MULTNOMAH COUNTY
FAMILY VIOLENCE
COORDINATING COUNCIL

Multnomah County Domestic Violence Fatality Review Team: 2025 Case Review

Domestic Violence Fatality Review Team

December 2025

Dedication

This report is dedicated to the loved ones of homicide victims who have lost their lives in Multnomah County as a result of domestic violence (DV). DV homicides have a profound impact on the family and friends of both the victim and the perpetrator. These preventable tragedies have ripple effects that spread trauma through the victims' and perpetrators' communities for generations. The goal of the Domestic Violence Fatality Review Team (DVFRT) is to prevent DV fatalities so survivors, abusers, and their loved ones do not endure the devastating impacts of a fatal tragedy. Thank you to all the individuals that provided information to the DVFRT for our 2025 case review. We could not have created the recommendations outlined in this report without you.

Trauma Exposure Warning

This report contains information about domestic violence homicides that have occurred in Multnomah County. By reading this report, you may be exposed to vicarious or secondary trauma. If you have lost someone to domestic violence or if you are a domestic violence survivor, we encourage you to be mindful of your body's response to this report and to take care of yourself during and after reviewing this report.

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Introduction

The Multnomah County Domestic Violence Fatality Review Team (DVFRT) is a multi-disciplinary team of countywide experts from private, public, and nonprofit organizations. The purpose of the DVFRT is to review domestic violence fatalities and make recommendations to prevent domestic violence fatalities by:

- Improving communication between public and private organizations and agencies.
- Determining the number of domestic violence fatalities occurring in the team's county and the factors associated with those fatalities.
- Identifying ways in which community response might have intervened to prevent a fatality.
- Providing accurate information about domestic violence to the community.
- Generating recommendations for improving community response to and prevention of domestic violence.

The DVFRT carries out its purpose with a deep respect for those who have lost their lives to domestic violence, as well as respect for the families, loved ones, community members, service providers, and responders directly affected by the tragic fatalities reviewed by the DVFRT. Out of respect to those who have lost their lives to domestic violence, the DVFRT maintains strict confidentiality of information shared with the team. DVFRT members recognize that the people who have lost their lives have not given the DVFRT consent to examine their lives. Each DVFRT member takes personal responsibility to maintain the privacy of victims, survivors, perpetrators, and their loved ones by ensuring all communication and documents shared with the DVFRT remain confidential. Oregon law (ORS 418.714) allows the DVFRT to publicly release recommendations from a fatality review without personal identifying information. This report details the recommendations of the DVFRT's 2025 case review.

Report Definitions

Abuser: a person who emotionally, psychologically, financially, sexually, and/or physically harms an intimate partner or a family member related to them by blood or marriage.

Domestic Violence (DV): A pattern of emotional, psychological, financial, sexual, and/or physical harm used to gain power and control over a family member or intimate partner.

Domestic Violence Fatality: The definition of a domestic violence fatality is outlined in ORS 418.712 and includes fatalities when:

- The person who died was a current or former intimate partner of the perpetrator.
- The person who died was an intimate partner of the perpetrator's current or former intimate partner.
- The person who died was the perpetrator of a homicide of a current or former intimate partner.
- The person died by suicide and there is evidence the suicide was related to domestic violence.
- A child died during a domestic violence incident in which their parent or the perpetrator also died.
- The person who died was at least 18 years old and their death was related to domestic violence. This could include the death of a family member, abuser, bystander, or law enforcement officer.

The legal definition of a domestic violence fatality is limited to abusive relationships within the context of family and intimate partner relationships. This definition excludes fatalities that occur within other types of abusive relationships such as those involving chosen family (individuals not related by blood or marriage), friends, roommates, neighbors, landlords/tenants, caregivers/patients, students/teachers/classmates, co-workers, or in child abuse situations when a child died but their parent or perpetrator did not die.

Family member: individuals related by blood or marriage.

Family violence homicide: a homicide committed by a perpetrator that is related to the victim through blood or marriage.

Intimate partner: a current or former spouse, fiancé, fiancée, dating partner, unmarried parents of a minor child, or individuals that had a current or former sexually intimate relationship.

Intimate partner violence (IPV): A pattern of emotional, psychological, financial, sexual and/or physical harm used to gain power and control over an intimate partner.

Murder-suicide: when a perpetrator kills a victim and then kills them self.

Perpetrator: a person that perpetrates a homicide. Additionally, this definition is used in this report to describe an abuser who's death was the only fatality in the domestic violence incident.

Survivor: a person who has experienced emotional, psychological, financial, sexual, and/or physical harm from an intimate partner or from a family member related to them by blood or marriage.

Victim: a person who was killed by a perpetrator during a domestic violence incident.

Oregon Domestic Violence Fatalities

The Oregon Coalition Against Domestic and Sexual Violence (OCADSV) reported that 426 fatal domestic violence incidents occurred in Oregon between 2009 and 2021. These incidents resulted in 578 domestic violence related deaths including the deaths of 430 victims and 148 perpetrators. One hundred and two of the deaths occurred in Multnomah County, which is an average of 7-8 domestic violence related deaths a year.

Domestic Violence Related Deaths in Oregon 2009-2021					
County	**Deaths**	**County**	**Deaths**	**County**	**Deaths**
Baker	2	Harney	0	Morrow	2
Benton	7	Hood River	5	Multnomah	102
Clackamas	43	Jackson	39	Polk	5
Clatsop	6	Jefferson	7	Sherman	0
Columbia	6	Josephine	17	Tillamook	9
Coos	29	Klamath	17	Umatilla	8
Crook	5	Lake	3	Union	2
Curry	1	Lane	62	Wallowa	1
Deschutes	31	Lincoln	4	Wasco	6
Douglas	16	Linn	25	Washington	59
Gilliam	0	Malheur	8	Wheeler	0
Grant	2	Marion	38	Yamhill	10

Number of deaths = 578
Source: OCADSV (2023). Fatal Domestic Violence in Oregon: Demographics Related to Victims, Perpetrators, and Incidents: 2021 Report.

Multnomah County Domestic Violence Fatalities

This section provides demographic information about domestic violence related deaths that occurred in Multnomah County from January 1, 2020 to December 31, 2024. Great care was taken to identify every domestic violence fatality that occurred in Multnomah County from January, 1 2020 to December 31, 2024. Unfortunately, this report may not include all domestic violence fatalities during this timeframe for the following reasons:

- It is difficult to identify incidents when domestic violence was a contributing factor in a death caused by suicide.
- It is difficult to track domestic violence homicides when the case is unsolved and the perpetrator is not known to law enforcement.
- There may be intimate partner related homicides where the intimate relationship was known only to the victim and perpetrator and therefore was not identified by law enforcement as a domestic violence homicide.

Additionally, the legal definition of a domestic violence fatality is limited to abusive relationships within the context of family and intimate partner relationships. This definition excludes fatalities that occur within other types of relationships. This report also does not include accidental fatalities where a death was caused by an intimate partner or family member but was determined by law enforcement or the medical examiner to be an accident and not related to domestic violence.

Individuals who experience domestic violence deserve to decide who they share their domestic violence experience with. Those who are no longer alive to give their consent deserve the utmost protections to preserve their right to privacy. Out of respect for the privacy of those who have lost their lives, and their loved ones, this report intentionally does not share identifying information about the individuals who lost their lives as a result of domestic violence.

Domestic Violence Related Deaths

Based on information provided by Portland Police Bureau, Gresham Police Department, Multnomah County Sheriff's Office, and Multnomah County District Attorney's Office, there were 40 fatal domestic violence incidents in Multnomah County from January 1, 2020 to December 31, 2024. These 40 incidents involved 40 perpetrators and resulted in 50 fatalities, including the death of 41 victims and 9 perpetrators. During this time frame there was an average of 10 deaths a year. Two of the 9 perpetrators died outside of Multnomah County, but they are included in this report because their deaths were directly linked to domestic violence homicides that occurred in Multnomah County.

Multnomah County Domestic Violence Related Deaths			
Year	**Victims**	**Perpetrators**	**Total Deaths**
2020	6	1	7
2021	5	0	5
2022	13	4	17
2023	12	2	14
2024	5	2	7
Total	**41**	**9**	**50**

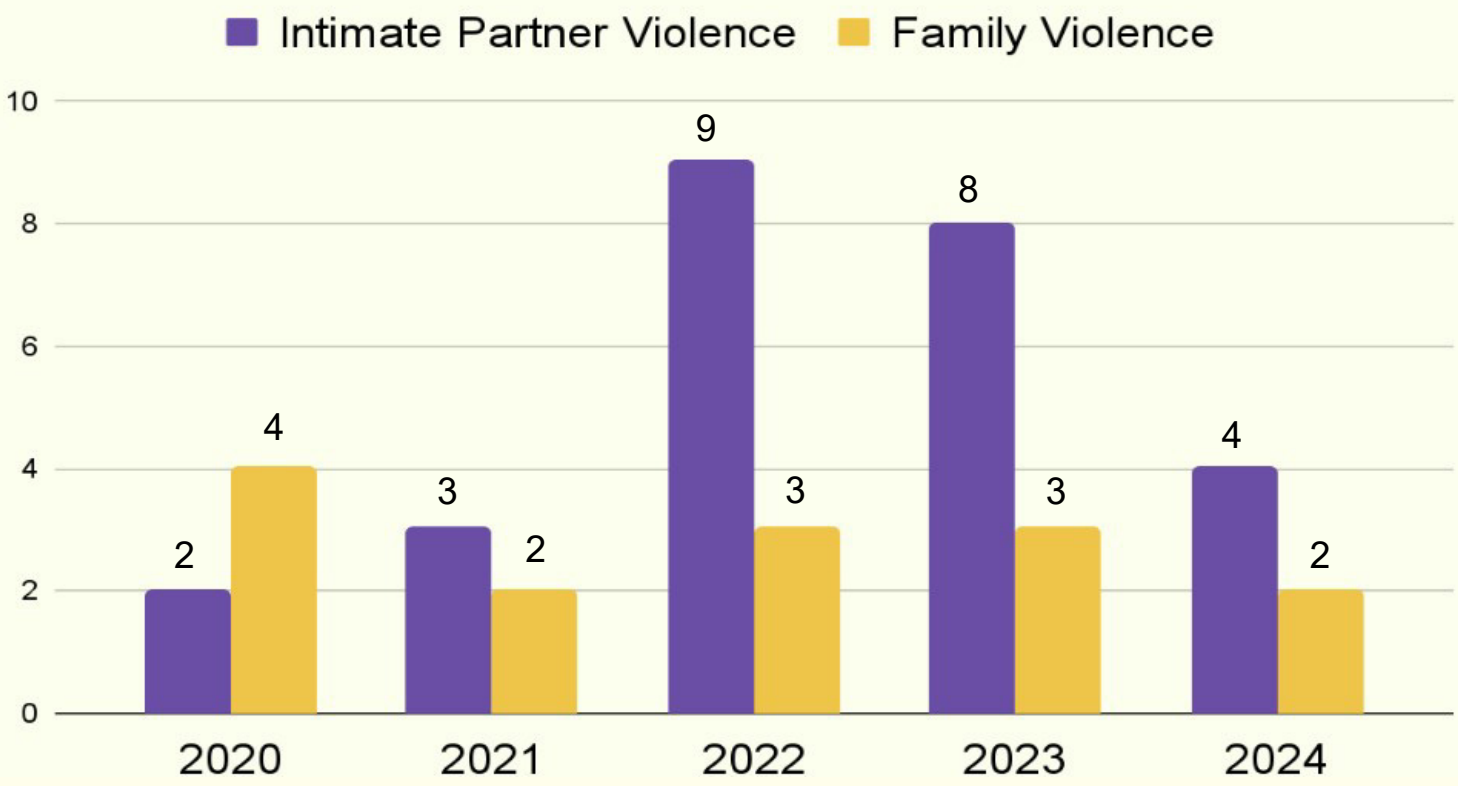
Protective Order History

For an Oregon protective order (also known as a restraining order) to be active, a survivor must apply for the order, a judge must grant the order, and the order must be served to the abuser. Eight victims/survivors (19.5%) had a history of applying for a protective order against the perpetrator in Oregon. In 7 of these cases, the victim/survivor had an intimate relationship with the perpetrator. In 1 case, the judge denied the protective order.

Four of the victims/survivors had applied for a protective order against the perpetrator less than a year before the fatality. On protective order was active. One victim had an open protective order at the time of their death that had not been served to the perpetrator. Two protective orders were dismissed prior to the fatal incident.

Intimate Parter and Family Violence Fatal Incidents

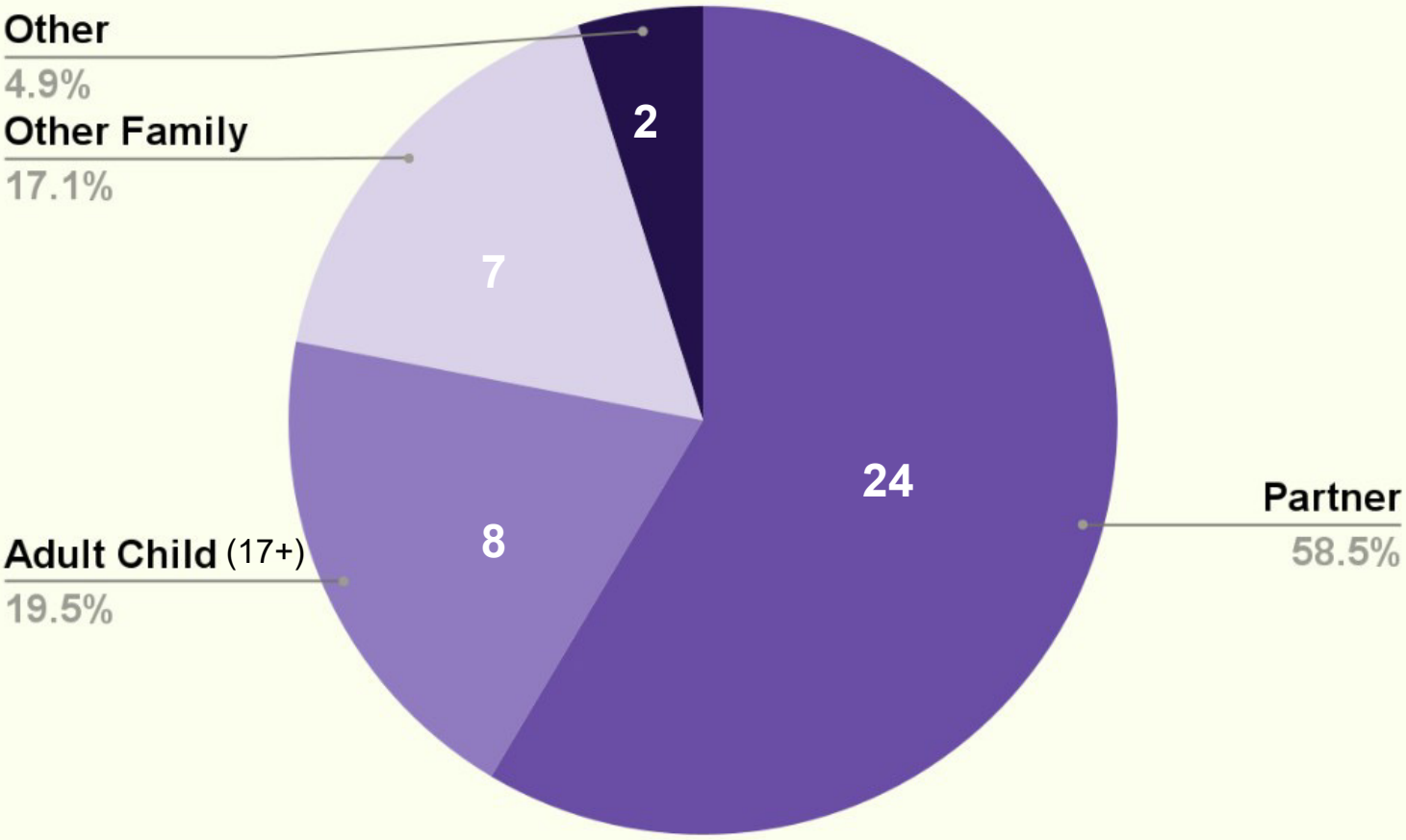
Of the 40 fatal domestic violence incidents in Multnomah County, 35% involved family violence while 65% involved intimate partner violence. All situations involving intimate partner violence were within heterosexual relationships.



Number of incidents = 40

Victim's Relationship to the Perpetrator

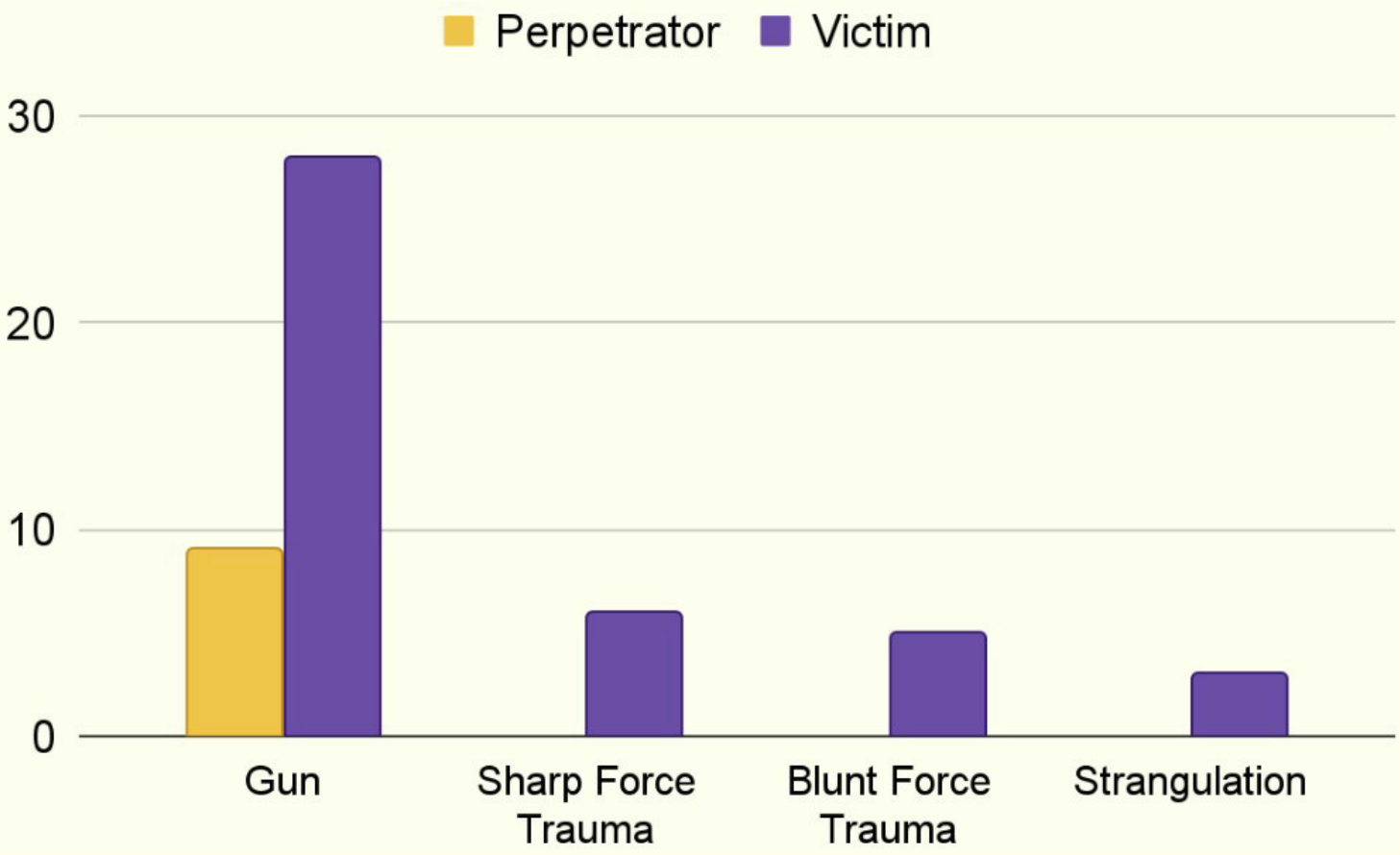
The majority of victims, a total of 24 people, were killed by a past or current intimate partner. Fifteen victims were killed by a family member, including 8 people who were killed by their adult or teen child. Two people were killed during an intimate partner violence incident, but the victims did not have an intimate or familial relationship to the perpetrator.



Number of victims = 41

Cause of Death

The majority of domestic violence fatalities were caused by gun violence. Twenty-eight victims (68%) died from a gunshot wound. Six victims died from sharp force trauma such as a stabbing. Five victims died from blunt force trauma and 3 victims died from strangulation. One victim died from multiple causes. Of the 9 perpetrators that died during a domestic violence incident, 100% died from a gunshot wound. Six of these perpetrators died by suicide, 2 were killed by law enforcement, and 1 perpetrator was killed by a family member of the homicide victim.



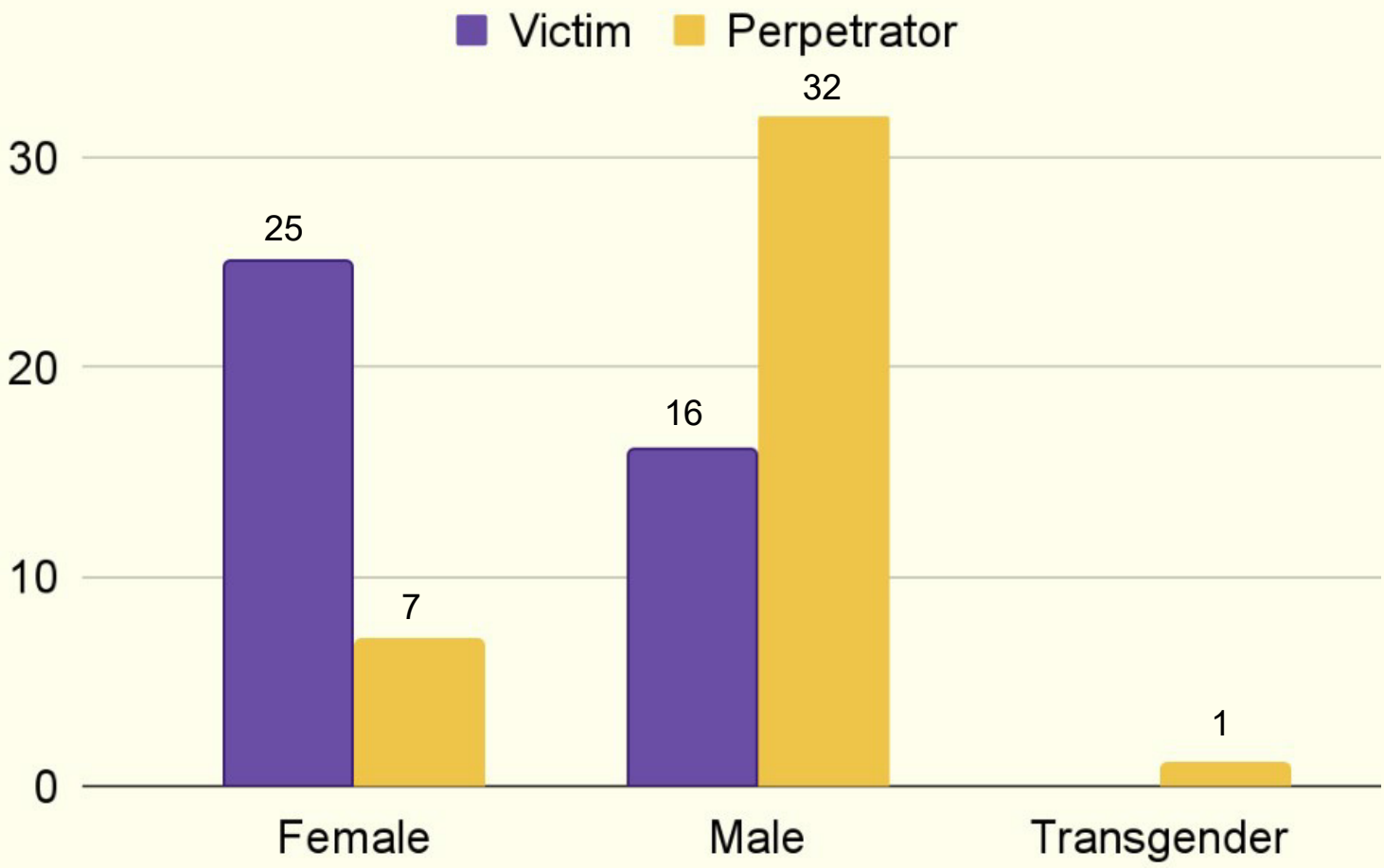
Number of victims = 41
Number of perpetrators = 9

Incidents Involving Murder-Suicide

Fifteen percent of the fatal domestic violence incidents involved murder-suicide. Half of these incidents were related to intimate partner violence, while the other half involved family violence. Of the 6 perpetrators that died by suicide, a majority (83%) were male, a majority (67%) were white, and all were 30 or more years old with the majority (67%) of perpetrators being over 45. There were 2 incidents involving murder-suicide where 2 victims died along with the perpetrator, resulting in 3 fatalities in each incident. One of these double murder-sucide incidents involved family violence while the other involved intimate partner violence.

Gender

The majority (61%) of homicide victims were female while the majority (80%) of perpetrators were male. Seven incidents involved a female perpetrator. One of the incidents with a female perpetrator involved family violence. A quarter of all intimate partner homicides were committed by a female perpetrator. In 2 of these intimate partner homicides, there is inconclusive information indicating that the homicide victim could have been the primary abuser within the relationship.



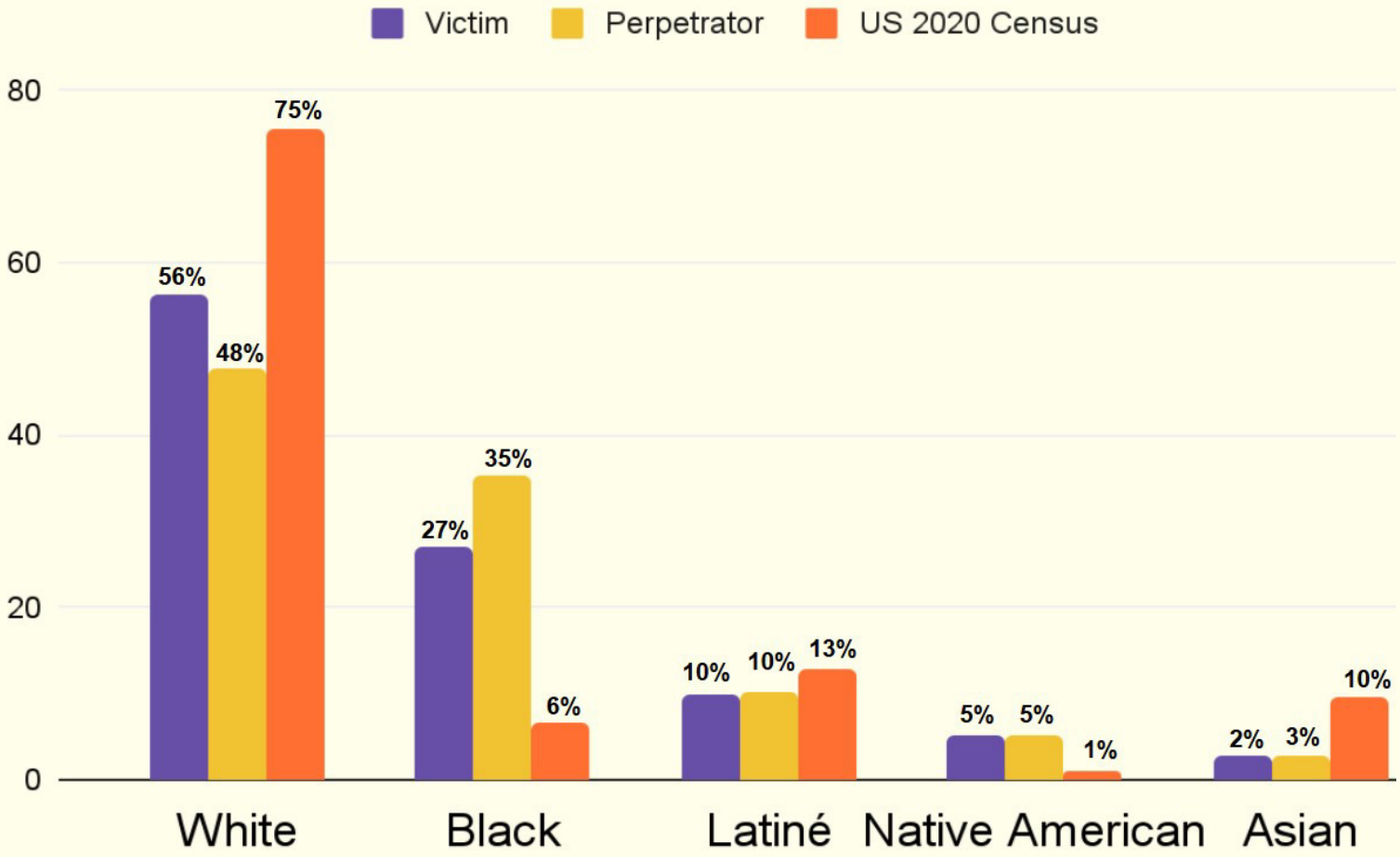
Number of victims = 41
Number of perpetrators = 40

Race and Ethnicity

The majority of victims (56%) were white and more than a quarter (27%) of victims were Black. Victims and perpetrators shared the same race or ethnicity in 90% of incidents. In incidents involving family violence, the majority (67%) of victims and perpetrator were white. Most incidents (91%) involving a Black victim were related to intimate partner violence. According to the 2020 US Census data for Multnomah County, Black and Native American people were disproportionately impacted by domestic violence fatalities.

The race and ethnicity of victims and perpetrators in this report comes from law enforcement databases which generally track one race/ethnicity for each individual. Therefore the information in this report fails to identify individuals who may self-identify as multiracial.

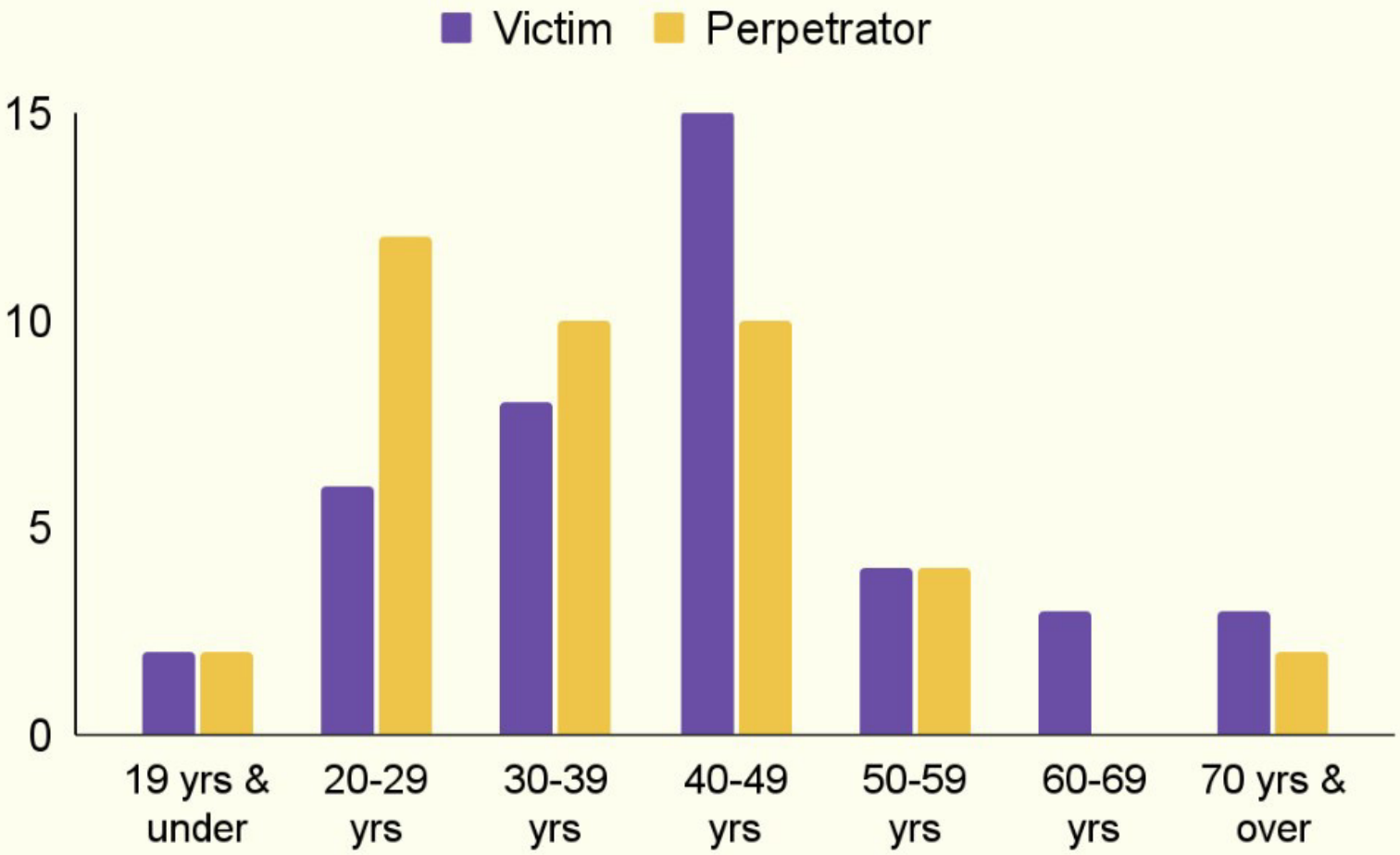
Race and Ethnicity by Percentage



Number of victims = 41
Number of perpetrators = 40
Percentages are rounded to the nearest point.
Source: United States Census Bureau, Oregon: 2020 Census data available at www.census.gov/library/stories/state-by-state/oregon.html

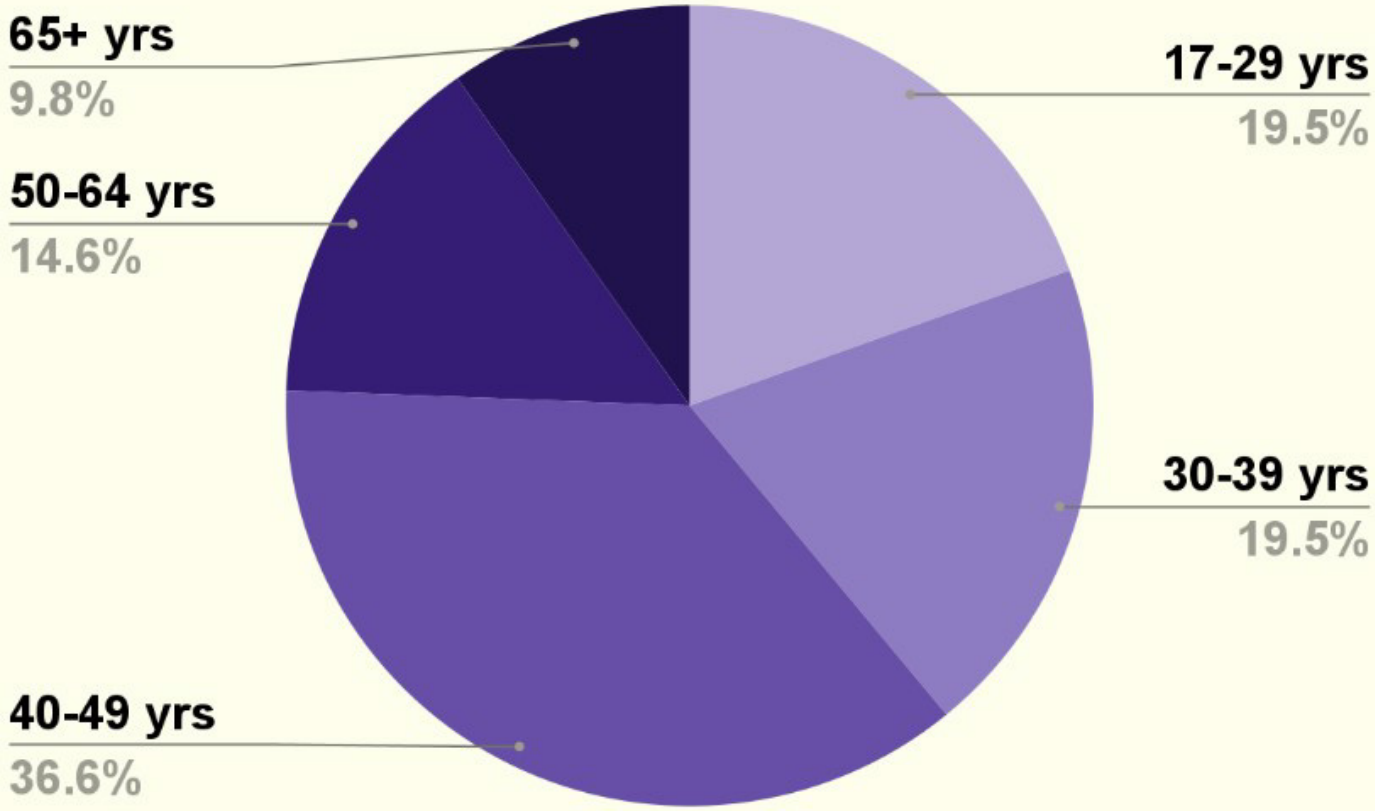
Age at Fatal Incident

The majority of victims (56%) were in their 30s or 40s at the time of the fatal incident. The majority of perpetrators (60%) were under 40 years old. Overall, perpetrators were generally younger than victims. The youngest victim was 18 and the oldest victim was 85. No victims were under 18. The youngest perpetrator was 17 and the oldest perpetrator was 78.



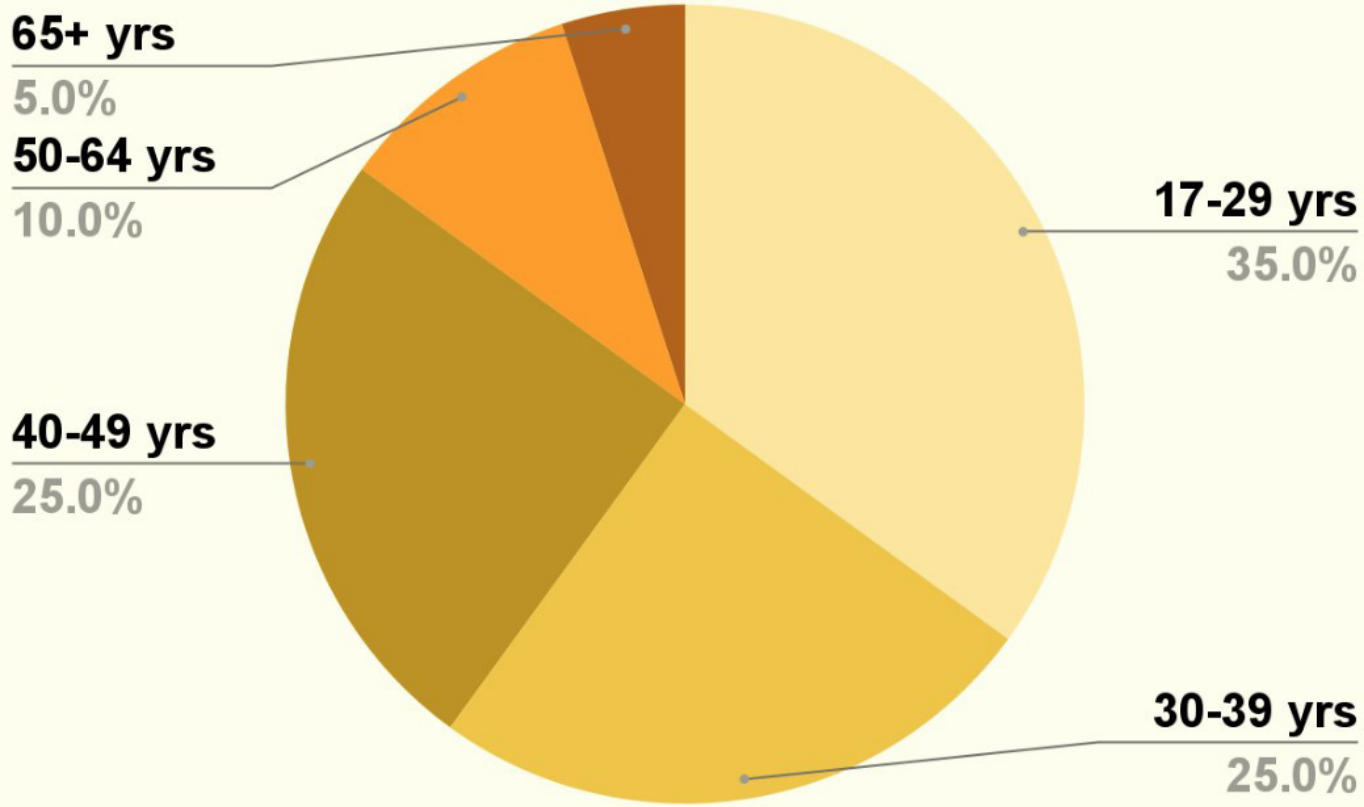
Number of victims = 41
Number of perpetrators = 40

Age of Victim



Number of victims = 41

Age of Perpetrator



Number of perpetrators = 40

Domestic Violence Fatality Review Team History

The history of Multnomah County's DVFRT starts in 2003, when a Portland woman was killed by her partner in front of their youngd child. A pattern of domestic violence within the family was well known to the criminal justice system and community based agencies. Multnomah County's Local Public Safety Coordinating Council belived a review of the case by a multidisciplinary team would help improve the community's response to domestic violence "because nearly every agency with a role in preventing or intervening in domestic violence had been involved (in the case)." In 2004, 22 individuals from local private, public, and non-profit agencies reviewed the case and generated 17 recommendations for improving the community's response to domestic violence. One of the recommendations was to "continue to hold Domestic Violence Fatality Reviews." This recommendation led to a collaboration with Oregon legislators to pass Domestic Violence Fatality Review Team legislation.

In 2005, the Oregon legislature created a law (ORS 418.714) that authorized the formation of Domestic Violence Fatality Review Teams. This law provides authority for a local domestic violence coordinating council to establish a "multidisciplinary domestic violence fatality review team to assist local agencies and organizations in identifying and reviewing domestic violence fatalities." In 2006, the Multnomah County Family Violence Coordinating Council established the Multnomah County Domestic Violence Fatality Review Team (DVFRT) and held its first official DVFRT case review in the fall of 2006. From 2006-2018, the DVFRT reviewed 18 domestic violence fatal incidents that occurred in Multnomah County. Due to staff capacity and the COVID-19 pandemic, the DVFRT did not review cases from 2019-2024. In the fall of 2024, the DVFRT Planning Committee reconvened and updated the DVFRT protocol in preparation for a 2025 case review. In the summer of 2025, the DVFRT reviewed one domestic violence fatal incident.

Domestic Violence Fatality Review Team Process

The first step in the DVFRT's process involved identifying all domestic violence fatalities in Multnomah County from January 1, 2020 to December 31, 2024. Aggregate data regarding these fatalities is shared in the Multnomah County Domestic Violence Fatality section of this report. The next step was to select a case to review. Cases that meet the following criteria were considered for review:

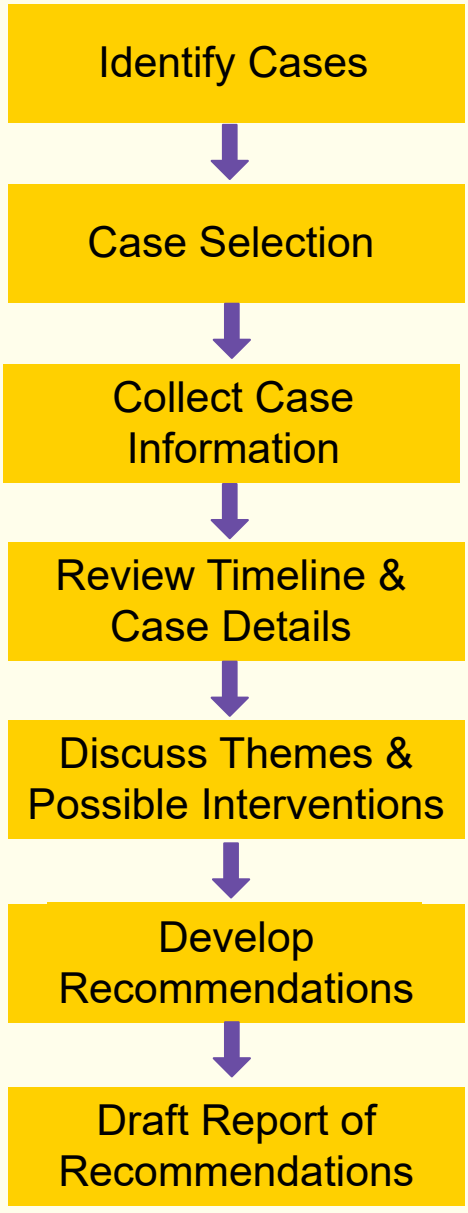
- Law enforcement had identified the perpetrator.
- The perpetrator was deceased or their criminal case related to the homicide was closed and there was no pending appeal.
- No criminal or civil legal cases involving the victim or perpetrator were open.

The DVFRT Planning Committee reviewed the eligible cases and considered trends in DV homicides, trends within Multnomah County, and the following victim, survivor, and perpetrator factors when selecting a case for review:

- Family size and composition
- Race or ethnicity
- National origin
- Immigration status of the household
- Sexual orientation
- Gender identity
- Criminal history
- Disability
- Level of involvement with criminal justice, civil legal, and social service systems
- Age
- Socio-economic status
- Relationship between the victim or survivor and the perpetrator
- Existence of additional victims, such as a murder-suicide, familicide, or by-standers
- Geographic location of fatality or residence of the victim, survivor, or perpetrator
- Degree of prior abuse by the perpetrator

Once a case was selected for review, the DVFRT collected information about the involved parties. A chronological timeline of key events was created based on the available information. The DVFRT met in-person to review the timeline and a summary of the case from the lead Detective and Deputy District Attorney involved in the criminal case. The DVFRT then identified the themes within the case, identified governmental and community based agencies that had contact with the victim or perpetrator, and discussed potential interventions that could have prevented the fatal outcome. After the in-person review meeting, DVFRT members individually reflected on possible recommendations related to the potential interventions. The team reconvened in-person to discuss possible recommendations. The DVFRT identified 5 recommendations for improving the community's coordinated response to DV. Lastly, the DVFRT Planning Committee drafted this report to publicly share the recommendations with the community.

Domestic Violence Fatality Review Team Steps



Recommendations

In the first 4 years the DVFRT convened, they created recommendations that were ambitious and often included extensive system improvements to Multnomah County's community response to domestic violence. Each review built upon the previous reviews' recommendations accumulating into 7 priorities, 19 goals, and numerous action items. In 2010, the DVFRT concluded that their goals were often too complex to successfully achieve. As a result, the DVFRT identified a need to create concrete and actionable recommendations that do not require high-level societal or complex system changes in order to successfully implement improvements.

Based on the learning from previous DVFRTs, team members involved in the 2025 case review focused on creating concrete recommendations that could be achieved within 1 year. Since the DVFRT does not have an operating budget, recommendations also focused on action items with a low or no cost to implement. The DVFRT identified 5 recommendations, and numerous action items, for improving Multnomah County's community response to domestic violence to decrease the risk of future homicides. Oregon law requires the information shared within the DVFRT to remain confidential but allows for the DVFRT's recommendations to be shared publicly. The following recommendations do not fully encompass the learning or discussions held during the 2025 case review meetings.

#1 Recommendation

Make resource materials of services accessible to domestic violence survivors, community members, advocates, and community partners.

Action item: Identify community resources to highlight for people impacted by DV. Include programs for children who witness DV and restorative justice programs.

Action item: Identify ways to simplify existing resource materials to ensure they are not overwhelming. Make resource materials accessible and include a QR code.

Action item: Create resource materials, with an emphasis on confidential resources, for people who don't want to report to law enforcement. Collaborate with law enforcement to share these materials with DV survivors who are not interested in prosecution.

Action item: Promote and share resource materials.

- Reach out to the organizations that manage the Black and African American Provider Resource Guide and Rose City Resource Guide to request that the DV resources be added to their guides.
- Share materials about resources with advocates, direct service providers, community health workers, and local libraries to increase awareness of available resources.
- Facilitate community presentations to spread information about resources.
- Share materials with members of the Family Violence Coordinating Council (FVCC).
- Explore with the Oregon State Bar which resources should be added to https://oregonlawhelp.org/.

Action item: In order to facilitate broader sharing of domestic violence resources, identify community partners that are missing from the FVCC's membership and invite them to attend.

#2 Recommendation

Assess the community's needs to adapt the Gateway Center's service model to provide consistent in-person and phone services.

Action item: Assess successes and challenges throughout the Gateway Center's 15 year history by gathering feedback from community and system partners, domestic and sexual violence survivors, and Gateway Center staff.

Action item: Assess if Gateway Center services are aligned with national and local best practices by:

- Reviewing national best practices for Family Justice Centers and survivor-led services.
- Seeking community feedback about where Gateway should align, or not align, with these practices.
- Seeking feedback from Clackamas and Washington Counties' Family Justice Centers about successes and barriers in their approaches.

Action item: Assess the Gateway Center's physical space for additional community partners to return to in-person services. Identify usability concerns and other possible on-campus options that may be utilized by staff and community partners.

Action item: Assess financial resources to increase compensation to Gateway Center's contracted partners and to extend County contracts to new community partners that could enhance Gateway Center's ability to support survivors.

Action item: Assess the benefit of Gateway Center's on-site and phone services for survivors and community partners. Use this information, within available resources, to guide survivor-centered decisions about the balance between phone and in-person services.

#3 Recommendation

Explore options for information sharing between local law enforcement jurisdictions.

Action item: Facilitate conversations with Multnomah County Sheriff's Office, Portland Police Bureau, Gresham Police Department, and Vancouver Police Department to explore possible options for sharing information between jurisdictions related to DV incident reports.

- Explore the possibility of a legislative bill to support law enforcement agencies in sharing data across jurisdictions or having a shared database. Share ideas with policymakers if appropriate.

Action item: Connect with state and local Law Enforcement Data Systems (LEDS) Coordinators to identify if it's possible to document probable cause for arrest for DV related crimes in LEDS in situations where an arrest did not immediately occur. Explore the possibility of creating a DV flag in LEDS. Discuss the possibilities with local law enforcement agencies. If appropriate, make a plan to train law enforcement agencies to enter probable cause in LEDS and utilize DV flags.

#4 Recommendation

After police respond to a high lethality risk DV incident, have an advocate reach out to the survivor to offer support.

Action item: Connect with Portland Police Bureau and Gresham Police Department to assess if their records departments have capacity to track high lethality risk DV incident reports and forward the reports to the Domestic Violence Crisis Response Unit for assignment to an advocate.

Action item: Request and analyze historical data from Portland Police Bureau and Gresham Police Department to determine the advocacy capacity required to respond to all high lethality risk DV incident reports.

Action item: Collaborate with the Portland Police Bureau, Gresham Police Department, and the Domestic Violence Crisis Response Unit to:

- Establish a process for identifying high lethality risk DV incident reports.
- Create a standard operating procedure or protocol for their records departments to send high lethality risk DV incident reports to the Domestic Violence Crisis Response Unit.

Action item: Collaborate with the Domestic Violence Crisis Response Unit to:

- Create a triage process to determine response priority.
- Explore partnerships with other advocacy agencies to handle referrals when the Domestic Violence Crisis Response Unit reaches capacity or the survivor requests on-going advocacy support.

#5 Recommendation

Provide dating violence prevention and interventions for juvenile system-involved youth.

Action item: Connect with Multnomah County's Juvenile Services Division to explore the possibility of adapting their Habilitation, Empowerment, Accountability, and Therapy (H.E.A.T.) or creating other curriculum to include domestic violence prevention and relationship conflict resolution skills.

Action item: Connect with Oregon Department of Health and Human Services Child Welfare to explore the feasibility of offering an adapted H.E.A.T curriculum to young people going through the dependency process.

Action item: Identify local community violence prevention programs for youth and explore opportunities to incorporate domestic violence prevention and relationship conflict resolution skills into their program curriculum. Explore how Restorative Justice principles could be included in the curriculum.

Implementation of Recommendations

During the development of recommendations, DVFRT members volunteered to lead efforts related to specific action items. The DVFRT Coordinator is responsible for collaborating with DVFRT members assigned to specific action items and appropriate governmental and community-based partners to address each action item. When a workgroup is needed to successfully implement an action item, the DVFRT Coordinator will convene a workgroup with pertinent community partners. Additionally, the DVFRT Coordinator will track the progress of each action item including any barriers or limitations for successfully implementing the action item. Updates on the progress of implementing the recommendations outlined in this report will be shared with DVFRT members and the Family Violence Coordination Council.

Domestic Violence Fatality Review Team Members

This report is a product of the Multnomah County Domestic Violence Fatality Review Team (DVFRT). The following individuals served on the 2025 Multnomah County DVFRT. Individuals with an asterisk (*) also served on the DVFRT Planning Committee.

DDA Amanda Nadell, Multnomah County District Attorney's Office*
Deputy Amie Banta, Multnomah County Sheriff's Office: Closed Street
Averi Sage, Multnomah County Domestic and Sexual Violence Coordination Office: DV Crisis Response Unit*
Brianna Ellison, Multnomah County Medical Examiner's Office
JCC De'Andre Frison, Multnomah County Department of Community Justice: Juvenile Services Division
PPO Dorcie Johnson, Multnomah County Department of Community Justice: DV Unit
Emily Brown-Sitnick, Legal Aid Services of Oregon*
Emily La Brecque, Oregon Crime Victims Law Center
Emmy Ritter, Raphael House of Portland*
Enrique Rivera, Multnomah County Local Public Safety Coordinating Council
Detective Fred Huffman, Gresham Police Department
Haley Pursell, Multnomah County Domestic and Sexual Violence Coordination Office*
Hope Hansmeyer, Multnomah County District Attorney's Office: Victim Assistance Program
Sgt. John Pemberton, Multnomah County Sheriff's Office
Kara Sydnor, Multnomah County Health Department: Racial and Ethnic Approaches to Community Health
Katie Schafer, Providence S.A.F.E. Center
Lindsay Spaulding, CARES NW
Madrona Piper, Domestic and Sexual Violence Coordination Office: Community Advisory Board Member
Maleea Briggs, Oregon Department of Human Services: Child Protective Services*

Meghan Huffman, Multnomah County, Aging, Disability, and Veteran Services: Adult Protective Services
Commissioner Meghan Moyer, Multnomah County Board of Commissioners, DVFRT Co-Chair*
Officer Natasha Haunsperger, Portland Police Bureau*
Neal Jappport, Multnomah County Circuit Court
Judge Pam Haan, Multnomah County Circuit Court, DVFRT Co-Chair*
Judge Shelley Russell, Multnomah County Circuit Court
Slavica Jovanovic, Portland Police Bureau: Victim Services
Spencer Grace, Native American Youth and Family Center: Healing Circle Program
Tiffany Thomas-Guice, Bradley Angle
Tim Logan, SOVALTI
Tristan Edwards, Metropolitan Public Defender
Yvonne Hart, Multnomah County Department of Community Justice: Victim and Survivor Services*

Thank you to the DVFRT members for contributing their time and energy to serving on the DVFRT and for their openness to discussing difficult subject matters with compassion and grace. Thank you also to the DVFRT Planning Committee for their invaluable support in reinstating the DVFRT, updating the DVFRT protocols, and drafting this report.