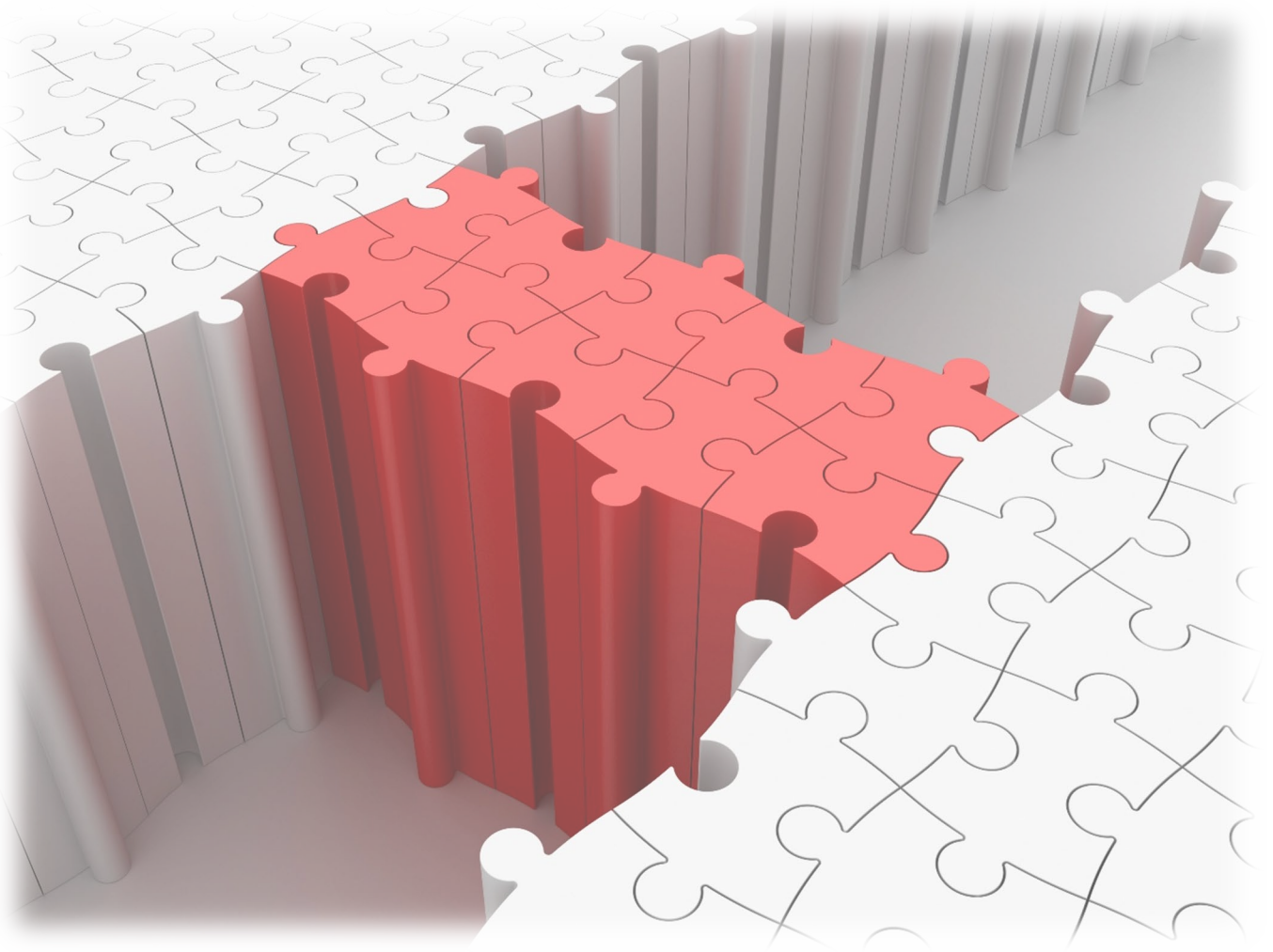




New Hampshire Domestic Violence Fatality Review Committee

2026 Biennial Report

October 1, 2026

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The DVFRC acknowledges that October is Domestic Violence Awareness Month and hopes that its report supports efforts to bring awareness to this issue.

For anyone impacted by domestic and sexual violence or stalking, free and confidential support services are available across the state 24/7 by contacting the statewide helpline at **1-866-644-3574**.

LETTER FROM THE CHAIR

Since 2021, I have served as New Hampshire's Attorney General and, in that capacity, I have become all too familiar with the deep sense of loss carried by both surviving family members and the community left behind by domestic violence fatalities. The New Hampshire Department of Justice Homicide Unit has the solemn responsibility to respond to and investigate every murder in the State. Domestic violence-related homicides, by their very nature, involve heinous and unthinkable acts of violence against intimate partners or other family members. These acts leave families shattered and have profound impacts on local communities, the people that support domestic violence victims, and those who serve in public safety.

The Domestic Violence Fatality Review Committee was created to tackle this problem head-on by examining past domestic violence-related homicides with a purpose of identifying ways to reduce future tragedies. The Committee is composed of a broad spectrum of professionals who are dedicated to preventing domestic violence and protecting victims. This includes members of the law enforcement community, attorneys and other professionals who work within the legal system, the judiciary, victim advocates, and specialists in batterer intervention programming, medical, mental health, and substance abuse treatment. Through the difficult and important work of the Committee, we hope to identify and pursue concrete solutions to reduce domestic violence fatalities. As provided by law, this Committee is responsible for publishing a report and recommendations every two years, beginning with this report.

I would like to thank the General Court and Governor Kelly Ayotte for establishing this Committee in statute by enacting RSA 21-M:16-a (SB 140) during the 2025 legislative session. I would also like to thank the members serving on the Committee for their hard work and thoughtful insight provided throughout the past year. Lastly, I would like to thank the DOJ's Office of Victim/Witness Assistance, especially Danielle Snook and Josanne May, for their incredible work coordinating this effort and providing invaluable assistance to this Committee.

Although this report contains recommendations for next steps, it is important to note that the work of this Committee is just beginning. The Committee will continue to meet, track and monitor the implementation of its recommendations, review cases, and make further recommendations in the years to come.

John M. Formella

Attorney General

Chair, NH DV Fatality Review Committee\

COMMITTEE MEMBERSHIP

John M. Formella, Chair **New Hampshire Attorney General**

Members	
Cristina Brooks	Merrimack County Attorney's Office
Deanna Campbell	New Hampshire Public Defender
Janet Carroll	SANE Program, New Hampshire Coalition Against Domestic and Sexual Violence
Ellen Christo	New Hampshire Judicial Branch
Mike Donati	Division for Children, Youth and Families, Department of Health and Human Services
Jennie Duval	Office of the Chief Medical Examiner
Jessica Erazo	New Hampshire Legal Assistance
Katja Fox	Division of Behavioral Health, Department of Health and Human Services
Amanda Grady Sexton	New Hampshire Coalition Against Domestic Violence
Ryan Grogan	Portsmouth Police Department
Scott Hampton	Ending the Violence
Michael Mosher	Jackson Police Department
Kevin O'Meara	Manchester Police Department
Peggy O'Neil	WISE
Shanna O'Rorke	Cheshire County Attorney's Office
Sean Smarz	New Hampshire State Police, Department of Safety

Administrators and Advisors	
Matt Broadhead	Attorney General's Office
Bob Frechette	Strafford County Attorney's Office
Josanne May	Attorney General's Office
Danielle Snook	Attorney General's Office
Lynda Ruel	Attorney General's Office

EXECUTIVE SUMMARY



This is the inaugural report of the New Hampshire Domestic Violence Fatality Review Committee (“Committee” or “DVFRC”) that was established by SB140 during the 2025 legislative session. While a prior version of the Committee operated under an Executive Order that was issued by Governor Jeanne Shaheen in 1999, SB140 codified the Committee in statute and provided enhanced authorities and tools for the DVFRC that will enable the newly reconstituted Committee to be more effective in its work.

Governor Kelly Ayotte signed SB140 on July 15, 2025, and asked the Committee to first review the murder of Marisol Fuentes, who was killed by her estranged husband on July 6, 2025. Marisol’s case received significant public attention and exemplified the devastating impact that domestic violence has on New Hampshire’s communities. While New Hampshire ranks high in various public safety metrics and rankings, historically over 50% of New Hampshire’s homicides are related to domestic violence. This statistic highlights the important work that the Committee is tasked with.

Since SB 140 became effective, the Committee has met ten times for a total of 25.5 hours and conducted in-depth reviews of two fatalities that were domestic violence homicides. Over the course of the in-depth reviews, the Committee received and reviewed 658 files of public and confidential material related to the individuals involved. Staff with the Department of Justice spent over 350 hours requesting, reviewing and preparing these records for the Committee. The public and confidential materials totaled 5,154 pages and 19 hours of audio/video recordings. The Committee also heard from invited guests. The law prohibits the Committee from publicly disclosing the specific documents reviewed and the identities of the individuals the Committee spoke with. The culmination of this information provided additional facts and context that were critical to effective Committee deliberations.

The Committee generated the following eleven recommendations that are related to offender accountability, training and support for professionals, multidisciplinary communication and collaboration and early interventions:

1. Create an enhanced level of offense for subsequent domestic violence convictions.
2. Explore domestic violence compliance efforts within the court system.

3. Explore evidence-based risk assessment tools or guides to be used by judges in both civil and criminal cases.
4. Assess the disparities between counties for accountability for offenders, including but not limited to pre-trial and post-trial services.
5. Increase knowledge on domestic violence protective order violations and appropriate charges.
6. Train dispatchers and call takers on the dynamics of domestic violence.
7. Strengthen organizational responses to compassion fatigue and secondary traumatic stress among law enforcement and prosecution personnel.
8. Explore the creation of Domestic Violence High Risk Response Teams.
9. Promote system-based victim advocacy for criminal cases handled in Circuit Court.
10. Revive domestic violence coordinating councils.
11. Expand ACERT teams to additional communities where appropriate.

The Committee believes that consideration of the recommendations will enhance the State's response to domestic violence. The Committee's observations and recommendations generated from both in-depth reviews are included in this report starting on page 14.

In addition to the observations and recommendations generated by the Committee from its case reviews, this report also includes data regarding domestic violence homicides in New Hampshire. This data is gathered by the Department of Justice's Office of Victim/Witness Assistance and provided to the Committee for the purposes of this report; it does not represent data collected by the Committee during its case reviews. Between 2022-2025 there were 44 domestic violence homicides committed by 35 different perpetrators in New Hampshire. Of those, 22 victims were killed by a family member, 20 were killed by an intimate partner, and 2 others lost their lives in a domestic violence related incident. Firearms were the leading cause of death and domestic violence victims were most frequently killed in the residences they shared with their perpetrator. The Committee felt that it was important to include this data to illustrate the breadth and scope of domestic violence homicides in New Hampshire.

INTRODUCTION



HISTORY OF DOMESTIC VIOLENCE FATALITY REVIEW

Many industries, including aviation and healthcare, conduct reviews of sentinel or critical events to better understand what happened and determine what could have been done differently to prevent the tragedy. The sentiment of this process informed the development of the domestic violence fatality review field.

Domestic violence fatality review emerged in the 1990s in the United States and has since expanded internationally. It has roots in the antiviolence and victims' rights movements and gained momentum through national initiatives such as the Violence Against Women Act and Victims' Rights Act. Nearly all states have a domestic violence fatality review committee or team. Some states have local or county teams, while others, like New Hampshire, have a statewide team; some jurisdictions have both.

The purpose of a domestic violence fatality review is to examine deaths related to domestic violence for the purpose of forming recommendations to stakeholders. The goal of these recommendations is to offer solutions that could reduce domestic violence fatalities in the future. A domestic violence fatality review committee is not an investigative body and does not make factual findings about specific cases. It is a forum for sharing information essential to the improvement of systems' responses to domestic violence fatalities.

The New Hampshire Domestic Violence Fatality Review Committee (DVFRC) was originally created by Executive Order of Governor Jeanne Shaheen in July 1999. In recent years, the DVFRC began to focus on moving the authority for the DVFRC from an Executive Order to legislation. Other

Domestic violence fatality review refers to the “deliberative process for identification of deaths, both homicide and suicide, caused by domestic violence, for examination of the systemic interventions into known incidents of domestic violence occurring in the family of the deceased prior to the death, for consideration of altered systemic response to avert future domestic violence deaths, or for development of recommendations for coordinated community prevention and intervention initiatives to eradicate domestic violence.” This deliberative process can be formal or informal, relatively superficial, offering basic demographic details of victims and perpetrators, or very detailed”

Barbara Hart

fatality review committees in New Hampshire were either established in statute or had already transitioned from an Executive Order to statute.

The New Hampshire Department of Justice (“DOJ”) collaborated with the National Domestic Violence Fatality Review Initiative, which is a national clearinghouse providing training and technical assistance to jurisdictions both domestically and internationally on establishing and operating domestic violence fatality review committees. This ensured that New Hampshire’s new approach reflected the updates in best practices in the field of fatality review. Through that process the DOJ connected with several fatality review teams and had the opportunity to attend a fatality review in another jurisdiction. This informed the DOJ about different approaches, structures and processes.

The DOJ then consulted with various stakeholders in New Hampshire, including prior members of the DVFRC. That collaboration helped determine what model should be pursued. The DOJ garnered support for this approach from additional stakeholders and worked to build its internal infrastructure to support the anticipated workload of the Committee.

Additionally, the DOJ examined domestic violence fatality review committee legislation from other jurisdictions, as well as existing New Hampshire fatality review committee statutes. All these efforts informed the legislative drafting process. SB140, which codified the work of the Committee in statute, was introduced and passed during the 2025 legislative session. SB140 became effective July 15, 2025 ([RSA 21-M:16-a](#)).

DVFRC MISSION

As outlined in the statute, the DVFRC is directed “[t]o conduct comprehensive, multidisciplinary reviews of deaths related to domestic violence for the purpose of preventing domestic violence related fatalities through the identification of barriers to victim safety, the evaluation of the response by law enforcement and other governmental and non-government agencies and service delivery systems, and the creation of recommendations to improve the systemic and community response to domestic violence.” [RSA 21-M:16-a, I](#). The Committee is not a mechanism to assign fault to a specific profession, agency or individual, but rather to address systemic issues and to improve the community response.

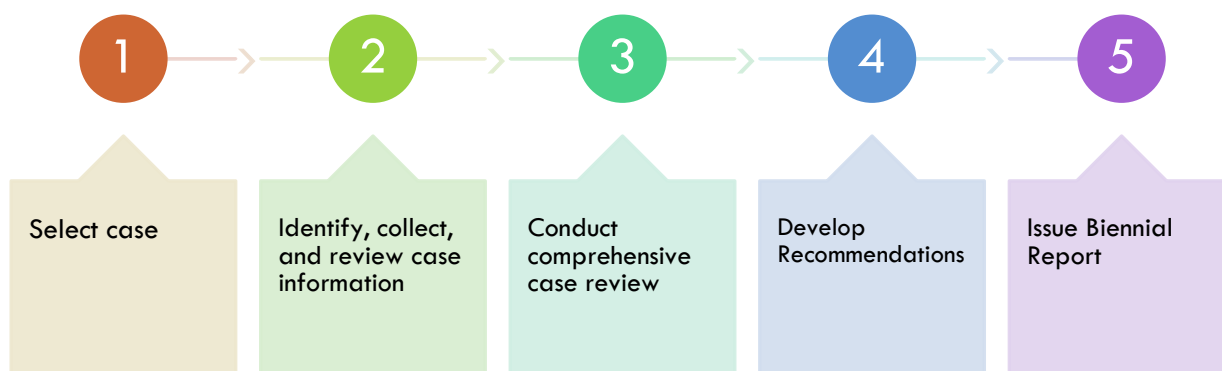
DEFINITIONS

For the purpose of a review by the Committee, “a "domestic violence fatality" means a death which arises as a result of an act of domestic violence as defined in [RSA 173-B](#), [RSA 631:2-b](#), or a fatality that, in the sole discretion of the domestic violence fatality review committee, was either directly or indirectly related to domestic violence”.

MEMBERSHIP

Committee membership is outlined in statute ([RSA 21-M:16-a, III](#)) and includes many of the systems that interact with victims or perpetrators of domestic violence, or their families. Members are appointed by the Attorney General and represent public, governmental and non-profit agencies from rural, as well as more populated, areas of the state. This approach ensures the variety of perspectives and experiences necessary to conduct comprehensive, in-depth reviews.

CASE SELECTION AND COMPREHENSIVE REVIEW PROCESS



The statutory framework of the DVFRC authorizes it to operate in a manner that is considered a “gold-standard” by national experts. It enables the sharing of both confidential and public information, which allows the Committee to dig deeper into the facts and circumstances of each case it reviews. Since the goal of the Committee is to develop recommendations that could prevent other fatalities, the Committee does not

focus solely on the events immediately preceding a fatality. Rather the Committee comprehensively examines the social, legal and personal histories of the parties involved requiring the review of extensive materials to prepare for each case review. This better informs Committee discussions and recommendation development for identifying intervention points and prevention strategies.

CASE SELECTION

The DOJ reviews cases for eligibility based upon the screening criteria set forth in the law. The DOJ provides the Committee with basic information about eligible cases to inform the selection process. The Committee considers cases for review based upon the initial information provided by the DOJ.

The Committee does not take referrals of cases from the public. The DVFRC statute specifies that cases “shall not be initiated until such time as the law enforcement criminal investigation has been completed or fully adjudicated, whichever comes later”. While a case may take several years to reach full adjudication through the criminal process, the requirement that a review begin only after the criminal process is complete is crucial to preserving the integrity of a criminal investigation and/or prosecution.

An amendment made to the DVFRC statute during the 2026 legislative session clarified that “any potential or pending civil litigation shall not preclude the committee’s review of a case and shall not constitute a basis for any organization, agency, or person to withhold records or testimony that are requested or compelled by the committee pursuant to this section”. This change allows the Committee to request information for the purpose of conducting a review even if civil litigation is a possibility or is pending.

IDENTIFY, COLLECT, AND REVIEW CASE INFORMATION

Once a case has been selected, it is the role of the DOJ to gather relevant information and records pertaining to the individuals involved in the case and share them with the Committee. This typically starts with any records the DOJ has from its investigation or prosecution of the fatality. Those records are reviewed and other sources of information are identified. The individuals involved in the fatality might have extensive social, legal or personal histories which resulted in other cases that are pertinent to the Committee’s review. Requests for those records are then made. Such additional sources of information or records can include, but are not necessarily limited to, reports of prior law enforcement contacts, copies of civil protection orders or bail conditions, records of previous convictions or information from social service providers or other interventions, including

child protection or the bureau of adult and aging services, and any other records or information that may be relevant to the Committee's review. The Judicial Branch is also requested to provide any records it may have on the individuals involved.

Once those records are received by the DOJ, they are then provided to the Committee. The Committee is directed to review the records and identify any additional records or additional sources of information they would like. The DOJ then requests those records. This whole process can take several months, depending on the volume and types of records or information related to a case.

The expectation is that Committee members review all the records provided to them in advance of the in-depth review. This is essential to gain a wholistic perspective of the case and to maximize the Committee's time when it meets. The expertise and perspective of the multidisciplinary Committee is necessary to critically review these cases.

Since these fatalities may result in hundreds of documents, totaling thousands of pages, Committee members, who are volunteers with full-time jobs, must be given enough time to thoroughly review the materials and familiarize themselves with the case.

CONDUCT COMPREHENSIVE CASE REVIEW

A case review typically starts with the Committee reviewing a timeline prepared by the DOJ utilizing events and interventions from the records the DOJ obtained. The timeline provides a high-level overview of important events in the lives of the parties involved in the case and orients those events in chronological order. This is a powerful visual representation of the individuals' lives and a compelling way to start the review.

Next, the Committee hears from invited guests that may have had contact with or provided services to the individuals involved in the case, or who may have expertise that would be helpful to the review.

After hearing from guests, the Committee discusses the totality of the information made available to the Committee. Through this discussion the Committee identifies things such as risk factors, barriers to safety or accountability, and gaps in services and response. The identification of these factors naturally leads to the development of recommendations.

DEVELOP RECOMMENDATIONS

The recommendations developed by the Committee are intended to enhance efforts to prevent future domestic violence fatalities. Ideas may be related to the specific case reviewed or may germinate from cross-disciplinary discussion that generates ideas which may proactively help prevent domestic violence homicide and other assaults.

The development of recommendations is an ongoing process. This is due in part to the review of multiple cases that may highlight the same or similar issues, and to the fact that the Committee may need to hold subsequent meetings to continue to refine its recommendations. An ongoing and continuously evolving review process is essential to ensure thorough, thoughtful, and intentional recommendations that are grounded in data collected through the review process.

ISSUE BIENNIAL REPORT

Pursuant to [RSA 21-M:16-a, XVI](#), the Committee issues a biennial report to the Governor, Speaker of the House of Representatives, the President of the Senate and the Chief Justice of the Supreme Court by the first day of October, each even numbered year, starting in 2026. The report describes trends and patterns of domestic violence deaths in New Hampshire, with any recommendations for changes in law, policy or practice that the Committee feels could prevent future deaths. The report is a culmination of the work of the Committee during the previous reporting period.

CONFIDENTIALITY

An integral component of an effective fatality review is confidentiality. Since the Committee receives personal and confidential information, protecting that information is paramount. This confidentiality promotes a culture where participants can share information and discuss difficult issues freely and safely. Fatality reviews must appropriately balance the public's right to know with both privacy rights and the need to preserve the integrity and effectiveness of the review process. The enabling legislation, [RSA 21-M:16-a](#), explicitly outlines the authority and protections afforded to the Committee. All records, meeting minutes, and deliberations of the DVFRC are confidential non-public records and cannot be accessed by anyone for any other purpose.

COMMITTEE OBSERVATIONS AND RECOMMENDATIONS



The aim of a domestic violence fatality review is to reduce the incidence of such deaths. To achieve that goal, the Committee used its observations and discussions in its two in-depth reviews to craft recommendations for improvements to strengthen the response to domestic violence in New Hampshire. Through the recommendation development process, themes or “goals” were identified. The below recommendations are organized around these goals. Though the Committee does not have the authority to mandate the implementation of recommendations, it has identified agencies or partners that the Committee believes to be the appropriate entity(ies) for implementing the recommendations. In future reports, the Committee anticipates providing updates on the status of these recommendations.

GOAL 1:

Increase offender accountability

Accountability for domestic violence offenders is paramount, not only within the criminal justice system but with other systems and stakeholders. Studies have shown correlations between offenders of domestic violence and other violent crimes, such as mass shootings.¹ Domestic violence offenders not only pose a risk to their families, but to their communities.

The Committee observed that existing responses to offenders do not consistently promote robust offender accountability. This is often due to lack of resources or access to best-practice tools. The Committee felt that exploring new approaches may assist in enhancing the state’s response.

¹ [The role of domestic violence in fatal mass shootings in the United States, 2014–2019](#)

RECOMMENDATION #1

Create an enhanced level of offense for subsequent domestic violence convictions.

Domestic violence often contains a pattern of behaviors, with many offenders committing acts of domestic violence against multiple victims. Amending the criminal statute to allow for a subsequent domestic violence offense to be charged as a felony acknowledges the seriousness of domestic violence and would provide the potential additional accountability for repeat offenders.

Action steps: The DOJ will help coordinate legislative efforts to achieve this goal. The DOJ will collaborate with the DVFRC and other stakeholders to discuss the legislation and to strategize what might be required to support the successful implementation of a new statute.

RECOMMENDATION #2

Explore domestic violence compliance efforts within the court system.

Compliance monitoring within the judicial setting can help increase accountability for abusive partners and promote the safety of domestic violence victims. Courts in some jurisdictions have developed specialized processes and other court-based efforts to monitor compliance with domestic violence-related court orders and conditions. These efforts may include monitoring compliance with protective orders, batterer intervention programming, and other conditions imposed to address domestic violence and reduce the risk of further abuse. They provide courts with opportunities to identify ongoing concerns, monitor risk, address noncompliance, and take appropriate action to promote offender accountability and enhance victim safety.

Action steps: The DVFRC recommends that the Judicial Branch explore the feasibility of developing or expanding court-based domestic violence compliance and accountability efforts. The Judicial Branch, in collaboration with stakeholders, could assess existing practices in New Hampshire and other jurisdictions and consider whether there are feasible and effective approaches that could enhance offender accountability and victim safety. Any potential effort should take into consideration available resources, training, and other implementation needs.

RECOMMENDATION #3

Explore evidence-based risk assessment tools or guides to be used by judges in both civil and criminal cases.

Evidence-based assessments draw on empirical research and validation and are used in a variety of settings to support informed decision-making and promote greater consistency in practice. In the area of domestic violence, several assessment tools and resources are available for different settings and purposes. These tools or guides may provide judges with additional information and context to consider when making decisions in domestic violence cases.

Action steps: The DVFRC recommends that the Domestic Violence Committee of the Judicial Branch explore the potential use of an evidence-based risk assessment tool or guide for judges. This exploration could include consideration of the available resources, their applicability to the New Hampshire court system, and input from relevant stakeholders. The Committee could also consider whether any changes to court rules or procedures would be appropriate.

RECOMMENDATION # 4

Assess the disparities between counties for accountability for offenders, including but not limited to pre-trial and post-trial services.

Counties have different resources, initiatives, and infrastructures which impact what tools are available to law enforcement officers, prosecutors and judges to hold offenders accountable and keep the public and victims safe.

Action steps: The DOJ, in conjunction with the DVFRC, will conduct an assessment to study the disparities and the scope of offender accountability resources throughout the state, including but not limited to pre-trial monitoring, batterer intervention programming, and probation. This should include getting feedback from law enforcement, prosecutors, judges, and victim service providers about how offender accountability options function, what works, what doesn't work, and what suggestions they have for improvement.

GOAL 2:

Strengthen the knowledge, skills and support of professionals addressing domestic violence

For professionals working in a relevant field, a comprehensive understanding of domestic violence, as well as the utilization of best practice approaches, is crucial to an effective response that best serves domestic violence victims and holds perpetrators accountable. Continued professional development is necessary to both be aware of new developments in law, practice, and procedure, and to hone the skills needed for effectively dealing with these very complex and difficult cases.

The Committee observed the impact that gaps in understanding and practice may have in the effective response to domestic violence. The Committee also acknowledges the challenges that agencies face such as staff inexperience, turnover or understaffing, as well as the emotional impact that these types of cases have on the professionals handling them.

RECOMMENDATION # 5

Increase knowledge on domestic violence protective order violations and appropriate charges.

Protective orders can be an important safety tool for victims of domestic violence. They are issued by a judge after a victim petitions the court and they prohibit an offender from abusing a victim. Protections can include staying a certain distance away from the victim or prohibiting contact with the victim. While a protective order is a civil document, there are criminal penalties for an offender who violates the protective order. It is important for law enforcement and prosecutors to understand what constitutes a violation of a protective order and what charges could be sought to hold the offender accountable for violating the protective order. This is particularly important when there are changes in statute or developments in case law.

Action steps: The DVFRC recommends that the DOJ work with the Police Standards and Training Council (“PSTC”) to develop or identify standardized training and reference materials addressing domestic violence protective-order violations, including the identification of violations, appropriate criminal charges, and relevant

evidentiary considerations. Training should include a focus on in-service training opportunities for officers, including supervisors and field training officers. The DOJ and PSTC should work with relevant stakeholders, including the New Hampshire Coalition Against Domestic and Sexual Violence and representatives from law enforcement and the prosecution bar. The training should be made available to law enforcement officers and prosecutors statewide.

RECOMMENDATION # 6

Train dispatchers and call takers on the dynamics of domestic violence.

The DVFRC obtained and reviewed a number of dispatch and 911 calls that spanned over several years and this recommendation is not related to any particular call or dispatcher. Dispatchers and call takers within law enforcement agencies are often the first contact that victims, perpetrators, or the public have when there is a domestic violence incident. Law enforcement and emergency medical response personnel rely on dispatchers and call takers to relay important information from the caller about the scene, the parties involved, and the nature of the incident. It is important that these critical front-line responders have the necessary training, tools, and support to be able to navigate these difficult calls.

Action steps: The DVFRC recognizes the important role that dispatchers have in an effective public safety response. The DVFRC supports the New Hampshire Emergency Dispatchers Association's efforts to create state-wide standards for training of dispatchers and call takers and recommends they incorporate the dynamics of domestic violence. The New Hampshire Emergency Dispatchers Association is encouraged to collaborate with the New Hampshire Coalition Against Domestic and Sexual Violence regarding developing content on this topic.

RECOMMENDATION # 7

Strengthen organizational responses to compassion fatigue and secondary traumatic stress among law enforcement and prosecution personnel.

Compassion fatigue often refers to the cumulative physical, emotional, and psychological toll experienced by professionals who regularly work with people in pain, trauma, or distress. Given the nature of the calls for service law enforcement respond to and the types of cases that prosecutors handle, they are acutely vulnerable to experiencing compassion fatigue. Compassion fatigue can have a negative impact on agency culture which impacts recruitment and retention and ultimately the outcomes of cases.

Action steps: The Department of Safety, pursuant to RSA 153-A:17-a, regulates the training standards for stress related to “acute or cumulative psychological stress or trauma to emergency response/public safety worker.” The DVFRC recommends that the Department of Safety consider pursuing legislation expanding the definition of “emergency response/public safety worker” to include prosecutors and broaden required trainings to cover compassion fatigue for law enforcement personnel and prosecutors who are eligible. Additionally, the Police Standards and Training Council should include in its model law enforcement policies protocols for addressing compassion fatigue and reports related to the handling of domestic violence matters.

GOAL 3:

Strengthen coordination, communication and response between law enforcement agencies, victim service providers, prosecutors, the court, and other stakeholders

Combating domestic violence requires a robust multidisciplinary response; it is not the sole responsibility of one entity or agency. To effectively address domestic violence, the various systems involved need to work collaboratively. This not only increases mutual understanding of each other’s roles but also promotes stronger working relationships.

The Committee observed that effective collaboration and communication can be crucial to holding offenders accountable and ensuring victims’ safety. The Committee also acknowledges that barriers exist that can make such collaboration challenging to achieve.

RECOMMENDATION # 8

Explore the creation of Domestic Violence High Risk Response Teams.

The Domestic Violence High Risk Team (“DVHRT”) Model is a nationally recognized approach, originated by the Jennie Gieger institute in Newburyport, Massachusetts. This multidisciplinary approach brings together law enforcement, prosecution, probation or pretrial services, parole and corrections, victim services and when possible, court-ordered offender intervention programs. The model promotes the early identification of the most

dangerous cases through evidence-based risk assessment; increased access to supportive services for high-risk victims; increased offender monitoring and accountability; and a coordinated response to high-risk cases through a multidisciplinary team.

Action steps: The DVFRC will research what is involved in implementing a High-Risk Domestic Violence Response Team, including what resources are necessary for it to be successful. It is anticipated that implementing a DVHRT would require a significant investment in resources, including strong coordination efforts and identifying appropriate team leadership.

RECOMMENDATION # 9

Promote system-based victim advocacy in criminal cases handled in Circuit Court.

Systems Based Victims' Assistance Providers (i.e. advocates) are a part of the criminal justice system and provide vital services to victims of crime. Every county attorney's office has Systems Based Victims' Assistance Providers that work with victims of felony level crimes. A few county attorney offices and police departments have these positions dedicated to criminal cases within the Circuit Court. At the Circuit Court level, the Systems Based Victims' Assistance Providers can be involved after an arrest and work with a victim through the adjudication of the case. They provide information regarding arrest and bail and become a point of contact for victims regarding what is happening within the criminal justice system. Systems Based Victims' Assistance Providers communicate to prosecutors regarding the victim's barriers and needs and provide referrals to community-based advocates and other social services that can provide additional support services and resources to victims.

Action steps: The DVFRC recommends that the DOJ explore potential grant opportunities that could be made available to provide startup funding to police departments to create or expand victim advocacy services within their departments for cases handled in Circuit Court.

RECOMMENDATION # 10

Revive domestic violence coordinating councils.

Domestic violence coordinating councils were established in New Hampshire in the 1990s in communities throughout the state, typically based on court jurisdiction. The Councils were designed to be multidisciplinary and generally included judges, clerks, prosecutors, defense attorneys, law enforcement, batterer intervention programs, and advocates. Leadership was often provided by the Judicial Branch. The Councils provided an opportunity for collaboration and coordination within a community and allowed participants to identify and address issues specific to their community or jurisdiction.

Action steps: The DVFRC recommends a subcommittee to explore opportunities to reestablish domestic violence coordinating councils or similar multidisciplinary collaborative groups in communities throughout New Hampshire. Interested stakeholders, including the courts, law enforcement, prosecutors, public defenders, advocates, and service providers such as mental health, substance use treatment providers, and other community partners, could identify whether there is a need and interest in reestablishing such groups and, if so, recommend best practices with respect to the structure and leadership model based on the needs and resources of each community.

GOAL 4:

Support early intervention efforts

Domestic violence has harmful and lasting effects on individuals, families, and communities. Many children exposed to domestic violence in their home are also victims of physical abuse. Studies have shown that children exposed to domestic violence are not only at increased risk for adverse mental health and physical conditions, but are at higher risk to perpetrate domestic violence or are more vulnerable to becoming a victim of

domestic violence later in life.² Worldwide, 1 in 4 children (around 610 million) live with mothers who have experienced intimate partner violence within the past year.³

The Committee observed that early interventions could be critical in providing education and support to vulnerable children. These services might lessen the risk of further traumatic events, including complicated medical and mental health issues later in life.

RECOMMENDATION # 11

Expand ACERT teams to additional communities where appropriate.

Adverse Childhood Experiences (“ACEs”) are traumatic events occurring before age 18, and can include emotional, physical, or sexual abuse; emotional or physical neglect; and household dysfunction such as parental substance misuse, mental illness, and domestic violence. These negative experiences can have a lasting effect on the physical, mental, and emotional health of children and youth. Adverse Childhood Experience Response Teams (“ACERT”) were created as a multidisciplinary collaborative approach to respond to children exposed to ACEs. New Hampshire currently has nine ACERTs serving 17 communities. ACERTs typically receive referrals from law enforcement who have had recent contact with a family. The ACERT engages with the family and offers access to an array of services. Referrals are voluntary and can include a variety of therapies, youth support groups, domestic violence services, athletic enrichment programs, home visiting, and many other child/family-based resources.

Action steps: The DVFRC recommends that the Department of Health and Human Services, the New Hampshire Coalition Against Domestic and Sexual Violence, Child Advocacy Centers, and other partners identify and strengthen pathways for children exposed to domestic violence and other identified risk factors. This should include an effort to identify existing services, gaps in availability, geographic or eligibility barriers, and opportunities to expand or coordinate services through ACERT teams and other community-based programs.

² Office on Women’s Health. [Effects of domestic violence on children’s health](#).

³ Data Brief on Violence Against Children at Home - Unicef for every child (November 2025) [UNICEF-Data-brief-on-VAC-at-home_Nov-2025.pdf](#)

HOMICIDE DATA



This section presents detailed domestic violence homicide data from 2022-2025, as well as highlights of aggregate data on domestic violence homicides from 2009-2025. The information presented in this section is from the Office of Victim/Witness Assistance (OVWA) at the DOJ. Excluded are deaths caused by negligence, suicide, accident, justifiable homicide, attempted murder, and homicides outside of the jurisdiction of the DOJ (such jurisdiction typically only includes capital, 1st and 2nd degree murders).

Where homicide data is used in this section, it refers to the victim that was killed unless otherwise specified. It is important to note that the number of perpetrators may be different from the number of victims as a homicide incident may have multiple victims and/or multiple offenders.

For the purposes of the data collected by OVWA, a homicide is categorized as a domestic violence homicide when the relationship between the perpetrator and the victim meets specific criteria and when the perpetrator has been publicly identified; it is not based on a criminal finding of guilt. Homicides that are unsolved, or where the perpetrator is otherwise not identified, cannot be categorized as domestic violence, and therefore are not included in these domestic violence statistics. If information becomes available later and a perpetrator is publicly identified, OVWA will update the data.

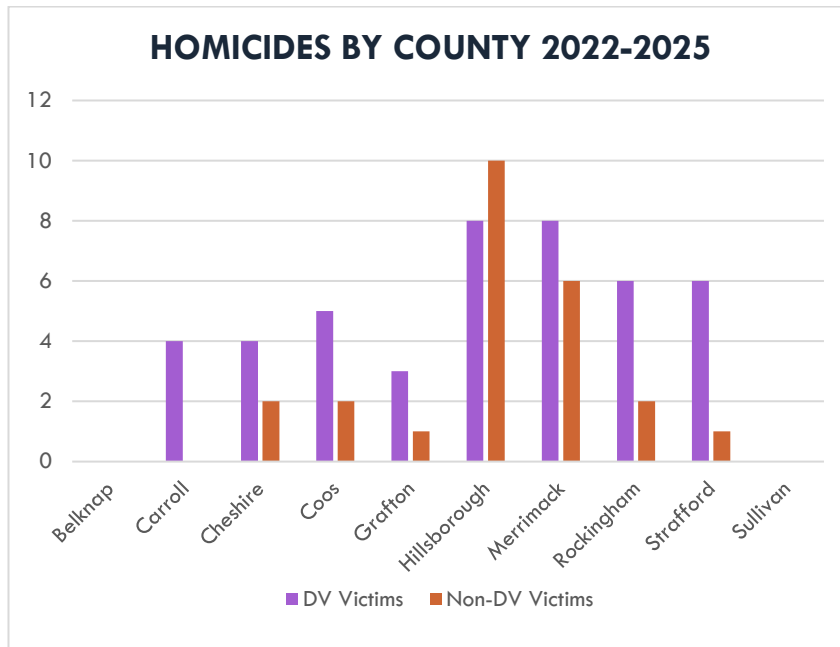
The OVWA defines a domestic violence homicide as one person killing another person by use of physical force or a deadly weapon where the relationship between the parties is either intimate partner, family member or domestic-violence related. These relationships are defined as:		
Intimate Partner	Family Member	Domestic Violence Related
includes both current or prior intimate relationships, including spouses, unmarried cohabitants or a dating relationship.	by and against family members but excludes intimate partners (e.g., when a parent kills a child). This also includes people not biologically related but are similarly situated as a family member, parent or guardian in the victim's life (i.e. step-mom, mother's boyfriend, etc.).	not intimate partners or family members, but the homicide has some relationship to domestic violence (e.g., estranged husband kills wife's current partner, bystanders killed as the result of a domestic violence incident).

CHART 1

NEW HAMPSHIRE HOMICIDES 2009-2025									
Year	# of Homicides Handled by Attorney General's Office	# of Domestic Violence Homicides	# Domestic Violence - Partner Homicides	# Domestic Violence - Family Member Homicides	# Domestic Violence - Related Homicides	% Homicides that are Domestic Violence	% Homicides that are Domestic Violence - Partner Only	Total # Murder/Suicides	% Domestic Violence Murder/Suicides
2009	12	7	6	1	0	58%	50%	4	100%
2010	12	9	5	2	2	75%	42%	3	100%
2011	16	8	4	4	0	50%	25%	2	100%
2012	13	6	3	2	1	46%	23%	6	33%
2013	16	9	4	5	0	56%	25%	2	100%
2014	15	11	5	4	2	73%	33%	8	75%
2015	14	7	2	4	1	50%	14%	4	100%
2016	13	4	1	3	0	31%	8%	1	0%
2017	12	5	2	3	0	42%	17%	1	100%
2018	19	9	5	3	1	47%	26%	6	100%
2019	28	17	9	7	1	61%	32%	9	44%
2020	11	5	1	2	2	45%	9%	2	100%
2021	11	8	4	4	0	73%	36%	2	100%
2022	20	9	4	4	1	45%	20%	2	100%
2023	20	14	6	7	1	70%	30%	3	100%
2024	10	9	6	3	0	90%	60%	2	100%
2025	18	12	4	8	0	67%	22%	5	100%
Totals	260	149	71	66	12	57%	27%	62	81%

Chart 1 is intended to provide historical data for the last seventeen years. In total, there were 260 homicides that occurred in New Hampshire and of those 57% were as the result of domestic violence. This percentage has fluctuated over time, increasing or decreasing as yearly data impacts the overall numbers, such as a low of 31% homicides in 2016 to a high of 90% in 2024. This chart also illustrates that while murder/suicides only account for 24% of homicides, in 81% of the murder/suicides, domestic violence was a factor.

CHART 2

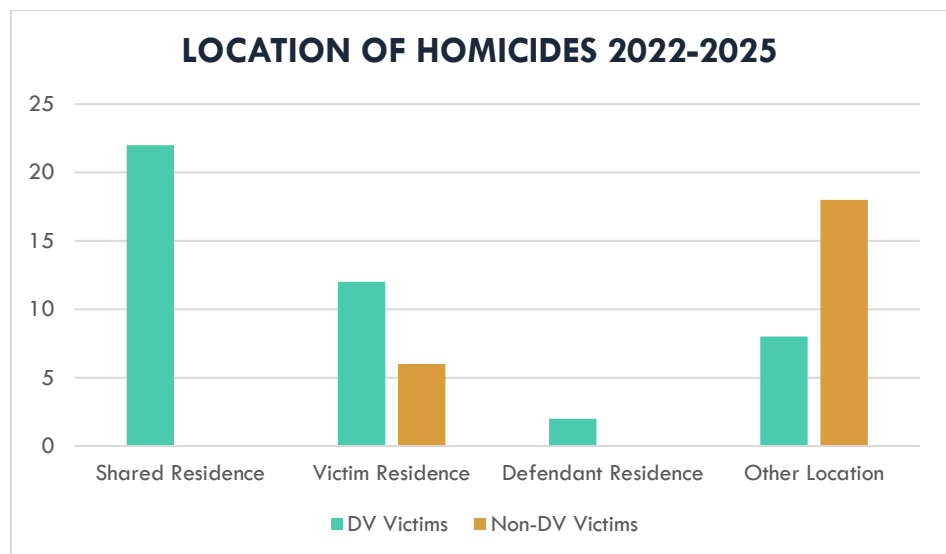


Between 2022 and 2025 there were a total of 68 homicides, of which 44 (64%) were categorized as domestic violence.

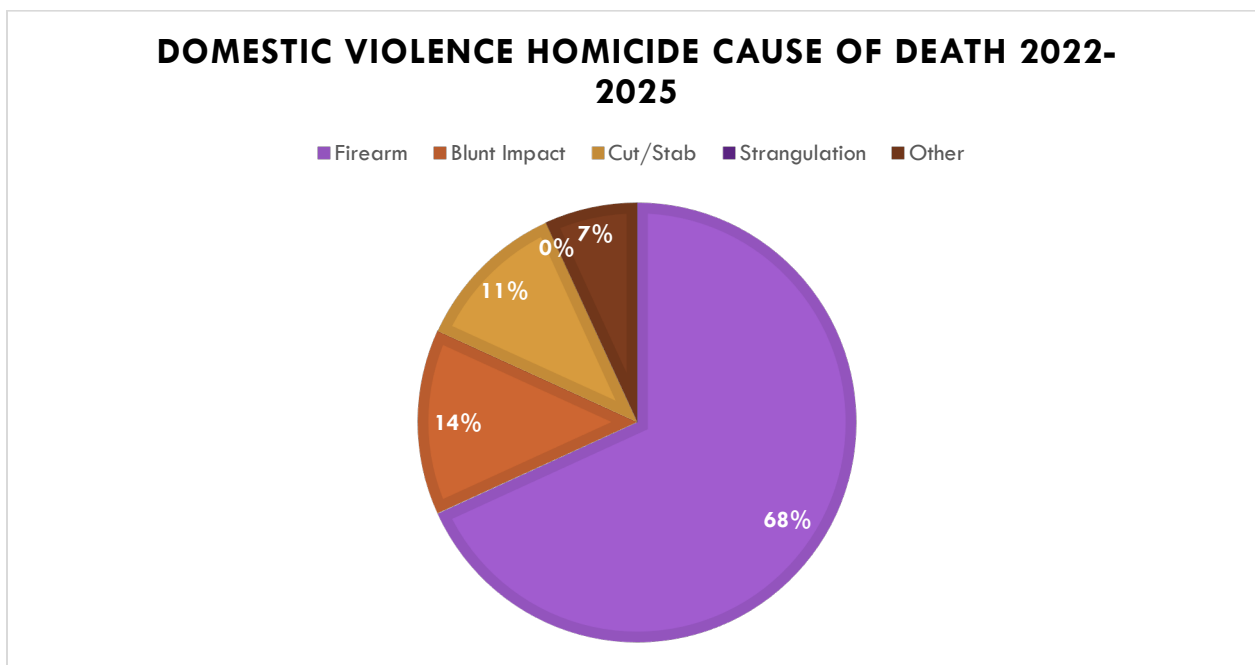
Homicides occurred in all but two counties, with Hillsborough county being the only county that had more non-domestic violence homicides than domestic violence homicides. Carroll County was the only county where all the homicides that occurred this reporting period were domestic violence.

CHART 3

Domestic violence homicide victims were murdered predominately in the residence they shared with the perpetrator. In comparison, non-domestic violence related homicides most frequently occurred in other locations (i.e. on the street or in a car). This is consistent with previous reporting periods.



HOMICIDES CAUSE OF DEATH 2022-2025		
Cause of death	Domestic Violence Homicide Victims	Non-Domestic Violence Homicide Victims
Firearm	30	12
<i>Hand Gun</i>	26	11
<i>Long Gun</i>	4	1
Cut/Stab	5	7
Blunt Impact	6	3
Strangulation	0	0
Other	3	2
Total	44	24



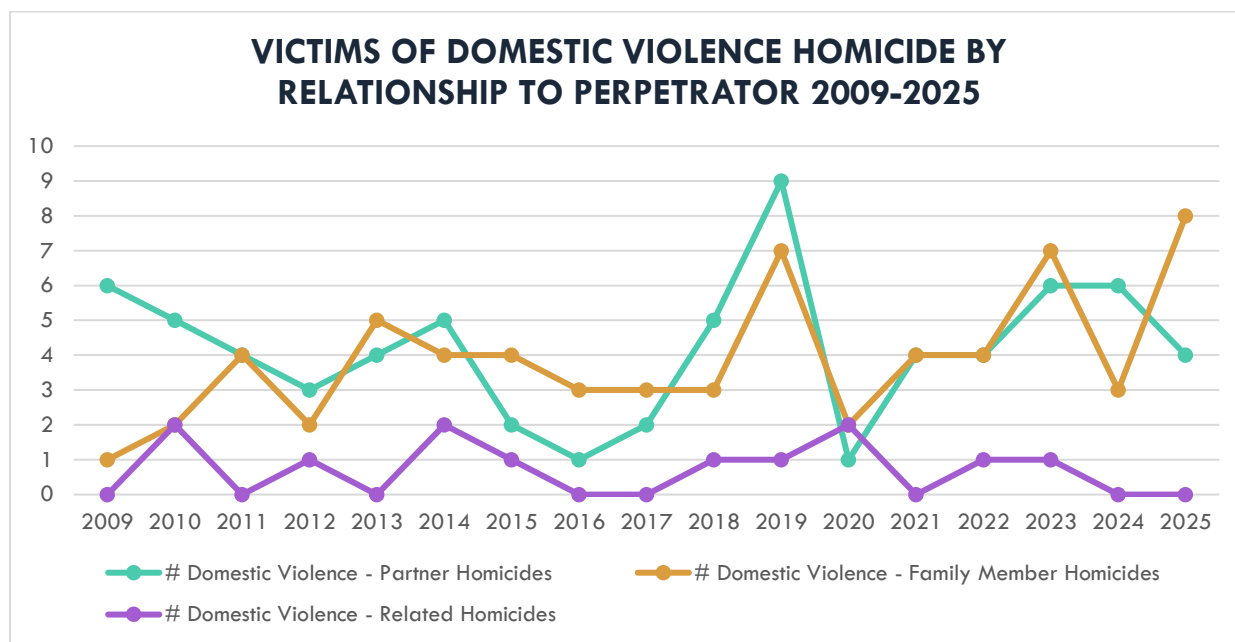
Firearms were the leading cause of death for both domestic violence and non-domestic violence homicides this reporting period.

CHART 6

For Chart 6, only the homicide victims are counted. All the murder suicides this reporting period were domestic violence.

Total Number Murder-Suicides 2022-2025	
Domestic Violence Murder-Suicides	12
Non-Domestic Violence Murder-Suicides	0
Total	12

CHART 7



Between 2009 and 2025, 71 victims were killed by an intimate partner, representing 48% of the domestic violence homicides. During this same period, 66 victims were killed by a family member, equaling 44% of all domestic violence homicides and 12 victims (8%) lost their lives in a domestic violence related homicide.

CHART 8

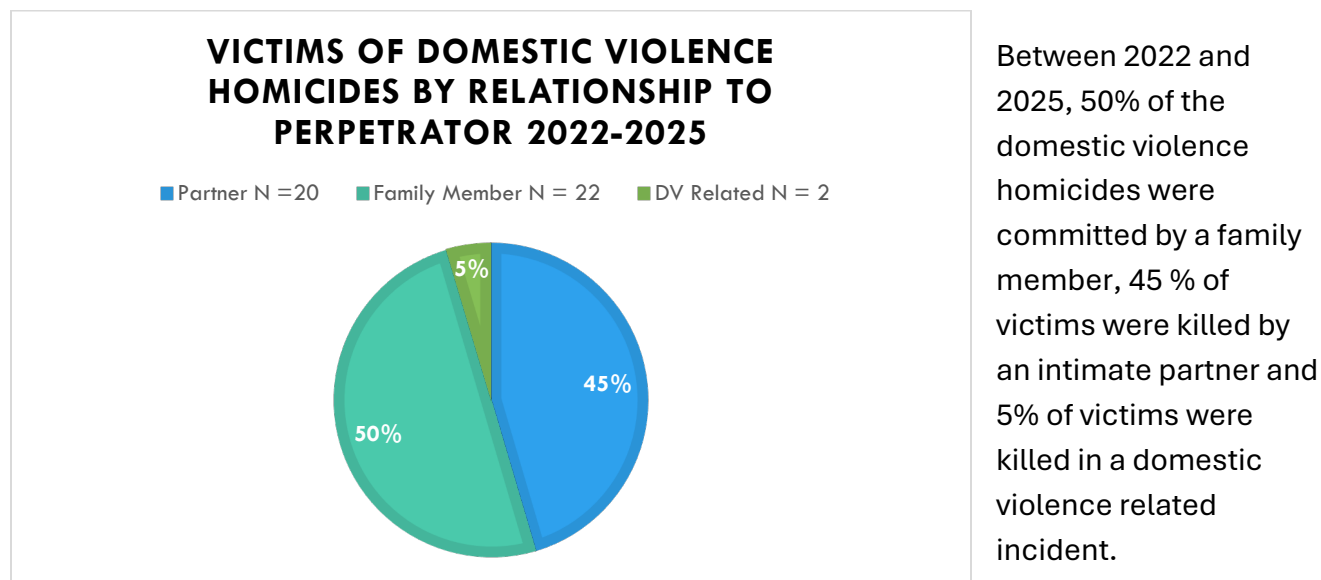


CHART 9

During this reporting period 85% of victims killed by an intimate partner, and 59% of those killed by a family member, were female.

Both of the domestic violence related victims, 40% of victims killed by a family member and 15% of victims killed by an intimate partner, were male.

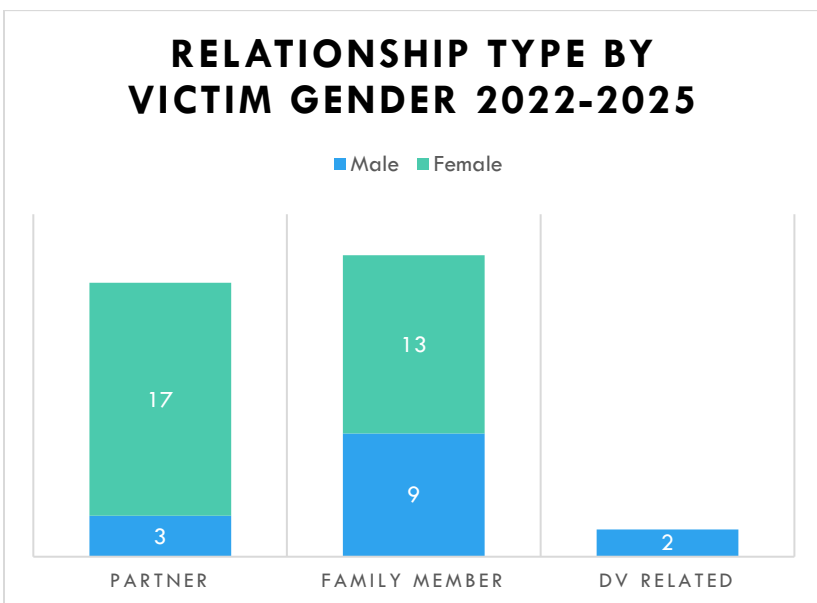
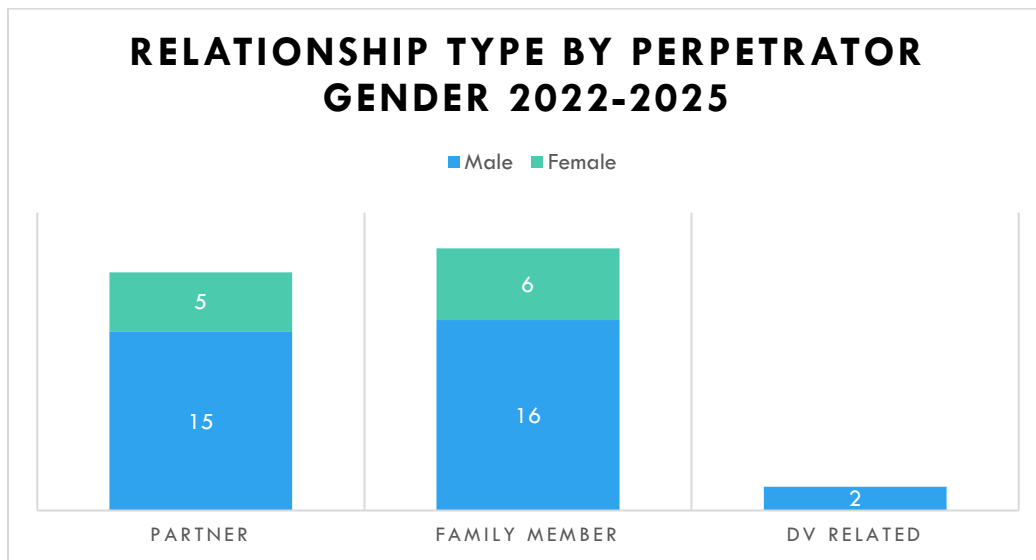


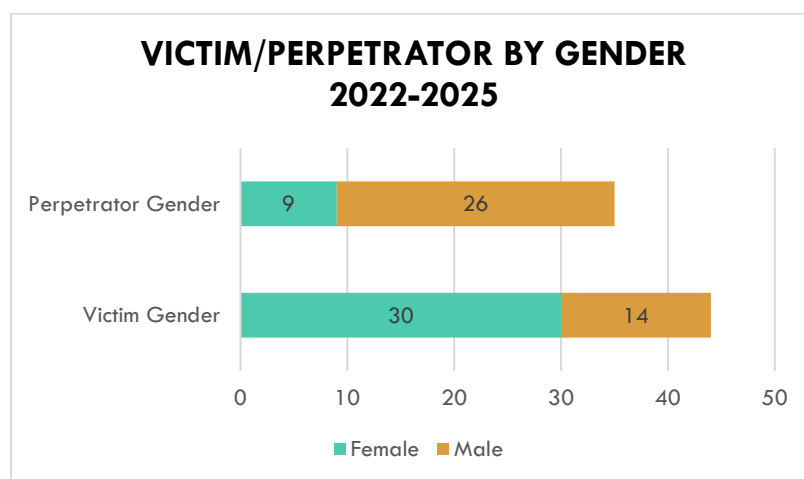
CHART 10



Between 2002 and 2025. There were several perpetrators that killed multiple victims. Chart 11 reflects the types of homicides committed and the gender of the perpetrator for each homicide.

Of the partner homicides, 75% were committed by a male perpetrator. Of victims killed by a family member, 72% were killed by a male perpetrator and both domestic violence related homicides were committed by a male perpetrator.

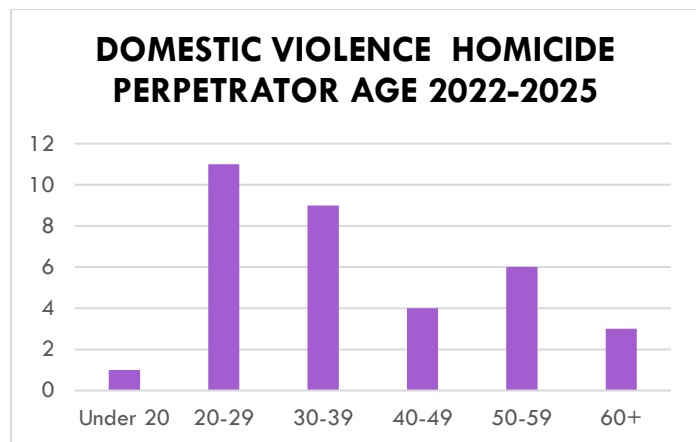
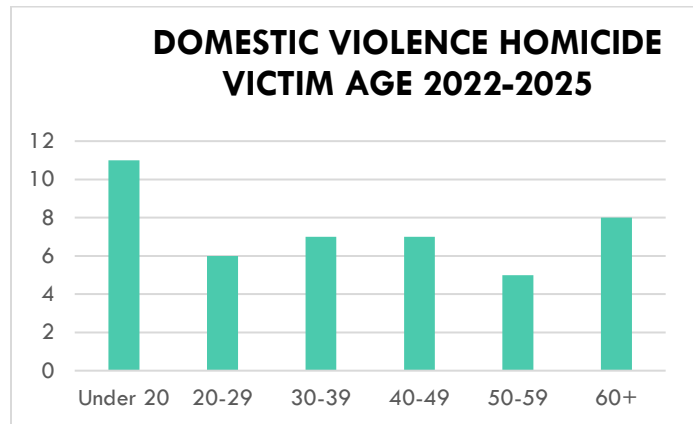
CHART 11



Between 2022 and 2025, over two-thirds of homicide victims were female, and almost three-fourths of homicide perpetrators were male.

For this reporting period, 25% of domestic violence homicide victims were under the age of 20.

The age group most responsible for committing domestic violence homicides was 20-29 at 31%.



The Domestic Violence Fatality Review Committee strives to promote greater awareness of domestic violence in New Hampshire and opportunities for building safer communities for all our citizens. The Committee is hopeful that this report may serve as a valuable resource to those who serve victims of domestic violence and other stakeholders whose work can meaningfully impact systemic and community responses that can help prevent domestic violence.



CONCLUSION

The comprehensive, in-depth review of these cases reinforces a fundamental principle of domestic violence fatality review: preventing future deaths requires more than an effective response from any single agency or system. It requires a coordinated and sustained community response that recognizes risk, strengthens offender accountability, supports victims and their children, and addresses gaps in communication, training, and access to services.

The cases reviewed during this reporting period raised several topics discussed by the Committee. The Committee's recommendations reflect opportunities to strengthen our state's response at multiple points—from early intervention with children exposed to domestic violence, to improved information sharing and multidisciplinary coordination, to more consistent use of tools and practices that promote offender accountability and victim safety. While the Committee formalized the recommendations listed above, there are some topics that the Committee has identified that require further exploration and were therefore not included in the Committee's current recommendations. The Committee may return to these topics in the context of future fatality reviews and recommendations in subsequent biennial reports. Although the Committee does not have the authority to mandate implementation of these recommendations, it believes that meaningful progress can occur when the agencies and communities responsible for responding to domestic violence examine these recommendations, identify practical steps for implementation, and work collaboratively to address the barriers identified through the review process.

Fatality review is not intended to assign blame for what has already occurred. Its purpose is to learn from tragedy and use that knowledge to improve the systems and relationships that may prevent the next tragedy. The Committee therefore encourages New Hampshire's law enforcement agencies, courts, prosecutors, victim service providers, behavioral health and child-serving systems, policymakers, and communities to view these recommendations not as isolated initiatives, but as interconnected opportunities to strengthen the state's response to domestic violence.

The Committee recognizes that preventing domestic violence fatalities is an ongoing effort. It will continue to review cases, examine emerging trends, assess the implementation and impact of its recommendations, and identify additional opportunities to improve New Hampshire's collective capacity to recognize danger, intervene effectively, and protect victims and their families. The ultimate measure of this work will be whether the lessons learned from these deaths contribute to a statewide response better prepared to prevent the next one.

APPENDIX A:

DVFRC SUMMARY RECOMMENDATIONS

Goal	Recommendation	Partner Agencies	Year
Offender Accountability	Create an enhanced level of offense for subsequent domestic violence convictions.	• DOJ • DVFRC	2026
Offender Accountability	Explore domestic violence compliance efforts within the court system.	• Judicial Branch	2026
Offender Accountability	Explore evidence-based risk assessment tools or guides to be used by judges in both civil and criminal cases.	• Judicial Branch	2026
Offender Accountability	Assess the disparities between counties for accountability for offenders, including but not limited to pre-trial and post-trial services.	• DOJ • DVFRC	2026
Training and Support	Increase knowledge on domestic violence protective order violations and appropriate charges.	• DOJ • PSTC	2026
Training and Support	Train dispatchers and call takers on the dynamics of domestic violence.	• NHEDA • NHCADSV	2026
Training and Support	Strengthen organizational responses to compassion fatigue and secondary traumatic stress among law enforcement and prosecution personnel	• DOS • PSTC	2026
Coordination and Communication	Explore the creation of Domestic Violence High Risk Response Teams.	• DVFRC	2026
Coordination and Communication	Promote system-based victim advocacy for criminal cases handled in Circuit Court level.	• DOJ	2026
Coordination and Communication	Revive domestic violence coordinating councils.	• DVFRC	2026
Early Interventions	Expand ACERT teams to additional communities where appropriate.	• DHHS • NHCADSV • CACs	2026