Colorado Domestic Violence Fatality Review Board

Protocol Manual 2025

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 the Denver Metro Domestic Violence Fatality Review Team (Denver Review Team). This team was formed as the first Colorado based Review Team in 1996 and was one of the first Review Teams formed in the United States. A committed group of professionals came together 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. Review Teams 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 Board. The Board aggregates all Review Board data and reports out on trends from these cases and all other DVFs which occurred statewide each year. The Board identifies trends and makes recommendations on how to prevent future DVFs.

It has been a longtime goal of the Board to see local Review Teams created across the state. This document serves as a guide for communities that are considering developing their own Review Team and as a resource for communities with existing teams. Each community's Review 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

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. Review Teams across the country can be and have been catalysts for systemic change. Other teams have implemented robust training for criminal and civil justice personnel, health care providers, and mental health professionals to help them develop early intervention strategies.

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 (PDF)** of the Board. 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.

One of the recommendations from the 2022 Board Report was to develop this protocol manual to support and enhance the work of local FRTs. 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. § 24-31-704. 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 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 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 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 benefitted 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-in 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 DV intersections to determine the agencies and individuals who may engage with victims, survivors, and offenders and can bring expertise to discussions regarding DV dynamics and implementing risk mitigation strategies. In order to maintain confidentiality and sustain trust, it is recommended and supported by the statute that the review team is a closed group with consistent participation by designated members. 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
- Trained and qualified DV treatment 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, as guests, to enhance the review process of a particular case (e.g, teachers, healthcare providers, or other allied professionals who may provide information or insight to a specific case review).

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 meeting, 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 into 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 the 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 DVFs 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 address if the cases reviewed represent the community in terms of race, class, (dis)ability, sexuality, and so on. In light of these conversations, we feel it is important to name the communities that 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
- 2SLGBTQIA+ communities
- Missing and Murdered Indigenous Peoples

"Missing White Woman Syndrome"

In recent years, language around who is a "perfect victim" has commanded national attention and has called to the forefront the way in which cases are highlighted publicly and how they are highlighted. The heightened and pervasive media coverage of Gabby Petito, a young White woman who went missing in 2021 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.

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 relevant to 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 specific to their jurisdiction.

The first set of relevant case information is likely 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 Teams 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 to incorporate collateral interviews

The Board is aware that information about relationship dynamics is not often reflected in system-based data that is typically reviewed by local teams. Rather, this information is most often held by those in the intimate partner relationship and family and friends of the partners. Where appropriate, it may be valuable for the team to incorporate collateral interviews with the DV perpetrator where they survived and/or with both the victim and DV perpetrator's family, friends, and coworkers. These are called "Collateral Interviews."

Collateral Interviews Generally

Collateral interviews are a critical component of in-depth domestic violence fatality reviews. While official documents such as police reports, court records, and autopsy findings provide valuable facts, they often lack the nuanced, lived experiences of those directly involved in or witness to the relationship, events, and dynamics leading up to a homicide. Interviews with those impacted by the DVF including witnesses, family members, friends, neighbors, and even the DVF perpetrator (if alive and incarcerated) provide indispensable context that cannot be captured in official records alone.

These interviews offer a fuller understanding of the risk factors, systemic limitations and failures, and relationship patterns that contributed to the fatality. They can reveal overlooked red flags, the impact of historical and intergenerational trauma, unrecognized attempts to seek help, and barriers to safety. These interviews also can give survivors, families, and communities a voice—allowing them to contribute to recommendations that may help prevent future tragedies. When conducted with empathy and respect, collateral interviews can be healing, humanizing, and transformative.

Local fatality review teams should strive to conduct a full set of collateral interviews where possible, including with the DVF perpetrator in cases where they are alive and incarcerated. The below provides guidance for best practices for each category of collateral interviews.

Interviewing surviving family members and friends/community members of the DV victim and DV perpetrator

Interviews with surviving family members—of both the victim and the perpetrator—offer essential insight into the individuals' lives, barriers to safety, and systemic interactions. Families can shed light on the victim's efforts to seek help, how the system responded (or failed to), and the complex interpersonal dynamics that preceded the fatality. These interviews should be voluntary, trauma-informed, and conducted with deep respect for grief and emotional complexity. Ideally, these interviews are conducted by someone well-trained in DV dynamics and trauma-informed interview practices. Interviewers should acknowledge the pain and potential catharsis such participation may bring, and allow family members to share their story on their own terms. The interviewers should also be clear about the goal of the interview (to collect information and understanding) and that the information collected from others may not be available to be shared.

When interviewing the family of the **DVF victim**, consider exploring their understanding of the relationship, the victim's disclosures (or lack thereof), and past efforts to seek safety. Be attentive to the potential for victim-blaming or internal family conflict. If multiple family members hold divergent views, consider separate interviews. For families of the DVF **perpetrator**, inquire about their awareness of controlling or violent behaviors, trauma history, and any efforts to intervene. Avoid judgment and focus on insight. This is for purposes of information collection, and not information correction.

Collateral interviews with **friends, neighbors, teachers, or agency professionals** can also add key details, including contradictory accounts that challenge assumptions. Using a snowball approach — "Is there anyone else we should speak to?" — can help identify new sources. Each interview, regardless of source, is an opportunity to reconstruct a fuller, more human portrait of the victim, perpetrator, and system interactions—and to inform more effective, grounded recommendations for prevention.

The below provide questions some of which are more relevant to family and others to community members, but many overlap.

Example questions for collateral interviews associated with the DVF perpetrator:

Background and Early Life

- Tell me about the perpetrator.
- What was their childhood like?
- Who were their support systems and safe places?
- Who were unsupportive or negative influences in their lives?
- Did they experience or witness abuse, violence, or crime as a child or young adult?
- Were there other hardships or traumatic events (mental health struggles, bullying, discrimination, poverty, accidents, loss of loved ones, etc.)?
- Was there cruelty to pets or animals in their upbringing or adulthood?
- What were their strengths and vulnerabilities?
- What made you proud to know them?
- What did they enjoy doing for fun or hobbies?
- What was their religious or faith preference and how did they practice it?
- Did they have a history of alcohol or substance use?
- Did any of your caregivers misuse or abuse substances while caring for you?
- Looking back to the relationships of your caregivers, what were lessons you learned growing up about romantic relationships?

Relationships and Family

- Tell me about their past romantic relationships.
- How did their relationship with [the victim] begin, and how did it change over time?
- Were there good times in the relationship?
- If there were children: how did parenting affect the relationship? Were there children from other relationships present?
- Did the children ever witness violence, or experience abuse or neglect? Did they try to intervene or how did they respond during conflict?
- Was there cruelty to pets or animals present in the relationship?

Awareness of Violence and Help-Seeking

- Were you aware of abuse or violence (physical, emotional, financial, or controlling behaviors) in the relationship? If so, when and how did you become aware?
- Did the perpetrator ever attempt to get support or help (from family, friends, therapists, community agencies, faith groups, or law enforcement)? What was their experience like? What were the barriers to getting support, if any?
- Were you aware of system involvement (child welfare, probation, domestic relations court, protection orders, etc.)?
- Were you aware of the [victim and/or perpetrator's] access to firearms? What was their relationship with firearms.

Reflections

- When was the last time you spoke with them?
- What do you think contributed most to the fatal outcome?
- If you could advise another family who sees someone they love engaging in harmful behaviors, what would you tell them?
- What do you wish had been available to help your family member change or get support?
- What would you like their legacy to be? How would you like them to be remembered?
- Do you have recommendations for the Review Team, or any resources you think would help other families?
- Any final thoughts you would like to share?

Example questions for collateral interviews associated with the DVF victim:

Background and Early Life

- Tell me about the victim.
- What was their childhood like?
- Who were their support systems and safe places?
- Who were unsupportive or negative influences in their lives?
- Did they experience or witness abuse, violence, or crime as a child or young adult?
- Were there other hardships or traumatic events (mental health struggles, bullying, discrimination, poverty, accidents, loss of loved ones, etc.)?
- What were their strengths and vulnerabilities?
- What made you proud to know them?
- What did they enjoy doing for fun or hobbies?
- What was their religious or faith preference and how did they practice it?
- Did they have a history of alcohol or substance use?
- Did any of your caregivers misuse or abuse substances while caring for you?
- Looking back to the relationships of your caregivers, what were lessons you learned growing up about romantic relationships?

Relationships and Family

- Tell me about their past romantic relationships.
- How did their relationship with [the perpetrator] begin, and how did it change over time?
- Were there good times in the relationship?
- If there were children: how did parenting affect the relationship? Were there children from other relationships present?
- Did the children ever witness violence, or experience abuse or neglect? Did they try to intervene or how did they respond during conflict?
- Was there cruelty to pets or animals present in the relationship?

Awareness of Violence and Help-Seeking

- Were you aware of abuse or violence (physical, emotional, financial, or controlling behaviors) in the relationship? If so, when and how did you become aware?
- Did they ever confide in you about the relationship? What did they share?
- Did they attempt to get support or help (from family, friends, therapists, community agencies, faith groups, or law enforcement)? What was their experience like? What were the barriers to getting support, if any?
- Were you aware of system involvement (child welfare, probation, domestic relations court, protection orders, etc.)?
- Did they ever share their experiences, positive or negative, with law enforcement or the courts?
- Tell me about any safety plans or steps you took to reduce harm.

Reflections

- When was the last time you spoke with them?
- Did you learn anything new about their life after their death?
- What do you think could have changed the outcome?
- If you could advise another family whose loved one may be in a dangerous relationship, what would you tell them?
- What would you like their legacy to be? How would you like them to be remembered?
- Do you have recommendations for the Review Team, or resources you wish had been available to them?
- What do you wish more people understood about your experience?
- Any final thoughts you would like to share?

Interviewing the DVF Perpetrator

Interviewing the perpetrator of a domestic violence fatality—typically an incarcerated individual—requires a trauma-informed, ethically grounded approach that prioritizes rapport-building and information-gathering over interrogation. These interviews are not about re-litigating the case, but about exploring the perpetrator's developmental history, relationship dynamics, stressors, and perceptions. Interviewers should be professionals trained in working with DV offenders with experience in sensitive interviewing. As a best practice, those certified through the DVOMB should conduct the interview.[1] Prior to the interview, ensure all appellate and civil matters are resolved, and be transparent with the perpetrator that the interview will not influence parole, sentencing, or conditions of incarceration. Inform them of mandatory reporting responsibilities and maintain clear confidentiality boundaries.

Effective interviews with perpetrators often explore early life trauma, adverse childhood experiences, neurodevelopmental disruptions, and adult stressors that may have shaped the individual's capacity to regulate emotions, manage conflict, or perceive threats. Perpetrators may have experienced significant trauma—such as neglect, abuse, abandonment, or brain injury—that impacts their worldview and behavior. Interviewers should remain alert to signs of dissociation, hypervigilance, or malingering and avoid confrontation, instead gently probing for deeper context.

1 These interviews are not offender evaluations or assessments.

Example questions:

Background and Early Life

- Can you share with me why you are interested in participating in this interview?
- What was your childhood like?
- How were your grandparents and parents raised? What were their relationship dynamics like?
- How were you raised? How were you disciplined?
- Who were your support systems and safe places growing up?
- Who were unsupportive or negative influences in your life?
- Did you experience or witness abuse, violence, or crime in your family or community?
- Did you experience other hardships or traumatic events (e.g., bullying, injuries, loss, poverty, racism, discrimination)?
- What were your strengths and vulnerabilities as a child and young adult?
- What made you proud of yourself?
- What did you enjoy doing for fun, hobbies, or activities?
- What was your religious or faith background, and how did you practice it?
- Did any of your caregivers misuse or abuse substances while caring for you?
- Looking back to the relationships of your caregivers, what were lessons you learned growing up about romantic relationships?

Purpose and Identity

- How would you describe yourself?
- How do you think others would describe you?
- As a child: What was your role in your family as a child?
- As an adult: What was your role in your family as partner?
- As an adult: What was your role in your family as parent?
- What were some of your hopes and dreams for your own life before this?

Adolescence and Adulthood

- Describe important friendships, relationships, or mentors you had growing up and as an adult.
- What were your friend groups like? What kinds of activities did you do together?
- Describe your schooling (education level), sports, activities, and family gatherings that were significant in your life.
- Describe your history with employment (hirings, firings, successes, unemployment).
- Do you have a history of alcohol or substance use? Mental health diagnosis or treatment?
- Describe your education experience (ease, difficulty, accommodations, disabilities, etc.).

Romantic Relationships

- Walk me through your past romantic relationships from beginning to end. (A more quantitative approach may work better for some, so consider questions like: How many romantic relationships have you been in? How long did they last? Why did they end? Was there abuse present in any relationships?
- How did your relationship with [the victim] begin? How did it change over time?
- What were some good times in the relationship?
- What challenges or stressors did you experience together (financial, parenting, housing, job loss, etc.)?
- If you had children, how did that affect the relationship? Were there children from other relationships?
- Did the children ever witness violence, or experience abuse or neglect? Did they try to intervene or how did they respond during conflict?
- Was there cruelty to pets or animals present?

Violence and System Involvement

- Tell me about any abuse or violence (physical, emotional, financial, etc.) that occurred in the relationship.
- How would you describe your use of power, coercion, or control in the relationship to get outcomes you wanted?
- How did you feel or what were you experiencing in the days or weeks before the incident?
- Were there previous system involvements in your life (child welfare, criminal justice, probation, therapy, substance use treatment, etc.)?
- Did you or the victim ever try to get support from people, therapists, agencies, or law enforcement? What was that experience like? What were the barriers to getting support, if any?
- Tell me about your relationship with firearms? Have you ever owned firearms? If so, tell me about them.

Reflections and Looking Forward

- If you could speak to yourself one day, one hour, or one week before the incident, what would you say?
- If you could speak to someone else going through a relationship like yours, what would you tell them?
- Do you view the world as a threatening or safe place (past, present, or future)?
- What services did you receive before the incident (therapy, groups, counseling, etc.)?
- What services do you think would have been helpful?
- What do you think would have helped you most before things escalated?
- What recommendations would you share with our team, or resources you wish had been available?
- What do you wish more people understood about your experience?
- Any final thoughts you would like to share?

You also will want to ask questions about important timeline markers in these interviews. Below are some markers to consider.

Important Timeline Markers for Both Interviews (prompt as needed):

- Education milestones or graduation
- Marriages/divorces
- Births of children
- Employment changes, job loss
- Accidents, hospitalizations, or major health issues
- Arrests, probation, or jail/prison stays
- Major moves or relocations

7) How are selected cases shared with the team?

Review Teams 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. And where involved the victim advocate is also invited. 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.

8) 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. If there is a Team Manager or Lead, the information can be prepared in advance and reviewed by the full team during the meeting. 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 evidence-based 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 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.

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 Rehfeld at keishar@roseandomcenter.org. 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. The resultant findings are used to produce the statewide Board's annual report. These reports are available here.

9) 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 the 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.

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.

Review Teams should agree to take appropriate administrative, technical, and physical safeguards to protect the data from any unauthorized use or disclosure. For example, 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 Fatality Program Manager Keisha Rehfeld, or Rose Andom Center Executive Director Whitney Woods, 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 Keisha Rehfeld at keishar@roseandomcenter.org, 720-337-4451 or Whitney Woods at whitneyw@roseandomcenter.org.

In addition, for data-specific questions, Keisha Sarpong and Dr. Joanne Belknap are available and can be reached at:

- Keisha Rehfeld – keishar@roseandomcenter.org
- Dr. Joanne Belknap – joanne.belknap@colorado.edu

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