FOURTH JUDICIAL DISTRICT
DOMESTIC FATALITY
REVIEW TEAM

2025
Annual Report

Project Chair:

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Minnesota Fourth Judicial District

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2025 Local & Community Partners:

Bloomington City Attorney's Office
Bloomington Police Department
Central Minnesota Legal Services
Cornerstone
Domestic Abuse Project
Eden Prairie Police Department
Edina Police Department
Health Partners
Hurd Law PLLC
Innovative Solutions
Maple Grove Police Department
Minneapolis City Attorney's Office
Missions Inc. Home Free Shelter
Plymouth Police Department
Standpoint

2025 County & State Partners:

Hennepin County Adult Representation Services
Hennepin County Attorney's Office
Hennepin County Child Protection
Hennepin County Community Corrections & Rehabilitation (HCCCR)
Hennepin County Health & Human Services
Hennepin County Law, Safety and Justice
Hennepin County Medical Examiner
Hennepin County Psychological Services
Hennepin County Public Defender's Office
Hennepin County Sheriff's Office
Hennepin Healthcare Assault Response Team
Minnesota Fourth Judicial District Court Administration
Minnesota Fourth Judicial District Court Criminal, Family & Juvenile Divisions
Minnesota Fourth Judicial District Court Research

This report is a product of:

Minnesota Fourth Judicial District Domestic Fatality Review Team
https://www.mndfrt.org/

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Acknowledgements

The Minnesota Fourth Judicial District Domestic Fatality Review Team acknowledges with gratitude the individuals and system partners who supported the Team's work and case review process in 2025. The Team is especially grateful to those who demonstrated a commitment to working across Hennepin County, its cities, and the state to strengthen system interventions and prevent domestic violence in our communities:

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

The Hennepin County Law, Safety and Justice Department who manages the contract;

The agencies and individuals who promptly provide information critical to case reviews;

The leaders of partner organizations who willingly commit staff time to the Team;

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

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

Local law enforcement agencies across Hennepin County;

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

The State Court Administrator's Office who supported the Team's case review process and guiding policies;

Community and system partners who welcomed presentations to learn about and incorporate the Team's annual findings into their work;

The following professionals and content experts who joined the Team in 2025 to present information pertinent to each case review:

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

Sarah Meyers, M.D.; Hennepin County Medical Examiner's Office

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

Amanda Spencer, D.O.; Hennepin County Medical Examiner's Office

Prevention & Support Services for Domestic Violence

Important Note from the Domestic Fatality Review Team

A central theme of the Team's 2025 Annual Report recognizes domestic violence as both a public health and public safety crisis occurring throughout our communities. To prevent future domestic fatalities, the Team remains steadfast in its message: meaningful change demands collaboration, compassion, collective care, and decisive action from every system that serves in our communities. We share a collective responsibility to break the silence, raise awareness, and end domestic violence.

It is important to recognize that anyone can witness an active domestic dispute, become an innocent bystander, or experience intimate partner violence.

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

The National Domestic Violence Hotline

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

The National Deaf Domestic Violence Hotline

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

Minnesota Day One Crisis Hotline

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

Hennepin County Domestic Abuse Service Center

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

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

About the Domestic Fatality Review Team

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

Minnesota Statutes §611A.203 authorizes any judicial district in Minnesota to form a Domestic Fatality Review Team and outlines its purpose. The statute establishes membership criteria and governs data practices, confidentiality, immunity, definitions of domestic violence death, and the evaluation and reporting process.

In August 2000, the Fourth Judicial District formed its Domestic Fatality Review Team, which has remained active since its formation and is the only team in Minnesota created pursuant to statute. Although membership has changed over the years, the Team's mission and purpose have remained constant: proposing opportunities for change to address gaps across systems in responding to and preventing domestic homicides. This year marks the Team's 25th year of service. The Team's longevity and annual operations rely on a robust volunteer footprint and sustained (single-sourced) funding for the Team's Project Director position, which is made possible through Hennepin County's Law, Safety and Justice Department.

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

For the purposes of this report and the Team's review of cases from 2019 and 2022, it is important to recognize that all Opportunities for Intervention remain relevant and applicable to current practices and standards. The Team remains committed to this critical work each year, continuously adapting to emerging trends and challenges. And while the Team acknowledges meaningful progress over time, significant work remains to reduce domestic violence fatalities in Hennepin County and across the state.

Purpose:

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

Goal:

The goal of Team is to discover factors that will prompt improved identification, intervention, and prevention efforts for future cases. It is important to emphasize that the Team's intention is not to place blame for the death, but rather to actively improve all systems serving persons involved with domestic violence.

Team Members:

The Team includes professionals whose roles intersect with [1]systems most likely to engage with individuals affected by domestic violence. Members include, but are not limited to, professionals from the criminal justice system, family and juvenile courts, law enforcement, and child protection.

Team membership reflects leadership from Fourth Judicial District judicial officers, law enforcement, Hennepin County prosecutors and public defenders, family law attorneys, probation, domestic abuse advocates, health providers, and community representatives from across Hennepin County and its 45 cities.

Advisory Board:

The Advisory Board is composed of elected members who have served on the Team for a minimum of six months. Members are nominated by existing Board members and approved by the Board Chair. As the governing body of the Fourth Judicial District Domestic Fatality Review Team, the Advisory Board operates in accordance with Minnesota Statutes and Team Bylaws to support the Project Director and oversee appointments made to the Team. The Advisory Board meets bi-monthly, or on an *ad hoc* basis, throughout each review year and is responsible for: upholding the Team's Code of Ethics, ensuring respectful, professional, and confidential operations in compliance with data practice mandates, and holding members accountable to the Team Meeting Guidelines.

Executive Leadership:

The Team's Project Director oversees the work of the Domestic Fatality Review Team with guidance and support from the Advisory Board. Responsibilities include implementing the Advisory Board's mission and objectives, developing an annual work plan, leading the case review process, facilitating Team meetings, publishing the Team's Annual Report, and offering presentations to system partners to promote public education and awareness campaigns.

In 2022, the Advisory Board appointed Makenzie Nolan as the Team's Project Director. Makenzie brings experience leading violence prevention initiatives, including domestic violence and sexual assault legal advocacy, and serves as a liaison between victims, system partners, policymakers, and community organizations across Hennepin County and Minnesota. Prior to joining the Team, Makenzie led Community-Based Crime Reduction (CBCR) programming through the Office of Justice Programs, focused on reducing serious and violent crime in Minneapolis.

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

Meeting Structure:

In 2020, following the Covid-19 Global Pandemic, the Team transitioned from an in-person-only meeting structure to a fully remote virtual meeting platform. Since then, the Team has slowly reintroduced regular in-person meetings and maintains a balanced schedule of virtual and in-person meetings throughout the year. In 2025, the Team implemented a new protocol requiring in-person meetings at the start *and* conclusion of every case. A total of four in-person meetings were held in January, May, October and December of 2025.

Guiding Standards:

- The perpetrator is solely responsible for the homicide.
- All findings are based on the specific facts of the homicide cases reviewed.
- The Team only reviews cases where prosecution and any appellate processes have been concluded.
- Findings are primarily informed by official reports and records concerning the individuals involved, both before and after the crime.
- The Team seeks consensus on each identified Opportunity for Intervention.
- While the Team cannot determine whether an identified Opportunity for Intervention would have prevented a death, each intervention is presented as a potential deterrent or catalyst for system improvement.
- The Team operates on a foundation of trust, confidentiality, and immunity from liability among its members.
- The Team does not conduct statistical analysis and does not review a statistically significant number of cases.

The Review Process

Each year, the Team selects two to three cases for review and examines one case at a time. With consideration to the Team's monthly meeting schedule, the review of a single case typically spans several months and may require four to six meetings to complete. The number of cases reviewed annually, and the duration of each review, depend on the availability and scope of information needed to conduct an in-depth examination and gathering of facts. This framework leaves room for exceptions—determined on a case-by-case basis, and subject to oversight from the Advisory Board.

The Team approaches each case with a commitment to honesty, humility, integrity, and curiosity, fully recognizing the gravity and responsibility inherent in the review process. As part of its unique role, the Team has access to comprehensive information spanning the lifetimes of both victims and/or perpetrators, which informs each review. As a result, the Opportunities for Intervention identified are grounded not only in the specific facts of each case, but also in a broader understanding of the lived experiences and systemic contexts that shape them. To ensure a consistent and thorough examination, the Team employs the following processes in the review of each case:

Case Selection

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

In cases involving a homicide/suicide where no criminal prosecution occurs, the Team waits a minimum of one year before considering the case available for review. Allowing time between the incident and the Team's review helps reduce the risk of secondary trauma and emotional distress for Team members, particularly those with direct involvement to the case.

The Case Review Process

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

2. **Confidentiality, Personal Disclosure, and Creation of Case Chronology:** To begin each case, every Team member is required to complete a confidentiality agreement to ensure the utmost care and discretion is used when handling sensitive information. Every Team member is also expected to disclose any prior involvement or personal connection to a case before beginning the formal review process. This practice ensures complete transparency and helps the Team conduct a comprehensive and unbiased review. The Project Director then consolidates all available data into a detailed chronology, which narrates the life events of both the victim and perpetrator, and serves as a primary reference point for members throughout the duration of the case review process. Each case chronology establishes a working timeline that includes the following information for consideration: date of birth, major life events, interactions with various systems, the date of domestic homicide, and events preceding the homicide.

3. **Case Introduction and Team Meeting Structure:**

    A. **Presentation of Life:** The Project Director opens every case review in person with a preliminary "Presentation of Life," which contains all known/available information, photos, and other humanizing details that describe how each victim lived, how they were loved, and who they impacted and are remembered. This is a ritual observed by the Team to remember and honor each victim's individual story and humanity before confronting their mortality and the violence they endured.

    B. **Presentation of Death and Autopsy Findings:** The Team proceeds with a "Presentation of Death," which is the clinical presentation and scientific discovery of autopsy findings from the Hennepin County Medical Examiner. In 2025, the Team was fortunate to welcome the lead pathologists associated with each case. This provided the Team with a first-hand account of findings, observations, and other information specific to each pathologist's case involvement that helped inform the Team's review. This is a critical step in the Team's review process that is focused on objective, scientific analysis of the cause and manner of death, and supports the contextual examination of all contributing factors associated with each victim's death. Additionally, the autopsy findings often substantiate other documents reviewed during the evaluation.

4. **Case Observations and System Analysis:** As part of the Team's review process and meeting structure, subsequent meetings are dedicated to the systemic review of source documents until sufficient information is obtained to develop formal observations and recommendations that inform the Team's identified Opportunities for Intervention. These source documents (the same documents used to construct the case chronology) are assigned to two Team members for review: one representative from the agency (or similar agency) that provided the information, and one member offering an external perspective.

    Each month, Team members rotate these review and presentation responsibilities using the same assignment structure. During the review process, the Team assesses both the factual content and associated system responses. These assessments support the Team's identification of risk factors and potential Opportunities for Intervention that may have influenced the case outcomes or could help prevent future domestic homicides.

5. **Engaging Case Experts and Families:** Recognizing hindsight offers valuable perspective, Team members who had direct professional involvement in a case while it was active may support in the review process. The Team may also invite external system partners with prior case involvement to provide observations. This process allows professionals across systems to offer additional insight regarding their role, proximity to the case, and participation in coordinated system response efforts. Contributions may include professional observations, investigative findings, crime scene analysis, and digital evidence.

   In cases where system documentation is limited, these contributions help the Team identify missed opportunities, system gaps, and potential interventions for future consideration. Case experts may include first responders; lead detectives, investigators or prosecutors; victim-witness assistants or advocates; and, in some instances, members of the victim's family.

   On a case-by-case basis, when there are strong indicators of prior victim family involvement—such as advocacy, case cooperation, or sustained relationships with system providers—and with a majority vote from the Advisory Board, the Project Director may extend an optional invitation for the victim's parents to have contact with the Team. These invitations are intended to give impacted families an opportunity to learn about the Team's work and to share any additional information they may wish to contribute to the review process. If there is any indication that outreach could cause additional harm or distress to a victim's family, the Team will always prioritize each family's privacy, safety, and peace.

6. **Final Case Outcomes:** By the conclusion of each review year, the Team compiles a comprehensive record of all key issues, observations, risk factors, and Opportunities for Intervention identified throughout the totality of cases reviewed. These findings are integral to the development of the annual report. The final review meeting, held in-person each December, includes small group discussions that contribute to broader group conversations. During these sessions, each group presents their recommendations and supporting information to advocate for the inclusion of specific Opportunities for Intervention in the report. This collaborative process also provides Team members with the opportunity to draw connections across cases and introduce new, often more expansive, Opportunities for Intervention that reflect the broader scope of the Team's yearlong review.

Improving Public Awareness: Annual Reporting and Presentations

Using annual insights and data collected by the Team, the Project Director compiles and produces an annual report and call to action that identifies system interventions and prevention efforts for city, county, and state consideration. Each report undergoes a series of reviews and copy edits by the Advisory Board to ensure judicial oversight and implementation feasibility. Once finalized, the report is published on the Team's website and widely distributed to relevant system partners across the criminal justice system, state legislature, government agencies, and community-based organizations.

In 2025, the Project Director provided presentations on findings published in the Team's 2024 Annual Report and offered technical assistance to system partners interested in the Domestic Fatality Review Team model. Public engagement and awareness efforts extended to organizations, state agencies, service providers, and representatives from the Minnesota Supreme Court, Third Judicial District Bench and Court Administration, Fourth Judicial District Family Violence Coordinating Council, and Hennepin County Attorney's Office.

Annual presentations, speaking engagements, and event attendance can be requested and coordinated at any time by contacting the Team's Project Director or submitting a formal request on the Team's website.

- **Request a Presentation:**

  Contact: Makenzie Nolan, Project Director

  Email: minnesotadfrt@gmail.com

  Online Request Form: https://www.mndfrt.org/contact

Executive Summary

In 2025, the Domestic Fatality Review Team reviewed three homicide cases, two of which are included in this report, with the third case extending into to the next reporting year. Out of respect for the privacy of the victims and their families, all identifying information has been omitted.

By design, the Domestic Fatality Review Team exclusively reviews cases where prosecution has been concluded. Therefore, the case selection process for 2025 was largely determined by case availability rather than chronology and were reviewed in no particular order. It is important to also note that the cases reviewed often vary by year and do not include 2025 homicide data or cases that correspond with the calendar year of each annual report, largely because prosecution has not been concluded.

The purpose of each annual report is to raise awareness and help strengthen the collective systems response to domestic violence using the identification of recurring thematic patterns, or Opportunities for Interventions, for further application to everyday practice. This report presents the findings of the Domestic Fatality Review Team following the conclusion of prosecution in Hennepin County's Fourth Judicial District for two domestic homicide cases occurring in 2019 and 2022 respectively.

Each case offered substantial evidence that opportunities for early intervention and prevention were missed throughout each victim's life and across multiple system touchpoints. The Team identified consistent patterns of prolonged abuse, physical violence, and coercive behaviors used by perpetrators to exert power and control over victims. These patterns also included sustained efforts to limit, restrict, or isolate victims' movements; and displays of intimidation, threats, or high-risk behaviors that compromise the safety and wellbeing of children, family members, and other bystanders. Notably, patterns of power and control extended beyond the immediate victim-perpetrator relationship. In each case, the perpetrator had documented history of abuse, prior convictions, or violent encounters involving former intimate partners, third parties, or other domestic relationships; sometimes beginning as early as adolescence. Collectively, these findings underscore a critical need for earlier detection, prevention, and coordinated system responses that recognize domestic violence as both a public health and public safety crisis within our communities.

The Team's findings further demonstrate a collective need for strengthened system accountability, consistency between disciplines, and informed pattern recognition across agencies. Reliance on isolated incidents or case outcomes alone can often obscure escalating risk. Instead, cumulative indicators of risk and violence must help guide standardized prevention practices that are rooted in early detection, coordinated risk reduction, and timely intervention.

To address these gaps, this report outlines a series of Opportunities for Intervention designed to translate lessons learned by the Team, into tangible system improvements and response measures that can be applied across courts, agencies, and jurisdictions. These recommendations emphasize consistent use of cumulative risk assessment, early referral to services, and proactive judicial oversight (particularly during the pre-disposition phase) to reduce lethality risk and interrupt pathways to severe and fatal violence.

For each case, the team documented the presence of risk factors and relevant homicide data for the State of Minnesota and Hennepin County, including cause of death, victim age, and relationship context. Corresponding Opportunities for Intervention can be referenced beginning on page 23.

The Domestic Fatality Review Team offers this report to support meaningful improvements in policy and practice aimed at preventing future domestic homicides. Agencies across municipal jurisdictions and state government are encouraged to implement the Opportunities for Interventions cited throughout the report.

Continued regional collaboration across all ten of Minnesota's judicial districts remains a priority for Minnesota's Fourth Judicial District Domestic Fatality Review Team, with the shared goal of strengthening prevention efforts and enhancing safer outcomes for individuals, families, and communities statewide.

Presence of Risk Factors

In 1986, Jacquelyn Campbell, a professor at Johns Hopkins School of Nursing, developed the Danger Assessment (a 20-item questionnaire) to assess an individual's risk of being killed or seriously injured by their intimate partner. The Team documents risk factors observed in each victim-perpetrator relationship prior to the domestic homicide. The presence of risk factors corresponding to the 2019 and 2022 homicide cases are noted below to increase public awareness and support the early detection and prevention of escalating violence in future cases of domestic violence.

In 2025, the Team formally incorporated an additional risk factor (italicized below) into its review process and its evaluation of lethality risk in domestic violence cases; further examined on pages 25-26.

Risk Factors:	**Case 1**	**Case 2**
The violence had increased in severity and frequency during the year prior to the homicide.	**X**	**X**
Perpetrator had access to a gun.	**X**	**X**
Victim had attempted to leave the abuser.	**X**	**X**
Perpetrator was unemployed and/or experienced temporary unemployment.	**X**	**X**
Perpetrator had previously used a weapon to threaten or harm victim.		
Perpetrator had threatened to kill the victim.		
Perpetrator had previously avoided arrest for domestic violence.	**X**	**X**
Victim had children not biologically related to the perpetrator.		
Perpetrator sexually assaulted victim.		
Perpetrator had a history of substance abuse.		
Perpetrator had previously strangled victim.		**X**
Perpetrator attempted to control most or all of the victim's activities.	**X**	**X**
Violent and constant jealousy.	**X**	**X**
Perpetrator was violent to victim during pregnancy.		**X**
Perpetrator threatened to commit suicide.		**X**
Victim believed perpetrator would kill him/her.		**X**
Perpetrator exhibited stalking behavior.	**X**	**X**
Perpetrator with significant history of violence.	**X**	**X**
Victim had contact with a domestic violence advocate.	**X**	**X**
Perpetrator had a history of animal abuse and/or was violent towards animals.		
Victim had entered a new romantic relationship.	**X**	
**Perpetrator committed violence or threats of violence (with or without use of a weapon) against member(s) of the victim's family and/or close friend(s).*	**X**	**X**

Domestic Homicide Data

The Team's 2025 Annual Report is not meant to reflect homicide data that is congruent with the reporting year. Rather, it documents the year in which each homicide case under review took place and offers corresponding data for that year. This report only includes data detailing domestic homicides that occurred in 2019 and 2022 across the State of Minnesota and Hennepin County area. All data included in this report has been collected using public data sources and does not constitute as research conducted by the Team.

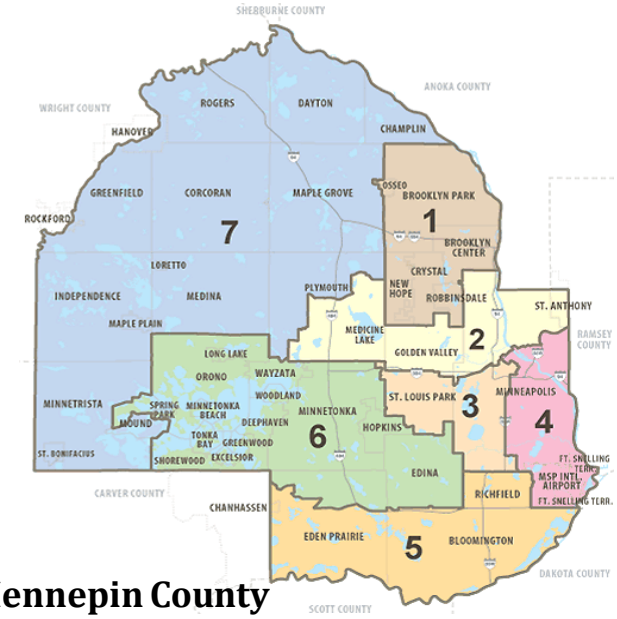
Population

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

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

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

Minnesota Fourth Judicial District

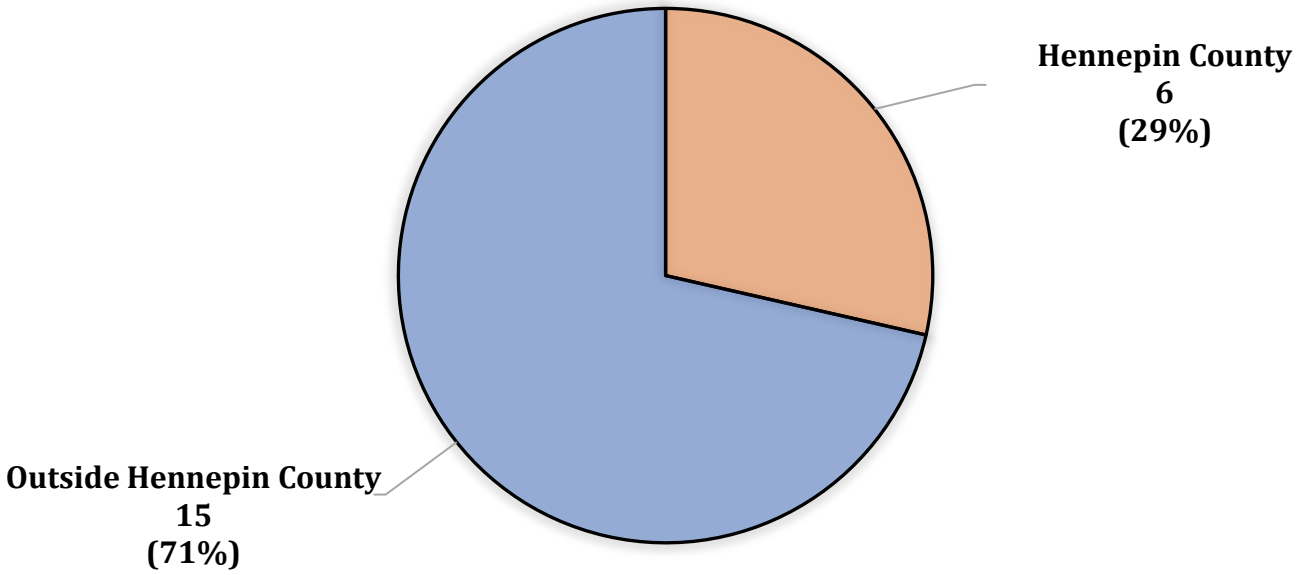


Hennepin County

2019 Domestic Homicide Data

In 2019, at least 21 Minnesotans were killed due to violence resulting from domestic abuse. **A total of six domestic homicides were recorded in Hennepin County** (Bloomington [1], Minneapolis [4], Orono [1]); and 15 domestic homicides were recorded as occurring outside of Hennepin County (Blaine [1], Duluth [1], Gary [1], Mounds View [1], Nevis [2], New Brighton [1], Owatonna [1], Ponemah [1], Redby [1], Sauk Rapids [1], St. Paul [2], Swatara [1], Woodbury [1]).

2019 STATE OF MINNESOTA DOMESTIC HOMICIDES
TOTAL FATALITIES: 21

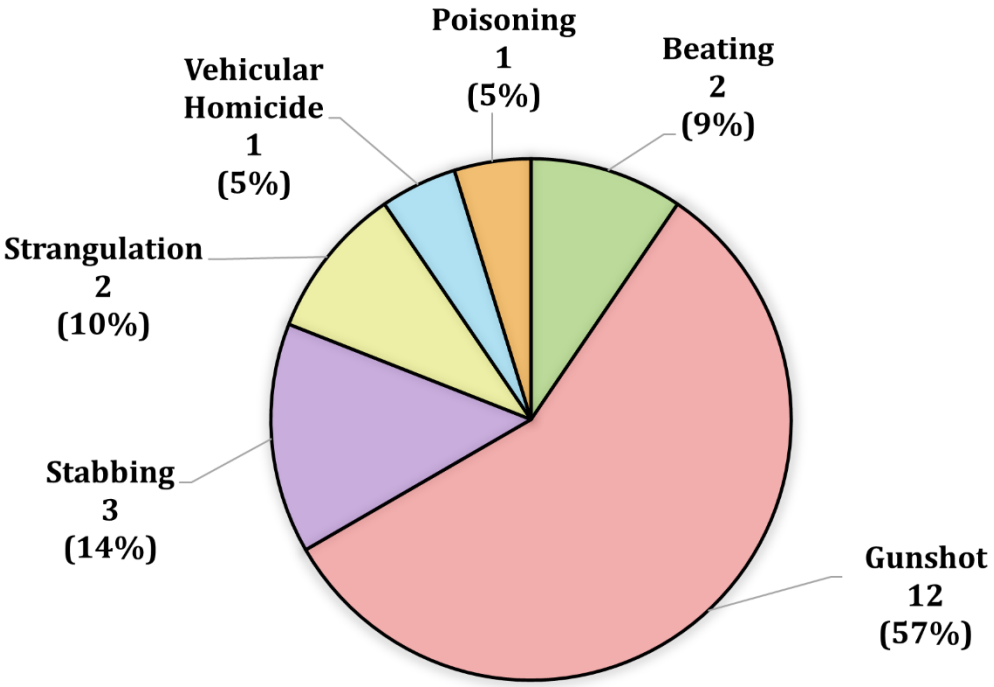


Of the 21 total domestic homicides reported in the State of Minnesota in 2019, at least 18 of the victims identified as women and at least four were from Hennepin County. At least 14 of the 21 victims of domestic homicide were parents and/or had children, and at least three of those victims lived within Hennepin County.

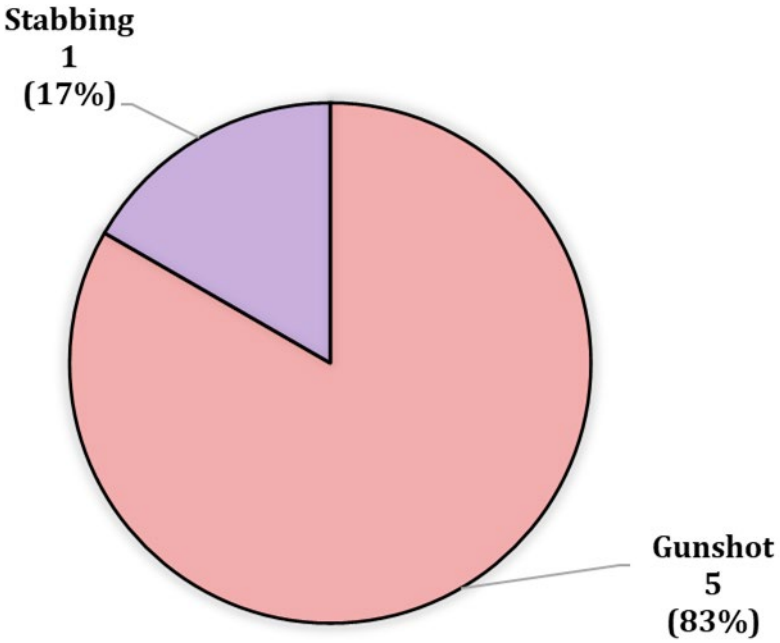
In 2019 domestic homicides left at least 47 people in the state without a parent; at least seven of those impacted were from Hennepin County. Data outlining the specific cause of death for each victim of domestic homicide in 2019 can be reviewed on page 18.

Homicide-suicides accounted for at least 24% of the homicide cases reported in 2019, with a total of five perpetrators committing suicide; two of which occurred in Hennepin County.

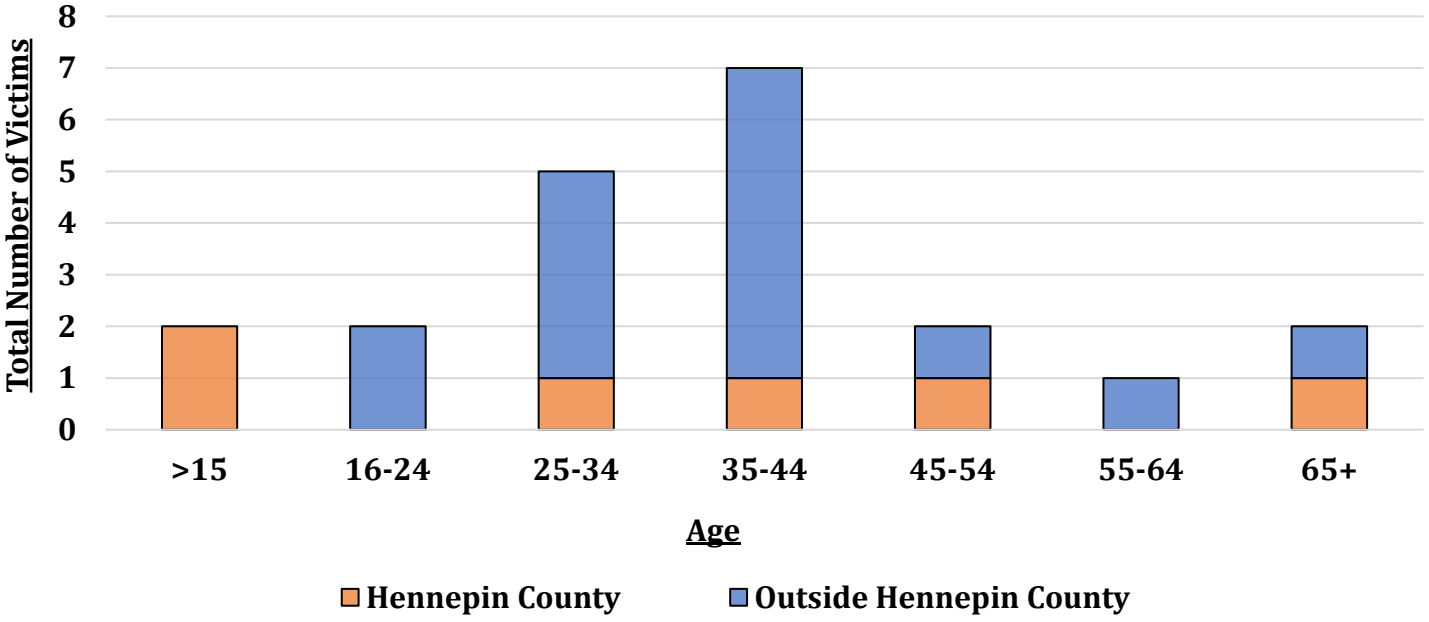
2019 STATE OF MINNESOTA DOMESTIC HOMICIDES CAUSE OF DEATH



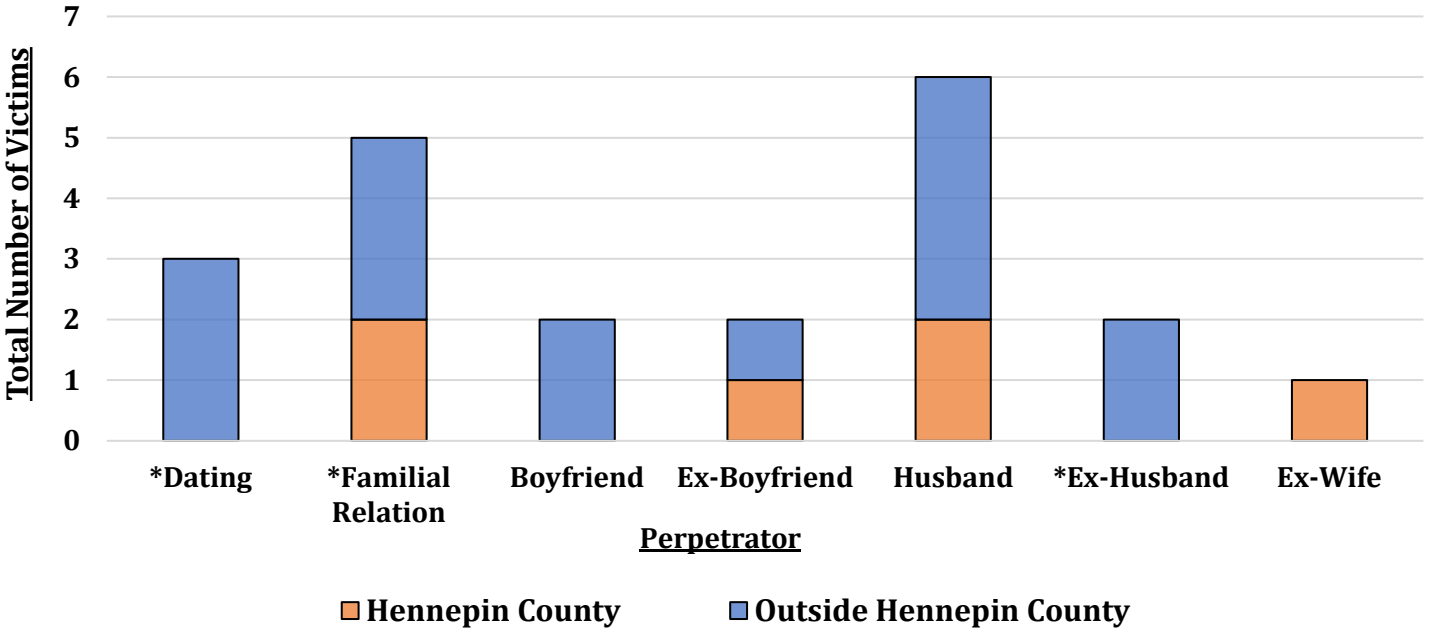
2019 HENNEPIN COUNTY DOMESTIC HOMICIDES CAUSE OF DEATH



2019 STATE OF MINNESOTA DOMESTIC HOMICIDES
AGE OF VICTIMS



2019 STATE OF MINNESOTA DOMESTIC HOMICIDES
VICTIM & PERPETRATOR RELATIONS

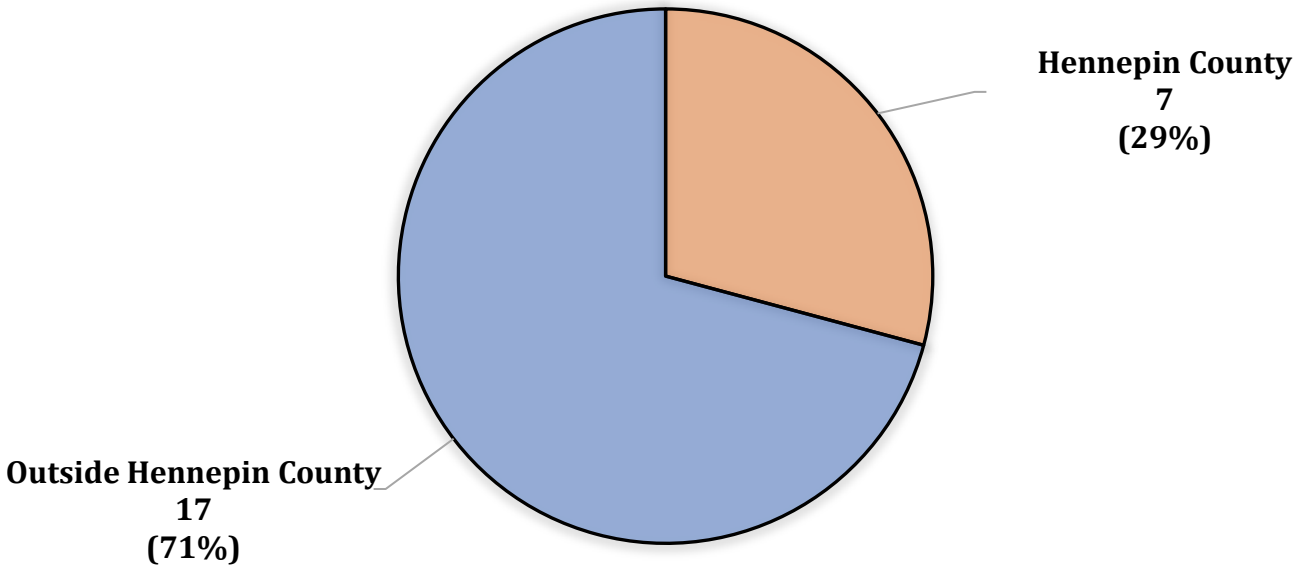


"Dating" is used to describe casual dating and romantic relationships. "Familial Relation" includes extended family and in-laws. "Ex-Husband" includes separation without divorce. These relationship dynamics were unique to each case and not commonly represented. The perpetrator relations include: a son-in-law of ex-husband, a sister-in-law to perpetrator, a cousin's boyfriend, a separated married couple, and casual dates or romantic relationships.

2022 Domestic Homicide Data

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

2022 STATE OF MINNESOTA DOMESTIC HOMICIDES
TOTAL FATALITIES: 24

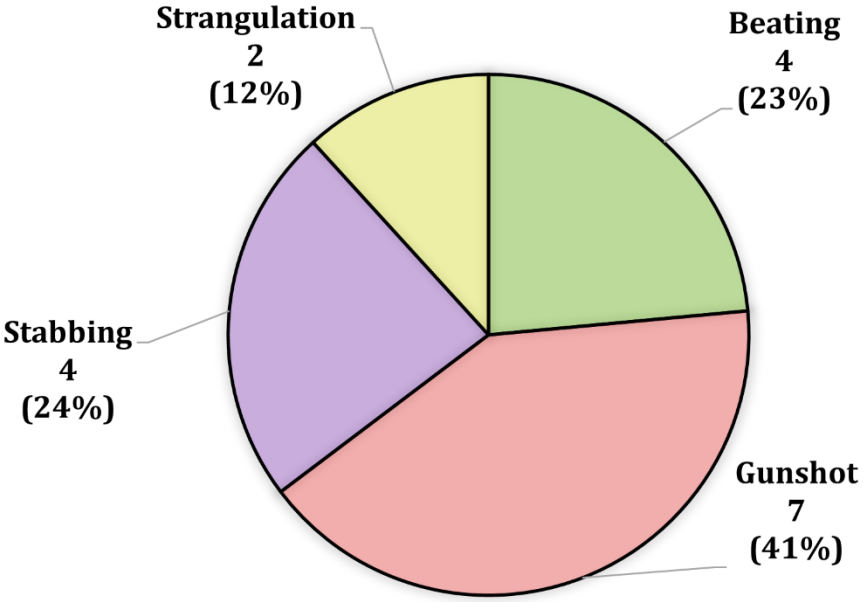


Of the 24 domestic homicides reported in the State of Minnesota in 2022, at least 21 of the victims identified as women and at least five were from Hennepin County. Additionally, at least one of the 24 victims was pregnant; and at least three of the victims identified as vulnerable adults. At least 23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

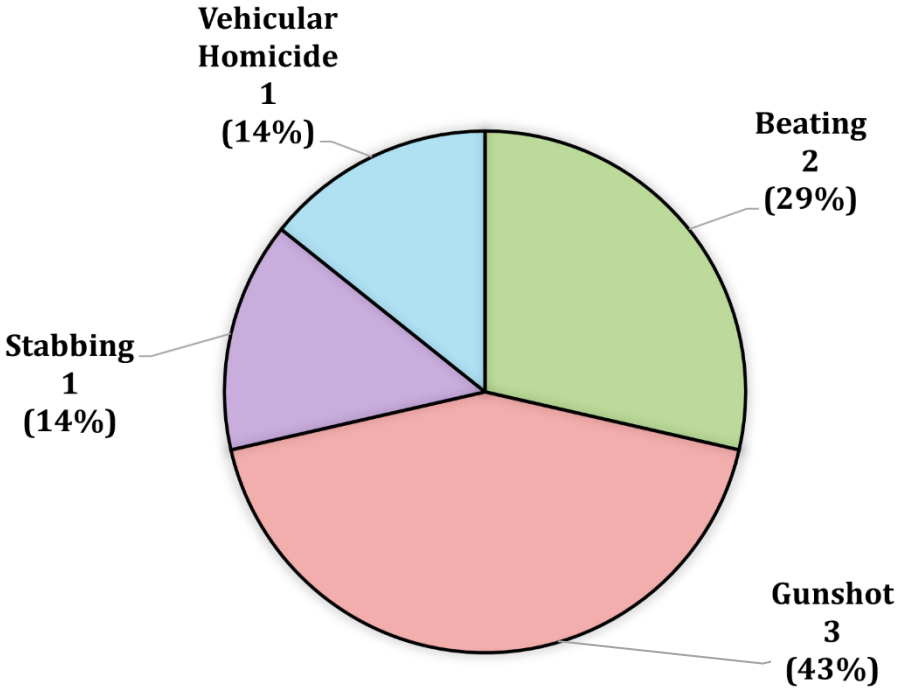
In 2022 domestic homicides left at least 22 people in the state without a parent; at least seven of those affected were from Hennepin County. Data outlining the specific cause of death for each victim of domestic homicide in 2022 can be reviewed on page 21.

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

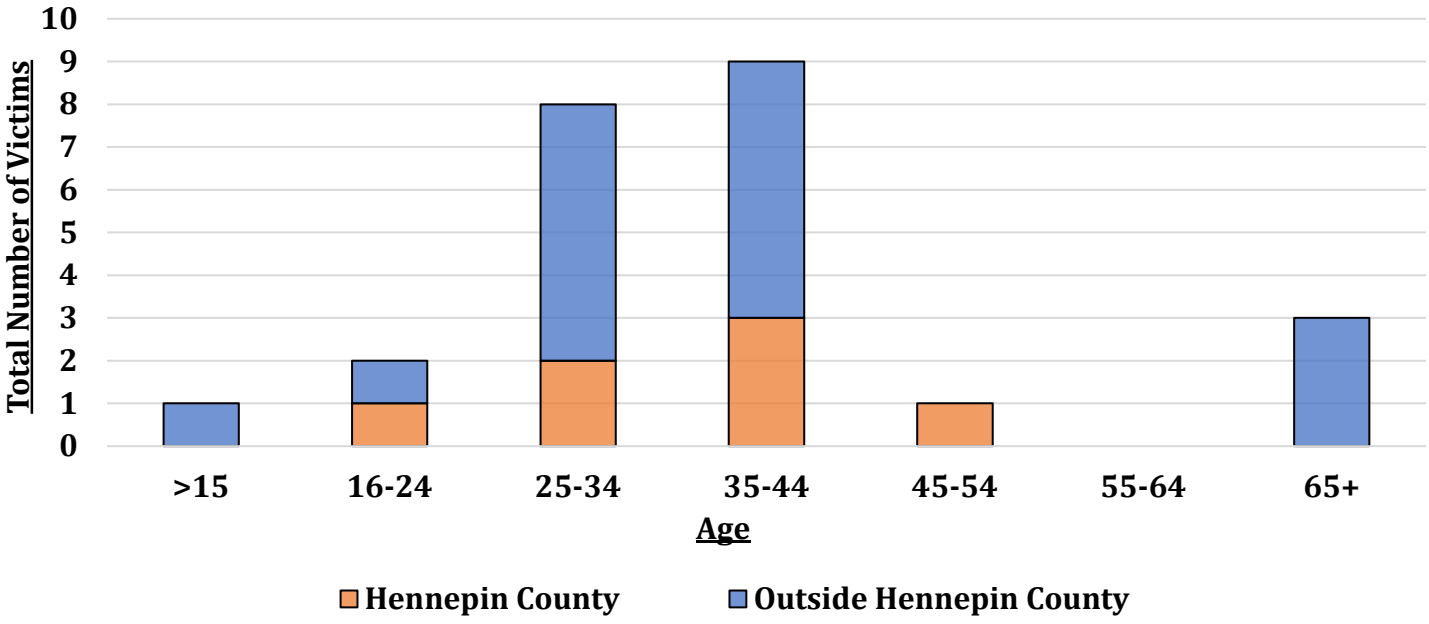
2022 STATE OF MINNESOTA DOMESTIC HOMICIDES CAUSE OF DEATH



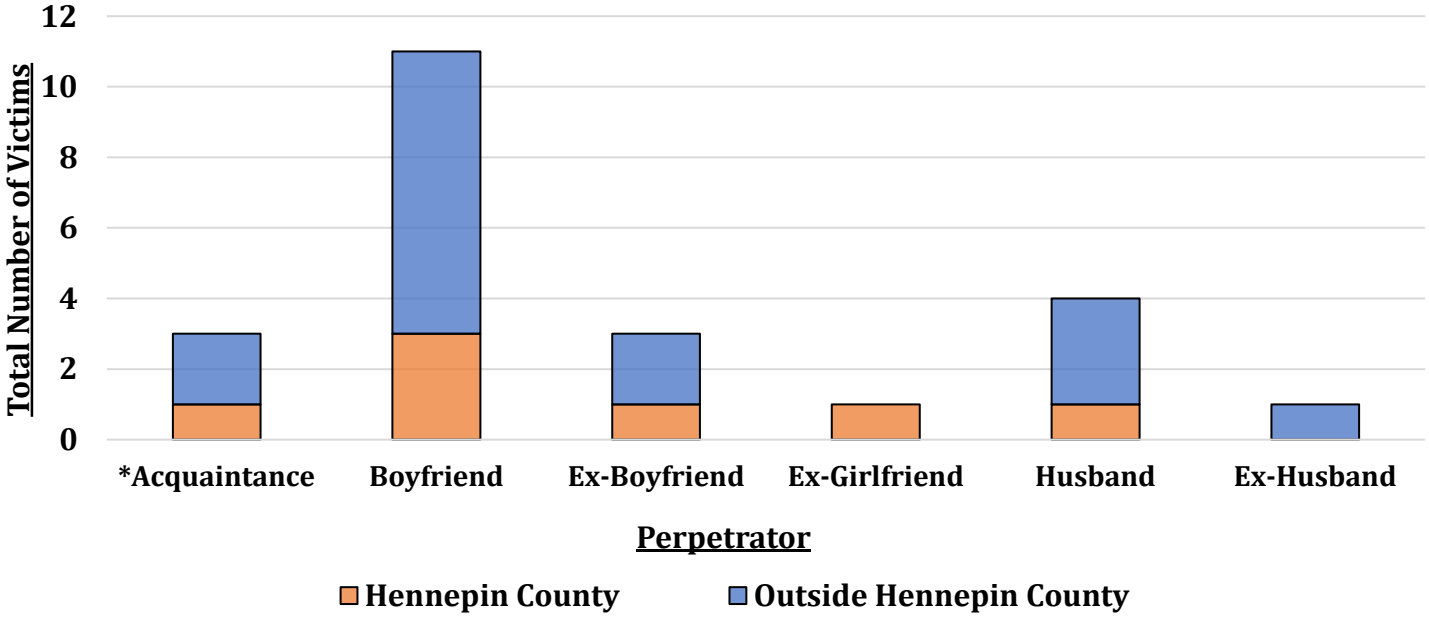
2022 HENNEPIN COUNTY DOMESTIC HOMICIDES CAUSE OF DEATH



2022 STATE OF MINNESOTA DOMESTIC HOMICIDES
AGE OF VICTIMS



2022 STATE OF MINNESOTA DOMESTIC HOMICIDES
VICTIM & PERPETRATOR RELATIONS



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

2025 Opportunities for Intervention

In order to understand the circumstances preceding each fatality, observations about the cause and manner of each victim's death, past incidents of abuse, attempted system interventions, and a thorough examination of lethality risk factors all contribute to the Team's formal identification and development of Opportunities for Intervention.

Although it is unknown if any of the identified interventions would have prevented the deaths cited in this report, the Team's primary objective is to offer recommendations informed by careful analysis of the facts of each case under review. Each Opportunity for Intervention is designed to be integrated into daily practice and processes across all systems that work with people—extending beyond agencies traditionally involved with serving victims or perpetrators of domestic violence, such as law enforcement or advocacy organizations. The Opportunities for Intervention cited in this report are inclusive of systems and providers who offer public healthcare and educational resources to children, youth, and families; to businesses that provide hospitality services and public lodging or shelter; and every facet of our criminal justice system that is tasked with reinforcing accountability, instituting protections, and upholding state laws—from the courthouse to the state legislature.

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

The 2025 Opportunities for Intervention are organized into six categories, with three subsections, to help readers identify areas where system interventions may be most effective. These categories are cross-referenced throughout the report for ease of navigation. **The complete list of Opportunities for Intervention appears on pages 24-45**. The categories and subsections outlined in this report include:

1. **Identifying Lethality Risk: Early Intervention as Prevention**
   - **A.** Updating Lethality Risk Assessments
   - **B.** Early Intervention and Risk Mitigation in Pre-Disposition Cases
   - **C.** Strengthening System Protections Through Legal Advocacy
2. **Healthcare as Prevention: Strengthening Domestic Violence Screening and Response Protocols**
3. **Emergency Response and Law Enforcement: Critical Frontline Interventions and POST Board Oversight**
4. **Protecting Children, Youth, and Families: Intentional System Intervention and Reform**
5. **The Hotel Industry as Prevention: Promoting Early Detection and Public Safety**
6. **After Homicide: Long-Term Healing and Support for Impacted Families**

1. Identifying Lethality Risk: Early Intervention as Prevention

Throughout the Team's case review, critical gaps were identified across multiple systems, emphasizing the need for greater investment in early intervention strategies, and a more effective, coordinated response. Domestic violence impacts victims but also impacts others in the family, including children. In order to stop the cycle of domestic violence from being repeated, early interventions are essential. These findings include recommendations to standardize processes that could improve harm reduction efforts and better address victim and bystander safety by mitigating heightened lethality risks. These strategies are intended to interrupt domestic violence before it escalates to serious or lethal outcomes. They focus on updating and improving standardized lethality assessments, leveraging opportunities for early court interventions, and expanding legal advocacy protections to enhance victim safety, reinforce system accountability, and support coordinated, cross-system prevention.

Applying a prevention and harm reduction lens, the Team identified several Opportunities for Intervention, organized into three sections:

A. Updating Lethality Risk Assessments

B. Early Intervention and Risk Mitigation in Pre-Disposition Cases

C. Strengthening System Protections Through Legal Advocacy

Each intervention is detailed on pages 25-31 and is accompanied by case annotations that provide context and explain how the Team reached its determinations.

A. Updating Lethality Risk Assessments

Domestic violence is frequently preceded by warning signs such as escalating threats, stalking, physical violence, prior criminal behavior, and access to weapons. A standardized lethality risk assessment is a critical prevention tool that can help professionals evaluate the severity of a threat, determine if a victim needs immediate protection, and decide if interventions such as protection orders or arrests are warranted. When risk assessments are consistent and comprehensive, professionals are better equipped to prioritize victim safety, hold perpetrators accountable, and help save lives.

While the presence of any of the risk factors can signify domestic violence, that risk is elevated when there are multiple risk factors present. Assessing the totality and severity of lethality risks provides a clear warning system and heightened sense of urgency to gauge a victim's proximity to lethal risk and guide timely, lifesaving protection measures.

As part of an identified Opportunity for Intervention, the Team added one additional risk factor to its review of each case, expanding on Jacquelyn Campbell's 20-question "Danger Assessment," detailed on page 15. This added risk factor was informed by thematic and reoccurring risks presented in the Team's review of homicides in 2019 and 2022. The risk includes instances of escalation where a member of the victim's family (immediate or extended), or a close friend, becomes a direct target of violence, threats of violence, or is in fear of retaliation from the perpetrator (with or without the presence and use of a weapon). The Team will continue to prioritize this additional lethality factor in future reporting, as it indicates heightened risk for all families and friends, as bystanders of domestic violence. Therefore, the Team encourages the following:

- **Recognizing Violence Against Family and Close Friends as a Lethality Indicator**
  - Incorporate the following language: "*perpetrator committed violence or threats of violence (with or without use of a weapon) against member(s) of the victim's family and/or close friend(s)*" as a lethality factor that is used and considered in all future victim risk assessments.
    - Violence, or threats of violence, directed beyond the primary victim reflects an advanced stage of escalation and may indicate reduced inhibition, diminished regard for accountability or outcomes, and an increased willingness to engage in extreme violence and potentially lethal harm.
  - If a perpetrator has a known history or established pattern of retaliation or harm toward a victim's family members or friends, this should prompt immediate or early system intervention.
    - The Team advises that all bystanders—family or friends—be promptly offered and connected to separate support and protections that are not reliant on the primary victim's involvement.
  - At a minimum, every bystander should be provided with information about protection orders and other available system referrals to support a coordinated response.
    - This requires strengthening system referral practices between system providers and members of law enforcement or first responders, to ensure referrals are being established, coordinated, and followed-through directly following reported incidents.

Expanding standardized lethality risk assessments to include violence or threats directed toward a victim's family members or close friends reflects the cumulative and escalating nature of domestic violence risks. Incorporating this additional lethality indicator will help relevant system partners to conduct more comprehensive assessments that account for the full scope of risk present within abusive relationship dynamics. Accurately identifying cumulative risk in escalating situations helps to strengthen systems' ability to initiate timely, proactive, prevention-oriented interventions. It also reinforces protective responses for extended family members and primary support networks who may also be exposed to escalating risk or retaliatory harm.

B. Early Intervention and Risk Mitigation in Pre-Disposition Cases

Operating at the intersection of the criminal justice system, diversion courts, behavioral health services, and advocacy systems, the Team's case review identified strong evidence supporting the need for standardized practices that prioritize early engagement well before final case dispositions in court proceedings. For the purposes of this Opportunities for Intervention section, the Team's analysis primarily references the criminal court system; however, the identified interventions are also applicable and relevant within other judicial settings. Pre-disposition interventions represent active prevention points rather than procedural holding periods. Improving intentional intervention efforts, these prevention points offer critical, often underutilized, opportunities to interrupt patterns of escalating violence, and reduce lethality risk while cases remain active and move through the criminal court system.

In practice, misdemeanor and gross-misdemeanor domestic violence offenses that result in arrest and criminal charges often proceed over extended timeframes—sometimes months or longer—prior to reaching final resolution. Delaying referrals to services for defendants, victims, or affected family members until disposition risks missing critical opportunities for early intervention, particularly when threats to victim safety are most immediate and the risk of escalation is heightened. Beginning at the earliest point of court contact, an effective system response requires timely referrals that connect defendants and victims to the appropriate resources, promote continuity of care, encourage engagement, and improve long-term safety outcomes.

Throughout the cases reviewed by the Team, abusive relationship dynamics were often accompanied by high-risk behaviors, complex mental health needs, and limited housing or employment stability. Within this context, expectations for sustained court engagement or behavior change—without interventions that address cumulative factors—are not effective or sustainable for harm reduction long-term. Although these conditions vary by individual and by case, their prevalence underscores the need for a paired public health and public safety approach to judicial oversight during the pre-disposition phase, when early interventions can have the greatest preventative impact.

With active judicial oversight, courts are positioned to suggest the integration of behavioral health support, risk-informed supervision, and stabilization services in the pretrial and diversion processes. Embedding these principles into diversion eligibility, pretrial supervision practices, bail determinations, and conditions of release not only raises system standards; it redefines what meaningful progress and successful health and safety outcomes can look like. By moving beyond a crisis-driven response model, courts can advance toward a more responsive, prevention-oriented approach that prioritizes early intervention, reduces escalation, and mitigates the collective risk of future domestic violence fatalities.

The Team proposes the following Opportunities for Intervention for further consideration, continued on pages 28-29:

- **Early Interventions Prior to Court Resolution**
  - Activate early intervention pathways at the first point of court contact, including arraignment, bail review, pretrial supervision, or diversion screening, to connect defendants and affected parties with the appropriate services while cases remain active or pending.
    - Guarantee interventions occur during periods of heightened risk, rather than waiting for adjudicated outcomes.
  - Ensure referrals to counseling, behavioral health treatment, educational programming, and advocacy supports are available regardless of case disposition in domestic violence cases.
    - Early engagement and coordinated response efforts can help reduce reliance on crisis-driven interventions and emergency response by disrupting patterns of abuse before escalation.
    - Improved pathways for offender programming during key intervention points can help disrupt patterns of abuse or escalating violence, particularly when lethality risks are heightened or emerging.
  - Standardize early education on court processes and diversion pathways delivered by court services, probation, or diversion staff at the earliest point of system contact.
    - Encourage early education supports, informed decision making, and participation in alternative resolutions.
      - *This is especially important when working with impacted bystanders and family members affected by abuse, as varying levels of system familiarity can create unnecessary barriers to accessing available support and services.

- **Early Case Assessment for Proactive Risk Management**
  - Require comprehensive and early case review for all domestic violence-related offenses, regardless of charge level. Use case data and early risk indicators to proactively target and determine intervention intensity, rather than solely relying on offense severity or case outcome.
    - Reviews should include criminal history, protective order history, prior child protection involvement, and documented risk indicators to ensure decisions are informed by patterns of behavior and risk mitigation, rather than isolated or fragmented incidents.
    - Individuals with elevated risk profiles may require enhanced monitoring, specialized programming, or coordinated supervision across systems.
  - Use unresolved or contested cases after a charge or complaint as opportunities for further intervention and harm reduction during the pre-adjudication period, rather than deferring referrals for additional services or treatment until final disposition.
    - When allegations are denied, minimized, or later recanted, system partners should continue to offer or require supportive programming using trauma-informed approaches to help maintain service connection, promote safety, and improve case outcomes.
    - Inconsistent participation or case disengagement could point to safety concerns, coercive control, or system barriers, rather than an absence of risk.
    - Ensure case continuity and coordinated referrals still happen during the interim between court action to help keep all parties safe from further escalation or retribution.

- Integrate structured lethality and risk indicators into early assessment processes used by prosecutors, probation, court services, and diversion programs. Trigger additional assessments when elevated risks are identified, not limited to including, but not limited to, probation, behavioral health, or substance-use evaluations.
    - Align supervision conditions and service referrals with identified risk, ensuring intervention responses are proportionate and prevention oriented.
        - Earlier identification allows supervision and service plans to be attuned to actual risk, further improving safety and accountability long-term.

The Team's review identified recurring missed opportunities for early intervention in cases involving documented histories of domestic violence, prior felony offenses, and escalating lethality risks that intensified over time. In both cases, perpetrators continued to escalate in both frequency and severity, including violence that extended beyond the primary relationship, with access to weapons—despite existing probation conditions and supervisory oversight. The breakdown in continuity, monitoring, and cross-system coordination elevated public safety risks. Early connection to appropriate programs can help offenders understand the impact of their actions, the risks of continued escalation, and the personal, social, and legal consequences of violent behaviors.

In cases involving prolonged abuse, opportunities for risk assessment and safety planning were often missed during interim periods between court actions, including the time between the issuance and dismissal of protection orders. Collectively, these findings underscore the importance of treating pre-disposition phases as active intervention points, rather than procedural waiting periods. Strengthening early case review, mandated risk assessment, and coordinated referrals during these system touchpoints can help improve system accountability and support more effective long-term prevention outcomes.

Integrating cumulative risk factors across key decision points promotes greater consistency in charging decisions, bail determinations, supervision levels, and referral practices. It also reduces variability across jurisdictions and helps prevent the underestimation of risk in cases that may initially appear low level. Notably, some of the most severe patterns of abuse identified by the Team occurred without formal law enforcement reports or prior convictions. In these instances, the only documented evidence of violence was contained within the victim's medical records.

Together, these findings highlight the court's essential role in addressing escalating violence and heightened lethality risks in domestic violence cases. By pairing early intervention with sustained judicial oversight, courts can help facilitate coordinated, cross-system responses that move beyond case resolution and address the underlying determinants of violence. Consistent application of standardized court processes promotes accountability, supports tailored referrals, advances risk mitigation and de-escalation, strengthens perpetrator interventions, and helps ensure communities can live free from escalating violence.

C. Strengthening System Protections Through Legal Advocacy

Domestic violence rarely occurs in isolation, and legal advocacy services are most effective when intentionally integrated into court systems and judicial processes. Family members and close friends often serve as the first points of disclosure and support for victims seeking help and may recognize escalating risk before formal system involvement occurs. When advocacy services are formalized, accessible, and embedded within court operations, they expand the system's protective reach beyond the primary victim and support earlier, coordinated intervention.

Strengthening legal advocacy infrastructure within court systems is essential to ensure that all individuals impacted by domestic violence have clear and meaningful pathways to risk assessment, safety planning, and protective intervention. Establishing dedicated resource coordination teams within judicial districts can further improve timely access to services and reduce system fragmentation by enhancing procedural clarity, expectations, and informing steps for sustained court engagement.

The Team's case review identified documented histories of abuse and indicators of escalating violence that affected the primary victim as well as members of the victim's family and support network. In one case, reports to law enforcement documented incidents of abuse or escalating violence; however, early intervention opportunities were missed when requests for information about protection orders, advocacy services, or legal options went uncoordinated across systems. The case review also revealed repeated patterns of protection orders issued against the same perpetrator over time, including an order obtained by the homicide victim that was later dismissed. In this instance, dismissal may have indicated victim fear, coercion, or external pressures rather than a reduction in risk, as violence persisted and ultimately escalated to a fatal outcome.

This section, continued on page 31, outlines Opportunities for Intervention designed to strengthen protective networks by broadening access to legal advocacy beyond the primary victim and embedding coordinated, prevention-focused supports within the court system.

- **Expand Legal Advocacy Resources and Coordinated Prevention Strategies**
  - Provide dedicated funding for each judicial district court to maintain an embedded resource coordination team responsible for centralized case coordination, service referral, and continuity between the family and criminal court systems.
    - Resource coordinators would also help strengthen system cooperation and cohesion across diversionary courts, probation, behavioral health service providers, and community-based advocacy organizations.
  - Establish clear, accessible pathways for bystander support that connect family members and close friends affected by a loved one's abuse to qualified legal advocates. These structured supports should offer case consultation, increase awareness of lethality risk factors, and assist concerned individuals in identifying appropriate system interventions and available court-based protections.
    - Ensure services are confidential, trauma-informed, and accessible in-person and via virtual platforms to improve follow-through and to help promote public awareness through the extension of resources, safety planning, and system referrals.

- **Expand Training and Collaboration for Judicial Officers**
  - Provide ongoing, multidisciplinary training for judicial officers on domestic violence dynamics and the application of no-contact orders.
    - Training should integrate perspectives from victim advocates, prosecutors, defense counsel, probation, and service providers to support informed, balanced decision-making.
  - Ensure judicial education addresses the purpose, limitations, and unintended consequences of no-contact orders, including:
    - How coercive control, fear, and economic dependence can affect victim compliance, participation, and safety outcomes.
    - Equity-informed and survivor-centered approaches to risk assessment and imposing court-ordered conditions.
  - Standardize risk assessments to recognize that a lack of prior documentation does not equate to an absence of risk, particularly when managing cases involving recantation, delayed reporting, or limited system contact.

Collectively, the above Opportunities for Intervention illustrate how courts can institutionalize early intervention as a core system function, rather than a discretionary or reactive response. By embedding legal advocacy, resource coordination, and standardized risk-informed practices within court operations, the judicial system can strengthen the broader protective networks that surround victims.

These system-level improvements can help enhance safety not only for victims, but also for affected family members and bystanders who are often exposed to elevated risk but remain outside traditional court protections. When domestic violence affects entire family systems, the court plays a critical role in aligning legal authority with advocacy and service pathways that address risk comprehensively and help sustain protections beyond individual cases or events. Implementing these interventions reinforces the court's capacity to assist in interrupting patterns of abuse, supporting long-term safety, and reducing the likelihood of future domestic violence fatalities.

2. Healthcare as Prevention: Strengthening Domestic Violence Screening and Response Protocols

Healthcare systems are uniquely positioned to support the intervention of domestic violence, especially when levels of harm and violence escalate or result in minor to serious physical injury. Individuals experiencing abuse frequently encounter healthcare settings during moments of acute risk, such as emergency care, hospitalization, or routine medical visits. Pregnant patients, in particular, engage in regular prenatal care throughout pregnancy; intimate partner violence during pregnancy is a documented maternal and fetal health risk associated with adverse outcomes. These encounters make healthcare facilities critical entry points for trauma-informed assessment, early identification, timely intervention, and coordinated care that prioritizes victim safety. Strengthening continuity of care is especially important for children, youth, and families who rely on routine healthcare visits as accessible and trusted points of contact for protection and support.

Ensuring consistent and standardized best practices are utilized across all healthcare facilities when responding to cases of domestic violence is essential, but often remains variable based on facility, clinic, and provider. Variable screening practices, limited staff training requirements, and nonstandard protocols across healthcare facilities can result in missed opportunities to identify escalating danger and connect patients to lifesaving supports. The Team's review of case outcomes indicates a critical need for healthcare system continuity by adopting a dedicated response infrastructure that treats domestic violence as a serious public health and safety concern.

The Team identified a series of Opportunities for Interventions to help strengthen response protocols and screening assessments across all healthcare settings. The Team also identified training mandates for all healthcare professionals who are responsible for direct-patient care, as well as security staff, to ensure both patient and staff safety. These recommendations are designed to provide healthcare institutions with the tools and structural capacity necessary to support harm reduction and deliver an effective response.

To prevent future domestic fatalities and improve safety during periods of heightened risk, healthcare systems must be able to deliver consistent, coordinated patient protections. The Team's recommendations below identify key Opportunities for Intervention, continued on pages 33-34:

- **Early Identification and Family-Centered Protective Supports**
  - Adopt universal, trauma-informed domestic violence screening for children, youth, and families during pediatric, adolescent, and family wellness visits.
  - Integrate family-centered safety planning into pediatric and family healthcare visits when safety concerns are raised about a child's safety, or caregiver risk, without delaying or compromising necessary medical evaluation or treatment.
  - Strengthen early intervention by positioning healthcare and family-focused systems as key entry points for early risk identification and cross-system coordination.
  - Reduce barriers for caregivers with minor children by establishing rapid referral pathways from healthcare services to advocacy services that support childcare and safety resources when risks are identified.

- **Universal Domestic Violence Screening and Risk Assessment**
  - Standardize domestic violence screening protocols across all healthcare facilities and clinics, outlining clear accountability measures that can be easily embedded into staff on-boarding processes, and further reinforced through mandated annual training and renewal processes.
    - Establish policies that mandate confidential one-on-one screenings be available in a patient's preferred language, including policies that guide the separation of visitors prior to screening to protect patient autonomy, privacy, and safe disclosure.
    - Implement passive screening techniques by providing multilingual materials that can be displayed in patient and employee facing areas, not limited to discreet access to hotline resources via QR codes or other efficient modes for sharing information.
- **Mobilize Domestic Violence Investigation and Response Teams**
  - Require all hospital and emergency healthcare settings maintain a dedicated on-site Domestic Violence Investigation and Response Team to provide expert support, coordinated care, and safety oversight for patients, visitors, and healthcare staff when indicators of domestic violence are present.
    - Prioritize time-sensitive interventions, referrals, safety planning, legal advocacy, and case management when patients are at their most vulnerable and require prolonged recovery or overnight hospitalization.
  - Equip healthcare settings with a comprehensive domestic violence referral network that establishes strong working partnerships with local law enforcement, community-based organizations, emergency shelters, and other critical services to help inform patient discharge plans when patients require additional interventions to prevent escalation or lethal violence.
    - This includes trained nurses, social service providers, victim advocates, and security professionals who can render timely aid, victim-centered care, and connect victims to the appropriate resources whenever abuse is suspected or disclosed.
- **Mandate Domestic Violence Training Requirements for All Healthcare Personnel**
  - Require domestic violence training for all licensed medical and nursing personnel as part of initial licensure and ongoing renewal.
  - Partner with academic institutions to integrate domestic violence education into medical and nursing curricula training, including during residency and early clinical training.
  - Provide ongoing training for all healthcare personnel on recognizing signs of abuse, safely engaging with patients, and creating opportunities for disclosure across all clinical interactions.
    - Ensure staff are fully prepared to respond when a patient discloses safety concerns, moving beyond risk assessment to include immediate response actions and safety interventions.

- Strengthen victim-centered safety planning within healthcare security protocols to guarantee all facilities are prepared to respond effectively to complex and high-risk domestic violence dynamics.
    - Establish clear protocols and standard operating procedures for situations involving repeated and ongoing attempts to access a patient, including in-person visits, phone contact, third-party communication, or unauthorized entry.
    - Implement visitor screening practices to limit patient access and ensure there is a clear and cohesive communication and alert system that involves security staff, all healthcare professionals and building staff, so that there are no gaps or oversights that could compromise victim safety.
    - Develop specific response plans for stalking behaviors, threats of violence, or credible fear of harm, including the use of specialized safety codes or coordinated emergency response measures.
    - Partner with community-based organizations and local law enforcement to ensure safe transportation is available following medical discharge when a patient cannot safely return home or is attempting to leave an abusive or unsafe situation.

The measures outlined in the section underscore the importance of treating domestic violence response measures as a core healthcare responsibility, rather than a supplemental function. In the case that informed the Team's findings, emergency healthcare settings were one of the only systems where injuries from domestic violence were consistently documented over the course of the victim-perpetrator relationship. These records revealed repeat abuse, life-altering injuries that resulted in permanent disability, and violence that directly impacted pregnancy outcomes. The health and safety of children was also impacted, as abuse during pregnancy contributed to fetal harm and lifelong medical consequences.

It was during a period of profound vulnerability—following recurring cases of harm and escalating risk—that the victim was ultimately able to seek help while hospitalized. At that critical moment, it was the healthcare team that provided protection, coordination, and connection to safety. Most notably, these actions and interventions were driven by individual initiative rather than a standardized hospital protocol. It remains unclear whether the same protections would have been initiated in a different healthcare setting or with a different care team, underscoring the need for consistent, system-wide response standards. This is especially common in cases where victims are afraid to report abuse or may never file a report with law enforcement, making the healthcare system a critical intervention point with life-saving potential.

Standardized screenings, dedicated response teams, coordinated referrals, and comprehensive mandated trainings can create a reliable and accountable healthcare response to domestic violence. These measures strengthen patient and staff safety, support healthcare professionals in managing high-risk situations, and ensure that disclosures of abuse prompt timely interventions. By improving healthcare system's ability to recognize risk, respond consistently, and prioritize patient safety, these recommendations advance public health and prevention goals, reduce preventable harm, and reinforce the healthcare systems role as a trusted provider for individuals and families affected by domestic violence.

3. Emergency Response and Law Enforcement: Critical Frontline Interventions and POST Board Oversight

Law enforcement and emergency dispatchers are often the first system response when domestic violence escalates to immediate danger, placing them at the front line of prevention, protection, and crisis response. Officers and dispatchers are routinely called into highly dangerous or escalating situations marked by fear, volatility, and incomplete information—domestic violence calls for service often being the most dangerous or most lethal for responding officers. Add to this the potential presence of weapons, decisions made over the span of minutes can carry life-altering consequences and have significant safety implications. However, inconsistent training standards across law enforcement entities as well as limited access to cross-jurisdictional information can create discrepancies in processes, protocols, and response measures that serve the broader community.

Case findings identified incidents in which both the victim and the perpetrator placed multiple 911 calls during escalating conflict on the same day as the homicide. Law enforcement responded to the scene where they made contact and cleared the initial call. This sequence of events represented a significant missed opportunity for intervention pre-homicide. Early identification of heightened lethality indicators could have confirmed risk and provided probable cause for law enforcement to initiate proactive intervention, de-escalation strategies, as well as victim protections. This opportunity also emphasized a critical missed intervention point when the safety of a minor was placed at lethal risk. Had the circumstances differed slightly, and had the perpetrator acted in ways consistent with other domestic homicide cases, this incident could have resulted in a double homicide. The Team highlights this case to raise awareness and offer recommendations for system reform and POST Board oversight, noting that the Opportunities for Intervention identified reflect agreement and input from Team members representing five different police departments across Hennepin County.

The Team's review identified two additional critical intervention points that warrant emphasis for all system providers, as they may help prevent or mitigate future fatalities. First, perpetrators commonly use control over personal belongings or items of value as a means of maintaining power and attempting continued contact with victims. Put plainly, the retrieval of personal belongings—especially post-separation, after the victim has safely exited the relationship or acted on the decision to leave—can become a point of extreme lethality risk. Beyond the case reviewed by the Team, a victim's attempt to retrieve personal belongings immediately preceding a homicide is a recurring pattern in domestic violence fatalities, often reflecting a final effort by the perpetrator to re-exert control. While this is not true in every dispute involving personal property, the Team's homicide review indicated this opportunity for prevention and clear system action, such as encouraging the use of law enforcement escorts to obtain belongings.

The second critical intervention opportunity also occurred on the day of the homicide. The victim placed several additional 911 calls following initial law enforcement contact, but because the scene was cleared in response to an earlier call, the other calls went without response or follow-up. This included the final call that was made at the time the victim was murdered and while dispatch was still on the line.

These tragic circumstances and the resulting domestic violence fatality provided a clear roadmap for the Opportunities for Intervention (continued on page 37), which are intended to help prevent future domestic homicides. These include standardized trainings through POST Board authority, strengthened accountability and professional oversight of field conduct and front-line response, and the expansion of prevention-oriented policing models.

- **Standardized Training through POST Board Authority**
  - Establish POST Board mandated domestic violence training requirements for all peace officers, reinforced through academy instruction and continuing education credits for peace officer license renewal.
  - Ongoing domestic violence training requirements should include:
    - Risk assessments and lethality indicators.
    - Implicit and systemic bias (i.e., race, gender, victim credibility, neighborhood bias).
    - How to respond to coercive control and non-physical forms of abuse.
    - Trauma-informed interviewing and response.
    - Clear training protocols for cases involving dual callers or allegations of mutual combat, ensuring officers can distinguish resistive violence from primary aggression.
  - Require annual secondary trauma training for peace officers to support decision making, officer wellness, and professional conduct; especially when officers are involved in cases where a victim is pronounced dead on scene.
  - Mandate specialized training for 911 dispatchers, recognizing dispatch is the first point of contact for victims, and is essential for relaying messaging and evaluating risk. Training curricula should include:
    - Domestic violence dynamics and escalation.
    - Risk and lethality assessment.
    - Secondary trauma and trauma-informed communication.
    - Clear training protocols for cases involving dual callers or allegations of mutual combat, ensuring officers can distinguish resistive violence from primary aggression.

- **Strengthening Accountability and Oversight**
  - Create clear, enforceable, accountability mechanisms to ensure domestic violence response policies are consistently followed at the city, county, and state levels.
  - Consider standardized review processes to examine:
    - Officer documentation of resources offered to victims and families.
    - Compliance with required safety, and referral protocols.
  - Strengthen supervisory accountability by requiring documented review, corrective action, and follow-up when response policies and compliance with Minnesota Statutes §629.341 Subdivisions 3 and 4 are not adhered to.
    - Implement progressive disciplinary pathways, up to and including termination, when patterns of negligence, noncompliance, or failure to improve are identified in accordance with POST Board model policies.

- **Improve Front-Line Response Practices**
  - Set minimum due diligence standards for on-scene response, including:
    - Persistent and reasonable efforts to make contact with callers or witnesses.
    - Adequate time on scene to assess safety.
  - Require confirmation of victim safety prior to clearing call, including:
    - Relevant background checks (i.e., protection orders, prohibited persons, restricted weapon access).
  - Assessment of immediate risk following officer departure. Ensure consistent availability of civil standby services to support the safe retrieval of personal belongings, recognizing this stage as a frequent point of heightened risk and potential lethality.
    - Establish coordinated escort protocols through county, local law enforcement, and district court partnerships to provide law enforcement accompaniment when victim lethality assessments indicate elevated risk.
    - These protocols should include sustained staffing and resource allocation to support multijurisdictional response and ensure timely access to civil standby services across jurisdictions is available to victims exiting abusive relationships.

- **Expand Prevention-Oriented Policing Models**
  - Adapt and expand Toward Zero Deaths (TZD) framework to address domestic violence and law enforcement collaboration across jurisdictional boundaries.

Consideration and implementation of these measures would support earlier identification of escalating danger and reduce variability in response across jurisdiction by reinforcing domestic violence as a core public safety priority. In addition, these measures establish clear expectations and provide meaningful support for officers and dispatchers, promoting sound decision-making, professional accountability, and public trust. Together, these Opportunities for Intervention provide a practical, prevention-oriented framework for strengthening emergency response while advocating for long-term safety outcomes for first responders**,** victims, their families, and the broader community.

The Opportunities for Intervention outlined in this section respond directly to challenges identified through case review by advancing a more cohesive statewide response infrastructure. Through POST Board authority and oversight, these recommendations strengthen training continuity and mandate consistency, reinforce accountability at every level of supervision, and improve on-scene response practices. Collectively, these interventions are designed to support law enforcement professionals by providing clearer standards, consistent guidance, and effective prevention tools that enhance safety for victims, families, and responding officers alike—affirming domestic violence response as a fundamental public safety responsibility rather than a discretionary function.

4. Protecting Children, Youth, and Families: Intentional System Intervention and Reform

Children and young people affected by domestic violence often move through multiple systems, including healthcare, child protection, court, and schools, without any single system holding a complete or coordinated understanding of their circumstances or needs. Fragmented pathways across these systems can result in early warning signs being overlooked or inadequately addressed, delaying meaningful intervention, and placing an undue burden on families to navigate complex systems during periods of heightened stress, risk, and instability. Research and case experience consistently demonstrate that children who experience or witness domestic violence are at increased risk of either victimization or involvement in violence later in life, underscoring the long-term consequences of early response.

Case review findings from 2019 and 2022 highlighted early childhood trauma after minor children witnessed the homicide. Following the death of the victim, these children were left in the presence and custody of the perpetrator. Although these children were not physically injured or directly threatened, their exposure to lethal violence and the resulting psychological harm was substantial and undeniable. These cases underscore crucial Opportunities for Intervention to strengthen early protective responses and improve outcomes, particularly in cases involving Child Protections Services, Family Court involvement, child witness response protocols, and coordinated forensic practices.

A more intentional, developmentally responsive, and trauma-informed approach is needed. One that recognizes how children experience harm, seek safety, and recover overtime. The following section presents a coordinated set of system-level strategies identified by the Team to strengthen protections across systems that are most likely to engage with children, youth, and families. These recommendations emphasize shared accountability and sustained engagement over time, recognizing that children's adaptation to living in violent or unpredictable environments can significantly affect development, education, and wellness outcomes.

In cases reviewed by the Team, children's long-term exposure to domestic violence, particularly during adolescence, was often accompanied by a lack of coordinated assessment, treatment planning, and follow-up across systems. Most concerning was the drop-off in continuity of care and support as children aged, despite ongoing developmental and trauma-related needs. As a result, long-term supports often failed to follow youth through critical stages of development into adulthood. Too often, systems implicitly assume children will recover without sustained intervention, rather than providing consistent, overlapping supports embedded into their daily routines, educational settings, and community environments.

Refining how systems identify risk, exchanging critical information, supporting developmentally informed decision-making, and sustaining continuity of care is essential to interrupt cycles of harm. By reinforcing protective relationships and coordinated supports that promote long-term stability and wellbeing, systems can help ensure children, youth, and families are supported toward healthy development and resilience, rather than left exposed to conditions that perpetuate intergenerational patterns of violence.

The following Opportunities for Intervention, detailed on pages 39-41, are recommended for consideration and implementation.

- **Child-Centered Investigation, Forensic Response, and Advocacy**
  - Integrate domestic violence risk and lethality indicators into Child Protection Services (CPS) screening, investigations, and case assessments to support consistent identification of prolonged exposure, escalating risk, and potential lethality.
    - Standardize CPS prompts to assess history and patterns of domestic violence, coercive control, and prior system involvement when domestic violence or sexual assault is present in the home.
    - Use cumulative risk and lethality assessments to inform safety planning, service referrals, and case decisions.
    - Require more comprehensive family-system assessments that consider mental health screening and follow-up as standardized CPS case outcomes when domestic violence is present.
  - Strengthen cross-system coordination across CPS, courts, law enforcement, healthcare settings and advocacy organizations in cases involving child witnesses, children who have been exposed to domestic violence for an extended period of time. Expand and standardize access to child advocacy and forensic interviewing services for children exposed to domestic violence or homicide.
    - Increase availability and flexibility of forensic interviews.
    - Expand access to greater Minnesota for cases supporting alternative locations for forensic interviews.
    - Ensure clear understanding of forensic interview protocols for cases where parental or guardian presence restricts authentic engagement or when the child's caregiver is deceased.
      - The goal is to ensure child safety, evidentiary integrity, and minimizing negative influence by a perpetrator prior to the forensic interview.
  - Commit to continuous, community-informed improvement in child protection and forensic response.
    - Incorporate findings from fatality reviews, case reviews, community feedback, and best practices to strengthen community outreach activities, build rapport, close system gaps, and improve consistency in practice through outreach, investigation, and advocacy.

- **Strengthening School-Family Partnerships and Protective Factors**
  - Expand domestic violence-informed training for school-based professionals, including teachers, school social workers, counselors, administrators, and other student-facing staff, to support early identification, prevention, and coordinated response.
    - Trainings should emphasize monitoring educational progress alongside social-emotional wellbeing to ensure academic milestones are supported throughout recovery and development.
    - Recommended training curricula should include:
      - Domestic violence dynamics, coercive control, and patterns of escalation.
      - Identifying indicators of domestic violence exposure in children and youth across developmental stages.
      - The impact of trauma and grief on learning, behavior, and emotional regulation.

        - Trauma-informed, developmentally appropriate, and culturally responsive practices.
        - School-based safety planning and coordinated response with families and community partners.
        - Supporting attendance, engagement, and academic continuity across learning environments.
        - Secondary-trauma awareness and staff wellbeing to support sustainable and effective response.
- Implement extended, culturally responsive, school-based support structures for students from families impacted by domestic violence-related homicide, ensuring continuity of care through high school graduation or until age 18.
    - Develop state-level guidance for regular, age-appropriate check-ins to assess academic progress and provide safe opportunities for student disclosure, as well as ongoing evaluation of mental and physical wellbeing.
    - Expand access to psychological and mental health services based on assessed need rather than behavioral presentation alone, recognizing that trauma responses may not always manifest through observable distress.
    - Standardize school-based response protocols for attendance, engagement, and participation concerns linked to domestic violence or household safety issues, with particular attention to online and hybrid learning environments.
        - Require an early, coordinated school response to assess safety considerations, barriers to participation, and needed supports prior to escalation.
        - Ensure early notification and coordinated follow-up by school social workers and caregivers when a student's academic engagement declines, with structured monitoring to support early intervention, appropriate resource referrals, and continuity of care.

➢ **Judicial Oversight and System Continuity for Long-Term Safety**

- Strengthen coordination among court personnel, judges, guardians ad litem, custody evaluators, parenting-time evaluators, and Alternative Dispute Resolution providers in cases involving children impacted by domestic violence or homicide.
    - Require standardized domestic violence and sexual assault informed training for all court-appointed professionals to provide clear role expectations, ethical boundaries and guidance on trauma-informed and child-centered practices.
    - Establish consistent protocols for collaboration and information sharing among judicial officers, court-appointed professionals, victim advocates, and service providers to support informed judicial decision making and protective outcomes.
- Ensure continuity of services and supports for children across all custody outcomes, including cases that do not result in adoption or termination of parental rights.
    - Provide ongoing access to trauma-informed services, educational supports, and mental health care following custody determinations— independent of case disposition.
    - Expand court support to children to continue beyond criminal or civil case closure by requiring referrals, documentation of services offered, and accountability for follow-through among involved court personnel.

- Promote long-term judicial monitoring and follow-up in cases involving domestic violence or child exposure to violence.
    - Encourage courts to consider post-disposition review hearings, judicial check-ins, or coordinated referrals when custody or parenting-time decisions involve escalated risk or documented exposure to domestic violence.
    - Establish follow-up processes that do not solely rely on family-initiated requests to help ensure continuity of support is offered to children with complex histories of trauma.

The Opportunities for Intervention identified by the Team's findings further underscore the need for long-term, developmentally informed supports that prioritize children's mental health, emotional wellbeing, and educational stability; recognizing that exposure to domestic homicide places children at heightened risk for future victimization, trauma-related challenges, and learned patterns of violence. Early and sustained intervention is essential to disrupt these trajectories and to support healthy development over time.

These Opportunities for Intervention also call on education systems and school-based professionals to assume an active, long-term role in supporting children impacted by domestic violence and homicide, including early identification of safety concerns, proactive engagement with caregivers, and continuity of care throughout a child's educational experience. In the cases reviewed by the Team, opportunities for early school interventions were missed, due in-part to enrollment in alternative or online learning environments where routine contact, monitoring, and follow-up were limited. This oversight represented a critical area for system reform and improved monitoring.

Together, these recommendations offer a practical roadmap for strengthening how systems respond to children, youth, and families affected by domestic violence. Their effectiveness depends on deliberate investment, cross-system coordination, and sustained implementation across healthcare settings, child protection, courts, and education systems. Advancing these strategies requires ongoing collaboration, evaluation, harm reduction, and continuity of care. Through coordinated action, systems can help ensure safer, more stable outcomes for children and families and can help reduce the long-term consequences of domestic violence exposure.

5. The Hotel Industry as Prevention: Promoting Early Detection and Public Safety

In cases where individuals were precariously housed or relied on public lodging while living with an abusive partner, the Team identified distinct Opportunities for Intervention within Minnesota's hotel and motel industry. Because stays in these settings can range from brief to extended, hospitality environments may become unintended but critical points of contact during periods of heightened risk, particularly when severe violence or ongoing abuse remains unseen during prolonged or repeated stays.

Individuals fleeing violence may also seek temporary or longer-term refuge in hotels or motels, making these settings an important, though often overlooked, component of the broader safety net. As a result, the hospitality industry is well positioned to support prevention and early intervention through targeted training, standardized protocols, and clear response pathways that enhance safety for both guests and staff.

The Team's case findings indicate missed opportunities in situations involving extended lodging stays and close quarters, where observable indicators of risk (such as patterns of behavior, physical signs of harm, or repeated disturbances) may have been present but went unrecognized or unaddressed. These findings underscore the need for consistent, trauma-informed guidance that helps hospitality staff identify concerning indicators without placing them in investigative or enforcement roles.

The Opportunities for Intervention outlined in this section focus on strengthening early identification, safe response, and referral practices within hospitality settings. The following recommendations, continued on page 43, are intended for consideration by all hotels and motels, as well as the state hotel and lodging association, as part of a coordinated, statewide approach to violence prevention and public safety.

- **Develop Legislation and Training Mandates to Include Domestic Violence Prevention Training within Minnesota's Hotel and Motel Industry**
  - Minnesota Statutes §157.177 (Sex Trafficking Prevention Training) provides an adaptable legislative framework that could be used to establish domestic violence prevention training requirements. Modeled after §157.177 Subdivision 2, such legislation would require annual certification of training completion by every person, firm, or corporation that operates a hotel or motel in Minnesota. It would also ensure that each on-site employee, including, but not limited to, owners, operators, and managers—receives the required training.
  - Mandated training curriculum and requirements should be developed with oversight from the Minnesota Department of Health, in partnership with the state hotel and lodging association.
  - Training curriculum should cover:
    - An overview of domestic violence and the different forms of abuse to help promote public awareness and education.
    - How to recognize risk factors and behavior patterns (that may emerge over extended stays) commonly associated with domestic violence, including tactics used to exert power and control.
    - How to identify if someone is unsafe or experiencing domestic violence.

    - Effective prevention strategies and best practices to notify appropriate personnel, report concerns, or provide anonymous tips of suspected violence.

- **Strengthen Privacy, Safety, and Non-Disclosure Practices**
  - Adopt industry-wide guest privacy and non-disclosure protocols to help protect individuals at risk or fleeing domestic violence. Considerations should include:
    - Optional opt-in or registration features allowing guests to restrict room calls, visitor access, or disclosure of guest information.
    - Clear policies preventing staff from confirming guest presence, room numbers, or length of stay without explicit consent.

- **Increase Safe Access to Information for Guests Experiencing Abuse**
  - Ensure discreet access to domestic violence resources for guests that are strategically placed in restrooms, laundry rooms, vending areas, or other private, unmonitored spaces that include:
    - Flyers with an unmarked tab or a code word to discreetly signal that assistance or intervention is needed if provided to front desk staff.
    - QR codes or resource cards.
    - Materials that are available in multiple languages and accessible formats.

- **Design Protocols that Minimize Safety Risks During Long-Term Stays**
  - Establish routine guest care services designed to identify safety concerns (without intrusion or accusation) that allow for periodic wellness and refresh services, room inspection, or safety check-ins for all long-term guests.
    - All practices must be trauma-informed and part of standardized protocols to promote consistency and care for all guests.
    - Must have a clear pathway for staff to report or refer guests if signs or suspicions of abuse or maltreatment are suspected.

Integrating these strategies into Minnesota's hotel and motel industry would establish a more proactive and coordinated approach to domestic violence prevention. Targeted legislation, standardized training, and strengthened privacy protections would equip hospitality staff to recognize risk factors, respond appropriately, and safeguard guest confidentiality. When combined with discreet access to resources and trauma-informed protocols for long-term stays, these measures create meaningful opportunities for early intervention, while minimizing safety risks.

Collectively, these actions position the hospitality sector as a critical partner in public safety, capable of reducing harm, supporting individuals in crisis, and reinforcing a statewide commitment to violence prevention and survivor-centered care.

6. After Homicide: Long-Term Healing and Support for Impacted Families

The Team observed specific Opportunities for Intervention where there were inconsistencies in post-homicide supports offered to families following system engagement or prosecution. These opportunities aim to strengthen follow-up care by system providers, ensuring secondary victims and families of domestic homicide receive the critical supports and resources they may need along their healing journey.

Providing the necessary support to secondary victims and families of domestic homicide is crucial to mitigating risks and preventing future harm. By enhancing follow-up care practices, system providers can better address the impacts of domestic violence, associated grief, and potential financial hardship individuals may experience post-homicide. Offering timely interventions and comprehensive support reinforces a community-care model that fosters a responsive and empathetic environment for healing and wellbeing. The following Opportunities for Intervention should be considered, and continue on page 45:

- **Establish a Long-Term Support Infrastructure for Secondary Victims**
  - Create a dedicated resource hub and hotline for secondary victims and families of domestic homicide. These resources and supports should be easy to locate and should be provided beyond the conclusion of the criminal justice process, prosecution, or system involvement; recognizing a documented decline in communication, advocacy, and supports once cases are resolved.
    - Cases involving suspicious death or murder suicide without systemic resolve or formal closure for secondary victims and families of domestic homicide should be provided additional specialized supports and resources.
  - Improve access to specialists trained in supporting children and families impacted by homicide, including those navigating complex grief, trauma, and long-term system involvement.

- **Ensure Continuity of Care for Children and Caregivers**
  - Offer coordinated trauma-informed follow-up for all children of domestic homicide victims and their caregivers, regardless of custody outcomes or legal arrangements.
    - Services should address safety, grief, developmental and cultural needs, and long-term stability.
    - Special attention is required when children and their caregivers remain connected to, or impacted by, existing abusive dynamics, which may create additional barriers and affect receptivity to available supports.
  - Identify and establish clear pathways for cross-system coordination among victim advocacy, child protection, family courts, and community-based providers to prevent gaps in services for families.

- **Expand System Capacity for Sustained Outreach and Follow-up**
  - Increase capacity within domestic violence and community-based organizations to allow for consistent and proactive follow-up with impacted families over time.
    - Sustained outreach helps to reduce isolation, supports healing, and improves long-term outcomes for families and children.
    - Grief, trauma, and service needs will likely evolve over time, and may resurface long after the homicide; providers should prepare appropriate adaptations to services and supports accordingly.

- **Standardize Post-Homicide Resource Delivery**
  - Develop a standardized post-homicide grief and resource packet for families of domestic homicide victims.
    - Distribution of resources should be coordinated through trusted system parters (i.e., county attorney's office, child protection services, or victim advocacy organizations) to establish timely and consistent access.
  - Materials should include information on grief support, counseling, financial assistance, legal processes, victim compensation, long-term advocacy resources, and specialized supports for children and caregivers.

While the Team's work is primarily focused on identifying Opportunities for Intervention that may prevent domestic violence fatalities, outreach to impacted families has revealed a significant and consistent decline in system contact, coordination, and support following a homicide. This drop-off most often occurs after arrest, prosecution, or sentencing, when systems that were previously engaged leave families to navigate long-term consequences with limited guidance or continuity of care.

Regardless of case outcomes, the long-term well-being of children and families impacted by domestic homicide must remain a shared responsibility across systems. The Team emphasizes the need for extended, accessible, and coordinated secondary victim supports that continue beyond prosecution and sentencing and are not limited to short-term or crisis-based involvement. Sustained support is critical to addressing trauma, grief, developmental disruption, and long-term stability of affected families.

The Team's findings underscore the need for systems to adopt comprehensive post-homicide follow-up protocols that prioritize continuity of care. Through consistent outreach, coordinated referrals, and clear education about available resources, system providers can improve family outcomes and reduce secondary harm. Strengthening these practices contributes to a more responsive and compassionate system that acknowledges the enduring impact of domestic violence and supports families through the profound and lasting grief that follows domestic violence homicide.

Summary of Findings

The Minnesota Fourth Judicial District Domestic Fatality Review Team's 2025 Annual Report examines two domestic homicides that occurred in Hennepin County in 2019 and 2022 and identifies evidence-informed strategies that could help prevent future loss of life. These Opportunities for Intervention emerged from a multidisciplinary review conducted by professionals with extensive experience working with victims, families, and perpetrators of domestic violence across various Hennepin County systems.

The Team's findings reinforce a critical reality: domestic violence fatalities are rarely isolated or unpredictable events. More often, they occur within broader, escalating patterns of harm marked by identifiable warning signs and repeated contact with systems over time.

Across the cases examined, escalating harm was frequently preceded by recognizable lethality risk indicators, including threats of violence, stalking or control over the victim's movements, prior violence and system involvement, barriers to safety, and missed opportunities for earlier, coordinated interventions. These findings demonstrate how system fragmentation, inconsistent practice, and delayed response can significantly influence case outcomes when patterns of abuse continue to intensify without intervention.

The report identifies current gaps across systems, and outlines areas where changes to policy, protocol, and practice could substantially improve the state's response to domestic violence. The findings and Opportunities for Interventions detailed throughout this report are intended to inform policymakers and guide the development of more effective, coordinated system responses, recognizing domestic violence as an urgent public health and public safety crisis.

While it is not possible to determine whether any single recommendation would have prevented the deaths examined in this report, the collective lessons are clear. Prevention depends on actions taken before crisis points, when victims, families, bystanders, and perpetrators of violence are still moving through everyday systems such as courts, healthcare settings, schools, workplaces, hospitality services, and emergency response.

The Opportunities for Intervention are designed as actionable improvements that can be embedded into routine systems and operations, rather than reserved for exceptional circumstances or emergency response alone. Together, they strengthen the conditions in which systems earlier identify risk, offer intervene without delay, respond with consistency and care, and sustain protections beyond a single report, 911 call, or court appearance.

Every Opportunity for Intervention is connected to a specific system or agency entry point where targeted process changes and standardization of practices are encouraged. Beyond individual system analysis, the Team's findings are grounded in five thematic truths—each reflected through the experiences of the victims whose lives were lost (see page 47).

1. **Domestic violence is both a public health and public safety crisis.** It affects physical and mental health, places significant demands on healthcare, legal, and social service systems, and exposes communities to heightened risk. Without coordinated prevention and early intervention, violence often escalates overtime, increasing the likelihood of serious injury, intergenerational trauma, and preventable loss of life.

2. **Early action saves lives.** When responses are delayed, referrals deferred, or cases dismissed, critical opportunities for intervention during periods of highest risk may be lost.

3. **Information gaps create missed opportunities.** When critical case context cannot be accessed, shared, or effectively interpreted across systems or jurisdictions, lethality risk may be underestimated and warning signs overlooked.

4. **Inconsistency is a safety issue.** Variation in screening, documentation, and response protocols across agencies, jurisdictions, facilities, or shifts results in uneven protection, with those most at risk bearing the consequences of inconsistent practice.

5. **Accountability and support must be paired.** Sustainable prevention requires clear standards, oversight, and mechanisms for accountability, alongside reliable access to resources that enable victims, families, and first responders to act safely, effectively, and with dignity.

The Team calls for sustained commitment to prevention from every system partner, grounded in the shared understanding that lives can be saved when systems respond with urgency, coordination, and collective care. This commitment requires recognizing early warning signs as opportunities for intervention and protection, rather than isolated incidents, by responding without delay. Improving how risk is identified, information is shared, decisions are made, and supports are delivered—earlier, more consistently, and with greater continuity— communities across Hennepin County and throughout Minnesota can move toward a more effective, prevention-oriented response to domestic violence by working decisively to prevent future harm.

Implementing the recommendations outlined in this report provides a clear and actionable path to reducing domestic violence, preventing loss of life and strengthening public health and safety statewide. The Team urges policymakers, law enforcement, healthcare professionals, and community organizations to prioritize these recommendations in the year ahead, recognizing that the safety and wellbeing of Minnesotans depend on sustained, coordinated action across systems. Through shared responsibility and cross-sector collaboration, Minnesota can move toward a future where domestic violence fatalities are not viewed as inevitable, but a preventable --where every individual is afforded the safety and protection they deserve.

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