We speak for the dead to protect the living.

DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE

ANNUAL REPORT TO THE CHIEF CORONER: CASE REVIEWS OF DOMESTIC VIOLENCE DEATHS, 2002

Submitted by the DVDRC Chair:
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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 for an initial three-year term in December 2002 under the authority of the Coroners Act[1]. The committee met throughout 2003 to review domestic violence fatalities that occurred in 2002. The purpose of the committee, as outlined in its Terms of Reference, is to assist the Office of the Chief Coroner of Ontario in investigating and reviewing deaths of persons that occur as a result of domestic violence, and making recommendations to help prevent such deaths in the future. The cases referred to the committee are all homicides involving the death of a person and/or her or his child(ren), committed by the person's partner or ex-partner from an intimate relationship. The mandate of the committee is to help reduce 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 to make recommendations for effective intervention and prevention strategies;
- reporting annually on domestic homicides to enhance public understanding and awareness of the issues,[2] and conduct and promote further research where appropriate.

a. Why is there a need for a Domestic Violence Death Review Committee?

Since the early 1970's, there has been enormous growth in the amount of public and professional attention directed at violence within the family. As a result, domestic violence has moved from a private to a public concern, prompting various legal reforms and the implementation of numerous community and government initiatives targeting this social problem. However, in Ontario, and in various other jurisdictions throughout Canada and the United States, killings have continued to occur between intimate and ex-intimate partners, and sometimes their children and other family members. These tragedies serve as reminders of why domestic violence needs to be taken more seriously and how much more work still needs to be done to address the complexities of preventing these deaths.

One response to the growing recognition that these deaths are preventable has been the development of Domestic Violence Death Review Committees, principally in the United States. The main goal of these committees is to seek a better understanding of how and why domestic homicides occur, through a detailed multi-disciplinary examination and analysis of individual cases. Information is collected to establish the context of the death(s), including the history,

[1] Section 15 (4) of the Coroners Act, R.S.O. 1990, c.37, as amended
[2] See Appendix A, DVDRC Terms of Reference.

circumstances, and conduct of the abusers/perpetrators, the history and circumstances of the victims and their families, as well as community and systemic responses. The purpose is to determine the primary risk factors in these cases and identify possible points of intervention, with the goal of preventing similar deaths in the future.[3]

b. Purpose of the DVDRC

Between 1998 and 2002, three major coroner's inquests into domestic violence-related killings have been held in the province of Ontario. The first inquest was held in 1998, and focused on the deaths of Arlene May and Randy Iles. May was killed by her estranged boyfriend, Randy, who then committed suicide. During more than four months of testimony, jurors heard from 76 witnesses, and 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 during the period October 2001 to February 2002 after the domestic homicide-suicide of Gillian and Ralph Hadley of Pickering in June the previous year.

Consistent with the findings of DVDRC's in the United States, the major themes emerging from these inquests and the Report of the Joint Committee on Domestic Violence[4] were:

- Improve mechanisms for communication among and coordination of domestic violence resources and responses;
- Provide more effective education and training on domestic violence for every sector of the response system;
- Ensure access to essential services for victims, their batterers, and their families, especially children exposed to domestic violence;
- Implement standardized risk assessment and safety planning tools across the system in Ontario;
- Conduct ongoing research to more fully understand the circumstances leading to domestic violence fatalities and the responses to it.

c. Committee Membership and Composition

In response to recommendations from the May/Iles and Hadley inquests, as well as the Report of the Joint Committee on Domestic Violence, a proposal was made to create the Domestic Violence Death Review Committee to review and advise the Office of the Chief Coroner with respect to all domestic violence fatalities that occur in Ontario. During the fall of 2002, individuals from a variety of backgrounds were appointed to the committee.

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[3] See Appendix B: *Domestic Homicide: Critical Issues in the Development of Death Review Committees*, a literature review and discussion paper prepared by Peter Jaffe, PhD and Myrna Dawson, PhD for the Office of the Chief Coroner, Province of Ontario, December, 2002.

[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.

The members of the committee are domestic violence experts, and are from a variety of professional backgrounds:

- coroners
- healthcare professionals
- crown attorneys
- law enforcement personnel
- court administration and judicial education
- victim witness assistance personnel
- social workers, psychologists, and other counsellors
- shelter workers
- advocates[5]

d. Committee Review Process

The committee began reviewing cases that had occurred in 2002. All of the Regional Supervising Coroners and their staff across the province were requested to provide information to the committee about the domestic violence fatalities that had occurred in their respective regions. This process identified 25 separate occurrences, with 40 fatalities. The number of fatalities included the deaths of the primary victims, in several instances their children and other family members, and in a number of instances the perpetrator as well. Of the 25 occurrences, 9 were either homicide-suicides or multiple homicide-suicides, making up a total of 24 fatalities.[6] The committee deferred the review of any cases where a perpetrator is before the courts to avoid any potential disclosure or other prosecutorial complications. The committee intends to schedule the review of these cases when the trials are completed.

The committee met monthly throughout 2003 and reviewed a case from 2002 at each meeting. All of the information gathered as a result of the Coroner's death investigation was provided to the committee. The information was presented by members who had reviewed the investigative materials in advance, as well as by investigating police officers who had assisted in the Coroner's investigation. Each review resulted in a report containing a *factual narrative* of the circumstances, the committee's analysis of whether the circumstances of the death or deaths were preventable, and recommendations arising from the review. All reports were submitted to the Chief Coroner, and were subject to confidentiality and privacy limitations imposed by the Coroners Act, s.18 (2) and the Freedom of Information and Protection of Privacy Act.

In addition, a *data collection summary form* was created to organize and collate the information obtained from the review of each case. The summary form permitted the recording of information particular to the victims and perpetrators, as well as their contacts in the community and potential risk factors.[7] The committee intends to use the statistically analyzed aggregate information collected through these forms, in combination with the points of potential intervention noted in the case specific narrative reports, to identify trends, patterns, and risk factors, and to make recommendations for preventing death in similar circumstances.

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[5] See Appendix C: Committee Membership List
[6] See Appendix D: Case Tracking Form for 2002
[7] See Appendix E: Data Summary Collection Form

e. Review and Report Limitations

The individual case reports and data summary collection forms 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 has been subject to the confidentiality and privacy limitations imposed by the Coroners 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, still 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.[8]

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, result from 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 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. However, the more narrow focus of this report's recommendations 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.

f. Case Reviews and Recommendations

Given the limitation of not reviewing cases still before the courts, the committee was able to review 11 of the 25 domestic violence fatality cases that occurred in 2002. As a result of those case reviews, the committee made a number of recommendations specific to each case. Generally, the recommendations fall into three major subject areas of potential intervention.

Awareness and Education:

Our review of the cases revealed there is a continuing need to heighten awareness in the general population of domestic violence, and to provide educational programs and opportunities for professionals and others who work with or come into contact with victims and perpetrators of domestic violence. The recommendations in this area address the need for developing programs that will enhance individual and general public understanding of risk factors indicating an increased potential for domestic violence in their lives, or the lives of others known to them.

In many of the cases, victims, family members, and friends had concerns about certain of the perpetrator's behaviours, but did not appreciate the significance of those concerns and the risk of lethal violence. In one striking case, the perpetrator's brother, knowing his brother was

[8] See Appendix F: DVDRC Member Confidentiality Agreement

emotionally distraught, depressed, and suicidal after his wife left him, asked him to take care of a rifle he had in his truck because he could not travel with it into the United States. Within hours of being given the rifle, the perpetrator killed his estranged wife and killed himself.

It was also observed in a number of instances that both the victims and perpetrators were involved with healthcare professionals and counsellors who did not appear to appreciate warning signs of potential violence. In one instance, doctors and nurses were suspicious of the origin of the victim's injuries and the story she told of how she received them. She was referred to a social worker to query her story, but who questioned her in the presence of the perpetrator. Several of the recommendations speak to the training and continuing education of police, social workers, physicians, and others who provide services to those exposed to domestic violence or its perpetrators, particularly in identifying and understanding risk factors indicative of an increased potential for domestic violence.

In addition to developing general community public awareness educational programs, a number of case reviews indicated that youth-oriented programs should be incorporated into school curriculum. These programs should highlight the issues concerning domestic violence and its risk factors, and promote an understanding of healthy relationships. In one case, a young couple and their friends had recently completed high school. In fact, the victim and the perpetrator entered into an intimate relationship during their high school years. During this time, at least one teacher expressed her concern for the well-being of the victim due to the perpetrator's inability to deal with his anger. School staff observed several signs of abuse, such as possessiveness, jealousy, and open verbal abuse. The possessiveness and jealousy continued after high school. Shortly after separation and making declarations to his friend that he was going to kill her, he did so, as well as himself.

Assessment and Intervention:

Several of the recommendations address the need for those who work with victims and perpetrators of domestic violence to have appropriate tools available to better assess the potential for lethal violence in their lives. Correspondingly, victims and perpetrators of domestic violence need access to appropriate services and programs. For example, victims may need assistance with safety planning, and perpetrators may need access to counselling programs.

In a particularly tragic case of multiple-homicide, the recently estranged spouse had prepared an extensive narrative of past emotional and physical abuse against the victim and their children, as well as unfounded paranoid threats against two third parties. The perpetrator later murdered one of the third parties on the same night as the estranged spouse, and made an attempt on the life of the other. 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, but he later had a bail hearing and was released. The information was not apparently assessed or used, even after it was known he was continuing to harass his estranged spouse and violating the terms of release.

Resources:

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

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

Community programs designed to surmount cultural barriers that may exist in certain communities should be developed and/or strengthened. In addition, programs need to address barriers within mainstream organizations that inhibit people from seeking support from community services, and eliminate the circumstances that contribute to individuals living in fear and in silence.

In one instance, a divorced spouse suffered 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. He 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. This shame 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.

g. Statistical Analysis

The first year of DVDRC data collection focused on developing and testing the data forms used to assist in our analyses and recommendations for the future. Since we only reviewed eleven cases, our summary data is somewhat limited. However, the data is very consistent with the literature on domestic homicides and the annual reports of similar committees in the United States.

The data summary section of the report contains three tables and one figure. The tables provide a breakdown of the information by gender and characteristics of the victims and perpetrators, the nature of the homicides and the means used to cause death, as well as the risk factors that appear most frequently in the cases. The figure identifies the number of risk factors identified in the cases.

The characteristics of the victims and perpetrators described in Table 1 are consistent with the literature about domestic violence. Domestic violence is not gender neutral—100% of the primary victims were women and 91% of the perpetrators were men. The victims and perpetrators ranged in age from an adolescent couple to a couple in their 80's cohabiting in a seniors' residence. Table 2 reveals that 18% of the cases involved multiple homicides. In 82% of the cases, the perpetrator committed suicide following the homicide(s); however, that percentage reflects only the nature of the cases the committee was able to review, given the limitation of deferring cases before the courts (14 of the 25 cases from 2002). The majority of the deaths were caused by use of a weapon, 36% by gunshot and 36% by stabbing. It is noted in Table 3 that the most common risk factor in the relationship continues to be actual or pending separation. Figure 1 reveals that 82% of the cases had anywhere from 4 identifiable risk factors to more than 10. The significant finding from the statistical review is that of the 11 cases, 8 had a prior history of

domestic violence that was known to a variety of individuals beyond the victim and perpetrator, such as family, friends, and community professionals.

In 5 of the 11 cases reviewed, professionals with experience in domestic violence would likely have predicted a domestic homicide if presented with similar facts. 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 stressors or family conditions that ultimately became a factor in the homicide. For example, the perpetrators suffering from depression were not seen at risk of committing suicide or homicide, yet more effective interventions for them, as well as restrictions to their access to firearms, may have prevented the ultimate tragedy.

h. DVDRC Subcommittee on Risk Assessment

In recognition of the recommendations made in the earlier inquests and by the Joint Committee on Domestic Violence concerning the need for appropriate risk assessment tools for those dealing with domestic violence, and as a result of the review of several of the cases before the Domestic Violence Death Committee, a subcommittee was formed. This subcommittee conducted a survey of existing and proposed risk assessment instruments. A number of instruments were considered to be of great value in raising "red flags" as to the potential for a victim being at risk of future violence. Such instruments require the victim to provide yes or no answers to a number of questions (e.g., *Domestic Violence Supplementary Report* has nineteen questions; *Ontario Domestic Assault Risk Assessment* has thirteen questions; Jacquelyn Campbell's *Danger Assessment–2* has twenty questions, while the *Spousal Assault Risk Assessment Guide* (SARA) has twenty questions rated 0–2).

However, as a result of its review, the subcommittee observed that collecting specific contextually-based information concerning the actual violence or threat of violence in a person's life is also of great value. Gathering this information is useful not only for assessing the level of risk and danger the victim may be exposed to, but it also has potential evidentiary value for those engaged in the criminal justice system. More important, as only one in four victims come into the criminal justice system, this information will also be useful for those who help the victim and/or advocate develop a safety plan.

If there is a caution that arises from the subcommittee review, it is that a risk assessment tool in a yes/no format should be accompanied by a contextually-based questionnaire. The subcommittee has included a focused information collection questionnaire called *Domestic History* with this report, which is transferable and can be used by a variety of community agencies. The questionnaire is still a work in progress and requires further refinement. However, in its present form, the committee considers the questions will collect relevant and valuable information that can be used to produce a more effective and seamless systems response for the safety of the subject.[9]

[9] See Appendix G: Domestic History questionnaire

Chapter 2–History and Background to the Development of the DVDRC Process

a. Background and Origin of the DVDRC

After reviewing a number of domestic violence deaths that seemed to be occurring with alarming regularity across the province, the Office of the Chief Coroner decided in 1996 to call a representative inquest into one of the murder/suicides to:

- fully examine the circumstances;
- determine if lessons could be learned;
- identify systemic gaps; and
- make recommendations for prevention.

The inquest into the death of Arlene May and Randy Iles was held in 1998. It reviewed a number of systemic issues largely involving the judicial system, resulting in 213 recommendations. One of the recommendations encouraged the government to establish an independent implementation committee. The Attorney General, in turn, created the Joint Committee on Domestic Violence, chaired by the Honourable Justice Leslie Baldwin, which produced a report in August 1999 entitled *Working Towards a Seamless Community and Justice Response to Domestic Violence: A Five Year Plan for Ontario*. The Joint Committee made an additional 173 recommendations under a number of headings that were focused on obtaining a greater understanding of the factors that lead to domestic violence, as well as many initiatives for its prevention. One recommendation, in particular, was directed to the Office of the Chief Coroner:

> **Recommendation 172:** In order to ensure that local systemic issues are identified and addressed in all violence related homicides into increased public awareness of the extent of this lethal violence across the province, we recommend that the Chief Coroner create a committee, *the purpose of which shall be to assist the Office of the Chief Coroner in the investigation of any suspicious deaths of persons occurring within an intimate relationship context.* Each case should be examined by reviewing records and other relevant information with access to specialized expertise.

In the summer of 2000, another series of high profile and alarming domestic violence deaths occurred across the province. These deaths again gave rise to concern over the adequacy and efficacy of preventive measures implemented since the May/Iles inquest. The Office of the Chief Coroner decided to conduct a further inquest into the circumstances of domestic violence as related to the deaths of Ralph and Gillian Hadley. The inquest examined several issues not within the scope of May/Isles, but also reviewed the progress made with respect to recommendations made in that earlier inquest. The Hadley inquest jury made a further 55 recommendations, including one proposed by the counsel for the Attorney General and supported by Coroner's counsel that was patterned on the Joint Committee recommendation for a continuing Domestic Violence Death Review Committee to advise the Chief Coroner on domestic violence deaths:

> **Recommendation No. 54**: We recommend that the Office of the Chief Coroner establish a *Domestic Violence Death Review Committee comprised of specialists and experts to assist*

> *the Coroner's office in the investigation of suspicious deaths that occur within an intimate relationship.*

The Joint Committee and the Hadley inquest jury recognized that the inquest process provided for a detailed examination into the circumstances of the particular deaths that were reviewed. Considerable time and expense were devoted to examining the deaths of Arlene May, Randy Iles, and the Hadleys. Each inquest was preceded by at least a year of intensive coroner and police investigation. Each inquest took several months to conduct, and involved multiple parties representing a broad range of public and private interests. There is no doubt that the inquests focused considerable public and government attention on the problem of domestic violence. Indeed, May/Isles gave rise to the Joint Committee and a number of other government initiatives, such as the expanded Domestic Violence Courts. However, evidence heard at these inquests indicated there were approximately 25–30 deaths per year in Ontario committed by an intimate-partner or ex-partner. While many initiatives and benefits were derived from these inquests, at the end of the day, only 4 deaths had been extensively examined, and two circumstances in particular.

It became obvious that to properly understand and identify the gaps and/or systemic problems that exacerbate or fail to prevent domestic violence, an on-going review mechanism for each case investigated by the coroners was needed. An on-going review would allow for the identification of trends and patterns of abuse, and systemic difficulties from which recommendations could be made to improve government and community response to abuse victims and perpetrators. A continuing review would allow for the creation of a comprehensive database derived from an examination of each of these cases. This database would serve as a foundation for the implementation of mechanisms and responses to the prevention of such deaths in the future.

As part of the coroner's death investigation process, an on-going review mechanism allowing for a detailed examination of each domestic violence case and the creation of a comprehensive database would help to:

- accurately determine the number of homicides related to domestic violence;
- track and assess relevant risk factors, including social and demographic characteristics of the victim and the perpetrator, relationship issues, and personal histories of the parties involved; and
- track community intervention by documenting system contacts and responses, including medical, mental health, financial, and legal services (both civil and criminal), as well as community services obtained by the victim, perpetrator, and family prior to the fatal incident, and/or services provided after the fatality to the family members and/or others affected.[10]

b. Coroner Death Investigations and the Use of Expert Advisory Committees

Ontario, unlike most jurisdictions, employs an extensive death investigation process to not only answer the questions of who, when, where, how, and by what means a person came to his or her death, but also to make recommendations to improve public safety through regional coroner's

[10] See Appendix B: *Domestic Homicide: Critical Issues in the Development of Death Prevention Committees*, p. 18.

reviews and public inquiries. The Chief Coroner has authority pursuant to s.15 (4) of the Coroners Act, R.S.O. 1990, c.37, as amended, to make use of "experts" to more fully understand the results of the investigation, assist in analyzing those results, suggest avenues of further inquiry, and/or provide advice for recommendations directed towards prevention:

> Section 15(4) - Subject to the approval to the Chief Coroner, a Coroner may obtain assistance or retain expert services for all or any part of his or her investigation or inquest.

This authority has led to the creation of a number of Expert Advisory Committees in such specialized areas as obstetrics, anaesthesia, geriatrics, and paediatrics. Historically, the committees have been largely medical in focus. However, more recently, the Chief Coroner has established a number of death review committees that draw on expertise from a variety of disciplines, such as the Paediatric Death Review Committee (PDRC) that incorporates Crown Attorneys, Police Officers, and Children Aid Society representatives to examine all paediatric deaths that occur in the province of Ontario. Unlike other more medically oriented committees, the DVDRC, and to some extent the PDRC, needs expertise from a variety of disciplines and vocations to contribute to a more comprehensive review of the circumstances of the death.

In the context of domestic violence, it became patently clear as a result of the May/Iles and Hadley inquests that a multi-disciplinary approach to the analysis is essential to more fully understand the dynamics of domestic violence fatalities, and to develop recommendations and strategies to deal with them as a social phenomenon. Correspondingly, it was recognized that to derive a greater understanding from the review of all domestic violence deaths, the Coroner's death investigation required a multi-discipline approach from an expert committee made up of members engaged in a variety of services.

c. The Domestic Violence Death Review Process in Other Jurisdictions

No other jurisdiction in Canada or in the United States employs as extensive a death investigation or inquiry process directed to improving public safety as applied in Ontario under the Coroners Act. The Coroner system allows for not only an extensive investigation process, but also a systemic examination that provides the basis for recommendations for preventing deaths in similar circumstances. However, even though all domestic deaths are to be reported to the Coroner system pursuant to s.10 of the Coroners Act, and all such deaths are investigated, at least to the extent that the five questions are answered, no ongoing and detailed systematic review of all such deaths was made prior to the creation of the DVDRC.[11]

While none of the States in the United States has as extensive a death review process as Ontario, almost half of them have started to develop or have in place ongoing death review mechanisms designed specifically to review domestic violence fatalities in their jurisdictions. These mechanisms started to evolve over the last decade to detect trends and patterns from the data collected as a result of their reviews. The important feature of these committees is that they are ongoing and multi-disciplined in perspective.

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[11] A *Domestic Violence* code was added to the Ontario Coroner's Investigation and Classification System in 1999, which has facilitated the identification of such cases for review.

The National Council of Juvenile and Family Court Judges in the United States defines domestic violence death review in the following manner:

> It is the deliberative process for identification of deaths, both homicide and suicide, caused by domestic violence, for examination of systemic interventions into known incidents of domestic violence occurring in the family of the decease prior to death, for consideration of altered systemic response to avert future domestic violence deaths, or for development of recommendation for coordinated community prevention and intervention initiatives to eradicate, domestic violence.

California has, perhaps, one of the most advanced continuing Domestic Violence Death Review Committee processes in the United States. The State of California has amended its Penal Code to require each county to create an inter-agency domestic violence death review team. Section 11163.3(a) of the Penal Code provides that these teams will investigate both homicides and suicides related to domestic violence. The teams are to be established to ensure that the role of domestic violence is recognized in the circumstance of the death, and that subsequent preventative measures are introduced as a result.[12]

The California Penal Code, Section 11163.5, also provides for the coordination and integration of state and local efforts to address fatal domestic violence, and the creation of a body of information to help prevent domestic violence deaths. The legislation goes on to charge the California Department of Justice with the task of carrying out reviews as well. The California Department of Justice is to proceed with the cooperation of the State Department of Social Services, the State Department of Health Services, the California State Coroner Association, the County Welfare Directors Association, and the State Domestic Violence Coalition. It also directs that the Department of Justice produce an annual report of domestic violence deaths, with the local teams reporting their findings to the Department of Justice.[13] The intent and purpose of the scheme is to better understand the genesis and solutions to domestic violence.

The Los Angeles County Domestic Violence Death Review Team 2001 report typifies the stated objective and goals of most Domestic Violence Death Review Committees:

1. To provide and coordinate a confidential, multi-disciplinary, multi-agency forum for the systemic review of domestic violence related fatalities.
2. To create and maintain a comprehensive database of the fatalities in order to assess victim and perpetrator demographics, relationship history, prior abuse history, prior interventions and resources utilized, and case disposition.
3. To identify system gaps and shortcomings to facilitate improvement.
4. To develop and recommend coordinated prevention strategies and long term interventions based on case reviews/findings and investigations.
5. To improve communication and collaboration among local agencies.
6. To identify trends, risks and patterns in the cases reviewed to make policy recommendations for effective intervention.

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[12] It must be kept in mind that California, like all other states in the United States, does not have a centralized or statewide death investigative system as we do in Ontario.

[13] At this time, the County Death Review Committees are reporting only to their local Board of Supervisors and not on a statewide basis.

7. To issue and disseminate an annual report, setting forth data collected, recommendations for systems improvement from case reviews, and to find ways to better address the needs of surviving family members.

The California legislation states that the review team shall be comprised of, but not limited to, the following members, to ensure the process incorporates a multi-agency and inter-disciplinary approach to the investigation and analysis of the problem:

1. experts in the field of forensic pathology
2. medical personnel with expertise in domestic violence abuse
3. coroners and medical examiners
4. criminologists
5. district attorneys and city attorneys
6. domestic violence shelter service staff and battered women advocates
7. law enforcement personnel
8. representatives of local agencies that are involved with domestic violence abuse reporting
9. county health department staff that deal with domestic violence victim health issues
10. representatives of local child abuse agencies
11. local professional association of persons described in nos. 1–10

A nation-wide study of domestic violence deaths review committees in the United States found that although membership patterns vary slightly from state to state, the core of the teams appeared to be drawn from three main areas of concern: public health, criminal justice, and advocacy/social services.

d. Key Factors Identified for the Success of the DVDRC Process

Several key factors were identified as being crucial to the success of the DVDRC process, based on the experience of jurisdictions where they have been established. The first key factor is that committee members must ensure the confidentiality of the information provided to and examined by them. To ensure the confidentiality of the information supplied to Domestic Violence Review Committees, the California State Penal Code stipulates that all information, whether oral or written, is confidential and not subject to disclosure or discovery by a third party.

The second key factor is that team members must adopt a cooperative approach, with full acceptance that interests and agencies represented on the Committee, as well as their involvement or non-involvement in the lives of the victim or perpetrator, may be critically examined. The process must be collaborative and cooperative to provide constructive accountability.

Thirdly, the process must be conducted in a "non-blaming or shaming" environment. It is important to note that the Ontario Coroner System, governed by the Coroners Act, prohibits the finding of legal responsibility or the rendering of any conclusions in law.[14] The Coroner's investigative or inquest process is not responsible for determining wrongdoing. Professor Neil Websdale, of the Faculty of Criminal Justice at Northern Arizona University, noted the

[14] Section 31 (3) directs that an inquest jury shall not make any findings of legal responsibility or render any conclusions in law.

importance of the non-blaming or shaming component of the review process to its success in his article *Fatality Reviews: An Implementation Guide for Establishing Local Teams*, prepared for the Florida State Department of Children and Families:

> Many domestic violence fatality review teams have tried to adhere to a "no blame and same" ethos. Given that it is often the batterer or his violent behaviour that cause the death in question, review philosophies that point the finger at agencies, or seek to "blame and shame" individual agency personnel are counter productive. Such a "blaming" approach often referred to as "tombstone technology" in fields such as aviation and nuclear power, might encourage the covering up of information in cases of death. It is also the case that men who batter women blame their victims for much that is negative in their lives. Using reviews to blame others merely perpetrates that negative and destructive style of thinking and contributes little to healing.

The non-blame ethos advocated by Neil Websdale is reflected succinctly in the introductory comments of the *Los Angeles County 2001 Domestic Violence Death Review* report:

> It is recognized that when a fatality results from domestic violence, the perpetrator alone is ultimately responsible for the anti-social act. Beyond this fact, the DVDRT needs to discuss these fatalities, not to assign "blame," but rather to isolate the dynamics and circumstances that escalate and lead to fatal outcomes, so that overall prevention efforts can be effectively focused.

The three key factors discussed above are necessarily intertwined in the review process, and without them, any constructive or productive result is unlikely. An excerpt from the introduction to the *2001 Santa Clara County Domestic Violence Council Death Review Committee Report* also acknowledges the necessary link between these factors:

> The first problem encountered by the Domestic Violence Death Review Committee centred on confidentiality. How could several different groups and agencies both public and private come together and share pertinent information on identified decedents and domestic violence related deaths? There was an extended discussion by the Committee in an attempt to answer these very important questions. Eventually a solution was reached and we were able to move forward. The solution was grounded in our prior experience working together on other projects of the Domestic Violence Council. Trust and respect also played an important part in getting over this hurdle. We were able to come together with the understanding that our main charge was to make system wide changes that would save lives and not try to pinpoint blame on any particular agency.
>
> All death review committee members were also asked to sign a confidentiality agreement. This agreement requires that "all information discussed in Committee meetings remain confidential." This signed agreement is kept on file by the Committee Chair. The only agreed upon public disclosure of cases involved statistics and patterns and not particular victims or perpetrators.

The review of established Domestic Violence Death Review Committees in the United States reveals that:

- an ongoing review of all domestic violence fatality cases is essential to identifying trends, risk factors, and patterns to make meaningful recommendations for prevention;

- the undertaken review requires a multi-disciplinary perspective to more fully understand the phenomenon of domestic violence, to identify systemic and social factors, and to facilitate effective prevention recommendations;
- the key components to their successful operation are:
    1. there be a clear understanding of the confidentiality requirements inherent in the process to ensure a candid review and critique of the specific cases;
    2. there must be trust amongst the committee members to ensure a constructive critique; and
    3. the reviews be conducted in a "non-blame and shame" environment.

The Coroner death investigation system in Ontario has the following unique features:

- the largest centralized death investigation system in North America;
- the investigative authority for the collection of information relating to the circumstances of the death(s) under the Coroners Act; and
- a statutorily mandated non-blaming or fault finding process and culture as required by s.31 (3) of the Coroners Act.

Keeping these features in mind, the Ontario Domestic Violence Death Review Committee was created by incorporating the key factors proven successful in other jurisdictions into its terms of reference[15] and in the conduct of its reviews.

[15] See Appendix A: Terms of Reference, and Appendix F: DVDRC Member Confidentiality Agreement

Chapter 3–Cases Reviewed: A Brief Summary of 2002 Cases

Case 1: OCC #8738–02, 8739–02, and 8740–02

This case involves the homicides of an estranged wife, a male neighbour, the attempted homicide of another man, as well as the accidental death of the perpetrator during flight from the police. At the time of the homicides and the perpetrator's death, he was separated from his wife. He was released on a recognizance of bail, facing two charges of assault and threatening death involving his estranged wife.

Throughout their 24-year marriage, there was considerable marital discord, largely due to the husband's alcohol abuse problem, which traced back to his teens. They were married in 1978 and had two children. They operated a farm business. He was emotionally and physically abusive to his wife and children throughout the marriage. He had a prior criminal record and was convicted for assault—the victim of the assault was his wife. He was also a very possessive and jealous person who tried to isolate his wife and restrict her contact with family and friends, and also control her movements. He was under treatment for depression and receiving anti-depression medication. His wife, at the suggestion of their family physician, tried to engage him in family counselling, however it failed when he became aggressive and angry during his final session, claiming the counsellor was taking her side. Shortly after that he assaulted and threatened his wife's life on the unfounded belief she was involved with another man.

Subsequent to the perpetrator's arrest and release on bail, his wife provided a lengthy statement detailing the history of domestic violence in the lives of her and her children, as well as her husband's paranoid threats against two male neighbours. The perpetrator killed one of them and sought out the other the night he killed his wife. After his release on bail, he continued to harass his wife and breach its terms. Although the breach was reported to the police, he was not arrested.

He subsequently killed his wife at their matrimonial home with a shotgun in the presence of their children. Later, he went to the home of a neighbour and, using the same weapon, killed the neighbour at his front door. He then went to another residence, seeking to kill another man, but was prevented from doing so by the other man's elderly parents. The perpetrator subsequently died in a motor vehicle collision while in flight from the police.

Case 2: OCC #10280–02 and 10281–02

This is a case of homicide-suicide. The perpetrator and his wife were married for almost 28 years. They had several children, with only one of them living with them at the time. On the date of the homicide, the perpetrator was in a highly emotional state after learning his wife was having an admitted affair with another man. After finding out about his wife, he spoke with a number of people in his community, who all recognized that he was in a highly emotional state. In one instance, he told a friend and local counsellor that he felt like shooting the man involved. He was directed to the local police chief, to whom he said he wanted to beat the man up. He was

cautioned that he would be charged with a criminal offence. He then indicated he would leave the community to stay with family members in another, but that he wanted to take his daughter. The local children's aid society was contacted and no objection was made.

Shortly after arriving at the family members' residence, he indicated he was leaving to go back, and that he might kill himself. En route, he encountered another family member who had been sent to intercept him. After a brief roadside conversation, the family member left two rifles with the perpetrator for safekeeping because he was going across the border into the United States and could not take them with him. The perpetrator then stopped at a convenience store and purchased paper and envelopes. He composed five letters, addressed to various family members. In the letters, he explained the grief he was experiencing as a result of the news of his wife's long-standing extra-marital affair. He left information concerning the distribution of his assets and his burial, and he apologized for his intended actions.

He went to a business premise where he located his wife. As she exited the office, he confronted her. He was armed with a 30–30 lever action rifle. As the victim turned to run away, he shot her in the back. He continued to approach her where she lay on the ground, and fired two more shots into her back, killing her. He then turned the firearm on himself and discharged the weapon into his head, killing himself.

Case 3: OCC #4090–02 and 1468–02

This case involves the homicide of an elderly woman in a retirement home, followed by the suicide of her killer some time later. Both parties had previous partners. They had met and seen each other for a number of years in their retirement, and lived together for a period in the retirement home. She had suffered a debilitating stroke and he would attend to her daily needs. While he was hospitalized after falling and breaking his hip, her family members directed that she be moved to a private room. On the day of the homicide, he left a note expressing hostility and anger towards them and describing his intended actions.

When the perpetrator killed the victim a staff member witnessed him cut her throat with a knife as she sat in her wheelchair. The staff member removed the knife without difficulty, took it out of the room, and locked it in a linen closet. After calling for help, she re-entered the room and found the perpetrator trying to cut his own throat with a smaller knife he had with him. She removed that knife from him as well, and locked it in the same closet. He crawled across the floor to his dresser, opened a drawer, and took out scissors with which he tried to cut his throat again. An ambulance attendant who had arrived by that time took the scissors away from him.

Despite efforts to save the victim, she was pronounced dead at the scene. The perpetrator was taken into custody. He was charged with second-degree murder. Due to the need to change dressings and his advanced age, he was moved from a detention centre to a treatment centre. Approximately two weeks later, while at the treatment centre, he committed suicide by suffocation. He stuffed his nose and mouth with toilet paper and placed a plastic bag over his head. The bag he used to suffocate himself had held items he had obtained from the canteen that day.

Case 4: OCC #6672–02, 6674–02, 6675–02, 6677–02, and 6678–02

This case is a multiple homicide-suicide. The perpetrator met the victim two years before the murder as a result of business contact. They lived together for a brief period in the United States, where the perpetrator was a resident. They planned on getting married, but the victim called it off due to the perpetrator's abusive behaviour. The victim left the United States and returned to live in Ontario with her parents and a child from a previous relationship in their home.

The perpetrator continued to harass the victim and her family members. Her parents told him on a number of occasions to leave her alone. Because of his persistence and growing concern for his daughter's welfare, her father called a lawyer who did legal work for his company to speak about her problems with the perpetrator. He inquired about obtaining a peace bond restraining order. He was told to notify the police, ask for extra patrols, and request that the border be notified if there was any indication the perpetrator would cross the border and come into Ontario. He also recommended that if there was any indication that the perpetrator was mentally unstable, the family should leave the home.

Prior to the father taking any of the suggested steps, the perpetrator entered Canada and smuggled with him a semi-automatic handgun and ammunition hidden in his SUV. Days before, he had purchased the handgun and ammunition from a gun shop in his hometown. Shortly after crossing the border, he rented another motor vehicle. He then located his former girlfriend at a friend's home and shot her seven times, killing her. Immediately after shooting her, he drove to the nearby home of her parents. At their residence, he forced his way into the home, where he found the victim's mother and the victim's six-year-old daughter in the master bedroom watching television. He shot her mother and then the little girl as she lay on the bed beside her grandmother. As the initial victim's father rushed into the room, the perpetrator shot him, killing him as well. The perpetrator then put the gun in his mouth and, pulling the trigger, killed himself.

After the homicides and his death, it was learned he had a history of assaulting and stalking behaviour with females in his hometown, which resulted in charges and in one instance an application for a restraining order that was not pursued by the complainant.

Case 5: OCC #16097–02 and 16098–02

This is a case of homicide-suicide. In 1995, the perpetrator was diagnosed as suffering from paranoid schizophrenia and alcoholism. He had been receiving anti-psychotic medication from his family physician. He had a history of verbal abuse and harassing behaviour towards his wife, which increased over time. The perpetrator was known to have been to his wife's place of business to speak to her co-workers, as well as to monitor her activities and accuse her of infidelity. He also had a persisting delusion that his wife and daughter were trying to kill him by poisoning his food. Their son reported knowledge of one incident where the perpetrator had slapped his mother, but the abuse tended to be more of a verbal and emotional nature.

The victim resided with her son in the family home and was separated from her husband. Notwithstanding their separation and divorce, he frequently visited the residence and maintained contact with his ex-wife. His ex-wife felt he did not properly care for himself, so she fed him and allowed him to stay at the house from time to time. While he was under the care of a physician, he was not always compliant with taking medication. Due to his disturbing behaviour, the family

sought help from their rabbi who spoke with him and his ex-wife. There is no indication that the family was referred to or involved with outside agencies such as police, children's aid society, family and/or social services. There was some indication that, because of "shame" expressed by the family about the perpetrator's mental illness and behaviour, there may have been cultural barriers to their seeking assistance from outside services.

On the day of the homicide-suicide, the perpetrator entered his wife's bedroom and assaulted her with a kitchen knife. She sustained a lethal stab wound to her neck. She staggered from the upstairs bedroom and collapsed at the bottom of the stairs, where her son subsequently found her. After stabbing her, the perpetrator proceeded to the basement laundry room where he suspended himself by the neck from an overhead rafter and died.

Case 6: OCC #146–03 and 148–03

This case involves the ligature strangulation of a woman by her husband, who then killed himself by ligature strangulation. During the course of the investigation, investigators learned that the perpetrator had become increasingly despondent and agitated as a result of his wife's intentions to end the marriage of more than 30 years. The couple had immigrated to Canada in 1982 and had become well established. The marital relationship began to deteriorate more than 10 years ago. Investigators learned the perpetrator had sexually abused all three of their daughters while they were in their pre-teens. While the daughters reported the abuse to their mother, it was never disclosed to any agencies.

In later years, the victim travelled alone quite frequently to the United States to visit her daughter. On one trip approximately 4 years ago, she met a man with whom she began a long-distance extra-marital affair. She did not keep the affair hidden, as several family members and friends were aware of it. Eventually, sometime in 2001, her husband learned of the affair. Shortly afterwards, the perpetrator went on a rampage in the home, destroying his wife's property. He was charged with causing damage to the property and was put on probation with a term that he attends anger management counselling.

The female victim had spoken about separation or divorce for several years, and a few months before her death, she began to organize her personal financial affairs and prepare some documentation to begin the separation process. The perpetrator advised his daughter that he had located some of the documentation prepared by his wife. Family and friends reported that he appeared resigned to the separation, but began to drink more heavily and became increasingly despondent.

When he killed his wife, he strangled her in her bedroom. He then tried to make it appear as if she hanged herself. He then strangled himself. He left a suicide note.

Case 7: OCC #11988–02 and 11989–02

This case involves the death of a five-year old girl killed by her father at the same time he killed himself by carbon monoxide poisoning. Shortly after midnight, the wife of the perpetrator arrived home and noted that the carbon monoxide detector was sounding in the house. She checked the garage; there she found her husband's motor vehicle running and her five-year-old

daughter's legs hanging out of the van door. She called 911, and on arrival, police found both the wife's daughter and her husband dead in the van. He left a suicide note asking that he and his daughter be cremated together in the same coffin.

The wife reported their marriage had been in a state of turmoil and her husband had been depressed and was using alcohol excessively. He was not involved in any treatment for his depression. She indicated that over the last two years, their marriage had become colder and there was little communication between them. He seemed to have changed when his best friend died in the World Trade Centre bombing in New York City, September 11, 2001. She described the perpetrator as being a doting father to the deceased daughter. He would disappear sometimes overnight, or he would return intoxicated late in the evening after gambling with friends. Other family members indicated that he frequently drove impaired with his five year old daughter in the vehicle. They described his relationship to his five-year-old daughter as being "really obsessed with that child," and that "he tried to keep her away from everyone else."

In the week preceding their deaths, his wife visited a lawyer to seek advice concerning separation and divorce. She was advised to continue cohabitating with her husband. She did not have the financial means to move out, so she was advised they should live separately within the same house until property matters were resolved. Two days before he killed his daughter and himself, his wife told him she had sought and had received advice about separation and divorce. It was reported that he told her he was not going to go anywhere without his daughter, and that she had just been an "incubator" for the child.

Case 8: OCC #4952–02 and 4953–02

This is a case of homicide-suicide involving the slaying of a wife and the subsequent suicide of her husband. After shooting his wife with his shotgun, the perpetrator went to the basement and, while sitting in a chair, shot himself in the head. While there was no recorded history of domestic abuse involving the husband and wife, there appears to have been considerable emotional and some physical abuse in their relationship. No outside agencies were involved.

Witnesses provided statements that they observed bruising on the wife in the past, and that the husband had caused those injuries. The children of the deceased stated that while the relationship between their parents was generally amicable, it was strained and difficult due to the perpetrator's drinking problem. Friends and neighbours described him as an overbearing bullying braggart who was verbally, emotionally, and physically abusive to his wife and children. Both he and his wife had medical histories of depression and headaches. They had both received prescribed medications for these ailments.

There were significant stressors in the home at the time of the homicide-suicide. The perpetrator had just received a letter of discipline for damage he had caused while working in an auto repair shop. He had continuing conflict with his adolescent son and his daughter's boyfriend who was staying in the family home. On the day of the homicide, he had been drinking heavily and arguing with his son and daughter's boyfriend. He was upset at the boyfriend because he was unemployed, and he expressed the view that the boyfriend was just "using" the family. He berated his son for not finding summer employment. During the ongoing argument, the daughter observed her father remove a shotgun from the gun cabinet in the basement. In the process of removing it, he broke the wooden bracket holding the guns, which caused the cabinet lock to be

propelled across the room. She did not have concerns at that time that her father was contemplating use of the firearm, but rather thought he was blowing off steam and cleaning it. As a result of conflict with his son, his wife declared that she and her son would be leaving when he came home from school.

Case 9: OCC #11656–02

This is a homicide case involving a same sex couple that was living as man and wife. In this case, the roles of the victim and perpetrator were reversed. The perpetrator of the homicide acted in self-defence when she killed her partner, the aggressor, who was attempting to kill her. At that time, as the victim/aggressor advanced towards the perpetrator, the perpetrator stabbed the aggressor once in the abdomen with a kitchen knife. She later claimed her actions were made in self-defence; in fear her partner would kill her, as she had earlier threatened to do. When the police and emergency services personnel arrived, they found the aggressor sitting on the front step of the residence with the stab wound to her abdomen. She was still alive and, when asked by a police officer who had stabbed her, she replied, "yeah, it was my wife," in reference to her partner. The aggressor, who was transgender later died as a result of her injuries. Shortly after the arrival of the police, the perpetrator was arrested, at which time she stated, "he tried to kill me, it was self-defence." After the aggressor died, the perpetrator was charged with first-degree murder.

After a comprehensive investigation into their relationship, which detailed not only the extensive abuse perpetrated by the deceased with respect to the accused, but abusive conduct of a strikingly similar nature in a series of earlier relationships over the previous 10 years, the charge was withdrawn at the request of the Crown. It was withdrawn on the basis that the claim of the accused acting in self-defence was found to be credible due to the deceased's extensive history of severe and sadistic abuse of her previous partners, over whom she had exercised almost absolute control during their relationships. She had been involved in a number of intimate relationships wherein she had demonstrated extreme behaviours to control almost every aspect of the lives of her partners. She was found to have physically and sexually abused her partners in sadistic ways. She confined them, threatened to kill them or family members, and even controlled the amount of food they were allowed to eat. All of these behaviours were experienced by the accused. Her own family members and those of the deceased saw her with injuries indicative of abuse.

Shortly before the homicide, the accused had visited the hospital because of severe injuries to her vagina and blood loss due to her partner's sexual battery of her. The doctors and nurses were suspicious of the origin of the victim's injuries, and of the story that she received them falling from a horse. She was referred to a social worker to query her story, but the social worker questioned her in the presence of the perpetrator. She did not reveal the abuse.

Throughout the day of the homicide, the deceased threatened to kill her partner and another family member. That night, the deceased turned to her partner in bed and asked, "*what if I was to take your life?"* The deceased then grabbed her partner around her neck with both hands and started to choke her. Fearing for her life, her partner fought back and was able to break free while falling out of the bed. She ran out of the bedroom and into the kitchen, where she grabbed a large butcher knife from the kitchen counter on route to the rear door. A bicycle and other articles

blocked the exit, which forced her to turn back toward the interior of the house. As she did so, the deceased came into the kitchen and came towards her. The partner stated that at that point she "*had enough*"—she was cornered and had no place to go. As the deceased advanced, the partner/perpetrator stabbed her once in the abdomen. She stated later in interviews she believed that if she had not defended herself, the deceased would have killed her.

The deceased was a serial abuser of intimate partners. It is important to note that she lived in a number of different municipalities with different partners, although some lived in the municipality where the homicide occurred. However, the perpetrator, who was really the victim of the deceased's abuse, did not know these other intimate partners. The only source of information that led the police investigators to them after the aggressor's death was the deceased's own mother.

Case 10: OCC #9615–02 and 9616–02

This is a case of homicide-suicide involving a young couple aged 19 and 21 who had recently separated. Based on a forensic analysis of the scene where the bodies were discovered—a wooded area—and the autopsy results detailing the injuries, investigators concluded the female victim died as a result of the perpetrator reaching from behind and stabbing her once in the chest. He then attempted to hang himself using his shirt hooked on a tree limb, and finally stabbed himself in the chest, resulting in his death. Information suggested he had planned the event in advance—he had strapped a bayonet to his lower leg, and had placed a machete in the park near the logs where the female victim was found.

The victim and perpetrator had met in high school and lived together after finishing school. There were frequent disturbances while they lived together in an apartment. Information supplied by family and friends confirmed he had been controlling, possessive, and jealous of the victim. After she separated from him, he would become upset with her relationship with some of her friends, her attendance at area bars, and her association with other males.

The perpetrator's recent behaviour and statements suggested he was contemplating ending his own life. He had declared to his friends that he was moving away, but he would not tell anyone where he was moving. He had quit his job. When it was suggested to him that he transfer to another store, he said there were none where he was going. He had given up his apartment and set about selling his possessions. Several days before the homicide-suicide, he confided to a friend that he was thinking about killing her and himself. His friend did not know whether to believe him or how to disclose it to others. The same friend reported to police afterwards that just before the deaths, the perpetrator had left him a music cassette tape of a song entitled *Kim* performed by the rapper artist Eminem. The song contains explicit lyrics about murder/suicide in the context of a failed intimate relationship:

> …so now it's double homicide and suicide with no note
> I should have known better when you started to act weird
> We could have….**HEY!** Where are you going? Get back here!
> You can't run from me Kim
> Its just us, nobody else!
> You're only making this harder on yourself
> Ha! Ha! Got'cha!

(Ahh!)
Ha! Go ahead yell!
Here I'll scream with you!
AH SOMEBODY HELP!
Don't you get it bitch, no one can hear you?
Now shut the fuck up and get what's comin' to you
You are supposed to love me
{*Kim choking*}
NOW BLEED! BITCH BLEED!
BLEED! BITCH BLEED! BLEED!

Case 11: OCC #151–02

This is case of homicide involving the murder of a spouse by her husband of thirteen years. They ran a successful farming operation together with the help of other family members. However, for several years, the perpetrator had an unfounded belief that he would become physically disabled and as a result they would lose the farm.

Before the homicide, he had reported his concerns about the depression he felt to his family physician. In response, his doctor prescribed an anti-depressant and referred him for counselling. He told a psychiatrist that he thought of suicide and he described "catastrophic ends" to his difficulties. The perpetrator also spoke to a number of friends and neighbours about his belief that his wife was going to leave him and take their children with her. He spoke of his fear he would lose the farm as a result of her leaving him. He also spoke of suicide, which caused an acquaintance to refer him to a pastor for counselling.

The victim never reported any physical violence in their relationship. However, it was clear that her husband was emotionally abusive and controlling with regards to money and expenses. For some period of time leading up to the homicide, they were living separate and apart under the same roof.

On the day of the murder, the perpetrator woke his wife and asked her to help him get their van started. He walked up behind her as she exited the van and struck her on the back of the head, knocking her to the ground where she lay unconscious. He climbed onto a tractor and drove over her head. He then reversed the tractor and drove over her head again. He removed her body from the laneway with the tractor bucket and parked the tractor in the shed. He went about the remainder of his day as though nothing was amiss. Later, when a relative discovered her body, he admitted to police upon their arrival that he killed his wife. He was subsequently arrested for first-degree murder. He pled guilty to second-degree murder in the death of his wife and was sentenced to life imprisonment without eligibility for parole for 15 years.

While he did not try to kill himself at the time of the homicide, he stated he had both suicidal and homicidal thoughts in the days leading up to the murder. He attempted suicide several times in jail following his arrest.

Chapter 4–Summary of Data Analysis: Trends, Patterns, and Opportunities for Intervention

The first year of DVDRC data collection focused on developing and testing the data forms that would assist in our analyses and recommendations for the future. Since we only reviewed eleven cases, our summary data is somewhat limited, but it is very consistent with the literature on domestic homicides and the annual reports of similar committees in the United States.

Table 1 summarizes the information about victims and perpetrators in the reviewed domestic homicides.

Table 1–Victim and Perpetrator Information

Variable	Victim Information (n=10)	Perpetrator Information (n=11)
Gender	100% female	91% male
Age when incident occurred (years)	Minimum = 19 Maximum = 81 Median = 41	Minimum = 20 Maximum = 89 Median = 46
Type of relationship between victim and perpetrator	Married – 20% Separated (actual or pending) – 40% Estranged boyfriend/girlfriend – 20% Co-habiting – 20%	
Length of relationship	< 1 year – 10% 1–10 years – 30% 11–20 years – 10% 20–30 years – 50%	
Children in common	0 – 40% 1–2 – 20 % 3+ – 40%	
Residency status	Canadian – 70% Immigrant/Refugee – 30%	Canadian – 64% Immigrant/Refugee – 36%
Employment status	Employed – 70% Unemployed – 10% Retired – 10% Disability – 10 %	Employed – 64% Unemployed – 27% Retired – 9%
Criminal history	Yes – 10%	Yes – 45%
Prior counselling	Yes – 10%	Yes – 40%
Threats or attempted suicide	Yes – 0%	Yes – 64%
Significant life changes	Yes – 78%	Yes – 100%

Of the eleven cases reviewed, 100% of the victims were women and 91% of the perpetrators were men. This finding is consistent with the literature on domestic violence, which suggests this crime is not gender neutral. In fact, the one perpetrator who was a woman acted in self-defence after a documented history of victimization. This victimization was so well documented in medical reports that the Crown Attorney withdrew criminal charges.

The victims and perpetrators represented the life span, from adolescent relationships to a couple co-habiting in a seniors residence. The median age for victims was 41 years, and for perpetrators was 46 years.

Separation was a major factor in the majority of cases. A total of 60% of the represented couples had separated or the victim was planning to leave. In half the cases, the couple had been together for more than 20 years. In 60% of the cases, the couple had children together.

The vast majority of the victims and perpetrators were born in Canada and had gainful employment. In 7 out of the 11 cases, the perpetrators were described as depressed and as having made threats or attempts at suicide. All the perpetrators had experienced significant life changes related to the separation or difficulties with employment. The same was true for 78% of the victims.

Table 2 summarizes the nature of the homicides.

Table 2–Homicide Information

Type	Homicide – 18% Homicide-suicide – 64% Multiple homicide-suicide – 18%
Cause of death	Gunshot – 36% Stabbing – 36% Beating – 9% Strangulation – 9% Poisoning – 9%

Two of the 11 cases involved multiple homicides followed by the perpetrator's suicide. In these cases, the perpetrator killed family members and, in one instance, a man falsely accused of being involved with the victim. Six of the cases involved a homicide followed by the perpetrator's suicide. One of these cases involved the perpetrator killing his daughter after being told his wife had contacted a lawyer for a pending separation. In two cases where suicide was contemplated, the perpetrators did not take their own life after the homicide.

Table 3 summarizes the common risk factors found in the 11 cases included in the DVDRC review. The table rank orders the most common risk factors, which are consistent with previous literature in this field.

Table 3–Common Risk Factors from DVDRC Analysis

Risk Factor	Percentage
Actual or pending separation	82%
Depression (or other mental health or psychiatric problems)	73%
Prior history of domestic violence	73%
Prior threats to commit suicide or suicide attempts by perpetrator	55%
Access to or possession of firearms	55%
Obsessive behaviour (including stalking the victim)	45%
Control of most or all of victim's daily activities	45%
Excessive alcohol and/or drug use	45%
Attempts to isolate the victim	36%
Escalation of violence	36%
Destruction of victim's property	27%
Perpetrator unemployed	27%
Prior threats to kill victim or threats with a weapon	27%
Forced sexual acts or assaults during sex	18%
Isolation of victim	18%
New partner in victim's life	18%
Perpetrator witnessed domestic violence as child	18%
Violence against pets or livestock	18%

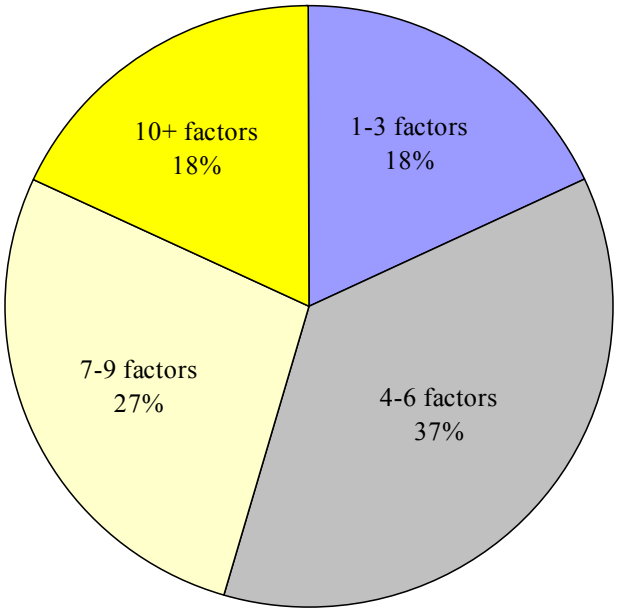
It is interesting to note that only 2 out of 11 cases actually had some form of risk assessment prior to the homicide. In one case, the police had done a thorough risk assessment, but the information was not made available to subsequent interveners. In another case, a children's aid society worker had completed a risk assessment for child abuse and identified domestic abuse as a factor, but lacked voluntary out-reach services for what was seen as a moderate degree of risk.

As indicated in Table 3, the most common factors found were:

- actual or pending separation
- depression
- prior history of domestic violence
- prior threats or attempts at suicide
- access to firearms
- excessive use of alcohol or drugs
- obsession over the victim (stalking)
- controlling behaviours by the perpetrator

Figure 1 provides an overview of the number of risk factors identified in each of the 11 cases.

Figure 1
Number of Risk Factors Identified in Cases Reviewed



All of the cases had apparent risk factors, ranging from 10 or more factors in two of the cases, 7 to 9 factors in three of the cases, 4 to 6 factors in four of the cases, and 1 to 3 factors in two of the cases.

Of the 11 cases, 8 had a history of domestic violence. The prior violence was known to a variety of individuals, ranging from family members to community professionals. In some of the cases, the most apparent abuse was possessiveness and controlling behaviour, which in hindsight was minimized due to the absence of physical violence or injuries. The police and the courts were actively involved in 2 of the cases. Family doctors, psychiatrists, and community counsellors knew of prior domestic violence in 4 of the cases. In all 8 cases with a prior history of domestic violence, family members had observed abusive behaviour or its aftermath with the couple.

With the benefit of hindsight and all the information gathered for the DVDRC reviews, some conclusions can be drawn as to whether or not homicides with similar presenting factors could be 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 stressors or family conditions that ultimately became a factor in the homicide or by placing limits on the behaviour of the perpetrator. For example, the perpetrators suffering

from depression were not seen as candidates for a homicide, yet more effective interventions for them, as well as restrictions in their access to firearms, may have prevented the ultimate tragedy.

The recommendations arising from this summary data and review of the 11 cases are outlined in greater detail in Chapter 5 of this report. The data presented raises issues to consider in our future reviews about the individuals and circumstances that pose the highest risk. This information will provide an important link to training, risk assessment, safety planning, and intervention strategies for victims and perpetrators in these circumstances. From this very limited data, the importance of public education and thereby better informed friends, relatives, and neighbours seems essential as the first line of defence in domestic homicide prevention.

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 obsessive involvement with his daughter that should have been apparent and troubling to 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.

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.

Implications and Future Trends

The first year of the DVDRC provided an opportunity for a multi-disciplinary team to complete comprehensive reviews of 11 out of 25 domestic homicides that occurred in Ontario during 2002. The overwhelming evidence suggests that in almost half of the cases, professionals with expertise in this area would have predicted a homicide in similar circumstances. In all the cases, there were clear signs of individuals or family systems under stress from factors such as marital separation and mental health difficulties that required more intensive assessment and intervention than they received.

The implications of our reviews are numerous. First and foremost, the prevention of domestic homicides requires an integrated community response with everyone involved aware of the warning signs and danger of domestic violence. This awareness starts with the immediate family members, relatives, friends, neighbours, and front-line professionals in healthcare, social services, faith communities, and education who represent the first line of defence. The system is only as strong as its weakest link. The weakest link in our reviews may rest with individuals who do not appreciate their critical role in supporting victims and helping perpetrators find non-violent means to express their distress.

The committee concluded that risk assessment tools and procedures when domestic violence is identified are crucial needs that are lacking. There needs to be broader public awareness of the warning signs of potentially lethal family circumstances. Front-line professionals need assessment tools to prioritize these dangerous situations and make referrals for more

comprehensive assessments. These assessments have to be linked to interventions that include a safety planning process for victims and risk management for perpetrators. Many of the circumstances we reviewed exhibited multiple risk factors, indicating the need for a coordinated plan to assess, monitor, and intervene to prevent tragic outcomes.

Improving community responses to domestic violence to prevent homicides will require adequate resources. Only one of the eleven cases reviewed by the committee was actively involved in the criminal justice system. Additional resources are needed throughout all systems in all communities. The demand for these resources will increase with better risk assessments and intervention strategies. Similar to advances in medical research and screening tools, the system has to expand to make room for progress in this field. If we improve awareness and assessment tools, more victims and perpetrators, as well as their family members, will seek services to address their difficulties.

The DVDRC is struck by the complex changes required of family and helping systems to prevent future homicides. These changes will demand a clearer vision that domestic violence is everybody's business, and that the necessary skills, resources, and incentives are in place for communities to effectively intervene. These are not isolated incidents of violence, but rather a reflection of broader social and systemic issues that render women and children vulnerable and allow them to be targets of violence.

In the future, we will broaden our reviews to analyze all the domestic homicides in Ontario, continue our search for the most effective assessment and intervention strategies, as well as identify gaps in our current systems to address these tragedies. We hope to stimulate more in-depth research and link our efforts to other professionals and committees across Canada and the United States to better inform these initiatives. We need to publicize our findings on an ongoing basis to enhance domestic violence prevention activities across Ontario.

Chapter 6–Special Project: Subcommittee Report on Risk Assessment Assessments and Information Gathering Forms

In the course of our reviews, it was observed that had appropriate risk assessments taken place, the consequences might have changed. In recognition of the recommendations made in the earlier inquests and by the Joint Committee on Domestic Violence concerning the need for appropriate risk assessment tools for those dealing with domestic violence, and as a result of the review of several of the cases before the Domestic Violence Death Review Committee, a subcommittee was formed to consider risk assessment and the tools available.

Many of the domestic homicide cases we have reviewed did not involve the criminal justice system. However, other systems could have been engaged in those cases, such as mental health, victim services, healthcare, child welfare, and the education system. We also examined cases where doctors, clergy, counsellors, lawyers, co-workers, families, friends, and neighbours were aware of the degenerating mental health or suicidal 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 specialized services.

Current research suggests that 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. Such persons should also act when they recognize risk in a perpetrator's behaviour. In assessing dangerousness in domestic violence cases, we need to determine how the specific incident of violence relates to the overall history and context of violence in the relationship. In other words, we are not just dealing with an incident, but with a process. Dangerousness is situational. It is not so much assessing the individual that is important, but assessing that individual in the context of the immediate overall situation. Once factors associated with dangerousness have been identified, it is necessary to intervene in a meaningful way to influence the outcome.

The subcommittee examined a number of tools or instruments designed to assist in determining potential risk both in recidivism and lethality. While these tools have value in risk assessment, they elicit only "yes/no" answers. It is the view of the subcommittee that this format limits the amount of information that can be collected. Decisions that occur in domestic violence cases are driven by the facts. For any risk assessment tool to have significant value as evidence in court, the answers must be specifically sourced and articulated. Questions that call for a "yes/no" answer do not convey the context, details, or value of the information. The other advantage to obtaining specific information rather than relying on a "yes/no" answer is that it may lead to further charges involving earlier events. It is not uncommon to discover that although the current incident may be relatively minor, much more serious earlier offences have occurred.

Domestic Violence Supplementary Report (DVSR):

In Ontario, as a minimum standard, the police are required to complete a *Domestic Violence Supplementary Report* (a one-page document, front and back) as part of a domestic violence investigation. Part of one page contains 19 questions that require a "yes/no" or "unknown" answer. There is no space on the form to source the answers. These questions focus on well-known lethality indicators that are present in many domestic homicide cases.

The guide to the DVSR prepared by the Ministry of the Solicitor General states:

> One of the main support tools recommended by the May/Iles Inquest was a development of a risk indicator's checklist that could be used by police officers in domestic violence occurrences. In response to this specific recommendation, identified risk factors that will assist police officers, crowns, and victims in domestic violence occurrences have been incorporated in the domestic violence supplementary report form.

As mentioned above, the difficulty with a checklist is that it provides no source information to explain the "what, when, where, why, and how" of an answer. For example, what weight can be given to an answer of "yes" to the question: "Has the suspect threatened or attempted suicide?" without knowing more of the details?

Ontario Domestic Assault Risk Assessment (ODARA):

The Ontario Provincial Police, in conjunction with researchers from the Mental Health Centre in Penetanguishene, recently developed a new tool called the *Ontario Domestic Assault Risk Assessment* (ODARA).

ODARA is a general violence-screening tool dealing with recidivism. It does not concern itself specifically with the question of lethality. The form contains 13 questions where "yes" answers are given a one-point score. If a person scores between 7 and 13, there is a 70% risk that the individual may commit another assault. This tool may be of great value as a general violence screening to raise "red flags" for the potential of a victim being at risk of future violence. However, there is a concern that the ODARA not take the place of the DVSR (or other tools to be discussed later) since it does not deal with the following questions:

- Has there been a recent escalation in frequency or severity of assaults/threats against the victim?
- Has there been a recent separation or change in their relationship?[16]
- Has there been recent change in the contact between the children and the suspect?
- Is there high stress: financial, loss of job, health?
- Are there mental health problems, loss of reality, bizarre behaviour?
- Is there jealousy or obsessive behaviour?
- Are there stalking behaviours?
- Is there sexual abuse of the victim or partner?
- Has the suspect threatened or attempted suicide?

[16] Jacquelyn Campbell, et al. (2003) Risk factors for femicide in abusive relationships: Results from a multi-site case-control study, *American Journal of Public Health.*

- Has the suspect threatened or destroyed property?
- Has the suspect injured or killed a pet?
- Does the suspect display anger, impulsiveness, or poor behavioural control?
- Does the suspect own or have access to firearms or weapons?
- Has the suspect used or threatened the use of these firearms?
- Does the victim fear she may be killed?

The latest research indicates that the following factors are of particular significance in domestic violence cases that become lethal:

- extreme jealousy
- choking
- escalation of violence in frequency and in severity, especially in the last 30 days
- mental illness, particularly depression
- access to weapons
- recent change in the relationship (separation)
- high stress
- suicidal behaviours
- stalking behaviours
- victim's fear of being killed

The factor of actual or pending separation of the involved persons was present in 82% of the deaths reviewed by the committee.

Danger Assessment Instrument–2:

Jacquelyn C. Campbell, Ph.D., R.N. of the John Hopkins University School of Nursing, is a leading expert and researcher in the United States. She recently took part in a study involving 12 cities in the United States and 545 homicide cases. As a result of this study, Campbell revised her *Danger Assessment Instrument*. DA–2 first asks the victim to record specific examples of abuse on a calendar. The instrument then poses 20 questions on lethality requiring a "yes/no" answer.

This tool is unique in that it is an interactive tool filled out by the victim. It was first developed in 1985 to increase the ability of battered women to take care of themselves. It aids in recall, and assists women to come to their own conclusions. It uses an adult learner approach, and as a result, is more persuasive. It establishes a pattern of frequency and severity of the violence during the past year, and serves as an important safety-planning tool, especially for victims who often minimize their level of risk.[17]

Spousal Assault Risk Assessment Guide (SARA):

The British Columbia Institute on Family Violence developed the *Spousal Assault Risk Assessment Guide* (SARA), and Ontario Corrections uses it as part of their risk assessment. SARA is a clinical checklist of risk factors for spousal assault. Most of the lethality indicators

[17] For a copy of DA–2, visit: http://www.son.jhmi.edu/research/cnr/homicide/danger03.pdf

referred to above are set out in the guide. The instrument is a two-page form with 20 questions that are rated 0–2. Like the above checklists, no specific information is recorded to source the answers.[18]

Initial Screening Tool and Comprehensive Risk Assessment Interview Guide (Durham Region):

In 1997, following the murder of a 3 year-old boy during his first unsupervised access visit with his father, Durham Region, under the guidance of the Violence Prevention Coordinating Council, conducted action research to explore the experience of woman abuse survivors and their children as they engaged with the family court system. One of the key findings identified by survivors, advocates, and professionals (including family court judges, lawyers, and court personnel) was the need for an initial screening tool to "red flag" domestic violence cases entering the family court system—especially high risk situations—and refer identified cases for a more comprehensive assessment with experts in the community.

A 21-question screening tool was created for all family court personnel to use in their initial contact with a family. If domestic violence was identified, then a comprehensive risk assessment interview guide covering 25 areas was available to aid community experts in assessing for further risk and conducting appropriate safety planning.[19]

Domestic History Form (Huron County):

This form was first developed in 1997, in co-operation with the police forces of Huron County and the office of the Crown Attorney. It was initially called *Assessing Dangerousness in Domestic Violence Cases*. This form has been used in a number of other jurisdictions in Ontario.

In its 1999 Report, the Joint Committee on Domestic Violence recognized the Huron County form as a "Best Practice":

> The Crown Attorney's office in Huron County in Ontario is currently using the Assessing Dangerousness in Domestic Cases form to ensure that information on risk assessment has evidentiary value in domestic violence proceedings. (p. 114)

Since 1997, in Huron County, the victim is interviewed as soon as possible after an assault. The interviewing process includes videotaping the victim under oath. The victim is first asked about the current incident. The officer then questions the victim using the *Domestic History Form*, recording the victim's specific answers.

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.

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[18] For more information, visit: http://www.bcifv.org/

[19] For more information, refer to pages 137–152 in the report: *In The Centre of The Storm, Durham Speaks Out: A Community Response to Custody and Access Issues Affecting Woman Abuse Survivors and Their Children* at http://www.durhamresponsetowomanabuse.com

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. Once dangerousness is recognized, intervention should occur to favourably influence the outcome. Immediate safety measures may be put in place, and the accused may be monitored.

Conclusions

Our committee has concluded that enhancing risk assessment efforts by all professionals involved with families and individuals in crisis has to be a priority in Ontario. Based on our collective experience, the cases reviewed and the literature that exists in the field we have chosen to revise the existing Huron County *Domestic History Form* to include questions from Jacquelyn Campbell's new research on DA-2, as well as questions from ODARA and SARA. The subcommittee recommends that the *Domestic History Form* be used not as a risk assessment tool per se, but as an information-gathering instrument to source and document relevant and timely information from the victim. With the information obtained through the completion of the *Domestic History Form*, it is possible to complete any of the risk assessment tools described above (i.e., DVSR, ODARA, SARA, and DA-2). The *Domestic History Form* should not take the place of any of these tools, but rather used to elicit the information required to properly answer the questions posed by the various risk assessment tools.

A generic *Domestic History Form* is attached to this report.[20] The form can be modified by any agency or organization to suit its needs. This form is not a finished product, but a work in progress. The subcommittee will develop a culturally-appropriate interview instructional guide with a training module. This form needs to be developed for use by other professionals and systems outside of the justice system to enhance communication and coordination of assessment and intervention strategies. We hope the form stimulates further research on risk assessment. The real value of a properly completed *Domestic History Form* is that it captures all of the source information so informed decisions can be made about the case.

We recognize that the science and practice of risk assessment in the domestic violence field is in its infancy and requires further research. Nonetheless, every effort has to be made to collect information on these cases to enhance collaboration amongst different service providers and to permit proper assessment and intervention with high risk domestic violence cases. In our view, this enhanced communication has the potential to save lives if the information helps victims to engage in effective safety planning and if perpetrators are challenged by the community to find alternatives to their threatening behavior.

[20] See Appendix G, Domestic History Form