We speak for the dead to protect the living

Domestic Violence Death Review Committee
Annual Report to the Chief Coroner
2005

Submitted by the DVDRC Chair:
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The Domestic Violence Death Review Committee would like to recognize the outstanding work carried out by the police investigators who assist Coroners with their investigations across the province - officers such as Detective Constable Steve Jones, Kirkland Lake Detachment, Ontario Provincial Police - who devote countless hours to investigating and documenting these tragic events. It is due in part to their dedication to service and community that the Committee is able to make informed recommendations directed to the prevention of similar needless tragedies in the future.

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Chapter 1 – Introduction and Report Overview

The Domestic Violence Death Review Committee (DVDRC) is a multi-disciplinary advisory committee of experts established to assist the Office of the Chief Coroner to investigate and review deaths of persons that occur as a result of domestic violence. The Committee then makes recommendations to help prevent future deaths in similar circumstances. The mandate of the Committee is to contribute to the reduction in domestic violence generally, and domestic homicides in particular, by:

- thoroughly reviewing all intimate partner and ex-partner homicides;
- identifying systemic issues, problems, gaps, or shortcomings of each case and making recommendations to address these concerns;
- creating and maintaining a comprehensive database about the perpetrators and victims of domestic violence fatalities and their circumstances;
- helping to identify trends, risk factors, and patterns from the cases reviewed in order to make recommendations for effective intervention and prevention strategies;
- reporting annually on domestic homicides to enhance public understanding and awareness of the issues;
- conducting and promoting research where appropriate.

The main goal of the Committee is to seek a better understanding of how and why domestic homicides occur by conducting detailed multi-disciplinary examinations and analyses of individual cases. The Committee collects information to establish the context of the death(s), including the history, circumstances, and conduct of the abusers/perpetrators, the history and circumstances of the victims and their families, and community and systemic responses. The Committee uses this information to determine the primary risk factors in these cases and to identify possible points of intervention with the goal of preventing similar deaths in the future.

The DVDRC was created in response to a recognized need to fully investigate and analyze all domestic violence fatalities to learn as many of the lessons each tragic circumstance can provide. The principle means used by the Coroner system in Ontario to examine the circumstances of domestic violence has been by inquest. Between 1998 and 2002, three major Coroner's inquests into domestic violence-related killings were held in Ontario. The first inquest was held in 1998 and focused on the deaths of Arlene May and Randy Iles. Arlene was killed by her estranged boyfriend, Randy, who then committed suicide. Jurors heard from 76 witnesses during more than four months of testimony. They returned with 213 recommendations intended to make the system more responsive to the needs of women and children experiencing domestic violence. The second inquest, held in January 2001, examined the events leading up to the domestic homicide of the Luft family of Kitchener. In July 2000, William (Bill) Luft killed his wife, Bohumila, and their four children, before taking his own life. The most recent inquest was held between October 2001 and February 2002 after the domestic homicide–suicide of Gillian and Ralph Hadley of Pickering in June the previous year.

In the context of trying to understand the circumstances that lead to these kinds of fatalities, inquests such as the ones mentioned above have helped to a limited extent in addressing the question of "why" they occurred. While each of these lengthy and costly inquests resulted in a number of important recommendations, there continue to be approximately 30 such fatalities in Ontario each year from which much more could be learned. However, without a significant realignment of resources, it would be impossible to conduct extensive inquiries in all such fatalities. Alternatively, only by examining the circumstances of all of these deaths with the same intensity - but with the benefit of the various expert perspectives represented on such committees as the DVDRC - can as much as possible be learned to try to answer the question "why." By identifying why these fatalities occur, then it may be possible to assess "when" they may occur, and finally to know "what to do" about preventing them from happening in the future.

Case Reviews and Statistical Observations

In 2005, the DVDRC reviewed 14 domestic violence cases which involved 19 fatalities. The case summaries are set out in Chapter 2. In the review this year, five cases involved homicide, five cases involved homicide–suicide, and four cases involved attempted homicide and suicide by perpetrators.

Since January 2003, the Committee has reviewed a total of 34 cases involving 88 fatalities—11 cases with 24 fatalities in 2003, 9 cases with 11 fatalities in 2004, and 14 cases with 19 deaths in 2005. Over the three-year period 2003–2005, 111 cases were reported (of which 100 investigations have been completed). Approximately one-third of the cases have been reviewed and the remainder will be reviewed when they are concluded before the courts.[1] In keeping with the mandate of the Committee, however, relevant data has been collected on all of the cases investigated and identified as domestic violence fatalities, in an attempt to create a more comprehensive database. The results of the data collection process are reflected in the statistical analysis in Chapter 3 of the report. The Committee continues to refine the risk factor definitions used in the date collection process. The definitions can be found in **Appendix A**, along with a copy of the *Data Summary Collection Form*.

As with the previous reviews, predominantly women are the primary victims[2] in these cases. In 2005, 12 out of 14 cases involved a male perpetrator and female adult victim who was the primary target of the domestic violence. In one of the other two cases, the male perpetrator's intended victim was his daughter. He attempted to take her life in retaliation against his estranged wife. In the remaining case, the perpetrator was a female who killed her ex-husband.

In identifying and assessing the presence of risk factors in the 14 cases reviewed in 2005, as well as the overall common factors for 2003, 2004, and 2005 combined, the most consistent factors appear to be:

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[1] In order to avoid any potential disclosure or other prosecutorial complications, the Committee defers the review of the cases that are before the courts involving a perpetrator to a later date when they have been completed. The Committee intends to schedule the review of those cases when notified that they have been concluded and are no longer *sub judice*.

[2] "Primary victim" is the intended target of the domestic violence, the partner or ex-partner, although in one instance the targeted victim was the daughter of the relationship. In this case, her father attempted to take her life in retaliation against her mother.

- an actual or pending separation;
- prior history of domestic violence; and
- depression (or other mental health or psychiatric problems).

A perpetrator who has made threats to harm himself or his partner in the past, has a history of substance abuse, and exhibits stalking behaviour and escalating violence appear to be present in about half of all cases.

An important concern to the DVDRC is the extent to which the fatalities reviewed appear to be both predictable and preventable with the benefit of hindsight and the analysis of well-known risk factors. In 2003, the DVDRC concluded that in five of the eleven cases reviewed, had professionals with experience in domestic violence been presented with similar facts, the potential for lethal violence would more likely than not have been predicted. Further, the Committee identified numerous points of intervention in the vast majority of cases where appropriate action might have been taken to prevent the tragic outcome. In 2004, the Committee concluded that in seven of the nine cases, the fatalities appeared to have been both predictable and preventable based on having identified seven or more risk factors present in each of those cases. In 2005, the deaths appear to have been both predictable and preventable in ten out of fourteen cases, again with at least seven or more risk factors clearly identifiable in the history of the family circumstances.

For the three years combined, 22 out of 34 cases (65%) had at least seven or more known domestic risk factors associated with lethal violence. A formal risk assessment had been done in only two of the cases reviewed in 2005, but unfortunately this assessment did not lead to a coordinated safety plan and risk management strategy in either instance.

Recommendations

In previous reports, the identified issues and the resultant recommendations fell into one of three broad categories: awareness and education, assessment and intervention, and the need for resources. Ongoing reviews continue to reveal a need to generally heighten awareness and provide education about domestic violence. In every case reviewed, family members, friends, neighbours, co-workers, and/or professionals had some knowledge of the escalating circumstances between the perpetrators and victims. However, these individuals did not appreciate the significance of the situation, the information or warning signs available to them, or what to do about it. It is also important to ensure that domestic violence education and awareness work be done in a culturally competent manner[3], using multiple strategies and approaches. Secondly, there is a need to have appropriate tools available to those who work with victims and perpetrators of domestic violence to better assess the potential for lethal violence in their lives, and corresponding access to appropriate services and programs. Lastly, adequate resources are

[3] "Cultural Competence" is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enable effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behaviour that include language, racial, ethnic, religion, or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of cultural beliefs, behaviours, and needs presented by consumers and their communities. (Cross, T. et al. 1989).

required to institute programs that will help ensure victim safety and reduce the perpetrators' risk.

Observing recurring themes in the cases reviewed was not unexpected, given the Committee's decision not to review cases until they have been completed before the courts. Many of the cases reviewed this year occurred during previous years, but only became available for review this past year. In this report, the Committee decided to only include recommendations that address new issues or additional features of past recommendations. However, recommendations from the previous annual reports are set out in their entirety in **Appendices B and C**.

The recommendations in this report address the need for:

- educational programs for mental health professionals in the dynamics of domestic violence, use of risk assessments, and high-risk case management and intervention strategies;
- public awareness programs to address specific risk factors, particularly in combination, such as actual or pending separation with signs of depression, threats of suicide or attempts, threatened or actual violence, and an escalation of violence;
- an appreciation that suicide attempts or ideation is a significant factor in forecasting the potential for lethality, not only with respect to the individual who has attempted it or speaks of it, but also to others in situations of high stress relationship breakdowns;
- an awareness campaign and education program including how to recognize warning signs and effectively respond to domestic violence—such as recommended in the "Neighbours, Friends and Family Campaign"—and encouragement to report concerns to police;
- professionals and persons in authority to not minimize the seriousness of domestic violence disclosures, but rather respond with appropriate information and guidance;
- domestic violence to be included as part of the curriculum in family law courses at law schools, bar admission courses, and continuing legal education programs for family law lawyers;
- ongoing training for social services assisting immigrant women and their children on identification, risk management, and safety supports;
- child protection services to interview parents separately and to ensure that an examination for domestic violence issues is an integral part of the risk assessment process;
- employers to establish policies and processes to address domestic violence as it relates to the workplace and how to effectively respond to it;

- education and training for those who deal with issues relating to children, particularly custody and access, to encourage recognition not only of the importance of domestic violence in the emotional, cognitive impairment, and behavioural maladjustment of children, but also its long-term consequences into adulthood.

Appendix D includes an article by a member of the DVDRC committee and researcher that summarizes the findings and recommendations of this Committee and 14 others in the US as they pertain to children as victims and witnesses of intimate partner violence fatalities. The findings reflect that an alarming number of children are being victimized in various ways, including a significant number of them being killed by perpetrators or exposed to horrifying acts of violence where others, notably their mothers, are killed. In many cases the safety of children is often overlooked or not considered because their circumstances did not fit the traditional view of child abuse or domestic violence. For example, cases not considered as child abuse because the mothers were considered the primary targets, or cases not considered domestic violence because the children were the intended or unintended victims of the perpetrators seeking revenge against the primary target for leaving.

Subcommittee Report

In the DVDRC's first report in 2003, the Subcommittee on Risk reviewed and reported on a number of risk assessment instruments. While each was determined to be of value, it was observed that contextual information is of vital importance in assessing risk, in particular for court purposes. To that end, the Subcommittee recommended using the *Domestic History Questionnaire* to assist in collecting relevant contextual information. In this year's report, the Subcommittee has included a *Guide to the Domestic History Questionnaire*, which can be found in **Appendix E**.

In a number of the cases reviewed by the DVDRC, the perpetrator was recognized as dangerous and the victim was recognized as being at high risk. Unfortunately, there was no effective case management response, resulting in dire consequences to the victim. Recognizing that assessment followed by effective intervention are part of the same continuum in providing safety and preventing lethal violence, the Subcommittee laid out a basic case management framework in the second DVDRC report in 2004. It also conducted a preliminary examination of a number of different approaches that have been used by some communities in an effort to manage identified high-risk cases.

This past year, the Subcommittee has reviewed different models used in the management of high-risk domestic violence cases. The Subcommittee recognizes that much work has been done to use risk assessment tools to identify high-risk domestic violence cases. The problem is that once a case has been so identified, what is done to actively manage the case? The sad reality for many communities is that little, if anything, is being done. It is one thing to recognize that a person is dangerous; it is quite another thing to do something about it. The challenge for each community is to establish a case management model and process to actively manage and maintain continuing vigilance of high-risk domestic violence cases. In this way, a swift and affirmative response to minimize the risk and protect the potential victim is possible. A number

of initiatives in Ontario and the US attempt to deal with this most critical phase of high-risk domestic violence cases, and the Subcommittee outlines several in Chapter 5.

Future Trends and Directions

The Committee continues to attract many inquiries from other jurisdictions across Canada and the United States. The chairperson and other members of the Committee have been called on again this past year to present the findings of the annual reports at provincial, national, and international conferences, and advise on the creation of a successful fatality review process. Senior government officials in several provinces have expressed interest in establishing similar committees in their jurisdictions. The Committee has also been called on by a number of local organizations to assist them in understanding the review process and its keys to success, with a view to establishing their own local review process in the event of a tragic domestic violence fatality in their communities.

The greatest need continues to be educating all members of the community about the warning signs of domestic violence and the appropriate action necessary to prevent it. Both in this report and previous ones, the DVDRC has emphasized that people closest to the victim and perpetrator often hold critical information that may have predicted and perhaps even prevented domestic homicides. This information is often more obvious with the hindsight of case reviews, but it still provides a foundation for educating the community and preventing similar tragedies. Often individuals observed red flags for lethal domestic violence, however they did not fully comprehend the significance of these indicators. These indicators should form the basis of public education programs.

One example of how to raise awareness about the warning signs of woman abuse, as well as safety planning and risk reduction strategies, is the *Neighbours, Friends and Family Campaign*. This campaign was developed with the assistance of an expert panel chaired by Tim Kelly, Director of Changing Ways in London, and funding from the Ontario Women's Directorate (OWD). Preliminary work on this campaign is already underway, with presentations taking place across the province, including the November 2005 OWD Conference, *Finding Common Ground: Working Together to Reduce Domestic Violence* which is available on web-cast (www.findingcommonground.ca)

Future announcements about available material are imminent as this annual report goes to press. Updates can be found by searching for the website currently under construction (www.neighboursfriendsandfamilies.on.ca) or for materials linked to the OWD site (http://www.citizenship.gov.on.ca/owd/) and the Centre for Research and Education on Violence Against Women and Children website (http://www.crvawc.ca/).

Individual members of the Committee continue to participate in community forums to convey the lessons learned from these reviews. At last year’s Finding Common Ground conference convened by the province of Ontario, the focus was on learning about the best practices used here and in other jurisdictions to reduce domestic violence. Committee members contributed to the conference by organizing panels and presentations on the importance of risk assessments and the need for high-risk case management initiatives to enhance prevention. **Appendix F** includes a reprint of an article from the Medical Post by Celia Milne, *Long Road to Prevention*. The

article reports on the risk assessment panel discussion and observations by members of the DVDRC and others that there has been a reduction in domestic violence in jurisdictions where an effective and coordinated prevention program has been established.

The Committee's goal continues to be to strive to understand why these fatalities occur, to have a better understanding of when they may occur, and to determine what can be done to prevent them from happening in the future.

Review and Report Limitations

The individual case reports and data summary collection sheets that form the basis of the case reviews and analysis have not been released to the public. All of the information obtained as a result of the Coroner's investigation and provided to the Domestic Violence Death Review Committee is subject to the confidentiality and privacy limitations imposed by the Coroner's Act of Ontario and the Freedom of Information and Protection of Privacy Legislation. Unless and until an inquest is called with respect to the specific death, the confidentiality and privacy interests of the deceased, as well as those involved in the circumstances of the death, prevail. Accordingly, the individual reports, as well as the review meetings, remain private and protected. Each member of the Committee has entered into and is bound by the terms of a confidentiality agreement that recognizes these interests and limitations.

The terms of reference for the DVDRC direct that the Committee, through its chair, report on an annual basis to the Chief Coroner the trends, risk factors, and patterns identified as a result of its review, and make appropriate recommendations to prevent deaths in similar circumstances. The recommendations in this report, while generalized, are a result of the review of the facts of the specific cases before the Domestic Violence Death Review Committee. Each reviewed case resulted in recommendations specific to that case, which were then distilled for the purpose of this report. This report's recommendations, as with the last report, may not be seen by some to cover as broad a spectrum of issues as those produced as a result of the domestic violence inquests and the report of the Joint Committee on Domestic Violence[4]. However, the more narrow focus should not be seen in any way to diminish or detract from the importance of the earlier recommendations of those other processes. Indeed, this report's recommendations and any future reports of the Committee should be seen as supplementary to them.

The cases summaries below are provided only to give a general sense of the circumstances that led to the fatalities and issues that assisted the Committee in formulating recommendations. They do not represent all the detail available, nor all of the issues necessarily observed by the DVDRC during the reviews. Further, the following caveat forms part of each case review and applies to this report as well:

> *This document was produced by the DVDRC for the sole purpose of a Coroner's investigation pursuant to section 15 (4) of the Coroner's Act, R.S.O. 1990 Chapter c. 37, as amended. The opinions expressed do not necessarily take into account all of the facts and*

[4] *Working Towards a Seamless Community and Justice Response to Domestic Violence: A Five Year Plan for Ontario, A report to the Attorney General of Ontario by the Joint Committee on Domestic Violence*, August 1999.

circumstances surrounding the death. The final conclusion of the investigation may differ significantly from the opinions expressed herein.

Chapter 2– Case Review Summaries

Case #1: OCC 2002–186

This case involves the homicide of a woman (age 29) by her estranged husband (age 32) in January 2002. He stabbed his wife to death in front of their infant son. Their two older children were at school at the time. The couple had been married in 1993 and later moved to Canada from their home country in the Middle East. One child was born in their home country, while the two younger siblings were both born in Canada. The husband had a history of mental instability while living in Canada, and he had frequently been physically abusive to his wife.

The perpetrator had a history of domestic assault prior to his marriage. Early in 1993, when he was residing in Vancouver, he was charged twice with assaulting and threatening to kill his then common-law partner. It was reported that notwithstanding a no-contact order as a result of the charges, he continued to harass her. Ultimately, there was no finding of guilt or a conviction. The perpetrator returned to his home country, where he met and married the victim in 1993.

The perpetrator started to become aggressive with the victim and children in 1999. In April 2000, the Children's Aid Society was involved with the family when he was seen slapping his 5-year-old son at school. Husband and wife were separated at the time. The three children were assessed for signs of child abuse, but no problems were noted, no ongoing protection concerns were identified, and the case was closed.

In May 2001, the perpetrator had an acute psychotic episode for which he was involuntarily admitted to a psychiatric ward of a local hospital. For weeks prior to the admission, he was seen acting in a bizarre manner and he expressed unfounded concerns that his wife was having a relationship with his brother and other men. He also became violent with his wife and other family members. During an argument with his wife, he struck her hard and frightened the children. His brother feared for the victim and children's safety and brought them to live with him. The police were called and they took the perpetrator to a local hospital for an assessment. There he acknowledged having feelings of paranoia and hearing voices in his head at the time of the incident. The perpetrator was released on a pass and never returned for treatment. The perpetrator's mental instability also made it difficult for him to retain employment. On several occasions, the perpetrator's family urged him to seek medical attention for his behaviour.

The victim came to Canada in 1995. When she arrived, she claimed refugee status and also claimed she was married to the perpetrator with whom she had a son. The victim was accepted as a landed immigrant in 1999. She was scheduled for her citizenship test in January 2002. After a long stay with her brother-in-law following an assault by her husband in 2001, the victim obtained subsidized housing for herself and her children, but her husband continued to harass her. In addition to receiving social assistance, she obtained legal aid assistance to deal with family law matters resulting from the separation. She was in the process of sorting out her legal

rights at the time of her death. She was also taking English language classes to help her live as an independent woman and single mother.

Even though separated, the perpetrator occasionally resided with the victim and their three children. Due to family pressures to reconcile and her fears that she would lose her children if she did not make an effort to reconcile, she permitted her husband to stay with them on occasion. His family had assured her that he was better since he had been in a hospital. The victim, however, informed the school of the domestic disputes and the school made sure that the children were not permitted to leave school property with the perpetrator.

The assaults and harassment continued. The night before the homicide, the couple got into an argument over the victim taking her upcoming citizenship test. The argument was heated and loud enough for the neighbours to hear. The perpetrator left the apartment to go and visit a friend. While at the friend's house, he asked to borrow a small amount of money, saying he was going to leave town. On the day he killed his wife, he bought a bus ticket.

That day, after leaving her infant child with a sitter and taking her two older children to school, the victim attended her English language classes. When she returned to her apartment after picking up her baby from the sitter later that afternoon, her husband, who was waiting inside, attacked her with a knife. A neighbour who heard the commotion and the baby crying went to the apartment and found the victim dead from stab wounds.

The perpetrator was found to be not criminally responsible in the death of the victim due to a mental disorder, and he was committed to a psychiatric facility.

Case #2: OCC 2003–10672

This case involves an attempted homicide of the victim (age 42) with a chain saw, and the suicide of the perpetrator (age 31) in July 2003. The perpetrator and the victim had been in an on-again off-again relationship over several years. They met through a mutual friend, and a few years later became involved in a sexual relationship. The perpetrator had a history of mental health issues. At age 26 he was diagnosed with paranoid schizophrenia. He was depressed, moody, and had trouble sleeping and a decreased appetite. These problems increased over the winter months; he did not feel like doing anything, he worried about everything, and had no ambition. The perpetrator had stopped taking his medication at the time of the incident.

The morning of the incident, the victim and perpetrator set out to the perpetrator's family cottage for a relaxing getaway. The perpetrator had mentioned to the victim that his feelings were changing toward her, but he never explained what he meant. The perpetrator's father was at the cottage that day to deliver an appliance and food. With the help of his son, he moved the appliance into place. While there he did not notice anything untoward between his son and his girlfriend. The father asked his son if he wanted him to help work on the cottage, but his son declined and told his father that he planned to take a couple of days off to relax.

After the father left, the couple settled in for the evening to watch video movies. During one of the movies, the perpetrator got up and left the cabin without explanation. He returned with a running chainsaw in hand. Without warning, while uttering something inaudible, the perpetrator attacked the victim with the chainsaw. The chainsaw stalled at one point during the attack, and he then began to stab the victim with a steak knife and continued the attack. When the perpetrator turned the knife on himself, the severely-wounded victim had a chance to escape. She ran to the neighbour's cottage next door. The neighbour, a nurse, provided first aid to the victim until the ambulance arrived. She survived the attack.

The perpetrator was found inside the cabin, dead from self-inflicted knife wounds.

Case #3: OCC 2002–1209

This case involves a young couple in their early twenties who had been in a volatile and abusive dating relationship for several years. The perpetrator made numerous threats to kill the victim and her family in attempts to control the victim. In one such incident several months prior to the homicide in early May 2002, while the victim was at a club with friends, the perpetrator grabbed her by the arm and told her if he ever saw her talking to his friends again he'd kill her, "you're done, your life is over." The victim went to her parents, told them of the threat, and she reported the incident to the police the next day. The perpetrator was arrested and charged with assault and uttering a death threat. He was released after a bail hearing with a condition that he not have contact with the victim or her family. The perpetrator's mother was named as surety. Although there were conditions for the perpetrator and the victim to not have any contact, they continued to see each other and frequent the same places.

A few days prior to her death, the victim decided to finally end her relationship with the perpetrator. She had recently started a new relationship. She had also learned that the perpetrator had been intimate with her roommate. She told others that she was looking forward to moving to a new apartment and getting on with her life.

In the early morning hours on the day of homicide, the perpetrator visited the victim's apartment where they argued until 4 a.m. The victim finally told the perpetrator to leave. After leaving the apartment, the perpetrator drove around town and consumed alcohol and cocaine with two other women he met. He eventually returned to the victim's apartment. Later that morning, the victim and perpetrator agreed to meet to exchange personal belongings. They met behind a nearby school at approximately 10:30 a.m. The perpetrator sat in the victim's car with her. He then pulled a knife from a gym bag he had brought with him and attacked her with it. The perpetrator had purchased this knife a few days prior. He stabbed the victim 58 times, causing her to bleed to death.

After the attack, the perpetrator placed the victim's body in the passenger seat of her car and drove to an apartment building downtown where he left the vehicle in an alleyway. The perpetrator then went into the building, called the police, and told them where they would find her body. Once the officers arrived, the perpetrator confessed to stabbing the victim. The

perpetrator was arrested and charged with first-degree murder. At trial he was convicted of second-degree murder and was sentenced to life imprisonment with parole eligibility set at fourteen years.

Case #4: OCC 2002–14980

This is a case of homicide involving a teenaged victim (age 15) and an adult perpetrator (age 24) who were involved in an intimate relationship for eight and half months prior to the murder in November 2002. The perpetrator and the victim, notwithstanding her young age, had expressed a desire to move in with one another and had discussed plans for a long-term relationship with marriage and children. The victim, while still living with her mother, planned to move in with the perpetrator as soon as she was able. However, their relationship started to become abusive. There were also allegations that the perpetrator had been cheating with other girls. The perpetrator was known to be very possessive, controlling, and demanding of the victim. He often displayed jealousy, and once struck another man for sharing a cigarette with her. There was at least one break-up during the course of the relationship, and two incidents of violence where he struck her. In addition, he was often verbally abusive and demeaning to her in the presence of others. He had been overheard saying, "if I can't have her no one will." The perpetrator had a criminal history, including sexual assault and assault, and was also known locally as a "peeping Tom."

A few days prior to her death, the victim decided to end her relationship with the perpetrator. She was unhappy with the manner in which the perpetrator treated her and his suspected infidelities. The victim also became interested in dating another individual. The victim told a friend about her intention to break off her relationship with the perpetrator. At the time, she expressed her concern about how the perpetrator might react because he had been violent with her in the past. The victim decided to give the perpetrator a letter advising him of her decision to break off the relationship. In fact, much of their relationship had been captured in written letters and notes due to the perpetrator's hearing disability.

On the afternoon of her death, the victim went to a friend's house. The victim had received permission from her mother to spend the weekend at her friend's house, just as she had on many other occasions. The friend, the perpetrator's father's girlfriend, lived in the same house as the perpetrator. Although the friend and the perpetrator had separate apartments in the home, they often spent time in the one apartment.

The victim arrived at her friend's residence shortly after 4:00 p.m. She met briefly with the perpetrator and then walked to her brother's house nearby. She returned to the residence at about 7:00 p.m., where she again met with the perpetrator. In the presence of her friend, the victim gave the perpetrator the letter indicating her decision to break off the relationship. The victim and perpetrator argued about the break up for several minutes. She then left her friend's apartment and entered the perpetrator's apartment to retrieve some of her personal possessions. The perpetrator followed her there where he struck the victim in the face, strangled her into unconsciousness, and then stabbed her three times in the torso causing her to bleed to death.

Following the stabbing, the perpetrator returned to the friend's apartment where he reported that the victim had run away. In the early morning hours, the perpetrator moved the victim's body to a nearby wooded area. Police were eventually called and began a missing person investigation. The victim's body was discovered and shortly thereafter the perpetrator was arrested and charged with second-degree murder. Although the perpetrator did not confess to police, he described the homicide to a number of people. At trial, he was convicted of second-degree murder.

Case #5: OCC 2004–12375 & 2004–16826

This case involves a homicide–suicide of the victim (age 43) and the perpetrator (age 59) who had been in a dating relationship for several years. A few months prior to the incident in September 2004, the victim decided to end her relationship with the perpetrator due to his possessive and jealous behaviour. Within two weeks of the incident, the victim and perpetrator rekindled their relationship, but problems persisted.

The victim had been diagnosed with several physical disorders involving a degenerative nerve disorder and imbalances causing fatigue. She received a disability pension and worked part-time in her family's business. Despite her disabilities, the victim was known locally as a social butterfly and had many acquaintances and friends. She was known as a gentle and kind-spirited person who always appeared happy and smiling. She enjoyed going to local bars and dancing with friends. She was close with her family and had excelled in school and enjoyed her job.

The perpetrator had little formal education and worked as a casual labourer. Unlike the victim, he did not seem to have any known friends and was considered a loner by nature. Neighbours and casual acquaintances reported that he was very quiet and did not like going out. He was also known to be very controlling, jealous, and aggressive with the victim. He would often go to her workplace and drive by her house several times a day, and he interrupted the victim's conversations with others.

After the initial break-up, the perpetrator found temporary work in the forestry industry out of town and for a few months the two did not communicate. However, when he returned to town, he told her that if she did not rekindle their relationship, he would commit suicide. The victim felt sorry for the perpetrator and allowed him back into her life. On the day of the deaths, the victim spoke to her brother about the problems she was having with the perpetrator. She told her brother that she had felt sorry for him and let him into her apartment to talk. She also confided in her brother that the perpetrator wanted her back and that he had said he could not live without her. She described the perpetrator as being paranoid and possessive.

Later that morning, a neighbour saw the couple engaged in an emotional conversation. The perpetrator then left the victim's house, only to return a short time later with a .22 calibre rifle. He shot the victim twice, once in the back of the neck and then in the chest, before turning the gun on himself.

The victim's mother, knowing of her daughter's difficulties with the perpetrator, became upset when she saw the perpetrator's car outside the victim's home later that morning. When she entered the apartment, she found her daughter and the perpetrator fatally wounded.

Case #6: OCC 2003–16000 & 2003–16001

This case involves the homicide–suicide of a couple who had been married for approximately forty years and who had two children. In late November 2003, the husband (age 60) stabbed his wife (age 57) to death and then himself. Twenty-five years earlier the couple had tragically lost their only children, boys ages 7 and 9, from accidental carbon monoxide poisoning at a family farm. The victim had been in a coma from that accident for a period of time and suffered ongoing health problems as a result. There had been several incidences of domestic violence over the course of the marriage. The victim and perpetrator separated once in the 1990s, but only for about a week or so.

The victim and perpetrator were known to have long-standing marital discord with issues around finances, health, gambling, and use of alcohol. The victim was a compulsive gambler and had dissipated their savings. Her husband had to mortgage their home as a result. The perpetrator, in turn, was seen by others outside the home to be both dominating and verbally abusive toward the victim. He was very controlling. The perpetrator had retired ten years prior to the homicide–suicide and did not want the victim to have access to his money since she did not work and because of her gambling. However, the perpetrator had forbidden the victim to work. She was also not allowed to obtain a driver's license. The perpetrator told a neighbour openly that if the victim were to ever leave him and go after his pension, he would kill her.

The victim's mother saw black and blue marks on her daughter many times. She also said after her daughter's death that her daughter never complained to police, or friends, or agencies; she kept the abuse to herself. In fact, a few weeks before the deaths, the victim's mother took pictures of the bruising as evidence of the perpetrator's abusive behaviour toward the victim.

A few days prior to the incident, the victim confided to a friend that she was planning to leave the perpetrator for good and divorce him. On the day of the deaths, the victim told the perpetrator she was leaving him. The victim called her mother, who was in her 80s, and started crying. Her mother, aware of the earlier violence, asked if the perpetrator was being nasty to her. The victim replied "yes," but then added that she "couldn't talk" and ended the call. The victim's friend of over 40 years saw the perpetrator at approximately 1:30 p.m. that same day. The friend later told the police that the perpetrator was very depressed and had been talking about suicide, which according to the friend was not unusual for him.

The victim phoned her mother again later that same evening at approximately 7:00 p.m., and apologized to her mother for not being able to talk when she had called earlier. She told her mother that she was ready to leave the perpetrator. At 9:30 p.m., the perpetrator called the

victim's mother's home and demanded that someone to tell him what was going on. The mother's male companion asked to speak to the victim and after some time, arguing, and persuasion, the perpetrator gave the victim the telephone. The mother's friend offered to go to the victim's house to pick her up and take her back to their home in another city. The victim agreed. The mother and her male companion attached a trailer to their car for transporting the victim's belongings, and then departed.

Upon arrival at the perpetrator and victim's residence, there was no answer at the front door. Aware that the perpetrator owned firearms and other hunting weaponry, and fearing for the safety of her daughter, the mother an

d her companion had a neighbour contact the police to notify them of the lack of response and the potential for violence toward the victim. Police arrived on scene and, after failing to get a response at the door; they looked through a window at the side of the house and saw two motionless bodies lying on the living room floor. The police used force to gain access to the household and discovered that the perpetrator had stabbed his wife with a kitchen knife and then stabbed himself. The victim died of two stab wounds; one into her heart. The perpetrator died of a single self-inflicted stab wound to the chest area.

Case #7: OCC 2004–12069

This case involves the attempted homicide of the victim (age 35) and her two children, (ages 6 and 10), and the suicide of the perpetrator (age 37) in late April 2004. The perpetrator arrived at his matrimonial home where he set his car, his wife's car, and then their house on fire. Earlier that month he had been released on bail for assaulting and threatening to kill his wife. He had been ordered not to visit the home or to contact his wife. When he arrived, after initially arguing with his wife about his being there, he proceeded to pour gasoline on his and her car, the family home, and himself, and set everything on fire. He died as a result of the injuries sustained. His wife and two young daughters were able to escape the burning house by jumping out a bedroom window at the rear of the house. They sustained only minor physical injuries as a result.

Both the victim and the perpetrator held jobs with the same employer, as did a few other family members. The victim and perpetrator had been married for about 12 years and had begun experiencing domestic issues in the last few years. A few years prior to the incident, the perpetrator's father died and he had a hard time coping with the loss. Engaging in an affair with his brother-in-law's wife further complicated his life. This affair apparently went on for some time before she disclosed the affair to her husband. Fearing that his wife would become aware of the affair, the perpetrator became further despondent, and in 2003 attempted suicide by hanging. The hanging mechanism broke, however, and he survived. He was admitted to hospital where he underwent psychiatric assessment and treatment. He was diagnosed with depression and was released from hospital one month later. Notwithstanding the affair, his wife was willing to try to salvage their marriage and they reconciled once he was released from the hospital. The victim

made a decision to shield the children from the troubles in the home, and they were unaware of their father's suicide attempts. The perpetrator was also laid off from his job.

A few weeks prior to the incident in April 2004, the perpetrator was arrested for assaulting his wife. She had been having considerable difficulty in dealing with the fact that her husband had an affair. She, in turn, began a relationship with someone over the Internet. When he learned about his wife's relationship with this other person, he severely beat her and attempted to strangle her with one of the children's skipping ropes. He also threatened to kill her and himself. However, after rendering her unconscious, he stopped the attack and called the police himself. She was hospitalised and later released. The perpetrator was arrested for the assault and subsequently released on bail. He was prohibited by the bail conditions from visiting the matrimonial home and from contacting his wife, except through a third party to arrange child access. He was on this release when he killed himself and tried to kill his wife and children.

Case #8: OCC 2004–7713 & 2004–7712

In this case, a husband (age 51) shot and killed his wife (age 52) in their home during the early morning hours with one of his hunting rifles, and then killed himself in June 2004. Their 12-year-old son found their bodies in the morning. Their other son (age 13) remained asleep in his bed in the basement until police arrived. The victim was on the floor of the bedroom with two gunshot wounds to her upper body and head. Two spent ammunition casings were beside her and she had a cell phone in her extended right hand. The perpetrator was found seated at his computer desk with a single gunshot wound to the head, with a handwritten will on the desk.

It was the second marriage for both of them. The victim also had a 26-year-old son from her previous marriage. Neighbours said they had spoken with both parties the day before and had not noticed anything out of the ordinary. They heard what sounded like shots, but assumed they were in fact firecrackers. One neighbour even mentioned hearing childlike screams around the same time as the shots were heard. The couple's sons reported they had not heard any gunshots during the night.

The relationship was not without its problems. There had been two police contacts in 1993, initiated by the perpetrator due to disturbances in the home. However, no charges were laid and there was no information as to how the couple resolved their issues. Their 12-year-old son reported that his parents argued about all manner of things—mostly over small things—and he heard them arguing again on the evening before their bodies were found. In an interview afterwards, the perpetrator's mother said she felt both parties were "volatile" personalities, however she also said it looked as if their marriage was stronger than ever prior to their deaths. The only stress known to her at the time of their deaths was the perpetrator's struggle with a computer virus. On June 20, the day of or before his death, he told his father he was very frustrated with his inability to deal with a virus on his computer. He appears to have spent several hours attempting to do so. One of the last items found on the home computer was his inquiry about creating the will.

The perpetrator, however, was also known to be frustrated with his lack of advancement at work; he had been trying to get a promotion. While noted to be intelligent, he had some "people skills" problems and had been unsuccessful in a number of job competitions. In a résumé, the perpetrator described himself as a "person of disability." He suffered from both a tic disorder and attention deficit disorder. The victim believed these disorders affected him emotionally and thereby inhibited his career advancement. However, his physician reported that he was under an effective regime of medication and had apparently been handling these disorders well. His doctor saw no danger signs for violence or stress in the marriage. The only recent stress reported had been a language course that the perpetrator had been required to take for his employment, which he had successfully completed.

The victim was under the care of a psychiatrist, whom she saw within a month of her death. Her doctor reported that she was taking an antidepressant. The victim's psychiatrist characterized the marriage as "toxic," having deteriorated over the previous eight years. According to her, the perpetrator belittled the victim and he "kept her under his thumb." She recollected that the victim was frightened by a confrontation between the perpetrator and their 13-year-old son, and she reported she was in "fear for her life." The parties were sleeping apart, confirmed by the police officers' observation that the perpetrator had been using a couch in the basement as a bed. The psychiatrist had advised the victim to leave the relationship.

The perpetrator was a hunter and belonged to a number of gun associations. He killed himself and the victim with one of his hunting rifles. He had other guns and a crossbow in the house as well. The police found that all of the weapons were properly registered and safely stored. Notwithstanding the victim's disclosure of fear to her psychiatrist, she had not expressed any concerns to her family, friends, or others about the guns in the house.

Case #9: OCC 2004–6112 & 2004–6111

This case involves a homicide–suicide of a couple who had been in a violent intimate relationship for about three years prior to their deaths in May 2004. The victim (age 31) and perpetrator (age 32) had lived together for only a few months during that time. He had severely assaulted her numerous times. He had been recently released on a conditional sentence after spending almost five months in custody for assaulting her, when he beat her to death and cut his own throat, killing himself with a knife. As part of the conditional sentence, he was not to have any contact with her and he was to reside in a psychiatric halfway house.

The victim suffered from bi-polar disorder and was on medication for the mental illness. She had a criminal record for fraud. In the fall of 2002 she was institutionalised, but was released the following year to live with her parents. A long-time friend of the victim described the couple's relationship as "rocky and violent." Despite a documented history of turbulence, a male friend of the victim indicated that the victim would say "she could not be without him," "to be with him meant that she would have to put up with the abuse," and "she can't help herself with him." However, at one point the victim indicated she was terrified of the perpetrator because he had told her several times that he would kill her if she ever called the police.

The perpetrator had an extensive and documented history of violence and episodes of mental instability. He was attending monthly appointments with a doctor and being treated with medication, however he continued to have conflict with the law, primarily as a result of violence against his female partners. He also made several suicide attempts. In 1991, the perpetrator was involved in a non-fatal auto accident in which he sustained a head injury; according to police reports he had suffered from mental instability since that event. His parents were killed in a plane crash in 2001, and it was alleged that he blamed himself for their deaths and would lapse into episodes of depression.

They were married in December 2001 in the US, but their marriage was not recognized in Canada. The victim had two children from another relationship and the perpetrator had one child from another relationship. Although the victim stayed with the perpetrator most of the time, she resided with her parents and her two children until her parents asked her to move out in September 2003 because of the risk they perceived her relationship with the perpetrator posed to her children. The victim's parents had filed for and were granted custody of their daughter's children, shared with their biological father. The victim and perpetrator then lived together until he was arrested for assaulting her in the winter of 2004 and detained in custody.

When the perpetrator was released from custody to serve the conditional sentence, he was to reside at a psychiatric halfway house as a condition of his sentence. While he initially stayed at the halfway house following his release, he left the next day. There was no follow-up as to his whereabouts until a few days later. By that time he had made contact with the victim, visited her apartment, beat her to death, and took his own life by cutting his throat.

Case #10: OCC File 2004–15755

This case involves the attempted homicide of the victim (age 49) and suicide of her husband, the perpetrator, (age 52) in November 2004. The couple had been married for 24 years, but had separated the fall of 2003. There was significant physical and emotional abuse throughout the marriage, as reported by the victim. In 1991, the victim left the perpetrator and went to stay with her parents in the US, but returned just over a year later due to financial difficulties. The couple had three adult children; at the time of the death they were living outside the home.

Both the perpetrator and the victim were well-liked and respected in their communities, church, and workplaces. As a child, the perpetrator witnessed domestic violence. He did not have a criminal record. Drugs and alcohol were not a problem, however during the separation he began drinking more than usual. The perpetrator had suicidal thoughts and had once been prescribed antidepressants, but refused to take them. He would sometimes display obsessive behaviours toward the victim and his children. He would obsess and repeat activities. Shortly before his death, he changed his will and gave his dog and favourite car away. The victim had worked hard to get where she was in her career. At the time of their first separation in 1991, the victim went back to school to further her education. While she returned to the perpetrator, due to her education she was able to gain some measure of financial control of her life so she did not have to be so dependant on the perpetrator.

In the fall of 2004, the victim began divorce proceedings and the family home was put up for sale. The house was sold and the closing scheduled for November 1st. The perpetrator, who had been living in the house, was supposed to leave by October 31st. On that day, the victim arrived at the house to see if he had left and found he had not removed his belongings. She packed his things and was later told by neighbours that the perpetrator had been watching her in the laneway the entire time. The house did not close the day it was supposed to.

During the separation, the victim and perpetrator worked in the same office building. The perpetrator used intimidation tactics with the victim; he followed her and harassed her by sending over 100 emails and several voicemails trying to get her to reconcile. Both the victim and the perpetrator's colleagues complained to their respective managers about his behaviour, but there was no follow-up.

On the day of the death, the victim was returning from a business appointment and was forced off the road by another vehicle; unbeknownst to her, the vehicle was driven by her estranged husband. He approached her vehicle carrying a crossbow. He fired at her through her window, striking her in the arm with the bolt, narrowly missing her chest. She managed to put her window up and lock the car doors. However, the perpetrator returned from his vehicle with an axe and was able to break the window and continue his attack on the victim. She was able to get out of the car, but tripped with the perpetrator landing on top of her. A passer-by who had stopped his vehicle heard the victim screaming and went to assist. The perpetrator got back into his vehicle and began driving at both the victim and the passer-by. Both were able to avoid the vehicle and run to get help. The police arrived at the scene of the attack and discovered the perpetrator's car empty. They followed his footprints for over a kilometre where they discovered his body. He had shot himself using the crossbow.

After the perpetrator's death, the police found suicide notes in his residence written by him to each child. Later the victim discovered a suicide note dated November 1st 2004 written by the perpetrator and left in her journal at their family cottage.

Case #11: OCC 2005–2605 [5]

This case involves the attempted homicide of a child (age 5) and the suicide of her father (age 48) in March 2005. He threw his daughter off a bridge and then jumped off the bridge after calling his wife on a cell phone to tell her that she would never see her daughter or him again. Miraculously, their daughter survived her life-threatening injuries. He died. The couple were going through a divorce and custody dispute at the time. The couple separated when their child was only a few weeks old and had remained separated. The mother had sole custody while the perpetrator/father had visitation rights. The mother was in process of trying the get the court to reverse the access order so he would only be permitted supervised visits with his daughter due to his mental instability. He, on the other hand, was going to request spousal support from her.

[5] While the Committee began this case review in 2005, it has not been completed. However, it has been included in the annual report because the circumstances were included in the statistical analysis for this report.

The perpetrator immigrated to Canada 25 years prior. He reported a previous marriage, which only lasted approximately 6 months. He blamed interference by his wife's family for the marital problems. He attended university and obtained a degree in math and physics. However, his employment history was erratic. Most recently he had worked in restaurants and in the dry cleaning business. He and his wife met and married in 1998. It became quickly apparent, according to his wife, that he had an extensive gambling problem and debts. Their marriage was marked by difficulties, including financial hardship and a number of suicide threats and attempts by the perpetrator. In 1999, after he threatened to commit suicide by jumping from his ninth floor balcony, they separated. In 2002, he was hospitalized for a drug overdose after his wife asked for a divorce. After being discharged to reside in his brother's home, his medical care was to be followed by his family doctor and a psychiatrist. The perpetrator continued to see his doctor for treatment for a while, but in 2004 he ceased to attend appointments. The doctor's secretary called him several times for up-coming appointments, but he always had an excuse not to attend.

There was extensive litigation regarding access to their daughter. The mother stated that the perpetrator had very little to do with the victim, but once she was able to walk and talk, he fought for his rights to see the child. The mother stated the perpetrator did not care for their child, but he knew that he would be able to "get to" her through the child. He continually used their daughter to harass his wife. He made allegations to the courts, the police, and the child protection services that his estranged wife had abused her; none of these allegations were substantiated. He also became involved in conflicts with his daughter's school. In June 2004, his estranged wife sought a restraining order to stop his harassing behaviour. She was granted an order to deny his access to their daughter, but that order was reversed two weeks later.

In the spring of 2004, the perpetrator picked his daughter up with her passport and health card. The mother gave the perpetrator written permission to take their daughter on a day trip to the US. The perpetrator returned the victim to the mother that evening, however refused to return the victim's passport and health card. The mother called the police and the perpetrator returned the passport and health card. On several occasions, the perpetrator called to speak with his daughter after the agreed upon time. The mother would refuse to wake her and the perpetrator would call the police and CAS to lodge a complaint.

On the day he attempted to kill his daughter, the perpetrator picked her up during his scheduled access. Later that day, he called her mother and asked if he could keep the victim for a longer period. She reminded him of the court's decision and denied him permission. When she said no, he began calling her names and he told her that she would never see her daughter again. He then insisted that she call him from her cellular phone, not her home phone. He stated that he had bugged her home phone and wanted to talk to her on her cellular phone. He also warned her not to call police or anyone else. The mother immediately hung up and dialed 911. She then called the perpetrator back and he again called her names. The victim's mother asked the perpetrator why he was doing this, and he replied he knew she was sleeping around and that she had one last chance to admit the truth. He also accused her of ruining his life. He told her that by tomorrow, everyone in the community would know what kind of "slut" she was. He hung up several times, but each time he called back, calling her names and accusing her of infidelity.

During these calls, the police located him standing on a highway overpass bridge with his daughter. They spoke to him by telephone and he told them he was going to kill his daughter and himself. The officers on the scene witnessed the perpetrator flip his daughter over the bridge railing to the roadway below. He then rolled himself over the railing. The little girl was rushed to the hospital and survived the fall. The perpetrator was pronounced dead at the scene.

Case #12: OCC 2005–2698 & 2005–2699

This case involves the homicide–suicide of a couple in early January 2005. Friends and family described the couple as appearing to be loving and happy. The husband (age 62) shot and killed his wife (age 54), set their home on fire, then shot and killed himself. The responding firefighters found both of their charred remains.

The couple had been married for 38 years and had three adult children. Earlier in their marriage, the victim had considered leaving the perpetrator because he was drinking heavily and had been verbally abusive toward her. There were no reports of any evidence of physical abuse. The perpetrator became seriously ill, stopped drinking, and their relationship improved. The couple was secure financially and had been preparing to leave for a holiday prior to the incident. While the victim loved to travel, the perpetrator did not. Family and friends who saw the couple shortly before their deaths reported they had not seen any evidence of marital discord.

The victim had lived in the community for all of her life and was well respected throughout the area. She rarely complained to others about the perpetrator or the relationship, except to note that she wished he would be more independent of her. Since his illness, the victim was the main decision-maker and the perpetrator relied on her judgement in most matters.

Others saw the perpetrator as being a quiet man and not very sociable. He did not cope well with change and he would let incidents that others saw as small, bother him. There was some indication that he suffered from depression following his illness, however he does not seem to have received treatment. There was also a history of depression in his family.

Neighbours saw flames coming from the couple's home on the day of their deaths, early in the morning. Firefighters and police recovered two bodies that were later confirmed to be the perpetrator and victim. Forensic evidence suggested the perpetrator shot the victim once in the head with a .22 calibre rifle as she was sleeping, and then shot her in the head again with a larger rifle. He then set fire to the house with gas accelerant and shot himself in the head. Cause of death was determined to be a self-inflicted gun shot wound to the head and smoke inhalation. The pathologist report indicated the perpetrator had consumed a large quantity of alcohol just prior to his death. Charred letters from him to the victim, dating from the 1960s, were found near his body.

Case #13: OCC 2002–10874

This case of homicide involves a divorced couple who both remarried other partners. In August 2002, the ex-wife (age 39) shot her ex-husband (age 42) eight times and left him dead outside his home. She had gone there because she was angry that their youngest daughter wanted to reside with him and that her ex-husband had made arrangements to enrol her in a private school, of which she disapproved.

The victim and the perpetrator had two children together. The perpetrator had another child with her second husband. While the victim, her ex-husband, had custody of the children, the perpetrator had generous access, including alternating week access. The same year as the death, the perpetrator decided to move the children to another province in contravention of a Court Order restraining her from removing the children from the province of Ontario. At the time, however, the children told their father that they wanted to move with their mother to the other province. Given the situation, he relented and decided not to pursue a contempt proceeding. Within a short period of time, the circumstances reverted. The eldest child returned to Ontario to attend university, and the youngest child wanted to move back to Ontario to live with her father. The perpetrator became very angry when the idea was suggested. However, the youngest child did return to her father's home. The perpetrator became even more agitated when her ex-husband made arrangements to enrol their daughter in the private school he had attended as a youth. These circumstances brought the perpetrator back to Ontario to confront her ex-husband.

On the day of the homicide, the perpetrator arrived at the victim's home with her newborn baby to speak to her youngest daughter about returning with her. She had a loaded handgun with her. She drove her vehicle into the driveway of the victim's residence, parked it, and left her baby inside. The victim's second wife saw the perpetrator approach their home and asked the victim to handle the problem. The perpetrator rang the doorbell and knocked on the window. The victim answered the door, while at the same time calling 911 for help as the perpetrator was extremely agitated and causing a disturbance. The victim's second wife took the children downstairs in the home as the yelling continued upstairs. Some of the children, including the victim and perpetrator's youngest child, hid in a closet.

The victim's wife heard a banging noise coming from outside the house. She left the basement, believing the perpetrator was damaging their car. When she went outside, she found her husband lying in a pool of blood on the ground, not moving. He had multiple gunshot wounds to his head, neck, and chest. His ex-wife was gone.

The perpetrator was arrested a short time later and charged with first-degree murder. At trial she was convicted of second-degree murder and sentenced to life imprisonment with parole eligibility set at 13 years.

Case #14: OCC 2002–2898

This case of homicide involves a common-law couple who were separating. The victim (age 37) had a daughter from a previous marriage. The perpetrator (age 56) and the daughter were quite close. Prior to her death in February 2002, the victim told the perpetrator she was going to leave

the relationship and that she had started to see another man from work. The perpetrator was aware that the victim had been involved in another relationship for at least one month, and had used various methods to try to get the victim to leave her new partner. These methods ranged from threats to physical abuse. There were no prior contacts with the police.

The victim worked in a factory and her employer described her as being a very kind and friendly person who always appeared to be in a good mood. Other employees at work also described her as being helpful and out-going. She was in good health and had not experienced any trouble with alcohol or substance abuse.

The perpetrator worked at various jobs in and around the county in which the couple lived. He had recently quit his full-time job because he said he was tired of the long hours and wanted to spend more time with his family. An Internet marketing company hired him to sell website advertising to local businesses, however his performance was poor. The perpetrator informed his employer that he was having marital problems. He sent an email declaring he would be unavailable to work for the next several months. He also stated that things were going to get worse before they got better.

The perpetrator had been previously married for 22 years. His ex-wife stated he had minimal contact with his three children since he began the relationship with the victim. During his first marriage, the perpetrator reportedly suffered from alcoholism, however he had stopped drinking for the last 10 years. Many in the community described the perpetrator as a loner with a few friends who he would go hunting with. The perpetrator did not have a valid firearms licence. However, rather than take the test, on several occasions he approached the local firearms examiner and asked if he could pay him money for the licence. He was refused.

The day before her death, the victim told the perpetrator that she was going to leave him. The next day the perpetrator insisted that the victim come home from work for lunch and discuss matters or he would dispose of her belongings. The perpetrator also made arrangements with the victim's daughter, explaining what to do if he was not there to pick her up after school.

That day the perpetrator wrote several notes to family and friends indicating his intention to kill the victim and himself. The victim returned to the apartment as discussed, and as she entered through the doorway he shot her three times. He then called 911 and stated, "I shot my wife." When the police and ambulance attendants arrived, the victim was pronounced dead and the perpetrator was arrested and taken into custody. He was charged with first-degree murder. The perpetrator pled guilty to second-degree murder and received a sentence of life imprisonment with parole eligibility set at 12 years.

Chapter 3 – Summary of Data Analyses 2005

In 2005, the DVDRC reviewed 14 domestic violence cases that involved homicides. There were 19 deaths in total; five of the cases involved a homicide followed by a suicide. One of the cases involved the attempted-homicide of a toddler by a father who was targeting his estranged spouse by attempting to kill their child (the father subsequently committed suicide). This case involved a perpetrator with a criminal history and the incident occurred during a custody and access dispute. For a more detailed discussion of children's deaths in the context of domestic violence, see **Appendix D**.

Since the inception of the DVDRC in 2003, the Committee has primarily reviewed cases cleared by the court in the previous year. In the Committee's first year of operation, it reviewed more homicide–suicides because there was no court involvement in these matters. In 2003, the Committee reviewed cases principally from 2002; in 2004, it reviewed cases from 2003. In 2005, the DVDRC reviewed five cases from 2002, two cases from 2003, five cases from 2004, and two cases from 2005. These complex and time-consuming reviews have limited the Committee's ability to complete this process for every case. As indicated in Table 1, the number of homicide cases per year, between 2002 and 2005, has averaged 28 cases, with an average of 38 deaths.

Table 1 – Domestic Violence Homicides in Ontario 2002–2005

Year	Incidents	Deaths	Women	Children	Men	Details
2005	30	41	24	3	14	20 deaths homicide-suicide 4 attempted homicide-suicide
2004	30	38	26	1	11	15 deaths homicide-suicide 3 attempted homicide-suicide
2003	25	29	19	0	10	8 deaths homicide-suicide 5 attempted homicide-suicide
2002	26	40	21	5	14	15 deaths homicide-suicide 1 attempted homicide-suicide

In reviewing nine cases in 2004, the DVDRC thoroughly analyzed almost one-third of the available cases for that year. Over the past three years, approximately 30% of all cases have been reviewed. It is important to note that certain values in Table 1 may have increased from the

values reported in previous annual reports. The reason for this increase is the recognition and referral of new cases that Police agencies or Coroners had not initially identified as domestic homicides.

For the cases reviewed in 2005, 12 out of 14 cases involved a male perpetrator and female adult victim who was the primary target of the domestic violence. The term primary target is used because the actual victim was a child in one of the cases. The overall data from Ontario domestic violence homicides, shown in Table 1, suggest that approximately 80% of the cases involve males as perpetrators and women as victims, a four-to-one ratio. This percentage and ratio is comparable to other DVDRC findings in the US and the national homicide data according to Statistics Canada.

To add context to the cases that the Committee reviewed (presented later in this chapter), it first analyzed basic information from a sample of 100 of the total 111 cases from the past four years. Twenty-seven of these cases occurred in 2002, 25 occurred in 2003, 29 occurred in 2004, and 19 occurred in 2005. The number of cases from 2005 is lower because some of the investigations of these cases have not been completed.

Table 2 illustrates that the most common form of intimate partner violence fatalities for these 100 cases were single homicide cases, followed by homicide–suicides, attempted homicide–suicides, and attempted-homicides in which the perpetrator was subsequently killed in an event related to the domestic violence incident.

Table 2 – Types of Domestic Violence Fatalities

Type	Percent % (n=100)
Homicide	61.0
Homicide–suicide	24.0
Attempted homicide–suicide	12.0
Attempted homicide and related homicide (e.g., police shooting)	2.0
Attempted homicide and related accidental death (e.g., car accident during police pursuit)	1.0
Total	100.0

A small number of cases involved multiple victims being attacked and/or killed by perpetrators. In the majority of cases, a single victim was attacked and killed (92%). Fourteen percent of cases involved attempted-homicide followed by perpetrator suicide or related death. Also, close to one in every 10 cases involved attacks on multiple victims by perpetrators, and roughly one in every 20 cases involved multiple victim deaths. When more than one victim was attacked and/or killed, the additional victims were usually the children of the primary victim and/or perpetrator. It should be noted that the percentage of cases in which two or more victims were attacked may

be underestimated, as not all Coroners document additional victims who were attacked but survived.

It is important to note that domestic violence fatalities are not gender-neutral events. When examining the sample of 100 cases, females were victims in 93% of cases and perpetrators in only six percent of cases. By contrast, males were fatally wounded in around seven percent of cases, but were perpetrators in 94% of cases (see Table 3).

Table 3 – Gender of Victims and Perpetrators

Gender	Victim % (n=100)	Perpetrator % (n=100)
Female	93.0	6.0
Male	7.0	94.0
Total	100.0	100.0

Upon investigating the causes of death in the sample of 100 cases (see Table 4), it was discovered that the most common ways that victims were killed was from knives and other sharp objects (33%), firearms (28%), being beaten by the perpetrator's fists or legs or with other blunt objects (15%), and being choked either manually or with a ligature (13%).

Table 4 – Rank Ordered Victim Causes of Death

Cause of Death	Percent % (n=100)
Stabbing/cutting	33.0
Shooting	28.0
Beating/assault	15.0
Strangulation/smothering	13.0
Other (e.g., struck by car; thrown from a high place; set on fire; poisoned; drowned)	8.0
Missing information	3.0
Total	100.0

In contrast, in the US, over half of female domestic violence homicide victims (54%) were killed by firearms, while one in five were killed by knives or other cutting instruments.[6]

[6] Violence Policy Centre (2004). When Men Murder Women: An Analysis of 2002 Homicide Data. Washington, DC: Author

As can be seen in Table 5, domestic homicides and murder–suicides occurred most commonly in or around the victims' and perpetrators' homes.

Table 5 – Rank Ordered Locations of Domestic Violence Fatalities

Location	Percent % (n=100)
Residence	78.0
Urban outdoors	9.0
Rural outdoors	8.0
Other (e.g., work)	5.0
Total	100.0

Twenty-two percent of the cases occurred away from the home. Some of these cases involved attacks on the victims at their places of employment, or attempts by perpetrators to run the victims over with their cars in public places (usually during a period in which the perpetrator had been stalking a former partner). Although relatively rare, there were a few occurrences in which perpetrators lured their partners or ex-partners to isolated areas (e.g., wooded areas) for attacks.

As part of analyzing the locations of the cases, the Committee examined the cities in which the fatalities occurred, with the assistance of census data from Statistics Canada.[7] [8] [9] Table 6 ranks orders the cities by population size.

Table 6 – Ontario Cities and Domestic Violence Fatalities

City	Population	Percentage of Domestic Homicides in Ontario %	Percentage of Population of Ontario %
Toronto	2 481 494	22.0	21.748
Ottawa	774 072	5.0	6.784
Mississauga	612 925	4.0	5.372
Scarborough	593 297	6.0	5.200
Hamilton	490 268	2.0	4.297

[7] http://www12.statcan.ca/english/census01/products/standard/popdwell/Table-UR-D.cfm?T=1&SR=1&S=1&O=A&PR=35

[8] http://www12.statcan.ca/english/census01/products/standard/popdwell/Table-CSD-M.cfm?T=1&PR=35&CD=3557

[9] http://www12.statcan.ca/english/profil01/CP01/Index.cfm?Lang=E

Etobicoke	338 117	1.0	2.963
London	336 539	5.0	2.949
Brampton	325 428	1.0	2.852
Windsor	208 402	2.0	1.826
Kitchener	190 399	2.0	1.668
Vaughan	182 022	2.0	1.595
Sudbury	155 219	1.0	1.360
Oshawa	139 051	2.0	1.219
Richmond Hill	132 030	1.0	1.157
St. Catharines	129 170	2.0	1.132
Nepean	124 878	1.0	1.094
Kingston	114 195	1.0	1.001
Chatham	107 341	1.0	0.941
Barrie	103 710	1.0	0.909
Whitby	87 413	1.0	0.766
Brantford	86 417	1.0	0.757
Northumberland County	77 497	1.0	0.679
Sault Ste Marie	74 566	1.0	0.653
Ajax	73 753	1.0	0.646
Peterborough	71 446	2.0	0.626
Sarnia	70 876	2.0	0.621
Bruce County	63 892	1.0	0.560
Port Rowan (Norfolk Township)	60 847	1.0	0.533
Cornwall	45 640	1.0	0.400
Orangeville	25 248	1.0	0.221
Dundas	21 797	1.0	0.191
Owen Sound	21 431	1.0	0.188
Grimsby	21 297	2.0	0.187
Bolton	20 553	1.0	0.180
Thorold	18 048	1.0	0.158
Lindsay	17 757	1.0	0.156

Huntsville	17 338	1.0	0.152
Kenora	15 838	1.0	0.139
Bracebridge	13 751	1.0	0.120
Pembroke	13 490	1.0	0.118
Coldwater (Severn Township)	11 135	2.0	0.098
Millgrove (Hamilton Township)	10 785	1.0	0.094
Alliston	9 679	1.0	0.085
Embro (Zorra Township)	8 052	1.0	0.071
Port Perry	7 244	1.0	0.063
Iroquois Falls	5 217	1.0	0.046
Marathon	4 416	1.0	0.039
Marmora	3 985	1.0	0.035
Atikokan	3 632	1.0	0.032
Port Stanley	2 521	1.0	0.022
Wikwemikong	2 427	1.0	0.021
Barry's Bay	1 259	1.0	0.011
St. Charles	1 245	1.0	0.011

Table 6 presents the percentage of the 100 cases that occurred in each specific city, and also provides information related to the size of each city as a percentage of the overall population of Ontario. While many homicides occurred in relatively large urban centres (e.g., the General Toronto Area, Ottawa, Hamilton, London), a sizable number of domestic violence fatalities occurred in rural areas. When taken together as a whole, these rural areas do not comprise a large percentage of Ontario; however, they do make up a substantial percentage of the 100 cases. For example, one-quarter of the cases occurred in communities of 25,000 people or less that totalled less than 3% of the population of the province.

The perpetrator died in 39% of the 100 cases. In three of these cases, the death was a result of either a related homicide (e.g., a police shooting) or a related accident (e.g., a car accident during a police pursuit). The remaining perpetrator deaths were a result of suicide. Table 7 presents the causes of death for the perpetrators in the 39 cases.

Table 7 – Causes of Death for Perpetrators

Cause of Death (self-inflicted)	Number of Cases (n=39)	Percent (n=39)
Shooting	19	49.0
Cutting/stabbing	6	15.0
Motor vehicle collision	6	15.0
Hanging	4	10.0
Other (e.g., jumped from a high place; carbon monoxide poisoning; set self on fire)	4	10.0
Total	39	~ 100

The results in Table 7 show that the majority of perpetrator suicides were a result of self-inflicted gunshot wounds (close to 50%). The next most common methods of perpetrator suicide were through self-inflicted stab wounds (15%) and by throwing themselves in front of oncoming vehicles, such as cars, subways, or trains (15%). Approximately 10% of perpetrators committed suicide by hanging themselves. Table 7 is limited in that it only captures perpetrators who completed suicide, not the number of perpetrators who attempted suicide but survived. As a result, the above numbers only provide part of the overall picture of perpetrator suicidal behaviour during domestic homicide cases.

The remaining portion of this chapter is dedicated to presenting the data from the cases that the Committee reviewed in-depth. The data presented for 2005 represent 14 cases. The summary tables that follow provide an overview of these cases, as well as an accumulated picture from the totals of the cases from 2003, 2004, and 2005 combined (34 cases = 11 from 2003 + 9 from 2004 + 14 from 2005). Tables 8 and 9 provide an overview of victim and perpetrator background information.

Table 8 – Victim and Perpetrator Information

Variable	2005		2003–2005 Combined	
	Victim (n=14)	Perpetrator (n=14)	Victim (n=34)	Perpetrator (n=34)
Gender	86% female 14% male	7% female 93% male	91% female 9% male	9% female 91% male
Age when incident occurred (years; adults	Min = 15 Max = 58	Min = 24 Max = 61	Min = 15 Max = 81	Min = 21 Max = 89

Variable	2005		2003–2005 Combined	
	Victim (n=14)	Perpetrator (n=14)	Victim (n=34)	Perpetrator (n=34)
only)	Mean = 40 Median = 42	Mean = 43 Median = 43	Mean = 41 Median = 42	Mean = 43 Median = 40
Residency status (adults only)	Canadian Citizen – 79% American Citizen – 7% Immigrant/ Refugee – 14%	Canadian citizen – 93% American Citizen – 0% Immigrant/ Refugee – 7%	Canadian citizen – 82% American citizen – 3% Immigrant/ Refugee – 15%*	Canadian citizen – 85% American citizen – 3% Immigrant/ Refugee – 12%
Employment status (adults only)	Employed full-time – 50% Unemployed – 36% Other – 14%	Employed full-time – 29% Unemployed – 43% Other – 28%	Employed full-time – 45% Unemployed – 26% Other – 29%**	Employed full-time – 45% Unemployed – 33% Other – 22%
Criminal history (adults only)	Yes 7%	Yes 50%	Yes 9%	Yes 50%
Prior counselling (adults only)	Yes 36%	Yes 58%	Yes 31%***	Yes 50%****
Threats or attempted suicide (adults only)	Yes 7%	Yes 50%	Yes 3%***	Yes 59%*****
Significant life changes (adults only)	Yes 64%	Yes 79%	Yes 49%*	Yes 88%

*n=33, **n=31, ***n=32, ****n=30, *****n=29

Table 9 – Relationship between Victim and Perpetrator

Variable	2005		2003-2005 Combined	
	Victim (n=14)	Perpetrator (n=14)	Victim (n=34)	Perpetrator (n=34)
Type of relationship between victim and perpetrator	Legal spouse 36% Estranged legal spouse 29% Common-law partner 7% Estranged boyfriend/girlfriend 14% Boyfriend/girlfriend 14% Other 0% (divorced/former partner/current friend/same sex partner)		Legal spouse 44% Estranged legal spouse 15% Common-law partner 12% Estranged boyfriend/girlfriend 12% Boyfriend/girlfriend 9% Other 9% (divorced/former partner/current friend/same sex partner)	
Length of relationship (adults only)	<1 year = 14% 1 -10 years = 50% 11 – 20 years = 7% 21 – 30 years = 14% Over 30 years = 14%		<1 year = 9% 1 - 10 years = 53% 11 – 20 years = 9% 21 – 30 years = 24% Over 30 years = 6%	
Children in common (adults only)	0 36% 1–2 50% 3+ 14%		0 32% 1–2 47% 3+ 21%	

NOTE: The information reported in the previous tables is only relevant to the perpetrator and intimate partner (i.e., if the victim of homicide was a child, his/her information was not reported).

The previous tables show that the majority of the cases involved Canadian citizens who were married couples with children. As mentioned previously, 12 of the 14 cases involved male perpetrators. For the cases from 2003, 2004, and 2005 combined, background information suggests that the perpetrator likely had a criminal record (17 out of 34 cases), had made previous threats or attempts of suicide (17 out of 29 cases), and had experienced significant life changes such as job loss (30 out of 34 cases).

Table 10 provides an overview of the nature of the reviewed cases.

Table 10 – Homicide Information

	2005 (n=14)		2003–2005 (n=34)	
Type	Homicide	36%	Homicide	41%
	Attempt homicide–suicide	29%	Attempt homicide–suicide	12%
	Homicide–suicide	36%	Homicide–suicide	41%
	Multiple homicide	0%	Multiple homicide	3%
	Multiple homicide–suicide	0%	Multiple homicide–suicide	3%
Cause of death	Stabbing	43%	Stabbing	41%
	Gunshot wound	29%	Gunshot wound	29%
	Beating	0%	Beating	9%
	Strangulation	7%	Strangulation	6%
	Poisoning	0%	Poisoning	3%
	Burns	7%	Burns	3%
	Other	14%	Other	9%

As can be seen in Table 10, five of the 14 cases were homicide–suicides. Six out of the 14 cases involved stabbing as the cause of death, which is comparable to the 2003 and 2004 data. Firearms were used in four out of 14 cases in 2005, and in 10 out of the 34 cases (29%) for the three years combined.

Table 11 provides an overview of the common risk factors associated with the domestic violence cases reviewed.

Table 11 – Common Risk Factors from DVDRC Analysis

Risk Factor	2005		2003–2005	
	n (n=14)	Percentage	n (n=34)	Percentage
Actual/pending separation	11	79%	27	79%
Prior history of domestic violence	12	86%	24	71%
Depression (or other mental health/psychiatric problems)	11	79%	24	71%

Obsessive behaviour (including stalking)	8	57%	19	56%
Escalation of violence	8	57%	18	53%
Prior threats to kill victim or threats with a weapon	8	57%	17	50%
Excessive alcohol and/or drug use	5	36%	15	44%
Control of most or all of victim's daily activities	4	29%	13	38%
Perpetrator unemployed	7	50%	11	32%
Child custody/access dispute	3	21%	7	21%
Extreme minimization/ denial of spousal assault history	1	7%	5	15%

Table 11 highlights the most common factors found in the 14 cases reviewed in 2005, as well as the overall common factors for the cases reviewed in 2003, 2004, and 2005 combined. The most consistent factors appear to be an actual or pending separation, prior history of domestic violence, and depression (or other mental health or psychiatric problems). A perpetrator who had made threats to harm himself or his partner in the past, with a history of substance abuse, and who exhibited stalking behaviour and escalating violence appeared to be present in around half of all cases. Three of the 14 cases in 2005 involved child custody/access disputes, in contrast to this issue not being identified in the 2003 reviews. For definitions of the above terms, refer to the Ontario Domestic Violence Death Review Committee Risk Assessment and Coding Manual in **Appendix A**.

In addition to the above risk factors associated with lethal intimate partner violence, the Committee has been flagging other factors believed to exacerbate the intimate couples' situations. In 11 (79%) of the 14 cases reviewed this year, and in 21 (62%) of the overall 34 cases, additional factors were documented in an "Other factors that increased risk" category. Some of the factors in this category included:

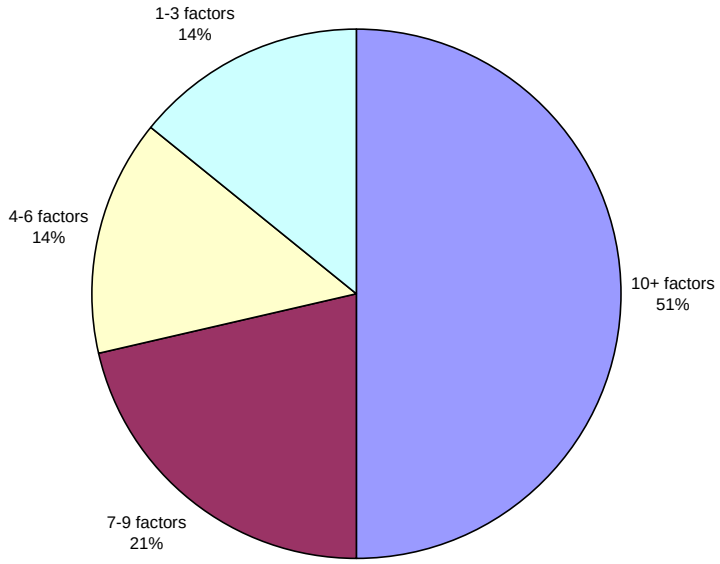
- poor health conditions
- perpetrator isolation
- breaching Court Orders
- gambling addiction
- violence outside of the home
- events of violence involve few precipitating factors
- distress over disruption of retirement plans

- financial issues and/or difficulties caused by pending separation/divorce
- continued co-habitation after intention of separation
- threats of child abduction
- perpetrator minimizes psychiatric condition and refuses to comply with medication schedules and follow-up appointments with physician

Although there may be a lack of research demonstrating empirical support for many of these factors as indicators of lethal domestic violence, it is the Committee's hope that further inquiry and research into these factors will be initiated by disseminating the findings.

An important concern to the DVDRC is the extent to which the homicides reviewed appeared predictable and preventable with the benefit of hindsight and the analysis of well-known risk factors. In 10 out of 14 cases, the homicide appeared both predictable and preventable. To illustrate this fact, the Committee reviewed the number of known risk factors in the cases from 2005. These results are shown in Figure 1 and suggest that in 10 out of 14 cases, at least seven or more risk factors were clearly identifiable in the history of the family circumstances.

Figure 1 – Number of Risk Factors Identified in Cases Reviewed (2005)



For the three years combined, 22 out of 34 cases (65%) had at least seven or more known domestic risk factors associated with lethal violence. A formal risk assessment had been done in

only two of the cases reviewed in 2005, but unfortunately it did not lead to a coordinated safety plan and risk management strategy.[10]

Appendix A provides detailed definitions used by the DVDRC in determining the presence of risk factors. Through discussion of the risk factors for lethal intimate partner violence, the Committee decided an expanded and more specific tool and coding manual were needed to assist in conducting more accurate, reliable, and timely risk assessments, as well as to collect more descriptive data from the cases. Consistent definitions ensure better agreement among reviews about the presence of certain factors. Other provinces have expressed interest in developing DVDRCs and this material may assist them in this process. The manual in **Appendix A** gives a sense of the indicators of lethality that the Committee is attempting to identify in each case. The Committee expects that data relevant to this expanded manual will be outlined in future annual reports (once it has been used to review enough cases).

[10] The Committee acknowledges the assistance of Mr. George Goodall, a graduate student in the Library and Information Science program at the University of Western Ontario, in developing the database and conducting data analysis.

Chapter 4 – Recommendations

In previous reports, the identified issues and the resultant recommendations fell into one of three broad categories: awareness and education, assessment and intervention, and the need of resources. In ongoing reviews, the DVDRC continues to see a need to heighten awareness and generally provide education about domestic violence. In every case reviewed, family members, friends, neighbours, co-workers, and/or professionals had some knowledge of the escalating circumstances between the perpetrators and victims. However, these individuals did not appreciate the significance of the situation, the information, or warning signs, and did not know what to do about them. Also, it is important to ensure that domestic violence education and awareness work is done in a culturally competent manner, using multiple strategies and approaches. Secondly, there is a need to have appropriate tools available to those who work with victims and perpetrators of domestic violence to better assess the potential for lethal violence in their lives, and corresponding access to appropriate services and programs. Lastly, adequate resources are required to institute programs to help ensure victim safety and reduce the perpetrator's risk.

Observing recurrent themes in the reviewed cases from 2005 was not unexpected, given the Committee's decision not to review cases until they had been completed before the courts. Many of the cases reviewed occurred during earlier review periods and only became available for review this past year. This report includes only recommendations that address new issues or that address additional features of past recommendations. However, recommendations from the previous annual reports are set out in their entirety in Appendices B and C.

Awareness and Education

It is recommended that all training material for professionals and public education programs emphasize the harmful nature of emotional and psychological abuse.

The focus of community education on domestic violence has long been on physical violence. This focus is based on the fact that it is much easier to identify and respond to the signs of physical violence such as cuts, bruises, and broken bones. The healthcare system and the justice system can better document these symptoms as a foundation for immediate treatment and potential criminal charges.

However, physical violence rarely occurs without emotional abuse, and that emotional abuse is probably much more prevalent than physical violence. Emotional abuse can be more damaging in terms of victims' sense of safety and security, as well the accumulative effects on self-esteem. Emotional abuse may put victims at risk because it is harder for women to prove its existence and more difficult for others to notice. In the reviewed cases where it was relatively obvious that there was emotional abuse, there should have been community education highlighting the seriousness of this kind of abusive behaviour. In one case, the emotionally abusive nature of the relationship was widely known throughout the community. However, without community education strategies and information that verified it was a serious problem requiring intervention, community members did not know how to intervene and/or did not think intervention was necessary.

Accessible, plain language education campaigns must be available that identify what emotional abuse is, the serious damage that it inflicts upon the victim, and what people in the community who know it is happening can do. For such a campaign to be useful, there must be a clearly coordinated response that identifies where concerned friends, family, and members of the public can go for help.

It is recommended that the significance of prior perpetrator suicide attempts or threats be emphasized in domestic violence training and education as a risk factor in forecasting the prospect of future lethal harm to not only themselves, but also others.

The Committee notes that in a significant number of the cases studied to date (2003–2005), the perpetrator either attempted or threatened suicide prior to causing the death(s). In one of the cases reviewed this past year, the perpetrator entered the matrimonial home after setting fire to his wife's car in the driveway. He set the home on fire and was burned to death, however both his wife and children were able to escape. The perpetrator was on a bail release prohibiting him from visiting the home. The bail was for a serious assault on his wife and had been set only a month previous. At the bail hearing, the presiding justice was presented with all of the relevant information involving the allegations, including attempted suicide by the perpetrator in the prior year. Notwithstanding this information, the justice referred to the assault charge before him as an "isolated incident." The assault was a severe one involving choking the victim to unconsciousness, and there had been a prior history of suicidal thoughts and behaviour. The Committee's experience indicates that suicide attempts in the context of domestic violence are often associated with lethality. It is important to recognize that suicidal behaviour is an indication of increased risk not only to the perpetrator, but also to his spouse and children.

It is recommended that family members, friends, and community professionals be educated to contact police immediately and report their concerns when they are aware of individuals who have potential access to firearms and who are in a relationship where domestic violence is suspected. This is particularly important when the couple is going through a separation or the individual is showing signs of depression or suicidal or homicidal thoughts.

This is an elaboration on a previous recommendation made in the 2002 report, recommendation #15 in **Appendix B**, which deals with the need to take the appropriate steps to remove firearms from those displaying significant warning signs of a risk for violence. Access to firearms is an important risk factor. Moreover, restricting access to firearms is important in terms of effective intervention and risk management. The best means for *family members, friends, and community professionals* to intervene in these cases is by reporting their concerns to police. Police are trained and equipped and have the legislative means to intervene when firearms are accessible in such cases. In one case, numerous friends and family members of both the perpetrator and the victim were aware of the couple's recent separation, the perpetrator's suicidal threats, ongoing arguments, and the fact that the perpetrator had access to firearms, yet no one contacted police. This did not appear to be a deliberate act of non-involvement, but merely a lack of understanding of when and how to react to their concerns. This sentiment was best captured in a statement made to police by one of the witnesses:

"Most of the time they were short—the episodes were short—they'd have their fight then I'd hear her singing in the bathtub. And my son told me that they fought a lot. He probably heard them more than me. I don't know where to draw the line, really when should you call the OPP? How bad does it have to be?"

There appears to be a need to better educate the public in terms of when it is appropriate to contact police and how best to go about it.[11]

1. ***It is recommended that professionals and persons in authority be educated in terms of giving victims of domestic violence the proper information and guidance, whether they seek their advice in a formal or informal setting. There should be follow up with the victims to ensure they were given sufficient information to make an informed decision. This recommendation is directed to include professionals such as police officers, lawyers, and doctors.***

In a number of cases, victims were afraid or not aware of how to properly access help or report incidents of domestic abuse. If given an opportunity in a formal or informal setting, they may reach out and seek advice from those in a position of authority and perceived to be knowledgeable. These professionals must be understanding and sensitive to victims. They must realize this may be the first and perhaps the only opportunity for the victim to report or inform someone who can help them. They must not minimize the seriousness of the information and must provide the victim with the proper advice and counsel, or direct her to the proper authorities. In addition, they should ensure the victim follows through on the advice given.

In one of the reviewed cases, the victim privately outlined her concerns for her safety to a senior police official in attendance at an informal social gathering. By the nature of the response given, the victim felt her concerns were not taken seriously. No referral was made and there was no follow-up. The victim then felt that the avenue of involving the police was closed off to her and felt discouraged to take any further action.

2. ***It is recommended that domestic violence be a regular part of the curriculum in family law courses at faculties of law in Ontario, the bar admission course, as well as continuing education programs for family law lawyers.***

This is an elaboration of a previous recommendation in the 2004 report, recommendation #4 which can be found in **Appendix C**. Although domestic violence has been well recognized in the criminal justice system for almost a quarter century in terms of legislation, policy, support/counselling programs, and enhanced collaboration with other systems, the practice of family law has not witnessed the same developments. The focus on conflict resolution, parent education programs, and pressure for parents to put the past behind them for the sake of the children has not served the unique needs of abuse victims and their children. Abuse victims face many challenges in seeking safety for themselves and their children after separation. They may be supported in developing a safety plan in the criminal courts, but the family court may undermine these efforts by promoting access to a perpetrator of domestic violence. The history of domestic violence may not be recognized as a significant factor compared to child abuse since the former is seen as an "adult" issue. The Committee's reviews indicate there have been a

[11] See reference to *Neighbours, Friends and Family Campaign* in the Future Trends and Directions section below.

number of tragedies associated with the lack of recognition of domestic violence as a critical factor in determining child custody and access arrangements (see **Appendix D** for a fuller discussion of this issue). Family law practitioners require enhanced education in terms of identifying these issues and the specialized assessment and intervention strategies required.

In one case, the victim's family law lawyer allegedly made comments about restraining orders not being effective and proposed no other legal solutions. The victim was discouraged from taking any action and remained in a dangerous situation. These comments reflect broader community and professional attitudes about the lack of potential support in the justice system for domestic violence victims within family law hearings. This case and others highlight the need for legal education in terms of domestic violence and family law proceedings.

It is recommended that social services assisting immigrant women and their children have access to ongoing training in terms of education, awareness, and interventions on issues relating to domestic violence, including identification, risk management, and community support.

The committee recognizes that immigrant women and their children face many additional barriers in seeking assistance after incidents of domestic violence. In one case, English was not the woman's first language, she was isolated and lived in poverty. Her primary support was from her classmates and teachers in an English as a Second Language (ESL) course. She did not have any family in Canada, and was unaware of her legal rights. Her ESL teachers informed her of her right to social assistance, subsidised housing, and legal aid, and referred her to a family law lawyer for a consultation regarding custody and access arrangements for her children. Her friend disclosed that the night before her death, her husband had been upset with her for taking her citizenship test, scheduled for the next day. The victim had just recently expressed to her classmates and to her teachers how grateful she was for their help so she could access the resources she needed; she could finally see being able to make a life for herself and her children, in Canada, on her own.

Assessment and Intervention

3. It is recommended that health and social service professionals assess the possibility of childhood histories of exposure to domestic violence and develop intervention strategies to recognize this factor as part of an overall treatment plan.

While there is increasing recognition of the impact of exposure to domestic violence on children's emotional, cognitive, and behavioural adjustment, there is less awareness of the long-term consequences into adulthood. Some research points to the possibility that this exposure to violence may be associated with adult attitudes and propensity to use or condone violence within intimate relationships. In one case review, this issue was identified as one of the precursors to a domestic homicide. As part of the assessment by a mental health professional, the following comment was noted about the perpetrator: *"He tells me he feels angry with his father for bringing him up in the manner so that he hates women especially his mother, which seems to be having an effect on him at present in a way he is having difficulty in relationships."* Although the issue is clearly identified in this note, it often appears in the background history of other perpetrators as well. Seeking this information as a standardized part of any assessment as well as identifying intervention strategies to help adults cope with this childhood history are important

factors. These strategies may form part of an overall treatment plan, as exposure to domestic violence is most often only one dimension of presenting problems.

4. ***It is recommended that mental health professionals including psychiatrists, psychologists, social workers, and psychiatric nurses have ongoing training in the dynamics of domestic violence, as well as risk assessment, high risk case management, and intervention strategies including safety planning for the woman, her children, and family members.***
   - ***This training needs to make safety of victims and children a priority irrespective of who the referred patient/client may be.***
   - ***Assessments should include collateral information from all relevant sources, including family, friends, police, and children protection services, with respect to the potential risk to the woman and her children posed by the perpetrator's behaviour.***
   - ***Concerns about any risks to children must be reported to children protection services.***

In a number of cases, individuals and/or their family members reached out to mental health professionals and facilities for help. In addition, several reviewed cases included the dual problems of domestic violence and mental health illness. Treating one aspect of the problem may not resolve the other. In one case, the perpetrator had a history of assaulting the women in his life and he also had a history of mental health illness. According to his family and a psychiatric report, he had a history of experiencing paranoia and hearing voices telling him to hate certain people and kill them. His family urged him to seek medical help on numerous occasions. On one particular occasion, they requested the police assist them after he had assaulted his wife. The police took him to the hospital for a mental health exam and he was assessed for violent psychotic behaviours. He was released on a pass and never returned. There was no follow-up notification to his wife and family, and they were not informed or involved with his assessment and treatment. It appears that he was treated with medications to deal with the immediate mental health symptoms, and once they were brought under control, there was no intervention to assist with the abusive aspects of his behaviour that placed his wife and family at risk.

It is recommended that when a Children's Aid Society (CAS) conducts a child abuse investigation, each parent should be interviewed separately. The issue of domestic violence should be an integral part of their risk assessment process.

This recommendation builds on recommendation #3 from the 2004 Annual Report in Appendix C that deals with the critical role of the CAS in risk assessment and intervention in domestic violence cases.

In one of the cases, there was an opportunity for the CAS to intervene but due to the fact that an individual interview was not held with the mother, critical information was not disclosed. This information may have better informed the assessment and intervention efforts.

It is recommended that all workplaces design and implement a policy to address domestic violence as it relates to the workplace. The policy should include:

- educating employees about the issue of domestic violence to help them identify an abusive relationship in which they may be involved and about how to reach out to co-workers;
- training employers and managers to identify the signs of abuse and respond appropriately to employees who are victims and perpetrators of domestic violence;
- providing a resource list of appropriate referral agencies;
- providing an organized response to direct threats of domestic violence that occur in the workplace;
- developing and implementing a safety plan for the victim to ensure that a number of security measures are in place for her protection.

In one of the cases reviewed, the victim and the perpetrator worked in close proximity to each other and the victim felt intimidated every time she passed his office. Management and co-workers were aware of the situation but did not intervene.

Chapter 5 – Subcommittee on Risk

In the first report of the DVDRC, the Subcommittee on Risk reviewed a number of risk assessment instruments and recommended the use of the *Domestic History Questionnaire* to assist in collecting relevant contextual information. In the second report of the DVDRC, the Subcommittee laid out a basic case management framework as well as a preliminary examination of a number of different approaches that have been used by some communities in an effort to manage high-risk cases.

In this year's report, the Subcommittee has included a Guide to the *Domestic History Questionnaire*. As well, the Subcommittee has spent the last year focusing on management of high-risk domestic violence cases. The Subcommittee recognizes that much work has been done on identifying high-risk domestic violence cases. The problem is that once a case has been identified, what is done to actively manage the case? The sad reality for many communities is that little, if anything, is done. It is one thing to recognize that a person is dangerous; it is quite another thing to do something about it.

In a number of the cases the DVDRC has reviewed, the perpetrator was recognized as being dangerous and the victim was recognized as being at high risk. Unfortunately, there was no effective case management response. This resulted in dire consequences to the victim. The challenge for each community then is to establish case management models and processes to actively manage high-risk domestic violence cases. There are a number of initiatives in Ontario and the US that have attempted to deal with this most critical phase of a high-risk domestic violence case.

This year, the Subcommittee delved more deeply into how these cases can be managed. What has become apparent is that there is no perfect model for every community. What follows is a survey of the approaches from a number of communities. What all of these approaches have in common is the recognition that communities need to engage in a formal management process once a high-risk case has been identified.

Guide

The Subcommittee of the DVDRC developed a *Domestic History Questionnaire* (DHQ) to enable a wide range of service providers and community members to identify high risk situations. This year the Subcommittee focused on developing a supporting document to assist the interviewer in using the *Domestic Violence History Questionnaire*. The guide includes guiding principles, important considerations in doing this work, and a summary checklist. The summary checklist covers risk management, safety planning and support, and referral to specialized services. Those currently using the Questionnaire can adapt or modify it to suit the unique needs of an agency or community. It is the Subcommittee's hope that service providers will find the Guide and DHQ helpful in identifying, assessing, and effectively intervening in high-risk situations.

Bail Safety Pilot

In February 2002, the jury in the Coroner's inquest into the deaths of Gillian and Ralph Hadley delivered its recommendations. While out on bail, Ralph Hadley killed his wife Gillian and then

committed suicide. Recommendation #12 of the inquest indicated that the Ministry of the Attorney General work with the Ministry of the Solicitor General to develop a specialized domestic violence bail program.

In response to this recommendation, the Ministry of the Attorney General, Criminal Law Division, the Ontario Victim Services Secretariat, and the Ministry of Community Safety and Correctional Services received Management Board funding and modeled a program after an early-interview pre-bail program previously implemented in Chatham, Ontario. The first pilots were implemented in August 2002. As of November 29, 2005, six new sites have received bail safety funding for the next three years. Both anecdotal and empirical evidence indicate that the program enhances victims' feelings of safety, as well as increases their physical safety. The main underlying rationale of the program is ensuring safety for victims at the bail stage.

The program acknowledges that the victim is the one who holds information about the history of the relationship and its potential lethality. The program consists of interviewing the victim in each domestic violence case where the accused is held for bail. At the time of the occurrence, the police ask the victim to come in for a pre-bail interview with the bail safety team the following day. Victim/Witness Assistance Program (V/WAP) staff call the victim the next day to set up an interview time if she does not arrive on her own. Transportation is provided to the victim if needed. When a victim is unable to physically come in for an interview, the interview is conducted over the telephone.

V/WAP, Police, and the Crown Attorney interview the victim using a pre-set checklist including agreed-upon risk factors. The interview checklist focuses on a number of areas:

- the history of the relationship
- the details of the family composition including questions pertaining to children, if applicable
- issues of power and control relating to the behaviour of the accused in the relationship
- the victim's perceptions of risk
- re-visiting the Risk Factor Checklist completed by the police

During this interview, support, education, and safety discussions occur. Information and referrals are given to the victim from community agencies in the areas of emergency and long-term housing, support, income support, immigration, counselling, and Children's Aid. The victim is provided with the opportunity to discuss her safety issues and concerns and staff members are given the opportunity to explain risk factors and the cycle of violence.

Police gather information about the accused person's past convictions, access to weapons, and proposed surety. Every attempt is made to gather as much information as possible for the bail hearing. The Crown Attorney reviews the file in its entirety with the interview information and additional justice system history prior to making bail recommendations.

The bail recommendations are geared to the individual accused and take the above-mentioned information into account. If the Crown consents to the release of the accused on conditions, these conditions maintain physical parameters for safety, and they stress no contact with the victim. Conditions of release often include that the accused is not able to go to the victim's residence, place of work, place of recreation, place of worship, or family members' homes. These conditions are taken seriously and breaches are thoroughly investigated.

The victim immediately receives referrals, safety planning, and support in the bail safety program. This immediate support is imperative to keep victims feeling less isolated and more supported by the system. Since the victim is more apt to feel supported, she also reaches out to the system in the future. The larger community is able to respond quickly to offer supports to the victim as the referrals are made so early in the process.

For more information, contact Ruth Greenspan, Project Manager, Bail Pilot Program at 905. 645.5252 X3881, or email Ruth.Greenspan@jus.gov.on.ca

Team Approaches

The models that follow indicate that a team approach to domestic violence high-risk case management requires a dedicated group of people willing to be proactive, think outside the box, challenge the status quo, and be innovative. Above all, they should not wait for perfection; they should take action to effectively intervene in high-risk domestic violence cases.

Communities considering establishing a management team should consider the following questions:What is a high risk domestic violence case?

- What criteria (if any) are used?
- Are any assessment tools used?
- Do charges have to be laid?
- Who makes the final decision?
- Once accepted, does the high-risk domestic violence case get ranked?
- What system is in place to respond to it?
- Who are the members of the team?
- When and how often does the team meet?
- What filing/data system is in place?
- Who inputs and updates the data?
- Where is the data kept?
- Are minutes kept of each meeting? By whom?
- Are there any confidentiality issues?
- Is there a waiver? Who signs it?

- How are referrals made?
- How are assignments made?
- What case management strategies are used for the victim and accused?
- Who has carriage of the case? Is there a boss? Accountability?
- What kind of follow up is there?
- How long does the case stay active?
- What kind of future planning/resources takes place?

High Risk Consult Team, Woman Abuse Council of Toronto (WACT)

WACT is a policy development and planning body with a mandate to develop a coordinated response to woman abuse. Since 2000, WACT has been working to develop materials and models for responding to high risk and potentially lethal situations. WACT created a *High Risk Tool Kit* that provides information and resource materials about potentially lethal situations, and outlines a case management model recommended for high-risk cases. Over forty agencies in Toronto have been trained with this kit. Practitioners are encouraged to use this tool on an ongoing basis. Other tools are also used. In particular, WACT recommends training on Dr. Jacqueline Campbell's *Danger Assessment* and the *Ontario Domestic Assault Risk Assessment* (ODARA) instrument.

In 2003, the WACT formed the High Risk Consult Team to provide expert consultation to front-line practitioners struggling with high-risk and potentially lethal cases. The Team is an inter-disciplinary group of practitioners, all of whom have extensive experience working with abused women and their families. The Team's purpose is to review the case and explore new options for keeping the potential victim safe, as well as manage the risk posed by the abuser. Any agency staff-person in the community can contact WACT for assistance. Before a case comes to the Team, a thorough interview is completed, a high risk assessment is undertaken, and a review takes place of the interventions already attempted. If the practitioner still has serious concerns about safety and would like support regarding the case, it is brought forward to a monthly meeting of the Team. Cases are presented to the Team without any identifying information.

The Team includes: a representative from a child welfare agency and the Victim/Witness Assistance Program, a therapist who works at a shelter, a counsellor who works in a hospital, a counsellor who works in a community health setting, a children's mental health worker who specializes in woman abuse, an immigration lawyer, a transitional and housing worker, and WACT staff. The Team's purpose is to brainstorm case management strategies, some of which may be "out of the box," creative, and unusual. The hope is that through an educational process that fosters discussion, new and effective strategies will be offered and some of these will be used in a way that is comfortable for the practitioner and the woman involved.

The Team focuses on ways to constrain the abuser's access to the victim and manage the risk he poses, as well as how to work with the woman to enhance her safety and the safety of her children. The Team provides a forum for discussion; it raises ideas and options, but does not assign tasks. While safety planning is important, the Team also focuses on how to manage the

risk posed by the abuser. The Team assists front-line practitioners by providing opportunities to learn about possible interventions through various sectors. The Team shares creative ways of working with abusers and women victims. The Team develops its collective wisdom as cases are discussed and recommendations for interventions and approaches are identified.

The Team meets once a month for an afternoon and usually consults on one case per meeting. Occasionally the Team discusses two cases in one afternoon; however this is not an ideal situation as it does not allow sufficient time for full discussion. WACT staff undertake a comprehensive review of the case with the practitioner before it is brought to the Team. However, a case is rarely turned down. In some cases, where it is relatively clear that the intervention of one sector is problematic and needs to be rectified, the practitioner is encouraged to contact that specific agency or sector first. In one of these cases, the practitioner did work with the identified agency. However, the case was eventually brought forward to the Team since the level of risk continued to be significantly high.

Criminal charges do not have to be laid for a practitioner to bring a case to the Team, although they have been laid in about half of the cases reviewed. The cases the Team discusses are not ranked; the case is ultimately identified as high risk by those involved with the case. If they deem it to be high risk, the case is explored by that worker.

The Team is not a decision-making body. It provides options and ideas for enhanced interventions and new ways of working with a woman who is in danger. All decision-making concerning the case rests with the practitioner, her/his supervisor, and the agency. Once the Team meets, options and ideas are discussed. In some cases concrete plans are made for specific sectors to follow up with the practitioner and/or woman. WACT checks in with the practitioner within two months of the consultation in an attempt to determine if the information gained at the consultation was useful, and to gather information to assist in evaluating the impact of the Team process.

Records of the cases brought forward are kept by WACT; however, these records are minimal. There is no identifying information kept after the consultation. The case notes are shredded and only basic demographic information about the case is kept for record-keeping and evaluation purposes. Key themes are recorded along with the recommended options for enhanced response. This information is recorded and managed by the High Risk Consult Team Coordinator. This is a staff position at the WACT, funded by the Ontario Trillium Foundation. Any information that is kept, (i.e., themes and trends), is maintained in the WACT office. Minutes of the meetings include information that relates to organizational issues. In addition, minutes are kept of the meetings of the High Risk Advisory Committee (a committee of the general Council that meets quarterly to review the work of the Team). These minutes are recorded by the WACT High Risk Consult Team Coordinator.

There are no confidentiality issues associated with the Team since cases are presented without identifying features, no names are used, and the discussion is generic. Most practitioners who bring a case forward inform the woman they are working with that they would like to bring her situation to the Team. They explain the situation and try to obtain her agreement. However, the Team has reviewed cases where the woman has not been asked about bringing the case forward,

particularly in situations where a key issue in the case has been the minimization of danger by the woman. All members of the Team sign a waiver that explains the Team's role is to offer options and information, but the Team is not a decision-making body that can take any action. Any follow-up or action regarding a case is carried out solely by the practitioner directly involved with the case.

The Team does not make specific referrals; members provide information and ideas. They mention agencies or professionals who may be able to assist in the situation. Any information about resources is provided to the practitioner during the course of the meeting. After the meeting, the practitioner may follow up with an individual member of the Team in his/her professional capacity. A follow-up letter is sent out to the practitioner thanking the practitioner for using the Team and asking him/her to complete an evaluation of the process. Once the consultation is completed, the case reverts back to the practitioner. The Team does not have an active caseload. The High Risk Consult Team has been operating for almost a full year and has discussed ten cases. Many of the situations had numerous indicators of potential lethality (e.g., separation, unemployment, and access to weapons). While a few of the cases did not have numerous indicators, the practitioner had serious concerns about the case. In over half the cases, the major issue that practitioners struggled with was that the woman did not recognize the risk that the practitioner identified.

The benefits of the Team have been documented by those who have used the consultation process. Feedback has focused on how helpful it is to have a full and comprehensive discussion about a serious situation with a group of practitioners who understand woman abuse and risk. Virtually everyone who has used the Team has stated that they found the process an excellent learning experience and the Team very supportive. Support and back-up for the practitioner is critically important in these cases, given the stresses that agency staff experience when working with a woman in a high-risk situation.

For more information, call Vivien Green at 416.944.9242 or email wact@womanabuse.ca, WACT website: http://www.womanabuse.ca

Partner Assault Support Team (PAST); Ottawa, Ontario

In 1997, PAST was implemented in Ottawa to promote a coordinated criminal justice system response to partner assault cases. Membership of PAST consists of the police, the victim crisis unit, the Crown, the V/WAP, regional social services, CAS, and probation. Team members are responsible for referring high-risk cases for review and providing information about their involvement in each case review. The Team reviews high-risk cases on a weekly basis, where concerns are identified and action is undertaken, including follow-up. All team members can refer cases to be reviewed at PAST. When there are concerns, the Crowns decide if a case should be reviewed.

The Ottawa Police Service has a specialized domestic violence unit consisting of fifteen Detectives, four Sergeants, and one Staff Sergeant. All domestic violence incidents are subject to daily assessment by the unit case manager, with immediate priority given to high-risk files. The Partner Assault Unit participates in weekly meetings with PAST.

To identify high risk, the Team uses the *High Risk Assessment for Potential Homicide* from Ellen Pence with the Duluth University. The criteria include:

- accused is homicidal/suicidal (threats to kill)
- accused is depressed
- previous calls to police
- escalation of batterer risk (when a batterer acts without regard to legal or social consequences)
- use of weapons
- obsession/centrality—see their partner as central to their existence; feel they cannot live without them
- separation/access—cannot envision life without their partner; may use children to access partner
- out of touch with reality—hear voices; speak to themselves; difficulty focusing on reality; no sense of logic and lack inhibitions
- substance abuse—elevates risks
- pet abuse—more likely to abuse or kill partner
- hostage taking
- homosexuality—fear of partner "outing" may increase violence
- breach with same victim

The Ottawa Domestic Violence team has been piloting the ODARA assessment tool in the past year. The ODARA helps predict the risks of domestic violence recidivism. V/WAP and Crowns use this tool with victims and in court. The attending officer arresting in domestic violence cases also completes the *Domestic Violence Supplementary Report* and a copy is added to the Crown brief. Charges have to be laid for the PAST team to review a case. The team reviews the files and each member is responsible for taking notes to bring back to their respective team.

Since 1997, the team has met every Friday morning at 10:00 in the Crown's office. The meetings usually last two to three hours and an average of five to six files are reviewed every week. V/WAP receives referrals and prepares the list sent out to all team members every Thursday morning. V/WAP collects all police files for the Crowns, reserves the room, and co-chairs the meetings with the Crowns. In addition, V/WAP keeps the list and prepares statistics that are sent to all members every year. Minutes were taken for approximately one year when the committee was being established and implemented; no minutes have been taken since. There are confidentiality issues with the city of Ottawa. As a result, no names are mentioned at the meeting, only events. The number indicated on the list is used to refer to each case.

Domestic violence cases are rarely assigned. If the Crown attending PAST feels the case should be assigned, a pink sticker indicating "Assign Crown" is placed on the file and the Domestic

Violence Lead Crown reviews the file and the PAST notes before assigning it to a Crown on the Domestic Violence team.

Case management strategies are used for the victim and accused. These strategies vary depending on the case. Examples of strategies include:

- CAS will re-visit family with new information
- V/WAP will contact victims to attend the courthouse for a Crown interview
- police will do spot check, add charges, gather more evidence, re-interview, etc.
- Victim Crisis Unit will do outreach to the victim at home
- City of Ottawa will move the victims, change locks, give additional emergency funds, etc.
- probation will do system research and send further reports, PSR, etc.
- file can be brought back to the committee for follow-up

Cases are only reviewed while they are active in the criminal justice system. Occasionally, the Crowns will request a file be reviewed for community coordination after it has been completed. This happens when they have serious concerns for the victims.

For more information, call Rachel Theoret, Manager, Ottawa V/WAP, at 613.239.1229 or email Rachel.Theoret@jus.gov.on.ca

Huron Assessment Risk Reduction Team (HARRT); Goderich, Ontario

The Huron Assessment Risk Reduction Team was established in 2004. The Team consists of the Crown Attorney, a V/W Program worker, police, probation and parole, and CAS (as needed). HARRT consults with community agencies (Women's Shelter, Partner Response Program (PAR), mental health, Victim Crisis Assistance and Referral Services VCARS).

HARRT is co-chaired by the Crown Attorney and an OPP Detective Sergeant. Referrals are made to the Crown's Office. Reviewed cases are not restricted to criminal matters. HARRT is mindful of the well-accepted risk factors, but is not restricted to these risk factors when determining if a case should be discussed. As HARRT consists of criminal justice partners, information is exchanged freely with no confidentially issues.

HARRT meets monthly. A list of high risk cases is prepared, and the cases are ranked to determine priority. Specific actions are assigned to deal with the accused and the alleged victim. Minutes are taken of the meeting, and files are kept in the Crown Attorney's office. Action items are followed up at the next meeting.

HARRT does not always take an adversarial approach. Many murder/suicide cases result from the accused being chronically depressed, with little support, and having nothing to live for. HARRT considers how the individual can be helped or supported. HARRT allows for collective wisdom and a shared responsibility to keep victims safe and perpetrators held accountable.

Although all HARRT members play a key role, the probation office can play a vital role in managing high risk cases by the nature of its professional and special status. The probation office routinely assesses, analyzes, and gathers information about the clients and their risks, needs, strengths, progress, or instability. They develop a dynamic case plan that addresses the conditions of the supervision document and criminogenic targets. They maintain collateral contacts with victims, police, V/WAP, Crown, and service and treatment providers. The probation office has special needs funding when additional challenges are present.

The probation office may use other specific strategies, including:

- increased reporting frequency
- variation to terms on the supervision document to reflect the current or changing needs of the offender or victim, or community safety
- influence on the institutional placement and classification system
- work with institution partners about discharge plans and notification to police
- take an "exit" photo of offenders leaving the institution to enhance identification of known high-risk offenders
- prepare Pre-Parole Reports and make recommendations about release on parole or terms of release into the community
- ESP (Electronic Supervision Program) to monitor curfew and residence conditions while on a conditional sentence
- specific counselling direction (e.g., PAR, substance abuse counselling, etc.)
- enforcement tolerance, including swift enforcement for non-compliance
- Victim Support Line

For more information, contact Robert Morris, Crown Attorney, at 519.524.9272 or email Robert.Morris@jus.gov.on.ca

Hamilton Police Service High Risk DV Operational Team; Hamilton, Ontario

During the latter part of 2003, the Victim Services Branch and the Family Violence Resource Unit of the Hamilton Police Service recognized the need to identify and manage high-risk domestic violence cases. The High Risk Domestic Violence Operational Team and the Community Advisory Team of the Hamilton Police Service were developed as a result.

The High Risk Operational Team is comprised of: two Detectives from the Family Violence Resource Unit; the Coordinator and Administrator from the Victim Services Branch; and a Detective from the Bail Pilot Project at the Courthouse. The High Risk Operational Team meets each Tuesday to review and determine cases for high-risk status.

In 2005, the Community Advisory Team was finalized and participants signed Memorandums of Understanding with respect to confidentiality and legal requirements. The Community Advisory

Team is a six month pilot and will be reviewed in June 2006. The first of the monthly meetings was held on December 14, 2005 and included participants from the following services and agencies: Hamilton Police Service, Interval House, Catholic Family Services, Catholic Children's Aid Society, Correctional Services of Canada, Ministry of Community Safety & Social Security, Hamilton Health Sciences Sexual Assault Domestic Violence Care Centre, and a citizen of Hamilton. (A few invited participants were unable to join the Community Advisory Team due to their inability to sign the Memorandum of Understanding.)

In determining high risk, the Operational Team relies on their joint expertise in conducting an analysis of the significant elements of each particular case. They rely on the following in identifying risk indicators: *Risk Factor Checklist*; OPP Behavioural Sciences Threat Assessment and Case History.

In most cases, the Patrol Staff Sergeants make the preliminary identification and refer the case to the High Risk Operational Team for review. Charges have to be laid to be considered as high risk. Community agencies and other justice partners may also make referrals to the Operational Team. The Operational Team jointly determines whether the case is high risk.

The Operational Team maintains an index identifying the current cases being monitored on an ongoing basis. In addition to the index, the weekly Operational Team Meeting is recorded by a stenographer who distributes the minutes by the end of the day to ensure adequate time for the Operational Team to take action on the items highlighted during the meeting. Minutes are also used in the meetings to ensure that the Team continues to monitor and bring forward action items to review.

Prior to the monthly meeting of the Community Advisory Team, the Operational Team selects two cases to be discussed. The two cases are selected on a priority basis depending on the current situational needs and circumstances (e.g., wanted status, upcoming release date). Summaries of the two selected cases are sent out to the community participants prior to the meeting for their review. All copies of the summaries are returned to the Hamilton Police Service at the meeting. During the Community Advisory Team meetings, a stenographer records the minutes and distributes them to Hamilton Police Service participants to ensure follow-up items discussed during the meeting are completed. Minutes for both the Operational and Community meetings are distributed to internal members of the High Risk Domestic Team and not the community participants.

Once designated as high risk, cases stay active for varying lengths of time. Once all plans for offender and victim management have been exhausted and/or there has been a significant length of time without further contact, cases are closed. Both the Family Violence Resource Unit and Victim Services Branch assign staff to cases and staff are responsible to follow through. During the weekly meetings, updates and information is exchanged to ensure continued accountability and the benefit of shared expertise. The Operational Team makes a joint decision to close cases.

For more information, call Elizabeth Repchuk, Manager, Victim Services Branch, at 905. 546.3879 or email erepchuck@hamiltonpolice.on.ca

Highrisk Action Review Team (HART); Belleville, Ontario

Since its inception in 2002, HART teams have reviewed an average of forty-seven cases of domestic violence each year. Cases are identified as high risk by information contained in the police brief, including the DVSR and/or by information known to the referring agency. To enhance risk identification, police services are implementing an expanded DVSR. Led by Quinte West OPP, the current DVSR has been electronically modified to allow for officer's notes and contextual information to be documented within the form itself. It is hoped that this step will assist in more consistent identification of high-risk cases. The possibility of using other tools, such as ODARA, will continue to be discussed by team members and further implementation of risk assessment tools will evolve.

High risk is defined as a case where, when considering all the circumstances, the abuser is seen as posing a particularly high threat of causing serious bodily harm or death to a particular victim or victims. For the case to be reviewed by HART, charges *must* have been laid, and:

- charges are still outstanding before the courts, or
- the case must have been recently completed by the court, or
- the sentence is currently being served, or
- the offender is about to be released from custody (either on bail or following the completion of sentence) and the team receives information that indicates the risk remains or has become high.

The Victim/Witness Assistance Program coordinates the bi-weekly HART list and ensures that review participants are notified of the scheduled review. Reviews occur by telephone conference so that all participants can phone in from their offices and have all resources at their disposal during the review (e.g., the police have access to Records Management System (RMS) during the meeting).

HART includes:

- the designated Domestic Violence Assistant Crown Attorney or delegate
- the manager of the Victim/Witness Assistance Program or delegate
- the Domestic Violence Coordinator for the police service or delegate
- the designated representative of the Children's Aid Society, where there are children
- the Regional Manager for Probation and Parole Services or delegate, when that agency is currently involved with the accused person
- the Director of CRCS (PAR) or delegate, where the offender has been referred to the program through the DVC

- The Director or delegate of any agency providing direct service to a victim and who has obtained the consent of their client to participate

Each agency maintains its own notes during HART reviews and undertakes any follow-up tasks as determined during the review. With team agreement, cases can be scheduled for a follow-up review and this has proved invaluable in terms of ensuring assigned tasks are carried out and in giving team members an opportunity to re-assess ongoing risk issues.

When a HART team involves members of community-based agencies, information regarding an accused person that is protected through the Freedom of Information and Protection of Privacy Act, through other legislation, or through agency policy is not shared during the review. A consent form signed by the agency's client outside the criminal justice system must accompany the referral, or the Consent Form is faxed to the HART Coordinator prior to the start of an agency's involvement in HART.

V/WAP makes every effort to advise victims when a case is scheduled for review and shares outcomes with the client to enhance safety and to keep people informed of what is happening on their behalf.

Common outcomes of HART reviews include:

- providing inter-service coordination
- referring clients for safety planning and other needs
- providing residential security scan/audit by police (CPTED trained)
- fast-tracking referrals for financial assistance to the Quinte District Victim's Fund for security and safety needs (e.g., secure doors, locks, some moving costs, alarm system)
- providing an address flag on RMS
- referring to OPP Threat Assessment Unit
- conducting further investigation (e.g., laying additional charges, taking additional statements, rectifying errors or things missed, collecting previous occurrence information)
- ensuring internal notification to police officers on shift regarding identified risk and sense that a call from a victim could be likely
- coordinating between police and probation to monitor a post-release situation
- conducting internal communication between Crown offices and within local office to ensure information and position of DVC Crown on matter is known and followed
- sharing Crown's position on a guilty plea so that all system agencies are aware
- deciding upon conditions to be sought by the Crown should probation result

- sharing CAS position on matters and sharing information that is collected during their investigation that is pertinent to risk management

For more information, contact Michele Arsenault, Manager, Belleville V/WAP, at 613.962.3005 or email Michele.Arsenault@jus.gov.on.ca

HighRisk Action Review Team (HART); Kingston, Ontario

Kingston HART is based on the Belleville HART model. The first HART meeting was held in November, 2004. Referrals are accepted by any agency working with the victim. Referrals must meet the following criteria:

- the abuser is seen as posing a particularly high threat of causing serious bodily harm or death to a particular victim or victims
- charges have been laid whereby the case is still before the courts, very recently completed in court, the sentence is currently being served, or the offender is about to be released from custody and the team receives information that indicates a high level of risk

No particular assessment tools are used other than reviewing the crown brief, DVSR, and concerns of the referring agency. The V/WAP manager receives referrals and acts as HART coordinator by liaising with the Crown and police to determine the suitability of the referral for review (to date, consensus has not been a problem), compiles the list of cases, emails team members for a suitable meeting date, emails list to HART members, and provides HART reports to the Domestic Violence Court Advisory Committee and Kingston Frontenac Domestic and Sexual Violence Council (KFDSVC). The V/WAP Manager has a binder of the referral forms and lists of cases reviewed.

Unlike Belleville, Kingston HART does not meet regularly; rather, the Team meets as required. Kingston HART is a work-in-progress—to date, there have been twelve meetings and twenty-three cases have been reviewed, some of which have been follow-up case reviews. The meetings are held at the Victim/Witness Assistance Program office. If more convenient, members may participate by conference call. In the near future, the Team will discuss whether the absence of a regular schedule may have a bearing on the number of referrals.

Typically, the HART members consist of the Domestic Violence Assistant Crown Attorney, the Manager of the Victim/Witness Assistance Program, the Domestic Violence Coordinator of the Kingston City Police (unless an OPP case, then an OPP Court Officer), the Area Manager of Probation & Parole, and a Manager of CAS. Sometimes the assigned CAS social worker and V/WAP worker also attend.

The list of cases (name of accused, D.O.B.) being reviewed is sent by email to the above members, as well as the rest of the HART members: the OPP, the Military Police, the Coordinator of the Partner Abuse Response Program (considered a Justice Partner), and the Community Outreach Worker of the local women's shelter. Only those members who have

involvement with the accused or victim participate in the meeting. Community agencies can only participate with the signed consent of the victim, who fully understands the obligation for disclosure and the police directive to lay further charges if new information is shared. Community agencies are not privy to confidential information regarding the accused and the criminal case. To date, no community agency has attended a HART meeting.

The HART meeting begins with the police providing an overview of the case, then each agency provides details about their involvement and concerns. There is opportunity for sharing information, perspectives, group brainstorming, and problem solving. No minutes are taken and members keep notes according to their own agency's policy and procedures. There is an effort to be action-oriented and not paper-bound. The Team determines what each member will undertake on each case. It is expected that each participating member will follow through on any tasks agreed upon as a result of their participation in HART. There is no formal follow-up process in place unless, at the end of the case review, the Team decides it needs to be discussed at a later meeting. Should there be any further concerns, any Team member can refer the case back to HART for review.

There are no confidentiality issues amongst HART members, other than the members' agency confidentiality policy. V/WAP advises the victim when HART is reviewing her case. While the confidential details of the review are not discussed, V/WAP provides the victim with the actions undertaken by members to address the safety of the victim.

For more information, contact Janet Lee, Manager, Kingston V/WAP, at 613.548.6213 or email Janet.Lee@jus.gov.on.ca

Domestic Violence Enhanced Response Team (DVERT); Colorado Springs, Colorado

Since 1996, the Domestic Violence Enhanced Response Team (DVERT) in Colorado Springs has used a multi-disciplinary method to engage families suffering from serious and/or ongoing domestic violence. The Team consists of three detectives, three confidential advocates, two child welfare caseworkers, one CASA (Court Appointed Special Advocate) child advocate, and a prosecutor.

The unit uses a screening process when it receives family referrals from many community sources, such as law enforcement, hospitals, shelters, schools, etc. The Team meets three times a week to review the referral. Background information from the various partner agencies is collected and presented. The Team discusses the "big picture" of the case and completes an evaluation of risk. The Team is not required to use a strict checklist for assessing lethality, but follows norms and indicators by taking into account issues such as pregnancy, alcohol and drug abuse, power and control, children, separation, access to weapons, severity of violence, frequency of violence, etc. Cases involving high lethality risk, ongoing domestic violence, and/or the co-occurrence of child abuse are focus points for the unit and are best served in the multi-disciplinary fashion.

Because DVERT has a referral-based client caseload, criminal charges are not always the first indicators or entry points for the Team. If an obstetrician refers a case of assault on a pregnant

victim, DVERT can become involved regardless of whether future criminal charges are made. Often, confidential advocates are able to work with and support the victim who is not ready to report to law enforcement for a period of time. In some of these cases, when the victim becomes ready to report, the advocates have helped her keep documentation, photos, and statements about the criminal offence so that charges might be successful even months later.

Advocates (who actually work for a community non-profit organization, protected by confidentiality statute) offer confidentiality to every client. They also inform and teach the clients about the benefits of allowing them to share the information with the Team. In approximately 75–80% of DVERT's cases, a confidentiality waiver is signed upon the first home visit contact with the victim. The Team then coordinates their efforts and services to minimize the impact on the victim and her children.

DVERT maintains an open caseload of approximately fifty families at a time. Cases typically stay open for three to four months, but can be open for as long as a year or more depending on the circumstances, such as trial or continuing violence or risk. Team members meet with supervisory staff every other week to go over each case. This meeting provides accountability and task management for the Team, and also a chance to evaluate the staff for issues such as vicarious trauma and burnout.

The DVERT method has been successful over the past 10 years. DVERT members break down typical system barriers by being cross-trained, but also by knowing each other personally. The camaraderie within the Team benefits victims, even though each member has his/her own area of responsibility that can, at times, conflict. The seamless approach helps the victim navigate a system that is not victim friendly, establish trust, and hopefully feel empowered.

For more information, contact Sgt. Cari Graves, Director, DVERT at 719.444.7996 or email gravesca@ci.colospgs.co.us

DVERT website: http://www.dvert.org/

Chapter 6 – Future Trends and Directions

The Committee continues to attract many inquiries from other jurisdictions across Canada and the United States. The chairperson and other members of the Committee have been called on to present the findings of the annual reports and advise on the creation of a successful fatality review process at provincial, national, and international conferences. Senior government officials in several provinces have expressed interest in establishing similar committees in their jurisdictions. The Committee has also been called on by a number of local organizations to assist them in understanding the review process and its keys to success, with a view to establishing their own local review process in the event of a preventable domestic violence fatality in their respective communities. The Committee continues to hope that all jurisdictions will establish a process so that some day there will be a national understanding of and approach to reducing the tragedy of domestic violence.

The greatest need continues to be educating all members of the community about the warning signs of domestic violence and the appropriate action necessary to prevent it. Both this report and previous ones have emphasized that people closest to the victim and perpetrator often hold critical information that may have predicted and perhaps even prevented domestic homicides. This information is often more obvious with hindsight, but still provides a foundation for educating the community and preventing similar tragedies. Often individuals observe red flags for lethal domestic violence, however they do not fully comprehend the significance of these indicators. These indicators readily form the basis of public education programs. One example of how to raise awareness about the warning signs of woman abuse as well as safety planning and risk reduction strategies is the *Neighbours, Friends and Family Campaign* that has been developed with the assistance of an expert panel chaired by Tim Kelly, Director of Changing Ways in London, and funding from the Ontario Women's Directorate (OWD).

Preliminary work on this campaign is already underway with presentations taking place across the province, including the OWD Conference, *Finding Common Ground: Working Together to Reduce Domestic Violence* that took place in November 2005. This conference is available on web-cast (http://www.findingcommonground.ca/DV6_e_pro.htm). Future announcements about available material are imminent as this annual report goes to press. Future updates can be found by searching for the website (currently under construction) (www.neighboursfriendsfamily.on.ca) or materials linked to the OWD site (http://www.citizenship.gov.on.ca/owd/) and the Centre for Research and Education on Violence Against Women and Children website (http://www.crvawc.ca/).

The focus of last year's conference, *Finding Common Ground*, was on learning about the best practices used here and in other jurisdictions to reduce domestic violence. Committee members contributed to the conference by organizing panels and presentations on the lessons learned from the work about the importance of risk assessments and the need for high-risk case management initiatives to enhance prevention. **Appendix F** includes a reprinted article from the Medical Post by Celia Milne, *Long Road to Prevention*. This article reports on the risk assessment panel discussion and observations by members of the DVDRC and others that there has been a reduction of domestic violence in jurisdictions where an effective and coordinated prevention program has been established.

The Committee's continuing motivation in conducting these tragic and disturbing reviews is to report on the lessons learned, to assist in facilitating similar reviews in other jurisdictions, to encourage local communities to learn from preventable deaths, and to identify those risk factors and warning signs that, if recognized by individuals, may be acted on to prevent the ultimate tragedy. The Committee members strive to understand why these fatalities occur, to have a better understanding of when they may occur, and what can be done to prevent them from happening in the future.

Committee Membership

Al J.C. O'Marra, B.A., M.A., LL.B., LL.M.
Committee Chair
Counsel to the Chief Coroner and Chair of the Domestic Violence Death Review Committee,
Office of the Chief Coroner
Coroner's Counsel in the May/Iles & Hadley Inquests

Susan C. Abell, MSW
Port Hope, Ontario
Former Executive Director, Children's Aid Society of Ottawa
Member of Coroner's Paediatric Death Review Committee

Gary Crowell, B.A., M.O.M.
Halton Region
Chief, Halton Regional Police Service
Former Board Member of Peel Victim Services
National Advisory Committee, Family Services Canada

Myrna Dawson, Ph.D.
Department of Sociology & Anthropology
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Claudette Dumont-Smith, R.N., B.ScN., M.PA.
Hull, Québèc
Member, Aboriginal Circle on the Canadian Panel on Violence Against Women
Executive Director (former), Aboriginal Nurses Association of Canada

Dr. David Eden
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Regional Supervising Coroner, Niagara Region, Office of the Chief Coroner

Debbie Elman MD CCFP
Toronto, Ontario
Assistant Professor University of Toronto
Department of Family and Community Medicine

Len Favreau, M.A.
Peel Region, Ontario
Inspector, Peel Regional Police
Past member of the Peel Committee Against Woman Abuse (PCAWA)
Member of the Solicitor General's Policing Standards Branch working group that established new standards for police response to domestic violence and criminal harassment

Vivien Green
Toronto, Ontario
Executive Director, Woman Abuse Council of Toronto
Member of Ontario Government commissioned Joint Committee on Domestic Violence

Peter Jaffe, Ph.D.
London, Ontario
Professor, Faculty of Education

Academic Director, Centre for Research on Violence Against Women & Children
University of Western Ontario
Director Emeritus, Centre for Children and Families in the Justice System of the London Family Court Clinic

Beth Jordan
Toronto, Ontario
Managing Director, Adobe Consulting Services
Former Director of Programs & Services, Assaulted Women's Helpline

Dr. Barbara Lent, M.A., M.D., CCFP, FCFP
London, Ontario
Family Physician
Associate Professor, Department of Family Medicine
Associate Dean, Equity and Gender Issues, and Faculty Health
The University of Western Ontario

Robert Morris
Goderich, Ontario
Crown Attorney, Ministry of the Attorney General
Co-founded the first Domestic Assault Review Team (DART) in Canada
Implemented the first questionnaire for domestic assault victims to identify risk and potential lethality

Susan Physick, R.N.
Toronto, Ontario
Manager (former) with the Victim/Witness Assistance Program
Developed Early Intervention Programme for young offenders in dating relationships, the R.S.V.P. (Relationship Skills in Violence Prevention)

Dr. Bonita Porter, B.Sc., Phm., M.Sc., M.D., C.C.F.P
Toronto, Ontario
Deputy Chief Coroner – Inquests

Deborah Sinclair, M.S.W.
Social Worker with an independent practice in Toronto
Founding member of the Emily Stowe Shelter for Women
Author of "Understanding Wife Assault," "In the Centre of the Storm, Durham Speaks Out," "Overcoming the Backlash," and other articles and papers related to violence against women and children

Kevin Sisk
Barrie, Ontario
Assistant Crown Attorney, Ministry of the Attorney General since 1991
Former Co-lead Simcoe County Domestic Violence Court Project
Chairperson Domestic Assault Review Team (DART), Midland

Dawna Speers
Mississauga, Ontario
Executive Director, The Speers Society
The Speers Society is committed to the prevention of youth relationship abuse through education and support
www.speerssociety.org

Lynn Stewart, Ph.D., C.Psych.
National Manager, Family Violence Prevention programs

Correctional Service Canada

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London, Ontario
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Research Assistant, Centre for Research on Violence Against Women and Children

Ex Officio

Dr. Barry McLellan
Chief Coroner of Ontario,

Dr. Jim Cairns
Deputy Chief Coroner – Investigations, Office of the Chief Coroner

Regional Supervising Coroners:

Dr. William Lucas, Central (Brampton)
Dr. Karen Acheson, Central West (Guelph)
Dr. Andrew McCallum, Eastern (Kingston)
Dr. Peter A. Clark, Northeastern (Peterborough)
Dr. David A. Legge, Northwestern (Thunder Bay)
Dr. Jim Edwards, Toronto East
Dr. David H. Evans, Toronto West

OCC Staff

Tom Girling
Executive Officer

Julie McCreary
Administrative Assistant

Appendix A

Domestic Violence Death Review Committee
Office of the Chief Coroner of Ontario
Data Summary Form

OCC Case #(s): 2003-_____ OCC Region:

OCC Staff: _____

Lead Investigating Police Agency: _____

Officer(s): _____

_____

_____

Other Investigating Agencies:_____

Officers: _____

_____

_____

VICTIM INFORMATION

**If more than one victim, this information is for primary victim (i.e. intimate partner)

Name

Gender	
Age	
DOB	
DOD	
Marital status	
Number of children	
Pregnant	
If yes, age of fetus (in weeks)	

Residency status	
Education	
Employment status	
Occupational level	
Criminal history	
If yes, check those that apply…	____ Prior domestic violence arrest record ____ Arrest for a restraining order violation ____ Arrest for violation of probation ____ Prior arrest record for other assault/harassment/menacing/disturbance ____ Prior arrest record for DUI/possession ____ Juvenile record
	____ Total # of arrests for domestic violence offenses ____ Total # of arrests for other violent offenses ____ Total # of arrests for non-violent offenses ____ Total # of restraining order violations ____ Total # of bail condition violations ____ Total # of probation violations
Family court history	
If yes, check those that apply…	____ Current child custody/access dispute ____ Prior child custody/access dispute ____ Current child protection hearing ____ Prior child protection hearing ____ No info
Treatment history	
If yes, check those that apply …	____ Prior domestic violence treatment ____ Prior substance abuse treatment ____ Prior mental health treatment

	____ Anger management ____ Other – specify _____ ____ No info
Victim taking medication at time of incident	
Medication prescribed for victim at time of incident	
Victim taking psychiatric drugs at time of incident	
Victim made threats or attempted suicide prior to incident	
Any significant life changes occurred prior to fatality?	
Describe:	
Subject in childhood or adolescence to sexual abuse?	
Subject in childhood or adolescence to physical abuse?	
Exposed in childhood or adolescence to domestic violence?	

-- END VICTIM INFORMATION --

PERPETRATOR INFORMATION

**Same data as above for victim

Gender	
Age	
DOB	
DOD	
Marital status	
Number of children	
Pregnant	
If yes, age of fetus (in weeks)	
Residency status	
Education	
Employment status	
Occupational level	
Criminal history	
If yes, check those that apply…	____ Prior domestic violence arrest record ____ Arrest for a restraining order violation ____ Arrest for violation of probation ____ Prior arrest record for other assault/harassment/menacing/disturbance ____ Prior arrest record for DUI/possession ____ Juvenile record
	____ Total # of arrests for domestic violence offenses _____Total # of arrests for other violent offenses ____ Total # of arrests for non-violent offenses ____ Total # of restraining order violations ____ Total # of bail condition violations ____ Total # of probation violations

Family court history	
If yes, check those that apply…	____ Current child custody/access dispute ____ Prior child custody/access dispute ____ Current child protection hearing ____ Prior child protection hearing ____ No info
Treatment history	
If yes, check those that apply …	____ Prior domestic violence treatment ____ Prior substance abuse treatment ____ Prior mental health treatment ____ Anger management ____ Other – specify _____ ___ No info
Perpetrator on medication at time of incident	
Medication prescribed for perpetrator at time of incident	
Perpetrator taking psychiatric drugs at time of incident	
Perpetrator made threats or attempted suicide prior to incident	
Any significant life changes occurred prior to fatality?	

Describe:	
Subject in childhood or adolescence to sexual abuse?	
Subject in childhood or adolescence to physical abuse?	
Exposed in childhood or adolescence to domestic violence?	

-- END PERPETRATOR INFORMATION --

INCIDENT

Date of incident	
Date call received	
Time call received	
Date of death	
Incident type	
Incident reported by	
Total number of victims **Not including perpetrator if suicided	
Who were additional victims aside from perpetrator?	
Others received non-fatal injuries	
Perpetrator injured during	

incident?	
Who injured perpetrator?	

Location of crime

Location of incident	
If residence, type of dwelling	
If residence, where was victim found?	

Cause of Death (Primary Victim)

Cause of death	
Multiple methods used?	
If yes be specific …	
Other evidence of excessive violence?	
Evidence of mutilation?	
Victim sexually assaulted?	
If yes, describe (Sexual assault, sexual mutilation, both)	
Condition of body	
Victim substance use at time of crime?	
Perpetrator substance use at time of crime?	

Weapon Use

Weapon use	
If weapon used, type	
If gun, who owned it?	
Gun acquired legally?	
If yes, when acquired?	
Previous requests for gun to be surrendered/destroyed?	
Did court ever order gun to be surrendered/destroyed?	

Witness Information

Others present at scene of fatality (i.e. witnesses)?	
If children were present:	How many minor children were present? _____ List ages of all children present ____ ____ ____ ____ Did they hear fatal incident? _____ Did they observe the fatal incident? _____ Were children directly involved? _____
What intervention occurred as a result?	

Perpetrator actions after fatality

Did perpetrator attempt/commit suicide following the incident?	

If committed suicide, how?	
Did suicide appear to be part of original homicide?	
How long after the killing did suicide occur?	
Was perpetrator in custody when attempted or committed suicide?	
Was a suicide note left? *If yes, was precipitating factor identified*	
Describe: *Perpetrator left note attached to envelope and within the envelope were photos of the victim and her boyfriend and correspondence regarding the purchase of a house in North Dakota and money transfers etc.*	
If perpetrator did not commit suicide, did s/he leave scene?	
If perpetrator did not commit suicide, where was s/he arrested/apprehended?	*(At scene, turned self in, apprehended later, still at large, other – specify)*

-- END INCIDENT INFORMATION --

VICTIM/PERPETRATOR RELATIONSHIP HISTORY

Relationship of victim to perpetrator	
Length of relationship	
If divorced, how long?	

If separated, how long?	
If separated more than a month, list # of months	
Did victim begin relationship with a new partner?	
If not separated, was there evidence that a separation was imminent?	
Is there a history of separation in relationship?	
If yes, how many previous separations were there?	*(Indicate #, unknown)*
If not separated, had victim tried to leave relationship?	
If yes, what steps had victim taken in past year to leave relationship? (Check all that apply)	____ Moved out of residence ____ Initiated defendant moving out ____ Sought safe housing ____ Initiated legal action ____ Other – specify end relationship

Children Information

Did victim/perpetrator have children in common?	
If yes, how many children in common?	
If separated, who had legal custody of children?	

If separated, who had physical custody of children at time of incident?	
Which of the following best describes custody agreement?	
Did victim have children from previous relationship?	
If yes, how many?	*(Indicate #)*

History of domestic violence

Were there prior reports of domestic violence in this relationship? Not reported to police?

Type of Violence? *(Physical, other)*

If other describe: _____

_____

_____

If yes, reports were made to: (Check all those that apply)

____ Police

____ Courts

____ Medical

____ Family members

____ Clergy

____ Friends

____ Co-workers

____ Neighbours

____ Shelter/other domestic violence program

____ Family court (during divorce, custody, restraining order proceedings)

____ Social services

____ Child protection

____ legal counsel/legal services

____ Other – specify_____

Historically, was the victim usually the perpetrator of abuse?

If yes, how known?

Describe _____

_____

Was there evidence of escalating violence? _____

If yes, check all that apply:

____ Prior attempts or threats of suicide by perpetrator

____ Prior threats with weapon

____ Prior threats to kill

____ Perpetrator abused the victim in public

____ Perpetrator monitored victim's whereabouts

____ Blamed victim for abuse

____ Destroyed victim's property and/or pets

____ Prior medical treatment for domestic violence related injuries reported

____ Other – specify_____

-- END VICTIM-PERPETRATOR RELATIONSHIP INFORMATION --

SYSTEM CONTACTS

Background

Did victim have access to working telephone?_____

Estimate distance victim had to travel to access helping resources? (KMs) available at school and in town _____

Did the victim have access to transportation? _____

Did the victim have a Safety Plan? _____

Did the victim have an opportunity to act on the Plan? _____

Agencies / Institutions

Were any of the following agencies involved with the victim or the perpetrator during the past year prior to the fatality? _____

***Circle who had contact, describe contact and outcome. Locate date(s) of contact on events calendar for year prior to killing (12-month calendar)*

Criminal Justice / Legal Assistance:

Police (Victim, perpetrator, or both)

Describe: _____

_____

Outcome:_____

_____

Crown attorney (Victim, perpetrator, or both)

Describe: _____

_____

Outcome:_____

_____

Defense counsel (Victim, perpetrator, or both)

Describe: _____

_____

Outcome:_____

_____

Court/Judges (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Corrections (Victim, perpetrator or both)

Describe: _____

_____

Outcome: _____

_____

Probation (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Parole (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Family court (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Family lawyer (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Court-based legal advocacy (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Victim/witness assistance program (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Victim Services (including domestic violence services)

Domestic violence shelter/safe house (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Sexual assault program (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Other domestic violence victim services (Victim, perpetrator, or both)

Describe: _____

_____

Outcome:_____

_____

Community based legal advocacy (Victim, perpetrator, or both)

Describe: _____

_____

Outcome:_____

_____

Children services

School (Victim, perpetrator, children or all)

Describe: (Did school know of DV? Did school provide counselling?): _____

_____

Outcome:_____

_____

Supervised visitation/drop off centre (Victim, perpetrator, or both)

Describe: _____

_____

Outcome:_____

_____

Child protection services (Victim, perpetrator, children, or all)

Describe: _____

_____

Outcome:_____

_____

Health care services

Mental health provider (Victim, perpetrator, or both)

Describe: _____

_____

Outcome:_____

_____

Mental health program (Victim, perpetrator, or both)

Describe: _____

_____

Outcome:_____

_____

Health care provider (Victim, perpetrator, or both)

Describe: _____

_____

Outcome:_____

_____

Regional trauma centre (Victim, perpetrator, or both)

Describe: _____

_____

Outcome:_____

_____

Local hospital (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Ambulance services (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Other Community Services

Anger management program (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Batterer's intervention program (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Marriage counselling (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Substance abuse program (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Religious community (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Immigrant advocacy program (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Animal control/humane society (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Cultural organization (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Fire department (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

Homeless shelter (Victim, perpetrator, or both)

Describe: _____

_____

Outcome: _____

_____

-- END SYSTEM CONTACT INFORMATION --

RISK ASSESSMENT

Was a risk assessment done? _____

If yes, by whom? _____

When was the risk assessment done? _____

What was the outcome of the risk assessment? _____

Ontario Domestic Violence Death Review Committee Risk Factor Coding Form (see descriptors below)

A= Evidence suggests that the risk factor was not present

P= Evidence suggests that the risk factor was present

Unknown (Unk) = A lack of evidence suggests that a judgment cannot be made

Risk Factor	Code (P,A, Unk)
1. History of violence outside of the family by perpetrator*	
2. History of domestic violence	
3. Prior threats to kill victim	
4. Prior threats with a weapon*	
5. Prior assault with a weapon*	
6. Prior threats to commit suicide by perpetrator*	
7. Prior suicide attempts by perpetrator*	
8. Prior attempts to isolate the victim	
9. Controlled most or all of victim's daily activities	
10. Prior hostage-taking and/or forcible confinement	
11. Prior forced sexual acts and/or assaults during sex	
12. Child custody or access disputes	
13. Prior destruction of victim's property	
14. Prior violence against family pets	
15. Prior assault on victim while pregnant	
16. Choked victim in the past	
17. Perpetrator was abused and/or witnessed domestic violence as a child	
18. Escalation of violence	
19. Obsessive behaviour displayed by perpetrator	
20. Perpetrator unemployed	
21. Victim and perpetrator living common-law	
22. Presence of stepchildren in the home	
23. Extreme minimization and/or denial of spousal assault history	

24. Actual or pending separation	
25. Excessive alcohol and/or drug use by perpetrator*	
26. Severe and excessive alcohol and/or drug use by perpetrator*	
27. Depression – family/friend/acquaintance opinion - perpetrator*	
28. Depression – professionally diagnosed – perpetrator*	
29. Other mental health or psychiatric problems – perpetrator	
30. Access to or possession of any firearms	
31. New partner in victim's life	
32. Failure to comply with authority – perpetrator*	
33. Perpetrator exposed to/witnessed suicidal behaviour in family of origin*	
34. After risk assessment, perpetrator had access to victim*	
35. Youth of couple	
Other factors that increased risk in this case? Specify: _____	

* = Revised or new item

DVDRC COMMITTEE RECOMMENDATIONS

Was the homicide (suicide) preventable in retrospect? (Yes, no)

If yes, what would have prevented this tragedy?

_____
_____
_____
_____
_____
_____
_____
_____
_____

What issues are raised by this tragedy that should be outlined in the DVDRC annual report?

_____
_____
_____
_____
_____
_____
_____
_____

_____
_____

Future Research Issues/Questions: _____

_____
_____
_____
_____
_____
_____

Additional comments:

_____
_____
_____
_____
_____
_____

Risk Factor Descriptions

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

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.).

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.

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."

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).

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.).

Any 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 ("I'm going away"). Acts can include, for example, giving away prized possessions.

Any actual 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.

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").

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.).

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).

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.

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.

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.

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.

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.

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).

As a child/adolescent, the perpetrator was victimized and/or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment.

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.

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.

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.

The victim and perpetrator were cohabiting.

Any child(ren) that is(are) not biologically related to the perpetrator.

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).

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.

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. For example, people described the perpetrator as constantly drunk or claim that they never saw him without a beer in his hand. Please include comments by family,

friends, 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.

Within the past year, and regardless of whether or not the perpetrator received treatment, substance abuse that substantially impaired the perpetrator's health or social functioning (e.g., resulted in an overdose, or job loss, or arrest, etc.).

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.

A diagnosis of depression by any mental health professional (e.g., family doctor; psychiatrist; psychologist; nurse practitioner), regardless of whether or not the perpetrator received treatment.

For example: psychosis; schizophrenia; bi-polar disorder; mania; obsessive-compulsive disorder, etc.

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.

There was a new intimate partner in the victim's life.

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.

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.

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.

Victim and perpetrator were between the ages of 15 and 24.

Appendix B

Recommendations Year 0ne, Report 2002

Chapter 5–Recommendations

This report is based on the cases the committee reviewed during meetings in 2003, and includes all 2002 Ontario domestic violence deaths as defined in the committee's mandate, except a significant proportion still before the courts. The following recommendations are based on the specific cases reviewed in the committee's first year. The limited or narrow focus of the recommendations in this report are derived from the specific case reviews, and should not be seen as diminishing or detracting from the recommendations or reports of previous inquests in this area.

The recommendations made by the committee fall into three major subject areas of potential intervention, all addressing heightening and increasing **awareness and education**, **assessment and intervention**, and **resources.**

Firstly, there is a need to heighten awareness and provide education about domestic violence. In every case review we examined, family members, friends, neighbours, and/or professionals had some knowledge of the escalating circumstances between the perpetrators and victims. However, these individuals did not appreciate the significance of the situation, the information available to them, or what to do about it. Accordingly, many of the recommendations address the continuing need for targeted public awareness and professional educational programs that teach about the signs of domestic violence and the risk factors leading to potentially lethal consequences.

Secondly, there is a need to have appropriate tools available to those who work with victims and perpetrators of domestic violence to better assess the potential for lethal violence in their lives, and corresponding access to appropriate services and programs. As an example, victims may need assistance with safety planning and perpetrators may need access to counselling programs or the need of restrictions to control their behaviour to better manage the risk.

Thirdly, adequate resources are required to ensure victim safety and reduce perpetrator risk. All programming and services require resources to become operational. These include, but are not limited to:

- support for helping the victim to be removed from the situation;
- affordable alternative housing;
- counselling services for victims and families; and
- other community-based support systems for victims and perpetrators and children exposed to domestic violence.

These areas for intervention are links in a chain—if one or more is weak or absent, the chain breaks, and opportunities for prevention are lost. In many of the cases reviewed, one or more of these links were present, but an adverse outcome was attributable to the absence of another. For instance, a properly performed risk evaluation is of little value if the police or others do not use it

for safety planning, or the admissible information on which it is based is not brought before the criminal courts when necessary.

Awareness and Education

As observed in the verdicts of several inquests and in the Report of the Joint Committee on Domestic Violence, there is a continuing need to heighten awareness and provide educational programs that focus on the signs of domestic violence, including the risk factors that may lead to lethal circumstances. This awareness and these programs should also focus on the necessary individual and community response by:

- the general public (friends, neighbours, relatives, employers, family, community leaders, as well as the victims and perpetrators themselves);
- all front line professionals (teachers, lawyers, clergy, social workers, etc.) who, in the course of their work, come into contact with victims, perpetrators, or the children of domestic violence;
- professionals whose primary function is to serve victims of domestic violence (such as police officers and healthcare professionals).

We can draw conclusions from our reviews as to whether or not homicides with similar presenting factors could have been predicted or prevented. In 5 of the 11 cases reviewed, a domestic homicide would likely have been predicted if similar facts were presented to professionals knowledgeable about domestic violence. In 6 out of 11 cases, a domestic homicide would not have been anticipated per se. Nonetheless, in these cases, a tragedy may have been prevented in similar circumstances by intervening with the stressors being experienced by individuals or family conditions that ultimately became a factor in the homicide.

1. **There is a need to better educate the public about the dynamics of domestic violence and appropriate responses where such dynamics are recognized in potential abusers or victims.**

It is troubling to the committee that the inquests and other reports on domestic violence have seen the need to continue to address this issue. We note that the Ontario Women's Directorate and outside agencies have sponsored excellent campaigns, however there is a need for a more widespread, ongoing and consistent strategy of public education efforts. In eight of eleven cases reviewed by the committee, family, friends, or neighbours observed indicators of domestic violence in either the victim or perpetrator or both. Notwithstanding their concerns, they neither recognized the significance of those indicators, nor did they act upon them. In each case, risk factors were identified on review. In nearly half of the cases, four to more than ten risk factors were present.

The implementation and use of effective public education programs need to be increased to heighten awareness of the warning signs of symptomatic abusive behaviour and appropriate courses of action for victims, perpetrators, and others to take in response. All too often, domestic violence is only recognized as physical abuse. Emotional abuse also needs to be recognized, such as jealousy, economic abuse, intimidation, threats, controlling behaviours, and isolation.

Domestic violence public awareness programs should contain features directed to increasing awareness that the non-reporting of abuse by victims, or threatening behaviours of perpetrators, can not only impact their own safety, but the safety of others close to them. Non-reporting can also impact the safety of others who later enter into relationships with the abuser. It was noted in one case that as many as three prior victims resided near the perpetrator, however not all had reported the abusive behaviour. In some instances, it was not until the aftermath of the domestic violence death that other victims of abuse divulged information.

2. **Public education should target potential victims and perpetrators of domestic violence. The education should:**
    - include the fact that risk of violence increases substantially during the time that a partner is leaving the relationship;
    - address the needs of depressed and suicidal men who require counselling and risk reduction interventions, such as the removal of firearms from the home to prevent the escalation of the circumstances that result in the tragedies we have reviewed;
    - be directed towards persons of all cultures, languages, and faiths; and
    - address the need to overcome cultural barriers and the feeling of "shame" as related to mental health issues, with the goal of reducing stigma.

In one instance, a divorced spouse suffering from paranoid schizophrenia and alcoholism, with a history of verbal and physical abuse as well as the obsessive monitoring of his former spouse's activities, openly voiced suspicions to his family members about his ex-wife poisoning his food. Even though divorced, he continually stayed at his estranged wife's home. The family, fairly recent émigrés from an eastern European country expressed considerable shame about the perpetrator's mental illness, which appears to have inhibited them and his estranged wife from reaching out to community services that might have assisted. One evening, after voicing his suspicions to his son, he stabbed his estranged wife to death and hanged himself.

3. **The requirement for third parties to report child abuse when a child's safety and life is placed at risk needs to be more widely publicized.**

In one case, the committee noted that the perpetrator demonstrated an unnatural and his family and friends. He was also known to put the child at risk when he took her out with him for extended periods of time, after which he would drive his car in a highly intoxicated condition. At the point of declared separation by his wife, the perpetrator killed himself and his daughter.

4. **There is a need for ongoing training in the issues of domestic violence and potential lethality for police, social workers/counsellors, clergy, and physicians.**

Training must deal with two issues: the first is recognizing domestic violence in all its forms—emotional, psychological, and physical—and the second is identifying high-risk situations that require intensive assessment and immediate intervention strategies. In several case reviews, the committee observed numerous points of intervention at which steps could have been taken to respond to the escalation of aggressive and threatening behaviour. Evidence was present that should have signalled to the professionals that potential fatal outcomes were possible and/or probable, however there was no apparent appreciation of the significance of the evidence or

application of an assessment to evaluate its significance and the appropriate action to minimize risk to the victim.

5. **Police and other front-line workers (health/educational/social) need to be made aware of the resources available in their respective communities to address issues of family breakdown, conflict, and mental health, and to make referrals when necessary.**

In one instance, a family counsellor who was conducting sessions with both spouses directly observed the perpetrator's irrational paranoia and volatility during a session. The counsellor, however, did not discuss a safety plan with the victim beyond advising her to contact police if she felt in danger.

6. **Training workshops have to be developed and delivered by trained experts from the cultural communities being served.**
7. **Cross-cultural and cultural competence training should be a mandatory component of all training programs for front line workers, such as police, healthcare, and social workers.**

The review included a number of cases where the victims and perpetrators came from other diverse ethnic or cultural backgrounds, including people of the First Nations. Religious and spiritual leaders can play an important role in assisting their congregations to access cultural and community services to help them deal effectively with mental health and domestic violence issues. In several cases, the perpetrators had direct involvement with religious or spiritual leaders, having been sought out or referred by others due to concerns about the deterioration of their relationships with their spouse and their threatening behaviour. In one instance, the perpetrator threatened to kill himself, and in another, he threatened to shoot a person he believed was involved with his spouse.

8. **Physicians require further education about the dynamics of domestic violence and the potential lethality, particularly where alcohol abuse, depression, anxiety, or suicidal ideation is present and diagnosed.**

Of all the professional groups that we encountered during the case reviews, the role of the family doctor was pivotal. In many of the cases, the victims and perpetrators were involved with family physicians to deal with depression from a variety of stressors having an impact on their relationships. One case review revealed that both the victim and perpetrator were patients of one family physician for more than 20 years. While patient confidentiality is paramount and to be respected, questioning of the patient's personal circumstances might have elicited information about the spouse, particularly the perpetrator in this case, which might have created a clearer picture of the risk for violence in their lives.

Educational programs should address the following:

- Patients may talk to their family physicians with whom they have long-term relationships about the difficulties they are experiencing in their intimate relationships. Family physicians need to be aware of how common the problem of

domestic violence is. In addition, family physicians should be able to assess the risk in their patients' home environments. If physicians feel they lack the skill or expertise to make such assessments, they should ensure they know of other healthcare providers or community agencies to which they can refer these patients.

- A prior history of abusive behaviour, combined with a diagnosis of depression and inappropriate use of alcohol, street drugs, or prescription drugs, should alert professionals to the strong possibility of repeated violence. In such a situation, healthcare professionals should inform their patients about the risk of the situation, and urge these individuals to seek help. Depending on their assessment of the risk and the apparent impulsivity of the abusive partner, family physicians may need to consider warning the other partner or informing the police of their concerns about the possibility of worsening violence.
- When treating patients for depression and/or anxiety, it is essential to ask about suicidal and/or homicidal thoughts, and to consider the risk of the patient acting on such thoughts. The patient's depression and/or anxiety may reflect the patient's experience of domestic violence, or may increase the likelihood of abuse. In addition, physicians need to be particularly attentive to the possibility of access to firearms or other weapons, especially when working in rural communities.
- In situations where physicians find themselves caring for both the victims of abuse within an intimate or family context and the perpetrators of the same abuse, they must ensure that the needs of the abused women and the perpetrators are addressed independently, such that their rights to autonomy, confidentiality, honesty, and quality of care are maintained. Couple or marital therapy is contraindicated unless the woman's safety can be ensured and the man has taken responsibility for his abusive behaviour.

9. School boards should institute curriculum-based healthy relationship programs as an essential part of the education system.

Educational programs should address the following:

- The program should provide a continuum of educational materials (kindergarten to grade 12) to promote building skills and strategies for positive interpersonal relationships.
- The program should include programming to develop awareness of the warning signs of abuse and the potential for violent/abusive behaviour. The program needs to recognize the different roles in which children and adolescents come in contact with domestic violence. These roles include exposure to violence at home, in the media, and in dating relationships as victims, perpetrators, and peer groups.
- School boards should enlist community resources to support and sustain healthy interpersonal relationship choices in prevention and intervention programs.

- Teachers and community agencies have a unique opportunity to collaborate on program development and implementation. By working together as a team, they have the opportunity to promote awareness, understanding, skills, and knowledge.

This recommendation arises from the nature of the cases we reviewed. In one case, the perpetrator had confessed his intention to kill his former girlfriend to a peer who did not know how to handle this disclosure. The girlfriend had been warned about the nature of the relationship by her mother and a guidance counsellor, but minimized the abuse as "only" possessiveness and jealousy. The facts of the case speak to the importance of broader curriculum initiatives that engage potential perpetrators, victims, and peers who observe abuse and receive disclosures.

In several cases, perpetrators grew up in families where child abuse and exposure to domestic violence were present. Although there was little information available about how these problems were addressed in childhood for each perpetrator, it does raise the importance of early identification and prevention programs for children in these circumstances. As well, several of our cases illustrate the dilemma adolescents and young adults face in dealing with the violence in their parents' marriage. Without putting unreasonable expectations or burdens on these adolescents to intervene with adult issues, their potential learning experiences about domestic violence in school may alert them to the dangers in their homes. Obviously, as part of these lessons, safety planning that does not endanger them or other family members has to be addressed.

Although we often think of adults worrying about the welfare of children, it is not unusual to find children and adolescents bringing home changing social attitudes and behaviours about smoking, drinking and driving, and polluting the environment. Domestic violence may be another such topic that leads to potentially life-saving discussions. In two of our cases, the children themselves became homicide victims. In several other cases, it appears they might have been targets who were spared only by fortuitous circumstances. In these homes, domestic violence and safety planning was as essential as learning about fire, traffic, or water safety. obsessive involvement with his daughter that should have been apparent and troubling to

Assessment and Intervention

10. **There is a need to have appropriate assessment tools available to those who work with victims and perpetrators of domestic violence to better assess the potential for lethal violence in their lives. Correspondingly, once the risk is identified, victims and perpetrators of domestic violence need access to appropriate services and programs. The person at risk requires access to:**

    - a specialized and comprehensive risk assessment by an appropriate agency;
    - skilled assistance to engage the victim in developing a safety planning process; and
    - risk management, for both the victims and the perpetrator.

In a particularly tragic case of multiple-homicide, the recently estranged spouse had prepared an extensive narrative of past emotional and physical abuse against her and their children, as well as unfounded paranoid threats against two third parties. One of the third parties was later murdered

on the same night as the estranged spouse, and an attempt was made on the life of the other by the perpetrator. The perpetrator later died at the end of a police chase when he crashed the vehicle he was driving. The detailed narrative had been provided to the police, at their request, after the accused had been arrested. However, he was released after he had a bail hearing. No apparent assessment was made of the information, nor was it used even after it was known that he was continuing to harass his estranged spouse and violating the terms of release.

11. **All victims experiencing any form of domestic violence should be referred to and directly involved in a safety planning process whenever abuse is disclosed to social workers/counsellors, shelter, or other services for abused persons, such as physicians, the police, and victim services.**

Notwithstanding the need for safety planning seen in a number of the cases, the victim was provided with safety planning information in only one case. In that one instance, the victim visited a resource centre for abused women in a distant community with the assistance of her sister. She received information to assist her in dealing with the abuse and how to go about safety planning.

12. **It is recommended that each police service appoint an appropriate number of officers, specially trained in the issues of domestic violence, as case managers. The case managers' duties would include reviewing all domestic violence cases, identifying—i.e., "red flagging"—any high risk matters, and tracking the cases as they proceed to completion.**
13. **All front-line professionals that deal with individuals and families in crisis should adopt an appropriate risk assessment process and a mechanism or protocol at a local level to facilitate and enhance communication between agencies and professionals when a person is identified to be at risk. For example, such a protocol should permit any professional evaluating a high risk case to contact the local police service's case manager or domestic violence coordinator to establish a case conference to ensure appropriate tracking and response to the case.**

In one particular instance, after the bail court had dealt with the matter involving the perpetrator, the victim at the request of the police completed a "dangerousness assessment in domestic violence" questionnaire. The responses contained sufficient information about prior abuse and threats to the victim and others to make it a high-risk case. After his release, the perpetrator continued to harass the victim and repeatedly breach the terms of his recognizance, most of which was reported to the police service involved in the original complaint. If a case manager or domestic violence case coordinator had been assigned, the continuing complaints about the perpetrator's alleged breaches may have been dealt with differently and with greater attention, particularly if assessed by one officer possessing all of the information reported to the police service.

14. **There is a need for greater use of case conferencing systems that share information and action plans between justice partners, health professionals, and counsellors regarding safety issues and "high risk" cases.**

Many cases the committee reviewed had multiple community agencies and professionals involved who held important information about the case, but had no formal mechanism to share that information. Had they known the totality of the information, there might have been a more effective response to ensuring the safety of the victim? All professions need to explore ways that permit their practitioners to participate meaningfully in case conferencing opportunities while respecting privacy and confidentiality constraints.

15. **It is recommended that every effort be made by family members, friends, and community professionals to have firearms removed from individuals who are going through a separation in their relationships and showing signs of depression or suicidal or homicidal ideation.**

Access to firearms is an important risk factor. Moreover, restricting access to firearms is important in terms of effective intervention and risk management. Four of the eleven cases reviewed involved the use of firearms and situations where family members and friends were aware it was not in the perpetrator's interest to possess them due to mental and/or emotional issues during a time immediately preceding the homicides. It is also well established that the time of separation can be the most dangerous time, and in all of the cases involving the use of firearms, the homicides occurred shortly after separation or in anticipation of it occurring.

16. **Every community where a domestic violence related homicide takes place should be supported to undertake a community-based education process focusing on prevention. It is recommended that a central provincial resource be identified to provide resources, support, and expertise to assist that community to use the tragedy as a catalyst for action. Ensuring that members of the local community take the lead in planning the educational process, the provincial government should provide necessary assistance, such as funding for public education materials, meetings, and other public awareness events. This provincial response to each domestic violence homicide would ensure that each community is supported in creating its own unique response that promotes collective awareness of spousal and child abuse, and can help make a difference in the prevention of future deaths.**

Resources

17. **All of the above recommendations require adequate resources to ensure victim safety and reduce perpetrator risk. They address the lack of programming and services, and the recognition that all programming and services require the necessary resources to become operational. These resources include, but are not limited to:**

    - support for helping the victim to be removed from the situation if appropriate;
    - affordable alternative housing;
    - counselling services for victims and families; and
    - other community and culturally based support systems and services for victims, perpetrators, and children exposed to domestic violence.

It is obvious that the demand for these resources will increase with better risk assessments, interventions, and risk management strategies.

Information is the necessary resource to ensure the effectiveness of the DVDRC. The more information available to the DVDRC about the circumstances of the victims and perpetrators, the better the committee will be able to:

- identify systemic issues, gaps, and shortcomings;
- establish a comprehensive database; and
- identify trends, patterns, and risk factors for prevention.

18. It is recommended that a protocol be established for the complete investigation of domestic violence fatalities where the facts involve both homicide and suicide.

In 64% of the cases reviewed by the committee, the perpetrator subsequently took his own life. Because such cases do not generally give rise to criminal charges, the police may not investigate the deaths as thoroughly as they would if charges were to occur, notwithstanding the fact that the police use a major case management investigation model for the cases. The committee has had the benefit of some very thorough investigations for its work. However, some cases were not investigated to completion, leaving the committee uncertain as to the actual facts of the related deaths. The committee is dependant on a complete set of facts for each investigation to extract the lessons that may be learned from each case to make recommendations to prevent deaths in similar circumstances. The committee suggests that an investigative protocol be established requiring all homicide/suicides be as completely investigated as those leading to criminal charges. Such an approach will assist in the community's efforts to better understand the root causes of domestic violence, the best course, and practices for its prevention.

Appendix C

Recommendations Year Two, Report 2004

a. Awareness and Education

In the case reviews of domestic violence deaths in the year 2002, we looked at three major subject areas of potential intervention. One of the subject areas addressed increasing awareness of and education about domestic violence. In every case that was examined, family members, friends, neighbours, and/or professionals had some knowledge of the escalating circumstances between the perpetrators and victims. Some did not recognize the warning signs, nor did they act upon them. Many of 2002–2004 cases showed the continuing need to target culturally competent public awareness and education.

It has been proven that community alliances are critical to optimal success. In many communities, support for awareness and education on domestic violence initiatives has been received from community-based violence against women (VAW) services, police, victim services, family and children counselling services, and the private sector working together as a team.

1. **There is a continuing need to better educate both the public and professionals who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence and the need to take appropriate action with potential abusers, victims, and their children. In particular, this education has to include an awareness of the risk factors for potential lethality.**

There appears to be increasing public awareness of and professional training about domestic violence. However, the cases we reviewed this year highlight the need to expand this awareness and make the links to appropriate action. In many of the cases we reviewed, the indicators for domestic violence were present and even recognized, but there seemed to be a lack of any referrals and/or interventions focussing on safety for victims and treatment for perpetrators. In short, people know how to recognize the occurrence of domestic violence but do not know what to do upon this discovery. Public awareness campaigns need to emphasize steps that may be taken such as where/who to call (Assaulted Women's Helpline—a Provincial crisis line available 24 hours a day, seven days a week—or distress centres) when they think there may be a domestic-related crisis brewing. Ideally, the process of raising awareness should be embedded in the public education system so students learn about these issues early in their lives before their transition to adulthood.

In most cases we reviewed, there were at least seven or more risk factors associated with potentially lethal violence. It is important to understand that domestic violence occurs along a continuum. This continuum includes minor and isolated incidents, progressing to an overall pattern of behaviour over time within the relationship. This overall pattern of behaviour suggests a high likelihood of repeat violence, dangerous behaviour, and even the potential for life-threatening harm. Throughout our case reviews, we again found multiple opportunities for intervention by friends and family, by front-line professionals such as family doctors, and by more specialized domestic violence services such as police and shelters for abused women.

When properly done, risk assessments offer a number of benefits to the victims, as well as inform victims of the potential danger they are in. The assessment process also gives the assessor an opportunity to provide victims with direct services or referrals to services available that promote safety and help reduce the risk.

Victims of domestic violence need information about risk factors for lethality and what to do about them. In one case of attempted homicide–suicide, the surviving victim suggested that she and other victims needed to have more information about what kind of the services are available; she had no idea what was available. In another case, the surviving spouse of an attempted homicide–suicide seemed totally overwhelmed and felt like she was basically on her own due to her lack of knowledge and trust in the system. She advised that the perpetrator had caused such fear in her life that, even after he was gone, she still felt his controlling influence. These cases also help illustrate that waiting for decisions by the justice system, whether during family, criminal, or child protection proceedings, can leave some victims vulnerable, unprotected, and without support throughout the process due to lack of information about how to access services.

In a number of cases, we observed that professionals might have in fact minimized the danger victims were in because they focused exclusively on other factors, such as mental health and alcoholism issues involving the victims and perpetrators. Problems in other areas of adjustment may escalate the risk offenders present and magnify the vulnerability of individual victims.

Individuals in the workplace have a unique opportunity to observe the impact of domestic violence on victims, or to observe the perpetrator's disconcerting behaviour. Both employers and co-workers have a potential role and responsibility to provide support and either seek out or help activate appropriate community interventions. In the same manner in which a workplace culture can foster caring through resources such as employee assistance programs that tend to focus on mental health and alcohol-related problems, domestic violence needs to be recognized as a significant issue requiring intervention.

In one of our cases, there were many warning signs of an employee's escalating distress in the context of a known prior mental health diagnosis that might have led co-workers and supervisors to intervene. In response to high-risk cases, friends, neighbours, family, and co-workers have an essential role to play as part of a wider community coordinated response. We do not intend to place an extraordinary responsibility on individual citizens, but hope that an enhanced awareness on the part of the public will be joined by a growing sensitivity on the part of professionals and community agencies in activating an appropriate response to the domestic violence in the lives of their family members, friends, neighbours, fellow co-workers, and employees.

All public education recommendations include the fact that any domestic violence training must be done within an integrated anti-oppression framework, which is inclusive of race, class, ability, sexual orientation, age, and religion.

2. **It is recommended that child welfare and protection agencies receive ongoing training to recognize the risk factors for domestic violence. Furthermore, this training should address effective interventions that promote the safety of mothers and children.**

3. **It is recommended that child welfare and protection agencies address the following issues:**

    - All child welfare organizations should follow the provincial policy currently in place, known as the *CAS/VAW Collaboration Agreement*. This policy informs how both the violence against women and child welfare sectors must work together in situations where there is violence against women. It also ensures that perpetrators are held accountable to the fullest extent possible within the parameters of each sector's mandate.
    - Specialized training and education should be provided for all child welfare staff on the most effective ways to intervene in domestic violence cases. Currently, assessment focuses primarily on the mother's ability to protect her children. There is minimal focus, if any, on intervening directly with the offender on risk reduction and containment, and assessing if access should be permitted, particularly if the abuser remains untreated.
    - Present assessment reports that address a comprehensive analysis of domestic violence issues, including the risk factors for potential lethality, should be provided to Family Court judges so they have the necessary information prior to making decisions regarding custody and access to children.
    - It is suggested that there be a quality assurance component built in to the child welfare sector to ensure that best practices and standards of care for interventions are maintained.
    - Child welfare workers need to have the opportunity to increase their skill and comfort level in acting to locate, interview, and assess abusers to safely intervene in ways that enhance the safety of mothers and children and to hold abusers accountable.
    - Child welfare workers need to have the opportunity to increase their skill and comfort level in interviewing women at risk and how to connect them to support systems in the community to enhance the safety of mothers and children.

In all the cases we reviewed involving children, the child welfare sector was involved and had a key role to play in assessing risk to mothers and their children. Opportunities existed to provide safety planning for both mothers and their children, make referrals to supportive violence against women services (VAW), help decrease their isolation, and respond to their ongoing need for assistance and protection, particularly when faced with custody and access issues. As a result of its role and mandate, the child welfare and protection sector is in a unique position to assess the dangerousness of the abuser. In addition, this sector can also make recommendations to the court systems regarding decisions related to access to children and appropriate interventions with the abuser related to risk management, parenting capacity, and accountability.

In the cases involving children, a number of risk factors associated with the perpetrators were clearly present, including histories of past violence, criminal convictions accompanied with numerous breaches of court orders, addictions, separation, custody and access disputes, and ongoing harassment and stalking of mothers and their children. In two tragic cases where young

children were killed, no attempt was made to assess the potential lethality risk of untreated abusers fighting for access to their children as a way of continuing to exert control over the mothers of the children. Without the appropriate assessment and characterization of the perpetrator's behaviour, the mothers and their children were exposed to the risk of escalating violence and ultimately the deaths of the children. The murders of the children were a way for the perpetrator to punish the mothers. In one case where child welfare was involved, we heard that the abused mother was reluctant to reveal her fears to the CAS due to her belief that they would remove her child from her care. In another case, the mother did not see the child welfare worker as a potential ally in seeking safety and assistance. In a candid revelation to the committee, she felt the worker was only interested in the state of cleanliness of her home.[12]

4. **It is recommended that lawyers in family law practice receive continuing education on understanding and recognizing the dynamics of domestic violence and the risk factors for lethality associated with separation, divorce, and custody and access.**

Family law lawyers are well placed to recognize domestic violence and the escalating risks in a couple's separation. In our review of cases in the past two years, separation and a prior history of domestic violence are significant risk factors for women and children facing death at the hands of the intimate partner. Lawyers often see victims and perpetrators in crisis, and have a unique opportunity to intervene to make appropriate referrals and develop plans to enhance safety where there is conflict over child custody, support, and possession of the matrimonial property. This type of representation is among the most important that a lawyer can provide: it can save lives.

There is no family law case more complicated than a case in which safety issues are present and the abuser uses the legal system to continue to harm and harass. These cases are both challenging and time-consuming. Family law lawyers would benefit from the opportunity to receive specialized training in the dynamics of domestic violence and assistance in identifying risk indicators that might lead to lethal violence. This specialized knowledge would guide them in seeking appropriate assessments. Trying to have clients benefit from community counselling programs and promoting safe access through supervised visitation programs are essential strategies. We reviewed two cases where toddlers were killed in an apparent attempt to punish the victim for leaving an abusive relationship. In retrospect, more information should have been available to the court to help identify the level of risk that these toddlers and their mothers faced. In one case, advice was given—as it often is—that the victim should remain in possession of the home to protect property rights prior to actual separation. However, there was no clear understanding of the risk factors present. If these factors had been recognized, it might have resulted in a different course of action and outcome. [13]

5. **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 a time of high risk requiring special vigilance. These cases require the development of a high-risk case management protocol specific to domestic violence**

[12] See also recommendations no. 23 to 26 below regarding child-related issues and domestic violence.
[13] For more information on best practice guidelines for family law lawyers, see *The Centre of The Storm Durham Speaks Out: A Community Response to Custody and Access Issues Affecting Woman Abuse Survivors and Their Children*, www.womanabuseprevention.com

cases. Such a protocol needs to be accompanied by appropriate training focused on addressing the dual goals of victim safety (intervention) and offender risk reduction/containment (case management).

The criminal justice system is concerned with the safety of the alleged victim in cases of domestic violence. We have seen that when there is a combination of actual or pending separation, child custody disputes, and a prior history of domestic violence, it can be a dangerous time requiring special vigilance by the police. In one of our case reviews, a perpetrator with a prior history of violence and breaching court orders did not return the child to a supervised access centre at the specified time. At the time, the police did not perceive it to be a high-risk situation, and no immediate action was taken. The perpetrator murdered the child.

When responding to domestic violence calls, it is critical for police to be aware of the indicators of dangerousness. Police training should include an understanding that domestic violence is a process and not a single event. Accordingly, when high-risk indicators are present, a case management protocol needs to be put into effect to ensure there is ongoing monitoring and supervision. Breaches of bail need to be dealt with swiftly. As discussed in our risk assessment subcommittee section, optimally a case manager should be responsible for the safety of the victim by receiving ongoing information about the behaviour of the accused while on bail. Police should also receive training on understanding family law restraining orders and their enforcement.

6. **It is recommended that awareness and education programs address the *culture of silence* surrounding domestic violence and its apparent acceptance that still exists in some families and small communities.**

The committee has reviewed a number of cases where family or members of small communities were well aware of threatening or abusive conduct, but failed to act upon it in an effective way. In one instance, members of the community were said to be figuratively wagering on which of the partners in the relationship would kill the other first. The committee considered a number of possible reasons for this reluctance to act, including: fear of the perpetrator; social or familial consequences in getting involved; cultural barriers (e.g., being ostracized from their families and community); inability to recognize the conduct as a serious indicator of risk for escalating violence; and the fact that some victims minimized the conduct and did not want third parties involved. Whatever the basis, this culture of silence is a barrier to violence being reported, the victim getting necessary help, and the creation of a safer environment for all parties. Unfortunately, in some respects, it harkens back to another time when domestic violence was considered a private matter.

7. **It is recommended that all healthcare providers be taught to be mindful of the dynamics of domestic violence and the potential for lethality, especially when working with patients who have a history of alcohol and/or drug abuse, depression, anxiety, or suicidal ideation. When domestic violence is identified in the patient's life, the potential for lethality should be assessed by the healthcare provider, or the patient should be referred to others with an expertise in making such assessments.**

In three of the cases, the perpetrators were seen by their physicians or another counsellor for mental health concerns, but there was no evidence or documentation of risk assessments having

been done. Subsequently, these perpetrators went on to commit homicide. Consideration should be give to including education about the dynamics of domestic violence and the potential for lethality and its assessment in the undergraduate and postgraduate curricula for medical students and students of other healthcare professions. Similar information could also be incorporated into continuing medical education and professional development for other healthcare professionals.

8. **It is recommended that front line service providers (police, shelter workers, paramedics, medical staff) receive training in recognizing that the effects of drug and/or alcohol addictions on the victim can sometimes cloud the assessment of underlying domestic abuse.**

In two of the cases reviewed by the committee, the victim's and perpetrator's alcoholism presented a barrier to their ability to access services. The service providers had difficulty recognizing that domestic violence was occurring. As a result, the professionals the victims and perpetrators came into contact with missed opportunities for intervention in both cases. In one case, repeated physical injuries to the eventual homicide victim were written off as having occurred as a result of alcoholism and not as a result of domestic violence since the victim did not complain about the perpetrator.

9. **Persons working in occupations with access to firearms, such as police, may experience barriers in the workplace to the disclosure of mental health and emotional problems. It is recommended that a change in the organizational culture be initiated to establish a climate conducive to such disclosure, without fear of recrimination or employment restrictions.**

Police service managers, supervisors, and police officers should receive training to recognize the link between the potential for self harm and harm to others associated with access to firearms. This is especially true when an officer experiences significant job-related and life stressors. Further, once it is recognized that an officer is in a potentially vulnerable position, the organization should ensure the officer is treated respectfully and in a non-discriminatory way to enable him or her to continue to be a productive and valuable employee. The fear of job loss or recrimination from the reporting or acknowledgment of personal strife has to be eliminated for it to be disclosed and acted on appropriately.

10. **It is recommended that where feasible and practical, police services should give consideration to supervised control of issue firearms when officers are off duty.**

Supervised control of issue firearms includes but should not be limited to having the officer complete a sign-out sheet identifying the reason the firearm is being removed from its secure location, and a record of the supervisor's approval of its removal. An example would include when an officer requires his or her firearm for a non-scheduled task (e.g., off-duty training and firearm practice). It is acknowledged that it would be impractical to require all police officers, depending on their duty assignments, to lodge their issue firearms in a supervised control access location, however this should be considered the exception rather than the rule.

In one case reviewed by the committee, a police officer who was required to lodge his firearm in his locker at his police division retrieved it, along with ammunition, without explanation when off-duty. He used it shortly afterwards to kill his wife and himself.

11. **It is recommended that the Ontario Court of Justice consider using high-risk cases where judicial interim releases occurred, as reviewed by the DVDRC, as case scenarios as part of the ongoing educational programs for Justices of the Peace who conduct the majority of bail hearings in the province.**

The committee has examined several tragic cases involving perpetrators with a number of pre-existing risk factors who had been released on bail and who subsequently killed their spouse or child. In the circumstances of court proceedings, unless there is an appeal or review and superior court direction, the opportunity to benefit from post-event analysis is lost. There are no appeals from these cases. The lessons that these cases can offer must not be lost. It is common practice for physicians and others to re-examine their cases to learn whether improvements can be made in how the case was treated. While every case will be determined on the evidence and the circumstances particular to it, these are the kind of cases that should be used by all involved to ascertain the lessons they may learn to help avoid future tragedies.

b. Assessment and Intervention

12. **The Committee recommends that healthcare providers use risk assessment tools to assess the potential for domestic violence/abuse, suicide, and/or homicide.**

As the concept of risk assessment becomes better understood, it is important for community professionals to recognize that these assessments are not limited to use by professionals involved in the justice system. Every sector, including the healthcare sector, needs to use these tools when clients reveal domestic violence in their lives. Healthcare providers in hospital and community settings are well placed to gather critical information after victims or perpetrators present physical injuries or mental distress as symptoms. The nature and history of domestic violence, as well as precipitating crises such as separation and custody disputes, need to be thoroughly explored. Without a risk assessment framework, information gathered might not be seen in the serious light in which it should be understood.

In one particular homicide–suicide case, the perpetrator was given a series of tests by a physician/psychotherapist to take home to complete. It was not until after the homicide–suicide that police obtained the results as part of the coroner's investigation. As a matter of practice, the committee recommends that when such tests and risk assessment tools are used, they should be administered and completed in the presence of the healthcare provider.

13. **It is recommended that intake workers at women's shelters use standardized risk assessment tools to thoroughly assess and manage the potential risk of the woman seeking assistance. Current existing risk assessment tools should be tailored to meet the needs of community-based violence against women services and the women they serve. Further, all workers should receive training on the use of such standardized risk assessment tools.**

14. **It is recommended that, in any community where there are a number of shelters available to assist victims of domestic violence, a central registry of available beds for victims, as well as a means of transportation to the available facility, be established.**

15. **It is recommended that shelters be supported to create ways to effectively coordinate services and referrals to minimize the need for a woman seeking shelter to navigate the system on her own, and to maximize the ways shelters can work together to provide a seamless and supportive response to the woman and her children.**

A woman in need of assistance and protection should only have to make one call to access the shelter system. Shelters provide key services in response to women and children seeking safety from abusers. In one of the cases reviewed, the victim who disclosed indictors of high risk—including death threats, the abuser having been recently released from jail, and threats to take her child—sought assistance from a shelter and was advised space was not available. She was directed to contact other shelters. It was also suggested that she contact other services on her own. She was advised that if she had concerns for her child's safety, she should contact the local Children's Aid Society. It was reported that she declined out of fear that CAS might remove her child. In another case, a shelter assessed a victim as being in a low to moderate risk situation without supporting documentation. It would be helpful to have a standardized province-wide risk assessment process for shelter intake.

In another complex situation that involved a number of barriers—including geographic isolation, cultural factors, addictions, and absence of batterer intervention programs—a woman, who was both a victim and herself a perpetrator of violence, sought and received her greatest support from the local shelter even though the workers were fearful of her. In this case, it was said that members of the community expected one of the partners to eventually kill the other as a result of their continuous history of significant violence toward one another. Given the trust the woman held for them, the shelter appeared to have been in the best position to manage the case and take the lead in a case conference to implement an effective community response. However, the shelter lacked the proper resources or other local services to do so. A local case coordination of services and support process might have made the necessary difference to avoid the anticipated death of one of the partners in this case.

While police are currently completing *Domestic Violence Supplementary Reports* in an attempt to gather information and identify situations where the likelihood of further violence is of concern, it would appear that very little is being done to clearly identify high-risk cases that require additional monitoring. The police are obliged to record answers to questions in the *DVSR*, but there is no specific analysis of what the answers mean and what qualifies as a high-risk case. Our committee has recommended that specific information on lethality be gathered using a form such as the *Domestic History* form. This form captures the victim's detailed responses to specific questions. The information gathered can then be used at a bail hearing, and can be used to source other risk assessment tools. A tool such as *ODARA* may help to determine whether another assault may occur. A tool like J. Campbell's *Danger Assessment* may help identify potential lethality.

A number of cases reviewed over the past year were involved in the criminal justice system. Some of these cases involved accused persons who had been released on bail with conditions. It would appear that none of these cases were red-flagged for immediate intervention and management. As the case was never identified as a high-risk case, and even though there were

ongoing breaches of bail and an escalation of dangerous behaviours, no monitoring or management of the case took place. A proper risk assessment is necessary to identify a high-risk case. Once identified, it should trigger a high-risk case management response. The risk assessment process also has a number of benefits to victims. One benefit is that victims will be informed about the potential danger they may be in. Another benefit is that victims can then be made aware of a number of appropriate services available to assist them.

16. **It is recommended that police put processes into practice to identify, monitor, and manage high-risk cases, and to vigorously enforce bail conditions arising from a violent offence or threat of violence. Further, it is recommended that police services institute a dedicated police unit that has links to community-based experts to deal specifically with high-risk domestic violence cases, to ensure an appropriate case management response in such cases.**

Several reviewed cases involving the criminal justice system were not identified as high-risk cases and no high-risk monitoring or management ever took place. In some of these cases, police services had the grounds to arrest an offender for breach of conditions but failed to do so at the first opportunity. Instead, they chose to allow the offender to voluntarily turn himself in to police. During the resulting delay, the offender demonstrated lethality.

Where the offender is living outside the jurisdiction where the precipitating offence took place, the original investigating police service must ensure that the police service in the jurisdiction where the offender is living is advised of the circumstances of the case, conditions of bail, and degree of risk. A high-risk case management unit will ensure this is done expeditiously. In this way, there can be oversight and continuity with respect to the ongoing monitoring and management of the high-risk case.

17. **It is recommended that the Ministry of Community Safety and Correctional Services, Policing Standards Section either develop a stand-alone model to manage high risk domestic violence cases, or include domestic violence in the current standard that addresses high-risk cases.**

The Model Police Response to Domestic Violence is the minimum standard for police in Ontario. It does not specifically address the management of “high-risk” domestic violence cases. While there exists a guideline for Police Response to High-Risk Individuals, this guideline is not specific to domestic violence cases. Although some of the investigative techniques outlined in this document could be used in domestic violence cases, it does not address the unique management requirements of a high-risk domestic violence case.

18. **It is recommended that police services put processes into practice to ensure that 911 call-takers and dispatch personnel receive specialized training in domestic violence. Guidelines should be established with prioritized questions to assist 911 call-takers and dispatch personnel to assess immediate risk to the caller and to first responders.**

In one case, the victim was on the phone with 911 when the offender arrived at her place of residence. The responding police were rapidly dispatched, arriving within minutes of the call, and arriving at the residence just as the perpetrator entered the residence to kill the caller and himself. The committee had the opportunity to review the call, which revealed a very quick

development of events. There is no indication that anything could or should have been done during the call that would have effected a different outcome. However, based on the case, the committee determined that a template consisting of a series of questions specifically for domestic violence calls, much like the templates used in medical emergency calls, would help to fully assess the nature of the emergency and provide valuable information to the responding police officers. The Domestic Violence Occurrences section of *The Provincial Adequacy Standards Manual 2000* discusses a call-taker asking appropriate questions to establish the level of risk the caller may be in.[14] A template or guideline would assist the call-taker to accomplish this goal. It is also noted that 911 calls are frequently used as evidence in domestic violence prosecutions, and the information obtained during the call may be of value in that process as well.

19. It is recommended that a protocol be established between police and Crown counsel to ensure that persons proposed as surety: 1) be properly investigated as to their suitability to act as surety; 2) be fully informed about their responsibilities as surety both in writing and on the court record; and 3) be warned, in writing and on the court record, as to their potential liability under estreatment and as party to a criminal offence in the event they breach their duty.

One of the issues that arose in a number of cases that gave the committee cause for concern involved sureties and their role in the release of perpetrators who later murdered their partner or their child and take their own lives. Several of the cases reviewed identified weaknesses in the screening process of sureties who act in support of bail applications. It was apparent that the sureties in these cases were inappropriate due to having criminal records, being unable to exercise control over the accused, failing to contact the police when the accused failed to comply with conditions, and lacking understanding of the consequences of failing to meet the obligation of being a surety. In one particularly tragic case, the surety was a party to the breach that led to the homicide. In fact, after leaving court following the granting of bail, the surety drove the accused directly to the home of the victim. The accused shot his wife in the presence of their daughter and then took his own life in the same manner. In another case, the surety was the father of the perpetrator's wife. He provided a false name, as he believed he would not be approved as the father of the victim. The accused was released on bail and later murdered the surety's grandson.

20. Is recommended that, in cases of domestic violence, the police give persons proposed as surety written or video information about the risk factors for potential lethality, and that receipt of that material be confirmed on the court record.

The committee observed that in a number of cases where bail releases occurred in high-risk circumstances, sureties might have made a difference in preserving the lives of the victims had they acted in compliance with their obligations to report breaches. There were instances of sureties being aware of non-contact breaches with the victim, but they did not report the breach or seek to revoke their surety. In one case, a son-in-law and daughter of the perpetrator who acted as sureties failed to report the perpetrator's non-contact breaches or not residing where he was required out of fear of hurting their father or causing him to be incarcerated. In another instance, the surety—who had a criminal record and with whom the perpetrator was to reside—

[14] Police Services Act, *Adequacy Standards Manual 2000*, Domestic Violence Occurrences Section #8.

drove the perpetrator on his release directly to the home of the victim. In both cases, the perpetrators killed their partners within days of the violations. In another case, a person who posed as another person was approved as a surety without identification.

As an example, consideration should be given to requiring potential sureties to watch an educational videotape detailing their obligations and responsibilities before they are approved as sureties in cases of alleged domestic violence. The video should also include information about risk factors the surety should be aware of.

21. It is recommended that a protocol be established for immediately entering restraining orders into the CPIC (Canadian Police Information Centre) system so that if there is a breach, the police can act immediately under the Family Law Act.

It is not uncommon for parties who are separating to seek a restraining order in the family court. Such orders usually provide that the respondent be restrained from contacting the applicant, visiting the residence, or harassing the applicant. These orders also deal with custody and access conditions. Many domestic violence victims are not involved in the criminal justice system, but may be involved in Family Court about child custody or seeking protection by application for a restraining order. Concerns have been expressed that civil orders from the Family Court are not taken as seriously and may not be enforced by the police. As an example, in one case we reviewed, the accused had been breaching his conditions on his restraining order for several months. These breaches had been reported to the police, but no action had been taken. The order in this case had not been entered into CPIC (Canadian Police Information Centre) prior to the homicide.

22. The committee recommends that the provincial policy stating that, upon conviction for a domestic violence offence, the Crown seek an order requiring an offender to attend a batterer intervention program such as Partner Assault Response (PAR) as part of a probation term be followed.

In one case we reviewed, an accused person had been convicted of assault and was not ordered to attend a PAR program. Current provincial policy with regards to the operation of the Specialized Domestic Violence Courts requires that convicted offenders be directed into PAR programs as a part of their sentence. These are important socio-educational programs that can help increase victim safety by: 1) intervening with the offender; 2) providing education for the offender; 3) monitoring the offender on an ongoing basis; and 4) ensuring contact with the partner.

Child-Related Issues:

23. **It is recommended that the province review the *Children's Law Reform Act* and work in collaboration with the federal government's review of the *Divorce Act* to ensure that domestic violence is given a prominent role in judicial decision-making when considering child custody. Similarly, the *Child and Family Services Act* should also be reviewed to ensure consistency with the legislation noted above in requiring specific consideration of the presence and effect of domestic violence in custody matters.**

Currently, half of the states in the U.S. have a legislated rebuttable presumption against a domestic violence perpetrator having custody or joint custody of children, which should be considered in Ontario.

24. It is recommended that before deciding on the nature of access, assessment reports for Family Court judges, prepared by qualified assessors with domestic violence training, should be considered. This assessment is especially valid when dealing with someone who has a history of domestic violence as demonstrated by a prior criminal record for related offences.

Although professionals and the general public are beginning to understand the impact of domestic violence on children, there appears to be an inconsistent application of this knowledge in the assessment and intervention strategies we reviewed. We understand that some children who are exposed to domestic violence may suffer serious emotional harm that may be comparable to children who are abused directly. These children may be exposed to inappropriate role models in their families, and be impacted in their development of future trust relationships. The potential harms that result have been documented in both short-term and long-term consequences.

In the area of domestic homicides, children may witness extreme violence and death. U.S. and Canadian studies suggest as many as one-quarter of homicides have children present. Children are also in danger of becoming homicide victims themselves as the perpetrator may kill children as part of an overall homicide–suicide plan, or kill children to punish their estranged partner for leaving the adult relationship. We reviewed two such cases in 2004, where a toddler's homicide was a direct act of revenge for a woman seeking to end an abusive relationship. Both of these tragic circumstances reflect the lack of clarity in law and practice on how to intervene with children exposed to domestic violence.

One area that needs to be addressed is the role of the Children's Aid Society (CAS). In responding to domestic violence calls involving children, current practice by police in Ontario involves sending a copy of the occurrence report to the CAS for their investigation. The CAS intervention varies, depending on a number of issues such as local practice and protocols as well as the nature of the circumstances. A common circumstance in potentially lethal cases is parental separation. The CAS worker has to decide whether this is a case that requires their protection and/or counselling mandate, or whether the case can be managed in the private custody and access sector involving other resources such as family law specialists, supervised access centres, mediators, and custody evaluators. The CAS decision also happens in a context of not wanting an abused spouse to feel re-victimized by the intervention (e.g., You're an abuse victim but also a bad parent for letting your child live with this violence). Without assigning blame in the cases we reviewed, it appeared that the CAS workers were well-intentioned in their contact with the abuse victim, but failed to assess the perpetrator, support safety planning or risk reduction, or coordinate their efforts with other professionals.

Some confusion exists in the field regarding roles and responsibilities in dealing with children in the context of domestic violence. The criminal court properly assumes innocence until the allegations are proven beyond a reasonable doubt. The process of preliminary hearings and trials may take many months, and in some cases may take years. However, the victim and children

may need an immediate safety plan that either suspends contact with the perpetrator or requires supervised visits or exchanges between the parents. The challenge to the court system and community services is how to manage such a plan and respect the presumption of innocence. The Family Court can make interim findings on the balance of probabilities if proper evidence is presented. Some scepticism is usually found within the courts when one parent raises allegations of abuse against the other parent and tries to limit contact, since the system depends on friendly and cooperative parents willing to put the past behind them in the best interests of the children. This approach is counter-intuitive for a domestic violence victim who is seeking safety and an end to the violence. The CAS may also be sceptical that they are being drawn into a private family law dispute with allegations being made by separating parents.

The cases we reviewed illustrate many of the points outlined above. Access was offered in cases where there should have been none, or where there should at least have been strictly supervised visits. The criminal court and family court did not coordinate their services or interventions. It was unclear whether the CAS should intervene or leave matters to private child custody proceedings. The CAS appeared to focus on the basic care of the children rather than the danger the perpetrator continued to present. There were no systematic approaches to risk assessment and risk reduction. Violations of court orders were ignored or seen as low priority in the face of a disconcerting pattern of behaviour that could have been readily identified at the time. There seemed to be a lack of any comprehensive assessment that addressed the risks that the victim and her children faced in the context of domestic violence. Ultimately, it was unclear who was in charge of the case and who was accountable.

25. It is recommended that child welfare and protection agencies screen for domestic violence in all cases. As part of the process, it is necessary for them to locate, interview, and assess all partners involved. Where there is evidence of domestic violence, they must take the necessary steps to use their authority under the Children and Family Services Act to make appropriate interventions with the abuser to protect the mother and child.

26. It is recommended that the province develop a discussion paper and inter-ministerial guidelines for all cases involving domestic violence, children and custody, or access disputes. The paper and guidelines should encourage enhanced coordinated practices and protocols within and between the family and criminal courts, as well as court-related services such as victim–witness services, mediation, supervised access, CAS, batterer intervention programs, and probation supervision.

An effective response to domestic violence requires not only well-informed individual interventions, but also coordination of services by different professionals involved with family members. Previous research on intervention strategies with perpetrators of domestic violence has reinforced the notion that the "system matters" and successful outcomes are more likely with the justice system and community services working together.[15] In eight of the nine cases we reviewed, tragedies may have been averted if different individuals had had an opportunity to put risk factors together as pieces of the same puzzle, rather than appearing to be isolated and

[15] Gondolf, E. W. (2002). *Batterer Intervention Systems: Issues, Outcomes, and Recommendations.* Thousand Oaks, CA: Sage Publications.

unconnected incidents. At the same time, in retrospect, interventions by individual professionals lacked the effectiveness that might have been achieved with genuine collaboration.

Several of the 2004 cases highlighted the need for ready access to critical information, such as having restraining orders placed in a timely fashion on CPIC (Canadian Police Information Centre) to help subsequent police interveners recognize a potential red-flag situation. Several cases we reviewed suggest the importance of coordination of information and interventions within family and criminal law proceedings. Families in which domestic violence occurs may find themselves in three different streams of court proceeding: criminal, child custody, and child protection hearings. There is considerable confusion about the roles and responsibilities of the latter two systems regarding when domestic violence is an issue for state intervention (e.g., the CAS on behalf of provincial child protection legislation) versus an issue for parents to settle privately through provincial laws for custody and access post-separation. There appears to be no formal mechanisms in place to foster communication between the family court and criminal court in coordinating issues around child custody and safety of individual family members. These cases raise the importance of understanding the special circumstances surrounding children exposed to domestic violence and the fundamental relationship between victim and children's safety.

c. Resources

27. It is recommended that when a case is identified as "high risk," an appropriate immediate response is necessary, requiring adequate resources to effectively respond to and manage the risk.

In one of the cases, the mother of a missing child had to physically go to the police station and beg the police to start an investigation. It was reported that the officer that spoke to the mother responded in a frustrated and confused manner and seemed unsure of the correct way to proceed. The protocols already in place under the *Police Services Act, Domestic Violence and Missing Persons* should have been immediately implemented. The investigating officer from a large urban police service advised the committee that his jurisdiction had a large number of domestic violence cases, at least five reports per shift, and the officers felt frustrated because they did not have adequate personnel to respond effectively.

28. It is recommended that additional resources be made available to develop or provide access to domestic violence services for people living in northern (rural and remote) communities.

In reviewing the cases of the past year, it became apparent that the accessibility and availability of domestic violence services for people residing in rural and remote northern communities is gravely lacking in comparison to domestic violence services available in the more populated southern communities. Resources should be made available to develop domestic violence services that are culturally specific and appropriate for the population served. Services should be delivered to the community where domestic violence services are needed, and/or the people requiring domestic violence services should be provided with transportation to areas where such services can be accessed.

29. It is recommended that appropriate resources be allocated to implement those recommendations herein directed to the training and provision of the necessary tools to protect children and assess the risk associated to domestic violence.

The committee has made a number of recommendations identifying a need for resources for training within child welfare and protection agencies. In addition, other agencies in a position to provide valuable assistance to the courts when these courts are called to render decisions require resources and training to help them administer appropriate assessment tools and techniques. Four of the nine cases reviewed by the committee involve parents who were engaged in custody and access disputes. In two instances children were murdered, and in one of those cases and in a number of the other cases children also became surviving victims of domestic violence who suffered the loss of a parent and/or a sibling.

Appendix D

CHILDREN AS VICTIMS AND WITNESSES OF DOMESTIC HOMICIDE:

LESSONS LEARNED FROM DOMESTIC VIOLENCE DEATH REVIEW COMMITTEES

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The views expressed in this article are those of the authors and are not necessarily those of the Office of the Chief Coroner of Ontario.

Summary

Domestic Violence Death Review Committees (DVDRCs) are interdisciplinary teams dedicated to understanding how and why domestic homicides occur through a comprehensive examination of individual cases. DVDRCs also offer suggestions on what can be done to prevent future tragedies. This article reviews and summarizes the findings and recommendations of one Canadian and 14 U.S. DVDRCs as they pertain to children as victims and witnesses of intimate partner violence fatalities. The findings reflect that an alarming number of children are being victimized in various ways. A significant number of children are killed by perpetrators or exposed to these horrifying acts of violence. The safety of these children may be overlooked as they do not fit the traditional view of child abuse (because their mothers are the primary targets) or the traditional view of domestic violence (because the children may be the intended or unintended victims of the perpetrators). In reviewing the DVDRCs' recommendations, consistent themes emerge that can be readily grouped in relationship to: (1) training and policy development; (2) resource development; (3) coordination of services (4) legislative reform; and (5) prevention programs. The implementation of these recommendations may be critical as there is emerging evidence to support the utility of DVDRCs in preventing the deaths of children and adults in the context of domestic violence.

Children as Victims and Witnesses of Domestic Homicide: Lessons Learned from Domestic Violence Death Review Committees

"Children bereaved by the death of one parent at the hands of the other, almost always the father, in effect lose both parents. The children are then uprooted, losing their home and, quite often, their familiar routine in essential relationships. The combined effects of trauma, dislocation and loss are dramatic, but little has been written so far about such tragedies and the implications for everyone concerned in the future of the affected children." (Harris-Hendriks, Black, & Kaplan, 1993, p. 1).

Between 1994 and 2003 there were 1,695 family-related homicides in Canada, with 47% classified as intimate partner homicides (Canadian Centre for Justice Statistics, 2005). Hilton, Harris, Rice, Lang, and Cormier (2004) highlighted that when a woman is murdered by a current or former intimate partner, the public often wants to know why the woman was not protected and the homicide not prevented. A recent approach to preventing these fatalities is the formation of domestic violence death review committees (DVDRCs), teams comprised of coroners, medical and mental health professionals who specialize in domestic abuse, criminologists, prosecutors, shelter staff and women's advocates, law enforcement staff, and representatives from child protection services (Websdale, 2003). DVDRCs are dedicated to understanding how and why intimate partner homicides occur through a detailed examination of individual cases. The DVDRCs are also dedicated to providing recommendations on how to prevent future deaths (Jaffe & Dawson, 2003). The typical cases reviewed include intimate partner: (1) homicide; (2) homicide-suicide; (3) attempted-homicide followed by suicide; (4) attempted-homicide followed by related accidental death (e.g., the perpetrator was killed in a car accident during a police pursuit); and (5) attempted-homicide followed by related homicide (e.g., the perpetrator was killed in a police shooting). Some reviewed cases include the deaths of any individuals connected to incidents of intimate partner violence, such as third-party interveners (e.g., police), friends, neighbours, co-workers, new partners, extended family members, and children.

The most frequent forms of child victimization that DVDRCs encounter include: (1) children left parentless following homicides and/or suicides; (2) children exposed to the violent deaths of parents; (3) children indirectly killed as a result of being "caught in the crossfire" during violent episodes between parents; (4) children directly killed by a parent as punishment to the partner who decided to end a relationship; (5) children directly or indirectly killed as part of an overall murder-suicide plan by a parent who decides to annihilate family members; and (6) adolescents killed as a result of violence in dating relationships (not a focus of this article). Senior researchers in this field have pointed to the paucity of any literature describing the connection between adult domestic homicide and child homicide (Websdale, 1999). It is argued by the authors of this paper that harm to children in these cases may be overlooked as the cases do not fit the traditional view of child abuse (because the mothers are the primary targets) or the traditional view of intimate partner violence (because the children may be intended or unintended victims of intimate partner violence perpetrators).

According to Lawrence (2004), child homicide in the context of domestic violence usually involves the termination of the parents' relationship as the precipitating factor. The man reacts to the end of the relationship with rage or depression and murders his child or stepchild. In some cases multiple children in the family are murdered, and sometimes the former partner of the man is also killed. A substantial number of these violent acts are followed by perpetrator suicide. Of the 1,695 family-related homicides in Canada, 25% involved children as victims (Canadian Centre for Justice Statistics, 2005). A parent was the offender in 90% of these cases, with fathers as perpetrators in 58% of cases and mothers in 32% of cases (Canadian Centre for Justice Statistics, 2005). In 25% of parent-child murders, the perpetrator had a history of domestic violence, and this history was twice as likely when the offender was the father as opposed to the mother (31% vs. 16%, respectively) (Canadian Centre for Justice Statistics, 2005). Between 1961 and 2003, there were 1,994 homicide victim deaths followed by perpetrator suicide; 76% were committed by family members, of which, 57% were intimate partner homicides, and 33% were committed by parents against children (Canadian Centre for Justice Statistics, 2005). In 85% of the homicide-suicide cases, men killed only their partners, but in 15% of the cases they killed others, with the next most common victim being their children (Canadian Centre for Justice Statistics, 2005). In addition to the 834 women killed in homicide-suicides, there were an additional 214 victims, of which, 71% were children (Canadian Centre for Justice Statistics, 2005).

There are no epidemiological studies addressing parental loss due to domestic violence fatalities, but Lewandowski, Campbell, Gary, and Barenski (2004) estimated that approximately 3,300 children lose parents to domestic homicide every year in the U.S. These authors also estimated that there are roughly three attempt-homicides for each completed homicide, raising the number of children affected even higher. In 121 cases of femicide and attempted-femicide, Lewandowski et al. (2004) found that children witnessed 35% of the femicides and 62% of the attempted-femicides, and discovered the bodies of their mothers in 37% of the femicides and 28% of the attempted-femicides.

Eth and Pynoos (1994) highlighted that "the traumatic nature of a child's experience viewing catastrophic family violence is a relatively underreported area of exploration" (p. 287); however, some of the documented effects, likened to post-traumatic stress disorder, include "enuresis,

sleep disturbances, temper tantrums, flashbacks, dissociation, anxiety and psychosomatic disorders, and passive and aggressive behaviours" (Burman and Allen-Mears, 1994, p. 29). Children may have to deal with fear and insecurity over living arrangements after the death of one or both parents as well as the stigma of having a homicidal parent. There may be ongoing loyalty conflicts with maternal and paternal family systems as well as traumatic memories of the perpetrator's violence and the victim's injuries. There are often profound feelings of the helplessness of the victim, the powerlessness of the child, and the guilt, anger, depression that are likely to set in (Burman & Allen-Mears, 1994). These children may not receive the help they need, as their new caregivers may not recognize trauma symptoms in their desire to re-establish some routines in the children's lives. For example, Black and Kaplan (1988) found that the range in treatment hold-up for children exposed to domestic homicides was anywhere from two weeks to 11 years.

This article attempts to expand our awareness and knowledge of the plight of these children by reviewing the information available from DVDRCs on the number of children affected and the recommendations being suggested to improve community prevention and intervention efforts.

Methodology

The most recently published online annual reports of 14 DVDRCs from across the United States were accessed from the National Domestic Violence Death Review Initiative (NDVRI) website (http://www.ndvfri.org/) and reviewed, as well as two online annual reports from Ontario's DVDRC in Canada. (http://www.mpss.jus.gov.on.ca/english/home/pubs.html). To be included in this review, the reports must have had some data available on children as witnesses or victims of domestic homicide, or made some recommendations to address this vulnerable population.

Findings of DVDRCs Related to Children as Victims and Witnesses of Domestic Homicide

The number of children involved as victims and witnesses to domestic homicides according to the DVDRC annual reports reviewed for this paper can be seen in Table 1.

Table 1

Summary of Most Recent Findings by DVDRCs on Children as Victims and Witnesses of Domestic Homicide

DVDRC	Total Incidents	Total Deaths	Total Number of Children Killed	Total Number of Child Witnesses	Percentage of Cases with a child witness	Total Number of Children Affected[16]	Percentage of Cases with a child affected
California - Santa Clara County	6	6	0	7	-	10	-
California – San Diego County	61	61	0	12	-	52	-
California – Contra Costa County	17	20	2	3	-	10	-
Ohio – Cuyahoga County	31	31	8	-	-	-	-
State of New Jersey[17]	58	125	2	-	19	-	-
State of Maine	12	13	1	-	-	-	58
State of New Mexico	33	45	1	7	21	-	50
State of Delaware	30	41	-	-	20	-	37
State of Georgia	25	34	1	30	60	-	-
State of Oklahoma[18] [19]	113	126	-	-	36	-	43
State of New Hampshire	133	133	26	-	-	-	-
State of Washington[2]	313	416	147	40	6	-	35
State of Florida[3]	60	67	6	14	-	-	-
State of New York[3]	57	62	2	-	42	-	63

[16] For example, left parentless
- Not reported
[17] This State only reviews cases of murder-suicide
[18] This State reported aggregate data, not necessarily data from the cases reviewed
[19] Perpetrator fatalities not counted under total number of fatalities

Ontario, Canada	20	35	4	8	30	18	65

The findings presented in Table 1 should be interpreted with caution, as they are limited in several ways. Not all committees randomly selected their cases for review, so these cases may not be representative of all fatal intimate partner violence cases. For example, New Jersey's Board only reviewed cases of homicide-suicide. Some DVDRCs only reviewed homicides in their counties while other committees reviewed homicides that occurred across their state, and some DVDRCs only reported their yearly findings, while others reported the findings that they accumulated over years of conducting death reviews. Therefore, it should not be concluded that the frequency of homicide in one region is higher than that in another region. The reader should also be aware that, although many DVDRCs are required by law to conduct these death reviews in their jurisdictions, not all committees are in the practice of recording or reporting certain data, as many of them operate on a volunteer basis and do not receive funding for their reviews or collection of data over time.

Table 1 reflects the reality that an alarming number of children are being victimized in various ways due to the actions of domestic violence perpetrators. The number of children who are killed by parents in the context of domestic violence is significant. Too many children and adolescents are exposed to the horrifying acts of violence, as well as children who may have not necessarily been present to witness the deaths, but are nonetheless affected by the losses of parents and undoubtedly haunted by the traumatic nature of these deaths. The numbers in Table 1 reflect only the 'tip of the iceberg' in relation to children impacted by domestic homicide, as there is not a standardized method among DVDRCs in recording or reporting findings. The absolute total number of children exposed to the homicides in many states is not known. For example, Oklahoma's Board found that, in 113 reviewed incidents, children were witnesses in 36% of cases; however, they also reported that anywhere from one to 30 children witnessed a single death. Furthermore, the numbers in the table do not capture the horrific circumstances that many children face. For example, of Florida's 60 reviewed cases, perpetrators made prior threats to kill the victims' children or other family members in seven cases. In addition, New York's Commission found that three children were physically injured during three separate homicides. As the violence erupted in one case, a couple's eight year-old son attempted to protect his mother, until his father grabbed him by the throat and tossed him to the ground. The man then killed the boy's mother and grandmother. From the New York Commission report, it is clear that the simple statistics do not do justice to the horrors represented by individual cases.

Available demographic information on children impacted by domestic homicide

Ages of children impacted. The domestic violence literature points to the fact that the most serious incidents involving police intervention tend to be associated with younger families with vulnerable infants and toddlers (Fantuzzo et al, 1997). Many of the homicides involved younger children although only several DVDRCs have dispersed this information. Santa Clara County reported that children left parentless were between the ages of nine months and 15 years of age. Oklahoma's Committee noted that child witnesses ranged from less than one-year-old to 17 years-old, with a mean age of seven. Washington's Review found that, of the children present

during the murders, 37% (43) were age five or younger. Of the children living at home at the time of the murders, 13% were under age two, 16% were between age three and five, 26% were between age six and 10, and 19% were between age 11 and 17 (the ages of 17% of children were unknown). It was highlighted that at least 20 of 88 women had adult children who often had to assume responsibility for younger siblings, indicating that children and youth of all ages are affected by fatal domestic violence.

Child Protection Service involvement. Child protection agencies were involved in five of eight child homicides in Cuyahoga County, Ohio. Two of the deaths were open abuse or neglect cases, three cases had been closed within the year of the homicides, and one of the cases was a new referral. Three of the child victims had no prior history with CPS suggesting a subgroup of children that may be at risk for homicide without the warning sign of a documented history of direct child abuse.

Child custody/access disputes. Four of Ontario's nine cases involved custody/access disputes. Two of the homicides were non-custodial parents murdering their children as punishment to partners who ended relationships. In one case, access to the adult victim was restricted to supervised exchanges of children, and in another case, a court order refused to allow any contact between the adult victim and perpetrator. In 21 of Oklahoma's cases the perpetrator and partner had children in common, and in 12 of these cases, the adult victim and offender were living separately. In one case a child was kidnapped, and in four other cases the perpetrators used their children to send threatening messages to their ex-partners. Three femicides in Oklahoma occurred during child exchanges. Additionally, New York's Commission stated that custody/access disputes were present in three of 36 cases where victims had children. Furthermore, two of these femicides in New York occurred in association with child exchanges. Collectively, these observations highlight the risk for some perpetrators of domestic violence to utilize children in various ways to further victimize their former partners following separation.

Hidden victims: Pregnancy and domestic homicide. It has been established that the risk for intimate partner violence increases when a woman is pregnant (McFarlane, Parker, & Soeken,1995). Georgia found that, of 25 cases reviewed, two victims were pregnant at the time of death. In Oklahoma, two of their 58 female victims were also pregnant. Washington's Review reported that at least four women murdered were pregnant.

Themes in Recommendations Relevant to Children Put Forth by DVDRCs

Every DVDRC utilizes the benefit of hindsight to suggest what could have been done in their community to prevent each fatality with the goal of preventing the future deaths of those who find themselves in similar situations. After reviewing all of the DVDRCs' recommendations and selecting those that made reference to children, consistent themes emerged that we grouped in relationship to: (1) training and policy development; (2) resource development; (3) coordination of services; (4) legislative reform; and (5) prevention programs (see Table 2).

Table 2

Summary of Themes in Recommendations Relevant to Children Put Forth by DVDRCs

Themes and Recommendations
Training and Policy Development
Increased education regarding domestic violence lethality indicators for Child Protection Services
Monitoring and follow-up of all child, elder, and spousal abuse cases before any closure
Risk management during child custody and access disputes in domestic violence cases
Routine and frequent screening of domestic violence for women receiving pre-natal care
Continuing education on domestic violence for family lawyers
Resource Development
Increase in services for domestic violence victims involved in civil legal issues
Increased funding for mental health services for children exposed to domestic violence
Support for new caregivers of children who lost their parent(s) to domestic homicide
Coordination of Services
Research into the association between contact with Child Protection Services and lethal domestic violence
Revise Child Protection Services policy regarding responding to families with a history of domestic violence
Sharing of information with Child Protection Services
Research into state practices regarding care of children when a parent has a serious mental illness
Greater communication between criminal justice and family law courts
Increase police understanding of domestic violence
Overlap between child death review committees and DVDRCs
Legislative Reform
Increased effort in reporting all suspected instances of child abuse and neglect
Legislature to increase resources for domestic violence programs for victims
Prevention Programs
Encouragement of parental enrollment into healthy parenting education classes
Increase the role of childcare facilities in providing information to domestic violence victims
Increase the role of alternative dispute resolution and child impact programs for families in the justice system
Training for school staff on how to respond to children who reside in violent homes
School curricula aimed at educating children and adolescents about domestic violence

Training and policy development. Overall, the DVDRCs suggest enhanced training for different front-line professionals on risk assessment in domestic violence cases in order that lethality factors are recognized and appropriate safety planning can begin. This training is suggested across many sectors, including more thorough and frequent screening for domestic violence for women receiving pre-natal care. For example, according to the State of Washington's Review, over a quarter of women killed by their intimate partners since 1997, who had children in the home, had given birth to a child in the previous five years. Furthermore, over half of the women had children who were two years old or younger. Review members were aware that at least four of their homicide victims were pregnant at the time of their deaths. This Review also recorded the number of abuse-related miscarriages, but due to the lack of available information that would provide the frequency of these tragedies, the data was no longer collected. However, they are recommending that public health researchers take up the task of tracking abuse-related miscarriages to illustrate this hidden and devastating effect of domestic violence. Similarly, Georgia's Project has argued that all women receiving pre-natal care must be screened for domestic violence by health care professionals, as some of their homicide victims were pregnant

at the time of their deaths. Importantly, Washington's Review highlighted that medical appointments may be the only interaction that victims have with potential interveners if they are involved with extremely isolating abusers. As a result of this possibility, Washington's Review has recommended that nurses and physicians screen all pregnant women for domestic violence at each trimester and postpartum to ensure safety.

Areas in need of further training and enhanced policy development are those that provide, or could provide, risk management during custody and access disputes of children in domestic violence cases. The State of Maine's Panel has expressed a need for increased public and professional awareness regarding the potential for dangerousness during the sharing and exchange of children when parents have a history of domestic violence. They highlighted that the direct exchange of children creates ongoing contact between the victims and the perpetrators and may put the victims and children at further risk for violence. This Panel noted a lack of supervised visitation options in their state. In the Panel's fatality review cases, many times supervision was provided by a family member of the abuser or other biased third parties (e.g., an abuser's new partner). As a result, it was recommended that the Department of Human Services conduct research with the Department of Public Safety and Maine's Coalition to End Domestic Violence on the ability to provide supervised visitation centers. Washington's Review argued that it was essential for those who supervise visitation and exchanges to be trained in matters pertaining to domestic violence, the possibility for perpetrators to use access to children as a means to stalk and manipulate their victims, and the increased risk to children when a parent has a history of intimate partner violence. The State of Georgia's Project found that there were several instances among their cases when judges were relying on the offenders and victims to sort out and decide on visitation agreements, thereby putting the perpetrators in a situation of ongoing control and manipulation of the victims and children. The Project recommended that judges should decide on details relating to visitation after reviewing and analyzing all information relevant to the case, such as the history of violence and safety concerns for the children and former partner. The New York Commission on Domestic Violence took a more restrictive approach in their report stating that two rebuttable presumptions be adopted regarding custody and visitation of children in domestic violence cases: that sole or joint custody of a child not be granted to a perpetrator of domestic violence, and that visitation, if granted at all, be supervised.

Many DVDRCs have stressed the importance of the possible opportunities for the family law sector to address domestic homicide. DVDRC reports have often mentioned the necessity of continuing education on domestic violence for lawyers in family law. Ontario's Committee urged that family law lawyers receive ongoing training in identifying and understanding risk for lethal domestic violence when couples are separating and disputing over issues regarding child custody and access. The Committee commented that family law lawyers have a unique opportunity to develop plans to enhance safety where there is conflict over child custody, support, and possession of the matrimonial property. There is also a need to recognize the danger inherent in family law cases that involve applications for financial support. Maine's Panel has articulated the need to inform all litigants requesting child support from their spouses or ex-spouses, via letter, that the risk for violence may escalate during times of separation and that their safety may be jeopardized after a letter requesting child support has been sent, thereby creating a need for risk assessment and safety planning.

Another common recommendation falling under the umbrella of enhanced training and policy development is the need for increased monitoring and follow-up of all child and spousal abuse cases. San Diego County's DVDRC stressed that all cases of abuse and neglect reported to intervention systems must be monitored as long as any risk for lethality is present. Children at risk must be assessed and followed-up with in-person with specialized domestic violence case service workers before the closure of any case, and it was also emphasized that these children not be interviewed in the presence of any parent and that collateral contacts should be interviewed within confidentiality limits.

Furthermore, all sectors should work to identify and manage danger to staff. DVDRC's have begun to recognize the apparent risks to professionals trying to intervene in domestic violence cases. Georgia's Committee has further recognized that many professionals, who work with families where domestic violence is present, are put in danger daily. To manage this danger it was recommended that all staff in the child protection system receive training on lethality and danger assessment and have access to law enforcement in high-risk situations where safety of the caseworker is an issue.

Resource development. The DVDRCs have also come to the realization that many of these tragedies will continue to occur unless there is an enhanced investment into resources, services, and professionals for the purposes of intervening with victims and perpetrators. Under the category of resource development is a recommendation from Washington State's Fatality Review Team that expressed a need for more resources directed to the immediate needs of abused women and children including housing, employment and financial support. This was evidenced by a direct quote in the Washington report from a woman just prior to her homicide, "Before I can do anything, I have to find a new job that pays more and save some money, so I can take care of my girls and pay the rent for a few months until I get some sort of child support" (Washington State Domestic Violence Fatality Review, 2004, p. 55). The Washington Review expressed a need for resources for domestic violence programs to assist with material support for victims, including costs associated with child–rearing assistance and deposits for attorney and housing fees.

An even more specific recommendation by Washington's Review was an increase in services for domestic violence victims involved in civil legal issues. Review members recommended that increased funding should be directed to legal aid programs for domestic violence and family law issues, and that these programs should work in partnership with advocates to provide the most widespread service. The Review felt that funding should be allocated to advocacy programs to allow for the contract hiring of attorneys, specialized in domestic violence issues, to represent victims. It was further recommended that State and local Bar Associations should partner with domestic violence programs to create pro bono panels to represent victims in criminal and family law proceedings. The members expressed that individuals who participate in such efforts should be recognized and receive free continuing legal education for taking such cases. Lastly, it was suggested that low-cost and/or free legal representation services should be provided to allow for accessibility of services to victims, and that these services be flexible (e.g., providing various times for intake appointments). Efforts should be made so that domestic violence victims are given priority status. In some fatality review cases the perpetrators attained legal services first, resulting in the denial of victims' cases due to conflicts of interest.

Many members from DVDRCs have also noticed a startling lack of support for new caregivers of children who lost their parent(s) to domestic violence. The State of Delaware's Team has recognized that relatives, friends, or acquaintances that take the role of caregiver/guardian following a homicide or homicide-suicide are also traumatized. Georgia's Project found that most of these individuals are not linked to advocates or professionals to assist them. The myriad of challenges these individuals encounter include, for example: grief; newly acquired child-rearing responsibilities and costs; funeral costs and resolving the financial issues of the deceased; problems with evidence and property recovery; and feelings of isolation or betrayal from the community, especially if the family had been involved with multiple systems prior to the homicide. Delaware's Team asserted that these new caregivers have good intentions, but may be overwhelmed with the tragedies and, as a result, may not be equipped to monitor the effects of the fatalities on the children. Delaware's Team stated that agencies such as the Division of Family Services and the Violent Crimes Compensation Board could possibly be able to assist with providing support. Georgia's Project suggested that such advocacy and services should be provided by a broker that has not been previously involved with the family, as many of those connected to the tragedy may be upset with how former agencies did or did not assist them.

Coordination of services. Many committees have pointed to the importance of existing services and systems trying to better coordinate risk assessment and intervention strategies. Often, one service provider may have critical information that needs to be shared with other services and systems to ensure that decision-makers, such as the court, have access to a full picture of the dangers inherent in the family circumstances. For example, members of Ontario's Committee have urged that there be ongoing training for police officers on intervention in domestic violence cases, especially those involving child custody and access disputes. In fact, the DVDRC argued that these particular cases are high-risk and demand special vigilance, along with the development of a high-risk case management protocol. This need is underlined in cases where the family is involved in both criminal and family law proceedings. Ontario's DVDRC report demonstrated that confusion often exists in the field regarding the roles and responsibilities in dealing with children in the context of domestic violence. The criminal court properly assumes innocence until the allegations are proven beyond a reasonable doubt. The process of preliminary hearings and trials may take many months, and in some cases may take years. However, the victims and children may need an immediate safety plan that either suspends contact with the perpetrators or requires supervised visits or exchanges between the parents. These matters can be further complicated if the family finds itself in the middle of child protection hearings. There is much uncertainty between the responsibilities of each of the systems regarding if intervention should be on the state's behalf as opposed to an issue for parents to settle privately through civil laws after separation. Ontario's Committee highlighted that there are often no formal mechanisms in place to foster communication between family court and criminal court in coordinating issues around child custody and safety of individual family members. There was recognition for better guidelines that should encourage coordinated practices and protocols within and between family and criminal courts, as well as court-related services such as victim-witness services, mediation, supervised access, CPS, batterer intervention programs, and probation supervision.

In a similar fashion, Delaware's Team has argued that CPS be given access to the criminal histories of all family members under investigation. Such criminal information would aid in the

assessment of risk for lethality and would allow CPS to prioritize and respond to complaints received. The State of Washington's Review stated that it is imperative that CPS policies address safety as a priority. They insisted that the interactions between CPS staff and families should focus on three main goals; namely, to protect the child, to help the abused parent protect herself and her children through the use of supportive and empowering interventions, and to hold the domestic violence perpetrator responsible for stopping the abusive behaviour. Washington Review members realized that CPS was a significant point of intervention for perpetrators and victims.

Moreover, The New York Commission on Domestic Violence has advocated against the response of charging the non-violent parent with failure to protect the child. The Commission believed that this response is inappropriate, as it places the responsibility of ending the violence on the victim rather than the offender. Washington's Review also argued that policies should include: (1) universal and helpful screening for domestic violence with each parent that includes the identification of any homicidal or suicidal threats; (2) probing for any current or defunct Protection Orders, domestic violence convictions, and the attainment of copies of Protection orders; (3) institute joint information-sharing relationships with the family court system and service providers who conduct domestic violence and parenting evaluations for the civil courts; and (5) regular referral to agencies specialized in providing services to women who have experienced domestic violence. Washington's members believed that CPS staff requires intensive training to allow for appropriate implementation of policies and procedures, and that training should also involve local domestic violence advocates to ensure sharing of information between resource providers. It has also been recommended that research into the association between contact with CPS and lethal domestic violence be conducted. The Washington State Review urged CPS and State Coalitions Against Domestic Violence to network with researchers to examine how many domestic violence victims killed in the context of intimate partner violence had come into contact with their services, if they were assessed for domestic violence, if any interventions were utilized, and how this group compares to their larger caseload. A related recommendation from San Diego County's DVDRC suggested that membership overlap between DVDRCs and Child Death Review Committees must exist, so that all relevant cases of child homicide in the context of intimate partner violence could be reviewed for altered systemic responses and to ensure coordination of efforts and minimization of repetition of work between the two bodies.

Lastly, Delaware's Team raised the special concerns involved with parents who are suffering from serious mental health disorders. They suggested that the State Division of Adult Mental Health conduct further research into how other states manage children who have one or both parents suffering from a serious mental disorder. The Delaware Team claimed that clear policy is badly needed for the efficient assessment and monitoring of children whose custodial parent is suffering from a serious mental disorder.

Legislative reform. The New York Commission on Domestic Violence recommended increased effort in reporting all suspected instances of child abuse and neglect. To assist with this recommendation the Commission suggested that the law be amended to consider the commission of any violent act against an adult or child in the family or household by any person legally responsible for the care and custody of the child as sufficient for a charge and conviction of

Endangering the Welfare of a Child. Santa Clara County's DVDRC has asserted that because children are the most vulnerable population in society, when any child expresses genuine fear of a parent or if they appear in danger of abuse or neglect, then those who are aware of the danger must report the information to CPS. These recommendations are consistent with the belief of Ontario's DVDRC that the duty to report child abuse and neglect needs to be more widely publicized. At the same time, the concern that victims of domestic violence should not be re-victimized by the child protection system, but rather offered support and access to services, is essential (Feldheim, 2005).

Many DVDRCs also see the requirement for changes in legislation to address the needs of children living with the aftermath of homicides. One such Committee is Maine's Panel. Members identified the absence of any protocol or process for responding to the needs of a child left 'parentless' by domestic homicide. They stated that when the parents of children are unavailable as a result of death, hospitalization, incarceration, or some other cause, then law enforcement agencies must report the case to the Department of Human Services Central Intake where the safety of the child must be assessed and the appropriate steps outlined by Maine Law and Department policy can be carried out. The Panel members reviewed cases of children who witnessed the deaths and were left parentless and the cases led them to recommend that courts and prosecutors consider in Step One of the sentencing analysis that a child witnessed the homicide and to consider the emotional injuries inflicted due to exposure to the homicide in Step Two of the sentencing analysis.

Prevention programs. As was mentioned earlier, a central goal of DVDRCs is to provide recommendations that will assist in preventing these tragedies before they occur. Such a goal would not be feasible without the existence of prevention programs aimed at addressing the problem of domestic violence and homicide. One such recommendation put forth by DVDRCs is the widespread encouragement of parental enrollment into healthy parenting education classes. Santa Clara's DVDRC has noticed that programs that discuss the impact of children's exposure to domestic violence are badly needed. Parents can be targeted by strengthening the role of alternative dispute resolution and child impact programs for families. It was recommended by the State of New Hampshire's Committee that any parties who are involved in divorce or child custody proceedings should receive educational information on domestic violence, separation and danger to assist them with the stress that may occur. If certain families are not involved with the justice system, they can also be targeted through other community agencies and businesses, such as increasing the role of childcare facilities in providing information to domestic violence victims. The State of Georgia's Project has recognized that childcare facilities are among the few places that over-controlling and isolating domestic violence perpetrators allow their spouses to visit. Therefore, Project members recommended that domestic violence information be provided at all day care centres.

One of the most badly needed primary prevention strategies that is also among the most promising is school curricula aimed at educating children about domestic violence. Children of all ages require age-appropriate education surrounding healthy and unhealthy peer and family relationships. For adolescents, many require awareness and skills aimed at reducing the risk for domestic violence, dating violence, and stalking. Ontario's DVDRC set forth what it believes to be core aspects of such an educational program. The program should include: (1) a continuum of

educational materials from kindergarten to grade 12 to foster skill-building and strategies for positive interpersonal relationships; (2) instruction to develop awareness of the warning signs of abuse and the potential for abusive behaviour; (3) a recognition of the different ways that children and adolescents come in contact with domestic violence, including exposure to violence at home, in the media, and in dating relationships as victims, perpetrators, and peer groups; (4) enlisted community resources to sustain and support healthy interpersonal relationship choices; and (5) the input of teachers and community agencies that have a unique opportunity to collaborate on program development and implementation. Community agencies and teachers, as a team, have the opportunity to promote awareness, understanding, and skills as a team. Members of the State of Delaware's Team asserted that professionals in the education system require intensive in-service training aimed at identifying children who live in homes characterized by domestic violence and how to respond to them. Similarly, the State of Maine's Panel has encouraged the education system to promote the use of its professionals (e.g., teachers and guidance counsellors) to identify children and adolescents engaging in maladaptive behaviour, such as aggression and exploitation. Panel members highlighted that schools should document all known information and provide forums for discussion around such troubling behaviours. It was believed that if training for school staff on responding to children who reside in violent homes is actively promoted and provided, then such prevention programs within the education system would be maximally effective. It is imperative to note that this kind of training and these forms of prevention programs should not be limited to the school system, but should be widespread. Washington's Review recommended that legislature should fund community-based juvenile delinquency and child abuse prevention programs in trusting and credible agencies.

Conclusion

There is growing recognition that children are severely victimized in the context of intimate partner violence, and not necessarily in the way that many researchers, clinicians and other professionals conceptualize as direct child abuse. Those employed in the criminal justice system (e.g., police, probation officers, judges, lawyers, custody/access evaluators, forensic clinicians), and those involved in other related helping professions (e.g., mental health professionals, family doctors, shelter staff, child protection services, teachers, religious leaders, family counsellors) must be aware that there is a subgroup of children who are at risk for homicide, but on the surface, the risk for lethality may not be clearly visible, as not all of these children have a documented history of having been directly abused in the past by their mothers' partners. Although there may be a smaller number of children who are killed 'in the crossfire' of a violent altercation, by perpetrators who are seeking revenge against a former partner, or by parents planning to annihilate all family members before killing themselves, there is a sizable number of youth exposed to these horrifying acts of violence as well as children who may not have witnessed the tragedies but are nonetheless profoundly affected by the loss of parents.

Importantly, there is emerging evidence supporting the utility of DVDRCs with not only providing data and recommendations with regard to intimate partner violence fatalities, but also with assisting the overall effort of reducing the incidences of deaths through the implementation of their recommendations. For example, Santa Clara County's Committee highlighted that, even though there were 6 intimate partner violence deaths in 2004, of 5337 domestic violence cases referred to the District Attorney's office for prosecution, not one person was killed. It was also

noted that 2004 was the third year in a row that their community had been without police-assisted suicides. This Committee stated that they did not lose any children in 2004, as compared to five children lost in 2003, and six children in 2002. They asserted that "there was also an increase last year in citizen's calls to law enforcement in domestic violence cases and we will continue to track and study domestic violence related death cases and we are convinced that this work saves members of our community from early and tragic death" (p. 14).

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Appendix E

This guide is to be used in conjunction with the *Domestic History Questionnaire*

Introduction:

Enhancing risk assessment efforts by all professionals involved with families and individuals in crisis has to be a priority in Ontario. Many domestic homicide cases do not involve the criminal justice system but may involve other systems such as mental health, victim services, healthcare, child welfare, and the education system. In some of the cases, doctors, clergy, counsellors, lawyers, co-workers, families, friends, and neighbours were aware of the degenerating mental health or suicidal or tendencies of the perpetrator, but did not recognize the potential link to domestic violence and lethality. Consequently, they did not act to address the issues related to domestic violence, such as risk management, safety planning, and referral to community-based services.

Many domestic homicides may have been prevented if the criminal justice system, or alternatively the persons named above, had better engaged the victim in risk assessment and safety planning. The *Domestic History Questionnaire* can be used to gather information about potential risk and lethality to the victim. Information from the assessment can also be used to alert and assist those in contact with the perpetrator. Case management protocols can then be engaged. It is important to appreciate that the assessment itself has little value if there is no immediate action to effectively intervene. The victim and the interviewer may be left with a false impression that the completion of the form in and of itself is a sufficient response rather than one step in an ongoing process.

Guiding Principles:

In preparation, these principles provide an integral foundation with which to approach the interviewing process.

2. Everyone has the right to live a life free of violence. No one deserves to be abused and no one has the right to control another person.
3. Once violence starts, it will not stop spontaneously. Active intervention is required.
4. Violence against women is not the result of an argument that gets out of hand. It goes beyond the normal tension that all couples in intimate relationships experience.
5. Identifying and understanding the issues of power, privilege, and control are fundamental to the task of ending violence against women.

6. Victims should be empowered, not disempowered. Empowerment occurs when a woman is believed, supported, has access to accurate information, and is referred to appropriate services and advocacy.
7. Violence against women is not "cultural." Violence against women exists in all cultures and societies, across the globe. Violence against women transcends race, class, socio-economic, sexual orientation, ability, age, and religion.
8. Ending domestic violence is everybody's business. The community has a right and a responsibility to get involved. No one family, worker, agency, or system can stop domestic violence alone. A comprehensive coordinated community approach is essential.
9. Prevention means addressing the root causes of domestic violence, not just the symptoms. Violence is a learned behaviour that can be changed. Awareness and education is a prerequisite to prevention.
10. Domestic violence must be understood within an anti-racist, anti-oppression framework. This framework acknowledges that oppression exists in our society and that based on one's social location, abuse will have a differential impact. Every intervention we make must be examined in light of how it improves the quality of the daily reality of a woman's life. To understand this, consider the following:
    - Financial circumstance/fear of poverty
    - Geographic isolation
    - Physical and mental health issues
    - Previous negative experiences with helping systems and social agencies
    - Discrimination based on race, ethnicity, gender, age, sexual orientation, class, religion, ability, and/or any other bias
    - Language and cultural barriers
    - Immigration and refugee status
11. The use of risk indicators and lethality tools must be considered in combination with a comprehensive understanding of the dynamics of domestic violence and in the individual context of each woman's life as she seeks help.
12. There is a dual approach to effective intervention in high-risk cases. It is critical to equally address risk management/containment of the abuser as well as safety planning strategies with the abuser's partner. Given assessment and intervention occur simultaneously, the appropriate support services must be offered immediately, e.g., referrals to victim services and/or community based VAW Services.

Important Considerations:

- This form is a generic set of questions that capture well-recognized lethality indicators. The form itself will continue to be revised.
- This form may be used as part of a risk assessment process. Once the information is gathered, it will provide a factual context so that decisions about risk assessment can be made. The answers given in this form may complement other risk assessment tools.
- The victim should be informed that the information disclosed is subject to disclosure rules. Although this information is confidential outside the criminal justice system, as a third party record it may be subject to production and disclosure by Court Order.[20]
- Dangerousness is situational. High-risk cases need to be immediately red-flagged with other professionals who are involved with the victim—most importantly the information gathered needs to be filed, flagged, and cross-referenced so future professionals who become involved, such as police officers and Crown Attorneys, know that the risk assessment exists and can be accessed.
- Disclosure of abuse may be a process that often takes place over a period of time and requires a trusting relationship. The first disclosure may be incomplete and over time more disclosures of abuse and details about these incidents, particularly in areas related to sexual abuse and traumatic memories, may be revealed. Therefore, incremental disclosure should not be held against victims. Reassure victims that they are not in trouble. Attempt to decrease the levels of shame that women may feel in the process.
- When the victim's first language is not English, the provincially designated Cultural Interpreter program should be used, wherever possible. American Sign Language interpreters and/or other appropriate supports may be required. Children, family, community members and witnesses should not be used as interpreters.
- It is important to be aware of cultural considerations. Explain the interviewing process thoroughly, including the various steps assuring the interviewee that they are not in trouble. Attempt to decrease the level of shame that may be experienced.

[20] In a criminal case, if a third party record is being sought, the defense is obligated to notify the complainant and the record holder of the pending application to seek production and disclosure of the records. The complainant has a right to have independent counsel at the hearing. As well, a subpoena is issued to the custodian of the records for the agency in question to attend court with the documents. These documents are confidential and should not be disclosed to anyone until ordered to do so by the presiding judge. In other words, the custodian should not turn the documents over to the defense until ordered to do so. At the hearing, arguments will be made to the presiding judge to support the production on the basis that these records are relevant. If the judge decides that these records are relevant, the judge will then review the documents and determine what, if any, disclosure ought to occur. It may be that disclosure will be ordered, but the documents may be vetted or edited.

- When interviewing in a same-sex partner relationship, all questions should be thoroughly explored as in a heterosexual situation. Be aware of LGBTTQ (lesbian, gay, bi, trans, two-spirited, and queer) services in the community for appropriate referrals. The largest concern from the LGBTTQ community who have gone through this process is that they were not taken seriously and/or treated with the same respect as their heterosexual counterparts. Cultural competence training will increase the interviewer's understanding of the additional barriers facing members of the LGBTTQ community.

- It is important to pay attention to language and to use words that describe behaviours in concrete terms, e.g., punching, hitting, choking. It is critical to understand the range of abusive behaviours (e.g., verbal abuse, yelling, put-downs, harassment, financial, withholding immigration documents, denying primary care needs, sexual, threats regarding the custody of children). When using interpreters or speaking with women for whom English is not their first language, be aware that there are not always direct translations for English words, such as the word "abuse."

- It is extremely important to document and capture information in as much detail as possible from the victim. Use quotation marks for direct quotes.

- Interviewers may be faced with disturbing information given the high-risk nature of this work. To reduce the isolation and stress, it is important that the interviewer work within a team.

- Interviewers should recognize that women with children often have fears around CAS involvement (e.g., threat of removal of children due to the abuser's behaviour). It is important that the interviewer explain the role of CAS to the best of his/her ability, (e.g., "child welfare may become involved in this case to assist in protecting you and your children").

- Given the complexity of both criminal and family court, most women are not familiar with their legal rights and remedies. Where possible, the interviewer should help the victim understand any current orders in force, or at a minimum provide the victim with resource information to ensure that women are made fully aware of the orders. In Ontario, if a person is identified as a victim of domestic violence, she is entitled to two free hours of independent legal advice.

- Within the criminal justice context, once the interview is concluded and the detailed document completed, the information in the document becomes available to the police in the event they decide to release the accused on bail. If the accused is held for a bail hearing, the Crown and the Court have access to this information. In addition, the police and the Crown get a real sense of the overall history and context of the domestic violence, and manage the case accordingly.

Summary Checklist:

- At the conclusion of the interview, review the following information:
  - **Risk Management:**
    - High-risk case? Y N
    - Refer to specialized unit? Y N
  - **Safety planning and support:**
    - Discuss how they will be protected by police, including their rights and responsibilities as related to the safety plan.
    - The Personal Safety Plan is an action plan developed by victims who fear their safety is at risk from a current or former violent partner. The plan prepares for the possibility of future violence and the best method to get the victim and dependents—e.g., children, elderly parent, pets—to safety.
  - **Referral to Specialized Services**
    - Provide them with contact numbers, etc., to ensure they are connected to their local shelter or women's centre for ongoing support, VICARS, VWAP.
    - Ensure that women with disabilities have their accessibility needs addressed, including: information in Braille and/or on audiocassette, larger font size (12pt or higher) for women with mild visual impairments, wheelchair access, or other aids that would be beneficial to mobility, hearing, speaking, seeing.
    - Ensure that women with substance abuse or mental health issues have their specific needs addressed through appropriate referral.
    - Refer victims to independent women's advocates to support them through the process. Ensure they are aware of their right to apply to the Criminal Injuries Compensation Board.
    - The Victim Support Line (VSL) is a province-wide toll free information line providing a range of services in English and French to victims of crime. The Ontario Telephone number is 1-888-579-2888; the local Toronto number is 416-314-2447.
    - Assaulted Womens Helpline (AWHL) is a 24-hour, 7-day-a-week telephone crisis line for women who have experienced violence. The AWHL also offers referrals information and support to third party callers. Services are available in 157 languages:
      - **1-866-863-0511**
        1-866-863-7868 TTY

- The Criminal Injuries Compensation Board (CICB) is an independent agency that awards compensation to victims of violent crime that result in personal injury or death as defined by the Compensation for Victims of Crime Act.

  Criminal Injuries Compensation Board
  439 University Avenue, 4th Floor
  Toronto, Ontario
  M5G 1Y8
  Toll-Free: 1-800-372-7463
  Toronto Calling Area: 416-326-2900

Domestic History Questionnaire

NAME: _____

INTERVIEWER: _____

OTHER: _____

_____

_____

_____

In a domestic violence case, it is important to obtain detailed information about the specific incident. It is also critical to determine how the specific incident of violence relates to the overall history and context of abuse in your relationship. For this document, abuse includes emotional, verbal, financial, spiritual, as well as physical abuse. In this regard, it is necessary to consider several risk factors to determine the level of danger that may apply to your situation. Please voluntarily answer these questions, and use specific examples where applicable. If your answer is "yes" to any of these questions, please give details. Please attach additional pages if required. Please sign and date each page.

Please note: this document may be subject to disclosure and if there are criminal proceedings, it will be provided to the defence.

PRIOR ABUSE

1. Please circle the answers to the following questions:
    - Has your partner assaulted you, or been emotionally or sexually abusive with you, prior to this incident? Yes / No
    - Has he/she ever forced you to have sex when you did not wish to do so? Yes / No
    - Has he/she ever choked you? Yes / No
    - If you have been pregnant, has your partner assaulted you during your pregnancy? Yes / No
    - Have you ever received medical attention as a result of being assaulted? Yes / No
    - Were there times when you should have sought medical attention but did not do so? Yes / No

If you answered yes to any of these questions, please provide details.

2. To the best of your knowledge, has your partner assaulted or been abusive to any other person (e.g., socially, to co-workers or strangers)? Please explain.

3. To the best of your knowledge, has your partner assaulted or been emotionally or sexually abusive with any previous spouse(s)/intimate partner(s), family members, or children from another relationship? Please describe. How did you acquire this information?

YOUR CHILDREN

4. How old are your children/stepchildren? Which children are from this relationship? Were any children present during this incident? Did they witness the incident? Were they directly involved in this incident? Have they been present for any prior incidents? Have the children ever seen you being hit before this incident occurred?

5. Have your children/stepchildren been assaulted, and/or have they experienced emotional or sexual abuse by your partner? How do they feel about your partner?

YOUR PARTNER

Stress

6. Is your partner experiencing an unusual degree of stress (family, financial, immigration, racism, homophobia, disability, work-related, medical, etc.)? How is your partner coping?

Isolation

7. Does your partner have friends, family, or outside agencies for support? Please list these persons. Do you think your partner's support system, if any, helps or hinders your partner's abusive behaviour? Is your partner isolated from others?

Children

8. Has your partner ever removed children from your care? Has your partner ever not returned children when required to do so? Has your partner attempted or threatened to do so? Is your partner using the children to control or influence you? Do you fear for the safety of your children in the presence of your partner?

Drugs and Alcohol

9. Does your partner use drugs or alcohol? How much and how often does your partner drink? Is your partner drunk every day or almost every day? What type of drugs are used and how frequently are they used? Is your partner addicted to any drugs, and if so, what drugs?

Mental Health

10. Is your partner under care for any mental health issues, or has your partner been under such care in the past? If so, for what? Does your partner suffer from any delusions, paranoia or depression? Explain.

11. Is your partner on any prescription medication? Please describe all prescription medications. Is your partner taking such medication as prescribed?

12. Has your partner ever participated in any treatment programs for alcohol/substance abuse or mental health issues? Has your partner ever refused to participate in such programs?

Counselling

13. Has your partner ever participated or received counselling in a program designed to deal with domestic violence? Please describe. What was your partner's attitude about taking the program? Did your partner benefit from the program?

Court Orders

14. Has your partner ever failed to obey any past family or criminal court order (e.g., breach of restraining order, breach of bail condition, breach of probation, breach of parole)? Explain.

Property

15. Has your partner destroyed or damaged or threatened to damage: a) any of your belongings or contents of your home; b) property owned by your children, other family members, or friends?

Pets

16. Has your partner injured or killed a pet or domestic animal or threatened to do so?

Prior Police Response

17. Have the police been called to respond to any domestic situations involving you and your partner prior to this incident? What happened? What was your partner's reaction? Were any other social services involved?

Firearms / Weapons

18. In the past, has your partner owned or had access to any firearms or other weapons? If so, please describe the firearms/weapons and indicate whether they belonged to your partner or someone else.

19. Does your partner currently own or have access to any firearms or other weapons? If so, please describe these firearms/weapons, where they are presently located, and whether they are properly stored.

20. Has your partner ever possessed a firearms licence or FAC (Firearms Acquisition Certificate)? Does your partner currently possess one? Where does your partner keep his/her firearms documentation?

21. Is your partner currently prohibited from possessing firearms? Has your partner ever been prohibited from possessing firearms? When and where did the prohibition order get made? When did it start, and if over, when did it end? Why was the prohibition order made?

22. Is your partner familiar with the use of firearms or other weapons? Has your partner received any previous training (e.g., military, law enforcement)? Does your partner belong to any shooting clubs or ranges? Has your partner expressed an obsession or fascination with firearms or other weapons? Does your partner subscribe to or read any firearms or para-military publications?

23. Has your partner ever used, or threatened to use, firearms or other weapons on other occasions in the past? Explain.

Separation

24. Have you ever separated or discussed separation with your partner? If so when? How is your partner reacting (e.g., aggressive, threatening, jealous, depressed, etc.)? Do you have any concerns for your safety?

Controlling Behaviours

25. How does your partner behave with you? Please circle your answers.

- Is your partner obsessed, jealous, or controlling with you? Yes / No
- Has your partner ever confined you, or prevented you from using the telephone, leaving the house, going to work, or contacting family or friends? Yes / No
- Does he/she control most or all of your daily activities? Yes / No
- Does he/she tell you how much money you can use or when you can take the car? Yes / No
- Does your partner withhold medical care or support? Yes / No
- Are you dependent on your partner for attendant care or other daily needs? Yes / No
- Are you sponsored by your partner or your partner's family? Yes / No
- Does he/she control your immigration documents? Yes / No
- Has your partner threatened to "out" you to friends, co-workers, or family? Yes / No
- Has your partner ever isolated you, intimidated you, or belittled you? Yes / No
- If you answered yes to any of these questions, please provide details.

26. To the best of your knowledge, has your partner displayed any of the behaviours listed above in previous relationships? How are you aware of this information?

Threats to Harm

27. Has your partner ever threatened to kill you or harm you? In these threats, have there been specific details of a plan or method (e.g., a specific weapon or dangerous act)? Has your partner ever attempted to act on such threats?

28. Has your partner ever threatened to kill or harm other family members, children, friends, or helping professionals? In these threats, have there been specific details of a plan or method (e.g., a specific weapon or dangerous act)? Has your partner ever attempted to act on such threats?

29. Has your partner ever threatened or tried to commit suicide? If so, when? In these threats, have there been specific details of a plan or method (e.g., a specific weapon or dangerous act)?

Stalking Behaviours

30. Has your partner engaged in any of the following behaviours with you in the past? Please circle your answers.
    - Harassing phone calls or other communications to you, your friends, or family? Yes / No
    - Watching, photographing, or videotaping? Yes / No
    - Letter writing? Yes / No
    - Leaving notes? Yes / No
    - Frequenting your workplace? Yes / No
    - Following? Yes / No
    - Contacting you through third parties? Yes / No

If yes, when did they occur, and under what circumstances? Did any of these behaviours result in face-to-face contact?

31. To the best of your knowledge, has your partner engaged in any of the behaviours listed above with any other person? When did this occur, and under what circumstances? If so, how did you acquire this information?

Escalation

32. Has there been an increase in severity and frequency of abuse, stalking and/or controlling behaviours, and/or threats to kill by your partner during the past year?

Victim's fears and concerns

33. Do you believe your partner is capable of severely injuring or killing you (or your family or anyone else)? Do you believe your partner is capable of committing

suicide? Do you have any fears for your safety, or the safety of others? What are your fears, and why?

If you are not aware of support services which may assist you with information, counselling, emergency shelter, and accommodation, please ask the interviewer who will assist you.

If circumstances have changed, or if you think of additional, relevant information, please immediately notify the interviewer, to update the information on this form.

_____ _____

Date Victim's Signature

_____

Witness's Signature

Referrals and Safety Plan

NOT TO BE DISCLOSED

1. Do you have a personal safety plan in place to help protect you and your family in the event of a problem with your partner? If not, you may want to contact your local police service, women's shelter, or community agency.

2. Are the local police, your neighbours, your employer, and your children's school aware of any potential for problems?

3. Have you consulted a lawyer, or obtained a custody order or a restraining order?

4. Please provide a telephone number and address where you can be reached (home and work).

5. Please provide a telephone number and address of a friend or relative (home and work) who will know your whereabouts.

Appendix F

The Long Road to Prevention[21]

The warning signs have been defined, now programs are taking aim at domestic violence—and its sometimes deadly outcome

By Celia Milne

In death, Lori Dupont, a 37-year-old nurse and mother, taught us a lot about the lethality of love gone wrong.

Nine months before she was stabbed to death, Lori broke off a relationship with her boyfriend, Dr. Marc Daniel. There was much about Dr. Daniel, an anesthesiologist, that signalled danger ahead: He was controlling, possessive, manipulative, highly competitive and mentally unstable, according to Barbara Dupont, Lori's mother, who spoke with the *Medical Post*. After the break-up, Dr. Daniel stalked and harassed Lori, and became so distraught he attempted suicide. "He could not accept rejection," said Dupont, who lives in Amherstburg, Ont.

Dupont's description of her daughter's ex-lover echoes coroner Dr. David Eden's description of the typical perpetrator of femicide. "One of the striking features of the perpetrators of domestic violence is that the risk markers are very similar to those for suicide," he told the audience at a recent Toronto conference on domestic abuse. "The leading risk markers for completed suicide in males are mental illness, drug and alcohol abuse, access to weapons, recent loss, prior suicidality and impulsive behaviour." In cases of men who commit domestic violence, add recent separation and "control over the woman."

Of these predictors of domestic assault deaths, said Dr. Eden, "imminent or recent separation is 'the' risk marker. It is outstanding in its importance." Dr. Eden is a member of Ontario's domestic violence death review committee, and as such studies the patterns that precede these deaths (about 24 a year in Ontario), which 90% of the time involve male-on-female violence. In an interview, he said physicians have a role to play in preventing these deaths. "When a male comes in and says, 'I've broken up with my wife,' you need to ask yourself, is he a risk to himself? Is he a risk to his wife?"

Dr. Eden was one of the speakers at a recent Toronto conference called "Finding Common Ground: Working Together to Reduce Domestic Violence." The conference was a key component of the Ontario government's four-year, $66-million domestic

[21] Reprinted with permission of the author and the Medical Post.

violence action plan. The over-arching theme: Domestic violence is difficult to detect, difficult to treat, difficult to prevent and difficult to stop. But attempts must be made, as family violence that spirals out of control can result in death.

Lori Dupont was stabbed to death Nov. 12 at Hôtel-Dieu Grace Hospital in Windsor, during her regular Saturday shift. Less than an hour later, Dr. Daniel was found unconscious in his car; he died two days later. Lori was the mother of an eight-year-old girl; Dr. Daniel was the father of two teenagers.

"It's fixable"

Dr. Eden, regional coroner for Hamilton, Niagara, Brantford and Haldimand, Ont., said the rate of domestic violence deaths could be halved. The U.K., for instance, where government has implemented a comprehensive program to reduce domestic violence, has seen a 50% reduction in cases. "It's fixable," said Dr. Eden. "That's what's so cruel about it. These are preventable deaths in people who by and large are young and missing years with their family. I don't think 50% prevention is unreasonable."

Rates of spousal violence have been holding for the last five years. Statistics Canada figures show 7% of women and 6% of men report violence in their relationships. Women were three times more likely to fear for their lives and twice as likely as men to be the targets of more than 10 violent episodes. Sixty-two per cent of women who are murdered by an intimate partner were stalked beforehand.

Around the world, violence at the hands of an intimate partner is more prevalent than rape or assault committed by strangers or acquaintances, according to a recent report by the World Health Organization. Researchers interviewed 24,000 women in 10 countries. They found that women who had been abused, even long ago, were twice as likely to have physical and mental health problems. One in 11 victims of abuse by their partners said they had attempted suicide.

"This study shows women are more at risk from violence at home than in the street," said Dr. Lee Jong-wook, director-general of WHO. "(It) also shows how important it is to shine a spotlight on domestic violence globally and to treat it as a major public health issue."

According to Dr. Eden, there are four links in the chain that society can provide to prevent domestic violence deaths:

- awareness of risk by the public and by professionals such as physicians, police, aid workers and nurses;
- development of a plan;
- implementation of the plan; and
- making sure the legal system works properly for victims.

"Physicians have a role to play in this first step. This means helping the woman be aware of risk and making sure she has access to experts, resources such as shelters and alternative housing, and law enforcement such as police, crown and courts."

Doctors already know how to do lethality assessments in primary care, so it is not a leap to assess for risk of family violence, said Dr. Eden. There are numerous tools available to physicians. "If you use the tools, they're quite good," said Dr. Harriet MacMillan, a psychiatrist and pediatrician at McMaster University in Hamilton. "What's missing is the piece of the puzzle: Where do you refer women? What do you actually do when violence is identified?"

Dr. MacMillan's research group is conducting a randomized clinical trial to find out whether screening is effective. Simply identifying abuse doesn't fix it, she said. "At the end of the day, we hope to have an answer to whether it actually reduces violence in women's lives and improves their quality of life."

Dr. Eden said doctors should be alert to coverups. He said in one case, a woman with life-threatening internal pelvic trauma told her doctor she fell from a horse. "Be aware of the inconsistency. Get the partner out of the room. Had the health-care professional removed the abuser from the room, things would have been different," he said, referring to a death that occurred in that family. "Be skeptical; ask pretty blunt questions to get at the cause. Look with your own eyes."

Referring a suspected victim of violence to an expert, said Dr. Eden, is much like setting up a Pap test. "You might say, 'I'm using a screening tool. That doesn't mean you have the disease, it just means you need to see a specialist.' "

Toll on mental health

Even if a woman's life is not in danger, the mental health consequences of domestic violence and stalking are many, according to Dr. Gail Erlick Robinson, director of the women's mental health program at the University Health Network in Toronto. Consequences include low self-esteem, self-doubt, guilt, fear, helplessness, hopelessness, shame and isolation.

She recommended several points of discussion to help women in this situation: "Tell her about the frequency of this; tell her it is not her fault. Tell her what it does to people. Tell her, 'This is not OK; there is nothing you do that is so wrong you deserve to be beaten up.' Suggest she tell others and seek support. Establish safety routes; break off all contact (with the perpetrator)."

Doctors and therapists dealing with these patients may themselves begin to feel frustrated, impatient, helpless, angry, vulnerable and scared. "You may think, 'Why are you telling me this week after week?' They don't stay because they're masochistic; they stay because they still love the guy, or they have kids, or they are afraid or they have no money. "Give them time to make that shift. There is never no way out."

Several speakers at the conference stressed that women themselves are the best experts on what is happening to them. "If she says, 'I'm going to get killed,' never underestimate that," said Jacquelyn Campbell (PhD) from the Johns Hopkins School of Nursing in Baltimore.

Doctors who believe someone is about to be harmed walk a very fine line between maintaining patient confidentiality and protecting the intended victim. The Hippocratic Oath states: "Whatsoever things I see or hear concerning the life of men, in my attendance on the sick…I will keep silence thereon, counting such things to be as sacred secrets." But the Supreme Court of Canada, in the 1999 case of Smith v. Jones, ruled that physicians' duty to warn and protect outweighs doctor-patient confidentiality.

The Canadian Psychiatric Association (CPA) calls this "the physician's dilemma." Doctors have a legal duty to protect intended victims of their patients, which may involve informing police or the person in danger or both, but may be addressed by detaining and/or treating the patient. "But physicians' discretion to report may not protect them from charges of professional misconduct," reports a CPA position paper.

Just because it's difficult, doesn't mean it's not worthwhile. Dr. Peter Jaffe (PhD), like Dr. Eden, is a member of Ontario's domestic violence death review committee. He said he believes many of the deaths are predictable and therefore preventable. "We just reviewed 20 homicides and 19 of them involved women as victims of the homicide who were often stalked after separation by their partner. In fact, eighteen out of the first 20 cases we looked at had at least seven risk markers. They're not out of the blue."[*] Dr. Jaffe is professor in the faculty of education and academic director of the Centre for Research on Violence Against Women and Children at the University of Western Ontario in London.

Keynote speaker Gloria Steinem lauded the efforts of professionals like physicians, who work on the front lines trying to patch up the problem, but she stressed the importance of societal change. Family violence costs Canada $4 billion a year, she said. "Some of us are standing at the edge of the river rescuing those who are drowning. That is vital and necessary and infinitely rewarding. More of us have to go to the head of the river and see why they are falling in."

Steinem cited a program that is making a difference in the U.S. Organizers at the Family Violence Prevention Fund invite basketball, hockey and football stars who come from violent homes to talk to children about what it meant to grow up in a home where the mother was being beaten and humiliated. "To see the tears in their eyes is making a huge difference to young men and women," said Steinem. "There are gentle men; there are men who cry; there are men who have been hurt by family violence and are willing to stand up against it."

[*] Minor edit to comment made according to transcript from the OWD Conference, Finding Common Ground 2005.

For Dr. Jaffe, more must be done. "Saying domestic violence or femicide is unpredictable is not acceptable. We know too much," he said. "As long as boys in this province are growing up with violence in their homes, games with themes of violence, violence in national sports, in music, in culture that glorifies violence and sees violence as a form of entertainment, we ignore it at our peril."

Grieving mother Barbara Dupont wonders what could have been done to save her daughter's life. "In retrospect, there were signals," she said. "But you never think the worst is going to happen."