Colorado Domestic Violence
Fatality Review Board

Protocol Manual

2023

Colorado Office of the Attorney General

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Introduction

This document serves to support the work of existing Domestic Violence Fatality Review Teams (Review Teams) and to lay the groundwork for new teams.

This document grew out of the work and mission of the Colorado Domestic Violence Fatality Review Board (CDVFRB or Board) and was informed by the experience of many subject matter experts who have long served on Denver Metro Review Team. This review team was formed as the first Colorado based Review Team in 1996 and was one of the first Review Team formed in the United States. A committed group of professionals came together to form this first team after Terry Petrosky, her co-worker Dan Suazo, and first responding officer Sgt. Timothy Mossbrucker were murdered by Petrosky's estranged husband. This case served as a tragic example of the lethality of domestic violence (DV) and why it needed to be taken more seriously.

The goal of the Denver Review Team and Review Teams across the state and country is to learn from domestic violence fatalities (DVFs)—identifying common risk factors and potential intervention points in order to prevent future DVFs. Effective Review Teams facilitate conversations that promote improved understanding of and responses to DV at the individual, community, and institutional levels, taking particular care to respect the primary DV victim and avoid placing blame on them or any of the intervening entities. DVFRTs are critical catalysts for change—from implementing robust training for stakeholders, to helping develop early intervention strategies, to establishing clearer lines of communication and cooperation.

In Colorado, local Review Teams report their case review findings to the statewide board – the CDVFRB. The statewide board seeks to identify other DVFs not reviewed by local boards and then publishes an annual report on the reviewed cases and other identified DVFs which identifies trends and makes recommendations on how to prevent future DVFs.

It has been a longtime goal of the CDVFRB to see local Review Teams created across the state. This document serves as a guide for communities that are considering developing their own DVFRT and as a resource for communities with existing teams. Each community's team and approach may look slightly different based on local needs and resources, but this document lays out foundational elements for fatality review and can help build consistency throughout the state.

Background Information

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; and
>
> (E) Make annual policy recommendations concerning domestic violence to the Colorado General Assembly.

The Board was established in 2016, and its mandate was renewed for another five years in 2022. The Board is composed of a multi-disciplinary set of leaders and subject matter experts from across Colorado committed to preventing DV and DVFs. You can see the full list of members in the annual report of the Board found here. The Board works with community stakeholders to publish an annual report detailing data and trends on DVFs 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.

One of the recommendations from 2022 Board Report was to develop this protocol manual to support and enhance the work of local fatality Review Teams. The Board believed that the creation of this protocol manual is consistent with the Legislature's mandate that the Board "coordinate with stakeholders to develop best practices for collecting data on domestic violence-related fatalities"; "coordinate [with local review teams] to implement effective information-sharing related to identified domestic violence fatalities"; and "prioritize development and support of local review teams in underserved and rural communities". See C.R.S. § 24-31-702(4). The Board recommended that this manual be developed in an effort to reduce the barriers in establishing boards and to help establish consistency in DVF data collection and review, which in turn, can support more targeted prevention and response efforts.

What is a Domestic Violence Fatality?

The CDVFRB 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 abuser's, that may be a response to intimate partner violence.

In identifying DVFs, the Board and local Review Teams are not making any determinations of guilt or taking convictions into account but simply considering if there was a death that based on the available information arose in the context of domestic violence. Some cases never involve a prosecution (e.g. murder/suicide cases), some have pending charges, and some involve fully resolved prosecutions.

Whether, on those facts, a conviction of any individual would result was a different question and is not the determining factor in identifying whether a death was a DVF.

Domestic Violence Fatality Review Teams Generally

Review Teams are authorized by statute. See C.R.S. § 24-31-703. The statute identifies specified roles and responsibilities for teams. Of note Review Teams are required to collect data on DVFs, conduct case reviews of those fatalities, and report the resultant information back to their communities and the Board.

The purpose of a Review Team is to review and analyze DVFs in their community. As addressed in more detail below, a Review Team is composed of a wide variety of community stakeholders who all have unique insights on DVFs. When a team identifies a DVF they collect the key data points identified in the provided Codebook (attached to this document in Appendix C). Once the key data has been collected, the information is compiled and presented to the whole Review Team who together identify red flags, interventions used, and possible interventions missed. The team uses the information to fill out the Codebook and pass on the completed Codebook to the Board.

This model allows for uniform statewide DVF collection which enhances the ability of the Board to uncover statistically significant trends and risk factors, to identify and provide improved responses and interventions to DV. Beyond providing better data, the process of reviewing cases at a local level allows communities to better understand and improve their responses to DV including risk assessments and safety planning. It also often helps communities identify gaps in resources and streamline communications.

Guidelines for a Local Domestic Violence Fatality Review Team

1) Who should initiate the creation of a review team?

As indicated in the statute, a city, county, or judicial district may create a Review Team. Review Teams have been initiated in Colorado by a variety of stakeholders. An advocacy agency, Project Safeguard, instigated the formation of the Denver Review Team and the Board has long benefited from a collaborative partnership between system actors like the District Attorney and law enforcement and with community organizations. A subcommittee of a local Domestic Violence Task Force spearheaded the Mesa County Review Team. The District Attorney Victim Coordinator and Court Administrator co-chair the Review Team. Mesa County attributes the success of their team to the buy-on of the District Attorney's Office and its ability to bring together well-respected and well-connected members of the community to participate in the review process.

Communities interested in forming a Review Team should consider convening some initial stakeholder meetings to determine the appropriate scope of the team (city, county, or judicial district) and the community's ability and readiness to establish a team. Many communities have a robust ecosystem of stakeholders who intersect with DV. Communities ready for a Review Team likely have strong inter-agency partnerships and it is important to lean into those connections to decide the community's readiness to establish a Review Team.

Although forming a Review Team is compelling for most communities, it requires a commitment to establishing alignment between interested stakeholders. Initial planning meetings should be used to consider team composition, goals, objectives, and team philosophies, leadership, and data collection processes. Developing trust among members and clear roles and expectations are critical elements of team formation as well.

2) Who should be on the review team?

It is important to consider the many potential stakeholders who may engage with victims, survivors, and offenders and who can bring expertise to discussions regarding DV dynamics and implementing risk mitigation strategies. When possible, review teams should have someone represented from the following entities:

- Local community based DV agencies
- Law enforcement agencies
- Prosecutor/District Attorney offices
- One or more county departments of public health
- One or more county departments of human or social services
- One or more coroner offices or county medical examiner offices
- Batterer (DV abuser) intervention services providers
- Community supervision agencies (Probation, Parole, Pretrial Services)
- Hospitals and medical providers
- County and district court judges
- County and district court clerks
- DV survivors

Review Teams should be inclusive rather than exclusive and should be open to incorporating new members and agencies that can give insight into specific populations. For example, while Review Teams need to consider confidentiality parameters, teams can consider inviting citizens at large or other community representatives deemed important to enhance the review process of a particular case (e.g., teachers, healthcare providers, or other allied professionals).

To fully understand the context and dynamics of a case and interventions or help-seeking strategies that may or may not have been used, it is important that a Review Team reflect the broad diversity of the community the team serves. The team should include individuals with a range of backgrounds and perspectives including expertise and experience in the field of DV, but also personal experiences and community knowledge, particularly of underserved and traditionally unrepresented segments of the community.

3) Who should lead the review team and what does their role entail?

It is critical to determine who will provide leadership to a Review Team in the initial development stages of the planning process. Leadership responsibilities include: determining the frequency of the meetings, meeting facilitation, sending out notices and agendas, compiling data for review, presenting data to the team, ensuring the confidentiality of all documents dispersed during the meetings and reporting case review data to the statewide Board. These responsibilities can be managed by a particular individual or broken up several positions with determined roles and responsibilities. Some teams have identified an agency to provide administrative support. These roles and responsibilities are often held on a volunteer basis, but the Denver Review Team has a dedicated paid program manager position which is funded through S.T.O.P. VAWA grant program.

4) Which DVF cases should be selected?

Per the statute, the cases that are reviewed must be closed cases with no pending legal action. See C.R.S. § 24-31-703. Some communities may be able to review all DVF's that occur in their jurisdiction while others may only have the capacity to address a subset of DVFs occurring in the area. Where all cases cannot be reviewed Review Teams could choose to review those cases with particular dynamics or factors the community has a particular interest or concern in addressing. Below are some factors that DVFRTs should consider in selecting cases.

Inclusion of marginalized identities

In selecting cases, it is important that diversity, equity, and inclusion is at the forefront in the process. Research consistently finds that the most vulnerable individuals (e.g., due to sexism, racism, classism, disability) in society are often those most at risk of DV (and other forms of gender-based abuse), including DVFs. Thus, DVFRTs need to consciously consider these dynamics in selected cases and should ensure that the cases reviewed represent the community in terms of race, class, (dis)ability, sexuality, and so on. Certain communities have historically been left out of DV discussions and DVF case review:

- People who are disabled
- Elderly populations
- Immigrant and refugee communities
- People of Color
- LGBTQI communities
- Missing and Murdered Indigenous Peoples

"Missing White Woman Syndrome"

Historically only certain types of victims, particularly DVF victims, receive attention nationally and locally. Which cases receive attention and how their stories are covered raises questions about who constitutes a "perfect victim". Last year, the heightened and pervasive media coverage of Gabby Petito, a young White woman who went missing while on a cross country road trip (and subsequently found deceased) with her intimate partner brought up the disparities in coverage when Black or Indigenous people of color are missing and murdered.

The term, "Missing White Woman Syndrome," coined by the late PBS news anchor Gwen Ifill in 2005, has been used to address the media and criminal legal system focus on white women and girls who have gone "missing," and who have survived or died via gender-based violence, while ignoring or minimizing women and girls of color with these same victimizations. This historical pattern should be carefully considered, and teams should seek to counteract these trends by ensuring cases reviewed reflect the cross-section of identities of DVF victims.

5) How to identify DVF cases and access case information?

Selecting a case for review at least four to six weeks before the meeting date is helpful. This provides enough time to thoroughly review the associated materials for the case and to contact the necessary parties who were involved. In addition, this approach provides ample time to submit and receive records requests needed for the review.

Ideally, the Review Team has developed partnerships with relevant agencies so that DVF cases are brought to the attention of the team. Law enforcement is the most likely agency to initially identify cases. To facilitate information sharing the Review Team should identify a point of contact for the team and conduct outreach to relevant stakeholders about how and when to bring cases to the Review Team. Media outlets often report on DVF cases, so a member of the Review Team should consider setting up alerts in an effort to identify cases.

The first set of relevant case information likely is in the possession of the local law enforcement agency and/or prosecutors' office. To access these records, the team should submit a Records Request Letter. Under C.R.S. § 24-31-704 the Board and Review Reams are authorized to access records necessary to fulfill the statutory mandate. Specifically, the statute states:

Notwithstanding any other state law to the contrary, but subject to the requirements of applicable provisions of federal law, the review board and review teams have access to records and information that are relevant to a review of a domestic violence fatality and that are in the possession of a state or local governmental agency.

An example letter drafted by the Colorado Attorney General's Office can be found in Appendix B. Other public entities may also have relevant case information. These entities include the coroner's office (for autopsies), probation (for supervision history), courts (for civil matters), police departments (for criminal records), the local Department of Human Services (for human services involvement). The same records request form can be submitted to these agencies.

It is important to seek additional information from non-government sources including news articles and obituary postings. Where appropriate it also may be valuable for the team's data collection point of contact to connect with the victims' family, friends, and coworkers.

6) How are selected cases shared with the team?

Review Team may develop their own specific processes for how they share selected cases. Detail on how the Denver Review Team functions in this regard may be instructive. The Fatality Review Program Manager (FRPM) selects cases for review and then develops a presentation (usually with an accompanying PowerPoint) that includes general information about the case. This presentation includes a timeline about the parties involved and the events leading up to the incident being reviewed to get an idea of who the individuals were, relationship history and dynamics, in addition to any system and or agency involvement. Some suggested additional items to include in the presentation are:

- Location (city, county) of incident
- Victim and perpetrator employment information
- Any criminal or civil legal involvement; outcome of cases
- Citizen status of victim or perpetrator
- Disclosure of abuse (when and to whom)
- Victim's attempts to leave and/or other protective or help-seeking actions
- Significant changes in victim or perpetrator's life (job loss, relocation, etc.)
- Information on collateral victims, if applicable

The FPRM also invites both the detective and prosecutor who investigated and/or prosecuted the case to participate in the review process and often talks to them before the case presentation to ensure accuracy and comprehensiveness of information. Where appropriate, the detective or prosecutor may present the case themselves as they are often the individuals with the most information about given DVFs. A case review checklist is available in Appendix A.

7) How to collect data during the case review and how to share review data with the CDVFRB

During the case review, the Review Team should walk through and fill out the DVF Codebook available in Appendix D. This Codebook was developed over the years by the Denver Review Team. It was developed to facilitate the gathering of consistent, objective information from which patterns, trends and risk factors can be better determined and used as a basis to inform policy, practice or legislative recommendations.

The Codebook represents the full set of optional data to collect. The goal of any given Review Team case review is to collect as much data on each DVF as possible, recognizing that for every case it is likely that there will be missing data or variables that don't apply to a particular case. For example, two of the Codebook identified data points are first, whether sexual abuse was one the DV perpetrator's forms of abuse, and second, who knew about the DV prior to the DVF. The former is very difficult to ever verify, and the latter is hard to confirm the list is comprehensive.

It is important to note that the Codebook has many “skip patterns” in it. For example, if the perpetrator suicided, then no court data will exist regarding the case outcome and this should be marked as “not applicable” in the Codebook. As another example, if there are no collateral victims, these items will also be “not applicable” in the Codebook.

Once the Codebook is complete during a case review this information should be securely sent to Keisha Sarpong at Keishas@roseandomcenter.org.[1] The information from the completed Codebooks are entered into a research database (SPSS) that contains all other cases that are reviewed by a Review Team in Colorado. This data is then reviewed and analyzed collectively by Dr. Joanne Belknap.[2] The resultant findings are used to produce the statewide Board’s annual report. These reports are available here.

8) How to manage Confidentiality and Privacy of Review Team Data

The effectiveness of a Review Team’s work is contingent upon the confidentiality of the review process and the information shared. Under C.R.S. § 24-31-704, all Review Team meetings; activities of the Team, including activities of any issue specific panel or ad hoc subcommittee formed by the review Team; Team meeting notes and statements; health information and medical records obtained by the Team; and any information obtained in connection with the Team are confidential and are not subject to:

- The open meetings provisions of the “Colorado Sunshine Act of 1972” set forth in section 24-6-402;
- The “Colorado Open Records Act,” part 2 of article 72 of title 24; or
- Subpoena, discovery, or introduction into evidence in any civil or criminal proceeding, unless the information was obtained from another source that is separate and apart from the review board or review teams.

How to internally manage confidentiality?

All participants in Review Team are required to sign a confidentiality agreement, pursuant to C.R.S. § 24- 31-704. A sample confidentiality agreement is provided in Appendix C. This agreement should provide that case review materials are not to be shared outside of a review team meeting, except to the extent the information is provided to the statewide board. It is up to the Review Team to determine when and how case review materials should be shared.

1 Keisha is the Fatality Program Manager for the statewide Board.

2 Dr. Belknap is a Professor Emeritus of Ethnic Studies at the University of Colorado and past President of the American Society of Criminology, and expert in the field of gender-based violence, with expertise in IPV and numerous scholarly publications on the topic.

In order to maintain confidentiality and sustain trust, Review Teams were designed to be closed to the public with consistent participation by the designated members. Under the statute, all Review Team meetings and related activities are not subject to the open meetings provisions of the Colorado Sunshine Act and other similar laws as detailed above. See C.R.S. § 24-31-704 (2)(a). Managing expectations when members are onboarded to the Review Team is critical to maintaining these best practices.

How to manage confidentiality?

Review Teams should agree to take appropriate administrative, technical, and physical safeguards to protect the data from any unauthorized use or disclosure. As an example, the of such protections, the CDVFRB keeps all electronic case files on a limited access shared drive. Any physical case files are stored behind two secure doors and in a locked file cabinet.

Contact Us

The Denver Metro Domestic Violence Fatality Program Manager Keisha Sarpong, or Rose Andom Center Executive Director Margaret Abrams, are available to provide technical assistance and support to communities interested in developing a local fatality review team. If questions or concerns arise at any time during the process of forming a local DVFRT, selecting or conducting a case review, and/or for training to complete the coding manual, you may contact the Denver Metro Domestic Violence Fatality Program Manager Keisha Sarpong at Keishas@roseandomcenter.org, 720-337-4470 or Margaret Abrams at Margaretabrams@roseandomcenter.org.

In addition, for data specific questions, Dr. Joanne Belknap is available and can be reached at joanne.belknap@colorado.edu.

For questions related to the CDVFRB and the Attorney General’s involvement, you may contact Shalyn Kettering Shalyn.Kettering@coag.gov.

Appendix A
Case Review Checklist

Appendix B
Example Record Request Letter

Appendix C
Sample Confidentiality Agreement

Appendix D
Codebook