

2021 Annual Report

Minnesota Fourth Judicial District Domestic Fatality Review Team

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2021 County & State Partners:

Hennepin County Adult Representation Services Hennepin County Attorney's Office

Hennepin County Child Protection

Hennepin County Community Corrections & Rehabilitation (HCCCR)

Hennepin County Domestic Abuse Service Center

Hennepin County Family Court Services

Hennepin County Medical Examiner

Hennepin County Psychological Services

Hennepin County Public Defender's Office

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Fourth Judicial District Domestic Fatality Review Team www.amatteroflifeanddeath.org

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Acknowledgements

Together, Mary Madden- Project Chair, and Makenzie Nolan- Project Director, would like to offer their gratitude and recognition to former Project Director, Deena Anders, who led the Fatality Review Team for 15 years before resigning at the end of 2021. Deena's passion for this work, profound advocacy, and expertise proved to be an incredible asset to the Team, Hennepin County, and the State of Minnesota. On behalf of the Team, and those who served on the Team over the past 15 years, we thank Deena Anders for her commitment and humble service in the prevention of domestic homicide.

We would also like to acknowledge members and supporters of the Fourth Judicial District Domestic Fatality Review Team:

The Hennepin County Law, Safety, and Justice Department who manages the contract;

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

The leaders of partner organizations who willingly commit staff time to the Team and encourage changes and procedures based on the Teams findings;

Members of the Advisory Board who oversee the work and membership of the Team;

The members of the Team who give their time generously and offer their professional expertise in the review of each case;

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

The following professionals and content experts that joined the Team in 2021 to present on information pertinent to each case review:

Dr. Loren Jackson

Pheng Thao

About the Domestic Fatality Review Team

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 where the victim of the homicide is not the primary victim of abuse.

The Fourth Judicial District Domestic Fatality Review Team is a collaboration of private, public and non-profit organizations and citizen volunteers from throughout Hennepin County. The Fourth Judicial District Domestic Fatality Review Team was created to improve policies and procedures to better address domestic violence in our county.

The work of the Fourth Judicial District Domestic Fatality Review Team is also protected under Minnesota State Statute, Section 611A. 203, which outlines the Domestic Fatality Review Team's purpose, definition of domestic violence death, criteria for Team membership, terms of data practice and confidentiality, Team immunity, and our Team's process for evaluation and reporting.

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 Team's intention is not to place blame for the death, but rather to actively improve all systems that serve persons involved with domestic abuse.

Advisory Board:

The Advisory Board represents a group of elected members who have served on the Team for a minimum of 6 months, and are recommended by an existing Advisory Board member with the approval of the Board Chair. As the governing body of the Fourth Judicial District Domestic Fatality Review Team, the Advisory Board is responsible for adhering to the Minnesota State Statute and Team Bylaws, and is charged with appointing members to the Review Team. The Advisory Board generally meets bi-monthly and is also tasked with upholding the Team's Code of Ethics, to ensure the Team operates in a respectful, professional, and confidential manner that adheres to data practices and Team Meeting Guidelines.

Team Members:

The Team includes professionals in select roles, often embedded within the system, who are most likely to overlap with perpetrators and victims of domestic abuse. Our members reflect leadership from civic organizations, criminal and civil attorneys and Judicial Officers, probation, law enforcement, mental health professionals, and advocates from across Hennepin County and its respective 45 cities. The Team also strives to have community representatives or members from community organizations that may have a wide array of backgrounds, and bring knowledge and perspective apart from the professional "systems" vantage point.

Meeting Structure:

Historically, all Fatality Review Team Members would gather and conduct monthly in-person meetings for each case under review. However, in the wake of the Covid-19 Global Pandemic, the work of the Team shifted in 2021 to accommodate a safe, remote, and virtual meeting platform for its members. The Team was able to successfully adapt to virtual processes and procedures for each case review, and held virtual monthly meetings for the duration of 2021.

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 only selects cases in which prosecution is completed.
- Findings are based primarily on information contained within official reports and records regarding the individual's 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 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.

The Review Process

The Team is able achieve its goal and purpose through the intentional and meticulous review of each domestic homicide case. Using a multi-disciplinary lens, the members of the Team engage in a collaborative review process that leans on the professional expertise and lived experience of each Team member.

The Team approaches this work with a willingness to engage in the review process with honesty, humility, integrity, and curiosity. The Team also recognizes its unique and privileged position with access to information that extends across 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 each case. The Team utilizes the following processes in the review of each case:

Case Selection

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 Team members to determine which cases to review. A list of cases is then compiled and brought to the Advisory Board for a final vote. Once consensus is reached by the Advisory Board, and it is confirmed that the case is closed to further prosecution, the case is then reviewed by the Team. In circumstances where a case may include a homicide/suicide where no criminal prosecution takes place, the Team waits at least one year before the case is considered for reviewed. Allowing 1-2 years to pass between an incident and the Team's review can help alleviate some of the emotion and tension experienced by members who may have had direct involvement in the case.

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 serve as the first source(s) of information, and often leads to the identification of other agencies that may have records related 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 the perpetrator and/or victim prior to the homicide, are all examples of additional data sources used in the Teams review process.

The Project Director compiles all of the available information to create a chronology of the case. Names of police, prosecutors, social workers, doctors, or other professionals involved in the case are not used. This chronology is then sent to Team members prior to the case review meeting. In addition, each source document that is used to develop the case chronology is assigned for review by two team members; one member from the agency that provided the information, and another member with an outside perspective. Each Team member is also responsible for completing a confidentiality agreement at the beginning of each new case.

At Team meetings, the members who reviewed source documents report their findings, and a series of observations are made in relation to the case. These observations are then used 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.

Executive Summary

The goal of the Annual 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 selects 2-4 cases for review each year, in which prosecution is completed. The number of cases reviewed depends on the amount of information that is available to the Team for an in-depth examination and gathering of facts. Once information is compiled for each case and ready to be reviewed by the Team, a designated confidential case chronology is created. Each confidential case chronology establishes a working timeline that includes the following information for both the perpetrator and victim: date of birth, major life events and involvement with the system(s), the date of the domestic homicide, and events proceeding the domestic homicide.

Members of the Team often begin each case review by independently examining the confidential case chronology, which is provided in advance of Team meetings. When the Team comes together, the confidential case chronology is then used by the group to make observations about specific elements of the case being reviewed. Sometimes the observations assist in identifying the context of the crime. Other times, they illuminate a clear missed opportunity to avoid the domestic homicide. From these observations, the Team identifies and creates Opportunities for Intervention that directly correspond to facts or patterns observed by the Team.

In 2021, the Team reviewed 3 cases. From each case review, the Team developed Opportunities for Intervention that include: court reassignment for supervised probation; cultural inclusion; early detection, intervention, and prevention in schools; education to raise awareness; emergency alternatives; gun violence prevention; investigations equivalent to level of crime; juvenile justice intervention and treatment; and reducing language barriers in both civil and criminal court. The full list of Opportunities for Intervention begins on page 11.

The Review Team hopes that the information in this report will prompt active changes to policy and practice that may help to prevent future domestic 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.

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 in itself.

Risk Factors: 2021	Case 1	Case 2	Case 3
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
Victim had attempted to leave the abuser.			
Perpetrator was unemployed.	X	X	X
Perpetrator had previously used a weapon to threaten or harm victim.		X	
Perpetrator had threatened to kill the victim.			
Perpetrator had previously avoided arrest for domestic violence.		X	
Victim had children not biologically related to the perpetrator.		X	
Perpetrator sexually assaulted victim.			
Perpetrator had a history of substance abuse.			
Perpetrator had previously strangled victim.			
Perpetrator attempted to control most or all of the victim's activities.			
Violent and constant jealousy.			
Perpetrator was violent to victim during pregnancy.		X	n/a
Perpetrator threatened to commit suicide.			
Victim believed perpetrator would kill him/her.			
Perpetrator exhibited stalking behavior.			
Perpetrator with significant history of violence.		X	
Victim had contact with a domestic violence advocate.			

2021 Opportunities for Intervention

The Fourth Judicial District Domestic Fatality 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 Interventions, which 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 also include agencies or groups that may offer educational information about domestic violence, risk factors of domestic homicide, and/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.

Court Reassignment for Supervised Probation

• Improve process for communication between court and probation to ensure that appropriate probation supervision is reassigned after a person has violated their initial conditional release but has again appeared before the court.

Cultural Inclusion

- Increased interfacing with cultural communities on the definitions and dynamics of domestic violence.
- Share how matters of domestic violence are handled across-cultures, offering methods to create a shared understanding and more beneficial connection between system actors and community members. (Work formerly done through Justice for Families Project)

Early Detection, Intervention, and Prevention in Schools

- Consider psychological and psychotherapeutic interventions
- Increased funding to support academic support specialists that are available on-site and able to
 meet with students multiple times a week for early intervention following pattern of violent
 episodes.
- Emphasize psychosocial academic support with wraparound family-school case management that teach pro-social competencies.

Education to Raise Awareness

- The absences of common knowledge about resources for abuse, the complicated factor of
 involving police in communities that do not trust police; and the persistent, internalized, belief
 that violence and abuse is a private matter leads to missed opportunities for intervention.
 Consider raising awareness about what each person can do if they witness abusive or violent
 behavior. Ideas included:
 - Awareness raising campaign akin to "see something say something" along with resources for intervention.
 - Expanded social media strategies that speak out about the domestic violence and support general awareness that can be tailored to all ages.
 - Possible inclusion of information in community education pamphlets that are already going to people's homes.

Emergency Alternatives

- The creation of emergency alternatives to 911 to access intervention services.
- Publicize the availability of anonymous reporting to CPS.
- There are no direct questions within commonly used danger/lethality assessments about the potential for escalation of violence or abuse caused by the perpetrator's concern about losing face in community or being perceived as not conforming to social norms or expectations. Consider the inclusion of this line of inquiry.

Gun Violence Prevention

Creation and inclusion of a section in the application for firearm purchase and accompanying customer
information packet that is dedicated to sharing information and resources for any person with potential
safety concerns. This should include a broader focus on safety concerns that could potentially be
motivating the gun purchase.

Investigations Equivalent to Level of Crime

- Allocate adequate resources to investigative resources proportionate to the level of violence used in the commission of the crime. Investment of time and resources allocated to police investigation mirrors the level of violence perpetrated in a violent crime for future police investigations where ID not readily available or provided in police report
- Ensure that the resources invested in investigating crimes, including the time and effort taken to identify parties not immediately known at the time of the initial report, is commensurate with the level of violence used in the crime.

Juvenile Justice Intervention and Treatment

- Incorporate research and best practices on adolescent brain development, decision-making, and the effects of trauma and stress- rather than just public safety- when considering alternatives to the certification of juveniles as adults in criminal proceedings.
- Create clear and effective transition planning and programming specifically for young people who
 were imprisoned during their adolescence that focuses on building independent living skills and
 meaningfully supporting them as they return to community (food, housing, mentoring, family
 support, etc.)
- Shift the use of treatment or intervention programming in the juvenile justice system from: intervention that is short-term, punitive, and rapidly shifted based on the actions of the young person; to consistent, relational, and supportive while prioritizing accountability.
- Invest resources in early childhood trauma-intervention practices that are long-term, accessible, and address the barriers that may keep parents from supporting their child's participation (food, transportation, wrap-around family support).

Reducing Language Barriers: Civil and Criminal Court

- The interpretation required in the court setting places the onus on prosecutors, defense attorneys, and the bench to ensure that the legal concepts and language are understood by the person using an interpreter because the interpreter is not able to convey the contextual elements of the situation.
- Consider the addition of a court personnel position, like a court navigator, who could take extra time with parties to ensure that they understand the court process and meaning of legal or court terminology and answer any questions that arise. This service could be available for people using an interpreter as well as for people who are simply unfamiliar with court
- Court personnel, prosecutors, defense attorneys and members of the bench may benefit from ongoing training on working with interpreters in the court setting to better understand:
 - o How familiar, colloquial, phrases in other languages might be misunderstood and affect the courts perception of the speaker when repeated word for word in English.
 - The way that dynamics between the interpreter and party (age, gender, perceived position of authority) can affect the type and manner of information shared.
 - The importance of helping the person using an interpreter understand the interpreter's role and that they are not available to provide advice or guidance in the court setting.
 - Best practices for working with interpreters like using an interpreter for the entirety of a hearing, not just certain words or phrases, to ensure clear understanding of all elements.
 - What the certification process for interpreters entails to better recognize any challenges that may arise in using uncertified interpreters.

Advisory Board Members 2021

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