upon

further examination

2012 Findings and Recommendations from the Connecticut Domestic Violence Fatality Review Committee
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This report is a product of the Connecticut Domestic Violence Fatality Review Committee, a collaboration of private, public and non-profit organizations operating throughout Connecticut.

Written by
Connecticut Coalition Against Domestic Violence
East Hartford, CT

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This report is dedicated to the memory Tiana Angelique Notice, who lost her life on February 14, 2009 at the hands of her ex-boyfriend James Carter II. Alvin Notice, Tiana's father, continues to be an instrumental voice for victims of domestic violence.

On January 13, 2012, James Carter II was sentenced to 60 years in prison for the murder of Tiana.
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Acknowledgements

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A special thanks to the family members of the homicide victims who were willing to talk with us about their perceptions and experiences. Thank you to Justin Norton and Lauren Valentine, CCADV interns who worked tirelessly to gather the critical data necessary to review these fatalities. Those who serve on the Domestic Violence Fatality Review Committee also deserve thanks for their commitment and dedication in sharing their time and expertise.

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According to the State Department of Emergency Services and Public Protection Crimes Analysis Unit, 16 violent interactions resulted in 18 domestic violence related deaths from January 1, 2010-December 31, 2010. Domestic violence homicide is not diminishing in our state, rather the numbers remain steady from year to year.

Upon the request of Connecticut residents Shirley and Larry Bostrom, the Connecticut Coalition Against Domestic Violence (CCADV) established a fatality review committee in October 2001. The Bostroms tragically lost their daughter, Margaret, at the hands of her abusive husband in 1996. When the Bostroms approached CCADV about implementing a review team, the premise was to gather professionals who might not have otherwise collaborated for this process. In an effort to develop an understanding of barriers domestic violence victims face and to prevent these types of fatalities, the Connecticut Domestic Violence Fatality Review Committee was created.

Since its inception, the Connecticut Domestic Violence Fatality Review Committee (“Committee”) has worked to prevent future deaths by conducting multi-disciplinary, systemic examinations of violent intimate partner fatalities.

The Committee’s objectives are to:

- Enhance the safety of victims and accountability of batterers
- Identify systemic gaps and barriers to service
- Implement coordinated community responses
- Influence public policy for intervention and prevention

The Committee brings together key individuals in social service, medical, education, advocacy and justice systems for detailed examinations of domestic violence fatalities. They do not and will not assign blame for fatalities to individuals, agencies or institutions. The perpetrator of the homicide is assumed to be ultimately responsible for the fatality.

Domestic violence homicides traumatize not only those close to the victim but also entire communities. None of the individuals involved with these families would consider death an acceptable conclusion to a life where violence existed. Therefore, rather than investigate these fatalities, the Committee conducts a reflective review by creating an environment conducive to open and honest conversations for the purpose of effecting positive change. The Committee focuses on community responses to domestic violence such as services, policy, practice, training, information, communication, collaboration and resources. Members of the Committee also promote specialized mobilizations against domestic violence within their own disciplines.

The Connecticut Domestic Violence Fatality Review Committee defines a domestic violence fatality as a death that arises from an individual’s efforts to assert power and control over his/her intimate partner.
The fatalities in this report include:

- Any homicide in which the victim was an intimate partner or former intimate partner of the individual responsible for the homicide
- Any suicide of the perpetrator of an intimate partner fatality

This report is the Committee's second to issue findings and recommendations. The recommendations and findings from the first report, Upon Further Examination, (released in July 2011) continue to be relevant; therefore this report should be considered to be its complement, not its substitution.

"Over 600 people attended Megan's wake, people from her work and her woman's group. A woman who knew Megan said Megan gave her the strength to leave."

Erin Blatchley-mother of Megan Reyes
The Committee selects cases to be reviewed in which all criminal and civil cases pertaining to the victim and perpetrator are closed with no pending appeals. Once the cases are selected, the Committee conducts a detailed review of all public records and other documentation related to these homicides, and meets with family members, friends and individuals who came in contact with the victim. A timeline, a linear chronology of the case, is then constructed. The timeline focuses on the principal markers of the case and enables the Committee: (1) to see how and when the batterer’s tactics escalated over time, (2) to look at the red flags as they pertain to both the batterer and the victim, (3) to review the community’s involvement in the case and (4) to make recommendations to community stakeholders with full expectation of implementation. The following outlines the collection tools employed by the Committee.

**Medical Examiner Reports**
Medical Examiner reports are gathered to determine the cause of death, manner of death, age, gender and race of the victim.

**Police Reports**
Police reports relating to both the perpetrator and victim are requested from the city or town of the homicide occurrence. These reports are used to determine if known circumstances of domestic violence existed prior to the fatality and to gather data regarding the circumstances surrounding the homicide.

**Criminal Justice Inquiry**
At the State of Connecticut’s Judicial Branch Homepage (www.jud.ct.gov), the case look-up feature provides information about all criminal and family court proceedings throughout the state. From this information, it can be determined if there was a history of restraining orders against the perpetrator, pending divorce proceedings and child custody motions. Additionally, the Committee used data from the Connecticut Department of Correction homepage (www.ct.gov/doc) that provides public information regarding the sentencing status of offenders.

**Interviews**
When possible, interviews are conducted with friends and family members. Generally, the Committee appoints members who have direct experience with the loss of a loved one to assist with the interviews. Previous to meeting with friends or family members, they are contacted via letter or telephone to seek their permission to be interviewed and to explain the fatality review process. Interviewing surviving friends and family is not mandatory in the data collection process, but the Committee recognizes that the insights that may be offered are unique and an important part of getting to know the victim.

**Media Reports**
Most media outlets in Connecticut provide some type of coverage when there is a domestic violence related fatality. CCADV maintains an inventory of all domestic violence related articles and those related to fatalities are cataloged for use in the review process.
Findings

While the Committee tracks all domestic violence homicides, staffing capacity dictates that only a small portion of these fatalities can be reviewed in depth. The Committee compiles a great deal of information on cases reviewed from public information sources such as police reports, media coverage, the Office of the Chief Medical Examiner and stories from families and friends. For those cases that are not reviewed, we gather a smaller amount of data, which may include demographic information, news accounts and the dates and circumstances of the homicide. Anecdotes from friends and family, coupled with detailed information from January 1, 2010 through December 31, 2010 form the basis for this year's findings and recommendations.

Chief findings from this year's reviews are as follows:

1. In every case reviewed, family members, friends, and/or professionals were not fully aware of the escalating circumstances between the perpetrator and the victim. These individuals did not recognize the significance of the situation or the warning signs.

2. In cases reviewed, the abusive relationship was established when the victim was a teenager. According to the State Department of Health “2011 Connecticut Health Survey” approximately 10% of all students surveyed reported that they were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend. Teens need the tools and knowledge necessary to develop healthy relationships and essential life skills.

3. Connecticut’s lack of culturally and linguistically systemic response has a detrimental effect on a victim's ability to access services.

4. In most cases, the victim worked outside the home. Employers are uniquely positioned to link survivors to support and resources; time at work may be the only time the victim is away or free from the abusive partner’s direct influence.

5. Surviving families and friends are deeply impacted by domestic violence homicides/suicides, yet most did not feel connected to any professional or organization who could immediately assist them in many of the effects of the homicide.
In this report, we found that the issues identified and the resulting recommendations fell into one of three broad categories:

- Awareness and education
- Assessment and intervention
- Need for resources

**Awareness and Education**

There is a continuing need to better educate both the public and professionals who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence. In particular, this education should include an awareness of risk factors for potential lethality.

There appears to be increasing public awareness of and professional training about domestic violence. However, the cases we reviewed this year highlight the need to expand this awareness and make the links to appropriate responses. In many of the cases we reviewed, the indicators for domestic violence were present, but there seemed to be a lack of any immediate referrals and/or interventions focusing on safety for victims and treatment for perpetrators.

Domestic violence public awareness programs should contain features directed to increasing awareness that the non-reporting of abuse by victims, or threatening behaviors of perpetrators, can not only impact their own safety, but the safety of others close to them. Non-reporting can also impact the safety of others who later enter into relationships with the abuser.

Public education targeted at potential victims and perpetrators of domestic violence should:

- Include the fact that risk of violence increases substantially during the time that a partner is leaving the relationship
- Be directed towards persons of all cultures, languages, and faiths
- Address the need to reduce the stigma of domestic violence

The process of raising awareness should be embedded in the public education system so students learn about these issues early in their lives before their transition to adulthood.

Also, it is important to ensure that domestic violence education and awareness be facilitated in a way that is responsive to Connecticut’s underserved, underrepresented and/or not served communities, using multiple strategies and approaches.
As individuals in the workplace have a unique opportunity to witness the impact of domestic violence on victims, both employers and co-workers have a role and responsibility to provide support and seek out help. Workplace culture can foster caring through resources such as employee assistance programs.

Training for professionals must deal with two issues: the first is recognizing domestic violence in all its forms—emotional, verbal and physical. The second is identifying high-risk situations that require intensive assessment and immediate intervention strategies to respond to the potential escalation of aggressive and threatening behavior.

**Assessment and Intervention**

There is a need to have appropriate tools available to those who work with victims and perpetrators of stalking to better assess the potential for lethal violence in their lives.

The prevalence of stalking is difficult to measure as not all offenses are reported to law enforcement, and not all victims seek services. Oftentimes, victims view these acts of stalking as nuisance behavior and disregard them because they do not recognize the potential for increased violence.

Stalking behaviors can be varied in nature and if a victim does not possess an order of protection, many of these behaviors would not be classified as illegal in Connecticut. Anyone working with domestic violence victims should discuss the potential for increased violence when a victim attempts to leave the relationship, with stalking as one of an abuser's tactics to gain control over the situation. Victims, their family and friends should have reliable information on the stalking tactics used so that victims can pursue safety and supportive assistance. Advocates with domestic violence agencies should receive specialized training on stalking, including electronic stalking.

There is a need to develop a more appropriate culturally and linguistically response to individuals, experiencing and perpetrating violence, who are typically underrepresented, underserved, not served or have limited English proficiency.

It is vital to understand the complex ways in which people respond to domestic violence, given their cultures and practices. In an effort to respond to the diverse experiences of victims, help must meet the unique needs of each population and/or community. At every juncture in the response to domestic violence, respondents must ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to obtain help.

According to the 2010 United States Census, Latinos comprise the second largest demographic population in Connecticut. They also represent the second largest population of individuals receiving domestic violence services (CCADV Shelter and Host Home Statistical Report). There should be a Spanish specific statewide help line for domestic violence victims.
Connecticut would be better served with leadership to implement training and intervention focused on underserved and/or underrepresented communities. Culturally relevant materials to increase outreach and awareness for underserved and underrepresented victims of domestic violence must be developed.

**Surviving families and friends are deeply impacted by domestic violence homicides and suicides, yet most do not feel connected to any professional or organization who could immediately assist them in the aftermath.**

While there are a host of service providers that work with victims throughout Connecticut, many intervene at the point of arraignment when there is a criminal case, or solely at the request of a surviving family member. Immediately after a homicide or homicide/suicide, surviving family members appear to have no designated person or organization to turn to respond to their immediate questions or concerns. To rectify this concern, the Committee recommends that they work with Connecticut’s victim services organizations to clarify who is responsible for immediately supporting surviving family members.

**Need for Resources**

It has been determined that community alliances are critical to optimal success. In many communities, support for awareness and education on domestic violence has been received from domestic violence agencies, police, family counseling services, and the private sector working together as a team.

Every community where a domestic violence related homicide takes place should be supported to initiate awareness focusing on domestic violence prevention. It is recommended that CCADV provide resources, support, and expertise to assist that community in using the tragedy as a catalyst for action. Each community should create its own unique response that promotes an awareness of domestic violence to help make a difference in the prevention of future deaths.
Summary of 2011 Recommendations

In July 2011, the Committee issued its first report, Upon Further Examination, which covered the Fatality Review's findings from its inception in 2000 through 2009. That report contained a series of findings and recommendations. The Committee is pleased to report that meaningful steps have been taken implement the recommendations.

The following information highlights the major accomplishments per the recommendations of the 2011 Fatality Review Report:

Public Awareness

• CCADV initiated a public awareness campaign in 2011-2012 to increase Connecticut’s understanding of access to domestic violence services. In June, the Connecticut Law Tribune presented CCADV with their prestigious “Publisher’s Award ” in recognition of its efforts to help victims recognize the full range of services available to them.

• CCADV published "Reporting Domestic Violence in Connecticut: A Guide for Media." CCADV engaged Connecticut's journalists to discuss the effective use of the media.

• CCADV, the Connecticut Commission on Children and the Office of the Child Advocate co-sponsored "Domestic Violence Through the Eyes of a Child," which featured national expert Betsy McAlister Groves, Founder and Executive Director of the Child Witness to Violence Project at Boston Medical Center. Lead child advocates, health professionals, policy makers and law enforcement deliberated over solutions to develop and implement early intervention strategies for children exposed to domestic violence.

• CCADV, in partnership with the Connecticut Bar Association and the Connecticut Judicial Branch, co-sponsored "Family Violence: Trauma, Trends and Triage." This forum brought together policy makers, attorneys, advocates, judges and national and state experts to assess the status of domestic violence in our state with an aim to offer systemic solutions. Topics presented and discussed were coercive control, legislative response and update, the psychology of domestic violence, lethality considerations and a view from the bench and the bar.

Training

• CCADV, in partnership with the Connecticut Police Academy- Police Officer Standards and Training Council (POST) was one of ten nationally selected to implement Connecticut's Lethality Assessment Project (LAP). LAP is a two-pronged intervention process that makes use of a specialized lethality assessment instrument and an accompanying protocol to identify and respond to high risk cases of domestic violence. Starting in September 2012, trained police officers on the scene of a domestic violence incident
Summary of 2011 Recommendations

will assess a victim's risk for serious injury or death using the one-of-a-kind Lethality Assessment Screen. Officers will then immediately link "high risk" victims to the community-based domestic violence victim services help line in their area with the goal of having victims receive program services.

• CCADV facilitated advanced training on trauma to its member domestic violence agencies to enable advocates to offer sensitive trauma services, which evaluate the role of trauma, deliver services to avoid unintentional re-traumatization, facilitate victim participation and prioritize victim’s safety.

• In September 2011, CCADV opened its Training Institute which has provided 65 trainings for over 1,500 participants including domestic violence advocates, prosecutors and public defenders, legal services attorneys, police officers, clinicians, state agency personnel and staff of other community based organizations. All trainings were designed to increase the capacity of those individuals and agencies who work with domestic violence victims and offenders to respond in a more effective manner. Training topics included the impact of domestic violence on children, electronic stalking, teen dating violence, trauma, strangulation and orders of protection.

Public Policy

• CCADV's Executive Director co-chaired the Law Enforcement Response to Family Violence Task Force which resulted in significant recommendations to create one uniform policy to be used by law enforcement when responding to family violence incidents and violations of orders of protection.

• CCADV successfully advocated for new laws that include increased accountability for domestic violence abusers enrolled in the Family Violence Education Program, the extension of restraining orders from six months to up to one year, and enhanced strategies for locating offenders for service of process. In addition, the new laws will strengthen the violation of orders of protection and will improve safeguards for college students who possess an order of protection.

• As a part of the “Annual Legislative Advocacy Day” sponsored by the National Network to End Domestic Violence, CCADV traveled to the nation’s Capitol and then throughout the state to meet with Connecticut lawmakers to successfully garner their support for the Violence Against Women Act (VAWA), which creates and supports comprehensive, effective and cost saving responses to the crimes of domestic violence, dating violence, sexual assault and stalking.
Data Findings

Statistics compiled by CCADV and the Committee are based upon the State of Connecticut, Department of Emergency Services and Public Protection, “Family Violence Homicides: A Summary of 2010 Incidents.”

This data represents all the domestic violence related deaths known to us at the time of this report. While the report includes statistics on all family violence victims and related persons such as children and other family members, the Committee is reporting only on those crimes considered to be intimate partner violence. It is important to note that 63% of all victims were in the process of leaving the abusive relationship when the fatality occurred.

Gender
The greatest number of homicide victims were female while the greatest number of perpetrators were male.

Homicide Victims
- 17 homicide victims were female.
- 1 homicide victim was male.

Homicide Perpetrators
- 15 homicide perpetrators were male.
- 1 homicide perpetrator was female.
Data Findings

Age

In 2010, victims were spread out relatively evenly between the age ranges while the majority of perpetrators were between the ages of 40-49.

Relationship

The majority of fatalities occurred between spouses followed by live-in partners. Other persons killed were an 80 year old grandmother and a 73 year old mother-in-law who both happened to be in the home when the fatalities occurred.
Data Findings

Cause of Death

Gunshot wounds remain the number one cause of death, closely followed by the more intimate form of contact, namely stabbing and physical force.

Month of Death

The largest number of deaths occurred in May. No fatalities were recorded in either August or October.
Data Findings

Location of domestic violence fatalities.
Fatalities

When deaths occur from accidents or unnatural causes, we ask why the death occurred. In motor vehicle accidents we ask whether the driver was impaired or whether there was a problem with the automobile or road conditions. When someone dies unexpectedly with no apparent cause, we do everything possible to identify the cause and/or method of death. To make the necessary changes to avoid such deaths in the future, the Connecticut Domestic Violence Fatality Review Committee sees it as their responsibility to find answers to these questions.

The Connecticut Domestic Violence Fatality Review Committee honors the following individuals who unnecessarily lost their lives due to domestic violence in 2010:

- Madeline Bisson
- Ignacia Delvalie
- Cynthia Dunn-Cannon
- Carmen Feliciano
- Rona Knight
- Olga Louniakova
- Bonnie Mackay-Belanger
- Tobin Melish
- Dia Palafox
- Enid Pitkins
- Allison Owen
- Shengyl Rasim
- Megan Reyes
- Patti Rothermel-Dore
- Roxanne Young
- Joan Vanacore
- Yeliza Vasquez
- Sandia Walters