendations and referrals that will be followed up prior to discharging from care.
- Any suicidal thought/ideation should be considered high risk by medical professionals no matter the patient's rating and should be followed up immediately with collateral contacts, including family

Probation

- Consider standardization of administrative probation to include: 1) adherence to guidelines for determining whether administrative probation is the appropriate placement for the person, 2) consistent conditional criteria required for people on administrative probation related to leaving the state and frequency of check-in policies.

Court

- Study the potential benefit of implementing of diversionary dispositions on first time misdemeanor domestic violence offenses that focus on fulfilling six-twelve month clinical intervention requirements designed to decrease likelihood of recidivism.

Explore the development of a process to define traumatic brain injuries as "great bodily harm" and thereby chargeable as 1st Degree Assault.

- Develop a screening tools for head trauma that can be administered by responding officers, advocates, or medical responders and used by prosecuting attorney.
- Provide training to first responders, advocates, attorneys, and judicial officers on the causes, signs, and consequences of traumatic brain injury.

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

Linda Berberoglu, PhD*
Senior Clinical Forensic Psychologist
Fourth Judicial District Court

Janice Blackmon‡
Supervisor– Seward Neighborhood Probation
Hennepin County Community Corrections & Rehabilitation

Enid Boeding, MD**
Assistant Medical Examiner
Hennepin County Medical Examiner's Office

Bernie Bogenreif*
Detective
Hennepin County Sheriff's Office

Pat Chelmo‡
Detective
Hennepin County Sheriff's Office

Mike Condon*
Career Probation Officer– Adult Division
Hennepin County Community Corrections & Rehabilitation

Carrie Crockford, MA, LMFT
Men's Program Supervisor
Domestic Abuse Project

Pam DeWitt-Meza
Labor & Delivery Nurse/SARS Nurse
Hennepin County Medical Center

Valerie Estrada‡
Corrections Unit Supervisor
Hennepin County Community Corrections & Rehabilitation

Bruce Folkens
Commander, Special Crimes Investigation
Minneapolis Police Department

Erica Glassberg
Assistant City Attorney
Bloomington City Attorney's Office

Sarah Greenman, PhD
Assistant Professor
Criminal Justice & Forensic Science
Hamline University

Chela Guzman*
Attorney
Hennepin County Public Defender's Office

Michelle Hatcher‡
Assistant County Attorney
Hennepin County Attorney's Office

Loretta Huffman
Child Protection Program Manager
Hennepin County Child Protection Investigations Unit

The Honorable Fred Karasov*
Judicial Officer
Fourth Judicial District Court

Deirdre Keys‡
Advocacy Support Program Manager
StandPoint (formerly BWLAP)

The Honorable Joseph Klein**
Judicial Officer
Fourth Judicial District

Anna Lamb
District Court Administration
Fourth Judicial District Court

Neal Margolies
Supervisor– Adult Division
Hennepin County Community Corrections & Rehabilitation

Anne McKeig‡ **
Presiding Judge– Family Court
Fourth Judicial District

Chris Millard
Detective
Eden Prairie Police Department

Stephanie Morgan
Assistant County Attorney– Juvenile
Hennepin County Attorney's Office

Christine Olson
Officer
South Lake Minnetonka Police Department

Linnea Olson
Probation Officer
Hennepin County Community Corrections & Rehabilitation

Jen Prax
Family Court Services
Hennepin County Community Corrections & Rehabilitation

Kathy Rygh
Assistant City Attorney
Minneapolis City Attorney's Office

John Staloch**
Corrections Unit Supervisor
Hennepin County Community Corrections & Rehabilitation

* Member of Advisory Board
** Resigned the Team in 2016
‡ Joined Team in 2016

Fourth Judicial District Domestic Fatality Review Team

Project Chair:
The Honorable Fred Karasov
Minnesota Fourth Judicial District

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

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