



**OFFICE OF THE
NEW MEXICO ATTORNEY GENERAL**

**VIOLENT CRIME REVIEW
TEAM PROCESS
FINAL REPORT**



**ATTORNEY GENERAL
HECTOR BALDERAS**

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2nd Judicial District Attorney’s Office
7th Judicial District Attorney’s Office
Albuquerque Police Department
Bernalillo County Metropolitan Detention Center
Bernalillo County Sheriff’s Department
City of Rio Rancho
New Mexico Administrative Office of the Courts
New Mexico Administrative Office of the District Attorneys
New Mexico Children, Youth, & Families Department
New Mexico Crime Victim Reparations Commission
New Mexico Criminal Defense Lawyers Association
New Mexico Department of Corrections
New Mexico Department of Public Safety
New Mexico District Attorney’s Association
New Mexico Human Services Department
New Mexico Public Education Department
New Mexico Sentencing Commission
New Mexico State Police Department
Rio Rancho Police Department
U.S. Marshals Service

In addition, a very special thanks to each of the community members and partners who joined us for the Phase III discussion of recommendations and the creation of government/community partnerships.

A full list of MVCRT Phase I and II meeting participants is provided in Appendix 1. A list of Phase III invited individuals and agencies can be found on page 11.

We would also like to thank those who provided rooms for MVCRT meetings: the National Hispanic Cultural Center, Albuquerque Family Advocacy Center, Albuquerque Police Academy, New Mexico State Capitol Building, and New Mexico State Records Center and Archives.

The New Mexico Office of the Attorney General contracted with Danielle Albright, Ph.D. to perform team training and meeting facilitation. Dr. Albright has a Ph.D. in Sociology from the University of New Mexico. She works in the UNM Department of Emergency Medicine, where she coordinates the New Mexico Intimate Partner Violence Death Review Team. She has over five years of experience facilitating fatality review and has worked for over a decade in criminal justice evaluation research.

Multi-disciplinary Violent Crime Review Team Process Report

Background

The Multi-disciplinary Violent Crime Review Team (MVCRT) is an inter-agency team assembled by the New Mexico Office of the Attorney General (NMOAG) to examine system response to repeat violent criminal offending. The MVCRT was formed in response to the tragic homicide death of Officer Gregg Anthony “Nigel” Benner of the Rio Rancho Police Department. Officer Benner was killed during a traffic stop on May 25, 2015, and the suspect in Officer Benner’s homicide was a known repeat criminal offender. Throughout the state, professionals working in crime prevention and intervention recognized that this pattern of repeat violent offending was not an isolated case. In fact, multiple violent death incidents with repeat offenders as suspects occurred during the five months of MVCRT activities. These deaths also informed the team’s discussion of how we might meet the goal of improving our systems of prevention and intervention to prevent future injury and death at the hands of repeat criminal offenders.

This report summarizes the process used by the MVCRT. The purpose of a process report is to provide an account of the activities of the team and to document the methods used by the team to produce the recommendations found herein. The report has four primary sections. The first section provides a description of the project objectives. The second section defines and details the methods of fatality review, a method of inquiry used by the team to identify system issues and generate recommendations. The third section is a summary of the activities of the MVCRT. The final section presents team recommendations resulting from this process.

Project Objectives

The Multi-disciplinary Violent Crime Review Team (MVCRT) is an inter-agency team of law enforcement, government and social service professionals seeking to engage in a solution-based process of evaluation to identify weaknesses in the systems and agencies upon which New Mexicans rely to protect them from violent criminals.

In July 2015, key stakeholders were identified and invited to participate by the Honorable Hector Balderas, New Mexico Attorney General. A complete list of participants is provided in Appendix 1. Attorney General Balderas commissioned the team to carry out three primary objectives:

1. To put into practice a comprehensive, systematic approach called fatality review to evaluate the efficacy of systems aimed at providing critical prevention and intervention services to accused offender Andrew Romero prior to the May 25th homicide death of Officer Gregg Anthony “Nigel” Benner.
2. To use this case study as a means to facilitate communication between agencies to provide an open and thorough assessment of both agency specific response and the coordination of various community and criminal justice system interventions.
3. To identify solution-based recommendations about duplicating identified successes, filling gaps, and addressing failures in our systems of prevention and intervention.

Following an orientation with all prospective members on August 5, 2015, the MVCRT carried out these objectives in three phases. In Phase I, a Core Team comprised of law enforcement, prosecution, corrections, and social service professionals performed a records review of facts and circumstances for the system contact history of Andrew Romero prior to May 25th. In Phase II, Critical stakeholders joined the Core Team to analyze concepts and practices identified in the case review. During this phase, team members generated recommendations for improving policies, procedures, and practices in both government and community agencies. All participants in Phases I and II participated under an agreement of confidentiality (see Appendix 2). In Phase III, community stakeholders joined the team to discuss the recommendations and to identify existing resources and opportunities for government/community collaboration.

Fatality Review

In the investigation of system contacts, the team used a process called fatality review.¹ Fatality review is a method of inquiry that aims to identify problems, gaps, and failures in community systems of prevention, intervention, interdiction, and suppression that may be identified as contributing to a near-fatal or fatal outcome.² Fatality review involves reviewing a chronological history of events in order to trace the contacts of individuals with these systems. The practice of fatality case review is labor and time intensive and as such, is generally reserved for the assessment of rare, but theoretically preventable incidents of serious injury, death, or the

¹ This is not an investigation of the homicide. We use the term fatality review to refer to a type of inquiry aimed at studying the circumstances leading up to a fatal incident. We will not be reviewing the details of the incident leading to Officer Benner’s homicide or the response to offender Andrew Romero during or following the incident. Rather, the review of contacts will be restricted to events prior to May 25th.

² Dufree, M. and Tilton-Dufree, D. 1995. Multi-agency child death review teams: Experience in the United States. *Child Abuse Review*, 4, 377-381.

destruction of vital infrastructure. The process can be thought of as a peer-review practice. It provides an opportunity to learn about the scope and limitations of the interactions of agencies with the service population and with one another.

The Practice of Fatality Review

Fatality review is practiced by professionals in public health, criminal justice, and in various areas of industry. There are currently two full time fatality review projects in New Mexico. The New Mexico Child Fatality review (NMSA § 7-4-5.1) is administered by the Department of Health. They review cases of sudden infant death syndrome, motor-vehicle related, child abuse and neglect, and child suicides. The New Mexico Intimate Partner Violence Death Review Team (NMSA §31-22-4.1), also called the New Mexico Domestic Violence Homicide Review, is funded by the Crime Victim Reparations Commission and Administered by the UNM Department of Emergency Medicine. The team primarily reviews cases of intimate partner, dating violence, and sexual assault related homicide. This includes homicide deaths of IPV or sexual assault victims, accused perpetrators, and bystanders or persons responding to these incidents.

Both of these teams are multi-disciplinary groups. Both review the universe of cases in the state, which fall under the definitions of reviewable cases in order to generate findings and recommendations which are used to inform policies and practices in governmental and community agencies. These teams not only produce evidenced based recommendations, but also provide a venue for inter-agency discussion of shared problems in service delivery. Neither team interferes with the investigation, prosecution, determination of guilt, or the punishment of persons convicted of crimes as a result of the deaths under review. The focus of fatality review is aimed primarily at understanding how one arrived at the incident in question.

Websdale, Town, and Johnson (1999)³ and Wilson and Websdale (2006)⁴ document four primary assumptions that guide the work of fatality review teams:

1. Crime victims, system actors, and system agencies are not responsible for an individual's use of violence.

In other words, individuals who commit acts of violence are responsible for their behavior. Fatality review is not used to make a determination of guilt, but rather seeks to acknowledge that we do not blame victims for their own victimization or death. Furthermore, fatality review is not used to shame system actors for mistakes

³ Websdale, N., Town, M. and Johnson, B. 1999. Domestic violence fatality reviews: From a culture of blame to a culture of safety. *Juvenile and Family Court Journal*, 61-74.

⁴ Wilson, J.S. and Websdale, N. 2006. Domestic violence fatality review teams: An interprofessional model to reduce deaths. *Journal of Interprofessional Care*, 20, 535-544.

made during the provision of services to alleged perpetrators, nor are we looking to lay the blame for fatal outcomes on any particular system agency.

2. Reasonable interventions can prevent violent incidents.

Violent incidents in general and homicide deaths specifically are not inevitable. In fact, the prevention and intervention work of government and community agencies likely prevents such deaths on regular basis.

3. While we believe violence is preventable, we review these cases because no single system actor, professional group or agency alone can prevent the circumstances that lead to an incident of violence.

Websdale, Town, and Johnson (1999) note that the breakthrough for the expansion of fatality review is credited to child fatality review practitioners who identified risk and error as “inevitable aspects of the coordinated delivery of complex services.” Our systems of prevention and intervention are complex and overlapping. Still, the work of these agencies is often carried out within isolated organizations and practices. It is important to recognize that the population at risk for committing acts of violence does not necessarily experience our prevention and intervention efforts as intended or in their totality.

4. Our systems of prevention, intervention, interdiction, and suppression are accountable for ensuring their practices lead to increased safety and welfare of members of our community.

These assumptions form the basis of guiding principles for the formation and practice of the MVCRT.

MVCRT Fatality Review Method

Fatality review is undertaken in different ways depending on the context and purpose of cases to be reviewed.⁵ The application of the method used by the MVCRT employed a single case, multi-disciplinary team review, with agency report out during the review of case facts.

Single-case study was used because the goal of the review was an in-depth analysis of a specific problem or when we want to identify possibly unknown problems for further analysis. The case review was conducted by a multi-disciplinary team in order to ensure a full analysis of the multi-agency systems of prevention,

⁵ For additional information on methods of fatality review see: Dufree, M. and Tilton-Dufree, D. 1995. Multi-agency child death review teams: Experience in the United States. *Child Abuse Review*, 4, 377-381. And Websdale, N. 2003. Reviewing Domestic Violence Deaths. *NIJ Journal*, 250, November 2003, 26-31.

intervention, interdiction, or suppression relevant to the case being reviewed. The case review was conducted over a series of confidential Core Team meetings where agency representatives provided a report out of the internal review of their respective contact with the case subject. Core Team members were provided with a presentation guide for internal review and team report out (see Appendix 3). The internal reviews were reported to the team within the legal duties and professional ethics of each participating agency.

Following each agency report out, the team engaged in a discussion of observed concepts and practices relevant to the success or failure of each system contact appearing during the case review. These concepts and practices, along with articulated recommendations, were documented and carried over to meetings with a larger group of critical stakeholders where recommendations were formed and discussed.

The MVCRT confidentiality agreement applied to both the Core Team case review and Critical Stakeholder Team discussion of concepts, practices, and recommendations. Fatality review is generally practiced in confidential sessions. Confidentiality is essential to promoting openness and transparency among team members. The purpose of confidentiality is twofold. First, it provides protection of case information that may not be publicly available to designated personnel. Second, it creates a protected environment for discussing critiques of existing system agencies, policies and procedures.⁶

Multi-disciplinary Violent Crime Review Team Activities

The NMOAG coordinated the MVCRT, including activities related to membership, meeting scheduling and coordination, records maintenance, and correspondence with all participants throughout the work period. The activities began with planning meetings in July of 2015. The NMAOG contracted with Danielle Albright, Ph.D. to develop an orientation for team members on the practice of fatality review, to facilitate team meetings, and to assist in the production of the process report. The following sections provide additional details on MVCRT meetings and activities.

MVCRT Orientation

August 5, 2015

A MVCRT orientation was held at the National Hispanic Cultural Center in Albuquerque, from 9 am to 12 pm. The orientation was opened by Attorney General Hector Balderas. The orientation also included remarks by Mrs. Julie Benner and an introduction to the MVCRT on the practice of fatality review by Danielle Albright, MVCRT Facilitator. In total, 43 participants attended the orientation.

⁶ McHardy, L.W., and Hofford, M. 1999. Domestic violence fatality reviews: Recommendations from a national summit. Reno, NV: National Council of Juvenile and Family Court Judges. October 1998.

Objectives of the training seminar included:

- Introduction to the goals, objectives, and method of inquiry to be used by the Multi-disciplinary Violent Crime Review Team for in depth case review,
- A review of the assumptions, goals, and procedures of the practice of fatality review, and
- A discussion of the application of fatality review by the Multi-disciplinary Violent Crime Review Team.

Following the orientation, the activities of the MVCRT were carried out in three phases. This section of the report describes each phase, identifies agencies participating in each phase, and provides a general description of team activities at each meeting.

Phase I: Core Team Case Review Meetings

During Phase I, a Core Team comprised of law enforcement, prosecution, corrections, and social service professionals performed a records review of facts and circumstances for the system contact history of Andrew Romero prior to May 25, 2015.

The body of law in New Mexico provides some prohibitions regarding the dissemination of law enforcement materials or knowledge to persons or agencies that are not considered law enforcement. This necessitated limiting the case review at the onset so that sensitive and known confidential information regarding the facts of individual cases and contacts could be shared freely, and to ensure ample participation of all agencies with documented contact. For this reason case facts and records review was conducted by a Core Team of designated law enforcement personnel. These agencies included:

2nd Judicial District Attorney's Office
7th Judicial District Attorney's Office
Albuquerque Police Department
Bernalillo County Metropolitan Detention Center
Bernalillo County Sheriff's Department
New Mexico Children, Youth, & Families Department
New Mexico Department of Corrections
New Mexico Office of the Attorney General

The Core Team met four times. Each Phase I meeting is described below.

August 26, 2015

The Core Team met at the Office of the Attorney General in Santa Fe from 9 am to 12 pm. Twenty-three (23) team members were in attendance. The meeting was opened

by the MVCRT facilitator, who reviewed the team's mission and objectives. Representatives from the Albuquerque Police Department presented the results of their internal review of contacts with the case subject. Due to records policy, representatives from the Children Youth and Families Department presented on protocols related to contacts similar to those expected during agency contact with the case subject, but were unable to provide case information. Core Team participants discussed case facts and documented concepts and practices observed during these presentations that spoke to system functions.

September 9, 2015

The Core Team met at the Office of the Attorney General in Santa Fe from 9 am to 12 pm. Twenty-four (24) team members were in attendance. The meeting was opened by the MVCRT facilitator, who reviewed the team's mission and objectives. Representatives from the Bernalillo County Sheriff's Office, 7th Judicial District Attorney's Office, and the New Mexico Department of Corrections presented the results of their respective internal reviews of contacts with the case subject. Core Team participants discussed case facts and documented concepts and practices observed during these presentations that spoke to system functions.

September 23, 2015

The Core Team met at the Albuquerque Family Advocacy Center from 9 am to 12 pm. Sixteen (16) team members were in attendance. The meeting was opened by the MVCRT facilitator, who reviewed the team's mission and objectives. Representatives from the Bernalillo County Metropolitan Detention Center and the 2nd Judicial District Attorney's Office presented the results of their internal review of contacts with the case subject. Core Team participants discussed case facts and documented concepts and practices observed during these presentations that spoke to system functions.

October 14, 2015

The Core Team met at the Albuquerque Family Advocacy Center from 9 am to 12 pm. Eighteen (18) team members were in attendance. The meeting was opened by the MVCRT facilitator, who reviewed the team's mission and objectives. The team reviewed concepts and practices observed during the Phase I case review meetings and identified and drafted recommendations related to their observations.

Phase II: Critical Stakeholder Concepts, Practices, and Recommendation Review Meetings

In Phase II, Critical Stakeholders joined the Core Team to analyze documented concepts, practices, and recommendations derived from the case review in Phase I. The goal of the critical stakeholder review in Phase II was to take concepts from Phase I and build structures that will be beneficial to the judicial system as a whole. The Critical Stakeholder Team identified recommendations for improving system response and community capacity to address problems identified in Phase I. No

confidential information on specific cases and contacts were shared at this level, however, all team participants were bound by the confines of the confidentiality agreement. The focus of this review stage was to identify ways to strengthen every agency's capacity to improve violent and repeat criminal offending prevention and intervention activities. The Critical Stakeholder Team was comprised of all Core Team members and representatives of the following organizations:

City of Rio Rancho
New Mexico Administrative Office of the Courts
New Mexico Administrative Office of the District Attorneys
New Mexico Crime Victim Reparations Commission
New Mexico Criminal Defense Lawyers Association
New Mexico Department of Public Safety
New Mexico Human Services Department
New Mexico Public Education Department
New Mexico Sentencing Commission
New Mexico State Police Department
Rio Rancho Police Department
U.S. Marshals Service

The Critical Stakeholder Team met three times. Each Phase II meeting is described below.

October 28, 2015

The Critical Stakeholder Team met at the Albuquerque Police Academy from 9 am to 12 pm. Thirty-one (31) team members were in attendance. The meeting was opened by the MVCRT facilitator, who reviewed the team's mission and objectives. The team reviewed concepts and practices observed during the Phase I case review meetings and identified and drafted recommendations related to these observations.

November 10, 2015

The Critical Stakeholder Team met at the New Mexico State Records Center and Archives in Santa Fe from 9 am to 12 pm. Twenty-six (26) team members were in attendance. The meeting was opened by the MVCRT facilitator, who reviewed the team's mission and objectives. The team reviewed concepts and practices observed during the Phase I case review meetings and identified and drafted recommendations related to these observations.

December 2, 2015

The Critical Stakeholder Team met at the New Mexico State Capitol in Santa Fe from 9 am to 12 pm. Twenty-eight (28) team members were in attendance. The meeting was opened by the MVCRT facilitator, who reviewed the team's mission and objectives. The team reviewed drafted recommendations related to their observations. The team consolidated and elucidated recommendations for revision.

Following the conclusion of Phase II activities, this process report was prepared for presentation of team activities and recommendations at the Phase III meeting.

Phase III: Community Stakeholder Recommendation Review Meeting

In Phase III, the MVCRT was expanded to include community heroes and stakeholders. The goal of the Community Team is to review the MVCRT recommendations and generate feedback from community stakeholders on existing resources and opportunities for government/community collaboration in implementation. The Community Team was comprised of all Core and Critical Stakeholder Team members and the following *invited* individuals and organizations:

Mrs. Julie Benner
Mrs. Michelle Carlino-Webster
Yolanda H. Cline, COPS Past National President
Ms. Lynda Johnson
Lee Ann McCracken, Retired Supervisor of Investigations CYFD
Richard Pacheco, Bail Bondmen Association of New Mexico
Rosa Romero
Albuquerque Behavioral Health, LLC
Delancy Street Foundation
Desert Oasis Recovery
The Life Link
Mothers Against Drunk Driving (MADD)
New Mexico Coalition Against Domestic Violence
New Mexico Coalition to End Homelessness
New Mexico Coalition of Sexual Assault Programs, Inc.
New Mexico Workforce Connection
PB & J Family Services
R.O.b.D. Taking Action on Repeat Offenders
UNM Psychiatric Center
Youth Shelters and Family Services

January 14, 2016

The MVCRT Community Team met at the National Hispanic Cultural Center in Albuquerque from 1:30 pm to 5 pm. The meeting was opened with remarks by the Honorable Hector H. Balderas. The MVCRT facilitator reviewed the team's mission and objectives and presented the recommendations derived from Phase I and Phase II meetings. The meeting included a period of public comment on the recommendations and opportunities for government/community collaboration.

Following the conclusion of the MVCRT Phase III meeting, a supplemental report documenting Phase III participants and a summary of comments will be prepared by the team's facilitator and submitted to the Office of the Attorney General. The recommendations derived during Phases I and II are provided in the next section.

Recommendations

The MVCRT constructed recommendations throughout each phase of the review process. In Phase I, the team ended each meeting by generating a list of concepts, practices, and recommendations resulting from the case review. In Phase II, members discussed these concepts, practices, and recommendations in depth. Each member contributed their professional knowledge and expertise to assist in focusing and revising the recommendations. In the final two meetings of Phase II, the members examined each recommendation offered in the course of team meetings. During these conversations, members articulated both support and opposition to proposed recommendations. The recommendations were narrowed to a list that most completely represented the ideas generated from these discussions. **In keeping with the philosophy of the practice of fatality review, members were not asked to reach consensus on recommendations. As such, participation in team meetings should not be construed as individual endorsement of any or all recommendations presented below.** The recommendations are presented in three groups:

1. Recommendations to improve offender accountability,
2. Recommendations to improve statewide availability of offender prevention and intervention resources, and
3. Recommendations to improve system accountability across agencies and to the community at large.

Each recommendation is followed by a list of considerations that were part of the team's discussion. Some of these considerations extend or clarify the recommendation, while others suggest possible collaborations between agencies.

Recommendations to Improve Offender Accountability

Recommendation 1: Identify/create best practices for supervised offender transportation following sentencing to community intervention programs and develop model language for judgment and sentence documentation of orders related to reporting and monitoring compliance with these programs.

Considerations:

- Incarcerated offenders can be transported by the Sheriff's Office in most jurisdictions. However, there is no provision for transporting offenders who are not in-custody; thereby creating a reliance on self-reporting. In such circumstances, there may be a time gap between sentencing and the requirement to report to the assigned program. These gaps create opportunities for absconding, reoffending, and substance abuse.
- The Team recommends collaboration between the Administrative Office of the Courts, community intervention providers, Sheriff's offices, defense attorneys, prosecutors, and judges to identify best practices for closing these

gaps and to identify an agency, entity, or community based service that is uniquely situated to provide transports from incarceration to community intervention services.

In keeping with the Team's non-consensus approach, Recommendation 2 is presented as four alternative recommendations about limiting lenient discretionary decisions in cases involving habitual offenders and/or repeat violent offenders.

Recommendation 2a: Adopt policies and practices to mandate the generation and use of risk assessment for all discretionary decision-making points in the adjudication of violent or repeat offenders.

Considerations:

- Decision-making points include decisions about pre-trial release and conditions, plea agreements, sentencing, determination of post-conviction supervision level, and conditions of post-conviction release.
- Create a system for sharing risk assessment outcomes in an inter-agency environment to reduce duplicate resource use. This activity may require an examination of legal and technical issues related to data and information sharing.

Recommendation 2b: Assess the feasibility of mandating the generation and use of risk assessment for all discretionary decision-making points in the adjudication of violent offenders.

Considerations:

- Identify obstacles and possible delays in case adjudication that may result from mandatory risk assessment.
- Identify legal and technical issues related to generating, using, and sharing risk assessments.
- Explore limited application to a specific group of offenses.

Recommendation 2c: Require the use of presentence reports in all cases involving habitual offenders and repeat violent offenders.

Considerations:

- Identify obstacles and possible delays in sentencing that may result from requiring presentence reports in all cases.
- Consider utilization of comparable reports at other stages of the process, e.g. pre-plea bargain.
- Consider limiting application to a specific group of offenses.

Recommendation 2d: Create policy and practice that requires criminal history records check for all discretionary decision-making points in the adjudication of criminal offenders.

Recommendation 3: Adopt offender management data system that provides for inter-agency sharing of information across all system agencies.

Considerations:

- A shared data system would require technology to provide and limit access based on statutory provisions related to access to information.
- The team recommended a study of practices in other jurisdictions to observe practices related to streamlining the transfer of information to improve provision of system services and prevent gaps in offender supervision.
- Explore possibility of adding modules to the Odyssey system utilized by the courts.

Recommendation 4: Create guidelines about the use of the STEPS program, a graduated penalty program that allows automatic sanctions for violations of probation without having to go before a judge, for violent offenders.

Considerations:

- Evaluate use of STEPS program in sentences for violent offenders to determine current practice.
- Consider modifications to or prohibition of STEPS program for violent offenders.
- Develop best practice guidelines regarding the appropriateness and practice of the STEPS program.

Recommendations to Improve Statewide Availability of Offender Prevention and Intervention Resources

Recommendation 5: Create, support, and maintain a statewide public database of resources for community prevention and intervention programs, including but not limited to governmental and non-governmental programs for behavioral health, substance abuse, mental health, housing, medical care, education, employment, and family services.

Considerations:

- Collaborate with existing resource database providers to improve program identification, indexing, and search capacity (e.g. The NM Department of Aging and Long-Term Services operates the *New Mexico Social Service Resource Directory* www.nmresourcedirectory.org, 1-800-432-2080. *SHARE New Mexico* is a community generated database of resource providers across a variety of issues and resource types, www.sharenm.org. The initiative is funded by philanthropic and corporate giving).
- Secure stable funding for this effort to ensure continuity and longevity of the database.

- Collaborate with resource database providers to ensure the resources are indexed such that organizations providing services to those who are charged with or convicted of a criminal offense and those on probation or parole can be identified.

Recommendation 6: Address the comprehensive need for and continuity of substance abuse treatment for criminal offenders, specifically, and throughout the state of New Mexico, more broadly.

Considerations:

- Review funding structure for state allocation of resources targeting substance abuse (in all communities and prevention or intervention systems) and create comprehensive plan/formula for funding services in affected populations.
- Assess appropriateness of existing substance abuse outpatient and inpatient programs for criminal offenders.
- Educate criminal justice personnel on appropriate substance abuse treatment programs for assignment for criminal offenders.
- Increase availability of inpatient beds available in substance abuse treatment programs that serve as alternatives to incarceration.
- Create options for detox admission for offenders awaiting entry to substance abuse programs in order to reduce rejection from these programs due to interim substance use.
- Reinforce activities aimed at preventing inmate access to substances during incarceration.
- Strengthen collaborations between offender supervision agencies and community organizations that provide substance abuse services.
- Provide incentives for the creation of one or more secure substance abuse treatment facility.

Recommendation 7: Evaluate obstacles to employment for offenders during and after release from supervision.

Considerations:

- The Team suggested a better understanding of the obstacles to employment is needed to accurately identify the gap to be addressed. Some areas of inquiry included: improving identification of employable offenders, building job skills during supervision, investigating tort liability issues for employers, and examining tax credits and other incentives for employers who provide job opportunities to offenders.
- Members also identified ongoing initiatives that can contribute experiences relevant to understanding current issues in New Mexico: PB & J Family Services in Albuquerque <http://pbjfamilyservices.org/>, New Mexico Department of Workforce Solutions <http://www.dws.state.nm.us/>, and New Mexico Department of Corrections <http://cd.nm.gov/>. It was recommended that the

State provide resources to strengthen the efforts of these groups and encourage inter-agency collaboration.

- Previous research from NMSC has examined employment consequences related to criminal arrest, conviction, and incarceration. One example of this work documents all statutes and rules related to employment prohibitions: <http://nmisc.unm.edu/reports/2008/CollConsq.pdf>

Recommendations to Improve System Accountability

Recommendation 8: Create proactive statewide community advocacy group to engage in system monitoring across all criminal justice system areas.

Considerations:

- Coordinate violent crime victim advocacy group through the Office of the Attorney General, Victim Advocate Program.
- Examine similar advocacy programs (e.g. MADD <http://www.madd.org/>, Court Watch <http://nationalfamilycourtwatchproject.org/>) to identify possible program models and existing tools for monitoring system accountability.
- Assess availability of federal grant funds available through the Victims of Crime Act (VOCA).

In keeping with the Team's non-consensus approach, Recommendation 9 is presented as three alternative recommendations.

Recommendation 9a: The New Mexico Supreme Court should continue to monitor the implementation of LR2-400 and create ongoing opportunities for dialogue about the impact of implementation on Criminal Justice System workload and case outcomes, especially for violent criminals. LR2-400, also called the Case Management Order, is a special pilot rule governing time limits for criminal proceedings in the 2nd Judicial District Court.

Considerations:

- The Team recognized the goals behind the implementation of the pilot rule in Bernalillo County, but urges continued monitoring of the implementation in order to ensure proper resource application for police, defense attorneys, prosecutors, and the judiciary through the transition.

Team members had differences of opinion on the best course of action related to specific recommendations on the implementation of LR2-400. Some members of the team were unopposed to the implementation of the rule in the current form. However, recommendations 9b and 9c were offered as considerations for changes related to the rule.

Recommendation 9b: Either lengthen or abolish deadlines for cases involving violent offenses.

Considerations:

- In lieu of abolishing the deadline for all violent offenses, the team also discussed excluding 1st and 2nd degree felony offenses from the scope of deadlines established by the rule.

Recommendation 9c: Increase resources for prosecutors and law enforcement to allow these agencies to meet the demands of the rule.

Additional Items Discussed

The Team discussed a number of additional items that were not fully constructed recommendations at the end of the Phase II process. Three of these items were aimed at improving tools for system actors to apprehend and enact penalties on persons absconding from pre-trial or post-conviction supervision. Members viewed this issue as an important part of the conversation, but ultimately identified the need for more information on the scope, nature, and existing policies related to the problem of absconding. Recommendations about absconding considered by the team included:

Item A: Enact legislation to make absconding a felony offense.

Item B: Enact legislation to provide graduated penalties for violent criminals absconding from supervision.

Item C: Increase resources for apprehension of absconders.

Discussion points:

- Engage in study of population of offenders who abscond to evaluate the size and nature of the problem.
- There was some objection to “making more crimes.”
- If absconding is made a felony offense, it should only be applied to originating offenses classified as felonies.

Appendix 1:

Multi-disciplinary Violent Crime Review Team Members

Participants

The following individuals represented their respective agencies at one or more of the MVCRT orientation, Phase I or Phase II meetings:

2nd Judicial District Attorney's Office

Kari Brandenburg, District Attorney
Troy Davis, Chief Deputy District Attorney

7th Judicial District Attorney's Office

Clint Wellborn, District Attorney
Gloria McCary, Assistant District Attorney (retired)

Albuquerque Police Department

Gorden Eden, Chief
Eric Garcia, Deputy Chief
Tim Gonterman, Major
Les Brown, Commander
Paul Hansen, Commander
Mike Runyan, Lieutenant
John Sullivan, Lieutenant
Cori Lowe, Sergeant

Albuquerque Public Schools

Toni Cordova, Chief of Staff

Bernalillo County Metropolitan Detention Center

Phillip Greer, Chief of Corrections
Donald Vigil, Assistant Chief of Corrections

Bernalillo County Sheriff's Office

Manny Gonzales, Sheriff
Edward Mims, Chief Deputy
B. Lindley, Lieutenant

City of Rio Rancho

Greg Hull, Mayor
Gina Manfredi, Assistant City Attorney
Jennifer Vega-Brown

Community Members

Mrs. Julie Benner
Ms. Lynda Johnson

Juvenile Public Safety Advisory Board

Heidi Alvarez-Wynn, Director

New Mexico Administrative Office of the Courts

Patricia Galindo

New Mexico Administrative Office of District Attorneys

Henry Valdez, Director

New Mexico Children Youth and Families Department

Monique Jacobson, Cabinet Secretary
Michael Heitz, Chief General Counsel
Nick Costales, JJS Deputy Director of Field Services

New Mexico Crime Victim Reparations Commission

Frank Zubia, Director

New Mexico Defense Lawyers Association

Matthew Coyote, President
Richard Pugh, Representative

New Mexico Department of Corrections

Gregg Marcantel, Cabinet Secretary
Mark Myers, Deputy Secretary
Joe Booker, Deputy Secretary
Rose Bobchak, Director Probation and Parole
Daniel Barela, Deputy Director Probation and Parole
Jerry Roark, Director Adult Prisons
Melissa Ortiz, Deputy Director Adult Prisons
Alexandria Tomlin, Director Public Affairs

New Mexico Department of Public Safety

Greg Fouratt, Cabinet Secretary
Amy Orlando, General Counsel

New Mexico Human Services Department

Brent Earnest, Cabinet Secretary

New Mexico Office of the Attorney General

The Honorable Hector H. Balderas, Attorney General
Sharon Pino, Deputy Attorney General
Sonya Carrasco-Trujillo, COS Policy and Public Affairs

John Wheeler, Chief Legal Counsel
Clara Moran, Director of Special Prosecutions
Benjamin Baker, Director of Investigations
Celia Munoz, Assistant Attorney General
Greer Rose, Deputy Director of Special Prosecutions
Joseph Spindle, Assistant Attorney General
Francesca Narro, Legal Assistant
Deborah Segovia, Legal Assistant
Leanne Vigil, Administrative Assistant

New Mexico Public Education Department

Hanna Skandera, Cabinet Secretary
Paul Hipolito Aguilar, Deputy Secretary

New Mexico Sentencing Commission

Tony Ortiz, Director
Linda Freeman, Deputy Director

New Mexico State Police

Pete Kassetas, Chief
David Martinez, Deputy Chief
Tim Johnson, Major

Rio Rancho Police Department

Michael Geier, Chief
Gary Wiseman, Deputy Chief
Jason Bowie, Captain

U.S. Marshals Service

Conrad E. Candelaria, District of New Mexico United States Marshal
Alex Ramos, Chief Deputy Marshal

Appendix 2: Confidentiality Agreement

Multi-Disciplinary Violent Crime Case Review Team

CONFIDENTIALITY AGREEMENT

I, _____ (name),

on behalf of _____ (agency), as a designated **multi-disciplinary violent crime case review team member**, agree to abide by the following terms as a condition for my participation in the Multi-Disciplinary Violent Crime Case Review Team created by the Office of the New Mexico Attorney General;

1. All records, reports, or case history information shared or viewed during team presentations regarding Andrew Romero are confidential and shall not be discussed outside of internal development of presentations or team review sessions.
2. All records, reports, or case history information shared or viewed during team presentations regarding agency critique are confidential and shall not be discussed outside of internal development of presentations or group sessions.
3. All communications made by team members, agents, or designees during compilation and investigation of Andrew Romero's case history prior to review are confidential and shall not be shared outside of group sessions.
4. All communications made by team members, agents, or designees during compilation and investigation of internal review or case-reviews, case studies, or agency history prior to review are confidential and shall not be shared outside of group sessions.
5. Team members shall not disclose information related to review team discussions except pursuant to a valid court order.
6. Any materials presented to the Violent Crime Case Review Team containing identifiers or specific case information shall not be taken from team meetings and shall be held by the original agency and custodian of the materials or information.

I understand the above terms and agree to maintain the confidentiality of all records and communications of the Multi-Disciplinary Violent Crime Case Review Team.

Name (please print) _____

Signature _____ Date _____

Appendix 3: Core Team Presentation Guide

Multi-disciplinary Violent Crime Review Team

Guide for Conducting the Internal Agency Review and Preparing the Core Team Agency Presentation

Internal Review

1. **Identify your agency contacts and interventions with the subject prior to May 25th.** The definitions of contact and intervention will depend in part on the purpose and mission of your agency. For example, law enforcement may define a *contact* as each response to an incident involving the subject and the *intervention* as the arrest of the subject. Prosecution may define each contact by court cases and corrections may define each contact as each period of incarceration regardless of how many arrests or court cases led to the incarceration.
2. **Review the chronology of each contact.** Start with the initiation of the contact and review the following elements:
 - a. **Exposure:** What were the circumstances leading to contact? How was the contact initiated? (e.g. CYFD received a call reporting suspected abuse, police respond to a call and identify subject as a suspect in a criminal incident, etc.)
 - b. **Intervention:** How did your agency respond to the initiated contact? (e.g. initiated an investigation, took subject into custody, charged subject, referred client to a behavioral health service, etc.)
 - c. **Appropriateness:** Did the intervention match the problem? Given your agency purpose, professional standards, and best practices is the intervention appropriate?
 - d. **Compliance:** How did the subject respond to the intervention? Discuss whether or not the subject successfully complied with or performed the intervention (e.g. cooperation, adherence to the intervention prescription, any violations, etc.)
 - e. **Outcome:** Did the subject complete the intervention? Did your agency refer or discharge the subject to another agency? The outcome of your contact may fall under the auspices of another agency (e.g. arrest & prosecution). Report on all outcomes for which you have information.
 - f. **Subsequent contacts.** Did your agency have subsequent contact with the subject? If yes, repeat the review for each additional contact.
3. **Identify state and federal statutes, public agency policies, training, standard operating procedures, and best practice guides relevant to your agency contact.** Public information documents can be forwarded to the MVCRT organizers for distribution to Team members prior to your presentation.
4. **Additional considerations:**
 - a. Were there any disruptions to the intervention? If yes, describe the disruption. How were disruptions resolved?
 - b. Were there other agencies involved in the intervention or agency contact? If yes, describe agency overlaps and any problems or gaps in inter-agency cooperation or service provision.

Presentation to the Core Team

The presentation of your agency contacts with the subject prior to May 25th will take place in confidential meetings with designated law enforcement agents. No notes will be taken about the case facts. No reports or documents will be constructed from the review of case facts or Core Team discussion. At the conclusion of Phase 1, the Core Team will prepare a list of system issues to be reviewed in Phase 2.

Please Note: In reporting to the team, agencies should abide by their own legal duties and professional ethics in decisions on information sharing. An internal review by the agency is shared to the extent it can be, and supplemented by the agents professional expertise on gaps and problems observed during the internal review where case information cannot be shared.

At the meeting:

1. Introduce yourself and your agency.
2. Provide a definition of “contact” and “intervention” in a way that best captures the manner in which your agency interacts with clients or offenders.
3. Present the facts of the case in chronological order with as much detail from item 2 of the internal review. If you had more than one contact, discuss the first contact in full and then move to the next contact.
4. Report on state and federal statutes, public agency policies, training, standard operating procedures, and best practice guides relevant to your agency contact.
5. Identify any additional considerations for the Team review.

Tips

This is a guide. Please adjust your review and presentation as needed.

Be as descriptive and deliberate as possible. Core Team members outside of your agency may not be familiar with the way your agency interacts with clients or offenders. We will not be reviewing documents, so the team’s knowledge about the contact will be restricted to your presentation.

You do not need to identify personnel within your agency during your report to the Core Team. Uncovering the mistakes of individuals is not our task; we are concerned with identifying systemic issues.

Any documents created or used in your presentation must be returned to your respective agencies and maintained in accordance with New Mexico statutes and your agency policy governing records.