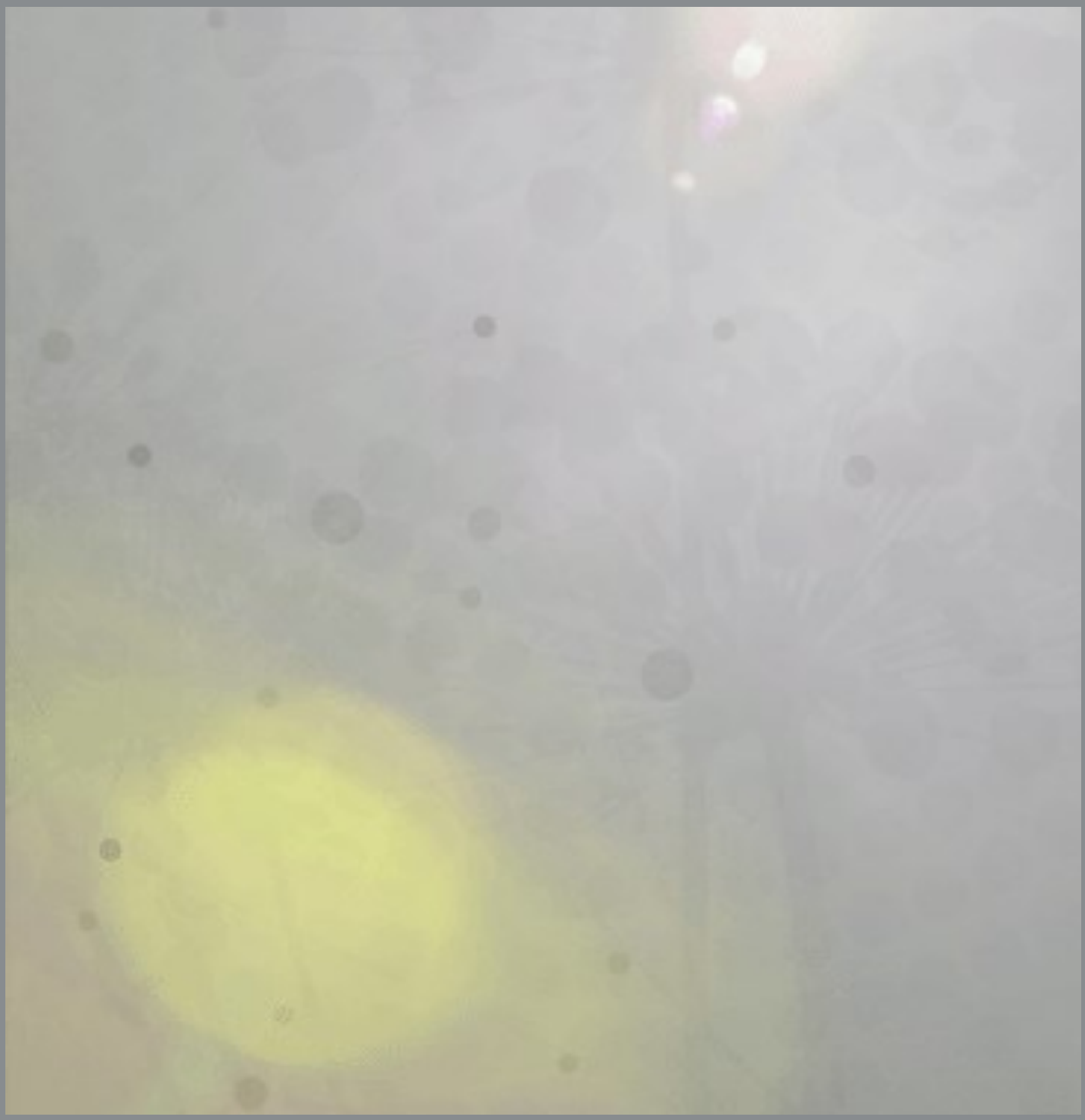

FOURTH JUDICIAL DISTRICT
DOMESTIC FATALITY REVIEW TEAM

2020 Annual Report

Project Chair:

Referee Mary Madden
Minnesota Fourth Judicial District

2020 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

2020 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

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 2020:
Dr. Hannah Dietrich
Leah Erickson
Jovanna Lopez
Chris Millard

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 2020, the Team reviewed four cases. From these reviews, the Team developed Opportunities for Intervention that include: working to expand the holistic perspective at every stage of system intervention in intimate partner violence; examining the barriers to participation that eligible individuals experience in accessing or succeeding in problem-solving courts; training for law enforcement, prosecutors, and defense attorneys on recognizing the signs of sex and labor trafficking; and offering targeted, accessible, relevant, and incentivized services of varying lengths for youth who are involved in traumatic incidents regardless of their role in the incident. The full list of Opportunities for Intervention begins on page 9.

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.

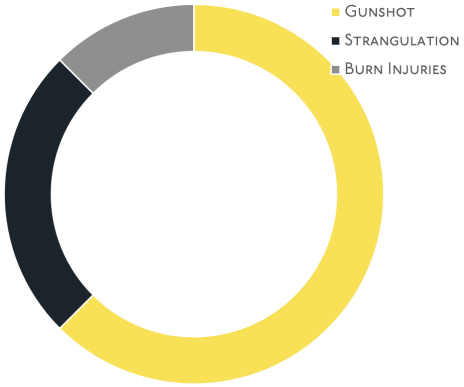
Each Review Team meeting begins with members signing a confidentiality agreement. At the meeting, individuals who reviewed the case report their findings. The Team then develops a series of observations related to the case. Small groups of Team members use these observations to identify opportunities 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

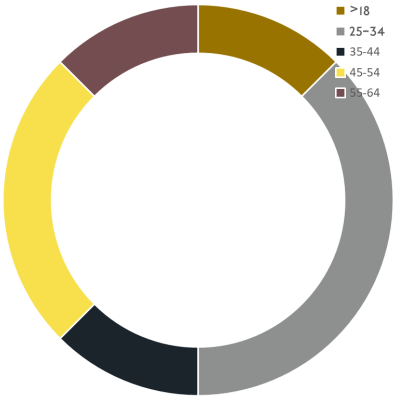
We review cases of domestic homicide– homicides related to domestic abuse which is defined as a pattern of physical, emotional, psychological, sexual and/or stalking behaviors that occur within intimate or family relationships between spouses, individuals in dating relationships, former partners and 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 deaths in 2020.

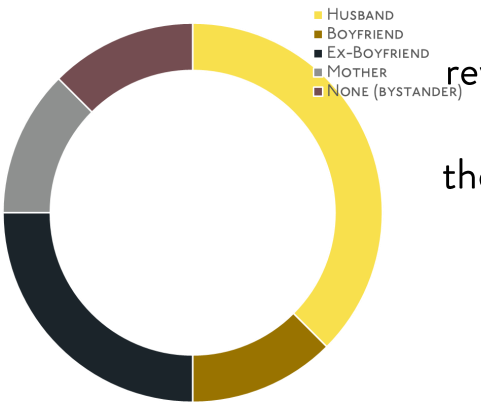
Cause of Death 2017



Age of Victim 2017

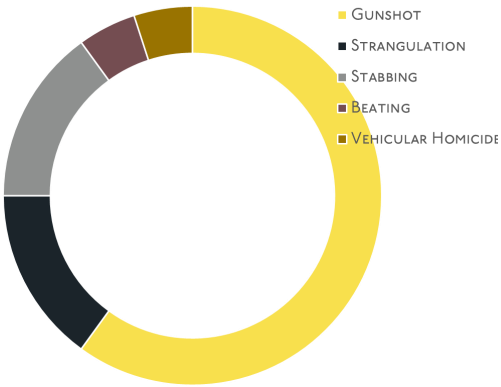


Relationship of Perpetrator 2017

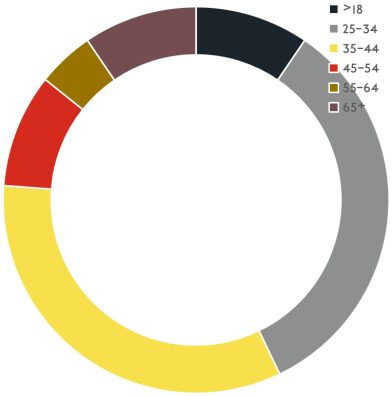


In 2019, at least **21** people were killed in domestic homicides in Minnesota. **6** of these deaths occurred in Hennepin County and we reviewed **4** of these deaths in 2020.

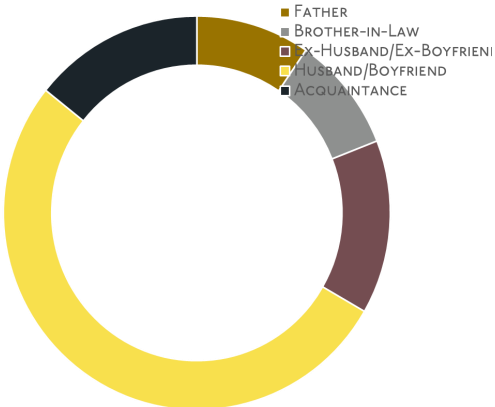
Cause of Death 2019



Age of Victim 2019



Relationship of Perpetrator 2019



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– 2020	Case 1	Case 2	Case 3	Case 4
The violence had increased in severity and frequency during the year prior to the homicide.	X	X	X	
Perpetrator had access to a gun.	X			X
Victim had attempted to leave the abuser.	X	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		
Perpetrator had previously avoided arrest for domestic violence.	X	X	X	
Victim had children not biologically related to the perpetrator.	n/a	n/a	X	
Perpetrator sexually assaulted victim.				
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	
Violent and constant jealousy.	X			
Perpetrator was violent to victim during pregnancy.	n/a	n/a	n/a	
Perpetrator threatened to commit suicide.				X
Victim believed perpetrator would kill him/her.				
Perpetrator exhibited stalking behavior.	X			X
Perpetrator with significant history of violence.	X	X		
Victim had contact with a domestic violence advocate. (this is a protective factor)				

2020 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.

Collaborative/Cross-System Efforts

- Work to expand the holistic perspective at every stage of system intervention in intimate partner violence and use each system interaction with a person experiencing abuse as an opportunity to share information about realities of domestic violence. This effort must include:
    - Expanding lethality assessments to screen for non-physical or coercive control tactics of abuse;
    - Law Enforcement asking contextual questions and expanding assessments to all people at the scene;
    - Judicial officers understanding and responding to context of domestic violence situations with appropriate conditions and intervention referrals;
    - Knowledge among probation officers and lawyers of dynamics of domestic violence and varied types of intervention for patterned behavior.
- Strengthen proactive partnerships between Law Enforcement, Child Protective Services, and Adult Representation Services to encourage interviews with child witnesses of domestic violence. These interviews can enhance the efficacy and appropriateness of the interventions offered to each member of the family and the family as a whole.
- Create cross-disciplinary processes that provide comprehensive screening and intervention for mental health, chemical use, and domestic violence where professionals are able to regularly assess and address the

priority issue at any given time rather than sequentially.

- Given the positive outcomes associated with the practice, ensure that all law enforcement organizations in Hennepin County have a co-responder program pairing mental health professionals with officers available at all times.

Court Administration/Research

- Examine the barriers to participation that eligible individuals experience in accessing or succeeding in problem-solving courts. This inquiry may expand to include perceptions of the courts among people who are eligible to use them and explore why a person may or may not choose to participate.

Community

- Develop a bystander intervention campaign that builds the skills and knowledge for members of the community to effectively respond to situations of abuse in the moment, report incidents of abuse when necessary, talk to people who they believe may be experiencing or using abuse in relationship, and find helping resources.
- Publicize mental health resources that can be readily used by community members who are concerned about the mental health of a family member, friend, or acquaintance. Beneficial resources include:
    - NAMI- 651-645-2948 (education and advocacy)
    - Hennepin County COPE– Adult 612-596-1223 and Child 612-348-2233 (emergency)
    - Ramsey County Adult Mental Health Crisis Line– 651-266-7900 (emergency)
    - Ramsey County Children's Mental Health Crisis Line– 651-266-7878 (emergency)
    - Dakota County Crisis Response Unit– 952-891-7171 (emergency)
    - Call **CRISIS (274747) from anywhere in Minnesota to reach the local county crisis team

Providers

- Expand supportive resources and information about and for parents who are experiencing abuse by their children.
- Develop and offer specific programming addressing intrafamilial domestic violence for both those using and those experiencing the abuse. The dynamics differ between intrafamilial and intimate partner violence significantly enough to justify unique intervention strategies.
- Offer targeted, accessible services of varying lengths for youth who are involved in traumatic incidents regardless of their role in the incident. It is imperative that these services be relevant and incentivized to overcome the barriers young people without adult support have in engaging with helping resources.

Training Opportunities for Improved System Response

- Cross training for law enforcement, prosecutors, and defense attorneys on recognizing the signs of sex trafficking and labor trafficking and effectively working with people who are being trafficked to build a case against traffickers.
- Training for Judges and all criminal justice partners on intrafamilial violence dynamics, implications, and effective interventions.

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** Member of Advisory Board ** Resigned the Team in 2020 ‡ Joined Team in 2020*

Fourth Judicial District Domestic Fatality Review Team

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