New Mexico Intimate Partner Violence Death Review Team

Process Evaluation Report 2013

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Contents

Introduction

In December 2010, the New Mexico Intimate Partner Violence Death Review Team (Team) adopted a policy to produce an annual program evaluation. The evaluation is two pronged, consisting of both an assessment of outcomes and a process evaluation. The first report was completed in January 2011. The current report continues this work by updating prior evaluations and documenting new developments in the Team's process.

Outcomes Evaluation

In an effort to assess outcomes of the Team's work, Team members, in collaboration with the coordinator, monitor activities around the State that can be identified as consistent with the Team's recommendations from prior years. Activities may include, but are not limited to, developments in legislation, policy, and agency practice. Keeping track of these activities helps the Team assess the relevance of their recommendations over time. Team members report activities related to these recommendations at meetings as they occur throughout the year. These reports are documented by the coordinator and reported in the *Recommendation Updates* section of the Annual Report.

Process Evaluation

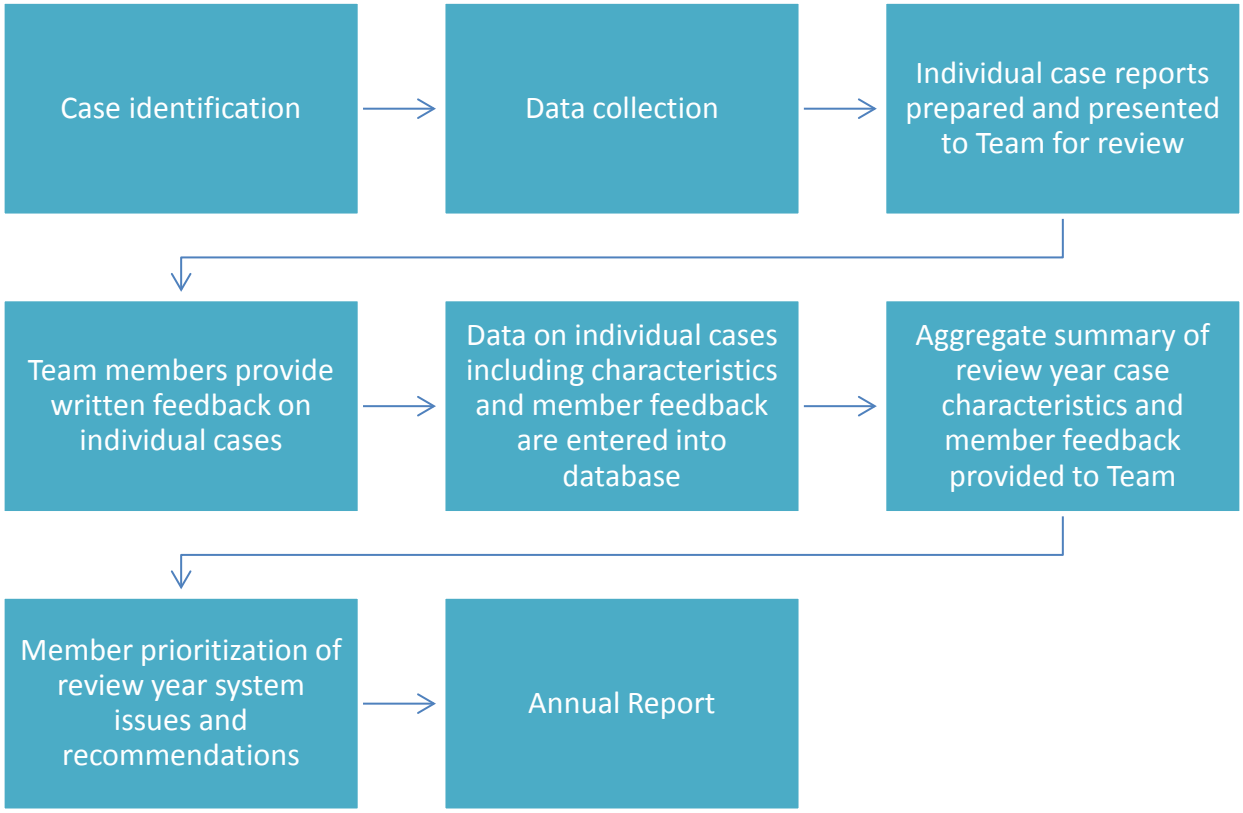
The second component of the evaluation plan is a process evaluation. Since 2011, the coordinator has provided the Team with a report on the case review process, including the case data collection strategy, case review procedures, and adherence to the Team's statutory mandate. This report is presented at the January meeting where the Team discusses the findings and provide feedback on improving the review process to better serve the mission, goals, and objectives established in *NMSA 1978 §31-22-4.1*.

Overview of the Death Review Process

The Team is tasked with reviewing the facts and circumstances of domestic violence related deaths and sexual assault related deaths in New Mexico. Each identified death incident is reviewed individually. The purpose of the review is to identify the causes of the fatalities and their relationship to government and nongovernment service delivery systems.

Recommendations for system improvements are made following each case review. Review findings and recommendations are compiled and reported in the aggregate at the end of each review year. This knowledge is produced with the goal of developing more effective methods of domestic violence prevention. Figure 1 provides a diagram of the review process.

Figure 1. Case Review Process



The present report provides an assessment of three components of the review process:

1. Meeting statutory directives, including: membership, meetings, and objectives,
2. The case review process from identification through data collection, and
3. The case review process from case presentation through Team member feedback.

This work is intended to serve as a discussion guide for the Team to review and make recommendations for improving the case review process.

Statutory Objectives

NMSA 1978 §31-22-4.1 defines the Team's composition and sets out specific objectives to be accomplished.

Membership

The statute identifies 11 occupational categories to be represented in the Team's appointed membership. A twelfth category consists of other appointees designated by the Crime Victims Reparation Commission. In 2013, the Team had 29 appointed members. Table 1 shows the number of appointed members by appointment category. The Team Coordinator is currently working with CVRC to fill the vacancy in the public defender category.

Table 1. Number of 2013 Appointed Team Members by System Category

System	Number of representatives in system area
Administrative Office of the District Attorney	1
Attorney General's Office	1
Civil Legal	3
Courts	3
Criminologist	1
Law Enforcement	2
Medical	2
Other Members	5
Public Defender	0
State Agencies	3
Tribal	3
Victim Services	5
Total Number of Members	29

In addition to appointed members, the Team also invites additional participants from system agencies. These members represent a diverse group of local, state, tribal, and federal agencies. Table 2 shows the distribution of invited members participating in the Team's 2013 meetings by system category.

Table 2. Number of 2013 Invited Participants by System Category

System	Number of invited participants in system area
Administrative Office of District Attorneys	0
Attorney General's Office	2
Civil Legal	2
Courts	3
Criminologist	1
DA Victim Advocate*	3
Law Enforcement	5
LE Victim Advocate*	2
Medical	0
Other Members	2
Public Defender	0
State Agencies	6
Tribal	3
Victim Services	10
Total Number of Members	39

*District Attorney's Office (DA) Victim Advocate and Law Enforcement (LE) Victim Advocate are not areas of appointment. However, members of these professions regularly participate in team meetings and contribute to team case reviews.

Meetings

In 2013, there were 12 regular Team meetings. Meetings were held on the third Thursday of the month from 10 am to 12 pm. All meetings took place at the Albuquerque Family Advocacy Center. The January meeting was dedicated to reviewing the Team's review process. Case reviews began in February and ran through the October meeting. One additional ad hoc case review meeting was held in October. In November, the Team also reviewed aggregate findings from the case review meetings and prioritized recommendations for the annual report. In December, the Team held its annual business meeting.

The average attendance at Team meetings was 25 people total. The average number of appointed members in attendance was 20. The average number of appointment categories represented at each meeting was nine out of 12 categories. Quorum, as defined in the Team's policies and procedures, was reached in all twelve 2012 Team meetings. Table 3 documents meeting attendance by month.

Table 3. 2013 Meeting Attendance by Month

Meeting Month	Total # of people in attendance	# of appointed members in attendance (%)* (N = 29)	# of appointment categories represented**
January	18	14 (48)	8
February	21	18 (62)	8
March	29	23 (79)	11
April	29	25 (86)	10
May	24	21 (72)	11
June	23	19 (66)	9
July	22	17 (59)	9
August	27	21 (72)	9
September	33	24 (83)	9
October	24	17 (59)	10
November	27	20 (69)	9
December	23	19 (66)	8

**Seven of 12 categories must be represented to establish quorum.

At case review, appointed members and invited participants provided insight into the policies and procedures of their respective agencies. Since Team goals include a holistic evaluation of system response, it was important to have all system categories present for each case review meeting. With the exception of the vacancy of the Public Defender's Office position, most appointed member absences were offset by the participation of invited members in the same category. The Coordinator is working with CVRC to fill the vacancy in the Public Defender's Office category. Table 4 describes system representation at 2013 Team meetings.

Table 4. System Representation at 2013 Team Meetings

System	# of meetings with at least one appointed member representing system area in attendance	# of meetings with at least one invited participant representing system are in attendance	# of meetings with at least one person representing system area in attendance
Administrative Office of District Attorneys	5	0	5
Attorney General's Office	12	7	12
Civil Legal	12	1	12
Courts	10	6	11
Criminologist	11	0	11
DA Victim Advocate*	n/a	4	4
Law Enforcement	12	7	12
LE Victim Advocate*	n/a	9	9
Medical	8	0	8
Other Members	12	3	12
Public Defender	0	0	0
State Agencies	11	6	11
Tribal	11	2	11
Victim Services	12	8	12

* District Attorney's Office (DA) Victim Advocate and Law Enforcement (LE) Victim Advocate are not areas of appointment. However, members of these professions regularly participate in team meetings and contribute to team case reviews.

In addition to the Team meetings, the Team's Committees also met throughout the year. The Native American Committee held two organizational meetings and one case review meetings. Two meetings were held in Albuquerque; one took place in Farmington, New Mexico. The Teen Dating Violence Committee held one organizational meeting, four case review meetings and one meeting for generating recommendations. The Friends and Family Committee held one organizational meeting and sent invitations to prospective interviewees. The Marginalized Populations Committee held two meetings in 2013: one organizational meeting and one panel discussion with members of the broad systems community whose work intersects with issues related to youth homelessness and substance abuse.

Objectives

The Team's statute defines 5 specific objectives to guide the Team's work. Table 5 lists each objective alongside corresponding 2013 activities and 2014 goals. Goals for 2013 were documented in the Team's 2012 Process Evaluation Report.

Table 5. Statutory Objectives, Team Activities, and Future Goals

Statutory Objectives	2013 Activities	2014 Goals
Review trends and patterns of domestic violence related homicides and sexual assault related homicides in New Mexico	Team compared patterns of risk factors and case characteristics across 2010 homicide and suicide cases. Coordinator added 2010 cases to data entry (2006-2010).	Complete Team activity for 2011 deaths, and Continue multi-year data entry and comparison of these characteristics (deaths occurring between 2005 and 2011).
Evaluate the responses of government and nongovernment service delivery systems and offer recommendations for improvement of the responses	Team compared system interventions preceding these deaths for both victim and offender and compared criminal charges and prosecution outcomes for 2010 homicides. Coordinator compiled intervention response variables for deaths occurring in 2010.	Complete Team activity for 2011 deaths, and Continue compilation of intervention response variables for deaths occurring in 2011.
Identify and characterize high-risk groups for the purpose of recommending developments in public policy	Team identified risk factors for each 2010 reviewed death, Coordinator compiled lethality risk variables for each case reviewed. Coordinator also updated the research reference table on lethality risk factors (See Appendix 1).	Complete activity for 2011 deaths, and Continue to monitor research on lethality risk factors and maintain list of research publications.
Collect statistical data in a consistent and uniform manner on the occurrence of domestic violence related homicides and sexual assault related homicides	Team utilized standardized form for collecting and reporting case data for each 2010 reviewed death. Coordinator updated database including all data elements and team feedback, for all reviewed 2010 cases.	Complete activity for 2011 deaths, and Maintain database of collected data elements (including the Team's feedback), enter case data for 2011.
Improve collaboration between tribal, state and local agencies and organizations to develop initiatives to prevent domestic violence	Team worked toward improved collaboration through organizational representation in Team membership, by monitoring community and agency prevention and intervention activities statewide, and by providing recommendations derived from multi-disciplinary case review discussion	Continue to assess ways in which organizations are working together to improve both prevention efforts and response to domestic violence.

Case Review Process: Identification through Data Collection

Case Identification

The coordinator identified cases for review using several methods: researching death records at the Office of the Medical Investigator, reviewing media reports regarding domestic and sexual violence, and receiving case suggestions from Team members or other professionals. The coordinator attempted to gather information on all domestic and sexual violence deaths that occurred in the state. However, domestic or sexual violence deaths are not always reported as such, and therefore, may be difficult to identify through public records.

Table 6 lists the types of cases that the Team considered for review, provides a brief definition of each, and identifies the number of reviewed calendar year 2010 cases (CY2010) that fit in each category. In 2013, the Team reviewed 33 deaths that resulted from 28 incidents of intimate partner violence A full report of findings on CY2010 cases is available in the Team's 2013 Annual Report.

Table 6. Types of CY2010 Intimate Partner Violence (IPV) Related Deaths Reviewed in 2013

Type of Case	Definition	Number of incidents reviewed in 2012
Intimate Partner Homicide	Homicide where the victim and offender are current or former intimate or dating partners (homicide decedent may be the victim or perpetrator of the incident of intimate partner violence), includes cases of murder-suicide	9
Sexual Assault Homicide	Homicide with a sexual assault component, regardless of the relationship between the victim and offender	2
Bystander-Involved IPV-Related Homicide	Homicide of any child, family member or other party or the death of the intimate partner violence perpetrator where the homicide is committed by someone other than his or her intimate partner, when the death occurs during an incident of intimate partner violence	11
IPV-Related Offender Suicide	Suicide by an intimate partner violence perpetrator when the death occurs during or directly following an act of intimate partner violence and the victim survives	6

Over time, the Team has altered the decisional criteria for case selection to include additional case types that may provide insight for preventing future injury and death resulting from intimate partner violence. Table 7 documents the case years (year of homicide incident) and review years (year of Team review) for which each type of case has been reviewed.

Table 7. Case Year by Types of Cases Selected for Review

Types of Case	Case Years	Review Years
Female Intimate Partner Homicide Victims	1993 - present	1998 - present
Female Sexual Assault Homicide Victims	1997 - present	1999 – present
Male Intimate Partner Homicide Victims	1999 - present	2001 – present
IPV Bystander Homicides	2003 - present	2007 - present
IPV Victim and IPV Offender Suicide Alone	2007 - present	2009 – present

Data Collection

Once cases were identified for review, the coordinator collected information about the victim and offender and the death incident. In addition to demographic and relationship information, the coordinator also determined which agencies or systems the victim or offender had contact with prior to or following the death and contacted each of those agencies to obtain all pertinent and available reports and case information. The coordinator also researched available media reports or other relevant information sources (i.e. websites) regarding the death or prior incidents with the victim or the offender. Once compiled, this information was entered into the Team's *Confidential Case Review Form* as completely as possible. Table 8 details the types of information collected by the coordinator for use in case investigation and compilation with notes on the availability and accessibility of each type of information.

Table 8. Case Review Data Types, Sources, and Access Review and Update

Types of Information	Source(s)	Access	Comments
Law enforcement reports, including crime scene investigations and detective's investigative reports	Individual law enforcement agencies	Good	Law enforcement reports are public records available upon request. Acquiring these documents may require a fee for copying/mailing and can take from a few days to two or three weeks to obtain.
Media reports	Albuquerque Journal Subscription Archive* Internet Search	Good	Stories of intimate partner violence related deaths are collected in real time. Media coverage of homicide is consistent statewide and generally leads to stories on the arrest and prosecution of the offender. Murder-suicide is generally covered but to a lesser extent that homicide and there is no coverage of suicide unless it occurs in a public manner.
Details of any prior protective orders (temporary and permanent)	Identified through state court database, Retrieved from individual courts	Good	Protection order documents are public records available upon request. Acquiring these documents may require a fee for copying/mailing and can take from a few days to two or three weeks to obtain.
Civil court data regarding divorce, termination of parental rights, child custody, or child visitation	Identified through state court database, Retrieved from individual courts	Fair	Divorce proceedings are easily identified and those without children can be ordered from individual courts although we generally do not request these documents unless they are immediate / relevant to the death review. We do not have access to the content of proceedings for parentage, child custody, and visitation cases. The outcomes are generally noted in the data available on the court database.

Table 8. Continued

Types of Information	Source(s)	Access	Comments
Criminal histories of the offender and the victim	Identified through state court database, If relevant to review, reports may be requested from individual law enforcement agencies and / or courts	Fair-Good	Consistent access to criminal histories within the State of NM. Limited access to criminal histories for persons who are from out of state or have spent significant time outside of NM and those that live on the State's border with another state or Mexico.
CYFD protective services data (regarding referrals for service made in cases of alleged child abuse or neglect identified in case reviews)	Team Member Report Out	Good	No direct access to CYFD records. Information is limited to referrals for service in cases involving minors with CYFD contact.
Adult protective services summary data and prior abuse history	Team Member Report Out	Fair	No direct access to records.
Summaries of psychological evaluations or reports appearing in public record documents, such as police files	As documented in law enforcement and / or court documents	Fair - Poor	No direct access to mental health care records. Rarely documented unless symptoms and/or treatment are reported immediately preceding the death
OMI autopsy report	OMI Database** In person review of autopsy records	Good	
Workplace information (stalking/harassment, alerts among co-workers)	As documented in law enforcement and / or court documents	Poor	Rarely documented unless the workplace and/or co-workers are tied in some way to the incident (location, witnesses, construction of timeline, etc…).

Table 8. Continued

Types of Information	Source(s)	Access	Comments
Medical reports and hospital emergency room information	As documented in law enforcement and / or court documents	Poor	Rarely documented unless immediately preceding the death.
Shelter or program services information from domestic violence or sexual assault advocates (if appropriate and legally permissible)	Team Member Report Out, As documented in law enforcement and / or court documents	Fair-Good	Difficult to identify shelter use unless reported in law enforcement documentation, Information on use of services and referrals by Sexual Assault Nurse Examiners is available by Team member report out.
School reports regarding children reporting abuse in the home	As documented by school personnel,	None-Fair	Limited success in accessing education records for teen and young adult decedents only. The content of records varies by school, but may document enrollment, grades, test scores, graduation, etc… Retrieved records do not typically contain information on suspected or reported abuse
Statements from neighbors, friends or witnesses (often found in police files as transcribed material or in court documents or trial transcripts)	As documented in law enforcement and / or court documents	Fair-Good	In homicide and undetermined death cases, witness reports and interviews with relevant parties are generally documented. Witness reports are less rigorously documented in cases involving suicide and murder-suicide
Pre-sentence investigation report (probation)		None	
Parole information (including victim notification)	Team Member Report Out, Court case information obtained through state court database	Fair	Electronically available court records do not contain a full report of the conditions of release, treatment orders, etc… but rather document only the terms of the original sentence. Details available in the electronic court record are limited to formal violations of court mandated conditions of release, and whether or not the parolee successfully completes the terms of parole.

Table 8. Continued

Types of Information	Source(s)	Access	Comments
Information regarding weapons confiscation, purchase, and background checks	As documented in law enforcement and / or court documents	Fair-Poor	Rarely documented unless directly related to or immediately preceding the death
Drug and alcohol treatment information	As documented in incident reports and court records.	Poor	Limited to the determination of whether or not an individual has been mandated by the court to attend drug and/or alcohol treatment. No information on treatment for those with no criminal or DVOP history. At times, the facility for treatment is documented. Unless the individual is on probation and/or parole and violated for failure to attend or complete treatment, we do not have access to information on the outcome of treatment.

*The Department of Emergency Medicine at UNM maintains a subscription to the Albuquerque Journal archives.

**In accordance with agency policies, the Department of Emergency Medicine at UNM has submitted the Use of Decedent Protected Health Information form to the UNM Human Research Protections Office in order to be granted access to autopsy records from the Office of the Medical Investigator. This data source is critical to identifying cases for review.

Definitions

Throughout the case identification and data collection process, the coordinator used a number of working definitions to guide selection of appropriate cases and coding of case characteristics. Appendix 2 contains a list of working definitions used for this purpose. These definitions were based in part on existing research, but were also adapted based on the Team's experience with case review. The appendix also contains commonly used abbreviations.

Case Reporting and Team Feedback Procedures

During closed sessions of Team meetings, the coordinator distributed the *Confidential Case Review Form* and other relevant documents (i.e. news articles, court docket entries) to the Team. The form included detailed information about the victim, offender, the relationship between the parties, the death incident, system response to the death, and a narrative that included a timeline of events surrounding the death. Team members reviewed the information provided and the narrative was read aloud. Team members asked questions to clarify issues or obtain additional information about the case. When appropriate, the coordinator invited representatives from agencies or systems that had contact with the offender or victim prior to or following the death to the meetings in order to provide the Team with additional information not available in the written records.

After reading and discussing the facts of the death, Team members conducted a thorough review of the death and factors associated with the death. In particular, Team members looked for: risk factors for the victim or the offender prior to the death, system failures associated with the death, and recommendations for policy or systems improvement. At the conclusion of the meeting, all documents related to the case were collected by the coordinator and either secured for storage or destroyed.

As of the 2013 review year, all information contained in the *Confidential Case Review Form* was recorded in a database so that case similarities and differences can be identified and monitored over time. Data entry has been completed for CY 2006-2010 cases.

Feedback

Each Team member was responsible for participating in the case review discussion and for providing written feedback on case findings and recommendations. The Team relies on the professional expertise of each of its members and therefore, it was important for Team members to analyze each case according to their profession and contribute ideas and suggestions for inclusion in the Team's recommendations. After each review, the coordinator summarized the findings and recommendations identified in the review and maintained case statistics for aggregate reporting, such as age, race, and gender of victims and offenders and the relationship between victim and offender. Member feedback was also recorded in the case information database.

Each year, the Team discusses modifications to the feedback process. Our goal is to generate recommendations that closely address the system issues observed during case reviews. The current *Team Member Case Review Feedback Form* is provided in Appendix 3 for discussion.

Appendix 1: Intimate Partner Violence Lethality Risk Factors

The following is a draft list of intimate partner violence lethality risk factors with citations for the publication of the source research. Risk factors are organized into types and are otherwise listed in no particular order. Most of this research is based on the homicide death of female IPV-victims killed by male IPV-perpetrators. Some of the early works are based on professional experience of the author and non-systematic research methods. Not all of these factors increase lethality risk in the same way, to the same extent, or in all populations. The documentation of lethality risk factors is an ongoing task and will (in the future) be updated to include more information on the circumstances under which the characteristic increases risk. In the meantime, **if you are planning to cite these works, please see source materials** for information on research design, sampling, and generalizability and to ensure that the research finding is applicable to the item you are referencing.

Lethality Risk Factor	Citation
Prior Violence	
Forced sex of female partner	Anderson, Draughon, and Campbell 2013; Campbell 1995, 1986; Campbell et al. 2003a, 2003b; Campbell et al. 2007; Dobash et al. 2007; Nicolaidis et al. 2003;
Attempt of suicide by offender	Websdale 1999; Hart 1988
Attempted homicide by offender	Hart 1998
Prior history of domestic violence	Campbell et al. 2003a, 2003b; Websdale 1999; Bailey et al. 1997
Serious victim injury in prior abusive incidents	Campbell 1995, 1986
Stalking of the victim	Websdale 1999
Nonfatal strangulation and/or prior choking	Glass et al. 2008; Campbell et al. 2003a, 2003b;
History of violence in general, may include prior criminal history of violent crime	Websdale 1999
Weapons	
Threats with weapons	Campbell 1995, 1986
Use of weapon in prior abusive incidents	Campbell 1995, 1986

Lethality Risk Factor	Citation
Access to/ownership of guns	Websdale 1999; Bailey et al. 1997; Campbell 1995, 1986; Hart 1988
Morbid fascination with firearms	Websdale 1999
Access to weapons increases severity of domestic violence	Folkes, Hilton, and Harris 2012
Offender Criminal History	
Violent Criminal History	Websdale 1999
Prior Contact with Police for Domestic Violence	Websdale 1999
Other Offender Behavioral Factors	
Drug or alcohol abuse	Campbell 1995, 1986; Hart 1988
Obsessiveness/extreme jealousy/extreme dominance	Websdale 1999; Campbell 1995; Hart 1988;
Threats of suicide by offender	Websdale 1999; Campbell 1995, 1986; Hart 1988
Fantasies about homicide	Hart 1988
Threats to kill victim, victim's family or friends (often specifies details of plan)	Websdale 1999
Threats to harm children	Campbell et al. 2003a, 2003b
Isolation of the batterer	Hart 1988
Dependence of batterer on victim	Hart 1988
Depression or poor mental health	Hart 1988
Access to the victim	Hart 1988
Sleep disturbances (chronic, sometimes receiving treatment)	Websdale 1999
Relationship Characteristics	
Longstanding relationship* M-S	Morton et al. 1998;
Marital Status/Cohabitation Status	James and Daly 2012;
Situational Factors	
Estrangement, separation, or an attempt at separation (usually by the female party)* M-S	Websdale 1999;
Step-children in home	Miner et al. 2012;
Female victim's employment outside the home	Powers and Kaukinen 2012;

Lethality Risk Factor	Citation
Social Structure	
IPV homicide rates are lower in countries with higher gross domestic product per capita	Agha 2009;
Neighborhood environment differentiates the characteristics of urban and rural intimate partner homicide	Beyer et al. 2013
Other Citations of Note	
Murder-Suicide	Banks et al. 2008; Barber et al. 2008; Bossarte et al. 2006; Kozoil-McClain et al. 2006; Comstock 2005; Websdale 1999; Morton et al. 1998; Bailey et al. 1997; Stack 1997; Block and Christakos 1995; Buteau, Lesage, and Kiely 1993;
Risk of child death in domestic violence homicide incidents	Hamilton, Jaffe, and Campbell 2012
Non-Intimates as victims in IPV-related homicides	Dobash and Dobash 2012;
Homicide of law enforcement officers responding to domestic violence	Kercher, et al. 2013
System actors' accuracy in assessing victim risk	Robinson and Howarth 2012
Risk factor differences for female IPV homicide offenders and male IPV homicide victims	Belknap et al. 2012; Bourget and Gagne 2012; Reckdenwald and Parker 2012; Weizmann-Henelius et al. 2012
Media coverage of domestic violence homicide	Gillespie et al. 2013
IPV Risk Assessment Instruments (Reliability and Validity)	Belfrage and Strand 2012; Belfrage et al. 2012; Kropp and Cook 2013; Messing and Thaller 2012; Williams 2012; Winkel and Baldry 2013

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Appendix 2: Common Abbreviations & Working Definitions

Abbreviations

DV	Domestic Violence
DVOP	Domestic Violence Order of Protection
IPV	Intimate Partner Violence
IPVDRT	Intimate Partner Violence Death Review Team
SA	Sexual Assault
TDV	Teen Dating Violence

Definitions

Bystander

A bystander is defined as a person who is not involved in the act of intimate partner violence or sexual assault, but is identified as a witness to the incident of intimate partner or sexual violence. This includes children, neighbors, family members and/or any other individuals who may be present at the scene of an incident of intimate partner or sexual violence. At times, bystanders to the incident may become either the victim or the offender in the homicide.

Child Witness

A child is a witness to intimate partner or sexual violence when an act that is defined as such is committed in the presence of or perceived by the child. The witnessing of violence can be auditory, visual, or inferred, including cases in which the child perceives the aftermath of violence, such as physical injuries to family members or damage to property (Child Welfare Information Gateway 2009). The team identifies child witnesses only for cases involving minor children (aged 17 years and younger).

Homicide

Homicide is defined as any death not classified as natural, accident or suicide, where a person dies as the result of an act performed by another, regardless of who perpetrated the incident. The Team's definition of homicide includes cases that may not meet the legal definition of murder.

Homicide Offender

The homicide offender is defined as the individual who committed the act of homicide, regardless of whether or not the individual was involved in the act of IPV or SA.

Homicide Decedent

The homicide victim is the decedent of the act of homicide, regardless of whether or not the individual was involved in the act of IPV or SA.

Intimate Partner Violence (IPV) Perpetrator

The identified perpetrator of the act of intimate partner violence, and may be either the victim or offender in the homicide.

Intimate Partner Violence or Sexual Assault-Related Death (IPV- or SA-related death)

An IPV-related death is a one that occurs either during or directly following an incident of intimate partner violence, dating violence, or sexual violence (regardless of relationship). The Team reviews intimate partner violence related deaths in the following categories:

- Decedent was murdered by an intimate partner,
- Decedent was murdered following a sexual assault (no relationship required),
- Decedent was murdered during / following an act of intimate partner violence,
- Suicide of a victim of domestic violence that is carried out in the context of the violent incident, closely following such an incident, or the violence and/or legal consequences are identified as a reason by the decedent prior to death.
- Suicide of a perpetrator of domestic that is carried out in the context of the violent incident, closely following such an incident, or the violence and/or legal consequences are identified as a reason by the decedent prior to death. This includes cases involving the attempted murder of the domestic violence victim with a completed offender suicide (attempted murder-suicide);
- Suicide of a sexual assault victim that is carried out in the context of a sexual assault incident, closely following such an incident, or sexual assault is identified as a reason by the victim prior to death;
- Suicide of a sexual assault perpetrator that is carried out in the context of a sexual assault incident, closely following such an incident, or sexual assault is identified as a reason by the perpetrator prior to death;
- Accidental death from asphyxiation, toxicity, or overdose that happens in the context of an incident of domestic or sexual violence or closely following such an incident.

Intimate Partner Violence (IPV) Victim

The victim in the act of intimate partner violence, and may be either the victim or offender in the homicide.

Sexual Assault Perpetrator

The perpetrator in the act of actual or attempted sexual assault. The sexual assault perpetrator may be either the victim or offender in the homicide.

Sexual Assault Victim

The victim of an actual or attempted sexual assault. The sexual assault victim may be either the victim or offender in the homicide.

Technological Abuse

Intentional behavior used to control, harass, coerce, stalk, intimidate or victimize that is perpetrated through the internet, social networking sites, spyware or global positioning system (GPS) tracking technology, cellular phones, instant or text messages, or other forms of technology. Technological abuse can include unwanted, repeated calls or text messages, non-consensual access to email, social networking accounts, texts or cell phone call logs, pressuring for or disseminating private or embarrassing pictures, videos, or other personal information (see VAWA Reauthorization draft definition).

Teen Dating Violence (TDV)

Actual or threatened acts of physical, sexual, psychological and verbal harm, including technological abuse, stalking, and economic coercion by a partner, boyfriend, girlfriend or someone wanting a personal or intimate relationship involving at least one individual 10-19 years of age, regardless of gender identity or sexual orientation (based in part on the VAWA Reauthorization draft definition, see https://www.ncjrs.gov/teendatingviolence).

Stalking

Stalking is defined as "the willful, malicious, and repeated following and harassing"(Kilmartin & Allison 2007) of an individual in a course of conduct "that would cause a reasonable person fear"(Tjaden & Thoennes 1998). Stalking may involve persistent harassment over time and often more than one type of activity (Sheridan, Davies, & Boon 2001).

Stalking includes physical acts: following, tracking with GPS device, trespassing, spying or peeping, appearing at one's home, business, or favored social location, leaving written messages or objects, vandalizing property, and surveillance. This definition also includes acts defined as *non-consensual communication*: unwanted phone calls, postal mail, e-mail, text messages, instant messaging, contact through social networking sites, sending or leaving gifts or other items.

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Appendix 3: Team Member Case Review Feedback Form

NM Intimate Partner Violence Death Review Team
Team Member Feedback

Instructions: Think about the need for and use of system agencies by the individuals described in the case reviewed today. Identify system-related gaps or problems observed in this case and **for each problem** answer the following questions:

<table>
<tr><th>Case Review Worksheet</th><th>Feedback and Recommendation # 1</th></tr>
<tr><td>Would you define this case as intimate partner (or sexual assault) violence-related? If no, please explain.
☐ Yes ☐ No
Comments:</td><td>Briefly state the problem (system gap or failure) from the worksheet that you are addressing.</td></tr>
<tr><td rowspan="2">Identify IPV fatality risk factors observed in this case:</td><td>What evidence or example of the gap or failure was observed in this case?</td></tr>
<tr><td>To which system area does this recommendation primarily relate?
☐Law Enforcement ☐Prosecution
☐Courts ☐Corrections
☐Probation and Parole ☐Victim Services
☐Medical Services ☐Legislation and Public Policy
☐Mental and Behavioral Health Services
☐Other, specify (e.g. social services, schools, community):</td></tr>
<tr><td>Actual system contacts by one or more persons observed in this case:
☐Law Enforcement ☐Prosecution
☐Courts ☐Corrections
☐Probation and Parole ☐Victim Services
☐Medical Services ☐Legislation and Public Policy
☐Mental and Behavioral Health Services
☐Other, specify (e.g. social services, schools, community):</td><td>To what specific component(s) of this system is your recommendation related?
☐ law/legislation ☐ policy ☐ agency/organization
☐ program/service ☐ practice/implementation ☐ education/knowledge
☐ training ☐ evaluation/research
☐ coordination/cooperation/communication between agencies
☐ other (specify):</td></tr>
<tr><td>System contact or resources needed, but no known contact by any persons observed in this case:
☐Law Enforcement ☐Prosecution
☐Courts ☐Corrections
☐Probation and Parole ☐Victim Services
☐Medical Services ☐Legislation and Public Policy
☐Mental and Behavioral Health Services
☐Other, specify (e.g. social services, schools, community):</td><td>What change to this system or system component would you recommend to address this gap or failure?</td></tr>
<tr><td>Draft a list of possible system gaps and failures in this case:
1.
2.
3.
4.
5.
6.
7.</td><td>Identify all system actors or organizations who you think should be involved in the design, promotion, or implementation of the recommended system change.</td></tr>
</table>

Appendix 4: Team Member Evaluation Comments

Please detach this form and return to coordinator at your convenience
Feedback can also be emailed to dalbright@salud.unm.edu

Participation

What did you gain as a result of participation in the Intimate Partner Violence Death Review Team?

How do the knowledge/skills gained as a result of participation on the Team relate to your work?

Statutory Objectives

Comments on and/or recommendations for agency representation in Team membership:

Comments on and/or recommendations related to meeting the Team's statutory objectives:

Team Member Evaluation Comments, Continued

Case Review

Comments on and/or recommendations for improving case identification:

Comments on and/or recommendations for improving data collection (Please note: if recommending access to information not currently collected, please provide point of contact for the owner of the data):

Comments on and/or recommendations for improving the case report out process and forms:

What aspect of this activity do you find to be most valuable? Least valuable?

Thank you for your feedback!