Colorado Domestic Violence Fatality Review Board

Annual Report

2018

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Attorney General

Chair

Per C.R.S.§ 24-31-702(4), this report is respectfully submitted to the Health and Human Services and Judiciary Committees of the Colorado Senate and the Public Health Care and Human Services and Judiciary Committees of Colorado House of Representatives.

This report is available on the web site of the Colorado Department of Law at the following link: https://coag.gov/OCE/prevent-domestic-violence.

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I. Dedication to the Victims Killed in Domestic Violence Related Incidents in 2017

The Colorado Office of the Attorney General enlisted the assistance of the staff of the Denver Metro Domestic Violence Fatality Review in collecting information on domestic violence related fatalities in the state of Colorado that occurred in 2017 in order to assist the work of the Colorado Domestic Violence Fatality Review Board. The data collected includes information on murders, murder/suicides, suicides, collateral deaths, familicides, and any other death determined to be the result of, or occurring within, the context of domestic violence. This report provides an overview of 2017 data and a complete list of incidents can be found at www.DDVCC.org/fatality-review.

Dedicated to the 25 victims who were killed in Colorado in 2017 as a result of domestic violence, and to victims and survivors of domestic violence everywhere.*

Elizabeth "Stacy" F. (age 40) and Ian F. (age 5)

Lucero B. (27), Laela B. (5), and Rodolfo B., Jr. (8)

Savannah M. (22) and Tristian K. (26)

Jeremy B. (45)

Dominic P. (20)

Guadalupe "Julian" D. (32)

Karrie B. (33)

Melissa E. (37)

Svetlana I. (40)

Ally R. (18)

Ashley M. (24)

Charles L. (55)

Crystal M. (33)

Heather A. (31)

Morgan D. (21)

Zalynnda K. (17)

Danielle C. (26)

Erika B. (26)

Anne F. (53)

Amanda P. (43)

Christie M. (32)

*This list does not include names of individuals who were determined to be perpetrators of domestic violence.

II. Acknowledgements

The Colorado Office of the Attorney General is grateful for the expertise of the Denver Metro Domestic Violence Fatality Review Team and Staff who assisted in the collection of data on domestic violence fatalities for presentation to the Review Board and for preparing this annual report. The staff members are Doralee Larson, Barb Lamanna, Jenn Doe, and Rachel Dyer.

This work also included the research and technical expertise of Dr. Joanne Belknap, Associate Chair of Undergraduate Studies at the University of Colorado Department of Ethnic Studies with an emphasis in Criminology and Social Justice. Assisting Dr. Belknap were the following students: Jordan Spinelli, Kalen Fern, Ayomi Rajapakse, Stephen Abeyta, Katie Leigh, and Quian Sun.

III. Message from Attorney General Cynthia H. Coffman

The goal of the domestic violence fatality review process is to better understand the dynamics when a fatality occurs in order to help prevent future tragedies of intimate partner violence. The findings can be integrated into training of professionals and utilized to improve practices and to determine what policies may be needed.

As chair of the Colorado Domestic Violence Fatality Review Board, I am very pleased to provide this report, which illustrates considerable progress made during the first year of the Review Board.

The members of the Review Board are exceptional experts in their respective fields of professional occupation and they were aided by the many years of experience of the staff members of the Denver Metro Domestic Violence Fatality Review Team, a group that has been in existence since 1995.

In addition to reviewing data collected and analyzed with regard to domestic violence fatalities in Colorado, the Review Board focused on preparing the Local Domestic Violence Fatality Review Team Packet, utilizing work done by the Denver Metro Domestic Violence Fatality Review Team. This packet helps guide the efforts of local groups in forming review teams and conducting domestic violence fatality reviews. The packet also facilitates the collection and submission of data on domestic violence fatalities for use at the local level and for review by the Review Board.

This past year, the work of the Review Board helped to foster interest among several communities to form local domestic violence fatality review teams. This effort was further supported by training sponsored by the Colorado Office of the Attorney General and by the Colorado District Attorney's Council for representatives of various jurisdiction with an interested in establishing such teams.

As government representatives, domestic violence advocates and citizens, we must always be asking ourselves what we can do better. I believe that by working collaboratively with a diverse group of stakeholders from across our state, the local review teams and the Review Board will help us better understand the root causes of domestic violence in our communities and help prevent these unthinkable tragedies from happening in the future.

IV. Executive Summary

Per C.R.S. § 24-31-702(2)(a), the Colorado Attorney General serves as the statuary chair of the Colorado Domestic Violence Fatality Review Board, which consist of nineteen members (see Appendix I for a list of members). The Review Board is charged by the Colorado General Assembly to:

a. examine data collected by review teams during the preceding year;
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; and
d. make annual policy recommendations concerning domestic violence to the Colorado General Assembly.

The statute also authorizes the Colorado Domestic Violence Fatality Review Board to encourage the formation of local domestic fatality review teams. In 2018 there were two active teams, one in Denver encompassing the 1st, 2nd, 17th, and 18th Judicial Districts and a second in the 21st Judicial District. One additional local team was established in 2018 in the 9th Judicial District and there are three additional teams poised to be created in the 4th, 6th, and 20th Judicial Districts.

Statewide Domestic Violence Fatality Data, 2017

The Denver Metro Domestic Violence Fatality Review team maintains a comprehensive list of fatalities in Colorado resulting from an incident determined to be an act of, or in the context of domestic violence or intimate partner abuse. The information is gathered from public sources, including media reports, arrest affidavits, and information provided by law enforcement representatives.

In 2017 the state of Colorado had at least 29 incidents where domestic violence resulted in a fatality and 39 people died as a result of these incidents. Of the 39 individuals killed, 18 were the primary victim of domestic violence, 3 were collateral children, 4 were collateral adults, and 14 were the primary perpetrator of domestic violence. The majority (15, or 38%) were women killed by a current or former male partner, followed by men who died by suicide (12, or 31%).

Most common was murder only (14, or 48%) and in three of those incidents a primary domestic violence victim was killed, as well as at least one collateral victim. The next most

common were incidents involving a suicide only (7, or 24%), one of which was a suicide by the primary domestic violence victim, while the other 6 were the primary domestic violence perpetrator. This trend of suicide within the context of domestic violence alarming and more research needs to be done in this area to understand the connections between suicide and domestic violence.

The majority of domestic violence fatality incidents for 2017 of which the Review Board is aware occurred in Jefferson County, with 5 (21%) in Lakewood and 1 in unincorporated Jefferson County. It is worth noting that 4 of the incidents that occurred in Jefferson County involved perpetrator suicides and the other 2 involved collateral deaths only, so no primary victims of domestic violence were killed in these 6 incidents. El Paso County had the next highest rate of fatal domestic violence-related incidents with 5 (17%) incidents occurring in Colorado Springs.

Gunshot wounds were involved in 17 (59%) incidents, making this the most common type of fatal injury (5 of these were incidents involving suicide only). Next were blunt trauma, stab wounds, and strangulation, with 3 (10%) incidents each involving these types of fatal injury. Hanging was involved in 2 (7%) incidents, and in 1 (3%) incident, the type of injury that resulted in death was unknown because the victim was dismembered.

Of the domestic violence victims killed in 2017, the youngest was 17 and the oldest 55, with an average age of 32. Of the domestic violence perpetrators killed, the youngest was 19 and the oldest 60, with an average age of 29. Age was unknown for 2 of the domestic violence perpetrators killed.

2017 Reviewed Cases of Domestic Violence Fatalities

A total of seven cases of domestic violence fatalities reviewed were reviewed in 2017 by two active local Domestic Violence Fatality Review teams. The Colorado Domestic Violence Fatality Review Board reviewed findings from these cases with the assistance of staff of the Denver Metro Domestic Violence Fatality Review team. Given that Colorado's legislation related to the work of domestic violence fatality reviews states that cases must be closed in order to be reviewed, and a trial may take years, cases reviewed are those that occurred one to several years prior. The majority of cases reviewed by Colorado local review teams in 2017 were primarily from 2016 (n =3, or 42.9%), followed by 2012 (n = 2, or 28.6%), and one case each (14.3%) in 2015 and 2011.

Case information is compiled with the cooperation of respective law enforcement agencies and/or prosecutors' offices, as well as any other entities authorized local review team and a coding manual is completed and data is analyzed by Dr. Joanne Belknap, Department of Ethnic Studies at the University of Colorado Boulder. The findings, which appear in detail the main body of this report, were then shared with and reviewed by the Colorado Domestic Violence Fatality Review Board.

Of the seven cases reviewed, two occurred in Aurora (Arapahoe County), another two occurred in Denver (Denver County), and there was one case each that occurred in Commerce City (Adams County), Lakewood (Jefferson County), and Mesa (Mesa County). The fatal incidents most often occurred in the victims' and perpetrators' joint residence (n = 3) followed by the victim's sole residence (n = 2).

Among the cases reviewed, there were ten fatalities. Specifically, four (57.1%) of the cases involved one death and three (42.9%) involved two deaths. Sixty percent (n = 6) of the total deaths across the seven cases were by gunshot. In two of these cases, the perpetrators fatally shot their victims and then themselves. In another, the perpetrator fatally shot his partner's daughter (the only collateral victim in the cases reviewed) and then himself.

In four of the cases, the couples were married with a range of 11 months to 16 years of marriage. The length of the intimate partner relationship for the unmarried couples ranged from 1 to 4.5 years. In four of the intimate partner relationships (57.1%), the parties were separated at the time of the fatal incident. These separations ranged in length from 2 weeks to 2 months.

The domestic violence victims' ages ranged from 31 to 73 years old, with an average age of 40 years old. The perpetrators' ages ranged from 31 to 61 with an average of 47 years old. Four (57.1%) of the victims were White, two (28.6%) were Latina, and one (14.3%) was African American. Two-thirds (n = 4, 66.7%) of the perpetrators were Latino, one (16.7%) was White, and one (16.7%) was African American (The race was unknown for one of the perpetrators). All 7 victims and all 7 perpetrators were U.S. citizens.

There was no indication that any of the victims suffered from mental illness, but there was indication that one (14.3%) of the perpetrators suffered from mental illness (bi-polar diagnosis).

Among the six perpetrators for which there was prior domestic violence conviction information available, two had no prior convictions, one had one, one had two, one had 4, and one had eight prior domestic violence convictions. Among the six perpetrators for which there were conviction data on the past five years, five had no domestic violence convictions in the past

five years, one had “only” one such conviction, and one had three domestic violence convictions in the prior five years.

Three of the victims had domestic violence arrests prior to the DOI. Among these three victims with prior arrests, they had one, two, and three prior domestic violence arrests. In the previous five years, four of the victims had no domestic violence arrests, two had one and one had two such arrests.

Red Flags for Domestic Violence Fatalities

Notably, the most common red flag was the perpetrators’ history of domestic violence assaults—in all cases the perpetrator had a history of domestic violence assaults. The next most frequently occurring red flags were:

- perpetrator underemployment or unemployment;
- perpetrators possessiveness of their victims;
- perpetrators stalking/monitoring their victims;
- perpetrator perceived loss of control;
- perpetrator history of alcohol/drug abuse;
- perpetrator history of non-domestic violence assaults;
- perpetrator financial dependence on their victim;
- perpetrator estrangement of the victim;
- perpetrator threats to kill the victim;
- pending legal actions against the perpetrator; and
- perpetrator believing or knowing the victim was in a new intimate relationship.

Conclusions

The findings described in this report on the seven cases are consistent with much of the existing research. Intimate partner homicide (IPH) is a crime primarily committed by men against women, and often when they believe they have lost control of their intimate partner. The two women who killed their intimate partners were considered by the criminal legal system to have done so in self-defense, which is also consistent with the existing research on IPHs. Also consistent with existing IPH research, many men who murder a current or former intimate partner, subsequently kill themselves. The primary weapon used by men in the killing of a

partner, a collateral victim, and for suicide, was a firearm. Women were more likely to use knives and stabbing, which is also consistent with the IPH scholarship. The analysis also found a fairly extensive criminal history for most of the perpetrators, as well as for a few of the victims.

The findings include a reminder of the wide-reaching consequences of intimate partner abuse, which do not only affect the individuals involved in an intimate relationship. Family members may be killed by the perpetrator, as was true in one of the seven cases we reviewed in which the victim's daughter was shot to death by her perpetrator while trying to help her mother leave this abusive man. In this case, the offender shot and killed his wife's adult daughter who had come to pick her up to take her to lunch, where she planned to discuss how to keep her mom safe after the divorce. The perpetrator then killed himself. The Denver Metro Domestic Violence Fatality Review (DMDVFR) had the opportunity to extensively interview the surviving sisters, who had this to say:

> "He wanted to control mom. He was upset anytime the girls tried to offer assistance. I didn't like being around him. He seemed 'dark' and was distant with the grandkids. He was kind of estranged from his family, he thought they were trying to get money out of him…He was feeling like he was losing control. He would check up on mom to see where she was and what was going on. He called her that day [day of incident] to see who was coming to pick up mom. He knew it was going to be M___. Mom now feels like there were indications that he was 'evil.' Mom said that on the date of incident, things changed, he was acting different, and he didn't even look the same…I think he shot my sister to punish my mom."

A variety of individuals in both the victims' social lives and the official system knew about the domestic violence. Clearly one step toward solutions is having more education about domestic violence in general, and prevention of IPH, and this should be done in police departments and courts, as well as in schools, workplaces, and healthcare facilities.

Limitations

One of the limitations encountered in compiling this data is the small sample size. Because Colorado only had two active local domestic violence fatality review teams in 2017, case review data is limited and not representative of domestic violence fatality cases statewide. One additional local review team was formed this year (2018), and at least three more judicial districts are preparing to create a team in the foreseeable future. Although data is collected on domestic violence fatalities statewide, as presented in the previous section of this report, Colorado does not have the capacity to complete an in-depth review of every one of these cases, so data is limited to basic information about the cases that is publically available. More local domestic violence fatality review teams in Colorado, and increased funding for these teams, would certainly enable us to gather more data about all domestic violence fatalities occurring in the state, which would allow for richer and more comprehensive data analysis.

V. Policy and Practice Change Recommendations

By statute, the Colorado Domestic Violence Fatality Review Board is required to provide the Colorado General Assembly with recommendations for:

- reducing the incidence of domestic violence in the state; and
- improving responses to domestic violence incidents by the legal system and by communities; and
- recommendations directed at primary prevention of domestic violence.

A. The Review Board recommends convening a group of content experts to more clearly define the term "knowingly" as defined differently or more clearly under current statute with regard to the distinction intend between Murder in the First Degree (C.R.S. 18-2-102) and Murder in the Second Degree (C.R.S. 18-3-103).

   The term “knowingly” appears in the statutory definitions of Murder in the First Degree and of Murder in the Second Degree, but when applied in either one of those cases the sentencing is different: Life in prison for Murder 1 versus 16-48 years in prison for Murder 2.

B. With regard to firearms restrictions compliance for individuals charged with a domestic violence offense, the Review Board recommends the inclusion of two check boxes on the protection order issued at the advisement of rights.

   One box would indicate the following by the offender:

   > "I acknowledge that I own/possess/have access to firearms and will surrender such firearm(s) within 72 hours."

   The second box would indicate the following by the offender:

   > "I do not own/possess or have access to firearms."

C. The Review Board recommends that there be a mandated affidavit to confirm relinquishment of firearms by domestic violence offenders as a further measure to ensure this legal requirement is being met by the courts and by the offenders.

VI. Background and Introduction to Domestic Violence Fatality Review in Colorado

The Denver Metro Domestic Violence Fatality Review (DMDVFR) was one of the first domestic violence fatality review teams formed in the United States. The long-time aspiration of that team has been to increase and broaden the focus and functions of Denver Metro's Domestic Violence Fatality Review to include more near-death, collateral death and/or suicide-only case reviews. A larger goal was to expand the work statewide and form the state-level domestic violence fatality review board. This dream was realized when Colorado Attorney General Cynthia Coffman, Director of the Office of Community Engagement José Esquibel, and Director of Legislative Affairs Jennifer Anderson, worked tirelessly and passionately with stakeholders and legislators to ensure the passage of Senate Bill 2017-126.

With bipartisan support led by Senators Lucia Guzman (D) and Bob Gardner (R) and Representatives Millie Hamner (D) and Yeulin Willet (R), the bill to form the Colorado Domestic Violence Fatality Review Board was passed by the Colorado General Assembly and signed into law by Governor John Hickenlooper on June 8, 2017 as Colorado Revised Statutes (C.R.S.) 24-31(702-705). The new law not only enables but also strongly encourages professionals from different disciplines across the state to join our efforts to help prevent domestic violence fatalities.

The Colorado Office of the Attorney General has the statutory authority to lead the Colorado Domestic Violence Fatality Review Board (CDVFRB) with the Colorado Attorney General as the statutory chair. This leadership by a state elected official helps to improve collection of domestic violence fatality data, which will potentially help us understand how domestic violence fatalities can change over time and result in policy and practice advancements to improve domestic violence prevention and response services.

Changes in technology that make stalking easier, serious changes in population sizes, economic and political changes, environmental disasters, have all been linked to changes in domestic violence and thus will likely always require increased analysis of these phenomena. Strengthening the internal capacity of the DMDVFR to support the work of the CDVFRB is crucial in order to continue, and broaden, this strategic and invaluable work.

C.R.S. 24-31(702-705) encourages the formation of local domestic fatality review teams. The longest running team in Colorado is the DMDVFR, formed in 1996 under the leadership of the Denver Domestic Violence Coordinating Council (DDVCC) with funds from the U.S. Office on

Violence Against Women. The DMDVFR is a multi-disciplinary group of more than twenty-five members from criminal and civil legal systems and community-based entities, driven by the intention of increasing victim and community safety and offender accountability. In addition to the primary efforts of helping to decrease domestic violence homicides, attempted homicides and suicides, the goals of the DMDVFR continue to include heightening public/community and criminal legal systems' awareness of the ever-present potential of domestic violence fatalities, and the overall dynamics of intimate partner abuse.

Until recently the DMDVFR was strictly limited to reviewing cases and collecting data on Denver Metro domestic violence fatalities. However, even with this limitation, the DMDVFR is nationally recognized for capturing some of the most detailed domestic violence fatality review data. Researcher and former president of the American Society of Criminology, Dr. Joanne Belknap (Department of Ethnic Studies at the University of Colorado-Boulder) guides the data collection, oversees data input, and analyzes the data to share findings in reports and presentations. DMDVFR has been successful in our on-going detailed data collection and reporting, expanding the data collected from cases and garnering national recognition (e.g., published findings in the scholarly journal *Homicide Studies*, and presentations at the National Domestic Violence Fatality Review Initiative 2015 conference).

Currently, the staff of the DMDVFR work with professionals across the state with an interest in initiating a local Domestic Violence Fatality Review Team (DVFRT) in their judicial districts. In addition to the Denver Metro DVFRT, the DMDVFR team was successful in helping create two viable, working DVFRTs in Colorado (in the 9th and 21st Judicial Districts) in a very short period of time on behalf of the Colorado Domestic Violence Fatality Review Board. There are three additional Judicial Districts (the 4th, 6th, and 20th) poised to create Domestic Violence Fatality Review Teams, and the DMDVFR staff has provided a considerable technical assistance and training to them and others.

What was learned from the first two local teams established is that the technical assistance and training is an ongoing necessity, which requires a lot of expertise and effort. Through a comprehensive planning process, the DMDVFR continues to work with the Colorado Attorney General's Office of Community Engagement and the CDVFRB. The passage of Senate Bill 2017-126 resulted in a significant paradigm shift because we now have a statewide Domestic Violence Fatality Review process that will guide the local efforts and there is an expectation that more teams will be formed in various judicial districts as the word gets out and additional funds are secured to provide the training and technical assistance. The level and quality of technical

assistance and training that is provided by the staff of the DMDVFR is very resource intensive, but it is crucial that support is provided to local teams as they develop.

While it is too early to determine with the specific results or outcomes the CDVFRB and Domestic Violence Fatality Review Teams across the state may have, anecdotal information from reports of other states suggests that the process revitalizes coordinated community responses to domestic violence and provides an enhanced focus for interagency liaison work and communication. This appears to be of vital community importance, especially for areas that have not enjoyed affiliative and coordinated relationships in the past.

The Colorado Office of the Attorney General is very pleased to have the expertise of the staff of the DMDVFR to support the work of the CDVFRB. In 2018, this collaboration has resulted in this annual report, the revision of 34-page coding manual to ensure consistent data collection throughout the state, and a manual to provide guidance to judicial districts looking to form a DVFRT. Additionally, several training opportunities were offered to professionals across the state related with regard to responding to domestic violence and the importance of domestic violence fatality review. Web links to the prepared documents and a list of trainings can be found in the appendices.

VII. 2017 Statewide Findings on Domestic Violence Related Fatalities

A. Data Collection Process

The DMDVFR maintains a comprehensive list of fatalities in Colorado resulting from an incident determined to be an act of, or in the context of domestic violence or intimate partner abuse. The information is gathered from public sources, including media reports, arrest affidavits, and information provided by law enforcement representatives. This information is distributed and available to every person in the state that has an interest in domestic violence prevention. Due diligence is given to compiling the most accurate information possible and we appreciate all of the feedback received from law enforcement, prosecution, victim services and any other agencies, or individuals, statewide to help ensure our research is accurate and complete. It is acknowledged that there may be additional cases that have not been captured in this data and that additional information may come to light in the future that would result in changes to this data.

All fatalities in the context of domestic violence are counted, including collateral deaths (friends, family members, neighbors, and other bystanders) and suicides (this includes suicides that occurred after a homicide, as well as perpetrator or victim suicides only). **Complete definitions of the types of fatalities for which information is collected is found Appendix B of this report.** There is an online system for entering basic information about local fatal incidents in communities that appear to be in the context of domestic violence, which is available at www.DDVCC.org/fatality-review. That web site also includes a compilation of domestic violence fatalities from across the state for the year 2017 and for past years. Address any comments and questions about the collection process to denverdvcouncil@gmail.com.

B. Summary of Colorado Domestic Violence Fatalities

The following information describes what we know about domestic violence related fatalities that occurred in Colorado in 2017. Note: Percentages may not equal 100 due to rounding.

In 2017 the state of Colorado had *at least* 29 incidents where domestic violence resulted in a fatality and 39 people died as a result of these incidents. Of the 39 individuals killed, 18 were the primary victim of domestic violence, 3 were collateral children, 4 were collateral adults, and 14 were the primary perpetrator of domestic violence. **Table 1** shows the number and percentage of individuals killed by category. The majority (15, or 38%) were women killed by a

current or former male partner, followed by men who died by suicide (12, or 31%). Collateral deaths of men were the next most common category (4, or 10%), followed by children killed (3, or 8%). The "Other" category includes 2 deaths that resulted from law enforcement action, self-defense, etc., and represents 5% of 2017 domestic violence related deaths. The remaining categories each represented 2.5% of deaths and included 1 each of women killed by a current or former female partner, women who died by suicide, and men killed by a current or former female partner.

1. Number of People Killed in DV-Related Incidents		
Women Killed by Male Partner/Ex-partner	15	38%
Women Killed by Female Partner/Ex-partner	1	2.5%
Collateral Women Killed	0	0%
Suicides by Women	1	2.5%
Men Killed by Female Partner/Ex-partner	1	2.5%
Men Killed by Male Partner/Ex-partner	0	0%
Collateral Men Killed	4	10%
Suicides by Men	12	31%
Children Killed	3	8%
Other (LE, self-defense, etc.)	2	5%

Total Incidents: 29
Total Deaths: 39*

***18 primary DV victims (one under 18), 3 collateral children, 4 collateral adults, 14 DV perpetrators**

Table 2 describes the types of fatal domestic violence incidents that occurred in Colorado in 2017. Most common was murder only (14, or 48%) and in three of those incidents a primary domestic violence victim was killed, as well as at least one collateral victim. The next most common were incidents involving a suicide only (7, or 24%), one of which was a suicide by the primary domestic violence victim, while the other 6 were the primary domestic violence perpetrator. This number was higher in 2017 than previous years, which does not necessarily mean this type of incident increased from previous years, but this indicates that information was more readily available on those cases than has been in the past. This trend suicide within the context of domestic violence alarming and more research needs to be done in this area to understand the connections between suicide and domestic violence. Additionally, victims of domestic violence who witness and/or are impacted by the suicide of their perpetrator do not necessarily have access to resources such as Crime Victim's Compensation and the law

enforcement response to those cases may look very different than the response to a domestic violence call.

Table 2 goes on to illustrate that the third most common type of domestic violence-related fatal incidents were murder, followed by suicide by the perpetrator of domestic violence (6, or 21%). Of note, in two of those cases, the perpetrator killed the primary domestic violence victim, as well as at least one collateral victim, before killing themselves. The final two categories each represent 3% of the fatal domestic violence related incidents and include an incident where law enforcement officers shot and killed a perpetrator of domestic violence while responding to a call and an incident where a perpetrator was killed in self-defense. In the latter, the son of a primary domestic violence victim killed the perpetrator of domestic violence and it was determined by law enforcement that the son acted in self-defense.

2. Type of Fatal DV-Related Incidents		
Murder Only*	14	48%
Suicide Only**	7	24%
Murder/Perpetrator Suicide***	6	21%
Killed by LE****	1	3%
Self-defense*****	1	3%

***3 involved primary victim and collateral**
****1 was the primary DV victim**
*****2 involved primary victim and collateral**
******DV perpetrator shot during DV call after opening fire on officers**
*******primary DV victim's son killed perpetrator**

Tables 3 and 4 provide data on the locations of fatal domestic violence-related incidents occurring in 2017. The majority of incidents occurred in Jefferson County, with 5 (21%) in Lakewood and 1 in unincorporated Jefferson County. It is worth noting that 4 of the incidents that occurred in Jefferson County involved perpetrator suicides and the other 2 involved collateral deaths only, so no primary victims of domestic violence were killed in these 6 incidents. El Paso County had the next highest rate of fatal domestic violence-related incidents with 5 (17%) incidents occurring in Colorado Springs. Of these incidents, 1 was a familicide (the perpetrator killed a mother and two children, then himself), 1 involved a perpetrator killed in self-defense by the victim's son, 1 involved a collateral death, 1 was a murder/suicide that also injured two collateral victims who survived, and 1 involved a female perpetrator (predominant aggressor) who killed her male partner.

Arapahoe County had 4 (14%) fatal domestic violence related incidents in 2017, with 1 murder of a domestic violence victim occurring in Centennial, 1 perpetrator suicide in Glendale,

and 1 each murder and murder/suicide occurring in Aurora. Adams County saw 3 (10%) fatal domestic violence related incidents in 2017, with 1 murder occurring in Federal Heights, 1 murder occurring in Commerce City, and 1 murder/suicide occurring in Westminster.

Boulder County, La Plata County, and Mesa County each had 2 (7%) fatal domestic violence related incidents. In Boulder County, 1 murder occurred in the city of Boulder and 1 familicide occurred in Erie. Both incidents in La Plata County occurred in Durango, with 1 involving a murder and 1 a perpetrator suicide. Both incidents in Mesa County involved the murder of a domestic violence victim and occurred in Grand Junction.

Finally, Denver County, Gunnison County, Larimer County, Montezuma County and Pueblo County all had 1 (3%) fatal domestic violence related incident in 2017. Of these incidents, 1 involved a murder (Denver), 1 a suicide by a domestic violence victim (Gunnison), 1 a murder of a domestic violence victim and a collateral victim (Fort Collins), 1 a Law Enforcement involved shooting of a domestic violence perpetrator, and 1 a female domestic violence victim killed by a female ex-partner.

3. Fatal DV-Related Incidents by County		
Adams	3	10%
Arapahoe	4	14%
Boulder	2	7%
Denver	1	3%
El Paso	5	17%
Gunnison	1	3%
Jefferson	6	21%
La Plata	2	7%
Larimer	1	3%
Mesa	2	7%
Montezuma	1	3%
Pueblo	1	3%

4. Fatal DV-Related Incidents by City		
Aurora	2	7%
Boulder	1	3%
Centennial	1	3%
Colorado Springs	5	17%
Commerce City	1	3%
Denver	1	3%
Durango	2	7%
Erie	1	3%
Federal Heights	1	3%
Fort Collins	1	3%
Glendale	1	3%
Grand Junction	2	7%
Gunnison	1	3%
Lakewood	5	17%
Pleasant View	1	3%
Pueblo	1	3%
Unincorporated Jefferson County	1	3%
Westminster	1	3%

Table 5 describes the type of injury that resulted in death in each incident. Gunshot wounds were involved in 17 (59%) incidents, making this the most common type of fatal injury (5 of these were incidents involving suicide only). Next were blunt trauma, stab wounds, and strangulation, with 3 (10%) incidents each involving these types of fatal injury. Hanging was involved in 2 (7%) incidents, and in 1 (3%) incident, the type of injury that resulted in death was unknown because the victim was dismembered.

Table 6 goes on to provide a breakdown of the number of people killed by each type of injury. Again, gunshot wounds were the most common, with 26 (67%) people dying as a result of this type of injury. Those killed by gunshot wound included 5 suicides, 17 murders and/or murder/suicides, 1 perpetrator killed in self-defense, 1 perpetrator killed by law enforcement, and 2 additional perpetrators who killed themselves with a gun after killing their victim(s) with another method. Stab wounds resulted in 4 (10%) deaths and blunt trauma and strangulation both resulted in 3 (8%) deaths. There were 2 (5%) suicides by hanging and, again, one victim's cause of death was unknown due to the body having been dismembered.

5. Fatal DV-Related Incidents by Injury Type		
Gunshot wounds*	17	59%
Blunt Trauma	3	10%
Stab wounds	3	10%
Strangulation	3	10%
Hanging**	2	7%
Unknown***	1	3%

*5 were suicide
**Both were suicides
***Victim's body was dismembered

6. DV-Related Deaths by Injury Type		
Gunshot wounds*	26	67%
Stab wounds	4	10%
Blunt Trauma	3	8%
Strangulation	3	8%
Hanging	2	5%
Unknown	1	2%

*5 were suicide only, 17 were murder or murder/suicide, 1 was a perpetrator killed in self-defense, 1 was a perpetrator killed by responding Law Enforcement, 2 perpetrators used a gun for suicide, but another method for homicide (stabbing, strangulation)

Tables 7 through 10 provide information about the ages of individuals killed in fatal domestic violence related incidents. Of the domestic violence victims killed in 2017, the youngest was 17 and the oldest 55, with an average age of 32. Of the domestic violence perpetrators killed, the youngest was 19 and the oldest 60, with an average age of 29. Age was unknown for 2 of the domestic violence perpetrators killed. Adult collateral victims killed ranged in age from 20 to 45, with an average age of 31, and of the child collateral victims killed, 2 were 5 years old and 1 was 8 years old.

7. Ages of DV Victims Killed	
17	1
18	1
21	1
22	1
24	1
26	2
27	1
31	1
32	1
33	2
37	1
40	2
43	1
53	1
55	1
Average Age	**32**

8. Ages of DV Perpetrators Killed	
19	1
24	1
28	1
30	2
38	1
42	1
43	1
48	2
53	1
60	1
Unknown	2
Average Age	**29**

9. Age of Collateral Adult Victims Killed	
20	1
26	1
32	1
45	1
Average Age	**31**

10. Age of Collateral Child Victims Killed	
5	2
8	1
Average Age	**6**

Finally, **Table 11** provides a comparison of the number of domestic violence-related fatalities in Colorado over the past five years, based on information obtained from media sources and/or reported to the DMDVFR and the Colorado Domestic Violence Fatality Review Board. Definitions of the types of fatalities reference above can be found in Appendix B of this report and complete lists with descriptions of fatal domestic violence related incidents in Colorado can be found at www.DDVCC.org/fatality-review. Questions about this data should be directed to DMDVFR staff at 303-522-0932 or via email denverdvcouncil@gmail.com.

11. Year	2013	2014	2015	2016	2017
Total Deaths (at least)	42	38	37	58	39

VIII. 2017 Case Review Data on Domestic Violence Related Fatalities

A. Case Review Data Collection

The following data is based on cases reviewed in 2017 by Domestic Violence Fatality Review Teams (DVFRTs) in Colorado. Cases are selected for review based on several factors, including status of the case (must be closed with no civil action pending), availability of records, recommendations by DVFRT members, and incident location. In 2017, there were two active DVFRTs in Colorado. The Denver Metro Domestic Violence Fatality Review team encompasses the 1st, 2nd, 17th, and 18th Judicial Districts and meets monthly, conducting 6-8 case reviews per year and rotating between judicial districts. The 21st Judicial District formed a DVFRT in 2016 and has reviewed 4 cases to date. They meet monthly and select cases by consensus, with each DVFRT member playing a role in gathering information for case reviews, which occur every six to eight months. Since the passage of SB 2017-126 and the creation of the CDVFRB, a DVFRT also formed in the 9th Judicial District in 2018 and has reviewed three cases to date.

Case information is compiled with the cooperation of respective law enforcement agencies and/or prosecutors' offices, as well as any other entities authorized to release information related to the case. The case is then presented to members of the respective DVFRT and a coding manual is completed and data is analyzed by Dr. Joanne Belknap, Department of Ethnic Studies at the University of Colorado Boulder. The following report provides detailed information about the findings of Dr. Belknap's research, based on data from the seven cases reviewed by DVFRTs in Colorado in 2017. The complete coding manual and more information on case review procedures are available at the following web link: https://ddvcc.org/fatality-review.

B. 2017 Case Review Findings

Table 1 lists the locations and dates of the cases reviewed in 2017 by Domestic Violence Fatality Review Teams (DVFRTs) in Colorado and shared with the Colorado Domestic Violence Fatality Review Board. Specifically, of the seven cases reviewed, 28.6% (n = 2) occurred in Aurora (Arapahoe County), another 28.6% (n = 2) occurred in Denver (Denver County), and there was one case (14.3%) each that occurred in Commerce City (Adams County), Lakewood (Jefferson County), and Mesa (Mesa County). The fatal incidents most often occurred in the victims' and perpetrators' joint residence (n = 3, or 42.9%), followed by the victim's sole residence (n = 2, or 28.6%). In one case, the incident occurred at the perpetrator's sole residence (14.3%) and another at the victim's place of work (14.3%).

Recent research has found that when the victim and perpetrator were in an intimate relationship at the date of incident (DOI), the fatal incident was more likely to occur at the victim's sole residence (Yousuf et. al., 2017). Perpetrator deaths occurred at the victim's residence (n = 1, or 14.3%), victim and perpetrator joint residence (n = 1, or 14.3%), and the victim's place of work (n = 1, or 14.3%). Given that Colorado's legislation related to the work of DVFRTs states that cases must be closed in order to be reviewed, and a trial may take years, cases reviewed are those that occurred one to many years prior. The majority of cases reviewed by Colorado DVFRTs in 2017 were primarily from 2016 (n =3, or 42.9%), followed by 2012 (n = 2, or 28.6%), and one case each (14.3%) in 2015 and 2011. Almost three-fifths of the incidents occurred in February (n =3, or 42.9%), with the remainder, one (14.3%) each, in June, September, and November.

Table 1: Locations and Dates of Fatal Incidents (N = 7)

	%	(n)
City, County		
Aurora, Arapahoe	28.6	(2)
Commerce City, Adams	14.3	(1)
Denver, Denver	28.6	(2)
Lakewood, Jefferson	14.3	(1)
Mesa, Mesa	14.3	(1)
Site of Incident[a]		
Victim's & Perpetrator's Joint Residence	42.9	(3)
Victim's Residence	28.6	(2)
Perpetrator's Residence	14.3	(1)
Victim's Work	14.3	(1)
Year of Incident		
2011	14.3	(1)
2012	28.6	(2)
2015	14.3	(1)
2016	42.9	(3)
Month of Incident		
February	57.1	(4)
June	14.3	(1)
September	14.3	(1)
November	14.3	(1)

[a]Perpetrators' suicides occurred one each in a joint residence, the victim's residence, and the victim's place of work.

Table 2 summarizes the victim-perpetrator relationships in cases reviewed. Four (57.1%) were married on the DOI, which is consistent with the findings of a recent British study (Sebire, 2017). These marriages ranged from 11 months to 16 years, and the length of the intimate partner relationship for the unmarried couples ranged from 1 to 4.5 years. In four of the intimate partner relationships (57.1%), the parties were separated at the DOI. These separations ranged in length from 2 weeks to 2 months. None of the couples were divorced at the DOI and none of the victims were pregnant.

Table 2: Victim-Perpetrator Relationship

Ever married to each other	7	57.1	(4)
Still married on DOI	7	57.1	(4)
Divorced on DOI	7	0.0	(0)
Separated on DOI	7	57.1	(4)
Victim was pregnant on DOI	7	0.0	(0)

Table 3 describes the demographic characteristics of the domestic violence victims and perpetrators. All seven of the intimate partner relationships in the cases reviewed were different-sex (as opposed to same-sex) couples, and in every case the perpetrator was male and the victim female. This is consistent with Fox and Fridel's (2017) recent review of national intimate partner homicide (IPH) data, which found that the rate of women killing men, as the primary aggressor (i.e., not in self-defense), is decreasing.

The domestic violence victims' ages ranged from 31 to 73 years old, with an average age of 40 years old. The perpetrators' ages ranged from 31 to 61 with an average of 47 years old. Four (57.1%) of the victims were White, two (28.6%) were Latina, and one (14.3%) was African American. Two-thirds (n = 4, 66.7%) of the perpetrators were Latino, one (16.7%) was White, and one (16.7%) was African American (The race was unknown for one of the perpetrators). All 7 victims and all 7 perpetrators were U.S. citizens.

Of the five perpetrators for whom employment at DOI was known, two were unemployed (n = 2, 40.0%), another two were underemployed (n = 2, 40.0%), and one perpetrator was illegally employed (n = 1, 20.0%). Of the six victims for whom employment at DOI was known, half (n = 3) were legally employed, one (16.7%) was retired, one (16.7%) was disabled and on SSDI, and one (16.7%) was illegally employed. Educational data were largely unknown, particularly for the

perpetrators. Of the four victims for whom education was known, there was one each (25.0%) categorized as “some high school,” “a high school graduate”, “technical school”, and “some college”. The two known educational attainments of perpetrators were half “some high school” and half “some college.”

There was no indication that any of the victims suffered from mental illness, but there was indication that one (14.3%) of the perpetrators suffered from mental illness (bi-polar diagnosis). Of the six known disability statuses at DOI among the victims, one (16.7%) was disabled (developmental disability). Of the four known disability statuses among the perpetrators, none were disabled. The military status was unknown for any of the perpetrators. None of the seven victims had ever served in the military.

Table 3: Victim and Perpetrator Characteristics (N = 7)

Characteristic	Victim			Perpetrator		
	N	%	(n)	N	%	(n)
Age[a]	7			7		
25 and Younger		0.0	(0)		0.0	(0)
26-40		28.6	(2)		28.6	(2)
41-55		57.1	(4)		42.9	(3)
56+		13.3	(1)		28.6	(2)
Gender/Sex						
Female	7	100.0	(7)	7	0.0	(0)
Male		0.0	(0)		100.0	(7)
Ethnicity	7			6		
White		57.1	(4)		16.7	(1)
Latina/o		28.6	(2)		66.7	(4)
African American		14.3	(1)		16.7	(1)
Asian American		0.0	(0)		0.0	(0)
Native American		0.0	(0)		0.0	(0)
Other		0.0	(0)		0.0	(0)
Is a U.S. Citizen	7	100.0	(7)	7	100.0	(7)
Employment Status	6			5		
Legally Employed		50.0	(3)		0.0	(0)
Unemployed		0.0	(0)		40.0	(2)
Retired		16.7	(1)		0.0	(0)
Disabled/SSI		16.7	(1)		0.0	(0)
Student		0.0	(0)		0.0	(0)
Underemployed		0.0	(0)		40.0	(2)
Illegally Employed		16.7	(1)		20.0	(1)
Education	4			2		
Some high school		25.0	(1)		50.0	(1)

High School Grad.		25.0	(1)		0.0	(0)
Technical School		25.0	(1)		0.0	(0)
Some College		25.0	(1)		50.0	(1)
College Graduate		0.0	(0)		0.0	(0)
Post Graduate		0.0	(0)		0.0	(0)
Indication of Mental Illness	7	0.0	(0)	7	14.3	(1)
Disability	6	16.7	(1)	4	0.0	(0)
Military Status	7	0.0	(0)	0	----	-----

[a]Victim ages ranged from 31-73 years ($\mu = 40.0$). Perpetrator ages ranged from 31-61 ($\mu = 46.7$).

Table 4 reports on the near, attempted and actual fatalities in the cases reviewed. Two (28.6%) of the cases involved one death, whereby the perpetrator murdered the DV victim. Two (28.6%) of the cases involved the perpetrator murdering the victim and then killing himself. One (n = 1, 14.3%) case involved the perpetrator murdering the victim's daughter, and then killing himself. Two (28.6%) of the cases were determined by law enforcement to be self-defense killings, whereby the victim killed the perpetrator in self-defense. Charges were either never filed or dismissed in both of these cases. In one of these cases, the victim attempted suicide while on the phone with 911 when she called the police to report having killed her partner (in self-defense).

Table 4 also includes the number and cause of the deaths. Among the cases reviewed, there were ten fatalities. Specifically, four (57.1%) of the cases involved one death and three (42.9%) involved two deaths. Sixty percent (n = 6) of the total deaths across the seven cases were by gunshot. In two of these cases, the perpetrators fatally shot their victims and then themselves. In another, the perpetrator fatally shot his partner's daughter (the only collateral victim in the cases reviewed) and then himself.

In both cases of fatalities caused solely by stabbing, the self-defending victims had their charges dismissed because they were found to be the primary victims acting in self-defense against their perpetrators. In one case a perpetrator used both strangulation and stabbing with a screwdriver to kill his victim, and in another, the perpetrator combined strangulation and trauma with a blunt object to kill his partner.

Among these cases, there were no attempted murders/near-deaths and all three of the completed suicides were by male perpetrators who fatally shot themselves. Two shot themselves after fatally shooting their victims, and the third fatally shot himself after killing his primary victim's daughter. As noted, among the cases, there was one attempted suicide and it was by a

victim who had just killed the perpetrator in self-defense. None of the cases involved the police or someone else (other than the victim) killing the perpetrator. Notably, consistent with a recent study using National Incident-Based Reporting System (NIBRS) data, the men were more likely to kill using guns and the women were more likely to kill by stabbing with a knife (Addington & Perumean-Chaney, 2014).

Table 4: Case Type and Fatalities (N = 7 Cases)

	%	(n)
Type of Crime/IPH		
Murder ("Only" Death)	28.6	(2)
Murder & Suicide	28.6	(2)
Collateral Death & Suicide	14.3	(1)
Self-Defense Murder ("Only" Death)	14.3	(1)
Self-Defense Murder & Attempted Suicide	14.3	(1)
Number of Deaths/Fatalities per Incident		
0	0.0	(0)
1	57.1	(4)
2	42.9	(3)
Cause of Death (N = 10 Deaths)		
Gunshot Wound	60.0	(6)
Stabbing	20.0	(2)
Stabbing & Strangulation	10.0	(1)
Blunt Trauma & Strangulation	10.0	(1)
Attempted Murder/Near Death	0.0	(0)
Collateral Death[a]	14.3	(1)
Completed Suicide[b]	42.9	(3)
Attempted Suicide[c]	14.3	(1)
Perpetrator Killed by Victim in Self-Defense[d]	28.6	(2)
Perpetrator Killed by Police or Someone Else	0.0	(0)

[a]Daughter of primary victim
[b]All completed suicides were perpetrators by gunshot.
[c]One victim who killed in self-defense attempted suicide while on phone to the police.
[d]Both of these were victims who fatally stabbed their perpetrators.

Table 5 summarizes the perpetrators' and victims' criminal histories prior to the DOI. Of the six cases where criminal history data were available for the perpetrators, 83.3% (n = 5) had prior domestic violence arrests. Of the five perpetrators with known prior domestic violence arrests, one had one such prior arrest, one had two, one had 4, and one had 8; number of domestic violence arrests was unknown for one perpetrator known to have prior arrests. Within the five years prior to the DOI, two perpetrators had one domestic violence arrest and one had three domestic violence arrests.

Among the six perpetrators for which there was prior domestic violence conviction information available, two had no prior convictions, one had one, one had two, one had 4, and one had eight prior domestic violence convictions. Among the six perpetrators for which there were conviction data on the past five years, five had no domestic violence convictions in the past five years, one had "only" one such conviction, and one had three domestic violence convictions in the prior five years. Notably, one perpetrator had a total of eight prior domestic violence arrests and convictions.

Three of the victims had domestic violence arrests prior to the DOI. Among these three victims with prior arrests, they had one, two, and three prior domestic violence arrests. In the previous five years, four of the victims had no domestic violence arrests, two had one and one had two such arrests. For the three victims with prior domestic violence convictions, two had one prior domestic violence conviction and the other had three prior such convictions. Among the six victims, three had one domestic violence conviction in the past five years. Notably, all three of the victims with prior domestic violence arrests were convicted of domestic violence, while two-thirds (66.7%, n = 4) of the six known perpetrators with prior domestic violence arrests were convicted of these crimes.

Table 5: Perpetrators' and Victims' Criminal History (N = 7)

Event History	Victim			Perpetrator		
	N	%	(n)	N	%	(n)
Prior DV Arrests	7	42.9	(3)	6	83.3	(5)
Number of DV Arrests	7			5		
0		57.1	(4)		20.0	(1)
1		14.3	(1)		20.0	(1)
2		14.3	(1)		20.0	(1)
3		14.3	(1)		0.0	(0)
4+[a]		0.0	(0)		40.0	(2)
Number of DV Arrests Past 5 Years	7			5		
0		57.1	(4)		50.0	(2)
1		28.6	(2)		33.3	(2)
2		14.3	(1)		0.0	(0)
3		0.0	(0)		16.7	(1)
Prior DV Convictions	7	42.9	(3)	6	66.7	(4)
Number of DV Convictions	6			7		
0		57.1	(4)		28.5	(2)
1		14.3	(1)		16.7	(1)
2		0.0	(0)		16.7	(1)
3		14.3	(1)		0.0	(0)
4+ [a]		0.0	(0)		42.8	(3)
Number of DV Convictions Past 5yrs	7			7		
0		57.1	(4)		71.4	(5)
1		42.9	(3)		16.7	(1)
2		0.0	(0)		0.0	(0)
3		0.0	(0)		16.7	(1)
Arrests for other Assaults or non-Drug/Alcohol Offenses (yes)	7	42.9	(3)	7	85.7	(6)
Attend DV Intervention/Treatment	3	0.0	(0)	2	50.0	(1)
DUI/Possession Arrest	7	42.9	(3)	6	83.3	(5)
Protection Order Arrest	6	16.7	(1)	6	33.3	(2)
On Probation at DOI	4	0.0	(0)	3	0.0	(0)
On Parole at DOI	6	0.0	(0)	4	25.0	(1)

[a]Perpetrator DV arrests and convictions both ranged from 1 to 8.

Table 6 provides the findings on who knew about prior domestic violence in the intimate partner relationships. This is divided into potential supporters in the victims' social spheres and potential system/official supporters. This is still included in this report, although there is a fair amount of missing data. The available data located indicate that the most frequently known individual in the victims' social lives who knew about the domestic violence were a friend(s) (66.7%), followed by a parent(s), a sibling(s), a religious official (e.g., clergy), and a neighbor. Each of these kinds of individuals were found to be 50% of the "who knew" among potential social supporters. There was no indication of the victims' coworkers knowing about the domestic violence. Neither was there any indication that childcare/teachers/schools knew about the domestic violence. Notably, there was no account of the perpetrators' parents, siblings, friends, or coworkers knowing about the domestic violence.

Table 6: Who Knew of DV (N = 7)

Identities of People/Agencies Who Knew	**N**	**%**	**(n)**
Potential Social Supporter			
Victim's Friend(s)	3	66.7	(2)
Clergy/Religious Person(s)	4	50.0	(2)
Neighbor(s)	4	50.0	(2)
Victim's Parent(s)	2	50.0	(1)
Victim's Sibling(s)	2	50.0	(1)
Perpetrator's Friend(s)	2	0.0	(0)
Perpetrator's Parent(s)	1	0.0	(0)
Perpetrator's Sibling(s)	1	0.0	(0)
Victim's Coworker(s)	1	0.0	(0)
Perpetrator's Coworker(s)	1	0.0	(0)
Childcare staff/Teacher/School	2	0.0	(0)
Potential System Supporter			
Police/Sherriff	6	83.3	(5)
Civil Court (e.g., divorce or custody)	3	33.3	(1)
Attorney/Legal Services	3	0.0	(0)
Medical Provider (e.g., nurse or doctor)	3	0.0	(0)
Social Services/Child Protection	5	0.0	(0)
DV Shelter	2	0.0	(0)

[a]The relationships of "who knew" about the DV is listed in the order of frequency they were indicated across the reviewed cases, not in the order they are listed in the codebook.

Table 7 reports on the criminal legal system outcomes. Given that in three of these seven cases the perpetrators died by suicide, their cases were not prosecuted. As previously noted, two of the seven cases were determined to be victims who killed their perpetrators in self-defense. In the remaining two cases, charges were filed against the perpetrators, and in both cases the charges filed at arrest were for first-degree murder. One of these cases went to trial and in the other the perpetrator accepted a plea deal. The perpetrator who went to trial was convicted of first-degree murder and the one who accepted a plea deal plead to second-degree manslaughter. The perpetrator convicted of first-degree murder received a sentence of life in prison without parole and the perpetrator who plead guilty to second-degree manslaughter was sentenced to seventy-two years in prison.

Table 7: Criminal Legal System Response to the Incident

System Response	N	%	(n)
Charges Filed at Arrest	7		
1st Degree Murder		28.6	(2)
2nd Degree Murder		0.0	(0)
Manslaughter		0.0	(0)
N/A Perpetrator Suicided		42.9	(3)
No Charges: Self-Defending Victims		28.6	(2)
Process[a]	2		
Went to Trial		50.0	(1)
Accepted a Plea Bargain		50.0	(1)
Charges Dropped		0.0	(0)
Disposition	2		
1st Degree Murder		50.0	(1)
2nd Degree Murder		0.0	(0)
Conspiracy to Commit Murder		0.0	(0)
1st Degree Manslaughter		0.0	(0)
2nd Degree Manslaughter		50.0	(1)
Sentence	2		
Probation		0.0	(0)
1 – 10 years		0.0	(0)
11- 20 years		0.0	(0)
21-30 years		0.0	(0)
31-40 years		0.0	(0)
41+ years		50.0	(1)
Life without Parole		50.0	(1)

[a]Given that 2 perpetrators were processed as killing in self-defense and 3 perpetrators suicided, there were only 2 cases when charges, processes, disposition, and sentencing were meaningful.
[b]The one perpetrator who received determinate sentencing (not LWOP), was sentenced to 72 years.

Finally, **Table 8** reports on the presence of "red flags" within the intimate partner relationship and is based on information of known red flags for each of the seven cases reviewed. Notably, the most common red flag was the perpetrators' history of domestic violence assaults —in all cases the perpetrator had a history of domestic violence assaults. The next most frequently occurring red flags, indicated in 85.7% (n = 6) of the cases were perpetrator underemployment or unemployment and perpetrators' possessiveness of their victims. The next most frequently occurring red flags, indicated in 71.5% (n = 5) of the cases were perpetrators' stalking/monitoring their victims, perceived loss of control, history of alcohol/drug abuse, history of non-domestic violence assaults, and financial dependence on their victim. The next most common red flags, indicated in 57.1% (n = 4) were estrangement of the victim, threats to kill the victim, pending legal actions, and the perpetrator believing or knowing the victim was in a new intimate relationship.

In three (42.9%) of the seven cases, there was evidence of the intimate partners' imminent separation, perpetrators' loss of housing, a whirlwind courtship/relationship, violation of protection orders, emotional dependence on the victim, escalated threats of suicide, prior non-fatal strangulation, perpetrator known to carry a weapon, perpetrator known to use a weapon, perpetrators feeling abandonment/betrayal, perpetrators' death of a close friend or family member, and perpetrators dependent on victims for social interaction.

In one of the seven cases, there were stepchildren in the home, loss of perpetrator's coping mechanisms, perpetrator being obsessed with weapons, perpetrator exploiting "caretaking" victims, the victim and perpetrator meeting "one last time," perpetrator decompensation, perpetrator's changes in daily living, perpetrators' known mental health diagnosis or issues, and perpetrator's threats to kill the victim's children, family or friends. In these seven cases there was no evidence of the following red flags: perpetrators' gambling, unusual enmeshment with their mothers, prior threats to the victim with a firearm, believing or knowing the victim is pregnant, or a history of animal cruelty.

Table 8: Red Flags Checklist (N = 7)

Known Red Flag[a]	%	(n)
History of Domestic Violence Assaults	100.0	(7)
Perpetrator Underemployed/Unemployed	85.7	(6)
Possessiveness of Victim	85.7	(6)
Stalking/Monitoring	71.4	(5)
Significant Loss of Perceived Control	71.4	(5)
History of Drug/Alcohol Abuse	71.4	(5)
History of non-DV Assaults	71.4	(5)
Financially Dependent on Victim	71.4	(5)
Estrangement/Separation from Victim	57.1	(4)
Threat to Kill Victim	57.1	(4)
Pending Legal Actions	57.1	(4)
Believes or Knows Victim is in New Relationship	57.1	(4)
Financial Struggles	57.1	(4)
Separation Imminent	42.9	(3)
Violation of Protection Orders	42.9	(3)
Significant loss of housing	42.9	(3)
Emotionally Dependent on Victim	42.9	(3)
Access to Firearm	28.6	(2)
Whirlwind Courtship/Relationship	28.6	(2)
Escalated Threats of Suicide	28.6	(2)
Prior Strangulation Attempts	28.6	(2)
Known to Carry a Weapon	28.6	(2)
Known to Use a Weapon	28.6	(2)
Experiencing Feelings of Abandonment/Betrayal	28.6	(2)
Death of Close Friend/Family Member	28.6	(2)
Dependent on Victim for Social Interaction/Support	28.6	(2)
Stepchildren in the Home	14.3	(1)
Threat to Kill Victim's Children, Family, &/or Friends	14.3	(1)
Significant Loss of Mechanisms	14.3	(1)
Indication of Obsession with Weapons	14.3	(1)
Exploits Victim's Tendency to "Caretake"	14.3	(1)
Perpetrator and Victim Meet "One Last Time"	14.3	(1)
Decompensation Indication	14.3	(1)
Perpetrators Changes in Daily Living	14.3	(1)
Known Mental Health Issues/Diagnosis	14.3	(1)
Prior Threats with Firearm	0.0	(0)
Believes Victim is Pregnant	0.0	(0)
History of Animal Cruelty	0.0	(0)
Unusual Enmeshment with Mother	0.0	(0)
Gambling	0.0	(0)

[a]If anything, these red flags are underreported. All cases coded as "yes" are "known." In addition to "nos" coded as "no," so are missing data cases reported as "nos." The red flags are listed in the order of frequency they were indicated across the reviewed cases, not in the order they are listed in the codebook.

IX. Appendices

A. Colorado Domestic Violence Fatality Review Board Members

B. Guidelines for a Domestic Violence Fatality Review Team

C. Local Domestic Violence Fatality Review Team Packet

D. List of Trainings Related to Statewide Domestic Violence Fatality Review

Appendix A: Colorado Domestic Violence Fatality Review Board Members

By statute, the number of Board members must be at least seventeen and no more than 20. The list below includes recommendations for 19 members. The Attorney General constitutes the 20th member.

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

    - **Tomie Kuehl, MPA, Interpersonal Violence Prevention Unit Supervisor**

3. Colorado District Attorneys' Council Designee

    - **Allison Rocker, Senior Deputy District Attorney, Domestic Violence Prosecution Specialist at Rose Andom Center (Initial Designee)**
    - **Brian Mason, Chief Trial Deputy District Attorney, 17th Judicial District Attorney's Office (Current Designee)**

4. Criminal Defense Attorney

    - **David J. Thomas, JD, O'Brien, Thomas & Bibik, LLC**

5. Denver Metro Domestic Violence Fatality Review Committee

    - **Linda Johnston, EVAW Project Director, Colorado District Attorney's Council**

6. Department of Human Services' Adult Protection Services

    - **Kathleen Calderon, Adult Protection Services Specialist, Division of aging and Adult Services, Office of Access and Independence**

7. Department of Human Services' Child Protection Services

    - **Lucinda Connelly, Manager, Child Protection Services Unit, Division of Child Welfare, Office of Children, Youth and Families**

8. Domestic Violence Survivor (one of two positions)

    - **Tracey Swindle, RN, FRN, Emerus SCL Health**

9. Domestic Violence Survivor (second of two positions)

    - **Phillip Clark, Senior Facilities Technician, LenderLive**

10. Domestic violence advocate representing a shelter or other domestic violence service organizations

    - **Carmen Hubbs, Executive Director, Rise Above Violence (aka Archuleta County Victim Assistance Program), 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

    - **Dr. Brenna Dee Tindall, Director Treatment and Evaluation Services, Ft. Collins-Greeley**

13. Judge or magistrate

    There are two candidates for consideration for this position:

    - **Judge Shannon Gerhart, 4th Judicial District, El Paso County Court,**

14. Law enforcement agency

    - **Sgt. Lonnie Chavez, Grand Junction Police Department**

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, Probation Officer Supervisor, Pretrial Services and Electronic Monitoring, City and County of Denver, Department of Safety, Division of Criminal Corrections**:

17. Statewide nonprofit organization that offers training and expert advice to domestic violence programs that serve survivors of domestic violence, dating violence, and stalking

    - **Deborah Bittner, Division Director, Domestic Violence Services, Family Tree**

18. Attorney General Selected Appointee (first of two):

- **Andrew Steers, Senior Deputy District Attorney, 18th Judicial District**:

19. Attorney General Selected Appointee (second of two):

- **Jan Schiller, Executive Director, S.H.A.R.E., Fort Morgan**

Appendix B: Guidelines for a Domestic Violence Fatality Review Team

Developed by the Denver Metro Violence Fatality Review/Denver Domestic Violence Coordinating Council (© 2018) and endorsed by the Colorado Domestic Violence Fatality Review Board

Definitions:

Coding Manual: Data collection tool approved by the Colorado Domestic Violence Fatality Review Board (CDVFRB). When completing the coding manual, victim and perpetrator information should refer to the parties determined to be the victim and perpetrator of domestic violence within an intimate partner relationship, even if the deceased is not the primary domestic violence victim (e.g., primary domestic violence victim kills the perpetrator in self-defense and/or the deceased is a collateral death and primary DV victim/perpetrator survive).

Collateral Death: The death of a person, other than the person with whom the perpetrator was involved in an intimate relationship, which occurred in the context of domestic violence.

DOI: Date of incident. This is the date that the incident resulting in a domestic violence related fatality occurred. The date of any related death(s) may differ from this (e.g., perpetrator dies by suicide at a later date and/or victim is kept alive on life support and dies at a later date).

Domestic Violence Fatality Review Team (DVFRT): A local or regional group of professionals who review incidents that occurred in the context of an intimate partner relationship and result in death (e.g., murder, murder/suicide, collateral death). Refer to C.R.S. § 24-31-703 for more information on membership.

Domestic Violence Perpetrator: The party within an intimate partner relationship determined to be the predominant aggressor or person inflicting abuse on their intimate partner. This may not always be the person listed as the offender in a domestic violence fatality case; some victims may use self-defending behavior against the person who is abusing them.

Domestic Violence Victim: The party within an intimate partner relationship determined to be/have been experiencing abuse by intimate partner. This may not always be the person listed as the victim in a domestic violence fatality case; some victims may use self-defending behavior against the person who is abusing them.

Familicide: a type of murder or murder/suicide in which a perpetrator kills multiple close family members in quick succession, most often children, spouse, siblings, or parents.

Fatality: The death of any person resulting from an incident determined to be an act of, or in the context of, domestic violence or intimate partner abuse.

Murder: The death of one person resulting from the deliberate actions of another person in the context of an intimate partner relationship.

Murder/Suicide: An event resulting in the death of a person from the deliberate actions of another person who subsequently takes their own life, in the context of a current or former intimate partner relationship.

Near Death: An injury to a person at the hands of an intimate partner whereby that injury could likely result in the death of that person. A near death case could also include any of the above listed types of fatalities (e.g., attempted murder/suicide, attempted murder/collateral death).

Red Flags Check List: A list of factors, many of which have been proven by research to represent risk factors in intimate partner violence that results in death.

Suicide: The death of a person who takes their own life in the context of intimate partner abuse/domestic violence (e.g., abusive partner takes their own life in front of non-abusive partner during an argument or with the intention of the non-abusive partner discovering them. This could also include cases where a victim takes their own life to escape abuse).

Local DVFRT Members: DVFRTs should include individuals with expertise or experience in the field of intimate partner abuse and should reflect the racial and ethnic makeup of the city, county or judicial district. The local DVFRT makeup should follow the recommendations specified in the C.R.S. § 24-31-703 as closely as possible.

Purpose:

The purpose of a DVFRT is to review and analyze domestic violence related fatalities and/or near death incidents. The information is compiled and presented to a multidisciplinary team in order to identify red flags present, interventions utilized, and possible interventions missed. This data is complied, analyzed and used to develop reports and recommendations that will potentially improve risk assessment and safety planning for victims, their families and friends, and the community. Findings can also influence policies and practices related to perpetrator containment and accountability. This work enhances advocacy efforts to effectively leverage the civil and criminal legal systems to help victims achieve long-term safety for themselves and their families. The success of a statewide domestic violence fatality review process will necessitate the most varied expertise of the DVFRT members, as well as drawing on the most current research and practices regarding risk assessment and management.

Procedures:

Each DVFRT may select a closed case, with no pending civil actions, that is recommended by a team member in that community and/or included on the statewide list, to review (if your DVFRT identifies a case that is not included on the statewide list for the year in which it occurred, please submit case information at https://ddvcc.org/fatality-review). Case information is compiled with the cooperation of respective law enforcement agency and/or prosecutors' office, as well as any other entities authorized to release information related to the case. It is also helpful to complete a Google search on the parties involved in case review, as well as looking them up on social media to gather supplemental information that may provide more context for the review. A PowerPoint presentation should be created and presented to the multi-disciplinary DVFRT, followed by discussion about risk factors, interventions used and interventions missed and gaps that may have been present in the incident. Keep in mind that this is a very time and resource consuming; preparation for a case review presentation can take 10-12 hours, possibly more.

When possible, it is helpful to invite anyone who was involved in the case, or has knowledge of the victim and/or perpetrator, to be present for the review (i.e., detectives, prosecutors, victim advocates). If there is a member of the team who has the authority to access criminal background and/or child or adult protective services information, send them the names and birthdates of the parties involved prior to the case review meeting. They may not be able to provide that information directly the parties presenting the case review, but may be able to attend the meeting and share such information with the group during the discussion. It is also helpful to assign a note-taker for case reviews, in order to capture information that comes up in the discussion, which may not be recorded elsewhere. All participants are required to sign a confidentiality agreement, pursuant to C.R.S. 24-31-704 and case review materials are not to be shared outside of this meeting, unless identifying information has been redacted.

The group should use a consensus process to complete a Red Flags Checklist, which is based on a large body of research, as well as common factors that have been observed and recorded over the past twenty+ years. DVFTRs should use the Red Flags Checklist and Coding Manual (modeled after instruments established and utilized by the Denver Metro Domestic Violence Review) selected by the Colorado Domestic Violence Fatality Review Board (CDVFRB), pursuant to C.R.S. § 24-31-703. A master Red Flags Checklist will be created with factors compiled from all Red Flags checked during the review. The case review PowerPoint, Red Flags Checklist, and any additional meeting notes are then used to complete the Coding Manual for each case reviewed. The completed Coding Manual, Master Red Flags Checklist, and case review PowerPoint should then be submitted via email to the Denver Metro Domestic Violence Fatality Review (DMDVFR), to be entered into a research database and analyzed by Dr. Joanne Belknap, University of Colorado, and her research assistants. The resultant findings will be used to produce an annual report and incorporated into the current body of research. To view past reports and published research, please visit https://ddvcc.org/fatality-review.

If questions or concerns arise at any time during the process of forming a local DVFRT, selecting or conducting a case review, and/or completing the coding manual, you may contact the DMDVFR at denverdvcouncil@gmail.com or 303-522-0932. This team has over 20 years of experience related to domestic violence fatality reviews, has consulted with DVFRs nationwide and presented at national conferences on the topic. The DMDVFR has been referenced as the most research based domestic violence fatality review process in the country and has been designated by the CDVFRB as the official provider of training and technical assistance for DVFRTs in Colorado.

Basic information on domestic violence fatality cases (reviewed by a DVFRT or not) should be submitted for inclusion in the statewide DV fatality list online at https://ddvcc.org/fatality-review or by contacting the DMDVFR at denverdvcouncil@gmail.com or 303-522-0932.

Appendix C: Local Domestic Violence Fatality Review Team Packet

C.R.S. § 24-31-702(2)(a) encourages the formation of local domestic violence fatality review teams in judicial district. To assist local teams, the Colorado Domestic Violence fatality review Board work with the Denver Metro Domestic Violence Fatality Review Team on a standard Local Domestic Violence Fatality Review Team Packet.

The packet consists of the following:

- Community Readiness Form
- Guidelines for Domestic Violence Fatality Review Team
- Guest and Member Confidentiality Agreement
- Case Review Checklist
- Red Flags Checklist
- Colorado Domestic Violence Fatality Review Codebook
- Domestic Violence Fatalities Data Submission Form

The documents are designed to assist local teams in conducting review of closed domestic violence fatality cases in their judicial district in order to better understand ways to improve policies and practices to prevent future fatalities. In addition, the codebook and data submission form provide a means for the local fatality review funding to be submitted to the Colorado Domestic Violence Fatality review Board along with any policy and practice recommendations for consideration at the state level.

Each of the above documents are available at the following web link:

https://ddvcc.org/fatality-review

Appendix D: 2018 Trainings Related to Domestic Violence Fatality Review and Prevention

1. **"Domestic Violence Fatality Review: Establishing and Managing Intimate Partner Death Review Teams,"** sponsored and conducted by the Colorado District Attorney's Councils Ending Violence Against Women Project. February 21, 2018**.**

2. **"Strangulation: The Last Warning Shot,"** sponsored by the Colorado Office of the Attorney General and conducted by Alliance for HOPE International. October 3, 2018.

3. **"Domestic Violence Fatality Review Team Training**," co-sponsored by the Colorado office of the Attorney General and the National Domestic Violence Fatality Review Institute, and co-conducted with the Denver Metro Domestic Violence Fatality Review Team staff. October 28, 2018