DELAWARE'S FATAL INCIDENT REVIEW TEAM

REPORT

Submitted to The Domestic Violence Coordinating Council

Published October 1, 2001
Domestic Violence Coordinating Council
900 King Street
Wilmington, DE 19801
(302) 577-2684

DOMESTIC VIOLENCE COORDINATING COUNCIL MEMBERS

Hon. Vincent J. Poppiti, Chair
Chief Judge, Family Court

Hon. Patricia M. Blevins, Vice Chair
Delaware Senate

Dr. Rhoslyn J. Bishoff
Commission on Family Law

Ms. Cynthia M. Boehmer
Executive Director
Families in Transition

Hon. M. Jane Brady
Attorney General

Col. John L. Cunningham
New Castle County Police

Mary W. Davis
Chair, Domestic Violence Task Force

Hon. Cari DeSantis
Dept. of Services for Children, Youth & Their Families

Hon. James L. Ford
Department of Public Safety

Dr. Matthew Hoffman
Christiana Hospital

Hon. Deborah Hudson
Delaware House of Representatives

Geraldine Lewis-Loper
Delaware Center for Justice

Maria Picazo
Executive Director
Abriendo Puertas

Hon. Henry duPont Ridgely
President Judge, Superior Court

Hon. Lawrence M. Sullivan
Public Defender

Hon. Stanley W. Taylor
Commissioner, Department of Correction

DVCC Staff: Ronald T. Keen
Executive Director

INTRODUCTION

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. Although the work of the Fatal Incident Review Team has been emotionally difficult, it has provided insight and through this insight, the experience has also given us hope.

Domestic violence is a devastating problem, and deaths resulting from this crime are the ultimate acts of abuse. During the five-year period 1996 through 2000, Coordinating Council records indicate that seventy-one Delawareans lost their lives as a result of domestic violence. This figure represents both homicides and suicides resulting from domestic violence and includes those cases where the perpetrator killed the victim and then committed suicide. Although some of these victims had sought safety by accessing legal remedies and/or obtaining assistance from private services, they were nevertheless unable to obtain the protection necessary to prevent them from dying at the hands of their abusers.

Fatal incident reviews are difficult. For a successful review, the team must ask all of the relevant agencies involved to come together and openly and honestly address what the system could have done better. The team becomes intimately familiar with the life of someone who has died too soon. It is difficult not to be shaken by these stories.

Domestic violence victims are young and old, rich and poor, members of different races and religions. They lived throughout the state, in large cities and in small towns, some were married, and some were not. While the circumstances of their lives varied, the homicide victims have one thing in common -- they were all killed by someone they loved. And they left behind family members forever devastated by their deaths.

In some cases, the victims had surviving children. In fact, in several of the cases reviewed, the children lost both parents – in addition to the parent who was murdered, the children also lost the other parent either to suicide or to jail. Most tragically, in one case reviewed, children were killed as well.

This report only includes data from the sixteen case reviews completed to date. While other fatal incidents have been reviewed, (including several from the year 2000), the Panel Findings in those cases are not yet complete, therefore that data is not included in this report.

Sadly, there are far too many fatal incidents yet to review. We have an obligation to those victims, and to their families, to do whatever we can to help prevent future domestic violence deaths. The participants in the review process have been unwavering in their commitment to this goal. As we are discovering, it is only by 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 empowered the Domestic Violence Coordinating Council to establish a review panel to investigate and review the facts and circumstances of all domestic violence related fatalities occurring in Delaware.

The Legislative Drafting and Review Subcommittee of the Coordinating Council developed the legislation. This committee includes representatives from the Department of Justice, law enforcement, victim advocates, the courts, and others. The committee spent over a year working on this legislation.

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, 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 panel 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 Chiefs 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 panel.

The review team invited other law enforcement personnel to serve and participate as full members of the review panel 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 panel 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 panel 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 Panel 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 panel 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 panel of the Child Death Review Commission and the domestic violence fatal incident review panel.

Each review panel 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 panel. 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 panel. The report must also describe any systemic changes that were effectuated as a result of the panels work. The report will not identify the specific case or case review that led to particular findings or recommendations.

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.

V. PROCEDURES

The review panel meets monthly, provided that there are cases eligible for review. The co-chairs of the panel, or any two other panel 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 panel 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. Panel members also provide recommendations for review witnesses.

Staff begins each review by providing panel 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. Panel members are given the opportunity to ask questions of each witness. Each panel 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 Panel Findings Report and then submits it to the Review Team for final approval. Findings and recommendations of the panel 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. A total of twenty-one meetings were held in during 1998, 1999 and 2000, 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 included, further defining the types of cases the Team will review, defining the role of witnesses, exploring confidentiality issues and discussion about including family members in the review process.

B. REVIEWS COMPLETED

In all, the Review Team completed one mock and fifteen regular reviews during the three-year period. 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		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. FINDINGS

While many conclusions may be reached based on the data in this report, it bears repeating that the information contained herein represents only sixteen cases, which occurred over a two year period. As the work of the Review Team continues we will expand our base of data and thereby increase our ability to identify trends and patterns and make significant findings. That having been said, the following Findings are noteworthy for several reasons; the first two because they identified at risk populations not previously known and the third because it points out one of the greatest obstacles to reducing domestic violence fatalities, ignorance about the danger of abusive relationships.

Six of the sixteen victims (37%) were over the age of sixty.

Abuse in elderly couples is less discussed and more difficult to detect than abuse among younger couples. Abuse in elderly couples generally takes one of two forms. It may be abuse grown old which means that the abuse has been present throughout the relationship and has continued into old age. Or it may start late in life, related to stressors such as illness, retirement, dependency, changing patterns in relationships, and/or sexual dysfunction. Abuse in elderly couples may be more difficult to detect than in younger couples. Reasons for this increased reluctance include that the victims: grew up in an era when social norms discouraged them from revealing family problems to outsiders; depend more heavily on the abuser for care and/or financial support; fear the unknown and feel it is too late to start anew; lack the legal, economic, and family resources to establish alternative living arrangements; and are less likely to perceive separation and divorce as acceptable solutions.

In four (25%) of the cases reviewed, parties presented with severe mental illness.

Of those four cases, two of the victims were parents killed by their children and two of the victims were intimates, killed by their partner. As with victims, perpetrators may also disclose information about the abuse with attorneys, clergy, counselors, and employers, who may not have the information necessary to appropriately respond. This situation is particularly difficult for counselors working with perpetrators. One of the complicated issues, which then arise, is the duty of the counselor to warn the victim of possible harm by the perpetrator. The Review Team requested and received information on this issue from the Psychiatric Society of Delaware. The information obtained indicates that mental health providers must warn victims only if: (1) they have a duty to protect an identifiable victim; (2) an actual threat has been made; and (3) the intent to carry out the threat and the clinician's belief that the patient has the ability to carry out the threat are both present. Counselors working with perpetrators may not understand their duty to warn victims of potential harm. Counselors also need to be aware of the impact of the patients' mental illness on family members.

Three of the victims (19%) had had prior contact with a victim service agency.

One of the findings of the Review Team was the lack of contact the victims in these cases had with the criminal justice system or victim services. In only three of the cases, the victims had made prior complaints to police, in the other three cases where there was prior police contact, the victims were reported to be the perpetrators. Only two of the victims had Protection From Abuse orders and only three of the victims had had contact with advocacy or police based victim services. Victims sometimes did not seek out services because they minimized the danger. While some family's indicated that they were aware the couple often argued, most did not consider this abusive and did not feel either party was at risk. Often family and friends will not intervene because they believe it is a private, family matter. In a few of the cases reviewed, family members knew there had been physical abuse but they felt they could handle it by talking to the perpetrator. In almost all of the cases, individuals who knew the victim and/or the perpetrator were reported to have indicated that they had no idea the perpetrator was capable of such actions. Unfortunately, many people are unaware of the dynamics of domestic violence and continue to underestimate the dangerousness of abusive relationships.

VICTIM FINDINGS

- 69% of the homicides occurred at the parties' shared residence.
- 13% of the homicides occurred at the victims' residence.
- 56% of the victims' families and or neighbors indicated knowledge of abuse, prior to the fatality.
- Two children witnessed their mother's murder.
- Two children died in an arson fire, the result of a domestic dispute.
- In the 16 cases reviewed, 18 victims died as a result of domestic violence.

PERPETRATOR FINDINGS

- 50% of the perpetrators were between the ages of 30 to 45.
- 25% of the perpetrators were over the age 60.
- The youngest perpetrator was 14 years old; the oldest was 75.
- 69% of the perpetrators were Caucasian, 31% were Black.
- 50% of the perpetrators had criminal histories.
- 44% of the perpetrators showed evidence of drug or alcohol abuse at the time of the fatality.
- 50% of the weapons used were firearms, 25% of the weapons were knives.
- 75% (7) of the male perpetrators committed suicide following the fatality.
- None of the female perpetrators committed suicide following the fatality.

D. RECOMMENDATIONS

Recommendations were made in twelve of the sixteen cases reviewed and are listed by agency or discipline. A number of the recommendations included in this report are appearing for the first time. For those agencies or disciplines receiving recommendations for the first time, the Domestic Violence Coordinating Council will report on implementation in the next annual report. Recommendations already implemented appear in bold print underneath the corresponding recommendation.

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 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 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.

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 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.

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.

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 services agencies should develop Visitation Safety Plan Brochures.

Victim services staff and volunteers should educate victims of 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 has never recommended delayed reporting for incarceration in any Domestic violence case. That issue generally

presents 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.

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.

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.

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 dependent 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;
4. 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 EDUCAITON

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.

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 panel 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.**

That education be provided for health care providers on 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.

Greater efforts are needed to publicize domestic violence resources statewide.

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.

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.

E. IMPLEMENTING THE CHANGES

The Domestic Violence Coordinating Council is responsible for helping to implement the recommendations of the Review Team. According to the Review Team's procedures, the Coordinating Council shall work with other state agencies and private organizations to help implement recommendations of the panel. Also, the Coordinating Council will use the recommendations of the Review Team to assist in the development of prevention and public awareness programs.

F. 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 make the initial contact and hopefully attend the review with the family member.

The Review Team found that in some cases there is simply not enough information available for recommendations to be made and in other cases there was so much information the case review spanned several months.

Neil Websdale, Ph.D, noted researcher and author in the field of domestic violence fatalities, characterized the work of review teams well when he said, Domestic Violence fatality reviews are not a science, they are an art. The Fatal Incident Review Team process continues to develop and improve and with it, so too we hope, does our ability to increase system response and decrease future tragedies.