2012

A Matter of Life and Death

Fourth Judicial District Domestic Fatality Review Team

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

Project Chair:

The Honorable Gina Brandt
Minnesota Fourth Judicial District

2012 Community Partners:

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

2012 County and State Partners:

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

This report is a product of:

Fourth Judicial District Domestic Fatality Review Team

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Acknowledgments

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

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

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

Bethany Dorfe & Erin Raffensperger, who, as Team Volunteers, make our meetings run smoothly, make our reports readable, and generally make our lives better;

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

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

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

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Rochelle Thompson , Dakota County Child Protective Services
Adam Piccolino, Department of Corrections
Roxanne Anderson, Minnesota Trans Youth Network
Lori Swenson, Hennepin County Mental Health Court Coordinator
Pam Haas, COPE

Executive Summary

The Fourth Judicial District Domestic Fatality Review Team was created in 2000 with a mandate to review and observe cases of domestic homicide. Each year the Team produces a report to discuss their observations and possible Opportunities for Intervention. These Opportunities for Intervention are designed to encourage safety for victims of domestic violence and accountability for abusers in a way that is accessible and relevant. Out of respect for the privacy of the victims and their families, all identifying details have been removed. Also included in this report are facts about the domestic homicide rate in Hennepin County during the years in which these cases occurred to assist readers in putting the case information in context.

The Fourth Judicial District Domestic Fatality Review Team intentionally focuses on a few specific cases each year. This allows for an in-depth examination of all the facts of those cases from the varied perspectives of Team members. Members of the Team examine the case chronologies and then, as a group, make observations about specific elements of the case. These observations can better illuminate the context of the crime, or identify a missed opportunity to prevent the homicide. It is our hope and intention that these efforts will prevent domestic homicides in the future.

The Team has the privilege to assess multiple elements in the lives of those involved in a homicide. Often the members of the Fatality Review Team are the only representatives of the criminal justice system who have looked at the full scope of a person's involvement with social service, community, and criminal justice organizations throughout their lifetime, which uniquely qualifies the Team to develop relevant and informed Opportunities for Intervention.

In 2012, the Team reviewed four cases. In three of those cases, mental health issues figured prominently. In these cases, we found that the victims, perpetrators, and family member all had multiple points of contact with mental health services, whether in a hospital, clinic, or court setting. Understanding the prevalence of this interaction allows the Team to identify opportunities for the mental health system to enhance support for victim safety and perpetrator accountability. For example, the Team encourages Mental Health Professionals to incorporate tools of domestic violence screening both at intake and periodically throughout treatment. These tools should address overt acts of domestic violence in the past or present as well as elucidate behavior that is highly controlling, emotionally, or psychologically abusive. Additionally, the Team acknowledges that treatment for families in which domestic violence is present requires a specialized intervention. In order to ensure that mental health professionals are able to effectively assess for and successfully intervene in domestic violence dynamics, the Team suggests that licensing boards require domestic abuse education, as they do for ethics, alcoholism, drug abuse, autism, and child sexual abuse.

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

Guiding Standards

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

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

The Review Team reviews only cases in which prosecution is completed.
All prosecution must be completed before cases are reviewed. In addition to allowing all participants to discuss cases freely, the passage of time also allows some of the emotion and tension surrounding them to dissipate, generating more openness and honesty during the review process.

Findings are based primarily on information contained within official reports and records regarding the individuals involved in the homicide before and after the crime.
Whenever possible, information is supplemented by interviews with friends, family members, or service providers associated with the case. The findings of the Review Team are limited to the availability of information reported by these sources.

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

Many incidents that reflect exemplary responses to domestic violence, both inside and outside the justice system, are not included.
Instead, this report focuses on areas that need improvement.

The Review Team appreciates that several of the agencies that had contact with some of the perpetrators or victims in the cases reviewed have made or are making changes to procedures and protocols since these homicides occurred.
However, the observations included in this report are based on our review of actual case histories and what was in place at the time of the homicide.

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

We will never know if the recommended interventions could have prevented any of the deaths cited in this report.
We do know, in most instances, that the response to the danger in the relationship could have been improved.

The Review Team operates with a high level of trust rooted in confidentiality and immunity from liability among committed participants.
This process fosters honest introspection about policies, procedures, and criminal justice system responsiveness.

The Review Team does not conduct statistical analysis and does not review a statistically significant number of cases.
Actual numbers, not percentages, are used to ensure that analyses are not misleading.

The findings should not, alone, be used to assess risk in other cases.
Cases with similar scenarios will not necessarily result in the same outcome. However, the findings do address situations of potential danger for victims.

Homicide Data

In **2010,** 15 women, seven children, and two men were killed in domestic homicides in the State of Minnesota. Four of those homicides occurred in Hennepin County. The Fatality Review Team reviewed one of the cases in 2012.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Complex Homicidal Violence	19	Female	Boyfriend
Stabbed	42	Female	Husband
Stabbed	56	Female	Husband
Gunshot	28	Female	Boyfriend

Homicide Data

For the purposes of the Fourth Judicial District Domestic Fatality Review Team, domestic abuse is defined as a pattern of physical, emotional, psychological, sexual and/or stalking behaviors that occur within intimate or family relationships between spouses, individuals in dating relationships, former partners and against parents by children. This pattern of behavior is used by the abuser to establish and maintain control over the victim. Occasionally the Team reviews homicides that occurred in the context of domestic violence but in which the victim is not the primary victim of the abuse. The Review Team examined four domestic homicide cases in 2012. The Team only reviews cases in which more than a year has passed since the homicide and the case is closed to further prosecution. The following information includes all domestic homicides in Hennepin County in those years as well as the cause of death, age and gender of the victim and the relationship of the perpetrator to the victim:

In 2009, 12 women, one child, and one man were killed in domestic homicides in the State of Minnesota. Two of those homicides occurred in Hennepin County. The Fatality Review Team reviewed one of the cases in 2012.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot	24	Female	Former Boyfriend
Blunt Trauma	8 months	Male	Father

In 2011, 23 women, four children, and one man were killed in domestic homicides in the State of Minnesota. Eight of those homicides occurred in Hennepin County. The Fatality Review Team reviewed two of the cases in 2012.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Strangulation	45	Female	Boyfriend
Blunt Force Trauma	34	Female	Husband
Gunshot	20	Female	Former Boyfriend
Gunshot	21	Male	Girlfriend's Former Boyfriend
Gunshot	27	Male	Friend's Estranged Husband
Strangulation	40	Female	Boyfriend
Stabbing	58	Female	Husband
Stabbing	38	Female	Husband

Presence of Risk Factors

It is not possible to accurately predict when a perpetrator of domestic violence may kill the victim of abuse. However, researchers* have identified approximately 20 factors – from unemployment and substance abuse to death threats and access to guns – that are often present in cases of domestic homicide. The Fourth Judicial District Domestic Fatality Review Team notes the presence of risk factors in the reviewed cases and spotlights raising public awareness of risk factors for homicide as an opportunity for intervention.

Potential Predictors of Homicide	Case 1	Case 2	Case 3	Case 4
The violence had increased in severity and frequency during the year prior to the homicide.				X
Perpetrator had access to a gun			X	X
Victim had attempted to leave the abuser			X	X
Perpetrator was unemployed	X		X	X
Perpetrator had previously used a weapon to threaten or harm victim	X	X		X
Perpetrator had threatened to kill the victim	X	X		X
Perpetrator had previously avoided arrest for domestic violence	X	X		X
Victim had children not biologically related to the perpetrator.			X	
Perpetrator sexually assaulted victim				X
Perpetrator had a history of substance abuse	X		X	X
Perpetrator had previously strangled victim	X			X
Perpetrator attempted to control most or all of victim's activities			X	X
Violent and constant jealousy			X	X
Perpetrator was violent to victim during her pregnancy				
Perpetrator threatened to commit suicide			X	X
Victim believed perpetrator would kill 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		X

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

2012 Opportunities

The Review Team examines cases of domestic homicide and the lives of those involved, looking for points where a change in the practice of various agencies or individuals might have changed the outcome of the case. Review Team members examine the case chronologies and make observations about elements of the case. Sometimes the observations assist in identifying the context of the crime, other times they illuminate a clear missed opportunity to avoid the homicide. From these observations, the Team identifies Opportunities for Intervention that correspond to the observations.

This resulting information is focused on specific actions, or Opportunities for Intervention, that agencies could initiate in order to ensure that the incident seen in the case will not be repeated. These Opportunities for Intervention are not limited to agencies that commonly have interactions with the victim or perpetrator prior to the homicide, like law enforcement or advocacy, but include agencies or groups that may serve as a source of information about domestic violence, risk factors of domestic homicide or make referrals to intervention services. The Opportunities are organized into categories to assist the reader in identifying potential areas of focus. The Review Team recommends that all agencies refer clients to a domestic violence advocacy agency for safety planning, lethality/risk assessment, and other services whenever domestic violence indicators are present.

Opportunities for Legislative or Policy-Making Organizations

Introduce legislation to ease the process to extend an Order for Protection if the respondent has been incarcerated for a portion of the originally allotted protect time. This will assist victims of domestic violence in having confidence in their safety following the release of their abuser.

Enhance state health education curriculum recommendations to include comprehensive education to Elementary, Middle and High school children about domestic violence, dating violence, healthy relationships, and resources to help prevent violence.

Opportunities for Criminal Justice Response to Domestic Violence

Courts

Develop consistent responses to probation violations with heightened accountability when victim safety or victim contact is an issue.

In cases that have a domestic violence component, consider ordering domestic violence intervention and domestic risk assessment as a part of the sentence.

In consultation with Child Protection and representatives from the correctional facility, implement a process for determining when, or if, an inmate incarcerated for offenses against a child may have contact with children.

Ensure that the Mental Health civil court considers a person's history of domestic violence in assessing whether that person is dangerous to others for purposes of release and appropriate commitment.

Department of Corrections

Jail and prison personnel should check for Orders for Protection at booking or intake and enforce them by blocking calls, letters and visits. Make information on means to block calls and contact available to the person who petitioned for the order.

Integrate screening for domestic violence history and risk, through offender self-report, validated risk assessment tools, and a review of criminal history, into the intake and release planning process.

Provide opportunity and encouragement for inmates incarcerated for violence against a family member to access programming in parenting and domestic violence intervention. Further, make programming of this type available in all Minnesota Department of Corrections prison facilities.

Law Enforcement

Attempt to interview all witnesses to a domestic assault to enhance evidence-based prosecution. When interviewing children who have witnessed a domestic assault, conduct the interview in an age-appropriate and trauma-informed manner to minimize further trauma.

Have law enforcement consistently provide referrals to sexual assault programs for people who report being victims of sexual abuse.

It is a best practice for law enforcement to facilitate immediate contact between a victim of domestic violence and an advocate.

Consider providing regular officer training on the topics of identifying dissociative responses to trauma at the crime scene or during interviews and sexual assault resources for victims.

Offer referrals for support for the victims of domestic violence and family members of the victim who are also affected by the abuse.

Implement changes to NCIC criminal history to improve clarity, completeness, and content; include the name of the victim in domestic violence cases. Having this information can assist the prosecutor in enhancing charges when appropriate.

Offer an opportunity for COPE, or similar immediate response psychiatric team, to meet with victims who are in need of mental health assessment at the crime scene or in the hospital.

Adult Community Corrections & Rehabilitation

Ensure that all information in the probation file is shared, within one month, between transferring and receiving probation officers when a case is transferred between counties so that services are continuous and the client has consistent supervision. Further, phone contact is between transferring Probation Officer and receiving Probation Officer is considered best practice for ensuring that quality services are continued.

Encourage probation officers to file Arrest and Detention orders, as appropriate, when victim safety or victim contact is an issue.

Juvenile Community Corrections & Rehabilitation

In developing a programming plan for offenders, consider violence against family members as a predictor of future abusive behavior in relationships, and offer appropriate referrals for intervention programming.

Opportunities for Human Service Response to Domestic Violence

Child Protection Services

Provide victims of domestic violence specific, relevant information about resources in the community at intake screening and at closing of the case by Child Protection Services.

Opportunities for Other Mandated Reporters or Helping Professionals

Advocates

Develop relationships with area hospitals to support victims of domestic violence who are identified by medical personnel. Implement a collaborative response procedure to respond when contacted by Sexual Assault Resource Services (SARS) nurses or medical personnel to assist a victim of domestic violence at the hospital.

Mental Health Professionals

Treatment for families in which domestic violence is present requires a specialized intervention. In order to ensure that mental heath professionals are able to effectively assess for and successfully intervene in domestic violence dynamics, licensing boards could require domestic abuse education, as they do for ethics, alcoholism, drug abuse, autism, and child sexual abuse.

Incorporate tools for domestic violence screening both at intake and periodically throughout treatment. These tools should address overt acts of domestic violence in the past or present as well as elucidate behavior that is highly controlling, emotionally or psychologically abusive.

Provide educational and awareness materials in the clinic setting that includes information about all forms of domestic abuse including examples of controlling behavior and extreme jealousy. Extreme jealousy and control of a partner is a lethality indicator, but it is not readily identified in the general public as a form of domestic violence. If victims of this behavior have an expanded knowledge of the danger that it poses to them, they may make different decisions about their safety.

Medical and Hospital Professionals

Implement best practices for Sexual Assault Nurse Examiners to identify patients who are particularly vulnerable to further abuse (LGBTQ, marginally-housed, trading sex, immigrants, etc.) and provide culturally specific resource connections and further to record information regarding referral to an advocate or counselor.

When receiving a report of abuse , hospital personnel should contact an advocacy agency and connect person reporting the abuse with an advocate. Hospital staff should follow-up to see if the victims needs additional services.

Modify current procedure to have medical staff chart exchanges with family members that disclose information about threats of violence or past violence to ensure follow-up referral to social work department or law enforcement. Current practice appears to give the impression that the information will have an effect, while there is no mechanism for it to be shared with professionals who can provide help to the affected family members.

Court Administration

Develop an auditing system to verify the accuracy of MNCIS records.

Include risk information, safety planning, and referral to advocacy for domestic abuse victims in the self-help packets for child custody/parenting time and dissolution.

Opportunities for Education and Awareness

Create public education of the gender bias inherent in domestic violence and the increased vulnerability to violence of the members of the LGBTQ community and other marginalized persons.

2012 Achievements

A benefit of the current structure is the change-making work that has organically developed from the process of case reviews within the Fourth Judicial District Domestic Fatality Review Team. Since all the Team members are in some way connected to community, justice or government systems that serve those who may become the perpetrator or victim of a domestic homicide, each member also brings a unique perspective on ways in which their agency's work can prevent homicide. The trusting relationships Team members build with each other often enhance their ability to work within their organization and the broader community with more creativity and a clearer understanding of how various system components can be utilized to address the factors that can lead to domestic homicide.

The Domestic Fatality Review Team has published nine previous reports in which we have identified recommendations for changes to system procedures that increase safety for victims and hold perpetrators accountable. After each of the reports, we collect information about changes that were made in response to Opportunities for Intervention identified by the Team. Additionally, some members of the Review Team, having identified a better way to keep victims safe and hold abusers accountable through case reviews, are able to share their knowledge and skills as part of larger initiative to change policy or practice. Some examples of these efforts are highlighted below.

- Ramsey County has formed an ad hoc committee to explore the creation of a Fatality Review Team for the Second Judicial District. If this process continues in its positive direction, this will be only the second Fatality Review Team to be formed in Minnesota. Our enabling legislation was amended in 2009 to extend the opportunity to begin a Domestic Fatality Review Team to every judicial district in Minnesota.
- Through a VAWA STOP grant administered by Minnesota Office of Justice Programs, the Minneapolis City Attorney's Office partnered with Minneapolis Police Department Domestic Assault Unit and Domestic Abuse Project (DAP) in a project to enhance enforcement of Domestic Abuse No Contact Orders (DANCOs) issued by the court and on-site access to advocacy support for victims of domestic violence. In the year of this project, in which a DAP advocate and police officer teamed up to visit the homes of victims of domestic violence to offer advocacy help and determine that the DANCO is being obeyed, a higher conviction rate was achieved.
- Judge Karasov and Assistant City Attorney, Michelle Jacobson, who have both been members of the Fatality Review Team, now conduct a one hour training on domestic violence and statutory requirements for all new judges in the Fourth Judicial District.
- The Domestic Violence Best Practices guide has been compiled and ready to be approved for use in all courts in the Fourth Judicial District.

Project History

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

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

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

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

During the process of developing the proposed legislation, the Advisory Board assembled a larger Planning Committee comprised of 34 members representing private, public and nonprofit agencies and organizations to gain a variety of perspectives on particular topics and to develop broader support for the project. The

Planning Committee worked primarily on establishing a definition of domestic homicide and on identifying who should be represented on the Review Team. Once critical decisions had been made about participation and structure, the existing Advisory Board worked with Senate counsel to put together legislation that would create and fund the project. The legislation also included important data privacy and immunity provisions that would enable the project to gain access to confidential records related to these cases and provide immunity to those who spoke openly to the Fatality Review Team about case information.

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

The Advisory Board returned to the legislature during the 2000 session to pursue the data privacy and immunity provisions. The legislation passed and was signed by the Governor. It became effective on August 1, 2000. In 2004, the State Legislature granted an extension to these provisions until June 2006. In 2006, the Team was granted another extension, this time to December 2008. In 2009, the legislature made permanent the data access that enables the work of the Team and extended the opportunity to develop a Fatality Review Team to all Judicial Districts in Minnesota with Statute 611A.203.

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

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

Fourth Judicial District Domestic Fatality Review Team

Purpose

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

Goal

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

Structure & Processes

The Review Team Structure

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

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

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

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

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

Case Selection

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

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

The Project Director uses information provided by the Minnesota Coalition for Battered Women's Femicide Report and homicide records from the Hennepin County Medical Examiner's Office to determine which cases to review. The Team reviews a mix of cases that differ from one another based on race, location of the homicide and gender of the perpetrator.

The Case Review

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

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

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

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

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

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