

New  
Mexico  
Intimate  
Partner  
Violence  
Death  
Review  
Team

Annual  
Report  
2017

Findings &  
Recommendations  
from CY2014  
Intimate Partner  
Violence Deaths



# **New Mexico Intimate Partner Violence Death Review Team Annual Report 2017**

The New Mexico Intimate Partner Violence Death Review Team (Team), also known as the Domestic Violence Homicide Review Team, is a statutory body enabled by the New Mexico Legislature under NMSA §31-22-4.1 (Appendix A). The Team is funded by the New Mexico Crime Victims Reparation Commission. Team coordination and staff services are housed at the Department of Emergency Medicine, University of New Mexico Health Sciences Center. The Team is tasked with reviewing the facts and circumstances surrounding each intimate partner and sexual violence related death that occurs in the State of New Mexico, with the aim of reducing the incidence of these deaths statewide. The Team is a multidisciplinary group of professionals who meet monthly to review the facts and circumstances surrounding each New Mexico death related to intimate partner violence (IPV) or sexual assault (SA). This report presents findings and recommendations from the Team’s review of 2014 intimate partner violence and sexual assault related deaths.

## **Contents**

<b>Acknowledgments.....</b>	<b>1</b>
<b>Team Membership.....</b>	<b>2</b>
<b>Incidents of Intimate Partner Violence and Sexual Assault Resulting in Death, CY2014.....</b>	<b>3</b>
<b>Relationship and Person Characteristics in IPV Related Death Incidents, CY2014.....</b>	<b>5</b>
<b>Team Recommendations.....</b>	<b>8</b>
<b>Appendix A: About the New Mexico Intimate Partner Violence Death Review Team:.....</b>	<b>13</b>
<b>Appendix B: Statutory Authority for the Domestic Violence Homicide Review Team.....</b>	<b>15</b>

## **Acknowledgments**

The New Mexico Intimate Partner Violence Death Review Team wishes to thank:

- The New Mexico Crime Victims Reparation Commission (CVRC), Director Frank Zubia and the entire Crime Victims Reparation staff and Commission, for their support of the Team’s work,
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- All of the criminal justice and community service professionals across the State of New Mexico who assisted with the record collection necessary for conducting effective case reviews.

The Team staff wishes to thank both appointed and invited Team members for all of the work that they do to generate the findings and recommendations contained in this report.

Finally, this report is written, and the Team’s work is conducted, on behalf of and in memory of, intimate partner and sexual violence victims and the family members who have suffered the loss of their loved ones. Our wish is that our reviews and our subsequent recommendations improve responses to victims of intimate partner and sexual violence and ultimately prevent future injury and death associated with this violence.

Visit our website for more information about the New Mexico Intimate Partner Violence Death Review Team, our case review practice, and the production of findings and recommendations for this report.

[emed.unm.edu/cipre](http://emed.unm.edu/cipre)  
Revised 3/12/2018.

## **Team Membership**

### **Appointed Members**

Julia Anderson, Office of the Attorney General  
Gabriel Campos, City of Albuquerque  
Rosemary Cosgrove-Aguilar, Bernalillo County  
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Joan Shirley, Resource Center for Victims of  
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Alexandria Taylor, Valencia Shelter Services  
Lisa Vigil-Roybal, Administrative Office of the  
District Attorney  
Lisa Weisenfeld, NM Coalition Against Domestic  
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### **Invited Members**

Samantha Acuff, CVRC  
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Arlene Armijo, Bureau of Indian Affairs  
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Persephone Wilson, Planned Parenthood of the  
Rocky Mountains  
Ingrid Yitamben, UNM CIPRE

### **Special Thanks to Out Going Team Members**

Socorro Salazar, NM DOH  
Antoinette Sedillo-López, Enlace Comunitario  
Sherry Stephens, NM Parole Board  
Maria Velez, UNM Department of Sociology  
Jane Zhi, New Mexico Legal Aid

### **Special Thanks to Team & Committee Chairs**

Joan Shirley, 2017 IPVDRT Chair  
Dale Klein-Kennedy & Joan Shirley, Friends and  
Family Committee Chairs  
Joel Hagaman, Marginalized Populations  
Committee Chair  
Cheryl Eaton, Native American Committee Chair  
Heather Sandoval, Teen Dating Violence  
Committee Chair

## Incidents of Intimate Partner Violence and Sexual Assault Resulting in Death, CY2014

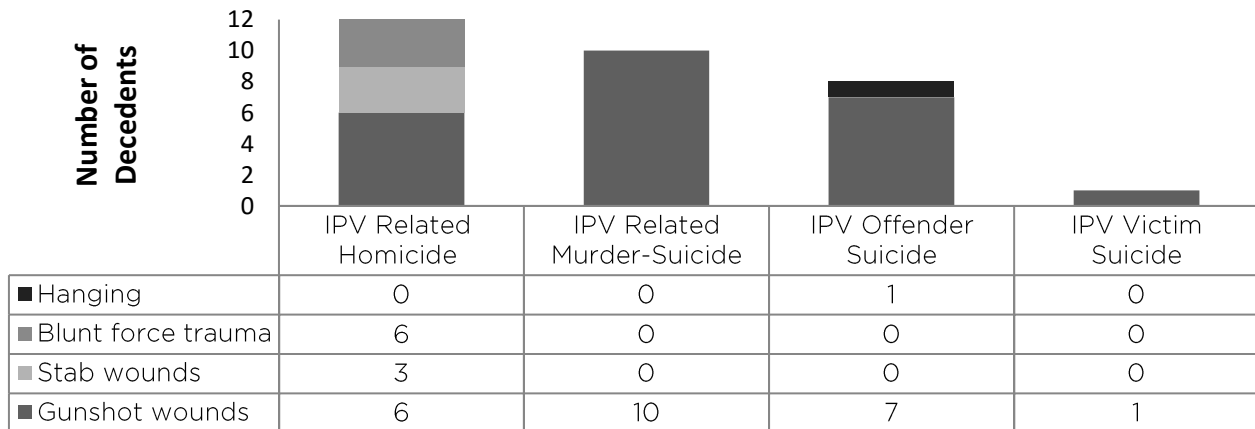
In calendar year 2014 (CY2014), the Team reviewed 29 incidents of intimate partner violence (IPV) that resulted in at least one death. In these 29 incidents, 34 people died: 20 deaths were the result of homicide, and 14 were acts of suicide. The Team identified seven additional IPV incidents resulting in a homicide death in CY2014 that could not be reviewed because of an unresolved investigation or ongoing criminal court proceeding. IPV related death incidents occurred in 12 counties across the state and 34% of these incidents occurred in rural areas.<sup>1</sup>

The Team reviewed 15 cases of homicide, five cases of murder-suicide, and nine cases of suicide alone. In 19 cases, 24 (71%) deaths were the result of gunshot wounds, including 11 homicide deaths (32%) due to gunshot wounds. Stab wounds were the cause of three homicide deaths; six homicide deaths were the result of blunt force trauma, one suicide death was the result of hanging. Three incidents involved an actual or attempted sexual assault and two total sexual assault exams were performed postmortem.

The Team observed six homicide offenders who were known to be legally prohibited by federal law from possessing a firearm. Two reviewed cases, one a homicide and one a murder-suicide, involved a homicide offender who was a prohibited person in possession of a firearm. Additionally, the Team observed four IPV victims who were known to be legally prohibited by federal law from possessing a firearm. Of those four victims, three were killed in the death incident.

Eight death incidents (28%) took place in a public location, including three incidents on the side of roadways, one inside a motel room, one in front of the IPV victim's new partner's workplace, one in a parking lot in front of the decedent's apartment, one in an empty lot, and one in a campground. The 21 other cases occurred at a personal residence, with more than half (52%) of residential based incidents occurring at a residence shared by the IPV victim and perpetrator. The remaining six incidents took place at the residence of either the IPV victim or the IPV perpetrator. Eight (27%) IPV related death incidents were witnessed by a minor child. The figure below shows the distribution of location for cases reviewed by type of death incident.

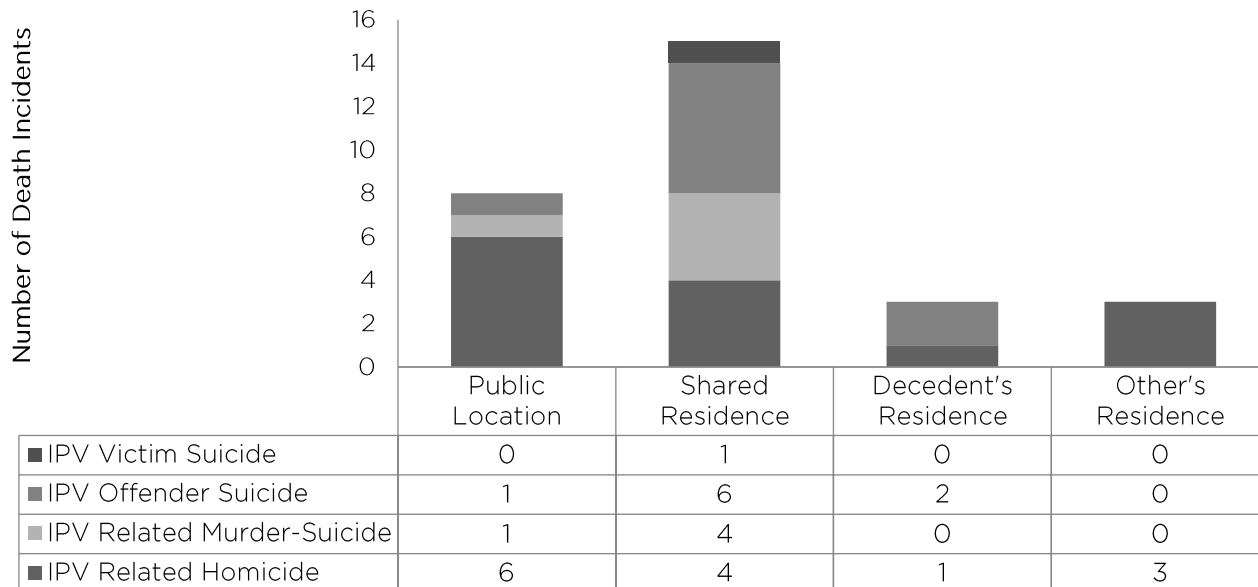
Cause of Death (Number of incidents = 29; Number of decedents = 34)



<sup>1</sup> The Team uses the Rural Urban Commuting Areas (RUCA) definition to identify rural and urban areas in the state. The definition is consistent with the Team's purpose

of assessing access to resources in the victim's residential community.

**Location of Incident (Number of incidents = 29)**



**Criminal Charges**

A state prosecutor filed criminal charges against offenders in 14 homicide incidents, involving 16 offenders. Only 15 offenders received a murder charge. One homicide incident involved an on-duty police officer, who was working in his official capacity and responding to a domestic violence incident, against whom charges were not filed. A conviction on at least one charge was obtained against the homicide offender in all of the cases where charges were filed. However, one homicide offender pled to a lesser charge that did not include murder charges. In the remaining cases, no charges were filed. In 14 incidents, the offender committed suicide immediately following the IPV incident. The table below shows the adjudicated charge and sentence range for all reviewed CY2014 IPV homicide convictions.

**Conviction and Sentencing**

Prosecutors obtained convictions on all of the 14 charged cases. Of these convictions, ten resulted from plea agreements and four from jury conviction. In cases with a conviction, the minimum sentence on the most serious charge was six months in custody for voluntary manslaughter and the maximum sentence was 30 years to life in prison for 1<sup>st</sup> degree murder. In the case where voluntary manslaughter was the most severe charge, the offender was given an 18 month deferred sentence. Four of the convictions involved a sentence that was totally or partially suspended.

**CY2014 Homicide Conviction Sentence Range by Charge Type (Number of cases = 14; Number of homicide offenders = 15)**

Most Serious Adjudicated Charge	Number of Cases	Sentence Range in Years, After Time Suspended
Involuntary Manslaughter	3	6 months to 1.5 years
Voluntary Manslaughter	1	1.5 years
2 <sup>nd</sup> Degree Murder	9	6 to 20 years
1 <sup>st</sup> Degree Murder	1	30 years to Life

## Relationship and Person Characteristics in IPV Related Death Incidents, CY2014

### Relationship between the Intimate Partner Pair

In all reviewed CY2014 cases, the death incident occurred either during or immediately following a threatened or actual incident of intimate partner violence. In nine cases (31 %) of incidents, the intimate partner pair was currently married, 12 cases (41 %) involved couples who were dating at the time of the incident, and six cases (20 %) were former spouses or dating partners. One incident involved a sex worker and client and another incident involved a

sexual assault between parties with no prior intimate relationship. Fifty-two percent of all couples had shared biological or adopted children. Over one-third (34%) of intimate partner pairs were in the process of separating at the time of the incident. The following table reports relationship characteristics for intimate partner pairs involved in the intimate partner violence related incident that resulted in at least one death reviewed by the team.

Relationship Characteristics For the Intimate Partner Pair (Number of partner pairs = 29)	Number of Cases	%
<b>Relationship Status</b>		
Spouse or partner	9	31
Boyfriend or girlfriend	12	41
Ex-boyfriend or ex-girlfriend	5	17
Ex-spouse or ex-partner	1	3
Sexual assault related homicide, including sex worker and client	2	7
Recently separated or in the process of separating	10	34
<b>Habitation Status at the Time of Incident</b>		
Lived together	17	59
Previously lived together	6	21
Never lived together	5	17
Unknown	1	3
<b>Children</b>		
Couple has any shared biological or adopted child(ren) of any age	15	52
Shared biological or adopted minor child(ren) in household	9	31
Step-child(ren) in household	4	14
Any minor child(ren) in household	9	31
<b>History of Intimate Partner Violence within Pair</b>		
Known history of intimate partner violence in relationship	20	67
At least one domestic violence police call for service	11	38
At least one arrest for intimate partner violence	6	21
Any history of a domestic violence order of protection <sup>2</sup> between parties	5	17
Domestic violence order of protection between parties at the time of the incident	3	10
Petition for domestic violence order of protection between parties within the last 90 days	4	14
Criminal domestic violence charge pending at time of incident	3	10
Any history of child custody cases	1	3

<sup>2</sup> For definitions regarding domestic violence orders of protection, see the New Mexico Family Violence Protection Act (§§40-13-1 to -12 NMSA 1978).

## IPV Victims

IPV victim refers to the victim of intimate partner violence. The IPV victim may be the decedent, offender, or surviving partner in the death incident. In CY2014 reviewed cases there were 29 IPV victims who were either the decedent or the surviving intimate partner. Victims ranged in age from 19 to 90 years old and the median age was 36 years. Most (83%) were female. Three (10%) IPV victims became

parents when they were teenagers. Four (14%) IPV victims had a prior arrest for a domestic violence offense. Over half (62%) of IPV victims were homicide decedents in the death incident; in the remaining incidents the IPV victim survived. The table below presents background characteristics for IPV victims in reviewed incidents.

<b>Background Characteristics of IPV Victims, CY2014 (Number of victims = 29)</b>	<b>Number of Victims</b>	<b>%</b>
<b>Sex</b>		
Female	24	83
Male	5	17
<b>Race/Ethnicity</b>		
Hispanic	17	59
White	8	28
Native American	2	7
African American/Black	1	3
Asian/Pacific Islander	1	3
<b>Substance Abuse &amp; Mental Health</b>		
Known history of alcohol abuse	9	31
Known history of drug use	7	24
Known history of depression or other mental illness	4	14
Known history of a chronic illness	4	14
<b>Criminal History</b>		
At least one prior arrest	11	38
At least one arrest for DWI	8	28
Convicted of at least one felony crime	4	14
At least one term supervised probation or parole	8	28
On probation or parole at the time of the incident	3	10
<b>Intimate Partner Violence History</b>		
Known history of intimate partner violence victimization	17	59
Known history of intimate partner violence perpetration	5	17
At least one arrest for domestic violence	4	14
At least one conviction for domestic violence	1	3
Restrained party in at least one prior domestic violence order of protection	2	7



## IPV Perpetrators

IPV perpetrator refers to the identified perpetrator of intimate partner violence. The perpetrator may be the decedent, offender, or surviving partner in the death incident. In CY2014 reviewed cases, there were 29 IPV perpetrators. Perpetrators ranged in age from 22 to 93 years old, with a median age of 40 years. Most (83%) of IPV perpetrators were

male. Over half (32%) were surviving homicide offenders in the death incident, 13 (34%) were both homicide offenders and suicide decedents, 9 (31%) of IPV perpetrators committed suicide alone, and one (3%) IPV perpetrator was killed by an on-duty police officer. At the time of the incident 48% of IPV offenders were drinking alcohol and 31% were using illicit drugs.

Background Characteristics of IPV Perpetrators, CY2014 (Number of perpetrators = 29)	Number of Perpetrators	%
<b>Sex</b>		
Female	5	17
Male	24	83
<b>Race/Ethnicity</b>		
Hispanic	14	48
White	9	31
Native American	3	10
African American/Black	3	10
<b>Substance Abuse &amp; Mental Health</b>		
Known history of alcohol abuse	16	55
Known history of drug use	13	45
Known history of depression or other mental illness	11	38
Known history of a chronic illness	3	10
Use of alcohol at time of death incident	14	48
Use of illicit drugs at time of death incident	9	31
<b>Criminal History</b>		
At least one prior arrest	17	59
At least one arrest for DWI	16	55
Convicted of at least one felony crime	9	31
At least one term of supervision by probation or parole	14	48
On probation or parole at the time of the incident	2	7
<b>Intimate Partner Violence History</b>		
Known history of intimate partner violence victimization	4	14
Known history of intimate partner violence perpetration	19	66
At least one arrest for domestic violence	11	38
At least one conviction for domestic violence	6	21
Restrained party in at least one prior domestic violence order of protection	4	14
<b>History of Associations</b>		
Suspected gang involvement	1	3
History of military service	4	14

## Contacts with Service Providers

In addition to formal criminal and civil legal systems, the Team evaluates other known service contacts for both IPV victims and offenders.<sup>3</sup> Nine had a known prior contact with community intimate partner violence programs or advocates. Seven of those individuals were IPV perpetrators who attended a court ordered batterer intervention program. The most common service contacts were with behavioral and mental health service providers. Twenty-four percent of IPV victims and 48% of IPV perpetrators had at least one contact with a behavioral health service provider. These visits included mental and behavioral health treatment, including anger management. Fourteen percent of IPV victims and 41% of IPV perpetrators had at least one known contact with a medical provider through primary care or emergency department visits. Ten percent of both IPV victims and IPV perpetrators utilized substance abuse treatment services.

## Bystanders: Secondary Offenders and Victims

Bystander refers to a person who is not involved in the act of intimate partner violence, but is identified as a witness to the intimate partner violence. At times, bystanders to intimate partner violence may be either the decedent (a secondary victim) or offender (a secondary offender) in the death incident. Five cases involved six secondary offenders who committed an act resulting in homicide. An on-duty police officer shot and killed an IPV perpetrator after a domestic violence call for service. Another secondary offender was a neighbor who was trying to intervene during a domestic violence incident. The other three cases involved homicide offenders who believed that they were defending another person through homicide. Among the six secondary offenders, four were convicted of a murder charge. The on-duty police officer was not charged and one offender was acquitted of the murder charge.

The term secondary victim is used to denote bystanders to the intimate partner violence who are injured or killed during the incident. In CY2014, the Team reviewed four cases involving seven bystanders as secondary victims in the death incident. One case, which occurred at the workplace of the IPV victim's new partner, involved four secondary victims. One secondary victim was the new partner of the IPV

victim/decedent and was injured when the homicide offender tried to hit the new partner with a car. The new partner suffered bruises and abrasions of the legs and chest. The three other secondary victims were shot during the IPV incident and survived. In another case, the secondary victim was fighting with the homicide decedent and hit in his face and body during the death incident. A third case involved the son of the IPV victim and IPV perpetrator/homicide offender. The son was hit by the homicide offender during the death incident. The final case involved a homicide offender who was attempting to stop an IPV incident. The IPV perpetrator/decedent physically attached the homicide offender, resulting in abrasions and bruises on his body.

## Team Recommendations

### Legislation/Policy

**Create New Mexico legislation that mirrors the existing Federal statute prohibiting possession, sale, or transfer of firearms while subject to an order of protection, following conviction for a misdemeanor domestic violence offense, and following a finding of mental health related incompetency (see 18 U.S.C. 922 (d) and (g)).** The New Mexico Legislature should require that under these circumstances a prohibited person surrender firearms, and that law enforcement be granted the authority to confiscate firearms and the resources needed for storing those firearms. Not only would state legislation reinforce the importance of removing firearms from the hands of these offenders, but it could also provide resources for retrieving and storing these weapons and create a more comprehensive system for monitoring compliance with the law.

**Create New Mexico legislation that mirrors the existing Federal statute requiring that all orders of protection issued under the Family Violence Protection Act be entered into the National Crime Information Center (NCIC).** The New Mexico Legislature should require all respondents subject to a valid order of protection be prohibited from possessing a firearm or ammunition under state law. This would enable all order of protection cases to be entered into NCIC to ensure that they are searchable by court and law enforcement personnel. The Native American Committee

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<sup>3</sup> Our identification of known contacts with services outside the criminal and civil justice system is limited. We document known contact from prior court history and

investigative documents related to the homicide and other prior interactions with the police or courts.

further recommends that tribal agencies coordinate with non-tribal state and local agencies to ensure the recording and enforcement of protection orders.

**Amend the No Written Instructions; Priority of Others to Determine Disposition statute (NMSA § 24-12-1) to disallow the release of decedent remains to a surviving spouse, if the surviving spouse is the homicide offender.** The Team has observed cases where the remains of the decedent are released to the accused homicide offender, who is also the surviving spouse. The Team recommends not releasing the decedent to the homicide offender.

**The Teen Dating Violence Committee recommends amending the Public Education Graduation Requirement statute (NMSA § 22-13-1.1.(J)) to expand the health education graduation requirement for high school students to one credit and to include information about healthy relationships, intimate partner violence, consent, and sexual assault.** We recommend that the standards require inclusion of information about the connection between teen dating violence, self-harm, and suicidal ideation. Additionally, we would like to see education given about firearm safety and mental health.

#### **Tribal Policies and Services**

**The Native American Committee recommends the development and implementation of culturally appropriate and holistic educational programs about intimate partner violence and sexual assault.** In keeping with cultural values, these programs should take into account local traditions, community needs, and be appropriate for individuals at every stage of life.

**The Native American Committee recommends supporting victims, children, and families by ensuring that tribal agencies collaborate with community, local and state government agencies to offer culturally appropriate services that meet the needs of all tribal members.** Victim advocates, tribal home visiting program staff, Children Youth and Families Department staff, and law enforcement officers should collaborate to ensure that children who witness violence receive early intervention services and forensic interviews immediately after a crime. Continued collaboration will provide children and families with tribal support and follow up as they heal.

#### **Law enforcement**

**Improve accountability and quality control measures for the investigation, documentation, and reporting of incidents of violent death by law enforcement agencies statewide by creating model policies.** The Team observed a number of cases in which prior calls for service were properly documented and demonstrated knowledgeable and thorough responses to victims by police. However, there continues to be an unknown number of instances in which calls for service are not documented and investigations are abbreviated. The Team supports the recommendation of the International Association of Chiefs of Police who advocate for the creation and implementation of model policy that includes standardized investigations for all domestic violence related incidents, including standardized evidence collection protocols, required domestic violence incident reporting forms that include a lethality assessment, and the utilization of on scene domestic violence advocates to support survivors.<sup>4</sup> The policies should also include continuing education for law enforcement officers about investigation, emergency orders of protection, summons, and warrants. Agencies should ensure that senior leadership receives proper training on best practices in investigation and documentation, including documentation for testimony. Leadership should hold their staff accountable for following established protocols.

**Law enforcement agencies should ensure officers are provided increased training on all aspects of intimate partner violence, including the dynamics of the violence and the appropriate documentation of incidents that involve IPV.** An increase in the required amount of both academy training and continuing education for law enforcement professionals is one step towards improving the responses of officers towards victims of violence. The Team and its Committees recommend that officers are trained on offering trauma informed response to victims and survivors of violence.

**Create standardized protocols that include provisions for collaboration between law enforcement agencies and other local, state, or tribal agencies, such as local district attorney's offices and the Children, Youth, and Families Department, to ensure timely and appropriate referrals for victims following incidents of intimate partner violence and**

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<sup>4</sup> International Association of Chiefs of Police. 2016. "Domestic Violence Model Policy." Retrieved Dec. 11, 2017 (<http://www.theiacp.org/MPDDomesticViolence>).

**sexual assault.** The Team has observed inconsistencies in the way law enforcement agencies engage with survivors following domestic violence incidents. Law enforcement agencies should collaborate and coordinate with advocates and other service providers to create trauma-informed, best practice protocols that model documentation of incidents and injuries after incidents. Victim advocates with training on the dynamics of domestic violence should be called to the scene to assist with survivors, victims, and child witnesses and their adult caretakers to ensure that survivors are receiving appropriate services. These advocates may be employed by either law enforcement agencies or community-based victim advocate groups. Advocates may assist victims with orders of protection, safety planning, shelter access, referrals to other services such as counseling, and aftercare. Advocacy organized in an ongoing case management structure may also provide a point of contact for victims following the incident and improve victim access and use of services. Law enforcement agencies should encourage the use of victim advocates in the field.

### **Victim Services**

**Provide follow-up and case management services to victims after incidents of intimate partner and sexual violence.** Service providers are in a unique position to offer survivors of violence resource lists and referrals after incidents of violence. Providers, especially those in rural areas, should work with victims who would like to file domestic violence orders of protection, seek medical treatment, or seek therapy. These providers should also work with the local district attorney's office to ensure that the victim has access to any necessary legal services.

**Identify, inventory, and leverage existing resources to improve the distribution of domestic violence services in rural areas.** Almost 35% of reviewed deaths occurred in rural areas of the state. The Team recognizes that additional resources, including telehealth, are needed and recommends agencies look for ways to maximize existing resources to improve access to services whenever possible.

**Improve the visibility of intimate partner violence, mental health, sexual assault, substance abuse, and trauma-informed grief services among all local stakeholder agencies.** The Team recognizes that there is a shortage of services in all of these areas throughout the state and that when these services exist, coordination is lacking. The Team recommends

cross-training for service providers in each of these areas. Communities with intimate partner violence or sexual assault community coordinated response or multidisciplinary teams should maintain communication with, and representation from, intervention agencies outside of those directly focused on IPV. The Children, Youth, and Families Department and local law enforcement agencies should collaborate to improve knowledge of services available for referral. Broader knowledge of the available service agencies within a community may help IPV service agencies provide more comprehensive services for victims.

### **Prosecution**

**Address policy and resource gaps in the prosecution of domestic violence and sexual assault cases, including the use of best practices when negotiating plea bargains with IPV perpetrators.** Although guided by departmental policies, prosecutors have discretion regarding the charging, prosecuting, reducing, and dismissing of charges. The Team advocates that no intimate partner violence case should be plead down to a non-household member crime and that offenses committed against household members should be charged as such. Further, domestic violence incidents should be charged as felonies when possible and firearms should be removed from offenders. Charging decisions should also follow thorough investigations and the consideration of evidence based prosecution regardless of whether victims are available for testimony. Prosecutors may improve victim safety by ensuring proper notification of victims about charging decisions and collaborating with other agencies to improve investigations. District Attorneys should support the participation of their investigators, advocates, and prosecutors in local or regional domestic and sexual violence related community coordinated response or multidisciplinary teams when available. Additionally, prosecutors could benefit from training and continuing education on domestic violence and the law.

### **Courts**

**Address policy and resource gaps in the sentencing of domestic violence and sexual assault cases, including the use of best practices when accepting plea bargains with IPV perpetrators in domestic violence cases.** Although guided by statute and prosecutorial recommendations, judges have discretion in sentencing and plea bargain decisions. The Team advocates that no intimate partner violence case should be plead down to a non-

household member crime and that offenses committed against household members should be charged and sentenced as such. Further, domestic violence charges should be elevated to felonies as permitted by the multiple convictions of battery or aggravated battery statute (NMSA § 30-3-17) when possible and sentencing conditions should include the relinquishment of firearms. Additionally, judges and court staff could benefit from training and continuing education on domestic violence and the law.

**Courts should prioritize monitoring of offenders, both those awaiting trial for violent crimes and those sentenced to court monitored probation. Courts should evaluate both the need and the capacity for monitoring offenders.** An evaluation will help identify the resources necessary to develop an appropriate system of compliance monitoring to meet the needs of each jurisdiction. Relatively few pretrial monitoring programs exist statewide, with only a handful of counties having programs at the district or magistrate court level. When available, pretrial programs should monitor offenders who are awaiting trial for violent crimes, including those charged with either felony or misdemeanor domestic violence.

Magistrate courts also have few resources for supervising probation sentences, including those involving convictions for misdemeanor domestic violence. Court officials at all levels should ensure that providers of court ordered services associated with conditions of release are reporting violations and lack of compliance in a timely fashion. Monitoring compliance with domestic violence offender treatment/batterer intervention programs requires collaboration between courts, domestic violence service providers, and probation and parole. The Team recommends courts require this treatment to be completed in a CYFD certified domestic violence offender treatment program. This recommendation is consistent with the National Institute of Justice position<sup>5</sup> that courts hold violent offenders accountable for abiding by conditions of release and impose consequences when they do not.

### **Post-Conviction**

**Address policy and resource gaps in the monitoring and supervision of offenders, including support for professional monitoring of sentence compliance and attendance of**

**court ordered rehabilitation and Batterer Intervention Programs.** A review of IPV perpetrator criminal histories showed that 48% had at least one prior contact with state probation and parole services. Two perpetrators committed IPV homicide while serving a probation or parole sentence. Even when arrested for new crimes, offenders were not always charged with probation or parole violations. In a few cases, violations were processed but did not necessarily result in changes to the terms of supervision. The Team suspects that ineffective monitoring is at least due in part to understaffing, excessive caseloads, and a lack of collaboration between courts of all levels and relevant state or county agencies. Increased staffing may improve violation notifications to the court and provide more comprehensive monitoring for those with violation histories. Resource should be applied to ensure that courts hold offenders accountable when violations are identified.

### **Medical, Mental, and Behavioral Health Care Services**

**Provide follow-up and case management to individuals who seek medical, mental, and behavioral health treatment.** The Team observed cases where over 40% of perpetrators and almost 25% of victims had sought treatment for physical or mental health conditions. However, it was not always clear if those individuals completed prescribed treatment. Follow-up can ensure that individuals are accessing the services they need, including long-term services to ensure that individual needs are met and case management to enhance adherence. It also gives more opportunities for providers to screen their patients for a history of experiencing intimate partner violence.

**Eliminate barriers and improve knowledge of and access to substance abuse services.** Fifty-five percent of the IPV perpetrators had a history of alcohol abuse, 45% had a history of illegal drug use, and 55% had at least one arrest for DWI. Most of these individuals had little to no contact with substance abuse treatment services. Most of the nine perpetrators with a history of substance abuse services were court ordered into treatment as a result of drug or alcohol related offenses. The Team recommends dedicating resources to substance abuse programs to create more initial and long-term

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<sup>5</sup>National Institute of Justice. 2009. "Practical Implications of Current Domestic Violence Research: For Law Enforcement, Prosecutors, and Judges."

Retrieved Dec. 11, 2017  
(<https://www.ncjrs.gov/pdffiles1/nij/225722.pdf>).

services. Substance abuse service providers should receive training to identify warning signs of and best practices in responding to the co-occurrence of IPV and substance use by all individuals impacted by IPV. They should also agree to include information on intimate partner violence in their curricula and to treat violent and repeat offenders. The Team recommends the development of trauma informed, culturally appropriate and holistic services for teens and young adults, military veterans, and Native American populations in both urban and tribal locations. The Team also recommends the addition of aftercare services for individuals who have completed rehabilitation programs.

**Eliminate barriers and improve knowledge of and access to mental health services throughout the state.**

The Team recognizes the need for additional mental health resources that are trauma informed, long-term, and also exist in rural areas. The Team recommends the development of culturally appropriate and holistic services for teens and young adults, military veterans, the elderly, those who threaten and/or attempt suicide, and Native American populations. The Native American Committee is especially concerned about the availability of and access to mental health services for tribally affiliated individuals. Similarly, the Teen Dating Violence Committee expressed concerns about the availability of and access to mental health services for children and adolescents. They would like to see an increase in the availability of mental health services to youth. The Team also recommends that mental health care providers work to improve both visibility and accessibility of existing services and provide opportunities for caretaker education on issues related to both warning signs and intervention for suicide, self-harm, firearm storage and weapon safety, and dealing with crisis situations.

**Cross-Cutting Recommendations for the Community**

**Improve universal awareness and recognition of intimate partner violence. The Team recommends expanding public awareness education aimed at improving the recognition of IPV.** These efforts should work to raise awareness on the warning signs of intimate partner violence, lethality risk factors, safety

planning, and advice on how to talk about violent relationships. Prevention advocates should coordinate local resources and stakeholders to develop community capacity to engage in IPV prevention. This may include city, county, and state government agencies, community based service providers, schools, and, where present, IPV or sexual assault Community Coordinated Response Teams (CCRs) or Multi-Disciplinary Teams (MDTs). The team recommends defining the target audience broadly, including culturally and age appropriate messaging for children, parents, organization, and adults in the community at large. These activities should be inclusive of boys and men of all ages, providing education on male violence victimization and perpetration as well as engaging men as allies in IPV and sexual assault prevention.

**Increase public outreach efforts on how and when to report witnessed incidents of intimate partner violence and sexual assault.**

Public information initiatives should provide details not only on safe and appropriate response to incidents of physical abuse but should also help community members identify controlling behaviors, stalking, and other forms of abuse. Service providers can support these efforts by increasing visibility of services and resources in their communities. Provider outreach efforts should be designed for local communities, including work places, and be culturally and age appropriate for targeted audiences.

**The Children, Youth, and Families Department (CYFD) should improve personnel knowledge and capacity to advocate for and intervene with families in which children witness domestic violence in their homes.**

CYFD plays an important role in keeping children safe in New Mexico. CYFD should increase education for all of their staff, including case workers and social workers, on intimate partner violence, sexual violence, early intervention, and the effects of domestic and sexual violence on children. This training should aim to protect children, while avoiding victim blaming. They should also maintain intensive and prolonged contact with families experiencing domestic or sexual violence.

## **Appendix A: About the New Mexico Intimate Partner Violence Death Review Team**

The Intimate Partner Violence Death Review Team (Team), also known as the Domestic Violence Homicide Review Team, is a statutory body enabled by the New Mexico Legislature under NMSA §31-22-4.1 (Appendix A). The Team is funded by the New Mexico Crime Victims Reparation Commission. Team coordination and staff services are housed at the Department of Emergency Medicine, University of New Mexico Health Sciences Center. The Team is tasked with reviewing the facts and circumstances surrounding each intimate partner and sexual violence-related death that occurs in the State of New Mexico, with the aim of reducing the incidence of these deaths statewide.

### **Types of Deaths Reviewed**

The Team only reviews closed cases and does not re-open the investigations of those deaths. Closed cases are those in which the offender is dead or the case has gone through initial judicial proceedings. When a reasonable amount of time has passed since the death, the Team also reviews those cases that are classified as unsolved by law enforcement or when an offender was never criminally charged for the death.

The Team reviews cases in which the manner of death is classified by the Office of the Medical Investigator (OMI) as homicide, suicide, or undetermined. The majority of the cases the Team reviews fit into the following categories:

**The New Mexico Intimate Partner Violence Death Review Team is authorized by NMSA §31-22-4.1 to:**

Review the facts and circumstances of domestic violence related homicides and sexual assault related homicides in New Mexico,

Identify the causes of the fatalities and their relationship to government and nongovernment service delivery systems, and

Develop methods of domestic and sexual violence prevention.

- Homicide committed by the victim's current or former intimate or dating partner, whether male or female, including same-sex relationships,
- Homicide with a sexual assault component,
- Suicide by a victim of prior intimate partner violence,
- Suicide by a perpetrator of intimate partner violence or sexual assault (even if the victim survives) when the suicide is related to an incident of intimate partner or sexual violence or stalking,
- Homicide of the intimate partner violence or sexual assault perpetrator if related to an incident of intimate partner violence, sexual violence, or stalking (officer-involved shootings or bystander interventions), and
- Homicide of any child, family member or other individual killed during an incident of intimate partner or sexual violence or stalking.

### **Case Review Process**

Case reviews are conducted during confidential sessions. Prior to participating in a review, Team members and invited guests sign an agreement to abide by the confidentiality standards specified in the Team's statute (see Appendix A).

For each case, the Team, through its staff, collects case-specific data, including demographic information, autopsy reports, criminal and civil court histories of the victim and the offender, other known history of intimate partner violence, information regarding the use of legal or advocacy services, media reports, and the details of the incident including those occurring both just prior to and following the death.

During each case review, members first review the details of the death in a report containing the above listed information. Then members and invited guests contribute any additional information they may know about the death. For this additional information, the Team often asks for assistance from the agencies and individuals who work in the jurisdiction in which the death occurred, sometimes the same individuals or agencies that investigated that death or worked with the victim or the offender in that case. Invited guests also provide the Team with details about the local environment surrounding the

case, including the attitudes, traditions, and resources of that community, and the policies and practices of local prevention and intervention agencies.

Team members make note of the patterns and trends they observe and identify risk factors for the victim or the offender involved in each death. These risk factors include, but are not limited to, prior history of violence or abuse, availability of weapons, pregnancy, alcohol or drug use, mental health conditions, suicidal expressions, and recent separation.

For each case, Team members discuss the ways in which both the victim and the offender interacted with legal and other advocacy systems. These systems can include:

- the criminal justice system (law enforcement, district attorneys, courts, judges, corrections, or probation and parole);
- medical, behavioral, and mental health systems;
- social services (health departments, social service departments, child and family services, non-profit victim service agencies, shelters or income assistance agencies);
- the education system (public schools, private schools, higher educational institutions); and
- other systems the victim or the offender may have been in contact with prior to or following the death.

The Team identifies which systems the victim or the offender had contact with prior to, during, and after the death. These interactions are discussed during the case review. Knowledge about system contact and usage helps the Team identify recommendations for improvement to that system's response to intimate partner violence.

In making system recommendations, the Team does not aim to place blame on any individual or organization. Instead, the recommendations made throughout the year are compiled and presented as broad, rather than case specific, suggestions for systemic improvements. Team recommendations reflect the ways in which what the Team has learned from case circumstances can be used to improve system responses across the range of agencies and service providers.

### **Team Philosophy**

The Team recognizes that offenders of intimate partner violence and sexual assault are ultimately responsible for the death of their victims.

Therefore, when identifying gaps in service delivery or responses to victims, the Team chooses not to place blame on any professional agency or individual but rather learn from our findings in order to better understand the dynamics of intimate partner and sexual violence and how to prevent future associated deaths.



## **Appendix B: Statutory Authority for the Domestic Violence Homicide Review Team**

*(also known as the Intimate Partner Violence Death Review Team)*

*NMSA 1978 §31-22-4.1: Domestic violence homicide review team; creation; membership; duties; confidentiality; civil liability.*

- A. The “domestic violence homicide review team” is created within the commission for the purpose of reviewing the facts and circumstances of domestic violence related homicides and sexual assault related homicides in New Mexico, identifying the causes of the fatalities and their relationship to government and nongovernment service delivery systems and developing methods of domestic violence prevention.
- B. The team shall consist of the following members appointed by the director of the commission:
- (1) medical personnel with expertise in domestic violence;
  - (2) criminologists;
  - (3) representatives from the New Mexico district attorneys association;
  - (4) representatives from the attorney general;
  - (5) victim services providers;
  - (6) civil legal services providers;
  - (7) representatives from the public defender department;
  - (8) members of the judiciary;
  - (9) law enforcement personnel;
  - (10) representatives from the department of health, the aging and long-term services department and the children, youth and families department who deal with domestic violence victims’ issues;
  - (11) representatives from tribal organizations who deal with domestic violence; and
  - (12) any other members the director of the commission deems appropriate.
- C. The domestic violence homicide review team shall:
- (1) review trends and patterns of domestic violence related homicides and sexual assault related homicides in New Mexico;
  - (2) evaluate the responses of government and nongovernment service delivery systems and offer recommendations for improvement of the responses;
  - (3) identify and characterize high-risk groups for the purpose of recommending developments in public policy;
  - (4) collect statistical data in a consistent and uniform manner on the occurrence of domestic violence related homicides and sexual assault related homicides; and
  - (5) improve collaboration between tribal, state and local agencies and organizations to develop initiatives to prevent domestic violence.

- D. The following items are confidential:
- (1) all records, reports or other information obtained or created by the domestic violence homicide review team for the purpose of reviewing domestic violence related homicides or sexual assault related homicides pursuant to this section; and
  - (2) all communications made by domestic violence homicide review team members or other persons during a review conducted by the team of a domestic violence related homicide or a sexual assault related homicide.
- E. The following persons shall honor the confidentiality requirements of this section and shall not make disclosure of any matter related to the team's review of a domestic violence related homicide or a sexual assault related homicide, except pursuant to appropriate court orders:
- (1) domestic violence homicide review team members;
  - (2) persons who provide records, reports or other information to the team for the purpose of reviewing domestic violence related homicides and sexual assault related homicides; and
  - (3) persons who participate in a review conducted by the team.
- F. Nothing in this section shall prevent the discovery or admissibility of any evidence that is otherwise discoverable or admissible merely because the evidence was presented during the review of a domestic violence related homicide or a sexual assault related homicide pursuant to this section.
- G. Domestic violence homicide review team members shall not be subject to civil liability for any act related to the review of a domestic violence related homicide or a sexual assault related homicide; provided that the members act in good faith, without malice and in compliance with other state or federal law.
- H. An organization, institution, agency or person who provides testimony, records, reports or other information to the domestic violence homicide review team for the purpose of reviewing domestic violence related homicides or sexual assault related homicides shall not be subject to civil liability for providing the testimony, records, reports or other information to the team; provided that the organization, institution, agency or person acts in good faith, without malice and in compliance with other state or federal law.
- I. At least thirty days prior to the convening of each regular session of the legislature, the domestic violence homicide review team shall transmit a report of its activities pursuant to this section to:
- (1) the governor;
  - (2) the legislative council;
  - (3) the chief justice of the supreme court;
  - (4) the secretary of public safety;
  - (5) the secretary of children, youth and families;
  - (6) the secretary of health; and
  - (7) any other persons the team deems appropriate.



**For more information or for additional copies, please contact:**

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