New Mexico Intimate Partner Violence Death Review Team

Process Evaluation Report 2024

July 31, 2024

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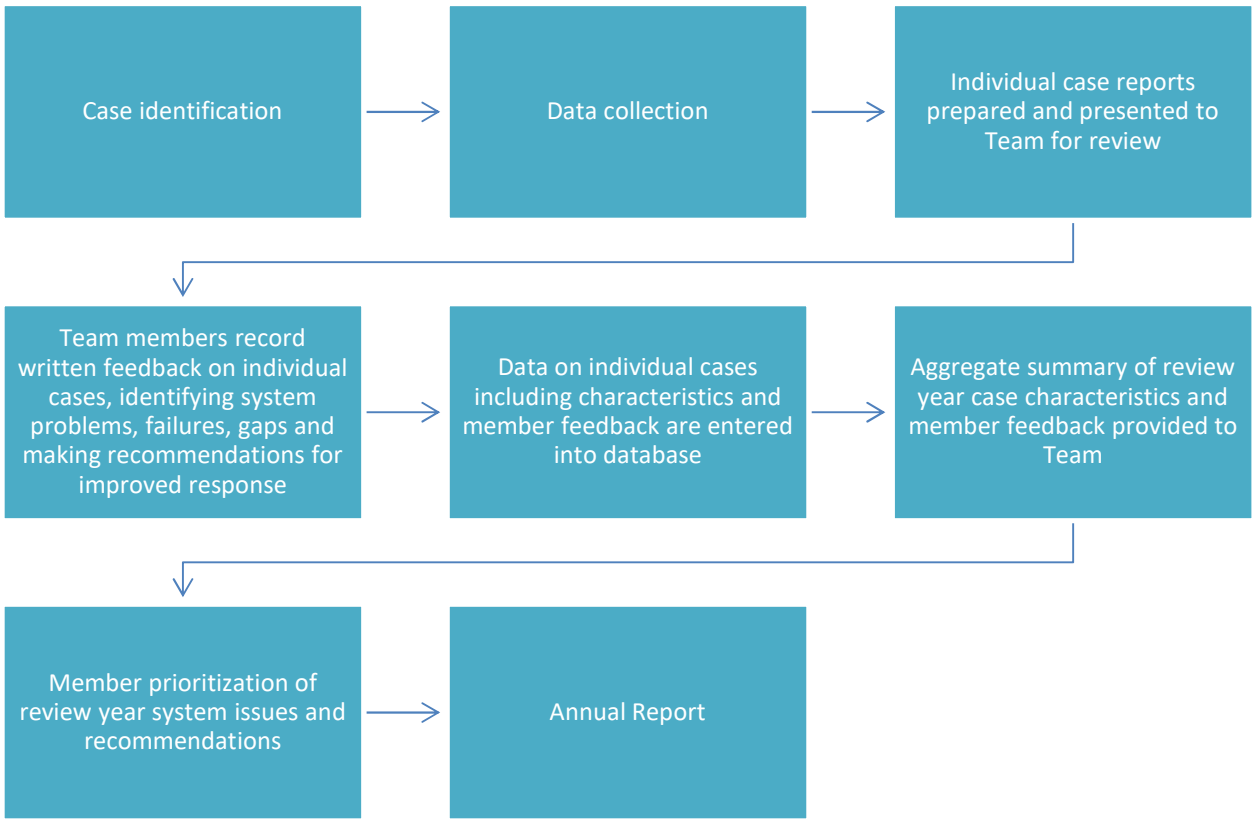
Introduction

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 https://isr.unm.edu/centers/new-mexico-statistical-analysis-center/ipvdrt/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 was traditionally 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.* That report is now being made available to the Team in August.

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 five 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, the statutory authority for the Team, and the Team's Policies and Procedures.

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 Victim Reparations Commission. In FY 2024, the Team had 21 appointed members.[1] Table 1 shows the number of appointed members by appointment category.

Table 1. Number of FY 2024 Appointed Team Members by System Category

System	Number of representatives in system area
Administrative Office of the District Attorney	Vacant
Attorney General's Office	Vacant
Civil Legal	1
Courts	3
Criminologist	1
Law Enforcement	1
Medical	3
Other Members	2
Public Defender	Vacant
State Agencies	4
Tribal	3
Victim Services	4
Total Number of Appointed Members	22

In addition to appointed members, the Team also invites 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 who participated in the Team's FY 2024 meetings by system category.

Table 2. Number of FY 2024 Invited Participants by System Category

System	Number of invited participants in system area
Administrative Office of District Attorneys	2
Attorney General's Office	1
Civil Legal	0
Courts	0
Criminologist	0
Law Enforcement	2
Medical/Behavioral Heatlh	3
Other Members	5
Public Defender	0
State Agencies	1
Victim Services	3
Total Number of Members	22

[1] Fiscal Year 2024 (FY 2024) includes the 12-month period beginning July 1, 2023 and ending June 30, 2024.

Meetings

In FY 2024, there were ten regular Team meetings and one ad hoc meeting. FY 2023 activities were completed during the first two meetings (August and September 2023) of FY 2024. The Team reviewed FY 2023 recommendations in August 2023, and reviewed and approved the 2023 annual report in September 2023. The Team reviewed cases from calendar year 2020 in FY 2023.

Case reviews for FY 2024 commenced in October 2023 and were completed in April 2024. The Team reviewed FY 2024 recommendations at the May meeting and approved the report in June. The Team reviewed cases from calendar years 2010-2020 that had not been reviewed previously.

The June meeting was a hybrid meeting, offering Team members the option to attend in person or via Zoom. The in-person portion took place at the Crime Victims Reparation Center. All other meetings were held via Zoom.

The average attendance at regular Team meetings which were held was 20 people total. The average number of appointed members in attendance was 11. The average number of appointment categories represented at each meeting was 8 out of 12 categories. Quorum, as defined in the Team's policies and procedures, was reached in 5 out of 10 2024 Team meetings. Table 3 documents meeting attendance by month.

Table 3. FY 2024 Team Meeting Attendance by Month

Meeting Month	Total # of people in attendance	# of appointed members in attendance (%)*	# of appointment categories represented**
July (No meeting)	N/A	N/A	N/A
August	15	11	6
September	16	13	7
October	14	12	8
October ad hoc*	6	5	4
November	15	9	6
December (No meeting)	N/A	N/A	N/A
January	15	10	6
February	14	9	6
March	25	11	7
April	18	11	7
May	16	9	5
June	23	15	9

*Not included in average regular Team meeting calculations
**7 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. Most appointed member absences were offset by the participation of invited members in the same category.

Table 4 describes system representation at FY 2024 Team meetings.
Table 4. System Representation at FY 2024 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	N/A	4	4
Attorney General's Office	N/A	1	1
Civil Legal	4	0	4
Criminologist	9	0	6
Judiciary	9	2	10
Law Enforcement	7	8	9
Medical/Behavioral health	6	5	8
Other Members	11	5	11
Public Defender	N/A	0	0
State Agencies	11	1	11
Tribal	8	8	11
Victim Services	9	5	10

*10 Regular Team meetings and one ad hoc meeting were held in FY2024.
**Does not include invited members attending as proxy for appointed member

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 three committees of the Team: (1) the Native American Committee, (2) the Marginalized Populations Committee, and (3) 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 FY2024 the Native American Committee reviewed three intimate partner violence related cases that led to three deaths occurring between 2010 and 2017. Native American FY2024 case data for homicide are incorporated in the presentation of findings found in the 2024 Annual Report. The Committee continues to work on improving case identification and data collection efforts for these cases. The Committee's recommendations are included in the Recommendations section of the 2024 Annual Report.

Marginalized Populations Committee

The Team recognizes that several populations are underserved or marginalized in our society, including but not limited to people with disabilities, members of the LGBTQ community, people with limited English language capacity, immigrants, sex workers, people experiencing homelessness, and the elderly. 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.

In FY2024, the Marginalized Populations Committee reviewed one intimate partner violence related case that led to one death. The Marginalized Populations Committee is incorporated in the presentation of findings found in the 2024 Annual Report. The Committee continues to work on improving case identification and data collection efforts for these cases.

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 involvement of individuals outside of the intimate partnership during public incidents resulting in dating violence-related death.

The Teen Dating Violence Committee did not review any deaths in FY2024 because eligible cases were not yet fully resolved.

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 **FY 2024**.

August

The Team's coordinator and a Team member presented on the fatality review process to a group of students from the Native American Social Work Studies Institute (NASWSI) from the New Mexico Highlands University (August 4, 2023).

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 https://isr.unm.edu/centers/new-mexico-statistical-analysis-center/ipvdrt/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. The website also contains multi-year data.

Objectives

The Team's statute defines 5 specific objectives to guide the Team's work. Table 5 lists each objective alongside corresponding FY 2024 activities.

Table 5. Statutory Objectives and Team Activities

Statutory Objectives	2024 Activities
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 2010-2020 homicide cases. Reviewed cases were added to database.
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 2010-2020 homicides. Intervention response variables for reviewed cases were compiled and added to database.
Identify and characterize high-risk groups for the purpose of recommending developments in public policy	Team identified risk factors for each 2010-2020 reviewed death, Lethality risk variables for each case reviewed were compiled and added to the database.
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 2010-2020 reviewed death. Updated database with all data elements and team feedback, for all cases reviewed in FY 2024.
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.

Case Review Process: Identification through Data Collection

Case Identification

In FY2024, the Team reviewed cases that had been identified between 2010 and 2020 as involving intimate partner violence or sexual assault but had not been reviewed by the Team. Prior coordinators identified these 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 coordinators 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 cases reviewed in FY 2024 from incidents that occurred in calendar years 2010-2020 cases that fit in each category. In FY2024, the Team reviewed 20 deaths that resulted from 18 incidents of intimate partner violence. A full report of findings on FY2024 reviewed cases is available in the Team's 2024 Annual Report.

Table 6. Types of 2010-2020 Intimate Partner Violence (IPV) Related Deaths Reviewed in FY2024

Case Type	Definition	Number of Reviewed Incidents	Number of Deaths
	Intimate Partner Homicide		
Intimate Partner Homicide	Homicide where the primary decedent 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) and the homicide offender survives.	10	10
Intimate Partner Murder-Suicide	Homicide where the decedent 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) and the homicide offender dies by suicide.	0	0
	IPV-Related Homicide		
Secondary party IPV-Related Homicide	Death incident where the homicide is committed by someone other than an intimate partner, or where the homicide decedent is someone other than an intimate partner, when the death occurs during an incident of intimate partner violence.	7	9
	IPV-Related Suicide		
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.	0	0
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.	0	0
	IPV-Related Undetermined Death		
Undetermined cause of death	A death occurring during or immediately following an incident of intimate partner violence where the cause of death is listed as undetermined by the Office of the Medical Investigator	0	0
	Sexual Assault Related Death		
Sexual Assault Related Death	Homicide or Suicide with a sexual assault component	1	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 was eligible to be 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 Secondary Victim and Offender 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 and research technicians 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. Note that this reflects data availability and access for cases that were reviewed during FY2024; current availability and access may differ.

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 than 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	The Team Coordinator was able to request appropriate access to view domestic violence order of protection in Odyssey. However, that access was lost following their departure. It has since been restored. 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- Fair	No direct access to CYFD records. Information is typically limited to referrals for service in cases involving minors with CYFD contact.
Summaries of psychological evaluations or reports appearing in public record documents, such as police files	As documented in law enforcement, OMI, and / or court documents	Poor- Fair	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, however, older criminal histories may have been purged. 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.
Adult protective services summary data and prior abuse history	Team Member Report Out	Poor	No direct access to records.
OMI autopsy report	OMI Database** In person review of autopsy records	Poor-Good	OMI records had already been collected for the cases reviewed in FY2024. Cases that did not have OMI data were not included for review this year.
Workplace information (stalking/harassment, alerts among co-workers)	As documented in law enforcement and / or court documents	Poor-Fair	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 but that access is not current.
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	Poor- Fair	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	Historically, limited success in accessing education records for teen and young adult decedents only. No records were requested for cases reviewed in FY2024

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-Fair	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 as well as whether treatment was completed.

*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 shared a Powerpoint with information from the *Confidential Case Review Form* to the Team. The form includes detailed information about the victim, offender, the relationship between the parties, the death incident, system response to the death, and a narrative that includes a timeline of events surrounding the death. Team members asked questions to clarify issues or obtain additional information about the case after the presentation. 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. Team members recorded their observations in an online form accessible only to project staff.

Case data collected from the *Confidential Case Review Form* in FY 2024 was recorded in a database for ongoing monitoring.

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, Team members analyze each case according to their profession and contribute ideas and suggestions for inclusion in the Team's recommendations. After all reviews were completed, the coordinator and research staff summarized the findings and recommendations identified in the reviews. Member feedback was also recorded in the case information database. The current *Team Member Case Review Feedback Form* is provided in Appendix 3.

Appendix 1: Intimate Partner Violence Lethality Risk Factors

The following is a draft list of intimate partner violence lethality risk factors with citations. 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 use 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 continue to 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	Logan et al 2019; 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, Edelstein 2018 ; Ward-Lasher et al 2020 ; Caponera 2022;
Serious victim injury in prior abusive incidents	Campbell 1995, 1986
Stalking of the victim	Johnson et al 2017; Websdale 1999, Spencer et al 2018; Todd et al 2020
Nonfatal strangulation and/or prior choking	Douglas and Fitzgerald 2014; Glass et al. 2008; Campbell et al. 2003a, 2003b, Spencer et al 2018
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	Stansfield et al 2021; Wallin et al 2021; Folkes et al 2012; Zeoli et al 2020; Lyons et al 2020; Kivisto and Porter 2020
State firearm policy	Siegel and Rothman 2016; Zeoli et al 2016

Lethality Risk Factor	Citation
Offender Criminal History	
Violent Criminal History	Sapardanis 2017; Websdale 1999
Prior Contact with Police for Domestic Violence	Websdale 1999
Perpetrator avoidance of arrest	Ross 2017
Prior incarceration	Fraga Rizo et al 2021; Fraga Rizo et al 2019; Cirone et al 2020
Other Offender Behavioral Factors	
Drug or alcohol abuse	Campbell 1995, 1986; Hart 1988, Spencer et al 2018, McPhedran et al 2018
Obsessiveness/extreme jealousy/extreme dominance	Johnson et al 2017; Dawson and Piscitelli 2017, Websdale 1999; Campbell 1995; Hart 1988, Spencer et al 2018, Edelstein 2018
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
Chronic disposition to risky activities	Loinaz et al 2018
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	Cheng and Jaffe 2021; Sapardanis 2017; Heron 2017; Dawson and Piscitelli 2017; Lysell, et al 2016; Flynn et al 2016; Hart 1988; Spencer et al 2018 McPhedran et al 2018
Access to the victim	Hart 1988, Spencer et al 2018; Musielak et al 2020
Sleep disturbances (chronic, sometimes receiving treatment)	Websdale 1999

Lethality Risk Factor	Citation
Relationship Characteristics	
Longstanding relationship* M-S	Morton et al. 1998
Marital Status/Cohabitation Status	Ellis 2016; James and Daly 2012, McPhedran et al 2018
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, Spencer et al 2018, Edelstein 2018, Karbeyaz et al 2018
Child caregiving	Randell et al 2019; Reif 2020
Stepchildren 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
Location of death incident (private vs public)	McPhedran et al 2018
Perpetrator unemployment	Dawson and Piscitelli 2017
Pregnancy/Suspected pregnancy	Kivisto, A et al 2021; Spence and Huff-Corzine 2021; Koch et al 2016; Wallace et al 2016; Morrison et al 2020
Demographic / Life Course Characteristics	
Age	Heron 2017; Salari and Maxwell 2016, Karbeyaz et al 2018, Sabri et al 2018, McPhedran et al 2018, Loinaz et al 2018; Adhia et al 2019; Bush 2020; Cations et al 2020
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, Sabri et al 2018; Clare et al 2020
Sex of victim	Yousuf et al. 2017
Immigration status	David and Jaffe 2021; Vatnar et al 2017, Sabri et al 2018

Lethality Risk Factor	Citation
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; Emma et al 2020; Schwab-Reese et al 2020
Risk of child death in domestic violence homicide incidents	Lyons et al 2021; Jaffee et al 2014; Hamilton et al 2012
Non-Intimates as victims in IPV-related homicides	Dobash and Dobash 2012; Kivisto and Porter 2020
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; Websdale et al 2019; Sexton et al 2020
Media coverage of domestic violence homicide	Hanson and Lysova 2021; Gillespie et al. 2013; Lee and Wong 2020
IPV Risk Assessment Instruments (Reliability and Validity)	Graham et al 2021; Kafonek et al 2021; Messing et al 2021; Graham et al 2019; 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	Velopulos et al 2019; Heron 2017; Gnisci and Pace 2016; Spencer and Stith 2020; Overstreet et al 2020; Kafka et al 2020
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

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[2] (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.

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[2] Child Welfare Information Gateway. 2009. Child Witness to Domestic Violence: Summary of State Laws. Washington, D.C.: U.S. Department of Health and Human Services. Available [On-line]: http://www.childwelfare.gov/systemwide/laws_policies/statutes/witnessdvall.pdf.

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.

Secondary offender

A witness to an incident of intimate partner or sexual violence who commits an act of homicide.

Secondary Victim

A witness to an incident of intimate partner or sexual violence who is killed during the 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"[3] of an individual in a course of conduct "that would cause a reasonable person fear".[4] Stalking may involve persistent harassment over time and often more than one type of activity.[5]

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).

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[3] Kilmartin, C., & Allison, J. 2007. Men's violence against women: Theory, research, and activism. New Jersey: Lawrence Erlbaum Associates.

[4] 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.

[5] Sheridan, L., Davies, G. M., & Boon, J.C.W. 2001. Stalking: Perceptions and prevalence. *Journal of Interpersonal Violence* 16: 151-167.

Appendix 3: Team Member Case Review Feedback Form

NM IPVDRT Member Feedback Form Rev

Instructions:

1. Record the case number under question 1.

2. Use the space in question 2 to take notes during the case presentation.

3. Record whether you would define this case is IPV or sexual assault.

4. Make a list of system successes, gaps or failures you observed in this case.

5. Following the group discussion, beginning with question 5, complete one feedback and recommendation 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

Q1: Case Number

Q2: Use this space to take notes on the case.

Q3: Would you define this case as either intimate partner violence or sexual assault related? If no, please explain.

Yes ☐ No ☐

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Q4: Draft a list of possible system successes, gaps, ,and failures observed in this case:

Q5: Briefly state one system success, gap, or failure from the worksheet that you are addressing.

Q6: To which system area does this system success, gap, or failure primarily relate?

- [ ] Law Enforcement
- [ ] Courts
- [ ] Probation & Parole
- [ ] Medical Services
- [ ] Substance Abuse Services
- [ ] Prosecution
- [ ] Corrections
- [ ] Victim Services
- [ ] Mental Health Services
- [ ] Legislation/Policy
- [ ] Other, specify (e.g. social services, schools, community)

If you have chosen "other", please specify:

Q7: What change or changes to the system you identified would you recommend to promote this observed success or address this gap or failure?

Q8: Additional comments on recommendation #1

Q9: Briefly state one system success, gap, or failure from the worksheet that you are addressing.

Q10: To which system area does this system success, gap, or failure primarily relate?

- ☐ Law Enforcement
- ☐ Courts
- ☐ Probation & Parole
- ☐ Medical Services
- ☐ Substance Abuse Services
- ☐ Prosecution
- ☐ Corrections
- ☐ Victim Services
- ☐ Mental Health Services
- ☐ Legislation/Policy
- ☐ Other, specify (e.g. social services, schools, community)

If you have chosen "other", please specify:

Q11: What change or changes to the system you identified would you recommend to promote this observed success or address this gap or failure?

Q12: Additional comments on recommendation #2

Q13: Briefly state one system success, gap, or failure from the worksheet that you are addressing.

Q14: To which system area does this system success, gap, or failure primarily relate?

- ☐ Law Enforcement
- ☐ Courts
- ☐ Probation & Parole
- ☐ Medical Services
- ☐ Substance Abuse Services
- ☐ Prosecution
- ☐ Corrections
- ☐ Victim Services
- ☐ Mental Health Services
- ☐ Legislation/Policy
- ☐ Other, specify (e.g. social services, schools, community)

If you have chosen "other", please specify:

Q15: What change or changes to the system you identified would you recommend to promote this observed success or address this gap or failure?

Q16: Additional comments on recommendation #3

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.

Appendix 5: Policies and Procedures

Approved 12/16/09, revised 9/16/10, revised 12/16/10, revised 01/19/2012, revision 2019, revision 2020, revision 2023

Mission Statement

The New Mexico Intimate Partner Violence Death Review Team (IPVDRT) is authorized by NMSA 1978 §31-22-4.1 (IPVDRT enabling legislation) in order to:

1. Review the facts and circumstances of domestic violence related homicides and sexual assault related homicides in New Mexico,
2. Identify the causes of the fatalities and their relationship to government and nongovernment service delivery systems, and
3. Develop methods of domestic and sexual violence prevention.

Goals and Objectives

The Team is tasked with the following objectives under the IPVDRT enabling legislation:

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.

IPVDRT members created additional goals and objectives for the Team to achieve:

1. Bearing witness to victims' stories and honoring their lives.
2. Identifying best practices for systems improvement and policy recommendations.
3. Evaluating Team recommendations for effectiveness (documenting change in system response).
4. Providing community outreach and public education regarding our findings and recommendations.
5. Increasing the knowledge base of Team members.
6. Facilitating communication among Team members and their respective agencies.

Philosophy

The IPVDRT recognizes that offenders of domestic violence and sexual assault are ultimately responsible for the death of their victims. Therefore, when identifying gaps in service delivery or responses to victims, the IPVDRT chooses not to place blame on any professional agency or individual but rather learn from our findings in order to better understand the dynamics of domestic and sexual violence and how to prevent future associated deaths.

Team Membership & Member Responsibilities

The IPVDRT has two types of membership: *appointed members* and *invited members*. Each type of membership has responsibilities as a team member and must comply with all confidentiality and other legal and ethical requirements of the Team.

Appointed members

Pursuant to the IPVDRT enabling legislation, appointed members are appointed by the Director of the New Mexico Crime Victims Reparation Commission to represent their profession and/or agency on the IPVDRT.

Appointed members must comply with the confidentiality provisions of the IPVDRT enabling legislation as well as sign and comply with the IPVDRT Confidentiality Agreement.

Appointed members have full voting rights and therefore, should attend each meeting of the IPVDRT or send a representative proxy from their profession to attend on their behalf. Appointed members shall consider the recommendations and opinions of the entire team (both invited and appointed members) when submitting their vote on an issue.

Appointed members may resign a position in writing to the Team's Coordinator.

When an appointee is no longer affiliated with the agency from which they were appointed, the appointed position on the Team is considered vacated. Members who wish to continue as a voting member of the Team may make a request to the Team's Coordinator who will forward the request for a change of appointment to the Director of the New Mexico Crime Victims Reparation Commission for consideration.

For any vacancy, the Team's Coordinator will notify the New Mexico Crime Victims Reparation Commission of the vacancy and request a new appointee.

The appointed members of the Team shall vote annually to elect a Vice-Chair of the IPVDRT. The Vice-Chair will serve for one year, followed by a one-year term as Chair. Both the Chair and Vice-Chair must be appointed members of the Team and are responsible for following certain duties as described in the Meeting Structure section of these policies and procedures. ***(revised 9/16/10)***

The statute specifies that the appointed Team membership consist of representatives from the following categories:

- Medical personnel with expertise in domestic violence,
- Criminologists,
- Representatives from the New Mexico District Attorney's Association,
- Representatives from the Attorney General's Office,
- Victim Service Providers,
- Civil Legal Service Providers,
- Representatives from the Public Defender Department,
- Members of the judiciary,
- Law enforcement personnel,
- 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,
- Representatives from tribal organizations who deal with domestic violence, and
- Any other members the Director of the Commission deems appropriate.

A current list of appointed members can be obtained from the Team's Coordinator and will be included in the annual report each year.

Invited Members

Multi-disciplinary professionals from across the state may be invited to attend IPVDRT meetings. After approved by the Chair, these invited members can participate in confidential case reviews and discussions as long as they comply with the confidentiality provisions in the IPVDRT enabling legislation, sign and comply with the IPVDRT Confidentiality Agreement and comply with team policies and procedures. The Chair makes the final decisions regarding who can participate in confidential case reviews. All invited members must speak with the IPVDRT coordinator prior to attending their first meeting in order to learn about team process and confidentiality provisions.

Member Responsibilities

To achieve the IPVDRT's goals and assist with the case review process, both *appointed* and *invited* members of the IPVDRT will:

1. Provide confidential case information from their agency's records (as their legal and ethical obligations permit);
2. Participate in the case review discussion and analysis in a fair, thoughtful and meaningful way;
3. Serve as a liaison to their professional counterparts, bringing back recommendations and lessons learned at team meetings to their professional community;
4. Provide definitions and explanations of their profession's terminology and practices;
5. Interpret the procedures and policies of their agency and/or profession; and
6. Explain the legal or ethical responsibilities or limitations of their profession as they relate to the Team's process.

Meeting Structure

Unless otherwise specified, the IPVDRT will meet on the third Thursday of each month) from 10am to 12pm. The Team or its coordinator may deem it necessary to increase or decrease the number or length of sessions based on the number of cases to be reviewed. Sessions will be held either in-person in a location allowing confidential discussion, or via a remote session platform according to the guidelines provided by the New Mexico Office of the Attorney General. ***(revised 2023)***

In addition, the IPVDRT will convene at least one organizational meeting annually in order to conduct regular team business and to review findings and recommendations from case reviews and discuss contributions to the Team's Annual Report (*see* Findings & Recommendations). The Team can vote to hold this organizational meeting on a different date or before, during, or after one of the IPVDRT regular meetings. At the end of the Review Year, the Team will hold an organizational meeting. ***(revised 2019)***

For each of administrative session held, where quorum is established, the IPVDRT must comply with the New Mexico Open Meetings Act (NMSA 1978, §10-15-1 through 10-15-4). Compliance with this act includes: (1) proper notice of all meetings, (2) membership voting rights and quorum requirements, (3) appropriate meeting process, and (4) the drafting, voting and publishing of meeting minutes.

(1) Notice and Agenda:

The time and location of the meetings are determined by the Team members at their annual organizational meeting. Also at that meeting, appointed team members vote on the Team's *Compliance with Open Meetings Act* resolution that decides the Team's meeting notice requirements and compliance with other sections of the Open Meetings Act. The IPVDRT coordinator is then responsible for complying with that resolution and its mandated deadlines throughout the year.

The IPVDRT coordinator, with the Chair and Vice-Chair's input, prepares an agenda for each meeting. The agenda is published in accordance with the Team's *Compliance with Open Meetings Act* resolution.

The agenda must contain a list of specified items of business to be discussed or transacted at the meeting. At team meetings, members may discuss, but cannot take action on, matters that are not listed as specific items of business on the agenda. Action on items outside the published agenda must be taken at a subsequent meeting.

(2) Quorum and membership voting rights

At the start of every IPVDRT meeting, team members must determine if there is a quorum present. Quorum for the IPVDRT is met when there are appointed members present from at least seven (7) of the twelve (12) categories of appointed members (*see* Membership & Member Responsibilities). Appointed members may send representational proxies to the meetings to act in their capacity. These proxies must be from the same professional category as the appointed member. At least two hours prior to the meeting, the appointed member must inform the IPVDRT coordinator or the Chair of the Team in writing (email is acceptable) if they are sending a proxy to that meeting and who the proxy will be.

Only appointed members of the Team have voting rights, however, appointed members shall consider the recommendations and opinions of the invited members of the Team when submitting their votes. A motion passes when the majority of the present appointed members vote to approve the motion.

(3) Meeting Process

All IPVDRT meetings are open to the public unless otherwise exempted.

a. The Chair (or Vice-Chair in the Chair's absence) convenes each meeting and determines which appointed members are present at the meeting and which are absent.
b. The Chair leads the Team in introductions and encourages team members to share updates from their respective agencies.
c. The Chair then calls for any Committee reports, which are to be reported by that Committee's Chair (or appointee). Any Committee report that contains confidential case information must wait to be reported during the Team's closed session.
d. If there are case review records to discuss during the administrative session, the Chair closes the session in order to conduct confidential case reviews:
    - To do so, the Chair shall make a formal motion calling for a vote on a closed session. This motion shall include, with reasonable specificity:
        - the authority for the closure: NMSA 1978 §10-15-1(H) and the confidentiality provisions of the IPVDRT enabling legislation, and
        - the subjects to be discussed during the closed sessions.
    - The motion shall be approved by a majority vote of the quorum. The vote shall be taken while in an open meeting and the vote of each individual member shall be recorded in the minutes. Only those subjects announced or voted upon prior to closure may be discussed in the closed session.
    - Following completion of any closed session, the minutes of the open meeting that was closed (or the minutes of the next open meeting if the closed meeting was separately scheduled) shall state that the matters discussed in the closed meeting were limited only to those specified in the motion for closure or in the notice of the separate closed meeting. This statement shall be approved by the Team as a part of the meeting minutes.
e. When case reviews are complete, the Chair re-opens the meeting. The Chair must make a statement declaring that matters discussed in the closed meeting were limited only to those specified in the motion for closure and that no formal action was taken during the closed session. If formal action was recommended during the closed session, team members can now revisit that action and act accordingly. The Chair is responsible for closing the meeting.
f. If the closed meeting is called for when the IPVDRT is not in an open meeting, the IPVDRT coordinator must provide notice of that closed session and, with reasonable specificity, the subject to be discussed at the meeting to the members of the Team and to the general public. ***(revised 2023)***

(4) Minutes

The IPVDRT coordinator shall keep written minutes of all team meetings. The minutes shall include date, time and place of the meeting, the names of appointed members in attendance and those absent, the substance of the proposals considered and a record of any decisions and votes taken that show how each member voted. All minutes are open to public inspection.

Draft minutes shall be prepared by the IPVDRT coordinator within ten (10) working days after the meeting and shall be approved, amended or disapproved at the next meeting where quorum is established. Minutes shall not become official until approved by the Team.

Case Review Process

Types of Cases

The IPVDRT only reviews closed cases and does not attempt to re-open the investigations of those cases. Closed cases are those where the offender is dead or has been convicted of the death and most or all criminal appeals have expired. When a reasonable amount of time has passed since the death, the Team also reviews those cases which are classified as unsolved by law enforcement or where the offender was never criminally charged for the death.

The Team reviews cases involving a death associated with domestic violence or sexual assault. The deaths can be classified by the Office of the Medical Investigator (OMI) as homicide, suicide, accidental or undetermined manner of death.

The majority of the cases the Team reviews fit into the following categories:

- Homicide committed by intimate or dating partners
- Homicide with a sexual assault component
- Suicide by a victim of prior domestic violence
- Suicide by an offender of domestic violence (even if the victim survives) when the suicide is related to domestic or sexual violence
- Homicide of the offender if related to domestic violence (officer-involved shootings or bystander interventions)
- Accidental death from asphyxiation, toxicity, or overdose where there is a history of domestic or sexual violence
- Homicide of any child, family member or bystander killed during a domestic violence incident

Review Process

1. Case Identification: The IPVDRT coordinator identifies cases for review using several methods: researching death records at OMI, reviewing media reports regarding domestic and sexual violence, requesting information from local domestic violence and sexual assault agencies on homicides in their communities, and receiving case suggestions from team members or other professionals. The coordinator attempts to gather information on all domestic and sexual violence deaths that occur in the state, recognizing, however, that many deaths are not reported in conjunction to domestic or sexual violence and therefore, may be difficult to identify as such through public records.

2. Case Investigation and Compilation: The IPVDRT coordinator determines which agencies or systems the victim or offender had contact with prior to or following the death and contacts each of those agencies to obtain all pertinent reports and case information from them. The IPVDRT coordinator also researches all available media reports or other relevant information sources (i.e. websites) regarding the death or prior incidents with the victim or the offender. The IPVDRT coordinator compiles this information and enters it into the Team's *Confidential Case Review Form* as completely as possible.

   The following are the types of information collected by the IPVDRT coordinator for use in case investigation and compilation:

   - Law enforcement reports, including crime scene investigations and detective's investigative reports
   - Media reports
   - Details of any prior protective orders (temporary and permanent)
   - Civil court data regarding divorce, termination of parental rights, child custody, or child visitation
   - Criminal histories of the offender and the victim
   - CYFD protective services data (regarding alleged child abuse or neglect involving either the victim or the offender) and juvenile justice data (prior delinquency history of the offender or the victim)

- Adult protective services summary data and prior abuse history
- Summaries of psychological evaluations or reports appearing in public record documents, such as police files
- OMI autopsy report
- Workplace information (stalking/harassment, alerts among co-workers)
- Medical reports and hospital emergency room information
- Shelter or program services information from domestic violence or sexual assault advocates (if appropriate and legally permissible)
- School reports regarding children reporting abuse in the home
- Statements from neighbors, friends or witnesses (often found in police files as transcribed material or in court documents or trial transcripts)
- Pre-sentence investigation report (probation)
- Parole information (including victim notification)
- Information regarding weapons confiscation, purchase, and background checks
- Drug and alcohol treatment information

3. Case Presentation: During closed sessions of the IPVDRT meetings, the coordinator distributes the *Confidential Case Review Form* and other relevant documents (i.e. news articles, court docket entries) to the Team. Team members review the information given to them and ask questions to clarify issues or obtain additional information about the case. The IPVDRT coordinator invites representatives from those 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. ***(revised 2020)***

4. Case Review: After reading and discussing the facts of the death, IPVDRT members will begin a thorough review of the death and factors associated with the death. In particular, team members look for:

    - Risk factors for the victim or the offender prior to the death
    - System failures associated with the death
    - Recommendations for policy or systems improvement

5. Case Findings and Recommendations: Each team member present at the session is responsible for participating in the case review discussions and documenting findings and recommendations. The Team relies on the professional expertise of each of its members and therefore, it's important for team members to analyze each case according to their profession and contribute ideas and suggestions for inclusion in the Team's recommendations. ***(revised 2020)***

6. Review Completion: Following each in-person team session, the IPVDRT coordinator will assure that all case related materials that were distributed are left in the room to be shredded or returned to the provider of those materials.

    After each review, the IPVDRT coordinator summarizes the findings and recommendations identified in the review and maintains case statistics for aggregate reporting, such as age, race, and gender of victims and offenders and the relationship between victim and offender. ***(revised 2023)***

Confidentiality

IPVDRT members acknowledge that confidentiality is essential to the review process. Confidentiality is approached on two levels: team confidentiality and member confidentiality. Team confidentiality includes all activities that occur during a team session. Written information will be disseminated, reviewed, collected at the end of the session and then shredded. Virtual sessions will be attended using technology and procedures that provide private communication. Member confidentiality dictates that individual members must keep confidential any information that is revealed about specific cases. Other than as permitted by law, or required by a court order, team members should not share or speak about case information with anyone else, including others in their agency. Information should not leave the session room and each member is expected to sign and adhere to the IPVDRT Confidentiality Agreement. ***(revised 2023)***

Confidentiality provisions in the IPVDRT enabling legislation:

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.

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.

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.

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.

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. (NMSA 1978 §31-22-4.1)

Committees

The IPVDRT employs working committees to assist with carrying out the Team's goals and objectives, including following up on recommendations made during case reviews.

Committee membership is voluntary and can be made up of both appointed and invited members of the Team. A majority of the Team members shall vote annually on a Chair for the committee. This Committee Chair is responsible for planning committee sessions. The IPVDRT coordinator is responsible for conducting committee sessions, taking notes of committee recommendations and presenting those recommendations to the Team at regular IPVDRT sessions. ***(revised 2023)***

IPVDRT committees are working groups for the whole team and as such, shall not make any formal decisions or recommendations without reporting back to the Team and obtaining a majority vote approval of the quorum of the Team. Committee initiated research activities involving human subjects must receive preapproval from the Team and the Human Research Review Committee at University of New Mexico.

There are two categories of team committees: permanent and ad hoc. Permanent committees are those determined necessary by the Team in order to meet certain goals and objectives.

As of November 1, 2009, the following are the IPVDRT's permanent committees:

1. **Native American**:

   The Native American committee collaborates with tribes and tribal organizations from across the state in reviewing intimate partner violence deaths that occur on tribal lands or that involve a Native American victim or offender.

   The IPVDRT recognizes and honors the sovereignty of Native American tribes. Therefore, when reviewing cases of intimate partner deaths that occur on tribal lands, the Team will work to ensure that there is at least one tribal representative at the review and will not review the case if the tribe objects to the review or any part of its process.

   The Native American committee also assists the Team by providing specialized assistance, education and insight to the Team when reviewing cases that involve either a Native American victim or offender.

2. **Marginalized Populations**:

   The IPVDRT recognizes that there are several populations who are underserved or marginalized in our society. Therefore, the Marginalized Populations committee researches how these populations are affected by intimate partner violence (particularly through our case reviews) and creates strategies and recommendations to specifically address those populations and their unique needs. As of July 1, 2010, the Marginalized Populations group is addressing elder abuse and missing/trafficked/prostituted women. As of January 1, 2019, the Marginalized Populations committee is reviewing cases involving immigrants, individuals with limited English language proficiency, LGBTQ individuals, people experiencing homelessness, sex workers, and individuals aged 60 and above. ***(revised 2019)***

3. **Teen Dating Violence:**

   After reviewing several deaths involving teen victims of dating violence and stalking, the IPVDRT voted to create a separate committee to review cases that involve youth between the ages of 10 and 19. The Teen Dating Violence committee is comprised of members from youth-serving governmental and community agencies (state, local and tribal), teen suicide and pregnancy prevention agencies, CYFD, school representatives, law enforcement representatives (school resources officers) juvenile justice professionals, and substance abuse professionals. The committee will review each case with the goal of making tailored recommendations to the Team regarding the policy and systems changes necessary for reducing youth injury and death associated with dating violence.

   The Teen Dating Violence committee also assists the Team by providing specialized assistance, education and insight to the Team when reviewing cases that involve youth ages 10 to 19.

Ad hoc committees arise when the Team discovers new findings or recommendations that require additional research or other further work in order to resolve an issue or move forward a new idea.

Findings & Recommendations

The IPVDRT coordinator will compile the findings and recommendations of the Team after every team meeting. At the end of the review year, at the Team's annual organizational meeting, the Team will convene to discuss all of the findings and recommendations from the prior year and develop a list of the more relevant and important recommendations to include in the Team's Annual Report. ***(revised 2019)***

Pursuant to the Team's enabling legislation, the Annual Report is submitted to the Legislature, the Governor, and various other state and nonprofit agencies at least 30 days prior to the first day of the Legislative session (typically mid-January). The report is also disseminated to the media as a means of education and outreach to the general public.

Periodically, the Team may wish to publish a more thorough publication on the findings and recommendations of the Team, like 's *Getting Away with Murder* publications. The IPVDRT coordinator will collect and maintain the data, findings and recommendations for inclusion in these publications and, with the assistance of team members, will write and publish these findings on a regular basis.

Additionally, the Annual Reports and the Team's publications will be posted on the IPVDRT website. The coordinator will maintain the website regularly to ensure that the Team's recent findings and recommendations are easily accessible to the public.

Evaluation

The IPVDRT and the Team's Coordinator will evaluate the activities for each review year. The evaluation will contain two components: an outcomes evaluation and a process evaluation.

1. **Outcomes Evaluation**

   The Team, in collaboration with the IPVDRT Coordinator will perform an annual assessment of progress around the State on Team recommendations from prior years. Updates on recommendations will be included in the Annual Process Evaluation Report. ***(revised 2019)***

2. **Process Evaluation**

   The IPVDRT Coordinator will prepare a report that examines the review process, including the case data collection strategy, case review procedures, and adherence to the Team's mission, goals, and objectives. The report will be presented to the Team for discussion at the organizational meeting. ***(revised 2019)***