New Mexico Intimate Partner Violence Death Review Team

Process Evaluation Report 2017

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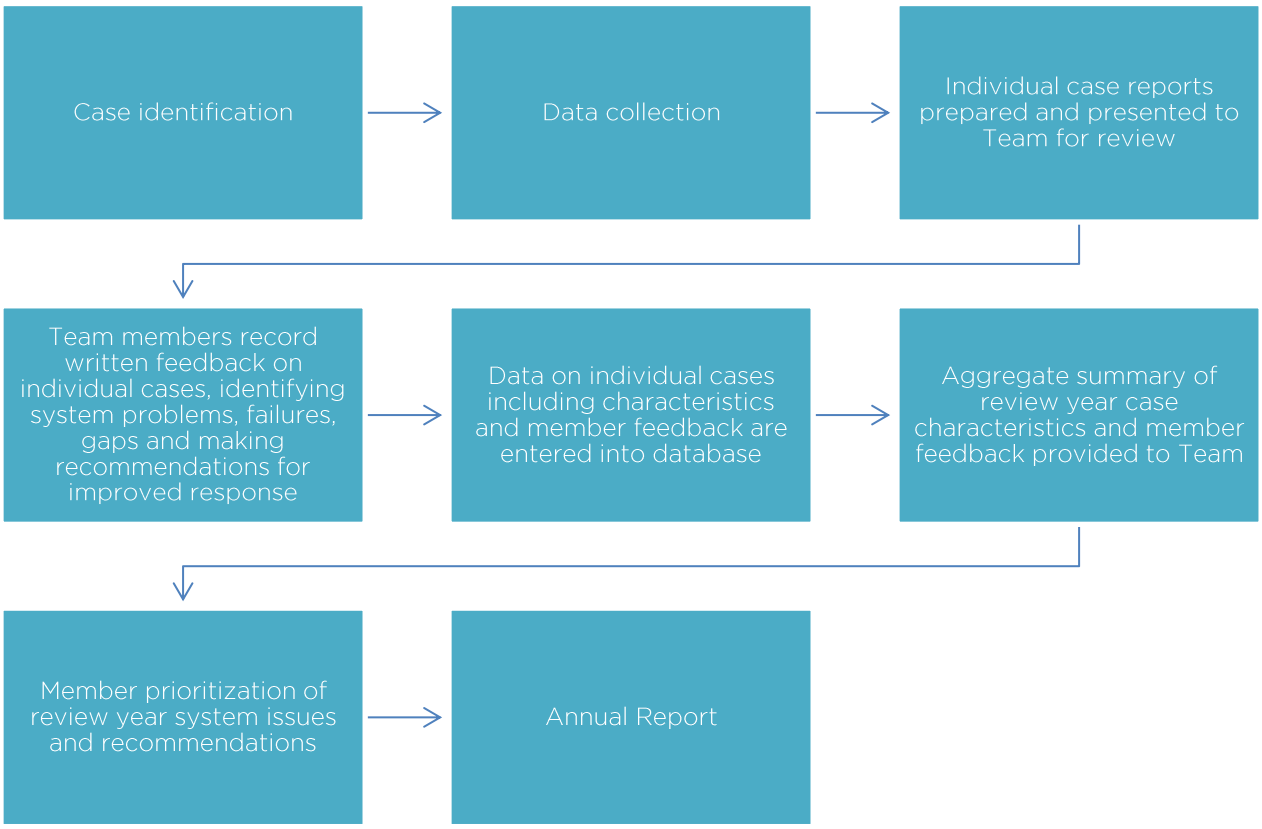
Introduction

The New Mexico Intimate Partner Violence Death Review 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



In December 2010, the 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 Process Evaluation (reports available at http://emed.unm.edu/cipre/programs/intimate-partner-violence-death-review/index.html).

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 made available to the Team in January, where the Team may discuss 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.*

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.

The report also includes four appendices: A selected literature review for intimate partner violence lethality risk factors, a list of common abbreviations and working definitions, the Team member case review feedback form, and the statutory authority for the Team.

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

Revised 3/27/2018

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 Victim Reparations Commission. In 2017, the Team had 27 appointed members. Table 1 shows the number of appointed members by appointment category. Three appointed positions were vacant in 2017: Public Defender Department, Victim Service Agency, and Aging and Long Term-Services Department. At the end of the year, there were eight vacancies: a criminologist, victim services provider, civil legal service provider, Public Defender Department, Department of Health, Aging and Long-Term Services Department, and Parole Board. Two statutory categories were vacant at the end of 2017. Team Coordinator is currently working with CVRC to fill these vacancies.

Table 1. Number of 2017 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	1
Courts	3
Criminologist	Vacant
Law Enforcement	3
Medical	3
Other Members	3
Public Defender	Vacant
State Agencies	1
Tribal	3
Victim Services	4
Total Number of Members	23

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 2017 meetings by system category.

Table 2. Number of 2017 Invited Participants by System Category

System	Number of invited participants in system area
Administrative Office of District Attorneys	1
Attorney General's Office	1
Civil Legal	4
Courts	2
Criminologist	0
Law Enforcement	3
Medical	1
Other Members	2
Public Defender	0
State Agencies	2
Tribal	6
Victim Services	4
Total Number of Members	26

*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 2017, 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. Case reviews began in January and ran through the October meeting. Three additional ad hoc meetings were held. One meeting was held on March 16 to review intimate partner violence related homicide cases and two additional meetings were held on August 3 and October 19 to review the Team's multi-year recommendations. In November, the Team 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 21 people total. The average number of appointed members in attendance was 14. The average number of appointment categories represented at each meeting was eight out of 12 categories. Quorum, as defined in the Team's policies and procedures, was reached in all twelve 2017 Team meetings. Table 3 documents meeting attendance by month.

Table 3. 2017 Meeting Attendance by Month

Meeting Month	Total # of people in attendance	# of appointed members in attendance (%)*	# of appointment categories represented**
January	20	14	7
February	16	11	8
March	26	19	9
April	23	14	9
May	28	18	10
June	18	12	8
July	26	18	9
August	18	16	10
September	19	11	7
October	20	10	7
November	22	12	8
December	25	15	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. We have been tracking the participation of Law Enforcement advocates in previous years. In 2016, a Law Enforcement advocate was appointed under the Law Enforcement category.
Most appointed member absences were offset by the participation of invited members in the same category.

Table 4 describes system representation at 2017 Team meetings.

Table 4. System Representation at 2017 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 area in attendance	# of meetings with at least one person representing system area in attendance
Administrative Office of District Attorneys	6	1	6
Attorney General's Office	10	2	10
Civil Legal	12	11	12
Courts	10	3	10
Criminologist	0	0	0
Law Enforcement	7	3	8
Medical	12	6	12
Other Members	12	12	12
Public Defender	0	0	0
State Agencies	10	2	10
Tribal	11	6	11
Victim Services	10	10	11

In addition to the Team meetings, the Team's Committees also met throughout the year. The Native American Committee held three case review meetings and one meeting for generating recommendations. The Teen Dating Violence Committee held one case review meeting and one meeting for generating recommendations. Neither the Friends and Family Committee nor the Marginalized Populations Committee held any meetings in 2017.

Team Activities

In addition to conducting case reviews and fulfilling the tasks mandated by the New Mexico Legislature (*see* Appendix 4), the Team works to increase member knowledge about intimate partner violence and associated system responses and to improve the quality and relevance of the case review process. These goals are accomplished through specialized committee work, providing educational activities for Team members, and through the dissemination of the Team's findings and recommendations. Further, Team members share this knowledge with their agencies, staff, and others throughout the state, in hopes of contributing to improved system and community response to intimate partner and sexual violence.

Team Committees

The Team employs working committees to assist with carrying out the Team's goals and objectives. There are currently four committees of the Team: (1) the Native American Committee, (2) the Friends & Family Committee, (3) the Marginalized Populations Committee, and (4) the Teen Dating Violence Committee.

Native American Committee

The Native American Committee collaborates with tribes and Native American organizations statewide in an effort to facilitate reviews of deaths related to intimate partner violence and sexual assault occurring on tribal lands and those involving a Native American victim or offender regardless of the incident location. The Team recognizes and honors the sovereignty of Native American tribes. Therefore, when reviewing Native American intimate partner deaths, the Team ensures that there is at least one tribal representative at the review and will not review the case if the representative objects to the review or any part of its process. Although considered during the case review, the Committee chooses not to identify the areas of Indian Country in which these deaths occur or the tribal affiliation of the individuals in published reports. Instead, review findings are used as a tool for generating recommendations for both tribal and state lawmakers and agencies.

In 2017 the Native American Committee reviewed three intimate partner violence related cases that led to four deaths, including one murder-suicide, and one sexual assault related death involving a Native IPV victim, Native IPV perpetrator, or both occurring between January 1, 2014 and December 31, 2014. Native American case year 2014 (CY2014) case data are incorporated in the presentation of findings found in the 2017 Annual Report. The committee held three case review meetings, two that were in Albuquerque and one that was in Dulce in the Jicarilla Apache Nation. The recommendation meeting was held in Albuquerque. The Committee continues to work on improving case identification and data collection efforts for these cases. The Committee's recommendations are included in the 2017 Recommendations section of the 2017 Annual Report.

Friends & Family Committee

The Friends & Family Committee is charged with acquiring additional personal and relationship characteristics for case reviews using structured, face-to-face interviews with family members, friends and coworkers of the decedent. Details derived from these interviews produce a more complete understanding of the cases and allow the Team to better evaluate risk factors and victim and offender system resource utilization. The committee did not hold meetings in 2017.

Marginalized Populations Committee

The Team recognizes that several populations are underserved or marginalized in our society, including but not limited to people with disabilities, the elderly, and people of color. The Marginalized Populations Committee assesses how these populations are affected by intimate partner violence and sexual assault and creates strategies and recommendations to specifically address the unique needs within these populations. The committee did not hold meetings in 2017.

Teen Dating Violence Committee

The Teen Dating Violence Committee, also known as the Dating Violence Systems Analysis Subcommittee (DVSAS), reviews cases of intimate partner or dating violence-related deaths involving victims and offenders ages 10 to 19 years. The DVSAS is comprised of professionals working in youth serving agencies from around the state. The impetus for designating a committee to focus on teen dating violence-related deaths stems from the recognition that teen dating relationships, the dynamics of teen dating violence, barriers to safety, and the systems that teen victims and offenders come into contact with differ from the adult population.

To recommend youth-appropriate prevention and intervention strategies, the Team requires a more targeted case review process. Individual risk factors being analyzed for teens include age difference between victim and perpetrator, pregnancy and the perception of pregnancy, immigration status, stalking behaviors, substance use, and access to firearms. Environmental risk factors being analyzed include levels of caregiver knowledge of, and response to, dating violence and bystander involvement during public incidents resulting in dating violence-related death.

In 2017, the Committee reviewed one sexual assault-related homicide death involving teens and two dating violence-related suicide deaths occurring between January 1, 2014 and December 31, 2014. Teen CY2014 case data are incorporated in the presentation of findings found within the 2017 Annual Report. Recommendations provided by the Teen Dating Violence Committee are provided in the 2017 Recommendations section of the Annual Report (*see* recommendations within Legislation/Policy and Medical, Mental, and Behavioral Health Care Services).

Team Presentations and Data Requests

Public sharing of the Team's findings provides members with the opportunity to exchange knowledge with stakeholders statewide. The following list documents the Team's invited presentations and data requests for 2017.

May

- The Team's principal investigator provided the Crime Victims Reparation Commission with information about Reviewed IPV-Related Homicide Incidents in New Mexico Involving Any History of Strangulation (May 29, 2017)

July

- The Team's coordinator and principal investigator participated in a mock intimate partner violence fatality review led by a team member and law professor at the University of New Mexico School of Law (June 27, 2017).

September

- The Team's principal investigator provided risk factor information to assist clinicians with identification of domestic violence related cases in the Emergency Department (September 25, 2017).

November

- The Team's principal investigator compiled and provided information about the Use of Firearms in Reviewed New Mexico Intimate Partner Violence Related Homicide and Suicide Incidents from 2006-2013 in response to a media request. As part of the media request, a Team member gave an interview regarding the ongoing Team Recommendation that the New Mexico Legislature create legislation that mirrors the existing Federal statute prohibiting possession, sale, or transfer of firearms while someone is subject to an order of protection, following conviction for a misdemeanor domestic violence offense, and following a finding of mental health related incompetency (November 7, 2017).

Dissemination of Team Recommendations

Each year the Team prepares an Annual Report for the Governor, New Mexico Legislators, Cabinet Secretaries, professionals from state and local government and non-profit agencies, and other stakeholders. The Annual Report is a tool for educating the public about the dynamics and the potential lethality of intimate partner and sexual violence. The report is available on the Team's website which can be found at http://emed.unm.edu/cipre/programs/intimate-partner-violence-death-review/index.html. The website is an additional medium for providing information to the general public, as it also links visitors to each of our member agency websites, including available domestic and sexual violence resources across the state.

Recommendation Updates

The Team monitors statewide developments in legislation, policy, and agency practice to assess the relevance of their recommendations over time. In 2017, we identified ongoing progress and accomplishments consistent with the Team's recommendations from previous years. Here, we report on the activities of agencies represented by Team members and on other statewide efforts addressing priorities previously identified by the Team. Many of these activities were either led or supported by agencies represented by Team members.

Create New Mexico legislation that mirrors the existing Federal statute prohibiting an offender's possession of firearms while subject to an order of protection or following conviction for a misdemeanor domestic violence offense (see 18 U.S.C. 922 (d) and (g)).

- The Coalition Against Domestic Violence in collaboration with a number of agencies and organizations introduced a bill in the 2017 legislative session that mirrors existing Federal law prohibiting a domestic violence offender's possession of firearms while subject to a final order of protection. The bill passed both houses of the Legislature and was vetoed by the Governor.

The Native American Committee recommends the development and implementation of culturally appropriate and holistic educational programs about intimate partner violence and sexual assault.

- The Jicarilla Behavioral Health Department offered a number of community focused trainings and presentations, including two *Honor Healthy Boundaries, Get Consent! Building Blocks to Healthy Relationships*! community presentations, the community event *Stop Domestic Violence: Together We Can Overcome* with James Junes, and multiple a teen dating violence presentations at Dulce High School and during the Second Annual Youth Conference., and a second annual Youth Conference

Create standardized protocols for addressing the needs of survivors following intimate partner violence incidents resulting in serious injury or death.

- In 2015, the City of Albuquerque's Office of Diversity and Human Rights and the Albuquerque Police Department finalized procedures for processing U-Visa applications for victims of crime, including domestic violence. The standing policy continued into 2017.
- The AOC received VOCA funding to design and implement domestic violence order of protection kiosks at three district court locations: Las Cruces, Gallup and Las Vegas. The grant allowed the AOC to develop an interactive computer interview that guides a petitioner through questions which will auto-populate the answers in the court application (petition) to obtain a temporary order of protection. The kiosks are accessible in English, Spanish and Navajo (Diné) in written and audio formats.
- The AOC finalized the translation of all domestic violence and domestic relations court-approved forms and has them available for use in a bilingual format, with the Spanish translation immediately following the English text. These bilingual forms will be available, both in person and online, beginning in spring 2018.
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Provide continuing education to judges and court staff on the New Mexico Family Violence Protection Act (NMSA Chapter 40, Article 13) to ensure consistent application of the law and improve continuity in the use of domestic violence orders of protection across jurisdictions.

- The Rozier E. Sanchez Judicial Education Center (JEC), housed at the UNM School of Law, offered domestic violence education to state court judges and staff in 2017 at both mandatory and voluntary programs. JEC also invited tribal judges to attend various of its programs. In May, August, September and October, JEC offered webinars to judges, hearing officers and other court staff on a variety of domestic violence topics, including procedural justice in domestic violence cases, the Family Violence Protection Act, the judicial role regarding U-Visa certification and Special Immigrant Juvenile Status findings, and cultural responsiveness in domestic violence cases. In June, the annual Judicial Conclave for appellate, district, and metropolitan court judges, domestic violence commissioners, hearing officers, and staff attorneys included two domestic violence workshops on orders of protection and on custody issues. In conjunction with the Judicial Conclave, JEC offered a full day domestic violence training for district court staff who provide evaluative and mediation services in domestic matters. In September, magistrate court judges attended a plenary session at their mandatory annual conference on domestic violence and firearms. In November and December, JEC provided a two day training for judges, hearing officers and other court staff on the intersection of domestic violence and immigration in the civil arena.

Expand training for domestic relations court personnel on custody and divorce cases involving domestic violence.

- In June the New Mexico Coalition Against Domestic Violence co-sponsored three separate workshops for judges, domestic relations court personnel, and attorneys and advocates on *A SAFER Approach: Screening, Assessing, Focusing on the Effects and Responding to Domestic Violence in Child Custody and Visitation Cases*.
- The Rozier E. Sanchez Judicial Education Center (JEC), housed at the UNM School of Law, offered domestic violence education to state court judges and staff in 2017 at both mandatory and voluntary programs. JEC also invited tribal judges to attend various of its programs. In May, August, September and October, JEC offered webinars to judges, hearing officers and other court staff on a variety of domestic violence topics, including procedural justice in domestic violence cases, the Family Violence Protection Act, the judicial role regarding U-Visa certification and Special Immigrant Juvenile Status findings, and cultural responsiveness in domestic violence cases. In June, the annual Judicial Conclave for appellate, district, and metropolitan court judges, domestic violence commissioners, hearing officers, and staff attorneys included two domestic violence workshops on orders of protection and on custody

issues presented by Judge Steven Aycock (ret.), and Loretta Frederick, JD, and Anton Tripolskii, Battered Women's Justice Project. In conjunction with the Judicial Conclave, Ms. Frederick and Mr. Tripolskii presented a full day domestic violence training to district court staff who provide evaluative and mediation services in domestic matters. In September, magistrate court judges attended a plenary session at their mandatory annual conference on domestic violence and firearms presented by Judge Rosemary Cosgrove-Aguilar and Patricia Galindo, JD. In November and December, JEC provided a two day training for judges, hearing officers and other court staff on the intersection of domestic violence and immigration in the civil arena, including sessions provided by New Mexico experts as well as sessions by national experts – Liberty Aldrich, JD, Center for Court Innovation (New York); Judge Susan Breall (California); Judge Rosemary Collins (Illinois); Leslye Orloff, Law Professor and Director, National Immigrant Women's Advocacy Project (Washington DC); and Dr. Sujata Warrier, Battered Women's Justice Project (Minnesota).

Encourage the use of Sexual Assault Nurse Examiners (SANE) for injury documentation and medical/forensic services for victims of intimate partner violence.

- Albuquerque SANE has secured funding to continue offering IPV exams, at no charge, to any patient who has experienced intimate partner violence and is at least 18 years old and has experienced the assault in the previous 2-3 weeks of seeking services. The medical and psycho-social care received by a patient at SANE is often times the only medical care these survivors will receive. The availability of photo-documentation of injuries provides assistance with restraining orders and other criminal or civil legal proceedings. In addition, they also secured funding to educate other New Mexico SANE programs on how to perform and bill for these exams. They have trained staff at four programs.

Improve the coordination of services for IPV victims who experience the co-occurrence of intimate partner violence and substance abuse, criminal offending, mental illness, or specialized medical conditions.

- The New Mexico Crime Victims Reparation Commission in collaboration with the New Mexico Coalition of Sexual Assault Programs, New Mexico Coalition Against Domestic Violence, and the Coalition to Stop Violence Against Native Women held the 22nd Annual Advocacy in Action (AIA) Conference in Albuquerque in March of 2017. AIA provides two and one-half days of workshops on domestic and sexual violence prevention and intervention and related topics for attorneys, counselors, law enforcement, nurses, social workers, and other related professions.
- The Jicarilla Behavioral Health Department held a two day Sexual Assault and Domestic Violence Training in June 2017 for law enforcement officers, criminal investigators, first responders, and community members. The training included information about SANE advocacy, suicide prevention, PTSD, self-care, historical trauma, domestic violence, the Care for Kids program, and the Safe Dates curriculum.
- The Jicarilla Behavioral Health Department presented a workshop about Teen Dating Violence to EMS youth employees and a workshop on historical trauma to clinicians, law enforcement officers, first responders, and community members.
- Homeland and El Refugio domestic violence shelter collaborated to offer the second annual two day multidisciplinary domestic violence training in Silver City. The training provided over 80 law enforcement officers and therapists Continuing Education Units.

Improve the visibility of intimate partner violence, mental health, sexual assault, substance abuse, and trauma-informed grief services among all local stakeholder agencies.

- Homeland offered in-service law enforcement training for the Corrales, Bosque Farms and Isleta Police Departments that included domestic violence updates.

The Team will continue to monitor statewide developments in legislation, policy, and agency practice consistent with their recommendations from both previous and current review years.

Multi-Year Recommendation Project

The Team created a master list of Team recommendations from the recommendations made from 2008 to 2016. They identified repeat recommendations, documented how recommendations have changed over time, and selected language that communicated each repeat recommendation best.

Objectives

The Team's statute defines 5 specific objectives to guide the Team's work. Table 5 lists each objective alongside corresponding 2017 activities and 2017 goals. Goals for 2017 were documented in the Team's 2016 Process Evaluation Report.

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

Statutory Objectives	2017 Activities	2017 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 2014 homicide and suicide cases. Research assistant added 2014 cases to data entry (2006-2014).	Complete Team activity for 2014 deaths, and Continue multi-year data entry and comparison of these characteristics (deaths occurring between 2005 and 2014).
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 2014 homicides. Coordinator compiled intervention response variables for deaths occurring in 2014.	Complete Team activity for 2014 deaths, and Continue compilation of intervention response variables for deaths occurring in 2014.
Identify and characterize high-risk groups for the purpose of recommending developments in public policy	Team identified risk factors for each 2014 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 2014 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 2014 reviewed death. Research assistant updated database including all data elements and team feedback, for all reviewed 2014 cases.	Complete activity for 2014 deaths, and Maintain database of collected data elements (including the Team's feedback), enter case data for 2014.
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 related deaths that occurred in the state. However, domestic or sexual violence related 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 2014 cases (CY2014) that fit in each category. In 2017, the Team reviewed 34 deaths that resulted from 29 incidents of intimate partner violence. A full report of findings on CY2014 cases is available in the Team's 2017 Annual Report.

Table 6. Types of CY2014 Intimate Partner Violence (IPV) Related Deaths Reviewed in 2017

Type of Case	Definition	Number of incidents reviewed in 2017
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	16
Sexual Assault Homicide	Homicide with a sexual assault component, regardless of the relationship between the victim and offender	1
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	3
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	8
IPV-Related Victim Suicide	Suicide by an intimate partner violence victim when the death occurs during or directly following an act of intimate partner violence and the perpetrator survives	1

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 and social media) 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.

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.

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	Fair-Good	Due to changes in the Odyssey data system, the Team Coordinator is no longer able to view protective orders online. 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	Good	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. The transition to the Odyssey data system by the Administrative Office of the Courts has improved access to these data.
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	Poor	No direct access to CYFD records. Information is typically limited to referrals for service in cases involving minors with CYFD contact. In 2017 the CYFD member category was filled, but no case information was provided.
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.

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. Updates to the Odyssey data system introduced issues, such as cases found prior to the update not being available after update and cases not available prior to the update being available after update.
Adult protective services summary data and prior abuse history	Team Member Report Out	Fair	No direct access to records.
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.).
Medical reports and hospital emergency room information	As documented in law enforcement and / or court documents	Fair	Rarely documented unless immediately preceding the death. In 2016, a medical team member was approved to provide prescription drug monitoring information for case review.
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.

Table 8. Continued

Types of Information	Source(s)	Access	Comments
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.
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.

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 the 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 2014 review year, all information contained in the *Confidential Case Review Form* was recorded in databases so that standardized case data can be monitored over time. Data entry has been completed for CY 2006-2014 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 et al 2013; Campbell et al. 2007; Dobash et al. 2007; Nicolaidis et al. 2003; Campbell et al. 2003a, 2003b; Campbell 1995, 1986;
Attempt of suicide by offender	Dawson and Piscitelli 2017, Hillbrand, M. 2014; Websdale 1999; Hart 1988
Attempted homicide by offender	Hart 1998
Prior history of domestic violence	Johnson et al 2017; Dawson and Piscitelli 2017, Yousuf et al. 2017; 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	Johnson et al 2017; Websdale 1999
Nonfatal strangulation and/or prior choking	Douglas and Fitzgerald 2014; Glass et al. 2008; Campbell et al. 2003a, 2003b
History of violence in general, may include prior criminal history of violent crime	Websdale 1999
Return to abuser after separation due to abuse	McFarlane et al. 2016
Escalation of violence	Ross 2017; Dawson and Piscitelli 2017
Weapons	
Threats with weapons	Ross 2017; Campbell 1995, 1986
Use of weapon in prior abusive incidents	Ross 2017; Campbell 1995, 1986
Morbid fascination with firearms	Websdale 1999
Access to weapons increases severity of domestic violence	Folkes et al 2012
State firearm policy	Siegel and Rothman 2016; Zeoli et al 2016
Offender Criminal History	
Violent Criminal History	Sapardanis 2017; Websdale 1999

Lethality Risk Factor	Citation
Prior Contact with Police for Domestic Violence	Websdale 1999
Perpetrator avoidance of arrest	Ross 2017
Other Offender Behavioral Factors	
Drug or alcohol abuse	Campbell 1995, 1986; Hart 1988
Obsessiveness/extreme jealousy/extreme dominance	Johnson et al 2017; Dawson and Piscitelli 2017, Websdale 1999; Campbell 1995; Hart 1988
Threats of suicide by offender	Johnson et al 2017; Ross 2017; Dawson and Piscitelli 2017, 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)	Dawson and Piscitelli 2017, Websdale 1999
Threats to harm children	Campbell et al. 2003a, 2003b
Isolation of the batterer	Hart 1988
Attempt to isolate victim	Dawson and Piscitelli 2017
Dependence of batterer on victim	Hart 1988
Depression or poor mental health	Sapardanis 2017; Heron 2017; Dawson and Piscitelli 2017; Lysell, et al 2016; Flynn et al 2016; 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	Ellis 2016; James and Daly 2012
Current partnership between victim and perpetrator	Yousuf et al. 2017
Situational Factors	
Estrangement, separation, or an attempt at separation (usually by the female party)* M-S	Dawson and Piscitelli 2017, Websdale 1999
Step-children in home	Miner et al. 2012
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
Female victim's employment outside the home	Powers and Kaukinen 2012

Lethality Risk Factor	Citation
Perpetrator unemployment	Dawson and Piscitelli 2017
Pregnancy/Suspected pregnancy	Koch et al 2016; Wallace et al 2016
Demographic / Life Course Characteristics	
Age	Heron 2017; Salari and Maxwell 2016
Gender of Perpetrator	Caman et al 2016; Stewart et al. 2014; Belknap et al. 2012; Bourget and Gagne 2012; Reckdenwald and Parker 2012; Weizmann-Henelius et al. 2012
Sex of victim	Yousuf et al. 2017
Immigration status	Vatnar et al 2017
Other Citations of Note	
Murder-Suicide	Heron 2017; Salari and Sillito 2016; Flynn et al 2016; Kalesan et al 2016; Huguet and Lewis-Laietmark 2016; 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 et al 1993;
Risk of child death in domestic violence homicide incidents	Jaffee et al 2014; Hamilton et al 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	Chalkle and Strang 2017; Thornton 2017; Robinson and Howarth 2012
Media coverage of domestic violence homicide	Gillespie et al. 2013
IPV Risk Assessment Instruments (Reliability and Validity)	Chalkle and Strang 2017; Thornton 2017; Messing and Campbell 2017; Ross 2017; Messing et al. 2016; Storey and Hart 2014; Kropp and Cook 2013; Winkel and Baldry 2013; Belfrage and Strand 2012; Belfrage et al. 2012; Messing and Thaller 2012; Williams 2012
Conceptualization of fatality risk	Heron 2017; Gnisci and Pace 2016
Offender lack of violent history	Thornton 2017; Johnson et al 2017

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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 decedent (called secondary victim) or the offender (secondary 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 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.

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.

Intimate Partner Violence (IPV) Perpetrator

The identified perpetrator of the act of intimate partner violence, and may be either the survivor, decedent, or offender in the death incident.

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 intimate partner 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 intimate partner 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. This includes cases involving the attempted murder of the intimate partner 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 intimate partner 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 survivor, decedent, or offender in the death incident.

Sexual Assault (SA) Perpetrator
: The perpetrator in the act of actual or attempted sexual assault. The sexual assault perpetrator may be either the survivor, decedent, or offender in the death incident.

Sexual Assault (SA) Victim
: The victim of an actual or attempted sexual assault. The sexual assault victim may be either the survivor, decedent, or offender in the death incident.

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.

Suicide Decedent
: The suicide decedent is an individual who committed an intentional act of violence against him or herself that resulted in death. The term is used to designate both those who commit suicide alone as well as those who commit suicide following the homicide or attempted homicide of an intimate partner.

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).

References

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Tjaden, P., & Thoennes, N. 1998. Stalking in America: Findings from the National Violence Against Women Survey. Washington, DC: National Institute of Justice and Centers for Disease Control and Prevention. Available [On-line]: https://www.ncjrs.gov/pdffiles/169592.pdf.

Appendix 3: Team Member Case Review Feedback Form

New Mexico Intimate Partner Violence Death Review Team Member Feedback Form **Case # 2011-**

Instructions
1. During the reading of the case narrative, complete the case review worksheet in column one.
2. Use the numbered spaces at the bottom of the case review worksheet to make a list of system successes, gaps or failures observed in this case.
3. Following the group discussion, complete one "feedback and recommendation" column **for each system success, gap, or failure identified**.

Please note: we want to capture all system issues in the written feedback; however, it may be necessary to prioritize gaps and failures for discussion.

Case Review Worksheet

Would you define this case as either intimate partner violence or sexual assault related? If no, please explain.
☐ Yes ☐ No
Comments:

Background Characteristics / Fatality Risk Factors	IPV/SA Perpetrator	IPV/SA Victim
Less than high school education	☐	☐
Unemployed	☐	☐
Alcohol abuse	☐	☐
Illicit drug abuse	☐	☐
Mental health problem	☐	☐
Threatened to commit suicide	☐	☐
Access to firearm	☐	☐
Prior domestic violence victimization	☐	☐
Prior domestic violence perpetration	☐	☐
Prior arrest for violent crime	☐	☐
Prior arrest for domestic violence	☐	☐
Separated from partner	☐	☐
Threatened to kill partner	☐	☐
	☐	☐
	☐	☐
	☐	☐

Draft a list of possible system successes, gaps, and failures observed in this case:

1.
2.
3.
4.
5.
6.
7.
8.

Feedback and Recommendation #1

Briefly state one system success, gap, or failure from the worksheet that you are addressing.

To which system area does this system success, gap or failure primarily relate?
☐ Law Enforcement ☐ Prosecution
☐ Courts ☐ Corrections
☐ Probation & Parole ☐ Victim Services
☐ Medical Services ☐ Mental Health Services
☐ Substance Abuse Services ☐ Legislation/Policy
☐ Other, specify (e.g. social services, schools, community)

What evidence or example of this success, gap, or failure was observed in this case?

What change or changes to the system you identified would you recommend to promote this observed success or address this gap or failure?

Additional comments on recommendation #1:

Appendix 4: 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.