Domestic Violence Death Review Committee 2013-14 Annual Report

Office of the Chief Coroner for Ontario

October 2015

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Message from the Chair

Many readers will note that it has been two years since the last report of the Domestic Violence Death Review Committee (DVDRC). Regrettably, a variety of factors, including personnel changes and resource issues were responsible for this delay.

The publication of the 2013-2014 Annual Report of DVDRC represents the twelfth year that the Office of the Chief Coroner has reported on its reviews and on the incidence of domestic homicide and domestic homicide-suicide in Ontario. Since its inception in 2003, the DVDRC has now reviewed 199 cases involving 290 deaths.

For those who have been anxiously awaiting this report, you will note some changes to this report's format. In addition to a statistical overview of cases reviewed in 2013 and 2014, we have provided a cumulative analysis of our statistics from the Committee's inception. As our database continues to grow, we believe that the importance of this information is stronger and more valid in analyzing trends, patterns and emerging issues.

For logistical reasons, this year's report does not contain a chapter of abbreviated case reviews. However, any recommendations arising from those cases are contained in Appendix A. For readers interested in receiving a more fulsome, redacted version of the DVDRC report on individual cases, they may be requested directly from the Executive Lead, Committee Management, at the Office of the Chief Coroner: occ.inquiries@ontario.ca

I would also like to acknowledge Kathy Kerr, Executive Lead, Committee Management, who is temporarily on secondment assisting another branch of our Ministry, and Tara McCord, A/Executive Lead, who has done a spectacular job at stepping into a new and challenging position. Without their very capable assistance, resourcefulness and perseverance, the Committee would not have been able to accomplish so much.

As we look forward to 2015-2016, we will continue to enhance our database in a way that is meaningful and of assistance to all who look to it as a valuable resource.

W.J. Lucas

William J. Lucas, MD CCFP
Regional Supervising Coroner – Central West
Chair, Domestic Violence Death Review Committee

Committee Membership

William Lucas, MD, CCFP.
Committee Chair
–Regional Supervising Coroner – Central West

Karen Bridgman-Acker, MSW, RSW (2013-2014)
Child Welfare Specialist, Paediatric Death Review Committee

Jessica Diamond (2014)
A/Executive Lead, Child Welfare, Office of the Chief Coroner

Marcie Campbell, M.Ed
Counsellor, PAR Program, John Howard Society of Toronto

Gail Churchill, M.D.
Investigating Coroner

Kimberley Clark, MBA
Ontario Network of Victim Services Providers

Myrna Dawson, Ph.D.
Associate Professor, Department of Sociology & Anthropology, University of Guelph

Monica Denreyer
Detective Sergeant, Ontario Provincial Police, Threat Assessment Unit

Barb Forbes
A/Deputy Regional Director
Western Regional Office – Ministry of Community Safety and Correctional Services

Jim Glena
Sergeant, Thunder Bay Police Service

Craig Harper
Crown Attorney

MaryEllen Hurman (2013-2014)
Crown Attorney

Peter Jaffe, Ph.D., C.Psych.
Professor, Centre for Research on Violence Against Women & Children, Western University

Leslie Raymond
Detective Sergeant, Ontario Provincial Police, Abuse Issues Coordinator, Central Region

Deborah Sinclair, M.S.W.
Social Worker

Lynn Stewart, Ph.D., C.Psych.
National Manager, Family Violence Prevention Programs, Correctional Service Canada

Mark Gauthier
Detective Sergeant, Ontario Provincial Police

Kathy Kerr, M.A. (2013-2014)
Executive Lead, Committee Management, Office of the Chief Coroner

Tara McCord (2014)
A/Executive Lead, Committee Management, Office of the Chief Coroner

Executive Summary

Cases reviewed from 2003-2014:

- From 2003-2014, the DVDRC has reviewed 199 cases, involving 290 deaths
- 61% of the cases reviewed were homicides.
- 39% of the cases reviewed were homicide-suicides.
- 72% of all cases reviewed from 2003-2014 involved a couple where there was a history of domestic violence.
- 69% of the cases involved a couple with an actual or pending separation.
- The other top risk factors were:
    - obsessive behaviour by the perpetrator
    - a perpetrator who was depressed
    - an escalation of violence
    - prior threats or attempts to commit suicide
    - prior threats to kill the victim
    - prior attempts to isolate the victim
    - a victim who had an intuitive sense of fear towards the perpetrator
    - a perpetrator who was unemployed
- In 80% of the cases reviewed, seven or more risk factors were identified.

Cases Reviewed in 2013:

- There were 19 cases reviewed by the DVDRC in 2013. These included 17 homicide cases and two homicide-suicide cases, resulting in 22 deaths (20 homicide victims and two perpetrator suicides).
- 9 recommendations were generated through these reviews.
- Of the 20 victims in the cases reviewed, 17 (85%) were female and three (15%) were male.
- 16 (80%) of the 19 cases involved male perpetrators and four (20%) involved female perpetrators (Note: one case involved two perpetrators, of which one was male and one was female).
- The victims ranged in age from 1.5 years to 66 years.
- The average age for victims was 33.0 years.
- The perpetrators ranged in age from 20 to 69 years.
- The average age for perpetrators was 41.2 years.
- The average number of risk factors identified in the cases reviewed was 11.26.
- The number of risk factors ranged from one to 22.
- 15 (79%) of the cases had seven or more risk factors.

Cases Reviewed in 2014:

- There were 16 cases reviewed by the DVDRC in 2014. These included 15 homicide cases and one homicide-suicide cases, resulting in 17 deaths (16 homicide victims and one perpetrator suicide).
- 25 recommendations were generated through these reviews.
- Of the 16 victims in the cases reviewed, 14 (90%) were female and two (10%) were male.
- 14 (90%) of the 16 cases involved male perpetrators and two (10%) involved female perpetrators.
- The victims ranged in age from 16 years to 82 years.
- The average age for victims was 45.1 years.
- The perpetrators ranged in age from 22 to 82 years.
- The average age for perpetrators was 46.4 years.
- The average number of risk factors identified in the cases reviewed was 9.13.
- The number of risk factors ranged from one to 17.
- 11 (69%) of the cases had seven or more risk factors.

Domestic Violence Death Review Committee Aims & Objectives:

Purpose

The purpose of this committee is to assist the Office of the Chief Coroner in the investigation and review of deaths of persons that occur as a result of domestic violence, and to make recommendations to help prevent such deaths in similar circumstances.

Objectives

1. To provide and coordinate a confidential multi-disciplinary review of domestic violence deaths pursuant to Section 15(4) of the Coroners Act, R.S.O. 1990, Chapter c. 37, as amended.
2. To offer expert opinion to the Chief Coroner regarding the circumstances of the event(s) leading to the death in the individual cases reviewed.
3. To create and maintain a comprehensive database about the victims and perpetrators of domestic violence fatalities and their circumstances.
4. To help identify the presence or absence of systemic issues, problems, gaps, or shortcomings of each case to facilitate appropriate recommendations for prevention.
5. To help identify trends, risk factors, and patterns from the cases reviewed to make recommendations for effective intervention and prevention strategies.
6. To conduct and promote research where appropriate.
7. To stimulate educational activities through the recognition of systemic issues or problems and/or:
    - referral to appropriate agencies for action;
    - where appropriate, assist in the development of protocols with a view to prevention;
    - where appropriate, disseminate educational information.
8. To report annually to the Chief Coroner the trends, risk factors, and patterns identified and appropriate recommendations for preventing deaths in similar circumstances, based on the aggregate data collected from the Domestic Violence Death Reviews.

Note: All of the above described objectives and attendant committee activities are subject to the limitations imposed by the Coroners Act of Ontario Section 18(2) and the Freedom of Information and Protection of Privacy Act.

Chapter One: Introduction and Overview

History

The Domestic Violence Death Review Committee (DVDRC) is a multi-disciplinary advisory committee of experts that was established in 2003 in response to recommendations made from two major inquests into the deaths of Arlene May/Randy Iles and Gillian and Ralph Hadley.

The Terms of Reference for the DVDRC are included in **Appendix B**.

Membership

The DVDRC consists of representatives with expertise in domestic violence from law enforcement, the criminal justice system, the healthcare sector, social services and other public safety agencies and organizations.

Several members of the present committee have been involved since the DVDRC's inception in 2003. Membership has evolved over the years to address changing and emerging issues that have been identified. In some cases, external expertise on specific issues may be sought if necessary.

Definition of Domestic Violence

Within the context of the DVDRC, domestic violence deaths are defined as "*all homicides that involve the death of a person, and/or his or her child(ren) committed by the person's partner or ex-partner from an intimate relationship.*"

For the purposes of statistical comparisons, it is important to note that the definitions and criteria of domestic violence deaths utilized by other organizations and agencies, including Statistics Canada, may be different than those used by the DVDRC.

Method for Reviewing Cases

Reviews are conducted by the DVDRC only after all other investigations and proceedings – including criminal trials and appeals – have been completed. As such, DVDRC reviews often take place several years after the actual incident.

When a domestic violence homicide or homicide-suicide takes place in Ontario, the relevant Regional Supervising Coroner notifies the Executive Lead of the DVDRC and the basic case information is recorded in a database. The Executive Lead, together with a police liaison officer assigned to the DVDRC, periodically verify the status of judicial and other proceedings to determine if the review can commence. Since cases involving homicide-suicides generally do not result in criminal proceedings, cases are reviewed in a more timely fashion.

Once it has been determined that a case is ready for review (i.e. all other proceedings and investigations have been completed), the case file is assigned to a reviewer (or reviewers). The case file may consist of records from the police, Children's Aid Society (CAS), healthcare professionals, counselling professionals, courts, probation and parole, etc.

Each reviewer conducts a thorough examination and analysis of facts within individual cases and presents their findings to the DVDRC as a whole. Information considered within this examination includes the history, circumstances and conduct of the perpetrators, the victims and their families. Community and systemic responses are examined to determine primary risk factors, to identify possible points of intervention and develop recommendations that could assist with the prevention of similar future deaths. In general, the DVDRC strives to develop a comprehensive understanding of why domestic homicides occur and how they might be prevented.

Recommendations

One of the primary goals of the DVDRC is to make recommendations aimed at preventing deaths in similar circumstances and reducing domestic violence in general. Recommendations are distributed to relevant organizations and agencies through the Chair of the DVDRC. Recommendations are listed in Appendix A. The phrase "no new recommendations" means that either no issues requiring recommendations were identified from the case review; or that an issue or theme was identified where a previous recommendation (or recommendations) had been made in a prior case.

Similar to recommendations generated through coroner's inquests, the recommendations developed by the DVDRC are not legally binding and there is no obligation for agencies and organizations to implement or respond to them. Organizations and agencies are asked to respond back to the Executive Lead, DVDRC on the status of implementation of recommendations within one year of distribution.

Review and Report Limitations

Information collected and examined by the DVDRC, as well as the final report produced by the committee, are for the sole purpose of a coroner's investigation pursuant to section 15 of the *Coroners Act*, R.S.O. 1990 Chapter c.37, as amended. For this reason, there may be limitations on the types of records accessed for the DVDRC review, particularly as they relate to living individuals (e.g. perpetrators) and therefore protected under other privacy legislation.

All information obtained as a result of coroners' investigations and provided to the DVDRC is subject to confidentiality and privacy limitations imposed by the *Coroners Act* of Ontario and the *Freedom of Information and Protection of Privacy Act*. Unless and until an inquest is called with respect to a specific death or deaths, the confidentiality and privacy interests of the decedents, as well as those involved in the circumstances of the death, will prevail. Accordingly, individual reports, as well as the minutes of review meetings and any other documents or reports produced by the DVDRC, remain private and protected and will not be released publicly. Review meetings are not open to the public.

Each member of the committee has entered into, and is bound by, a confidentiality agreement that recognizes these interests and limitations.

Reviews are limited to the information and records collected for the purposes of furthering the coroner's investigation. It is not the intent or mandate of the DVDRC to re-open or re-investigate cases, question investigative techniques or comment on decisions made by judicial bodies.

Annual Report

The terms of reference for the DVDRC direct that the committee, through the chairperson, reports annually to the Chief Coroner regarding the trends, risk factors, and patterns identified through the reviews, and makes appropriate recommendations to prevent deaths in similar circumstances.

Disclaimer

The following disclaimer applies to individual case reviews and to this report as a whole:

This document was produced by the DVDRC for the sole purpose of a coroner's investigation pursuant to section 15 of the *Coroners Act*, R.S.O. 1990 Chapter c. 37, as amended. The opinions expressed do not necessarily take into account all of the facts and circumstances surrounding the death. The final conclusion of the investigation may differ significantly from the opinions expressed herein.

Chapter Two: Statistical Overview

Collection of Data

Since its inception in 2003, a variety of data has been collected from homicide cases involving domestic violence that have been investigated by the Office of the Chief Coroner. As the committee has evolved, so too have the processes for reviewing, collecting and analyzing information that has been obtained. The DVDRC strives to provide information and analyses that are accurate, valid and useful to relevant stakeholders.

Types of Data

It is important to recognize that there are two separate and distinct sets of data relating to domestic violence homicides in Ontario:

1. Data relating to the actual number of homicide cases where domestic violence has been identified as an involvement factor.

In Ontario, a Coroner's Investigation Statement (Form 3) is prepared for all cases investigated by a coroner. The Form 3 includes basic personal information (e.g. date of death, age, address, etc.) pertaining to the deceased, as well as a narrative that describes the circumstances surrounding the death. Investigating coroners are encouraged to identify death factors (e.g. trauma – cuts-stabs, shooting – shotgun, asphyxia-hanging, etc.) and involvement factors (e.g. abuse – domestic violence, alcohol involvement, Children's Aid involvement, etc.). The Form 3 also identifies the 'manner of death' or 'by what means' the death occurred. In Ontario, manner of death must be classified as one of the following: natural, accident, suicide, homicide or undetermined. Information from the Form 3s for all coroners' investigations are maintained within the electronic Coroner's Information System (CIS) maintained by the Office of the Chief Coroner.

Statistics generated for the purposes of this annual report reflect a 12-year period of cases occurring from 2002-2013 where: 'homicide' has been identified as the manner of death for at least one victim; 'abuse – domestic violence' has been identified and coded as an involvement; *and* the case meets the DVDRC's definition of a domestic violence death. Some cases where the manner of death is 'undetermined' and where there is involvement of domestic violence, are included in the data set.

It is important to note that some homicide cases identified with the 'abuse – domestic violence' involvement code occurring are still pending review by the DVDRC. In many cases, DVDRC reviews have not commenced because legal or other proceedings are still underway or pending.

2. Data relating to the findings of cases that have been reviewed by the DVDRC.

The second set of data relates to cases that have undergone review by the DVDRC. This data would

include information pertaining to risk factors, type and length of relationship and number/gender of victims and perpetrators. This data is collected in the thorough review conducted by the DVDRC.

The following statistics reflect the findings of analyses of the two different data sources.

Statistical Overview: Homicides with Domestic Violence Involvement (2002-2013)

The following statistics relate to homicides in Ontario occurring between 2002-2013 where 'abuse – domestic violence' has been identified as an involvement code, and that meet the DVDRC's definition of a domestic violence death. Some of these cases may have already undergone review by the DVDRC while others are pending review upon completion of other proceedings (e.g. criminal trials).

Chart One: Homicides with Domestic Violence Involvement (2002-2013)
Domestic Violence Deaths in Ontario 2002-2013

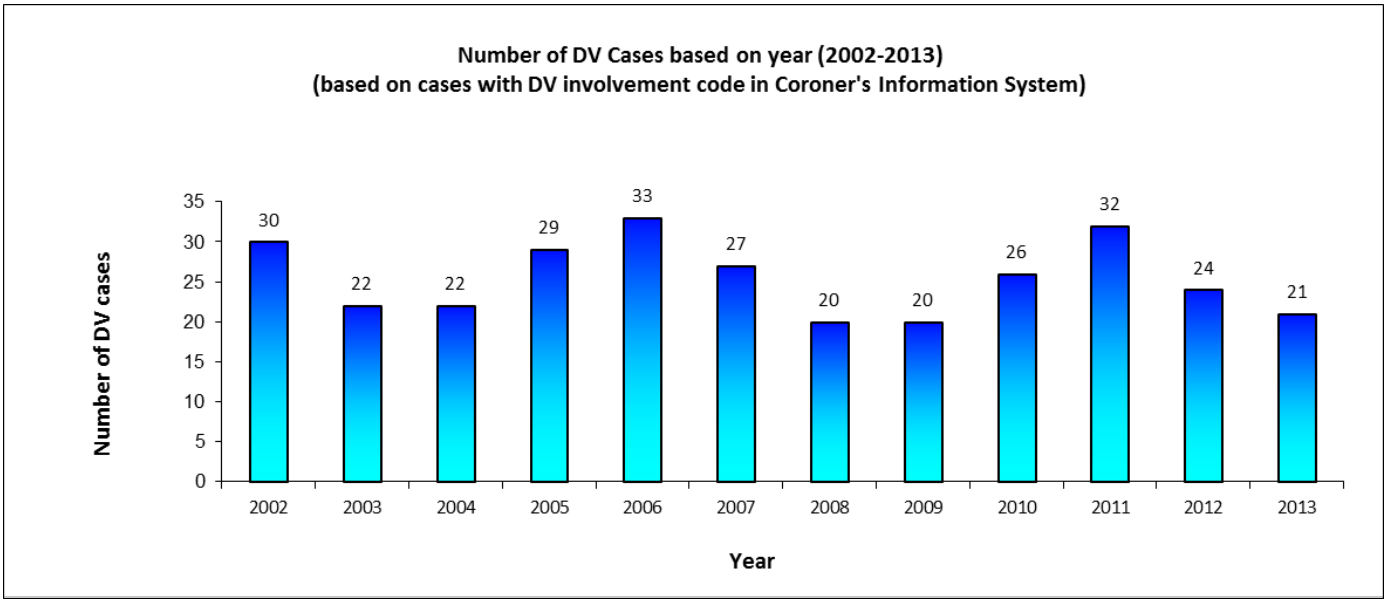
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013*	Totals
Number of cases	30	22	22	29	33	27	20	20	26	32	24	21	306
Homicides	19	18	13	21	26	17	15	15	20	25	15	17	221 72%
Homicide-suicide	11	4	9	8	7	10	5	5	6	7	9	4	85 28%
Total # of deaths	46	26	32	37	52	44	29	29	33	39	31	28	426
Total # of homicide victims	35	22	23	29	45	34	24	25	27	30	24	24	342 80%
Total # of homicide victims – female (adult)	26	19	21	29	28	27	20	20	22	28	19	21	280 82%
Total # of homicide victims – female (child)	4	1	1	0	8	1	0	3	1	0	0	0	19 6%
Total # of homicide victims – male (adult)	4	1	1	0	3	4	4	2	4	2	4	3	32 9%
Total # of homicide victims – male (child)	1	1	0	0	6	2	0	0	0	0	1	0	11 3%
Average age of homicide victim	37.8	34.9	40	38.2	28	34.7	43.3	37.2	36.1	45.6	44.8	38.8	38.3
Total # of perpetrator deaths (suicide or other)	11	4	9	8	7	10	5	4	6	9	7	4	84 20%
Total # of perpetrator deaths (suicide or other) – female (adult)	0	0	1	0	0	1	0	0	0	0	0	0	2 2%
Total # of perpetrator deaths (suicide or other) – male (adult	11	4	8	8	7	9	5	4	6	9	7	4	82 98%
Average age of deceased perpetrator	42.5	45.5	42.2	45	51.1	45.2	43.8	60	44.67	45.1	76.6	41	48.6

- In 2009, one homicide-suicide involved the suicide death of the male perpetrator outside of Ontario. His death was not an Ontario coroner's case and is not reflected in the statistics on perpetrators.
- One homicide was removed from the 2013 statistics because the victim was transported to Ontario from a territory for treatment
- *Updated October 22, 2015

Chart One: Summary

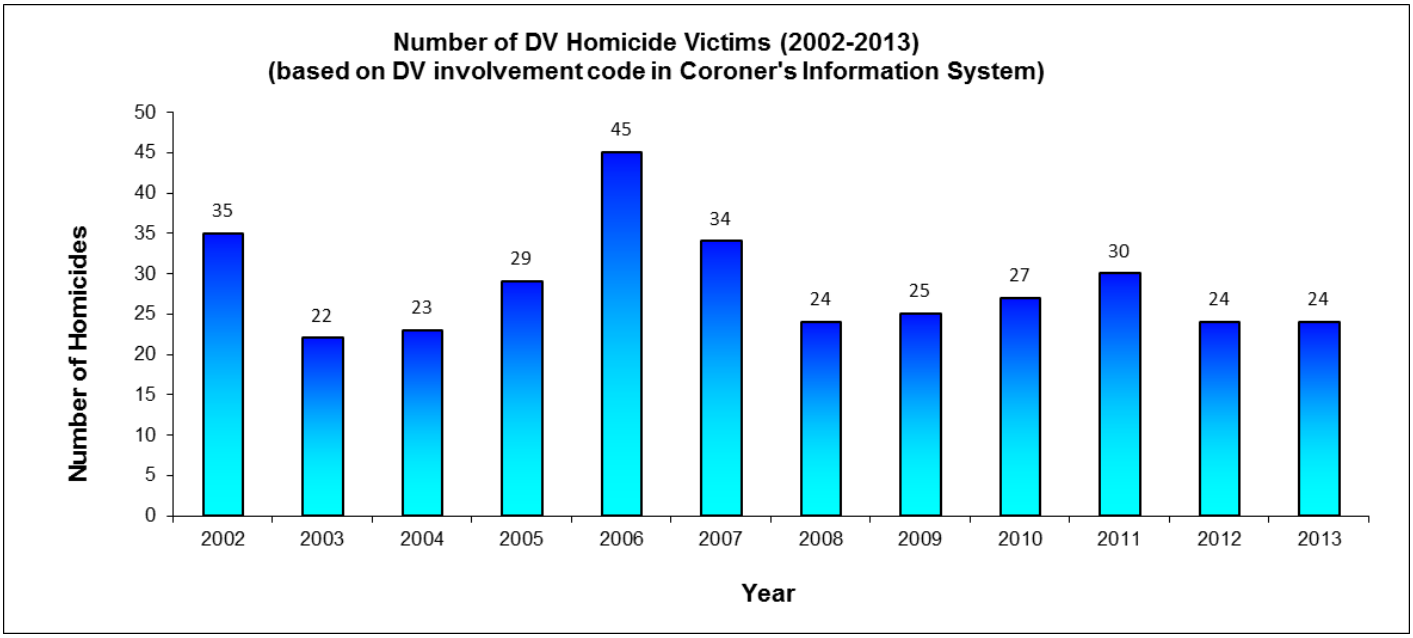
- There were 306 domestic homicide and/or homicide-suicide cases that occurred in Ontario between 2002-2013, based on cases investigated by the Office of the Chief Coroner for Ontario, where domestic violence was identified as an involvement code.
- 221 (72%) of the cases were homicides and 85 (28%) of the cases were homicide-suicides.
- The 306 cases resulted in a total of 426 deaths.
- 342 (80%) of these deaths were homicide victims and 84 (20%) were perpetrators who committed suicide or were otherwise killed (e.g. shot by police).
- There was an average of 26 domestic homicide and/or homicide-suicide cases per year from 2002-2013.
- There was an average of 28.5 domestic homicide victim deaths per year from 2002-2013.
- 280 (82%) of the homicide victims were adult females.
- 30 (9%) of the homicide victims were children.
- 32 (9%) of the homicide victims were adult males.
- 82 (98%) of the perpetrator deaths were adult males.
- The average age of homicide victims was 38.3 years.
- The average age of perpetrators who died was 48.6 years.

Graph One: Number of DV cases based on year (2002-2013) – based on cases with DV involvement in Coroner's Information System



Graph One shows the number of domestic violence cases that occurred per year from 2002-2013. The number of case occurrences per year has been as low as 20 cases in 2008 and as high as 33 cases in 2006.

Graph Two: Number of DV Homicide Victims (2002-2013)



Graph Two shows the number of domestic violence homicide victims per year from 2002-2013. The number of victims per year has varied from 22 in 2003 to 45 in 2006.

Death Factors

Death factors are utilized within the Coroner's Information System (CIS) to assist with data retrieval/extraction and analysis. Death factors describe the underlying mechanism or force responsible for non-natural deaths (e.g. trauma – motor vehicle collision) or the anatomical area or system involved for natural deaths (e.g. cardiovascular system, central nervous system). Coroners are encouraged to identify the death factor most appropriate to the circumstances of the situation, and which lead to the fatal injuries sustained by the victim.

Chart Two illustrates the death factors most commonly cited in domestic violence deaths (homicides and perpetrator deaths) identified in the CIS from 2002-2013.

Chart Two: Top Death Factors in Domestic Violence Deaths (2002-2013)

Death Factor *	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013*	Total	% of Total Deaths (2002-2013)
Trauma - cuts, stabs	15	8	11	9	21	14	8	11	16	15	7	12	147	35%
Trauma - beating, assault	5	4	4	5	6	2	0	0	3	3	2	4	38	9%
Shooting - handgun	8	5	2	4	1	9	1	3	3	1	6	4	47	11%
Shooting - rifle	2	0	3	5	5	3	3	2	1	2	0	0	26	6%
Shooting - shotgun	7	1	2	2	2	2	1	2	6	0	5	5	35	8%
Shooting - weapon (not spec.)	0	0	1	0	0	0	1	0	0	0	0	0	2	0%
Asphyxia - airway obstruction	0	1	1	0	0	1	0	1	1	2	1	0	8	2%
Asphyxia - strangulation	0	3	4	5	6	4	4	0	0	3	3	1	33	8%
Asphyxia - neck compression	0	0	0	1	2	0	2	3	0	0	0	1	9	2%
Other	**9**	**4**	**4**	**6**	**9**	**9**	**9**	**7**	**3**	**13**	**7**	**1**	**81**	**19%**
Total	46	26	32	37	52	44	29	29	33	39	31	28	426	

*Updated October 22, 2015

Summary of Chart Two: Top Death Factors in Domestic Violence Deaths (2002-2013)

- 43% of the deaths involved a death factor of trauma (cuts/stabs and beating/assault).
- 26% of the deaths involved a death factor of shooting (handgun, rifle, shotgun or gun not specified).
- 12% of the deaths involved a death factor of asphyxia (airway obstruction, strangulation and/or neck compression).
- 19% of the deaths involved other death factors including: trauma by motor vehicle, train/vehicle or blunt force; asphyxia from hanging, anoxic environment and carbon monoxide; drug toxicity; jump/fall; fire with smoke inhalation or thermal injury; burns–thermal; drowning; and deaths where the factor was unascertained.

Statistical Overview: Cases Reviewed by the DVDRC (2003-2014)

From 2003-2014, the DVDRC has reviewed 199 cases that involved a total of 290 deaths. This includes 122 homicide and 77 homicide-suicide cases, some of which may have involved multiple victims.

The following statistics relate to all cases reviewed by the DVDRC from 2003-2014 inclusive.

Chart Three: Number of Cases Reviewed by the DVDRC (2003-2014)

Year	# of cases reviewed	# of deaths involved	Type of case: Homicides	Type of case: Homicide - Suicides
2003	11	24	3	8
2004	9	11	5	4
2005	14	19	5	9
2006	13	21	4	9
2007	15	25	7	8
2008	15	17	13	2
2009	16	25	6	10
2010	18	36	6	12
2011	33	41	27	6
2012	20	32	14	6
2013	19	22	17	2
2014	16	17	15	1
Total	**199**	**290**	**122 61%**	**77 39%**

* One case involved a perpetrator that was shot by police while in the commission of the homicide. For the purposes of this review, this case will be considered a homicide-suicide.

Summary of Chart Three: Number of Cases Reviewed by the DVDRC (2003-2014)

- In the period between 2003 and 2014, the DVDRC has reviewed 199 cases, involving 290 deaths.
- 122 (61%) of the cases reviewed were homicides.
- 77 (39%) of the cases reviewed were homicide-suicides.

Analysis of Risk Factors: Common Risk Factors

Based on extensive research, the DVDRC has created a list of 39 risk factors that indicate the potential for lethality within the relationship examined. The recognition of multiple risk factors within a relationship potentially allows for enhanced risk assessment, safety planning and possible prevention of future deaths related to domestic violence through appropriate interventions by criminal justice system and healthcare partners, including high risk case identification and management.

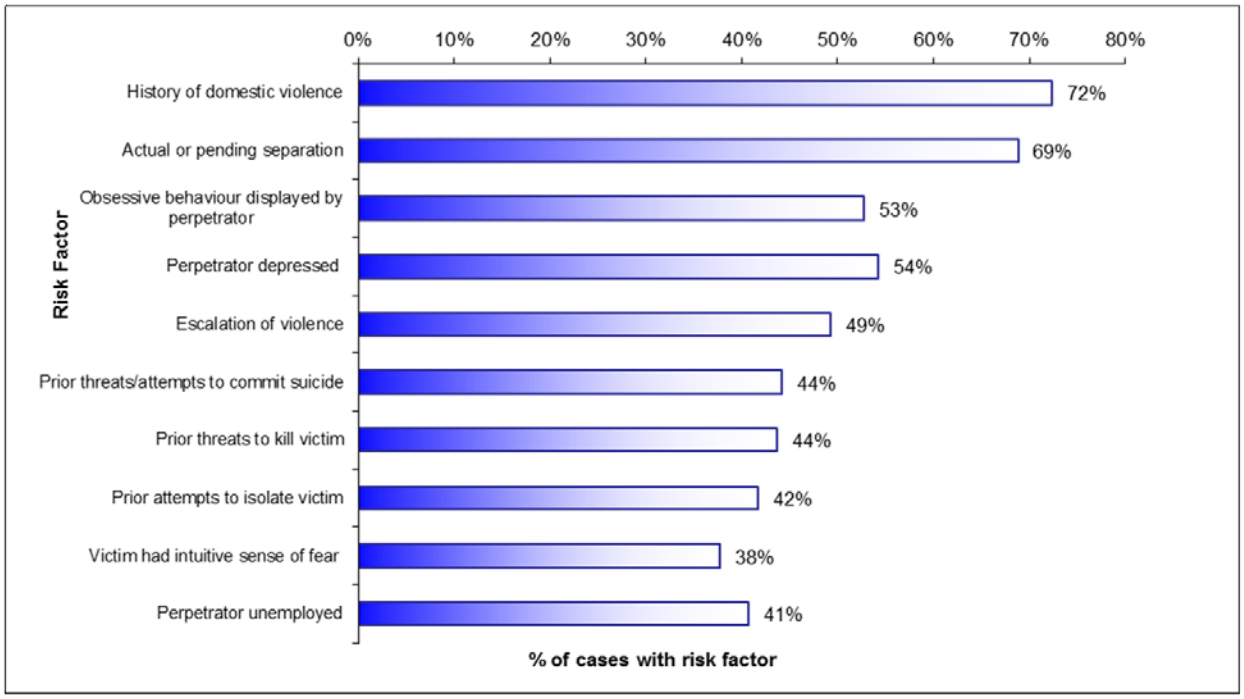
A complete list of all risk factors analyzed, as well as the definition of each, is included in **Appendix B**.

When reviewing a case, the DVDRC identifies which, if any, of the 39 risk factors were present in the relationship between the victim and the perpetrator.

Graph Three: Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2014) demonstrates the most frequently observed risk factors that have emerged from all cases reviewed by the DVDRC from 2003-2014. The most common risk factors are:

- history of domestic violence
- actual or pending separation
- obsessive behaviour
- depressed perpetrator
- prior threats or attempts to commit suicide
- escalation of violence
- prior threats to kill the victim
- prior attempts to isolate the victim
- victims who had an intuitive sense of fear
- a perpetrator who was unemployed.

Graph Three: Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2014)



Summary of Graph Three: Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2014)

- When reviewing a case, the DVDRC identifies which of the 39 established risk factors were present in the relationship between the perpetrator and the victim.
- 72% of all cases reviewed from 2003-2014 involved a couple where there was a history of domestic violence.
- 69% of the cases involved a couple with an actual or pending separation.

Analysis of Risk Factors: Number of Risk Factors per Case

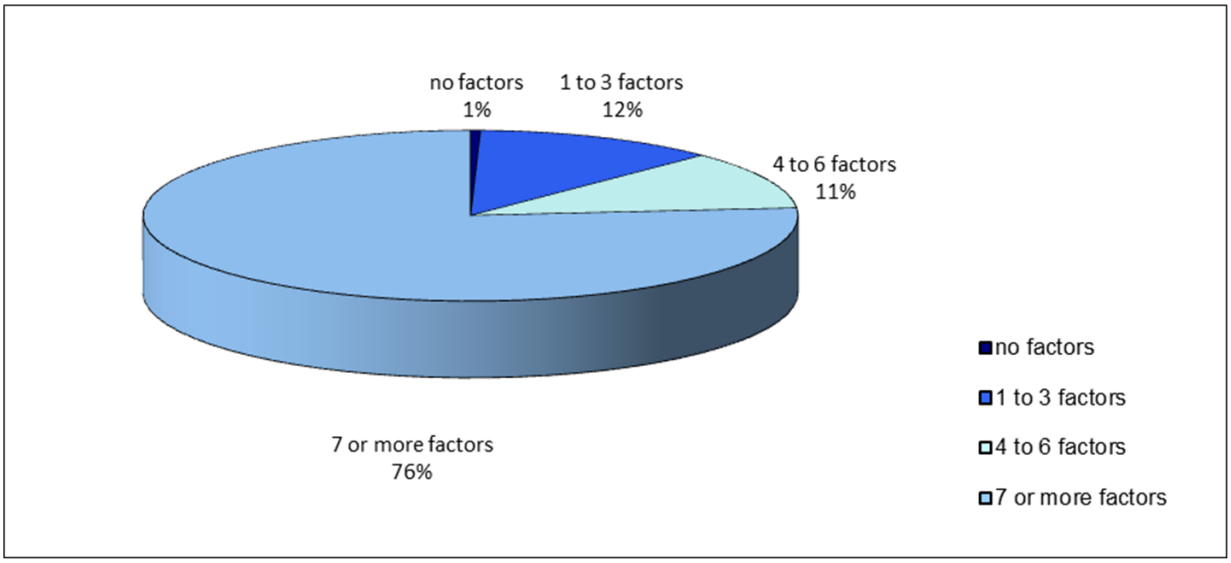
Chart Four: Number of Risk Factors per Case – All DVDRC cases reviewed (2003-2014), demonstrates that in the vast majority of cases (80%), seven or more risk factors were identified. The significance of this finding is that many domestic homicides may have been predicted and prevented with earlier recognition and action towards identified risk factors for future lethality.

Chart Four: Number of Risk Factors per Case – All DVDRC Cases Reviewed (2003-2014)

# of risk factors per case	2003-2014 (n=199)	% of total cases
no factors	1	1%
1 to 3 factors	25	13%
4 to 6 factors	23	12%
7 or more factors	150	80%

Chart Four demonstrates that in 80% of the DV cases reviewed from 2003-2014, there were seven or more risk factors identified. In 12% of the cases there were 4-6 risk factors identified and in 13% of the cases there were 1-3 risk factors identified. Only one percent of cases had no risk factors identified.

Graph Four: Percent (%) of cases based on number of risk factors per case – All DVDRC cases reviewed (2003-2014)



Summary of Chart Four and Graph Four: Number of Risk Factors per Case – All DVDRC cases reviewed (2003-2014)

- In 80% of the cases reviewed from 2003-2014, seven or more risk factors were identified.
- In 12% of the cases reviewed from 2003-2014, four to six risk factors were identified.
- The combined proportion of cases with four or more risk factors was 92%.
- In 13% of the cases reviewed from 2003-2014, one to three risk factors were identified.
- In 1% of the cases reviewed from 2003-2014, no risk factors were identified.
- The recognition of multiple risk factors within a relationship allows for enhanced risk assessment, safety planning and possible prevention of future deaths related to domestic violence.

Statistical Overview: Cases Reviewed by the DVDRC in 2013 and 2014

Chart Five: Summary of DVDRC Cases Reviewed in 2013

DVDRC Case #	Year of death	Homicide	Homicide-Suicide	# of victims	Age of victims	Age of perpetrator	Gender of victim Female	Gender of victim Male	Gender of perpetrator Female	Gender of perpetrator Male	# of risk factors	# of recs
1	2007	✓		1	51	60	1			1	22	1
2	2002	✓		1	40	44	1			1	11	0
3	2002	✓		1	46	45		1	1		2	0
4	2006	✓		2	3 1.5	31	1 1		1		10	3
5	2012		✓	1	66	69	1			1		
6	2006	✓		1	33	35	1			1	3	0
7	2010	✓		1	54	49	1			1	7	0
8	2008		✓	1	27	43	1			1	12	0
9	2007	✓		1	25	31	1			1	7	2
10	2008	✓		1	21	20	1			1	17	0
11	2010	✓		1	46	42 49		1	1	1	1	0
12	2006	✓		1	32	43	1			1	9	0
13	2009	✓		1	33	33	1			1		
14	2010	✓		1	33	50	1			1	20	0
15	2002	✓		1	57	52	1			1	13	0
16	2003	✓		1	23	34	1			1	18	1
17	2005	✓		1	23	30	1			1	4	0
18	2003	✓		1	20	20		1	1		18	0
19	2004	✓		1	26	43	1			1	17	0
Total or Average		**17**	**2**	**20**	**33.0**	**41.2**	**17**	**3**	**4**	**16**	**15**	**0**

Summary of Chart Five: Summary of Cases Reviewed in 2013

- There were 19 cases reviewed by the DVDRC in 2013. This included 17 homicide cases and two homicide-suicide cases, resulting in 22 deaths (20 homicide victims and two perpetrator suicides).
- 9 recommendations were generated through these reviews.
- Of the 20 victims in the cases reviewed, 17 (85%) were female and three (15%) were male.
- 16 (80%) of the 19 cases involved male perpetrators and four (20%) involved female perpetrators. In one case there were two perpetrators, one male and one female.
- The victims ranged in age from 1.5 years to 66 years.
- There were two child victims: two girls (ages 1.5 and 3 years)
- One victim, a pregnant 21 year old woman, was First Nations.
- The average age of victims was 33.0 years.
- The perpetrators ranged in age from 20 to 69 years.
- The average age of perpetrators was 41.2 years.
- The average number of risk factors identified in the cases reviewed was 11.26.
- The number of risk factors ranged from one to 22.
- 15 (79%) of the cases had seven or more risk factors.

Chart Six: Summary of DVDRC Cases Reviewed in 2014

DVDRC Case #	Year of death	Homicide	Homicide-Suicide	# of victims	Age of victims	Age of perpetrator	Gender of victim Female	Gender of victim Male	Gender of perpetrator Female	Gender of perpetrator Male	# of risk factors	# of recs
1	2008	✓		1	48	48	1			1	11	0
2	2003	✓		1	66	67	1			1	2	0
3	2010	✓		1	45	30		1	1		16	0
4	2011	✓		1	41	48	1 1			1	3	0
5	2012	✓		1	57	70	1			1	10	1
6	2007	✓		1	33	31	1			1	7	0
7	2006	✓		1	31	39	1			1	3	2
8	2010	✓		1	48	52	1			1	17	2
9	2011	✓		1	80	70	1			1	11	0
10	2011	✓		1	19	22	1			1	19	7
11	2011	✓		1	26	28				1	9	3
12	2011	✓		1	38	48	1			1	16	1
13	2011	✓		1	58	44	1			1	9	3
14	2011	✓		1	**82**	82	1			1	1	0
15	2011	✓		1	34	46		1	1		7	0
16	2011		✓	1	16	17	1			1	5	5
Total or Average				**16**	45.1	**46.4**	**14**	**2**	**2**	**14**	**9.13**	**24**

Summary of Chart Six: Summary of Cases Reviewed in 2014

- There were 16 cases reviewed by the DVDRC in 2014. This included 15 homicide cases and one homicide-suicide cases, resulting in 17 deaths (16 homicide victims and one perpetrator suicides).
- 24 recommendations were generated through these reviews.
- Of the 16 victims in the cases reviewed, 14 (90%) were female and two (10%) were male.
- 14 (90%) of the 16 cases involved male perpetrators and two (10%) involved female perpetrators.
- The victims ranged in age from 16 years to 82 years.
- The average age of victims was 45.1 years.
- There was one child victim, a 16 year old girl.
- One victim, a 58 year old blind woman, was First Nations.
- The perpetrators ranged in age from 22 to 82 years.
- The average age of perpetrators was 46.4 years.
- The average number of risk factors identified in the cases reviewed was 9.13.
- The number of risk factors ranged from one to 17.
- 11 (69%) of the cases had seven or more risk factors.

Analysis of Risk Factors: Number of Risk Factors per Case

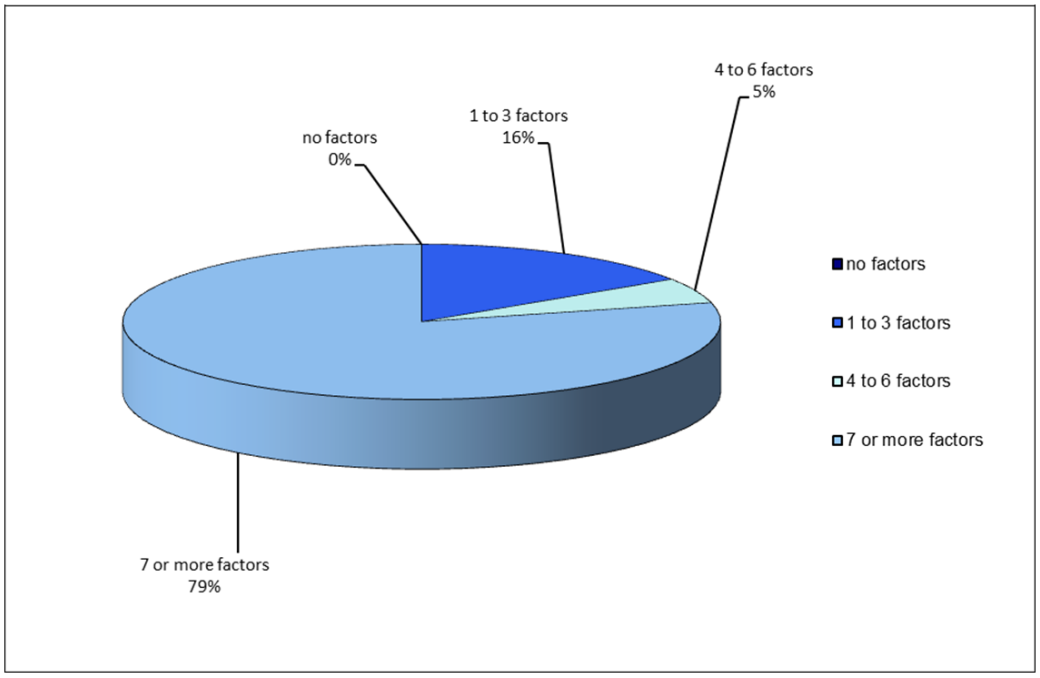
The data in **Chart Seven: Number of Risk Factors Identified in Cases Reviewed (2013 and 2014**), are consistent with the findings of cases reviewed (2003-2014) which clearly demonstrate that the vast majority of cases resulting in domestic homicide or homicide-suicide, had a significant number of risk factors (i.e. seven or more) and therefore were potentially predictable and preventable. It is important to again stress that the recognition of multiple risk factors within a relationship allows for enhanced risk assessment, safety planning and possible prevention of future deaths related to domestic violence.

Chart Seven: Number of Risk Factors Identified in Cases Reviewed (2013 and 2014)

# of risk factors per case	2013 (n=19)	% of 2013 cases	2014 (n=16)	% of 2014 cases	2003-2014 (n=199)	% of total cases (2003-2014)
no factors	0	0	0	0	1	1%
1 to 3 factors	3	16%	4	25%	25	13%
4 to 6 factors	1	5%	1	6%	23	12%
7 or more factors	15	79%	11	69%	150	80%

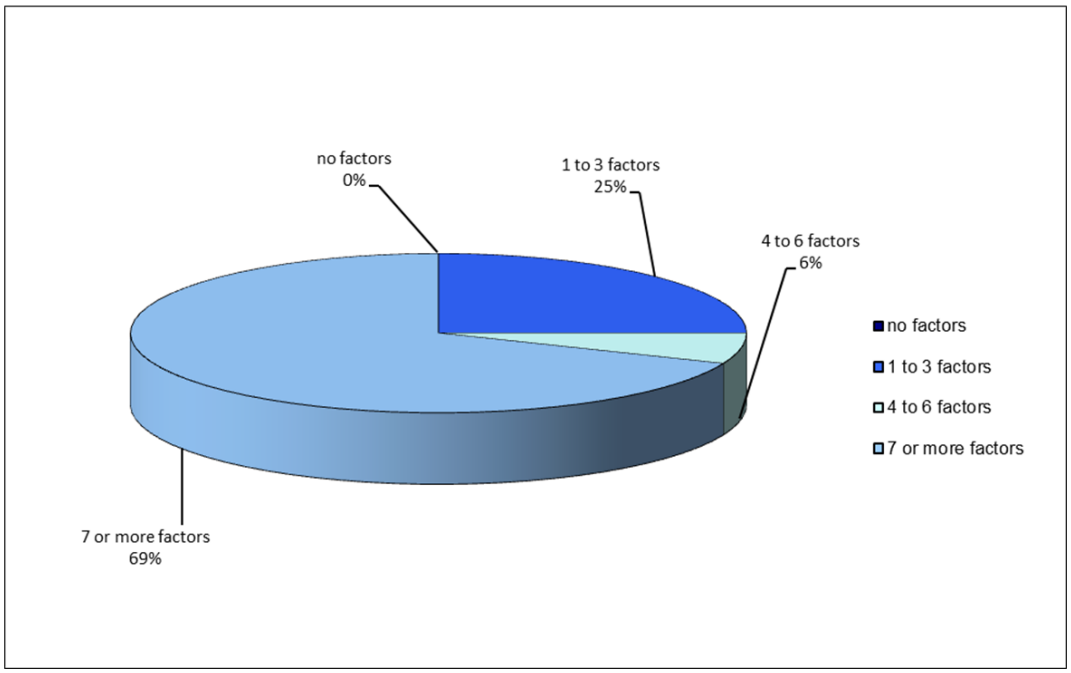
Chart Seven breaks down the number of identified risk factors in the cases reviewed in 2013 and 2014 and overall from 2003-2014. The chart indicates that in the majority of cases (79% in 2013 and 69% in 2014) there were seven or more risk factors identified. In 5% of cases reviewed in 2013 and 6% of cases reviewed in 2014, there were four to six risk factors; and in 16% of cases reviewed in 2013 and 25% of cases reviewed in 2014, there were one to three risk factors. There were no cases in these review years where no risk factors were identified.

Graph Five: % Cases Based on Number of Risk Factors per Case – DVDRC Case Reviews in 2013



Graph Five demonstrates the number of identified risk factors in the cases reviewed in 2013. The graph indicates that in the majority of cases, 79%, there were seven or more risk factors identified. In 5% of cases reviewed there were four to six risk factors and in 16% of there were one to three risk factors. There were no cases in this review year where no risk factors were identified.

Graph Six: % Cases Based on Number of Risk Factors per Case – DVDRC Case Reviews in 2014



Graph Six breaks down the number of identified risk factors in the cases reviewed in 2014. The chart indicates that in the majority of cases, 69%, there were seven or more risk factors identified. In 6% of cases there were four to six risk factors; and in 25% of cases there were one to three risk factors. There were no cases in these review years where no risk factors were identified.

Analysis of Death Factors

Chart Eight: Death factors for cases reviewed in 2013 shows that the majority of cases reviewed in 2013 involved some type of trauma (including cuts, stabs, beatings, assaults) or shooting.

Death Factor	Victim	Perpetrator
Trauma - cuts, stabs	8	
Trauma - beating, assault	3	
Trauma - train/vehicle		1
Shooting - handgun	2	
Shooting - rifle		
Shooting - shotgun	1	
Shooting - weapon n/s		
Asphyxia - strangulation	1	
Asphyxia - neck compression	2	
Fire - Smoke inhalation		1
Drowning	3	
Total Number of Deaths	20	2

Chart Nine: Death factors for cases reviewed in 2014 shows that the majority of cases reviewed in 2014 involved some type of trauma (including cuts, stabs, beatings, assaults) or shooting.

Death Factor	Victim	Perpetrator
Trauma - cuts, stabs	6	
Trauma - beating, assault	2	
Shooting - handgun	1	
Asphyxia - hanging	1	
Asphyxia - strangulation	1	
Asphyxia - neck compression	1	
Drug Toxicity	1	
Jump/Fall	1	1
Fire - Smoke inhalation	2	
Not ascertained	1	
Total Number of Deaths	17	1

* Death factors as coded within the Coroner's Information System (CIS) - the database of all cases investigated by the Office of the Chief Coroner for the Province of Ontario.

Discussion and Significant Findings

The 19 cases reviewed in 2013 included homicides and/or homicide-suicides that occurred as far back as 2002 and as recently as 2012; and the 16 cases reviewed in 2014 included cases ranged from 2003 to 2012. Two of the cases reviewed in 2013 involved perpetrators who committed suicide following commission of the homicide; and in one case reviewed in 2014 the perpetrator committed suicide following the homicide.

The average number of risk factors identified from reviews conducted in 2013 and 2014 was significant at 11.26 and 9.13, per case, respectively. The implication of numerous risk factors associated with these cases is that there was likely significant opportunity to predict (and prevent) future lethality in these cases. Alternatively, in one case in each review year, there was only one risk factor and therefore limited predictability for future lethality.

Chapter Three: Learning from 12 Years of DVDRC Reviews

This report marks the twelfth year that the DVDRC has produced an annual report. Much has been learned through the review of 199 cases (122 homicides and 77 homicide-suicides) that resulted in 290 tragic deaths involving intimate partner violence. Trends relating to risk factors and the nature or theme of recommendations have emerged over the past twelve years.

Risk Factors

It is important to note that risk factors identified in case reviews are risk factors for **lethality** and are not limited to being predictive for recurrent domestic violence of a non-lethal nature. The trends in risk factors identified from case reviews conducted from 2003-2014 were demonstrated in Graph Three and Chart Four In 72% of all cases reviewed over the past twelve years, the couple had a history of domestic violence. In 69% of the cases, there was an actual or pending separation. The other most common risk factors were obsessive behaviour by the perpetrator, a perpetrator who was depressed (diagnosis by a physician and/or observed by others), an escalation in violence, prior threats or attempts to commit suicide, prior threats to kill the victim, a victim who had an intuitive sense of fear of the perpetrator and a perpetrator who was unemployed.

What is the importance of multiple risk factors?

In 80% of the cases reviewed from 2003-2014, seven or more risk factors were identified in the relationship between the victim(s) and the perpetrator.

The recognition of multiple risk factors within a relationship may be interpreted as “red flags” that require proper interpretation and response. Recognition of multiple risk factors potentially allows for enhanced assessment of the risk for lethality to determine if intervention by the criminal justice sector and societal partners (e.g. social service and community agencies), including safety planning and high-risk case management, may be necessary in order to prevent future violence and possibly death.

What is the significance of the trends in risk factors?

Risk factors that frequently recur in our case reviews may demonstrate consistent gaps in a number of areas, including awareness, education and training. Not uncommonly, family, friends and co-workers have been aware of “troubled” relationships, but did not seem to know how to react in a constructive way to prevent further harm. Similarly, police, social service and other support agencies frequently have opportunities to intervene at an early stage, but those opportunities are often missed. Legal advisors, family and criminal courts also miss opportunities for proactive interventions that would bring safety for potential victims, and much needed counselling and supports for perpetrators of domestic violence.

Nature of Recommendations

Policing

In the early years of the DVDRC, many of the recommendations addressed issues pertaining to police response to incidents of domestic violence. In response to these recommendations, the policing community has taken significant steps towards educating officers on the dynamics of domestic violence and implementing firm policies and procedures towards intervention in cases of volatile domestic relationships. The establishment of high-risk and/or multi-disciplinary teams acknowledges the emphasis on a collaborative response to the issue of domestic violence within and between communities, professionals and sectors. Use of the Domestic Violence Supplementary Report (DVSR), and more recently the adoption of the Domestic Violence Risk Management (DVRM) tool have advanced the ability of front-line officers, as well as their supervisors, to better assess true high-risk cases. Although some very significant gains have been made in training and response by many police services, there is still a need for expansion of these types of approaches in some jurisdictions.

Healthcare system and criminal justice sector (CJS)

While recommendations continue to be made towards improved risk assessment by healthcare and judicial professionals, the emphasis is now towards improving education for professionals at the certification and/or continuing education phase of their careers. The spectrum of healthcare and CJS and judicial professionals has expanded to include not only doctors, nurses and the judiciary, but also therapists, personal support workers (PSWs), counsellors, family lawyers and Justices of the Peace.

Victim services and shelters

The provision of victim services, including shelters and other resources, has been significantly enhanced over the past 12 years. This includes better integration, cooperation and liaison with the law enforcement and judicial communities. Again, the collaborative approach to addressing issues of domestic violence has gradually resulted in the DVDRC identifying fewer issues in these areas, and thus fewer recommendations addressed to victim services and shelters.

Public Policy

As a result of recommendations generated by the DVDRC and coroners' inquests, there has been a significant change in public policy, particularly as it relates to the intersection of domestic violence with workplace violence. Progress has been achieved in acknowledging the impact that domestic violence has within the broader community, and in particular, the workplace.

In 2010, Bill 168, (an Act to amend the Occupational Health and Safety Act with respect to violence and harassment in the workplace and other matters) made specific reference to addressing the issue of domestic violence that may overlap into work environments. Bill 168 states that, "if an employer

becomes aware, or ought reasonably to be aware, that domestic violence that would likely expose a worker to physical injury may occur in the workplace, the employer shall take every precaution reasonable in the circumstances for the protection of the worker."

The Ministry of Labour subsequently produced a new compliance guideline to assist employers in understanding the legislative changes resulting from Bill 168. Resources were also developed by the Occupational Health and Safety Council of Ontario (OHSCO) entitled *Developing Workplace Violence and Harassment Policies and Programs: What Employers Need to Know and A Toolbox*. Various other health and safety organizations produced training and public information resources about workplace violence and workplace harassment.

Public education and targeted communities

Throughout the 12 years of the DVDRC reviews, recommendations continue to be generated towards the need for better public information and education on the dynamics of domestic violence. There is an expectation that increased awareness will lead to decreased public tolerance of domestic violence, more appropriate and timely interventions, and ultimately a decreased incidence of intimate partner violence. While there are several comprehensive and innovative public education initiatives aimed at preventing domestic violence, in many of the cases reviewed by the DVDRC, people outside of the intimate relationship (e.g. family, friends, neighbours and co-workers) either did not/could not intervene, or did so unsuccessfully. Many members of the general public still appear to be reticent or unsure about intervening when domestic violence is identified or suspected, or may regard it as "not my problem."

Case reviews have also identified that some specific, or targeted communities, may require additional attention in order to emphasize and bring attention to addressing issues of intimate partner violence within their unique environments or situations. This would include the geriatric population, including elderly couples (particularly where there is a care-giver/care-recipient relationship and the presence of depression), as well as some ethnic/religious communities where traditional cultural values have entrenched gender inequality within their relationships. Although significant work has already been done to address domestic violence within these particular communities, DVDRC reviews continue to identify inconsistencies in resources, services and responses that are community-focused.

Child victims

In several cases reviewed to date, the dangers to adult victims were recognized, but the danger to children was not. In many child homicides, the children had not been abused in the past, but were killed by a parent motivated by revenge, usually against the mother, for leaving an abusive relationship. Based, in large part, on recommendations from the DVDRC and inquests, the Child Welfare System in Ontario has recognized that woman-abuse and child protection are linked and that in order to provide safety for women and children who have experienced and/or been exposed to violence, enhanced assessment, intervention, and collaborative strategies are necessary. Over the past 12 years, improvements have been made to policy, programs and training to assist in

understanding, investigating, assessing and servicing families where domestic violence is a problem. Collaboration agreements have been developed with the violence against women (VAW) sector and a joint training curriculum has been developed and is being delivered across the province on a regular basis. All referrals to Children's Aid Societies are screened for domestic violence, some agencies have domestic violence designated workers or teams and many agencies participate in community high-risk domestic violence teams. In addition, there is an ongoing urgency to recognize high-risk cases going before the family and criminal courts, so that professionals can engage in a coordinated effort to ensure that the safety plan for a parent in these circumstances extends to the children as well.

Chapter Four: DVDRC - Looking forward

As the DVDRC continues to collect, analyze and interpret data from reviews of homicides involving domestic violence, our understanding of the complex relationship dynamics and issues will be further strengthened through both qualitative and quantitative validation of trends and themes. This, combined with the opportunity for further academic research based on DVDRC databases, will help contribute to a broader and more comprehensive knowledge and awareness that will encourage and promote additional measures aimed towards the prevention of domestic violence within our province.

We continue to explore the many societal, legal and cultural implications of domestic violence in Ontario. The DVDRC will continue to fulfill its purpose of reducing domestic homicides and domestic violence in general, through the detailed and thorough review of cases and the collection, analysis and interpretation of data collected. The first 12 years of the DVDRC has demonstrated that positive change is possible and that with a collaborative and multi-disciplinary effort we can continue to learn from the past in order to make Ontario a healthier and safer place in the future.

Appendix A

Summary of Recommendations – 2013 Case Reviews

Year/Case #	Recommendation
2013-01	To the Ministry of the Attorney General, Ministry of Community Safety and Correctional Services, the Ontario Network of Victim Services Providers and the Ontario Network of Sexual Assault and Domestic Violence Treatment Centres: 1. .Justice partners (including police, Crown, probation and parole), together with shelter and victim services workers, are encouraged to develop a systems-approach to managing cases involving victims who are at high risk for intimate partner violence.
2013-02	No new recommendations
2013-03	No new recommendations
2013-04	To the Ministry of Child and Youth Services (MCYS): 1. In order to address the need for improved service coordination in cases where a parent's adult mental health is a concern, it is recommended that MCYS require that CASs, in collaboration with mental health services in their communities, develop a protocol for working with parents experiencing mental health difficulties. Such a protocol should, at minimum, outline the importance of discharge planning when patients are leaving the hospital to resume their parenting role. In addition, a protocol could include a collaborative case conference format which will assist with critical and dynamic information sharing allowing for a more coordinated service response, enhancing safety for children in these cases.
2013-04	To the Ontario Association of Children Aid Societies (OACAS): 2. It is recommended that OACAS develop training for child protection staff that will assist them in working collaboratively with mental health professionals in order to better assess the impact of a parent's mental health issues, discharge plan and medical treatment on parenting capacity.
2013-04	To the Ministry of the Attorney General: 3. Family courts should develop a triage function for an initial assessment of cases to determine the degree of urgency required to hear the matter; the need for additional resources and community referrals to assure safety planning; and appropriate risk management interventions to reduce domestic violence and child abuse.
2013-05	No new recommendations
2013-06	No new recommendations
2013-07	No new recommendations
2013-08	To the Ontario Alliance of Mental Health Practitioners, Ontario Psychological Association, Ontario Psychiatric Association, College of Physicians and Surgeons of Ontario, The College of Psychologists of Ontario, and the Ontario Association of Social Workers: 1. Mental health professionals (i.e. psychiatrists, psychologists and social workers) should enhance learning opportunities on the assessment and treatment of domestic violence perpetrators.
2013-08	To the Ministry of the Attorney General: 2. The Ministry of the Attorney General (MAG) should review policies dealing with perpetrators referred to the Partner Assault Response (PAR) program to ensure that they receive screening at intake for level of denial of their offence, in comparison to police and court findings. The courts should ensure that PARs receive a detailed account of the offence, including any victim statements, and that PARs use this to assess the client's level of denial/accountability. Perpetrators who maintain a high level of

Year/Case #	Recommendation
	denial at program completion should be required to repeat the PAR program, or receive other community referrals.
2013-09	No new recommendations
2013-10	No new recommendations
2013-11	No new recommendations
2013-12	No new recommendations
2013-13	No new recommendations
2013-14	To the Ministry of Community Safety and Correctional Services, Policing Services Division, and the Ontario Association of Chiefs of Police: 1. It is recommended that there be ongoing training for police on the appropriate response to domestic violence cases that involve child custody and access, which may be at high risk requiring special vigilance. Even when there is no reported history of violence between the couple, these cases require a protocol that includes appropriate risk assessment and subsequent attention to safety planning when there was alleged prior abuse against any children in the relationship. Such a protocol needs to be accompanied by appropriate training focused on addressing the potential danger for the victim and/or the child if either has been subject to previous abuse by the perpetrator during separation.
2013-15	No new recommendations
2013-16	No new recommendations
2013-17	No new recommendations
2013-18	No new recommendations
2013-19	To the Ministry of Labour and Ontario Woman's Directorate: 1. The Ministry of Labour should work collaboratively with the Ontario Women's Directorate in workplaces across Ontario to promote awareness of domestic violence and community supports for victims and perpetrators through distribution of Neighbours, Friends and Family materials and information sessions.
2013-19	To the Ministry of Labour and Ontario Woman's Directorate: 2. The Ministry of Labour and the Ontario Women's Directorate is encouraged to work with domestic violence experts, Health and Safety Ontario and the Ontario Federation of Labour to establish a non-profit initiative to engage employers in the work of preventing and responding to domestic violence. The new non-profit initiative should provide workplace specific information, resources and advice for employers.

Summary of Recommendations – 2014 Case Reviews

Year/Case #	Recommendation
2014-01	No new recommendations
2014-02	No new recommendations
2014-03	No new recommendations
2014-04	No new recommendations
2014-05	To the Ministry of Community and Social Services: 1. Social Assistance (Ontario Works & Ontario Disability Support Program) Case Workers should receive specialized training in the dynamics of domestic violence. This training should include recognizing the signs and symptoms of domestic violence and how to effectively respond in the event they suspect a client is being abused. It is important that the training focuses on: all aspects of domestic violence including the psychological/emotional/verbal abuse that many victims experience; recognizing high risk cases such as when there is a recent or pending separation between the couple and depression on the part of the perpetrator; and education about supports in the community for victims and their children (e.g., women shelters).
2014-06	No new recommendations
2014-07	To the Ontario Women's Directorate: 1. Encourage the Neighbours, Friends and Families Campaign for Immigrant and Refugee Communities (http://www.immigrantandrefugeenff.ca/) to develop a specific outreach campaign for the Sri Lankan community.
2014-07	To the Ministry of Labour: 2. Review compliance in Ontario workplaces with the provisions in the Occupational Health & Safety Act that require employers to have a program for preventing and responding to domestic violence that could cause harm to an employee at work, and that require instruction on that program.
2014-08	To the Ministry of Community Safety and Correctional Services: 1. That a working group of police and risk assessment experts explore the feasibility of developing a brief lethality assessment protocol for domestic calls that do not involve charging for domestic violence.
2014-08	To the Ministry of Community Safety and Correctional Services: 2. That a working group of police and risk assessment experts develop a process for conducting an internal review in police services where a death occurred despite the history of a family's several help-seeking contacts with the police where calls were deemed low risk. Lessons learned from these real life situations could serve as a teaching tool in subsequent domestic violence training programs for police officers.
2014-09	No new recommendations
2014-10	To the Ministry of Children and Youth Services and Children's Aid Societies 1. The Children's Aid Society (CAS) involved with this family should conduct an internal review to examine its assessment of risk, not only for child abuse or neglect, but also for intimate partner violence.
2014-10	To the Ministry of Children and Youth Services and Children's Aid Societies 2. All Children's Aid Societies should be strongly encouraged to conduct an internal review whenever a

Year/Case #	Recommendation
	domestic violence death occurs in a family that had received services of the Society within the preceding 12 months of the death, and where potential domestic violence issues had been identified.
2014-10	To the Ministry of Children and Youth Services and Children's Aid Societies 3. It is recommended that the Ministry of Children and Youth Services update and enhance the training available to all CASs regarding assessing potential for domestic and intimate partner violence and ensure that it reflects the most recent literature and best practices. It is recommended that the training of front line CAS workers and supervisors include training on issues related to intimate partner violence.
2014-10	Recommendations related to the training of psychiatrists and counsellors. 4. It is recommended that all medical schools and their departments of psychiatry in Ontario ensure that domestic violence, as well as risk assessment, safety planning, and risk management, are a mandated part of their training programs and certification processes. Safety is a top priority, therefore, it must be ensured that trainees at all levels obtain competency in risk assessment and risk management techniques.
2014-10	Recommendations related to the training of psychiatrists and counsellors. 5. It is recommended that the facts and circumstances of the case (with identifiers removed) be used to assist in the education of members of the Canadian Professional Counsellors Association (CPCA) about the dynamics of domestic violence and the risk factors of lethality so that they can adequately assess and counsel clients with relationship problems.
2014-10	Recommendations related to the training of psychiatrists and counsellors. 6. It is recommended that continuing education of CPCA members include an emphasis on the importance of understanding the dynamics of domestic violence and the risk factors of lethality so that they can adequately assess and counsel clients with relationship problems.
2014-10	To the Involved Police Service 7. It is recommended that the Domestic Violence Coordinator of the Police Service review the Service's various interactions with the victim and perpetrator, with a view to ensuring that all appropriate policies, procedures and directives were followed. Where appropriate, lessons learned from the review could be incorporated into ongoing domestic violence training and updates for service members.
2014-11	To the Ontario Hospital Association and the Ministry of Health and Long-Term Care: 1. Information should be embedded into pre-natal curriculums regarding risk during pregnancy and resources available to assist. During pregnancy, a woman may be at heightened risk of domestic violence, especially in her third trimester. The curriculum for prenatal programs should include a presentation and resource material regarding violence against women to assist if this is occurring in her relationship. Reference: Talk to Me Program – Mount Sinai Hospital
2014-11	To Immigration Canada: 2. Programs that promote support safe integration for newcomers to Canada should be implemented. Curriculum in English as a Second Language, and cultural centres can provide information regarding a victim's rights in Canada. The issue of violence against women should be discussed along with resources available to support the victim.
2014-11	To the Ministry of the Attorney General 3. Recommend that prompt victim contact by PAR when high risk is identified, and consideration of victim referrals for newcomers or where ESL. When a perpetrator completes the intake assessment

Year/Case #	Recommendation
	with the PAR provider, and there is evidence of high risk to the victim – the PAR agency should immediately notify the police, the referral source, the victim and the perpetrator. A partner contact needs to occur immediately in order to assess her safety and provide necessary referrals, safety assessment, supports, risk management and ongoing follow-up. The PAR program needs to pay particular attention to the issues of a victim who is a newcomer to Canada, and in particular cases where isolation and language barriers may escalate risks to her.
2014-12	To the Ontario Association of Naturopathic Doctors, the Canadian Association of Naturopathic Doctors, the Canadian College of Naturopathic Medicine, and the College of Naturopaths of Ontario: 1. It is recommended that all schools of naturopathic medicine in Ontario ensure that domestic violence, as well as risk assessment, safety planning, and risk management, are a mandated part of their training programs and certification processes. This training should include recognizing the signs and symptoms of domestic violence and how to effectively respond in the event they suspect a client is being abused. It is important that the training focuses on all aspects of domestic violence, including the psychological/emotional/verbal abuse that many victims experience. Furthermore, naturopathic doctors who work with potential perpetrators should be able to assess the risk for depression, substance use, suicidal and homicidal ideation, history of domestic violence, mental health issues and separation anxieties.
2014-13	To the Ministry of Community Safety and Correctional Services (MCSCS), Policing Standards Division; and the Ontario Association of Chiefs of Police (OACP): 1. It is recommended that there be ongoing training for police on the appropriate response to domestic violence cases that involve victims with disabilities (in this case, blindness). Cases involving women with disabilities often involve less obvious forms of domestic violence (e.g. withholding a wheelchair; holding back medication) because of the victim's potential reliance on her abuser and/or her increased vulnerability to the abuser because of his/her disability.
2014-13	To the Ontario Women's Directorate: 2. It is recommended that the Ontario Women's Directorate develop and implement public education programs about domestic violence with a specific focus on women with disabilities and their increased risk of domestic violence, less obvious forms of violence that they may be experiencing, and the various agencies that are available to help this population.
2014-13	To the Ministry of Community and Social Services, Canadian National Institute for the Blind, Community Living Ontario, and other agencies providing services to persons with disabilities: 3. It is recommended that agencies or organizations who work with women living with disabilities receive training about their increased risk of violence, including domestic violence, such as the various ways that women with disabilities may experience violence because of their increased vulnerability in some cases.
2014-14	No new recommendations
2014-15	No new recommendations
2014-16	To the Ministry of Education: 1. It is recommended that school professionals (*e.g.* social workers, psychologists, and school counsellors) be trained on the need to work collaboratively when students with suicidal behaviour or risks are identified. School professionals should be trained to actively pursue information from other professionals inside and outside the education system, as well as collateral sources.
2014-16	2. Ensure that educational programs are implemented for adolescent students to help them identify abusive and controlling behaviours in the context of both platonic and romantic relationships. These

Year/Case #	Recommendation
	programs should also help students identify these behaviours to allow for intervention or safety planning. In particular, students should receive education on the issue of blackmailing-over -text in the context of suicide threats so that they will be encouraged to seek the assistance of adults.
2014-16	3. It is recommended that that school professionals be given training on developing safety plans for students once the student has been assessed as being at risk for suicide and that these students be given priority for support by the school. Guidelines should be developed to recognize the unique circumstances and risk of these students and the importance of connecting them to school-based supports. This could include a transition or planning meeting prior to the student returning to school so that information can be shared among team members.
2014-16	4. It is recommended that training be provided to school professionals and students about the impact relationship dynamics can have on the risk of suicidal behaviour.
2014-16	To the Ministry of Education and the Ministry of Health and Long-Term Care: 1. It is recommended that formal partnerships be developed between hospitals that provide psychiatric assessment and public schools to allow schools to communicate with and create safety plans for students who have been admitted as patients due to suicidal thoughts or behaviour.

Appendix B

Risk Factor Descriptions

Perpetrator = The primary aggressor in the relationship
Victim = The primary target of the perpetrator's abusive/maltreating/violent actions

1. **History of violence outside of the family by perpetrator:** Any actual or attempted assault on any person who is not, or has not been, in an intimate relationship with the perpetrator. This could include friends, acquaintances, or strangers. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.).
2. **History of domestic violence:** Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who has been in, or is in, an intimate relationship with the perpetrator. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.). It could be as simple as a neighbour hearing the perpetrator screaming at the victim or include a co-worker noticing bruises consistent with physical abuse on the victim while at work.
3. **Prior threats to kill victim:** Any comment made to the victim, or others, that was intended to instill fear for the safety of the victim's life. These comments could have been delivered verbally, in the form of a letter, or left on an answering machine. Threats can range in degree of explicitness from "I'm going to kill you" to "You're going to pay for what you did" or "If I can't have you, then nobody can" or "I'm going to get you."
4. **Prior threats with a weapon:** Any incident in which the perpetrator threatened to use a weapon (e.g., gun; knife; etc.) or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.) for the purpose of instilling fear in the victim. This threat could have been explicit (e.g, "I'm going to shoot you" or "I'm going to run you over with my car") or implicit (e.g., brandished a knife at the victim or commented "I bought a gun today"). Note: This item is separate from threats using body parts (e.g., raising a fist).
5. **Prior assault with a weapon:** Any actual or attempted assault on the victim in which a weapon (e.g., gun; knife; etc.), or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.), was used. Note: This item is separate from violence inflicted using body parts (e.g., fists, feet, elbows, head, etc.).
6. **Prior threats to commit suicide by perpetrator:** Any recent (past 6 months) act or comment made by the perpetrator that was intended to convey the perpetrator's idea or intent of committing suicide, even if the act or comment was not taken seriously. These comments could have been made verbally, or delivered in letter format, or left on an answering machine. These comments can range from explicit (e.g., "If you ever leave me, then I'm going to kill myself" or "I can't live without you") to implicit ("The world would be better off without me"). Acts can include, for example, giving away prized possessions.

7. **Prior suicide attempts by perpetrator:** Any recent (past 6 months) suicidal behaviour (e.g., swallowing pills, holding a knife to one's throat, etc.), even if the behaviour was not taken seriously or did not require arrest, medical attention, or psychiatric committal. Behaviour can range in severity from superficially cutting the wrists to actually shooting or hanging oneself.
8. **Prior attempts to isolate the victim:** Any non-physical behaviour, whether successful or not, that was intended to keep the victim from associating with others. The perpetrator could have used various psychological tactics (e.g., guilt trips) to discourage the victim from associating with family, friends, or other acquaintances in the community (e.g., "if you leave, then don't even think about coming back" or "I never like it when your parents come over" or "I'm leaving if you invite your friends here").
9. **Controlled most or all of victim's daily activities:** Any actual or attempted behaviour on the part of the perpetrator, whether successful or not, intended to exert full power over the victim. For example, when the victim was allowed in public, the perpetrator made her account for where she was at all times and who she was with. Another example could include not allowing the victim to have control over any finances (e.g., giving her an allowance, not letting get a job, etc.).
10. **Prior hostage-taking and/or forcible confinement:** Any actual or attempted behaviour, whether successful or not, in which the perpetrator physically attempted to limit the mobility of the victim. For example, any incidents of forcible confinement (e.g., locking the victim in a room) or not allowing the victim to use the telephone (e.g., unplugging the phone when the victim attempted to use it). Attempts to withhold access to transportation should also be included (e.g., taking or hiding car keys). The perpetrator may have used violence (e.g., grabbing; hitting; etc.) to gain compliance or may have been passive (e.g., stood in the way of an exit).
11. **Prior forced sexual acts and/or assaults during sex:** Any actual, attempted, or threatened behaviour, whether successful or not, used to engage the victim in sexual acts (of whatever kind) against the victim's will. Or any assault on the victim, of whatever kind (e.g., biting; scratching, punching, choking, etc.), during the course of any sexual act.
12. **Child custody or access disputes:** Any dispute in regards to the custody, contact, primary care or control of children, including formal legal proceedings or any third parties having knowledge of such arguments.
13. **Prior destruction or deprivation of victim's property:** Any incident in which the perpetrator intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the perpetrator. This could include slashing the tires of the car that the victim uses. It could also include breaking windows or throwing items at a place of residence. Please include any incident, regardless of charges being laid or those resulting in convictions.
14. **Prior violence against family pets:** Any action directed toward a pet of the victim, or a former pet of the perpetrator, with the intention of causing distress to the victim or instilling fear in the victim. This could range in severity from killing the victim's pet to abducting it or torturing it. Do not confuse this factor with correcting a pet for its undesirable behaviour.
15. **Prior assault on victim while pregnant:** Any actual or attempted form physical violence, ranging in severity from a push or slap to the face, to punching or kicking the victim in the stomach. The key difference with this item is that the victim was pregnant at the time of the assault and the perpetrator was aware of this fact.

16. **Choked/strangled victim in past:** Any attempt (separate from the incident leading to death) to strangle the victim. The perpetrator could have used various things to accomplish this task (e.g., hands, arms, rope, etc.). Note: Do not include attempts to smother the victim (e.g., suffocation with a pillow).
17. **Perpetrator was abused and/or witnessed DV as a child:** As a child/adolescent, the perpetrator was victimized and/or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment.
18. **Escalation of violence:** The abuse/maltreatment (physical; psychological; emotional; sexual; etc.) inflicted upon the victim by the perpetrator was increasing in frequency and/or severity. For example, this can be evidenced by more regular trips for medical attention or include an increase in complaints of abuse to/by family, friends, or other acquaintances.
19. **Obsessive behavior displayed by perpetrator:** Any actions or behaviours by the perpetrator that indicate an intense preoccupation with the victim. For example, stalking behaviours, such as following the victim, spying on the victim, making repeated phone calls to the victim, or excessive gift giving, etc.
20. **Perpetrator unemployed:** Employed means having full-time or near full-time employment (including self-employment). Unemployed means experiencing frequent job changes or significant periods of lacking a source of income. Please consider government income assisted programs (e.g., O.D.S.P.; Worker's Compensation; E.I.; etc.) as unemployment.
21. **Victim and perpetrator living common-law:** The victim and perpetrator were cohabiting.
22. **Presence of step children in the home:** Any child(ren) that is(are) not biologically related to the perpetrator.
23. **Extreme minimization and/or denial of spousal assault history:** At some point the perpetrator was confronted, either by the victim, a family member, friend, or other acquaintance, and the perpetrator displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., batterer intervention programs). Or the perpetrator denied many or all past assaults, denied personal responsibility for the assaults (i.e., blamed the victim), or denied the serious consequences of the assault (e.g., she wasn't really hurt).
24. **Actual or pending separation:** The partner wanted to end the relationship. Or the perpetrator was separated from the victim but wanted to renew the relationship. Or there was a sudden and/or recent separation. Or the victim had contacted a lawyer and was seeking a separation and/or divorce.
25. **Excessive alcohol and/or drug use by perpetrator:** Within the past year, and regardless of whether or not the perpetrator received treatment, substance abuse that appeared to be characteristic of the perpetrator's dependence on, and/or addiction to, the substance. An increase in the pattern of use and/or change of character or behaviour that is directly related to the alcohol and/or drug use can indicate excessive use by the perpetrator. For example, people described the perpetrator as constantly drunk or claim that they never saw him without a beer in his hand. This dependence on a particular substance may have impaired the perpetrator's health or social functioning (e.g., overdose, job loss, arrest, etc). Please include comments by family, friend, and acquaintances that are indicative of annoyance or concern with a drinking or drug problem and any attempts to convince the perpetrator to terminate his substance use.

26. **Depression – in the opinion of family/friend/acquaintance:** In the opinion of any family, friends, or acquaintances, and regardless of whether or not the perpetrator received treatment, the perpetrator displayed symptoms characteristic of depression.
27. **Depression – professionally diagnosed:** A diagnosis of depression by any mental health professional (e.g., family doctor; psychiatrist; psychologist; nurse practitioner) with symptoms recognized by the DSM-IV, regardless of whether or not the perpetrator received treatment.
28. **Other mental health or psychiatric problems – perpetrator:** For example: psychosis; schizophrenia; bi-polar disorder; mania; obsessive-compulsive disorder, etc.
29. **Access to or possession of any firearms:** The perpetrator stored firearms in his place of residence, place of employment, or in some other nearby location (e.g., friend's place of residence, or shooting gallery). Please include the perpetrator's purchase of any firearm within the past year, regardless of the reason for purchase.
30. **New partner in victim's life:** There was a new intimate partner in the victim's life or the perpetrator perceived there to be a new intimate partner in the victim's life
31. **Failure to comply with authority:** The perpetrator has violated any family, civil, or criminal court orders, conditional releases, community supervision orders, or "No Contact" orders, etc. This includes bail, probation, or restraining orders, and bonds, etc.
32. **Perpetrator exposed to/witnessed suicidal behavior in family of origin:** As a(n) child/adolescent, the perpetrator was exposed to and/or witnessed any actual, attempted or threatened forms of suicidal behaviour in his family of origin. Or somebody close to the perpetrator (e.g., caregiver) attempted or committed suicide.
33. **After risk assessment, perpetrator had access to victim:** After a formal (e.g., performed by a forensic mental health professional before the court) or informal (e.g., performed by a victim services worker in a shelter) risk assessment was completed, the perpetrator still had access to the victim.
34. **Youth of couple:** Victim and perpetrator were between the ages of 15 and 24.
35. **Sexual jealousy:** The perpetrator continuously accuses the victim of infidelity, repeatedly interrogates the victim, searches for evidence, tests the victim's fidelity, and sometimes stalks the victim.
36. **Misogynistic attitudes – perpetrator:** Hating or having a strong prejudice against women. This attitude can be overtly expressed with hate statements, or can be more subtle with beliefs that women are only good for domestic work or that all women are "whores."
37. **Age disparity of couple:** Women in an intimate relationship with a partner who is significantly older or younger. The disparity is usually nine or more years.
38. **Victim's intuitive sense of fear of perpetrator:** The victim is one that knows the perpetrator best and can accurately gauge his level of risk. If the women discloses to anyone her fear of the perpetrator harming herself or her children, for example statements such as, "I fear for my life", "I think he will hurt me", "I need to protect my children", this is a definite indication of serious risk.
39. **Perpetrator threatened and/or harmed children:** Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual; etc.) towards children in the family. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family; friends; neighbours; co-workers; counselors; medical personnel, etc).

For further information, please contact:

Office of the Chief Coroner
Domestic Violence Death Review Committee
25 Morton Shulman Avenue,
Toronto, ON
M3M 0B1
mailto:occ.inquiries@ontario.ca