Office of the Chief Coroner
Province of Ontario

November 2018

Domestic Violence Death Review Committee

2017 Annual Report

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Message from the Chair

I am very pleased to conclude my first year as Chair of the Domestic Violence Death Review Committee (DVDRC) in conjunction with the publication of the 2017 Annual Report.

I came to the role of Chair after 23 years in the hospital settings where I provided front line acute and follow up care to victim/survivors of domestic violence and sexual assault. This was difficult but meaningful work. It was difficult to bear witness to women's experiences and injuries at the hands of their partners. At the same time, it was meaningful, to engage with a woman in crisis and provide for her identified needs, to make a difference.

Since inception, the DVDRC has reviewed 311 of cases involving 445 deaths. Although domestic violence often occurs in private, these deaths do not occur in isolation. The couple is connected to families, neighbours, workplaces, communities and systems i.e. policing, law, health care, child welfare and shelters. It is difficult to review the deaths of domestic homicide victims and the context in which they occur. It is meaningful and important to identify system gaps and opportunities for intervention through recommendations for change, upstream with the goal of preventing domestic homicide. It is also meaningful to know that the data generated in reviewing these deaths informs research conducted by the Canadian Domestic Homicide Prevention Initiative.

This work would not be possible without the members of the DVDRC, their unique expertise and ongoing commitment to doing this work well. Their contributions are greatly appreciated. I would also be remiss not to acknowledge and thank Kathy Kerr, Executive Lead, Committee Management, for her valuable historical perspective and leadership this year as I became familiar with the DVDRC.

It takes a village….

Deidre Bainbridge
Provincial Nurse Manager
Chair, Domestic Violence Death Review Committee

Committee Membership (2017)

William Lucas, MD, CCFP.
Committee Chair (Jan – Sept 2017)
Regional Supervising Coroner – Central West

Deidre Bainbridge, NP
Committee Chair (Sept – Dec 2017)
Provincial Nurse Manager
Office of the Chief Coroner

Dr. Lopita Banerjee, MSc MD FCFP
Family Physician/Coroner

Jessica Diamond
Executive Lead, Child Welfare, Office of the Chief Coroner

Marcie Campbell, M.Ed
National Research Coordinator, Centre for Research & Education on Violence Against Women & Children, Western University

Gail Churchill, M.D.
Investigating Coroner

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

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

Barb Forbes
Regional Director
MCSCS – Probation & Parole Western Region

Alison Freeman
Detective Sergeant, Halton Regional Police Domestic Violence Investigative Unit

Craig Harper
Crown Attorney

Anita Hass
Sergeant, Domestic Violence Coordinator
Greater Sudbury Police Service

Peter Jaffe, Ph.D., C.Psych.
Professor, Faculty of Education, Western University

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

Deborah Sinclair, MSW, Ph.D(c), RSW
Independent Practice

Lynn Stewart, Ph.D., C.Psych.
Senior Research Manager, Correctional Service Canada

Mark Gauthier
Sergeant, Ontario Provincial Police

Kathy Kerr
Executive Lead, Committee Management, Office of the Chief Coroner

Executive Summary

Cases reviewed from 2003-2017:

- From 2003-2017, the DVDRC has reviewed 311 cases, involving 445 deaths.
- Of the cases reviewed, 65% were homicides and 35% were homicide-suicides.
- Approximately 72% of all cases reviewed from 2003-2017 involved a couple where there was a history of domestic violence and 67% of the cases involved a couple with an actual or pending separation.
- The other top risk factors were:
    - a perpetrator who was depressed (50%)
    - obsessive behaviour by the perpetrator (46%)
    - prior threats or attempts to commit suicide (45%)
    - a victim who had an intuitive sense of fear towards the perpetrator (44%)
    - perpetrator displayed sexual jealousy (41%)
    - prior threats to kill the victim (38%)
    - excessive alcohol and/or drug use (40%)
    - a perpetrator who was unemployed (40%)
    - history of violence outside the family (34%)
    - an escalation of violence (32%)

- In 71% of the cases reviewed, seven or more risk factors were identified.

Cases reviewed in 2017:

- There were 22 cases reviewed by the DVDRC in 2017. These included 12 homicide cases and 10 homicide-suicide cases, resulting in 35 deaths (25 homicide victims and 10 perpetrator suicides).
- There were 33 recommendations generated through these reviews.
- Of the 25 victims in the cases reviewed, 20 (80%) were adult females, four (16%) were adult males and one (4%) was a female child.
- Of the 22 cases reviewed, 21 (95%) involved male perpetrators and one (5%) involved a female perpetrator.
- The victims ranged in age from six to 91 years.
- The average age for victims was 47.4 years.
- The perpetrators ranged in age from 24 to 95 years.
- The average age for perpetrators was 48.9 years.
- The average number of risk factors identified in the cases reviewed was 9.8.
- The number of risk factors ranged from two to 22.
- Seven or more risk factors were identified in 14 (64%) of the cases reviewed in 2017.

Domestic Violence Death Review Committee Aims and Objectives:

Purpose

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

Objectives

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

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

Chapter One: Introduction and Overview

History

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

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

Membership

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

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

Definition of Domestic Violence

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

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

Method for Reviewing Cases

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

When a domestic violence homicide or homicide-suicide takes place in Ontario, the relevant Regional Supervising Coroner notifies the Executive Lead of the DVDRC and the basic case information is recorded in a database. The Executive Lead, together with a police liaison officer assigned to the DVDRC, periodically verify the status of judicial and other proceedings to determine if the review can commence. Since cases involving homicide-suicides generally do

not result in criminal proceedings, those cases are reviewed in a more timely fashion.

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

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

Recommendations

One of the primary goals of the DVDRC is to make recommendations aimed at preventing deaths in similar circumstances and reducing domestic violence in general. Recommendations are distributed to relevant organizations and agencies through the Chair of the DVDRC. The phrase "no new recommendations" means that either no issues requiring recommendations were identified from the case review; or that an issue or theme was identified where a previous recommendation (or recommendations) had been made in a prior case. In some cases, recommendations made from previous reviews that may also be relevant to the current review, are noted for information purposes.

Similar to recommendations generated through coroners' inquests, the recommendations developed by the DVDRC are not legally binding and there is no obligation for agencies and organizations to implement or respond to them. Organizations and agencies are asked to respond back to the Executive Lead, DVDRC on the status of implementation of recommendations within six months of distribution. Commencing in 2017, all reports and recommendations are being distributed electronically.

Review and Report Limitations

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

All information obtained as a result of coroners investigations and provided to the DVDRC is subject to confidentiality and privacy limitations imposed by the *Coroners Act* of Ontario and the *Freedom of Information and Protection of Privacy Act*. Unless and until an inquest is called

with respect to a specific death or deaths, the confidentiality and privacy interests of the decedents, as well as those involved in the circumstances of the death, will prevail. Accordingly, individual reports, as well as the minutes of review meetings and any other documents or reports produced by the DVDRC, remain private and protected and will not be released publicly. Review meetings are not open to the public. Redacted versions of the report that do not contain personal information are available to the public.

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

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

Annual Report

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

Disclaimer

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

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

Chapter Two: Statistical Overview

Collection of Data

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

Types of Data

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

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

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

Statistics generated for the purposes of this annual report reflect a 15-year period of cases occurring from 2002-2016 where: 'homicide' has been identified as the manner of death for at least one victim; 'abuse – domestic violence' has been identified and coded as an involvement; *and* the case meets the DVDRC's definition of a domestic violence death. Some cases, where the manner of death is 'undetermined' and where there is involvement of domestic violence, are included in the data set.

It is important to note that some homicide cases identified with the 'abuse – domestic violence' involvement code occurring between 2002-2016 may still be pending review by the DVDRC. In many cases, DVDRC reviews have not commenced because legal or other proceedings are still underway or pending. The number of pending cases has been significantly reduced due to a concerted effort by the DVDRC to review outstanding cases.

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

The second set of data relates to cases that have undergone review by the DVDRC. This data would include information pertaining to risk factors, type and length of relationship and number/sex of victims and perpetrators. This data is collected in the thorough review conducted by the DVDRC.

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

Statistical Overview: Homicides with Domestic Violence Involvement (2002-2016)

The following statistics relate to homicides in Ontario occurring between 2002-2016 where 'abuse – domestic violence' has been identified as an involvement code, and that meet the DVDRC's definition of a domestic violence death. Some of these cases may have already undergone review by the DVDRC while others are pending review upon completion of other proceedings (e.g. criminal trials).

Chart One: Homicides in Ontario with Domestic Violence Involvement Code (2002-2016)

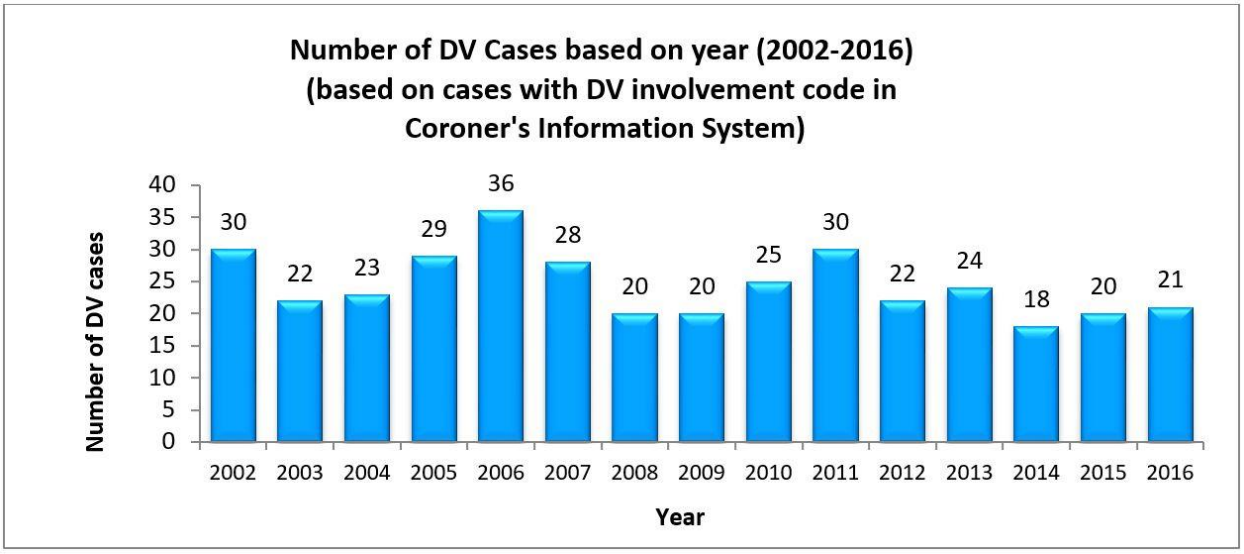
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Totals 2002-2016
Number of cases	30	22	23	29	36	28	20	20	25	30	22	24	18	20	21	**368**
Homicides	19	18	14	21	29	18	15	15	19	22	13	19	11	13	15	**261**
																71%
Homicide-Suicides	11	4	9	8	7	10	5	5	6	8	9	5	7	7	6	**107**
																29%
Total number of Deaths	**46**	**26**	**33**	**37**	**53**	**45**	**29**	**30**	**32**	**38**	**32**	**30**	**29**	**29**	**29**	**518**
Total number of Homicide Victims	**35**	**22**	**24**	**29**	**46**	**35**	**24**	**25**	**26**	**30**	**23**	25	**22**	22	23	**411**
																79%
Female victim (adult)	26	19	21	29	28	29	20	20	21	27	19	22	13	20	17	**331**
																81%
Female victim (child)	4	1	1	0	8	0	0	3	1	0	0	0	2	0	2	**22**
																5%
Male victim (adult)	4	1	2	0	3	4	4	2	4	3	3	3	3	2	4	**42**
																10%
Male victim (child)	1	1	0	0	7	2	0	0	0	0	1	0	4	0	0	**16**
																4%
Average age of Homicide Victim	**35.9**	**34.9**	**39.8**	**38.2**	**27.4**	**34.9**	**43.3**	**37.2**	**36.5**	**44**	**45.3**	**37.7**	**29.4**	**40.1**	**40.8**	**37.7**
Total number Perpetrator deaths (suicide or other)	11	4	9	8	7	10	5	5	6	8	9	5	7	7	6	**107**
																21%
Female perpetrator (adult)	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	**3**
																3%

Male perpetrator (adult)	11	4	8	8	7	9	5	**5**	6	8	9	5	7	7	5	**104**
																97%
Average age of Deceased Perpetrator	**48.5**	**45.5**	**42.2**	**45**	**51.1**	**45.2**	**43.8**	**60**	**44.7**	**50.8**	**59.6**	**41**	**47.1**	**58**	**42.5**	**48.3**

Chart One: Summary

- There were 368 domestic homicide and/or homicide-suicide cases that occurred in Ontario between 2002-2016 (based on cases investigated by the Office of the Chief Coroner for Ontario, where domestic violence was identified as an involvement code).
- Of those 368 cases, 261 (71%) were homicides and 107 (29%) of the cases were homicide-suicides.
- The 368 cases resulted in a total of 518 deaths.
- Of the 518 deaths, 411 (79%) were homicide victims and 107 (21%) were perpetrators who committed suicide or were otherwise killed (e.g. shot by police).
- There was an average of 25 domestic homicide and/or homicide-suicide cases per year from 2002-2016. Some of these cases may have included multiple victims.
- There have been 411 domestic homicide victims from 2002-2016.
- There was an average of 27.4 domestic homicide victim deaths per year from 2002-2016.
- Of the 411 homicide victims, 331 (81%) were adult females, 38 (9%) were children and 42 (10%) were adult males.
- Of the 107 perpetrator deaths, 104 (97%) were adult males.
- The average age of homicide victims was 37.7 years.
- The average age of perpetrators who died was 48.3 years.

Graph One: Number of DV cases based on year (2002-2015) in Ontario – based on cases with DV involvement code in Coroner's Information System



Graph One shows the number of domestic violence cases that occurred per year from 2002-2016. The number of case occurrences per year has varied from 18 cases in 2014 to 36 cases in 2006. Some cases may involve multiple victims. There was an average of 25 domestic homicide and/or homicide-suicide cases per year from 2002-2016.

Graph Two: Number of DV Homicide Victims (2002-2016)

Graph Two shows the number of domestic violence homicide victims per year from 2002-2016. The number of homicide victims per year has varied from 22 in 2003, 2014 and 2015 to 46 in 2006. There was an average of 27.4 domestic homicide victim deaths per year from 2002-2016

Death Factors

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

Chart Two illustrates the death factors most commonly cited in domestic violence deaths (homicides and perpetrator deaths) identified in the CIS from 2002-2016.

Chart Two: Top Death Factors in Domestic Violence Deaths (2002-2016) based on CIS data

Death Factor	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Total DV Deaths (2002-2016)	% of Total DV Deaths (2002-2016)	
Trauma - cuts, stabs	15	8	11	9	21	14	8	11	16	15	6	12	13	9	7	175	34%	**42%**
Trauma - beating, assault	5	4	4	5	6	2	0	0	3	3	2	4	0	2	0	40	8%	
Shooting - handgun	8	5	2	4	1	9	1	3	3	1	6	4	2	2	7	58	11%	**26%**
Shooting - rifle	2	0	3	5	5	3	3	2	1	2	0	0	0	5	3	34	7%	
Shooting - shotgun	7	1	2	2	2	2	1	2	6	0	5	6	2	4	0	42	8%	
Shooting - weapon (not spec.)	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	2	0%	
Asphyxia - airway obstruction	0	1	1	0	0	1	0	1	1	2	1	0	0	3	0	11	2%	**11%**
Asphyxia - strangulation	0	3	5	5	6	4	4	0	0	3	3	1	1	1	1	37	7%	
Asphyxia - neck compression	0	0	0	1	2	0	2	3	0	0	0	1	1	0	1	11	2%	
Other	9	4	4	6	10	10	9	8	2	12	9	2	10	3	10	108	21%	**21%**
Total	**46**	**26**	**33**	**37**	**53**	**45**	**29**	**30**	**32**	**38**	**32**	**30**	**29**	**29**	**29**	**518**		

* percentages are rounded off
**includes all deaths, including perpetrator suicides

Summary of Chart Two: Top Death Factors in Domestic Violence Deaths (2002-2016)

- Trauma (i.e. cuts/stabs and beating/assault) was a death factor in 42 % of the deaths.
- Shooting (i.e. handgun, rifle, shotgun or gun not specified) was a death factor in 26% of the deaths.
- Asphyxia (i.e. airway obstruction, strangulation and/or neck compression) was a death factor in 11% of the deaths.
- Other death factors such as: trauma by motor vehicle, train/vehicle or blunt force, asphyxia from hanging, anoxic environment and carbon monoxide, drug toxicity, jump/fall, fire with smoke inhalation or thermal injury, and burns–thermal drowning, were present in 21% of the deaths.

Statistical Overview: Cases Reviewed by the DVDRC (2003-2017)

From 2003-2017, the DVDRC has reviewed 311 cases that involved a total of 445 deaths. This includes 201 homicide and 110 homicide-suicide cases, some of which may have involved multiple victims.

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

The following statistics relate to all cases reviewed by the DVDRC from 2003-2017 inclusive.

Chart Three: Number of Cases Reviewed by the DVDRC (2003-2017)

				Type of Case	
Year		# of cases reviewed	# of deaths involved	Homicides	Homicide - Suicides
2003		11	24	3	8
2004		9	11	5	4
2005		14	19	5	9
2006		13	21	4	9
2007		15	25	7	8
2008		15	17	13	2
2009		16	25	6	10
2010		18	36	6	12
2011		33	41	27	6
2012		20	32	14	6
2013		19	22	17	2
2014		14	15	13	1
2015	Full	21	29	12	9
	Executive	49	57	46	3
2016		22	36	11	11
2017		22	35	12	10
Total		311	445	201	110
				65%	35%

* In 2015, a dedicated effort was made to address the accumulation of pending cases awaiting review by the DVDRC. All of the pending cases (49 in total), underwent "executive review" by a core team of representatives of the DVDRC. The executive review included a thorough analysis of the circumstances surrounding the deaths and compilation of risk factors identified in each case. None of the executive reviews conducted resulted in recommendations.

Summary of Chart Three: Number of Cases Reviewed by the DVDRC (2003-2017)

- In the period between 2003 and 2017, the DVDRC reviewed 311 cases, involving 445 deaths (including perpetrator suicides)
- Of the 311 cases, 201 (65%) were homicides and 110 (35%) were homicide-suicides.

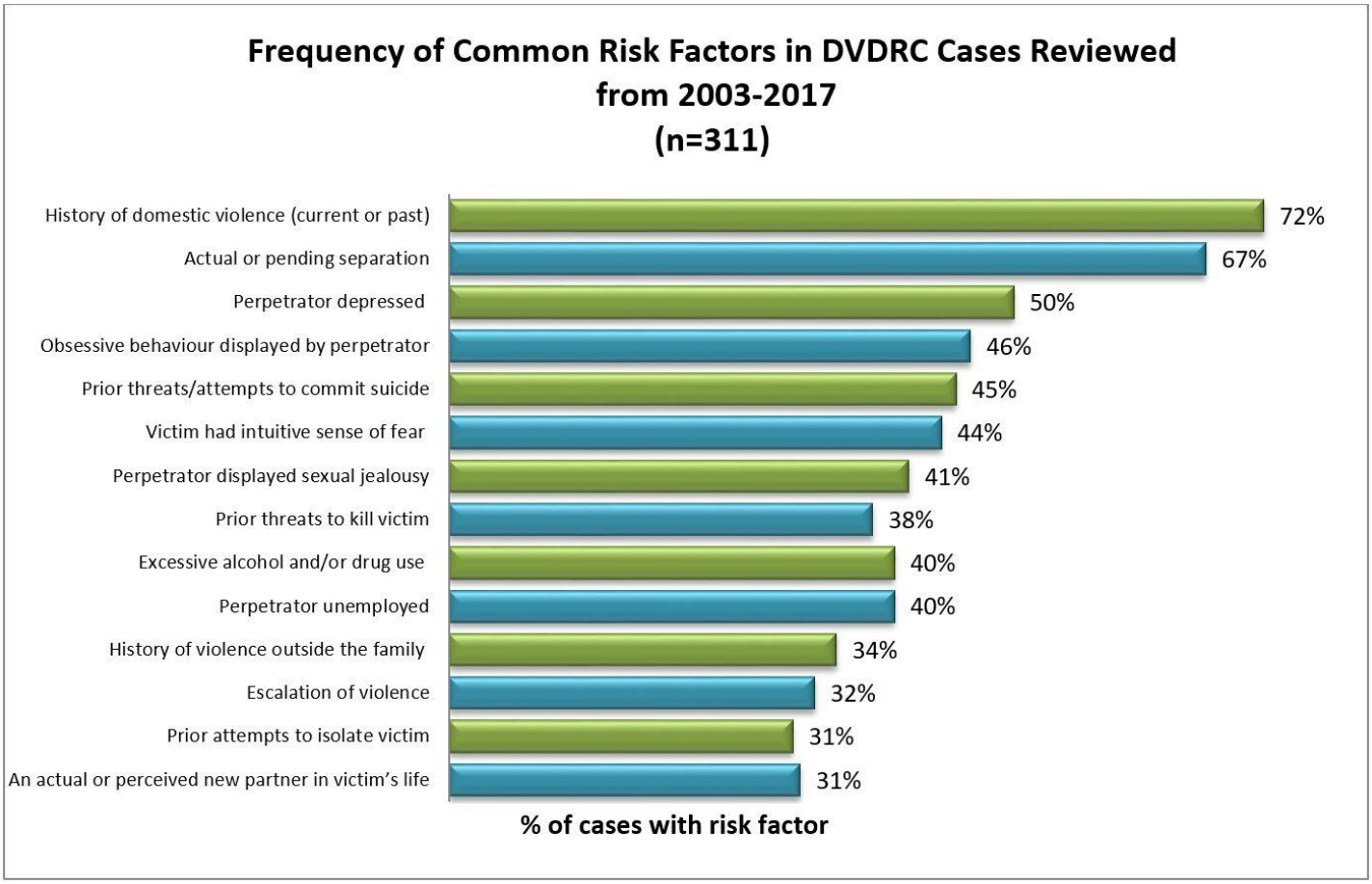
Analysis of Risk Factors: Common Risk Factors

Based on extensive research, the DVDRC has created a list of risk factors that indicate the potential for lethality within the relationship examined. For a number of years, 40 risk factors were assessed. In 2017, the additional risk factor of victim vulnerability was added to make 41 risk factors. The recognition of multiple risk factors within a relationship potentially allows for enhanced risk assessment, safety planning and possible prevention of future deaths related to domestic violence through appropriate interventions by criminal justice system and healthcare partners, including high risk case identification and management.

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

When reviewing a case, the DVDRC identifies which, if any, of the 41 risk factors were present in the relationship between the victim and the perpetrator.

Graph Three: Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2017)



*includes all reviews, including executive reviews in 2015

Summary of Graph Three: Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2017)

- When reviewing a case, the DVDRC identifies which of the 41 established risk factors were present in the relationship between the perpetrator and the victim.
- In 72% of all cases reviewed from 2003-2017, there was a history of domestic violence (past or present).
- In 67% of the cases, the couple had an actual or pending separation.
- In 50% of the cases, the perpetrator that was depressed (diagnosed and/or undiagnosed).
- In 46% of the cases, obsessive behaviour was displayed by the perpetrator.
- In 45% of the cases, the perpetrator had threatened or attempted at suicide.
- In 44% of the cases, the victims had an intuitive sense of fear.
- In 41% of the cases, the perpetrator displayed sexual jealousy.

- In 38% of the cases, there were prior threats to kill the victim.
- In 40% of the cases, excessive alcohol and/or drug use was involved.
- In 40% of the cases, the perpetrator was unemployed.
- In 34% of the cases, there was a history of violence outside of the family.
- In 32% of the cases, there was an escalation of violence.
- In 31% of the cases there was an attempt to isolate the victim.
- In 31% of the cases there was an actual or perceived new partner in the victim's life.

Analysis of Risk Factors: Number of Risk Factors per Case

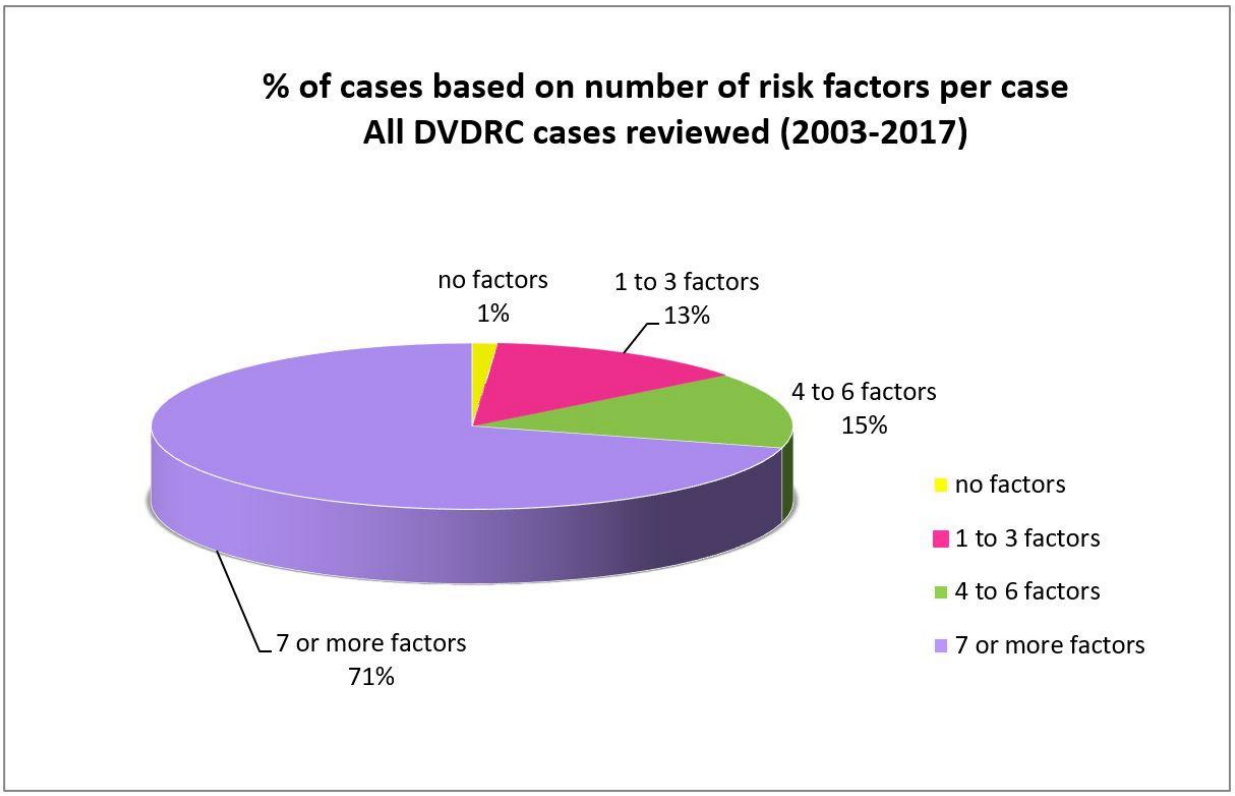
Chart Four: Number of Risk Factors per Case – All DVDRC cases reviewed (2003-2017), demonstrates that almost three quarters of all cases reviewed by the DVDRC had seven or more risk factors identified. The significance of this finding is that many domestic homicides may have been predicted and prevented with earlier recognition and action towards identified risk factors for future lethality.

Chart Four: Number of Risk Factors per Case – All DVDRC Cases Reviewed (2003-2017)

# of risk factors per case	2003-2016 (n=289)	2017 (n=22)	2003-2017 (n=311)	% of total cases
no factors	4	0	4	1%
1 to 3 factors	37	4	41	13%
4 to 6 factors	42	4	46	15%
7 or more factors	206	14	220	71%

The percentage of total cases based on number of risk factors is shown in a pie graph in **Graph Four: Percent (%) of cases based on number of risk factors per case – All DVDRC cases reviewed (2003-2017).**

Graph Four: Percent (%) of cases based on number of risk factors per case – All DVDRC cases reviewed (2003-2017)



Summary of Chart Four and Graph Four: Number of Risk Factors per Case – All DVDRC cases reviewed (2003-2017)

- In 71% of the cases reviewed from 2003-2017, seven or more risk factors were identified.
- In 15% of the cases reviewed from 2003-2017, four to six risk factors were identified.
- The combined proportion of cases with four or more risk factors was 86%.
- In 13% of the cases reviewed from 2003-2017, one to three risk factors were identified.
- In 1% of the cases reviewed from 2003-2017, no risk factors were identified.
- The recognition of multiple risk factors within a relationship allows for enhanced risk assessment, safety planning and possible prevention of future deaths related to domestic violence.

Statistical Overview: Cases Reviewed by the DVDRC in 2017

The DVDRC conducted 22 full case reviews in 2017 – 12 homicide and 10 homicide-suicide cases, resulting in a total of 35 deaths (25 homicide victims and 10 perpetrator suicides). A detailed summary, including the type of case (i.e. homicide or homicide-suicide) age and sex of victims and perpetrators, number of risk factors and relevant themes for each, is included in **Appendix C**.

A brief narrative on the circumstances surrounding the death(s), as well as recommendations towards the prevention of future similar deaths, is included in **Appendix D**.

Full, redacted versions of individual cases reviewed by the DVDRC in 2017 may be requested directly from the Executive Lead, Committee Management at the Office of the Chief Coroner: occ.inquiries@ontario.ca

Chart 5 – Summary of Cases reviewed in 2017

		% of 2017 reviews
Total number of cases reviewed:	**22**	
# of homicide cases	12	55%
# of homicide-suicide cases	10	45%
Total number of deaths reviewed:	**35**	
Homicide deaths:	**25**	
Female (adult)	20	80%
Female (child)	1	4%
Male (adult)	4	16%
Male (child)	0	0%
Average age of victim:	47.4	-
Suicide deaths:	**10**	-
Female	0	-
Male	10	-
Average age of all perpetrators:	48.9	-
# of male perpetrators	21	95%
# of female perpetrators	1	5%
# of cases with less than 7 risk factors:	8	36%
# of cases with 7 or more risk factors:	14	64%

Average number of risk factors:	9.8	-
# of cases involving age 65 or older:	4	16%
Homicide-suicides w/elderly	2	8%
# of recommendations made:	33	-

Chart 5 – Summary of Cases reviewed in 2017, demonstrates that:

- There were 22 case reviews conducted by the DVDRC in 2017. This included 12 homicide cases and 10 homicide-suicide cases, resulting in 35 deaths (25 homicide victims and 10 perpetrator suicides).
- As a result of these reviews, there were 33 recommendations made towards the prevention of future similar deaths.
- Of the 25 homicide victims in the cases reviewed, 20 (80%) were adult females, four (16%) were adult males and one was a female child.
- Of the 22 cases, 21 (95%) involved male perpetrators and one (5%) involved a female perpetrator.
- In 14 (64%) of the cases, seven or more risk factors were identified.
- The average number of risk factors identified in cases reviewed in 2017 was 9.8.

Further analysis of the cases reviewed in 2017 demonstrated that:

- The victims ranged in age from six to 91 years.
- The average age of victims was 47.4 years.
- The perpetrators ranged in age from 24 to 95 years.
- The average age of perpetrators (deceased and living) was 48.9 years.
- The number of risk factors for individual cases ranged from two to 22.

Analysis of Risk Factors: Number of Risk Factors per Case

The data in **Chart Six: Number of Risk Factors Identified in Cases Reviewed (2017**), are consistent with the findings with all cases reviewed by the DVDRC from 2003-2017 which clearly demonstrates that the vast majority of cases resulting in domestic homicide or homicide-suicide, had a significant number of risk factors (i.e. seven or more) and therefore were potentially predictable and preventable. It is important to again stress that the recognition of multiple risk factors within a relationship allows for enhanced risk assessment, safety planning and possible prevention of future deaths related to domestic violence. The number of risk factors for cases reviewed in 2017 ranged from two to 27.

For a number of years, 40 risk factors were assessed for each case reviewed. In 2017, the additional risk factor of *victim vulnerability* was added to make 41 risk factors.

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

Chart Six: Number of Risk Factors Identified in Cases Reviewed (2017)

# and % of risk factors per case	2017 Reviews (n=22)	Total Reviews 2003-2017 (n=311)
no factors	0	4
%		1%
1 to 3 factors	4	41
%	18%	13%
4 to 6 factors	4	46
%	18%	15%
7 or more factors	14	220
%	**64%**	**71%**

Chart Six breaks down the number of identified risk factors in the cases reviewed in 2017 and compares them to the number of risk factors for all cases reviewed from 2003-2017.

The chart indicates that:

- In 2017, no cases had zero risk factors identified. This compares to 1% of *all* cases reviewed from 2003-2016.
- In 2017, 4 (18%) cases reviewed had one to three risk factors identified. This compares to 13% of *all* cases reviewed from 2003-2017.
- In 2017, 4 (18%) cases reviewed had four to six risk factors identified. This compares to 15% of *all* cases reviewed from 2003-2017.

- In 2017, 14 (64%) of cases reviewed had seven or more risk factors identified. This compares to 71% of *all* cases reviewed from 2003-2017.

- The risk factor findings for cases reviewed in 2017 is consistent with the findings shown in Chart Four and Graph Four which indicate that the majority of *all* cases reviewed from 2003-2017 have seven or more risk factors.

Analysis of Death Factors

Chart Seven: Death factors for cases reviewed in 2017 shows that 32% of the cases involved some type of trauma (including cuts, stabs, beatings, assaults). Of the cases reviewed, 39% involved the use of a firearm, 15% were due to asphyxia (i.e. hanging, airway obstruction, strangulation or neck compression) and 12% were due to other factors such as jump/fall, or smoke inhalation.

Chart Seven: Death factors for cases reviewed in 2017

Death Factor	Victim	Perp	Total	%	
Trauma - cuts, stabs	9		9	26%	32%
Trauma - beating, assault	1		1	3%	
Trauma - blunt force		1	1	3%	
Shooting - handgun	4	2	6	17%	39%
Shooting - shotgun	2	2	4	11%	
Shooting - rifle	2	2	4	11%	
Asphyxia - hanging		2	2	6%	18%
Asphyxia - airway obstruction	1		1	3%	
Asphyxia - strangulation	3		3	9%	
Jump/Fall			0	0%	12%
Drug toxicity	1		1	3%	
Unascertained	2		2	6%	
Fire - smoke inhalation		1	1	3%	
Total Deaths	**25**	**10**	**35**		

*percentages are rounded off

Recommendations made from 2017 Case Reviews

In 2017, 33 recommendations were made from reviews conducted by the DVDRC.

In addition to new recommendations made, when appropriate, the DVDRC referenced previous recommendations that were relevant to the circumstances of the case under review.

Recommendations focused on:

- risk assessment and safety planning involving police, probation, family law, military, mental health and medical professionals and social workers;
- training for police services and crown attorneys on the National Framework for Collaborative Police Action on Intimate Partner Violence;
- disclosure of information on potential domestic violence offenders;
- public education on coercive control and for Indigenous communities;
- collaboration and sharing of information between agencies and
- resources to shelters including services to accept victims with pets.

A summary of all recommendations made in 2017 is included in Appendix D.

Discussion and Significant Findings for Cases Reviewed in 2017

The findings from reviews conducted in 2017 are consistent with the overall results from all reviews conducted from 2003-2017. More specifically:

- The majority of domestic violence homicide victims were female.
- The age range of victims is broad. In 2017, the range was from 6 to 91 years.
- The age range for perpetrators is also broad. In 2017, the range was from 24 to 95 years.
- The majority of cases reviewed had seven or more risk factors identified. The implication of numerous risk factors associated with these cases is that there was likely significant opportunity to predict (and prevent) future lethality in these cases.
- Trauma (e.g. stabs, beating, blunt force injury) was the top death factor, followed by shooting and asphyxia.

Chapter Three: DVDRC Reviews – Frequently Asked Questions

Mandate and Selection of Cases for Review

What is the mandate of the DVDRC?

The mandate of the DVDRC 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.

How does the DVDRC define "domestic violence?"

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

Periodically, the DVDRC reviews cases that do not meet the strict definition of domestic violence (as described above), but where the circumstances surrounding the relationship and subsequent death(s) were consistent with other cases reviewed by the DVDRC.

What cases are reviewed by the DVDRC?

The DVDRC reviews all homicides and homicide-suicides that occur in Ontario that are consistent with the above definition of domestic violence, or where the circumstances surrounding the death(s) are consistent with other cases reviewed by the DVDRC.

Review Process

How long does it take for a case to be reviewed?

Reviews are conducted by the DVDRC only after all other investigations and proceedings – including criminal trials and appeals – have been completed. As such, DVDRC reviews often take place several years after the actual incident. Cases of homicide-suicide are generally reviewed more expeditiously as no criminal proceedings would be pending.

What is the process for reviewing a case with the DVDRC?

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

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

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

Who is on the DVDRC?

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

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

Can family members or other stakeholders provide input into DVDRC reviews?

Family members and other stakeholders may provide input to the DVDRC through the relevant Regional Supervising Coroner responsible for the area where the homicide or homicide-suicide took place. Information provided through the course of the initial coroner's investigation will be included with the comprehensive package of materials available to the DVDRC reviewer.

What information is reviewed by the DVDRC?

The DVDRC will review all relevant information obtained through a Coroner's Authority to Seize that will contribute to a better understanding of the circumstances surrounding the death(s) with a view to identifying possible opportunities for intervention and the development of recommendations towards the prevention of future similar deaths. The DVDRC is a record-based review of the facts and does not include analysis of media or other unofficial sources. The DVDRC does not "re-open" cases and does not analyze investigative or judicial findings.

What are the limitations on information reviewed and the final report of the DVDRC?

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

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

Risk Factors

Why is identifying risk factors important?

Risk factors identified in case reviews are risk factors for **lethality** and are not limited to being predictive for recurrent domestic violence of a non-lethal nature. The trends in risk factors identified from case reviews conducted from 2003-2017 were demonstrated in Graph Three and Chart Four. In 72% of all cases reviewed over the past 15 years, the couple had a history of domestic violence. In 67% of the cases, there was an actual or pending separation. The other most common risk factors were a perpetrator who was depressed (diagnosis by a physician and/or observed by others), obsessive behaviour by the perpetrator, prior threats or attempts to commit suicide, a victim who had an intuitive sense of fear of the perpetrator and sexual jealousy by the perpetrator. Other key risk factors included an escalation in violence, prior threats to kill the victim, and a perpetrator who was unemployed.

Are some risk factors more important than others?

Risk factors identified in DVDRC reviews are all "weighted" equally. It is recognized however, that some risk factors (e.g. choked/strangled victim in the past) are likely more predictive of future lethality than other less serious or impactful risk factors.

What is the importance of multiple risk factors?

In 71% of the cases reviewed from 2003-2017, seven or more risk factors were identified in the relationship between the victim(s) and the perpetrator.

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

What is the significance of the trends in risk factors?

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

What does it mean when the number of risk factors is minimal?

Of the cases reviewed, 14% (see Chart Four) involved three or less risk factors. The lack of risk factors may impact the ability to predict or foresee lethality in the relationship and as a result, preventative or mitigating actions may not have been warranted or deemed necessary. Most of the homicide-suicide cases involving elderly individuals had very few risk factors identified. With minimal risks identified, it likely would have been difficult to predict, and therefore prevent, the tragic outcome.

Recommendations

How are recommendations developed and distributed?

If the DVDRC feels that there may be an opportunity to bring awareness to, or encourage change, to specific areas identified during the course of the review of the circumstances surrounding the domestic violence deaths, recommendations may be made.

One of the primary goals of the DVDRC is to make recommendations aimed at preventing deaths in similar circumstances and reduce domestic violence in general. Recommendations are distributed to relevant organizations and agencies through the Chair of the DVDRC. The phrase "no new recommendations" means that either no issues requiring recommendations were identified from the case review; or that an issue or theme was identified where a previous recommendation (or recommendations) had been made in a prior case. In some cases, recommendations made from previous reviews that may also be relevant to the current review, are noted for information purposes.

Are recommendations binding?

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

While they are not binding, recommendations are intended to encourage discussion and identify opportunities that may contribute to the prevention of deaths involving domestic violence in the province.

Are there trends in the theme of recommendations over the years?

The DVDRC has now reviewed a total of 311 cases since its inception in 2003. Upon analysis of those cases, the following general themes have emerged:

- The need for better **education** for the public and targeted professionals (e.g. physicians, counsellors, lawyers, police, etc.) on assessing and addressing the risks associated with intimate partner violence.
- The continued need for **public education** for neighbours, friends and families of victims or potential victims.
- Case reviews have identified that some **specific or targeted communities** may require additional focus in order to emphasize and bring attention to addressing issues of intimate partner violence within their unique environments or situations. This would include the geriatric population as well as ethnic/religious communities where

traditional cultural values have entrenched gender inequality with their relationships. [Note: While significant work has already been done to address domestic violence within these particular communities, DVDRC reviews continue to identify inconsistencies in resources, services and responses that are community-focused.]

- **Public policies** relating to violence in the workplace, bullying and stalking (including cyber and online harassment) continue to evolve.
- **Mental health** and how it impacts intimate partner violence.
- The recognition and assessment of **risk factors** (particularly the most prevalent risk factors of history of domestic violence, actual or pending separation and depression) when interacting with victims (or potential victims) and preparing safety plans.
- **Financial** and other stressors (e.g. health concerns).
- **Substance abuse** by victims and/or perpetrators.
- **Child custody,** family court decisions and child welfare concerns and the implications on intimate partner violence.

Is there follow-up to recommendations?

Organizations and agencies are asked to respond back to the Office of the Chief Coroner on the status of implementation of recommendations within six months of distribution. Much like recommendations from coroner's inquests, responding organizations are encouraged to "self-evaluate" the status of their response to the recommendations. The Office of the Chief Coroner does not challenge or question responses received.

Responses to recommendations are public documents and are available upon request to the Office of the Chief Coroner.

DVDRC Reports

Are DVDRC reports available to the public?

Redacted versions of individual final reports are available by contacting the Office of the Chief Coroner at occ.inquiries@ontario.ca.

Chapter Four: DVDRC - Looking forward

The year 2018-2019 marks the fourth year of the Five Year Strategic Plan for the Office of the Chief Coroner (OCC). The OCC has completed a thorough review of the inquest system in Ontario with the goal of transforming this system so that it is more innovative, effective and timely. This will, no doubt, impact our death review committees in terms of structure, approach and outcomes.

The OCC has been engaging with and cultivating relationships with Indigenous representatives of Ontario's rural and northern communities to ensure that death reviews are accessible, meaningful and responsive to their unique needs. Indeed, the frequency and severity of spousal assault and the frequency of domestic homicide are significantly higher for Indigenous women than for non-Indigenous women. [1] [2]

The DVDRC will also continue to partner with the Canadian Domestic Homicide Prevention Initiative as part of our strategy to capture robust data that creates knowledge and drives education to improve the health and safety of Ontarians with respect to domestic homicide. In turn, we are informed by the CDHPI of the similarities and differences between alternative DVDRC models nationally and internationally.

[1] General Social Survey on Victimization, 2014, Retrieved from hyttp://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=4504

[2] Homicide in Canada, 2014, Retrieved from https://www150.statcan.gc.ca/n1/daily-quotidien/151125/dq151125a-eng.htm

Appendix A: DVDRC – Terms of Reference

Purpose

The purpose of the Domestic Violence Death Review Committee (DVDRC) 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/her 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(s) leading to the death in the individual cases reviewed.
3. To create and maintain a comprehensive database about the victims and perpetrators of domestic violence fatalities and their circumstances.
4. To help identify the presence or absence of systemic issues, problems, gaps, or shortcomings of each case to facilitate appropriate recommendations for prevention.
5. To help identify trends, risk factors, and patterns from the cases reviewed to make recommendations for effective intervention and prevention strategies.
6. To conduct and promote research where appropriate.

7. To stimulate educational activities through the recognition of systemic issues or problems and/or:
   - referral to appropriate agencies for action;
   - where appropriate, assist in the development of protocols with a view to prevention;
   - where appropriate, disseminate educational information.
8. To report annually to the Chief Coroner the trends, risk factors and patterns identified and appropriate recommendations for preventing deaths in similar circumstances, based on the aggregate data collected from the Domestic Violence Death Reviews.

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

Appendix B

Risk Factor Descriptions (updated 2017)

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

	Perpetrator History	Definition
1	Perpetrator was abused and/or witnessed DV as a child	As a child/adolescent, the perpetrator was victimized and/or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment.
2	Perpetrator exposed to/witnessed suicidal behavior in family of origin	As a(n) child/adolescent, the perpetrator was exposed to and/or witnessed any actual, attempted or threatened forms of suicidal behaviour in his family of origin. Or somebody close to the perpetrator (e.g., caregiver) attempted or committed suicide.

	Family/Economic Status	Definition
3	Youth of couple	Victim and perpetrator were between the ages of 15 and 24.
4	Age disparity of couple	Women in an intimate relationship with a partner who is significantly older or younger. The disparity is usually nine or more years.
5	Victim and perpetrator living common-law	The victim and perpetrator were cohabiting.
6	Actual or pending separation	The partner wanted to end the relationship. Or the perpetrator was separated from the victim but wanted to renew the relationship. Or there was a sudden and/or recent separation. Or the victim had contacted a lawyer and was seeking a separation and/or divorce.
7	New partner in victim's life	There was a new intimate partner in the victim's life or the perpetrator perceived there to be a new intimate partner in the victim's life
8	Child custody or access disputes	Any dispute in regards to the custody, contact, primary care or control of children, including formal legal proceedings or any third parties having knowledge of such arguments.

	Family/Economic Status	Definition
9	Presence of step children in the home	Any child(ren) that is(are) not biologically related to the perpetrator.
10	Perpetrator unemployed	Employed means having full-time or near full-time employment (including self-employment). Unemployed means experiencing frequent job changes or significant periods of lacking a source of income. Please consider government income assisted programs (e.g., O.D.S.P.; Worker's Compensation; E.I.; etc.) as unemployment.

	Perpetrator Mental Health	Definition
11	Excessive alcohol and/or drug use by perpetrator	Within the past year, and regardless of whether or not the perpetrator received treatment, substance abuse that appeared to be characteristic of the perpetrator's dependence on, and/or addiction to, the substance. An increase in the pattern of use and/or change of character or behaviour that is directly related to the alcohol and/or drug use can indicate excessive use by the perpetrator. For example, people described the perpetrator as constantly drunk or claim that they never saw him without a beer in his hand. This dependence on a particular substance may have impaired the perpetrator's health or social functioning (e.g., overdose, job loss, arrest, etc). Please include comments by family, friend, and acquaintances that are indicative of annoyance or concern with a drinking or drug problem and any attempts to convince the perpetrator to terminate his substance use.
12	Depression – in the opinion of family/friend/acquaintance	In the opinion of any family, friends, or acquaintances, and regardless of whether or not the perpetrator received treatment, the perpetrator displayed symptoms characteristic of depression.
13	Depression – professionally diagnosed	A diagnosis of depression by any mental health professional (e.g., family doctor; psychiatrist; psychologist; nurse practitioner) with symptoms recognized by the DSM-IV, regardless of whether or not the perpetrator received treatment.
14	Other mental health or psychiatric problems – perpetrator	For example: psychosis; schizophrenia; bi-polar disorder; mania; obsessive-compulsive disorder, etc.

	Perpetrator Mental Health	Definition
15	Prior threats to commit suicide by perpetrator	Any recent (past 6 months) act or comment made by the perpetrator that was intended to convey the perpetrator's idea or intent of committing suicide, even if the act or comment was not taken seriously. These comments could have been made verbally, or delivered in letter format, or left on an answering machine. These comments can range from explicit (e.g., "If you ever leave me, then I'm going to kill myself" or "I can't live without you") to implicit ("The world would be better off without me"). Acts can include, for example, giving away prized possessions.
16	Prior suicide attempts by perpetrator	Any recent (past six 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.

	Perpetrator Attitude/ Harassment/ Violence	Definition
17	Obsessive behavior displayed by perpetrator	Any actions or behaviours by the perpetrator that indicate an intense preoccupation with the victim. For example, stalking behaviours, such as following the victim, spying on the victim, making repeated phone calls to the victim, or excessive gift giving, etc.
18	Failure to comply with authority	The perpetrator has violated any family, civil, or criminal court orders, conditional releases, community supervision orders, or "No Contact" orders, etc. This includes bail, probation, or restraining orders, and bonds, etc.
19	Sexual jealousy	The perpetrator continuously accuses the victim of infidelity, repeatedly interrogates the victim, searches for evidence, tests the victim's fidelity, and sometimes stalks the victim.
20	Misogynistic attitudes – perpetrator	Hating or having a strong prejudice against women. This attitude can be overtly expressed with hate statements, or can be more subtle with beliefs that women are only good for domestic work or that all women are "whores."

	Perpetrator Attitude/ Harassment/ Violence	Definition
21	Prior destruction or deprivation of victim's property	Any incident in which the perpetrator intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the perpetrator. This could include slashing the tires of the car that the victim uses. It could also include breaking windows or throwing items at a place of residence. Please include any incident, regardless of charges being laid or those resulting in convictions.
22	History of violence outside of the family by perpetrator	Any actual or attempted assault on any person who is not, or has not been, in an intimate relationship with the perpetrator. This could include friends, acquaintances, or strangers. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.).
23	History of domestic violence - **Previous** partners	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person **who has been 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.

	Perpetrator Attitude/ Harassment/ Violence	Definition
24	History of domestic violence - **Current** partner/victim	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who **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.
25	Prior threats to kill victim	Any comment made to the victim, or others, that was intended to instill fear for the safety of the victim's life. These comments could have been delivered verbally, in the form of a letter, or left on an answering machine. Threats can range in degree of explicitness from "I'm going to kill you" to "You're going to pay for what you did" or "If I can't have you, then nobody can" or "I'm going to get you."
26	Prior threats with a weapon	Any incident in which the perpetrator threatened to use a weapon (e.g., gun; knife; etc.) or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.) for the purpose of instilling fear in the victim. This threat could have been explicit (e.g, "I'm going to shoot you" or "I'm going to run you over with my car") or implicit (e.g., brandished a knife at the victim or commented "I bought a gun today"). Note: This item is separate from threats using body parts (e.g., raising a fist).
27	Prior assault with a weapon	Any actual or attempted assault on the victim in which a weapon (e.g., gun; knife; etc.), or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.), was used. Note: This item is separate from violence inflicted using body parts (e.g., fists, feet, elbows, head, etc.).

	Perpetrator Attitude/ Harassment/ Violence	Definition
28	Prior attempts to isolate the victim	Any non-physical behaviour, whether successful or not, that was intended to keep the victim from associating with others. The perpetrator could have used various psychological tactics (e.g., guilt trips) to discourage the victim from associating with family, friends, or other acquaintances in the community (e.g., "if you leave, then don't even think about coming back" or "I never like it when your parents come over" or "I'm leaving if you invite your friends here").
29	Controlled most or all of victim's daily activities	Any actual or attempted behaviour on the part of the perpetrator, whether successful or not, intended to exert full power over the victim. For example, when the victim was allowed in public, the perpetrator made her account for where she was at all times and who she was with. Another example could include not allowing the victim to have control over any finances (e.g., giving her an allowance, not letting get a job, etc.).
30	Prior hostage-taking and/or forcible confinement	Any actual or attempted behaviour, whether successful or not, in which the perpetrator physically attempted to limit the mobility of the victim. For example, any incidents of forcible confinement (e.g., locking the victim in a room) or not allowing the victim to use the telephone (e.g., unplugging the phone when the victim attempted to use it). Attempts to withhold access to transportation should also be included (e.g., taking or hiding car keys). The perpetrator may have used violence (e.g., grabbing; hitting; etc.) to gain compliance or may have been passive (e.g., stood in the way of an exit).
31	Prior forced sexual acts and/or assaults during sex	Any actual, attempted, or threatened behaviour, whether successful or not, used to engage the victim in sexual acts (of whatever kind) against the victim's will. Or any assault on the victim, of whatever kind (e.g., biting; scratching, punching, choking, etc.), during the course of any sexual act.

	Perpetrator Attitude/ Harassment/ Violence	Definition
32	Choked/strangled victim in past	Any attempt (separate from the incident leading to death) to strangle the victim. The perpetrator could have used various things to accomplish this task (e.g., hands, arms, rope, etc.). Note: Do not include attempts to smother the victim (e.g., suffocation with a pillow).
33	Prior violence against family pets	Any action directed toward a pet of the victim, or a former pet of the perpetrator, with the intention of causing distress to the victim or instilling fear in the victim. This could range in severity from killing the victim's pet to abducting it or torturing it. Do not confuse this factor with correcting a pet for its undesirable behaviour.
34	Prior assault on victim while pregnant	Any actual or attempted form physical violence, ranging in severity from a push or slap to the face, to punching or kicking the victim in the stomach. The key difference with this item is that the victim was pregnant at the time of the assault and the perpetrator was aware of this fact.
35	Escalation of violence	The abuse/maltreatment (physical; psychological; emotional; sexual; etc.) inflicted upon the victim by the perpetrator was increasing in frequency and/or severity. For example, this can be evidenced by more regular trips for medical attention or include an increase in complaints of abuse to/by family, friends, or other acquaintances.
36	Perpetrator threatened and/or harmed children	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual; etc.) towards children in the family. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family; friends; neighbours; co-workers; counselors; medical personnel, etc).

	Perpetrator Attitude/ Harassment/ Violence	Definition
37	Extreme minimization and/or denial of spousal assault history:	At some point the perpetrator was confronted, either by the victim, a family member, friend, or other acquaintance, and the perpetrator displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., batterer intervention programs). Or the perpetrator denied many or all past assaults, denied personal responsibility for the assaults (i.e., blamed the victim), or denied the serious consequences of the assault (e.g., she wasn't really hurt).

	Access	Definition
38	Access to or possession of any firearms	The perpetrator stored firearms in his place of residence, place of employment, or in some other nearby location (e.g., friend's place of residence, or shooting gallery). Please include the perpetrator's purchase of any firearm within the past year, regardless of the reason for purchase.
39	After risk assessment, perpetrator had access to victim	After a formal (e.g., performed by a forensic mental health professional before the court) or informal (e.g., performed by a victim services worker in a shelter) risk assessment was completed, the perpetrator still had access to the victim.

	Victim's Disposition	Definition
40	Victim's intuitive sense of fear of perpetrator	The victim is one that knows the perpetrator best and can accurately gauge his level of risk. If the women discloses to anyone her fear of the perpetrator harming herself or her children, for example statements such as, "I fear for my life", "I think he will hurt me", "I need to protect my children", this is a definite indication of serious risk.
41	Victim Vulnerability	A victim may be considered vulnerable due to problems and life circumstances which make reaching out for help more difficult. This may include: mental health issues and/or addictions, disability, language and/or cultural barriers (e.g., new immigrant or isolated cultural community), economic dependence, and living in rural or remote locations. Vulnerability may also be related to lifestyle choices that place victims at risk (e.g., sex trade worker or escort).

		Vulnerability is **not** defined by issues common to many people such as problems in self-esteem, youth, poverty or any one cultural group (e.g. Aboriginal).

Appendix C: Detailed Summary of Cases reviewed in 2017

Case #	Year of death	Homicide	Homicide-Suicide	# of victims	Age of Victims	Female Victim	Male Victim	Child Victim	Age of Perp	Male Perp	Female Perp	# of risk factors	# of recs	Themes
1	2012	1		1	50	1			52	1		12	2	safe separation
2	2012	1		1	47		1		54	1		6	2	alcohol, police, same sex
3	2007	1		1	40	1			43	1		21	0	probation
4	2013	1		1	59	1			57	1		5	1	workplace
5	2014		1	2	57 91	1	1		61	1		3	0	Depression
6	2013	1		1	54	1			49	1		13	4	Victim vulnerability
7	2011	1		1	24	1			25	1		17	2	child custody
8	2014		1	1	50	1			60	1		3	0	unemployed
9	2015		1	1	45	1			44	1		3	1	alcohol, depression, safe separation
10	2015		1	1	55	1			55	1		5	0	safe separation
11	2015		1	1	91	1			95	1		4	0	Elderly, depression
12	2016		1	1	28	1			24	1		7	1	safe separation
13	2013	1		1	28	1			50	1		9	2	PTSD, BDSM
14	2016		1	1	53	1			44	1		22	5	mental health, addictions
15	2016		1	1	46	1			48	1		9	0	safe separation
16	2014	1		1	6	1		1	35	1		7	1	depression
17	2013	1		1	39		1		24		1	17	2	Indigenous, alcohol, CAS
18	2014		1	1	43	1			47	1		20	2	child protection
19	2013	1		1	24	1			38	1		9	0	vulnerable victim
20	2011	1		1	61	1			63	1		2	2	elderly, caregiver, police investigation
21	2016		1	3	19 70 33	1 1	1		37	1		8	0	safe separation
22	2014	1		1	73	1			71	1		15	6	safe separation, risk assessment, pets

Appendix D

Summary of Cases and Recommendations – 2017 Case Reviews

Case #	Summary	Recommendation(s)
2017-01	This case involved the homicide of a 50-year-old woman by her 52-year-old husband. The couple was in the process of a difficult separation and there was an incident where the perpetrator destroyed valuable property belonging to the victim. There were 12 risk factors for intimate partner homicide identified.	1. The circumstances of this case should be used in training materials to family law mediators in order to demonstrate the importance of screening out cases where there is a power imbalance and/or history of domestic violence and to reinforce the importance of risk assessment and safety planning. **2.** The circumstances of this case should be used in police training on domestic violence in order to demonstrate the possible significance and implications of destruction of property, particularly during legal proceedings and/or separations, and how such actions may result in consideration of criminal charges against the perpetrator and a full risk assessment and/or safety planning for the victim.
2017-02	This case involved the homicide of 46-year-old man by his 54-year-old same-sex domestic partner. Both individuals were known to have alcohol overuse disorders. There were six risk factors for intimate partner homicide identified.	1. Police services in Ontario are reminded about the importance of risk assessment, safety planning and risk management for all domestic violence calls. 2. Police services should provide bi-annual training for all front-line officers on responding to domestic violence calls and the use of the Domestic Violence Supplementary Report (DVSR).
2017-03	This case involved the homicide of a 40-year-old [3] woman by her 43-year-old common law partner. The victim and perpetrator both abused substances. The couple had been in a relationship for two years and there was a history of domestic violence. There were 21 risk factors	No new recommendations.

[3] The victim was 39 years old at the time of her disappearance in January 2007. The date of death reflects the date when the victim was found deceased in April 2007. On the date of death, the victim would have been 40 years old.

Case #	Summary	Recommendation(s)
	for intimate partner homicide identified.	
2017-04	This case involved the homicide of a 59-year-old woman by her 57-year-old husband. The couple had been in a relationship for 14 years and the perpetrator had recently started a new relationship with somebody he met online. There were five risk factors for intimate partner homicide identified.	1. The Ministry of Labour should develop a model "Workplace Policy to Address Perpetrators of Domestic Violence" to assist workplaces to better identify their role and responsibility in addressing the behaviours of domestic violence perpetrators. These behaviours affect not only the well-being of direct victims, but also peers who are exposed to this conduct. Current policies and practices address how to respond to victims, but are not as explicit on how to respond to the perpetrators or how to appropriately address their behaviours.
2017-05	This case involved the homicides of a 57-year-old woman and her 91-year-old father-in-law, followed by the suicide of the 61-year-old perpetrator who was husband of victim 1 and son of victim 2. There were three risk factors for intimate partner homicide identified.	No new recommendations.
2017-06	This case involved the homicide of a 54-year-old woman by her 49-year-old boyfriend. The perpetrator had a history of domestic violence with previous partners. At the time of the homicide, the victim was trying to end the relationship. There were 13 risk factors for intimate partner homicide identified.	1. When domestic violence offenders have a condition to attend a Partner Assault Response (PARs) program, they should be directed and expected to complete the required counselling. When the offender offers numerous excuses and fails to attend the program, enforcement action should be swift and certain. Repeated warnings without follow through are ineffective. 2. When a domestic violence offender is engaged in a subsequent relationship, the Probation and Parole Officer should make ongoing efforts to engage the current partner as a collateral contact. 3. When an individual's Probation and Parole Officer has information from a victim about repeated contact, the officer should contact police and take action to ensure the safety of the victim.

Case #	Summary	Recommendation(s)
		4. The Ministry of Community Safety and Correctional Services and Ministry of the Attorney General should consider developing a policy and implementation protocol on how victims, family members or potential victims of domestic violence can access information on prior convictions of violent offences with an individual with whom they are residing or dating. Considering the complexity of this undertaking, it is recommended that the Ministries consider utilizing an advisory panel to deal with the legal and psychological aspects of such a policy and protocol as well as an evaluation strategy. This policy and protocol is described in other jurisdictions as a *Domestic Violence Disclosure Scheme (DVDS).*
2017-07	This case involved the homicide of a 24-year-old woman by her 25-year-old former common-law partner. The couple was involved in a dispute over the custody of their child. There were 17 risk factors for intimate partner homicide identified.	1. It is recommended that the MSW update the Neighbours, Friends, and Families (NFF) public education campaign to include more focused information on the risk, use, and impact of "coercive control" in intimate relationships. 2. The OACAS should promote training on domestic violence with a specific focus on elements of coercive control and emotional abuse for all Children's Aid Society (CAS) staff.
2017-08	This case involved the homicide of a 50-year-old woman by her 60-year-old husband who subsequently committed suicide. The perpetrator also attempted to kill his 16-year-old son. The perpetrator was experiencing health and financial stressors. There were three risk factors for intimate partner homicide identified.	No new recommendations.

Case #	Summary	Recommendation(s)
2017-09	This case involved the homicide of a 45-year-old woman by her 44-year-old husband who subsequently committed suicide. The perpetrator was depressed, suffered from alcoholism and the couple was in the process of separating. There were three risk factors for intimate partner homicide identified.	1. The residential treatment facility involved should conduct an internal review of the services provided to the perpetrator. This review should include, but not be limited to: • An evaluation of the psychiatric assessment conducted on the perpetrator particularly as it relates to his history of domestic violence and suicidal/homicidal ideation • An evaluation of the discharge process and whether the history of suicidal tendencies was considered and whether safety planning for the spouse could have been completed.
2017-10	This case involved the homicide of a 55-year-old-woman by her 55-year-old husband who subsequently committed suicide. The couple had been married for two years. The victim had recently started a new relationship that the perpetrator was aware of. There were five risk factors for intimate partner homicide identified.	No new recommendations.
2017-11	This case involved the homicide of a 91-year-old woman followed by the suicide of her 94-year-old husband. The victim's health had been declining and she was dependent on the perpetrator for care. Both the victim and perpetrator suffered from dementia. There were four risk factors for intimate partner homicide identified.	No new recommendations.
2017-12	This case involved the homicide of a 28-year-old woman by her 24-year-old boyfriend who subsequently committed suicide. The victim was in the process of ending the relationship. The perpetrator had	1. It is recommended that the Canadian Firearms Program include the "Safely Storing, Transporting and Displaying Firearms" pamphlet with license renewal applications as a reminder to their clients regarding the

Case #	Summary	Recommendation(s)
	access to firearms that were incorrectly stored at his parent's residence. There were seven risk factors for intimate partner homicide identified.	importance of safe storage to ensure public safety.
2017-13	This case involved the homicide of a 28-year-old woman by her 50-year-old husband. The perpetrator was in the military and reportedly suffered from post-traumatic stress disorder (PTSD). There were nine risk factors for intimate partner homicide identified.	1. The potential links between domestic violence and post-traumatic stress disorder should be part of a public and professional education campaign for military personnel, family members and professionals providing treatment for them. 2. The importance of having a safe word for couples involved in BDSM sexual practices should be reinforced as a potential marker between consensual activity and abusive behavior.
2017-14	This case involved the homicide of a 52-year-old woman by her 44-year-old common-law partner. The couple had a long history of mental health and addiction issues. The perpetrator had been charged after assaulting the victim in another province, but the charges were not pursued after the couple moved to Ontario. There were 22 risk factors for intimate partner homicide identified.	1. This case should be reviewed by the high risk team involved for a lessons learned case review about collaboration and information sharing. The team involved is encouraged to share the lessons learned with other high risk teams in the province. 2. Police services across Ontario should be reminded that domestic violence risk assessment is only the first step of a longer process that should include safety planning and risk management. 3. Health and mental health professionals who are involved with vulnerable patients involved in domestic violence should complete risk assessments focused on domestic violence and reach out to the police and justice system for advice on potential lethal circumstances with a documented history of concern. 4. Police services and crown attorneys should be aware of, and reinforce, the National Framework for Collaborative Police Action on Intimate Partner Violence which speaks to the importance of collaboration and information sharing across jurisdictions. (https://cacp.ca/index.html?asst_id=1200)

Case #	Summary	Recommendation(s)
2017-15	This case involved the homicide of a 46-year-old woman by her 48-year-old husband who subsequently committed suicide. The couple was in the process of separating and the perpetrator had a history of suicide in his immediate family. There were nine risk factors for intimate partner homicide identified.	No new recommendations.
2017-16	This case involved the homicide of a six-year-old girl by the perpetrator who was her 35-year-old father. At the time of the homicide, the child's parents were in the process of separating. There were seven risk factors for intimate partner homicide identified.	1. Social workers, psychologists and physicians are reminded of the importance of ongoing training on risk assessment, risk management and safety planning in the prevention of domestic homicides. Special emphasis should be given on the impact that depression has on domestic violence and domestic homicide.
2017-17	This case involved the homicide of a 39-year-old man by his 24-year-old female common-law partner. The couple was Indigenous and lived in a remote Indigenous community. Both the victim and perpetrator had significant histories that included domestic violence, child abuse, substance abuse and sexual assault. There were 17 risk factors for intimate partner homicide identified.	1. Individuals and organizations providing services and support to Indigenous communities are reminded that the Kanawayhitowin Campaign (based on the Neighbours, Friends and Family program) is a valuable resource to provide information and education on addressing the issue of domestic violence involving Indigenous people in Ontario.
2017-18	This case involved the homicide of a 43-year-old woman by her 47-year-old common-law spouse who subsequently committed suicide. The couple had five children together. The perpetrator was known to emotionally and psychologically abuse the victim and children. There were 19 risk factors for intimate partner homicide identified.	1. Child protection workers are encouraged to utilize the facts from this review as an educational case study to illustrate how controlling individuals can manipulate victims and control their disclosures to authorities. 2. Medical education to family physicians should include information pertaining to personality disorders, including risk assessment and possible methods of intervention and/or resources available.

Case #	Summary	Recommendation(s)
2017-19	This case involved the homicide of 24-year-old woman by a 38-year-old man who considered the woman to be his girlfriend. There were nine risk factors for intimate partner homicide identified.	No new recommendations.
2017-20	This case involved the homicide of a 61-year-old woman by her 63-year-old husband. The victim was dependent on the perpetrator as her primary caregiver after experiencing a stroke four years prior. There were two risk factors for intimate partner homicide identified.	1. It is recommended that the police service involved review their policies and procedures with respect to domestic violence investigations and that the Chief of Police educate the officers on the work of the DVDRC and information that is collected. 2. The police service involved should establish policies and procedures regarding the investigation of incidences involving members and/or family members of individuals (both uniformed and civilian) employed by the police service.
2017-21	This case involved the homicide of a 19-year-old woman (victim 1) by a perpetrator who was her 37-year-old boyfriend. The perpetrator also killed his 70-year-old mother (victim 2) and 33-year-old brother (victim 3), then killed himself. There were eight risk factors for intimate partner homicide identified.	No new recommendations.
2017-22	This case involved the homicide of a 73-year-old woman by her 71-year-old husband. There was a long history of domestic violence in the couple's 47-year marriage and just prior to the homicide, the victim had separated from the perpetrator. There were 15 risk factors for intimate partner homicide identified.	1. The provincial government should educate the general public and professionals involved with victims on programs (e.g. SafePet Program) available that aim to keep pets safe during times of crises or when attempting to leave an abusive situation so that they can make decisions to enhance their own safety and/or that of their children without worrying about the safety of their pets. This would also remove some power from abusers who use pets to control their victims. 2. The provincial government should ensure that shelters in Ontario are provided adequate

Case #	Summary	Recommendation(s)
		resources to allow them to accept pets or to adopt policies that will allow victims of domestic violence to bring their pets with them to the shelter such as on-site kennels or cooperation with safe pet programs. 3. If mental health issues are suspected or identified during intimate partner violence investigations, police officers and/or judicial partners (e.g. probation and parole) should make a mental health referral requesting follow up. 4. Police officers are reminded to ask or probe in instances where historical offences have been alleged or suspected in compliance with the provincial adequacy standards. If information is received, an investigation should be conducted and the outcome with supporting rationale documented. 5. Police officers should receive training on the elements of the offence of criminal harassment given that it is documented as a precursor to domestic homicide. 6. Police services should have a review process in place regarding all intimate partner violence occurrences, both criminal and non-criminal, to ensure oversight.

For further information, please contact:

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