



# A Matter of Life and Death

2018  
Review

Fourth Judicial  
District  
Domestic Fatality  
Review Team

# In This Report...

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Community Volunteers  
Create Impact Consulting  
Domestic Abuse Project  
Eden Prairie Police Department  
Hamline University  
Minneapolis City Attorney's Office  
Minneapolis Police Department  
Paradigm Counseling  
South Lake Minnetonka Police Department  
The Advocates for Human Rights

## 2018 County & State Partners:

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

## This report is a product of:

Fourth Judicial District Domestic Fatality Review Team

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## Fourth Judicial District Domestic Fatality Review Team

### Purpose

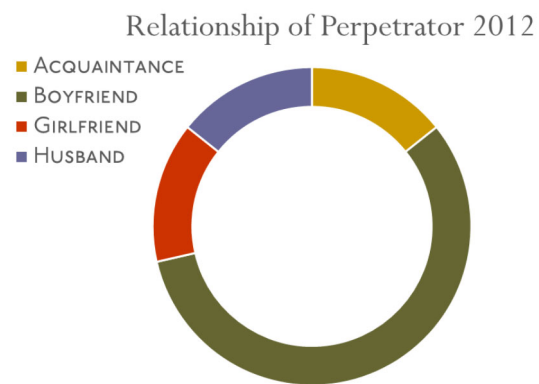
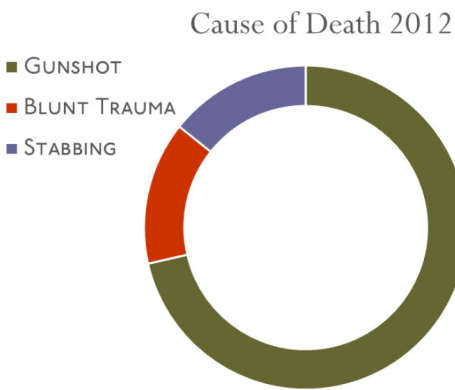
The purpose of the Fourth Judicial District Domestic Fatality Review Team is to examine deaths resulting from domestic violence in order to identify the circumstances that led to the homicide(s).

### Goal

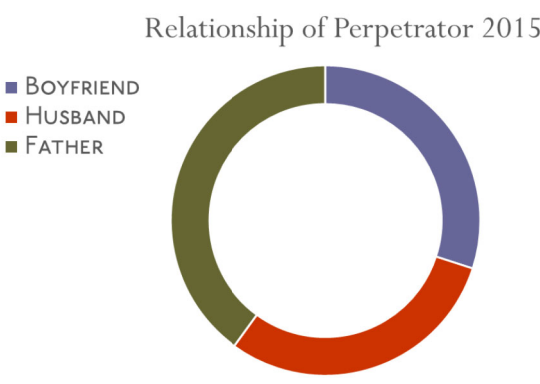
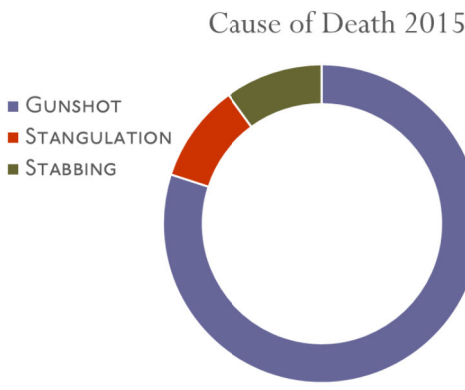
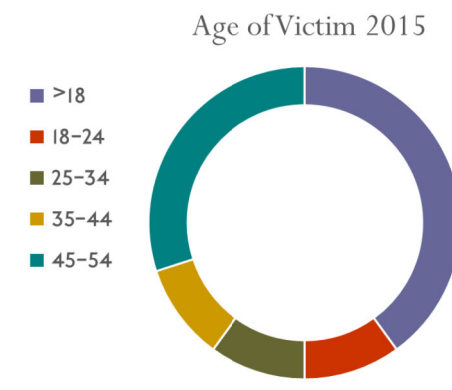
The goal is to discover factors that will prompt improved identification, intervention and prevention efforts in similar cases. It is important to emphasize that the purpose is not to place blame for the death, but rather to actively improve all systems that serve persons involved with domestic abuse.

# Homicide Data

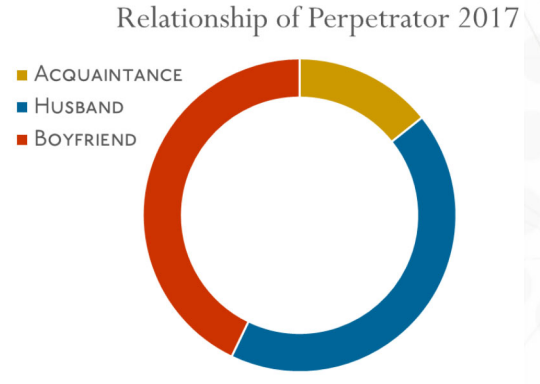
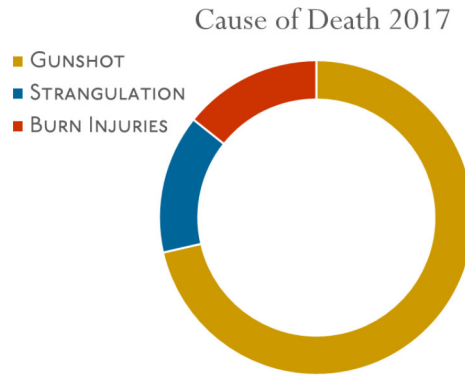
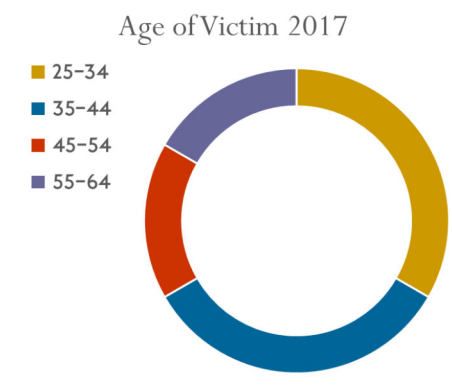
In 2012, at least 15 women, 3 men, were killed in intimate partner homicide in Minnesota. 7 of these deaths occurred in Hennepin County and we reviewed 1 of these cases in 2018.



In 2015, at least 22 women, 2 men, 4 children, and 5 family members were killed in intimate partner homicide in Minnesota. 10 of these deaths occurred in Hennepin County and we reviewed 1 of these cases in 2018.



In 2017, at least 19 women and 5 family members were killed in intimate partner homicide in Minnesota. 7 of these deaths occurred in Hennepin County and we reviewed 1 of these cases in 2018.



We review cases of domestic homicide– homicides related to domestic abuse which 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. 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.

# 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 20 factors that are often present in cases of domestic homicide. The Fourth Judicial District Domestic Fatality Review Team notes the presence of risk factors in the reviewed cases because public awareness of risk factors for homicide is an opportunity for intervention.

Risk Factors
The violence had increased in severity and frequency during the year prior to the homicide.
Perpetrator had access to a gun.
Victim had attempted to leave the abuser.
Perpetrator was unemployed.
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.
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.
Perpetrator attempted to control most or all of victim's activities.
Violent and constant jealousy.
Perpetrator was violent to victim during pregnancy.
Perpetrator threatened to commit suicide.
Victim believed perpetrator would kill him/her.
Perpetrator exhibited stalking behavior.
Perpetrator with significant history of violence.
Victim had contact with a domestic violence advocate. (this is a protective factor)

Case 1	Case 2	Case 3
		X
X	X	
X	X	X
X	X	X
X	X	X
X	X	X
X	X	X
X	X	X
		X
	X	X
X		X
n/a		n/a
		X
	X	X
X		X
		X

## Data Access

Grant access to juvenile records for City Attorney staff who are charging domestic abuse cases. This will allow for more accuracy in charging by allowing for accurate enhancement of charges where appropriate. This was previously identified as an opportunity in our 2010 report.

## Relaying Information

Create a way for law enforcement to consistently identify and designate tactics of intimate partner abuse occurring in the context of other cases, such as property damage, so that it can be considered in charging of the case, any plea agreements, and probation recommendation, and advocacy services may offer assistance to the identified victim.

Expand channels through which victims in domestic violence cases can communicate with advocates, victim/witness staff, prosecuting attorneys, jail, and law enforcement to include WhatsApp, Facebook Messenger, Snapchat which can be accessed without a data plan.

Incorporate evaluation of predatory offender registration compliance into probation reports to the court on cases where this is relevant.

Develop process through which all parties, including the prosecutor and defense attorney, are notified when violations of conditional release are reported to the judge by probation.

## Enhance Existing Intervention Services

Incorporate information and support services for friends and family members of people experiencing abuse into advocacy and domestic violence therapy intervention agencies. This will reduce isolation and create stronger, more informed support networks for people as they build lives free from abuse.

Develop more robust programming opportunities in jail and the workhouse to reduce barriers to access for treatment and intervention services. Similarly, create a supportive path from incarceration to supervised release and reentry that encourages the seamless continuation of educational, treatment, and therapeutic services. This can be made more financially feasible by cultivating strong community partnerships.

Include stronger mental health assessment and treatment components into the traditional domestic violence intervention programming for people who use abuse.

Adequately fund advocacy and domestic violence therapy intervention agencies to provide case management and individualized care plans for people who are experiencing challenges in mainstream programming.

Explore county wide funding from domestic violence crisis intervention and education services that function outside of the law enforcement response. The potential for negative outcomes, child protection involvement, or fear of repercussions for housing stability or legal status can be barriers to people seeking help from police for domestic violence.

## Increase Screening Points

Integrate domestic violence screening questions into court ordered forensic psychological evaluations and chemical dependency screenings. This will help to close the gap that occurs when mental health or substance

# 2018 Opportunities

use issues are addressed by the court in domestic violence cases by domestic violence screening or programming is not ordered.

Conduct further assessment in cases where a person has an extensive history of violence against others when determining whether to order Supervised Release or Intensive Supervised Release.

Reassess program and probation requirements for people who have repeat probation violations. Particularly in cases where the case and violations both involve domestic violence, the degree to which the person has engaged in domestic violence programming should be considered.

## Expanding Use of Lethality Assessment

*The factors that are most often present in cases of domestic homicide are well researched and well established but not widely known. The twenty points in the Danger Assessment informs the lethality assessments used by law enforcement and other agencies around the country. Our team tracks the factors present in the cases reviewed and reports them among our other findings annually. Increased recognition of these factors could also help to inform which cases require more resources and monitoring.*

Media may consider highlighting the lethality factors present, especially the less obvious like constant jealousy, controlling activity, and in cases of domestic homicide as a means of improving their audience's understanding and recognition of those factors.

In cases where a victim has answered affirmatively to items on the lethality assessment and the alleged perpetrator is not in custody, law enforcement could consider calling on other resources- advocacy agencies, crisis response teams, or community organizations- to address immediate safety needs.

The Review Team examines cases of domestic homicide and the lives of those involved, looking for points of contact between various agencies or individuals, the person killed, and the person who committed the homicide. 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 potential missed opportunity to avoid the homicide. From these observations, the Team identifies Opportunities for Intervention that correspond to the observations.

# 2018 Review Team Members

## Thanks

The Honorable Fred Karasov, 2018 Project Chair, gratefully acknowledges the supporters and members of the Fourth Judicial District Domestic Fatality Review Team:

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

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

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

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

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

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

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\* Member of Advisory Board \*\* Resigned the Team in 2018 † Joined Team in 2018

## *Guiding Standards*

*The perpetrator is solely responsible for the homicide.*

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

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

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

*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.*

*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.*

*The Review Team attempts to reach consensus on every opportunity for intervention.*

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

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

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

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

## *Fourth Judicial District Domestic Fatality Review Team*

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