A Matter of Life and Death

2008 Report

Hennepin Domestic Fatality Review Team

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

Project Chair:

The Honorable Gina Brandt
Minnesota Fourth Judicial District

2008 Community Partners:

Academy on Violence and Abuse
Bloomington Police Department
Community Volunteers
CornerHouse
Domestic Abuse Project
Minneapolis City Attorney's Office
Minneapolis Police Department
Minneapolis Public Schools
Minnesota Advocates for Human Rights
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Hennepin County Community Corrections & Rehabilitation
Hennepin County Human Services
Hennepin County Medical Center
Hennepin County Medical Examiner
Hennepin County Sheriff

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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Acknowledgments

The Honorable Gina Brandt, Project Chair, gratefully acknowledges the supporters and members of the Hennepin Domestic Fatality Review Team:

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The leaders of partner organizations who willingly commit the time of their staff to the Team and who encourage changes in procedures based on the findings of the Team. By doing so, these leaders send a clear message to the justice system and the community about the importance of addressing domestic violence.

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Assistant Hennepin County Attorney Deb Russell
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Connie Sponsler-Garcia, BWJP
Stephanie Yang, Multicultural Services, Minneapolis Department of Civil Rights

Executive Summary

The goal of this report is to share the work of the Hennepin Domestic Fatality Review Team and the opportunities for intervention identified by the team. Our opportunities for intervention are designed to capture the points relevant to our audience in a manner that encourages safety for victims of domestic violence and accountability for abusers. Out of respect for the privacy of the victims and their families, identifying details have been removed. Also included are facts about the domestic homicide rate in Hennepin County and Minnesota during the years in which these cases occurred to assist readers in putting the case information in context.

By design, the Hennepin Domestic Fatality Review Team process focuses on a few specific cases each year*. This opens the door to in-depth examination of all the facts of those cases from the varied perspectives of team members. Members of the team examine the case chronologies and then, as a group, make observations about specifics of the case. Sometimes the observations assist in identifying the context of the crime. Other times, they illuminate a clear missed opportunity to avoid the homicide. From these observations, the Team identifies opportunities for intervention that directly correspond to the observation and to the case.

As the Team reviewed cases this year, members noticed many trends. In two of the five cases reviewed in 2008, the victim was either pregnant or had recently given birth to a child when the homicide occurred. In those same two cases and a third, children were present either during the homicide or at the scene of an earlier domestic assault. Based on these observations, and a broader focus on early identification of risk factors of domestic homicide, the Hennepin Domestic Fatality Review Team identified two legislative opportunities for intervention: *Develop enhanced penalties for domestic assault against a pregnant woman and develop enhanced penalties for domestic assault in the presence of children*.

Another opportunity for intervention calls for *law enforcement to code all domestic related crimes including property damage, breaking and entering or unwanted person, as domestic crime- property damage, domestic crime- breaking and entering or domestic crime-unwanted person, to trigger proper follow-up by a domestic violence advocate*. This opportunity grew out of the Hennepin Domestic Fatality Review Team's observations from a number of cases in which the police had been involved with the victim and perpetrator prior to the homicide. Usually, police were responding to property damage or the removal of an unwanted person from the victim's home, but because the crimes reported to police were not identified as being related to domestic violence, the victim did not receive follow-up from a domestic violence advocate.

This report also sets out to highlight the excellent efforts of team members and participating agencies in incorporating the findings of the Hennepin Domestic Fatality Review Team and making changes to policy and procedure. This year, these achievements include: the expansion of the Minneapolis' Misdemeanor Domestic Assault Investigation Pilot, a collaborative project of the Minneapolis City Attorney's Office and the Minneapolis Police Department, from the 5th Precinct to the 3rd Precinct and citywide within a year; the on-going commitment of Hennepin County Medical Center to train healthcare providers and medical center staff about recognizing and addressing domestic violence with their patients; and the creation of a position within Hennepin County Community Corrections and Rehabilitation to oversee felony-level domestic assault offenders.

**for more on the Team's structure and guiding standards, see appendices B & C.*

Fatality Overview

For the purposes of the Hennepin Domestic Fatality Review Team, domestic abuse is defined as a pattern of physical, emotional, psychological, sexual and/or stalking behaviors that occur within intimate or family relationships between spouses, individuals in dating relationships and former partners and against parents by children. This pattern of behavior is used by the abuser to establish and maintain control over the victim.

Domestic Abuse & Fatality Statistics

National

- Intimate partner homicides make up 40% to 50% of all murders of women in the United States according to city or State specific databases. In 70% to 80% of intimate partner homicides, no matter which partner was killed, the man physically abused the woman before the murder (Jacquelyn C. Campbell et al., *Risk Factors For Femicide in Abusive Relationships: Results From A Multi-Site Case Control Study* , 2003)

- 76% of femicide victims had been stalked by the person who killed them. (Stalking Resource Center, *Stalking Fact Sheet)*

- Access to firearms yields a more than five-fold increase in risk of intimate partner homicide when considering other factors of abuse, according to a recent study, suggesting that abusers who possess guns tend to inflict the most severe abuse on their partners. (Jacquelyn C. Campbell et al., *Risk Factors For Femicide in Abusive Relationships: Results From A Multi-Site Case Control Study* , 2003)

- 61% of stalkers made unwanted phone calls; 33% sent or left unwanted letters or items; 29% vandalized property; and 9% killed or threatened to kill a family pet. (Stalking Resource Center, *Stalking Fact Sheet)*

- A study of intimate partner homicide found that for about one in five women, the fatal or life-threatening incident was the first physical violence they had experienced from their partner. This study also found that a woman's attempt to leave was the precipitating factor in 45 percent of the murders of a woman by a man (Block, C.R. . *How Can Practitioners Help an Abused Woman Lower Her Risk of Death In Intimate Partner Homicide?*, 2003)

Minnesota

- Twenty-one women, two men and seven children were murdered in Minnesota in 2008 as the result of domestic violence or child abuse. (Minnesota Coalition for Battered Women, *2008 Femicide Report,* 2009)

- About 15% of female students in grade 12 and 7% of male students in grade 12 reported that they had been hit, hurt, threatened or made to feel afraid by someone they were dating. Twenty-three percent of students in grade 6 and twenty-one percent of students in grade 9 reported that they had been physically abused by an adult living in the household. Twenty-five percent of grade 6 students and 24 percent of grade 9 students reported that someone in their household had been the victim of domestic violence. (*Minnesota Student Survey,* 2007)

The Review Team examined five domestic homicide cases in 2008. The homicides occurred in 2003, 2005 and 2006. The team only reviews cases in which more than a year has passed since the homicide and the case is closed to further prosecution. The following information includes all homicides in Hennepin County in those years as well as the cause of death, age and gender of the victim and the relationship of the perpetrator to the victim:

2003

Of 16 domestic homicides in Minnesota, 6 domestic homicides were committed in Hennepin County

Cause of Death	Age of Victim	Gender of Victim	Relationship of Perpetrator to Victim
Gunshot	48	Male	Neighbor
Gunshot	57	Female	Son
Multiple Stab Wounds	27	Female	Ex-Boyfriend
Multiple Stab Wounds	23	Female	Boyfriend
Gunshot	42	Female	Estranged Partner
Gunshot	41	Female	Boyfriend

2005

Of 19 domestic homicides in Minnesota, 7 domestic homicides were committed in Hennepin County

Cause of Death	Age of Victim	Gender of Victim	Relationship of Perpetrator to Victim
Gunshot	72	Female	Husband
Gunshot	27	Female	Boyfriend
Gunshot	49	Female	Husband
Multiple Stab Wounds	22	Female	Fiancé
Gunshot	43	Female	Boyfriend
Homicidal Violence	23	Female	Husband
Multiple Stab Wounds	25	Female	Boyfriend

2006

Of 28 domestic homicides in Minnesota, 7 domestic homicides were committed in Hennepin County

Cause of Death	Age of Victim	Gender of Victim	Relationship of Perpetrator to Victim
Gunshot	59	Female	Estranged Husband
Multiple Stab Wounds	20	Male	Girlfriend
Gunshot	28	Female	Ex-Boyfriend
Stab Wound	36	Male	Girlfriend
Stab Wound	22	Male	Girlfriend
Gunshot	66	Female	Husband
Multiple Stab Wounds	26	Male	Girlfriend

Potential Risk Factors

It is not possible to accurately predict when a perpetrator of domestic violence may kill the victim of abuse. However, researchers have identified approximately 20 factors – from unemployment and substance abuse to death threats and access to guns – that are often present in cases of domestic homicide. This research has been used to develop the Danger Assessment, a free tool that makes available a calendar and questionnaire. The Danger Assessment can be used with victims of domestic violence in various settings, helping to clarify the frequency and severity of the abuse and allowing the victim to identify behaviors or actions that may indicate an increased risk of homicide. The Hennepin Domestic Fatality Review Team notes the presence of risk factors in the reviewed cases and spotlights raising public awareness of risk factors for homicide as an opportunity for intervention.

Potential Predictors of Homicide	Case #1	Case #2	Case #3	Case #4	Case #5
Victim Has Attempted to Leave the Abuser	X		X	X	X
Perpetrator Threatened to Kill the Victim	X				
Access to Firearms	X	X			X
Perpetrator With Significant History of Violence	X				
Use or Threats of Use of a Weapon Against Victim	X				
Substance Abuse	X		X	X	X
Violent and Constant Jealousy			X	X	X
Stalking Behavior			X	X	X
Pregnancy or recent birth of a child	X	X			
Victim has children not biologically related to the perpetrator.	X				X

For more information about the research on risk factors for domestic homicide, look for Campbell, J.C, Assessing Risk Factors for Intimate Partner Homicide in the NIJ Journal, Issue 250, available here: http://www.ncjrs.gov/pdffiles1/jr000250e.pdf . The Danger Assessment is available at: http://www.dangerassessment.org.

Opportunities

The Review Team examines cases of domestic homicide and the lives of those involved, looking for points where a change in the practice of various agencies or individuals might have changed the outcome of the case. Review Team members examine the case chronologies and make observations about elements of the case. Sometimes the observations assist in identifying the context of the crime, other times they illuminate a clear missed opportunity to avoid the homicide. From these observations, the Team identifies opportunities for intervention that correspond to the observations. This resulting information is focused on specific actions, or opportunities for intervention, that agencies could initiate in order to ensure that the incident seen in the case will not be repeated. These opportunities for intervention are not limited to agencies that commonly have interactions with the victim or perpetrator prior to the homicide, like law enforcement or advocacy, but include agencies or groups that may serve as a source of information about domestic violence, risk factors of domestic homicide or make referrals to intervention services.

Opportunities for Legislative Changes

1. Enhance penalties for domestic assaults on pregnant women.
2. Enhance penalties for domestic assaults in the presence of children.
3. Remove or deny permits to conceal-and-carry from people with criminal and civil alcohol-related convictions.

Opportunities for Court Response to Domestic Violence

1. Provide adequate time for the completion of the Pre-Sentence Investigation. Given adequate time, the community correction staff writing the report would be able to gather criminal history information and corroborating evidence and provide a more complete and accurate report to the court.
2. Ensure that courts enforce federal and state ban on firearm possession laws.
3. Provide screening for domestic violence when a person files a claim for child support and offer information about potential heightened risks that might occur with the filing and information about services that can enhance safety for the filer.
4. Ensure the courts not discharge probation until all ordered programming/treatment is completed.
5. Ensure that sex offender evaluations are completed prior to sentencing.
6. Incorporate risk assessment information into the Pre-Sentence Investigation for misdemeanor and felony domestic assaults.

Opportunities for Law Enforcement Response to Domestic Violence

1. Code all domestic related crimes beyond assault and including property damage, breaking and entering or unwanted person, as domestic crime- property damage, domestic crime- breaking and entering or domestic crime-unwanted person, so that proper follow-up by a domestic violence advocate is triggered.
2. Conduct risk assessment and follow-up with victims who report that the alleged perpetrator has access to a gun.
3. Develop risk assessment cards for use by police with victims at the scene of the crime and to assist them in noting safety concerns in their report.
4. Ensure law enforcement refers all domestic cases in which there is a history of domestic assault related arrests for investigation.
5. Ensure the resource information given to victims at the time of the assault is accurate and frequently updated.
6. Develop a tracking system that allows police dispatchers to flag multiple domestic calls from the same address so the law enforcement personnel responding to calls do so with the appropriate contextual information.
7. Develop a protocol for police officers to contact advocacy agencies from the scene when responding to a domestic call to initiate conversation between the victim and an advocate.

Opportunities for Probation and Supervised Release

1. Ensure the supervising county maintains consistent application of existing transfer request protocols when a probationer moves from one county to another to make certain that probationers are continually supervised throughout the transfer process.
2. Allow public safety officials, including community corrections staff charged with completing Pre-Sentence Investigations, limited access to juvenile criminal histories for offenders. This would ensure accurate sentencing recommendations, risk assessments and release determinations.
3. Develop comprehensive re-entry protocol, including counseling on housing, employment, domestic violence services and transitional conferencing, to ease reintegration into family structure following the absence.

Opportunities for Medical Response to Domestic Violence

1. Ensure that medical providers offer domestic violence information to patients as part of STD screening and follow-up.
2. Expand standard domestic violence screening to identify potential abusive behavior in patients and offer services.
    - Define domestic violence.
    - Give examples of abusive behavior.
    - Identify resources.

Opportunities for Enhanced Education

1. Increase prevention education initiatives and include information about risk factors, e.g. information in OB/Gyn offices about the increased risk of homicide for pregnant women.
2. Call for employers to make available information about domestic violence and resources for victims available through posting, as they do with federal wage information, and handbooks.
3. Increase public awareness of the need for witnesses of violence to seek police assistance in domestic violence situations.
4. Develop community education on the signs and signals of domestic violence as it relates to the cultural experience of mental illness.
5. Require regular training of law enforcement on the difference between harassment orders and Orders for Protection and the degrees of relief each provides.

Opportunities for Military and Veterans Administration Response to Domestic Violence

1. Require completion of all ordered programming/treatment prior to deployment or redeployment.
2. Call for the debriefing process at the conclusion of service to address psychological, as well as physical, issues.

Opportunities to Address Cultural Issues in Domestic Violence Cases

1. Provide culturally relevant information about domestic violence-including what it looks like, the laws against it and available services- at common US entry points and as part of the resettlement process.
2. Provide information on domestic violence at English Language Learner centers or schools.
3. Develop a component of the immigration process that recognizes a family history of domestic violence and offers appropriate services.

Opportunities to Address the Impact of Domestic Violence on Children

1. Provide immediate therapeutic services to a child who has witnessed a domestic assault or domestic homicide, and offer follow-up with appropriate assessments for Post-Traumatic Stress Disorder and on-going mental health treatment.
2. Require supportive Child Protection Services for children who have witnessed a domestic homicide.

Achievements

A benefit of the current structure is the change-making work that has organically developed from the process of case reviews within the Hennepin Domestic Fatality Review Team. Since all the members of the Team are in some way connected to community, justice or government systems that serve those who may become the perpetrator or victim of a domestic homicide, each member also brings a unique perspective on ways in which their agency's work can prevent homicide.

The Domestic Fatality Review Team has published five previous reports in which we have identified recommendations for changes to system procedures that increase safety for victims and hold perpetrators accountable. After each of the reports, we document changes that were made in response to opportunities for intervention identified by the Team. Additionally, some members of the Review Team, having identified a better way to keep victims safe and hold abusers accountable through case reviews, have taken the initiative to make more immediate changes within their organization.

Below you will find highlights of recent modifications to policy or practice that resulted from the findings of the Review Team. We also have recognized the important work of other organizations that have implemented changes to discourage domestic homicide, provide safety for victims and their children and hold abusers accountable for domestic abuse.

- The Hennepin County Family Violence Coordinating Council Criminal Committee formed a work group to study police, prosecutor and advocacy response to Gone On Arrival (GOA) cases. The GOA Best Practices Workgroup was formed in response to the recommendation of the Hennepin Domestic Fatality Review Team and Battered Women's Justice Project to develop consistent GOA practices and encourage investigations of domestic cases. The GOA Best Practices Workgroup has just released their findings, *Best Practices and Procedures for Police Departments with Regard to the Handling of Domestic Violence Gone on Arrival Cases*.

- Hennepin County Community Corrections and Rehabilitation has developed a pilot position with a caseload of probationers with felony-level domestic assault. Previously, misdemeanor-level domestic assault offender had specialized probation officers while felony-level domestic assault offenders were supervised by a general felony probation officer. This pilot position offers the opportunity for more rigorous, specialized supervision by a probation officer who is trained and experienced in domestic violence issues.

- Minneapolis' Misdemeanor Domestic Assault Investigation Pilot, a collaboration project of the Minneapolis City Attorney's Office and the Minneapolis Police Department, which began on February 1, 2008 in the city's 5th Precinct, expanded to the 3rd Precinct on February 1, 2009 and will expand to the other Minneapolis precincts by the end of 2009. During the first three quarters of the pilot project, the conviction rate for cases occurring in the 5th Precinct rose 23% from 54.4% in 2007 to 77.5% after the introduction of the protocol.

- Beginning in 2009, Hennepin County Community Corrections and Rehabilitation will implement a domestic abuse screening tool in the felony-level Pre-Sentence Investigation. This screening process had previously been used during misdemeanor Pre-Sentence Investigation and provides judges, prosecutors and probation officers with the information they need to make well-informed decisions.

- In 2008, Hennepin County Community Corrections and Rehabilitation formed a group of employees who visit a variety of treatment facilities to which they refer clients to conduct audits of the services. This addresses the underlying concern in a 2007 Opportunity for Intervention: *Criminal justice should beware of automatically referring to the least restrictive and lowest cost treatment options for sex offender services, domestic violence intervention services or chemical dependency treatment as they may not be the most effective*.

- The Minnetonka City Attorney and police department collaborated to implement recommendations published by the Fatality Review Team; a shift from primary aggressor analysis to predominant aggressor analysis, the adoption of protocols requiring a speedy review of domestic assault police reports by a City Attorney for Gone on Arrival calls and the creation of a referral process to ensure that every documented incident of domestic violence is prosecuted at the appropriate level of severity.

While not the direct result of Review Team recommendations, one of the following changes directly addresses a Review Team recommendation from 2008: *Every law enforcement agency should establish a protocol for determining the existence of an active Order for Protection or Domestic Abuse No Contact Order on every domestic assault call*. Similarly, the efforts of HCMC to raise awareness of, and improve the medical response to, domestic violence are in line with several Review Team recommendations in previous years. People integral to these changes include current and former members of the Review Team.

- A recent legislative modification to the Order for Protection statute brought to light the absence of criminal court Domestic Abuse No Contact Orders (DANCOs) in the police database, the CJIS. This database, which police use to access information from their squad cares, contained information about Orders for Protection it did not contain No Contact Orders made by the court as a condition of release. A work group was formed to determine how to make DANCO information accessible in CJIS. As a result of the working group findings, DANCOs issued after December 16, 2008, will be viewable by police in the CJIS database.

- Hennepin County Medical Center has implemented training for medical staff about legal and medical response to strangulation since a 2006 law made strangulation a felony offense, has developed and implemented a self-learning packet for RNs about domestic violence, has provided "Clues to Domestic Violence" cards to paramedics and ambulance crews and incorporated domestic violence and strangulation education into the core curriculum for medical residents at the hospital.

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 an organization that would lay the foundation for the project. Upon receipt of funding, WATCH put together an Advisory Board of representatives from the primary public and private agencies that handle domestic violence cases. The Advisory Board included representatives from District Court, City and County Attorney, Police, Public Defender, Probation and Victim Advocacy Services, meeting up to four times a month.

Enthusiasm for the project was high from the outset. Consequently the Advisory Board spent very little time on the feasibility study and soon began laying out the framework for the project to be established in 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 multiagency participation. This would assist in creating a non-blaming environment and help to assure the neutral review of cases.

During the process of developing the proposed legislation, the Advisory Board assembled a larger Planning Committee comprised of 34 members representing private, public and nonprofit agencies and organizations to gain a variety of perspectives on particular topics and to develop broader support for the project. The Planning Committee worked primarily on establishing a definition of domestic homicide and on identifying who should be represented on the Review Team. Once critical decisions had been made about participation and structure, the existing Advisory Board worked with Senate counsel to put together legislation that would create and fund the project. The legislation also included important data privacy and immunity provisions that would enable the project to gain access to confidential records related to these cases and provide immunity to those who spoke openly to the Fatality Review Team about case information.

A proposal to create and fund the pilot passed during the 1999 session. However, for technical reasons the data privacy and immunity provisions were taken out of the enabling legislation. This language was critical to the success of the project, since many agencies were interested in providing information to facilitate the fatality review process but were not able to do so under existing statutes without suffering significant penalties.

The Advisory Board returned to the legislature during the 2000 session to pursue the data privacy and immunity provisions. The legislation passed and was signed by the Governor. It became effective on August 1, 2000. In 2004, the State Legislature granted an extension to these provisions until June 2006. In 2006, the Team was granted another extension, this time to December 2008.

Hennepin Domestic Fatality Review Team

Purpose

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

Goal

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

Guiding Standards

The perpetrator is solely responsible for the homicide.

The Review Team recognizes that the responsibility for the homicide rests with the person who committed the crime. That said, we also recognize that agencies and individuals can sometimes improve how they handle and respond to cases of domestic violence prior to the homicide.

Every finding in this report is prompted by details of specific homicides.

Many Review Team members have extensive experience with domestic assault cases. Consequently, it is tempting to draw on that broader experience, which may or may not be relevant when making findings in the review of a specific murder. The Review Team thus established a procedure to guarantee that all findings are based only on the specific cases reviewed.

The Review Team only reviews cases in which prosecution is completed.

All prosecution must have been completed before cases are reviewed. In addition to allowing all participants to discuss cases freely, the passage of time also allows some of the emotion and tension surrounding them to dissipate, generating more openness and honesty during the review process.

Findings are based primarily on information contained within official reports and records regarding the individuals involved in the homicide before and after the crime.

Whenever possible, information is supplemented by interviews with friends, family members, or services providers associated with the case. The findings of the Review Team are limited to the availability of information reported by these sources.

The Review Team occasionally uses the words "appear" or "apparent" when it believes certain actions may have occurred but cannot locate specific details in the documents or interviews to support our assumptions.

Many incidents that reflect exemplary responses to domestic violence, both inside and outside the justice system, are not included.

Instead, this report focuses on areas that need improvement.

The Review Team appreciates that several of the agencies that had contact with some of the perpetrators or victims in the cases reviewed have made or are making changes to procedures and protocols since these homicides occurred.

However, the observations included in this report are based on our review of actual case histories and what was in place at the time of the homicide.

The Review Team attempts to reach consensus on every recommended intervention.

While every recommendation is fully discussed by the Review Team, not every recommendation is supported by every member. The Review Team represents a wide variety of positions and complete consensus is not always obtainable.

We will never know if the recommended interventions could have prevented any of the deaths cited in this report.

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

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

This process fosters honest introspection about policies, procedures, and criminal justice system responsiveness.

The Review Team does not conduct statistical analysis and does not review a statistically significant number of cases.

Actual numbers, not percentages, are used to ensure that analyses are not misleading.

The findings should not, alone, be used to assess risk in other cases.

Cases with similar scenarios will not necessarily result in the same outcome. However, the findings do address situations of potential danger for victims.

Structure & Processes

The Review Team Structure

The enabling Legislation requires that the Hennepin Domestic Fatality Review Team have up to 35 members and include representatives from the following organizations or professions:

- The Medical Examiner;
- A Judicial Court Officer (Judge or referee);
- A County and City Attorney and a public defender;
- The County Sheriff and a peace officer;
- A representative from family court services and the Department of Corrections;
- A physician familiar with domestic violence issues;
- A representative from district court administration and DASC;
- A public citizen representative or a representative from a civic organization;
- A mental health professional; and
- Domestic violence advocates or shelter workers (3 positions)

The Team also has representatives from community organizations and citizen volunteers.

Review Team members are appointed by the District IV Chief Judge and serve three year terms of service. There is one paid staff person who supports the Team in the role of Project Coordinator.

The Review Team is governed by the Advisory Board, which is also the policy-making and strategic oversight body. The Advisory Board is made up of members of the Review Team with at least six months of experience. The Chair of the Review Team leads the Advisory Board and appoints Advisory Board members for three year terms.

Case Selection

The Fatality Review Team reviews only cases which are closed to any further prosecution. In addition, all cases - such as a homicide/suicide where no criminal prosecution would take place - are at least one year old when they were reviewed. This policy is based on the advice of several jurisdictions that were already well versed in the review process. In

their experience, letting time pass after the incident allowed some of the emotion and tension to dissipate, thus allowing for more open and honest discussion during case reviews.

A sub-committee of 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. The committee selects a mix of cases that differ from one another based on race, location of the homicide and gender of the perpetrator.

The Case Review

After a case is selected for Team review, the Project Coordinator sends requests for agencies to provide documents and reviews the information. Police and prosecution files typically provide the bulk of the information and identify other agencies that may have records that are important in reviewing the case.

The Project Coordinator reviews the records to develop a chronology of the case. The chronology is a step by step account of lives of the victim and perpetrator, their relationship, incidents of domestic violence, events that occurred immediately prior to the homicide and the homicide itself. Names of police, prosecutors, social workers, doctors, or other professionals involved in the case are not used.

A designated person from the Team contacts members of the family of the victim, and when appropriate, the perpetrator, to inform them that the Review Team is reviewing the case and to see if they are willing and interested in providing information and reflections on the case.

This chronology is sent to Review Team members prior to the case review meeting, and documents from the police records, prosecution records and, typically, medical records are sent to members of the team. Two team members are assigned to review each of these records, one member from the agency that provided the information and one who has an outside perspective.

Each Review Team meeting begins with members signing a confidentiality agreement. At the meeting, individuals who reviewed the case report their findings. The Team then develops a series of observations related to the case. Small groups of Team members use these observations to identify opportunities for intervention that may have prevented the homicide. The small groups then present their findings to the full Review Team, which discusses the issues and opportunities. The Review Team records key issues, observations and opportunities for intervention related to each case for later publication.

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