2024 Annual Report

Minnesota Fourth Judicial District
Domestic Fatality Review Team

Project Chair:

The Honorable Michael Burns
Minnesota Fourth Judicial District

2024 Local & Community Partners:

Bloomington City Attorney's Office
Bloomington Police Department
Brooklyn Center Police Department
Cornerstone
Domestic Abuse Project
Eden Prairie Police Department
Health Partners
Hurd Law PLLC
Maple Grove Police Department
Minneapolis City Attorney's Office
Minnetonka Police Department
Missions Inc. Home Free Shelter
Standpoint

2024 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 Health & Human Services
Hennepin County Law, Safety and Justice
Hennepin County Medical Examiner
Hennepin County Psychological Services
Hennepin County Public Defender's Office
Minnesota Department of Health
Minnesota Fourth Judicial District Court Administration
Minnesota Fourth Judicial District Court Criminal, Family & Juvenile Divisions
Minnesota Fourth Judicial District Court Research

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This report is a product of:

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

Domestic Fatality Review Team 2024 Annual Report
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Acknowledgements

Together, The Honorable Michael Burns- Board Chair, and Makenzie Nolan- Project Director, would like to acknowledge the people and partnerships that supported the Team's work and case review process in 2024.

The Minnesota Fourth Judicial District Domestic Fatality Review Team extends gratitude to every individual who has helped share or promote the work of the Team. This includes those who have demonstrated their commitment to working across Hennepin County, its cities, and the state, to advance efforts and system interventions to prevent domestic violence in our communities. The Team is especially thankful for:

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 Team's findings;

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

Members of the Team who selflessly offer their time and professional expertise in the review of each case;

Local law enforcement agencies across Hennepin County;

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

The Hennepin County Medical Examiner's Office who graciously host the Team's in-person meetings annually and support with the Team's case review process;

Community and system partners who have welcomed presentations to learn about the Team's work and annual findings, and who intentionally incorporate the Team's Annual Report into their work/

The following professionals and content experts who joined the Team in 2024 to present information pertinent to each case review:

Tara Ferguson Lopez, Esq.; Hennepin County Attorney's Office

Katherine Lindstrom, M.D.; Hennepin County Medical Examiner's Office

Owen Middleton, M.D.; Hennepin County Medical Examiner's Office

Prevention & Support Services for Domestic Violence

Important Note from the Domestic Fatality Review Team

To prevent future domestic fatalities, the Team believes that meaningful change requires cross-sector collaboration and active involvement from all system partners who serve our communities. It calls for compassion, rooted in our shared humanity, and a steadfast commitment to action.

It is important to recognize that anyone can witness an active domestic dispute, become an innocent bystander, or fall victim to intimate partner violence. This violence can affect those closest to us—friends, family, neighbors, co-workers, and members of our faith communities—and it often takes place behind closed doors. **YOU** can help break the silence around domestic violence by doing **YOUR** part to raise awareness and adopt violence prevention strategies in **YOUR** community.

The Domestic Fatality Review Team urges ALL agencies to refer individuals experiencing domestic abuse to a domestic violence advocacy organization for safety planning, lethality/risk assessments, and comprehensive support services whenever domestic violence indicators are present.

The National Domestic Violence Hotline

Available 24/7, 365 days a year, the National Domestic Violence Hotline provides essential tools and support services to help survivors of domestic violence get connected to highly trained advocates for confidential and compassionate support, crisis intervention information, education, and referral services in over 200 languages at no cost. The National Domestic Violence Hotline can be reached by calling: 1-800-799-7233 (TTY 1-800- 787-3224); SMS by texting: "START" to 88788; or through live chat on their website.

The National Deaf Domestic Violence Hotline

The Deaf Hotline is a 24/7 national hotline that is ASL accessible for people experiencing abuse who identify as Deaf, DeafBlind, or Hard of Hearing. Individuals can access safety planning, crisis intervention, and emotional support through videophone calls and by phone with connection to an interpreter at: 1-855-812-1001; or through email submission using their website.

Minnesota Day One Crisis Hotline

Day One is a statewide network that serves victims and survivors of general crime, domestic violence, human trafficking, and sexual violence. Cornerstone hosts the Minnesota Day One Crisis Line and connects individuals seeking safety and resources to service agencies statewide by phone: 1-866-223-1111; SMS by texting: 612-399-9995; email: safety@dayoneservices.org; or through live chat on their website.

Hennepin County Domestic Abuse Service Center

The Domestic Abuse Service Center (DASC) offers support services and safety planning for victims of domestic violence which includes advocacy, filing Orders for Protections, legal consultation and representation from pro-bono attorneys, and connection to the Hennepin County Attorney prosecution team. All services can be accessed by calling: 612-348-5073; or by visiting the Domestic Abuse Service Center located on floor A-14 of the Hennepin County Government Center at 300 South Sixth Street Minneapolis, Minnesota, 55487. DASC hours of operation can be found on their website.

Additional national and statewide victim support resources, safety planning, and enrollment information for Safe at Home Minnesota can be accessed by visiting the Office of the Minnesota Secretary of State website.

About the Domestic Fatality Review Team

The Minnesota Fourth Judicial District Domestic Fatality Review Team [the Team] is a collaboration of private, public, non-profit organizations, and citizen volunteers from throughout Hennepin County. The Domestic Fatality Review Team was created to improve policies and procedures that more effectively address domestic violence in our community.

Minnesota Statutes § 611A.203 authorizes a judicial district in Minnesota to form a Domestic Fatality Review Team and outlines its purpose. The statute provides criteria for Team membership, terms for data practice and confidentiality, immunity, definitions of domestic violence death, and the Team's process for evaluation and reporting.

In August of 2000, the Fourth Judicial District formed its Domestic Fatality Review Team, which has remained in operation to date, and is the only Team formed under statute in the State of Minnesota. The Team's longevity and annual operations depend on a robust volunteer footprint and sustained (single-sourced) funding for the Team's Project Director, which is made possible through Hennepin County's Law, Safety and Justice Department.

The Team is responsible for reviewing cases of domestic homicide, which refer to homicides directly linked to domestic violence. Domestic abuse, also known as "domestic violence" or "intimate partner violence," is defined as a pattern of behavior within any [domestic] intimate partner or family relationship used to gain or maintain power and control over another individual. Domestic abuse is defined by the United Nations to include physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes behaviors intended to frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound someone. Domestic abuse can occur in all types of relationships and affects individuals regardless of race, age, sexual orientation, religion, gender, socioeconomic background, or education level.

In 2023, Minnesota saw a significant increase in domestic violence fatalities compared to previous years, highlighting the urgent need for sustained focus on effective interventions and prevention strategies. For the purposes of this report and the Team's review of cases from 2021 and 2022, it is important to recognize that all Opportunities for Intervention remain relevant and applicable to current practices and standards. The Team remains committed to this critical work each year, continuously adapting to emerging trends and challenges. Notably, the Team acknowledges the positive changes observed over time, though much work remains to be done to reduce the incidence of domestic violence fatalities in the state.

Purpose:

The purpose of the Team is to assess domestic violence deaths reported in Hennepin County by developing recommendations for community prevention and intervention initiatives, policies, and protocols that help to reduce and eliminate incidences of domestic violence and resulting fatalities.

Goal:

The goal of Team is to discover factors that will prompt improved identification, intervention, and prevention efforts for future 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 serving persons involved with domestic violence.

Team Members:

The Team includes professionals in select roles, often operating within the various [1]systems which are most likely to interact and overlap with perpetrators and victims of domestic violence. Professionals include, but are not limited to professionals within the criminal justice system, family and juvenile courts, law enforcement, and child protection.

Team members reflect leadership from the Fourth Judicial District judicial officers, law enforcement, Hennepin County Prosecutors, Hennepin County Public Defenders, family law attorneys, probation, mental health providers, domestic abuse advocates, and other community members from across Hennepin County and its 45 cities.

Advisory Board:

The Advisory Board represents a group of elected members who have served on the Team for a minimum of six months. Board members are recommended by an existing Advisory Board member and receive approval from the Board Chair. As the governing body of the Fourth Judicial District Domestic Fatality Review Team, the Advisory Board must adhere to Minnesota Statutes and Team Bylaws to support the Team's Project Director and the appointment of members to the Domestic Fatality Review Team. The Advisory Board meets bi-monthly or on an *ad hoc* basis throughout each review year. The Advisory Board is tasked with upholding the Team's Code of Ethics, and ensuring that the Team operates in a respectful, professional, and confidential manner that adheres to data practices and Team Meeting Guidelines.

Executive Leadership:

The Team's Project Director is responsible for overseeing the work of the Domestic Fatality Review Team with the guidance and support of the Advisory Board. The Project Director conducts the mission and objectives set by the Advisory Board, devises a yearly work plan, leads on the Team's case review process, and facilitates Team meetings. At the end of each review year, the Project Director publishes an Annual Report of the Team's findings that is available for review and consideration by all agencies, organizations, and communities across the State of Minnesota and Hennepin County area.

In 2022, the Advisory Board appointed Makenzie Nolan to serve as the Team's Project Director. Makenzie comes to this work with a background and passion for violence prevention initiatives, including domestic violence and sexual assault legal advocacy, and continues to serve as a liaison between victims of violent crimes and multijurisdictional system partners, policy makers, and community organizations across Hennepin County and the State of Minnesota. Prior to joining the Team, Makenzie led Community-Based Crime Reduction (CBCR) programming established through the Office of Justice Programs to help reduce serious and violent crime in the City of Minneapolis.

[1] *"Systems," is meant to broadly reference the criminal justice system and will otherwise be more specific when referencing a specific system involved (i.e. law enforcement, child protection etc.)*

Meeting Structure:

In 2020, following the Covid-19 Global Pandemic, the work of the Team moved from in-person meetings to a remote virtual platform. Since then, the Team has continued to meet virtually with additional in-person meetings being offered annually. In 2024, the Team held a total of two in-person meetings (in June and December) to formally conclude each case reviewed by the Team. In 2024, the Advisory Board also devised a new meeting protocol that will guide the Team's annual case review process beginning in 2025. This new protocol will allow the Team to meet in-person at the beginning and conclusion of every case.

Guiding Standards:

- The perpetrator is solely responsible for the homicide.
- Each finding in this report is based on the details of specific homicide cases.
- The Team only reviews cases where prosecution and any appellate process have been concluded.
- Findings are primarily based on information from official reports and records regarding the individuals involved, both before and after the crime.
- The Team strives to reach consensus on every identified Opportunity for Intervention.
- While the Team cannot determine if an identified Opportunity for Intervention could have prevented the deaths cited in this report, each intervention is presented as a potential deterrent or catalyst for further system change.
- The Team operates with a high level of trust rooted in confidentiality and immunity from liability among its committed participants.
- The Team does not conduct statistical analysis and does not review a statistically significant number of cases.

Team Logo:

In 2024, the Fourth Judicial District Domestic Fatality Review Team proudly unveiled its first-ever logo design. The creation of this emblem marks an exciting milestone for the Team and is part of a broader awareness campaign aimed at preventing domestic fatalities through public education and outreach. This logo also symbolizes the Team's dedication and long-standing commitment to its mission of violence prevention and early intervention across Minnesota's Fourth Judicial District.

The color purple, representing domestic violence awareness, peace, and courage, is central to the design. The purple ribbon symbolizes support for survivors, advocates, and the shared vision of a future free from violence. This logo stands as a beacon of hope and solidarity, reminding us of the power of collective action. It serves as a call to invest in safer communities where all individuals—our relatives, friends, and neighbors—can thrive.

The Review Process

The Team achieves its goals and fulfills its mission through a thorough and deliberate review of each domestic homicide case. Employing a multi-disciplinary approach, the Team fosters collaboration, drawing on the professional expertise and lived experiences of each member to ensure a comprehensive and nuanced analysis.

The Team approaches this work with a commitment to honesty, humility, integrity, and curiosity, recognizing the critical responsibility of the review process. Acknowledging its unique position, the Team has access to a wealth of information that spans the victim's and/or perpetrator's entire lifetime to inform the review. As a result, the Opportunities for Intervention identified by the Team are not only informed by the facts of the case but are also deeply contextualized within the broader life experiences of those involved. To ensure a thorough examination, the Team employs the following processes in the review of each case:

Case Selection

The Project Director compiles information from a variety of sources, including Violence Free Minnesota's Intimate Partner Homicide Reports, homicide records from the Hennepin County Medical Examiner, news reports, and input from Team members, to identify potential cases for review. A list of these cases is then presented to the Advisory Board for a final vote on which cases to prioritize. Once the Advisory Board reaches a consensus and confirms that the case is closed to further prosecution, the Team formally reviews the case.

In cases involving a homicide/suicide where no criminal prosecution occurs, the Team waits a minimum of one year before considering the case for review. Allowing a period of one to two years between the incident and the review helps reduce the risk of secondary trauma and emotional distress for Team members, particularly those who may have had direct involvement in the case. This waiting period ensures that the review process is both thoughtful and sensitive to the emotional impact on those involved.

The Case Review Process

After a case is selected for the Team's review, the Project Director sends requests to relevant agencies to gather documents connected to the case. If the perpetrator was prosecuted for the crime, law enforcement and prosecution files typically serve as the primary sources of information, often leading to the identification of additional agencies that may hold records pertinent to the case. Additional data sources may include records from child protection, mental health providers, probation, advocacy organizations, courts, and input from family members, friends, and professionals who interacted with the victim and/or perpetrator prior to the homicide. These diverse records are essential to the Team's review process.

To begin each case, the Project Director compiles all available information to create a detailed chronology, which narrates the life events of both the victim and perpetrator. The names of law enforcement, prosecutors, social workers, doctors, or any other professionals involved in the case are excluded to maintain confidentiality. Each chronology establishes a working timeline that includes the following information for both the perpetrator and victim: date of birth, major life events, interactions

with various systems, the date of the domestic homicide, and events preceding the homicide.
Once the chronology is thoroughly documented, a copy is distributed to each Team member prior to the first review meeting. This document serves as a primary reference point for members and is used throughout the entire case review process. In addition, every Team member is required to complete a confidentiality agreement before reviewing a new case, ensuring the utmost care and discretion in handling all sensitive information.

In 2024, the Team introduced a new practice that has since become a formal part of the review process. Moving into 2025, each case reviewed by the Team will begin with a "Presentation of Life," which serves to remember and honor the victim by offering insight into their life prior to the fatal incident. This presentation allows the Team to gain a deeper understanding of the victim beyond the tragedy, emphasizing their individual story and humanity.

Following the "Presentation of Life," the Team proceeds with the "Presentation of Death," which is the clinical presentation of autopsy findings from the Hennepin County Medical Examiner. In 2024, each pathologist who conducted the initial autopsy of the victim presented their findings, as well as additional observations that could inform the Team's review. This step is crucial, as it provides an objective, scientific analysis of the cause and manner of death, helping clarify critical details that support the Team's overall assessment. Additionally, the autopsy findings often substantiate other documents reviewed during the evaluation.

At the first case review meeting, each Team member is also expected to disclose any prior involvement or personal connection to the case before the Team begins their review of source documents. This practice ensures complete transparency and helps the Team conduct a comprehensive and unbiased review. Members with prior involvement follow a similar protocol to guest presenters or case experts, who are invited to share personal observations, notations, and insights. These contributions may highlight potential Opportunities for Intervention or identify missed opportunities that the Team can consider in their review.

As part of the Team's review process and meeting structure, each subsequent Team meeting is devoted to a thorough review of source documents until enough information is gathered to make formal recommendations that shape the Team's Opportunities for Intervention. These source documents are the same documents that are used to develop the case chronology and are assigned for review by two Team members: one member from the agency (or similar agency) that provided the information, and another member with an outside perspective. Each month, Team members take turns reviewing and presenting these documents following this same assignment structure. During the review, the Team makes observations regarding the content of each document and the systemic responses involved. These observations help identify risk factors and potential Opportunities for Intervention that may have impacted the outcome of the case, or that could prevent future domestic homicides.

The Final Case Review Outcome

By the conclusion of each review year, the Team compiles a comprehensive record of all key issues, observations, risk factors, and Opportunities for Intervention identified throughout the totality of cases reviewed. These findings are integral to the development of the annual report. The final review meeting, held in-person each December, includes small group discussions that contribute to broader group conversations. During these sessions, each group presents their recommendations and supporting information to advocate for the inclusion of specific Opportunities for Intervention in the report. This

collaborative process also provides Team members with the opportunity to draw connections across cases and introduce new, often more expansive, Opportunities for Intervention that reflect the broader scope of the Team's yearlong review.

Using the insights gathered by the Team, the Project Director compiles and produces the annual report. This draft undergoes a series of reviews and copy edits by the Advisory Board to ensure accuracy and clarity. Once finalized, the report is published on the Team's website and widely distributed across various systems, including but not limited to the criminal justice system and government agencies.

In 2024, the Project Director conducted over six presentations for organizations, service providers, and representatives from the Fourth Judicial District Court, county, and state agencies. Moving into 2025, the Team aims to expand its outreach through increased event attendance, public speaking engagements, panel discussions, and group presentations on the Team's annual findings. These presentations and other forms of public engagement can be requested and coordinated through the Team's Project Director.

Executive Summary

By design, the Domestic Fatality Review Team exclusively reviews cases where prosecution has been concluded. As a result, the Team's case selection process for 2024 was largely determined by what was available to the Team; reviewed in no particular order. It is important to note that the cases reviewed by the Team often vary by year and do not include 2024 homicide data or cases that correspond with the year of each annual report.

Each year, the Team selects two to three cases to review and examines one case at a time. Since the Team meets monthly, the case review process typically occurs over several months, and can take the Team anywhere from three to six meetings to complete. The number of cases reviewed by the Team annually and the timeline for completion also depends on the amount of information that is available for the Team to complete an in-depth examination and gathering of facts. This process leaves room for exceptions, which are determined on a case-by-case basis, with oversight from the Advisory Board.

In 2024, the Team reviewed two homicide cases that occurred in 2021 and 2022. These homicides are documented in this report and include the Presence of Risk Factors; 2021 and 2022 Domestic Homicide Data for the State of Minnesota and Hennepin County; and the corresponding Opportunities for Intervention identified through the Team's case observations. All Opportunities for Intervention outlined in this report were developed based on findings from these specific cases in Hennepin County's Fourth Judicial District and can be referenced starting on page 21**.** Out of respect for the privacy of the victims and their families, all identifying information has been omitted.

The Domestic Fatality Review Team hopes the information in this report will prompt meaningful changes in policy and practice to prevent future domestic homicides. Agencies across municipal jurisdictions and state government are encouraged to utilize the Opportunities for Intervention outlined in the report.

Continued regional support for domestic fatality prevention efforts across the remaining 86 counties in Minnesota's nine judicial districts remains a priority for Minnesota's Fourth Judicial District Domestic Fatality Review Team.

Presence of Risk Factors

In 1986, Jacquelyn Campbell, a professor at Johns Hopkins School of Nursing, developed the Danger Assessment (a 20-item questionnaire) to assess an individual's risk of being killed or seriously injured by their intimate partner. The Team documents risk factors observed in each victim-perpetrator relationship prior to the domestic homicide.

The presence of risk factors observed in the 2021 and 2022 homicide cases are noted below to increase public awareness and support the early detection and prevention of escalating violence in cases of domestic violence.

In 2024, the Team formally added two additional risk factors to their review of each domestic homicide. These additional risk factors, and how the Team collectively evaluates and presumes risk in cases of domestic violence, are further examined in the Team's 2024 Opportunities for Intervention on pages 35-37.

Risk Factors:	**Case 1**	**Case 2**
The violence had increased in severity and frequency during the year prior to the homicide.		
Perpetrator had access to a gun.	**X**	**X**
Victim had attempted to leave the abuser.	**X**	
Perpetrator was unemployed and/or experienced temporary unemployment.	**X**	
Perpetrator had previously used a weapon to threaten or harm victim.		
Perpetrator had threatened to kill the victim.		
Perpetrator had previously avoided arrest for domestic violence.		
Victim had children not biologically related to the perpetrator.		**X**
Perpetrator sexually assaulted victim.		
Perpetrator had a history of substance abuse.		**X**
Perpetrator had previously strangled victim.		
Perpetrator attempted to control most or all of the victim's activities.	**X**	
Violent and constant jealousy.	**X**	
Perpetrator was violent to victim during pregnancy.	**NA**	**NA**
Perpetrator threatened to commit suicide.	**X**	
Victim believed perpetrator would kill him/her.		
Perpetrator exhibited stalking behavior.	**X**	
Perpetrator with significant history of violence.		**X**
Victim had contact with a domestic violence advocate.		
*Perpetrator had a history of animal abuse and/or was violent towards animals.		**X**
*Victim had entered a new romantic relationship.	**X**	**X**

Domestic Homicide Data

The Team's 2024 Annual Report is not meant to reflect homicide data that is congruent with the reporting year. Rather, it documents the year in which each homicide case under review took place and offers corresponding data for that year. This report only includes data detailing domestic homicides that occurred in 2021 and 2022 across the State of Minnesota and Hennepin County area. All data included in this report has been collected using public data sources and does not constitute as research conducted by the Team.

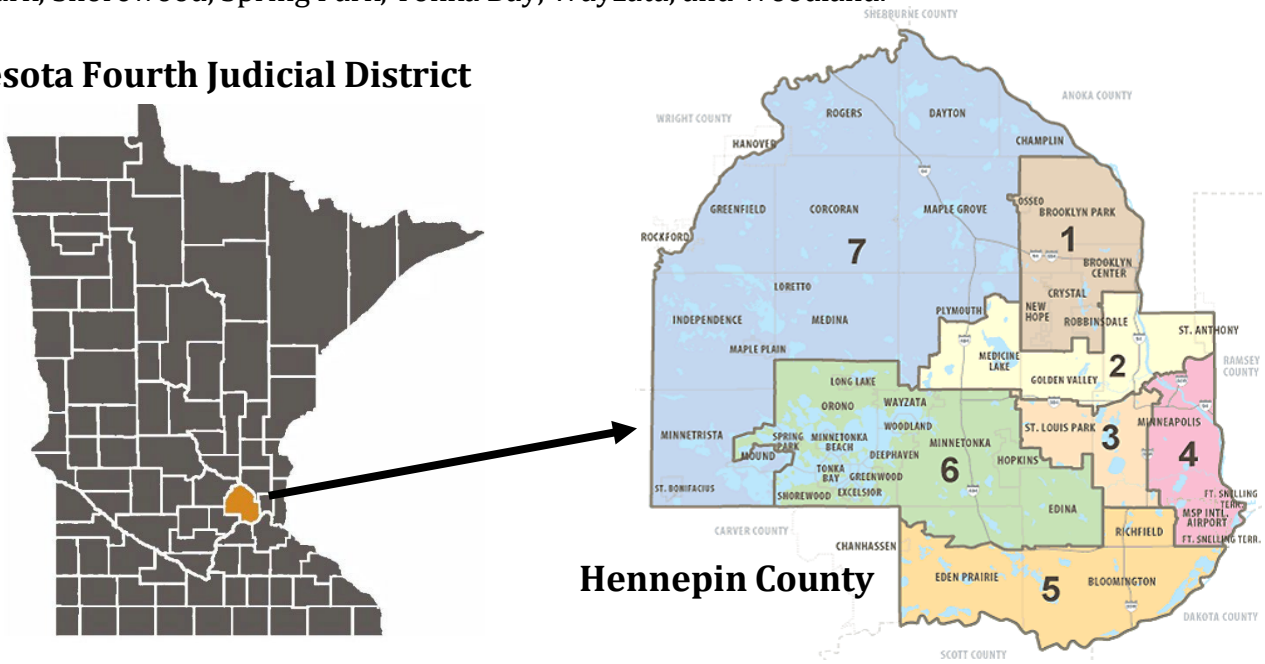
Population

Minnesota's Fourth Judicial District includes only Hennepin County, which is the state's largest trial court with 63 judges, 12 referees, and 582 staff who process approximately 40% of all cases filed in the state.

Hennepin County is located on the cultural, spiritual, and indigenous homeland of the Dakota Oyate (Dakota Nation) and is one of 87 counties in the State of Minnesota. Hennepin County has the largest population density of any county in the State of Minnesota, and is home to an estimated 1.2 million people, according to the United States Census Bureau. Hennepin County's total land area equates to only 554.0 square miles making it the 60th largest county in Minnesota by geographic area, and is bordered by Anoka, Wright, Dakota, Carver, Ramsey, Sherburne, and Scott Counties.

Hennepin County contains 45 cities, including: Bloomington, Brooklyn Center, Brooklyn Park, Champlin, Chanhassen, Corcoran, Crystal, Dayton, Deephaven, Eden Prairie, Edina, Excelsior, Golden Valley, Greenfield, Greenwood, Hanover, Hopkins, Independence, Long Lake, Loretto, Maple Grove, Maple Plain, Medicine Lake, Medina, Minneapolis, Minnetonka, Minnetonka Beach, Minnetrista, Mound, New Hope, Orono, Osseo, Plymouth, Richfield, Robbinsdale, Rockford, Rogers, St. Anthony, St. Bonifacius, St. Louis Park, Shorewood, Spring Park, Tonka Bay, Wayzata, and Woodland.

Minnesota Fourth Judicial District

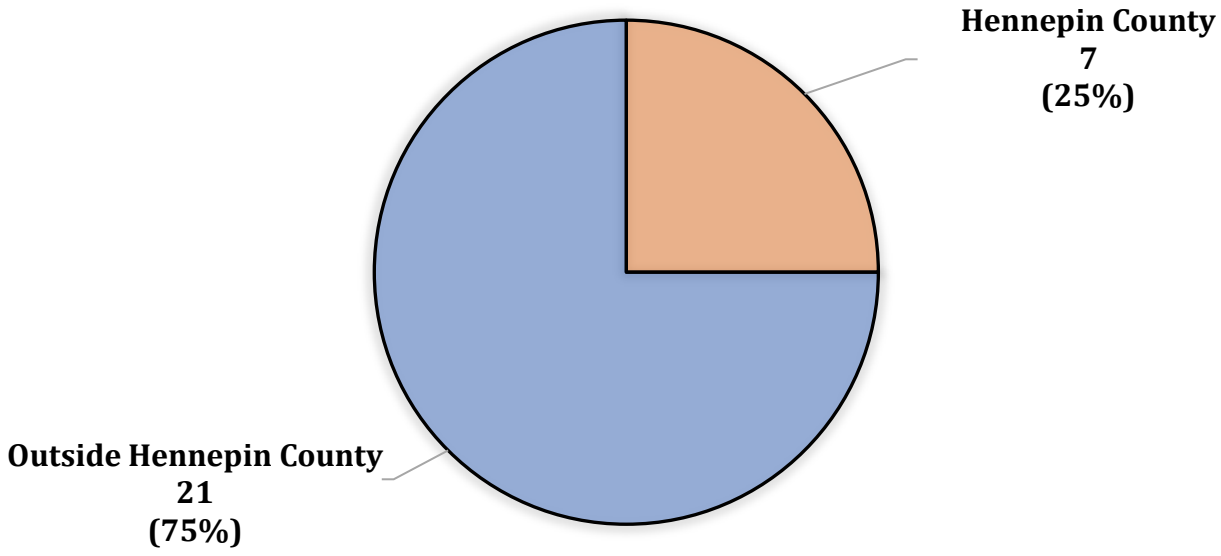


Hennepin County

2021 Domestic Homicide Data

In 2021, at least 28 Minnesotans were killed due to violence resulting from domestic abuse. **A total of seven domestic homicides were recorded in Hennepin County** (Brooklyn Park [1], Bloomington [1], Eden Prairie [1], Minneapolis [2], Rockford [1], Robbinsdale [1]); and 21 domestic homicides were recorded as occurring outside of Hennepin County (Austin [1], Faribault [1], Hastings [1], Isanti County[1], Kalevala Township [1], Lakeville [1], Little Falls [1], Mahtomedi [1], Nisswa [1], Oklee [1], Shakopee [1], St. Paul [7], Virginia [1], Winona [1], Woodbury [1]).

2021 STATE OF MINNESOTA DOMESTIC HOMICIDES
TOTAL FATALITIES: 28

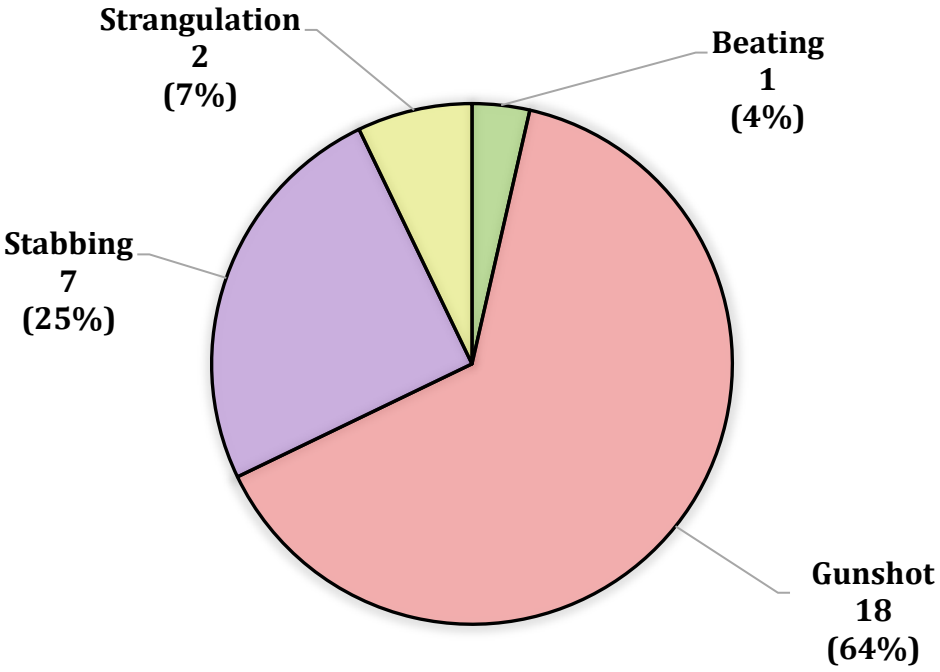


Of the 28 total domestic homicides reported in the State of Minnesota in 2021, at least 24 of the victims identified as women and at least six were from Hennepin County. Additionally, at least one of the 28 victims in the state were pregnant; and at least one of the victims identified as having a disability. At least 15 of the 28 victims of domestic homicide were parents and/or had children, and at least four of those victims lived within Hennepin County.

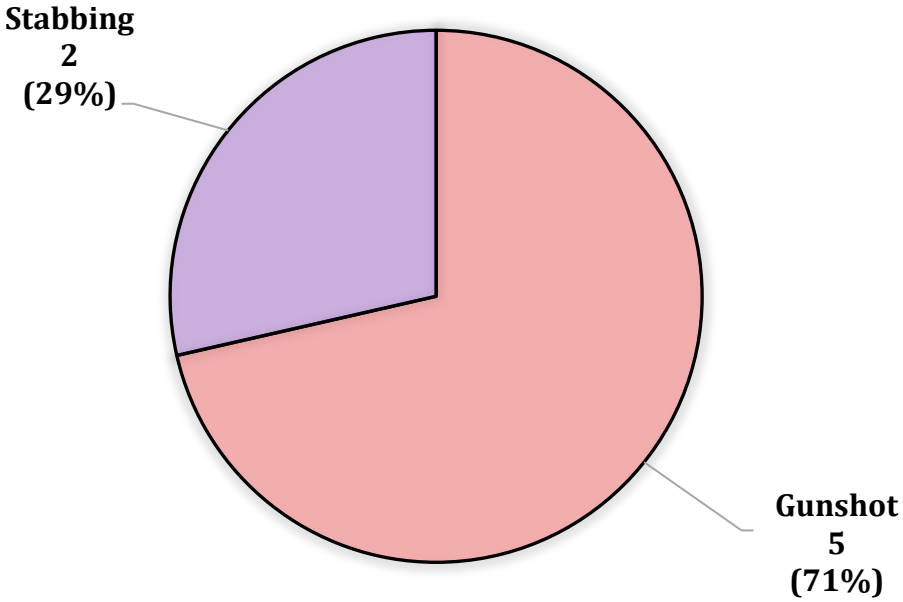
In 2021 domestic homicides left at least 37 people in the state without a parent; at least ten of those impacted were from Hennepin County. Data outlining the specific cause of death for each victim of domestic homicide in 2021 can be reviewed on page 16.

Homicide-suicides accounted for at least 21% of the homicide cases reported in 2021, with a total of six perpetrators committing suicide; three of which occurred in Hennepin County.

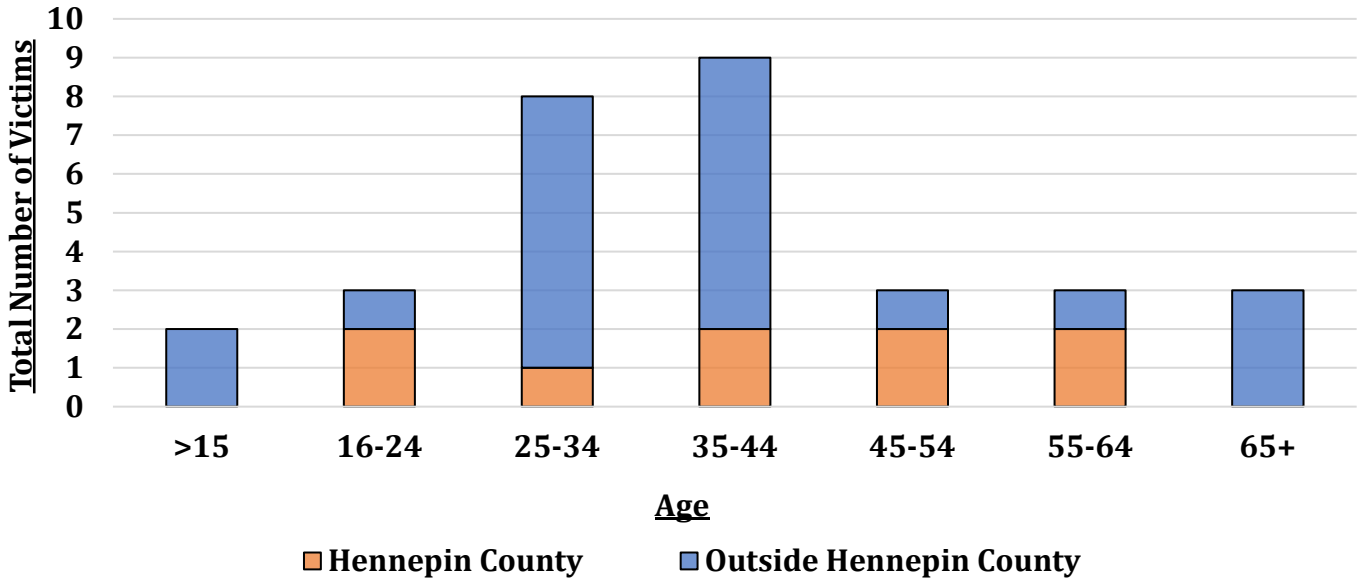
2021 STATE OF MINNESOTA DOMESTIC HOMICIDES CAUSE OF DEATH



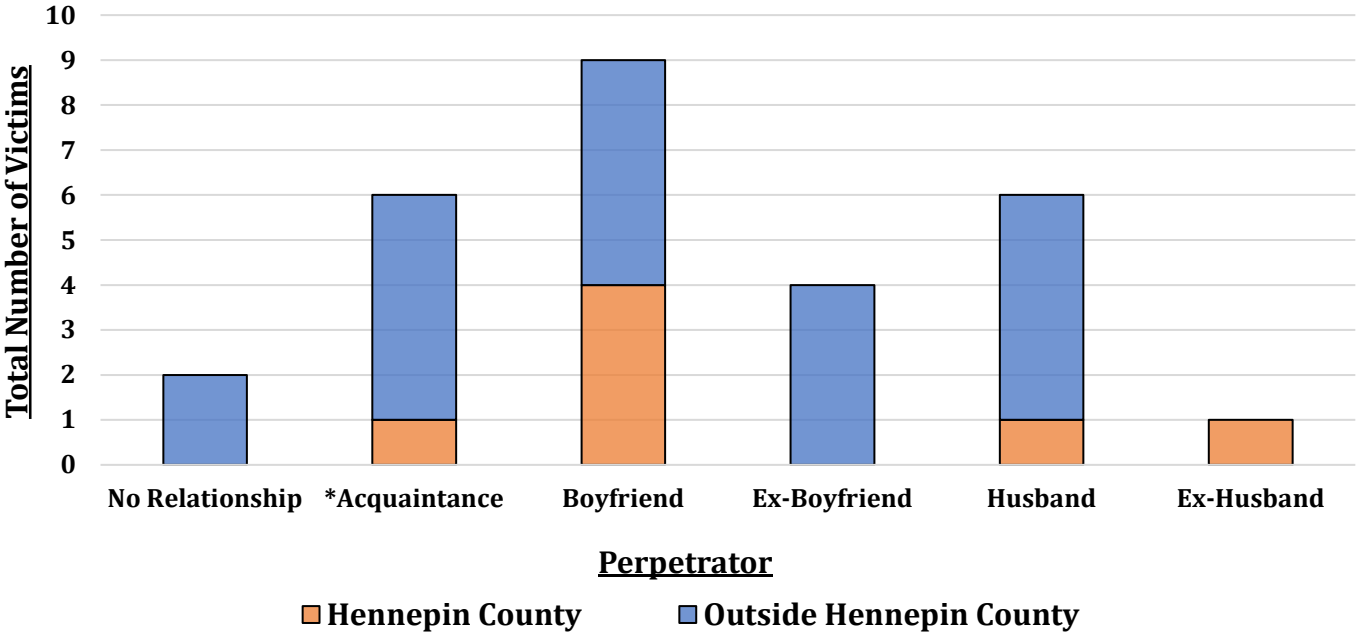
2021 HENNEPIN COUNTY DOMESTIC HOMICIDES CAUSE OF DEATH



2021 STATE OF MINNESOTA DOMESTIC HOMICIDES
AGE OF VICTIMS



2021 STATE OF MINNESOTA DOMESTIC HOMICIDES
VICTIM & PERPETRATOR RELATIONS

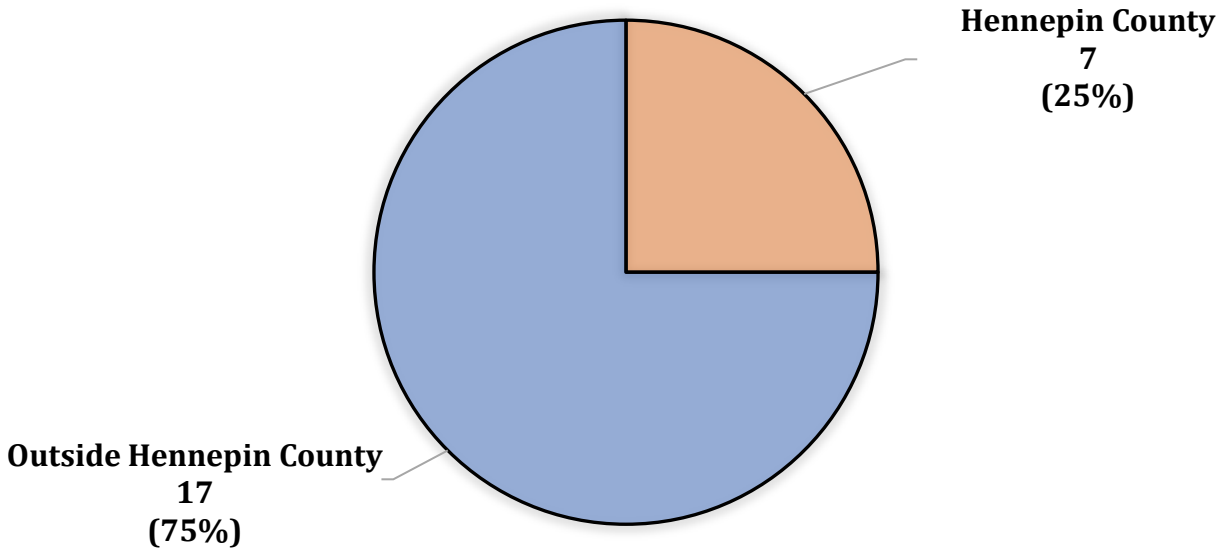


"Acquaintance" is used to loosely describe domestic relationships where the victim knew (or was familiar with) the perpetrator through a third party, relative, or friend. These relationship dynamics were unique to each case, and not commonly represented. The perpetrator relations include: a parent's ex-boyfriend, a current boyfriend of the ex-girlfriend, a person dating girlfriend, a person dating wife, and a casual date.

2022 Domestic Homicide Data

In 2022, at least 24 Minnesotans were killed due to violence resulting from domestic abuse. **A total of seven domestic homicides were recorded in Hennepin County** (Bloomington [1], Brooklyn Center [1], Brooklyn Park [1], Champlin [1], Medina [1], Minneapolis [1], and Plymouth [1]); and 17 domestic homicides were recorded as occurring outside of Hennepin County (Crow Wing County [1], Hibbing [1], Medford [1], Mora [1], Motley [1], North St. Paul [1], Olivia [1], Rochester [2], St. Cloud [1], St. Paul [5], Wadena [1], and Warren [1]).

2022 STATE OF MINNESOTA DOMESTIC HOMICIDES
TOTAL FATALITIES: 24

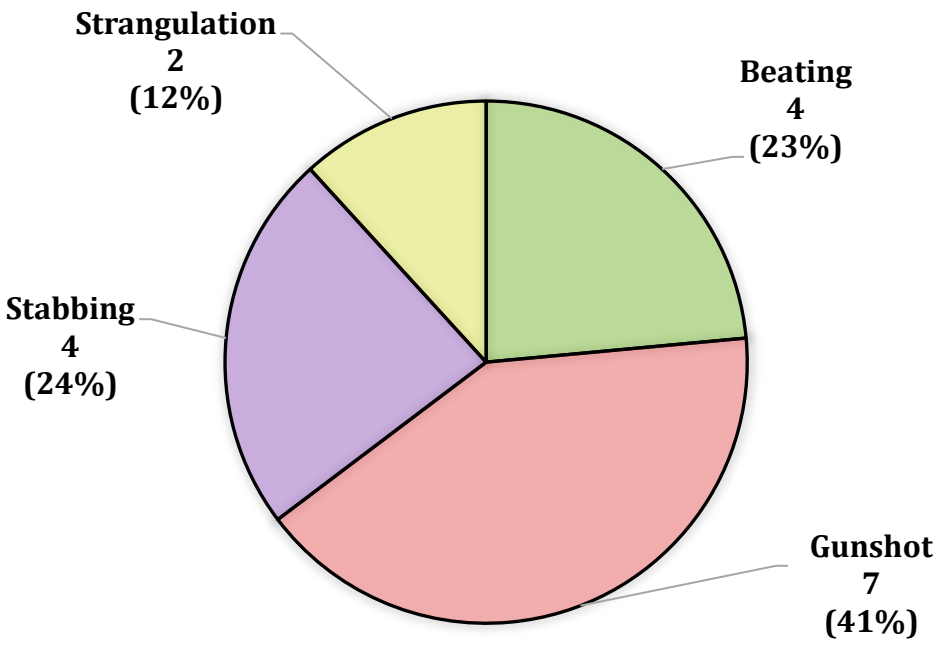


Of the 24 domestic homicides reported in the State of Minnesota in 2022, at least 21 of the victims identified as women and at least five were from Hennepin County. Additionally, at least one of the 24 victims was pregnant; and at least three of the victims identified as vulnerable adults. At least 23 of the 24 victims of domestic homicide were parents and/or had children, and at least seven of those victims lived within Hennepin County.

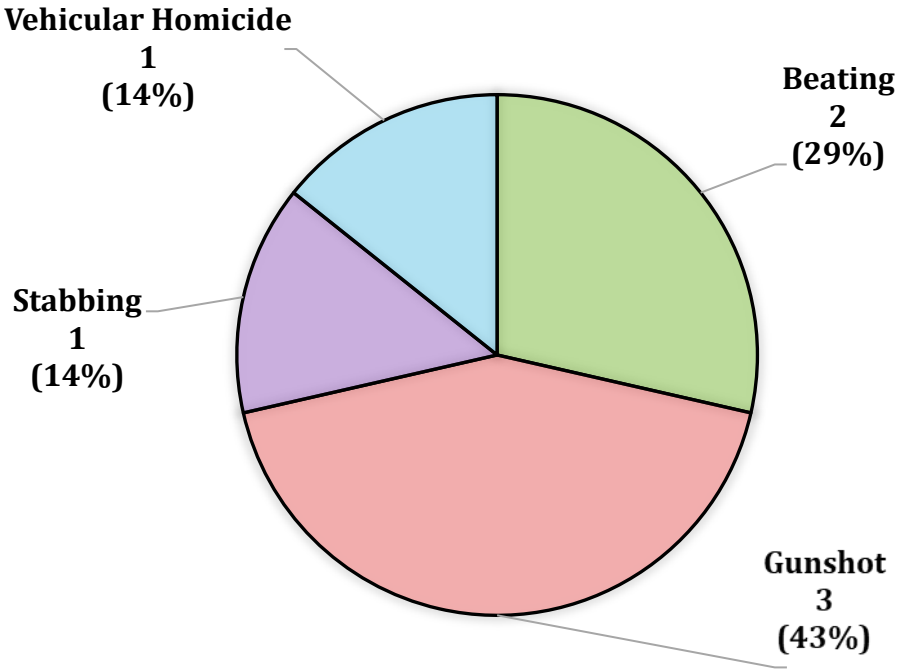
In 2022 domestic homicides left at least 22 people in the state without a parent; at least seven of those affected were from Hennepin County. Data outlining the specific cause of death for each victim of domestic homicide in 2022 can be reviewed on page 19.

Homicide-suicides accounted for at least 16% of the homicide cases reported in 2022 (all of which occurred outside of Hennepin County) with a total of four perpetrators committing suicide.

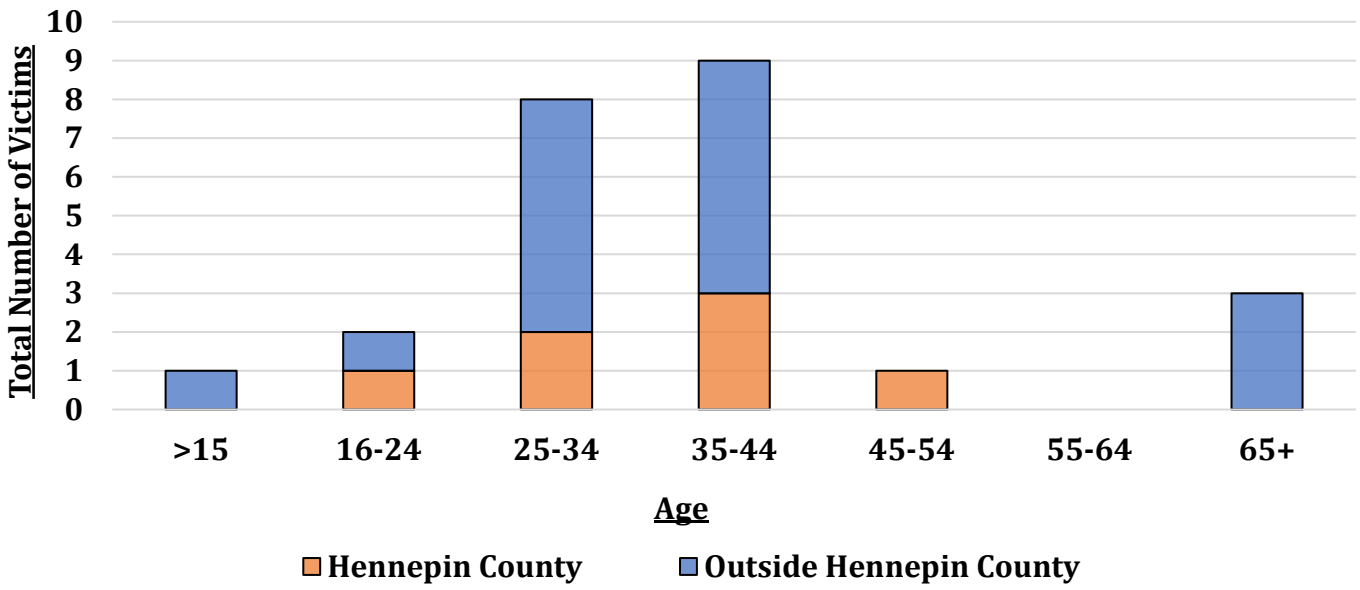
2022 STATE OF MINNESOTA DOMESTIC HOMICIDES CAUSE OF DEATH



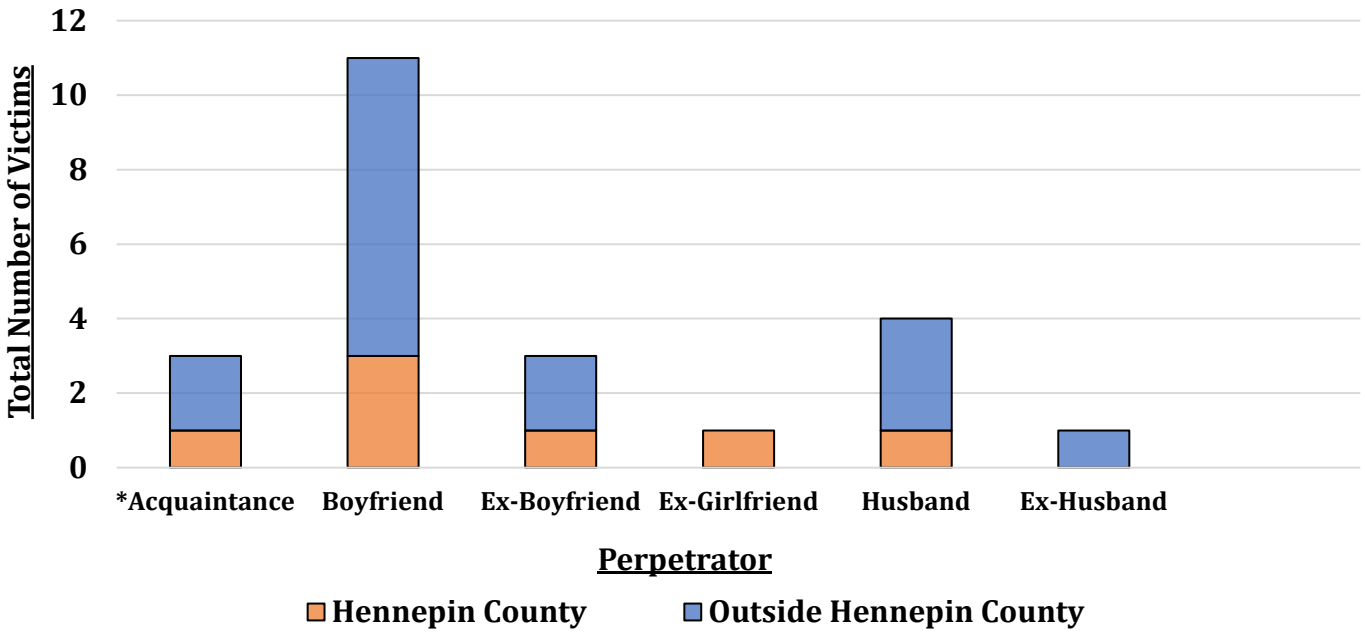
2022 HENNEPIN COUNTY DOMESTIC HOMICIDES CAUSE OF DEATH



2022 STATE OF MINNESOTA DOMESTIC HOMICIDES
AGE OF VICTIMS



2022 STATE OF MINNESOTA DOMESTIC HOMICIDES
VICTIM & PERPETRATOR RELATIONS



"Acquaintance" is used to loosely describe domestic relationships where the victim knew (or was familiar with) the perpetrator through a third party, relative, or friend. These relationship dynamics were unique to each case, and not commonly represented. The perpetrator relations include: a parent's ex-boyfriend, a friend to ex-wife, and a coworker.

2024 Opportunities for Intervention

The Fourth Judicial District Domestic Fatality Review Team examines cases of domestic homicide occurring in Hennepin County, and the lives of those involved, to understand the circumstances preceding each victim's death. For each domestic homicide reviewed by the Team, observations about the cause and manner of each victim's death; past occurrences of abuse; patterns of behavior; attempted system interventions; and a thorough examination of lethality risk factors contribute to the Team's findings and identified Opportunities for Intervention.

Although it is unknown if any of the identified interventions could have prevented the deaths cited in this report, the Team's primary objective is to offer recommendations that pull from the totality of facts and lessons learned from the 2021 and 2022 domestic homicides reviewed by the Team. Therefore, the goal of each annual report is to raise awareness and enhance the public's response to domestic violence by highlighting Opportunities for Interventions within key focus areas for system intervention. These opportunities are designed to be integrated into daily practices and processes across all systems that interact with individuals. They should not be limited to agencies traditionally involved with victims or perpetrators prior to a homicide, such as law enforcement and advocacy organizations, but should also encompass those that provide educational resources, address risk factors for domestic homicide, and facilitate referrals to intervention services.

Each Opportunity for Intervention should be considered by all agencies, organizations, and communities across the Hennepin County area and its 45 cities. The Team also encourages the State of Minnesota, and the remaining 86 counties in 9 judicial districts represented across the state, to view each opportunity as part of a larger statewide effort to end domestic violence fatalities across state, county, and city lines.

The 2024 Opportunities for Intervention are organized into five categories, with six subsections, to guide the reader in identifying potential areas for system intervention. These categories are linked throughout the report for easy reference. **The complete list of Opportunities for Intervention can be found on pages 22-43.** The five categories and six subsections outlined in this report include:

1. Strengthen Minnesota's Domestic Violence Response: Statutory Changes and Provisions to Existing Definitions, Protocols, and Processes
    A. Use Minnesota's Extreme Risk Protection Orders to Address Domestic Violence
    B. Include "Stalking Behaviors" and "Coercive Control" in Domestic Violence Statutes
    C. Create a Separate Sentencing Guideline Rubric for Domestic Violence Offenses
    D. Implement Rental Car Emergency Disclosure Forms
2. Reintroduce the Minnesota Court Information System
3. Update Lethality Risk Assessments and Enhance Police Reports
    A. Update Lethality Risk Assessments
    B. Enhance Police Reports
4. Address Domestic Violence Among Active-Duty Service Members and Veterans
5. Screen Chronic and Terminally Ill Patients for Domestic Abuse and Suicidal-Homicidal Ideation

1. Strengthen Minnesota's Domestic Violence Response: Statutory Changes and Provisions to Existing Definitions, Protocols, and Processes

Domestic violence is frequently preceded by warning signs such as escalating threats, stalking, physical violence, prior criminal behavior, and access to weapons. However, Minnesota's current statutes and criminal justice framework do not adequately address the unique risks associated with domestic violence and often fail to enforce essential protections. This system gap leaves both victims and law enforcement vulnerable to the escalation of violence and the presence of lethality risks.

Although several system interventions have been implemented since the 2021 and 2022 homicides, the Team identified four focus areas within the criminal justice system that could further enhance system interventions and improve public safety:

A. Use Minnesota's Extreme Risk Protection Orders to Address Domestic Violence
B. Include "Stalking Behaviors" and "Coercive Control" in Domestic Violence Statutes
C. Create a Separate Sentencing Guideline Rubric for Domestic Violence Offenses
D. Implement Rental Car Emergency Disclosure Forms

Each system intervention identified by the Team to strengthen Minnesota's domestic violence response can be located on pages 23-32 and should be evaluated within the context and insights provided by each case annotation.

A. Use Minnesota's Extreme Risk Protection Orders to Address Domestic Violence

In the cases reviewed by the Team from 2021 and 2022, there were multiple citations where convicted felons unlawfully possessed firearms and ammunition in various cities across Hennepin County. This pattern extended across jurisdictions into other counties across the State of Minnesota, and into neighboring states. Despite facing numerous criminal charges and serving jail time in various jurisdictions, these individuals continued to access firearms and commit preventable acts of gun violence with escalating threats of domestic violence.

To fully capture the context of the Opportunity for Intervention cited in this section, it is important to note the full scope of protection orders available to Minnesotans experiencing domestic abuse—while understanding that these differ from Domestic Abuse No Contact Orders (DANCOs), which can only be issued by a judge in a pending criminal court case where domestic violence or violation of a protection order is a factor (Minnesota Statutes § 629.75). The different protection orders available for victims of domestic violence vary by inclusion criteria that are statutorily required and can offer different forms of relief and protections. An Order for Protection (OFP) is specific to cases of domestic violence and is most often used to prevent contact and can protect people, places, and pets from a perpetrator; they also include temporary reliefs that require a court hearing and can bar a perpetrator from owning or possessing a firearm if imminent risk is determined (Minnesota Statutes § 518B.01). A Harassment Restraining Order (HRO) is another type of protection order that can be used for situations of stalking, harassment, or unwanted contact, but are not limited to cases of domestic abuse, and can prohibit contact not tied to a domestic relationship (Minnesota Statutes § 609.748).

On January 1, 2024, Minnesota law began to allow certain individuals to request an Extreme Risk Protection Order (ERPO); a new protection order that can be issued when there is evidence that an individual may be a danger to themselves, or others, due to crisis and/or behaviors that include threats of violence, domestic abuse, or mental health crises. Unlike other protection orders, the specific goal of an ERPO is to prevent harm by removing firearms from individuals who may be at high-risk of using them to commit gun violence. It also prevents someone from purchasing a firearm while the ERPO is in effect (Minnesota Statutes § 624.732). For the purposes of this report, the Team is only focused on ERPOs as they apply to extreme risk in cases of domestic violence and can serve as a tool to prevent fatalities.

Recognizing that ERPOs were not enacted and enforceable in the State of Minnesota until 2024, the Team identified several Opportunities for Intervention where ERPOs, specifically when used in cases of domestic violence, could retroactively be applied to prevent future fatalities related to gun violence. By analyzing the missed opportunities highlighted in each case from 2021 and 2022, the Team believes that ERPOs are especially effective in high-risk situations where the presence of firearms and/or imminent threats of lethal violence are involved. These orders also allow for early intervention—further reducing the risk of fatal outcomes—and are a critical part of the state's legal response to extreme cases of domestic violence.

In 2024, Minnesota's Fourth Judicial District recorded a total of 34 ERPOs that were filed in Hennepin County within the first year of the statutes being enacted. Of the 34 ERPOs filed, **four of these ERPOs were granted in cases involving domestic violence**, emphasizing significant lethality risks were identified and adequately mitigated for perpetrators who had access to firearms. By expanding ERPO language in Minnesota Statutes § 624.732 to clearly define and include domestic violence, it puts the onus on our systems to take proactive action, enforce protections, and intervene early on to help mitigate known lethality risks. The Team's recommendations for ERPO provisions are included on pages 24-25.

- **Explicitly Include Domestic Violence in ERPO Language**
  - Amend Minnesota's ERPO laws to specifically include domestic violence behaviors, threats, and extensive histories of violence as qualifying criteria in cases where victims face imminent harm or escalating threats of violence.
    - Include language that highlights lethality risks and considers the impact and safety of victims experiencing physical abuse, stalking, threats against new intimate partners or family members, and harm/threats to harm animals, as grounds for ERPO applications.

- **Support Warrant Authorization to Enforce ERPOs**
  - Grant law enforcement the legal authority to act swiftly and decisively in ERPO cases where indicators of domestic violence are present.
  - Provide clear statutory language that empowers law enforcement to obtain warrants for ERPO enforcement, including the authority to search for, seize, and secure firearms upon issuance of an ERPO.
  - Provide clear statutory language that outlines and simplifies standardized processes for law enforcement to obtain warrants for ERPO enforcement.

- **Require ERPOs as a Mandated Reporting Tool**
  - Expand mandated reporting requirements to include ERPO-related concerns, prioritizing public safety and community health risks.
    - Using ERPOs as a mandated reporting tool across systems will enhance early intervention strategies and help reduce the number of gun-related domestic fatalities annually.
    - This provision ensures that Minnesota's system providers can effectively address (and report) broader societal risks, including when mass or repeat offender violence is linked to domestic violence, access to weapons, and escalating lethality risks are present.
  - Include probation and parole officers as mandated reporters to monitor and report when extreme risks to individual or public safety are cited, particularly when offenders repeatedly violate probation or parole terms.
    - Parole officers maintain the authority to warrant arrests based on probable cause or violations of parole conditions, enhancing system accountability.
  - Include healthcare providers, educators, and social workers as mandated reporters, establishing clear guidelines indicating when a professional must petition for an ERPO.

- **Institute Stricter Penalties for ERPO Violations**
  - Institute harsher penalties to deter offenders from disregarding or violating ERPO terms and ensure accountability.
  - Designate violations as misdemeanors or gross misdemeanors, with a graduated penalty system based on the severity and frequency of violations.

- **Improve Training & Technical Assistance Provisions Across Systems**
  - Require mandatory training on ERPOs for all system stakeholders, including law enforcement, probation officers, social workers, court personnel, and community organizations.
  - Training curriculum should cover:
    - Identifying qualifying behaviors for ERPOs, including domestic violence warning signs.
    - The process for petitioning and enforcing ERPOs.
    - Best practices for collaboration across systems to ensure effective implementation and victim safety.

- **Support Recommendations from the Domestic Violence and Firearm Surrender Task Force**
  - Reference and implement recommendations from the [2]Domestic Violence and Firearm Surrender Task Force 2025 Legislative Report, specifically on ERPO policies, procedures, and considerations for cases involving domestic violence.
  - Formalize the Task Force's role in state statutes to oversee ERPO enforcement in domestic violence cases statewide.
    - Ensure continuous review of laws related to firearm surrender for individuals under protection orders, extreme risk protection orders, or those convicted of domestic assault, harassment, or stalking.
    - Empower the Task Force to oversee quality control that maintains standardized processes, protocols, and system accountability; include evaluations that improve implementation of ERPOs across jurisdictions.
  - Adopt best practices for firearm surrender to develop policies that prioritize the safety of victims, law enforcement, and first responders while reducing lethality risks in domestic violence incidents.

In cases where convicted felons continued to unlawfully possess firearms and commit preventable acts of gun violence, the Team's review underscores the need for stronger interventions that utilize Extreme Risk Protection Orders (ERPOs) to remove firearms from individuals who are at high risk of violence. By expanding ERPO criteria to include definitions of domestic violence, and improving ERPO policies, system protocols, and enforcement guidelines; we can work effectively across jurisdictions to support early intervention efforts that mitigate lethality risks and help save lives in cases of domestic violence.

[2] Minnesota Department of Public Safety. "Domestic Violence and Firearms Surrender Task Force." *Minnesota Department of Public Safety*, https://dps.mn.gov/about-dps/associated-boards-cmtes-and-task-forces/domestic-violence-and-firearms-surrender-task-force.

B. Include "Stalking Behaviors" and "Coercive Control" in Domestic Violence Statutes

In each domestic fatality case reviewed by the Team, both the frequency of abusive behaviors and the escalating severity of violence, perpetrated by offenders, were often exacerbated in cases where stalking behaviors and coercive control were identified as aggravating factors in the victim-perpetrator relationships. Stalking is a critical risk factor in domestic violence cases and, as observed by the Team, often signals escalation of abuse that can lead to severe violence or fatalities. In Minnesota, stalking is defined as engaging in conduct that causes the victim to feel frightened, threatened, oppressed, persecuted, or intimidated. Despite this definition, Minnesota's statutes fail to explicitly include stalking as qualifying behavior or conduct for obtaining an Order for Protection (OFP) in cases involving intimate partner relationships. While stalking is addressed in Minnesota Statutes § 609.748, it is not explicitly acknowledged in Minnesota Statutes § 518B.01, which governs domestic violence protections.

Similarly, coercive control, which is a pattern of oppressive behaviors that includes, but is not limited to manipulation, (fear of) punishment, intimidation, isolation, gaslighting, humiliation, harassment, and calculated control or deprivation of a person's basic needs (i.e., food, shelter, sleep, employment etc.); is not adequately represented or addressed in Minnesota laws. This lack of inclusion undermines a victim's right to access and petition for the protections necessary to mitigate lethality risks in cases of domestic violence.

To effectively prevent future domestic fatalities, it is critical that we address cases of stalking and coercive control. Drawing on lessons learned in the 2021 and 2022 homicide cases, the Team identified a series of Opportunities for Intervention to strengthen protections for victims, improve public awareness, and advance future interventions for stalking behaviors and coercive control in domestic violence cases. The Team proposes the following Opportunities for Intervention for consideration:

- **Amend Minnesota Statutes § 518B.01 to Include Stalking Behaviors**
  - While stalking is addressed under general harassment laws, it is not explicitly linked to domestic violence protections in statute. This omission limits victims' ability to access immediate and comprehensive protections.
  - Amended § 518B.01 Subdivision 2(a) to explicitly list stalking behaviors as qualifying conduct for filing an Order for Protection (OFP) in domestic relationships.
    - Research shows that stalking is often one of the most reliable predictors of lethal violence in domestic abuse cases. Including stalking in the OFP criteria allows for earlier intervention, thereby reducing the risk of escalation to severe harm or fatalities.
  - Integrate stalking definitions and language referenced in existing stalking statutes to ensure consistency and clarity across Minnesota's legal framework.
    - Example language: "Stalking behaviors, as defined in Minnesota Statutes § 609.749, shall be considered conduct that may lead to the issuance of an Order for Protection under this statute."
  - Track the number of OFPs issued based on stalking behaviors to assess the impact of the proposed statute change.

- **Add Coercive Control to Domestic Violence Statutes**
  - Carefully define coercive control using [3]evidence-based definitions and incorporate safeguards to prevent perpetrators from exploiting statutory language to further manipulate or control the victim through the criminal justice system (i.e., making false claims against the victim to gain custody of children or control victim assets).
    - Example language: "Coercive control is defined as a pattern of controlling behaviors, including manipulation, threats, intimidation, isolation, and deprivation of basic needs, aimed at dominating and subjugating a victim, with the intent to create fear, limit freedom, and undermine autonomy."
  - Track the number of OFPs issued based on cases of coercive control to assess the impact of the proposed statute change.

- **Provide Comprehensive Training and Public Education**
  - Implement system-specific training requirements and curriculum for professionals engaged in the criminal justice system, including:

    Law Enforcement and First Responders:
    - Implement training to help identify stalking behaviors and indicators of coercive control, including cases involving technology and surveillance.
    - Offer information and case examples that demonstrate the connection between stalking and escalating violence.
    - Gather feedback from law enforcement to identify areas for improvement in training and implementation.

    Social Workers and the Courts:
    - Educate professionals on the increased risks of violence and fatalities when certain indicators of stalking and coercive control are present.
    - Provide guidance on how to integrate stalking behaviors and coercive control into risk assessments and OFP considerations.
    - Gather feedback from courts and advocacy groups to identify areas for improvement in training and implementation.
    - Develop resources to help victims document stalking behaviors and coercive control to strengthen their cases when seeking OFPs.

    Public Education:
    - Invest in public awareness campaigns to help address and mitigate cases of stalking and coercive control.
      - **It is important to note: many victims, and those around them, do not recognize stalking behaviors as dangerous or indicative of escalating abuse. The same is true with coercive control, which due to its subtle nature, is often overlooked, rationalized, or dismissed.*
    - Provide public education on the dangers of stalking and coercive control, how to recognize these behaviors, and where to seek help.

[3]*The Battered Women's Justice Project (BWJP) could offer guidance to policymakers for drafting statutory language that protects victims without unintended consequences.*

- Develop materials (i.e., brochures, videos, social media campaigns) to educate the public on stalking behaviors and their connection to domestic violence.
- Offer information on cyberstalking and how violent offenders can use technology to monitor or harass victims, while highlighting resources for victims such as hotlines, advocacy groups, and legal options.

Including stalking behaviors and coercive control in Minnesota Statutes § 518B.01 is a necessary step toward preventing domestic violence fatalities. Aligning stalking laws and coercion with domestic violence statutes ensures that victims, law enforcement, and the courts have a unified understanding of the behaviors that warrant intervention and protection. Together, we can create a more cohesive and effective response system that recognizes stalking and coercive control as significant risk factors for lethality.

C. Create a Separate Sentencing Guideline Rubric for Domestic Violence Offenses

To invest in public safety, we must continue to invest in long-term interventions that effectively address harmful behaviors and prevent violence. Considering the chronology of reported abuse identified in each homicide case reviewed by the Team, there is evidence that suggests Minnesota's current sentencing guidelines for domestic violence fail to adequately address the severity, danger, and risk of lethality faced by victims of domestic violence.

Under Minnesota Statute § 609.2242, Subdivisions 1 and 2, a first-time offense of domestic assault is often charged as a misdemeanor, punishable by up to 90 days in jail and a $1,000 fine. If the offender has a prior domestic violence-related conviction within a 10-year period, the misdemeanor offense is elevated to a gross misdemeanor, carrying up to 364 days in jail and a $3,000 fine. The unfortunate reality is that many cases of domestic abuse result in minimal to no jail time, and offenders often face limited (minimally enforceable) conditions or probation oversight. During the Team's review of case outcomes, penalties, and conviction processes for domestic abuse vs. drug possession, the Team found that drug possession cases often carried higher criminal penalties. This highlights a crucial component of our current system's status quo, and further indicates where we assign meaning, assess risk, and hold individuals accountable. This has a direct impact on the outcome and prioritization of victim safety.

While cases of domestic violence are often complex and nuanced, the risks of lethality are not. And, as observed in each homicide reviewed by the Team, the danger and threats to a victim's safety only continue to increase (in severity) with each subsequent violent offense perpetrated by an abusive partner. A system that lacks significant penalties, particularly for repeat offenders, sets a dangerous precedent with little deterrence, accountability, or change to abusive behaviors. Further interventions are essential to break the cycle of violence.

To address these gaps, the Team proposes the creation of a separate sentencing guideline rubric for domestic violence cases. This new rubric would include a comprehensive scoring system that considers factors such as the severity and duration of abuse, the history of prior offenses, the use and possession of weapons, chronic substance use, coercive behaviors, long-term impacts on the victim, and indicators of escalating violence. In cases where the perpetrator of abuse also has a history of significant drug offenses, a separate sentencing guideline would pair accountability with holistic health measures aimed at addressing underlying substance use disorders to reduce recidivism and escalating violence.

The Team also recommends that Minnesota adopt a graduated penalty system for all cases involving domestic violence. This is a critical step to ensure that repeat offenders face progressively more severe penalties, including mandatory prison sentences paired with rehabilitation programs, when multiple violent offenses are committed or when a perpetrator demonstrates an increased risk of harm to the victim or others. Based on the Team's observations in each homicide case, if these system interventions were applied today, the Team believes domestic fatalities would decrease over time, and recidivism rates would decline due to adequate interventions and early prevention.

This Opportunity for Intervention and its standards for implementation are further outlined on page 30:

- **Develop a New Rubric for Sentencing Guidelines**
  - Create and establish a rubric outlining distinct sentencing guidelines, policies, and scoring criteria for all cases involving domestic violence or cases with a significant history of domestic violence-related charges.
  - Develop a comprehensive scoring system that evaluates the pattern of behavior, severity of incidents, lethality risks, and victim impact. This should be applied in cases where abuse has occurred over a prolonged period, there is a significant history of prior offenses (including but not limited to domestic violence), there is evidence of illegal possession or access to weapons, and indicators of escalating violence are present.
  - Re-evaluate the current designation of domestic violence offenses as gross misdemeanor for offenders with prior convictions within a ten-year period (Minnesota Statute § 609.2242, Subdivision 2) and consider applying felony designations to ensure penalties are proportional to the severity of the offense committed.
  - Implement a graduated penalty system for all cases involving domestic violence, incorporating aggravated factors into sentencing policies.

- **Designate a Pilot Program**
  - Select specific Minnesota Judicial Districts to test pilot programs, where there is capacity to implement and refine the new sentencing guidelines and policies for domestic abuse cases.
    - Collect and measure data from these pilot programs, and conduct listening sessions with professionals in the criminal justice system to assess the impact and effectiveness of the new guidelines.
  - Launch educational awareness campaigns to inform system providers and the public about the new sentencing guidelines and policies, including how they can be used to prevent domestic violence fatalities by increasing protections and early system interventions for victims.

By establishing a distinct sentencing guideline rubric for domestic violence, Minnesota's justice system demonstrates its commitment to prioritizing the health and safety of victims, while ensuring perpetrators are held accountable through system interventions more accurately reflect the severity and impact of each offense. This Opportunity for Intervention promotes a more effective and humane response to domestic violence, with the goal of reducing recidivism and addressing (or deterring) the behavioral patterns that threaten the safety of our communities.

D. Implement Rental Car Emergency Disclosure Forms

Violent offenders often have unrestricted access to rental cars, which can be used to evade law enforcement after committing acts of domestic violence or homicide. This was demonstrated during the Team's review where perpetrators, armed and escalating in violence, used rental cars to flee or avoid arrest after committing a homicide. In cases where a perpetrator's location is unknown, significant threats to public safety and an increased risk of lethality arise. These risks are amplified from the time a perpetrator flees the crime scene, to the time it takes for law enforcement to accurately locate the perpetrator to facilitate a safe and timely arrest.

The outcome of cases involving rental cars largely depends on the willingness of rental car companies to cooperate with law enforcement. This often includes disclosing critical information, such as the GPS location of a rental car, in emergency situations. Upon further review, the Team found that these emergency circumstances, which require coordination between law enforcement and rental agencies, are not uncommon. These situations are often time-sensitive and can have a significant impact on lethality outcomes. A concern, and the reasoning behind this identified Opportunity for Intervention, is the variability of response, and willingness of a company to comply, as there are currently no penalties for companies if they fail to provide this information.

This Opportunity for Intervention calls attention to the extreme lethality risks and potential liabilities faced by companies unwilling to comply during critical emergencies. The Team also aims to address the inefficiencies and inconsistencies of current processes, as this remains to be a challenge experienced by law enforcement when trying to locate violent offenders. Our current systems lack standardized, time-sensitive protocols and policies that require rental car companies to comply with and/or share critical information with law enforcement during emergencies.

The implementation and use of Emergency Disclosure Forms (EDFs) could help eliminate delays caused by slow subpoena processes, which often enables law enforcement to act quickly in life-threatening situations. This approach mirrors successful emergency disclosure practices in other industries, such as cell phone location data from service providers and account information from social media platforms, demonstrating its feasibility and effectiveness as an Opportunity for Intervention. Therefore, the Team proposes:

- Implement an Emergency Disclosure Form (EDF) protocol to help streamline the process for rental car companies, law enforcement agencies, and courts that can mitigate delays and improve response time in emergency situations.
    - While digital platforms have established emergency disclosure systems, no universal or state-approved system exists for rental car companies, despite the frequent use of rental vehicles in violent crimes.
- Develop a standardized EDF template and protocol, approved by Minnesota lawmakers, that rental car companies must follow when responding to emergency requests.
    - EDF forms should allow law enforcement to request rental car records quickly and securely such as: vehicle location, GPS tracking data, renter identity, and travel history, in emergencies involving domestic violence where there is an imminent threat of death or great bodily harm.
    - EDFs could be modeled after successful disclosure processes used by platforms such as Instagram and Microsoft.

- Ensure EDFs are used exclusively in verified emergencies, with clear criteria and thresholds for law enforcement requests, to protect renter privacy. This includes judicial oversight or a streamlined verification process for urgent situations.
- Partner with other states to create a model policy that can be applied nationwide, ensuring rental car companies are equipped to respond and coordinate across state lines in emergency situations.
- Encourage rental car companies to utilize GPS tracking technology to provide real-time updates in emergency situations.
- Mandate that rental car employees are trained to recognize and respond to EDFs, with penalties for non-compliance or delays in emergency situations.

Minnesota lawmakers and Hennepin County systems should mandate that rental car companies adopt state-approved EDF protocols to support time-sensitive investigations and emergency situations involving extreme risk to public safety in domestic violence cases. This proactive measure would enhance public safety, save lives, and establish a model for other industries and jurisdictions to follow.

2. Reintroduce the Minnesota Court Information System

The Minnesota Court Information System (MNCIS) historically served as an essential tool for professionals across the criminal justice system. Law enforcement, attorneys, and legal advocates relied on this system to access vital case information, track criminal history, and monitor system involvement for both victims and perpetrators in domestic violence cases. It provided information that was used by attorneys to assess determinants related to warrant requests, sentencing guidelines, and bail conditions. It also served as an enforcement tool and violence prevention measure for law enforcement agencies, and first responders, and was used across jurisdictions to access protection orders and criminal offense data; information that was used to inform and guide arrest decisions in compliance with charging criteria established in Minnesota Statutes § 609.02.1.

Following the discontinuation of professional access to MNCIS (except for judicial officers), this system was replaced by Minnesota Court Records Online (MCRO), which grants professionals public-level access to information. This decision has had severe consequences for system providers and the people that they serve, and it has also significantly disrupted cross-system collaboration. MNCIS previously enabled seamless information sharing and coordination efforts across jurisdictions, which informed system response, accountability, and protection measures for public safety. Without this tool, there is no longer a platform that can offer the same level of efficiency and system cohesion for professionals who need it most to make informed decisions and provide timely interventions.

The absence of MNCIS is compounded when system professionals are forced to rely on tools like Minnesota Government Access (MGA), which fails to offer comprehensive and detailed case information. The numerous limitations and inefficiencies professionals encounter when using MGA are not only concerning but also highlight the urgent need for significant reform and intervention. It should be noted that MGA does not offer real-time case updates such as protection orders, or case dispositions; and it also fails to offer crucial case determinants such as warrant requests, bail conditions, and sentencing guidelines (information that is essential for prosecutors, attorneys, and law enforcement to do their jobs effectively). The search engine capabilities of MGA are also limited and disjointed, making it harder for professionals to access complete case histories and cross-reference information in an efficient and time-sensitive manner.

In 2021 and 2022, the year of each homicide, MNCIS was still available with unfettered access to system professionals and supported real-time collaboration across jurisdictions in each homicide case. The Team identified this recent system change as a critical Opportunity for Intervention, underscoring that these significant gaps in information sharing only further increase known lethality risks for victims, law enforcement, and first responders in cases involving domestic violence. These limitations and barriers to information also grossly undermine professionals' ability to fulfill their roles and responsibilities in protecting public safety, as they lack a complete understanding of the potential dangers and lethality risks involved. Therefore, the Team strongly advocates for reintroducing MNCIS, identified by the following Opportunities for Intervention:

- Enhance system efficiency by mandating advanced search engine tools as a standard of practice for professionals within the criminal justice system, to further enhance cross-system communication and help foster a coordinated response across all jurisdictions by streamlining processes.

- Implement access provisions through policy, ensuring law enforcement, legal professionals, and social workers are legally authorized to access crucial data and case information (formerly available through MNCIS), that exceeds the current scope of MGA access.
    - Ensure real-time access to up-to-date data, protection orders, and case dispositions that provide a comprehensive view of criminal history and system involvement for both perpetrators and victims in domestic violence cases.
    - Strengthen the response to domestic violence by equipping law enforcement officers and other system officials with the tools they need to respond more effectively, enforce protective orders, and prevent further violence.
    - Support proactive monitoring of perpetrator violence and system engagement, enabling law enforcement and advocates to implement more effective intervention and prevention strategies to increase victim safety and reduce the risk of re-victimization.

By addressing inequities in the current system and restoring comprehensive access to critical information, we can create a safer environment for all individuals involved in domestic violence cases. Reintroducing professional access to the Minnesota Court Information System (MNCIS) is not just a technical necessity; it is a fundamental requirement for protecting victims, ensuring offender accountability, and preserving the integrity of the justice system. This restoration reinforces each system professional's obligation to safeguard public and individual safety by providing access to potentially life-saving information. It also empowers professionals to make informed decisions, identify patterns of violence, and intervene more effectively to prevent further harm; all while upholding the highest standards of confidentiality and discretion.

It is essential that Minnesota's legal system operates with the highest standards of transparency, efficiency, and effectiveness; and by reinvesting in the Minnesota Court Information System (MNCIS), Minnesota can take a vital step forward by rebuilding public trust in our judicial process and work more efficiently across systems to help break the cycle of violence in our communities.

3. Update Lethality Risk Assessments and Enhance Police Reports

During the Team's review, critical gaps were identified across systems, highlighting a clear need for increased investments in prevention strategies and a more efficient, coordinated response. The Team's findings include recommendations to standardize processes that could improve harm reduction efforts and better address victim safety by mitigating heightened lethality risks.

The cases reviewed by the Team revealed how victim risk assessments and police reporting can fail to capture the full extent of dangers posed by a perpetrator in domestic violence cases. This was especially evident in cases where perpetrators had extensive criminal history, prior offenses related to domestic violence or animal cruelty, and access to lethal weapons. Additionally, communication breakdowns between jurisdictions and inconsistent reporting standards further hindered efforts to address domestic violence.

Using a prevention and harm-reduction lens to address system gaps, the Team has identified several Opportunities for Intervention, outlined in two sections:

A. Update Lethality Risk Assessments

B. Enhance Police Reports

Each system intervention identified by the Team can be located on pages 36-39 and should be evaluated within the context and insights provided by each case annotation.

A. Update Lethality Risk Assessments

A standardized lethality risk assessment offers clear guidelines for law enforcement, social workers, and healthcare providers on how to respond in dangerous situations. These assessments can help professionals evaluate the severity of the threat, determine if the victim needs immediate protection, and decide if interventions such as protection orders or arrests are warranted. When risk assessments are consistent and comprehensive, professionals are better equipped to prioritize victim safety and hold perpetrators accountable.

The goal of comprehensive and standardized lethality assessments is to create a safer environment for victims. When these assessments accurately identify risks, appropriate protective measures can be implemented to prevent harm. Victims are also more likely to feel supported and understood when systems use evidence-based practices to assess danger and provide the necessary assistance.

As part of an identified Opportunity for Intervention, the Team added two additional risk factors to its review of each case, expanding on Jacquelyn Campbell's 20-question "Danger Assessment."

These new risk factors are directly informed by different lethality risks identified in the Team's review of homicides in 2021 and 2022. These include instances where a victim leaves an abusive relationship to enter a new one, or when a perpetrator harms or abuses animals. The Team will continue to prioritize these factors in future reporting, as they signal heightened risks for domestic abuse and violence driven by power, control, and jealousy dynamics. By considering these additional risk factors, all system agencies can more accurately identify high-risk situations and take proactive measures to prevent escalation and provide better protection for victims.

Updating lethality risk factor screenings focuses on refining the tools used to assess the immediate danger posed to victims, incorporating additional risk indicators, and improving the timeliness and accuracy of these assessments, therefore the Team encourages the following:

- Incorporate the victim "starting or entering into a new relationship" as a lethality factor that is used in all victim risk assessments.
    - In cases reviewed by the Team, this risk factor alone increased the frequency and risk of violence by a jealous or possessive ex-partner when the victim made attempts to safely exit and/or move on from the abusive relationship.
- Include "harm to animals" as a lethality factor that is used to track "if a perpetrator of domestic violence has a history of animal abuse and/or is violent towards animals," and apply this to all victim risk assessments.
    - In cases reviewed by the team where the perpetrator may have had a history of animal abuse and/or was violent towards animals, this was a clear and missed opportunity for intervention that should be mitigated whenever possible in cases of domestic violence.
    - [4]In recent years, a strong correlation linking animal abuse and domestic violence has been documented. National studies have shown that up to 80% of women who own pets and were entering domestic violence shelters reported that their abuser had injured, maimed, killed, or threatened their pet.

[4] "Animal Cruelty & Relationship Abuse." *Center for Relationship Abuse Awareness,* https://stoprelationshipabuse.org/educated/animal-cruelty-relationship-abuse/.

- Create and implement a real-time risk assessment for every 911 call related to domestic violence. This includes evaluating the risk factors mentioned in prior incidents and updating the risk score accordingly.
- Implement structured interviews that include specific questions about risk factors, such as new relationships and harm to animals and/or pets. This ensures that critical information is consistently captured.
- Develop an integrated response protocol that mobilizes appropriate resources based on the risk assessment.
    - This could include dispatching specialized personnel such as the Domestic Abuse Response Teams (DART) to provide immediate support services or resources to help keep a victim safe.

These recommendations support the Team's broader goal of improving response protocols and enhancing data-sharing systems to prevent the escalation of domestic violence and fatalities. By strengthening and standardizing risk assessment processes, Minnesota can more effectively identify high-risk cases and intervene before tragic outcomes occur.

B. Enhance Police Reports

The cases reviewed by the Team highlighted instances where disjointed efforts to track, document, and assess risks to public safety and victims of domestic violence were impacted by a lack of coordination between law enforcement jurisdictions across cities, counties, and states. This fragmentation can create significant gaps in law enforcement's ability to track and intervene in cases of recurring and escalating violence. In several cases, perpetrators exploited these jurisdictional divides to evade enforcement, increasing the risks faced by victims, law enforcement, and first responders.

Each law enforcement agency, whether city, county, or state, often operates using separate databases, policies, and priorities. This lack of system coordination can make it difficult for law enforcement and advocates alike to access comprehensive and up-to-date information about a perpetrator's domestic violence history. When key indicators of violence are present, jurisdictional boundaries often further complicate efforts to ensure public safety and implement cohesive violence prevention strategies. The consequences can be severe, and sometimes fatal, for all parties involved.

The absence of universal reporting standards, protocols, and documentation of "red flags" or lethality indicators in domestic violence cases prompted the Team to identify several Opportunities for Intervention that could help prevent future fatalities across city, county, and state lines. The Team's recommendations are as follows:

- Enhance data collection mandates that require police reports to include detailed information about a perpetrator's criminal history, prior domestic incidents, reported animal cruelty, drug possessions, and weapon-related charges.
    - Standardize data collection across all law enforcement agencies in Minnesota.
- Introduce a standardized risk scoring system that quantifies the threat level and lethality factors based on a perpetrator's criminal history and behaviors.
    - This risk score should be prominently displayed on all police reports to trigger a heightened response for repeat offenders who have protection orders issued against them, have access to weapons, or present indicators of escalating violence.
- Develop a state-wide integrated database (or reintroduce the Minnesota Court Information System (MNCIS)) that allows law enforcement, social services, and judicial officers to share and access comprehensive information about individuals involved in domestic violence cases.
- Establish a real-time alert system that notifies law enforcement of high-risk individuals during routine checks, 911 calls for service, or when responding to an incident.
- Mandate that victim risk assessments and reporting guidelines are offered and completed by law enforcement (if/when a victim is willing to comply) and is inclusive of domestic violence cases occurring within all domestic relationships (not solely limited to intimate partner violence).
    - Ensure cohesive standards of practice are implemented and maintained across city, county, and state so that all lethality factors are documented, updated, and flagged in instances of extreme risk to victim and/or public safety.
- In instances when no further action or arrests are required by law enforcement, and before law enforcement leaves the scene of the originating 911 call, implement prevention measures that equip law enforcement with resources (a one-pager or brochure) specifically designed for individuals who perpetrate abuse or violent behaviors.

- Similar to resources offered to victims, the Team sees each contact between a perpetrator of violence, and a system representative or member law enforcement, as an opportunity to connect people to information and services whenever possible.

Enhancing police reports to include standardized victim risk assessments, scoring measures, and documentation of red flags for high-risk or violent offenders will foster a united prevention effort and a real-time alert system across jurisdictions. By prioritizing information sharing, collaboration, and victim safety, Minnesota can overcome systemic barriers and ensure a more effective response to domestic violence cases with high lethality indicators. These changes will help to save lives, reduce violence, and create a safer future for all Minnesotans.

4. Address Domestic Violence Among Active-Duty Service Members and Veterans

The Team identified an Opportunity for Intervention specifically related to victims and/or perpetrators of domestic abuse who identify as active-service members or military veterans. When experiences of violence or abuse are present, the Team observed numerous complexities in reporting within these populations, as well as limited social protective factors within the Veterans Affairs (VA) systems which can discourage individuals from coming forward about experiences of abuse, coercive control, or stalking.

Domestic violence within the military and veteran populations presents unique challenges, including fear of career-ending consequences, stigmatizing language, inconsistent resources, and lack of cross- system communication. These barriers often deter victims from seeking help and hinder intervention efforts for perpetrators. In addition to existing resources within the Department of Veterans Affairs (VA) and military Family Advocacy Programs (FAPs), the Team identifies additional Opportunities for Intervention in the areas of screening, referral, education, and the consistent application of domestic violence intervention services across military branches as follows:

- **Review and Improve Screening and Referral Resources**
  - Conduct a comprehensive audit that assesses current domestic violence screening and referral processes within the VA and FAPs to identify gaps in consistency, accessibility, and effectiveness.
  - Develop and implement universal and standardized screening protocols across all military branches to ensure the early identification of victims and perpetrators of domestic violence.
  - Create a centralized and streamlined referral system that connects service members and veterans to advocacy groups, counseling, legal aid, and crisis intervention services.

- **Improve Cross Communication Between Courts and Military Systems**
  - Integrate district family/civil courts with veteran's courts to improve communication and ensure comprehensive case management and oversight for service members involved in domestic violence cases.
  - Develop protocols for sharing case information between the military justice system, civilian courts, and the VA while maintaining confidentiality and victim safety.
  - Foster collaborative case planning through partnerships between military FAPs, VA programs, and community organizations to provide coordinated interventions and support.

- **Campaign for Language Reform to Reduce Stigma**
  - Revise stigmatizing terminology by advocating for the removal of terms like "terroristic threat" and reframe policies and protocols to use restorative, trauma-informed language (i.e., "credible threat to safety" or "high-risk behaviors").
  - Shift the focus of military domestic violence narratives toward prevention, intervention, and rehabilitation, rather than emphasizing punitive measures alone.
  - Reduce the fear of repercussions by ensuring service members understand that seeking help will not automatically result in discharge or legal action but instead lead to safety and support.
  - Provide programs tailored to the specific stressors faced by military personnel, such as PTSD, financial strain, and reintegration challenges.

- **Provide Mandatory Training and Support Services at Re-entry Meetings**
  - Integrate domestic violence education, screening, and resource referrals as standard components of all re-entry and reintegration meetings for service members transitioning to civilian life or returning from deployment.
  - Make domestic violence training mandatory for all personnel, including officers and leaders, to foster top-down awareness, accountability, and a culture of prevention.
  - Use re-entry meetings as an opportunity to screen for early warning signs of domestic violence and provide immediate support and referrals for intervention.
  - Require participation in intervention programs for service members identified as perpetrators, ensuring both accountability and access to rehabilitation.

- **Awareness Campaign for Active-Duty Service Members and Veterans**
  - Launch a unified, branch-wide campaign to raise awareness about domestic violence resources available to all service members and veterans.
  - Incorporate domestic violence education and resource training into mandatory re-entry and transition programs for service members at all military ranks and career stages.
  - Partner with military domestic advocacy groups to develop culturally competent outreach programs that address stigma and encourage help-seeking behavior.

- **Offer Military-Specific Domestic Advocacy Groups**
  - Expand partnerships with military-focused advocacy organizations that understand the unique challenges of military life, such as frequent relocations, deployment-related stress, and the career consequences of domestic violence allegations.
  - Advocate for funding and resources to establish or expand advocacy groups specifically tailored to active-duty members and veterans.
  - Ensure that advocacy groups provide confidential, nonjudgmental support for victims, while emphasizing rehabilitation and accountability for perpetrators.

Addressing domestic violence within the active-duty and veterans population requires systemic change across the military, VA, and civilian systems. By standardizing resources, promoting education, reforming language, and fostering collaboration; Minnesota state lawmakers, Hennepin County systems, and military leadership can create a unified approach to intervention and prevention. These changes will protect victims, rehabilitate perpetrators, and reduce domestic violence and fatalities within military and veteran communities.

5. Screen Chronic and Terminally Ill Patients for Domestic Abuse and Suicidal-Homicidal Ideation

During the Team's case review, relationship dynamics where one individual assumes a caregiving role for the other, were identified as potential factors contributing to power imbalances. These dynamics are particularly prevalent in relationships involving aging individuals, those with disabilities or mobility restrictions, or situations where terminal illness or significant health issues affect daily life. In these relationships, one person may rely more heavily on the other for basic care or lifestyle support, which can create or amplify power imbalances.

With consideration to these different relationship factors, if indicators of domestic abuse are also present, it can often further exacerbate a victim's feelings of isolation. Patients with chronic or terminal illnesses are also at heightened risk of experiencing domestic abuse due to increased caregiver stress, financial strain, and power imbalances. Furthermore, chronic illness can worsen suicidal or homicidal ideation in both patients and caregivers.

In cases where these relationship dynamics were present, the Team observed specific Opportunities for Intervention particularly where there were inconsistencies in domestic violence and suicidal ideation screenings across healthcare settings. These opportunities aim to strengthen follow-up care by providers, ensuring that vulnerable patients receive the critical support they may need.

Providing the necessary support to the most vulnerable patients is crucial to mitigating risks and preventing harm. By enhancing follow-up care practices, healthcare providers can better address the complexities of domestic violence, offering timely interventions and comprehensive support. This approach improves patient safety, enhances outcomes, and fosters a supportive environment for recovery and wellbeing. The following Opportunities for Intervention should be considered:

- **Require Screening for Domestic Abuse and Suicidal/Homicidal Ideation**
  - Mandate healthcare providers and social workers to routinely screen all patients with chronic and/or terminal illnesses for:
    - Domestic abuse (including physical, emotional, and financial abuse).
    - Suicidal or homicidal ideation, particularly in cases of evident abuse or caregiver strain.
  - Utilize standardized screening tools such as the "Danger Assessment" for domestic violence, and the "Columbia-Suicide Severity Rating Scale" (C-SSRS) for suicidal ideation.
  - Ensure thorough documentation of risk assessments and clear communication across interdisciplinary teams to maintain continuity of care.

- **Provide Follow-Up Care and Counseling**
  - Mandate immediate follow-up for any positive screening results, including:
    - Referrals to mental health services for suicidal or homicidal ideation.
    - Counseling for victims of domestic abuse and caregiver stress.
    - Make connections with local advocacy groups or support networks for additional help.
  - Screen both patients and caregivers for existing support systems (family, friends, community

organizations) and provide additional resources as needed.

- **Educate Patients, Caregivers, and Providers**
  - Train caregivers to recognize warning signs of abuse, suicidal ideation, and caregiver burnout.
  - Provide clear instructions on how to report concerns to healthcare providers, social workers, or crisis lines.
  - Educate healthcare providers on conduct screenings, responding to disclosures, and navigating complex dynamics involving chronic illness and abuse.
  - Launch awareness initiatives to destigmatize discussions of domestic abuse and mental health issues in the context of chronic or terminal illnesses.

The Team's case review highlights the need for all healthcare systems to adopt comprehensive screening and follow-up care protocols. By implementing standardized tools, consistent screening practices, and educational initiatives, healthcare providers can enhance their ability to identify and address high-risk situations. These proactive measures will not only improve patient safety and outcomes but also contribute to a more supportive and effective healthcare system in addressing the complexities of domestic violence.

Summary of Findings

The Minnesota Fourth Judicial District Domestic Fatality Review Team's 2024 Annual Report examines two domestic homicides in Hennepin County from 2021 and 2022, offering critical recommendations to reduce future fatalities. These recommendations were developed by professionals with extensive experience working with both victims and perpetrators of domestic violence across various Hennepin County systems.

The report identifies current system gaps and outlines areas where policy, protocol, and process revisions could dramatically improve the state's response to domestic abuse. The findings and Opportunities for Interventions detailed throughout this report are intended to inform policymakers and guide the creation of more effective system interventions for domestic violence, recognizing it as a public health and safety crisis that demands urgent action.

To effectively reduce domestic violence and prevent future fatalities, a multi-faceted strategy is essential. The report's key recommendations focus on strengthening Minnesota's legal framework to better address escalating or recurring violence and lethality risks. This includes utilizing tools such as Extreme Risk Protection Orders (ERPOs) for early intervention and expanding definitions of domestic abuse to include stalking behaviors and coercive control. The report also calls for implementing enhanced system interventions and protocols that better equip professionals to respond in emergency situations. These measures include Emergency Disclosure Forms (EDFs), and improved information-sharing across the state's court systems, with comprehensive search engines to track domestic violence cases.

The Team also emphasizes the importance of better inter-agency coordination, urging the implementation of universal standards for law enforcement documentation and reporting protocols. These measures, along with improved lethality risk assessments, would enable more effective early identification of high-risk situations. Additionally, the Team supports the creation of a specialized sentencing rubric with graduated penalties to address repeat domestic violence offenses.

Furthermore, the report highlights the need for targeted interventions for specific populations, including active-duty service members, veterans, and individuals with chronic or terminal illnesses, who face increased risks of domestic violence. Screening protocols that incorporate lethality risk factors are crucial for healthcare providers and law enforcement to identify high-risk cases early. The patterns uncovered in the Team's review also reveal significant gaps in interjurisdictional communication, early-intervention protocols, and risk assessment systems that impede timely responses and prevention efforts. The creation of a statewide integrated database and real-time alert system is vital for improving communication, cross-sector coordination, and to ensuring professionals across jurisdictions are prepared to respond to emergency situations.

The report also identifies vulnerabilities in populations often underrepresented in domestic violence prevention efforts, such as individual in caregiving roles, and those struggling with caregiver strain and mental health crises. To address these unique barriers, the report calls for targeted approaches, including enhanced screening, specialized support services, and expanded coordination between healthcare, law enforcement, and community organizations.

Together, these recommendations form a comprehensive, proactive approach to preventing domestic violence fatalities. By strengthening legal protections, enhancing system coordination, refining risk identification methods, and addressing the needs of underserved populations, the proposed interventions aim to create a safer environment and reduce the tragic toll of domestic violence-related deaths.

The proactive measures outlined in this report are essential to building a more responsive system that protects lives and ensures accountability. By acting on the recommendations in this report, policymakers and stakeholders can reduce domestic violence, save lives, and create a Minnesota where every individual, regardless of their circumstances, can live free from fear and violence. The Team urges lawmakers, law enforcement, healthcare professionals, and community organizations to prioritize these recommendations in the year ahead, as the safety of all Minnesotans depends on it. Through collective action and cross-sector collaboration, we can work toward a future where domestic violence fatalities are no longer a tragic reality but a preventable outcome; where all individuals have the safety and protection they need.

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