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STATE OF DELAWARE
FATAL INCIDENT
REVIEW TEAM

REPORT

Submitted To
The Domestic Violence Coordinating Council

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Domestic Violence Coordinating Council
New Castle County Courthouse
500 N. King Street, Suite 9425
Wilmington, DE 19801-3732
302-255-0405

INTRODUCTION

The year 2002 saw a significant increase in domestic violence fatalities in Delaware. Last year, nineteen people died as a result of domestic violence in our State, as compared to eleven deaths in the year 2001. Three of those cases involved murder/suicide, where the abuser killed his partner and then killed himself. Tragically, children were witnesses to the murder of their mothers in three of the fatalities, which occurred as a result of domestic violence in Delaware last year.

Domestic violence continues to be a devastating problem and deaths resulting from this crime are the ultimate acts of abuse. The Domestic Violence Coordinating Council's Fatal Incident Review Team is tasked with conducting a thorough, interagency review of every death in Delaware resulting from domestic violence. This report contains data from fourteen new case reviews completed since the 2001 report was published, along with cumulative data gathered from the thirty case reviews completed to date.

During the three-year period 2000 through 2002, Domestic Violence Coordinating Council (DVCC) records indicate that forty-four Delawareans lost their lives as a result of domestic violence. This number represents both homicides and suicides resulting from domestic violence and includes those cases where the perpetrator killed the victim and then committed suicide. In several of these cases, victims had taken steps to protect themselves and/or their families from their abusive partner. Despite their efforts, some victims died at the hands of their abusers – people who claimed to love them.

Domestic violence victims are young and old, rich and poor, women and men, members of different races and religions. They live throughout the state, in large cities and in small towns. Some are married, and some are not. More than half of the victims included in this report were the parents of young children and, sadly, in several of those cases children lost both their mother and father to domestic violence.

Fatal incident reviews are difficult work. Identifying cases, collecting data, requesting agency files, and coordinating witnesses are all necessary components of a successful review. However, the real work of the Team is in coming together openly and honestly to ask the tough questions of their own

and other relevant agencies as to what the system could have done better, then using that information to formulate meaningful recommendations which will result in system improvements.

The new cases included in this report occurred during 1997, 1998, 1999, 2000, and 2002. The Team alternates between reviewing cases which occurred several years ago and cases which occurred several months ago in an effort to handle the backlog of fatalities while still remaining current in our system analysis. Although other fatal incidents have been reviewed in addition to the cases included in this report, the Team Findings on those cases are not yet complete; therefore, that data is not included in this report.

The participants in the review process remain committed in their efforts to prevent future domestic violence fatalities by continually reviewing and analyzing the facts and circumstances surrounding all domestic violence deaths in Delaware. The agencies and individuals who come together to participate in the fatality review process often represent disparate views in their approach to reducing domestic violence. Despite the challenges that working with the various disciplines presents at times, we have learned that it is only by respecting our differences and working together that we can effect meaningful change.

I. CREATION AND GOALS

In June 1996, Governor Thomas R. Carper signed into law the Domestic Violence Fatal Incidents Review Act. This legislation, which was written by the Domestic Violence Coordinating Council, established a Fatal Incident Review Team to investigate and review the facts and circumstances of all domestic violence related fatalities occurring in Delaware.

The concept for the Domestic Violence Fatal Incident Review Team is loosely based on Child Mortality Reviews that are conducted in Delaware and elsewhere. Child Mortality Reviews, however, are focused generally on data collection and determining whether a child's death was avoidable. Domestic violence deaths should be considered per se as avoidable.

The ultimate purpose of reviewing domestic violence fatalities is to try to reduce the incidence of such deaths in the future. By conducting system audits of state agencies and private organizations that had contact with the deceased victim or the alleged perpetrator, the system's response to domestic violence cases may be improved. Steps may be taken to prevent future deaths and injuries, including changes in individual organization's policies and procedures, and to generate information for intervention, prevention, public policy development, and education. Trends and patterns of domestic violence deaths can be described and high-risk groups and factors identified.

Although the domestic violence fatality reviews are retrospective in nature, their purpose is prospective. The reviews focus on identifying trends and obstacles in service delivery, assessing the adequacy of agency interventions, and, most importantly, developing recommendations for improved policies or practices aimed at reducing the incidence of domestic violence deaths. The reviews do not focus on the performance of individual agency personnel.

II. **MEMBERSHIP**

Each Domestic Violence Fatality Review Team included the following core members:

- the Attorney General
- the Director of the Division of Family Services
- the Chair of the Domestic Violence Task Force
- the Chief Judge of the Family Court
- the Chief Magistrate of the Justice of the Peace Courts
- a law enforcement officer to be appointed by the Delaware Chief's of Police Council and
- two members of the Domestic Violence Coordinating Council

Each of these individuals is able to appoint a designee to represent him or her on the Team.

The Review Team invited other law enforcement personnel to serve and participate as full members of the Review Team in cases in which their agency had investigated the death under review or any prior domestic violence incident involving the deceased. The review team also invited other relevant persons to serve on an ad hoc basis and participate as full members of the Review Team for a particular case. These persons included attorneys who had represented the deceased, public defenders who represented perpetrators, counselors and therapists who had treated either the victims or the perpetrators, advocates and victim service workers who assisted the victims and case workers who worked with the families. The Review Team also interviewed representatives from Adult Protective Services and Child Mental Health. Finally, the Review Team requested and obtained an opinion from the Psychiatric Society of Delaware on an issue raised during the reviews.

III. **STATUTORY AUTHORITY AND RESPONSIBILITIES**

The Review Team has the authority to investigate and review the facts and circumstances of all deaths that occur in Delaware as a result of domestic violence. The reviews may include both homicides and suicides.

The Fatal Incident Review Team may consider only deaths which meet the following two criteria:

1. The death must have occurred as a result of domestic violence, and

2. The victim must have been a Delaware resident at the time of the incident or must have died in Delaware.

The Review Team has adopted a broad definition of Domestic Violence, similar to that used by the Department of Justice. Use of a broad definition ensures that no domestic violence case escapes review. For purposes of these reviews, domestic violence is defined as follows:

> Domestic violence is any abusive act between family members (see 10 Del. C. 901(9)), ex-husband and wife, intimate cohabitants, former intimate cohabitants, dating couples, and former dating couples. Abusive acts include physical, sexual, and emotional abuse, threats of abuse, and destruction of property. Domestic violence shall also include abusive acts in which an individual who has a relationship with the domestic violence victim is killed as a result of the offender's actions. The offender and victim in a domestic violence case may be of the same sex.

Any case involving the death of a minor related to domestic violence will be reviewed jointly by the appropriate regional Team of the Child Death Review Commission and the Domestic Violence Fatal Incident Review Team.

Each Review Team must prepare a report that is maintained by the Review Team, which includes a description of the incident reviewed, and the findings and recommendations of the Review Team. The Review Team is required to issue a report to the Domestic Violence Coordinating Council. The report must summarize in aggregate fashion all findings and recommendations made over the year by each Review Team. The report must also describe any systemic changes that were effectuated as a result of the

Team's work. The report will not identify the specific case or case review that led to particular findings or recommendations. **Appendix I**

IV. CONFIDENTIALITY REQUIREMENTS

The confidentiality of the review process and all records of each review must be maintained. Therefore, the enabling legislation provides that the review process and any records created therein are exempt from the provisions of the Freedom of Information Act. All records of the reviews are confidential and kept in the Council office. These records may only be used by the Coordinating Council in the exercise of its proper function.
Appendix II

V. PROCEDURES

The Review Team meets monthly, provided that there are cases eligible for review. The co-chairs of the Team, or any two other Team members, can convene additional reviews if necessary. No review may be conducted unless authorized by the Attorney General's office.

Each participating member of the Review Team completes a data sheet providing information regarding their agency's contact with the victim and/or perpetrator. Members also provide their agency's documentation about a particular case to staff prior to the review. Following review of the case data, staff schedules witnesses to appear at the meeting. Team members also provide recommendations for review witnesses.

Staff begins each review by providing Team members with data forms and other information gathered prior to the review. Staff then summarizes the case under review and introduces the witnesses. Witnesses provide a summary of their contact with the victim and or perpetrator in the case, law enforcement officers then report on the fatal incident. Team members are given the opportunity to ask questions of each witness. Each Team member then orally summarizes their agency's information and shares any documentation regarding the deceased and/or the alleged perpetrator.

Following the case review, staff compiles a Domestic Violence Fatal Incident Review Team Findings Report and then submits it to the Review Team for final approval. Findings and recommendations of the Team are adopted only upon a sixty percent (60%) vote of participating members.

The Review Team then issues a report to the Coordinating Council summarizing in an aggregate fashion all findings and recommendations made in the cases reviewed. The report must also describe any systemic changes that were effectuated as a result of the Review Team's work.

VI. FATAL INCIDENT REVIEW TEAM ACTIVITIES

A. MEETINGS

The Fatal Incident Review Team held its first meeting on March 31, 1997. At this meeting the Review Team discussed the rules and procedures and worked on details of implementation. The Review Team decided that it should meet monthly, with a calendar of meetings developed in advance to ensure consistent attendance. Review Team members also discussed the types of information that they would need to access and how information used for reviews should be maintained. Information regarding each fatality review is gathered and maintained by the Coordinating Council staff, copies of case reports are distributed for review and then collected at the end of each meeting.

The Review Team also began a mock review of a 1995 Delaware domestic violence fatality at the March meeting. This review was completed several months later, after two additional meetings and testimony from several witnesses. Completion of the mock review led to several changes to the Review Team's forms, including improvements to the Findings Form developed by the Review Team. Additionally, the mock review made clear that it may be helpful to let members of professional organizations upon whom the Review Team may rely know about the Review Team's existence and goals.

Therefore, the Review Team sent letters to the President of the Delaware State Bar Association, the Presidents of each county's Medical Society, the Executive Director of the Delaware Medical Society, and the Executive Director of the Delaware Academy of Medicine. The letters described the work of the Review Team and indicated that the Review Team may need to call upon their membership for assistance in the future.

Following the completion of the mock review, the Review Team continued to try to meet on a monthly basis. Forty-one meetings were held during the first five years, including the March 31, 1997, meeting. The majority of time at meetings was spent reviewing cases, with some time spent on procedural and administrative issues.

Issues which the Team confronted over the years has included: discussions regarding the meeting format and methods for collecting data, confidentiality issues, discussion of family members role in the review process, further defining the role of witnesses and team members and review of the FIRT policies and procedures.

B. 2001 REPORT - CASE REVIEWS

In all, the Review Team completed one mock and fifteen regular reviews during the first three years of operation. The deaths reviewed occurred during 1996 and 1997 except for the 1995 mock review case. Not all of the domestic violence deaths, which occurred during 1996 and 1997, appear in this report.

Consistent with research regarding the prevalence of domestic violence, these cases included individuals of varying backgrounds.

VICTIM GENDER	VICTIM AGE/RACE	RELATIONSHIP TO PERPETRATOR	PFA ACTIVE/ EXPIRED	VICTIM CONTACT WITH SERVICES	VICTIM PRIOR CONTACT WITH POLICE	PERPETRATOR GENDER
Female	29 Caucasian	Wife *	No	No	Yes	Male
Female	34 Black	Mother	No	No	No	Male
Female	36 Caucasian	Wife *	No	No	No	Male
Female	30 Black	Intimate Partner	No	No	No	Male
Female	76 Caucasian	Wife	No	No	No	Male
Female	38 Caucasian	Wife *	Active	Yes	Yes	Male
Male **	42 Caucasian	Brother	No	No	Yes	Male
Male **	64 Black	Intimate Partner	No	No	Yes	Female
Female	61 Caucasian	Wife	No	No	No	Male
Female	63 Caucasian	Wife	No	No	No	Male
Female	28 Black	Partner *	No	No	No	Male
Male	76 Caucasian	Father	No	No	No	Male
Male	66 Black	Husband	No	No	No	Female
Female	35 Caucasian	Wife *	Active	Yes	Yes	Undetermined***
Female	33 Caucasian	Intimate Partner	Not Eligible	Yes	Yes**	Female
2 Male 1 Female	44, 8, 17 Caucasian	None	No	No	No	Male

* Victims in these cases had left the perpetrator or were attempting to leave the perpetrator.
** Victim was reported to have been abusive toward perpetrator.
*** Manner of death (homicide or suicide) undetermined by the Medical Examiner.

C. 2003 REPORT - CASE REVIEWS

This chart contains data on fourteen cases. The deaths reviewed occurred during 1997, 1998, 1999, 2000, and 2002. Not all of the domestic violence deaths that occurred during those years appear in this report. The team alternates between reviewing cases, which occurred several years ago to cases, which occurred several months ago in an effort to handle the backlog of fatalities while remaining current in our system review. Although other fatal incidents have been reviewed, in addition to the fourteen cases included in this report, the Team Findings on those cases are not yet complete; therefore, that data is not included in this report.

Consistent with research regarding the prevalence of domestic violence, the individuals included in this report came from varying backgrounds.

VICTIM GENDER	VICTIM AGE/RACE	VICTIM RELATIONSHIP TO PERPETRATOR	PFA ACTIVE/ EXPIRED	VICTIM CONTACT WITH SERVICES	VICTIM PRIOR CONTACT WITH POLICE	PERPETRATOR GENDER
Female	42 Caucasian	Intimate Partner *	Active	No	Yes	Male **m/s**
Female	47 Caucasian	Wife	No	No	Yes	Male
Male	63 Caucasian	Father-in-law *	No	No	Yes	Male **m/s**
Female	37 Caucasian	Wife *	Active	Yes	Yes	Male **m/s**
Female	45 Caucasian	Self	No	Yes	Yes	Female ****
Female	34 Caucasian	Self	No	Yes	Yes	Female ****
Female	40 Caucasian	Intimate Partner *	No	No	Yes	Male
Male	50 Caucasian	Husband	No	No	No	Female **m/s**
Male	69 Black	Intimate Partner	No	No	No	Female
Male	60 Black	Intimate Partner	No	No	Yes	Female
Female	38 Caucasian	Wife *	No	No	Yes	Male **m/s**
Male **	27 Black	Intimate Partner *	No	No	Yes	Female
Female	62 Caucasian	Wife	No	No	No	Male
Female	63 Caucasian	Mother	No	No	Yes	Male

* Victims in these cases had left the perpetrator or were attempting to leave the perpetrator.
** Victim was reported to have been abusive toward perpetrator.
*** Manner of death (homicide or suicide) undetermined by the Medical Examiner.
**** Suicide only, history of abuse by spouse/partner
m/s Murder/Suicide

D. 2001 and 2003 COMBINED CASE REVIEWS

VICTIM GENDER	VICTIM AGE/RACE	VICTIM RELATIONSHIP TO PERPETRATOR	PFA ACTIVE/ EXPIRED	VICTIM CONTACT WITH SERVICES	VICTIM PRIOR CONTACT WITH POLICE	PERPETRATOR GENDER
Female	42 Caucasian	Intimate Partner *	Active	No	Yes	Male **m/s**
Female	47 Caucasian	Wife	No	No	Yes	Male
Male	63 Caucasian	Father-in-law *	No	No	Yes	Male **m/s**
Female	37 Caucasian	Wife *	Active	Yes	Yes	Male **m/s**
Female	45 Caucasian	Self	No	Yes	Yes	Female ****
Female	34 Caucasian	Self	No	Yes	Yes	Female ****
Female	40 Caucasian	Intimate Partner *	No	No	Yes	Male
Male	50 Caucasian	Husband	No	No	No	Female **m/s**
Male	69 Black	Intimate Partner	No	No	No	Female
Male	60 Black	Intimate Partner	No	No	Yes	Female
Female	38 Caucasian	Wife *	No	No	Yes	Male **m/s**
Male **	27 Black	Intimate Partner *	No	No	Yes	Female
Female	62 Caucasian	Wife	No	No	No	Male
Female	63 Caucasian	Mother	No	No	Yes	Male
Female	29 Caucasian	Wife *	No	No	Yes	Male **m/s**
Female	34 Black	Mother	No	No	No	Male
Female	36 Caucasian	Wife	No	No	No	Male **m/s**
Female	30 Black	Intimate Partner	No	No	No	Male
Female	76 Caucasian	Wife	No	No	No	Male **m/s**
Female	38 Caucasian	Wife *	Active	Yes	Yes	Male **m/s**
Male **	42 Caucasian	Brother	No	No	Yes	Male
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Female	61 Caucasian	Wife	No	No	No	Male **m/s**
Female	63 Caucasian	Wife	No	No	No	Male
Female	28 Black	Partner *	No	No	No	Male **m/s**
Male	76 Caucasian	Father	No	No	No	Male
Male	66 Black	Husband	No	No	No	Female
Female	35 Caucasian	Wife *	Active	Yes	Yes	Undetermined***
Female **	33 Caucasian	Intimate Partner	Not Eligible	Yes	Yes**	Female
2 Male 1 Female	44, 8, 17 Caucasian	None	No	No	No	Male

* Victims in these cases had left the perpetrator or were attempting to leave the perpetrator.
** Victim was reported to have been abusive toward perpetrator.
*** Manner of death (homicide or suicide) undetermined by the Medical Examiner.
**** Suicide only, history of abuse by spouse/partner
m/s Murder/Suicide

E. FINDINGS

The Findings are based on the cumulative data collected from the thirty case reviews completed by the Fatal Incident Review Team over a five-year period. Although additional cases have been reviewed, the Team Findings in those cases are not yet complete; therefore that data is not included in this report. As the work of the Review Team continues, our database expands and we can begin to identify trends and patterns that are specific to domestic violence fatalities. The Findings below are helpful in identifying certain patterns of behavior and in revealing strengths and weaknesses in our response system.

Nine of the eleven murder suicide cases (82%) occurred when the victim had left or was attempting to leave the abusive relationship.

Of the thirty fatal incidents reviewed for this report, eleven of the cases were the result of murder/suicides, where the perpetrators killed their partners and then killed themselves. Upon comparison of the data gathered from the murder/suicide cases, it was noted that the majority (82%) of victims in those cases had recently left or were in the process of leaving their abusive partner. Research in the area of intimate partner violence has long since identified the period of time when the victim leaves or attempts to leave an abusive relationship as one of high risk. Analysis of the thirty cases included in this report proves consistent with that data. However, review of the Delaware data reveals a high correlation between the number of murder/suicides and the number of victims who, while attempting to leave, died as a result of murder/suicide, further indicating an increased risk for murder/suicide, during the period of time when a victim leaves or attempts to leave an abusive relationship.

Six of the thirty victims (20%) had contact with victim services.

Lack of contact between domestic violence victims and victim service providers continues to be a finding of the Review Team. While the data showed a significant increase in the percentage of victim contacts with law enforcement between the 2001 Report (38%) and the 2003 Report (79%), the rate of contact between victims and victim services remained low.

According to the 2001 Report, 19% of the domestic violence fatality victims had prior contact with victim services. That percentage increased only slightly to 21%, based on the 2003 Report. Of the thirty fatality cases reviewed, only six of the victims (20%) had known contact with victim services and only four of those victims had Protection From Abuse Orders. In a few of the cases, we learned that family and friends feared for the victim's safety and had urged the victims to call police and to take steps to protect themselves. In those cases, it appears that family and friends were attempting to engage the victim in basic safety planning. However, according to the data collected from the cases in this report, victims often did not access services.

In other cases, family members indicated they were aware of conflict between the parties but they did not consider verbal arguments abusive, or they believed the physical abuse to be a one-time event. In twenty of the thirty cases reviewed (67%), there was a known history of abuse between the victim and perpetrator. Yet, the vast majority of victims did not access the victim resources available in the community. The reasons for the lack of contact between victims and victim services are usually unknown. However, based on the information gathered from the case reviews, we do know that most of the victims did not access the domestic violence hotlines, shelters, or advocacy programs available to assist them. While the increased contact between domestic violence victims and law enforcement is a positive trend, it is only a part of the coordinated response necessary to assist victims of domestic violence in safely ending the abuse. Efforts should be undertaken to increase contact between victims and service providers so victims may be informed of the full range of options and services available to assist them in safely ending the abuse.

In eleven of the thirty cases (37%), the decedents were survived by minor children.

Increased focus is being placed on the child survivors of fatalities, who lose one or both parents as a result of domestic violence. Law enforcement provides the initial response and notifies the Division of Family Services of domestic violence cases involving children. Often family and friends step in to provide immediate assistance, and the Courts handle matters of custody and

guardianship. While the system provides for the basic welfare of children in these tragic cases, there is a sub-category of child survivors who present very special needs, the child witness. Of the thirty fatal incidents reviewed for this report, children were witnesses in six of the cases, either seeing a parent killed or discovering the parent's body.

The impact of witnessing such a horrific event is not always immediately evident; however, children who witness the killing of one or both of their parents by another parent or partner are in need of mental health evaluation and treatment services. Unfortunately, it was the finding of the review team that the majority of child witnesses did not receive counseling services.

Family members who find themselves thrust in the role of guardian following a fatality are also dealing with trauma. Despite their good intentions, the caregivers may be overwhelmed by the circumstances and, therefore, may not be equipped to recognize the effects of the event on the child. The Courts and the Division of Family Services made recommendations in several cases for child witnesses to receive counseling; however, they were recommendations, not court orders.

Agencies such as the Violent Crimes Compensation Board and the Division of Family Services can serve as potential funding sources for children's counseling services. However, in the absence of allegations that the lack of counseling constitutes harm, abuse or neglect, it seems there is no authority for agencies such as the Division of Family Services or Family Court to require counseling services for child witnesses to fatalities.

F. 2001 RECOMMENDATIONS

Recommendations were made in twelve of the sixteen cases reviewed for the first report and are listed by agency or discipline. Recommendations implemented appear in bold print underneath the corresponding recommendation. This section has been updated to reflect responses received since the October 2001 publication date.

DIVISION OF FAMLY SERVICES

DFS should have access to criminal information so they can review the criminal history of families under investigation. This is critical to their ability to prioritize and respond to complaints received.

The Child Abuse Prevention Act of 1997 (16 Del.C 906(6)) gave DFS the authority to conduct criminal background checks on all adults in the home. In 1998 DFS implemented policy that requires a search of DELJIS (Delaware Criminal Justice Information System) at specified times throughout the continuum of services (Intake, Investigation and Treatment).

There is a need for increased services for children living in violent homes. Children should be made aware that there are people they can talk to about the abuse they are witnessing in their homes and that they are not the only ones living with that problem.

In January 2001, a new interagency Children and Domestic Violence work group was created to develop recommendations for meeting the needs of children living in violent homes, whether they are active with DFS or not.

LAW ENFORCEMENT

Additional means of communication need to be developed to provide law enforcement with information regarding complaints received by DFS and to include victim services information in the loop.

In an effort to improve services to children and families and establish guidelines for collaboration and communication, the

Department of Services for Children, Youth and Their Families, Delaware Police Departments and the Department of Justice created a Memorandum of Understanding. The original memorandum of understanding was adopted in 1989 and has been revised as recently as November 1998.

Law Enforcement personnel should receive training on working with victims with substance abuse problems.
Police recruits receive domestic violence training during which the subject of substance abuse problems by the victims and abusers is discussed. The Delaware State Police have included training on the subject of substance abuse problems to recruits and twice a year at in-service training, since 1991.

Law Enforcement agencies should track repeated domestic violence households and treat them as high-risk situations.
Law Enforcement Officers are required to make a DELJIS inquiry to determine if the parties have had prior police contact in domestic related complaints. Several of the large departments in the state have separate domestic violence units where domestic incident reports are referred for evaluation and risk assessment. On-line information concerning past domestic related incidents have been available to police officers in the field since approximately 1996.

Officers suspecting domestic violence should provide victims with referrals to domestic violence services/agencies.
Under the Victim's Bill of Rights, each victim of domestic violence is provided with a copy of the police incident report which lists those services/agencies that are available in Delaware for assistance. Law enforcement agencies in Delaware utilize a separate Domestic Incident Report with information on services available.

Officers should continue to carry and distribute wallet-sized cards containing telephone numbers of victim services organizations in cases where domestic violence is indicated.
Law Enforcement Officers throughout Delaware distribute wallet-

sized referral cards listing domestic violence services. Officers have been using the wallet size resource cards since 1997.

Officers should utilize domestic incident reports whenever responding to a domestic complaint to track the history of domestic violence incidents and increase the opportunity for early identification of high-risk cases.
Law Enforcement Officers throughout Delaware, currently use the Uniform Domestic Incident Report developed by the DVCC Law Enforcement Subcommittee for reporting all domestic related crimes, criminal and non-criminal.

Law Enforcement officers should be made aware of the services offered by Adult Protective Services so that appropriate referrals can be made.
Officers are informed of the services available with Adult Protective Services during Recruit and in-service training.

A letter of notice should be sent to the Chief of the law enforcement agency involved regarding the concerns of the victim's relative about police activity in the case.
A letter outlining the concerns was sent from the Review Team Co-chairs to the appropriate law enforcement agency and a response was received.

FAMILY COURT

Family Court is urged to re-issue the policy regarding inclusion of gun relinquishment in PFA orders to clarify that the policy applies to consent orders as well as to orders issued pursuant to a finding.
February 1, 1999, Administrative Directive 99. 01 was issued that directed in part 1. Judicial officers entering any Protection From Abuse order, whether entered by default, consent or after a hearing shall obtain information on the respondent's possession of or access to firearms.

Family Court is urged to develop a policy regarding inclusion of visitation exchange conditions in PFA orders. The policy may state that

petitioners should be asked specifically about the inclusion of this important provision to ensure petitioners are aware the relief is available and that many problems occur during the exchange of children during domestic violence cases.

The statutory change in Title 10 section 1045 of the Delaware Code clarifies visitation center information.

Visitation center information should be disseminated in the courts, to judicial officers, and to members of the Bar.

Visitation Center information is given to judicial officers by Family Court.

Family Court's fast track policy for domestic violence cases helps to ensure that these volatile cases can be resolved as soon as possible, reducing the time available for escalation to occur. The Court is urged to comply with the fast track policy for domestic violence cases.

September 23, 1999, Administrative Directive 99. 07 was issued regarding speedy trial guidelines, which require that domestic violence cases be scheduled on an expedited basis. Total time from initial appearance to Trial is to be 28 days.

Family Court staff should be trained to identify domestic violence cases and makes appropriate referrals.

October 1994, Family Court staff statewide attended one day training on domestic violence sponsored by the Domestic Violence Coordinating Council, and in October 1997 Family Court staff statewide attended one day training on domestic violence sponsored by the Administrative Office of the Courts.

The language in PFA Orders should be changed to domestic violence treatment not anger management and the PFA language should be consistent throughout the state.

On June 8, 2000, modifications were made to the PFA automated order, incorporating the language "domestic violence treatment." Continued instances where anger management was written into the order prompted training that was completed during August 2000.

All courts should be encouraged to develop policies for referring domestic violence perpetrators for treatment programs and victims for services. Courts should routinely make referrals for substance abuse evaluation and treatment in cases where drugs and alcohol are a factor.

All courts should review their sentencing guidelines for domestic violence cases.

All court personnel should receive training on working with victims with substance abuse problems.

A Committee should be formed to review bail guidelines for domestic violence offenses. In particular, bail for violent misdemeanors, the category that most domestic violence offenses fall within, should be reviewed in light of information regarding domestic violence dynamics.

JUSTICE OF THE PEACE COURT

All courts should review their sentencing guidelines for domestic violence cases.
This issue would be more appropriately considered by SENTAC, rather than by individual courts. The JP Court does not have separate sentencing guidelines.

All courts should be encouraged to develop policies for referring domestic violence perpetrators for treatment and victims for services. Courts should routinely make referrals for substance abuse evaluation in cases where drugs and alcohol are a factor.
The Justice of the Peace Court worked with Family Court by hosting a program which placed a social worker in one of their 24-hour Court locations to evaluate defendants, assess risk factors, make bail recommendations/suggest conditions of release, and work with victims at the stage of presentment. The Court encouraged Justices of the Peace statewide to use the services of the social worker, who was available to be helpful

long-distance via telephone and videophone to the other JP Court locations. This worker made immediate referrals for both the defendants and victims. Victims were given PFA forms, referrals to shelters and/or counseling. Defendants were also given referrals for treatment immediately if they were interested. (Unfortunately, the funding period for this program has expired; the project has since ended.)

Most domestic violence cases come under the jurisdiction of Family Court. While the Justice of the Peace Court sees these defendants at presentment (when the case has just been initiated and bail/conditions of release are about to be set), these cases are transferred immediately to the appropriate Court. Those misdemeanor cases over which Family Court has no jurisdiction (for instance, co-habiting same-sex partners, or co-habiting opposite-sex partners who have no children under 18 years of age living with them) generally come under the concurrent jurisdiction of Court of Common Pleas and Justice of the Peace Court. Should the defendant elect to have his/her case heard in the Justice of the Peace Court, judges include, as part of their sentence, a requirement that the defendant undergo evaluation and subsequent treatment/counseling as recommended by the evaluator when the defendant is placed on probation.

The Justice of the Peace Court judges do not have access to staff, such as pre-sentence or pre-trial officers, social workers, etc., who might assist in identification of appropriate defendants to refer to substance abuse/psychological/violent behavior counseling. The exception to this is Court 20 in Wilmington. This Court currently has a pilot program which staffs the Court five days a week during the daytime hours with a deputy attorney general and an assistance public defender who routinely make recommendations to the Court for defendants to be evaluated and to subsequently participate in drug or alcohol rehab/counseling or anger management (as appropriate).

A committee should be formed to review bail guidelines for domestic violence offenses. In particular, bail for violent misdemeanors, the category that most domestic violence offenses fall within, should be reviewed in light of information regarding domestic violence dynamics.

Justice of the Peace Court has agreed to work with Family Court on review of bail guidelines for domestic violence offenses.

The committee should also consider whether magistrates making bail decisions should have access to the domestic violence risk assessment completed by law enforcement.

Justice of the Peace Court Judges are encouraged to work with Family Court's Domestic Violence Specialist located in Justice of the Peace Court # 3. Judges statewide can connect via videophone with the DV Specialist, who will make recommendations to the Court regarding bail and conditions of bail.

COURT OF COMMON PLEAS

A committee should be formed to review current bail guidelines in domestic violence cases. In particular, bail for violent misdemeanors, the category which most domestic violence offenses fall within, should be considered in light of information regarding domestic violence dynamics.

The Court of Common Pleas bail guidelines for domestic violence cases, are consistent with the SENTAC Guidelines and the other courts' bail guidelines. Appendix III

The Court of Common Pleas Chief Judge should be contacted to request information regarding CCP's policies and procedures for referring domestic violence perpetrators to treatment programs and victim's for services. In cases where substance abuse is involved the courts should consistently make referrals for evaluation and treatment.

The judges have adopted a policy to order domestic violence counseling or anger control management treatment as appropriate under the particular facts of the case.

SUPERIOR COURT

Training for court personnel on working with victims with substance abuse problems.

Each year, officers from the Investigative Services Offices of Superior Court attend the annual domestic violence conference sponsored by the Criminal Justice Council.

All courts should be encouraged to develop policies for referring domestic violence perpetrators for treatment programs and victims for services.

When Superior Court has been notified by the Department of Justice or by the Investigative Services Office that a case involves domestic violence, the Court's standard practice is to recommend that the offender undergo appropriate treatment for domestic violence and related issues as determined by the Department of Correction, both at Level V and continuing when the offender is released to the community. It is also the Court's standard practice to rely upon the Victims' Services Unit of the Department of Justice to ensure that the needs of the victims of domestic violence are being met. In those cases involving a Presentence Investigation, it is standard practice to inquire about the victim's present status and needs and to report them to the Court. If there is an immediate need that needs to be addressed, the victim is referred to the Victims' Services Unit of the Department of Justice.

Courts should routinely make referrals for substance abuse evaluation and treatment in cases where drugs and alcohol are a factor.

Superior Court in Delaware was one of the pioneers of the Drug Court Program and Delaware is one of the first states in the country with a statewide Drug Court. Referral for substance abuse evaluation and treatment is one of the basic components of this program.

VICTIM SERVICES

Victim's service agencies should develop Visitation Safety Plan Brochures.

Victim services staff and volunteers should educate victims about the opportunity to make phone records confidential or to otherwise restrict access to these records.

Victim services staff and volunteers should become more aware of domestic violence among elderly couples.
In 1995, the Delaware Center for Justice implemented Project Target, a program that provides services to female victims of domestic violence aged 50 and over. Additionally, the Delaware Coalition Against Domestic Violence has provided training on the topic of older victims of domestic violence.

Victim services staff and volunteers should become familiar with the services offered by Adult Protective Services so that appropriate referrals can be made.
In 1995, the Delaware Center for Justice implemented Project Target, a program that provides services to female victims of domestic violence aged 50 and over.

Hotline workers and mobile crisis staff should be trained about the dynamics of domestic violence and the danger to the victim when the perpetrator/partner is threatening suicide.

OFFICE OF THE ATTORNEY GENERAL

Attorney General's office should establish a policy that when a nolle prosequi is entered, the reasons for the decision to not go forward with the case be stated in the case documentation.
Since 1983, the Attorney General's office has required Prosecutors to document the reason(s) for a nolle prosequi. That policy was reiterated in a memorandum dated December 27, 2000, from the State Prosecutor to all Deputy Attorneys General.

Attorney General's office should review its no drop policy in domestic violence cases as well as the policy's implementation.
The "no drop" policy in domestic violence cases has been in effect since 1992. This policy states that a case shall not be nolle prossed solely because the victim requests that the charges be dropped.

Attorney General's Office should oppose delayed reporting for incarceration (sometimes granted so a perpetrator can get their affairs in order) in any case.
The Attorney General's office does not recommend delayed reporting for incarceration in any Domestic violence case. That issue is more likely to present itself in Driving Under the Influence and other motor vehicle offenses where the defendant is facing a mandatory sentence and is not incarcerated at the time of sentencing.

Attorney General's office should practice victimless prosecution of domestic violence cases, as victims' unwillingness to participate in prosecution is a common dynamic in domestic violence cases.
The Domestic Violence Unit has supported victimless prosecution since the creation of the unit in 1992.

Prosecutors in the Attorney General's office are encouraged to work with members of the advocacy community.
This recommendation has been previously addressed by the Domestic Violence Unit and is currently being implemented.

DELAWARE BAR ASSOCIATION

Attorneys, particularly those practicing family law, should be provided more education about domestic violence to assist them in identifying domestic violence cases, making appropriate referrals, identifying the level of risk and possibly assisting victims with safety planning.

The Family Law Section of the Delaware State Bar Association included presentations on domestic violence as part of their Fundamentals of Family Law Seminar. Additionally, the president of the DSBA wrote a series of articles on the issue of domestic violence, which appeared in *IN RE*:, the Journal of the State Bar Association.

Visitation Center information should be disseminated in the courts, to judicial officers and to members of the Bar. An article describing the Visitation Centers should appear in the Bar Association's Journal.

An article on Visitation Centers in Delaware appeared in the March 2003 edition of *IN RE*:, the Journal of the Delaware State Bar Association.

Efforts should be made to publicize all domestic violence resources to members of the Bar and to provide them with risk assessments, safety plan information, and referral information.

The president of the Delaware State Bar Association has asked all law firms in the state to make available in their waiting rooms or lobbies copies of the Safety Plan Brochure developed by the Domestic Violence Coordinating Council. DSBA mailed copies of the Safety Plan Brochure to law firms throughout the State.

DELAWARE HEALTH AND SOCIAL SERVICES

The State Division of Adult Mental Health should research other states' practices to identify how they deal with children where the custodial parent has significant mental illness and develop policy for the monitoring and assessment of children whose custodial parent has significant mental illness.

In 1999 a Memorandum of Agreement was developed between Delaware Health and Social Services and the Department of Services to Children Youth and Their Families to ensure that families that are involved with the Division of Family Services and have a substance abuse and/or a mental health problem are given priority for assessment and treatment from the Division of Substance Abuse and Mental Health. Additionally, staff of the Community Mental Health Clinics and staff in mental health contract agencies constantly assess the risks posed by their clients to themselves and others including dependant children.

PROBATION AND PAROLE

Probation officers should be given further access to online criminal justice information to help them monitor their probationers.

Since 1998, all Probation Officers have been trained and had access to all available DELJIS, domestic violence related screens.

Probation officers should follow-up with treatment providers to monitor probationer's compliance with court ordered treatment.

Procedure 7.3 (last updated April 4, 2000) requires; Officers will also supervise offenders where the court has previously ordered treatment with specific providers. Officers are required to contact these agencies to determine if a Release of Information form is necessary to verify attendance and offender progress in treatment.

DEPARTMENT OF EDUCATION

DVCC should meet with the Secretary of Education to discuss the critical role of schools in responding to children whose parents are in violent relationships. Plans should be made to provide in service training for teachers, possibly using DVCC Law Enforcement Training funds.
The Department of Services for Children, Youth and Their Families is currently charged with providing annual in-service education to all teachers on child abuse. Information regarding domestic violence can become a component of that training.

Information should be provided to schools to assist them in establishing policies for responding when students disclose that their parents are in a violent relationship.
Specific in-service training can be provided for school counselors, social workers, school psychologists and school nurses who are the personnel who work most closely with students in difficult situations. The State Board of Education has no authority either legal or regulatory over private school regulations and therefore recommend contact with the Delaware Association of Christian Schools, the Delaware Association of Independent Schools and Wilmington Diocese.

PRIVATE SCHOOLS

Information should be provided to schools to assist them in establishing policies for responding when students disclose that their parents are in violent relationships.

MEDICAL COMMUNITY

The Team recommends that a letter be sent to the Board of Medical Practice informing them of the allegations of sexual misconduct against a treating psychiatrist.
The complaint was assigned to the Board of Medical Practice and was investigated.

Education should be provided for health care providers about their responsibility to notify police of any potential crimes or threats of crimes (Duty to Warn).

The medical community should take a proactive role in helping families of terminally ill patients get support in dealing with the physical and emotional stress of the situation. Possibly they could offer, as a standard of care, to terminally ill patients and their families, pre-counseling and post-counseling. Steps should be taken to increase the level of awareness of family members to the dangerous potential of incidence of "mercy killing" and "assisted-suicide".

MENTAL HEALTH

Therapists should receive training about the dynamics of domestic violence, including the recognition that a perpetrator who appears to be suicidal is likely to be capable of harming someone else as well.

Therapists should be provided with information on their responsibility to notify police of any potential crimes or threats of crimes, when a duty to warn may arise and how to provide such a warning.

Therapists should be provided with risk assessments, safety plan information, and referral information.

Mobile Crisis workers should receive training on the dynamics of domestic violence and the danger to the victim when a partner is threatening suicide.

Delaware's Adult Mobile Crisis Intervention Unit has staff trained and awaiting certification as Domestic Violence Specialist. MCIS staff work closely with State, County and local law enforcement agencies in screening perpetrators and victims of domestic violence who may voice suicidal or homicidal ideations and train with local hostage negotiation teams to deal with situations that may rise to the level of extreme violence.

GENERAL ASSEMBLY

Legislation should be enacted to provide relief (similar to that in the Protection From Abuse Order) for individuals in relationships not covered by the PFA.

PUBLIC AWARENESS

Ongoing public education should be provided on the danger and dynamics of abusive relationships with emphasis on the resources, which are available to assist victims in safely ending the violence. **Copies of the Domestic Violence Coordinating Council Safety Plan Brochure were distributed to 36,000 State Employees with their paycheck during Domestic Violence Awareness Month in October 2002.**

Greater efforts are needed to publicize domestic violence resources statewide.
The Domestic Violence Coordinating Council and the Delaware Coalition Against Domestic Violence provide ongoing training on domestic violence issues and available statewide resources.
Agencies should develop public service announcements and begin a statewide education campaign.

The Public should be educated to the fact that suicide threats by an individual may be an indicator that the individual's partner may be in danger as well.

The Public should be educated about the existence of abuse in elderly people and why it is even more difficult to detect than domestic violence in younger couples.

Campaigns to increase understanding of the dynamics of domestic violence must be developed for the general public.

The Domestic Violence Coordinating Council conducted a Media Blitz in November of 2002, urging victims of domestic violence to access services available in the community and to develop plans for their own safety. The news alert received television, radio, and newspaper coverage and copies of the Safety Plan Brochure and Victim Resource Card were printed in several of the newspaper articles.

EMPLOYERS/WORKPLACE

Employers should receive information on how to make the workplace a safer place for victims, including providing victims with referral information.

In May of 2000, Delaware was one of fourteen states selected by the Family Violence Prevention Funds to participate in the development of a national strategy to address domestic violence in the workplace.

Under the direction of the Attorney General's Office, the Corporate Citizen Initiative team was formed with representatives from businesses, law enforcement, organized labor, private and public employers and non-profit agencies. The CCI team plans to present their Model Policy in the Fall 2001.

Governor Ruth Ann Minner in collaboration with the Domestic Violence Coordinating Council, sponsored a training for Cabinet Members, Agency Director's and Policy Advisor's on domestic violence. The four hour training provided information on the dynamics of domestic violence and an overview of Delaware's Coordinated Community Response including Delaware statues, statistics and community resources. The training also included a presentation by Diane M. Stuart, Director of the Federal Violence Against Women Office.

F. 2003 RECOMMENDATIONS

Recommendations were made in eleven of the fourteen cases reviewed and are listed below by agency or discipline. The responses to the 2001 Report recommendations were excellent. We thank the participating agencies for their thoughtful consideration of the recommendations and for their cooperation in responding to them.

The 2003 recommendations are appearing for the first time. The Domestic Violence Coordinating Council staff will notify the relevant agencies of the new recommendations. Approximately one year after the date of publication, staff will again contact the agencies and report on implementation in the next Fatal Incident Review Team Report.

DIVISION OF FAMILY SERVICES (DFS)

It is recommended that the DFS adhere to their policy to interview all family members separately.

The DFS should include screening questions on domestic violence in all of their investigations.

The DFS should work with representatives of the Advocacy Community in developing a protocol for responding to domestic violence cases.

LAW ENFORCEMENT

All law enforcement agencies in Delaware should require officers to sign warrants in misdemeanor domestic violence cases, so victims are not responsible for signing warrants.

Law Enforcement Officers should be trained to run prior complaint histories in all domestic incident cases involving an arrest or prior criminal history.

Law Enforcement Officers should make a referral to victim services in all cases where there is an arrest.

DELAWARE POLICE CHIEF'S COUNCIL

It is recommended the Delaware Police Chief's Council develop a "Hotline" or "Tipline" for members of the public to report individuals with a large number of guns and/or ammunition.

FAMILY COURT

Family Court should revise their Intake Form to include an additional address for Location Where the Respondent Can Be Served. This should be in addition to the respondent's home address and place of employment.

In cases involving a criminal violation (any Class A Misdemeanor) of a Protection From Abuse Order, the defendant should be ordered immediately to Family Court Pre-Trial Services.

SUPREME COURT

Members of the Domestic Violence Fatal Incident Review Team have a significant concern that the present Delaware Supreme Court Rules of Evidence 404 and 609 do not recognize the dynamics of domestic violence (the pattern of abusive behavior inherent in violent relationships) by excluding prior history from domestic violence cases. The Review Team recommends that the Delaware Supreme Court adopt the Federal Rules of Evidence regarding prior history in domestic violence and sexual assault cases.

The Delaware Supreme Court should adopt the Federal Rules of Evidence 413, 414, and 415 regarding allowing prior history in domestic violence and sexual assault cases.

VICTIM SERVICES

For all victim service programs, police-based and private: Custodians should be given written information regarding the availability of counseling services for all minor (children) survivors.

OFFICE OF THE CHILD ADVOCATE

The Office of the Child Advocate should monitor the provision of mental health evaluation and treatment services for child witnesses to homicide and suicide.

DEPARTMENT OF CORRECTION

Probation Officers should make periodic home visits during evening and night hours in Level III probation cases.

Probation and Parole should continue to review the criteria used in assigning domestic violence cases.

DOMESTIC VIOLENCE COORDINATING COUNCIL (DVCC)

The DVCC should work to ensure that child witnesses to homicide and suicide be classified as victims so as to be eligible for funding from the Violent Crimes Compensation Board for mental health treatment services.

DVCC staff should work with the Division of Family Services on providing a domestic violence component to the annual DFS school training.

The DVCC Legislative Subcommittee should look into removing the requirement "knowingly" found in Title 11, Sec. 1454, of the Delaware Code dealing with giving a firearm to a person prohibited.

The DVCC should follow through with the work of the Bail Review Committee currently under way.

The DVCC should provide domestic violence training for military Commanders and First Sergeants.

The DVCC should send a letter to the State Board of Education regarding mandatory training on domestic violence for educators.

The DVCC and Delaware Coalition Against Domestic Violence should include "Things to Do For Children" and referral information in the Safety Plan.

DOMESTIC VIOLENCE FATAL INCIDENT REVIEW TEAM (FIRT)

Team members should review jury instructions for Extreme Emotional Distress (E.E.D.) and the proposed legislation on use of the E.E.D. defense.

DELAWARE COALITION AGAINST DOMESTIC VIOLENCE (DCADV)

The DCADV should develop an education campaign targeting school-age students to report domestic violence when they see it.

It is recommended that the Delaware Coalition Against Domestic Violence provide training for advocates on professional, responsible behavior.

The DVCC and DCADV should include "Things to Do For Children" and referral information in the Safety Plan.

G. IMPLEMENTING THE CHANGES

The Domestic Violence Coordinating Council is responsible for notifying agencies of the recommendations resulting from the work of the Review Team. Each agency/discipline included in the 2003 Recommendations will receive a copy of the Fatal Incident Review Team Report. The DVCC shall work where possible with state agencies and private organizations to help implement recommendations of the Team.

The Coordinating Council staff will contact the agencies receiving recommendations within one year of publication of the report to follow up on the implementation of Team recommendations. Information regarding the status of Review Team Recommendations will be included in the next report.

The implemented Recommendations listed in this Report are the result of successful collaboration among state and local government, non-profit organizations and the private sector. While our efforts have proven successful in improving Delaware's response to domestic violence, prevention of domestic violence remains the ultimate goal.

H. REVIEW PROCESS COMMENTS

The Review Team has determined that, as a general rule, it will not call family members as witnesses. Exceptions may be made if the Team feels it is necessary and appropriate in a particular case. If a family member is to be called as a witness, someone who has already contacted the family, such as victim services, will be asked to make the initial contact. If a family member agrees to attend the review, the victim service provider will be invited to attend with the family member.

APPENDIX I

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DELAWARE CODE ANNOTATED

*****CURRENT THROUGH DECEMBER 2001*****
***** (2001 REGULAR SESSION OF THE 141ST GENERAL ASSEMBLY)*****
*****ANNOTATIONS CURRENT THROUGH APRIL 2002*****

TITLE 13. DOMESTIC RELATIONS

CHAPTER 21. DOMESTIC VIOLENCE COORDINATING COUNCIL
Go to Code Archive Directory For This Jurisdiction

13 Del. C. § 2105 (2001)

§ 2105. Fatal incident reviews.

(a) The Council shall have the power to investigate and review, through a Review Team, the facts and circumstances of all deaths that occur in Delaware as a result of domestic violence. This review shall include both homicides and suicides resulting from domestic violence. The review of deaths involving criminal investigations will be delayed for a least 6 months, and will under no circumstances begin until authorized by the Attorney General's office. Any case involving the death of a minor (any child under the age of 18) related to domestic violence will be reviewed jointly by the appropriate regional Team of the Child Death Review Commission and the domestic violence Fatal Incident Review Team. The death of a minor will only be reviewed by the domestic violence Fatal Incident Review Team where the minor's

parents or guardians were involved in an abusive relationship and the minor's death is directly related to that abuse.

(b) There shall be a Fatal Incident Review Team that will be co-chaired by 2 members of the Coordinating Council to be elected by the Council. In addition to the co-chairs, the Review Team shall consist of 6 other core members: the Attorney General or his or her designee, the Director of the Division of Family Services or his or her designee, the chair of the Domestic Violence Task Force or his or her designee, the Chief Judge of the Family Court or his or her designee, the Chief Magistrate of the Justice of the Peace Courts or his or her designee and a law enforcement officer to be appointed by the Delaware Chiefs of Police Council. All members of the Review Team, plus other individuals invited to participate, shall be considered part of the Review Team for a particular case or incident. The Review Team shall invite other law enforcement personnel to serve and participate as full members of a Review Team in any case in which a law enforcement agency has investigated the death under review or any prior domestic violence incident involving the decedent. The Review Team may also invite other relevant persons to serve on an ad-hoc basis and participate as full members of the Review Team for a particular review. Such persons may include, but are not limited to, individuals with particular expertise that would be helpful to the Review Team, representatives from those organizations or agencies that had contact with or provided services to the individual prior to his or her death, that individual's abusive partner or family member and/or the alleged perpetrator of the death.

(c) A Review Team shall be convened by the co-chairs of the Review Team on an as-needed basis and may also be convened by any 2 other members of the Review Team.

(d) As part of any review, a Review Team shall have the power and authority to administer oaths and to compel the attendance of witnesses whose testimony is related to the death under review and the production of records related to the death under review by filing a praecipe for a subpoena, through the office of the Attorney General, with the Prothonotary of any County of this State. Such a subpoena will be effective throughout the State and service of such subpoena will be

made by any sheriff. Failure to obey such a subpoena will be punishable according to the Rules of the Superior Court.

(e) Each Review Team shall prepare a report, to be maintained by the Review Team, including a description of the incident reviewed, and the findings and recommendations of the Review Team.

(f) Findings and recommendations by the Team shall be adopted only upon a 60 percent vote of participating members of the Review Team.

(g) The Review Team shall establish rules and procedures to govern each review prior to the first review to be conducted. The Review Team shall issue an annual report to the Domestic Violence Coordinating Council summarizing in an aggregate fashion all findings and recommendations made over the year by each Review Team and describing any systemic changes that were effectuated as a result of the Teams" work. The report shall not identify the specific case or case review that led to such findings and recommendations.

(h) The review process, and any records created therein, shall be exempt from the provisions of the Freedom of Information Act in Chapter 100 of Title 29. The records of any such review, including all original documents and documents produced in the review process with regard to the facts and circumstances of each death, shall be confidential, shall be used by the Coordinating Council only in the exercise of its proper function and shall not be disclosed. The records and proceedings shall not be available through court subpoena and shall not be subject to discovery. No person who participated in the review nor any member of the Domestic Violence Coordinating Council shall be required to make any statement as to what transpired during the review or information collected during the review. Statistical data and recommendations based on the reviews, however, may be released by the Coordinating Council at its discretion.

(i) Members of the Domestic Violence Coordinating Council, members of the Review Team and members of each Review Team, as well as their agents or employees, shall be immune from claims and shall not be subject to any suits, liability, damages or any other recourse, civil or criminal, arising from any act, proceeding, decision or determination undertaken or performed or recommendation made, provided such persons acted in good faith and without malice in

carrying out their responsibilities; good faith is presumed until proven otherwise, with the complainant bearing the burden of proving malice or a lack of good faith. No organization, institution or person furnishing information, data, testimony, reports or records to the Review Teams or the Coordinating Council as part of such an investigation shall, by reason of furnishing such information, be liable in damages or subject to any other recourse, civil or criminal. *(70 Del. Laws, c. 409, § 1.)*

APPENDIX II

CONFIDENTIALITY AGREEMENT
FOR DELAWARE'S
DOMESTIC VIOLENCE FATAL INCIDENT REVIEW TEAM

The purpose of the domestic violence fatality review process is to conduct a complete assessment of domestic violence fatal incidents. In order to assure an assessment that fully addresses all systemic concerns surrounding domestic violence fatality cases, Team members must have access to all existing records on the victim and/or perpetrator. These records include public health records, court documents, law enforcement records, mental health records, hospital or medical related data, and any other information that may have a bearing on the involved victim or perpetrator. The confidentiality of specific case information is required by statute. With the purpose of this review in mind, we the undersigned agree that all information secured in this review will remain confidential and will not be used for purposes outside the purview of the review process.

Parties to Team Review #_____

Date(s) of Review:_____

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