



**STATE OF CONNECTICUT, DEPARTMENT OF PUBLIC SAFETY-  
INVESTIGATION REPORT (DPS-302-E) (REVISED 2/3/06)**

Report #: 1200704559 - 00006829

Report Type: Initial Report:  Prosecutors Report:  Supplement:  Re-open:  Assist:  Closing:

Attachments: Statements:  Teletype:  Photos:  Sketchmap:  Evidence:  Other:

CFS NO 1200704559	INCIDENT DATE 12/14/2012	TIME 09:41	INCIDENT DATE 12/14/2012	TIME	PRIMARY OFFICER JEWISS, DANIEL E.	BADGE NO 0034	INVESTIGATING OFFICER VAN NESS, RACHAEL	BADGE NO 1431
INCIDENT ADDRESS 00012 Dickison Dr Dr/ Newtown 06482					APARTMENT NO	TOWN CD	TYPE OF EXCEPTIONAL CLEARANCE Not Applicable	CASE STATUS Active

Action Taken: On 1/2/13, this Detective contacted the Office of Victim Services (OVS), 225 Spring Street, Fourth Floor, Wethersfield, CT, and was directed to Rachel McKnight, Claims Supervisor for the Judicial Branch of OVS, regarding information that could be given to the families of any children that were physically present at Sandy Hook Elementary School on 12/14/12.

McKnight advised this Detective that some families may have been given the wrong forms to fill out on 12/14/12, and subsequently forwarded the correct form that the families should be submitting via e-mail to this Detective.

The correct application form, sent by McKnight, was the "Non-Relative Child Witness to Domestic Violence Compensation Application." It was explained to this Detective that one application for each child in a family that was present at S.H.E.S. on 12/14/12 should be prepared and submitted, and that OVS may help pay for up to \$2,000 for out-of-pocket counseling expenses and/or prescription costs not covered by insurance. McKnight also attached a copy of a letter explaining the application and clarifying which sections would need to be filled out by the applicants (see attached.)

It was further explained to this Detective that OVS compensation does not cover emotional trauma normally, and regularly would only cover physical or bodily injury, and that they were stretching their standard practice to include coverage for all of the students under a domestic violence canopy for this particular case. As a result, it was explained that as a result of this, they are not able to cover any expenses for parents such as missed work days or reimbursement as a result, which they would normally consider.

Copies of the application were e-mailed on 1/2/13 to **01 02 03 12**, parent of a surviving child from Miss Soto's class, with the request that she forward the information to the parents of the other survivors, all of whom she is in communication with (see attached email).

THE UNDERSIGNED, AN INVESTIGATOR HAVING BEEN DULY SWORN DEPOSES AND SAYS THAT: I AM THE WRITER OF THE ATTACHED POLICE REPORT PERTAINING TO THIS INCIDENT NUMBER. THAT THE INFORMATION CONTAINED THEREIN WAS SECURED AS A RESULT OF (1)MY PERSONAL OBSERVATION AND KNOWLEDGE; OR (2)INFORMATION RELAYED TO ME BY OTHER MEMBERS OF MY POLICE DEPARTMENT OR OF ANOTHER POLICE DEPARTMENT;OR (3)INFORMATION SECURED BY MYSELF OR ANOTHER MEMBER OF A POLICE DEPARTMENT FROM THE PERSON OR PERSONS NAMED OR IDENTIFIED THEREIN, AS INDICATED IN THE ATTACHED REPORT. THAT THE REPORT IS AN ACCURATE STATEMENT OF THE INFORMATION SO RECEIVED BY ME.				
INVESTIGATOR SIGNATURE: <b>/TFC RACHAEL VAN NESS/</b>	INVESTIGATOR I.D.#: 1431	REPORT DATE: 01/13/2013 12:20 pm	SUPERVISOR SIGNATURE <i>Sgt. [Signature]</i>	SUPERVISOR I.D.#: 130



STATE OF CONNECTICUT, DEPARTMENT OF PUBLIC SAFETY-  
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The status of the case remains actively under investigation.

<p>THE UNDERSIGNED, AN INVESTIGATOR HAVING BEEN DULY SWORN DEPOSES AND SAYS THAT: I AM THE WRITER OF THE ATTACHED POLICE REPORT PERTAINING TO THIS INCIDENT NUMBER. THAT THE INFORMATION CONTAINED THEREIN WAS SECURED AS A RESULT OF (1) MY PERSONAL OBSERVATION AND KNOWLEDGE; OR (2) INFORMATION RELAYED TO ME BY OTHER MEMBERS OF MY POLICE DEPARTMENT OR OF ANOTHER POLICE DEPARTMENT; OR (3) INFORMATION SECURED BY MYSELF OR ANOTHER MEMBER OF A POLICE DEPARTMENT FROM THE PERSON OR PERSONS NAMED OR IDENTIFIED THEREIN, AS INDICATED IN THE ATTACHED REPORT. THAT THE REPORT IS AN ACCURATE STATEMENT OF THE INFORMATION SO RECEIVED BY ME.</p>				
<p>INVESTIGATOR SIGNATURE: <b>/TFC RACHAEL VAN NESS/</b></p>	<p>INVESTIGATOR I.D.#: 1431</p>	<p>REPORT DATE: 01/13/2013 12:20 pm 00038</p>	<p>SUPERVISOR SIGNATURE <i>Sgt. [Signature]</i></p>	<p>SUPERVISOR I.D.#: 130</p>

## Van Ness, Rachael

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**From:** [REDACTED] 01 02 03 12  
**Sent:** Wednesday, January 02, 2013 1:47 PM  
**To:** Van Ness, Rachael  
**Subject:** Re: Child Witness Application Forms

Thank you.

Any news on meeting time and date? Very eager parents.

[REDACTED]

Sent from my iPhone

On Jan 2, 2013, at 1:03 PM, "Van Ness, Rachael" <[Rachael.VanNess@ct.gov](mailto:Rachael.VanNess@ct.gov)> wrote:

Hi [REDACTED]...Rachel McKnight was able to e-mail me this application and she tried to clarify the details for you as well (see below.) Once you open the attachment there is a cover page to try to simplify the parts of the application that need to be filled out for [REDACTED], please complete one application for each child...please pass this along to any of the other parents as well, this is the appropriate application for them to be using and is a little bit different than the one given out early on by the Victim Services contact person (Ashley Hall) from the FBI ...if you have any issue printing it just let me know and I will print them and drive them down to you....I hope the orientation for [REDACTED] went well, you are all in our thoughts. -Rachael

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**From:** McKnight, Rachel [<mailto:Rachel.McKnight@jud.ct.gov>]  
**Sent:** Wednesday, January 02, 2013 12:08 PM  
**To:** Van Ness, Rachael  
**Subject:** Child Witness Application Forms

Hi Rachael-Attached is an instruction letter and an Office of Victim Services Child Witness. The Office of Victim Services (OVS) may help pay for up to \$2,000 for out-of-pocket counseling expenses and any prescription costs not covered by insurance for any child that was present at Sandy Hook Elementary School on December 14, 2012. When meeting with the [REDACTED] family you may want to make two copies for a parent to complete. One for each child. It is ok to use copies. The application would just have to be mailed by to OVS as we need the original signature. Our address is on the last page of the application.

I have also enclosed my business card. If the [REDACTED] family, you or any of your colleagues have any questions, please feel free to call me.

Take Care,  
Rachel

OVS -- Proudly serving crime victims for over 30 years

Rachel McKnight  
Claims Supervisor  
Office of Victim Services  
225 Spring Street, Fourth Floor  
Wethersfield, CT 06109  
Telephone: 860-263-2761  
Fax: 860-263-2780

<Child\_Witness\_App.pdf>

<Business Card.pdf>

## Van Ness, Rachael

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**From:** McKnight, Rachel [Rachel.McKnight@jud.ct.gov]  
**Sent:** Wednesday, January 02, 2013 12:08 PM  
**To:** Van Ness, Rachael  
**Subject:** Child Witness Application Forms  
**Attachments:** Child\_Witness\_App.pdf; Business Card.pdf

Hi Rachael-Attached is an instruction letter and an Office of Victim Services Child Witness. The Office of Victim Services (OVS) may help pay for up to \$2,000 for out-of-pocket counseling expenses and any prescription costs not covered by insurance for any child that was present at Sandy Hook Elementary School on December 14, 2012. When meeting with the 01 02 03 12 family you may want to make two copies for a parent to complete. One for each child. It is ok to use copies. The application would just have to be mailed by to OVS as we need the original signature. Our address is on the last page of the application.

I have also enclosed my business card. If the 01 02 03 12 family, you or any of your colleagues have any questions, please feel free to call me.

Take Care,  
Rachel

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Rachel McKnight  
Claims Supervisor  
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225 Spring Street, Fourth Floor  
Wethersfield, CT 06109  
Telephone: 860-263-2761  
Fax: 860-263-2780

STATE OF CONNECTICUT  
JUDICIAL BRANCH  
OFFICE OF VICTIM SERVICES



RACHEL MCKNIGHT  
CLAIMS SUPERVISOR

225 SPRING STREET  
WETHERSFIELD, CT 06109  
E-MAIL: RACHEL.MCKNIGHT@JUD.CT.GOV

TEL: (860) 263-2761  
FAX: (860) 263-2780  
TDD: (860) 263-2779



CONNECTICUT JUDICIAL BRANCH  
**OFFICE OF VICTIM SERVICES**  
225 Spring Street, Fourth Floor, Wethersfield, CT 06109

Compensation Unit  
Telephone: 860-263-2761  
Toll-Free: 1-888-286-7347  
Fax: 860-263-2780  
TDD: 711

December 2012

We know that this is a very difficult time for you and your family and would like to provide you with information on an OVS program that may be helpful to you.

If your child(ren) were physically present at Sandy Hook Elementary School on December 14, 2012, the OVS **Compensation Program** may help pay up to \$2,000 for out-of-pocket counseling expenses and any prescription costs that are not covered by insurance.

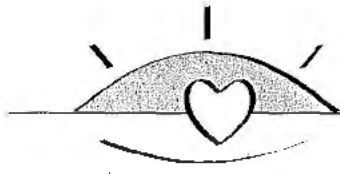
To apply for victim compensation, please complete sections 2, 3, 7, 8, and 9 of the OVS Non-Relative Child Witness To Domestic Violence Compensation application and return it to the address provided. Once OVS has received your application, you will be assigned a claims examiner who will work with you and be able to answer any of your questions.

If you would like referrals to other state and community agencies that may be able to help, please call Infoline at 211 or the OVS Helpline at **1-800-844-8428**.

We understand that you have received many offers for help and this might not be the appropriate time to focus on the services available to you through OVS, but please know that there is no time limit on accessing our services.

Sincerely,

The Staff of the Office of Victim Services



NON-RELATIVE CHILD WITNESS  
TO DOMESTIC VIOLENCE COMPENSATION

APPLICATION  
ID-VS-8W 10/12

OFFICE OF VICTIM SERVICES  
*Focusing on a brighter future*

**We are here to help.** If you have any questions about filling out this application or the Compensation Program, please call us toll-free at 1-888-286-7347. Please know that it is important that you tell us if your contact information changes. If we cannot reach you, your claim may be closed or you may miss important deadlines set by state law. If the child is related to the victim, you may have to fill out a different application. Please call us for more information.

**SECTION 1 - VICTIM INFORMATION**

The victim is the person who was physically injured in a domestic violence crime. Please fill out as much of the information that you know.

Name of victim (last, first, middle)

**TO BE COMPLETED BY OVS STAFF**

Address

City

State Zip

Gender:  Female  Male  Other \_\_\_\_\_

**SECTION 2 - CHILD WITNESS/CLAIMANT INFORMATION**

The witness is the child (under 18 years old) who saw the incident and needs mental health counseling because of the crime. Parents and legal guardians of a minor child (under 18 years old) must also fill out Section 3.

Name of witness (last, first, middle)

Birth date

Age

Address

City

State Zip

Home telephone

Gender:  Female  Male  Other \_\_\_\_\_

**SECTION 3 - PARENT/LEGAL GUARDIAN INFORMATION**

This section is for parents and legal guardians of children under 18 years old. (Legal guardians or conservators must provide a copy of the court order.)

Name of parent or legal guardian (last, first, middle)

How are you related to the child witness?

Address

City

State Zip

Home telephone

Work telephone

Cell phone

Email

Primary language spoken

Gender:  Female  Male  Other \_\_\_\_\_

*The parent/legal guardian of a minor child (under 18 years old) must sign Section 9 of this application. Applications that are not signed will be returned.*



**SECTION 4 - ATTORNEY REPRESENTATION**

Please fill out this section if an attorney is representing you on this application.

Name of attorney (last, first, middle)		Name of firm	
Address	City	State	Zip
Work telephone	Fax number	Juris number	

**SECTION 5 - STATISTICAL INFORMATION**

How did you find out about the Victim Compensation Program?

- |   |   |   |
|---|---|---|
| <input type="radio"/> community advocate  | <input type="radio"/> mental health provider    | <input type="radio"/> private attorney            |
| <input type="radio"/> family member       | <input type="radio"/> Office of Adult Probation | <input type="radio"/> prosecutor/state's attorney |
| <input type="radio"/> friend/acquaintance | <input type="radio"/> OVS victim advocate       | <input type="radio"/> public service announcement |
| <input type="radio"/> hospital            | <input type="radio"/> OVS web page              | <input type="radio"/> telephone book              |
| <input type="radio"/> Infoline 211        | <input type="radio"/> police                    | <input type="radio"/> other _____                 |
| <input type="radio"/> medical provider    | <input type="radio"/> poster/brochure           |   |

Statistics are voluntary and needed for federal reporting requirements.

- |                                |  |
|--------------------------------|--|
| <input type="radio"/> white    | <input type="radio"/> black/african american           |
| <input type="radio"/> hispanic | <input type="radio"/> native hawaiian/pacific islander |
| <input type="radio"/> asian    | <input type="radio"/> american indian/alaskan native   |
| <input type="radio"/> other    | <input type="radio"/> unknown                          |

**SECTION 6 - CRIME INFORMATION**

Please fill out this section.

Type of crime:  domestic violence personal injury  domestic violence homicide

Date of crime	Address and city or town where crime happened
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Is the child a relative of the victim?  yes  no

(If yes, you may have to fill out a different application. Please call the Compensation Program toll-free at 1-888-286-7347 for more information.)

Briefly describe how the child saw the crime and the child's physical or emotional injuries from witnessing it.

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**SECTION 7 - COUNSELING/MEDICAL INFORMATION**

Please list all of the hospitals, doctors, mental health counselors, and others who provided treatment or services to the child because he or she witnessed the crime and list the prescriptions (drugs) the child was given because of it (attach additional pages, if needed) and include copies of any crime related bills.

*Provider Telephone Address City State Zip*

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**SECTION 8 - INSURANCE & OTHER FINANCIAL RESOURCES**

*This section must be filled out.* Please check yes or no for each of the financial resources below that you have or may be able to get paid by. If the financial resource is not one that you can get paid by, please check no. You must contact us if any of the financial resources checked as No become available in the future.

<i>Financial Resources</i>	<i>Yes</i>	<i>No</i>	<i>Provider Name</i>	<i>Address</i>	<i>Telephone</i>	<i>Account No.</i>
Department of Social Services (MEDICAL)	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Health Insurance (PRIMARY)	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Health Insurance (SECONDARY)	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Health Savings/Spending Accounts						
Flexible Spending Account	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Health Reimbursement Account	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Health Savings Account	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Medicare	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Veterans Administration	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____

**SECTION 9 - STATEMENT OF FACTS AND AUTHORIZATION**

I certify that the information in this application for compensation is true to the best of my knowledge, information, and belief and I give permission to any hospital, physician(s) or other person(s) who attended, examined, or gave services to \_\_\_\_\_, any police or other municipal authority or agency, or public authorities including state and federal revenue services, any insurance company or organization having knowledge of the incident to give to OVS or its representative any and all information regarding the incident leading to the witness' application for compensation. A copy of this authorization will be considered as effective and valid as the original.

I, \_\_\_\_\_ give permission to OVS to disclose any information in its records, including confidential information, to the offices of the Court Support Services Division, the State's Attorney, the Attorney General and to private attorneys retained by OVS or the victim, and to communicate freely with them when necessary (Sections 54-208(e), 54-212, and 54-215 of the Connecticut General Statutes).

I understand that I must notify OVS if I file a lawsuit against whoever is responsible for the injury or death for which OVS paid the award within 30 days of the filing of the action in court. If I recover money from the lawsuit, either by a judgment or by settlement, I understand that OVS is entitled by law to 2/3 of the amount OVS paid. (Section 54-212 of the Connecticut General Statutes). If I have filed a lawsuit, I agree to provide a copy of the writ, summons, and complaint to OVS immediately.

I understand that OVS will have the right to bring a lawsuit in my name against whoever is responsible for the injury or death for which the money was paid. I also understand that if OVS recovers money from the lawsuit, it is entitled by law to keep 2/3 of the amount paid, plus costs and interest. OVS will pay me any balance over that amount (Section 54-212 of the Connecticut General Statutes).

I understand that if I receive money from any other sources, including payments from state or municipal agencies, insurance benefits, or workers' compensation as a result of the criminal incident, OVS is entitled by law to 2/3 of the amount OVS paid (Section 54-212 of the of the Connecticut General Statutes).

I understand that if the court orders restitution to the victim for expenses paid by OVS, OVS is entitled to receive full reimbursement, unless the court orders differently (Section 54-215 of the Connecticut General Statutes).

I also understand that my providers may be reimbursed directly for debts that I owe.

**Applicant signature** (A parent or guardian must sign if the claimant is a minor or incompetent adult)

**Date**

The parent/legal guardian of a minor child (under 18 years old) **must sign** this application. Applications that are not signed will be returned.

**Please return completed application to:**

Office of Victim Services  
225 Spring Street, 4th Floor  
Wethersfield, CT 06109

**Contact OVS at:**

1-888-286-7347 (Toll-free)  
860-263-2761  
[www.jud.ct.gov/crimevictim](http://www.jud.ct.gov/crimevictim)

FOR OFFICE USE ONLY

Claim Number

Claims Examiner