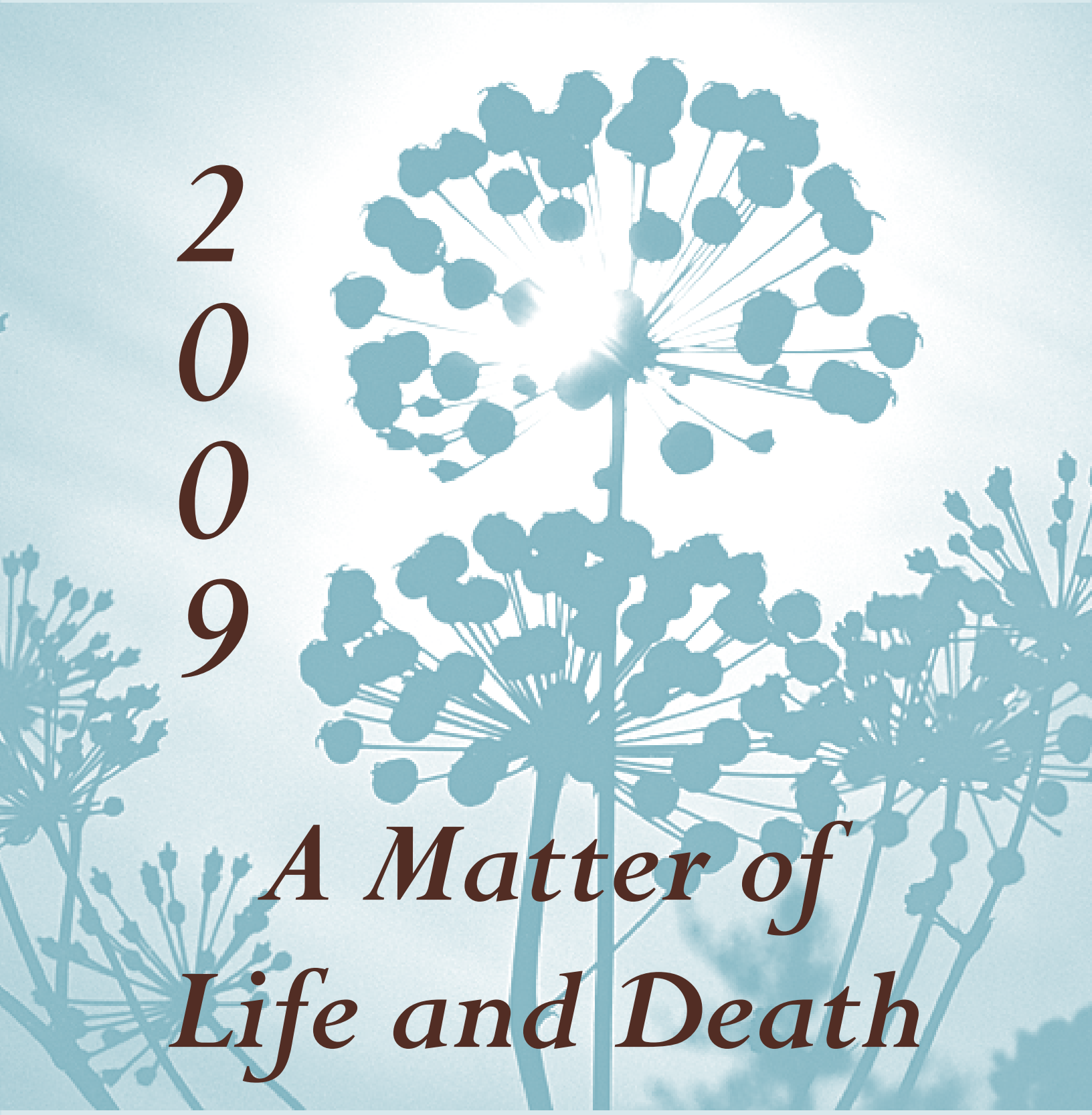

2009

A Matter of Life and Death

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

2009 Community Partners:

Battered Women's Justice Project
Battered Women's Legal Advocacy Project
Bloomington Police Department
Brooklyn Park Police Department
Community Volunteers
Domestic Abuse Project
Minneapolis City Attorney's Office
Minneapolis Police Department
Minneapolis Public Schools
Minnetonka City Attorney's Office
Mound Police Department
Outfront Minnesota

2009 County and State Partners:

Fourth Judicial District Court
Hennepin County Attorney's Office
Hennepin County Community Corrections & Rehabilitation
Hennepin County Family Court Services
Hennepin County Human Services
Hennepin County Medical Center
Hennepin County Medical Examiner
Hennepin County Public Defender
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

For more information please contact:

The Honorable Gina Brandt
Minnesota Fourth Judicial District
Project Chair
612-348-5049
or
Deena Anders
Project Director
651-263-2901

www.amatteroflifeanddeath.org

Table of Contents

Appendices

Acknowledgments

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

The Hennepin County Board of Commissioners, whose financial contribution makes the continued work of the Team possible.

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

The State Legislature for continuing its support of this project and for granting the Team access to the confidential information that is essential for this work. Specifically Senator Limmer and Representative Paymar for their authorship of the bill that made the data access permanent and extended the opportunity to start Fatality Review Teams to Judicial Districts throughout Minnesota. Thanks, too, to Libby Wyrum and Angela Starks for their patient assistance.

The Review Team and Advisory Board members who give their time generously, work tirelessly and share their experience and wisdom in the review of each case.

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

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

The Office of the Hennepin County Medical Examiner for providing space for the Team meetings.

The Domestic Abuse Service Center for the use of space for Advisory Board meetings.

And those who donated their time to present information to the Team:
Bri, Home Free Advocate
Melanie Terwey, Hennepin County Community Corrections & Rehabilitation
Lieutenant Steve Burke, Hennepin County Sheriff's Office
Denise Eng, Praxis International

Nicole Colson for her support and assistance- editorial and otherwise.

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 in this report 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 specific elements of the case. Sometimes the observations assist in identifying the context of the crime. Other times, they illuminate a clear missed opportunity to avoid the homicide. From these observations, the Team identifies Opportunities for Intervention that directly correspond to the observations yet are general enough to apply to agencies throughout our community.

In 2009, the Team reviewed three cases. In a typical year the Team reviews four or five cases during the twelve meetings, but the three cases selected for 2009 proved to be more complex and offered more opportunities for the Team to identify changes to policy and practice. Furthermore, the three cases in 2009 also had a good deal more in common with each other than have cases reviewed in past years. In all three cases, the victim was a young woman killed by an estranged boyfriend. In each case multiple lethality/risk factors were present in the months and weeks leading up to the homicide, and you can see, on page 7, a detailed summary of the lethality/risk factors the Team identifies and those present in the cases. Finally, in each of the cases the victim was aware of the danger and had sought help, to varying degrees, from social services agencies, advocates and friends. This is unusual to find in the cases we review and, while initially disheartening that the help-seeking behavior did not prevent the tragedies, gave the Team an opportunity to broaden its understanding of the policies and practices of not previously encountered agencies and professionals and identify new Opportunities for Intervention.

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. As well to acknowledging the good work of other organizations that help to ensure safety for victims of domestic violence and hold abusers accountable. This year, these achievements include: the adoption of a protocol by the Minneapolis Police Department to check for a Domestic Assault No Contact Order or Order for Protection on *every* domestic call; the distribution of The Domestic Violence Risk Assessment Bench Guide, created by the Supreme Court Gender Fairness Implementation Committee, to judges and referees throughout the state of Minnesota and the commencement of an internal systems audit at the Brooklyn Park Police Department on the handling and outcome of domestic calls.

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 reviews only 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 service 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 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.

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, former partners and against parents by children. This pattern of behavior is used by the abuser to establish and maintain control over the victim. The Review Team examined three domestic homicide cases in 2009. The homicides occurred in 2004 and 2007. The Team reviews only 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 domestic 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:

2004

Of 13 domestic homicides in Minnesota, 4 domestic homicides were committed in Hennepin County

Cause of Death	Age of Victim	Gender of Victim	Relationship of Perpetrator to Victim
Multiple Stab Wounds	47	Female	Husband
Multiple Stab Wounds	21	Female	Estranged Husband
Gunshot	32	Female	Boyfriend
Multiple Stab Wounds	26	Female	Ex-Boyfriend

2007

Of 21 domestic homicides in Minnesota, 9 domestic homicides were committed in Hennepin County

Cause of Death	Age of Victim	Gender of Victim	Relationship of Perpetrator to Victim
Gunshot	20	Female	Ex-Boyfriend
Strangulation	18	Female	Boyfriend
Gunshot	59	Female	Ex-Husband
Multiple Stab Wounds	24	Female	Ex-Boyfriend
Complex Homicidal Violence	32	Female	Husband
Gunshot	24	Female	Ex-Boyfriend
Multiple Stab Wounds	48	Female	Boyfriend
Strangulation	19	Female	Ex-Boyfriend
Gunshot	33	Female	Husband

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. 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
The violence had increased in severity and frequency during the year prior to the homicide.	X	X	X
Perpetrator had access to a gun			
Victim had attempted to leave the abuser	X	X	X
Perpetrator was unemployed	X		
Perpetrator had previously used a weapon to threaten or harm victim	X		X
Perpetrator had threatened to kill the victim	X		X
Perpetrator had previously avoided arrest for domestic violence	X	X	X
Victim had children not biologically related to the perpetrator.	X		
Perpetrator sexually assaulted victim	X		X
Perpetrator had a history of substance abuse	X	X	X
Perpetrator had previously strangled victim	X	X	X
Perpetrator attempted to control most or all of victim's activities	X	X	X
Violent and constant jealousy	X		X
Perpetrator was violent to victim during her pregnancy	X	X	
Perpetrator threatened to commit suicide	X	X	X
Victim believed perpetrator would kill her	X		X
Perpetrator exhibited stalking behavior	X		X
Perpetrator with significant history of violence	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. **The Review Team recommends that all agencies refer clients to a domestic violence advocacy agency for safety planning, lethality/risk assessment and other services when domestic violence indicators are present.**

Opportunities for Criminal Justice Response to Domestic Violence

Courts

- Pre-Sentence Investigations (PSIs) can be an excellent source of information for sentencing judges and allowing investigators the time they require to complete a thorough and corroborated PSI is essential to ensuring public safety.
- Prior to sentencing in all domestic violence cases, the Bench should ensure that a lethality/risk assessment has been completed and that the assessment findings are considered in the sentencing.
- Adherence to sentencing orders may be improved if all orders from the Bench are concise, clear, complete, written and available to all parties at the time of the hearing and through MNCIS.
- Consider including in all Conditions of Release for domestic violence offenders a Domestic No Contact Order, No Use of Drugs or Alcohol, Rule 20 where appropriate, and fingerprinting to improve public safety.

Prosecutors

- Regardless of the time that has elapsed, when the evidence in a case suggests a risk for bodily harm, a warrant is preferable to a summons when issuing a complaint to ensure that the receipt of a summons does not pose an increased danger to the victim.

- Ensure that prosecution plans require review of all strangulation cases for felony prosecution.

Law Enforcement

- Prioritize the processing and execution of domestic violence related warrants and ask victims for information about offender's possible location.
- Recognizing that strangulation is a risk factor for domestic homicide, conduct a thorough investigation into allegations of strangulation to support the allegation so that the crime can be charged properly.
- Provide access to technology that will allow Law Enforcement officers to run a criminal history check prior to clearing a call in domestic situations. The ability to do so will help the responding officers to put the incident in context, determine the appropriate response, provide accurate information for a lethality/risk assessment and to include the history in the incident report.
- Allocate resources to Law Enforcement to implement or increase surveillance on a victim's residence for domestic violence cases in which the alleged perpetrator is not in custody and multiple lethality/risk factors are present.
- When investigating a gun permit application, make specific inquiries regarding pending domestic violence charges and, when those charges are present, in accordance with state statutes, suspend the application process until the conclusion of the domestic violence case.

Community Corrections

- In felony cases where the sentence is a presumptive executed prison sentence, include alternative recommendations for treatment, services and Conditions of Release in the event that the judge departs from the sentencing guidelines and places the offender on probation.

Emergency Communications/Dispatch

- Follow protocols for high priority response for addresses with multiple domestic violence related police calls.
- Provide access to technology that allows Emergency Communications and/or Dispatch to review past reports on addresses or individuals so they can relay accurate, contextual information to Law Enforcement.

Opportunities for Human Service Response to Domestic Violence

- Increase availability of, and mandate referrals to, trauma response services for children affected by domestic violence, particularly services to children in the aftermath of domestic homicide.
- When working with potential victims or perpetrators of domestic violence in a social services setting, make every effort to assess for safety (see page 7 for information on assessment tools) and provide information, referrals and support appropriate to the client's developmental age and cultural background.

Child Protection Services

- When Child Protection Services investigators detect the presence of domestic violence, refer the victim to an advocate, the perpetrator to batterer intervention services and the children to mental health services and support each individual through the completion of the services recommended by the advocates or therapists.

Opportunities for Enhanced Education

- Continue and expand efforts to train all prosecutors, law enforcement, advocates and victims of domestic violence on the medical realities of strangulation. Because the injuries sustained in a strangulation attempt can be difficult to see and document, there exists a danger of underestimating the severity of the crime and the lethality risk it poses.
- Develop youth education program about gender justice to reach students starting in kindergarten. Include in this program, at the appropriate developmental stage, information about the harmful realities of the sex industry and the strong correlation between prostitution and domestic violence.

Opportunities to Address Cultural Issues in Domestic Violence Cases

- Develop a culturally-specific education campaign regarding domestic violence issues for immigrant populations including information about the intergenerational nature of domestic violence.
- Ensure interpretation services go beyond language specificity and are reflective of the client's cultural experience and knowledge.
- At the point of entry to the United States, provide screening for domestic violence and chemical dependency issues and offer referrals to appropriate intervention services.

Opportunities to for Public Response to Domestic Violence

- Create a nationwide hotline for people to call when they feel that they may become violent or abusive with a partner.
- Create a PSA reminding friends, family and bystanders of the importance of reporting domestic violence to police.

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 Team members 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 six 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 collect information about 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 recognize the important work of other organizations in implementing changes to discourage domestic homicide, provide safety for victims and their children and hold abusers accountable for domestic abuse.

- The Minnetonka City Attorney's Office incorporates the Opportunities for Intervention identified by the Team into their annual agency goals.
- The Brooklyn Park Police Department has undertaken an internal system audit on the handling and outcome of domestic calls.
- Minneapolis Police Department has adopted a protocol to check for a Domestic Assault No Contact Order or Order for Protection on every domestic call.
- The Fourth Judicial District Family Violence Coordinating Council subcommittees include the Review Team Opportunities for Intervention in their goal setting process.

The Review Team also commends efforts to improve the outcomes in cases of domestic violence and changes to policy and practice that further those efforts. Below are several changes that occurred in the past year:

- The Domestic Violence Risk Assessment Bench Guide, created by the Supreme Court Gender Fairness Implementation Committee, has been distributed to judges and referees throughout the state of Minnesota.

- The Minnesota State Legislature passed a law that doubled the amount of time police have to arrest defendants who flee the scene of misdemeanor domestic violence cases from 12 to 24 hours.
- The Criminal Committee of the Fourth Judicial District Family Violence Coordinating Council completed work on a Gone on Arrival Best Practices document and distributed it to all police departments and prosecutors in Hennepin County.
- Mound Police Department conducts a Lethality/Risk Assessment with victims at the scene of domestic assaults.
- In an effort to enforce the Federal and State ban on firearm possession by people convicted of domestic assault, the Fourth Judicial District has explicitly included the firearm ban on the Domestic Sentencing Order form.
- HCMC is providing specialized training on domestic violence to Registered Nurses working nights in the Emergency Department.

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. In 2009, the legislature made permanent the data access that enables the work of the Team and extended the opportunity to develop a Fatality Review Team to all Judicial Districts in Minnesota with Statute 611A.203.

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.

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 Director.

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 are 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.

The Project Director 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 Team reviews 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 Director sends requests for agencies to provide documents and reviews the information. Police and prosecution files typically provide the bulk of information and identify other agencies that may have records important in reviewing the case.

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

A designated person from the Team contacts members of the family of the victim 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.

Review Team Members

Ellen Abbott, J.D.
Mediator/Attorney
Community Volunteer

Kristine Arneson*
Minneapolis Police Inspector, 1st Precinct
Minneapolis Police Department

Angela Bailey, J.D.
Assistant Public Defender, Juvenile Division
Hennepin County Public Defender

Bev Benson, J.D.
Assistant County Attorney, Adult Division
Hennepin County Attorney's Office

Jeanette Boerner‡
Assistant Public Defender, Adult Division
Hennepin County Public Defender's Office

Bernie Bogenreif‡
Detective
Hennepin County Sheriff's Office

The Honorable Gina Brandt, Project Chair *
District Court Judge
Fourth Judicial District

Anna Crabb, J.D.
Assistant City Attorney
Minnetonka City Attorney's Office

Katheryn Cranbrook, Psy.D., LP
Senior Clinical Forensic Psychologist
Hennepin County 4th Judicial District Court

Michael Davis‡
Chief of Police
Brooklyn Park Police Department

Dorian Eder
Crime Victim Liaison
Community Volunteer

Sue Fite*
Manager
Hennepin County Domestic Abuse Service Center

Mike Gephart*
Program Manager- Adult Field Services
Hennepin County Community Corrections & Rehabilitation

Anne Gilmore, L.I.C.S.W.
Senior Social Worker
Domestic Violence Program Coordinator
Hennepin County Medical Center

Nancy Halverson, J.D.
Corrections Unit Supervisor
Hennepin County Community Corrections & Rehabilitation

Michelle Hatcher, J.D.
Assistant County Attorney, Juvenile Division
Hennepin County Attorney's Office

Jacquelyn Hauser**
Team Founder

Michelle Jacobson, J.D.*
Supervising Attorney
Minneapolis City Attorney's Office,

Tracy Kaczrowski**
Detective
Hennepin County Sheriff's Department

Deirdre Keys‡
Stalking Program Coordinator
Battered Women's Legal Advocacy Project

Jim Kurtz‡
Chief of Police
Mound Police Department

Brenda Langfellow‡
Criminal Court Operations Manager
Fourth Judicial District Court Administration

Dave Mathews, Psy.D., L.I.C.S.W.*
Director of Therapy
Domestic Abuse Project

Jahmal Mattson
Career Probation Officer
Hennepin County Community Corrections & Rehabilitation

Timothy Mulrooney
Referee
Fourth Judicial District Court

The Honorable Jeannice Reding, Project Vice-Chair*
District Court Judge
Fourth Judicial District Court

Jim Ryan**
Commander
Bloomington Police Department

Karen Shannon
Project Manager
Office of Student Attendance
Minneapolis Public Schools

Connie Sponsler-Garcia‡
Training & Technical Assistance Manager
Battered Women's Justice Project

Carol Tellett
Family Court Services
Fourth Judicial District

Margaret Thunder
Child Protection Program Manager,
Hennepin County Child Protection Investigations Unit

Rebecca Waggoner-Kloek
Anti-Violence Program Manager

* Member of Advisory Board
** Resigned the Team in 2009
‡ Joined Team in 2009

Hennepin Domestic Fatality Review Team

Project Chair:
The Honorable Gina Brandt
Minnesota Fourth Judicial District

Deena Anders, Project Director
651-263-2901

www.amatteroflifeanddeath.org