The 2010 Annual Report includes a description of the Intimate Partner Violence Death Review Team and its activities, as well as aggregate case review findings and recommendations published by the Team from its review of calendar year 2007 cases.

Findings & Recommendations from CY2007 Intimate Partner Violence Deaths
January 1, 2011

The Honorable Susana Martinez
Governor of the State of New Mexico
State Capital Building, 4th Floor
Santa Fe, NM 87503

Governor Martinez:

On behalf of the Intimate Partner Violence Death Review Team (Team), I am pleased to present to you our 2010 Annual Report. This report outlines findings and recommendations from the Team’s review of intimate partner and sexual violence related deaths that occurred in New Mexico in 2007. The report also provides a summary of the Team’s 2010 activities and highlights the activities of agencies who are engaged in work consistent with the Team’s recommendations from previous review years.

The Team is comprised of representatives from numerous local and state-level, community and governmental agencies from across the State. We are a statutory body enabled by the New Mexico Legislature under NMSA 1978 §31-22-4.1 and tasked with the review of the facts and circumstances surrounding domestic and sexual violence related deaths in New Mexico. In reviewing these deaths, the Team identifies gaps in system responses to victims at both local and state levels, and recommends strategies for improving these interventions.

The Team’s work is conducted on behalf of and in memory of victims and the family members who have suffered the loss of their loved ones. Our hope is that through the case review process we can create the knowledge necessary for developing strategies to prevent future injury and death associated with domestic and sexual violence.

The members of the Team wish to thank you for your commitment to addressing domestic and sexual violence in New Mexico and hope that you and other stakeholders will use this report to implement changes in policy and practice that will lead to the successful elimination of this type of violence in our State.

Sincerely,

Quintin McShan
Quintin McShan, 2010 Team Chair
Captain, New Mexico State Police

cc: New Mexico Legislature
Chief Justice, New Mexico Supreme Court
Secretary, New Mexico Department of Public Safety
Secretary, New Mexico Children, Youth and Families Department
Secretary, New Mexico Department of Health
Director, New Mexico Crime Victims Reparation Commission
New Mexico Attorney General
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Executive Summary

The New Mexico Intimate Partner Violence Death Review Team (Team) is a multi-disciplinary group of professionals who meet monthly to review the facts and circumstances surrounding each intimate partner and sexual violence related death in New Mexico, with the aim of reducing the incidence of these deaths statewide. In 2010, the Team reviewed 35 intimate partner violence related deaths that occurred in 15 New Mexico Counties during calendar year 2007. This included 21 homicides and 14 suicides.

The following are prominent findings from the Team’s review of CY2007 intimate partner violence related homicides:

**Intimate Partner Violence Related Homicides**
- 86% of victims were female, 14% male;
- 43% of reviewed homicides occurred in public places;
- The most frequent cause of death was gunshot wounds, followed by blunt force trauma;

**Homicide Offenders**
- 84% of homicide offenders were male, 16% female;
- 42% of homicide offenders had a known history of intimate partner violence;
- A majority of homicide offenders had a history of substance abuse, and over 60% had at least one prior arrest on a criminal charge. In addition, almost half of these offenders had contact with post-conviction services having spent time on either probation and/or parole;
- Two homicide offenders were law enforcement officers, and two were military veterans;

**Prosecution and Sentencing**
- 76% of homicide cases resulted in the prosecution of the offender. Of those not prosecuted, three cases involved investigations producing inconclusive evidence and in two cases the offender also died at the scene;
- 63% of the prosecuted homicide cases resulted in either a guilty plea or conviction. Sentences ranged from 6 years to life plus 12 years.

The following are prominent findings from the Team’s review of 14 intimate partner related suicides from CY2007:

**Intimate Partner Violence Related Suicides**
- 93% of suicide offenders were male;
- 86% of offenders had a known history of perpetrating intimate partner violence;
- 71% had a history of substance abuse;
- 79% died from gunshot wounds;
- Two cases were deaths in custody following an arrest on a domestic violence charge;
- The offender’s intimate partner was present in 79% of reviewed suicides, the intimate partner was injured in 43% of cases, and in 2 cases the intimate partner was also killed.

The full report of the Team’s case review findings can be found on pages 17-23.
In 2010, the Team identified recommendations for the following system areas: legislative, tribal agencies, law enforcement, victim serving agencies, prosecution, courts, post-conviction professionals, medical, and cross-cutting recommendations for the broader community. While these recommendations are organized by system areas, many can only be accomplished through improved coordination across both systems and jurisdictions. The Team recommends a statewide focus on coordinating responses to intimate partner and sexual violence. The following are prominent Team recommendations from 2010:

- **Create New Mexico legislation that mirrors Federal legislation (18 U.S.C. 922 (d) and (g)) regarding offender’s possession of firearms while subject to an order of protection or once convicted of a misdemeanor domestic violence offense.** State legislation would reinforce the importance of getting firearms out of the hands of these offenders and could provide resources for retrieving and storing these weapons.

- **Enact domestic violence codes within all tribal criminal codes.** By including domestic and family violence in the criminal code, tribal law enforcement and prosecutors will have an additional tool to ensure the protection of those who are victims of intimate partner and family violence.

- **Improve accountability and quality control measures for the investigation, documentation, and reporting of incidents of homicide and suicide in law enforcement agencies throughout the state.** The Team supports the standardization of investigations for all violent deaths and also recommends that agencies collect information from the intimate partner violence victim/witness relevant to understanding the circumstances of the suicide when possible. Agencies should ensure that senior leadership receives proper training on best practices in investigation and documentation and that they hold their staff accountable for following established protocols.

- **Improve post-conviction professionals’ ability to assess risk factors for intimate partner violence victimization and offending.** Contacts with post-conviction services represent opportunities for both prevention and intervention efforts for persons at risk for intimate partner violence. At present, probation and parole officers do not receive training on either the identification of risk factors for intimate partner violence or the availability of appropriate community resources for intervention.

- **Provide outreach and education on the importance of and safety considerations for bystander intervention in incidents of intimate partner violence.** In reviewing CY2007 intimate partner and sexual violence related deaths, the Team observed both missed opportunities for bystander involvement as well as attempts at intervention that ended in tragedy. Given that 43% of reviewed deaths occurred in a public place, public education on when and how to intervene safely is needed.

The full report of the Team’s recommendations can be found on pages 24-30.
Acknowledgments

The New Mexico Intimate Partner Violence Death Review Team is grateful to the Office of the Governor and the New Mexico Legislature for providing us with the opportunity to continue the important work of reviewing domestic and sexual violence related deaths in the state. The Team also wishes to thank:

- Sheila Allen, VAWA Grant Administrator, of the New Mexico Crime Victims Reparation Commission (CVRC), as well as the entire staff and board of the CVRC, for supporting the work of the Team.

- Quintin McShan, New Mexico State Police, and the Albuquerque Family Advocacy Center for providing our Team with a place to meet each month.

- Rebecca Montoya and Wayland Davis of the New Mexico Office of the Medical Investigator, for assistance with the data collection necessary for the case reviews.

Danielle Albright, the Team’s coordinator, wishes to thank the Team members for all of the work that they do to generate the findings and recommendations contained in this report. She would also like to thank Sandy Bromley, Dr. Laura Banks, Dr. Lisa Broidy, Sheila Allen, Deborah Dungan, Barbara Lambert, Connie Monahan and Anna Nelson for their contributions to the writing and/or editing of this report.

Ms. Albright also wishes to thank Sandy Bromley for her work as the Team’s coordinator for the first half of the 2010 review year, and all of the criminal justice professionals across the State of New Mexico who assisted with the record collection necessary for conducting effective case reviews.

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

The Intimate Partner Violence Death Review Team (Team), also known as the Domestic Violence Homicide Review Team, is a statutory body enabled by the New Mexico Legislature under NMSA 1978 §31-22-4.1. The Team is funded by the New Mexico Crime Victims Reparation Commission. Team coordination and staff services are housed at the University of New Mexico Health Sciences Center, Department of Emergency Medicine. The Team is tasked with reviewing the facts and circumstances surrounding each intimate partner and sexual violence related death that occurs in the state of New Mexico, with the aim of reducing the incidence of these deaths statewide.

Types of Deaths Reviewed

The Team only reviews closed cases and does not attempt to re-open the investigations of those deaths. 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 that are classified as unsolved by law enforcement or where an offender was never criminally charged for the death.

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

- Homicide committed by current or former intimate or dating partners, whether male or female,
- Homicide with a sexual assault component,
- Suicide by a victim of prior domestic violence,

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

- Review the facts and circumstances of domestic violence related homicides and sexual assault related homicides in New Mexico,
- Identify the causes of the fatalities and their relationship to government and nongovernment service delivery systems, and
- Develop methods of domestic and sexual violence prevention.
• Suicide by an offender of domestic violence (even if the victim survives) when the suicide is related to domestic or sexual violence or stalking,
• Homicide of the offender if related to domestic violence or stalking (officer-involved shootings or bystander interventions),
• Accidental death from asphyxiation, toxicity, or overdose where there is a history of domestic or sexual violence or stalking,
• Homicide of any child, family member or bystander killed during a domestic violence or stalking incident.

Case Review Process

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

At each case review, members first learn the details of the death in a report containing the above listed information. Then members and invited guests contribute any additional information they may know about the death. For this additional information, the Team often asks for assistance from the agencies and individuals who work in the jurisdiction where the death occurred, sometimes the same individuals or agencies that investigated that death or worked with the victim or the offender in that case. Invited guests also provide the Team with information about the local environment surrounding the case, including the traditions or customs of that community, policies and practices of local criminal justice professionals and the attitudes and beliefs held by community members.

Team members make note of the patterns and trends they observe across the cases as well as any known risk factors for the victim or the offender involved in each death. These risk factors include, but are not limited to prior history of violence or abuse, availability of weapons, pregnancy, alcohol or drug use, mental health conditions, suicidal expressions, and recent separation.
For each case, Team members discuss the ways in which both the victim and the offender interacted with legal and other advocacy systems. These systems can include:

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

The Team identifies which of the above systems both the victim and the offender had contact with and discusses the interactions of both parties with these systems prior to the death as well as system responses to the offender following the death. Knowledge about system contact and usage helps the Team make recommendations for improvement or change to that system’s response to intimate partner violence.

The Team identifies which of the above systems both the victim and the offender had contact with and discusses the interactions of both parties with these systems prior to the death as well as system responses to the offender following the death. Knowledge about system contact and usage helps the Team make recommendations for improvement or change to that system’s response to intimate partner violence.

System recommendations are not made to place blame on any one individual or organization. Instead, the recommendations are collected throughout the year and are not attributed to any one specific case or jurisdiction. Rather, these recommendations reflect the ways in which what the Team learned can be used to improve system responses more broadly.

Team Philosophy

The Team 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 Team chooses not to place blame on any professional agency or individual but rather learn from our findings in order to better understand the dynamics of domestic and sexual violence and how to prevent future associated deaths.
2010 Team Activities

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

**Team Committees**

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

**Native American Committee**

The Native American committee collaborates with tribes and Native American organizations from across the state in an effort to facilitate reviews of intimate partner violence deaths that occur on tribal lands as well as those involving either 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 tribe objects to the review or any part of its process. The committee chooses not to identify the tribal lands on which these deaths occur or the tribal affiliation of the individuals, instead review findings are used as a tool for generating recommendations both for the New Mexico Legislature and Tribal agencies in general.
In 2010, four Tribal Representatives were added to the Team’s appointed membership. The Native American committee also finalized a case review process, including procedures for reporting findings to the Team. Throughout the year, the committee reported case findings from Native American intimate partner violence related deaths occurring in calendar year 2006 to the Team along with their insights regarding both the cultural context of intimate partner violence and system availability and responses on Native American tribal lands. The committee’s recommendations are identified as such and included in the 2010 Recommendations section of this report (see recommendations: I.b., II, and IX.d).

**Friends & Family Committee**

The Friends & Family committee is charged with acquiring additional individual and relationship background characteristics for case reviews. During the 2010 review year, the Friends & Family committee developed a protocol for contacting people who knew the victim or the offender, including surviving family members, friends, co-workers or others who may have helpful information for the Team. Once the protocol is finalized and approved by the Human Subjects Research Review Committee at the University of New Mexico, the Friends & Family committee will be responsible for contacting and interviewing these individuals (following the approved protocol guidelines), gathering any additional information and presenting that information to the Team when those cases are reviewed. These details will produce a more complete understanding of the cases and allow the Team to better evaluate both risk factors and victim and offender system resource utilization.
Marginalized Populations Committee

The Team recognizes that there are several populations who are underserved or marginalized in our society, including but not limited to people with disabilities, the elderly, and people of color. Therefore, the Marginalized Populations committee assesses how these populations are affected by intimate partner violence (particularly through our case reviews) and creates strategies and recommendations to specifically address the unique needs within these populations. As of September 2010, the Marginalized Populations group is addressing two specific issues: elder abuse and trafficked/prostituted women.

Teen Dating Violence Committee

In 2010, the Team formed a fourth committee to provide specialized assistance with the review of intimate partner violence deaths involving victims and offenders ages 10 to 19 years, the Teen Dating Violence committee, also known as the Dating Violence Systems Analysis Subcommittee (DVSAS). The first of its kind nationally, the DVSAS is comprised of professionals working in youth serving agencies from across 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 often differ from those observed in the adult population. In order to recommend appropriate prevention and intervention strategies, the Team requires a more targeted case review process.

In 2010, the committee adapted the case review process to allow for the identification of case characteristics, risk factors and system usage specific to the target age group. The committee is also working on a research design for youth engagement on issues related to teen dating violence. In the next year, the committee will review all intimate partner violence related deaths

Results from the 2007 New Mexico Youth Risk and Resiliency Survey show:
One in nine New Mexico high school students reported that they have been hit or hurt on purpose by their dating partner.

Research has also found:
Dating violence victims are at increased risk for truancy, pregnancy, substance abuse, and suicide when compared to students who do not report being a victim of dating violence (Silverman et al. 2001).
involving victims and offenders age 10 to 19 years. Recommendations provided by the Teen Dating Violence Committee are identified as such and provided in the 2010 Recommendations section of this report (see recommendations: IX.c and IX.d).

Team Educational Activities

In April 2010, KC Quirk from the Rape Crisis Center of Central New Mexico provided the Team with information on how to improve communication about intimate partner violence that occurs in relationships between Lesbian, Gay, Bisexual, Transgendered, Queer, and Intersex (LBGTQI) persons.

In August 2010, three Team members and a member of the Team’s staff attended the National Domestic Violence Fatality Review Initiative’s annual conference in Phoenix, Arizona. The initiative is housed at Northern Arizona University and provides technical assistance to local and state level domestic violence fatality review teams. The conference allowed Team members to meet their counterparts from other states and share information about designing, executing, and evaluating an effective review process. Conference attendees reported back to the Team on death review processes in other states.

Dissemination of Team Recommendations

Each year the Team prepares an Annual Report for the Governor, the New Mexico Legislature, Cabinet Secretaries, other employees of state and local government and non-profit agencies and other interested persons. The Annual Report contains the Team’s yearly activities as well as findings and recommendations from that year’s case reviews. The Annual Report is also a tool for educating and informing the public about intimate partner violence and the potential lethality of domestic and sexual violence. The report is available on the Team’s website (http://hsc.unm.edu/som/programs/cipre/IPVDRT.shtml). The website is an additional medium for providing information to the general public, as it also links visitors to each of our member agency websites, including available domestic and sexual violence resources across the State.
Recommendation Updates

The Team monitors statewide developments in legislation, policy, and agency practice in order to assess the relevance of their recommendations over time. In 2010, we identified ongoing progress and accomplishments consistent with the Team’s recommendations from previous years. Here we report on the activities of agencies represented on Team, as well as other efforts throughout the State that address systemic issues identified by the Team in 2009.

New Mexico Legislature

In 2009, the Team recommended that a reduction in caseloads for Domestic Violence Special Commissioners would provide more time for courts to examine the circumstances of and respond effectively to cases of intimate partner violence. The Team suggested increasing the number of Commissioners statewide, but also identified the narrowing of the definition of ‘household member’ in both civil and criminal sections of the Family Violence Prevention Act as one way to accomplish caseload reductions and allow court staff more time to focus on cases involving intimate partner violence. In 2010, the New Mexico Legislature narrowed the statutory definition of ‘household member’ to limit the application of domestic violence laws to intimate partners, elder relatives, and parent/child relationships.

New Mexico Crime Victims Reparation Commission, Violence Against Women Act (VAWA) Implementation Plan 2010-2013

The State’s VAWA Implementation Plan is the basis for which proposals for the distribution of federal VAWA STOP Grant funding is developed. VAWA funding supports a number of statewide projects that work to decrease the incidence of intimate partner violence, sexual assault, stalking, and dating violence. The 2010-2013 plan includes a number of priorities endorsed by the Team in 2009. These include:

- Improving law enforcement officer ability to assess the threat that victims of intimate partner violence face through the utilization of the Uniform Domestic Violence Report Form. The VAWA Implementation plan includes a priority for a pilot project to develop software for the purpose of integrating this form into agencies reporting systems.
- **Ensuring elder victims have access to services.** A project funded jointly by VAWA and the State’s Aging and Long Term Services Department will evaluate service provision for elder victims, develop curriculum and provide training on elder abuse to service providing agencies.

- **Developing stronger policies regarding the prosecution of intimate partner violence cases.** The 2010-2013 plan includes provisions to fund specialized violence against women prosecution units. In addition, the NM Attorney General’s Office and the Administrative Office of District Attorneys used STOP Grant funds to co-sponsor regional training sessions on domestic violence and sexual assault investigation and prosecution techniques for both prosecutors and law enforcement officers. Trainings were held in Farmington, Santa Fe, Roswell, and Las Cruces in September of 2010.

- **Providing education to judges on intimate partner and sexual violence.** The New Mexico Administrative Office of the Courts received a VAWA grant to provide distance learning education on intimate partner and sexual violence to District and Magistrate Court staff. Tribal court staff will also be invited to attend these trainings. Training is scheduled to begin in the spring of 2011.

**New Mexico Attorney General’s Office**

In 2009, the Team recommended that the State support work that would *improve criminal justice professionals’ ability to better assess the threats that victims of intimate partner violence face by increasing educational opportunities available to all professionals who interact with victims.* The New Mexico Attorney General’s Office used funds awarded through the Grants to Encourage Arrest Policies and Enforcement of Orders of Protection to conduct surveys and interviews with a wide range of people who work in the criminal justice system. The purpose of this research was to identify and begin to address barriers to accessing and enforcing orders of protection. The resulting data revealed several important real and perceived barriers to the effective enforcement of protection orders within the State. The Attorney General’s Office
developed and disseminated a Best Practices Guide to enforcing protection orders and conducted several multi-disciplinary trainings throughout the State.

**Public Education and Media Outreach by Team and Represented Agencies**

In 2009, the Team recommended *increased public outreach and education on intimate partner violence and its effects on our communities*. Throughout the past year, the Team and a number of other agencies around the State engaged in activities aimed at increasing public awareness and understanding of intimate partner violence and intimate partner violence related death.

Unfortunately, public outreach is sometimes the result of a tragedy in the community. Both community agencies and New Mexico news media engaged in education efforts in response to the July 2010 workplace shooting at Emcore in Albuquerque. The Team released a statement to the press to extend their condolences to those affected by the shooting, but also to provide information on risk factors for intimate partner violence homicide and information on how victims can access intervention resources in the community.

The same incident led the United Way to partner with the New Mexico Coalition against Domestic Violence, the Albuquerque Police Department, and the Society for Human Resource Managers to provide training on how to recognize the warning signs of abuse in the workplace and what employers can do to help victims and to ensure a safe environment for their employees.

In September 2010, the University of New Mexico’s Departments of English and Women’s Studies, and the Women’s Resource Center collaborated with other university groups and community partners to host a conference on domestic violence and stalking in honor of two members of the university community who were killed after being stalked by one’s former intimate partner. The conference provided an opportunity for the members of the university community to exchange information with those involved in policy making, the criminal justice system, and victim service provision. Sessions were provided to address the extent and nature of intimate partner violence, available interventions for intimate partner violence, as well as public and campus policy issues.
SafeTeen New Mexico partnered with Christopher Productions to produce “Date Violence,” a short documentary to be used as a tool to help parents and community members talk with teens about dating violence. The video aired on KOB-TV, Channel 4 in September 2010. For more information, see the SafeTeen website: www.safeteennm.org.

The Team will continue to monitor statewide developments in legislation, policy, and agency practice consistent with their recommendations from both previous and current review years.
New Mexico Intimate Partner Violence Related Deaths, CY 2007

The team reviewed 35 New Mexico deaths related to intimate partner violence (IPV) occurring during calendar year 2007 (CY2007). Of these deaths, 21 were the result of homicide and 14 were acts of suicide. These deaths occurred in 33 separate incidents. The Team reviewed: 18 homicides, 3 murder/suicides, 3 attempted murder/suicides (where the victim survived), and 9 suicides. The Team identified 5 additional IPV related homicides in CY2007 that could not be reviewed because each had either an unresolved criminal or civil court case during the review year. The highlighted areas of the map identify New Mexico Counties with at least one CY2007 IPV related death reviewed by the Team.

<table>
<thead>
<tr>
<th>County</th>
<th># of CY2007 Cases Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bernalillo</td>
<td>9</td>
</tr>
<tr>
<td>Colfax</td>
<td>1</td>
</tr>
<tr>
<td>Dona Ana</td>
<td>1</td>
</tr>
<tr>
<td>Eddy</td>
<td>1</td>
</tr>
<tr>
<td>Grant</td>
<td>2</td>
</tr>
<tr>
<td>Hidalgo</td>
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</tr>
<tr>
<td>Lea</td>
<td>1</td>
</tr>
<tr>
<td>Otero</td>
<td>4</td>
</tr>
<tr>
<td>Quay</td>
<td>2</td>
</tr>
<tr>
<td>Rio Arriba</td>
<td>3</td>
</tr>
<tr>
<td>Sandoval</td>
<td>1</td>
</tr>
<tr>
<td>Sierra</td>
<td>1</td>
</tr>
<tr>
<td>Torrance</td>
<td>2</td>
</tr>
<tr>
<td>Union</td>
<td>1</td>
</tr>
<tr>
<td>Valencia</td>
<td>2</td>
</tr>
</tbody>
</table>

This report summarizes case review findings for CY2007 IPV related deaths in two sections:

1. Homicides (including victims of completed murder/suicides), and
2. Suicides.
Reviewed IPV Related Homicides, CY2007

Relationship between Victim and Offender
The Team reviewed 21 deaths resulting from homicide in CY2007. Three of these cases were suspected homicides but officially ruled as undetermined by investigators. Eighteen (86%) involved a victim and an offender who were either current or former intimate partners. Of the remaining three homicide cases, one was a stranger sexual assault, another involved the murder of a bystander who attempted to intervene in an IPV incident, and the third involved the death of an IPV offender who was restrained by a relative during an assault on his intimate partner.

Additional Relationship Characteristics

- 3 cases involved victims who were at least 10 years younger than the intimate partner offender, 2 were over 20 years younger than the offender;
- 5 cases involved a victim and offender who had children together. In 2 cases, at least one child was present during the incident, and in 1 case the victim’s children found the body;
- 4 cases involved intimate partners who were either separated or in the process of separating;
- 4 cases were identified as suspected “offender” homicides, where the homicide victim was killed during the perpetration of an act of domestic violence.
Individual Characteristics

Victim Characteristics (Number of cases = 21)

- Victims ranged in age from 19 years to 63 years old, with an average age of 41 years
- 71% were female
- 86% White, 14% some other race *
- 43% Hispanic (includes both White and some other race)
- 33% had been drinking at the time of death, 19% tested positive for illegal drugs
- 42% had a known history of domestic violence prior to the homicide
- 38% had a criminal history
- 24% had a history of depression or mental illness

Offender Characteristics (Number of cases = 21)

- Offenders ranged in age from 19 years to 69 years old, with an average age of 43 years
- 84% were male
- 76% White, 24% some other race *
- 40% Hispanic (includes both White and some other race)
- 76% had a history of substance abuse
- 42% had a known history of domestic violence prior to the homicide
- 62% had a criminal history
- 19% were on either probation or parole at the time of the homicide
- 2 cases involved offenders who were law enforcement officers
- 2 cases involved offenders who were military veterans
- 33% had a history of depression or mental illness

*Due to the small number of individuals in other racial categories and in order to maintain anonymity of offenders and victims in reporting, we collapsed offender and victim race into “White” and “some other race” categories. In 2010, the Native American committee reviewed Native American IPV related deaths for CY2006; as such these cases are not included in the CY2007 review findings presented in this report. See the section on the Team’s committees on page 9 for additional information.
Incident Characteristics

Twelve of the 21 reviewed homicides (57%) took place at a personal residence; the remaining cases occurred in a public location. These locations included parking lots, roadways, and parks. Victim deaths were most often due to either gunshot wounds or blunt force trauma.

**Homicide Victim's Cause of Death**

- Gun shot wound(s): 38%
- Stab wound(s): 24%
- Physical restraint: 5%
- Blunt force trauma: 33%

**Location**

- Victim’s home: 14%
- Offender’s home: 10%
- Shared home: 33%
- Public location: 43%

**Weapon**

- Firearm: 38%
- Knife: 24%
- Body (hands/feet): 24%
- Vehicle: 14%

Bystander Involvement in Reviewed IPV Homicides, CY2007

Bystanders are more likely to act when they are knowledgeable about IPV, are able to assess the situation as one requiring intervention, and believe that the intervention will be effective (Banyard 2008). However, direct intervention in a violent situation can also be dangerous. The team identified three types of bystanders in cases reviewed this year:

1. **Eleven cases (52%) involved at least one report of a bystander with advance knowledge of the potential for violence between the victim and offender but who did not attempt to intervene.** In four cases, witnesses failed to report to the police incidents occurring immediately before the homicide. In seven cases, friends and/or family members told police they knew about prior threats or abuse, but did not report the abuse or attempt to intervene.

2. **Three cases (14%) involved active bystander attempts to intervene in or prevent violence.** Of these, one resulted in the death of the bystander, another bystander killed the IPV offender, and the third called the police but was too late to prevent the victim’s death.

3. **Three cases (14%) involved bystander acts that may have facilitated the homicide.** In two cases, a friend provided the offender with the firearm used in the homicide—one was known to be a convicted felon. In the third case, a friend with prior knowledge of threats against the victim, rode with the offender to the scene and did not attempt to intervene.

The Team recognizes a need for increased knowledge and public awareness of appropriate and effective bystander responses to situations of IPV (see community recommendation: IX.b.).
ChargesProsecuted

The offender was charged with murder in 16 of the 21 cases reviewed by the Team. The chart below displays the proportion of cases by type of charge. In three cases, the suspect was not charged because the evidence was inconclusive. In two cases, the offender also died during the incident.

![Type of Murder Charge Prosecuted](chart)

Conviction and Sentencing

Of the 16 cases in which charges were filed, 10 resulted in a either a conviction or a plea agreement. In cases with a conviction, the minimum sentence was 6 years and the maximum sentence was life in prison plus 12 years. Of those not resulting in conviction, 2 offenders were acquitted, 1 committed suicide before trial, 1 was found to be incompetent to stand trial, and 2 were dismissed due to lack of prosecution.

| CY2007 Homicide Conviction Sentence Range by Charge Type (Number of cases = 10) |
|----------------------------------|-------------------------------|-------------------------------|-------------------------------|
| **Prosecuted Charge**            | **Number of Cases**           | **Sentence Range in Years**   |
| Manslaughter                     | 2                             | 6                             |
| 2nd Degree Murder                | 5                             | 14 to 16                      |
| 2nd Degree Murder w/Criminal Sexual Penetration | 1                             | 43                             |
| 1st Degree Murder                | 2                             | Life                          |
The Team reviewed 14 cases of IPV related suicide for CY2007. Offenders ranged in age from 19 to 59 years, with an average age of 37 years. The table below provides descriptive information on all 14 cases.

<table>
<thead>
<tr>
<th>CY2007 Reviewed IPV Related Suicides</th>
<th>Number of Cases</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>93</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>12</td>
<td>86</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Hispanic</td>
<td>8</td>
<td>57</td>
</tr>
<tr>
<td><strong>Toxicology Results</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive for Alcohol</td>
<td>5</td>
<td>36</td>
</tr>
<tr>
<td>Positive for Illegal Drugs</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td><strong>Location of Suicide</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimate Partner’s Home</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>Offender’s Home</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Shared Home</td>
<td>5</td>
<td>36</td>
</tr>
<tr>
<td>Public Location</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>In Custody</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td><strong>Manner of Death</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gunshot Wound(s)</td>
<td>11</td>
<td>79</td>
</tr>
<tr>
<td>Hanging in Custody</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Drug Overdose</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td><strong>Intimate Partner Information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimate Partner Present at Suicide</td>
<td>11</td>
<td>79</td>
</tr>
<tr>
<td>Intimate Partner Injured</td>
<td>6</td>
<td>43</td>
</tr>
<tr>
<td>Intimate Partner Attempted Suicide</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Suicide Followed Attempted Murder of Intimate Partner</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Suicide Followed Murder of Intimate Partner</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td><strong>Offender Background</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known History of Intimate Partner Violence</td>
<td>12</td>
<td>86</td>
</tr>
<tr>
<td>Known History of Substance Abuse</td>
<td>10</td>
<td>71</td>
</tr>
</tbody>
</table>
CY2007 IPV related suicides overwhelmingly involved the use of a firearm and most often occurred in the presence of the offender’s intimate partner.

- 43% of suicide cases also involved injury to or death of the offender’s intimate partner,
- 71% of offenders had a history of substance abuse; and
- 86% of reviewed suicides involved an offender with a known history of intimate partner violence prior to the suicide.

**Investigating Suicides**

The review of CY2007 IPV related suicide cases is limited because information about the offender and his or her intimate partner is difficult to access. This inaccessibility is due in large part to abbreviated inquiry and documentation by investigating agencies in cases that involve suicide. Even where another party is injured or killed, interviews with witnesses and descriptive reporting of evidence is less thorough when compared to cases of homicide alone. This brevity is logical given that the offender is both known and deceased. While the Team recognizes that investigating agencies have limited resources and must focus on cases requiring prosecution, the facts and circumstances of IPV murder-suicides and offender suicides are understudied. This lack of knowledge has implications for the development of IPV prevention and intervention strategies.

The Team reviewed 124 cases of female intimate partner homicide occurring between 1993 and 2002. Of the cases reviewed, 37% were combined murder-suicides (Banks, et al. 2008). Examining the circumstances and risk factors for suicide is important because identifying and helping persons at risk for self-harm may also prevent violence against others. Improved investigation and documentation of incidents of suicide would provide the Team with a better foundation for recommending prevention and intervention efforts related to both murder-suicides and intimate partner violence related suicides.

The International Association of Chiefs of Police (IACP) has also recommended the standardization of investigations of all violent deaths, including suicide. This includes documenting information used to determine that the death was the result of suicide: whether the deceased made a disclosure of suicidal intent, left a note, previously attempted suicide, had a substance abuse problem or mental illness, was experiencing trauma or other problems like divorce or an arrest, and if a firearm was used how the individual acquired the weapon (IACP 2007).

The Team supports the IACP recommendation for the standardization of investigations for all violent deaths and also recommends that agencies collect information from the IPV victim/witness relevant to understanding the circumstances of the suicide when possible (see also law enforcement recommendation: III.a.).
2010 Team Recommendations

At monthly Team meetings, the review process stimulates significant discussion about specific case facts and associated system responses. Each Team member submits detailed written recommendations following each case review. Throughout the year, these comments are collected and summarized. At the end of the calendar year, the Team organizes the recommendations into system areas and identifies those that are the most pressing and relevant to be included in the Annual Report. These recommendations reflect risk factors and system gaps directly identified during case reviews as well as those generated by Team members through the discussion of their professional experiences working in the system on similar cases.

In 2010, the Team identified recommendations for the following system areas: legislative, tribal agencies, law enforcement, victim serving agencies, prosecution, courts, post-conviction professionals, medical, and cross-cutting recommendations for the broader community. While these recommendations are organized by system areas, many can only be accomplished through improved coordination across both systems and jurisdictions. The Team recommends a statewide focus on coordinating responses to intimate partner and sexual violence. The following are the Team’s recommendations from 2010:

I. Legislative

a. Create New Mexico legislation that mirrors Federal legislation (18 U.S.C. 922 (d) and (g)) regarding offender’s possession of firearms while subject to an order of protection or once convicted of a misdemeanor domestic violence offense. The team found that a firearm was used in 38% of reviewed CY2007 homicides and 79% of reviewed IPV related suicides. At least one case involved an offender with a prior conviction of misdemeanor domestic violence in possession of a firearm. In addition, 3 cases involved a convicted felon in possession of a firearm. State legislation would reinforce the importance of getting firearms out of the hands of these offenders and could provide resources for retrieving and storing these weapons.
The Native American committee recommends that the New Mexico Legislature support participation in projects that improve the enforcement of domestic violence criminal and civil law violations across jurisdictional boundaries. One way to accomplish this would be to promote programs such as *Operation Passport* that encourage law enforcement agencies and officers to enforce the full faith and credit stipulations of domestic violence orders of protection from tribal and non-tribal courts. In addition, the committee recommends that the Legislature support the enactment of a uniform reporting statute and the adoption of a uniform reporting form that is consistent with national standards.

### II. Tribal Agency Recommendations from the Native American Committee

**a. Develop a culture of intolerance for intimate partner violence in tribal communities.** One way this culture can be developed is through appropriate agency response to victims and offenders. Tribal agencies should work to ensure that domestic violence is not minimized as a private concern or considered a traditional family practice.

**b. Enact domestic violence codes within all tribal criminal codes.** By including domestic and family violence in the criminal code, tribal law enforcement and prosecutors will have an additional tool to ensure the protection of those who are victims of intimate partner and family violence.

**c. Provide training for tribal law enforcement officers on the investigation and prosecution of domestic violence.** Training should focus on improving officers’ ability to assess the threat that victims of intimate partner violence face as well as best practices in the response to and documentation of intimate partner violence incidents (*see also* law enforcement recommendation III. a.).

**d. Increase utilization of local victim services in Native American communities.** One way to increase service utilization is by fostering leadership support for
improved confidentiality and privacy policies for victims of intimate partner violence who seek law enforcement or sheltering support at the tribal level.

III. Law Enforcement

a. **Improve accountability and quality control measures for the investigation, documentation, and reporting of incidents of homicide and suicide in law enforcement agencies throughout the state.** The Team also supports the standardization of investigations for all violent deaths and also recommends that agencies collect information from the IPV victim/witness relevant to understanding the circumstances of the suicide when possible. Agencies should ensure that senior leadership receives proper training on best practices in investigation and documentation and that they hold their staff accountable for following established protocols.

b. **Strengthen both policies and procedures for background screening for city, county, state, and tribal law enforcement personnel.** The Team reviewed two cases involving offenders who worked as law enforcement officers, both of whom had a documented history of intimate partner violence. Law enforcement agencies are not statutorily required to exclude persons with misdemeanor domestic violence convictions, nor are they required to revoke certification for such a conviction. Those that have not already done so should impose agency level hiring policies with these exclusions and employ systematic monitoring practices.

IV. Victim Serving Agencies

a. **Improve the coordination of services for individuals who are experiencing intimate partner violence but also have substance abuse issues, criminal histories, mental illness, and/or specialized medical needs.** The Team recognizes that decreasing the risk for intimate partner related death requires multiple types of intervention services. For example, it is not uncommon to see the co-occurrence of substance abuse and mental health issues for IPV victims and offenders. Co-occurring risk factors can present barriers to both providing
and using services. Learning about and collaborating with all available service agencies in our communities helps each agency provide more comprehensive assistance for IPV victims.

b. **Improve the distribution and accessibility of safety planning information.**
Most homicide victims in cases reviewed by the Team this year had little to no contact with either IPV related service agencies or the criminal justice system. The identification of varied distribution outlets in the community (e.g. community centers, medical provider offices), including youth serving agencies, could extend the reach of safety planning information to a broader population of victims of IPV. Another strategy would be to encourage news media to provide information on safety planning and IPV victim services when reporting on both fatal and non-fatal incidents of IPV. Information should be made available in Spanish and other languages commonly used throughout the State.

V. **Prosecution**

a. **Develop stronger policies and resources for the prosecution of intimate partner violence cases.** Include in those policies the goals of elevating domestic violence charges to felonies when possible and removing firearms from offenders. Provide dedicated domestic violence prosecutors and utilize support, training, and technical assistance provided by the Violence Against Women Resource Prosecution Unit of the NM Attorney General’s Office.

b. **Increase the presence of victim advocates in District Attorney’s offices statewide.** Victim advocates provide support, service referrals, and information about the prosecutorial process. In the prosecution of non-fatal IPV, these supports are crucial to ensuring victims have the proper tools to follow through in their role as witnesses, while keeping themselves and their families safe. Improving victim participation in the process can increase the success of prosecutorial intervention, which may in turn reduce future risk for IPV related death.
c. **Provide juror education on witness testimony in trials of intimate partner violence related crimes.** Victims are often reluctant to testify against their batterers at trial, and when they do they are often perceived as unconvincing in their descriptions of the abuse. Verbal descriptions of abuse incidents in general (whether provided by victims or witnesses) can be interpreted as inconsequential, especially when disconnected from the context in which occasional physical violence is used to reinforce the power of constant harassment, coercion, and threats. Prosecutors should provide juror education on victim and witness testimony for all trials related to intimate partner violence crimes, especially where a homicide has occurred.

VI. **Courts**

a. **Reduce caseloads of the Domestic Violence Special Commissioners.** Increasing the number of available commissioners will reduce their caseloads and give each Commissioner more time to fully respond to the case presented to them.

VII. **Post-Conviction Professionals**

a. **Reduce caseloads for post-conviction professionals, especially those who work with intimate partner violence offenders.** 19% of homicide offenders were on either probation or parole at the time of the incident. In each case, the offender was engaged in behaviors, like consuming alcohol, that would constitute a violation of the terms of supervision. Increased monitoring and more frequent drug and alcohol testing is needed for those under supervision.

b. **Improve post-conviction professionals’ ability to assess risk factors for intimate partner violence victimization and offending.** The Team found that 48% of offenders and 29% of victims in CY2007 reviewed homicides had at least one prior contact with post-conviction services. These contacts represent opportunities for both prevention and intervention efforts for persons at risk for intimate partner violence. At present, probation and parole officers do not receive training on either the identification of risk factors for intimate partner violence or the availability of appropriate community resources for intervention.
VIII. Medical

a. Improve continuity in the provision of health care and mental health care, especially for persons requiring either a part-time or full-time caretaker. The Team reviewed 11 homicide cases involving individuals with mental health issues, many of whom lacked consistent access to care. Additionally, the Team reviewed 3 cases involving persons with chronic medical conditions. Physicians and other health care professionals should be knowledgeable about the risk factors associated with IPV homicide and suicide among those needing and providing care.

b. Support consistent and systemic responses by medical investigators in conducting sexual assault exams and evidence collection from suspected IPV and sexual assault related deaths. A sexual assault exam was performed at autopsy in 4 of the 21 homicides reviewed this year. While the circumstances surrounding some incidents do not warrant a sexual assault exam, the absence of investigation of sexual assault at autopsy can inhibit an accurate identification of sexual assaults in intimate partner homicides.

IX. Community

a. Enhance and/or institutionalize curriculum development at schools for higher learning and establish special licensure or specialized intimate partner violence training for counselors, therapists, and social workers. The Team reviewed a number of cases where victims and offenders received psychiatric care, marriage counseling, or other services from licensed professionals in private practice. Educational requirements in these professions should include training in: the identification of risk for IPV victimization and offending, referrals to appropriate IPV intervention resources for victims, safety planning, and appropriate batterer intervention programs.

b. Provide outreach and education on the importance of and safety considerations for bystander intervention in incidents of intimate partner
violence. In reviewing CY2007 IPV related deaths, the Team observed both missed opportunities for bystander involvement as well as attempts at intervention that ended in tragedy. Over half of the reviewed homicides involved bystanders who had knowledge of prior abuse and/or threats and who chose not to intercede. Given that 43% of reviewed CY2007 IPV related deaths occurred in a public place, public education on when and how to intervene safely is needed.

c. **Improve knowledge on both the extent and nature of teen dating violence.**

The Teen Dating Violence committee recommends expanding research on dating violence to examine relationship forms and abusive behaviors that may differ in the youth population when compared to the adult population. One way to generate this knowledge would be to include additional questions on the 2013 New Mexico Youth Risk and Resiliency Survey for high school students. At present, the survey asks only about physical abuse. We know dating violence also involves other abusive behaviors (e.g. emotional, technological, verbal and sexual abuse, as well as threats and stalking). The Team recommends including at least one additional question assessing the dynamics of teen dating violence. Future research should also examine the nature and length of relationships in which violence is being reported.

d. **Provide outreach and education on healthy relationships.** Both the Native American committee and the Teen Dating Violence committee recommend the development of educational initiatives on healthy relationships. One way to begin this task is through increased attention to healthy relationships among staff and students in both Tribal and State schools. Schools should ensure their staff members receive training on healthy relationships and the prevention of teen dating violence. Established curricula like Expect Respect ([www.safeplace.org](http://www.safeplace.org)) and Safe Dates ([www.hazelden.org](http://www.hazelden.org)) are available for a fee. The curriculum *Dating Matters: Understanding Teen Dating Violence Prevention* seminar is available free of charge from the U.S. Centers for Disease Control ([http://www.cdc.gov/violenceprevention](http://www.cdc.gov/violenceprevention)).
Attachment A:
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.
Attachment B: Team Membership

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

The following are the Team’s current appointed members and the agencies they represented in 2010:

**Medical Representatives**

- Dr. Cameron Crandall, UNM Department of Emergency Medicine
- Erin Brooks, Office of the Medical Investigator

**Criminologist Representative**

- Dr. Lisa Broidy, UNM Institute for Social Research & Department of Sociology

**Victim Service Provider Representatives**

- Connie Monahan, NM Coalition of Sexual Assault Programs
- Pamela Wiseman, NM Coalition against Domestic Violence
- Doug Southern, Roswell Refuge
- Claudia Medina, Enlace Communitario
- Dale Klein-Kennedy, S.A.F.E. House

**District Attorney’s Representative**

- Kristina Faught-Hollar, 13th Judicial District Attorney’s Office

**Attorney General’s Office Representative**

- Michelle Garcia, Attorney General’s Office

**Civil Legal Services Representatives**

- Gabriel Campos, New Mexico Legal Aid
- Melissa Ewer, Catholic Charities VAWA Immigration Project
Public Defender Representative

Hugh Dangler  Chief Public Defender

Judicial Representatives

Deborah Dungan  Administrative Office of the Courts
Judge Sandra Clinton  Bernalillo County Metropolitan Court
Judge Angela Jewell  2nd Judicial District Court Domestic Violence Division

Law Enforcement Representatives

Captain Quintin McShan  New Mexico State Police
Detective Mark Myers  Las Cruces Police Department

State Agency Representatives

Craig Sparks  Children, Youth and Families Department
Vicki Nakagawa  Department of Health
Anna Nelson  Department of Health
Anthony Louderbough  Aging & Long Term Services Department/Adult Protective Services

Tribal Representatives

Evone Martinez  PeaceKeepers DV Program
Francine Gachupin  Southwest Tribal Epidemiology Center
Colleen Vigil  Coalition to Stop Violence against Native Women
Darlene Reid-Jojola  Urban Indian Advocacy Program

Other Appointed Members

Sheila Allen  Crime Victims Reparation Commission
Joan Shirley  Community Representative
Sharon Pino  Attorney General’s Office
Ella Frank  Adult Parole Board
The following are the Team’s current invited members:

Jolene Altwies, Attorney General’s Office
Yvonne Archuletta, APD
Carlos Aragüeta, APD
Ann Badway, Attorney General’s Office
Louisa Baca, Tewa Women United
Michael Bauer, UNM School of Medicine
Mark Benford, 2nd Judicial DA’s Office
Kay Bounkeua, NM Asian Family Center
Pam Brown, Corrections Department
Angela Campbell, DV Resource Center
Betty Caponera, IPV Data Central Repository
Kristen Carmichael, Christus St. Vincent Regional Medical Center
Frank Casaus, NM State Police
Domenick Ciccone, APD
Donald Clark, Indian Health Services
Rosemary Cosgrove-Aguilar, 2nd Judicial District Court
Teresa D’Anza, ABQ SANE Collaborative
Sanjay Digamber, OMI
Mary Everett, UNM Hospital
Dara Ferguson, Probation and Parole
Joanne Fine, United Way
Michele Fuller, S.A.F.E. House
Dominic Gachupin, Jemez Pueblo Social Services
Donald Gallegos, 8th Judicial DA’s Office
Josephine Gallegos, PeaceKeepers
Francine Garcia, Corrections Department
Liceth Garcia, S.A.F.E. House
Lynn Gentry-Wood, Resources, Inc.
Elena Giacci, Anti-Sexual Violence Spec.
Beth Gillia, UNM Institute of Public Law
Tish Goff, Five Stones International
Consuelo Gonzales, Catholic Charities
Kay Gomolak, COPE, Inc.
Alisa Hadfield, 2nd Judicial District Court
Ann Henz, Attorney General’s Office
Carol Horwitz, Santa Fe PD
Melanie Jacobs, BCSO
Julie Jessen, APD
Mark Kmatz, BCSO
Barbara Lambert, Battered Family Services
Toni Romero Lynn, NM Coalition Against DV
Alisha Maestes, 2nd Judicial DA’s Office
Anthony Maez, Attorney General’s Office
Inas Mahdi, Department of Health
Gregg Marcantel, BCSO
Erica Lavato-Mendoza, 2nd Judicial
Jeff McElroy, 8th Judicial DA’s Office
Carol Merriweather, Crisis Center of Northern NM
Sherry Mumford, Roswell Refuge
Christine Murillo, Silver City PD
Erin Olson, NM Legal Aid
Amy Ortiz, 2nd Judicial DA’s Office
Anita Perry, USAO Victim Unit
Paul Pino, Laguna Family Services
Deborah Potter, 1st Judicial DA’s Office
Shirl Robinson, Coalition to Stop Violence Against Native Women
Sophia Roybal-Cruz, CYFD
Beth Sanchez, Sandia Pueblo
Corryn Sanchez, Tewa Women United
Jennifer Searcy, ABQ SANE Collaborative
Deborah Seeley-Ramirez, 2nd Judicial District Court
Kristina Shelton, Haven House
Reed Sheppard, 2nd Judicial District Court
David Sklar, UNM Department of Emergency Medicine
Kyoko Sonoda, NM Asian Family Center
Edna Sprague, 2nd Judicial DA’s Office
Sherry Spitzer, NM Asian Family Center
Robert Stone, FBI Victim Specialist
Joy Bell Tauber, Haven House
Victoria Sant Torres, Probation and Parole
Cynthia Ulibarri, North Central Community Based Services
Lydia Vandiver, ABQ SANE Collaborative
Beatrice Vigil, PeaceKeepers
Jessie Wade, Probation and Parole
Loudine Wanoski, Jicarilla Apache
Behavioral Health
David Waymire, 2nd Judicial DA’s Office
Desiree Weekoty, Coalition to Stop Violence Against Native Women
Beverly Wilkins, Peaceful Nations
Coleen Widell, HEAL, Inc.
Paul Weyler, Las Cruces PD
Karen Wyman, NM Coalition Against DV
References


For more information or for additional copies, please contact:

Danielle Albright, Coordinator
Intimate Partner Violence Death Review Team
Center for Injury Prevention Research and Education
Department of Emergency Medicine, School of Medicine
University of New Mexico
2704 Yale Blvd. SE
Albuquerque, NM 87106
(505) 272-6272
Fax: (505) 272-6259
Email: dalbright@salud.unm.edu