2007 Findings of the
Domestic Fatality Review Team

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

A matter of life and death

The Domestic Fatality Review Team is a
collaboration of private, public,
and nonprofit organizations
as well as citizen volunteers
from throughout Hennepin County.

The views expressed within this report reflect
collective discussions and decision making
within this collaborative group
and do not necessarily reflect the views
of the respective organizations represented by its membership.

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Letter from the Project Director

I am pleased to present the 2006 report from the Hennepin County Domestic Fatality Review Team (Review Team). This report is intended to be a companion to the initial 2002 report and our subsequent progress report in 2004 .

The 35-member Review Team represents a diverse group of professionals, including judges, prosecutors, public defenders, physicians, advocates, probation officers, psychologists, corporate human resource directors, social workers, community volunteers, and policy makers. More than half of our members have experienced violence and abuse in their own immediate families.

While our Review Team is unique in Minnesota, it is part of a growing national movement to provide in-depth case reviews of the events and circumstances surrounding domestic homicides to identify responses and strategies to prevent similar tragedies in the future . We have gained a national reputation for the quality of our reports, the thoroughness of our review process, and our success in implementing changes. Alaska and Georgia have sought our assistance in helping them to establish a review process in their communities. Other communities in Minnesota have received training and technical assistance from our Review Team as well. Minnesota policy makers, legislators, survivors of domestic violence, and advocates, have encouraged our outreach within the state with the goal of establishing similar review teams in other judicial districts. We have recently received additional grant funding to work with other Minnesota communities to implement fatality review teams in their jurisdictions.

The review process in Hennepin County has spawned a level of trust and cooperation among group members that fosters rigorous introspection and examination of policies, procedures, and criminal justice system responses. We have found that the process constantly evolves as we strive to improve our investigation and implementation efforts and ultimately to be an effective catalyst for change.

We hope this report will inspire change that ensures the safety of women and children in their homes and result in a safer community for everyone.

In this report (at page 24) we have enumerated changes made by various criminal justice agencies that address recommendations made in our past reports. We want to recognize and commend the progress made in these specific areas. In the future we will continue to monitor initiatives in the community and the criminal justice system that correspond to opportunities for intervention identified in our reports. In this way we hope to better hold ourselves and others accountable for taking action based on what we have learned. Through positive change in our response to domestic violence, we can pay tribute to those whose lives and deaths we have examined.

Tim Reardon

Project Director 2003-2006

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I. Things to Keep in Mind While Reading This Report

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. We also recognize that agencies and individuals can sometimes improve how they handle and respond to domestic homicide cases.

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 only reviews cases that are closed to any further legal activity. All litigation, including opportunities for appeal, must have been completed for at least one year 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 services 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.

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 a 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 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.

II. Introduction

Sometimes a careful look back is the wisest way to move forward.

After a long history of domestic violence, a young boy witnesses his father murder his mother before taking his own life. As an adult, he is imprisoned for the murder of his own partner.

Another child witnesses his father murder his mother after he tries to intervene. The child, now a gang member, is imprisoned for drug-dealing and assault.

True stories like these are the tragic aftermath of domestic violence. The devastation of domestic violence spares no community—it transcends class, income, education, and culture. Over the past 13 years, at least 105 women, 35 children, and five men have been murdered as a result of domestic violence in Hennepin County. In 2005, the domestic assault filings in Hennepin County District Court alone were 217 felonies, 662 gross misdemeanors, and 3,358 misdemeanors. Order for Protection (OFP) filings were a record 2,676.*

The Hennepin County Domestic Fatality Review Team (Review Team) was created to improve policies and procedures to better address domestic violence in our county. The purpose of the Review Team is to examine deaths resulting from domestic violence to identify the circumstances that led to the homicides. 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 intent is not to place blame for the deaths, but rather to actively improve all systems that serve persons involved with domestic abuse.

The Review Team was established on August 1, 2000, through state legislation. Members are appointed by the Chief Judge of the Fourth Judicial District in Hennepin County with required representation from a number of agencies spelled out by statute. An advisory board composed of experienced members of the group guides the Review Team's work and handles administrative aspects of the project.

* Orders for protection may be obtained from the court upon a showing of imminent threat of harm to an intimate partner or children. The order prevents any contact of the victim by the perpetrator. The court may grant an initial order without input from the threatening party but the threatening party is given a hearing at which he may contest the order within days . The order that is issued after this contested hearing is effective for a period of one year and may be renewed upon a showing of an ongoing threat.

Early on, the Review Team developed a process for selecting and reviewing cases. Cases are chosen based on information provided in the Minnesota Coalition for Battered Women Femicide Report, which is published annually, and homicide records from the Hennepin County Medical Examiner's Office. Cases are selected to include domestic homicides with varying circumstances: murder/suicide; deaths occurring within immigrant communities; death of a child ; death of an uninvolved third party, for example. The Review Team's definition of domestic homicide included any death resulting from family violence. Documents are collected from any and all agencies that are identified as having contact with the family of the deceased around issues related to domestic violence. By statute these may include medical records, police reports, shelter records, psychological records, and child protection records. Advocates attempt to contact victims' family members to advise them of the review process, to arrange interviews, and to see whether they are aware of unidentified sources of information. In examining the gathered documents and anecdotal information, the Review Team looks for intervention opportunities that may have prevented the homicide and makes recommendations based on those observations .

Since our last report in 2004, significant improvements in public policy and the criminal justice system's response to domestic violence have been made, including:

- In 2005, the Minnesota Legislature passed a law making strangulation during domestic abuse a felony offense. The Review Team identified strangulation as a significant lethality factor in our 2002 and 2004 reports.

- City attorneys throughout Hennepin County have begun to review all domestic assaults to determine if the facts of the case and the perpetrator's criminal history support enhancing an offense to a felony. The Minneapolis City Attorney's Office now maintains an "enhancement list" that identifies individuals who, if arrested on a misdemeanor charge, can be booked on a felony instead.

- Observers and participants in the criminal justice system report that domestic violence police reports have significantly improved in documenting witnesses, weapons, and the injuries and demeanor of the victim and perpetrator at the scene. This improvement at the evidence gathering stage of the case allows prosecutors to make more informed charging decisions.

For this report, the Review Team examined 11 domestic homicide cases—four from Minneapolis and seven from suburban communities—chosen according to the criteria previously mentioned. All but one of the victims were female, and their ages ranged from 10 to 45 years. Four victims were from immigrant families, and one from a same-sex

couple. Children were present when the murder occurred in four cases.

In examining these homicides, the Review Team identified a number of areas of concern as well as corresponding opportunities for intervention as well as "best practices" that could be implemented within Hennepin County . The sections of the report are organized according to the following encompassing themes:

- Law Enforcement Response
- Conditions for Probation and Supervised Release
- Medical Examiner's Office Response
- Court System Response
- Impact of Domestic Violence on Children Who are Victims or Witnesses
- Medical Professionals and Hospital Emergency Department Staff Response
- Treatment and Mental Health Issues
- Implications of Domestic Violence in the Workplace
- Cultural Issues

The Review Team hopes that this report will assist the community in addressing domestic violence. Agencies are encouraged to implement the opportunities for intervention contained in these pages.

III. Case Observations/ Opportunities for Intervention

A. Case Summaries

Over a two year period, eleven cases of fatality related to domestic abuse were reviewed by the Team. The following summaries identify the factual scenarios of these cases. Each case represents a loss of human life. Each case represents the irreparable destruction of a family. Each case represents continuing costs to the community that must investigate and prosecute the crime and provide for the welfare of children and relatives left behind.

Case #1: The victim died of gunshot wounds to her head and neck. The perpetrator, who was the victim's boyfriend, was found critically wounded in the head from a self-inflicted gunshot and died of his wounds three weeks later.

Case #2: The victim told her mother and a friend that she planned to end the relationship with her abusive boyfriend. She said if anything happened to her, "He did it." Three months later, her body, tied to weights was found in a river. There was some evidence that the couple's child saw her dead body in the apartment. The perpetrator, was charged after the body was found and subsequently pled guilty.

Case #3: The perpetrator held the victim, his male ex-partner, at gunpoint on a street corner in front of police. The perpetrator shot the victim once in the head and again after the victim dropped to the ground. Police then shot and injured the perpetrator who later pled guilty to the shooting.

Case #4: The perpetrator was charged with the stabbing death of his former girlfriend. He had a previous record of assault and drug charges. The victim's young child was watching TV in the next room at the time of her mother's murder. The perpetrator pled guilty. This perpetrator's father murdered his mother when he was a child.

Case #5: The victim's boyfriend took his own life shortly after shooting the victim to death in their bedroom. The couple's daughter tried but couldn't get into the room after hearing the shots, so she went to a neighbor's house for help. The police had been called to the home five times before for domestic violence.

Case #6: The victim was stabbed to death following an argument with her husband. The perpetrator took their young daughter, who was in the house possibly sleeping at the time

of the murder, with him to the store to buy a saw, which he then used to dismember the victim's body. Three weeks later, the perpetrator confessed to the murder.

Case #7: This perpetrator stabbed the victim while she was sleeping. Their relationship began when the perpetrator was incarcerated. The night the victim died they had been watching videos and had a series of arguments. The victim had requested that her apartment management company change the locks to her building. The perpetrator had prior convictions for domestic assault from previous relationships. The perpetrator pled guilty to the homicide.

Case #8: A child spent the night at her father's house in accordance with a visitation plan spelled out in a Marriage Termination Agreement. The child called her mother several times requesting that the mother come get her. The victim asked her mother to bring the police with her when she came to pick her up because she did not believe the perpetrator would let her go. Police found the victim dead from multiple gunshot wounds in her bedroom and the perpetrator in a different bedroom with a self-inflicted gunshot wound to the head.

Case #9: People in the community knew of ongoing conflict in the victim's marriage, which was not reported to the police. Two weeks before the murder, the victim warned that if anything happened to her, her husband would be responsible. On the night of the murder, the victim was initially shot and injured during an argument. Children then took the gun from their father who subsequently stabbed the victim and ultimately shot her to death with a different gun. The perpetrator then killed himself and a son called 911. The couple's 13 children were home at the time of the killings.

Case #10: The perpetrator was on probation for Terroristic Threats when he stabbed and killed his wife, and injured her brother and daughter.

Case #11: The perpetrator had been diagnosed with cancer one week prior to the murder suicide and reportedly knew he had from a few months to a year to live. The perpetrator shot and killed his wife in their bed. The perpetrator attempted to kill their two sons with car exhaust and sedatives before killing himself. The boys woke up where their father had left them in the bed with the bodies of the victim and the perpetrator.

The following sections list observations from reviews of these cases. The observations illustrate gaps in the responses to domestic violence leading to homicide. Corresponding opportunities for intervention are laid out to guide future responses.

B. Law Enforcement Response

Case Observations

- Mother was concerned about calls from the child asking to be picked up from visitation with father and notified the police. This prompted a "health and welfare check" by law enforcement officers who did not force their way into the locked residence. Had they done so, they would have found the victim's body in the foyer.

- When law enforcement officers responded to repeated thefts against the victim by the perpetrator, they made no apparent inquiries about domestic violence within the relationship.

- The victim in a same-sex couple reported a number of incidents of domestic abuse to law enforcement officers. The police took information on numerous occasions but none resulted in criminal charges. In many of these instances the perpetrator was gone when police arrived.

- The victim's family in the above case concluded that law enforcement officers were not interested in gay, lesbian, bisexual, and transgender (GLBT) domestic assault cases.

- Law enforcement officers gave the victim a "blue card" listing domestic violence resources in several cases, but no domestic advocacy agency was ever involved.

- The victim's new partner was living in the victim's house at the time of the homicide. Law enforcement officers asked the partner to leave the house the night after the murder because he was not on the lease.

- Prior to the murder, the perpetrator contacted police and reported that he was going to detain his ex-wife's boyfriend who he claimed was abusing her and their child. Upon arrival police seized the perpetrator's loaded gun. The perpetrator was able to immediately purchase a new gun even though he has a history of mental health problems, a civil commitment and repeated threats to kill (law enforcement officers were aware of previous threats to kill). The gun permit application approval was based only on National Crime Information Center records.

Opportunities for Intervention

- Train law enforcement officers to identify circumstances that would provide a legal exception to warrant requirements when responding to a "health and welfare" check* when ongoing violence is suspected

- Train law enforcement officers to inquire about the presence of domestic violence when investigating reports of criminal activity between those in a current or prior domestic relationship.

- Develop consistent "gone on arrival" policies and practices for law enforcement in each jurisdiction throughout the county and state.

- Standardize investigation of domestic violence cases to ensure that police and prosecutors properly review GLBT domestic violence cases to determine whether they should be designated as felonies or misdemeanors and to insure that they are taken as seriously as violence between heterosexual couples.

- Train law enforcement officers on the dynamics of GLBT domestic violence and increase their awareness of resources for victims of domestic violence from these populations.

- Train law enforcement officers to go beyond simply giving a "blue card" to victims of domestic violence. Require them to contact a domestic service provider with victim information as part of their initial response at the scene so that the victim and advocate make an immediate connection, facilitating ongoing outreach and intervention. (Minneapolis is one of the municipalities currently implementing this recommendation.)

- Be sensitive to the needs of surviving household members when determining occupancy rights in the immediate aftermath of a domestic homicide.

- Require the Sheriff's Office to investigate an applicant's criminal history at the local, state, and national level as well as the applicant's mental health history, including any civil commitments, when deciding whether to issue a gun permit.

* A health and welfare check is a situation in which law enforcement officers have broad discretion, based on circumstances, probable cause or evidence to check on the well-being of an individual. In most circumstances this is done to determine if an individual is in danger to themselves or others, or is unable to care for themselves.

C. Medical Examiner's Office Response

Case Observations

- In several cases, victim's families did not understand why the Medical Examiner's office wanted them to provide dental records and items with the victim's fingerprints and DNA, such as a toothbrush, to identify the victim.

- In one case, the victim's family was reportedly charged a per-night fee to store the body in the Medical Examiner's Office and encountered obstacles when trying to remove it.

Opportunities for Intervention

- Review, clarify, translate, and update the pamphlet in the Medical Examiner's Office that explains all procedures, policies, and fees. The Medical Examiner's office does not charge families for storage at the morgue. The Medical Examiner's Office does not obtain dental records or other identification materials from the family of the deceased. It is unclear how this family had this understanding.

- Take special care in the explanation of unfamiliar procedures to families experiencing trauma. Train professionals around cultural differences around the death of a family member. Provide interpreters wherever applicable.

D. Court System Response

Case Observations

- It was unclear whether the prosecutor knew of the perpetrator's prior attempted murder conviction against a prior victim in another county when he was sentenced for a domestic assault charge. Time did not permit a pre-sentence investigation to be conducted between the time of the plea and the scheduled sentencing.

- The violence apparently escalated after an OFP was issued in several cases, but violations of the OFP were never reported and/or prosecuted.

Opportunities for Intervention

- Enforce the law requiring pre-sentence investigations for all domestic assault convictions and allow adequate time to complete them.

- Enforce the law and prosecute every violation of an OFP that is observed or reported.

- Provide every victim filing an OFP access to a domestic violence advocate.

- Provide education when an OFP is issued to victims, families, and friends regarding patterns of escalating violence that may occur in response to it, and ensure that every victim and concerned party has a safety plan.

- Do not release individuals arrested for domestic assault from custody until their likelihood for inflicting continued violence against the victim can be evaluated using a domestic violence, risk-assessment tool.

*By law a pre-sentence investigation is required in every domestic assault case to provide the judge and parties with the criminal history, treatment needs, victim input and other information that would assist in sentencing.

E. Impact of Domestic Violence on Children Who are Victims or Witnesses

Case Observations

- Children in more than one case who witnessed the murder of a parent and were exposed to violence in their homes received inconsistent screening and no ongoing care for post-traumatic symptoms.

- As a child, the perpetrator received many psychological evaluations and referrals for assistance after witnessing the murder-suicide of his parents. However, no consistent continuum of care was ever provided.

- A child with limited English ability was interviewed on two separate occasions about her mother's murder, which she may have witnessed. Records were unclear regarding the timeliness of the interviews and whether appropriate interpretive services were provided.

- The perpetrator, who had custody rights pursuant to his uncontested Marital Termination Agreement (MTA), murdered his daughter during a scheduled visit. Since the MTA was uncontested, Family Court did not appoint a *guardian ad litem* for the child nor did it conduct an outside investigation regarding custody or visitation, which would have included cross-referencing child protection and mental health files, before signing the agreement. Neither the perpetrator nor the victim had legal representation during the divorce process.

Opportunities for Intervention

- Immediately screen children who witness or are victims of domestic violence to address post-traumatic stress symptoms and provide ongoing access to therapeutic services with a system in place to continually monitor and assess their needs.

- Create a custody determination process for children who are left without a parent because of domestic violence to insure that custodians will follow-through with appropriate services.

- Train mental health workers to assess and effectively treat post-traumatic stress in adult clients who have experienced domestic violence as children.

- Allow minors to access therapeutic services without parental permission when a therapeutic professional deems it in their best interests.

- Provide a qualified interpreter when interviewing a child who primarily speaks a language other than English.

- Interview children who are witnesses or victims of domestic violence in a developmentally appropriate manner as soon as feasible after the event.

- Provide an evaluation to determine the best interests of the children in uncontested MTAs that involve children where there is evidence of risk factors for domestic violence, and investigate custody agreements before the judge signs them. Strategies for the judicial system to accomplish this goal include:

    - Appoint a *guardian ad litem*.*
    - Cross-reference and review files from Family Court Services and information regarding the custody petitioners.
    - Investigate the potential existence of chemical abuse or mental health issues or a history of violent behavior.
    - Establish an independent evaluator in MTAs to review any custody or visitation arrangements.
    - Train all custody evaluators and *guardian ad litems* in the dynamics of domestic violence.

* Some members of the Review Team had strong reservations about this recommendation.

F. Medical Professionals and Hospital Emergency Department Staff Response

Case Observation

- The victim in a same-sex relationship received medical and mental health treatment. There is no documentation that he was ever asked about whether he was safe in his home or his relationship.

Opportunities for Intervention

- Train medical and mental health professionals to screen for evidence of intimate partner violence with patients in same-sex and heterosexual relationships alike, and teach them strategies to support and intervene appropriately. Ensure that existing protocols are applied to patients in same sex relationships.

- Provide information about community resources when treating and referring patients who experience domestic violence.

G. Treatment and Mental Health Issues

i. Chemical Dependency

Case Observations

- The perpetrator was court ordered to complete a chemical dependency evaluation on two separate occasions. According to the records, he minimized his drug use in both evaluations so no further treatment was recommended.

- The domestic abuse perpetrator, who had requested in-patient drug treatment but received outpatient treatment instead, refused to live in a halfway house after completing the court-ordered program.

Opportunities for Intervention

- Collect information from other sources, including the victim, to corroborate a perpetrator's statements about his use in a chemical dependency evaluation.

- Enforce court-ordered participation in drug treatment aftercare.

- Develop effective methods to treat domestic violence in chemical dependency treatment programs and chemical dependency in domestic violence treatment programs.

ii. Treatment of Men who Batter

Case Observations

- The perpetrator was still on parole for a violent felony domestic assault when he met and began an abusive relationship with the victim. He had received no treatment for domestic violence in prison.

- The perpetrator was incarcerated from the time he was 20 until he was 30 for a litany of crimes, including domestic abuse. He continued to use drugs in prison. Batterer's treatment was never ordered. After his release, he continued assaultive behavior with virtually all of his female partners.

- The perpetrator was actively participating in an anger management program at the time of the murder. With his parole officer's approval, staff decided to move him into another group and extend his treatment longer than normal because of his inappropriate behavior. This information, however, was not shared with the victim since the program did not have the perpetrator's permission to speak to her about his progress.

Opportunity for Intervention

- Provide perpetrators with domestic violence counseling, treatment, and resources in prisons and during the period following their reentry into society. Also, make these same services available to those on parole and/or supervised release.

iii. Mental Health Issues

Case Observations

- Both the victim and perpetrator had mental health issues dating to adolescence.
- The perpetrator was being treated for depression, but stopped taking his medication since he did not like the side effects.
- The judge who approved the perpetrator's MTA and custody agreement knew he was a diagnosed schizophrenic and chemical substance abuser.
- The perpetrator exhibited progressively severe aggressive behavior throughout his childhood and adolescence, which was mirrored in his increasingly violent juvenile record. The psychologist's reports noted the perpetrator's lack of remorse and self-restraint.
- Psychiatric Hospital records were unclear about the victim's discharge plans and whether he had been referred to a domestic abuse service provider.
- Information about the perpetrator's mental health and child protection issues was not available to criminal justice agencies because of data privacy restrictions.

Opportunities for Intervention

- Require anger management and batterer's treatment programs to have perpetrators sign releases to allow relevant information to be shared with victims and probation or parole officers in order to check information with collateral sources and provide the victim with information to help her evaluate her safety.

- All relevant records relating to the perpetrator should be made available to treatment providers upon referral for treatment services. Encourage Hennepin County to develop a data-sharing system that can accommodate current and past interventions and services.

- Provide detailed and comprehensive case plans and discharge instructions to adolescent patients after a psychiatric hospitalization and follow up to ensure contacts are made with the respective service providers.

- Train mental health workers to assess and appropriately treat clients who have abused an intimate partner or family member.

- Eliminate using the term "anger management" when referring to batterer's treatment in domestic violence cases.

H. Implications of Domestic Violence in the Workplace

Case Observations

- In one case, rumors that the victim was experiencing domestic violence circulated in the workplace. In several other cases, co-workers knew for a fact about the violence in the victim's intimate partner relationship. In each situation, there was no indication that the employer offered the victim domestic abuse services or referrals, and no company policy existed to guide workplace interventions regarding domestic violence.

- The employer relied on an employee assistance program to address employees' personal issues, including domestic violence, but the victim never accessed these services.

- Temporary employment agencies were the primary source of employment for victims in the reviewed cases.

Opportunities for Intervention

- Encourage employers to develop and maintain policies and procedures that include and address:

    - Safety for victims of domestic violence and other employees in the workplace

    - Services for victims of domestic violence and other affected employees

    - Guidance for employees regarding the appropriate response to colleagues who may be experiencing domestic violence

- Provide education and training to temporary employment agencies regarding domestic violence.

- Encourage employee assistance programs and employers to seek assistance from domestic service providers when employees are dealing with issues of domestic violence.

I. Cultural Issues

Case Observations

- The victim stated that she did not understand U.S. laws and consequently feared deportation and the loss of her child if she reported her husband's abuse to law enforcement.

- Victims encountered language barriers in accessing assistance from police.

Opportunities for Intervention

- Educate immigrant and refugee women and men about U.S. laws and resources regarding domestic violence. Include in the training the dynamics of drug and alcohol use and other addictions as they relate to domestic violence.

- Provide culturally competent services for immigrant and refugee communities regarding domestic violence.

- Provide interpreter services necessary to allow immigrant and refugee communities to access help from law enforcement.

IV. Family, Friends, and Community Response to Domestic Violence

In reviewing this group of cases, the Review Team has noted the critical source of support families, friends, co-workers, neighbors, and faith communities provide to victims of domestic violence. We believe it is important to focus attention and hold discussions about the role of those most closely connected to victims so that the full spectrum of opportunities to lessen violence in the community can be examined. However, in no way is this an attempt to shift responsibility or blame for the deaths, which rest solely with the perpetrators.

The Review Team maintains that government should take the lead in addressing and effectuating societal change around the issue of domestic violence, including helping to shape and form community norms, attitudes, and behaviors that may help reduce its incidence. Government also can play a role in providing the resources to educate the community about effective strategies for intervening and preventing domestic violence.

Some members of the Review Team had concerns about focusing on friends and family members, believing that our purpose is to examine the response of our social institutions. However, since many victims did not confide in anyone outside their circle of family and friends, the Review Team determined that increasing public awareness so that private individuals increase their knowledge of services might increase the likelihood that victims will access them.

This is a challenging area for the Review Team because it was difficult to identify specific opportunities for intervention with family, friends, and community. We hope that this section of the report inspires community-based actions that may help victims in similar situations and ultimately prevent acts of violence.

Case Observations

- Prior to the murder both the victim's and perpetrator's family members had been concerned for the victim's welfare in the relationship.

- A neighbor knew and was concerned about the domestic violence that was occurring in the relationship but did not access outside resources.

- Despite involved neighbors reporting domestic and child abuse, no criminal charges were brought against the perpetrator.

- Prior to the homicide, the victim's family noticed a pattern of financial abuse and economic exploitation by the perpetrator against the victim. They approached her with their concerns, but the victim continued the relationship because she was afraid the perpetrator would die if she stopped caring for him. The perpetrator continued the pattern of abuse and exploitation.

- The victim's godmother witnessed the perpetrator threaten his daughter with a butcher knife, but there was no apparent follow-up.

- Family members and community members were aware of domestic abuse in the relationship, but did not report it to police.

- Several victims turned to supportive family for assistance, but outside resources were never accessed.

Opportunities for Intervention

- Provide public information and education outlining ways family and friends can help to address domestic violence, including its non-physical forms.

- Provide concerned individuals with information and strategies to intervene appropriately in domestic violence situations.

- Encourage people who witness acts of domestic violence to call police immediately.

- Develop and promote domestic violence advocacy resources for victims' families who are aware of domestic violence issues but do not know what to do about it.

- Increase awareness of domestic violence in GLBT relationships.

V. Progress on Past Opportunities for Intervention

The Review Team is a part of a larger movement towards a societal shift with respect to domestic violence. The opportunities for intervention from our past reports have already resulted in significant changes within many organizations, both inside and outside the collaborative. These changes take many forms. Some are part of formal initiatives; many occur as a result of Review Team members going back to their respective organizations with knowledge gained through direct involvement in the review process and implementing more appropriate and responsive practices and procedures. Since many in the group are senior members within their respective organizations, they have the clout to implement these needed changes.

Review Team members also participate in a variety of policy-making forums related to domestic violence, including the Hennepin County Family Violence Coordinating Council, the Sheila Wellstone Institute, Minnesota Advocates for Human Rights, The Battered Women's Justice Coalition, and the Minnesota Coalition for Battered Women. Many of these organizations work together on a variety of critical issues to stem the tide of domestic violence. While we do not take full credit for the encouraging progress on this front, we think it is important to highlight improvements that have occurred since our 2004 report.

In 2005, the Minnesota Legislature passed a law making strangulation during domestic abuse a felony offense. The Review Team identified strangulation as a significant lethality factor in our 2002 and 2004 reports. Senior attorneys at the Hennepin County Attorney's Office now review all felony strangulation cases and have charged over 190, including 88 where strangulation was the only offense.

- City attorneys throughout Hennepin County have begun to review all domestic assaults to determine whether the facts of the case support enhancing the offense to a felony. This has resulted in an increase in the number of felony filings.

- The Minneapolis City Attorney's office now publishes a "Probable Cause Felony Enhancement List" for the county jail that identifies people who, if arrested on a misdemeanor charge, can be booked on a felony charge.

- Members of the criminal justice system state that domestic violence police reports have significantly improved in documenting witnesses, weapons, and the injuries and demeanor of the victim and perpetrator at the scene. This improvement at the initial stage of the case allows prosecutors to make better informed charging decisions.

- The Family Violence Coordinating Council is now using the opportunities for intervention from past Review Team reports as a foundation for building its annual subcommittee work plans.

- The bail schedule for misdemeanor domestic assault cases has doubled from $1,200 to $2,400.

- In Family Court waiting rooms, petitioners seeking an OFP and respondents now have access to information kiosks that provide pamphlets on service providers specializing in domestic violence. Legal procedures for domestic violence cases are also available and have been translated into multiple languages.

- The Hennepin County Attorney's Office through the Domestic Abuse Service Center has designated a prosecutor to coordinate all suburban felony domestic violence cases.

- The Hennepin County "Gone on Arrival" Workgroup has drafted a best practices manual for use in training law enforcement officers.

- The City of Minneapolis through its various agencies is creating a domestic violence plan for the city.

- The Hennepin County Jail has revised its policies and procedures for notifying victims when a perpetrator is being released from custody.

- The Criminal Committee of the Family Violence Coordinating Council formulated a protocol for court staff, probation officers, and prosecutors to ensure victim notification when an offender is released following arrest on a warrant.

- Domestic Violence Court has written guidelines detailing graduated sanctions for perpetrators with repeat violations of conditions of release or probation.

- Minneapolis has changed its law enforcement reporting forms to make it easier for officers to record when guns are involved in alleged crimes and to list children as parties.

- Fourth Judicial District Court has convened a committee to implement and enforce the confiscation of guns in domestic assault cases. At this time, all cities in Hennepin County are participating.

- Minneapolis Public Schools now screens for domestic violence as part of the newly-implemented "Knock and Talk" school attendance protocol, which provides for visits to homes of truant children.

VI. Acknowledgements

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State of Minnesota, Fourth Judicial District Court (Hennepin County) 2005-2006 and ongoing

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CornerHouse
Domestic Abuse Project
Minneapolis City Attorney's Office
Minneapolis Police Department
Minneapolis Public Schools
Minnesota Advocates for Human Rights
Minnetonka City Attorney's Office
Minnesota Coalition for Battered Women
Sojourner Project, Inc.

County and State Partners:

State of Minnesota, Fourth Judicial District Court
State of Minnesota, Fourth Judicial District Public Defender's Office
Hennepin County Attorney's Office
Hennepin County Community Corrections
Hennepin County Human Services and Public Health Department
Hennepin County Medical Center
Hennepin County Medical Examiner's Office
Hennepin County Sheriff's Office