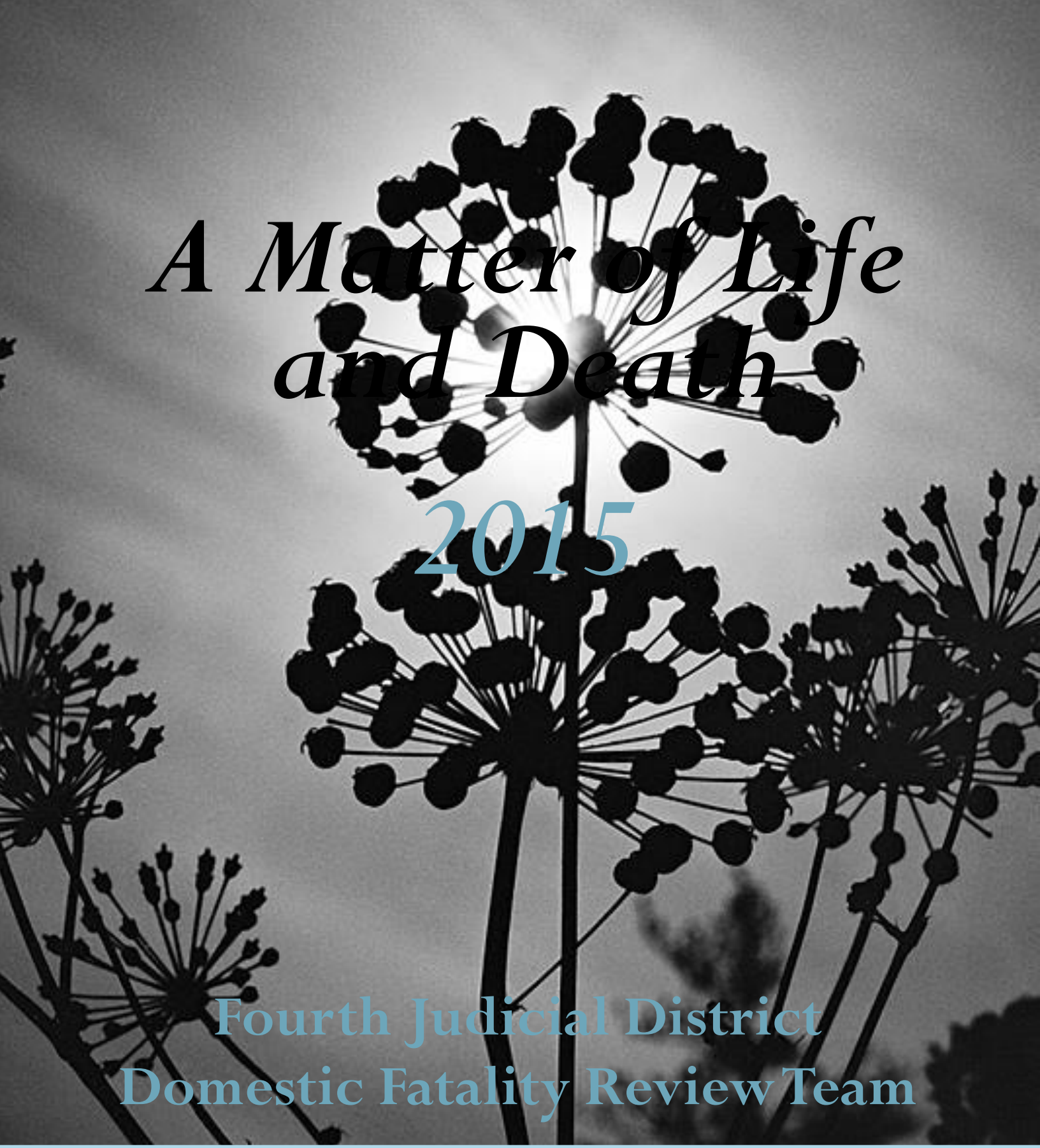

A Matter of Life and Death

2015

Fourth Judicial District Domestic Fatality Review Team

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

Project Chair:

The Honorable Fred Karasov
Minnesota Fourth Judicial District

2015 Community Partners:

Battered Women's Justice Project
Battered Women's Legal Advocacy Project
Bloomington City Attorney's Office
Brooklyn Center Police Department
Community Volunteers
Domestic Abuse Project
Eden Prairie Police Department
Hamline University
Minneapolis City Attorney's Office
Minneapolis Police Department
South Lake Minnetonka Police Department
Outfront Minnesota

2015 County and State Partners:

Minnesota Fourth Judicial District Court
Minnesota Fourth Judicial District Court Administration
Hennepin County Attorney's Office
Hennepin County Community Corrections & Rehabilitation
Hennepin County Family Court Services
Hennepin County Child Protection
Hennepin County Medical Center
Hennepin County Medical Examiner
Hennepin County Public Defender's Office
Hennepin County Sheriff

This report is a product of:

Fourth Judicial District Domestic Fatality Review Team

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Appendices

Acknowledgments

The Honorable Fred Karasov, Project Chair, gratefully acknowledges the supporters and members of the Fourth Judicial District 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 deaths;

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 in 2015:
Julie Young-Burns – Minneapolis Public Schools
Patina Park- Minnesota Indian Women's Resource Center
Lonna Hunter-Stevens– Minnesota Department of Health
Sasha Cotton– Minneapolis Department of Health
Sue Lantto,- DAP formerly Program Director, Project P.E.A.C.E.
Jenny Browning– Hennepin County Community Corrections & Rehabilitation
Dave Mathews– The Bridge for Youth
Nancy Laskaris– Hennepin County Public Defender's Office
Judith Hawley– Hennepin County Attorney's Office
Aaron Milgrom– Domestic Abuse Project

Executive Summary

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.

Inevitably themes emerge in the cases reviewed each year and in 2015 it was the need to promote adherence to, and understanding of, existing, or previously enacted, policies and protocols intended to keep victims of domestic violence safe and hold perpetrators accountable for their behavior. Further, all the cases reviewed during 2015 occurred in 2013, a year that domestic violence was frequently in the news with the disappearance, and subsequent discovery of, seven women in the first nine months of the year. The Team took an unusual step in exploring the disparities in quality, language, messaging, and effect of the media coverage of these women, their experience of violence, and their ultimate death.

Working the change the public's understanding of the dynamics of domestic violence, combatting the negative stereotypes that inhibit our collective response to it, the signs it is occurring, how to help a person who is experiencing it, and its effect on our children, community, and families, is a frequent conversation in the Team. The media would be a natural ally in this effort and we look forward to more nuanced coverage of these tragedies. Reacting as if domestic abuse is an anomaly, perpetrated only by psychopaths, an unpredictable horror, or not something that is happening in your neighborhood, only serves to undermine the good work that has been done over the last four decades of bringing it into the public discourse and developing effective responses to stop it and help people heal from it.

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 be 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.

Presence of Risk Factors

It is not possible to accurately predict when a perpetrator of domestic violence may kill the victim of abuse. However, researchers* have identified approximately 20 factors that are often present in cases of domestic homicide. The Fourth Judicial District Domestic Fatality Review Team notes the presence of risk factors in the reviewed cases because public awareness of risk factors for homicide is 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
Perpetrator had access to a gun.	X		
Victim had attempted to leave the abuser.	X	X	X
Perpetrator was unemployed.		X	X
Perpetrator had previously used a weapon to threaten or harm victim.	X		
Perpetrator had threatened to kill the victim.	X		X
Perpetrator had previously avoided arrest for domestic violence.	X		X
Victim had children not biologically related to the perpetrator.			
Perpetrator sexually assaulted victim.			
Perpetrator had a history of substance abuse.	X	X	X
Perpetrator had previously strangled victim.			X
Perpetrator attempted to control most or all of victim's activities.	X		
Violent and constant jealousy.	X	X*	X
Perpetrator was violent to victim during her pregnancy.			
Perpetrator threatened to commit suicide.	X	X	
Victim believed perpetrator would kill her.			
Perpetrator exhibited stalking behavior.	X		
Perpetrator with significant history of violence.	X		X
Victim had contact with a domestic violence advocate. (this is a protective factor)			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

Homicide Data

For the purposes of the Fourth Judicial District 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. Occasionally the Team reviews homicides that occurred in the context of domestic violence but in which the victim is not the primary victim of the abuse. The Review Team examined three domestic homicide cases in 2015 and pursued Opportunities for Intervention in all of those cases. The following information includes all domestic homicides in Hennepin County that occurred in the year from which the cases reviewed by the Team were drawn along with the cause of death, age and gender of the victim and the relationship of the perpetrator to the victim:

In 2013, at least 25 women and 8 men were killed by current or former intimate partners, as well as 5 family members/interveners, in the state of Minnesota. Nine of these homicides occurred in Hennepin County and the Fatality Review Team reviewed three of the cases in 2015.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Blunt Force Trauma	18	Female	Sexual Partner
Blunt Force Trauma	24	Female	Sexual Partner
Gunshot	24	Female	Ex-boyfriend
Gunshot	26	Female	Rejected date
Blunt Force Trauma	46	Female	Boyfriend
Gunshot	26	Female	Husband
Gunshot	21	Male	Sexual Partner
Blunt Force Trauma	58	Male	Girlfriend
Stabbing	48	Male	Wife

2015 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.

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Better Best Practices

Community Corrections & Rehabilitation

Community Corrections & Rehabilitation works closely with community service providers to assist their clients

in areas including: employment, sobriety, behavior modification, and mental health care. The capacity of both the service provider and the probation officer to successfully assist clients is exponentially enhanced by consistent and thorough communication. Through our review of a case this year, the Team identified opportunities to formalize both the method and content of communication between probation officers and services providers. The Team suggests that Community Corrections & Rehabilitation ***create clear expectations for partner agencies on progress reporting requirements related to shared clients and use a provider's adherence to these expectations as part of regular evaluation of agencies to which clients are referred.*** Inversely, many service providers would benefit from updates about how the client is progressing in goals they have identified with probation, particularly as they relate to the service provider's ability to hold clients accountable for their actions. The Team, therefore, also suggests that Community Corrections & Rehabilitation ***create a standard protocol for communicating with service providers, first through ensuring the presence of release of information agreements between the client, probation officer, and service provider, then by identifying which violations, revocations, new charges, or changes in the client's living or work situations, would be helpful for each type pf provider to know, and finally creating a method for that information to be communicated with service providers in a regular and automated fashion.***

Criminal Court

A key method available to Community Corrections & Rehabilitation probation officers, is the use of violations and revocations when a client fails to adhere to the conditions of his or her probation. Requiring a person who has been convicted of a crime to adhere to the orders of the court is also essential in preserving the integrity of the justice system. A few changes to procedure in the courts have negatively impacted the efficacy of these tools. The Team has identified two opportunities to improve the system by which perpetrators are held accountable for their behavior and victims are kept safe. The Team encourages Community Corrections & Rehabilitation to allocate the resources necessary to ***reassign a permanent probation officer to the courtroom for all violation and revocation hearings***. Similarly, the Team sees a benefit to the ***Fourth Judicial District giving priority to hearings for revocations and violations by either returning those hearings to the sentencing judge or creating a permanent misdemeanor calendar to hear them*** and to ***actively assign appropriate consequences when requested by the probation officer.***

Family Court

Judicial practice precludes a judicial officer from engaging in investigation of petitioners and respondents appearing before them. When parties appear pro se the judicial officer may have no background information on the parties and, therefore, is often unaware of other criminal or civil proceedings in which they may be involved. In an effort to improve integration of other court proceedings (civil and criminal) into Family Court decision making the Team encourages ***judicial officers to begin by asking parties permission to check background via the courts database at the first meeting.***

Another example of the unintended consequences that may occur with inconsistent communication was observed in a case reviewed in 2015. In this case, one government entity was actively facilitating contact between parties for whom a criminal no contact had been ordered. The agency had no regular practice of checking on separate criminal proceedings and, therefore, had no notice of the no contact order being in place. To avoid a similar situation in the future the Team urges that the ***current data sharing systems be used to facilitate ongo-***

ing, real-time, information transfer to all interested parties on case progression and orders in family and criminal court cases.

Sheriff's Office

Orders for Protection (OFPs), Harassment Restraining Orders (HROs), No Contact Orders (NCOs), and Domestic No Contact Orders (DANCOs) are all methods of relief available to people experiencing domestic violence. The first two are civil and the second two are issued by the court. Most iterations of these orders include a provision barring direct, and even third party, contact between the people listed in the order. However, there is no reliable mechanism for this provision to be enforced from within the Jail facilities. Jail staffers can block inmates from dialing defined numbers, but cannot as easily prevent an inmate from using other person's code to dial the restricted number. Furthermore, unless the contacted person knows to complain to the Jail, there is often no consequence for the caller who has failed to abide by the no contact order. The Team sees a need for *resources to be dedicated to enforce violations of OFPs, HROs, NCOs, and DANCOs when inmates contact petitioners, or protected parties, from jail.*

Media

The spring of 2013 brought multiple stories on the disappearance of Kira Steger, last seen leaving her place of work at the Mall of America, Danielle Jelinek, last seen with her ex-boyfriend, and Mandy Matula, who disappeared after going to meet an ex-boyfriend who committed suicide a day later. These stories are tragic, terrifying, and devastating to the families and friends of the women. But these three women were not the only women reported missing and later found dead during the same time period. In fact, an article published by CBS News on May 7, states, "Searches for missing women are becoming more and more common in the Minneapolis-area after the number of missing local young women has risen to three in the past six months, CBS Minnesota reports. Danielle Jelinek, 27, of Chisago; Kira Trevino, 30, of St. Paul; and Mandy Matula, 24, of Eden Prairie, have all been reported missing in the past six months and are currently unaccounted for." while, in fact, the number of local young women who had been reported missing during the time period covered in the article was actually at five, and would grow to seven before Mandy's body was found in late October. This article, and several others, excluded Brittany Clardy, who had been missing for 10 days when her body was discovered in the trunk of her car at an impound lot on February 21, and Klaressa Cook, who, at time of this piece had been missing since April 11.

The Team's analysis of the media coverage was by no means exhaustive, but the opportunity for intervention does not require that it be. The Team recorded the following observation: There is a perception of a difference in the amount and tone of media coverage of Mandy, Danielle, and Kira, all white, middle-class women from suburban communities when compared to the coverage of poorer women of color who disappeared and were killed during the same time period. The initial resulting opportunity for intervention is actually aimed at ourselves and we intend to *initiate a discussion within the Fourth Judicial District Domestic Fatality Review Team to explore both the perception, and reality of, disparities in the amount and tone of media coverage of domestic homicide and how race and economic status of the victim impacts that coverage.*

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 had routinely created chronologies of cases involving chronic domestic abusers and published those chronologies in a 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 the Fourth Judicial District. 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.

As other judicial districts begin to consider starting fatality review teams, the Fourth Judicial District Domestic Fatality Review Team formalized its practices and processes in preparing to provide technical assistance to new and forming teams. Advisory Board modified an earlier draft charter used by the Team and in January 2011 the Team adopted its first By-Laws.

One of the most noticeable changes that resulted from this effort was the name of the Team. Instead of A Matter of Life and Death: Hennepin Domestic Fatality Review Team A Collaboration of Private, Public and Non-profit Organizations Operating in Hennepin County, the Team is now officially named Fourth Judicial District Domestic Fatality Review Team which better defines both the scope and geographic focus of the Team.
The By-Laws also set the length of service on the Team to two-year terms and limit the number of terms that one can serve to three consecutive with the option of rejoining after a year off. The Team greatly benefits from having long time members who maintain an organizational memory but also thrives on the ideas and perspective newer members are able to bring to the process. This structure of term limits allows the Team to maintain both components in the work.

Fourth Judicial District Domestic Fatality Review Team

Purpose

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

Goal

The goal is to discover factors that will prompt improved identification, intervention and prevention efforts in similar cases. It'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 Fourth Judicial District 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 two 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 two 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

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Fourth Judicial District Court

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‡ Joined Team in 2015

Fourth Judicial District Domestic Fatality Review Team

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