DELAWARE FATAL INCIDENT REVIEW TEAM REPORT

Submitted To

The Domestic Violence Coordinating Council

June 30, 2004

Domestic Violence Coordinating Council
New Castle County Courthouse
500 N. King Street, Suite 9425
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INTRODUCTION

The year 2002 saw a significant increase in domestic violence fatalities. Nineteen people died as a result of domestic violence in Delaware that year. Tragically, children witnessed the murder of their mothers in three of those cases. During 2003, the number of domestic violence related deaths in Delaware decreased to seven. Although the reduction in fatalities was significant, domestic violence deaths should be considered per se as avoidable and the circumstances of every fatal incident should be thoroughly examined.

While resources for victims of abuse have increased significantly, both locally and nationally, domestic violence continues to be a devastating problem; and the deaths resulting from that 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 resulting from domestic violence in Delaware. This report contains cumulative data resulting from the review of forty fatal incidents which occurred between 1996 and 2002. Not all of the fatal incident cases that occurred during that time appear in this report. 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 remaining current in our system analysis.

During the four year period January 1, 2000 through December 31, 2003, our records indicate that fifty people died as a result of domestic violence in Delaware. This number represents both homicides and suicides and includes those cases where the perpetrator killed the victim and then committed suicide.

Domestic violence victims are young and old, rich and poor, women and men, married and single. They are members of different races and religions, and while their situations varied, most of the victims included in this report died at the hands of people who loved them. Sadly many victims left behind young families and, in several cases, children lost both parents as a result of domestic violence.

Fatal incident reviews are difficult work. Meeting monthly to investigate the facts and circumstances surrounding these tragic deaths is emotionally taxing. Collecting data, tracking cases, scheduling witnesses and securing agency files, are all time consuming tasks that are necessary components of a successful review. However, the real work of the Team is in coming together openly and honestly to ask tough questions of the agencies, to consider what the system could do better, and to use that information to formulate meaningful recommendations aimed at improving the system.

The individuals who come together to participate in the fatality review process represent different segments of the system, and, with that, bring different perspectives on the appropriate response to 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.

REVIEW TEAM MEMBERS & PARTICIPANTS

Co-Chairs
Cynthia M. Boehmer, Director, Families in Transition Women's Shelter
Honorable Vincent J. Poppiti, Domestic Violence Coordinating Council

Members and Participants
Honorable M. Jane Brady, Attorney General
Honorable Cari M. De Santis, Secretary, Department of Services for Children, Youth and Their Families
Mary Davis, Chair, Domestic Violence Task Force
Honorable Chandlee Johnson Kuhn, Chief Judge Family Court
Honorable Patricia Griffin, Chief Magistrate Justice of the Peace Courts
Diane Coffey Walsh, Attorney General's Office
Donald Roberts, Attorney General's Office
Marsha Epstein, Attorney General's Office
Cindy Mercer, Child Inc., Domestic Violence Shelter
Mark Daniels, Delaware State Police
Debbie Reed, Delaware State Police, Victim Services
*John Evan*s, Delaware State Police
Harry Downes, Delaware State Police
Gerald Donovan, New Castle County Police Department
Mary Devine, New Castle County Police Department
Mike Kelly, New Castle County Police Department
Renee Taschner, New Castle County Police Department
Alan Grinstead, Probation and Parole
Joseph Paesani, Department of Correction
Linda Shannon, Division of Family Services
Shirley Roberts, Division of Family Services
Leann Summa, Family Court
De Sales Haley, Family Court
Nicole Kennedy, Family Court
Anna Lewis, Justice of the Peace Courts
Tania Culley, Office of the Child Advocate

Staff
Bridget V. Poulle, Domestic Violence Coordinating Council

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.

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.

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 Police Chief's 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 also invites 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 include but are not limited to attorneys, 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, case workers, and representatives from other relevant agencies.

STATUTORY AUTHORITY & 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.

Following each case review, staff prepares a report, which includes a description of the incident reviewed and recommendations (if any) of the Review Team. Each year, the Review Team issues a report to the Domestic Violence Coordinating Council which summarizes in aggregate fashion the data and findings resulting from the case reviews. The report also includes responses to Review Team recommendations and the status of the implementation of those recommendations.

As required by Statute, the report does not identify the specific case review that led to particular findings or recommendations. **Appendix I**

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**

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DOMESTIC VIOLENCE DATA

The information contained in this report is based on cumulative data collected from forty cases, which occurred over a period of several years. There were fifty-seven deaths resulting from the forty cases in this report. The number of deaths includes homicides, suicides and murder/suicides, where the perpetrator killed the victim and then committed suicide.

The Fatal Incident Review Team has adapted a broad definition of domestic violence, similar to that used by the Department of Justice, to ensure that no domestic violence fatality escapes review. The team reviews fatalities, which occur between family members, husband and wife, ex-husband and wife, intimate cohabitants and former intimate cohabitants, dating couples and former dating couples. The perpetrator and victim may be of the same sex.

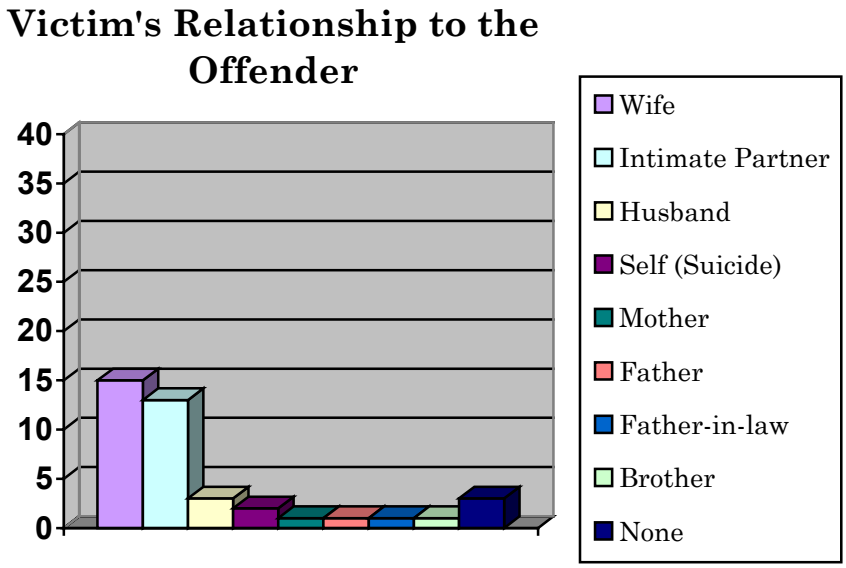
Based on the forty cases in this report, there were a total of forty-two victims. In one case, three victims died, in another case the manner of death (homicide or suicide) was not determined by the medical examiner, therefore the Victim's relationship to the offender is unknown.

Based on the data in this report, fifteen (36%) of the forty-two victims were the perpetrator's wife, thirteen (33%) of the victims were the perpetrator's intimate partner, and three (7%) of the victims were the perpetrator's husband.

Two of the victims were mothers, two of the victims committed suicide, (that relationship is regarded as self).

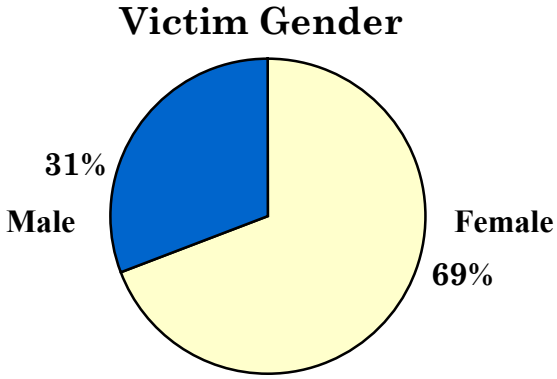
There was one victim in each of the following categories: father, father-in-law, and brother.

The category where there was no relationship between the victims and the perpetrator is None, there were three victims (7%) in that category.



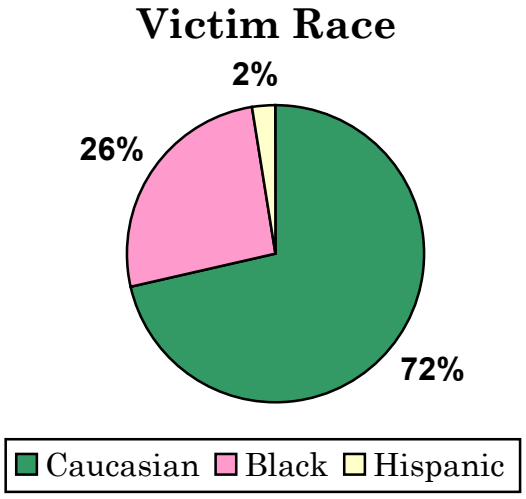
Victim Demographics

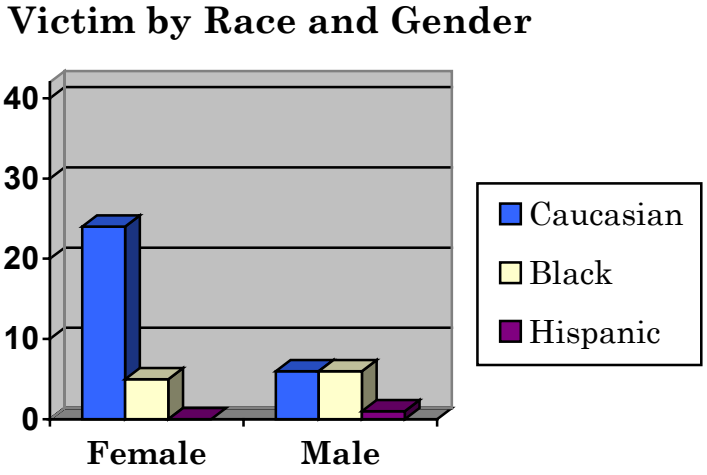
TOTAL NUMBER OF CASES = 40
TOTAL NUMBER OF DEATHS = 57
TOTAL NUMBER OF VICTIM DEATHS = 42
* One case included multiple victims.



This report contains data from forty cases, which resulted in fifty-seven deaths. The deaths include victims who were murdered, victims (with a significant history of being abused) who killed themselves and perpetrators who committed suicide after killing a victim. Of the forty-two **victim deaths**, twenty-nine (69%) of the victims were female and thirteen (31%) were male.

Based on the data in this report, thirty (72%) of the victims were Caucasian, eleven (26%) of the victims were Black and one (2%) of the victims was Hispanic.





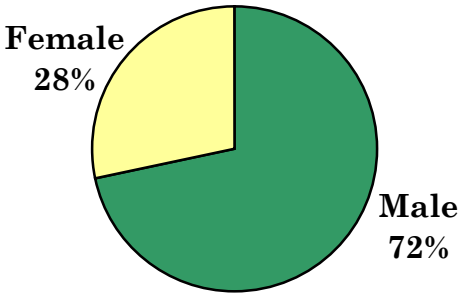
Females – Of the forty-two victims in this report, twenty-four (57%) were Caucasian females and five victims (12%) were Black females. The total of female victims was twenty-nine or 69%.

Males – Of the forty-two victims in this report, six (14%) were Caucasian males, six victims (14%) were Black males and one victim, was a Hispanic male. The total number of male victims was thirteen or 31%.

Perpetrator Demographics

TOTAL NUMBER OF CASES = 40
TOTAL NUMBER OF PEPETRATORS = 37
* In one case the manner of death (homicide or suicide) was undetermined
** In two of the cases, victims killed themselves (only) and are not considered perpetrators.

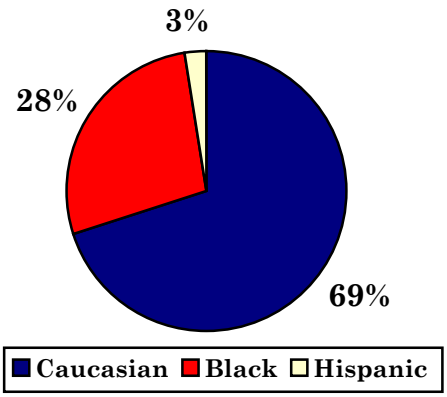
Perpetrator Gender



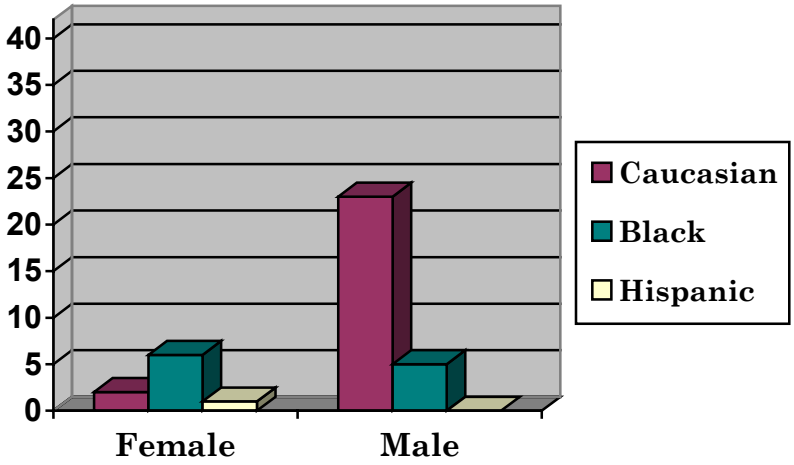
Twenty-eight (72%) of the thirty-seven perpetrators were male and nine (28%) of the perpetrators were female.

Perpetrator Race

Twenty five (69%) of the of the thirty-seven perpetrators were Caucasian, eleven (28%) of the perpetrators were Black and one (3%) of the perpetrators was Hispanic.

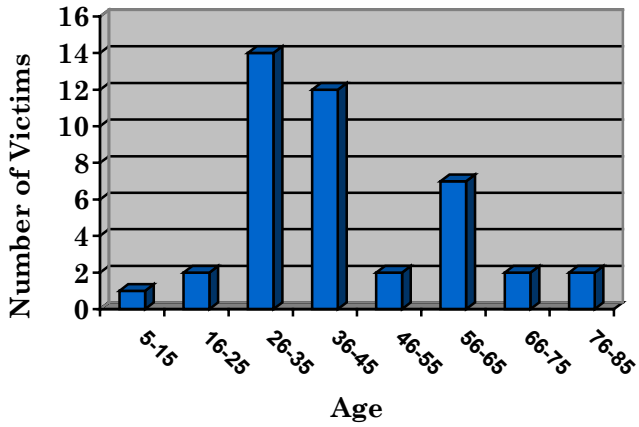


Perpetrator By Race and Gender



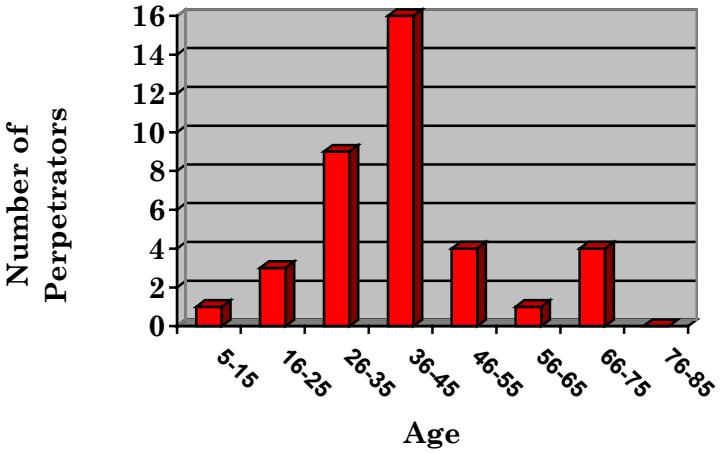
Females – Out of a total of thirty-seven perpetrators there were two Caucasian (5%), six Black (16%), and one Hispanic (3%) female perpetrators.
Males – There were twenty-three Caucasian (62%), and five Black (14%) male perpetrators. There were no Hispanic male perpetrators.

Victim's Age at Time of Death



Of the forty-two victims, one (2%) of the victims was between the ages of five and fifteen; two (5%) were between the ages of sixteen and twenty-five. **The highest number of victims, fourteen (33%) were between the ages of twenty-six and thirty-five**, followed by twelve victims (29%) between the ages of thirty-six and forty-five. Two victims (5%) were between the ages of forty-six and fifty-five, seven victims (16%) were between the ages of fifty-six and sixty-five. Two (5%) victims were between sixty-six and seventy-five and two victims (5%) were seventy-six to eighty-five.

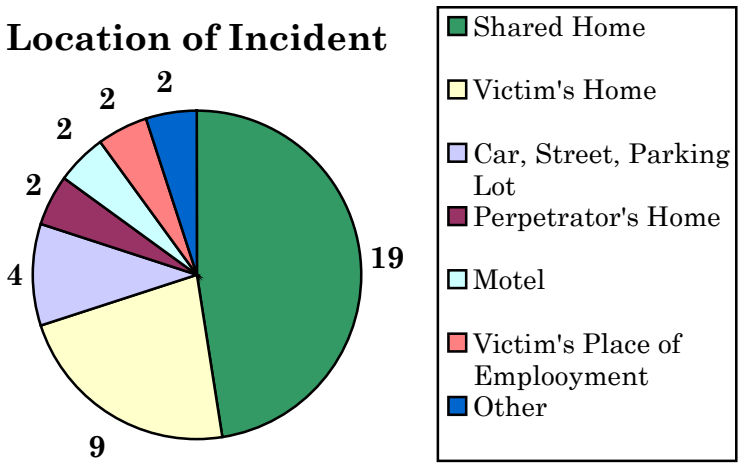
Perpetrator's Age at Time of Incident

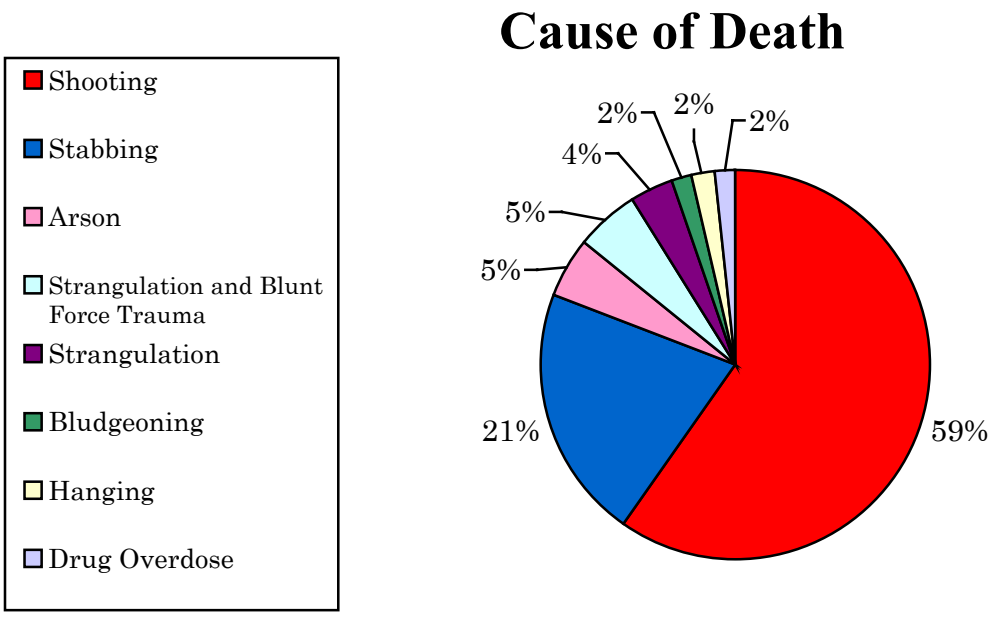


Of the thirty-seven perpetrators, one (3%) was between the ages of five and fifteen; three (8%) perpetrators were between the ages of sixteen and twenty-five, and nine (24%) were between the ages of twenty-six and thirty-five. **The highest number of perpetrators, sixteen (43%) were between the ages of thirty-six and forty-five.** Four (11%) perpetrators were between the ages of forty-six and fifty-five, and one (3%) was between the ages of fifty-six and sixty-five. Four (11%) were between the ages of sixty-six and seventy-five.

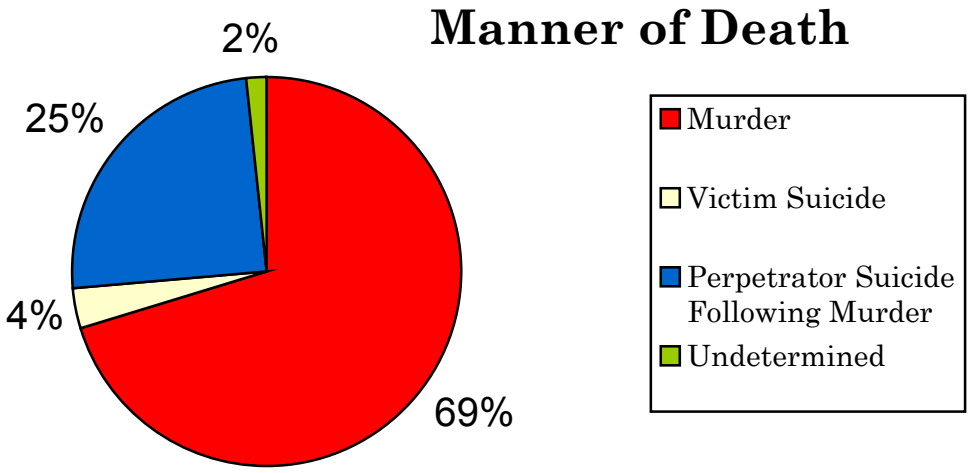
In nineteen (47%) of the forty cases, the incident occurred at the parties shared home. Nine (22%) of the incidents occurred in the victim's home. Four (10%) of the incidents occurred in the category of car, street, or parking lot. Two (5%) each of the incidents occurred at the victim's place of employment, the perpetrator's home and at a motel.
Other includes home of the victim's boyfriend, and a restaurant.

Location of Incident





Of the fifty seven deaths in this report, thirty-four (59%) occurred as a result of a shooting; twelve (21%) the result of a stabbing; three (5%) occurred as a result of strangulation and blunt force trauma; three (5%) resulted from arson; and two (4%) of the deaths occurred as the result of strangulation. One death resulted from drug overdose, one from bludgeoning and one death resulted from hanging.



Of the fifty-seven deaths included in this report, forty (69%) of the people died as a result of murder, fourteen (25%) of the deaths were perpetrator suicides following murder, two cases (4%) were single suicides, where the people had a history of being abused and in one case (2%), the manner of death (homicide or suicide) was undetermined.

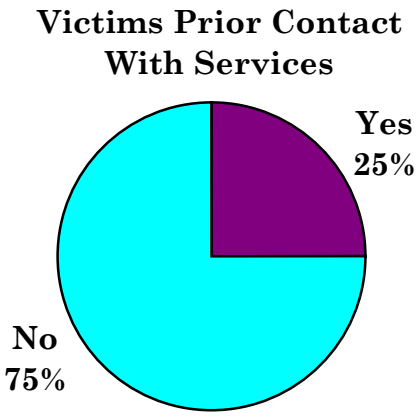
Accessing the System

LAW ENFORCEMENT

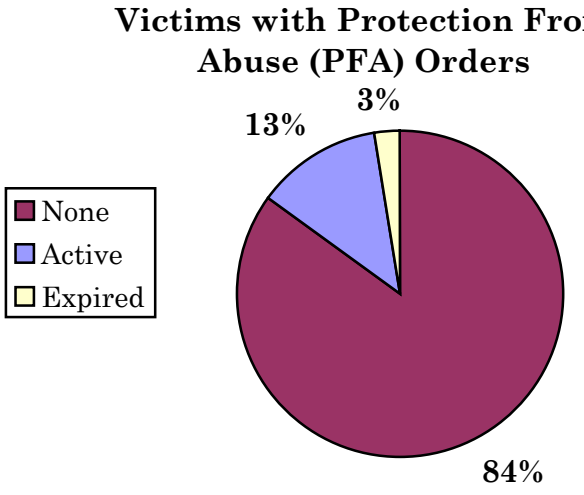
Victim's contact with police was defined by the victim reporting abuse by a current or previous partner, or family member, or police records of prior domestic incidents. Of the forty cases in this report, victim prior contact with law enforcement occurred in twenty (50%) of the cases.

VICTIM SERVICES

The victim's prior contact with victim's services includes contact made with domestic violence shelters or advocacy programs. Records indicate there was prior victim contact with services in ten (25%) of the forty fatality cases.



COURTS



Of the forty cases in this report, thirty-four (84%) of the fatality cases, victims did not have Protection From Abuse Orders. In five (13%) of cases there was an Active PFA at the time of the fatality. In one case, (3%), the victim had a PFA that expired several years earlier.

RECOMMENDATIONS & RESPONSES
IMPLEMENTING THE CHANGES

The ultimate purpose for reviewing domestic violence fatalities is to prevent such deaths in the future. The reviews focus on identifying obstacles in service delivery, assessing the adequacy of system intervention and most importantly, developing recommendations aimed at preventing domestic violence deaths in Delaware.

In July 2003, Review Team Recommendations were sent to relevant agencies and organizations throughout the State. Responses to the recommendations were received from state and local government and non-profit organizations.

We thank the participating agencies for their thoughtful consideration of the recommendations, for their cooperation in responding to them and for their efforts to implement the changes.

Information regarding the 2004 Review Team Recommendations and responses, will be included in the next report.

DIVISION OF FAMILY SERVICES (DFS)

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

DFS has an interview protocol in its policy that states, "When possible, family members should be interviewed in the following order:

- ***The identified child victim(s);***
- ***Siblings and other children in the home;***
- ***Adult caretakers who are not alleged to have maltreated the child;***
- ***The person who allegedly maltreated the child; and***
- ***The family as a whole."***

This policy expectation continues to be reinforced in meeting with Regional Administrators, frontline Supervisors, and with DFS professional development unit who are responsible for worker training.

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

It has been the policy of DFS since the summer of 1998 to screen for domestic violence during each investigation. The initial screening occurs during the Safety Assessment that is conducted at the time of the initial face to face contact with the child victim(s) and household caregivers. The Safety Assessment must be redone within thirty working days prior to returning a child home; within seven working days prior to case closure, and whenever circumstances suggest that a child's safety may be jeopardized.

Domestic violence screening does not end at investigation: in fact, it is screened throughout the life of the case. The Family Assessment Form (FAF) is a comprehensive tool completed by Treatment staff. Family violence is one of the areas screened as a part of this assessment. The FAF was implemented in August 2001. A Service Entry Needs and Strengths Screen (SENSS) is completed for every child in a case that is opened for DFS treatment services. One of the questions on the SNESS specifically addresses the presence of domestic violence. The SENSS was implemented in July 2002.
Additionally, as a part of the Division's Quality Assurance system and monthly case reviews, the following domestic violence questions must be answered by case reviewers:
At Intake: "Was the information regarding domestic violence considered at intake when determining the response time?"
At Investigation: "Were parental domestic violence converts addressed during the investigation?"
At Treatment: "Were parental domestic violence concerns adequately assessed in the Family Assessment Forms?"

<u>The DFS should work with representatives of the Advocacy Community in developing a protocol for responding to domestic violence cases.</u>
In January 2002, DFS and Families in Transition (FIT) implemented a collaborative pilot project that co-located a domestic violence advocate from FIT with DFS in Georgetown. Since then the project has expanded to New Castle (October 2002) and Kent Counties (December 2003). Services are managed by FIT in Kent and Sussex Counties and Child, Inc., in New Castle County. Quarterly meetings are held that include, DFS Program Managers for Intake, Investigation and Treatment, DFS Supervisors who have local oversight for the projects, and the administrators and advocates from the private agencies to ensure operational consistency by the advocates

in all counties. The process begins when advocates screen hotline reports to determine if advocacy services are needed. DFS is conducting an evaluation of the first two years of the project. The evaluation report is expected to be ready for dissemination by the summer of 2004. DFS plans to share this report with DVCC.

OFFICE OF THE CHILD ADVOCATE (OCA)

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

The Office of the Child Advocate provides legal representation to Delaware's abused and neglected children. In so providing that representation, OCA often represents children who are child witnesses to homicide and suicide. Where these children have legal representation, the attorneys are provided with initial training on the nuts and bolts of representing children. With that training, mental health services for the child are discussed. OCA also provides support and oversight to the attorneys should questions arise regarding services for the child. In addition, OCA has started a Brown Bag lunch series and one of the topics is "Accessing Mental Health Services for your Client." This seminar focuses more specifically on ensuring children get mental health services.

OCA also staffs the Child Protection Accountability Commission (CPAC) which is charged with monitoring Delaware's child protection system to best ensure the health, safety and well-being of Delaware's abused, neglected and dependent children. CPAC has a Foster Care Subcommittee co-chaired by Attorney General Brady and Janice Mink. That subcommittee has focused extensively on mental health evaluations and services for foster children, as well as focused more broadly on child crime victims.

DEPARTMENT OF CORRECTION

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

Most Level III Probation Officers make home visits during the evening

hours. Operation Safe Streets augments the Probation Officer by conducting curfew checks on the most serious of the Level III cases. As a result of SB 50, new procedures specify that home visits are required while defining a home visit so that the attempt is to be made when the offender is expected to be at his/her authorized residence thereby increasing the times an offender is seen in the evening or night hours.

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

This review is currently under way.

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.

The Supreme Court Permanent Advisory Committee on the Delaware Uniform Rules of Evidence was established by Administrative Directive No. 121 on May 16, 2000.

The Court charged the Committee, as an initial matter, to review Federal Rules of Evidence (FRE) 413 through 415, among other proposals, to analyze the merit of adopting similar amendments to the Delaware Uniform Rules of Evidence. In the enclosed report dated September 13, 2000, the committee concluded that "the potential for harm [from adopting FRE 413-415] would greatly exceed the goals of the rule change[s]." The Committee therefore recommended that the

Court <u>not</u> adopt FRE 413-415. The Justices of the Supreme Court, after careful consideration of the Committee's recommendation and its rationale, unanimously agreed.

FAMILY COURT

<u>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.</u>

In March of 2003 Family Court revised Intake Form number 240 and incorporated the following paragraph:

"X. Any additional information about Respondent that may aid the process server in locating him/her to serve this petition."

<u>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.</u>

Family Court will submit a grant adjustment request to the Violence Against Women Act Implementation Committee seeking their approval to include arrest for a Violation of a Protection From Abuse Order in the Pre-Trial Services Officer's case load for New Castle County. If approved the Court would pilot this approach during the grant period and after evaluation consider the viability of a statewide implementation of this approach.

DOMESTIC VIOLENCE COORDINATING COUNCIL (DVCC)

<u>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 (VCCB) for mental health treatment services.</u>

The VCCB indicates that minors who witness a murder or suicide are considered a secondary victim under the VCCB statutes. Their mental

health counseling expenses are reimbursable under the regular claim procedure. Further, this has not been brought forward as a problem in the Victim's Rights Task Force which is a forum for victim issues.

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

The DVCC has sent a letter to DFS requesting that their staff work with our staff to develop domestic violence training for the 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 has worked for this change for years and while progress has been made, the Delaware legislature has rejected any additional changes to this legislation.

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

The Bail Guidelines Ad Hoc Group continues to review bail practices in domestic violence cases.

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

The DVCC has begun working with the military to develop domestic violence training for military personnel.

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

The DVCC has sent a letter to the State Board of Education requesting that DVCC staff meet with their training staff in an effort to develop a domestic violence training course for educators.

The President of the State Board of Education contacted the Secretary of the Department of Education regarding the DVCC request. The Secretary has indicated Department of Education staff responsible for working with school nurses and guidance counselors would be willing to work with the Domestic Violence Coordinating Council to ascertain how they may be able to coordinate their activities and staff

development opportunities.

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

The DVCC has referred this idea to its Children and DV Subcommittee. It is expected that this group will review the Safety Plan as it relates to children and will recommend any appropriate changes to the DVCC.

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.

The staff of the Fatal Incident Review Team is working on this recommendation.

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.

The Delaware Coalition Against Domestic Violence provides information and resources on domestic violence to school-aged students upon request. The Coalition is also actively involved in the development of programs aimed at preventing dating violence such as the DELTA Program, and educating school professionals on the dynamics of domestic violence.

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

The Delaware Coalition Against Domestic Violence provides training for advocates on many topics related to effective domestic violence advocacy and professional, responsible behavior on an ongoing basis.

The DVCC and DCADV should include "Things to Do For Children"

and referral information in the Safety Plan.
DCADV includes information on safety planning for children through training, education and the distribution of resource material.

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.

Delaware State Police– The policy of the Delaware State Police "encourages" that all Troopers sign warrants in misdemeanor domestic violence cases. It is the "practice" that all Troopers sign warrants in misdemeanor domestic violence cases.

New Castle County Police Department– Mandating officers to sign warrants in all misdemeanor domestic violence cases would have a devastating effect on this department's ability to provide prompt, quality service to the citizens we serve. In 2003 alone, the New Castle County Police handled 6,771 domestic criminal cases. This number does not reflect the over 4,421 non-criminal domestic cases that we investigate. The New Castle County Police has a strict domestic violence policy that recognizes the need for enforcement intervention when the victim is unwilling, reluctant, or unable to pursue the matter themselves. We stand by our policy and are proud of the services we provide victims of domestic violence. We are adamantly opposed to any policy that would mandate officers to sign warrants in all misdemeanor domestic violence cases.

Wilmington Police Department – The current policy of the Wilmington Police Department is:

Directive 6.19 Domestic Complaint Procedures

I. Criminal Domestic Violence

D. Arrest Policy

3. ***Where probable cause is present, II Del. C. Sec. 1904 allows for immediate arrest and removal of a defendant from his/her residence in a domestic violence situation, and does not require the victim to leave the residence to obtain a warrant.***
4. ***The following circumstances may be considered in determining the existence of probable cause:***

a. ***There are obvious signs of physical injury to the victim;***
b. ***There is the potential for continued violence escalating to a felony;***
c. ***Threats to the victim are made in the officer's presence;***
d. ***Any other misdemeanor is committed in the officer's presence;***
e. ***Defendant's behavior suggests that he/she may inflict further injury to the victim or others***

5. ***Where the defendant is not present, the victim should be encouraged to sign a warrant.***

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

Delaware State Police – The Delaware State Police has a "checklist" for domestic violence cases that requires all Troopers to run prior complaint/criminal histories. This must be checked off on the checklist and the checklist is signed by their supervisor (Sergeant or Senior Corporal).

New Castle County Police Department – The New Castle County Police supports this recommendation. Each officer is trained to run complaint and criminal histories through the statewide CJIS computer system.

Wilmington Police Department – Officers are instructed to request the Data Center to check prior complaints. This is stressed in both the academy and in-service training.

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

Delaware State Police – It is the practice of the Delaware State Police to make a referral to Victim Services when an arrest is made. The Delaware State Police policy states that a Trooper must explain in the report why a referral was not made in any domestic violence incident; if none was made.

<u>New Castle County Police Department</u> – The New Castle County Police support this recommendation. NCCPD Victim Assistance workers and detectives assigned to the Domestic Violence Unit review all domestic related incidents and make the appropriate referrals. Furthermore, Patrol Officers are encouraged to make referrals in non-criminal cases where the officer suspects a problem may exist.

<u>Wilmington Police Department</u> – ***Officers are required to give victims a card with written information that includes the name and number of the domestic violence service coordinator, the victim service coordinator, and the domestic violence hotline.***

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.

VICTIM SERVICES

<u>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.</u>

The police-based victim service staff recommends counseling for survivors in cases of domestic fatalities, and discusses it in the context of compensation claims. From now on, written material will be given to custodians of minor children in theses cases.

APPENDIX I

Lexstat 13 DEL. C. 2105

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:_____

_____

Name (Please Print) Agency

_____

Signature Date