

**New
Mexico
Intimate
Partner
Violence
Death
Review
Team**

Annual
Report

2026

Findings &
Recommendations
from CY2022
Intimate Partner
Violence Deaths

June 25, 2026

The Honorable Michelle Lujan Grisham
Governor of the State of New Mexico
State Capitol Building, 4th Floor
Santa Fe, New Mexico 87503

Governor Lujan Grisham:

The Intimate Partner Violence Death Review Team (the Team) is a statutory body authorized by the New Mexico Legislature under NMSA 1978 §31-22-4.1. It is composed of members from state, community, and governmental agencies across New Mexico. Our role is to examine the underlying facts and circumstances of deaths related to intimate partner violence across New Mexico.

It is my great privilege to present the 2026 Annual report on behalf of the Team. This report summarizes the findings and recommendations from the Team's review of intimate partner violence-related fatalities that occurred in New Mexico in 2022. In reviewing these cases, Team members worked to identify gaps in system responses to all parties involved, including victims, perpetrators, and impacted family members, at both the State and local levels. In order to prevent future injury and death related to intimate partner violence, the Team also proposes strategies to improve prevention, intervention, and response efforts.

The Team's work is carried out in memory of victims and on behalf of their families and all those affected by intimate partner violence. By learning from their stories and applying effective prevention and intervention strategies, their deaths will not have been in vain.

We thank you for your ongoing commitment to addressing intimate partner violence in New Mexico and hope this report guides meaningful policy and practice improvements for a stronger, more effective response.

Respectfully,

A handwritten signature in black ink, appearing to read "Gail Starr", with a long, sweeping horizontal line extending to the right.

Gail Starr

New Mexico Intimate Partner Violence Death Review Team

Annual Report 2026

The New Mexico Intimate Partner Violence Death Review Team (the Team), also known as the Domestic Violence Homicide Review Team, is a statutory body enabled by the New Mexico Legislature under NMSA §31-22-4.1 (Appendix A). The Team is funded by the New Mexico Crime Victims Reparation Commission (CVRC). Team coordination and staff services are housed at the New Mexico Statistical Analysis Center (NMSAC) within the Institute for Social Research, University of New Mexico. The Team is a multidisciplinary group of professionals who meet monthly to review the facts and circumstances surrounding intimate partner violence (IPV) or sexual assault (SA) related deaths in New Mexico, with the goal of reducing the incidence of these deaths statewide. The current 2026 report presents findings and recommendations from the Team’s review of 29 partner violence-related deaths that occurred in 2022, except one that occurred in 2021.

Contents

Executive Summary	ii
Acknowledgments	vii
Team Membership	viii
Introduction	1
Incidents of Intimate Partner Violence Resulting in Death.....	2
Relationship and Person Characteristics in IPV Related Death Incidents	5
Team Recommendations	11

Executive Summary

The New Mexico Intimate Partner Violence Death Review Team (the Team) is a multidisciplinary group of professionals who meet monthly to review the facts and circumstances surrounding New Mexico deaths related to intimate partner violence (IPV) or sexual assault (SA). The Team reviewed 29 incidents of IPV-related fatalities resulting in 38 deaths in Fiscal Year 2026 (FY26).¹ One fatality occurred in calendar year 2021, and the remaining reviewed deaths occurred in calendar year 2022. The Team reviewed 15 incidents of homicide, 8 murder-suicides, 5 suicides, and 1 incident with an undetermined manner of death that appeared to be a suicide. The following are select findings from the Team's FY26 review of IPV-related deaths:

Incidents of Intimate Partner Violence (IPV) Resulting in Death

- The Team reviewed 29 incidents of IPV that resulted in 38 deaths.
- These incidents occurred in 14 New Mexico counties and one (3%) was in a rural area.
- Firearms were used in 23 incidents and 30 deaths. Ten IPV perpetrators were prohibited by federal law from possessing a firearm, four of whom used a firearm in the incident (two of these involved homicides).
- While most incidents occurred in a private residence, three deaths (10%) took place in a public location, including on streets and driveways.
- Charges were filed in 11 of the 15 homicide-only incidents. Three incidents involved two or more offenders. A total of fifteen individuals were charged, and ten were convicted. Sentences ranged from probation for voluntary manslaughter to 43 years in prison for 1st Degree Murder.
- The Crime Victims Reparation Commission (CVRC) provided compensation in 16 (55%) of the cases.

Relationship & Person Characteristics

Relationship between the intimate partner pair (IPP)

- Ten incidents (35%) involved couples who were currently married or in a domestic partnership; 15 (52%) involved IPPs who were dating; and in four incidents (14%), the IPP were former dating or domestic/married partners.
- Ten (35%) couples were in the process of separating at the time of the incident.
- Seven IPPs (24%) had shared minor children.
- Twenty-five (86%) IPPs had a known prior history of violence within their relationship.

IPV victims

- There were 29 IPV victims among the cases reviewed in FY26. IPV victims may be decedents (N=18), offenders (N=3) or surviving partners (N=8) of the death incident.
- Victims ranged in age from 17 to 72 years old and 86% of IPV victims were female.
- Five (17%) had a history of IPV victimization by a prior partner, and three (10%) had a history of IPV perpetration with another partner.

¹ The Fiscal Year begins on July 1 and ends June 30.

IPV perpetrators

- There were 29 IPV perpetrators. An IPV perpetrator may be the decedent (N=10), offender (N=18), or surviving partner (N=1) in the death incident.
- Perpetrators ranged in age from 16 to 73 years old and 83% of perpetrators were male.
- Nine (31%) had a history of IPV perpetration with another partner and six (21%) had a history of IPV victimization by another partner.

Native American-involved cases

- The Native American Committee reviewed four cases (14%) involving Native American decedents and/or offenders.

Contacts with service providers

- Both victims and perpetrators most frequently had previous contact with healthcare providers (N=10 and N=11, respectively), followed by the Children, Youth, and Families Department (N=9 for each).
- Awareness of the IPV by friends and family members was reported more often for victims (N=6) than for perpetrators (N=2).

Secondary offenders and victims

- At times, individuals outside of the intimate partner relationship are identified as a party to IPV-related homicides, as either the decedent (secondary victim) or offender (a secondary offender).
- Five cases involved secondary offenders, including one responding law enforcement officer. None of the cases reviewed in FY26 involved secondary victims.

Team Recommendations

In FY26, the Team developed recommendations addressing multiple stakeholder systems based on the cases reviewed this fiscal year. Each recommendation is summarized below, organized by system area. Details for each recommendation can be found in the report, beginning on page 11.

Legislation/Policy

- Require that offenders convicted of any crime against a household member be required to participate in and complete a domestic violence offender treatment or intervention program approved by the Children, Youth and Families Department, and provide funding for these programs.
- Increase funding for service outreach for Intimate Partner Violence (IPV) providers.

Law Enforcement

- Increase capacity of law enforcement agencies to respond to intimate partner and sexual violence by improving the availability of victim-centered resources and advocate support.

- Prioritize and create accountability mechanisms to ensure that officers attend court hearings for all violent crimes.
- Encourage law enforcement agencies to establish formal high-risk intimate partner violence protocols for cases involving indicators associated with elevated lethality.
- Create and implement standardized policies and culturally appropriate responses to domestic violence-related incidents. These policies should include clear protocols for investigating, documenting, and reporting such incidents; assessing firearm access and lethality risk; engaging victim advocates and making service referrals; notifying CYFD when children are present; and improving procedures for post-incident follow-up.

Law Enforcement and 911 Dispatchers

- Ensure that call takers and dispatchers document locations of repeat calls for services that may indicate IPV risk, share that with law enforcement when they are responding to calls, and maintain records of this information for analysis and reference for future calls for service. Law enforcement training should address the need to document such calls.

Prosecution

- Encourage evidence-based prosecution for all cases involving domestic violence or sexual assault while still ensuring that decisions are victim centered; employ a secure, shared data-exchange portal; use appropriate charging and plea strategies; include conditions to address offenders' underlying need; and ensure timely referral of victims to services.

Courts

- Expand training for court personnel for courts with jurisdiction over criminal charges, domestic matters, and domestic violence orders of protection to improve and maintain judicial officers' capacity to engage with victims, children present in the household, and perpetrators of domestic violence in a trauma-informed and culturally sensitive manner pre- and post-conviction.
- Civil and criminal courts should utilize evidence-based lethality risk assessment tools in domestic violence cases that are appropriate for court use.
- Encourage judges to require participation in, and enforce offender compliance with, court-ordered domestic violence treatment programs, substance use, and/or mental health treatment both pre- and post-adjudication.
- Encourage judges to prioritize safety and well-being when issuing Domestic Violence Orders of Protection (DVOPs) and to actively monitor and enforce the restrained party's compliance with the requirements of those orders.
- Encourage courts to consider implementing practices that support law enforcement agencies to prioritize officer attendance at domestic violence hearings and ensure offender accountability.
- Encourage the use and funding for an integrated domestic violence court system.

Probation and Parole

- Improve post-conviction professionals' ability to assess risk factors for intimate partner violence victimization and offending, including knowledge of lethality indicators, and ensure agency

personnel have current knowledge of the availability of appropriate victim services and offender intervention resources.

- Monitor offenders for compliance with court-ordered domestic violence, substance use, and/or mental health treatment; promptly report violations to the court; request and attend compliance hearings; and suggest appropriate sanctions and/or interventions.

Corrections and Jails

- Improve assessment and treatment of offenders for mental and behavioral health conditions during incarceration in county and state correctional facilities.

Victim Services

- Develop standardized, trauma-informed protocols that promote collaboration between non-governmental victim service providers and law enforcement, to ensure timely referrals and comprehensive follow-up support for victims of intimate partner violence and sexual assault.
- Increase and improve the visibility of intimate partner violence, sexual assault, and trauma-informed grief services among all local stakeholder agencies and the community by engaging in multi-agency collaboration.

Children, Youth, and Families Department (CYFD)

- Improve professional expertise and capacity to advocate for, and intervene with, families in which children are present in homes experiencing domestic violence.
- Initiate and facilitate collaboration with local community stakeholders to provide pathways to CYFD prevention services.

Medical Health Care Services

- Encourage medical providers to follow best practices for identifying and addressing IPV-related risk in adult patients throughout the course of patient care including intake, intervention, and discharge.

Mental and Behavioral Health Care Services

- Agencies should identify and adopt professional service policies and procedures, including professional codes of ethics, required by the licensure or certification boards relevant to the professional discipline(s) represented within the agency. Agencies should ensure that all employees are aware of, trained on, and adhere to, those standards.
- Identify, inventory, and evaluate the use of existing resources to eliminate barriers to mental health and substance use services in the state, especially in rural communities.
- Assess and adjust service provision policies to ensure effective and evidence-based support tailored to community needs.

Cross-Cutting Medical, Mental, and Behavioral Health Care Services

- Improve and coordinate follow-up and case management with individuals who seek medical, mental, or behavioral health treatment, particularly in rural areas.

Community

- Improve universal awareness and recognition of firearm safety.
- Improve universal awareness and recognition of IPV through education and prevention efforts beginning early and extending across the lifespan to improve healthy relationships, change the climate of IPV tolerance, and reduce the stigma of help-seeking.
- Encourage employers to become better educated about domestic violence and use best practices, (e.g., <https://workplacesrespond.org>) to respond effectively to DV in the workplace and to employees who are experiencing DV.
- Improve and increase education and prevention efforts addressing topics such as Adverse Childhood Experiences (ACEs), violence prevention, mental health, bullying, boundary setting, and help-seeking. These efforts should be culturally appropriate and accessible in multiple languages.

Cross-cutting Recommendations Across Multiple System Areas

- Develop standardized, trauma-informed protocols that promote collaboration between non-governmental victim service providers to ensure timely referrals and comprehensive follow-up support for victims of intimate partner violence and sexual assault.
- Establish a Coordinated Community Response Team in each community.
- Increase and improve the visibility of intimate partner violence, sexual assault, and trauma-informed grief services among all local stakeholder agencies and the community by engaging in multi-agency collaboration.
- Create statewide crisis response teams, composed of mental or behavioral health professionals, to respond to individuals experiencing mental health crisis.

Acknowledgments

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

- The New Mexico Crime Victims Reparation Commission (CVRC), Director Frank Zubia and the entire Crime Victims Reparation staff and Commission, for their support of the Team's work and assisting the Team with procuring meeting space;
- Dr. Sarah Lathrop and Garon Bodor of the New Mexico Office of the Medical Investigator for assistance with case identification and data collection;
- All of the criminal justice and community service professionals across the State of New Mexico who assisted with the record collection necessary for conducting effective case reviews; and
- The appointed and invited Team members for all of the work that they do to generate the findings and recommendations contained in this report.

This report is prepared—and the Team's work undertaken—in honor and memory of those who have lost their lives to intimate partner and sexual violence, as well as the family members who have suffered these profound losses. It is the Team's intention to share these findings and offer recommendations to improve systemic responses and, ultimately, to prevent future incidents of injury and death associated with intimate partner violence.

For more information about the New Mexico Intimate Partner Violence Death Review Team, please visit our website (<https://isr.unm.edu/centers/new-mexico-statistical-analysis-center/ipvdrt/index.html>). The site provides details about Team meetings and membership, as well as archived reports and select multi-year data.

Team Membership

Appointed Members

Dana Beyal, 2nd Judicial District Attorney's Office
Pam Brendler, Crime Victims Reparations
Commission (CVRC)
Judge Amber Chavez Baker, 2nd Judicial District
Court
Lucilla Clarke, New Mexico Legal Aid
Judge Rosemary Cosgrove-Aguilar, Bernalillo County
Metropolitan Court
Cameron Crandall, UNM Hospital
Anamaria Dahl, New Mexico Department of Health
(DOH)
Cheryl Eaton, Federal Bureau of Investigation,
Victim Services
Maribel Encarnacion, Children, Youth and Families
Department (CYFD)
Sara Yvonne "Bonnie" Escobar, Enlace Comunitario
Kathryn Farquhar, NM Aging and Long-Term
Services Department
Patricia M. Galindo, Administrative Office of the
Courts
Cheryl Hobbs, New Mexico Probation and Parole
Dr. Heather Jarrell, Office of the Medical
Investigator
Raylene Lujan, Eight Northern Indian Pueblos
Council (ENIPC)
Adaline Nuanez-Baca, New Mexico Corrections
Department (NMCD)
Demica (Mica) Reagan, New Mexico Coalition
Against Domestic Violence (NMCADV)
Gail Starr, Albuquerque Healthcare for the
Homeless
Eric K. Threlkeld, Eddy County Sheriff's Office

Invited Members

Danielle Albright, Emergency Medicine, UNM
Chearie Alipat, New Mexico Asian Family Center
Stacy Blazer-Clark, New Mexico Coalition of Sexual
Assault Programs
Maeve Cardwell, University of New Mexico School
of Medicine
Tiffany Corn, U.S. Attorney's Office – New Mexico

PrettyWater Duran, Bureau of Indian Affairs (BIA)
Honor Fisher, BIA
Ernest Frenier, ENIPC
Kayla Galvan, Valencia Shelter Services New Mexico
MaryEllen Garcia, NMCADV
Charolette Gonzales, Coalition to Stop Violence
Against Native Women (CSVANW)
Sonya Gonzales, ENIPC
Tiffany Jiron, CSVANW
Savannah Joe, U.S. Department of Justice
Gwendolyn Kasero, BIA
Jennifer Rose Kletter, New Mexico Legal Aid
Stacie Litke, Northern Navajo Medical Center- IHS
Donna Maestas, ENIPC
Kayla Martensen, Ph.D., UNM Department of
Sociology & Criminology
Quintin D. McShan, Homeland
Joella Montoya, Community Against Violence, Inc.
Dr. Carolyn Morris, Psychologist
Jennifer Nanez, UNM, Division of Community and
Behavioral Health
Becky O'Gawa, 2nd Judicial District Attorney's Office
Angelia Parent, Affirming Heart Victim Services
Melissa E. Riley, Ph.D., Native Community
Development Associates
Andrea Roman-Alfaro, Ph.D., UNM
Department of Sociology & Criminology
Jacqueline Sanchez, NM CVRC
Karol Thieme, Valencia Shelter Services
Alexis Torres, NM CVRC
Michelle Varela, New Mexico Office of the Attorney
General

Special Thanks to Team & Committee Chairs

Gail Starr, Team Chair
Demica (Mica) Reagan, Vice Chair
Sara Yvonne "Bonnie" Escobar, Chair of the
Marginalized Populations Committee
Demica (Mica) Reagan, Chair of the Teen Dating
Violence Committee
Tiffany Jiron, Chair of the Native American
Committee

Introduction

Intimate Partner Violence (IPV) is prevalent in New Mexico. A 2024 self-report survey found that in the prior twelve months, 19% of respondents experienced domestic violence.² Moreover, over one-third of adults living in New Mexico have experienced intimate partner violence in their lifetimes.³ According to a study published by the Center for Disease Control, New Mexico women's estimated rates of lifetime IPV are higher than national estimates (38.7% compared to 34.0%).⁴ While updated rates for men were not available in that study, a prior study indicated that New Mexico men are 2.4% higher than the national rate (33.3% versus 30.9%, respectively).⁵

At its most extreme, IPV results in death. In 2021, the National Violent Death Reporting system reported that nationally, 7.0% of homicides were committed by an intimate partner.⁶ According to the New Mexico Department of Health, 14.7% of homicides in New Mexico in 2021 were due to intimate partner violence. Further, once rates are disaggregated by gender, there is a notable difference. Nearly half (48%) of female homicide victims were killed by an intimate partner in 2021, and 7% of male homicide victims were killed by an intimate partner.

Many of these deaths could have been prevented. The New Mexico Intimate Partner Violence Death Review Team (IPVDRT), a legislatively established statutory body, reviews the facts and circumstances of deaths related to IPV and SA. Cases are identified for review using several methods: researching death records from the Office of the Medical Investigator (OMI), reviewing media reports regarding domestic and sexual violence, and receiving case suggestions from Team members or other professionals. During the review process, the Team identifies system failures, gaps and successes that occurred in each case. They then make recommendations based on the data with the aim of preventing future deaths. Since 1998, the Team has been reviewing cases involving IPV-related homicides. Each year, the Team publishes a report presenting its findings and recommendations.

During Fiscal Year 2026 (FY26) the Team reviewed cases that occurred in 2022, except for one case that occurred in 2021. The cases reviewed include only those that are fully resolved, meaning there are no known pending court cases associated with the incident. Additionally, only cases for which we are able to obtain information are reviewed. Thus, each year, there are fewer cases reviewed than there are incidents in that year. The characteristics of the cases reviewed may not be representative of all IPV-related fatalities that occurred in 2022.

² Dumont, R. & G. Shaler (2024). *New Mexico Crime Victimization Report*.

³ Caponera, B. (2022). *Incidence and Nature of Domestic Violence In New Mexico XX: An Analysis of 2021 Data from the New Mexico Interpersonal Violence Data Central Repository*. New Mexico Coalition of Sexual Assault Programs.

⁴ Zhang Kudon, H, Zhu S, Chen B, Breiding MJ, Leemis RW, Zhang X, Schwank A, Basile KC. The National Intimate Partner and Sexual Violence Survey (NISVS): 2023/2024 Intimate Partner Violence Data Brief. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2026. <https://www.cdc.gov/nisvs/media/pdfs/intimatepartnerviolence-brief.pdf>.

⁵ Caponera, supra note 3.

⁶ National Center for Injury Prevention and Control (2021). *NVDRS Violent Deaths Report* [Data set]. <https://wisqars.cdc.gov/nvdrs/>.

Incidents of Intimate Partner Violence Resulting in Death

The Team identified a total of 56 incidents of likely intimate partner violence (IPV) that resulted in at least one death per incident. These incidents occurred in calendar year 2022, apart from one case that occurred in 2021. The Team reviewed 29 of those 56 incidents. Of those reviewed:

- 11 were intimate partner homicide
 - One of these cases also involved secondary offender homicide
- 4 were secondary offender homicide
- 8 were murder-suicide
- 5 were suicide
- 1 was an undetermined manner of death

The remaining 27 incidents include 16 homicides, nine suicides, one murder-suicide, and one undetermined manner of death. The Team did not review ten of the homicide-only cases because there were pending court cases. The remaining 11 cases were not reviewed due

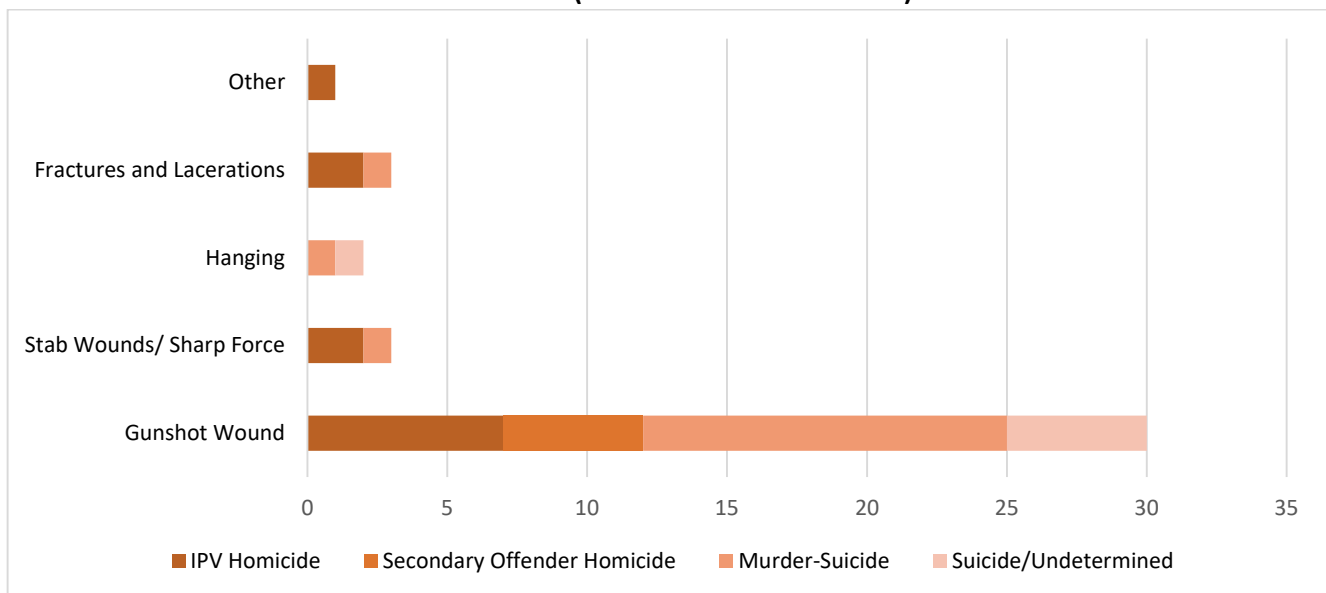
to insufficient information, time constraints, or other reasons. The incidents occurred in 14 counties across the state. One (3%) of these incidents occurred in rural or tribal areas.

Among the 29 reviewed incidents, 38 people died, including 17 IPV victims and 21 IPV perpetrators.

Of the 29 incidents, 23 (79%) involved a firearm. Of the 38 decedents, 30 (79%) deaths were the result of gunshot wounds, including one decedent who also suffered fractures and lacerations. Three deaths were the result of sharp-force injuries or stab wounds; three suffered fractures and lacerations to internal organs (including one who also suffered a gunshot wound); two deaths were the result of asphyxiation; and one person died from other injuries.

A postmortem sexual assault examination was conducted in one case, but the results were unknown.

Cause of Death in IPV Related Death Incidents (Number of decedents = 38)



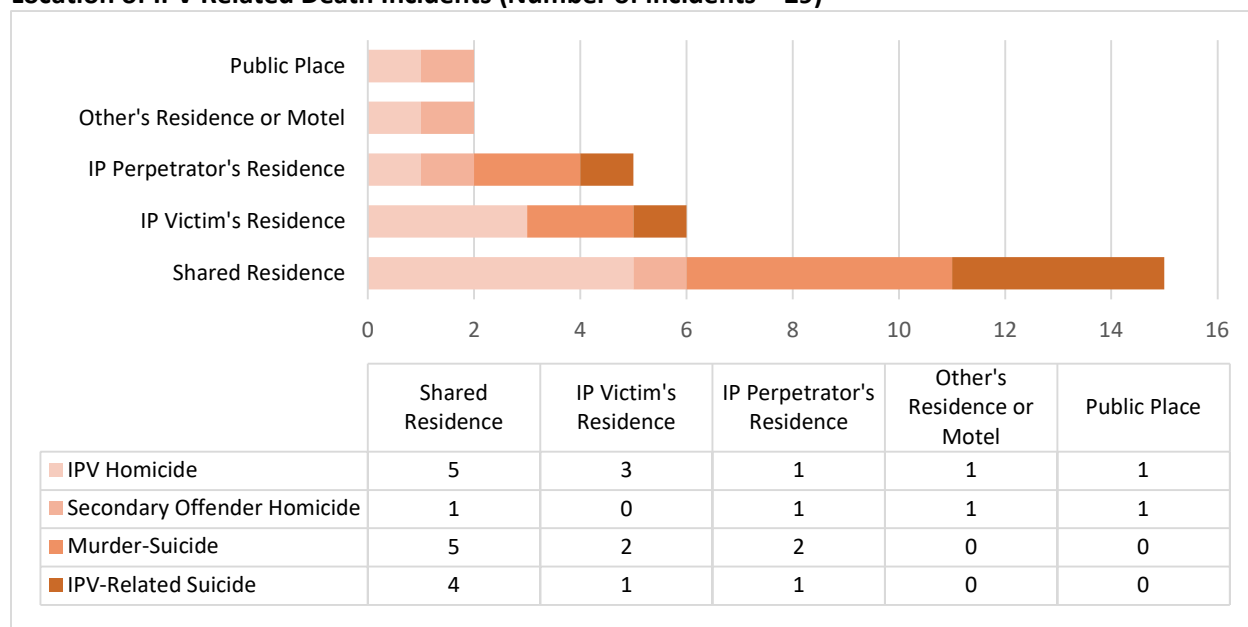
Note: N=39 due to one decedent having multiple causes of death.

The Team reviewed ten cases involving IPV perpetrators who were prohibited by federal law from possessing a firearm; in four of these, the perpetrator used a firearm during the death incident. This includes one IPV homicide, one murder-suicide, and two suicides.

Incidents occurred most often at the couple's shared residence (15 cases). In six cases, the incident occurred at the IPV victim's residence, and in another four cases, it occurred at the IPV

perpetrator's residence. In three cases, the incident occurred in a public location (alley, parking lot, or street), and in the remaining three cases, the incident occurred somewhere else (friend's residence, motel room, or jail). The figure below shows the distribution of type of death incident by type of location. The number of locations exceeds the number of incidents because in two murder-suicide cases, the suicide occurred at a different location.

Location of IPV Related Death Incidents (Number of incidents = 29)



N=29; sums to 31 as two cases had multiple sites of death incident

Criminal Charges

Murder charges were filed in 11 of the 15 homicide-only incidents reviewed. In three cases, two or more individuals were charged in connection with the homicide, resulting in a total of 15 offenders.

Prosecutors did not pursue charges in four homicide cases. In two cases, the homicide offender died before charges were filed; in one case, the homicide was determined to be justifiable; and in one case, it appears there was insufficient evidence to support criminal charges.

Prosecutors filed charges in two murder-suicide cases and one suicide-only case. In one murder-suicide case, the homicide offender later died. In the other, a secondary party was initially charged but was quickly exonerated. No charges were filed related to the suicide itself in the suicide-only case; however, prosecutors filed charges for an IPV-incident that occurred prior to the suicide. The perpetrator was convicted of that offense.

Conviction and Sentencing

Prosecutors obtained a conviction in 8 of the 11 homicide cases, and against 10 of the 15 individuals charged.

The prosecutor dismissed four of the five cases that did not result in a conviction; in two of these four cases, the offender later died. One

case resulted in an acquittal.

Nine people were convicted after a plea agreement and one after a jury trial. After accounting for time suspended, incarceration sentences varied from 0 to 43 years.⁷ This is illustrated in the following table.

FY26 Homicide Conviction Sentence Range by Charge Type (N = 8 cases, 10 offenders)

Most Serious Adjudicated Charge	Number of Convictions	Sentence Range in Years After Time Suspended (years in prison)
1 st Degree Murder	2	5 years to life imprisonment plus 13 years (43 years)
2 nd Degree Murder	5	14 years to 18 years
Voluntary Manslaughter	2	0 years (probation/parole only) to 6 years
Cyberstalking Resulting in Death	1	25 years

Assistance from CVRC

The New Mexico Crime Victims Reparation Commission (CVRC) assists victims of violent crimes, including domestic violence, with expenses that occur due to their victimization. Eligible individuals can receive compensation that may be used towards medical and dental care, mental health counseling, funeral and burial expenses, loss of earnings, eyeglasses, or other medically necessary devices.

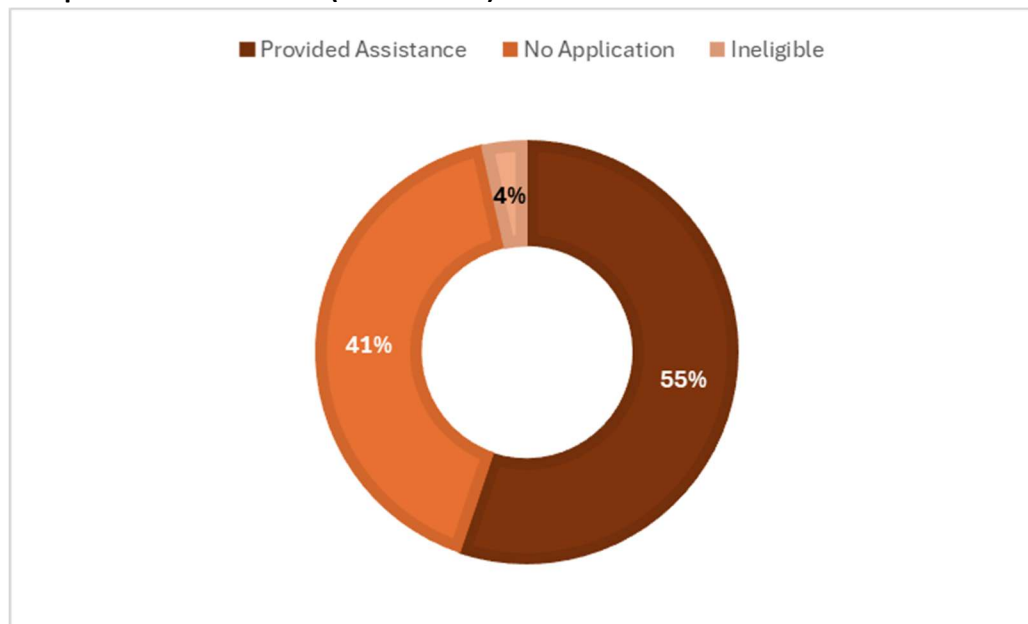
To qualify, the crime must have occurred in New Mexico, must have been reported, and the

application must be filed within two years of the incident. Victims of violent crimes, their dependents and/or family members, and anyone who voluntarily assumes funeral or medical expenses of the victim are eligible to apply.

CVRC provided financial compensation in 16 (55%) of the cases reviewed in FY26. The majority of those who did not receive compensation did not submit an application.

⁷ One person received a fully suspended sentence.

Compensation from CVRC (N = 29 cases)



Relationship and Person Characteristics in IPV Related Death Incidents

Relationship between the Intimate Partner Pair⁸

In ten of the 29 (35%) incidents, the intimate partner pair was married or in a domestic partnership at the time of the death. Fifteen incidents (52%) involved couples who were currently dating, and four incidents (14%) involved former domestic partners or dating partners. Ten intimate partner pairs (35%) were in the process of separating at the time of the incident, including three who had recently broken up. Most had lived together in the past or were currently living together. Nine incidents involved minor children. Seven couples had shared biological or adopted children and in two other cases, the woman was pregnant. Among the seven IPPs who had shared children, four lived in the household

with one or both parents. In three cases, stepchildren currently or previously lived with the couple. Children witnessed one or more acts of prior violence in 11 cases; in eight of those cases, the children were minors at the time of the incident. Six IPV related death incidents (21%) occurred with a minor child present at the scene; in four incidents, children witnessed the fatality. Almost all (86%, N=25) of the couples had a known history of abuse, with most (79%, N=23) experiencing physical violence. Just under half of the couples sought assistance from law enforcement or the courts.

⁸ The IPV pair refers to the victim and perpetrator of IPV leading to a death incident. The victim or perpetrator may be the homicide decedent, homicide offender, or surviving intimate partner following the homicide.

The following table reports relationship characteristics for incidents reviewed by the Team.

Relationship between the Intimate Partner Pair (N = 29)

	Number of incidents	%
Relationship Status		
Spouse or Partner	10	35%
Ex-spouse or Ex-domestic partner	1	3%
Boyfriend or Girlfriend	15	52%
Ex-boyfriend or Ex-girlfriend	3	10%
In the Process of Separating	10	35%
Habitation Status at Time of Incident		
Living together	18	62%
Previously Lived Together	7	24%
Never Lived Together	4	14%
Children		
Any minor child(ren) in household	9	31%
Couple has any shared biological or adopted child(ren) of any age	7	24%
Shared biological or adopted minor child(ren) in household	4	14%
Stepchild(ren) in household	3	10%
Children witnessed prior abuse ⁹	11	38%
Children were present at the time of the fatality incident	6	21%
Children witnessed fatality incident	4	14%
History of Intimate Partner Violence within Pair		
Known history of abuse in relationship	25	86%
At least one domestic violence police call for service	13	45%
At least one arrest for intimate partner violence	10	34%
Any history of a domestic violence order of protection between parties ¹⁰	3	10%
Any history of child custody cases involving the two parties	1	3%

⁹ Includes now-adult children who witnessed abuse between the couple when they were children.

¹⁰ Denotes a DVOP at any time during the relationship between the intimate partner pair.

IPV Victims

IPV victim refers to the victim of intimate partner violence leading to a death incident.

The IPV victim may be the decedent, offender, or surviving partner in the death incident. For the FY26 review, there were 29 IPV victims. This includes 18 decedents, three offenders, and eight surviving intimate partners.

Victims ranged in age from 17 to 72 years old; the median age was 37 years. Most victims (N=25, 86%) were female. Nine victims (31%) were teenage parents, and one additional teenager (3%) was pregnant at the time of the incident.

About 41% of victims had a known history of alcohol abuse and a criminal history, including six IPV victims (21%) who had a prior arrest for a domestic violence offense.

Five victims (17%) were known to have previously experienced intimate partner violence with another partner before this incident. Three (10%) had a known history of domestic violence in their family of origin.

The table below presents background characteristics for IPV victims in reviewed incidents.

Background Characteristics of IPV Victims (N = 29)

	# of Victims	%
Sex		
Female	25	86%
Male	4	14%
Gender		
Woman	13	45%
Man	2	7%
Unknown/Unspecified	14	48%
Race/Ethnicity		
White	13	45%
Hispanic	14	48%
Native American	2	7%
Health		
Known history of alcohol abuse	12	41%
Known history of Illicit drug use ¹¹	8	28%
Known history of depression or other mental illness	5	17%
Known history of a chronic disease	8	28%
Teen pregnancy and/or parenthood	10	35%
Criminal History		
At least one prior arrest	12	41%
Convicted of at least one felony crime	2	7%
At least one term supervised probation or parole	4	14%
On probation or parole at the time of the incident	0	0%

¹¹ One IPV victim had a known history of prescription drug misuse.

Intimate Partner Violence History		
Known history of intimate partner violence victimization ¹²	5	17%
Known history of intimate partner violence perpetration ¹³	3	10%
At least one arrest for domestic violence (any household member) ¹⁴	3	10%
At least one conviction for domestic violence (any household member)	1	3%
Party in at least one prior domestic violence order of protection ¹⁵	5	17%
Known history of intimate partner violence in family of origin	3	10%

IPV Perpetrator

IPV perpetrator refers to the identified perpetrator of intimate partner violence or sexual assault in an incident leading to a death.

The perpetrator may be the decedent, offender, or surviving partner in the death incident. There were 29 perpetrators, 10 of whom were decedents, 18 were offenders, and one surviving partner.

Perpetrators ranged in age from 16 to 73 years old; the median age was 40 years old. Most perpetrators were male (N=24, 83%).

At the time of the incident, 52% (N=15) of perpetrators were drinking alcohol and 35% (N=10) were using illicit drugs.

Background Characteristics of IPV Perpetrators (N = 29)

	Number of Perpetrators	%
Sex		
Female	5	17%
Male	24	83%
Gender		
Woman	3	10%
Man	10	35%
Unknown/Unspecified	16	55%
Race/Ethnicity		
White	10	35%
Hispanic	15	52%
Native American	3	10%
African American	1	3%

¹² Excludes current partner; with current partner this number increases to 25.

¹³ Excludes current partner; with current partner this number increases to 12.

¹⁴ Excludes current partner; with current partner this number increases to 6.

¹⁵ May be either as the petitioner or respondent. Excludes current partner; with current partner this number increases to 7.

Health		
Known history of alcohol abuse	18	62%
Known history of illicit drug use ¹⁶	14	48%
Known history of depression or other mental illness	13	45%
Known history of a chronic disease	5	17%
Teen parent/expectant parent	3	10%
Substance use at time of the incident	19	66%
Use of alcohol (alone or with another substance) at time of death incident	15	52%
Use of illicit drugs (alone or with another substance) at time of death incident	10	35%
Criminal History		
At least one prior arrest	18	62%
Convicted of at least one felony crime	8	28%
At least one term supervised probation or parole	9	31%
On probation or parole at the time of the incident	2	7%
Intimate Partner Violence History		
Known history of intimate partner violence victimization ¹⁷	6	21%
Known history of intimate partner violence perpetration ¹⁸	9	31%
At least one arrest for domestic violence (any household member) ¹⁹	4	14%
At least one conviction for domestic violence (any household member) ²⁰	3	10%
Party in at least one prior domestic violence order of protection ²¹	8	28%
Known history of intimate partner violence in family of origin	1	3%

Contacts with Service Providers

In addition to formal criminal and civil legal systems, the Team evaluates other known service contacts for both IPV victims and perpetrators.²² Most often, both victims (N=10) and perpetrators (N=11) had known contact with healthcare providers; of these, seven victims had known contact with emergency medical services as did eight perpetrators. Contact with the Children,

Youth and Families Department was the next most frequently accessed system for both victims and perpetrators. Victims sought assistance from friends and family more often than perpetrators, while perpetrators accessed mental health or substance abuse treatment more often than victims. The table below shows the distribution of known help seeking and system contacts.

¹⁶ Two IPV perpetrators had a known history of prescription drug misuse.

¹⁷ Excludes current partner; with current partner this number increases to 15.

¹⁸ Excludes current partner; with current partner this number increases to 25.

¹⁹ Excludes current partner; with current partner this number increases to 12.

²⁰ Excludes current partner; with current partner this number increases to 4.

²¹ Excludes current partner; with current partner this number increases to 10.

²² Our identification of known contacts with services outside the criminal and civil justice system is limited. We document known contact from prior court history and investigative documents related to the homicide and other prior interactions with the police or courts.

Known Contacts with Service Providers for IPV Victims and Perpetrators

	IPV Victims (N = 29)		IPV Perpetrators (N = 29)	
	Number of victims	%	Number of perpetrators	%
Service Contact History				
Domestic violence-related friends and family support	6	21%	2	7%
Children, Youth and Families Department	9	31%	9	31%
Domestic violence related services ²³	1	3%	1	3%
Health care services	10	35%	11	38%
Mental health services	5	17%	8	28%
Government services ²⁴	3	10%	3	10%
Sexual assault related services	0	0%	0	0%
Substance abuse treatment program	6	21%	7	24%

Secondary Offenders and Victims

Individuals outside of the intimate partner relationship are sometimes a party to IPV-related homicide, as either the decedent (a secondary victim) or offender (a secondary offender).

The Team reviewed five incidents involving secondary offenders. Four incidents involved secondary offenders who committed an act resulting in the death of one of the intimate

partners. In three of these cases, the secondary offender(s) was a friend of the IPV victim. In the other case, the offenders were the IPV victim's family members. In addition to these four cases, law enforcement officers responding to an IPV homicide killed the offender; this was determined to be justifiable.

²³ Two people, one victim and one perpetrator, were offered or referred to services, but it is unknown whether they engaged in the services.

²⁴ This includes state and federal services that require ongoing contact/supervision to receive benefits or services, such as Supplemental Security Income (SSI), WIC, SNAP-food stamps, etc., or services like Adult Protective Services that are not captured elsewhere.

Team Recommendations

Legislation/Policy

Require that offenders convicted of any crime against a household member be required to participate in and complete a domestic violence offender treatment or intervention program approved by the Children, Youth and Families Department, and provide funding for these programs.

In two cases, reviewers noted that judges did not require participation in an intervention or treatment program after an IPV-related offense.

Currently, offenders convicted of Misdemeanor Battery against a Household Member (§ 30-3-15) or Aggravated Battery against a Household Member (§ 30-3-16) are required to participate in and complete a domestic violence treatment or intervention program. There are five other statutes involving offenses against a household member (§§ 30-3-12, 30-3-13, 30-4-14, 30-3-17, and 30-3-18) that do not include this requirement. The Team recommends that all offenders convicted of any offense against a household member be required to participate in and complete an appropriate intervention program. Further, the Team recommends that the legislature fully fund these programs to ensure that they are available to those who need them.

Increase funding for service outreach for Intimate Partner Violence (IPV) providers.

In at least two cases, reviewers noted limited availability of community-based IPV prevention.

Allocate recurring state funds to IPV service providers to ensure adult survivors and children exposed to domestic violence receive assistance. Funds should be used to increase visibility of services and outreach efforts to better support survivors and other impacted by IPV; invest in abuse intervention/batterer's intervention programs; and provide services to both adult survivors and children who are exposed to domestic violence. Funds should be allocated on a

recurring basis and should increase annually proportionate to population growth and community need.

Law Enforcement

Increase capacity of law enforcement agencies to respond to intimate partner and sexual violence by improving the availability of victim-centered resources and advocate support.

In three cases, reviewers noted that in prior domestic violence-related calls for service, there was no record of DV packets, referrals for services, or victim advocate involvement.

Law enforcement agencies are short staffed, and officers often are called upon to do advocacy work. The Native American Committee recommends that law enforcement agencies develop an advocate workforce, which includes establishing a co-response model that partners victim advocates and/or peer support workers to assist law enforcement to ensure culturally appropriate responses while also lessening the workload of officers responding to these incidents of violence. Advocates providing these services should have an appropriate level of training to provide culturally competent and trauma-informed responses to domestic violence and sexual assault. When available, a co-response team should respond to the scene. If not available, victim advocates with training on the dynamics of domestic violence should be called to assist with survivors, victims, and child witnesses and their adult caretakers to ensure that survivors are receiving appropriate services. Advocates may assist victims with orders of protection, safety planning, shelter access, referrals to other services such as counseling, and aftercare. Advocacy organized within an ongoing case management structure may also provide a point of contact for victims following the incident and improve victim access and use of services via traditionally recognized practices and culturally responsive care.

Prioritize and create accountability mechanisms to ensure that officers attend court hearings for all violent crimes.

Reviewers noted that judges dismissed one or more prior court cases because the officer was absent.

While there are circumstances under which such absences cannot be avoided, the Team encourages law enforcement departments and leadership to develop an internal tracking and notification system to ensure officer court dates are prioritized and attended. Departments should institute a policy of progressive discipline for unexcused failures to appear and assign command oversight to monitor compliance.

Encourage law enforcement agencies to establish formal high-risk intimate partner violence protocols for cases involving indicators associated with elevated lethality.

In multiple cases, reviewers identified known high-risk factors (prior strangulation, escalating violence, threats to kill, stalking, firearm access, separation, etc.) and there was no evidence that these factors triggered enhanced intervention.

The Team recommends law enforcement agencies develop written procedures to identify and follow up on high-risk cases. This would include immediately contacting a victim advocate; consideration of emergency protective orders; follow-up contact within 72 hours; case review by investigative personnel; supervisor notification of high-risk cases; documentation of risk factors in RMS systems; and multidisciplinary case staffing, where available. Agencies should identify repeat victims and repeat offenders and prioritize intervention before escalation.

Create and implement standardized policies and culturally appropriate responses to domestic violence-related incidents. These policies should include clear protocols for investigating, documenting, and reporting such incidents; assessing firearm access and lethality risk; engaging victim advocates and making service referrals; notifying CYFD when children are present; and improving procedures for post-

incident follow-up.

Although law enforcement agencies frequently responded to domestic violence calls for service in accordance with established best practices, in at least 11 cases, responses deviated from best practices in one or more ways.

The Team recommends that law enforcement agencies develop and adopt policies aligned with the International Association of Chiefs of Police (IACP) Intimate Partner Violence Response Policy and Training Guidelines. [1] These guidelines promote a standardized and comprehensive response to all domestic violence-related incidents. These policies should address:

- a) Victim Services. Implement referral protocols to ensure certified victim advocates respond through on-scene deployment, agency-embedded advocates, or rapid follow-up within 24 to 72 hours. Advocates may assist with orders of protection, safety planning, shelter access, referrals to other services such as counseling, and aftercare.
- b) Documentation. Require written reports for all domestic violence calls regardless of visible injuries or arrest, with supervisory audits to ensure accuracy and compliance. Reports should note physical injuries, coercive control behaviors, and indicators of non-fatal strangulation, as well as any service referrals made.
- c) Firearm Risk. Integrate firearm risk assessments into the DV response protocols and establish referral process for ERFPO petition when applicable. Officers should offer gun safety locks to individuals who are known to have firearms.
- d) Lethality and other assessments. Require the use of a standardized lethality assessment for all qualifying DV incidents, and require strangulation screening questions, with high-risk response follow-up protocols including immediate advocacy referral and supervisor notification.
- e) Child welfare. Use field checklists and internal reporting systems to ensure immediate notification to CYFD or tribal social services department when children are on-scene or indirectly affected by IPV and collaborate with CYFD to strengthen the referral process.

f) Evidence collection. Support evidence-based prosecution strategies by collecting comprehensive evidence and collaborating with prosecutors to build cases that can be tried even without victim testimony when necessary. Law enforcement and prosecutors should use a shared, secure portal to track cases and provide timely exchange of evidence.

g) Investigation of all IPV-related deaths. Standardize investigations of all suspected IPV-related deaths, including suicides, adhering to homicide protocols. Law enforcement should request that a sexual assault evidence kit be completed after an IPV-related fatality, and request that the offender complete a toxicology exam.

h) Post-incident follow-up. Establish a formal post-incident follow-up process for all DV calls, to include welfare checks, reassess risk, and provide resources within 72 hours of the incident by designated personnel (e.g., specialized DV units, community policing teams). Advocates should continue to provide support and referrals to victims and their families based upon availability of community services.

i) Training. Expand academy training and continuing education on DV investigation and documentation. Law enforcement agencies should collaborate with local and/or state domestic violence experts that serve New Mexico who can provide appropriate training on domestic violence to officers. These subject matter experts should advise law enforcement on appropriate training topics, recommended training hours, level of instruction, and should offer training not currently available within the agencies. Training should address, but is not limited to, recognizing non-physical indicators of abuse, stalking, coercive control, and non-fatal strangulation including delayed symptom presentation; engaging in trauma-informed interviewing; pursuing emergency orders of protection, issuing summons, and executing warrants; responding to children exposed to violence including reinforcing statutory requirements for mandatory reporting of child endangerment; providing victim support including

written resource guides and safety planning; confiscating firearms from a prohibited person, including when and how to confiscate firearms, and Extreme Risk Firearm Protection Orders (ERFPO). The training should be offered annually and qualify for continuing education credit. Agencies should also ensure that senior leadership receives proper training on best practices in investigation and documentation, including documentation for testimony. Leadership should hold their staff accountable for following established protocols.

Law Enforcement and 911 Dispatchers

Ensure that call takers and dispatchers document locations of repeat calls for services that may indicate IPV risk, share that with law enforcement when they are responding to calls, and maintain records of this information for analysis and reference for future calls for service. Law enforcement training should address the need to document such calls.

In at least one case, there were multiple CFS to the same address for welfare checks.

The Team recommends that law enforcement and emergency communications agencies follow best practices identified by the Bureau of Justice Assistance²⁵. Specifically, law enforcement and emergency communications agencies should ensure that existing policies and procedures require call takers and dispatchers to identify, document, and flag locations associated with repeat calls for service involving welfare checks, stalking, domestic disturbances, threats, harassment, or other incidents that may indicate elevated intimate partner violence risk. This information should be communicated to responding officers to improve situational awareness, risk assessment, and safety planning. Agencies should also maintain and regularly review records of repeat calls and related incident histories to support pattern identification, informed decision-making, coordinated

²⁵ <https://bja.ojp.gov/program/pmhc/learning/essential-elements-pmhc-programs/4-call-taker-and-dispatcher-protocols>.

intervention efforts, and analysis of high-risk locations or individuals over time. Annual training should address the importance of documenting and responding to these calls.

Prosecution

Encourage evidence-based prosecution for all cases involving domestic violence or sexual assault while still ensuring that decisions are victim centered; employ a secure, shared data-exchange portal; use appropriate charging and plea strategies; include conditions to address offenders' underlying need; and ensure timely referral of victims to services.

In at least ten cases, reviewers noted that domestic violence-related cases were dismissed or domestic violence charges were dismissed, often due to plea agreements.

Prosecutors should always attempt to contact and involve the victims in decisions on how to resolve the charges but should be prepared to proceed without victim participation while still ensuring that decisions are victim centered. The Team recommends that:

- a) Prosecutors should proceed with victimless prosecution when necessary. Prosecutors should be trained and prepared to pursue cases using trauma-informed and evidence-based strategies, even without victim participation, while making reasonable efforts to involve victims. They should collaborate with law enforcement and advocates to help contact missing or uncooperative victims and address procedural challenges.
- b) Law enforcement and prosecutors should also use a shared, secure portal to track cases and provide timely exchange of evidence.
- c) Prosecutors should employ appropriate charging and plea strategies. Charges should reflect the nature of the offense, informed by thorough investigations and the offender's history including prior law enforcement contacts, substance use issues, and patterns of abuse or intimidation. Offenses committed against household members should be charged as such, and those charges should not be dismissed in plea agreements.
- d) Plea agreements should include meaningful

consequences, and judges should be informed of any lethality risks. When appropriate, plea agreements should include conditions to identify and respond to underlying offender needs that contribute to offending, such as requesting a mandatory substance use disorder assessment or mental health evaluation and require that offenders follow the recommendations of that assessment.

e) Prosecutors should collaborate with victim advocates to provide follow-up services and risk assessments, help connect survivors to protective orders, healthcare, therapy, and safety planning. Referrals should be made as soon as possible.

Courts

Expand training for court personnel for courts with jurisdiction over criminal charges, domestic matters, and domestic violence orders of protection to improve and maintain judicial officers' capacity to engage with victims, children present in the household, and perpetrators of domestic violence in a trauma-informed and culturally sensitive manner pre- and post-conviction.

In at least four cases, reviewers noted that there were observable IPV patterns and lethality risks that did not appear to be recognized by court staff or judges.

The Team suggests that judges engage in training to improve engagement with victims, perpetrators, and children throughout their involvement with the court to include appropriate time for the order of protection to be in place to best meet the needs of survivors and children. This training should provide information on safe and appropriate responses to incidents of physical abuse; help judges and hearing officers to identify controlling behaviors, stalking, and other forms of abuse and to identify lethality risk. Training should also include providing safe and appropriate responses to assist children who are exposed to violence. Training should include continuing education to judges and court staff on the New Mexico Family Violence Protection Act (NMSA Chapter 40, Article 13). In particular, the Team recommends that judges learn about the importance of issuing

protective orders for a sufficient length of time needed to protect domestic violence survivors and children. Training may also assist courts in developing policies and procedures to effectively prevent or address conflicting orders and consolidate services. Educational content should be produced in collaboration with professionals who work in domestic and sexual violence advocacy and service provision and be developmentally, culturally, and linguistically appropriate for the intended audience.

Civil and criminal courts should utilize evidence-based lethality risk assessment tools in domestic violence cases that are appropriate for court use.

In at least four cases, reviewers noted that there were observable IPV patterns and lethality risks that did not appear to be recognized by court staff or judges.

Lethality risk assessment tools can help court personnel to recognize risk factors to evaluate the danger for serious injury or death. These tools can help judges make informed decisions about pretrial release, child custody, length of protective orders, and other crucial case-related determinations. The Team suggests that courts use the findings from these assessments to inform their decisions.

Encourage judges to require participation in, and enforce offender compliance with, court-ordered domestic violence treatment programs, substance use, and/or mental health treatment both pre- and post-adjudication.

In at least seven cases, reviewers noted that judges either did not order counseling or treatment when warranted or did not follow up on court-ordered interventions.

The Team supports adhering to the guiding principles from the National Center for State Courts (NCSC), advocating for accessible and effective diversion programs for individuals with behavioral, mental health and substance use needs when appropriate and available. Judges should also ensure that individuals convicted of misdemeanor battery against a household member are assigned to and complete CYFD-approved domestic violence

offender treatment programs as required by NMSA § 30-3-15, as well as substance use and mental health treatment when needed subject to availability of services. Judges should also consider requiring CYFD-certified domestic violence offender treatment programs in both felony and misdemeanor domestic violence cases even if the underlying household member charges are dismissed. Mandated services should be trauma-informed and developmentally, culturally, and linguistically responsive. Courts should hold regular compliance hearings to monitor adherence to court-ordered intervention and take appropriate action when noncompliance is identified.

Encourage judges to prioritize safety and well-being when issuing Domestic Violence Orders of Protection (DVOPs), and to actively monitor and enforce the restrained party's compliance with the requirements of those orders

In one case, reviewers noted that the court did not address a known DVOP violation.

The Native American Committee recommends that courts hold regular compliance hearings for DVOPs to monitor adherence to court-ordered DVOP restrictions and take prompt, appropriate action when noncompliance is identified.

Encourage courts to consider implementing practices that support law enforcement agencies to prioritize officer attendance at domestic violence hearings and ensure offender accountability.

Reviewers noted that judges dismissed one or more prior court cases because the officer was absent.

The Native American Committee recommends that courts consider implementing practices that are likely to improve law enforcement officers' court attendance. This may include setting specific days and/or times for domestic violence hearings or providing alternatives to in-person appearance (virtual appearance) to avoid the absence of law enforcement personnel and ensure offender accountability.

Encourage the use and funding for an integrated domestic violence court system.

In at least three cases, reviewers noted that cases involving the same parties were heard by different judges, hindering offender accountability and victim support.

Individuals experiencing domestic violence, whether as offenders or victims, are often involved in multiple court cases concurrently. This may include DVOP hearings, other family or civil matters, and criminal proceedings. Judges in these various cases make decisions about the safety of household members and make recommendations related to screening, counseling, and service referrals. Additionally, both civil and criminal courts can issue stay away orders. These separate courts may not have a complete picture of those involved, which may result in ineffective decisions or contradictory orders. The Team encourages courts to research implementing a unified family court or integrated domestic violence court model, such as those used in Florida and New York. These courts use a “One Judge, One Family” model. In this system, one judge is assigned to all matters that affect one family, such as dissolution of marriage, custody, domestic violence, and juvenile delinquency proceeding, as well as other matters.

Probation and Parole

Improve post-conviction professionals’ ability to assess risk factors for intimate partner violence victimization and offending, including knowledge of lethality indicators, and ensure agency personnel have current knowledge of the availability of appropriate victim services and offender intervention resources.

In at least one case, reviewers noted that there was a pattern of domestic violence related violations by a probationer with a history of perpetrating IPV.

Post-conviction contacts represent opportunities for both prevention and intervention efforts for persons at risk for intimate partner violence. The Department of Corrections should ensure agency personnel have current knowledge of the availability of appropriate victim services and

offender intervention resources in their respective jurisdictions.

Monitor offenders for compliance with court-ordered domestic violence, substance use, and/or mental health treatment; promptly report violations to the court; request and attend compliance hearings; and suggest appropriate sanctions and/or interventions.

In at least three cases, reviewers noted that probation officers did not enforce court ordered treatment.

The Team recommends that probation officers monitor and enforce court-ordered treatment and provide navigation, support, and hold offenders who are not following the treatment protocols accountable. Referrals for abuse intervention and other treatment should be made within first 30 days, and officers should follow up to ensure compliance. Probation officers should ensure that any no-contact orders issued by the judge are enforced. Sanctions for non-compliance by the offender are in place currently and should be utilized by probation officers. Probation/parole supervisors should ensure that officers are providing notice of non-compliance in a timely and consistent manner to the courts.

Corrections and Jails

Improve assessment and treatment of offenders for mental and behavioral health conditions during incarceration in county and state correctional facilities.

In one case, reviewers noted that a detainee had known suicidal ideation that was not adequately addressed.

The Native American Committee recommends that corrections staff receive training to assess threats of self-harm or harm to others. Correctional facilities should coordinate with local mental health programs to determine if further care/services are needed for the party and correctional staff. Facilities should establish and adhere to mental and behavioral health response protocols. Assessment and treatment programs

should include but are not limited to substance abuse, mental health, domestic violence offender treatment, and sex offender counseling. The Team also recommends improving collaboration between programs in the facility and the agencies providing post-release supervision to ensure continuity of services as offenders transition back into the community.

Victim Services

Develop standardized, trauma-informed protocols that promote collaboration between non-governmental victim service providers and law enforcement, to ensure timely referrals and comprehensive follow-up support for victims of intimate partner violence and sexual assault.

In at least nine cases, reviewers noted that there was no documentation indicating referrals to victim services/advocates following an IPV incident.

Victim advocates trained in domestic violence should collaborate and coordinate with law enforcement to develop trauma-informed and culturally responsive best practice protocols that include the documentation of DV incidents and resulting injuries. Advocates trained in domestic violence dynamics should assist survivors and children present at the scene, ensuring they receive appropriate services. If an advocate cannot be present, especially in rural areas, law enforcement should contact them to provide telephonic support. Advocates may assist victims with filing protection orders, safety planning, accessing safe shelter options, referrals to counseling, medical services, and aftercare. The Team encourages the use of community response or multidisciplinary teams for IPV or sexual assault, when feasible. These teams include representatives from a range of agencies-not just those directly focused on IPV-to improve communication, referrals, and response to IPV. The Team encourages victim services agencies across the state to compile information like that available in the Bernalillo County & City of Albuquerque Domestic Violence & Sexual Assault Resource Packet for law enforcement and others to provide to survivors. This packet lists resources and provides information about intimate partner

violence and has links making the information available in multiple languages. The Native American Committee (NAC) highlights the importance of the role advocates serve, improving victim access and use of culturally appropriate services, including peace-making services, especially if they are organized in an ongoing case management structure.

Increase and improve the visibility of intimate partner violence, sexual assault, and trauma-informed grief services among all local stakeholder agencies and the community by engaging in multi-agency collaboration.

In at least nine cases, reviewers noted victims did not access services available to them, especially marginalized and underserved groups such as immigrants, youth, the elderly, and rural residents.

The Team encourages victim service agencies to work closely with agencies and organizations to promote safe spaces and focus on the needs of marginalized groups. Reluctance to engage with local law enforcement and the criminal justice system deters some, especially marginalized groups, from reporting incidents of intimate partner violence and seeking help. To build trust, increase awareness of available community resources, and better support victims, the Team recommends that victim services engage in a multi-agency collaboration to offer survivors alternative help-seeking avenues. The Team also urges agencies to engage in community outreach through K-12 presentations, workshops at community events, family-friendly events, and IPV education in higher education with an emphasis on early intervention programs. Outreach should be led by domestic violence service providers, who should offer confidential, nonjudgmental information about local services and eligibility requirements. Outreach efforts should be focused on building trust in a manner that encourages services to be sought out and completed in a culturally competent way.

Children, Youth, and Families Department (CYFD)

Improve professional expertise and capacity to advocate for, and intervene with, families in which children are present in homes experiencing domestic violence.

In at least five cases, reviewers noted that children witnessed violent incidents, had been abused, or were in a dangerous situation and needed additional intervention and assistance.

CYFD should increase trauma-informed domestic violence training for all staff; training should address the effects of domestic and sexual violence on children as well as adults. The Team also recommends that CYFD build a specialized response unit consisting of sexual assault and intimate partner violence experts to better address the needs of children and their families who experience and are exposed to these types of violence. Establishing this unit would lead to more consistent and higher quality investigations, while also reducing stress and burnout among staff who may struggle with limited knowledge, confidence, or training in managing these complex cases. CYFD staff should follow up with a victim and child-centered approach that provides families with autonomy. CYFD should increase appropriate Child Advocacy Center involvement to enhance their capacity to conduct interviews. The Team also recommends that CYFD offer counseling and intervention services to children present in the household. Services should be trauma informed and domestic-violence specific, and be developmentally, culturally, and linguistically appropriate. Services should address Adverse Childhood Experiences by offsetting them with services that highlight family strengths, such as Benevolent Childhood Experiences, which can be used to help the healing process.

Initiate and facilitate collaboration with local community stakeholders to provide pathways to CYFD prevention services.

In at least four cases, reviewers noted that children witnessed violent incidents or had been abused needed additional intervention and assistance.

The Team recommends that CYFD collaborate with local schools, law enforcement agencies, victim service providers and others who have contact with children to strengthen referrals, empowering these groups to report when a child has been exposed to violence. CYFD and CVRC should ensure all service providers know that children who witness domestic violence are eligible for victim compensation, including postvention services like family or individual counseling.

Medical Health Care Services

Encourage medical providers to follow best practices for identifying and addressing IPV-related risk in adult patients throughout the course of patient care including intake, intervention, and discharge.

In at least two cases, reviewers noted missed opportunities to assess lethality risk or specialized IPV-related care among IPV victims seeking medical assistance.

The Team recommends that medical providers evaluate their responses to patient safety risks and ensure adherence to evidence-based practices. These practices should be data-driven, trauma-informed, and culturally appropriate. While medical providers currently screen for intimate partner violence, the Team suggests adding screenings for mental health, firearms in the home, substance use, traumatic brain injury, and strangulation assessments in addition to lethality assessments, especially for patients with chronic illnesses or pain. The Team further recommends adopting a strategic and rapid crisis response model when IPV risk is indicated. Medical practitioners should receive updated information and recurring training on these models. A dedicated domestic violence employee or team should manage these efforts, including evaluation of medical practices, assessing screening tools and training efforts. Additionally, the Team recommends utilizing the Domestic Violence Employee or team and the Sexual Assault Nurse Examiner (SANE) when available to support patients experiencing IPV.

Mental and Behavioral Health Care Services

Agencies should identify and adopt professional service policies and procedures, including professional codes of ethics, required by the licensure or certification boards relevant to the professional discipline(s) represented within the agency. Agencies should ensure that all employees are aware of, trained on, and adhere to, those standards.

In one case, the reviewers noted an apparent HIPAA violation.

The Native American Committee recommends that agencies identify, adopt, and follow a standardized code of ethics as designated by their discipline's oversight and licensure boards. Agencies should ensure that their staff receive annual training on these practices, including rules regarding confidentiality/HIPAA, and apply sanctions for noncompliance with ethical codes.

Identify, inventory, and evaluate the use of existing resources to eliminate barriers to mental health and substance use services in the state, especially in rural communities.

In at least nine cases, reviewers noted that individuals had mental health and/or substance use needs that were not adequately addressed or not addressed at all.

The Team recognizes the need for more trauma-informed, long term, and holistic services in urban, tribal, and rural areas. The Team recommends that providers assess their current treatment practices and adopt evidence-based, developmentally, culturally, and linguistically appropriate holistic treatment for all those who need it, including teens, veterans, law enforcement, Native Americans, people with competency challenges, and those with serious mental illness. Providers should also work to make services more visible and accessible, including psychological first-aid intervention for both victims and perpetrators as a prevention tool. State agencies should allocate funds for these services.

Assess and adjust service provision policies to ensure effective and evidence-based support tailored to community needs.

In at least three cases, reviewers noted that individuals with mental health and/or substance use needs engaged in services but did not complete them or continued to have unmet needs.

Service providers should assess their current policies, procedures, practices, and training to ensure efficacious service provision. This assessment should review current practices to determine if they are evidence-based, data-driven, and culturally informed. This assessment should also consider the needs of the sub-populations served and adjust practices to fit the needs of those populations. The Team supports the use of peer support groups as well as hiring staff with lived experience, when applicable.

Cross-Cutting Medical, Mental and Behavioral Health Care Services

Improve and coordinate follow-up and case management with individuals who seek medical, mental, or behavioral health treatment, particularly in rural areas.

In at least four cases, reviewers noted that individuals with mental health needs had no known follow-up services after initial service contact.

The Team recognizes that there is a shortage of services in all these areas throughout the state and that when these services exist, coordination may be lacking. Coordination of services can ensure that individuals are accessing and adhering to the services they need, including long-term services. Coordinated case management also gives more opportunities for providers to screen their patients for IPV, lethality risk, and identify other needs, such as family counseling, trauma treatment, grief services, substance use treatment and primary prevention. Coordinated services will function more effectively if adequately funded. Funds from existing services may need to be reallocated to do so. The Team recommends training for service providers in each of these areas, emphasizing the

need to follow up with individuals after initial screenings. Service providers should consider the developmental level, mental health status, and competency of patients when making referrals. Services should be trauma informed and developmentally, culturally, linguistically appropriate.

Community

Improve universal awareness and recognition of firearm safety.

In 23 reviewed cases, a firearm was used leading to at least one fatality.

The Team recommends increased community education initiatives to increase firearm safety and responsible gun ownership. In addition to existing education efforts intended to raise awareness of ERFPO and the availability of free gun locks, topics should include general firearm safety, the importance of secure storage practices emphasizing gun locks and safes, risks associated with access to firearms, and the importance of proper training for individuals who own or carry firearms. Public awareness campaigns should also address misconceptions about firearms, emphasizing that firearm ownership does not always increase personal safety, as firearms may be used against the owner, accessed by children, or increase the risk of serious injury or death during domestic violence situations or other conflicts. Educational strategies could include mass media campaigns, public service announcements, workplace training, school- and youth-based education programs, community workshops, and targeted social media outreach. Messaging should be accessible, culturally responsive, and tailored to different audiences.

Improve universal awareness and recognition of IPV through education and prevention efforts beginning early and extending across the lifespan to improve healthy relationships, change the climate of IPV tolerance, and reduce the stigma of help-seeking.

In at least eight cases, reviewers noted that prior IPV incidents were known to others. In at least two

cases, there was no documentation of help-seeking prior to the fatal incident.

The Team recommends expanding public education to increase awareness, improve recognition, and strengthen the prevention of Intimate Partner Violence (IPV). Efforts should be universal, emphasize healthy relationships, and highlight the role of individuals who observe or learn about the abuse occurring in homes without being directly involved. Education should cover warning signs, recognizing lethality risk factors, safety planning, safe and effective intervention, and guidance on how to discuss violent relationships. Outreach should be developmentally, culturally, and linguistically appropriate, and tailored to the needs of local communities. It should engage a broad audience—including children, youth, adults, parents, and organizations—and incorporate inclusive messaging that acknowledges male victimization and promotes engaging men as allies. Recommended strategies include expanding existing violence prevention efforts by various local and state agencies (e.g., Albuquerque sexual assault and DV commission, CYFD, DOH), and non-profit agencies. Trusted community members, including relatives and traditional healers, should be involved as advocates and help raise awareness of services and resources in their communities.

Encourage employers to become better educated about domestic violence and use best practices, (e.g., <https://workplacesrespond.org>) to respond effectively to DV in the workplace and to employees who are experiencing DV.

In two cases, reviewers noted that an employer was aware of IPV but assistance was limited.

This includes employer-sponsored training(s) that address prevention of domestic violence, how to respond to domestic violence, and how to report domestic violence. For questions regarding location-specific policies connect with direct service providers in their areas (e.g. [Find New Mexico Resources — New Mexico Coalition Against Domestic Violence](#)).

Improve and increase education and prevention efforts addressing topics such as Adverse Childhood Experiences (ACEs), violence prevention, mental health, bullying, boundary setting, and help-seeking. These efforts should be culturally appropriate and accessible in multiple languages.

In at least two cases, reviewers noted there was no documentation of help-seeking prior to the fatal incident.

The Native American Committee (NAC) recommends statewide training on ACEs for both professionals and the broader community. This would strengthen the knowledge, skills, and abilities of caregivers, friends, family, and professionals in supporting early intervention efforts. Educational content should be developed by domestic and sexual violence experts and tailored to local communities, ensuring it is developmentally, culturally, and linguistically appropriate. Holistic, community-specific programs should be widely shared. Schools should also adopt IPV prevention curricula developed by domestic and sexual violence experts. These programs should address healthy relationship dynamics (romantic, platonic, and familial), teen dating violence, enthusiastic consent and sexual assault, male victimization, bullying, mental health, boundary setting, healthy masculinity, and help-seeking behaviors. This should be introduced early on through required school curricula including a sex education course and should include referral pathways and resources for help.

Cross-cutting Recommendations Across Multiple System Areas

Develop standardized, trauma-informed protocols that promote collaboration between non-governmental victim service providers to ensure timely referrals and comprehensive follow-up support for victims of intimate partner violence and sexual assault.

In at least nine cases, reviewers noted there was no documentation of support services after prior IPV incidents.

Victim advocates trained in domestic violence should collaborate and coordinate with law enforcement to develop trauma-informed best practice protocols that include the documentation of DV incidents and resulting injuries. Advocates trained in domestic violence dynamics should assist survivors and children present at the scene, ensuring they receive appropriate services. If an advocate cannot be present, law enforcement should contact them to provide telephonic support. Advocates may assist victims with filing protection orders, safety planning, accessing safe shelter options, referrals to counseling, medical services, and aftercare. Advocates serve a crucial role, improving victim access and use of culturally appropriate services, including peace-making services, especially if they are organized in an ongoing case management structure.

Establish a Coordinated Community Response Team in each community.

In at least nine cases, reviewers noted there was no documentation of support services after prior IPV incidents.

The Team encourages coordinated community response (CCR) for IPV or sexual assault, when feasible. CCRs include representatives from a wide range of agencies-not just those directly focused on IPV-to improve communication, referrals, and response to IPV. In addition to representatives from the criminal justice system and victim's advocates, teams may include representatives from schools, faith-based organizations, tribal government, medical and behavioral health services, and others.

Increase and improve the visibility of intimate partner violence, sexual assault, and trauma-informed grief services among all local stakeholder agencies and the community by engaging in multi-agency collaboration.

In at least nine cases, reviewers noted there was no documentation of support services after prior IPV incidents.

The Team encourages victim service agencies to work closely with local law enforcement, the

courts, and other stakeholders to increase awareness of available community resources to better support victims. The Team also urges agencies to engage in community outreach through K-12 presentations, workshops at community events, and IPV education in higher education with an emphasis on early intervention programs. Outreach should be led by domestic violence service providers, who should offer confidential, nonjudgmental information about local services and eligibility requirements. Outreach efforts should be focused on building trust in a manner that encourages services to be sought out and completed in a culturally competent way.

Create statewide crisis response teams, composed of mental or behavioral health professionals, to respond to individuals experiencing mental health crisis.

In several cases, reviewers noted that individuals who interacted with law enforcement had unmet mental health needs.

Law enforcement agencies are understaffed, and officers are often the first to respond to mental health-related calls. Crisis response teams can provide immediate response, assessment, and referrals to individuals in the community experiencing behavioral health emergencies. Crisis response teams can help reduce the burden on law enforcement and emergency departments by diverting individuals from cycling through criminal justice and hospital systems.

For more information or for additional copies, please contact:

Intimate Partner Violence Death Review Team

**New Mexico Statistical Analysis Center
Institute for Social Research
University of New Mexico
Building 085
400 Cornell NE
Albuquerque, New Mexico 87106
nmsac@unm.edu
505-277-0829**

<https://isr.unm.edu/centers/new-mexico-statistical-analysis-center/ipvdr/index.html>



New Mexico Statistical Analysis Center

