Sixth Annual Report

of

Domestic Violence Death Review Committee

Office of the Chief Coroner

Province of Ontario

2008

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Appendices

Message from the Chair

The year 2008 has been another transition year for the Domestic Violence Death Review Committee (DVDRC) of the Office of the Chief Coroner. As in calendar year 2007, we have completed reviews of fifteen cases of domestic homicides and homicides/suicides.

We continue to explore alternative ways to efficiently review and report on these cases, while ensuring that the statistics we accumulate and the important information and lessons we glean from them are captured in a meaningful way.

Similar to findings in other jurisdictions, we have seen similar themes, issues and identifiable risk factors recurring in many of the cases under review. As new risk factors are identified, both in the literature and through our experience, they are being added to our assessments, to enhance our understanding of the dynamics in these very tragic cases. (See Appendix B)

Rather than repeating the same recommendations made in the past, the reader will note that some of the reported cases have no new recommendations arising. It is our intention, as we move forward, to identify recurring issues, themes, and potential points of intervention, and incorporate them into our expanding database. Where unique or previously unseen concepts emerge from our examination of domestic violence cases, the DVDRC will direct corresponding recommendations to the appropriate ministries, agencies and organizations for consideration.

As with previous reports, a very brief summary of the circumstances of each case is provided with the expectation that it will provide some context for any recommendations that arise.

W.J. Lucas

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

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Chapter One
Introduction and Overview

Mandate

The Domestic Violence Death Review Committee (DVDRC) is a multi-disciplinary advisory Committee of experts that was established in 2003 in response to recommendations made from two major inquests into the deaths of Arlene May / Randy Iles and Gillian and Ralph Hadley. The mandate of the DVDRC is to assist the Office of the Chief Coroner with the investigation and review of deaths involving domestic violence with a view to making recommendations aimed at preventing deaths in similar circumstances and reducing domestic violence in general.

The DVDRC consists of representatives with expertise in domestic violence from law enforcement, criminal justice, healthcare sector, social services and other public safety agencies and organizations. By conducting a thorough and detailed examination and analysis of facts within individual cases, the DVDRC strives to develop a comprehensive understanding of why domestic homicides occur and how they might be prevented. Information considered within this examination includes the history, circumstances and conduct of the abusers/perpetrators, the victims and their respective families. Community and systemic responses are examined to determine primary risk factors and to identify possible points of intervention that could assist with the prevention of similar deaths in the future.

Since its inception, the DVDRC has reviewed 77 cases that involved a total of 117 deaths. The following chart details the number of cases and deaths reviewed since the establishment of the DVDRC in 2003:

Year	# of cases reviewed	# of deaths involved
2003	11	24
2004	9	11
2005	14	19
2006	13	21
2007	15	25
2008	**15**	**17**
Total	**77**	**117**

The results of the data collection process are detailed in the statistical analysis presented in Chapter 2 of this report. Risk factor definitions are included in **Appendix "B"**

The summaries and recommendations resulting from each of the 15 cases reviewed in 2008 are presented in Chapter 3 of this report.

Recommendations

One of the primary goals of the DVDRC is to make recommendations aimed at preventing deaths in similar circumstances and reducing domestic violence in general. Recommendations involving specific organizations and agencies are distributed through the applicable Regional Supervising Coroner. Recommendations that are more general in nature, or with province-wide implications, are distributed through the Chief Coroner.

Similar to recommendations generated through coroner's inquests, the recommendations developed by the DVDRC are not legally binding and there is no obligation for agencies and organizations to implement or respond.

Review and Report Limitations

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

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

The case summaries included in Chapter 3 are intended to provide a general sense of the circumstances that led to the deaths and subsequent issues that were considered by the committee when formulating recommendations. The summaries are an overview of key elements of the case and do not necessarily include all details or issues examined by the DVDRC.

Disclaimer

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

> ***This document was produced by the DVDRC for the sole purpose of a coroner's investigation pursuant to section 15 (4) of the Coroners Act, R.S.O. 1990 Chapter c. 37, as amended. The opinions expressed do not necessarily take into account all of the facts and circumstances surrounding the death. The final conclusion of the investigation may differ significantly from the opinions expressed herein.***

Chapter Two
Statistical Overview

Introduction

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

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

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

It is also important to note that reviews conducted by the DVDRC are completed only after all other investigations and proceedings – including inquests, criminal trials and appeals – have been completed. As such, DVDRC reviews often take place several years after the actual incident. DVDRC reviews completed within any given calendar year may relate to deaths that occurred several years previous.

Section 1 of the statistical overview provides an examination of the number of domestic violence deaths, as defined by the DVDRC, that have taken place in Ontario between 2002 and 2007. A significant number of the deaths noted in these statistics have not yet undergone a comprehensive review by the DVDRC as investigations and/or other proceedings are still ongoing.

Section 2 of the statistical overview provides an examination of the cases that were reviewed by the DVDRC during the 2008 calendar year. All investigations and/or proceedings (including appeals) were completed before these cases were reviewed by the DVDRC.

Section 1 Statistical Overview of Domestic Violence Deaths - 2002-2007

The following charts pertain to the number of domestic violence deaths, as defined by the DVDRC Terms of Reference, that have taken place in Ontario between 2002 and 2007. The specific details of these deaths have been obtained by examining reports prepared by investigating coroners.

Table 1 below outlines the total number of domestic violence deaths that occurred in Ontario between 2002 and 2007. There were a total of 166 domestic violence death cases that resulted in 230 deaths involving 142 women, 23 children, and 65 men. The majority of male deaths were suicides by the perpetrator. Table 2 illustrates the number of adult victim, perpetrator, and bystander deaths for women and men.[1] Child fatalities are excluded from this table.

[1] Bystander is defined as a family member, friend or acquaintance of the victim and/or perpetrator who happened to be present during the incident but may not have been a primary target.

Table 1 –Domestic Homicide-related Deaths in Ontario 2002-2007 [2]

Year	Incidents	Deaths	Women	Children	Men
2007	23	35	21	3	11
2006	30	44	26	12	6
2005	31	38	27	0	11
2004	29	38	24	1	13
2003	25	32	22	1	9
2002	28	43	22	6	15
Total:	**166**	**230**	**142**	**23**	**65**

Table 2 –Adult Victim, Perpetrator, and Bystander deaths in Ontario Domestic Homicides from 2002-2007

	Women			Men		
Year	**Victims**	**Perpetrators**	**Bystanders**	**Victims**	**Perpetrators**	**Bystanders**
2007	17	1	3	4	7	0
2006	26	0	0	2	4	0
2005	27	0	0	0	11	0
2004	23	1	0	2	11	0
2003	22	0	0	1	8	0
2002	21	0	1	2	11	2
Total:	**136**	**2**	**4**	**11**	**52**	**2**

Table 3 illustrates that the majority of domestic violence fatalities involved a single homicide, followed by homicide-suicide, attempted homicide-suicide, attempted homicide and related homicide, i.e. police shooting. *Reviewing cases of attempted homicide is no longer within the mandate of the DVDRC. The statistics on attempted homicide cases will be included in this year's annual report, but not in subsequent years.*

Table 3 – Types of Domestic Violence Fatalities 2002-2007

Type	Number of Cases	Percent % (n=166)
Homicide	111	67.0 %
Homicide-suicide	41	25.0 %
Attempted homicide-suicide	11	6.0 %
Attempted homicide and related homicide	3	2.0 %
Total	**166**	**100 %**

Table 4 shows that the majority of perpetrators of domestic homicides are male and the majority of victims are female. The main cause of death in Ontario for victims has been stabbing, followed by shooting and strangulation. Research has shown that non-fatal strangulation is a risk factor for subsequent domestic homicide in relationships with intimate partner violence; perpetrators have commonly used strangulation as a means to kill their intimate partners.[3] Approximately 33% of the 166 domestic homicide cases in Ontario involved the perpetrator committing suicide after killing or attempting to kill their partner or ex-partner. Almost half of the perpetrators killed themselves by a self-inflicted gunshot wound.

The majority of domestic homicides occur in a residence, with most occurring in the couple's shared residence or in the residence of the victim (if separated).[3]

[2] Numbers are based on statistics from the Office of the Chief Coroner
[3] Glass, N., Laughon, K., Campbell, J., Block, C.R., Hanson, G., Sharps, P.W., & Talliaferro, E. (2008). Non-fatal strangulation is an important risk factor for homicide of women. *The Journal of Emergency Medicine*, 35(3), 329-335.
[3] Source-Coroner's reports for place of injury/death

Table 4 – Descriptive Factors of all Domestic Violence Fatalities (2002-2007)

Category	Variable	Number of Cases	Percentage %
Gender of Victim	Female Male	152 14	92% 8%
Gender of Perpetrator	Female Male	14 152	8% 92%
Cause of Death for Victims	Stabbing Shooting Strangulation Other	57 34 28 47	34% 21% 17% 28%
Cause of Death for Perpetrators	Shooting Other	26 28	48% 52%
Location of Domestic Homicides	Residence Other	132 34	80% 20%

Table 5 illustrates that domestic homicides are not isolated to urban centres. Smaller communities (population of 50,000 or less) represent only 4.5% of Ontario's population, but over 25% of all domestic homicides.

Table 5 – Number of Domestic Homicides in Specific Populated Cities (2002-2007)

Population	Number of Cases	Percentage of all Domestic Homicides in Ontario %	Percentage of Ontario's Population %[4]
Over 1,000,000	40	24.0 %	19.0 %
500,001 to 1,000,000	26	16.0 %	25.0 %
100,001 to 500,000	42	25.0 %	29.0 %
50, 001 to 100,000	16	9.5 %	5.0 %
10,001 to 50,000	26	16.0 %	4.0 %
0 to 10,000	16	9.5 %	0.5 %

[4] Statistics Canada reported the population of Ontario as 12,929,000 in 2008

Section 2 - Statistical Overview of Cases Reviewed by the DVDRC in 2008

The following statistics are an analysis of data from the 15 cases reviewed in 2008, as well as an overview of all cases reviewed by the DVDRC since 2003. Table 6 outlines the number of reviewed cases that occurred in a particular year. Delays in reviewing the cases, as previously noted, are usually a result of matters being before the criminal courts.

Table 6 – Year of Homicide for Cases Reviewed in 2008

Year of Occurrence	Number of Cases
2002	1
2003	2
2004	5
2005	1
2006	6
2007	0
Total	**15**

Table 7 compares characteristics of victims and perpetrators and provides insight into some of the possible risk factors for domestic homicides. The aggregate data shows that the majority of perpetrators were male, with a significant percentage of them having a criminal history (although not necessarily related to domestic violence). A high percentage of victims and perpetrators had significant life changes prior to the domestic homicide, including a separation, pending divorce, major medical or mental health problem or financial difficulties.

Table 7 – Characteristics of the Victims and the Perpetrators

Category	Variable	2008				2003-2008 Combined			
		Victim (n = 15)		Perpetrator (n = 15)		Victim (n = 77)		Perpetrator (n = 77)	
Gender	Female	15	100%	0	0%	74	95%	5	6%
	Male	0	0%	15	100%	3	5%	72	94%
Age (years)	Min	23	-	21	-	15	-	17	-
	Max	66	-	68	-	81	-	89	-
	Mean	35	-	35	-	38	-	40	-
Employment	Employed	7	47%	8	53%	36	47%	31	40%
	Unemployed	5	33%	6	40%	21	27%	29	38%
	Other	3	20%	1	7%	20	26%	17	22%
Criminal History	Yes	2	13%	12	80%	12	16%	48	62%
Prior Counselling	Yes	10	67%	7	47%	31	40%	33	43%
Significant Life Changes	Yes	13	87%	13	87%	53	69%	68	88%

Table 8 shows the majority of domestic homicides occurred within couples who were legally married for a period of ten years or less. Many of these couples had children in common.

Table 8 – Relationship between Victim and Perpetrator

Category	Variable	2008		2003-2008 Combined	
		n = 15		n = 77	
Type of Relationship	Legal Spouse Common-law Boyfriend/girlfriend (incl. same sex)	5 6 4	33% 40% 27%	40 17 20	52% 22% 26%
Length of Relationship	<1 year 1 – 10 years 11 – 20 years Over 20 years	3 10 1 1	20% 66% 7% 7%	8 43 13 13	10% 56% 17% 17%
Children In Common	0 1-2 3+	8 7 0	53% 47% 0%	35 32 10	45% 42% 13%

The majority of domestic violence fatalities reviewed by the DVDRC in 2008 were single homicides followed by homicide-suicides (Table 9). *Reviewing attempted homicide cases is no longer within the mandate of the committee and will not be reported in subsequent annual reports.* The main causes of death for victims were stabbing/sharp force injuries and gunshot wounds.

Table 9 – Domestic Homicide Information

Category	Variable	2008		2003-2008 Combined	
		n = 15		n = 77	
Type of Case	Homicide	12	80%	36	47%
	Homicide-suicide	2	13%	25	32%
	Attempt homicide-suicide	0	0%	9	12%
	Multiple homicide-suicide	0	0%	4	5%
	Multiple homicide	1	7%	3	4%
Cause of Death for Victims	Stabbing/sharp force	4	27%	25	32%
	Gunshot wounds	2	13%	19	25%
	Other	9	60%	33	43%

Table 10 analyzes common risk factors that may increase the risk of lethality. Consistent with past DVDRC reports, the most common risk factor involved with a domestic homicide is an actual or pending separation. Other prevalent risk factors include: a history of domestic violence, obsessive behaviours by the perpetrator (e.g. stalking), reports of depression for the perpetrator, and an escalation of violence. A risk factor coding form is completed for each case reviewed by the DVDRC. This form, together with definitions for each risk factor, is included as **Appendix "B"**.

Other factors that may contribute to problems with intimate relationships include: health issues, financial difficulties, isolation, gambling addiction, and conflict with extended family members.

Table 10 – Common Risk Factors from DVDRC Review

Risk Factors	2008		2003-2008	
	n (n=15)	Percentage	n (n=77)	Percentage
Actual or pending separation	13	87%	62	81%
History of domestic violence	14	93%	61	79%
Obsessive behaviour displayed by perpetrator	9	60%	48	62%
Perpetrator depressed in the opinions of professionals (e.g., physician, counsellor) and/or non-professionals (e.g., family, friends, etc)	6	40%	45	58%
Escalation of violence	8	53%	44	57%
Prior threats to kill victim	8	53%	39	51%
Prior threats/attempts to commit suicide	9	60%	37	48%
History of violence outside the family	10	67%	34	44%
Prior attempts to isolate victim	6	40%	33	43%
Victim had intuitive sense of fear	7	47%	33	43%
Excessive alcohol and/or drug use	7	47%	32	42%
Access to or possession of firearms	4	27%	31	40%
Control of most or all of victim's daily activities	5	33%	31	40%
Perpetrator unemployed	5	33%	30	39%
An actual or perceived new partner in victim's life	6	40%	27	35%
Perpetrator failed to comply with authority	7	47%	27	35%
Prior threats with a weapon against victim	4	27%	25	32%
Perpetrator was abused and/or witnessed domestic violence as a child	5	33%	24	31%
Perpetrator displayed sexual jealousy	5	33%	24	31%
Extreme minimization and/or denial of spousal assault history by perpetrator	2	13%	21	27%
History of violence or threats against children	4	27%	21	27%
Victim and perpetrator living common-law	7	47%	18	23%
Choked victim in the past	6	40%	17	22%
Prior hostage-taking or forcible confinement	2	13%	16	21%
Other mental health/psychiatric problems	4	27%	16	21%
Age disparity between couple	2	13%	15	19%
Misogynistic attitudes displayed by perpetrator	4	27%	15	19%
Prior Assault with a weapon	2	13%	13	17%
Youth of couple	2	13%	12	16%
Presence of stepchildren in the home	3	20%	12	16%
Child custody or access disputes	2	13%	11	14%
Prior destruction of victim's property	3	20%	11	14%
After risk assessment perpetrator had access to victim	4	27%	11	14%
Forced sexual acts/assaults on victim by perpetrator	1	7%	8	10%
Prior violence against victim's pets	0	0%	3	4%
History of suicidal behaviour in perpetrator's family	0	0%	3	4%
Prior assault on victim while pregnant	1	7%	2	3%

Figure 1 and Figure 2 illustrate the number of risk factors present in cases reviewed by the DVDRC. The recognition of multiple risk factors within a relationship allows for enhanced risk assessment, safety planning and possible prevention of future deaths related to domestic violence.

Figure 1 – Number of Risk Factors Identified in Cases Reviewed in 2008

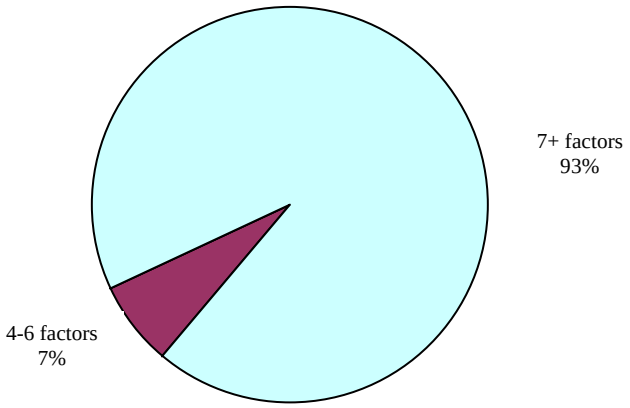
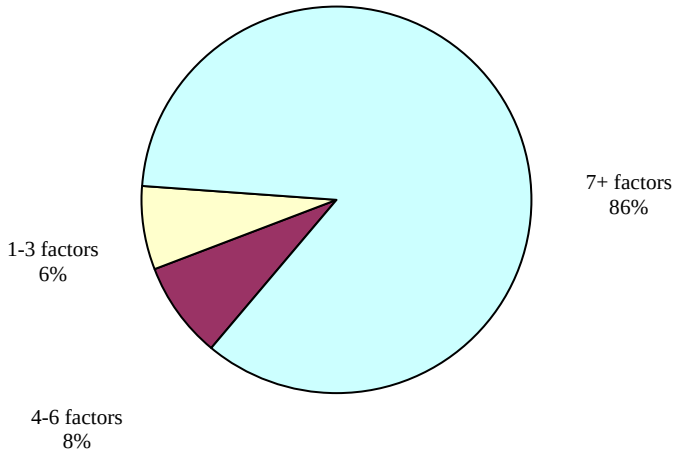


Figure 2 – Number of Risk Factors Identified in Cases Reviewed for 2003-2008



Chapter Three
Case Summaries and Recommendations

Case One
OCC file number: 2006-2602

This case involved the homicide of a female victim by her male partner. The victim and perpetrator had been dating for four months at the time of the homicide. The perpetrator had a long criminal history that included uttering threats, aggravated assault, assault, forcible confinement, failure to comply with probation orders and failure to attend court. The perpetrator also had a history of domestic violence with previous partners and was ordered to abstain from using alcohol and drugs. The perpetrator was not to have any contact with the victim after he was charged with breaking and entering into her home and criminal harassment. The victim willingly met up with the perpetrator and requested that the charges against him be dropped.

The perpetrator was extremely jealous and had left over 100 abusive text messages on the victim's telephone. Co-workers and neighbours suspected that the victim was being physically abused. On the day of the homicide, the perpetrator had used crack cocaine. The victim was stabbed to death.

There were 17 risk factors identified.

Recommendation 1:

To Ministry of the Attorney General:

It is recommended that judges receive continuing education on understanding and recognizing the dynamics of domestic violence and the risk factors for lethality. Judges need to receive and review all the information on a case to make appropriate decisions, for example, in bail hearings. Furthermore, it is recommended that the Ontario Court of Justice consider using high-risk cases where judicial interim releases occurred, as reviewed by the DVDRC, as case scenarios as part of the ongoing educational programs for Justices of the Peace who conduct the majority of bail hearings in the province.

Committee Comments: It appears as though the judge that presided over the bail hearing may not have recognized the high level of risk the perpetrator posed to the victim. The investigating police officer opposed bail for this perpetrator because he was aware of the perpetrator's domestic violence history. The judge may not have had all necessary information at the bail hearing, including the fact that the perpetrator did not complete a required batterer's program for an assault on a past partner.

Recommendation 2:

To Ministry of Community Safety and Correctional Services and the Ministry of the Attorney General:

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

Committee Comments: The perpetrator was allowed out on bail with his father acting as his surety. The perpetrator's father did not make his son go to counselling, nor did he monitor his son's whereabouts. The perpetrator admitted that he had visited a location that was in direct violation of his probation. The surety knew of the breach of probation, but apparently did not do anything.

Recommendation 3:

To Ministry of Community Safety and Correctional Services:

It is recommended that police put processes into practice to identify, monitor, and manage high-risk cases, and to vigorously enforce bail conditions arising from a violent offence or threat of violence

Committee Comments: The police were aware of the high risk this perpetrator posed due to his past police record and prior convictions for domestic assault. The perpetrator was released on bail even when the investigating officer opposed the decision. The victim and the perpetrator were breaking the bail conditions regularly when they would have contact with each other.

Recommendation 4:

To Ontario Women's Directorate:

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.

Committee Comments: Many friends, family members, and co-workers were aware of the abuse that was occurring between the perpetrator and the victim. However, no one knew exactly what to do about the situation or how to help. The victim was unable to recognize the danger that she was in and her friends and co-workers did not seem to know how to intervene effectively.

Recommendation 5:

To Ministry of Labour:

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

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

Committee Comments: The perpetrator was known to harass his partners at their places of employment. Co-workers and employers knew that something was going on and may not have known what to do to effectively intervene.

Recommendation 6:

To Ministry of Children and Youth Services; and Ontario Association of Children's Aid Societies:

It is recommended that the Ministry of Children and Youth Services and the Ontario Association of Children's Aid Societies provide enhanced training on a standardized risk/danger assessment tool and enforce the use of this tool in all cases where domestic violence and harassment are present. Once the level of risk has been identified for the victim, an adequate safety plan must be implemented. As well, it is essential that contact be made with the perpetrator to assist in the risk assessment and risk management process.

Committee Comments: The victim and the CAS did not seem aware of the level of risk posed by the perpetrator. A standardized risk assessment, had it been done, may have caused alarm to both the CAS and the victim and the appropriate actions to maintain the victim's safety could have been implemented. Although it appears the CAS made some attempt to contact the perpetrator without success, this contact should have been made a priority under these circumstances.

Case Two
OCC file number: 2004-12153

This case involved the homicide of a female victim by her intimate male partner of three years. The perpetrator claimed that he was asleep when the victim started to assault him after she returned home after a night of drinking with another male. The perpetrator fought back by wrapping the victim's head with plastic wrap. The victim died from suffocation.

The perpetrator had an extensive criminal history including: attempted murder, assault, break and enter, theft, domestic violence related assault, failure to comply with probation and drug related offences. The perpetrator's father was reportedly an abusive alcoholic. The perpetrator had a difficult childhood and demonstrated serious behavioural and anti-social problems at a young age. The perpetrator started using drugs and alcohol during his teenage years and continued to have substance abuse problems into adulthood.

The perpetrator had significant involvement with the mental health system and was hospitalized a number of times between 1991- 1999 with Bipolar, Polysubstance Abuse Disorder, Antisocial and Impulsive, Mixed Personality Disorder and Dysthymia. He was on a number of medications for his mental health issues.

The victim had previous unsuccessful and abusive relationships. The victim had a number of involvements with the criminal justice system, all of which were related to her alcohol abuse and mental health issues.
There were 18 risk factors identified.

Recommendation 1:

To Ontario Women's Directorate; and Ministry of Health and Long Term Care:

Funding and resources should be provided to create joint training opportunities for those working in mental health agencies and those working in violence against women services to ensure a more integrated and holistic response that can more effectively respond to the complexities of individual situations.

Committee Comments: It is important to build the capacity of those working in both sectors to better understand mental health issues and interventions, as well as to understand the complexities and dynamics of abusive relationships. The goal of joint training opportunities must be to create more informed and effective responses by practitioners in two different sectors who tend to work in isolation.

Recommendation 2:

To Ministry of Health and Long Term Care:

A common risk assessment tool should be developed and mental health practitioners should be trained to effectively and systemically utilize the tool to identify potential risks.

Recommendation 3:

To Ontario Women's Directorate; Ministry of Health and Long Term Care; and Ministry of Community Safety and Correctional Services:

Adequate levels of support and resources should be made available to services that can respond to individuals with multiple problems so that interventions can be organized to meet the particular needs of the individual, as opposed to being organized to meet the needs of a particular agency.

Committee Comments: This case demonstrates the need for services and interventions that can respond to the multiple problems that individuals have and the requirement for integrated and comprehensive services geared to the particular and complex needs of an individual. Individuals for example, may require both substance abuse *and* woman abuse services.

Recommendation 4:

To Ministry of Community Safety and Correctional Services:

Probation officers should utilize a common risk assessment tool as it relates to woman abuse and lethality. Although probation officers routinely use the LSI tool, often the dynamics and issues related to abusive relationships are not identified or dealt with, in any involvement. The explanation for this is that the focus of the intervention is on 'criminal behaviour'.

Recommendation 5:

To Ministry of Community Safety and Correctional Services:

Probation officers should receive training on the inter-relationship between substance abuse issues and intimate partner violence so that they can better respond and intervene with individuals who have a multiplicity of issues. This training would assist probation officers to effectively intervene with individuals who are in abusive and high risk relationships.

Recommendation 6:

To Ministry of Health and Long Term Care; and Ministry of Community and Social Services:

When an individual attempts suicide, there should be appropriate follow-up, support and referral to agencies that can explore the issues that resulted in the attempt. Criminal justice responses and interventions are generally not as effective as interventions from social and community based organizations and services.

Recommendation 7:

To Ministry of the Attorney General; and Ministry of Community Safety and Correctional Services:

The province should identify a process to ensure enforcement of attendance at court-mandated programs for batterers. Enforcement should include effective methods of tracking and monitoring offenders, mechanisms for systematically identifying levels of risk and risk management that is inter-disciplinary and inter-sectoral in nature.

Case Three
OCC file number: 2004-9653

This case involved the homicide of a female victim by her male partner who was 16 years younger. The victim confronted the perpetrator with allegations of infidelity, by hitting him while he slept. The perpetrator responded by strangling the victim.

The couple met in an Internet chat room. When they met, the victim was married to another partner. The victim and her former partner had grown children. The perpetrator, the victim and her former partner lived together in the U.S. The victim divorced her partner and married the perpetrator. The couple then moved to Canada.

The perpetrator grew up in Ontario and did not have any criminal history, although there were unreported allegations of fighting and abuse. The perpetrator became openly hostile to his spouse and told his co-workers that he wanted to kill her. Despite fairly specific threats, no one contacted the police. The perpetrator was employed and had a high school education.

The victim's former partner was abusive to her and her children. The victim suspected that the perpetrator was involved in a relationship with a co-worker and had confronted him with her allegations.

There were 5 risk factors identified.

No recommendations

Case Four
OCC file numbers: 2002-8813 and 2002-5659

This case involved the homicide of a female victim and subsequent suicide of her male partner, the perpetrator. The couple lived common-law for seven years and had two children together. The couple appeared to be happy with no outward signs of problems. The victim was not happy in the relationship with the perpetrator and had started to see another male. The perpetrator reacted calmly to learning of the new relationship and made arrangements to obtain a lawyer to seek custody of the children. The victim announced her intent to separate just two weeks prior to the homicide. Shortly thereafter, the perpetrator confronted the victim with a baseball bat. The victim died of blunt trauma head injury. The perpetrator subsequently committed suicide by shooting himself with a shotgun.

There were 7 risk factors identified.

Recommendation 1:

To Ontario Women's Directorate:

It is recommended that the Ontario Women's Directorate continue to educate the members of the public who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence and provide information on practical steps that can be taken to reduce the risk for assault and lethality at the time of relationship breakdown.

Recommendation 2:

To Ontario Women's Directorate:

It is recommended that criteria used in determining financial grants for the development of all information packages on domestic violence, training packages or any public education announcements should include a mandatory segment on the potential risk of lethal violence at the time of relationship break-down and provide family and friends with recommendations on how to support a "safe" break-up/separation.

Case Five
OCC file number: 2006-3026

This case involved the homicide of a female victim by her former male partner. The victim was estranged from her husband and had started a relationship with the perpetrator. The victim was in the process of reconciling with her husband, who was the employer of the perpetrator. The victim informed the perpetrator about her plans for reconciliation. While at the victim's residence, the perpetrator attacked her with an axe and killed her while she slept.

The perpetrator had an unconfirmed history of weapons dangerous offences within a domestic situation in 1999.

The victim had visited her family doctor and received counselling relating to her marriage and relationship with the perpetrator. The victim disclosed that the perpetrator had threatened to kill himself unless she returned to him. She also disclosed a previous physical altercation. The doctor voiced his concern to the victim about the mental stability of the perpetrator and stated that he was fearful of a murder/suicide. The doctor discussed contacting the police and getting a restraining order against the perpetrator. The doctor further sought, and was granted, the victim's permission to contact her husband to discuss his concerns. As a result of the call from the doctor, the victim's husband changed the locks and secured the windows on the residence. The victim's husband also told the victim to advise him if the perpetrator ever contacted her.

There were 9 risk factors identified.

Recommendation 1:

To Ontario Women's Directorate:

There is a continuing need to better educate family members, friends, and colleagues who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence. Public education should include action plans for persons who encounter individuals involved in domestic violence, and in particular address the increased risk associated to separation or pending separation and workplace stalking issues. In particular, this education should include a methodology to identify the risk factors for potential lethality and the specific steps to take when they are identified.

Committee comments: In this case, family, friends, neighbours and co-workers knew that the accused had assaulted the victim previously. In addition, many of them knew that the accused had threatened suicide and had made threatening comments similar to, "If I can't have you, no one can". The victim also disclosed to some friends that she feared that the accused would kill her. In addition, co-workers observed the accused stalking the victim at her place of employment. Notwithstanding this, no one seemed to recognize the risk of harm. The victim herself seemed to underestimate the danger she was in even though her doctor voiced his concern with her over his fears that the accused could perpetrate a murder/suicide.

Case Six
OCC file number: 2003-7749

This case involved the homicide of a female victim by her estranged common-law male partner. The couple had been in a relationship for 20 years, had been separated for 1.5 years and had two children together. The victim had begun dating another man.

There had been numerous separations throughout the couple's relationship due to domestic violence. The perpetrator was intermittently employed and had previous criminal convictions for assault, public mischief and dangerous driving. Family, friends and co-workers had reported that the perpetrator had a bad temper, had been involved in 'road rage' incidents and had threatened the safety of his wife and children. The victim had discussed her concerns about her personal safety with her family doctor.

There were reported incidents of the perpetrator watching the victim's residence. The children appeared to be afraid of the perpetrator and felt intimidated by his physical stature and temper.

The perpetrator was depressed and had recently become very upset about a request from the Family Responsibility Office for outstanding child support payments. The perpetrator had made prior threats to kill the victim and had previously threatened suicide.

The victim was attacked in her residence by the perpetrator. The cause of death was ligature strangulation complicated by blunt force head trauma.

There were 21 risk factors identified.

Recommendation 1:

To Ministry of the Attorney General:

It is recommended that the Ministry of the Attorney General design and implement a public education campaign that explains Restraining Orders in an understandable manner to laypersons.

Committee Comments – There was evidence that the victim was advised to get a restraining order against the perpetrator. For some reason, the victim felt she needed to gather more evidence (e.g. video) of the perpetrator driving by her home and harassing her.

Recommendation 2:

To Ministry of the Attorney General:

The Ministry of the Attorney General should review current courses and resource materials to ensure that information pertaining to restraining orders is easily available to all lawyers practicing family law.

Recommendation 3:

To Ministry of Health and Long Term Care:

Training for all mental health professionals should include assessment and intervention strategies dealing with male depression and the link between depression, suicidal ideation and domestic homicide.

Committee Comments – There was considerable evidence about the perpetrator's depression and suicidal ideation, but no risk assessment or intervention directed at the domestic violence or potential risk for lethal violence.

Recommendation 4:

To Ministry of Community Safety and Correctional Services:

The Ministry of Community Safety and Correctional Services should expand police standards in domestic violence cases to include risk assessment for all calls for assistance with a history of domestic violence, even when no assaults have taken place.

Committee Comments - The victim called the police for assistance when she felt concerned about potential problems with the perpetrator. Although no assault had taken place, the intervention was an opportunity to assist the victim through a risk assessment and safety planning as well as potential advice on a restraining order. It would appear that these interventions are generally not initiated unless charges are laid.

Recommendation 5:

To Ministry of Community and Social Services; and Family Responsibility Office:

When assessing applications for support, the Family Responsibility Office (FRO) should ask applicants to identify potential safety threats, including violence that may arise from support enforcement activities.

Committee comments – The FRO served notice on the perpetrator that he was in arrears in his child support payments. This came at a time of heightened stress, poor mental health and harassing behaviour. A safety plan for the victim and heightened vigilance about domestic violence may have been indicated.

Case Seven
OCC file number: 2006-12590

This case involved the homicide of a female victim by her common-law male partner. The victim had lived with the perpetrator for five months. Their relationship was one of constant conflict and both individuals had a history of alcohol and drug use. There had been a history of domestic violence and the perpetrator had a lengthy criminal history including: break and enter, weapons offences, trafficking and assault. A few months prior to the homicide, the perpetrator had been charged with unauthorized possession of a firearm and was advised not to have drugs, alcohol or a weapon. The victim was appointed as the perpetrator's surety at that time.

The victim had a history of Obsessive-Compulsive Disorder, Anxiety and Panic Disorder and was on medication. The victim was unemployed, but sometimes did housecleaning. The victim had moved out of the perpetrator's residence temporarily, but returned as she could not find a place to live.

On the evening of the homicide, the perpetrator used cocaine. The couple had an argument regarding money and the perpetrator assaulted and killed the victim, then buried her body outside. The cause of death was neck compression consistent with strangulation. The perpetrator subsequently attempted suicide, but survived.

There were 8 risk factors identified.

No recommendations.

Case Eight
OCC file numbers: 2006-8406 and 8407

This case involved the homicide of a female victim and subsequent suicide of her male partner, the perpetrator. The couple had been married for 34 years and had a tumultuous relationship that included encounters with the police dating back to 1983. The couple were in the process of separating and selling their home.

The perpetrator was said to be compulsive and controlling and was very upset about the impending sale of his home. The victim had told people that she wanted a divorce and that she feared her husband would kill her. The victim had developed medical problems and possibly mental problems.

The victim died after being stabbed by the perpetrator. The perpetrator called police and stated that he had killed his wife and was about to commit suicide. The victim and perpetrator were both found deceased by the police.

There were 11 risk factors identified.

No recommendations.

Case Nine
OCC file number: 2004-5084

This case involved the homicide of a female victim by her common-law male partner. The couple had been together for four years and had a 13 month old child together. The perpetrator was described as being arrogant, controlling, manipulative and possessive. The perpetrator controlled what the victim said to her family, who her friends were and what religion she followed.

The victim had openly discussed concerns regarding her safety to her family. The perpetrator indicated that he would hurt the victim's family if she ever left him. The perpetrator had a long criminal history dating back to 1980 when he was a youth and included robbery, assault causing bodily harm, trafficking, theft, breach of recognizance, possession of controlled substances and possession of weapons. The perpetrator was unemployed, but acquired money through criminal behaviour.

The victim was shot by the perpetrator while attending a family gathering at the perpetrator's mother's house.

There were 13 risk factors identified.

No recommendations.

Case Ten
OCC file number: 2003-10158

This case involved the homicide of a female victim by her male partner. The couple were married for 7.5 years and had one child. There were confirmed reports of domestic violence three years prior to the homicide. Four months prior to the homicide, the perpetrator assaulted the victim and was incarcerated for four weeks. The perpetrator was discharged on bail to his parents and was ordered not to communicate with the victim.

Following the court appearance, the perpetrator began displaying bizarre persecutory and paranoid behaviour and had threatened suicide. The perpetrator received psychiatric services, but there was no follow-up once released. The psychiatric caregivers were not aware of the domestic violence.

The families of both the victim and perpetrator were aware of the domestic violence.

The perpetrator stabbed the victim to death, and then called police to report the homicide.

There were 9 risk factors identified.

No recommendations.

Case Eleven
OCC file number: 2004-6039

This case involved the homicide of a female victim by her male partner. The victim was attempting to end her dating relationship with the perpetrator. There was a severe incident of abuse which involved strangling/choking, uttering a death threat and stealing the victim's car. The perpetrator was held in custody, and then released with a no-contact order and other conditions, including abstaining from alcohol and attending a counselling program. The perpetrator had no previous criminal record.

Although there was a no-contact order, the victim and perpetrator continued to have contact.

On the evening of the homicide, the perpetrator and victim were seen together in a local bar. The perpetrator was jealous and angry that the victim was conversing with other people. The perpetrator was removed from the bar for disruptive behaviour and excessive drinking. The victim was escorted home by two acquaintances who were concerned for her safety. Upon arrival home, the victim had an unrelated verbal argument with her daughter who lived in the basement with her infant child. The police were called and the daughter was advised to leave the residence and the infant would remain in the house with her grandmother, the victim.

At some point during the evening, the perpetrator returned to the victim's residence. Subsequently, there was an explosion and fire at the residence and the victim was found deceased. The infant and perpetrator were not injured. Autopsy results indicate that the victim died from stab wounds, prior to the fire.

There were 10 risk factors identified.

Recommendation 1:

To Attorney General for Canada:

The term "choking" should be revised to the term "strangulation" in the Criminal Code as that term more accurately reflects a serious, intentional act of harm to a victim. "Choking" is a medical term describing aspiration of a food bolus or object and is not appropriate in a domestic violence context, whereas strangulation refers to the application of pressure to the neck .
In cases of strangulation or head injury, police personnel should consider taking a victim to the hospital to receive immediate medical attention, especially by medical personal who have specialized training in recognizing the repercussions of such serious situations (i.e. DV/SAC nursing teams are currently housed in many emergency departments across the province and are often under-utilized).

Recommendation 2:

To Ministry of the Attorney General:

In cases of severe incidents of harm that include death threats and strangulation, even if there is no documented history of domestic violence, there needs to be recognition of the severity of a single, but critical assault at a bail hearing and evidence put forward for this incident to be considered a higher risk case and thus managed in that manner.

Issues for consideration:

a) Proactive engagement of the victim

There is documentation that the Family Consultants phoned the victim after the assault and followed the call up with a letter. The victim did not respond, so the case was closed. If this had been deemed a higher risk case, there may have been some more sophisticated strategies in place to educate and engage the victim.

b) Continued support for the aims of the Neighbours, Friends and Families Campaign

There was clear evidence of excessive drinking by the perpetrator in the bar prior to the homicide, violent behaviour towards other customers and a death threat uttered towards the victim. Patrons of the bar, including bar staff, observed the behaviour. The police however, were not called. Two concerned customers walked the victim home to ensure her safety.

c) Emotional and verbal abuse

In the Domestic Violence Supplementary Report (DVSR) consideration should be given to enhance current risk factors to clearly define the presence of emotional and verbal abuse as an opportunity to educate the victim, and the officer to see this as part of a domestic violence history. This would minimize the likelihood of a victim saying there was no prior history of domestic violence as she did in this case; when clearly there was a history of very controlling, verbally and emotionally abusive behaviour.

Case Twelve
OCC file numbers: 2006-2139, 2141 and 2142

This case involved the homicide of a female and her two children by her male partner who was the father of the children. The couple was married for eight years and had separated two months prior to the homicides. The perpetrator often stayed over at the victim's residence on weekends to look after the children. The victim was known to meet men through online dating services and at bars. Just prior to the homicides, the victim advised the perpetrator that she had met a man from another province and was moving there with the children.

On the night of the homicide, the perpetrator was at the victim's residence looking after the children. The victim returned home after an evening out at a bar and proceeded to engage in an intimate telephone conversation with a male. The perpetrator overheard the conversation, became enraged and proceeded to bludgeon the victim and two children to death with a baseball bat. The perpetrator fled the scene and subsequently contacted police to report the homicides.

The perpetrator had a long criminal history including theft, robbery, possession of narcotics, weapons, fraud and breaking and entering. The perpetrator was reportedly physically and emotionally abused as a child while in foster care and claims to have been traumatized from spending 11 years in prison.

There were 10 risk factors identified.

Recommendation 1:

To Ministry of Children and Youth Services; and Ontario Association of Children's Aid Societies:

The Ministry of Children and Youth Services, in consultation with the Ontario Association of Children's Aid Societies, should enhance standards for CAS interventions in DV cases by requesting DV perpetrators be involved in specific provincially approved batterers' programs before allowing unsupervised visits with children or terminating the CAS involvement in a case.

Committee Comments: The CAS in this matter apparently never required a batterer's intervention program and accepted the suitability of anger management and marriage counselling alone, which is not supported by current provincial standards or research on batterer intervention.

Recommendation 2:

To Ministry of Children and Youth Services (MCYS); and Ontario Association of Children's Aid Societies (OACAS):

The MCYS, in consultation with the OACAS, should ensure an internal death review is conducted by the CAS in any case where a parent or child has been a domestic homicide victim and where there has been active CAS involvement within the previous year, or possibly longer.

Committee Comments: There was a high level of CAS involvement in this matter, but the file had been closed for over a year at the time of the homicide, so no internal review was completed. As there already exists a Memorandum of Understanding between the MCYS, OACAS and Office of the Chief Coroner that all children's death are reviewed when they have been under active involvement with a CAS or had involvement within the previous year, an extension of this practice to include any domestic homicide could be of considerable value.

Recommendation 3:

To Ontario Women's Directorate:

There needs to be broader public awareness about the danger of separation with a DV perpetrator directed at DV victims and the risks in maintaining ongoing relationships that jeopardize the safety of women and children.

Committee Comments: The victim apparently believed she could manage the risk in this circumstance despite the advice of her family who warned her about the danger of staying involved with the perpetrator. Research on domestic homicides suggests that half of homicide victims do not recognize the potential lethal danger they face from the perpetrator. There may be many factors including finances, child care and attempts at managing risk by avoiding the setting of clear separation boundaries. There is no intention to blame the victim for her death, but there is a need for public education on separation – e.g. "Don't just leave, leave safely." This campaign can be designed by OWD, in consultation with women's groups.

Case Thirteen
OCC file number: 2006-6545

This case involved the homicide of a female victim by her male partner. The couple were involved in an intermittent 7 month relationship. The victim had a long history involving drugs and prostitution.

The perpetrator was known to befriend prostitutes. The perpetrator had a history of violence, including assault and forcible confinement. Three months prior to the homicide, the perpetrator had been charged with uttering death threats against the victim and was subsequently ordered not to communicate with the victim. The victim and perpetrator continued to communicate, usually after initiation by the victim, as she sought financial and housing support from the perpetrator. The victim threatened to report the breach of order if the perpetrator did not comply with her requests for assistance.

On the evening of the homicide, the victim called the perpetrator and asked him to attend her residence. The couple argued and the perpetrator stabbed the victim several times in the neck and torso. The perpetrator fled the scene and later reported the crime to police.

There were 13 risk factors identified.

No recommendations.

Case Fourteen
OCC file number: 2005-19356

This case involved the homicide of a female victim by her male partner. The common-law couple had been in a relationship for five years and had one child who was in the custody of the perpetrator's parents. A child from a previous relationship was in the custody of the victim's parents. The couple's relationship was tumultuous and there was a history of domestic violence, some of which was witnessed by the children. The victim had been strangled, threatened with a knife and forcibly confined by the perpetrator. As a result of a judicial order, the perpetrator was supposed to live with his parents and not with the victim. Contrary to the order, the perpetrator often stayed at the victim's residence.

The perpetrator had a lengthy criminal record dating back to his youth. Charges included: break and enter, mischief to property, weapons dangerous, theft of a vehicle, obstruct justice, utter threats to cause bodily harm, assault, breach of recognizance, breach of undertaking, assault with a weapon, breach of probation and careless driving. The perpetrator was prohibited from possessing a weapon.

The victim had a history of sexual, alcohol and drug abuse.

The homicide occurred after the perpetrator and some friends attended the victim's residence where they were consuming alcohol and smoking marijuana. The perpetrator briefly left to retrieve a rifle from his parent's residence. When he returned, he engaged in a scuffle with a neighbour, then entered the residence and shot the victim.

25 risk factors were identified.

Recommendation 1:

To the Ministry of Community Safety and Correctional Services; Policing Standards Division; and the Ontario Association of Chiefs of Police:

It is recommended that the Domestic Violence Supplementary Report (DVSR) be enhanced to require a verbatim narrative response to risk assessment questions where the answer is "yes" or "unknown". Further, that this enhanced DVSR be mandated, prohibiting any deviation or change in the content, for use by all police services, including First Nation police services.

Recommendation 2:

To First Nation Police Services:

It is recommended that all First Nation police services reinforce with their members the requirements of the Domestic Violence Occurrences (LE24) and Firearms Occurrences (LE029) of the Provincial Adequacy Standard Guidelines regarding mandatory charge, completion of the Domestic Violence Supplementary Report (DVSR) and the seizure of firearms during the course of domestic violence occurrences. This training should be conducted on an annual basis placing an emphasis on ensuring officers are appropriately educated on their authorities to conduct weapons seizures with and without a warrant.

Recommendation 3:

To Ministry of Community Safety and Correctional Services; and the Ministry of the Attorney General:

An enhanced protocol should be established between police services and Crown counsel to ensure that persons proposed as surety:

a) are properly investigated as to their suitability to act as surety including an assessment of their lawful access to firearms;
b) can guarantee all possessed and accessible firearms are secured from the accused for the duration of the surety contract;
c) are fully informed about the totality of the allegations against the accused, including information about risk factors and potential lethality;
d) are fully informed about their responsibilities as surety, both in writing and on the court record, following required viewing of an educational videotape on their role, specific to domestic violence cases (e.g. Huron County Crown video);
e) are warned in writing and on the court record as to their potential liability under estreatment and as party to a criminal offence in the event they breach their duty;
f) can accept that each police department will assign a police officer to routinely call all sureties in high risk cases to verify bail compliance and the stability of the accused.

Recommendation 4:

To the Ministry of Community and Social Services; and the Ontario Women's Directorate:

It is recommended that Aboriginal-focused public awareness programs paralleling the Neighbours, Friends and Families campaign be implemented and made available to all First Nation communities across the province.

Kanawayhitowin is an example of an Aboriginal public awareness campaign that was launched in the Fall of 2007 to raise awareness about the signs of woman abuse in First Nation communities so that people who are close to at-risk women, or abusive men, can provide support. This program reflects a traditional and cultural approach to community healing and wellness. Educational materials include brochures, public service announcements, a training video and CD-ROM.

Case Fifteen
OCC file number: 2004-4348

This case involved the homicide of a female victim by her male partner. The couple had been married for three years and had two children together. The perpetrator reportedly had a temper, was depressed and had threatened suicide in the past. There were reports that the perpetrator was physically and verbally abusive to the victim. The mothers of both the victim and perpetrator were aware of the tension and abuse in the couple's relationship.

On the day of the homicide, the couple and their children went shopping and upon returning home, the perpetrator struck the victim with a hammer. The victim died of severe head trauma. The children were not injured. When police arrived, the perpetrator threatened suicide, but was subsequently apprehended.

There were 7 risk factors identified.

Recommendation 1:

To Ontario Women's Directorate:

Neighbours, friends and family should be educated about the dynamics of domestic violence and the need to take appropriate action.

Recommendation 2:

To Ministry of Health and Long Term Care; and Ontario Women's Directorate:

Appropriate risk assessment tools need to be used by mental health professionals when dealing with victims and perpetrators of domestic violence.

Recommendation 3:

To Ministry of Health and Long Term Care:

Mental health professionals should have training in the dynamics of domestic violence, including high risk case management and intervention strategies, in particular, safety planning.

Chapter Four
Separation as a Critical Risk Factor

Since its inception, one of the main goals of the DVDRC has been to identify critical risk factors associated with domestic homicides. One factor that has repeatedly surfaced is the risk of an actual or pending separation between the couple. In a review of 72 domestic homicides*, an actual or pending separation was observed in 81% of the cases, with 56% (40) of these cases involving an actual separation and 25% having a pending separation. Analyses on the sample of cases classified as having an actual separation revealed that in 45% of these cases, the couple had been separated for three months or less. Two-thirds of the homicides occurred within six months of separation. In 12.5% (5) of the cases, couples were separated for longer than one year, but in 3 of the 5 cases divorce proceedings had been initiated within three months of the homicide (see Table 1). These statistics are consistent with research findings indicating that the period immediately after separation is most dangerous for abuse victims.[5] [6]

* The analysis is on 72 cases out of our total 77 cases which involve a male perpetrator of homicide. The other 5 cases involve female perpetrators and same-sex relationships which require a separate analysis but the numbers are felt to be too small at this point for any meaningful comparisons or analysis.

Table 1 – Length of Separation

Separated for 3 months or less	**45%** (18 Cases)
Separated for 3 months to 6 months	**22.5%** (9 cases)
Separated for 6 months to one year	**15%** (6 cases)
Separated for more than one year	**12.5%** (5 cases) [(3 cases) had divorce proceedings initiated within 3 months of the homicide]
Length of separation unknown	**5%** (2 cases)
Total	**100% (40 cases)**

Findings from the Washington State Domestic Violence Fatality Review Board are similar to those described for Ontario above.[7] Specifically, the review board noted that the victim had separated from, or was attempting to leave the perpetrator in at least 47% of the domestic homicide cases examined in their 2008 annual report. Furthermore, it was reported that between 1997 and 2006, 33% of domestic homicide victims and 43% of child victims were clients of the Department of Social and Health Services' Division of Child Support prior to the actual homicide. Twenty-one percent of these adult victims and 50% of these child victims were killed by "the non-custodial parent from whom child support was being collected" (Fawcett et. al., 2008, pg. 59). The Washington State Review Board stated that "efforts to collect child support from abusive fathers can motivate abusers to re-engage with victims and potentially escalate the abuse." (Fawcett et. al., 2008, pg. 57).

The relationship between separation and support/custody issues was raised in a 2008 DVDRC review where the woman became involved with the Family Responsibility Office (FRO) for collection of unpaid

[5] Brownridge, D.A. (2006). Violence against women post-separation. *Aggression and Violent Behavior*, 11, 514-530.

[6] Gartner, R., Dawson, M., & Crawford, M. as cited in Brownridge, D.A. (2006). Violence against women post-separation. *Aggression and Violent Behavior*, 11, 514-530.

3Fawcett, J., Starr, K., & Patel, A. (2008). "*Now that we know" Findings and recommendations from the Washington State domestic violence fatality review*. Seattle, WA: Washington State Coalition Against Domestic Violence

child support from her partner. The woman was subsequently killed by her partner after he received notice of enforcement of his outstanding support payments. The DVDRC found that within the domestic homicide cases where couples were separated at the time of the death(s), a significant reason for continued contact between the victim and the perpetrator was to deal with issues related to children (see Table 2). The risk of domestic homicide may be increased when couples maintain contact through separation, for whatever reason. particularly when that contact relates to child custody issues.

Table 2 – Separated status: Reasons for ongoing contact

Children	**13%** (9 cases)
Reconciliation	**6.5%** (4 cases)
Financial issues	**6.5%** (4 cases)
Unknown	**4%** (3 cases)
Worked together	**3%** (2 cases)
Retrieving belongings/things	**1%** (1 case)
Perpetrator wanted to get back together (not stalking)	**1%** (1 case)
Maintained civil relationship	**1%** (1 case)
Victim concerned over perpetrator's mental health	**1%** (1 case)
No contact (includes 13 cases of stalking)	**19%** (14 cases)
Not separated	**44%** (32)

Implications of Findings:

The implications of these findings for professionals and family/friends/co-workers involved with victims and/or perpetrators of domestic violence include:

- Victims and the general public should be educated on the risk of separation and how to separate safely. Victims and their support networks need to understand that a separation can be a long, drawn-out process rather than a discrete event, and that victims may have to maintain contact with an abuser for issues involving children, financial concerns, or a variety of other reasons. Victims and the general public should be educated on the dynamics of a separation, particularly when domestic violence was involved in the relationship.
- Although statistics indicate that a victim is at greatest risk of domestic homicide when separated from, or in the process of separating from the perpetrator, future research should examine this risk factor in greater detail. Ongoing research should identify key elements of safe separations including critical steps and issues to be considered when facilitating a separation involving a couple with a history of domestic violence or with significant risk factors toward impending domestic violence.

Appendix A

DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE (DVDRC)
TERMS OF REFERENCE

Purpose:

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

Definition of Domestic Violence Deaths:

All homicides that involve the death of a person, and/or his child(ren) committed by the person's partner or ex-partner from an intimate relationship.

Objectives:

1. To provide and coordinate a confidential multi-disciplinary review of domestic violence deaths pursuant to Section 15(4) of the Coroners Act, R.S.O. 1990, Chapter c. 37, as amended.

2. To offer expert opinion to the Chief Coroner regarding the circumstances of the event leading to the death in the individual cases reviewed.

3. To create and maintain a comprehensive database about the victims and perpetrators of domestic violence fatalities and their circumstances.

4. To help identify the presence or absence of systemic issues, problems, gaps, or shortcomings of each case to facilitate appropriate recommendations for prevention.

5. To help identify trends, risk factors, and patterns from the cases reviewed to make recommendations for effective intervention and prevention strategies.

6. To conduct and promote research where appropriate.

7. To stimulate educational activities through the recognition of systemic issues or problems and/or:
   - referral to appropriate agencies for action;
   - where appropriate, assist in the development of protocols with a view to prevention;
   - where appropriate, disseminate educational information.

8. To report annually to the Chief Coroner the trends, risk factors, and patterns identified and appropriate recommendations for preventing deaths in similar circumstances, based on the aggregate data collected from the Domestic Violence Death Reviews.

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

Appendix B

Ontario Domestic Violence Death Review Committee Risk Factor Coding Form

A= Evidence suggests that the risk factor was not present
P= Evidence suggests that the risk factor was present
Unknown (Unk) = A lack of evidence suggests that a judgment cannot be made

Risk Factors:

1. History of violence outside of the family by perpetrator
2. History of domestic violence
3. Prior threats to kill victim
4. Prior threats with a weapon
5. Prior assault with a weapon
6. Prior threats to commit suicide by perpetrator (revised or new item)
7. Prior suicide attempts by perpetrator (if check #6 and/or #7, only count as one factor)
8. Prior attempts to isolate the victim
9. Controlled most or all of victims daily activities
10. Prior hostage-taking and/or forcible confinement
11. Prior forced sexual acts and/or assaults during sex
12. Child custody or access disputes
13. Prior destruction or deprivation of victim's property
14. Prior violence against family pets
15. Prior assault on victim while pregnant
16. Choked victim in the past
17. Perpetrator was abused and/or witnessed domestic violence as a child
18. Escalation of violence
19. Obsessive behaviour displayed by perpetrator.
20. Perpetrator unemployed
21. Victim and perpetrator living common-law
22. Presence of stepchildren in the home
23. Extreme minimization and/or denial of spousal assault history
24. Actual or pending separation
25. Excessive alcohol and/or drug use by perpetrator (revised or new item)
26. Depression – in the opinion of family/friend/acquaintance – perpetrator (revised or new item)
27. Depression – professionally diagnosed – perpetrator (if check #26 and/or #27, only count as one factor)
28. Other mental health or psychiatric problems – perpetrator
29. Access to or possession of any firearms
30. New partner in victim's life (revised or new item)
31. Failure to comply with authority – perpetrator
32. Perpetrator exposed to/witnessed suicidal behaviour in family of origin
33. After risk assessment, perpetrator had access to victim
34. Youth of couple
35. Sexual jealousy – perpetrator (revised or new item)
36. Misogynistic attitudes – perpetrator (revised or new item)
37. Age disparity of couple (revised or new item)
38. Victim's intuitive sense of fear of perpetrator (revised or new item)
39. Perpetrator threatened and/or harmed children (revised or new item)

Risk Factor Descriptions

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

1. Any actual or attempted assault on any person who is not, or has not been, in an intimate relationship with the perpetrator. This could include friends, acquaintances, or strangers. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.).
2. Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who has been in, or is in, an intimate relationship with the perpetrator. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.). It could be as simple as a neighbour hearing the perpetrator screaming at the victim or include a co-worker noticing bruises consistent with physical abuse on the victim while at work.
3. Any comment made to the victim, or others, that was intended to instill fear for the safety of the victim's life. These comments could have been delivered verbally, in the form of a letter, or left on an answering machine. Threats can range in degree of explicitness from "I'm going to kill you" to "You're going to pay for what you did" or "If I can't have you, then nobody can" or "I'm going to get you."
4. Any incident in which the perpetrator threatened to use a weapon (e.g., gun; knife; etc.) or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.) for the purpose of instilling fear in the victim. This threat could have been explicit (e.g, "I'm going to shoot you" or "I'm going to run you over with my car") or implicit (e.g., brandished a knife at the victim or commented "I bought a gun today"). Note: This item is separate from threats using body parts (e.g., raising a fist).
5. Any actual or attempted assault on the victim in which a weapon (e.g., gun; knife; etc.), or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.), was used. Note: This item is separate from violence inflicted using body parts (e.g., fists, feet, elbows, head, etc.).
6. Any recent (past 6 months) act or comment made by the perpetrator that was intended to convey the perpetrator's idea or intent of committing suicide, even if the act or comment was not taken seriously. These comments could have been made verbally, or delivered in letter format, or left on an answering machine. These comments can range from explicit (e.g., "If you ever leave me, then I'm going to kill myself" or "I can't live without you") to implicit ("The world would be better off without me"). Acts can include, for example, giving away prized possessions.
7. Any recent (past 6 months) suicidal behaviour (e.g., swallowing pills, holding a knife to one's throat, etc.), even if the behaviour was not taken seriously or did not require arrest, medical attention, or psychiatric committal. Behaviour can range in severity from superficially cutting the wrists to actually shooting or hanging oneself.
8. Any non-physical behaviour, whether successful or not, that was intended to keep the victim from associating with others. The perpetrator could have used various psychological tactics (e.g., guilt trips) to discourage the victim from associating with family, friends, or other acquaintances in the community (e.g., "if you leave, then don't even think about coming back" or "I never like it when your parents come over" or "I'm leaving if you invite your friends here").
9. Any actual or attempted behaviour on the part of the perpetrator, whether successful or not, intended to exert full power over the victim. For example, when the victim was allowed in public, the perpetrator made her account for where she was at all times and who she was with. Another example could include not allowing the victim to have control over any finances (e.g., giving her an allowance, not letting get a job, etc.).
10. Any actual or attempted behaviour, whether successful or not, in which the perpetrator physically attempted to limit the mobility of the victim. For example, any incidents of forcible confinement (e.g., locking the victim in a room) or not allowing the victim to use the telephone (e.g., unplugging the phone when the victim attempted to use it). Attempts to withhold access to transportation should also be included (e.g., taking or hiding car keys). The perpetrator may have

used violence (e.g., grabbing; hitting; etc.) to gain compliance or may have been passive (e.g., stood in the way of an exit).

11. Any actual, attempted, or threatened behaviour, whether successful or not, used to engage the victim in sexual acts (of whatever kind) against the victim's will. Or any assault on the victim, of whatever kind (e.g., biting; scratching, punching, choking, etc.), during the course of any sexual act.
12. Any dispute in regards to the custody, contact, primary care or control of children, including formal legal proceedings or any third parties having knowledge of such arguments.
13. Any incident in which the perpetrator intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the perpetrator. This could include slashing the tires of the car that the victim uses. It could also include breaking windows or throwing items at a place of residence. Please include any incident, regardless of charges being laid or those resulting in convictions.
14. Any action directed toward a pet of the victim, or a former pet of the perpetrator, with the intention of causing distress to the victim or instilling fear in the victim. This could range in severity from killing the victim's pet to abducting it or torturing it. Do not confuse this factor with correcting a pet for its undesirable behaviour.
15. Any actual or attempted form physical violence, ranging in severity from a push or slap to the face, to punching or kicking the victim in the stomach. The key difference with this item is that the victim was pregnant at the time of the assault and the perpetrator was aware of this fact.
16. Any attempt (separate from the incident leading to death) to strangle the victim. The perpetrator could have used various things to accomplish this task (e.g., hands, arms, rope, etc.). Note: Do not include attempts to smother the victim (e.g., suffocation with a pillow).
17. As a child/adolescent, the perpetrator was victimized and/or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment.
18. The abuse/maltreatment (physical; psychological; emotional; sexual; etc.) inflicted upon the victim by the perpetrator was increasing in frequency and/or severity. For example, this can be evidenced by more regular trips for medical attention or include an increase in complaints of abuse to/by family, friends, or other acquaintances.
19. Any actions or behaviours by the perpetrator that indicate an intense preoccupation with the victim. For example, stalking behaviours, such as following the victim, spying on the victim, making repeated phone calls to the victim, or excessive gift giving, etc.
20. Employed means having full-time or near full-time employment (including self-employment). Unemployed means experiencing frequent job changes or significant periods of lacking a source of income. Please consider government income assisted programs (e.g., O.D.S.P.; Worker's Compensation; E.I.; etc.) as unemployment.
21. The victim and perpetrator were cohabiting.
22. Any child(ren) that is(are) not biologically related to the perpetrator.
23. At some point the perpetrator was confronted, either by the victim, a family member, friend, or other acquaintance, and the perpetrator displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., batterer intervention programs). Or the perpetrator denied many or all past assaults, denied personal responsibility for the assaults (i.e., blamed the victim), or denied the serious consequences of the assault (e.g., she wasn't really hurt).
24. The partner wanted to end the relationship. Or the perpetrator was separated from the victim but wanted to renew the relationship. Or there was a sudden and/or recent separation. Or the victim had contacted a lawyer and was seeking a separation and/or divorce.
25. Within the past year, and regardless of whether or not the perpetrator received treatment, substance abuse that appeared to be characteristic of the perpetrator's dependence on, and/or addiction to, the substance. An increase in the pattern of use and/or change of character or behaviour that is directly related to the alcohol and/or drug use can indicate excessive use by the perpetrator. For example, people described the perpetrator as constantly drunk or claim that they never saw him without a beer in his hand. This dependence on a particular substance may have impaired the perpetrator's health or social functioning (e.g., overdose, job loss, arrest, etc). Please include comments by family, friend, and acquaintances that are indicative of annoyance or concern with a drinking or drug problem and any attempts to convince the perpetrator to terminate his substance use.

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

Appendix C

Summary of Recommendations – 2008 Case Reviews

Case No.	No. of Risk Fact.	Rec No.	Recommendations	Organizations Where Recommendations are directed to:
1	17	1	It is recommended that judges receive continuing education on understanding and recognizing the dynamics of domestic violence and the risk factors for lethality. Judges need to receive and review all the information on a case to make appropriate decisions, for example, in bail hearings. Furthermore, it is recommended that the Ontario Court of Justice consider using high-risk cases where judicial interim releases occurred, as reviewed by the DVDRC, as case scenarios as part of the ongoing educational programs for Justices of the Peace who conducts the majority of bail hearings in the province.	Ministry of the Attorney General
		2	It is recommended that a protocol be established between police and Crown Counsel to ensure that persons proposed as surety: 1) be properly investigated as to their suitability to act as surety; 2) be fully informed about their responsibilities as surety, both in writing and on the court record; and 3) be warned, in writing and on the court record, as to their potential liability under estreatment and as party to a criminal offence in the event they breach their duty.	Ministry of Community Safety and Correctional Services Ministry of the Attorney General
		3	It is recommended that police put processes into practice to identify, monitor, and manage high-risk cases, and to vigorously enforce bail conditions arising from a violent offence or threat of violence.	Ministry of Community Safety and Correctional Services
		4	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.	Ontario Women's Directorate

Case No.	No. of Risk Fact.	Rec No	Recommendations	Organizations Where Recommendations are directed to:
		5	It is recommended that all workplaces design and implement a policy to address domestic violence as it relates to the workplace. The policy should include: • educating employees about the issue of domestic violence to help them identify an abusive relationship in which they may be involved and about how to reach out to co-workers; • training employers and managers to identify the signs of abuse and respond appropriately to employees who are victims and perpetrators of domestic violence; • providing a resource list of appropriate referral agencies; • providing an organized response to direct threats of domestic violence that occur in the workplace; • developing and implementing a safety plan for the victim to ensure that a number of security measures are in place for their protection.	Ministry of Labour
		6	It is recommended that the Ministry of Children and Youth Services and the Ontario Association of Children's Aid Societies provide enhanced training on a standardized risk/danger assessment tool and enforce the use of this tool in all cases where domestic violence and harassment are present. Once the level of risk has been identified for the victim, an adequate safety plan must be implemented. As well, it is essential that contact be made with the perpetrator to assist in the risk assessment and risk management process.	Ministry of Children and Youth Services Ontario Association of Children's Aid Societies
2	18	1	Funding and resources should be provided to create joint training opportunities for those working in mental health agencies and those working in violence against women services to ensure a more integrated and holistic response that can more effectively respond to the complexities of individual situations.	Ontario Women's Directorate Ministry of Health and Long Term Care

Case No.	No. of Risk Fact.	Rec No.	Recommendations	Organizations Where Recommendations are directed to:
		2	A common risk assessment tool should be developed and mental health practitioners should be trained to effectively and systemically utilize the tool to identify potential risks.	Ministry of Health and Long Term Care
		3	Adequate levels of support and resources should be made available to services that can respond to individuals with multiple problems so that interventions can be organized to meet the particular needs of the individual, as opposed to being organized to meet the needs of a particular agency.	Ontario Women's Directorate Ministry of Health and Long Term Care Ministry of Community Safety and Correctional Services
		4	Probation officers should utilize a common risk assessment tool as it relates to woman abuse and lethality. Although probation officers routinely use the LSI tool, often the dynamics and issues related to abusive relationships are not identified or dealt with, in any involvement. The explanation for this is that the focus of the intervention is on 'criminal behavour'.	Ministry of Community Safety and Correctional Services
		5	Probation officers should receive training on the inter-relationship between substance abuse issues and intimate partner violence so that they can better respond and intervene with individuals who have a multiplicity of issues. This training would assist probation officers to effectively intervene with individuals who are in abusive and high risk relationships.	Ministry of Community Safety and Correctional Services
		6	When an individual attempts suicide, there should be appropriate follow-up, support and referral to agencies that can explore the issues that resulted in the attempt. Criminal justice responses and interventions are generally not as effective as interventions from social and community based organizations and services.	Ministry of Health and Long Term Care Ministry of Community and Social Services
		7	The province should identify a process to ensure enforcement of attendance at court-mandated programs for batterers. Enforcement should include effective methods of tracking and monitoring offenders, mechanisms for systematically identifying levels of risk and risk management that is inter-disciplinary and inter-sectoral in nature.	Ministry of the Attorney General Ministry of Community Safety and Correctional Services

Case No.	No. of Risk Fact.	Rec No.	Recommendations	Organizations Where Recommendations are directed to:
3	5		No recommendations.	
4	7	1	It is recommended that the Ontario Women's Directorate continue to educate the members of the public who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence and provide information on practical steps that can be taken to reduce the risk for assault and lethality at the time of relationship breakdown.	Ontario Women's Directorate
		2	It is recommended that criteria used in determining financial grants for the development of all information packages on domestic violence, training packages or any public education announcements should include a mandatory segment on the potential risk of lethal violence at the time of relationship break-down and provide family and friends with recommendations on how to support a "safe" break-up/separation.	Ontario Women's Directorate
5	9	1	There is a continuing need to better educate family members, friends, and colleagues who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence. Public education should include action plans for persons who encounter individuals involved in domestic violence, and in particular address the increased risk associated to separation or pending separation and workplace stalking issues. In particular, this education should include a methodology to identify the risk factors for potential lethality and the specific steps to take when they are identified.	Ontario Women's Directorate
6	21	1	It is recommended that the Ministry of the Attorney General design and implement a public education campaign that explains Restraining Orders in an understandable manner to laypersons.	Ministry of the Attorney General
		2	The Ministry of the Attorney General should review current courses and resource materials to ensure that information pertaining to restraining orders is easily available to all lawyers practicing family law.	Ministry of Health and Long Term Care

Case No.	No. of Risk Fact.	Rec No.	Recommendations	Organizations Where Recommendations are directed to:
		3	Training for all mental health professionals should include assessment and intervention strategies dealing with male depression and the link between depression, suicidal ideation and domestic homicide.	Ministry of Health and Long Term Care
		4	The Ministry of Community Safety and Correctional Services should expand police standards in domestic violence cases to include risk assessment for all calls for assistance with a history of domestic violence, even when no assaults have taken place.	Ministry of Community Safety and Correctional Services
		5	When assessing applications for support, the Family Responsibility Office (FRO) should ask applicants to identify potential safety threats, including violence that may arise from support enforcement activities.	Ministry of Community and Social Services – Family Responsibility Office
7	8		No recommendations	
8	11		No recommendations	
9	13		No recommendations	
10	9		No recommendations	
11	10	1	The term “choking” should be changed to the term “strangulation” in the Criminal Code as that term more accurately reflects a serious, intentional act of harm to a victim. “Choking” is a medical term describing aspiration of food bolus or object and is not appropriate in a domestic violence context, whereas strangulation refers to the application of pressure to the neck. In cases of strangulation or head injury, police personnel should consider taking a victim to the hospital to receive immediate medical attention, especially to medical personal who have specialized training in recognizing the repercussions of such serious situations (i.e. DV/SAC nursing teams are currently housed in many emergency departments across the province and are often under-utilized).	Attorney General of Canada

Case No.	No. of Risk Fact.	Rec No.	Recommendations	Organizations Where Recommendations are directed to:
		2	In cases of severe incidents of harm that include death threats and strangulation, even if there is no documented history of domestic violence, there need to be recognition of the severity of a single, but critical assault at a bail hearing and evidence put forward for this incident to be considered a higher risk case and thus managed in that manner.	Ministry of the Attorney General
12	10	1	The Ministry of Children and Youth Services, in consultation with the Ontario Association of Children's Aid Societies, should enhance standards for CAS interventions in DV cases by requesting DV perpetrators be involved in specific provincially approved batterers' programs before allowing unsupervised visits with children or terminating the CAS involvement in a case.	Ministry of Children and Youth Services Ontario Association of Children's Aid Societies
		2	The MCYS, in consultation with the OACAS, should ensure an internal death review is conducted by the CAS in any case where a parent or child has been a domestic homicide victim and where there has been active CAS involvement within the previous year, or possibly longer.	Ministry of Children and Youth Services Ontario Association of Children's Aid Societies
		3	There needs to be broader public awareness about the danger of separation with a DV perpetrator directed at DV victims and the risks in maintaining ongoing relationships that jeopardize the safety of women and children.	Ontario Women's Directorate
13	13		No recommendations	
14	25	1	It is recommended that the Domestic Violence Supplementary Report (DVSR) be enhanced to require a verbatim narrative response to risk assessment questions where the answer is "yes" or "unknown". Further, that this enhanced DVSR be mandated, prohibiting any deviation or change in the content, for use by all police services, including First Nation police services.	Ministry of Community Safety and Correctional Services - Policing Standards Division, Ontario Association of Chiefs of Police

Case No.	No. of Risk Fact.	Rec No.	Recommendations	Organizations Where Recommendations are directed to:
		2	It is recommended that all First Nation police services reinforce with their members the requirements of the Domestic Violence Occurrences (LE24) and Firearms Occurrences (LE029) of the Provincial Adequacy Standard Guidelines regarding mandatory charge, completion of the Domestic Violence Supplementary Report (DVSR) and the seizure of firearms during the course of domestic violence occurrences. This training should be conducted on an annual basis placing an emphasis on ensuring officers are appropriately educated on their authorities to conduct weapons seizures with and without a warrant.	First Nation Police Services
		3	An enhanced protocol should be established between police services and Crown counsel to ensure that persons proposed as surety: • are properly investigated as to their suitability to act as surety including an assessment of their lawful access to firearms; • can guarantee all possessed and accessible firearms are secured from the accused for the duration of the surety contract; • are fully informed about the totality of the allegations against the accused, including information about risk factors and potential lethality; • are fully informed about their responsibilities as surety, both in writing and on the court record, following required viewing of an educational videotape on their role, specific to domestic violence cases (e.g. Huron County Crown video); • are warned in writing and on the court record as to their potential liability under estreatment and as party to a criminal offence in the event they breach their duty; • can accept that each police department will assign a police officer to routinely call all sureties in high risk cases to verify bail compliance and the stability of the accused.	Ministry of Community Safety and Correctional Services Ministry of Attorney General

Case No.	No. of Risk Fact.	Rec No.	Recommendations	Organizations Where Recommendations are directed to:
		4	It is recommended that Aboriginal-focused public awareness programs paralleling the Neighbours, Friends and Families campaign be implemented and made available to all First Nation communities across the province. Kanawayhitowin is an example of an Aboriginal public awareness campaign that was launched in the Fall of 2007 to raise awareness about the signs of woman abuse in First Nation communities so that people, who are close to at-risk women, or abusive men, can provide support. This program reflects a traditional and cultural approach to community healing and wellness. Educational materials include brochures, public service announcements, a training video and CD-ROM.	Ministry of Community and Social Services Ontario Women's Directorate
15	7	1	Neighbours, friends and family should be educated about the dynamics of domestic violence and the need to take appropriate action.	Ontario Women's Directorate
		2	Appropriate risk assessment tools need to be used by mental health professionals when dealing with victims and perpetrators of domestic violence.	Ministry of Health and Long Term Care Ontario Women's Directorate
		3	Mental health professionals should have training in the dynamics of domestic violence, including high risk case management and intervention strategies, in particular, safety planning.	Ministry of Health and Long Term Care

For further information, please contact:

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