one life lost as a result of DOMESTIC VIOLENCE is one too many

A Matter of Life and Death: The Domestic Fatality Review Team
A collaboration of Private, Public and Nonprofit Organizations
Operating in Hennepin County

2004 REPORT

Project Chair:
The Honorable Richard Scherer
Minnesota Fourth Judicial District

Community Partners:

Community Volunteers
Domestic Abuse Project
General Mills Community Action
Minneapolis City Attorney's Office
Minneapolis Police Department
Minneapolis Public Schools
Minnetonka City Attorney's Office
Minnesota Coalition for Battered Women
Sojourner Project, Inc.

County and State Partners:

Fourth Judicial District Court
Fourth Judicial District Public Defender
Hennepin County Attorney
Hennepin County Community Corrections
Hennepin County Human Services
Hennepin County Medical Center
Hennepin County Medical Examiner
Hennepin County Sheriff

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This report is a product of:

A Matter of Life and Death:
The Domestic Fatality Review Team
A Collaboration of Private, Public and Nonprofit Organizations Operating in Hennepin County

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"One life lost as a result of domestic violence is one too many."

~Jacquelyn Hauser
Founder,
Domestic Fatality
Review Team

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Executive Summary

Sometimes a careful look back is the wisest way to move forward.

The charge of the Review Team is to analyze domestic fatality cases, review public policies and procedures and try to eliminate opportunities for future homicides. We have learned a lot since this team was formed, and we have taken what we have learned and made changes. Since the review process began back in September of 2000, the Review Team implemented more than 25 substantive improvements in programs and services and has fostered better coordination between agencies. These improvements enhance support for victims and increase consequences for abusers. While we can point to success in improving systems, each new case unveils "missed opportunities". These "missed opportunities" and "opportunities for intervention" are outlined in this report.

Many factors converge to impact change in public policies. Our recommendations, along with advocacy from a host of other organizations, have influenced changes to the system. We have learned that:

- Perpetrators of domestic violence often flee before police arrive. With proper training, law enforcement officers were able to double the number of arrests for perpetrators who were "gone on arrival".

- When law enforcement accurately documents the victim's abuse including specific weapons used and the extent of the victim's injuries, one outcome is that cases are more likely to be charged at the proper level. City attorneys in Hennepin County now routinely review domestic abuse charges to ensure the detailed accuracy of the charges. As a result, felony and gross misdemeanor filings have increased dramatically. The number of misdemeanor charges dropped correspondingly as a result of the justice system's attention to prosecuting at the highest possible level. In 1999, there were nearly 500 gross misdemeanor charges filed for domestic abuse; in 2001, that number was more than 700. In 1999 there were 93 felony charges filed; in 2001 that number was 132.

- Strangulation is often one of the last abusive acts committed by a violent domestic partner before murder. The Hennepin County Attorney's Office is reviewing policies and laws, so they can better advocate for victims of strangulation.

- Children are frequently the targets of perpetrators. A public school in Minneapolis has now developed a model policy and procedure for staff, parents or students who have "Orders for Protection".

- Hospital emergency rooms are an opportunity to identify victims of domestic violence. Domestic violence patients at Hennepin County Medical Center now meet with Emergency Room staff trained to recognize and talk to victims of abuse.

We continue to learn more each time we conduct a case review. Over time, the number of cases reviewed continues

Executive Summary *continued*

to reveal patterns and provide greater insight. Recurring opportunities to improve identification, intervention and prevention are documented.

During the monthly review of cases in 2003 and the first half of 2004 it was noted that:

- Police departments differ in policies and procedures regarding investigation and pursuit of perpetrators who flee the scene of a domestic assault.
- Children have, on occasion, been victimized after being placed by the courts in a home that was deemed unfit to receive a foster care license.
- The workplace is a predictable location for a perpetrator to stalk the abuse victim.
- Members of the criminal justice system do not always have all the pertinent information about a perpetrator's criminal history, for example, patterns of violent behavior, that should be considered in the case.
- Perpetrators are sometimes allowed to be present in an emergency room when a victim is screened for domestic violence after a domestic assault.

The Domestic Fatality Review Team compiled observations based on the facts of the case records. Additional findings are documented in this report.

"Opportunities for Intervention" based on the case findings were created to suggest best practices that could be replicated within Hennepin County as well as other jurisdictions. This report is intended to be a companion to the initial report entitled ***A Matter of Life and Death: Findings of the Hennepin County Domestic Fatality Review Pilot Project, 2002***.

The "Opportunities for Intervention" summary is organized by the following topics:

When Perpetrators are Gone
When Police Arrive
Dual Arrests
Conditions for Probation and Supervised Release
Data Practices
Responding to and Documenting the Severity of a Domestic Assault
Children in the Child Protection System
Children in Schools
Orders for Protection
Medical Professionals and Hospital Emergency Department Staff
Treatment and Mental Health Issues
Implications of Domestic Violence in the Workplace
Cultural Issues

The Review Team hopes that the information in this report will prompt active interest in these cases. Agencies are encouraged to take advantage of the "Opportunities for Intervention" identified by the report. Support for domestic fatality prevention in Minnesota's 87 counties continues to be a future goal for the Review Team.

Preface

A school bus driver noticed that the oldest of four children had missed the bus for the past few days. When she reported her concern to school officials they called the home. The guardian's partner claimed the girl "had the flu". This grade school student had been beaten unconscious by her guardian's partner that morning in front of the other children and was lying in a coma when the school called. She died that evening of multiple blunt force injuries to her head, neck and abdomen.

True stories like this are the tragic aftermath of domestic violence. **Over the past 11 years, 93 women, 35 children and 4 men have been murdered as a result of domestic violence in Hennepin County.**[1] These extremely troubling statistics just scratch the surface of the human toll domestic violence has on our community. Last year domestic assault filings in District Court totaled 4,557: 132 felony domestic assaults, 705 gross misdemeanors, and 3,720 misdemeanors. There were 2,859 orders for protection. [2]

The devastation of domestic violence spares no community -- it is found in suburbs and the inner city; and among the rich and poor; among every race, color and creed. The Domestic Fatality Review Team was created in order to improve policies and procedures to better address domestic violence in our county.

The 34 member Review Team creates a case chronology that outlines the interaction between the victim, the perpetrator, their families and the various systems involved. Upon review of all documents, key issues and recommendations based on case findings are discussed and recorded. Small groups follow up with the recommended changes with the appropriate agencies and departments. The recommendations outlined below are the outcome of reviewing four domestic violence homicides. This report builds upon the initial set of recommendations documented in the report titled: ***A Matter of Life and Death: Findings of the Hennepin County Domestic Fatality Review Pilot Project 2002***.

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

1. Minnesota Coalition of Battered Women Femicide Report 1992-2003.
2. Fourth Judicial District Research Division, October 2003.

Preface *continued*

This process fosters honest inter-agency introspection about policies, procedures and system behavior. Sometimes a system's policies, past practices or procedures may unknowingly facilitate opportunities leading to domestic violence fatalities.

It is unique to find this type of candid critical analysis in a multi-agency collaborative effort that includes judges, prosecutors, public defenders, advocates, law enforcement, probation officers, corrections officials, medical examiners, physicians, psychologists, corporate human resource directors, citizens, social workers and policy makers. The unprecedented level of cooperation from the advocate community underscores the culture of trust that is present.

In this non-blaming setting, an agency can admit a missed opportunity where they "dropped the ball" and look to future improvement of practices to protect potential victims.

As Minnesota's first Fatality Review Team, we are part of a growing national movement to provide such reviews. The quality of the team's reports and recommendations provides a model program for other communities across the country.

Even after careful study, the Review Team cannot guarantee that its findings will ultimately save lives.

"This is not a crime that happens to someone else,

or exclusively happens in dysfunctional families, or only happens in families with drug and alcohol abuse.

Anyone, anywhere, anytime
can be a victim of domestic violence...

A friend helping a friend move out of her home as a result of a failed marriage...

A child visiting a friend overnight...

A daughter having an ever-so-brief relationship with an unstable suitor...

And other scenarios too numerous to mention.

It can happen to anyone."

~ 2002 A Matter of Life and Death Report

I Purpose and Goal

The purpose of the Hennepin County Domestic Fatality Review Board is to examine deaths resulting from domestic violence in order to identify the circumstances that led to the homicide(s).

The goal is to discover factors that will prompt improved identification, intervention and prevention efforts in similar cases. It's important to emphasize that the purpose is not to place blame for the death, but rather to actively improve all systems that serve persons involved with domestic abuse.

Notice: A Matter of Life and Death: The Domestic Fatality Review Team, is a collaboration of private, public and nonprofit organizations, as well as citizen volunteers from throughout Hennepin County. As a collaborative venture, the views expressed within this report reflect collective discussions and decision-making within the group and do not necessarily reflect the views of the respective organizations represented by the membership of this collaborative.

II Project History

The Fatality Review process in Hennepin County began in 1998 when WATCH, a nonprofit court monitoring organization, received a planning grant from the Minnesota Department of Children, Families and Learning. As part of its work, WATCH routinely creates chronologies of cases involving chronic domestic abusers and publishes them in its newsletter. While creating chronologies, WATCH often became aware of missed opportunities for holding abusers accountable. The organization felt strongly that in the vast majority of cases, these opportunities were not missed because of carelessness or disinterest on the part of the individuals handling the cases. Instead, many opportunities were missed because adequate and accurate information was not available at critical decision points and because the sheer volume of domestic abuse cases created significant pressure to resolve them quickly, oftentimes forcing an outcome that was less than ideal.

While attending a National District Attorneys Conference in 1997, a WATCH staff member learned about a movement to conduct Domestic Fatality Reviews, a movement that was gaining interest nationwide and that appeared to address many of the organization's concerns about the many places where chronic abusers could slip through the cracks of the justice system. When WATCH learned about the availability of planning funds from the Minnesota Department of Children, Families and Learning, it applied for, and soon after received, a $25,000 planning grant to determine the potential for establishing such a project in Hennepin County.

If representatives from the justice system and community agencies determined that such an effort was feasible, the grant called for the organization that would lay the foundation for the project.

Upon receipt of funding, WATCH put together an Advisory Board of representatives from the primary public and private agencies that handle domestic violence cases. The Advisory Board included representatives from District Court, City and County Attorney, Police, Public Defender, Probation and Victim Advocacy Services, meeting up to four times a month since March of 1998. Remarkably, nearly every Advisory Board Member has remained with the project since its inception.

Enthusiasm for the project was high from the outset. Consequently the Advisory Board spent very little time on the feasibility study and soon began laying out the framework for the project to be established in Hennepin County. It began with an extensive research effort to gather information from jurisdictions that had already implemented fatality review teams, gaining extremely valuable information in this process. Many jurisdictions stressed the importance of having enabling legislation to create the project and to lay the framework for the project to go forward with multi-agency participation. This would assist in creating a non-blaming environment and help assuring the neutral review of cases.

During the process of developing the proposed legislation, the Advisory Board assembled a larger Planning Committee

comprised of 34 members representing private, public and nonprofit agencies and organizations to gain a variety of perspectives on particular topics and to develop broader support for the project. The Planning Committee worked primarily on establishing a definition of domestic homicide and on identifying who should be represented on the Review Team.

Once critical decisions had been made about participation and structure, the existing Advisory Board worked with Senate counsel to put together legislation that would create and fund the project. The legislation also included important data privacy and immunity provisions that would enable the project to gain access to confidential records related to these cases and provide immunity to those who spoke openly to the Fatality Review Team about case information.

A proposal to create and fund the pilot passed during the 1999 session. However, for technical reasons the data privacy and immunity provisions were taken out of the enabling legislation. This language was critical to the success of the project, since many agencies were interested in providing information to facilitate the fatality review process but were not able to do so under existing statutes without suffering significant penalties. The Advisory Board returned to the legislature during the 2000 session to pursue the data privacy and immunity provisions. The legislation passed and was signed by the Governor. It became effective on August 1, 2000. In 2004 the State Legislature granted an extension to these provisions until June 2006.

The Review Team: The Review Team consists of 34 members, appointed by the Chief Judge of the Fourth Judicial District in Hennepin County upon the recommendation of the project's Advisory Board. The goal in structuring the team was to have multicultural representation and perspective.

The enabling statute stipulates a number of agencies required to be represented. Others were added in order to increase the level of community involvement and diversity. Several domestic abuse advocates who had personal experience with the cases under review were also invited to participate in those case discussions.

A two-member part-time staff support the project: a project director and a law clerk. In addition, the project is fortunate to have available to it the assistance of a professional facilitator whose services are donated.

Case Selection: The Domestic Fatality Review Team reviews only cases that are were closed to any further legal activity including opportunities for appeal. In addition, all cases - such as a homicide/ suicide where no criminal prosecution would take place - were at least one year old when they were reviewed. This policy was based on the advice of several jurisdictions that were already well versed in the review process. In their experience, letting time pass after the incident allowed some of the emotion and tension to dissipate, thus allowing for more open and honest discussion during case reviews.

The Advisory Board uses information

provided by the Minnesota Coalition for Battered Women's Femicide Report and homicide records from the Hennepin County Medical Examiner's Office to determine which cases to review. A subcommittee of the review team meets to examine the records and select cases for review. The committee selected a mix of cases that differed from one another based on race, age, location of the homicide, gender of the perpetrator and children witnessing a domestic homicide.

The Case Review: After a case was selected for ReviewTeam, members of the Advisory Board reviewed case files to identify documents critical to the case analysis. Usually the police and prosecution files provided information sufficient to identify other agencies that may have records that were important in reviewing the case.

Staff then sent out a request for agencies to provide documents to the Review Team.

Hennepin County Attorney Victim Witness Advocates attempted to contact the family to let them know about the review process, ask them if they would like to be interviewed, and ask them if they knew of records that would be helpful in the review, particularly records outside of Hennepin County and/ or medical records.

The Advisory Board and staff then reviewed the records in order to develop a chronology of the case. This chronology was sent to Review Team members prior to the case review. (This step was essential to a meaningful discussion since it was nearly impossible to keep track of the multitude of events and individuals involved in the case without this tool.)

Prior to the review, individual Review Team members were assigned to present agency information about the case at the monthly meeting. For example, the prosecution representative on the Review Team was assigned to report on the prosecution file. In addition, however, one other member of the Review Team, someone not associated with prosecution, was also asked to review the prosecution records. This gave the Review Team a fresh perspective on the case from someone who was not familiar with the agency's protocol. (Records were made available to Review Team members through a strict sign-out process. Confidential records were destroyed after the case review process.)

Each Review Team meeting started with members signing a confidentiality agreement. At the meeting, individuals who reviewed the case reported their findings. The Review Team then looked for missed opportunities for intervention that may have prevented the homicide and made recommendations based on the issues identified.

The Review Team identified key issues and recommendations related to each case. It also identified issues that required further investigation. In addition, members were given the opportunity to discuss their personal feelings about the case. This provided a way to address the emotional impact these cases had on the Review Team.

III Things to Keep in Mind While Reading This Report

- **The perpetrator is solely responsible for the homicide.** All members of the project recognize that regardless of any improvements that could have been made or may in the future be made by agencies or individuals, who have contact with the people involved in these cases, the responsibility for the homicide rests with the person who committed the crime. There is no room in the fatality review process for blaming. Every individual who participated in this process did so in an effort to learn from the tragedy and to improve the performance of their agency when handling cases of domestic violence.

- **There were many incidents that reflected exemplary responses to domestic violence, both inside and outside the justice system.** Since the report is geared toward addressing areas that need improvement, it may appear more negative than was the Team's experience in reviewing the cases.

- **Every finding in this report is prompted by details of a specific homicide(s).** Many of the Review Team members had extensive experience with domestic assault cases. Consequently, there was a temptation to draw on that broader experience when identifying the findings. The ReviewTeam believed, however, that one of its most important functions was to identify the types of issues that are a factor in domestic homicide cases as compared to more general concerns in the area of domestic violence.

  In light of the Review Team's decision to avoid a generalized focus, it established a procedure to guarantee that all findings are case-based. Those working in the field of domestic violence will not be surprised by many of the findings or opportunities for improvement identified by the Team. The Review Team hopes, however, that these issues take on greater importance since they are linked to the actual deaths of persons in real cases reviewed.

- **Findings are primarily based on information in official reports and records about the parties before and after the homicide.** Whenever possible, information was supplemented by interviews with surviving friends or family members. The findings of the Review Team are therefore limited to the availability of information reported in and from those sources.

- **The Review Team occasionally uses the word "appeared" when it believed certain actions may have been taken but could not locate specific details in the documents or interviews to support its assumption.** The Review Team did not consider this process to be an exhaustive investigation and consequently it did not go to extraordinary means to locate documents.

III Things to Keep in Mind While Reading This Report *continued*

- **Percentages are not used because the Review Team did not consider a statistically significant number of cases.** Instead, actual numbers are used to make certain the results are not misleading.
- **The findings should not be used as an indicator of lethality.** Many of the scenarios which appear in the report will be present in cases that do not result in a fatality. The Review Team does believe, however, that many of the findings are indicators of the level of potential danger to the victim.
- **The Review Team has identified "Opportunities for Intervention".** Since this project is based only on cases arising in Hennepin County, this report should be read as suggesting "best practices."
- **Case examples may appear in more than one category.** This shows the extent to which the issue exhibits itself as a problem in a variety of ways. It also reflects the complexity of these issues.
- **Perpetrators are referred to with male pronouns.** In most cases the person who committed the homicide(s) was male. According to data collected by the Bureau of Justice Statistics, males commit most domestic homicides against their female intimate partners. Consequently, the Review Team felt it was appropriate to use male pronouns when referring to batterers and murderers.
- **The Review Team appreciates that several of the agencies involved have made or are in the process of making changes in procedure and protocols since these homicides occurred.** However, the observations made are based on review of actual case histories, and the Review Team believes its observations will benefit not only Hennepin County agencies, but also others throughout the state and nation who review this report.

90–95% of domestic violence victims are women.

~ Bureau of Justice Statistics Selected Findings: Violence Between Intimates

We will never know if any of these deaths could have been prevented based on the recommended interventions in this report.

We do know, however, that in most instances there could have been an improved response to the danger that existed in the relationship.

IV Summary of Opportunities for Intervention

Topic	Summary of Opportunities for Intervention
Perpetrators Are Gone When Police Arrive	• Develop consistent "gone on arrival" policies in each jurisdiction throughout the County/State • Pursue evidence-based investigation of perpetrators who are "gone on arrival" • Document (Law Enforcement) each occurrence of domestic violence as mandated by law
Dual Arrests (when both parties in a domestic assault are arrested)	• Fully inform judges of the victim and perpetrator's criminal history • Provide the criminal justice system with training relative to the significance of patterns of violent behavior
Conditions for Probation and Supervised Release	• Examine the safety of halfway house programs and the appropriateness of these facilities for violent offenders
Data Practices	• Educate professionals to clarify the laws pertaining to the exchange of information
Responding to and Documenting the Severity of a Domestic Assault	• Refine a referral process inside the City Attorney's Office, the County Attorney's Office and the police departments, so that every documented incident of domestic violence is prosecuted at the level of severity warranted
Children in the Child Protection System	• Make services available to children who witness or are victims of domestic violence (within 24 hours whenever possible) to address post-traumatic stress symptoms and other ongoing mental health concerns • Avoid placements of children in non-licensable homes • Provide resources and referrals for services to families at the time of closing a Child Protection file, including coordination with other county programs • Mandate unannounced home visits to foster placements prior to any transfer of custody • Increase sharing of case information among and between professionals
Children in Schools	• Establish consistent processes and education for all staff regarding the mandated reporting on health and welfare concerns of children • Follow State laws regarding educational neglect and truancy • Conduct health and welfare checks in cases of truancy of elementary school children

IV Summary of Opportunities for Intervention *continued*

Topic	Summary of Opportunities for Intervention
Children in Schools	• Conduct a follow-up interview and a home visit where maltreatment has been reported • Develop a consistent policy statewide regarding release or removal of children from school • Provide schools with Child Protection placement information before the placement occurs
Orders for Protection	• Implement strategies to help children access protective services when they feel unsafe in their homes • Allow children over thirteen to seek advocacy and/or mental health services without parental permission • Trigger an immediate Child Protection report for any child who files an Order for Protection to determine whether or not intervention is needed.
Medical Professionals and Hospital Emergency Department Staff	• Include appropriate referrals for advocacy in hospital screening protocols for all domestic violence situations • Increase domestic violence awareness for hospital and emergency department staff • Develop an Emergency Room protocol to identify, whenever possible, past ER presentations to determine whether there have been previous visits with suspicious injuries • Work to incorporate consistent policies throughout Hennepin County hospitals regarding the treatment of possible victims of domestic violence • Interview patients who may be victims of domestic violence in privacy
Treatment and Mental Health Issues	• Integrate mental health, chemical dependency and domestic violence services for victims of violence • Implement a system of conditional release specific to clients with mental health concerns
Implications of Domestic Violence in the Workplace	• Provide education in the workplace to help employees access domestic abuse services and deal with harassment at the work site • Explore locating domestic violence advocacy in high volume public places such as shopping malls • Support and foster work being done locally and regionally to increase the sensitivity of area employers regarding domestic violence
Cultural Issues	• Mandate cultural competency training for professionals in the justice system • Provide community education to newly immigrated groups on domestic violence laws

V 2004 Case Observations and "Opportunities for Intervention"

Perpetrators Are Gone When Police Arrive

Case Observations

- A perpetrator physically abuses a victim and threatens the victim's child. The victim's child reports the incident to the police immediately, however the perpetrator flees the scene before the police arrive. There is no follow-up investigation when the perpetrator is "gone on arrival."

Opportunities for Intervention

- **Pursue evidence-based investigation of perpetrators who are "gone on arrival" so that the case can be prosecuted whether or not the victim chooses to testify.** This would hold perpetrators accountable even if they disappear before the police arrive.
- **Work to make the "gone on arrival" policy and procedure consistent in each jurisdiction throughout the county/state.**
- **Document (Law Enforcement) each occurrence of domestic violence as mandated by law.** These reports must be referred to the City or County Attorney's Office for review to ensure the crime is categorized correctly as a misdemeanor, gross misdemeanor or felony. An effort should be made to ensure that each jurisdiction in Hennepin County is addressing the reporting of domestic violence in a uniform manner. Incidents should be documented regardless of arrest in order to have a record of the incident.

Domestic violence victims account for over 25 % of all violent crime victims (in Minnesota).

~Minnesota Planning

V 2004 Case Observations and "Opportunities for Intervention"
continued

Dual Arrests

Case Observations

- In domestic violence situations where the perpetrator and victim were both charged with domestic assault (dual arrest), the prosecutors dropped charges against both parties.

Opportunities for Intervention

- **Fully inform judges of the victim and perpetrator's criminal history.** Pre-sentence investigations do not currently include a criminal history, previous charges or arrests. If there is a bail evaluation, a criminal history is attached, but that is not always the case. Non-conviction arrests and charges are helpful in understanding the context of the offender's violent behavior and determining who is the primary aggressor. Events not resulting in conviction are also important given that there is a significant dismissal rate of domestic violence charges. The courts should examine revising the pre-sentence investigation to include a complete criminal history as well as risk markers of prior arrests and charges which did not result in conviction. Any constitutional implications of including arrest information in pre-sentence investigations should be examined. This may require a longer time frame (currently four hours or less) for completing a misdemeanor and gross misdemeanor level pre-sentence investigation.
- **Provide the criminal justice system with training relative to the significance of patterns of violent behavior.** This should result in a determination about who is the dominant aggressor.

V 2004 Case Observations and "Opportunities for Intervention"

continued

Conditions for Probation and Supervised Release

Case Observations

- A perpetrator kept the victim at a halfway house under duress.

Opportunities for Intervention

- **Examine the safety of halfway house programs and the appropriateness of these facilities for violent offenders.** The level of supervision in these facilities should preclude individuals from committing additional crimes while residing in a halfway house.

Data Practices

Case Observations

- Mental health and chemical dependency issues of both the perpetrator and the victim were not adequately addressed because the information was not available to service providers.
- It is unclear if escalating problematic behavior observable by the school personnel and foster parents were communicated to or acted upon by appropriate Child Protection authorities.

Opportunities for Intervention

- **Educate professionals working on domestic violence issues to clarify the laws pertaining to the exchange of information among professional service providers.** This will allow for protocols for the exchange of information when appropriate and necessary to best serve the needs of a victim of domestic violence and his/her family.

V 2004 Case Observations and "Opportunities for Intervention"

continued

Responding to and Documenting the Severity of a Domestic Assault

Case Observations

- An alleged assault with a knife to the victim resulted in no charge against the perpetrator.
- A 911 call was made from the victim's residence the night before the murder. The victim reported being pushed. Police observed red marks on the victim's shoulder. Neither the victim nor the perpetrator acknowledged that they had a domestic relationship. The perpetrator denied any wrongdoing. Police sent him away but made no arrest.

Opportunities for Intervention

- **Refine a referral process inside the City Attorney's Office, the Count Attorney's Office and the police departments, so that every documented incident of domestic violence is prosecuted at the level of severity warranted.** This will prevent cases from being dropped without proper legal action.

During the 6 months following an episode of domestic violence,

~ Bureau of Justice Statistics: Preventing Domestic Violence Against Women

32% of battered women are victimized again.

V 2004 Case Observations and "Opportunities for Intervention"

continued

Children in the Child Protection System

Case Observations

- There are inadequate support services, including initial crisis assessment, post-traumatic intervention, mental health screening, therapy, and ongoing interventions, provided to children who witness homicides.
- When a child involved in Child Protection services is on probation, his/her Child Protection services files are discontinued and there is no follow-up from Child Protection workers with the probation officers.
- Legal custody of a child victim and her siblings was transferred to relatives who did not meet basic licensing standards.
- A transfer of legal custody of children was done under circumstances where risks (criminal history records, children with significant special needs) should have been obvious and yet the file was closed without any follow-up monitoring.
- Both caretakers of the child have a history of child abuse.
- A child is not able to file an "Order for Protection" on his or her own behalf when a parent does not support the action.

Opportunities for Intervention

- **Make services available to children who witness domestic violence or who are victims (within 24 hours whenever possible) to address post-traumatic stress symptoms and other ongoing mental health concerns or advocacy needs.** A continuum of care and extensive follow-up are often necessary for children who witness domestic violence. Educational opportunities and appropriate therapeutic intervention could assist parents and caregivers of children as well. Involvement by specialized medical and mental health clinicians, as well as domestic violence advocates, should be involved as appropriate during the criminal investigation this would help ensure the therapeutic needs of the children are addressed.
- **Avoid placements of children in non-licensable homes.** If the Court orders a child into a non-licensable home, it should make specific findings relative to the best interest of the child and address the safety concerns. It is against Hennepin County Child Protection Services policy to support placement in a home that cannot be licensed for foster care placement or approved for a Transfer of Legal Custody.

V 2004 Case Observations and "Opportunities for Intervention" *continued*

Children in the Child Protection System *continued*

Opportunities for Intervention *continued*

- **Provide resources and referrals for services to families at the time of closing a Child Protection file, including coordination with other programs within Hennepin County.**
- **Include collection and review of reports from the schools, therapists, tribes and agencies that may have information regarding specific issues the children are facing in child protection investigations.** Placement should occur only after a thorough review of input from all significant adults.
- **Mandate unannounced home visits to foster placements prior to any transfer of custody to determine whether there are licensing concerns, i.e. unauthorized individuals living in the home.**
- **Increase sharing of case information among and between professionals.**
- **Evaluate child safety and provide services to the parent to address the conditions that led to Child Protection's involvement with the family.** In open cases, Child Protection Services has an obligation to continue to provide services to the parent to address the conditions that led to safety issues, regardless of the child's involvement with other county departments.

Each year, an estimated 3.3 million children are exposed to violence by family members against their mothers or female caretakers.

~ Report of the American Psychological Association Presidential Task Force on Violence in Family

V 2004 Case Observations and "Opportunities for Intervention"

continued

Children in Schools

A recent study found that school-age children who witness violence exhibit a range of problem behaviors including depression, anxiety, and violence towards peers.

~ Family Violence Prevention Fund

Case Observations

- School personnel, including bus drivers, had an ongoing concern regarding children's absence based on their observation of the children and the comments made by other children which was not addressed.
- Siblings reported to a school social worker that a child's absence was due to "misbehavior" at home.
- A bus driver observed and questioned an adult male dragging a child from the bus line. The adult stated the child was sick. There is no clear documentation of bus driver or school response to this incident.
- A teacher solicited parent interaction and observed the adult caregiver using inappropriate physical discipline to children in the classroom. There is no documentation of what, if anything, the teacher did in response to this.
- It is unclear whether or not escalating problematic behavior observed by school personnel and foster parents was communicated to or acted upon by appropriate child protection authorities.
- School personnel and/or county workers made no unannounced home visits.

Opportunities for Intervention

- **Establish and communicate consistent policies and procedures for bus drivers and school staff for the mandated reporting of any concerns regarding the health and welfare of children.** Because time is of the essence, these concerns should be communicated directly to Child Protection or the police without going through an internal process within the school system.
- **Follow State laws regarding reporting of educational neglect and truancy.** The option to require professional verification after 3 consecutive or 4 cumulative absences within each school district should be followed.
- **Conduct health and welfare checks in cases of truancy of elementary school children**. This would assure their safety and possibly uncover problems that led to the truancy.

V 2004 Case Observations and "Opportunities for Intervention"
continued

Children in Schools
continued

Opportunities for Intervention
continued

- **Conduct a follow-up interview and a home visit where maltreatment has been reported.** This can help determine whether or not the child is safe.
- **Develop a consistent policy statewide regarding release or removal of children from school.**
- **Provide continuing in-service training for all mandated reporters on the specific elements of the law and their statutory obligations as reporters.**
- **Provide schools with Child Protection placement information before the placement occurs.**

70% of domestic violence victims were victimized more than once in 2001. Domestic violence victims accounted for over a quarter of all violent crime victims in 2001.

~ 2002 Minnesot a Crime Survey

Orders for Protection

Case Observations

- A young child may not file an Order for Protection on his or her own behalf, however, under Minnesota law certain adults may petition on a child's behalf. Where there is no parental support, an advocate is assigned to assist teenagers in filing for an Order for Protection.

Opportunities for Intervention

- **Implement strategies within public systems, such as the courts, police and child protection, which help children access protective services when they feel unsafe in their homes.** Children should have a right to seek and access a safe environment in which to live.
- **Allow children over thirteen to seek advocacy and/or mental health services without parental permission.**
- **Trigger an immediate Child Protection report for any child who files an Order or not for Protection to determine whether or not intervention is needed.**

V 2004 Case Observations and "Opportunities for Intervention"

continued

Medical Professionals and Hospital Emergency Department Staff

Case Observations

- Hospital staff was aware the victim had been abused but did not address the domestic violence issues.
- The perpetrator, who had not been identified as such, was allowed to remain with the victim during an Emergency Room screening after a domestic assault.

Opportunities for Intervention

- **Include appropriate referrals for advocacy in hospital screening protocols for all domestic violence situations.** Have domestic violence advocacy readily available in the Emergency Department or other areas of the hospital where victims may present.
- **Increase domestic violence awareness for hospital and emergency department staff.**
- **Develop an Emergency Room protocol to identify, whenever possible, past ER presentations to determine whether there have been previous visits with suspicious injuries.** Heightened scrutiny and careful documentation is crucial when a pattern of injuries suggests domestic violence.
- **Document carefully a patient's injuries and explanations of how they occurred and medical opinions as to whether the explanation is consistent with the injuries presented are valuable evidence in court proceedings.**
- **Work to incorporate consistent policies throughout Hennepin County hospitals regarding the treatment of possible victims of domestic violence.**
- **Interview, in private, Emergency Room patients who may be victims of domestic violence.**

37% of women who sought treatment in emergency rooms for violence-related injuries in 1995 were injured by a current or former spouse, boyfriend or girlfriend.

~ U.S. Department of Justice, Violence Related Injured Treated in Hospital Emergency Departments

Fewer than 10% of primary care physicians routinely screen patients for domestic violence during regular office visits.

~ The Journal of the American Medical Association-1999

V 2004 Case Observations and "Opportunities for Intervention"

continued

Treatment and Mental Health Issues

Mental Health and Chemical Dependency

Case Observations

- Mental health and chemical dependency issues of both the perpetrator and the victim were not adequately addressed. The victim's vulnerability was not assessed during a health and welfare hold.
- The perpetrator had a long history of mental health interventions, with no continuity of care and no oversight.

Opportunities for Intervention

- **Integrate mental health, chemical dependency and domestic violence services for victims of violence.**
- **Implement a system of conditional release specific to inmates with mental health concerns.** Mentally ill inmates are often discharged from prisons and jails without any follow-up treatment plan or transfer of supervision to a mental health professional. They end up using hospital emergency rooms as a primary source of medical care for medications and treatment with no continuity of care and no ongoing supervision by a clinician. Making post-conviction records from correctional facilities available to subsequent mental health providers for the same individual will help to coordinate the continuity of care for people leaving prison.

V 2004 Case Observations and "Opportunities for Intervention"

continued

Implications of Domestic Violence in the Workplace

Case Observations

- The workplace is a predictable location for a perpetrator to stalk the victim.
- A victim did not tell the employer about potential danger from her domestic relationship.

Opportunities for Intervention

- **Provide education in the workplace to help employees access domestic abuse services and deal with harassment at the work site.** Employers should look for "red flags"/signs of domestic abuse in their employees and explore non-punitive ways to support and work with a victim to keep her employed.
- **Explore locating domestic violence in high volume public places such shopping malls.** Explore the feasibility of on-site advocacy services, possibly in connection with police department sub-stations. Shopping malls provide significant opportunities for education and intervention around domestic violence and child abuse.
- **Support and foster work being done locally and regionally to increase the sensitivity of area employers regarding domestic violence.**

Over 1.7 million workdays in the United States are lost each year due to domestic violence. Employers lose between $3 billion and $5 billion every year in absenteeism, lower productivity, higher turnover, and health and safety costs associated with battered workers.

~ American Institute on Domestic Violence

V 2004 Case Observations and "Opportunities for Intervention"

continued

Cultural Issues

Case Observations

- There was ambiguity about the victim's and perpetrator's relationship. It was unclear whether they were unmarried, legally married, married in the eyes of their faith or committed to marriage by their families. There are cultural and religious ramifications involved in definitions of marriage and the response to infidelity.
- The victim's family and a witness were subject to intense pressure from the cultural community.

Opportunities for Intervention

- **Strengthen the mandated cultural competency training for professionals in the justice system.** Build the "cultural proficiency" of criminal justice agencies and community service providers to adequately address the cultural concerns relative to domestic violence through training and educational opportunities.
- **Provide community education to newly immigrated groups about how domestic violence is defined by Minnesota State Statutes and the potential criminal and social consequences as well as resources in the community for alternatives to domestic violence.**

Women of all races are about equally vulnerable to violence by an intimate.

~Bureau of Justice Statistics, Violence Against Women: Estimated from the Redesigned Survey

VI Hope for the Future

The Review Team is hopeful that this report will inspire continued improvements in the way the justice system and the entire network of providers handle domestic violence.

We are encouraged by the many changes that have already been implemented as a result of our review of domestic homicides. More than 25 substantive improvements in the justice system and participating agencies have been implemented resulting in enhanced support for victims and increased consequences for abusers as a result of earlier Review Team recommendations.

One of the most exciting results of the Review Team experience was that case reviews prompted an almost immediate effort by Team participants to personally address the issues identified by the reviews.

Examples:

1. Through training of law enforcement officers, the number of arrests doubled for perpetrators "gone on arrival" between 1997 and 2002.

2. A city attorney reviews each domestic abuse charge to ensure the accuracy of the classification at the scene of the crime. A corresponding dramatic increase in felony and gross misdemeanor filings resulted:

	1999	2001	2002	2003
Felonies	**93**	**132**	**132**	**145**
Gross Misdemeanors	**497**	**705**	**705**	**637**

The number of misdemeanor charges dropped as a result of the attentiveness of the justice system to prosecuting at the highest possible level.

Various agencies reported the following systemic improvements since the beginning of the review process. Many forces converge to impact change in public policies. The Review Team recommendations along with advocacy from a host of other organizations have influenced these changes to the system.

- **Minneapolis City Attorney's Office**

  The Domestic Abuse Service Center reviews all cases in which the perpetrator is "gone on arrival", within 24 hours

  Streamlined the felony referral process to the Hennepin County Attorney's Office by placing an attorney in the Family Violence Unit of the Minneapolis Police Department to coordinate referrals

  Reviews all felony level investigations completed by the police, which do not rise to the level of felony charges, to determine if misdemeanor charges are warranted, or if more investigation is needed to support felony level charge

  Actively and aggressively refers cases to the Hennepin County Attorney's Office when tab charged with misdemeanor offenses, but where facts may support a felony level offense

Minneapolis City Attorney's Office
continued

Coordinates referrals to identify enhancements for felony level prosecution

Developed a list to be used by patrol officers to identify cases where the potential for enhanced felony charges exist. The list is located in the jail and is checked by police officers on all arrests for misdemeanor assault, domestic assault, and violation of order for protection. The purpose of the list is to guide police officers where the arrestee has prior convictions that may warrant enhanced charges. The list now has 669 names on it.

Provided police training to all Minneapolis police officers regarding "gone on arrival" procedures and how those cases are reviewed and potentially prosecuted

Provided training to all Minneapolis police officers on domestic assault investigation, report writing, dynamics of domestic violence cases and laws pertaining to domestic violence cases

Provided training to all Minneapolis 911 operators and dispatchers regarding dynamics of domestic assault, laws and system responses to domestic violence

Provided training to all office domestic abuse team members regarding dynamics of domestic violence and domestic abuse prosecution strategies

Aggressively prosecutes all domestic abuse cases whenever possible by obtaining and reviewing evidence early in the case, including obtaining 911 tapes, witness statements, photos and medical records, as soon as possible after arrest

Worked to build connections with community-based advocacy groups by inviting them to meet with the office's domestic abuse team to better serve victims

Provided training to community-based advocates regarding how domestic violence cases are handled in the criminal justice system

Provided training to underserved and new immigrant communities regarding the dynamics of domestic violence and how domestic violence cases are handled in the criminal justice system.

VI Hope for the Future *continued*

- **Minneapolis Public Schools**

  Developed a policy and procedure for staff, parents and students who have an "Order for Protection"

- **Nonprofit Providers**

  Improved advocacy

  Improved information and referrals

- **Fourth Judicial District**
  Hennepin County

  Established Domestic Court Calendar

  Held a full day of training across departments and agencies

  Informed Judges about factors relevant to bail determination including threats of suicide and violence threats on dates close to the time protection orders are served

  Shared Fatality Review Team Report with Judges who rotate into Domestic Violence Court

- **Fourth Judicial District**
  Family Court

  Mandates four hours of training on domestic abuse for all staff

- **Fourth Judicial District**
  Juvenile Court

  Children's Mental Health remains a major concern of the Court. District Court and other partners are currently engaged in a pilot projects to better identify children's mental health issues in Juvenile Court

- **Hennepin County Attorney's Office**

  Reviews all cases in Minneapolis in which the perpetrator is "gone on arrival" within 24 hours.

  Coordinates referrals to identify enhancements for felony level prosecution

  Encourages police training on domestic violence

  Initiated national research on prosecution of strangulation cases

  Improved protocols for referring cases to the County Attorney's Office

  Improved information to present a more complete case for prosecution

  Encourages "Tab" charged threats to be referred for prosecution

  Provides training on protocols for interviewing children and referrals to child protection

  Assigned advocate to work with children in domestic abuse cases

VI Hope for the Future *continued*

- **Hennepin County Attorney's Office** *continued*

  Provides training on rights of custodial and non-custodial parents

  Discusses suicide as a factor of lethality

- **Hennepin County Community Corrections, Adult Probation**

  Implemented Domestic Violence Screening Inventory within the Probation Department to determine the level of supervision services being afforded to defendants post-conviction. (This information is not shared with the court for release decisions or sentencing decisions.)

  Modified pre-sentence Investigation Reports to better reflect dynamics of domestic abuse

  Permits advocates to sit in on Probation Officer's interviews with victims

- **Hennepin County Medical Center**

  Initiated training on domestic violence for Emergency Department Faculty and Residents and instituted intake interview screening of domestic violence

VI Hope for the Future *continued*

In addition, the Review Team has worked to compile a set of recommendations to improve four important areas:

Children Who Witness Domestic Violence
Outcome: Children who witness, or who themselves may be victims of, domestic violence will have appropriate intervention and support services.

Strangulation
Outcome: Create greater consequences for domestic violence cases involving victims who are strangled

Police Training
Outcome: Law enforcement officers will be trained on domestic violence issues. The law will be changed to mandate at least 5-8 hours of domestic abuse training every three years.

Medical Records
Outcome: Create a mechanism to make the pertinent medical records of victims of domestic abuse available in a timely manner to law enforcement agencies

The Review Team is working to implement these recommendations.

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This report is a product of:

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

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