A Matter of Life and Death

2014

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

2014 Community Partners:

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

2014 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 Child Protection
Hennepin County Medical Center
Hennepin County Medical Examiner
Hennepin County Public Defender's Office
Hennepin County Sheriff

This report is a product of:

Fourth Judicial District Domestic Fatality Review Team

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Acknowledgments

The Honorable Gina Brandt, outgoing Project Chair, gratefully acknowledges the supporters and members of the Fourth Judicial District Domestic Fatality Review Team:

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

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

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

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

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

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

The Domestic Abuse Service Center for the use of space for Advisory Board meetings;

And those who donated their time to present information to the Team in 2014:
Judge Liz Cutter– Fourth Judicial District
Therese Galatowitsch– Hennepin County Attorney's Office
Nancy Halverson– Hennepin County Community Corrections & Rehabilitation
Michelle Jacobson– Minneapolis City Attorney's Office
Owen Middleton, MD– Hennepin County Medical Examiner's Office

Executive Summary

The Review Team examines cases of domestic homicide and the lives of those involved, looking for points where a change in the practice of various agencies or individuals may, in a similar situation in the future, result in a more positive outcome. 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 and individuals 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 or individual that commonly have interactions with the victim or perpetrator prior to the homicide, like law enforcement or advocacy, but include agencies or groups that may serve as a source of information about domestic violence, risk factors of domestic homicide or make referrals to intervention services.

Inevitably a theme emerges in the cases reviewed each year and in 2014 it was involvement in services for mental health concerns. Each of the perpetrators had received services related to a mental health concern and one of the victims had just been released from an in-patient mental health facility. It is important to note that while the perpetrators appear to have struggled with depression, anxiety, and chemical dependency, the homicide they committed occurred within a pattern of abuse and violence established to maintain power and control in their intimate relationship.

Similarly, it is important to recognize how mental health concerns can increase the vulnerability of people who are abused. It is estimated that 1 in every 4 women and 1 in 7 men will experience abuse by a partner in their lifetime but that risk increases more than two fold in women who have depression and more than three fold in those who have anxiety disorders. Male victims of domestic abuse who have mental health concerns also experience an increase in likelihood of abuse, but to a lesser degree.

Finally, in the decade since the Fatality Review Team identified strangulation as a critical warning sign of potential homicide and the legislature made the crime of strangulation a felony, the rate of cases charged at this level has been steadily decreasing. The biggest barriers to convicting the perpetrator of strangulation have proven to be gathering adequate physical evidence that the crime occurred and the difficulty of trying a case without physical evidence. In response, the Team is recommending that innovative technology, such as Alternative Light Source (ALS) imaging, which illuminates areas of increased blood flow present in bruising even when bruises are not visually detectable, in combination with funding to provide no cost transport and a forensic nursing exam (including ALS), to victims of strangulation would promote the successful prosecution of these attempted murder cases at the appropriate felony level.

Guiding Standards

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

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

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

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

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

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

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

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

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

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

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

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

Presence of Risk Factors

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

Potential Predictors of Homicide	Case 1	Case 2	Case 3	Case 4
The violence had increased in severity and frequency during the year prior to the homicide.	X		X	X
Perpetrator had access to a gun.		X		
Victim had attempted to leave the abuser.	X		X	X
Perpetrator was unemployed.	X	X	X	
Perpetrator had previously used a weapon to threaten or harm victim.			X	
Perpetrator had threatened to kill the victim.	X	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			
Perpetrator attempted to control most or all of victim's activities.	X		X	X
Violent and constant jealousy.		X	X	X
Perpetrator was violent to victim during her pregnancy.			X	
Perpetrator threatened to commit suicide.	X	X	X	
Victim believed perpetrator would kill her.				
Perpetrator exhibited stalking behavior.	X	X	X	X
Perpetrator with significant history of violence.	X		X	X
Victim had contact with a domestic violence advocate. (this is a protective factor)			X	

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

Homicide Data

For the purposes of the Fourth Judicial District Domestic Fatality Review Team, domestic abuse is defined as a pattern of physical, emotional, psychological, sexual and/or stalking behaviors that occur within intimate or family relationships between spouses, individuals in dating relationships, former partners and against parents by children. This pattern of behavior is used by the abuser to establish and maintain control over the victim. Occasionally the Team reviews homicides that occurred in the context of domestic violence but in which the victim is not the primary victim of the abuse. The Review Team examined four domestic homicide cases in 2014 and pursued Opportunities for Intervention in all of those cases. The following information includes all domestic homicides in Hennepin County that occurred in the years that the cases reviewed by the Team also occurred along with the cause of death, age and gender of the victim and the relationship of the perpetrator to the victim:

In **2011,** 23 women, four children, and two men 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 2014.

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

In 2012, 15 women, and three men were killed in domestic homicides in the State of Minnesota. Seven of those homicides occurred in Hennepin County. The Fatality Review Team reviewed two of the cases in 2014.

Cause of Death	*Age of Victim*	*Gender of Victim*	*Relationship of Perpetrator to Victim*
Gunshot	32	Female	Boyfriend
Gunshot	45	Female	Estranged Husband
Blunt Trauma	42	Female	Former Boyfriend
Gunshot	26	Female	Boyfriend
Gunshot	27	Female	Acquaintance
Stabbing	43	Female	Boyfriend
Gunshot	42	Male	Former Girlfriend

2014 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.

Inevitably a theme emerges in the cases reviewed each year and in 2014 it was involvement in services for mental health concerns. Each of the perpetrators had received services related to a mental health concern and one of the victims had just been released from an in-patient mental health facility. It is important to note that while the perpetrators appear to have struggled with depression, anxiety, and chemical dependency, the homicide they committed occurred within a pattern of abuse and violence established to maintain power and control in their intimate relationship.

Similarly, it is important to recognize how mental health concerns can increase the vulnerability of people who are abused. It is estimated that 1 in every 4 women and 1 in 7 men will experience abuse by a partner in their lifetime but that risk increases more than two fold in women who have depression and more than three fold in those who have anxiety disorders. Male victims of domestic abuse who have mental health concerns also experience an increase in likelihood of abuse, but to a lesser degree.

Innovation

It has been more than a decade since the Fatality Review Team identified strangulation as a critical warning sign of potential homicide and ten years since the legislature made the crime of strangulation a felony. At the time, the criminalization of the act was cutting edge. In the intervening years, the biggest barriers to convicting the perpetrator at a level appropriate for the crime have proven to be gathering adequate physical evidence that the crime occurred and the difficulty of trying a case without physical evidence. The damage caused by strangulation is largely internal and does not consistently result in visible external bruising rendering current

crime scene methods, like officer observation of injury and photography, inadequate. Further, many victims of this crime decline medical intervention because of the cost of transport and emergency department treatment.

In the past ten years, technology has markedly improved in most facets of our society and the forensic detection of strangulation is no exception. Alternative Light Source (ALS) photography illuminates areas of increased blood flow present in bruising even when bruises are not visually detectable. At this time, ALS must be administered in a static environment and by a trained technician.

In order to address these technological constraints and to reduce the cost barrier to victims of strangulation receiving medical attention, the ***Team recommends that a funding stream allowing for no cost transport and a forensic nursing exam (including ALS), akin to that which funds Sexual Assault Nursing forensic exams, be developed.*** A service such as this would go far in achieving the other strangulation related opportunity identified by the Team, to ***provide training for Law Enforcement, Prosecutors, and members of the Bench, on the correlation between the act of strangulation and the increased likelihood of homicide and the physiological consequences that make it an act of attempted murder, to encourage the prosecution of such cases at a felony level.***

Risk Assessment & Follow-Up

In the cases reviewed this year, the homicide victim and/or the perpetrator had contact with either law enforcement or health care providers in the days and weeks before the murder. Many of the 2013 Annual Report Opportunities for Intervention focused on how each of member of the community has a role to play in knowing the risk factors for homicide and intervening when appropriate. This year, it happens that the victims and perpetrators had contact with professionals rather than community members so the Opportunities for Intervention target the healthcare, law enforcement, and advocacy fields.

The City of Minneapolis has piloted two initiative over the last five years that pair an advocate and a police officer to conduct visits with people for whom that court has ordered a Domestic Abuse No Contact Order and for people who are listed as the victim in a police report where the alleged perpetrator was not present when the police arrived. These efforts have resulted in both increased community understanding and victim safety. The Team recognizes that a similar initiative may be beneficial when a restricted person violates the Order of Protection against them. Such an initiative could ***provide law enforcement or advocate follow-up with petitioners within 24 hours when the suspect in a Violation of Order for Protection case is gone when police arrive and within a week following the release of a suspect charged with Violation of Order for Protection to ensure that there has been no further violation and that the petitioner is safe.***

When mental health providers encounter a client who exhibits fixation or perseverative behaviors, ***the Team recommends that the provider conduct a standard violence risk assessment. To facilitate adherence to this, the Team further recommends that the state licensing boards overseeing mental health practitioners adopt a standard violence risk assessment and that they require all licensed practitioners to receive annual continuing education on Duty to Warn.***

In recognition of the strong correlation between mental health diagnoses and the risk of being abused by an

intimate partner, the Team suggests that *all hospital discharge planning include screening for domestic violence risk and that visiting nurse follow-up be ordered for patients at risk for exploitation or abuse.*

Court

At times, the very systems established to provide relief to victims of domestic violence are used by perpetrators to maintain control and force the victim to have contact. In light of this infrequent, but damaging, occurrence, the Team recommends *training to judicial officers and court staff on how to assess whether a person is using the court system as a means of exerting power and control over a partner or former partner. To aid this assessment, the Team also encourages statewide monitoring of court filings, such as restraining orders, that are potentially being used as a mode of harassment.* The monitoring system could be informed by that used to identify drug-seeking behavior across multiple locations in the medical setting. Timely assessment, aided by statewide monitoring, could *encourage immediate response from the bench to the situations in which this is occurring to end the behavior.*

A pattern of court involvement emerged in the cases reviewed in 2014. Many of the victims and perpetrators in the homicide cases were previously involved, together and separately, in family court, juvenile court, criminal court, and community corrections simultaneously. While there are great efforts made to communicate among and within each of these entities, the various orders and expectations are not always clear to the person involved. To address this issues, the Team has identified two opportunities to ensure adherence. The first, *to review the efficacy of making compliance with other court divisions a condition of probation or release* and to, secondly, develop a process to *ensure consistency in expectations across court divisions with orders matching, rather than being in direct contradiction, in juvenile court, family court, and criminal court.*

Recognizing the Risks

A person without knowledge of what situations and interactions might increase risk of injury or homicide may, unwittingly, take an action intended to protect oneself that instead escalates a perpetrator's need to exert power and control. Embedding messages of safety and information about risk of harm directly into the materials associated with the action may encourage a person to seek the guidance of an advocate or the protection of law enforcement. Three examples of such messages and message locations were developed by the Team in 2014.

- *Launch an online education campaign to alert users to the signs of internet stalking, the corresponding risks of violence associated with stalking behavior, and how to get help.*
- *Include information in the divorce packet about risk factors and how to stay safe in the process of seeking a divorce from a person who has been abusive.*
- *Include information about tenants rights and protections for victims of domestic violence as addenda to all leases.*

Access to Weapons

One of the perpetrators in a case reviewed in 2014 purchased a firearm from a private party after having been denied a permit to purchase through the legal channels. Despite there being no requirement for a permit to purchase from a private seller, the buyer in this case did present the application for the permit and the seller, not being familiar with the intricacies of the process believed that to be sufficient. In this case there was no specific wrongdoing, but the Team saw an opportunity to *create a statewide database for private sellers to find denials of applications of permits to purchase to assist the private seller who wishes to avoid a sale to a person who has been denied a permit.*

Project History

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

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

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

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

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

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

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

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

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

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

Fourth Judicial District Domestic Fatality Review Team

Purpose

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

Goal

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

Structure & Processes

The Review Team Structure

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

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

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

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

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

Case Selection

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

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

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

The Case Review

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

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

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

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

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

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