

News Brief

CONNECTICUT'S REVIEW PROCESS

In 2001, Connecticut joined the growing number of states reviewing intimate partner fatalities to better understand and prevent future deaths. When domestic violence is not adequately addressed, it can intensify along a predictable pattern and at times tragically end in death. Fatality review has become a nationally recognized method for understanding why people who are subjected to domestic violence are killed.

To learn further, the Connecticut Domestic Violence Fatality Review Committee conducts multi-disciplinary, systemic examinations of violent intimate partner fatalities. After a critical examination of the circumstances leading up to these fatalities, it is the responsibility of the Committee to identify the gaps and develop a set of recommendations for systemic change.

The Committee starts by chronicling all of the domestic violence deaths that have occurred over the past year. The Committee then identifies and focuses on a small number of cases – three to five a year. This allows for an in-depth examination of all of the facts using the disciplinary expertise of each Committee member. The Committee then 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. All interviews are carried out with great care and sensitivity.

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. Potential solutions paired with action plans are crucial. The point is not to merely restate previously identified concerns.

It is important to note that the Committee is always mindful that we are taking a glimpse into a human life and death therefore, we are truly committed to treating each review with great respect. Respect for the privacy of the victims and their families is the reason that identifying details are removed from all reports and publications.

We strive to enhance safety for victims and increase accountability of batterers. The purpose is NOT to assign blame. The purpose is to create CHANGE.

WELCOME

We are pleased to present this first News Brief as your introduction to the Connecticut Domestic Violence Fatality Review Committee. This work group is convened by the Connecticut Coalition Against Domestic Violence (CCADV) and is comprised of dedicated representatives from organizations who support individuals and families impacted by domestic violence.

MISSION AND OBJECTIVES

The Connecticut Domestic Violence Fatality Review Committee seeks to prevent future deaths by conducting multi-disciplinary, systemic examinations of violent intimate partner fatalities.

Our 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

NATIONAL FATALITY REVIEW CONFERENCE

Select members of the Committee attended the New Directions in Domestic Violence Fatality Review conference in Phoenix, Arizona on August 16-17, 2010. Guest speakers at the conference included committee members, Larry and Shirley Bostrom, who are internationally known and respected for their work in the field of domestic violence fatality review. Their presentations included compelling testimony regarding the tragic death of their daughter, Margaret, interviewing techniques and family involvement in the fatality review process.

CCADV Fatality Review Training

On May 20, 2010, the Committee sponsored a training for individuals from domestic violence agencies, community providers, municipal and statewide organizations on the purpose and process of conducting a domestic violence fatality review.

The training was facilitated by David M. Sargent, owner of Sargent and Edwards Law Enforcement Consulting and a consultant and trainer for the Maryland Network Against Domestic Violence. Mr. Sargent was joined by Dorothy J. Lennig, director of the Domestic Violence Legal Clinic for the House of Ruth and chair of the Baltimore City Domestic Violence Fatality Review Team.

Those in attendance participated in a thorough review of a Connecticut domestic violence fatality. Representatives from the community where the fatality occurred presented the case information. Mr. Sargent and Ms. Lenning led the case analysis process which yielded a wealth of information. Law enforcement, victim advocates and community based service providers made several recommendations that are currently under review by the Committee. A theme that appeared throughout the review was the need to address the vicarious trauma that is experienced by all first responders to a domestic violence fatality. The following recommendations to enhance the Committee were immediately implemented:

- Add representation from a rural domestic violence agency: Lori Rivenburgh, Executive Director of Women's Support Services in Sharon joined the Committee.
- Add representation from the Office of Victim Services: Linda Cimino, Director of the Office of Victim Services (OVS) joined the Committee. Upon request, Victim Advocates from OVS will participate in reviews.

A full report detailing additional recommendations will be available August 1, 2011.



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