

Colorado Domestic Violence
Fatality Review Board

**Annual
Report**

2023

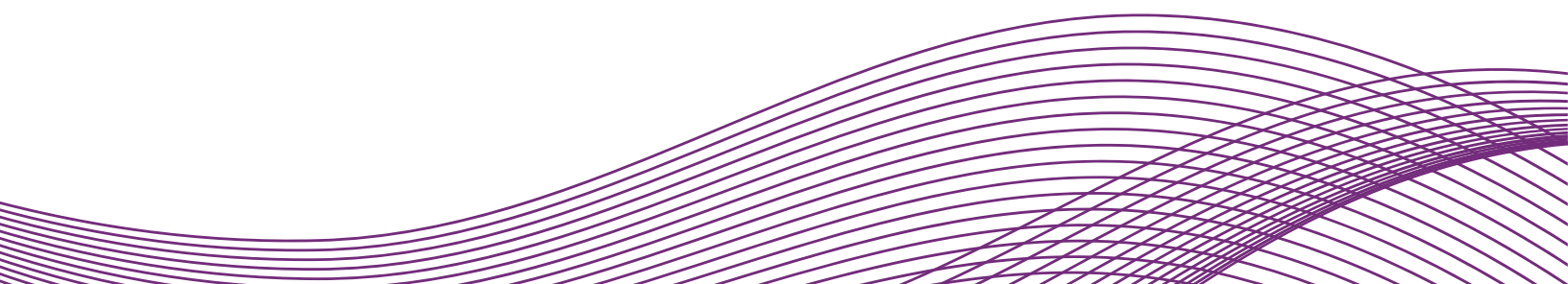
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In Memoriam: Victims of Domestic Violence Fatalities

This report is dedicated to the 39 current or former intimate partner victims and 22 collateral victims who died in Colorado in 2022 in the context of domestic violence. Each of these victims was someone's child, parent, sibling, family member, friend, neighbor, and/or colleague. Victims' ages are in parentheses after names.

Intimate Partner Domestic Violence Fatality Victims

Vanessa Anderson (27)

**Latasha Betterly
-Byrd (34)**

Rashelle Blevins (37)

Dina Casias (54)

Patricia Colmenero (42)

Lindsay Daum (41)

**Renee Francisca
Dominguez (38)**

Shelby Figueroa (28)

Amber Frost (34)

Daisha Fry (41)

Keisha Graeff (18)

Elizabeth Hatlas (50)

Melody Horton (44)

Shania Lenard (21)

Tegan Leslie (35)

Alicia Madera (28)

Adela Madrid (37)

Kaylie Marcum (23)

Melissa Martinez (44)

**Lizet Salinas-
Mijangos (26)**

Anastasia Milkova (39)

Adrianna Mills (29)

Alexandra Mittig (26)

Demixica Mosley (38)

Rhonda Pate (36)

Anaya Xuhny Perez (30)

Kathryn Sandt (68)

Michele Scott (55)

Najah Shumock (39)

Coleen Thomas (74)

Breana Tilley (50)

Taylor Trevino (20)

Nicole Vasquez (30)

Lisa Weildich (43)

**Raeanna Burch-
Woodhull (28)**

**Namantha Noller-
Rice (19)**

**Cindy Gomez-
Roman (28)**

Patricia Kraus (80)

Jasmine Lazaro (34)

Collateral Domestic Violence Fatality Victims

Abner Salmeron-Bautista (5)

Eduardo Espinoza Bencomo (23)

Sophia Berry (5)

Roy Bock (50)

Andrew Goodwin (21)

Christina Hardin (56)

Audrey Jane (6)

Ruben Jimenez (28)

Autumn Kirkpatrick (26)

Alan Kraus (61)

Ken Green Luque (20)

Cameron Lynn (8)

Andrew Peery (39)

Lewis Quinn (47)

Loretta Rhoades (58)

Rudolfo Salgado-Perez (49)

Jesus Serrano (51)

Mariana Serrano (22)

Tanya Scowden (47)

Meadow Sinner (16)

Dillon Vakoff (27)

George Weingarten (8 Months)

List of Acronyms

The following list includes acronyms used throughout this report.

CDVFRB or Board	Colorado Domestic Violence Fatality Review Board
CCRT	Coordinated Community Response Team
Denver Review Team	Denver Metro Domestic Violence Fatality Review Team
DV	Domestic Violence
DVF	Domestic Violence Fatality
Review Team	Domestic Violence Fatality Review Team
ERPO	Emergency Risk Protection Order
IPH	Intimate Partner Homicide
LAP	Lethality Assessment Program
TERPO	Temporary Emergency Protection Order

Language Considerations

Several labels are used for abuse that occurs in the context of a current or former romantic/intimate relationship, including domestic violence, intimate partner violence, and intimate partner abuse. Given that most legal entities, such as the police and courts, use the term “domestic violence” and the authorizing statute for this report uses the term domestic violence and “Domestic Violence Fatality Review Board,” this report primarily uses the term domestic violence (DV) instead of intimate partner violence or intimate partner abuse.

Similarly, intimate partner homicide or IPH is a term often used in research on DV fatalities, but the term is used more commonly in research focused on homicides among current or former romantic/intimate couples and is less likely to address collateral fatalities and suicides. For this reason, this report primarily uses the term “domestic violence fatality” or DVF.

This report also uses the term victim throughout this report to refer to a member of an intimate partner couple killed in the context of DV and to those who survived these situations. Because this report focuses on DVFs and the term victim is typically used in the criminal and legal context, the term “victim” fits best within the mandate of our Board. However, we recognize that the term survivor speaks to the sense of empowerment with which many of those experiencing non-fatal DV identify, and we acknowledge the important journey towards the recovery of all impacted by DV.

Message from Attorney General Phil Weiser

Last year, the 2021 report identified an all-time high number of domestic violence fatalities (DVF) in any year since the creation of the Board in 2016. Tragically, the number of DVFs identified in 2022 was even higher. While it is difficult to determine whether the increased number of DVFs is due to an increase in violence or because we are better at identifying deaths that occurred within the context of domestic violence, every DVF is one too many. The victims were parents, siblings, law enforcement officers, children, and bystanders and all were cherished members of their communities.

These tragedies should catalyze action. As chair of the Board, I am proud of the progress the Board has made in the past year to help prevent DVFs in Colorado. We have made it easier for community members to report DVFs to our office, developed a robust best practices guide to help facilitate and further the work of local fatality review boards, and have secured funding to continue our work training law enforcement on the use of the Lethality Assessment Protocol. This year, the Board is committed to investing in strategies to ensure firearm relinquishment in domestic violence cases, increase partnership with other statewide fatality review boards, and increase the use of risk assessment tools across the state.

The Board's dedicated members are all volunteers who have devoted significant time and effort to bring these changes to life and have painstakingly done deep analytical work to shed light on each DVF in Colorado. I am thankful for their commitment and for the work of the countless community members who support victims and work tirelessly to address this ongoing challenge.



Philip J. Weiser
Attorney General, State of Colorado

Executive Summary

This year's report addresses all DVFs that occurred across Colorado in 2022. It also presents far more granular data on the 16 DVF cases reviewed by local DVF review teams in 2021 and 2022. For details on the process of local DVF review teams please see pages 13-15.

Statewide Data

Last year, the 2021 report identified an all-time high number of Colorado DVFs in any year since the creation of the Board in 2016. Tragically, the number of DVFs identified for 2022 is higher—there were **94 DVF fatalities occurring in 62 cases**. This is **1.5 times the average** number of Colorado DVFs (65.7) over the Board's seven years of data collection (2016-2022). In these 62 DVF cases, 97% of the DV victims were female and 95% of the DV perpetrators were male, underscoring the continued gendered nature of both DV and DVFs specifically. The data calls for solutions that address structural and individual gender inequality. Investments in equity have important dividends—research suggests that male youths living in neighborhoods with higher gender equality were less likely than those who lived in other neighborhoods to report perpetrating relationship abuse over time.

The DVFs considered in this report include the primary DV victims, the collateral victims, and the DV perpetrators. Of the 94 fatalities, 39 were the primary DV victims, 22 were the collateral victims, and 33 were the DV perpetrators. It is worth noting that nearly **a quarter of the fatalities were collateral victims**. These victims included infant children, neighbors, law enforcement, and adult family members who sought to intervene. This percentage is extraordinarily high relative to years past and emphasizes that the lethal threat of DV often extends beyond the DV victims.

Nearly a quarter of all collateral fatalities were children. Our **communities lost 6 children ages 16 and under in 2022**. As noted in the recommendation section of this report, these gut-wrenching tragedies emphasize how critical it is for organizations that interact with domestic violence survivors—be it courts, advocacy agencies, law enforcement, and others—to use a risk assessment and risk management practices. The use of these tools is necessary to build a shared understanding of risks to safety so that the community can respond and manage the safety of adults and children exposed to DV appropriately and consistently.

Most of the DV perpetrators died by suicide (70%), but DV perpetrators were also killed by law enforcement, victims, and bystanders. The judicial outcomes of these cases ranged widely; no charges were brought in the cases involving law enforcement, but charges were brought in all the other cases, including in cases where victims killed the perpetrator. These situations underscore the complexities of DVFs and the challenges of addressing situations where deaths are caused outside of the immediate DV incident.

Consistent with existing DVF research and previous Board reports, firearms are the most common weapons involved in DVFs, and gunshot wounds are the most frequent causes of death. Specifically, in 2022 in Colorado, **86% (n = 79) of the DVFs were caused by firearms.** All DV perpetrator fatalities involved guns; 73% of the DV victim fatalities and 86% of the collateral fatalities were from a gunshot wound. Of the collateral fatalities, all law enforcement collateral victims and all but one of the children victims died from gunshot wounds. In the more detailed case review data discussed below, of the 16 cases reviewed, the DVF perpetrator had access to a gun in 13 of the cases. The ubiquity of guns in the DVF cases is one reason why the Board continues to recommend greater investment in the enforcement of Colorado's existing firearm relinquishment procedures.

DVF Review Team Data

There are three review teams across the state and these review teams review DVFs from six judicial districts. These teams were necessarily less active during the COVID-19 epidemic and less cases were reviewed in 2021 and 2022 than in years past. However, 16 case reviews were still conducted and shed light on important trends. As has been found in prior reports, DVF victims were far more likely to be employed (60%) than DV perpetrators (44%). Additionally, in half of the cases, the DV perpetrators were financially reliant on the victim and half were socially dependent on them. These realities underscore the complexity of how the power and control endemic in DV cases plays out in individual cases.

The challenges facing many of the couples involved in DVFs were various. A quarter of the DV victims and 44% of the DV perpetrators had indications of alcohol abuse and 31% of DV victims and 56% of DV perpetrators had indications of drug abuse. In the aggregate, in **13 of the 16 cases reviewed, the DV perpetrator abused either drugs or alcohol.** Additionally, while it is hard to account for precisely, nearly 20% of the victims and 25% of the perpetrators had indications of mental illness. Investments in mental health and addiction remain important measures to reduce DVFs and DV more generally.

The DVF couples had diverse interactions with system and community actors. A quarter of the DV victims had prior DV arrests; however, none of the DV victims' arrests resulted in convictions. While there are certainly some “mutually-combative” couples, research indicates this is not a large portion of DV couples. Thus, the relatively high arrest rate of the ultimate DVF victim coupled with the lack of any resulting convictions suggests **criminalization of victims may be occurring**. This criminalization may occur due to lack of understanding of the dynamics of DV or due to insufficient investigation into self-defending behavior. This reality underscores the need for continued investment in training, particularly on the proper use of the Lethality Assessment Protocol.

Of the cases reviewed, 44% of the DV perpetrators had prior DV arrests and 31% of the DV perpetrators' arrests resulted in a conviction. Yet, only 8% of the DV perpetrators had been in (or sentenced to) DV Intervention programming. While it is unclear based on available information whether the convictions were subject to the mandated offender treatment required by domestic violence sentencing laws, see C.R.S. § 18-6-801(2), increased treatment opportunities are critical. This is particularly true in light of the reality that last year, approximately 10% of the cases sentenced to the Colorado Department of Corrections included a finding by a judicial officer of domestic violence. The Board is focused on better understanding how DV intervention programming can be made more widely accessible and effective. The Board provides a review of the current status of prevention efforts, including DV Intervention programming on pages 47-52, and has identified this topic as an area of focus for 2023-2024.

The trends observed in the 16 cases highlight how **few social and institutional players knew of the underlying DV**. Family members were most likely to know of the abuse, but the awareness stood at 38% of the DVF victim's parents and 25% of siblings. Law enforcement was aware in only 25% of cases and there was no indication that any DV shelters knew of the DV. There are many reasons DV victims do not disclose their victimizations to others including those tied to their internal perception of the abuse—they may feel shame and guilt, fear of the perpetrator, not realize the behavior against them is abuse, hope that it will get better, or have economic concerns. Research suggests that in many cases victims do not seek services for lack of awareness the services exist.

This type of detailed and granular data remains critically important to the ability of the Board to fully meet its statutory mandate and to craft more targeted recommendations to prevent DVFs. In an effort to continue to invest in and support the development of local fatality review teams, this year the Board published a [Local Fatality Review Team Protocol Manual](#) to help jump-start new teams and ensure statewide consistency and integrity in data collection. The manual is available here. Additionally, the Board made it easier for communities and stakeholders to identify DVF cases and submit information for the Board and local fatality review teams' consideration. The Colorado Attorney General's Office has launched a [form](#) on its website where community members, organizations, and law enforcement can bring what they believe are DVFs to the attention of the Board. The form solicits high level information about the DVF and a member of the attorney general's staff or of the Rose Aodom Center will follow-up as appropriate. A more [detailed form](#) that solicits more information is also available on the Rose Aodom Center's [website](#). The intention of the Board is that both new reporting mechanisms will serve to streamline the data sharing process around DVFs statewide.

About the Colorado Domestic Violence Fatality Review Board

Per C.R.S. § 24-31-702(2)(a), the Colorado Attorney General serves as the chair of the Colorado Domestic Violence Fatality Review Board (CDVFRB or Board), which is charged to:

- (a) Examine domestic violence fatality data from the preceding year and identify trends;
- (b) Identify measures to help prevent domestic violence fatalities and near-death incidents;
- (c) Establish uniform methods for collecting, analyzing, and storing data relating to domestic violence fatalities and near-death incidents;
- (d) Support local fatality review teams;
- (f) Pursue implementation of any recommendations.
- (e) Make annual policy recommendations concerning domestic violence to the Colorado General Assembly; and

The Board was established in 2016, and its mandate was renewed for another five years in 2022.

The Board is comprised of a multi-disciplinary set of leaders and subject matter experts from across Colorado who are committed to preventing domestic violence and domestic violence fatalities. The Board works with community stakeholders to publish an annual report detailing data and trends on domestic violence fatalities statewide and identifying policy recommendations to prevent these tragedies. The Board also works closely with the Attorney General's Office to implement the policy recommendations from years prior. A full list of Board members can be found at the end of this report.

Defining a Domestic Violence Fatality

For this report, the Board defines a domestic violence fatality or DVF as the death of any person that results from an act of domestic violence or occurs in the context of an intimate partner relationship. Such deaths include:

- Homicides in which the victim was the perpetrator's current or former intimate partner.
- Homicides committed by an abusive partner in the context of intimate partner violence—for example, cases in which the homicide perpetrator kills a current or former partner's family member or new intimate partner, law enforcement officer, or bystander.
- Homicides that are an extension of or in response to ongoing intimate partner violence—for example, cases in which an abuser takes revenge on a victim by killing the victim's children.
- Homicides of abusers killed by intimate partner violence victims, often in self-defense.
- Homicides of abusers killed by friends, family, or bystanders intervening on behalf of an intimate partner violence victim.
- Suicide of the abuser committed in the context of an intimate partner violence incident.
- Suicides, other than the abusers, that may be a response to intimate partner violence.

In identifying DVFs, this report is not making any determinations of guilt or taking convictions into account, but based on the available information, the report is simply considering if there was a death that arose in the context of domestic violence. Some cases never involve a prosecution, some have pending charges, and some involve fully resolved prosecutions. Whether, on those facts, a conviction of any individual would result, is a different question and is not the determining factor in identifying whether a death was a DVF.

Domestic Violence Fatality Data Collection Process

The findings presented in this report include a compilation of the DVF information collected by the Rose Aodom Center on behalf of the Board and the Attorney General's Office. This report reviews both incidents and related DVF data analyzed by a local domestic violence fatality review team (Review Team), as well as other incidents identified but not reviewed by a Review Team. To identify DVFs that were not identified and reviewed by a local Review Team, a diligent search was made of publicly available sources, including media reports and arrest affidavits, as well as of non-public sources— primarily those provided by police, sheriffs, and district attorney's offices. Reports issued by the medical examiner's office, court data, and additional public source data such as [Gun Violence Archive](#) were also reviewed.¹ Identified DVFs were confirmed with local law enforcement agencies and district attorney's offices.

While the Board has made significant progress in the past six years in expanding the means of accessing data and ensuring that detailed diligence was given to identify as many cases as possible, there are still challenges with obtaining Colorado DVF data. It is therefore likely that some DVFs occurring in 2022 were not identified. The reasons for this vary, but a connection between a fatality and DV is often unknown or unreported, and the method of reporting any evidence of DV within fatality data remains inconsistent. Moreover, additional important DVF datapoints are also challenging to obtain such as the connection between an identified DVF and missing and murdered indigenous persons and the identification of LGBTQ+ victims. Gathering comprehensive data is important to accurately represent the prevalence, dynamics, and risks related to DVFs. The Board in partnership with the Rose Aodom Center is continuously seeking to evolve internal processes to continue to identify as many cases as possible and to draw out the critical datapoints within these cases.

The Board recognizes the pain created by a victim's absence - shared by family, loved ones, and communities left behind - is equally poignant in every DVF, whether or not the DVF is identified here. The Board is committed to improving and increasing data sharing and reporting across the state to ensure accurate and comprehensive reporting on DVFs.

¹ Some aggregated DVF data is available through the Colorado Bureau of Investigation (CB) but this data is deidentified and does not provide the information necessary for this report.

About Local Fatality Review Teams

C.R.S. § 24-31-703 enables communities across Colorado to form local Domestic Violence Fatality Review Teams (Review Teams) to review fatal and near-fatal incidents of domestic violence. Teams are composed of a wide array of stakeholders—law enforcement, prosecutors, judges, advocates, and survivors. The purpose of each team is to learn from these tragic cases—identifying common risk factors and potential intervention points to help prevent future domestic violence-related deaths. Review Teams review only closed cases with no current or pending legal action. The teams then review every aspect of the case, including risk factors, prior justice system interactions, resource access and barriers, government and non-profit advocates involvement, and other factors. The local teams then convey the local data on DVFs and their findings to the Board.

To encourage the formation of local teams across Colorado, the Fatality Review Program Manager (FRPM) reached out to communities across the state to ensure they have a point of contact if and when they are ready and able to form a DVF. The FRPM, other experienced Rose Aandom Center staff, and Board members are readily available to support new teams' advancement and answer questions as they arise. To further support the development of Review Teams, the Board has developed a best practices and protocol manual, available [here](#), which will be provided to existing local teams and to communities interested in developing Review Teams. This manual, [discussed in greater detail here](#), provides guidance on how to identify DVFs, how to conduct case reviews, and how to provide case review data to the Board. This document will continue to evolve and benefit from use and repeated review.

The local fatality review teams that currently exist in Colorado are detailed below.

Denver

The Denver Metro Domestic Violence Fatality Review Team (Denver Review Team) was formed in 1996 and was one of the first Review Teams in the country. The Denver Review Team is comprised of 25 professionals with a variety of perspectives and includes community- and systems-based advocates, child welfare advocates, medical providers, offender treatment providers, probation officers, law enforcement officials, prosecutors, and judges. The team meets monthly to review fatalities within the 1st, 2nd, 17th, and 18th Judicial Districts. The Denver Review Team is managed by the Fatality Review Program Manager at the Rose Amond Center. The Program Manager identifies which DVFs to review monthly and prepares a detailed case review. This case review involves a presentation from the assigned detectives and district attorney on the case who provide the context for the case which may include information such as the events leading up to the incident, relationship history, abuse history, and case disposition. Afterward, the entire team discusses the risk factors for lethality and what interventions were utilized or missed. Information from the reviews and additional case data are compiled and then analyzed at the end of the year. The findings are reported to the Board and are reflected here in this report.

Mesa County

Mesa County started its Review Team in 2015. The Mesa County Review Team has 16 members and representatives from various agencies within the 21st Judicial District. The Mesa County Review Team reviews roughly two cases per year and follows similar protocols to the ones discussed above for the Review Team. While Mesa County does not have a dedicated program manager, they have a chairperson, and their Review Team relies on the individual work of all team members.

Pagosa Springs

The town of Pagosa Springs operates a multidisciplinary team of nine professionals who work to improve responses to DV. The team was created in 2008 after an 18-month institutional analysis of the county's criminal justice response to DV. The team has since evolved into a Coordinated Community Response Team (CCRT), which acts as the local DVFRB and local Sexual Assault Review Team (SART). Reviews occur predominantly for near-lethal and fatal criminal cases, but also include misdemeanors and high-risk cases brought by an individual team member. The team meets monthly to identify concrete action steps to improve victim safety and offender accountability, including modification of processes, policies, and procedures within criminal justice, child welfare, victim advocacy, and medical systems.

Recent Colorado Programs and Legislation Mitigating Domestic Violence

Colorado has several protections that mitigate the risk of domestic violence, and DVFs specifically. Highlighted below are some recently created protections and programs. Details on additional long-standing protections including civil and criminal protection orders are available in the [2022 Report found here](#).

Lethality Assessment Program

In the 2020 Annual Report, the Board recommended the implementation of the Lethality Assessment Program (LAP) across Colorado. The LAP is an evidence-based tool of 11 questions that a law enforcement officer can use to assess risk and connect a victim of intimate partner violence with a victim advocate. A copy of the LAP is available as Appendix 1.

In 2021, the Office of the Attorney General was awarded a federal Justice Administration Grant to contract with a statewide coordinator tasked with implementing the LAP across Colorado. The statewide coordinator was hired in 2022 and spearheaded the creation of the Colorado Lethality Assessment Program or COLAP. COLAP established a clear process for communities wishing to receive free training on implementing LAP. Eleven agencies are now using an LAP program statewide and trainings with other communities are scheduled for 2023 and 2024. The statewide coordinator has and will continue to work with communities trained and using LAP to ensure continued improvement and use. By the end of 2023, there will be approximately 27 agencies spread across 5 counties in Colorado utilizing the LAP protocol. In 2023, the Office of the Attorney General was awarded a second federal Justice Administration Grant to continue this work.

Extreme Risk Protection Orders

Extreme risk protection orders (“ERPOs” or “red flag laws”) temporarily prohibit individuals determined by a judge to be at high risk of firearm violence—including any combination of violence directed at others, themselves, or large groups of people—from possessing or legally purchasing firearms. A family member, household member, law enforcement officer or agency, mental health professional, or school teacher or administrator may file for a temporary (14 day) or 364-day ERPO. If an ERPO is granted, the individual determined to be at risk must relinquish their firearms and concealed-carry permit, if they have one, and is prevented from purchasing additional firearms for the duration of the order. While similar firearm restrictions are available through DV protection orders, DV survivors who might not otherwise be able to obtain a DV protection order can consider utilizing ERPOs to mitigate against the risk of firearms.

Colorado Senate Bill 22-150 Missing and Murdered Indigenous Relatives

Missing and Murdered Indigenous Women and Girls are victims of pervasive violence that began centuries ago, one that has gone unrecognized by governments, institutions, and society as a whole. To fight this silencing, Native communities have come together to decolonize the narrative, advocate for MMIWG, and honor the lost lives of their daughters, sisters, and matriarchs (Ficklin et al., 2022, p. 53).

The Missing and Murdered Indigenous Women and Girls (MMIWG) movement started in Canada in 2016 and expanded to the United States. Colorado enacted the first MMIWG legislation in 2022— Colorado Senate Bill 22-150 (“SB22-150”). This legislation created the Office of Liaison for Missing and Murdered Indigenous Relatives which “helps bridge the gaps historically seen in Indigenous missing people cases.” (Bordelon, 2022). SB22-150 also mandated that the Colorado Department of Public Safety and the Colorado Bureau of Investigations create a Missing Indigenous Persons Alert Program. See Rule 8 CCR 1507-36. This program launched on December 30, 2022, and notifies local and statewide law enforcement, the media, and others of any reported missing Indigenous persons within 8 hours for adults and 2 hours for children. (Berg, 2023).

Colorado DVF Findings

The findings below are presented in two sections. The first section addresses DVFs in Colorado from the entire population (all DV-related fatalities in 2022), while the second presents far more granular data on the DVF cases reviewed by DVF review team in 2021 and 2022. The cases in the second section are not necessarily from 2021 and 2022 because cases must be closed before a Review Team can conduct an in-depth review. Last year's report did not include any of the cases reviewed by Review Teams thus, this year's includes all cases reviewed by Review Teams in 2021 (N = 6) and 2022 (N = 10).

Domestic Violence-Related Fatalities in Colorado in 2022

[Last year, the 2022 report](#) identified an all-time high number of Colorado DVFs in 2021, more than in any year since the creation of the Board in 2016. Tragically, the number of DVFs identified for 2022 is higher—there were 94 DVF fatalities occurring in 62 cases. This is 1.5 times the average number of Colorado DVFs (65.7) over the Board's seven years of data collection (2016-2022) (Chart A).

Chart A: Annual Number of DV-Related Fatalities in Colorado, 2016-2022



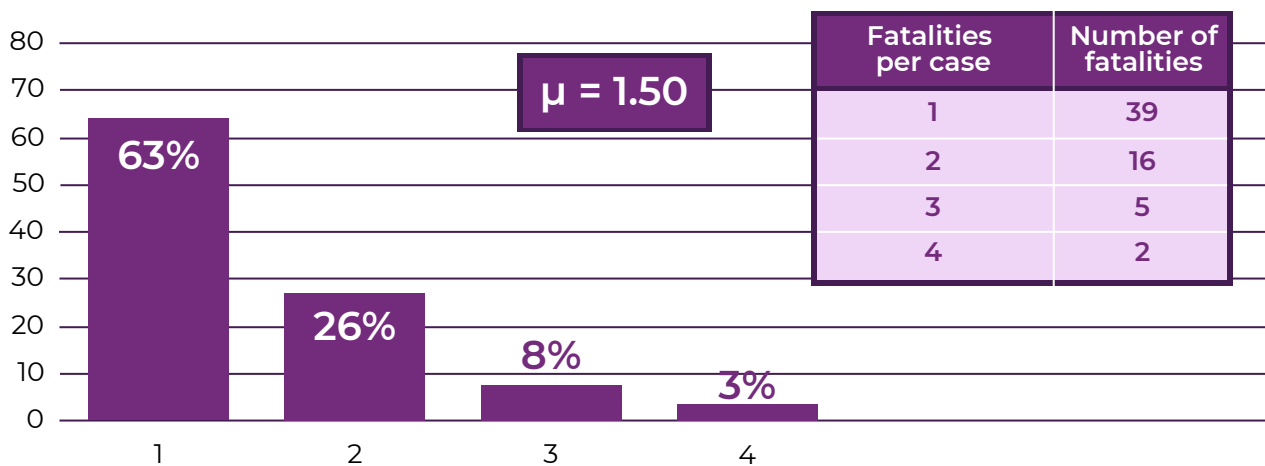
Number of Fatalities per Case (Incident)

The fatalities per case ranged from 1 to 4, averaging 1.5 deaths per case (see Chart B). Sixty-three percent (63%) of the 2022 Colorado cases involved one fatality, and about a quarter (26%) involved two fatalities. Seven percent involved three, and 4% of the cases involved four fatalities.

Chart B: In 2022, in Colorado, there were 62 DV Fatality Cases, Resulting in 94 Fatalities

N = 94 fatalities per 61 DVF cases

■ % of cases x N of fatalities

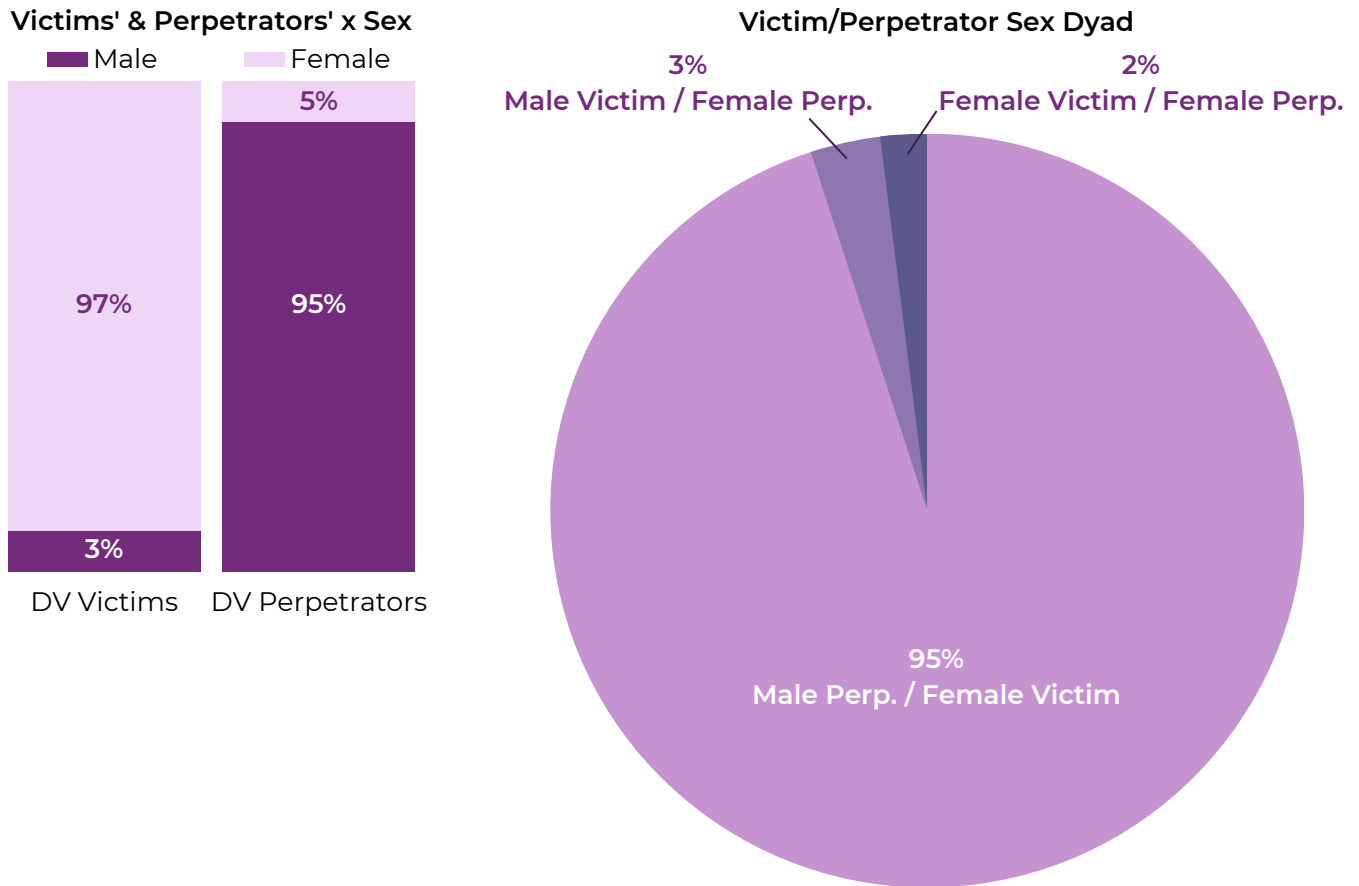


Characteristics of the DV Victim and DV Perpetrator

While the primary DV victims are not the fatalities in all the cases, this section identifies DV victim characteristics for all 62 DVF cases. In the 62 DVF cases, 97% of the DV victims were female, and 95% of the DV perpetrators were male (see Chart C). Male perpetrators with female victims constituted the vast majority (95%) of the 2022 DVF cases. Three percent of the cases involved female perpetrators with male victims. In the Colorado 2022 DVFs, female perpetrators with female victims comprised 2% of the DVFs, and there were no same-sex male DVF cases. Note that most DVF research indicates that same-sex couples constitute 2% to 3% of these homicides. (Gannoni & Cussen, 2014; Messing et al., 2021).²

² There were no indications of any DV victims or perpetrators identified as other than female or male, and no indications of transgender, intersex, or gender-nonbinary identities. Gannoni & Cussen (2014, p. 2) provide an excellent explanation of the need for including all sex identities if they are known and the ways that same-sex DVFs are likely undercounted. In most of the DVF cases collected for this report, it would likely be known if the DV victim or perpetrator were transgender or gender-nonbinary, but probably less so for intersexed persons. The Arizona IPH study found that out of 5 (3.2%) of DVFs were same-sex, and 1 (0.6%) was a transgender victim (Messing et al., 2021, p. 568).

Chart C: Sex and Sex-Dyads of the DV Partners / Ex-Partners (N=62)



The DV victims' ages ranged from 18 to 80, with an average age of 36. The DV perpetrators' ages ranged from 21 to 83, with an average age of 39 (Chart D).

The DV victims and perpetrators were predominantly white (50% of victims, 47% of perpetrators), followed by Hispanic (37% of victims, 36% of perpetrators). Nine percent of the DV victims and 15% of the DV perpetrators were African American/Black. Two percent of both the DV victims and the DV perpetrators were of Asian descent. One (2%) DV victims and none of the perpetrators were Native American (see Chart D). As detailed in the callout box in this section, the Native American victim DVF underscores the importance of SB22-150.

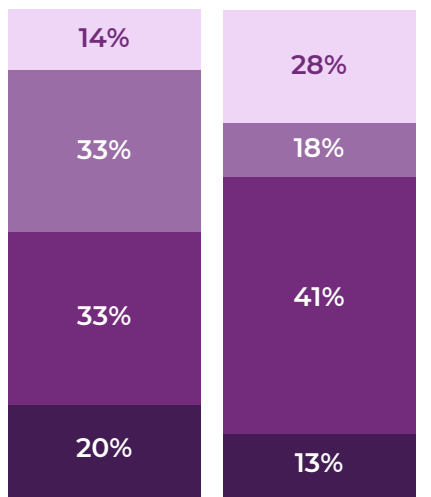
Impact story

When Raeanna Burch-Woodhill, 28 years old, pregnant, and a mother of two young daughters, went missing, her family was worried that her husband had harmed her, stating that she would never abandon her small children (Bordelon, 2022). The newly created Office of Liaison for Missing and Murdered Indigenous Relatives, created from SB22-150, hired its first director a week before Burch-Woodhill went missing. Burch-Woodhill's family notified this office after about a week of believing law enforcement officials did not sense any urgency that Burch-Woodhill might be dead. This was the first case for this office. The Director coordinated different entities (e.g., Southern Ute Police Department, Colorado Bureau of Investigations, and community members) and arrived to help search for Burch-Woodhill the day after being notified. That same day, Burch-Woodhill's body was found "in the area of Colorado State Highway 550 and County Road 310, south of Durango" (Case, 2022). Her husband was arrested and charged with second-degree murder. The Missing Indigenous Person Alert Program, also due to SB22-150, was implemented 27 days after Burch-Woodhill's body was found.

Chart D: DV Victims' & DV Perpetrators' Age and Race

DV Victim & DV Perpetrator Age

■ <26 ■ 26-35 ■ 36-45 ■ 46+



DV Victims DV Perpetrators

DV Victim & DV Perpetrator Race

Race	DV Victim (n=56)	DV Perpetrator (n=58)
White	50%	47%
Latinx	37%	36%
African American / Black	9%	15%
Asian descent	2%	2%
Native American	2%	0%

Victim age (N=55)

Victim range is 18-80 years
 $\mu = 36$

Perpetrator age

Perpetrator range is 21-83 years
 $\mu = 39$

Race dyads were calculated among the 53 DVF cases where both the DV victim and perpetrator races were known. Seventy percent (n = 37) of the couples were the same race (intraracial), 15% (n= 8) of the couples were white and Hispanic, of which half involved a white perpetrator and Hispanic victim and the other half involved a Hispanic perpetrator and white victim. Five percent (n = 3) of the cases involved a white victim and Black perpetrator. Three percent (n = 2) involved an Asian American victim and a white perpetrator. The remaining cases involved one with a Black victim and white perpetrator, one with a Native American victim and a Hispanic perpetrator, and one with a Hispanic victim and Black perpetrator.

The relationship status of the DVF couple on the date of the DVF indicates that 58% of the cases involved currently or formerly dating/romantic couples and 42% involved currently or formerly married couples (see Chart E). A third (33%) of the DVF couples were broken up/divorced/estranged, and two-thirds (66%) were still together. Notably, the crosstab analysis of broken up/together by dating/ever married was statistically significant, indicating that dating couples were more likely to be broken up and married couples were more likely to still be in the relationship at the time of the fatality ($p < 0.01$). More specifically, couples who were broken up at the time of the DVF were four times more likely to have been currently or formerly dating (80%, n = 16) than ever married to each other (20%, n = 4). Couples who were still together on the at the time of the DVF were more likely to have been married (at some point, not necessarily on the DOI), than couples who were dating (and had never married each other) (54% and 46%, respectively).

Chart E: Domestic Violence Couple Relationship at DOI (N=59)

	Dating	Married	Total
Broken up / estranged	27% (n=16)	7% (n=4)	34%
Together	30% (n=18)	36% (n=21)	66%
Total	58%	42%	100%

**For dating: DV victims' ages ranged from 18 to 55, $\mu = 32.5$ years old.
DV perpetrators' ages ranged from 21 to 62, $\mu = 35.8$ years old.**

**For married: DV victims' ages ranged from 23 to 80, $\mu = 40.2$ years old.
DV perpetrators' ages ranged from 27 to 83, $\mu = 43.2$ years old.**

Those Who Died

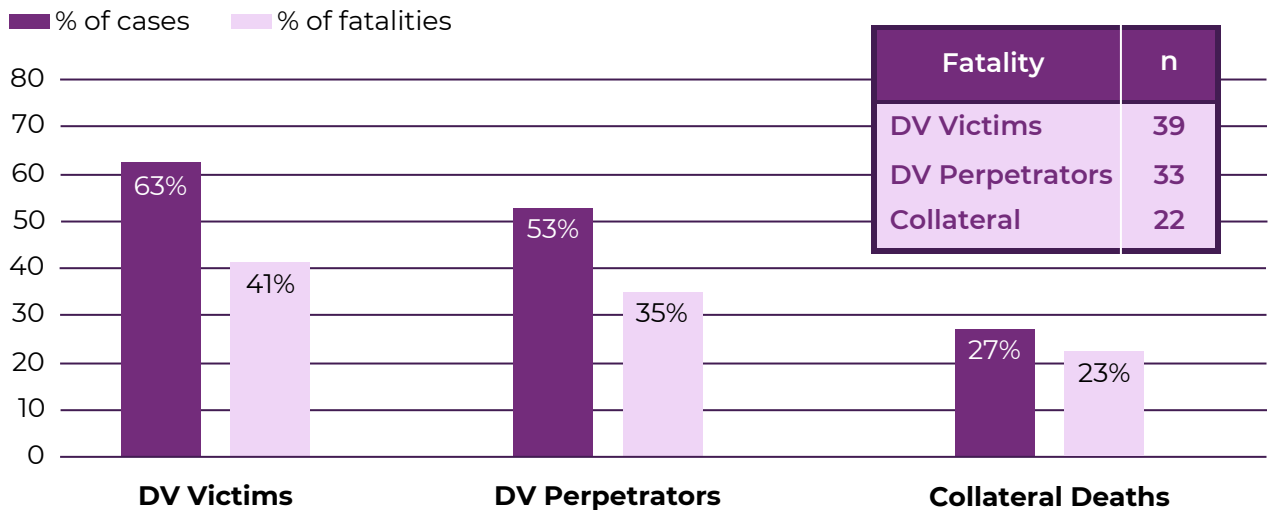
Chart F distinguishes fatalities among three primary groups: DV victims, DV perpetrators, and collateral victims.³ This chart includes the percentage representation of these three groups in terms of their incidence among the 62 cases and their prevalence among the 94 fatalities.

As expected, DV victims comprised the highest percentage of deaths in both the case (64%) and total fatality (43%) data. Next most likely were DV perpetrator deaths (52% of cases and 35% of total fatalities) and collateral deaths (26% of cases and 22% of total fatalities). These findings underscore that DVFs are not restricted to DV victims (or DV perpetrators). Indeed, in 36% of the cases, the DV perpetrator did not kill the DV victim. More detail on the collateral deaths is provided in Charts G through H.

DV perpetrators died by suicide in 41.0% of the cases where they killed their DV victims and suicided in 30.4% of the cases where they did not kill their DV victims. DV perpetrator suicided in 47.1% of the cases where they killed one or more collateral victims and in 33.3% of the cases where they did not kill any collateral victims. Although DV perpetrators were more likely to suicide when they killed collateral victims (47.1%) than when they killed their DV victims (41.0%), this relationship was not statistically significant.

³ Intimate partner homicide (IPH) research is usually limited to documenting fatalities among the two members of the intimate couple (DV victims and DV perpetrators). Collateral fatalities are any deaths in the context of a DV incident that are not the DV victims or DV perpetrators.

Chart F: Representation of Fatalities by Who Was Killed and Who Killed



*Percentages do not sum to 100.0% due to rounding.

Who Caused the Death

While Chart F summarizes those who died, Chart G summarizes who caused the deaths (including suicide and killing in self-defense or defense of others). As expected, DV perpetrators caused all (100%) the DV victim and collateral victim fatalities. Additionally, most of the DV perpetrator deaths, 70%, were self-inflicted (suicides). Law enforcement killed the DV perpetrator in 22% (n = 7) of the cases. In these cases, 14% also involved the death of the DV victim. No charges were brought against any law enforcement personnel who killed DV perpetrators.

One DV victim killed the DV perpetrator. Unlike most of these cases in our annual reports, the criminal legal system did not determine this to be in self-defense or to protect anyone else. The DV victim was charged with first-degree murder and pled guilty to second-degree murder, a “heat of passion” crime,⁴ a class 3 felony, and received a 15-year prison sentence. This report identified the individual in this case as a DV victim given the larger context of the case. Of note, two days before the fatality, the DV perpetrator assaulted the DV victim and her mother and then left a voicemail threatening to kidnap the DV victim's brother and kill him and the rest of her family if she did not give him (the DV perpetrator) their shared child. The DV victim reported the assaults to the police. At the time of the homicide, the DV perpetrator had not been picked up on the warrant for the reported assaults. It is worth noting that when DV victims kill their perpetrators at a time separated from an actual DV incident, many legal scholars stress that these cases should still be considered in the context of self-defense (C. K. Gillespie, 1989).

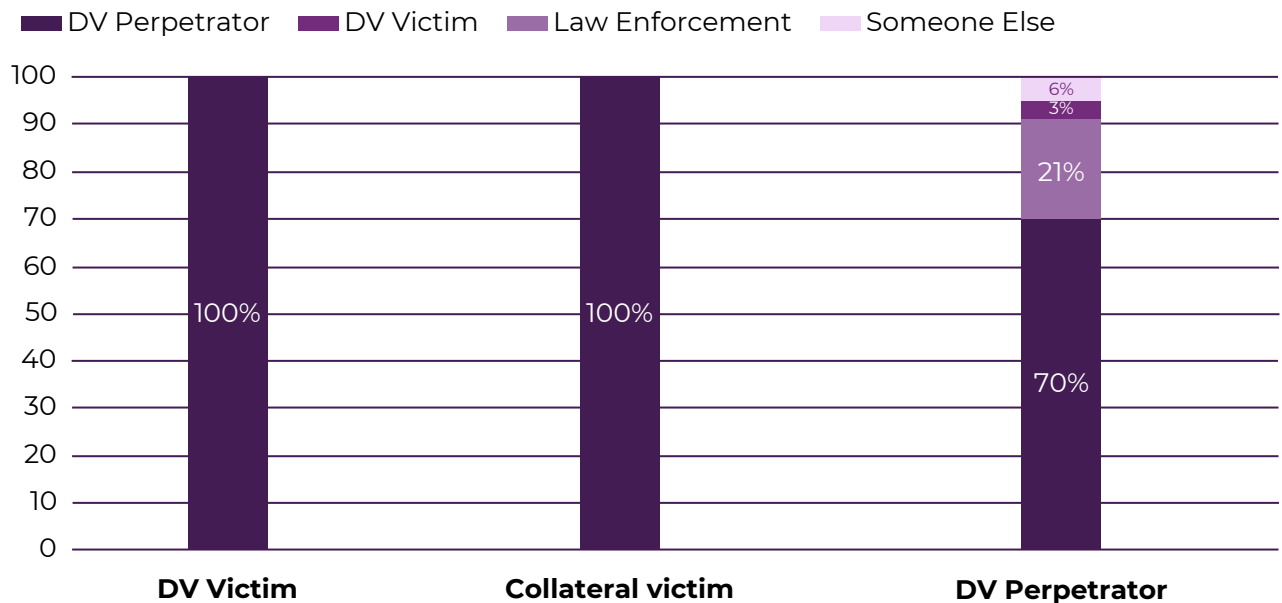
The remaining two DV perpetrator fatalities were attributed to civilians; one the DV victim's brother and one a mutual friend of the DV victim and perpetrator. The criminal legal system charged the DV victim's brother with first-degree murder. In that case, the DV (male) perpetrator assaulted the (female) DV victim earlier in the day (although this was not reported to the police) and then argued with her through the window of the residence she shared with her parents. She told him to leave. Her brother is charged with shooting and killing the DV perpetrator outside this shared residence.

⁴ That this is legally referred to as a “heat of passion” crime is troubling.

In the other case, where a civilian killed the DV perpetrator, the DV (male) perpetrator broke into his ex-girlfriend's trailer after threatening to kill her. She fired a warning shot into the ground, and he lunged at her. A mutual (male) friend of the DV perpetrator and victim was present at the time to witness the event and fired one shot which killed the perpetrator. The friend was investigated for the death of the DV perpetrator; the district attorney ultimately chose not to file charges.

These cases underscore the complexity of DVF cases and the challenges that are encountered in the judicial system's response to fatalities. These cases are often fraught with questions of intent and defense of self and others and are rarely straightforward.

Chart G: Who Killed the DV Victims, Collateral Victims, & DV Perpetrators



A Deeper Look at the Too-Often Invisible Victims: The Collateral DVF Fatalities

In 2019 and 2020, 5% and 6%, respectively, of the total DVFs were collateral fatalities. In 2021 this increased to 15%. In 2022 an unprecedented 23% (n = 22) of the 94 fatalities were collateral fatalities. This extraordinary increase in the last two years is deeply concerning and emphasizes that the lethal threat often extends beyond the DV victims (and perpetrators).

The number of collateral victim fatalities in 2022 ranged from 0 to 4. Chart H shows the breakdown in collateral victim fatalities per case. Twenty-three percent of the cases involved one collateral fatality, 2% involved two collateral fatalities, and 2% involved four collateral fatalities. (None of the 62 cases involved three collateral fatalities.)

The collateral victims ranged in age from 8 months to 61 years old, with an average age of 30.3 years old (Chart I). Of the collateral victims, tragically six were children (27% of all collateral fatalities). These victims were an 8-month-old, two 5-year-olds, a 6-year-old, an 8-year-old, and a 16-year-old. Four of the children were the DV perpetrators' (joint) children with the DV victim, one was the DV victim's child where the DV perpetrator was not the other parent, and one was a 5-year-old asleep in a nearby apartment killed by the fire set by the (female) DV perpetrator of her (male) DV victim's apartment.

Impact story

One DVF involved a DV victim who was emotionally and psychologically abused by her husband. She knew her husband owned guns. She took their 1- and 3-year old daughters and traveled to her parents' home, driving from Colorado to Missouri. When they left, he followed them. He threatened to shoot himself in front of his young daughters. The DV victim requested a parental responsibility evaluation (PRE) to determine whether he should be allowed to see the girls alone. The first one believed mom's account of the abuse but still gave dad unsupervised visitation with his young children. The dad requested a second PRE and which concluded the girls should be with their dad 4 out of 14 nights which was a significant increase from the first report. The DV victim with her lawyer fought in court to show the girls were not safe in the father's care. When the girls were 6 and 8 years old, and in his care (at his home), he shot and killed them and then himself.

Chart H: Collateral fatalities per case (N=22)

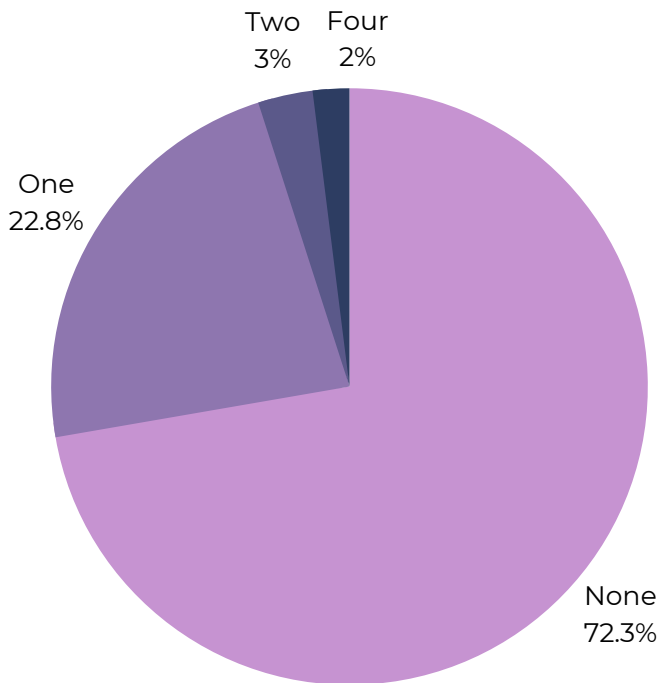
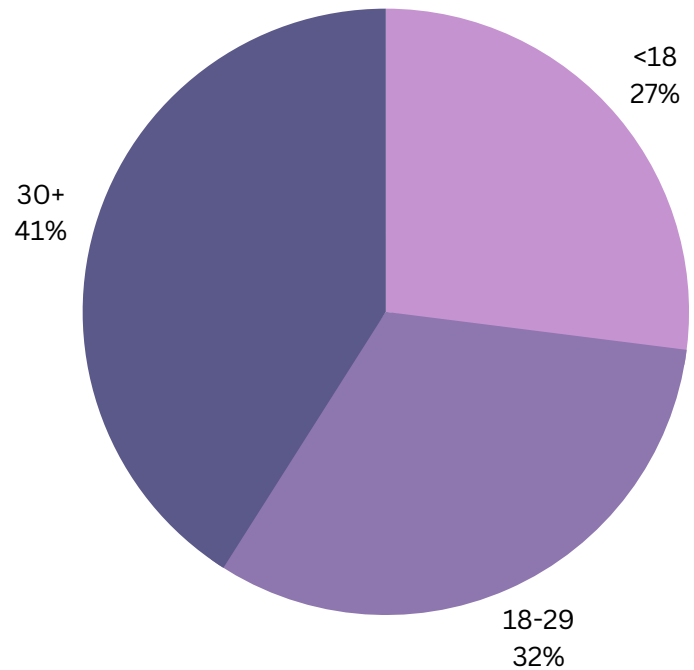


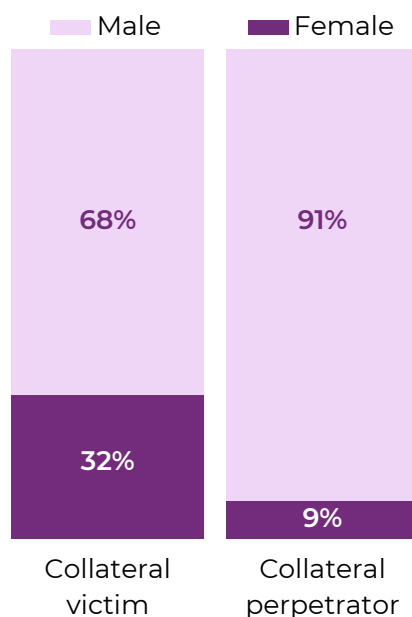
Chart I: Collateral victims' ages (N=22)
 Range: 8 months to 61 years
 $\mu = 30.3$



*Percentages do not sum to 100 due to rounding.

The 2022 Colorado data indicated that males killed nine-tenths (90%) of the collateral victims, and two-thirds of these victims were male. (Chart J). The two women DV perpetrators who killed collateral victims included the woman just listed who set her (male) DV victim's apartment on fire, killing a 5-year-old boy in the building, and a DV perpetrator who killed her estranged husband's new girlfriend.

Chart J: Collateral victims' and perpetrators' sex (N=22)



Recall that the DV perpetrators killed all DV victims and collateral victims (reported above). Chart K portrays the relationships between the collateral victims and the DV perpetrators. The largest category, 32% (n = 7) of the collateral fatalities, involved DV perpetrators killing their DV victims' family members (other than a joint child) (e.g., in-laws, but also one case where the DV perpetrator killed his DV victim's child from a previous partner). The next most common, 23% (n = 5), involved the DV perpetrator killing his and his DV victim's joint child(ren).⁵ Fourteen percent (n = 3) of the collateral cases involved the DV perpetrator killing the DV victims' friends and another 14% (n = 3) of cases involved the DV perpetrator killing someone who was in a new romantic relationship with their DV victim (not necessarily a "partner"). In 9% (n = 2) of the cases, the DV perpetrator killed a law enforcement officer responding to the scene, and in another 9%, neighbors of the DV victim or DV perpetrator were killed.

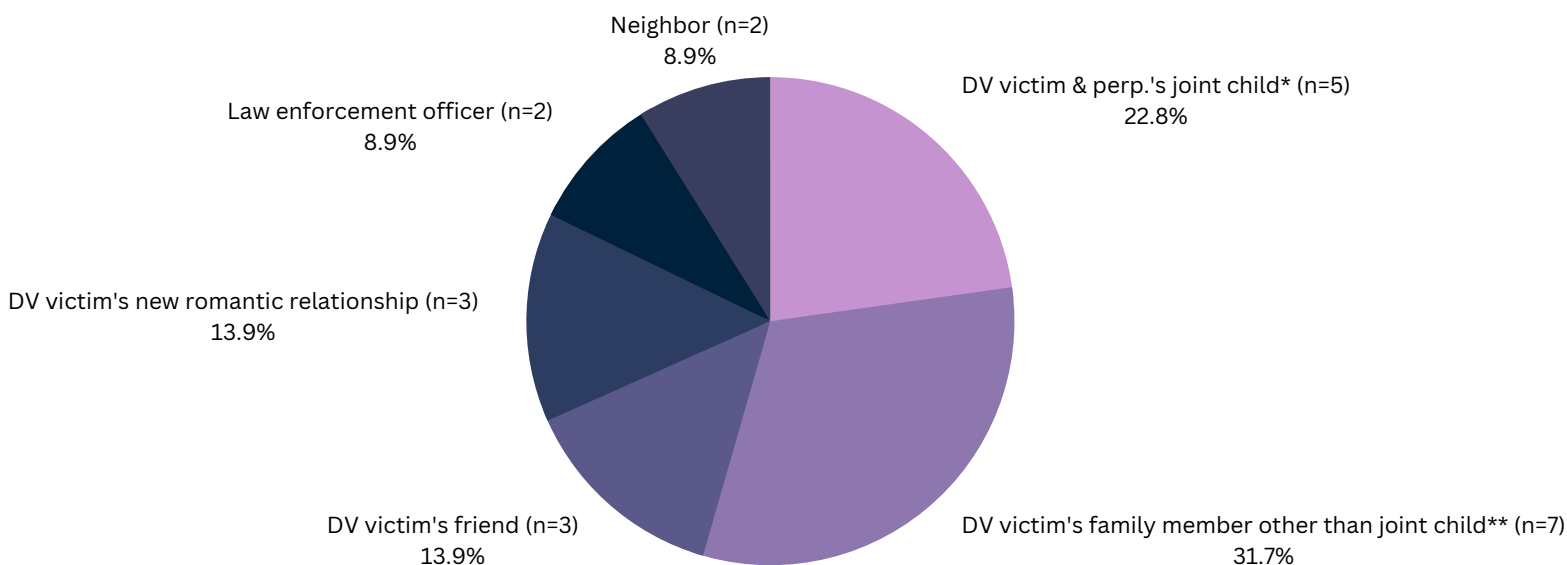
⁵ This is larger than the joint children in Chart I because in one case the joint child was an adult (61-years-old) son.

The complexities of these cases and risks to community members is significant. Consider:

In one DVF, police responded to a custody dispute call regarding a man whose children were in the custody of his ex-girlfriend's family. There was a history of DV in their relationship. A 27-year-old police officer was trying to break up the family dispute when the DV perpetrator shot him in the head, shot the DV victim's sister, and the DV victim in the leg. The sister survived, but the police officer died.

Police responded to a shooting where the DV perpetrator shot and killed multiple individuals: his ex-girlfriend's father, her twin sister, her sister's husband, and a neighbor who was renting an RV on the property. His ex-girlfriend and their two young children were inside their home during the shooting and were not injured.

Chart K: The relationship of the collateral death individuals to the male DV perpetrator who killed them (N = 13*)



Notes:

- *One case involved a DV perpetrator who killed his adult 61-year-old son
- **Includes one case where the collateral victim was the child of the DV victim from a previous partner.

Firearms are the Overwhelming Cause of DVFs

Consistent with existing DVF research and previous Colorado Domestic Violence Fatality Board reports, firearms are the most common weapons involved in DVFs, and gunshot wounds are the most frequent causes of death in DVFs (Chart L). Specifically, in 2022 in Colorado, 86% (n = 79) of the fatalities were from guns/gunshot wounds. All DV perpetrator fatalities (n = 33) were by guns, including the three cases which were not suicides (i.e., the two DV perpetrators killed by civilians and the one DV perpetrator killed by his victim). Almost three-quarters (73%) of the DV victim fatalities and 86% of the collateral fatalities were from a gunshot wounds. Of the six children who were collateral fatalities, all but one died of gunshot wounds. The only exception was a neighboring boy who died in a fire set by the DV perpetrator.

Strangulation/asphyxiation and/or other head trauma was the second most likely cause of death, 8% (n = 7) of the total fatalities and all were DV victim fatalities (i.e., none were DV perpetrator or collateral fatalities). Indeed, almost one-fifth (19%, n = 7) of the DV victims' deaths were due to strangulation/asphyxiation/head trauma.

Four percent (n = 4) of the fatalities were due to stabbing with a knife or other sharp object. Nine percent (n = 2) of the collateral victims' and 5% (n = 2) of the DV victims' cause of death was by these stabbings. The "other" category of causes of death involved a DV victim whose cause of death was due to both stabbing and blunt force, and the 5-year-old boy referenced earlier who died when the (female) DV perpetrator lit a fire in her (male) DV victim's apartment.

Chart L: Causes of Death (N=92)

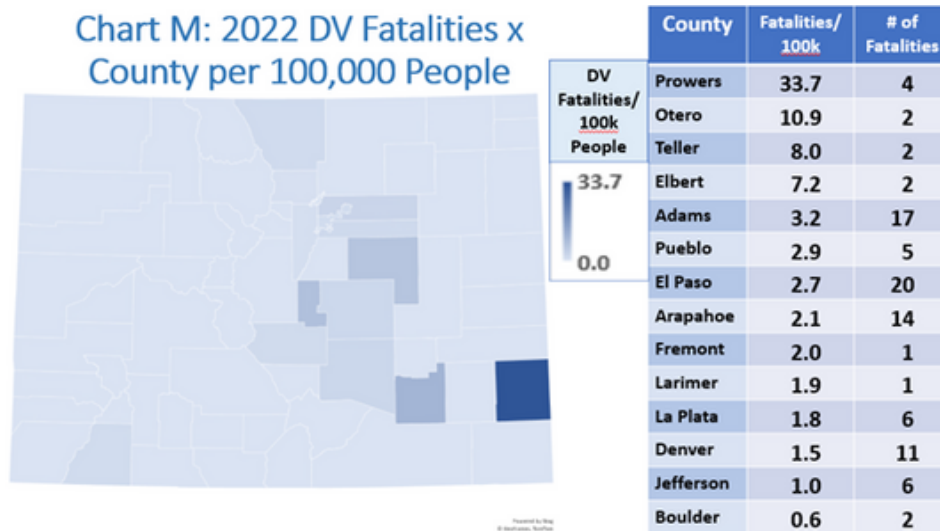
Weapon/Injury	Total (N=92)	DV victim (N=37)	Collateral victim (n=22)	Perp. fatality (n=33)
Firearm/GSW	86%	73%	86%	100%
Knife/Sharp Obj. /Stabbing	4%	3%	9%	0%
Strangulation/ Head Trauma	8% ^b	19% ^b	0%	0%
Other	2% ^{c,d}	3% ^c	5% ^d	0%

*Notes: Weapon/cause of death was unknown for two DV victims. Among DV victim fatalities: 5 were strangled, and 2 had blunt force head trauma. One “other” was a combination of stabbing and blunt force. Another “other” was an arson case where the victim likely died of smoke inhalation.

County and Population DVF Patterns

Finally, the 2022 DVFs data were mapped by Colorado county while controlling for the number of DVFs in a county per 100,000 people (Chart M). These rates ranged from 0 (most counties) to 33.7 per 100,000. Fourteen of the 64 counties (22%) had at least one DVF. Unlike the previous years we mapped the DVFs by county, the 2022 data were more concentrated in the highly populated counties (El Paso, Adams, Arapahoe, Denver, Jefferson, Larimer, and Boulder), although DVFs also occurred in some of the more rural counties: Otero, Logan, Elbert, Fremont, and La Plata. Some research indicates elevated DVFs in more rural than urban counties. (L. K. Gillespie & Reckdenwald, 2017).

Chart M: 2022 DV Fatalities x Country per 100,000 people



Colorado Cases Reviewed by Review Teams from 2021 to 2022

As previously noted, the first findings section of this report addressed data from all identified Colorado DVF cases in 2022. This section reports the data and trends based on information that is otherwise challenging to obtain without a DVF Review Team (Review Team). While the statewide data is representative of the Colorado cases in ways the ones sampled for Review Teams are not, the Review Team data allows a more granular examination of many of the characteristics associated with (according to existing literature) or potentially associated with DVFs.

The COVID epidemic stymied Review Teams’ efforts to review cases. (Dunne & Mathis, 2022; Messing & AbiNader, 2022; Rowlands, 2023; Swisher & AbiNader, 2022). Of note, Review Team data were not included in last year's DVF Board Report because there were too few reviewed cases (n = 6). The same was true for 2020, but we combined Review Team cases between 2017 and 2020 for the 2021 Final Report. This report identifies data and trends from the 6 cases reviewed in 2021 and the 10 reviewed in 2022.

A Summary of the 16 Review Team Cases

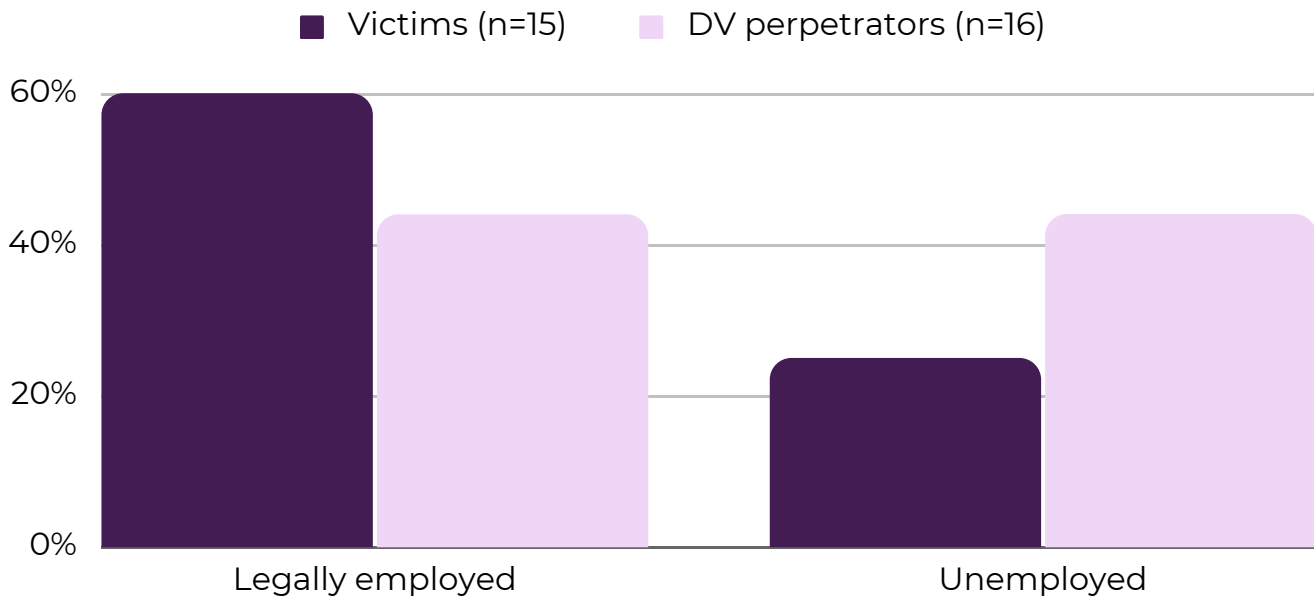
The 16 reviewed cases occurred between 2016 and 2021, with the majority occurring in 2019 (37.5%, n= 6) followed by 2021 (25%, n = 4). These cases included 23 fatalities. In the 16 cases, 15 of the 16 DV victims were murdered, one DV victim was a near death, 6 of the DV perpetrators suicided, and there was one collateral victim: the DV victim and the perpetrator's 1-month-old daughter. The 16 cases were primarily in Denver County (37.5%, n = 6), with the remaining divided equally (12.5%, n = 2, each) among Adams, Arapahoe, Douglas, Jefferson, and Mesa Counties. Among the DV victims, 94% (n = 15) were female and ranged in age from 17 to 51 ($\mu = 34.5$). The DV perpetrators were 88% (n = 14) male, aged 18 to 57 ($\mu = 35.8$). The only same-sex relationship was female-female.

One (6%) of the DV perpetrators was killed by the DV victim in self-defense (and ruled accidental). No law enforcement officers were killed, and no law enforcement killed anyone in the reviewed cases. At the date of the DVFs, most of the couples were currently cohabitating as spouses or partners (69%, n = 21), about a fifth were former spouses/partners not cohabitating (19%, n = 3), and two (12.5%) were in a relationship and had never cohabitated. Ten (62%) of the couples had no joint children, five (31%) couples had one joint child, and one couple (6%) had two children. The joint children ranged in age from one month to 14 years. At least six couples had minor children from a previous relationship (in the four cases where the parent was known, the DV victim's child(ren)) lived with them.

DV Victims' and Perpetrators' Employment

Among these 16 cases, DV victims were far more likely to be legally employed (60%) than DV perpetrators (44%) and DV perpetrators were far more likely to be unemployed (44%) than DV victims (25%) (Chart N). None of the DV victims or perpetrators appeared to be illegally employed or retired. One DV victim and no DV perpetrators received SSI (disability). Additionally, one DV victim and no DV perpetrators were students. Notably, one DV victim was unemployed due to a head injury caused by the perpetrator six years before the date of the DVF (although he was not collecting SSI). One DV victim and one DV perpetrator were underemployed (i.e., employed at a level below their qualifications). Both the DV victims' and DV perpetrators' jobs covered a wide range of employment statuses. These findings are consistent with research highlighting how unemployment, underemployment, and recent job changes, particularly during the COVID-19 pandemic, heightened the risk of DV. (Peitzmeier et al., 2021).

Chart N: DV Victim and Perpetrator Employment Status



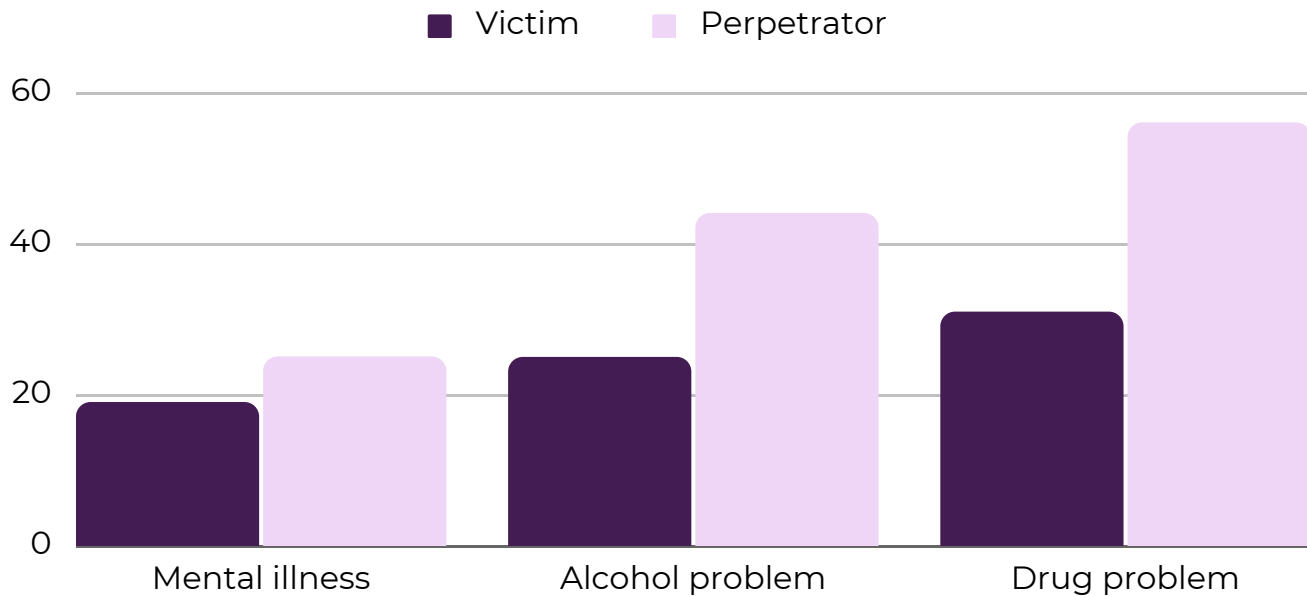
Indications of DV Victims' and Perpetrators' Mental Health and Alcohol and Drug Problems

The three issues presented in Chart O—mental health, alcohol abuse, and drug abuse—are often challenging to determine, even in the context of DVFTR case reviews. Moreover, mental illness indicators are often complex to confirm. For example, if victims are known to have depression, it is often unclear if the depression results from the abuse or not and it is also unclear the way mental illness is called upon by a perpetrator as part of their defense. However, review teams still consider mental health along with substance abuse, insofar as that data is available because these indicators are well-understood as red flags for DVFs.

Chart O presents the percentage of the 16 cases with a known or substantial likelihood of the issue; they may be higher. Regarding indications of mental illness, 19% (n = 3) of the victims and 25% (n=4) of the perpetrators had indications of mental illness. Among the DV victims, one was diagnosed with bipolar disorder, and two were diagnosed with depression and self-harming behaviors (e.g., cutting). Among the DV perpetrators, there was often a mix of depression and other diagnoses, and two had symptoms of bipolar disorder. Two perpetrators were diagnosed with autism spectrum disorder, but these were not included as mental illnesses in Chart O.

A quarter of the DV victims and 44% of the DV perpetrators had indications of alcohol abuse and 31% of DV victims and 56% of DV perpetrators had indications of drug abuse. The percentages in Chart O are higher for victims than in most years we have collected data.

Chart O: Percent of DV victims and perpetrators with indications of mental illness, alcohol problems, and drug problems (N=16)*



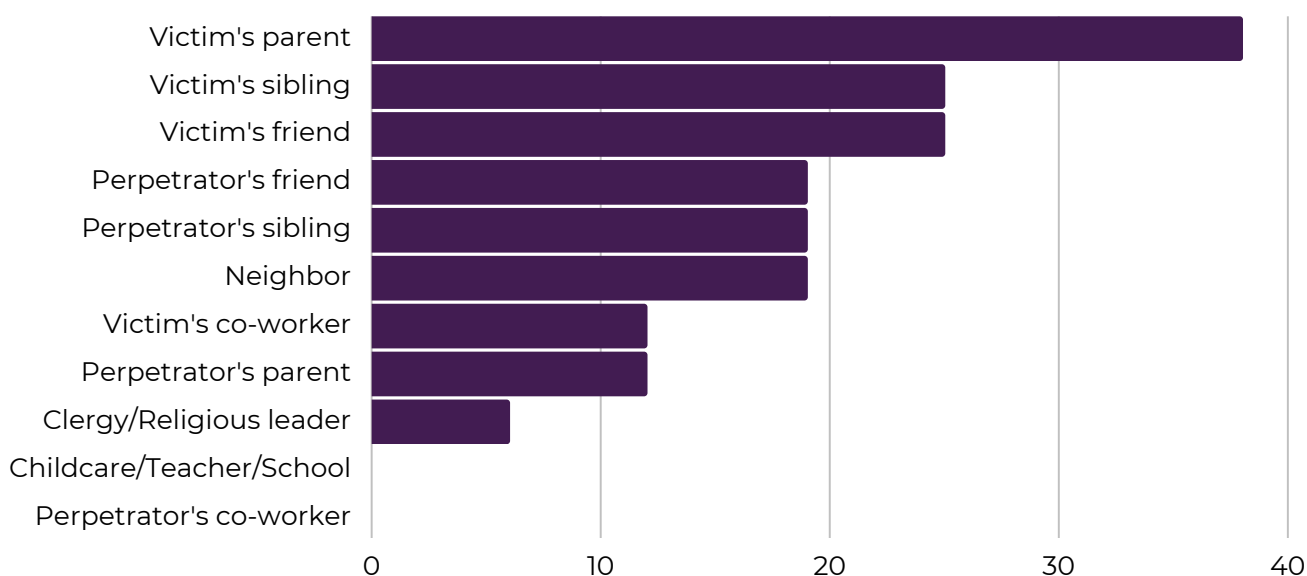
*There may be more who knew, but these were the percentages out of the 16 cases that were confirmed to have these problems.

Who Knew about the Domestic Violence?

Charts P and Q include the percentage of individuals/agencies in the DV victims' or perpetrators' social networks and official organizations who knew about the underlying DV present in the victims and perpetrators' relationships. As with other indicators, these may underestimate the scope of knowledge of community members, but the data below reflects what Review Teams were able to find. It is notable that in 25% of the cases there was no evidence that anyone in the social or formal networks knew about the abuse. Also, it is essential to remember that even if someone knows of abuse, it does not mean they support the victims.

The most likely categories of relationships to know about the underlying DV was the victim's parent(s) (38%), followed by the victim's friend(s) and sibling(s) (25% each). The next most likely, 19% each, were the perpetrator's friend(s), the perpetrator's sibling(s), and neighbor(s). The next most common, 12% each, were the victim's co-worker(s) and the perpetrator's parent(s). Six percent of the cases had a clergy/religious leader who knew. In 2022, there were no cases where it was listed that the perpetrators' co-workers or a childcare/teacher/school personnel knew about the DV.

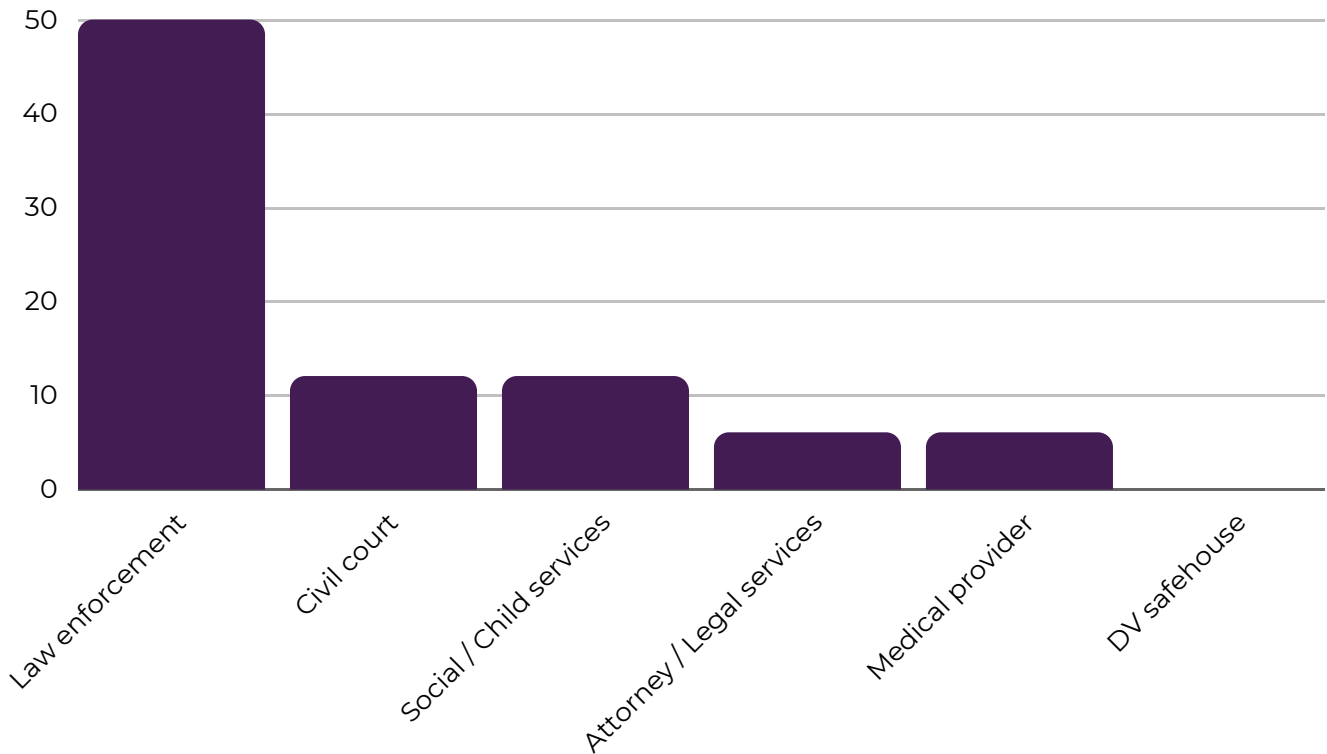
Chart P: Percentage of people among social networks known to be aware of the DV (N=16)*



*There may be more who knew, but these were the percentages out of the 16 cases that were confirmed to have known.

Turning to the percentage of official personnel/agencies who knew about the underlying DV, as expected, the most likely official personnel/agency to know about the DV was police/law enforcement (50%), followed by civil court and social services/child protection, both 12% (Chart Q). Six percent of the cases were known to an attorney/legal service and 6% were known to a medical provider. There was no indication that any safehouses/shelters knew about the DV abuse case. These findings suggest a far more limited awareness of the DV by police prior to the date of the DVF compared to other available data. For example, a recent study in Houston, Texas found 91% of the DV couples were known to the police prior to a DVF. (Koppa & Messing, 2021).

Chart Q: Percent of official agencies who knew about the DV



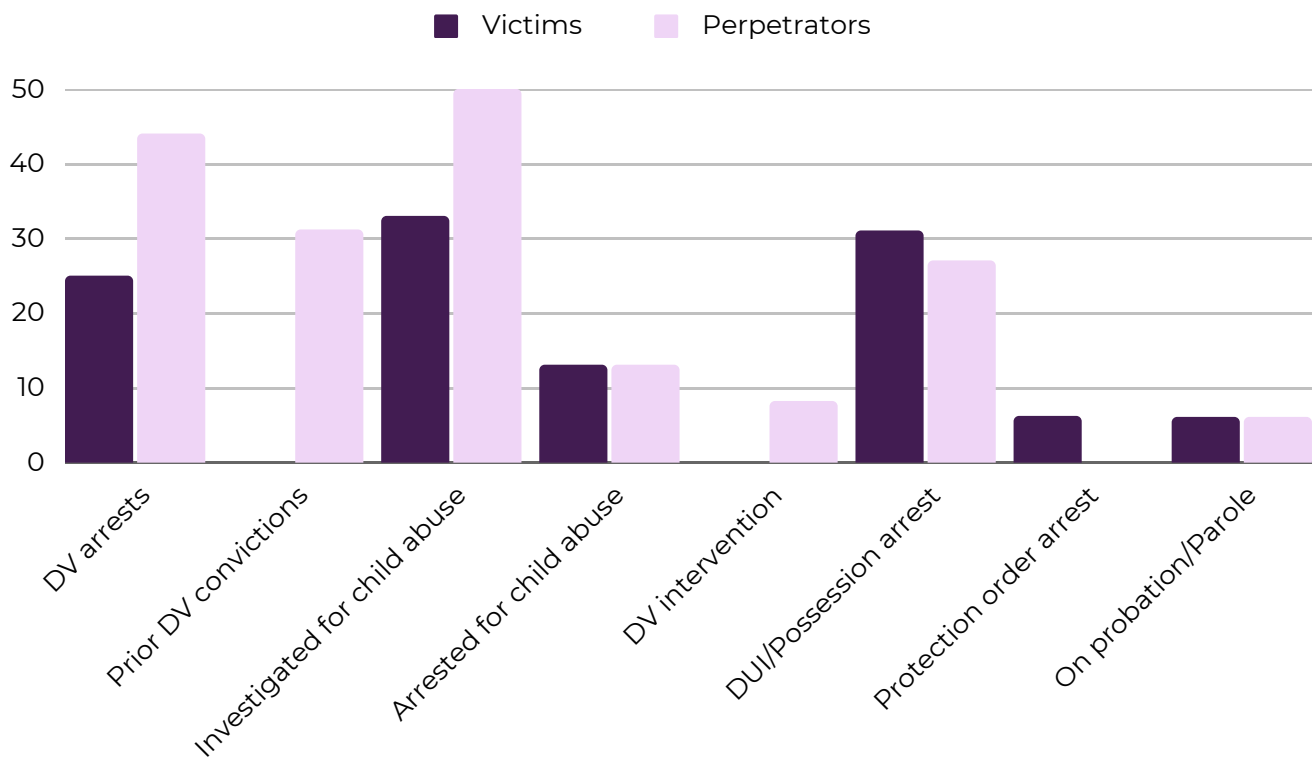
*There may be more who knew, but these were the percentages out of the 16 cases that were confirmed to have known.

DV Perpetrators' and Victims Criminal Histories

Chart R summarizes the DV perpetrators and victims' criminal histories which can include DV arrests and other criminal legal system involvement unrelated to the DV victim and perpetrator's relationship. Similar to the data on mental illness and drug and alcohol abuse, victims' criminal histories were more extensive in this report than in years prior. A quarter of the DV victims and 44% of the DV perpetrators had prior DV arrests, however, while none of the DV victims' arrests resulted in convictions and 31% of the DV perpetrators' arrests did. While there are certainly some "mutually-combative" couples, research indicates this is not a large portion of DV couples. Thus, the relatively high arrest rate of the ultimate DVF victim coupled with the lack of any resulting convictions suggests criminalization of victims may be occurring. This criminalization may occur due to lack of understanding of the dynamics of DV or due to insufficient investigation into self-defending behavior. This reality underscores the need for continued investment in training, particularly on the proper use of the Lethality Assessment Protocol.

A third of the DV victims and half of the DV perpetrators were investigated for child abuse, and 13% of each was arrested for child abuse. None of DV victims, and only 8% of the DV perpetrators had been in (or sentenced to) DV Intervention. Almost a third (31%) of the DV victims and 26% of the DV perpetrators had been arrested for DUI or possession of an illegal drug. Six percent of the DV victims and none of the DV perpetrators had been arrested for a protection/restraining order violation (none related to the DV victim). Six percent of both the DV victims and perpetrators were on probation or parole at the time of the DOI.

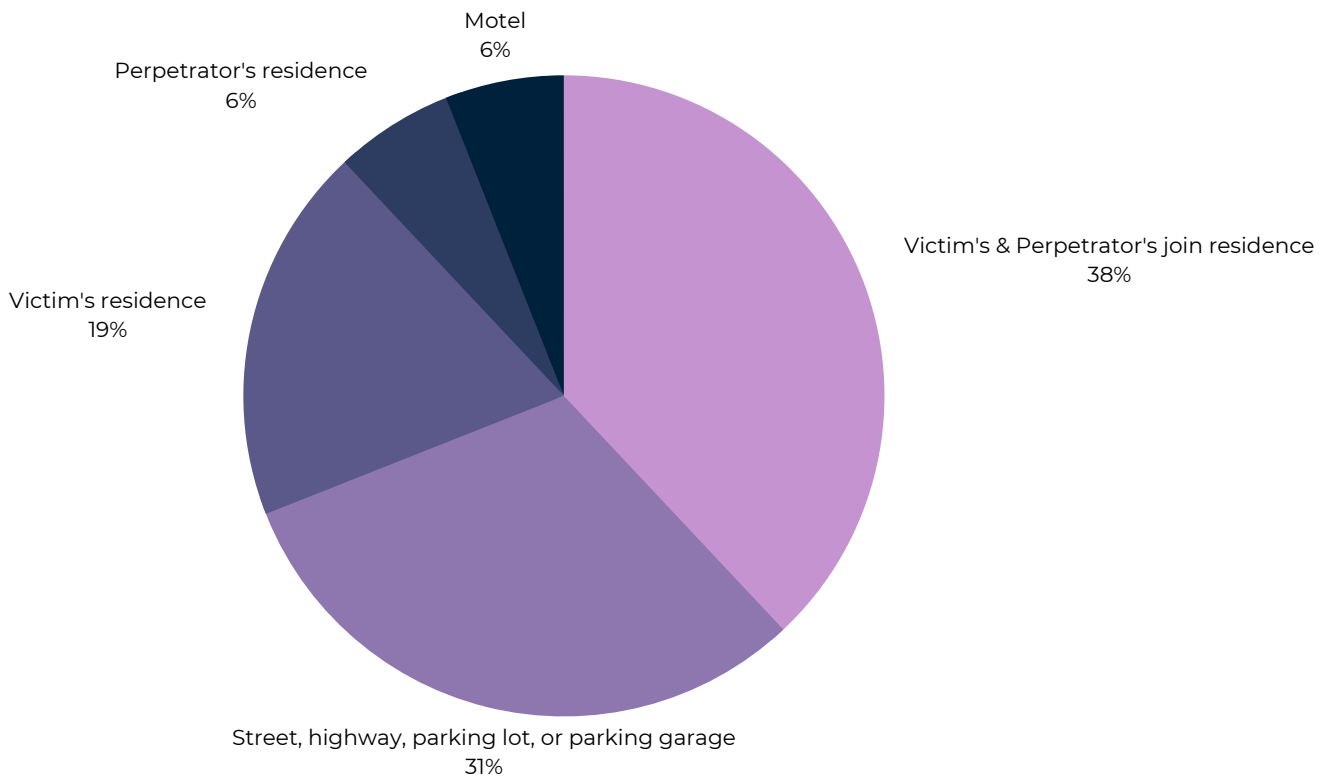
Chart R: Victims' and perpetrators' criminal histories



DVF Locations

Chart S shows the locations of the DVFs. The most common locations were the DV victim's and perpetrator's shared residence (38%, n = 6) followed by a street, highway, parking lot, or parking garage (31%, n = 5), and then the DV victim's residence (wherein the perpetrator did not live) (19%, n = 3). Only one (6%) DVF occurred at the DV perpetrator's residence (wherein the victim did not live) and the remaining DVF occurred in a motel room (6%, n = 1).

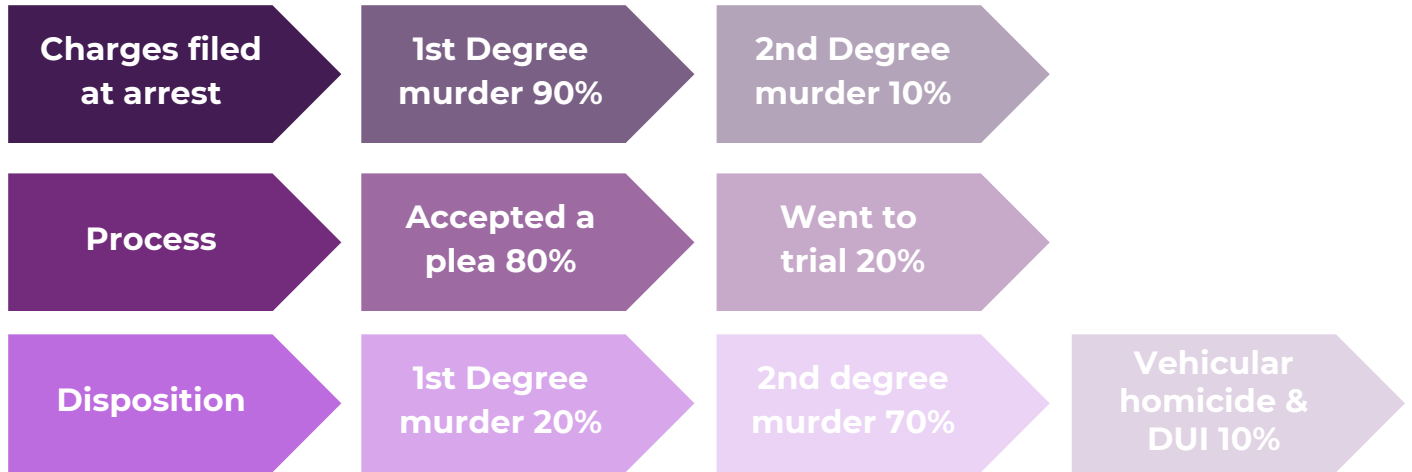
Chart S: Location of the DV fatality (N=16)



Criminal Legal System Process and Outcome

Six of the DVF cases were DV perpetrator suicides so there were no arrests. Chart T presents the processing of the other ten, where the perpetrators were alive. Of the 10, 90% of the DV perpetrators were charged with first-degree murder and the remaining 10% with second-degree murder. Eighty percent of the DV perpetrators accepted a plea and 20% percent went to trial. Most of the cases, 70%, resulted in (mostly plead to) second-degree murder, 20% in first-degree murder, and 10% in vehicular homicide and a DUI.

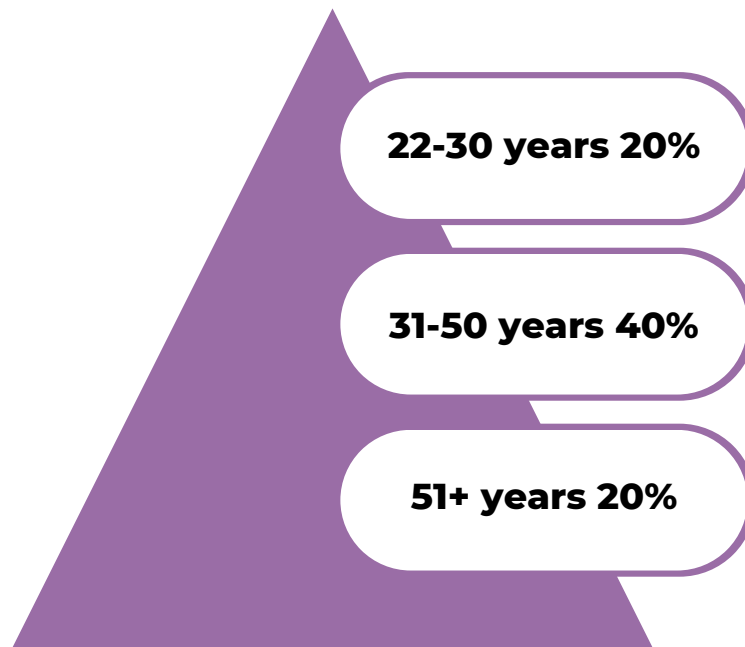
Chart T: The processing of DVF's through the criminal legal system (N=10*)



*Of the 16 cases reviewed, 6 did not go through the legal system because the perpetrator suicided.

Chart U summarizes the distribution of the sentences among the DV perpetrators who did not kill themselves (thus no criminal legal system involvement). One-fifth (20%) of the DV perpetrators were sentenced to a range from 22 to 30 years in prison. The largest group, 40%, was those DV perpetrators sentenced from 31 to 50 years of incarceration. The final fifth (20%) were sentenced to 51 or more years (including life) imprisonment.

Chart U: Sentencing in length of years (N=10)



The Presence of Red Flags (Risks for DVFs)

Charts V1 and V2 show the prevalence of various risks for DVFs as defined by research or from the decades that the Denver Metro area has conducted Review Teams. Chart V includes the most indicated risks and Chart V2, the less frequently reported risks. As with the data presented in some of the previous charts, it is likely that there are additional cases with some of these risks, but the data represents the red flags identified by the various Review Teams.

Chart V1 reports the most frequent red flags/risks among the 16 cases, those that were reported in seven to 13 of the 16 cases. The most common risk factors were:

- DV perpetrator's access to a gun – 13 cases
- DV perpetrator drug/alcohol abuse – 13 cases
- DV perpetrator feeling betrayed or abandoned – 12 cases
- DV perpetrators who were overly possessive of their victims – 10 cases
- DV perpetrator feeling a loss of control – 9 cases
- DV perpetrator having a DV history – 9 cases
- DV perpetrators who were socially dependent on their victims – 8 cases
- Pending legal cases – 8 cases
- Whirlwind courtships – 8 cases
- DV perpetrators where were financially dependent on their victims – 8 cases
- DV perpetrators who exploited their victim's "caretaking" personalities – 8 cases

Chart V1: Most commonly known red flags / risks (N=16)

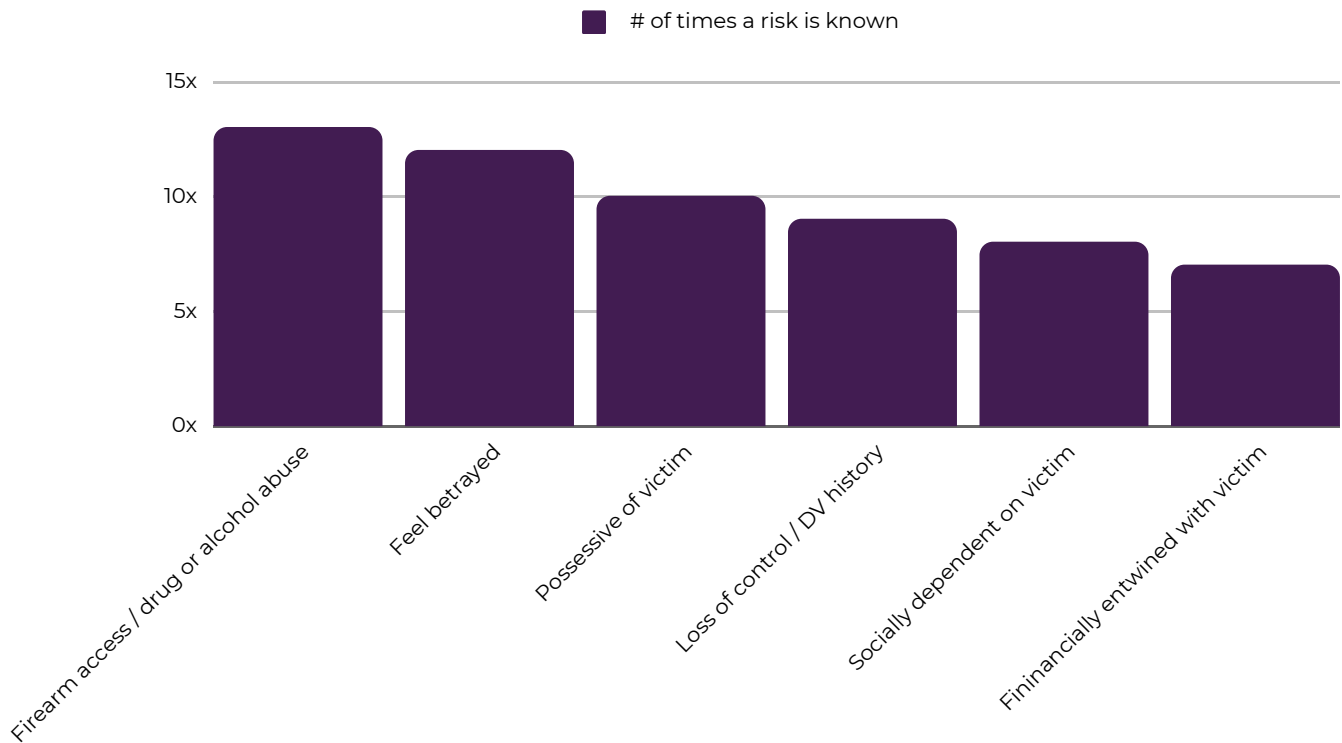
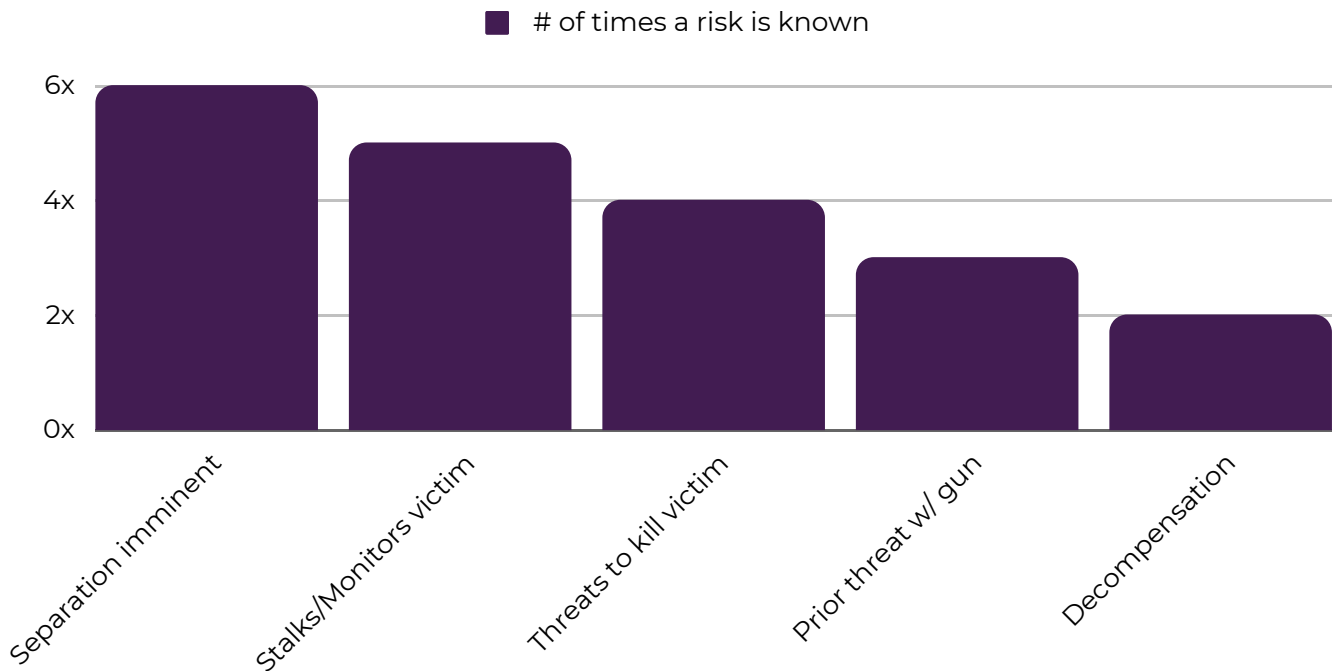


Chart V2 reports the less common red flags/risks. Specifically, identified in 6 (37.5%) of the cases were an imminent separation, a perpetrator with a non-DV assault history, strangulation attempts, DV perpetrator loss of coping skills, a DV perpetrator emotionally dependent on the DV victim, and a DV perpetrator known to carry a weapon. Notably, in the six cases where the DV perpetrator was known to carry a weapon, it was always a gun, and one perpetrator carried a gun and a knife.

Chart V2: Less commonly known red flags / risks (N=16)



Five of the cases included the risk factors of stalking/monitoring the DV victim, the DV couple were estranged, and there were indications of mental health problems. Four of the cases included prior (to the DOI) threats to kill the victim, un- and under-employment of the DV perpetrator, the DV perpetrator's loss of work, the DV perpetrators loss or diminished custody of the children, and stepchildren's presence in the home. Three of the cases included a prior threat with a gun, loss of housing, the perpetrator's daily living changes, and that the DV victim is in a new relationship or the DV perpetrator believes his/her victim is in a new relationship (when s/he is not). Two cases included a decompensating perpetrator, having used a weapon against the victim prior to the DOI, and the death of a close friend or family member of the DV perpetrator. Not listed in the charts are three potential risk factors that were not indicated in any of the Review Teams: the DV victim was pregnant, the DV perpetrator had an animal cruelty history, and the perpetrator had gambling problems.

Discussion of the Findings

Over time and locations, including this report, DVFs are perpetrated predominantly by men against their current or former women partners (e.g., Koppa & Messing, 2021). This requires solutions that address structural and individual gender inequality (L. K. Gillespie & Reckdenwald, 2017). The 2022 Colorado DVF findings also stress that fatalities are not restricted to the intimate partners who are murdered (and the perpetrators who suicide), but also the collateral victim fatalities. Indeed, in 2022 in Colorado, over a quarter (27%) of the cases included at least one collateral fatality, and almost a quarter (23%, $n = 22$) of the 94 fatalities were of collateral victims. All DV victims and all collateral victims were killed by the DV perpetrator. The murder of children among the DVFs continues to be a significant proportion of the collateral victims in Colorado. Reif and Jaffe (2019) refer to them as “the forgotten victims” in DVFs and stress the need for better policy and legislative implementation, enhanced child-services, and more training on DVFs and the risk for children in professional training and public awareness. In 2022, 27% ($n = 6$) of the collateral victims were children. The collateral fatality victims were most likely to be family members of the DV victim (32%, $n = 7$), followed by the DV victim’s and DV perpetrator’s joint offspring (23%, $n = 5$, 1 was an adult child of the DV couple). Collateral fatalities also included 3 friends of the DV victim, 3 new romantic interests/partners of the DV victim, 2 law enforcement personnel, and 2 neighbors. This is why this year, the Board recommends further investment in the use of risk assessment tools as noted on pages 54-60.

Although there was a less dominant role of DVFs in more rural counties in Colorado, their presence was still seen. This is consistent with Gillespie and Reckdenwald’s (2017) research on DVFs of women victims in North Carolina. Although they did not include variables on gun ownership, they did find a significant lack of DV services in rural compared to urban counties, and they attributed the elevated rural women’s deaths to gender inequality, primarily in terms of women’s disproportionate economic deprivation relative to men. Charts P and Q highlighted the limited number of both social and official venues where others knew about the DV. There are many reasons DV victims do not disclose their victimizations to others (e.g., shame and guilt, fear of the perpetrator, not realizing the behavior against them is abuse, hope that it will get better, economic concerns), and most are tied to awareness of services that can help and the service availability. (Ravi et al., 2023).

Research on FVIPHs (female victim intimate partner homicides) found that counties that participated in a community-coordinated response (CCR) to DV had significantly lower FVIPHs, while the presence of specific programs and ordinances (e.g., batterer intervention programs, DV ordinances, DV-related safehouse programming, and Review Teams) without community coordination were not related to reducing FVIPHs, indicating that such coordination among these agencies is an effective deterrent to DVFs. (Montanez et al., 2023).

Finally worth noting – consistent with Colorado’s previous reports and existing scholarship on DVFs – is the significant role that firearms play in DVFs. Two recent studies, one in North Carolina and the other in Arizona, stress the low compliance of judges to remove firearms in DV protection orders. (Kafka et al., 2022; Wallin & Durfee, 2020). The North Carolina study was particularly troubling given that DV protection order firearm removal was legislatively mandated. (Kafka et al., 2022). Thus, the authors stress that the DV protection order firearm restriction requires monitoring courtrooms to ensure judges communicate these provisions consistently and clearly to the litigants and have a protocol for assessing the assessment of firearm access and implementing the restrictions. (Kafka et al., 2022). One recent study concluded that “limiting firearm exposure will not only decrease the lethality of intimate partner violence, but will decrease the odds of perpetrator suicide following intimate partner homicide.” (Zimmerman et al., 2022, p. 2880). This and other research underscore the need to better understand and focus on the effective implementation of firearm relinquishment processes, as detailed in the Board recommendation found on pages 54-60.

2022 CDVFRB Recommendations Progress

Expand domestic violence training opportunities for judicial officers.

Status: Closed

Based on judicial officers' unique position to respond to DV in and out of the courtroom, the DVFRB recommended that judges receive sufficient DV training to achieve a trauma-informed courtroom while promoting public safety. The Board further recommended that all information pertinent to DV cases be organized in one central location for judges on the Judicialnet website and that the materials be regularly updated and reviewed for comprehensiveness.

Since the recommendation, individual Board members have met with representatives from the State Court Administrator's Office (SCAO), including the Violence Against Women Act (VAWA) Education Specialist. Professionals from SCAO were receptive to the Board's feedback. The Board suggested they consider updating existing DV training materials available to judges, improving the DV Bench book, and seeking outside expertise in these efforts. SCAO noted they would continue to ensure that the DV specific training was available at the 2023 Judicial Conference and that the judicial department is integrating all existing training materials, including DV specific materials, onto a more user-friendly platform—the Judicial Learning Portal.

Importantly, since the Board's recommendation, judicial training legislation was enacted. House Bill 23-1108 creates a task force to study victim and survivor awareness and responsiveness training requirements for judicial personnel. As part of its duties, the task force will determine and analyze current DV judicial training around the country, any gaps in Colorado's training, and best practices to promote trauma-informed practices and approaches in the courts. The task force has formed, and its report, including its findings and recommendations, is due on or before February 1, 2024. Margaret Abrams, the Executive Director of the Rose Adom Center and an advisor to the Board, is serving on this task force. Because of anticipated changes in the material available to judges and because HB 23-1108 seeks to accomplish the same goals articulated in the Board's recommendation, the Board will not pursue further independent work on judicial training at this juncture to avoid duplication of efforts. The Board will, however, closely track the changes made available to judges and the work of the task force and will re-evaluate its role relative to judicial training.

Create a mechanism for law enforcement agencies to report Domestic Violence Fatalities (DVF's) directly to the Attorney General's Office.

Status: Completed

The Colorado Attorney General's Office has [created a form](#) on its website where community members, organizations, and law enforcement can bring what they believe are DVFs to the attention of the Board. The form solicits high level information about the DVF and a member of the Attorney General's Office staff or of the Rose Adom Center will follow up as appropriate. A [more detailed form](#) that solicits more information is also available on the [Rose Adom Center's website](#). Both reporting mechanisms will hopefully serve to streamline the data sharing process around DVFs statewide.

Invest in diversity, equity, and inclusion efforts that improve the response to domestic violence statewide.

Status: Closed

Improving diversity, equity, and inclusion within the responses domestic violence statewide is certainly an ongoing effort without a clear end, last year the Board identified three areas of investment around this work.

First, the Board recommended that all organizations who interact with and serve victims of DV make and continue to make an intentional and carefully considered effort to address diversity, equity, and inclusion. The Board's membership represents a wide array of organizations addressing DV statewide and have all committed to continue to work within their organizations to see this work continue to progress.

Second, the Board recommended that a protocol and best practices manual be developed to support and enhance the work of local fatality review boards. It recommended that the manual include information on best practices for composing a board to ensure inclusion of a diverse and equitable distribution of voices and perspectives, as well as guidance for conducting case reviews mindfully to ensure that the diverse range of voices are heard and listened to. This manual has been completed with these objectives in mind. [The protocol manual can be accessed here.](#)

Third, the Board recommended that the Legislature provide funding to support the recruitment and retention challenges of the agencies and organizations who provide initial response functions to domestic violence, with a particular focus on encouraging efforts to recruit and retain individuals with diverse backgrounds. While the Legislature did not provide this funding, the Attorney General's Office did provide \$3 million in grant funding to domestic violence organizations across the state. In selecting the recipients of this grant, the Attorney General's Office sought to act upon the recommendation of the Board and provided grants supporting organizations' recruitment and retention efforts and were mindful of the organization's philosophies around diversity and culturally responsive advocacy. A full list of grant recipients will be published on the Attorney General's website by the end of October 2023.

Develop a local domestic violence fatality review team best practices and protocol manual.

Status: Completed

As detailed last year in the 2022 report, the Board's work is best achieved in partnership with local fatality review teams. To support the work of these teams and to ensure statewide consistency and integrity in data collection, the Board recommended that "Domestic violence Fatality Review Team Protocol and Best Practices Manual" (Protocol Manual) be developed to: (1) provide detail and training on uniform methods for collecting, analyzing, and storing DVF and related data, through the use of standardized, research-based data collection tool to ensure consistent statewide list data is collected; (2) identify best practices for conducting DVF case reviews and incorporating case review findings into community response to intimate partner violence; (3) provide training materials for onboarding new fatality review team members; (4) identify confidentiality parameters for case reviews; and (5) identify document retention policies for documents used in case reviews. A diverse and committed committee of the Board worked this year to develop the [Protocol Manual which is available here](#). The Board anticipates that the Protocol Manual will be an evolving document that will benefit from the feedback from local teams over time. The Board will circulate this document to the current local fatality review teams and will provide it to communities who have expressed interest in a team. The Board also will continue to re-evaluate the Protocol Manual on a yearly basis.

Invest in strategies that ensure firearm relinquishment.

Status: Continued

This past year, a committee of Board members carefully reviewed current efforts to address firearm relinquishment in the context of domestic violence. Specifically, the Board considered the firearms investigator model the Denver District Attorney has used in partnership with the Public Defender's Office. The specifics of this program are addressed in the 2022 Report on pages 39-41. The committee recognized that other jurisdictions may not have the funds to replicate the Denver District Attorney's model and this year is recommending that CBI be provided with the legislative authority to provide firearms relinquishment investigation support for a limited pilot program in Colorado. This adjusted approach to address the challenge of firearm relinquishment is addressed in the next section.

Third, the Board recommended that the Legislature provide funding to support the recruitment and retention challenges of the agencies and organizations who provide initial response functions to domestic violence, with a particular focus on encouraging efforts to recruit and retain individuals with diverse backgrounds. While the Legislature did not provide this funding, the Attorney General's Office did provide \$3 million in grant funding to domestic violence organizations across the state. In selecting the recipients of this grant, the Attorney General's Office sought to act upon the recommendation of the Board and provided grants supporting organizations' recruitment and retention efforts and were mindful of the organization's philosophies around diversity and culturally responsive advocacy. A full list of grant recipients will be published on the Attorney General's website by the end of October 2023.

Provide funding for a full-time law enforcement training position be provided by the legislature for the successful implementation of the LAP across Colorado.

Status: In Progress

In pursuit of the 2022 recommendation, the Attorney General's Office successfully obtained a grant from the Department of Justice to continue its program to train law enforcement on the use of the Lethality Assessment Protocol and to track implementation. Funding from this grant will allow for this training effort to continue through 2024. The Attorney General's Office also received funding to develop additional training for law enforcement and school professionals about the proper use of extreme risk protection orders (ERPOs). ERPOs are another tool that can help curtail domestic violence, and increasing awareness and understanding of ERPOs is, along with LAP, important to reducing DVFs. The Attorney General's Office may seek additional and ongoing funding based on the results of these programs.

2023 Recommendations

Increase Collaboration and Partnership with the Maternal Mortality Prevention Program, the Child Fatality Review Board, and the Office of Suicide Prevention.

Colorado currently has at least two other statewide fatality review entities—the Maternal Mortality Prevention Program (MMPP) and the Child Fatality Review Board (CFRB). While these entities focus on different challenges, there is intersection between their work and the work of the Board. Of specific note, DVFs which occurred during pregnancy or in the first year after giving birth would also be addressed by the MMPP, and DVFs of anyone under 18 would also be addressed by the CFRB. The MMPP and the CFRB have clearer mechanisms to identify fatalities than this Board and can serve as important partners in the identification of DVFs. A closer partnership with both entities is important to increasing the ability of the Board to more comprehensively identify and analyze DVFs. The Board recommends that over the next year the Attorney General’s Office and the Board work with the MMPP and CFRB to formalize data sharing arrangements.

Initial conversations with MMPP and the CFRB suggest that they often identify DV components of the cases under their review, but as they are not focused on the unique challenges of DV, they cannot always fully address the implications of DV in their cases. Closer collaboration between the Board and the other review teams could help identify additional trends and recommendations of mutual benefit to all entities. The Board therefore recommends that the Attorney General’s Office and the Board work with the MMPP and CFRB to coordinate on policy recommendations that serve the missions of all three entities. Where possible, the Board also recommends that the MMPP and CFRB coordinate on the issuance of their reports to maximize exposure and impact of their interrelated missions.

Many of the DVFs identified each year involve suicides. The Board also recognizes that threats of suicide are one of the known lethality indicators for DVF. The interconnected relationship with DVFs and suicide demonstrate the importance of suicide prevention work and the Board recommends that next year it invest in a closer collaborative partnership with the Colorado Office of Suicide Prevention.⁶ Our mutual efforts and mission around violence prevention remain critical to the prevention of DVFs statewide.

Implementation Committee: Shalyn Kettering, Keisha Sarpong, and James Connell.

Provide Increased and Sustainable Funding for the Board

Last year, the Board was tasked with shifting its lens from primarily reporting on DVFs to implementation. The expanded mandate includes a requirement to “pursue implementation of any review board recommendations.” These recommendations are required to pertain to a wide range of focuses including: “[i]mproving communication and information-sharing between public and private organizations and agencies as to domestic violence incidents and risk”; “[r]educing the incidence of domestic violence and domestic violence fatalities in the state”; and “[i]mproving responses to domestic violence incidents.” C.R.S. § 24-31-702.

This mandate is ambitious and wide-ranging.

The Board is provided with a limited appropriation from the legislature—the amount does not even cover the costs associated with the reporting function of the Board. Rather, to provide the robust analysis of DVFs, the Board relies on the significant pro bono work of multiple individuals including Joanne Belknap, Ph.D. Dr. Belknap is an experienced DV researcher and former emeritus professor at the University of Colorado and does a significant amount of the analytical work to understand the patterns and trends in the DVF data.

⁶ The Office of Suicide Prevention’s (OSP) mission is to serve as the lead entity for suicide prevention, intervention support, and postvention efforts in Colorado, collaborating with communities statewide to reduce the number of suicide attempts and deaths. OSP focuses on priority population parts of the state where there are high rates of suicide attempts and deaths, implementing prevention strategies to reach individuals prior to the escalation of a crisis; training individuals to recognize and respond to suicidal crises; supporting individuals and communities that have been impacted by suicide, including suicide loss; and leading collaborative partnerships. Initiatives through the OSP include Gun Safety and Suicide, The Follow-Up Project, Zero Suicide Colorado, and Youth and Young Adult suicide prevention.

Given this resource constraint, all implementation work requires leveraging organic connections of members of the Board and the Attorney General's Office. However, many of the recommendations would benefit from the Board having additional funding. The Board would particularly benefit from funding that it could distribute in order to 1) support organizations already pursuing implementation; 2) better leverage recruit time and talent for specific implementation efforts, and 3) provide training to critical stakeholders such as law enforcement, the judiciary, and advocates.

Implementation Committee: Shalyn Kettering and Keri Yoder

Increase the use risk assessment tools in organizations that work directly with domestic violence survivors

The case reviews that are summarized in this report identified risk factors that are common in cases that lead to a fatality. Risk assessment tools, generally, are screening tools that consider the type of risk factors identified in this report and can be used to help determine the level of risk faced by a domestic violence survivor and his or her family. The Lethality Assessment Protocol (LAP) is one such checklist that was developed specifically to identify situations where there is a high risk of lethality. Such checklists are common in the context of law enforcement and medicine but can be equally useful in any context where organizations are seeking to support survivors of domestic violence.

The Board understands that risk and safety assessment tools are used variably by the many organizations who play a role in the support of survivors. For example, some Colorado jurisdictions providing pretrial services use the Ontario Domestic Assault Risk Assessment (ODARA) as a predictor of future domestic violence behavior over a period of time. Additionally, advocacy organizations often use checklists – some clinically created, such as the Spousal Assault Risk Assessment Guide (SARA) or the Danger Assessment, and others internally created – based on the organization's experience.

The Board believes it is critical that any organization that interacts with domestic violence survivors use a risk assessment tool. The use of these tools is necessary to build a shared understanding of risks to safety, allowing an advocacy organization and its partners to respond and manage the safety of adults and children exposed to violence appropriately and consistently. When used properly, these tools serve to inform the first step in a larger risk management process – a dynamic, active and collaborative process that aims to promote the safety and security of adult and child survivors by developing an integrated strategy and service response to reduce and prevent further violence. Before the Board makes a concrete recommendation on the type and scope of risk assessment tools that it believes could and should be leveraged statewide, the Board believes it is critical to understand how risk assessment is understood in Colorado and what, if any, tools various stakeholders are currently using to measure risk for domestic violence survivors. The Board recommends that a survey be conducted to address these questions and to identify a set of risk assessment principles and best practices. Grounded with this understanding, the Board will seek to identify an actionable recommendation next year around implementation of risk assessment statewide.

Implementation Committee: Shalyn Kettering, Linda Johnston, Carmen Hubbs, Keisha Sarpong, Lindsey Dixon, Nicole Fisher, Megan Lechner, and Ami McCarthy

Provide Firearms Relinquishment Investigation Support for Limited Pilot Program in Colorado through the Colorado Bureau of Investigation

As in years prior, firearms were the leading cause of death in DVFs identified in this report. As noted in last year's report, the statistics around firearm access and DVFs are startling. Domestic violence perpetrators with access to firearms are five to eight times more likely to kill their victims than those without firearms. (Wintemute, et al., 2014); (Nanasi, 2019). Firearms are also used in non-lethal ways by DV perpetrators to exert power and control over their partners. A recent report indicates that 13.6% of American women alive today — around 25 million—have been threatened by a domestic abuser with a firearm. Possession of firearms by perpetrators of DV presents a threat not only to DV victims, but to their communities and the general public. This year firearms were the cause of all but two of the collateral DVFs and all but one of the child DVFs.

One of the most effective interventions to protect DV victims is removing firearms from known domestic abusers. Research indicates that abusers do not use alternative weapons to kill when they do not have access to guns. According to the Ontario Domestic Assault Risk Assessment (ODARA), the single most important red flag to predict a lethal response was a “recent separation.” 45% of DV homicides occur within 90 days of separation, most within the first few days. Thus, ensuring firearms are removed as soon as a victim seeks help is critical.

Colorado courts are authorized to prohibit defendants in DV cases from possessing or controlling firearms or other weapons. C.R.S. § 18-1-1001(3)(a)(III). In DV cases that involved the use of, attempt, or threat of physical force, the court shall order the defendant to:

(A) Refrain from possessing or purchasing any firearm or ammunition for the duration of the order; and

(B) Relinquish, for the duration of the order, any firearm or ammunition in the defendant’s immediate possession or control or subject to the defendant’s immediate possession.

C.R.S. § 18-1-1001(9)(a). The court shall also schedule a compliance hearing. Id.

Defendant’s must relinquish firearms and ammunition within 24 hours of being served with the order, with some exceptions. C.R.S. § 18-1-1001(9)(b).

Relinquishment options include selling or transferring firearms or ammunition to a federally licensed firearms dealer, arranging storage with a law enforcement agency, or selling or transferring to a private party in compliance with state and federal law. C.R.S. § 18-1-1001(9)(d). Within seven business days after the protection order issues, the defendant must complete an affidavit “stating the number of firearms in the defendant’s immediate possession or control...the make and model of each firearm, any reason the defendant is still in immediate possession or control of such firearm and the location of each firearm.” C.R.S § 18-1-1001(9)(e) (II). Alternatively, the defendant (II) advises the court that firearms were relinquished or that no firearms or ammunition are in the defendant’s possession. Id.

That legal framework is useful; however, there is lack of enforcement and the evidence suggests that very few firearms are relinquished in domestic violence cases despite evidence of significant levels of gun ownership and the use of guns in DV incidents. To address this issue, some jurisdictions have invested in various efforts to attempt to improve the rate of relinquishment in DV cases. The Denver District Attorney, for example, dedicated resources to create a team focused on the issue. The office funded a full-time investigator to review DV reports daily, conduct investigations as needed, and consult with a dedicated DV prosecutor if there was evidence that a defendant possessed a firearm. When the prosecution team suspects unlawful possession of a weapon or ammunition, the prosecutor contacts the defense attorney and attempts to negotiate lawful relinquishment. Mutually beneficial goals support relinquishment, as the defendant avoids further criminal charges, and it prevents criminal conduct. In the rare cases where relinquishment is contested, the dedicated DV prosecutor files appropriate motions and appears for hearings.

Other large District Attorneys' offices have similar teams that proactively review cases. Some offices are creating firearms relinquishment policies that align with recent changes to the Extreme Risk Protection Order statutes, which recently expanded the scope of people authorized to initiate the ERPO process. See §13-14.5-103 C.R.S. However, most small, rural offices are not equipped to replicate the Denver model. Smaller offices do not have the resources to dedicate full-time personnel to the effort; recruitment and retention are ongoing challenges in most prosecutors' offices, and competing priorities demand rural prosecutor's time.

Considering these limitations, the Board considered how to implement the Denver model statewide. Dedicating resources by judicial district to each District Attorney's office does not seem viable, given the aforementioned challenges facing rural communities. Instead, a statewide law enforcement agency could conduct case reviews on DV cases and provide necessary information to individual law enforcement agencies. Logically, the Colorado Bureau of Investigation (CBI) will be that agency because they have a statewide presence. CBI is currently a request agency, meaning that they are only authorized to assist upon request from another law enforcement agency. See C.R.S. § 24-33.5-412. CBI does not initiate its own investigations, nor does it accept referrals from private parties due to their statutory authority.

The Board recommends standing up a pilot project with a select set of regions with buy-in from prosecutors, law enforcement, and the defense bar. During this pilot, under the existing statutory authority, CBI could accept requests to review files and then would work in collaboration with the relevant law enforcement agencies as needed. Long-term, the Board recommends amending the CBI authorizing statute to expand CBI's jurisdiction – allowing statewide support on DV investigations without the need for a specific request.

Implementation Committee: Tally Zuckerman, Maggie Conboy, Linda Loflin Pettit, and Rudy Underwood.

Looking Ahead for 2024

To provide direction for its work in 2024, the Board felt it imperative to connect the goals accomplished this year to the work ahead. In addition to focusing on implementation efforts of the specific recommendations detailed on pages 53-59, the Board will also be focusing broadly on the prevention of domestic violence fatalities in 2024.

In this context, the Board defines “prevention” as efforts that reduce the incidence of violence.⁷

In order to identify the specific focus areas for prevention, the Board conducted a systematic review of the various aspects of prevention, including:

1. Treatment for persons using abuse
2. Youth relationship violence
3. Victim advocacy, resources, and support for survivors
4. Relationship between violence and youth academics
5. Family and domestic relations courts
6. Human Services and Child Welfare
7. Law Enforcement response to domestic violence calls

The below section provides a high-level overview of these various aspects of prevention and previews some potential action items for the Board in 2024.⁸ Jesse Hanson and Lindsey Spraker will be leading the efforts related to prevention in 2024.

Board members on the implementation committee include Carmen Hubbs, James Connell, and Sandie Campanella.

⁷ Prevention is commonly broken down into three parts of primary, secondary, and tertiary as detailed below⁷

- **Prevention: Primary Prevention** (aka universal interventions): The goal is to reduce the incidence of the violence by targeting the entire population, not just those at risk. Aimed at community in hopes that societal or environmental change will help resolve societal problems.
- **Secondary Prevention:** Targets people exhibiting early signs of perpetrating or experiencing violence or at risk for doing so. The goal is to curtail and prevent progression of the violence of those - who have not been seriously violent but appear at risk for future violent behaviors and those most likely to perpetrate violence - from engaging in future violence. Most secondary interventions incorporate some aspects of treatment.
- **Tertiary Prevention:** Treatment services for individuals who have already displayed violent behavior or identified by the legal system. The goal is to decrease recidivism.

⁸ While the data provided here is compelling, the Board recognizes it does not always provide an all-encompassing picture. Data and information provided here will be used as guides for next steps and further considerations in our work together.

TREATMENT FOR PERSONS USING ABUSE:

In FY2022-23, 10.1% (n=1,153) of the court cases sentenced to the Colorado Department of Corrections also included a finding by a judicial officer of domestic violence. Individuals who are convicted of a domestic violence offense can bypass requirements to complete state mandated treatment for their domestic violence offense if they are sentenced to the Colorado Department of Corrections or sentenced to jail.

Adults who are convicted of DV in Colorado are required by statute to be referred for an evaluation and treatment by someone who is approved through the Colorado Domestic Violence Offender Management Board (DVOMB). The DVOMB was charged with the promulgation of standards for the evaluation, assessment, treatment, and monitoring of DV offenders defined in C.R.S. § 16-11.8-102. However, individuals who are convicted of DV and are sentenced to the Colorado Department of Corrections are exempt from the requirement to complete the DV offender treatment pursuant to C.R.S. § 18-6-801(2).

Additionally, a Colorado Court of Appeals case, *People v. Trujillo*, 487 P.3rd 1051 (COA 2019) held that a defendant sentenced to a maximum jail sentence can be required to complete a DV treatment program under C.R.S. § 18-6-801(1)(a). DV offender treatment is frequently not available in jail or in prison. Though treatment is available after release, after an individual serves a maximum sentence in jail, there are no specific mechanisms for enforcing court orders for DV offender treatment after that individual is released from custody (considering that when sentenced to jail, there are no probation requirements). This means that despite having effective and research-informed treatment for perpetrators of DV, (Radatz, Hansen, & Thomasson, 2020; Travers et al., 2021; McNeeley, 2019), there are many instances where high-risk DV perpetrators complete their sentence without having addressed their offending attitudes and behaviors. This creates safety risks for victims and the community and can lead to DV perpetrators returning to the criminal legal system.

Efforts to provide information about the effects of DV offender treatment, the consequences associated with the limited treatment options in incarcerated settings, and ways to expand opportunities for DV offender treatment will be a focus for next year.

YOUTH RELATIONSHIP ABUSE:

In a 2019 study involving 3,745 middle and high school aged youth in the northeastern United States, 59% reported experiencing some form of dating violence victimization (Lachman et al., 2019).

In 2019 the Board recommended that the Colorado legislature examine juvenile relationship abuse, also known as teen dating violence (TDV). The Board encouraged exploration of the need for standardized treatments, age-appropriate responses to TDV, and increased investment in comprehensive programs for youth addressing TDV. Since then, youth relationship abuse continues to be a pressing issue with systemic gaps in services for primary and secondary interventions.

A 2022 National Institute of Justice study (Mumford et al., 2022) made findings from nationally representative survey data regarding the prevalence of different types of relationship abuse. It documented the characteristics of abusive relationships, assessed risk factors, and placed these estimates in the context of adolescents' key social relationships. This study found the rate of TDV was much higher than previously thought. This landmark study made notable findings about the precursors to domestic violence offending in adulthood and risk factors associated with TDV. Notably, the study found:

- Increasing or consistently high levels of TDV were associated with the presence of certain individual characteristics (for example, negative mental health) and family characteristics (for example, exposure to violence). In particular, when parents were victims of verbal abuse and physical violence by their own partners, their children were more likely to experience abuse and violence in their dating relationships.
- Higher levels of controlling behaviors by youth (by both individuals in the relationship) were associated with higher rates of dating abuse victimization and perpetration. Youth relationships characterized by unhealthy and intense relationship dynamics (for example, cheating, controlling behaviors, or lack of closeness) were associated with a higher probability of relationship abuse.

- Sexual harassment co-occurred with TDV, especially psychological abuse. Youths who were previously exposed to any violence were three times as likely to experience high levels of relationship abuse and sexual harassment (defined as unwelcome sexual comments jokes or gestures or physical intimidation in a sexual way), compared to those who were not previously exposed to violence. In addition, male youths who believed in traditional gender stereotypes were more likely than those who did not to perpetrate sexual harassment.
- Teen dating violence victimization and perpetration were found in both low and high crime neighborhoods. However, male youths living in neighborhoods with higher gender equality were less likely than those who lived in other neighborhoods to report perpetrating relationship abuse three years later.

Youth relationship abuse is increasing in complexity particularly given the increased use and reliance of technology and social media among youth. The growing number of platforms and online formats through which relationship violence can and does occur adds to the complexities of understanding and addressing youth relationship abuse. The CDVFRB will consider the wide array of complexities in youth relationship abuse and will focus, particularly, on the types of interventions proven to be effective in reducing and preventing this type of violence.

VICTIM ADVOCACY, RESOURCES, AND SUPPORT FOR SURVIVORS:

*In examining victim support services on survivor well-being, a study published in 2021 reported **over 75% of the survivor participants confirmed a decrease in abuse since beginning services.** Service supports included time with an advocate, help with life skills, employment assistance, safety planning, childcare solutions, immigration support, referrals to other partners as needed, and more (Wood et al., 2021).*

Victim-led support continues to prove successful in helping a survivor re-establish stability, safety, and community connections and reduce recurrence of abuse. The tools, resources, and education provided to the survivor have direct impacts on victim safety in the short and long term. Victim advocacy empowers planning and decision making to strengthen safety through compassionate and inclusive efforts from community agencies, volunteers, and paid professionals.

To expand on these benefits while focusing on fatality prevention, the CDVFRB will review community and public knowledge of DV victimization, explore opportunities to strengthen connections from survivors to advocacy supports or other services, and review learning opportunities for community providers of all types to deepen their best practice services for the survivor.

RELATIONSHIP BETWEEN VIOLENCE AND YOUTH ACADEMICS:

*A 2018 study reviewing the global association between violence in childhood and educational outcomes identified **children who have experienced any form of violence have a 13% probability of not graduating from school compared to those who have not experienced violence.** Regarding domestic violence in the home specifically, witnessing parental violence has shown an 8-percentile point reduction in standardized test scores (Fry et al., 2018).*

The Board feels it important to recognize the relationship between DV and educational outcomes. Sample participants identified as domestic violence offenders in a 2014 study showed that “[o]nly 25% of the offenders had a high school education” (Steward et al., 2014, pg. 153). Another study published in 2011 identified 76% of “welfare-to-work” participants did not have a GED or high school diploma in the participant sample. In this same article, a prior survey referenced reported 55% of welfare recipients had experienced “severe domestic violence” (Precin, 2011). DV affected youth can experience negative impact in their academic performance, educational outcomes, and even subsequent employment success as adults. This highlights the intersectionality of many critical issues. While the Board is not well positioned to provide significant feedback on mechanisms to increase educational outcomes statewide, it is nonetheless important to draw attention to the precursors of violence.

FAMILY AND DOMESTIC RELATIONS COURTS:

Intimate Partner Violence (IPV) used to create and maintain power imbalances was present by approximately 50% of couples participating in divorce / separation proceedings (Ellis, 1994; Ellis & Stuckless, 1996, as cited in Ellis, 2015).

While the civil legal system is a critical tool for survivors seeking to exit a violent relationship, the same system can be used to perpetrate violence and exert power and control over victims. Court processes related to family decisions contain natural layers of conflict, and these dynamics can be exploited when not managed carefully. Services such as mediation, parental responsibility evaluations, mental health assessments, supervised visitation (now called “family time”) and more can be used to mitigate against these risks. Professionals involved in these systems include attorneys, judges, magistrates, court staff, therapists, psychologists, social workers, and others. It is important that all stakeholders be properly trained on how to spot and properly respond to DV.

Increased screening, education, and support around victim issues, recognizing abusive behavior, and earlier intervention and supports provided for both victim and persons using abuse can reduce the ability for a partner to weaponize family and domestic relations courts and the processes therein. As noted in the recommendation for this year’s report, the use of risk assessments within the court may be a critical tool to identify and address DV dynamics within the court system.

HUMAN SERVICES AND CHILD WELFARE:

Childhood exposure to domestic violence tripled the odds of perpetrating violence toward a romantic partner. Experiencing childhood abuse doubled the odds of perpetrating violence toward a romantic partner (Ehrensaft et al., 2003).

Childhood exposure to domestic violence was identified as a form of child maltreatment as early as the 1990s. Exposure to domestic violence has direct links to problematic behavior from childhood through adulthood. Earlier recognition of DV and intervention through the child welfare systems can interrupt and buffer the adverse impacts on early exposure to DV.

In Ontario, Canada, a study was conducted involving case analysis of data relative to DVFs with prior child protection service involvement. As child protection services play a critical role in managing risk, assessing for domestic violence, and preventing tragedies of children, the following recommendations were identified specifically for the child welfare sector (Olszowy et al., 2020):

1. Enhanced screening for DV
2. Specialized DV training
3. Increased cross-sector collaboration (child protection, law enforcement, judicial, etc.)
4. Enhanced ongoing service provision
5. Amendments/reviews/updates of internal policies and protocols

This underscores the Board's recommendation regarding risk assessment checklists which are an important aspect of prevention.

LAW ENFORCEMENT RESPONSE TO DOMESTIC VIOLENCE CALLS:

*A study examining criminal and civil justice help-seeking by victims in a large urban police district identified **91% of femicide (female) victims and 73.3% of homicide (male) victims had contact with law enforcement in the three (3) years prior to the death** (Koppa & Messing, 2019).*

Law enforcement, as first responders, provide access to what may be considered the earliest stages of intervention when intimate partner violence exists between partners. Critical events occur during this time including interviews, investigation steps, victim support, information collection, information reporting, and decision making. It is for this reason that the Board continues to recommend the statewide use of LAP by law enforcement and has invested significant time and resources into this effort.

Colorado Domestic Violence Fatality Review Board Members

Attorney General Phil Weiser, Chair

1. City attorney's office in Colorado who has experience working with victims of domestic violence or prosecuting domestic violence offenders:
 - **Linda Loflin Pettit**, Manager of Government and Community Relations, Denver City Attorney's Office
2. Colorado Department of Public Health and Environment:
 - **Open**
3. Colorado District Attorneys' Council Designee:
 - **Maggie Conboy**, Senior Chief Deputy District Attorney, 6th Judicial District
4. Criminal Defense Attorney:
 - **Tally Zuckerman**, Partner, Zuckerman Law, LLC
5. Denver Metro Domestic Violence Fatality Review Committee:
 - **Linda Johnston**, EAW Project Director, Colorado District Attorney's Council
6. Department of Human Services' Adult Protection Services:
 - **Nicole Fisher**, Adult Protective Services Policy Specialist, Department of Human Services
7. Department of Human Services' Child Protection Services:
 - **James Connell**, Intake and Assessment Administrator, Division of Child Welfare, Office of Children, Youth and Families
8. Domestic Violence Survivor:
 - **Bridget Dyson**, Victim Advocate

10. Domestic violence advocate representing a shelter or other domestic violence service organizations:
 - **Carmen Hubbs**, Executive Director, Rise Above Violence, Pagosa Springs
11. Domestic violence offender management board:
 - **Jesse Hansen**, DV Offender Management Board Program Coordinator, Colorado Department of Public Safety
12. Domestic violence treatment provider specializing in offender treatment:
 - **Lindsey Spraker**, Executive Director, Lifelong, Inc.
13. Judge or magistrate:
 - **Judge Keri Yoder**, 7th Judicial District
14. Law enforcement agency:
 - **Sandra Campanella**, DV Investigator, 20th Judicial District
15. Medical professional with forensic experience:
 - **Megan L. Lechner**, Forensic Nurse Examiner, UCHealth Memorial Hospital (El Paso County)
16. Probation, parole, or community corrections program:
 - **Lindsey Dixon**, Pretrial Services Supervisor, Department of Public Safety, City and County of Denver
17. Non-profit organization that offers training and expert advice to domestic violence programs that serve survivors of domestic violence, dating violence, and stalking:
 - **Ami McCarthy**: Director of Training, COVA
18. AG Selected Appointee:
 - **Rudy Underwood**, Detective Sergeant with the Commerce City / Brighton Sexual Assault Taskforce

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Resources

If you or anyone you know is a victim of domestic violence or is in need of support services, there are organizations that can help.

If you are in a crisis or need immediate support, dial 911 or call the National Domestic Violence Hotline at (800) 799-SAFE (7233), and for a comprehensive list of resources available throughout Colorado please visit [Violence Free Colorado](https://www.violencefreecolorado.org) at www.violencefreecolorado.org.

