Office of the Chief Coroner
Province of Ontario

Domestic Violence Death Review Committee

2018 Annual Report

November 2019

Table of Contents

Message from the Chair

As Chair of the Domestic Violence Death Review Committee (DVDRC) I am very proud of the expertise and dedication each of the members bring to this important work. It is their contributions that shape the analysis and recommendations included in this report and ensure that these tragic deaths are not overlooked.

The end of 2018 represents 15 years since the committee was formed. Even though the work we are doing is comprehensive and well-serving, I believe we should always look for ways in which to better serve Ontarians and improve safety for women, children and men living with domestic violence.

The Office of the Chief Coroner is embarking on a comprehensive review of the committee, including an evaluation of the committee's mandate, function and composition. We will be taking a retrospective and prospective approach that will not only look inward – there are a number of other initiatives underway both inside and outside of government that may inform innovative approaches to these important reviews. Essentially, we want to learn from our experiences and the experiences of others.

It is our intention to conduct our review of the DVDRC in consultation with a diversity of internal and external stakeholders, experts, agencies and survivors and families.

This work would not be possible without the members of the DVDRC, their unique expertise and ongoing commitment to doing this work and doing it well. Their contributions are greatly appreciated. A special thank you to the following committee members who have left in 2018 or will be leaving the committee in 2019: D/Sgt. Alison Freeman, D/Sgt. Mark Gauthier, D/Sgt. Monica Denreyer, D/Sgt. Leslie Raymond and Pam Fusillo.

It is with great sadness that I also acknowledge the recent passing of Dr. Lynn Stewart, a long-time member of the DVDRC. Lynn was an active and engaging participant of the DVDRC for many years and she will be sadly missed.

Deidre Bainbridge
Chair, Domestic Violence Death Review Committee

Committee Membership (2018)

Deidre Bainbridge, NP
Committee Chair
Provincial Nurse Manager
Office of the Chief Coroner

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

Marcie Campbell, M.Ed
Counsellor/Counselling Supervisor (Sexual Violence)
York University

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

Claudette Dumont-Smith
RN, BScN, MPA, LL.D (Hon.)

Pamela Fusillo
Executive Director
Chatham-Kent Victim Services

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

Dahlia Saibil / Kelly Simpson
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, 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 2003-2018:

- From 2003-2018, the DVDRC has reviewed 329 cases, involving 470 deaths.
- Of the cases reviewed, 66% were homicides and 34% were homicide-suicides.
- Approximately 71% of all cases reviewed from 2003-2018 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 (44%)
    - a victim who had an intuitive sense of fear towards the perpetrator (43%)
    - victim vulnerability (43%)[1]
    - perpetrator displayed sexual jealousy (39%)
    - prior threats to kill the victim (36%)
    - excessive alcohol and/or drug use (40%)
    - a perpetrator who was unemployed (39%)
    - history of violence outside the family (33%)

- In 70% of the cases reviewed, seven or more risk factors were identified.

Cases reviewed in 2018:

- There were 18 cases reviewed by the DVDRC in 2018. These included 15 homicide cases and three homicide-suicide cases, resulting in 25 deaths (22 homicide victims and three perpetrator suicides).
- There were 28 recommendations generated through these reviews.
- Of the 22 victims in the cases reviewed, 13 (59%) were adult females, five (23%) were adult males, two (9%) were female children and two (9%) were male children.
- Of the 18 cases reviewed, 14 (78%) involved male perpetrators and four (22%) involved a female perpetrator.
- The victims ranged in age from four to 82 years.
- The average age for victims was 39.3 years.
- The perpetrators ranged in age from 23 to 82 years.
- The average age for perpetrators was 44 years.
- The average number of risk factors identified in the cases reviewed was 7.5.
- The number of risk factors ranged from one to 17.
- Seven or more risk factors were identified in 11 (61%) of the cases reviewed in 2018.
- There were three cases involving individuals (either victim or perpetrator) who identified as Indigenous.

[1] This risk factor has been tracked since 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 the Coroners Act.
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 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.

At the discretion of the Chair, the DVDRC may review other deaths if they occurred within the context of an incident where the intended victim was the perpetrator's partner or ex-partner, and the intended victim did not die, or in cases where there was the perception or possibility that the victim and the perpetrator were involved in an intimate relationship.

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. All reports and recommendations are distributed electronically. Responses to recommendations are available to the public upon request at occ.inquiries@ontario.ca.

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 16-year period of cases occurring from 2002-2017 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 2002-2017 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 (2002-2017)

The following statistics relate to homicides in Ontario occurring between 2002-2017 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).

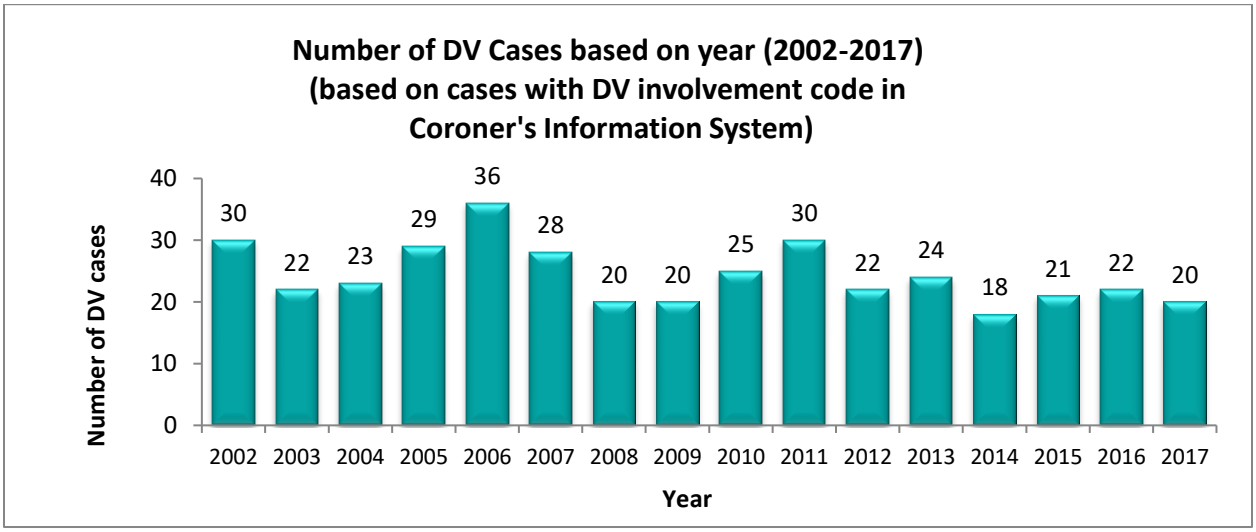
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Totals 2002-2017
Number of cases	30	22	23	29	36	28	20	20	25	30	22	24	18	21	22	20	**390**
Homicides	19	18	14	21	29	18	15	15	19	22	13	19	11	14	16	17	**280**
																	72%
Homicide-Suicides	11	4	9	8	7	10	5	5	6	8	9	5	7	7	6	3	**110**
																	28%
Total number of Deaths	**46**	**26**	**33**	**37**	**53**	**45**	**29**	**30**	**32**	**38**	**32**	**30**	**29**	**30**	**30**	**23**	**543**
Total number of Homicide Victims	**35**	**22**	**24**	**29**	**46**	**35**	**24**	**25**	**26**	**30**	**23**	25	**22**	23	24	20	**433**
																	80%
Female (adult)	26	19	21	29	28	29	20	20	21	27	19	22	13	21	17	17	**349**
																	81%
Female (child)	4	1	1	0	8	0	0	3	1	0	0	0	2	0	2	0	**22**
																	5%
Male (adult)	4	1	2	0	3	4	4	2	4	3	3	3	3	2	5	1	**44**
																	10%
Male (child)	1	1	0	0	7	2	0	0	0	0	1	0	4	0	0	2	**18**
																	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**	**43.8**	**43.4**	**38.2**
Total number Perpetrator deaths (suicide or other)	11	4	9	8	7	10	5	5	6	8	9	5	7	7	6	3	**110**
																	20%
Female (adult)	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0	**3**
																	3%
Male (adult)	11	4	8	8	7	9	5	**5**	6	8	9	5	7	7	5	3	**107**
																	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**	**68.3**	**49.6**

Chart One: Homicides in Ontario with Domestic Violence Involvement Code (2002-2017)

Chart One: Summary

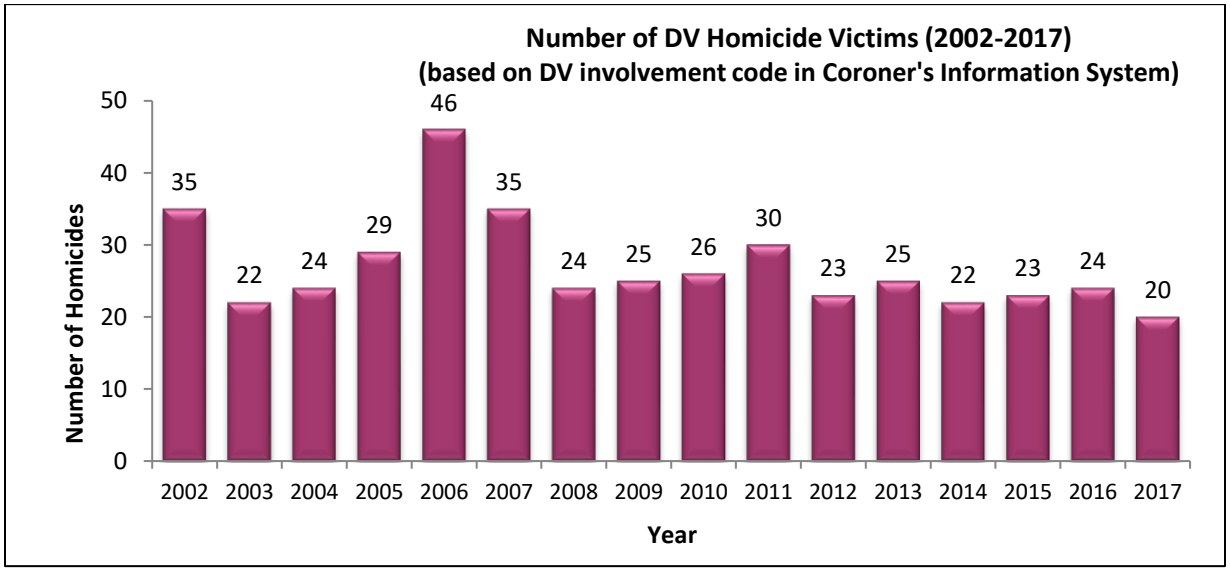
- There were 390 domestic homicide and/or homicide-suicide cases that occurred in Ontario between 2002-2017 (based on cases investigated by the Office of the Chief Coroner for Ontario, where domestic violence was identified as an involvement code).
- Of those 390 cases, 280 (72%) were homicides and 110 (28%) of the cases were homicide-suicides.
- The 390 cases resulted in a total of 543 deaths.
- Of the 543 deaths, 433 (80%) were homicide victims and 110 (20%) were perpetrators who committed suicide or were otherwise killed (e.g. shot by police).
- There was an average of 24 domestic homicide and/or homicide-suicide cases per year from 2002-2017. Some of these cases may have included multiple victims.
- There have been 433 domestic homicide victims from 2002-2017.
- There was an average of 27 domestic homicide victim deaths per year from 2002-2017.
- Of the 433 homicide victims, 349 (81%) were adult females, 40 (9%) were children and 44 (10%) were adult males.
- Of the 110 perpetrator deaths, 107 (97%) were adult males.
- The average age of homicide victims was 38.2 years.
- The average age of perpetrators who died was 49.6 years.

Graph One: Number of DV cases based on year (2002-2017) 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 2002-2017. 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 24 domestic homicide and/or homicide-suicide cases per year from 2002-2017.

Graph Two: Number of DV Homicide Victims (2002-2017)



Graph Two shows the number of domestic violence homicide victims per year from 2002-2017. The number of homicide victims per year has varied from 20 in 2017 to 46 in 2006. There was an average of 27 domestic homicide victim deaths per year from 2002-2017.

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 2002-2017.

Chart Two: Top Death Factors in Domestic Violence Deaths (2002-2017) based on CIS data

Death Factor	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Total DV Deaths (2002-2017)	% of Total DV Deaths (2002-2017)	
Trauma - cuts, stabs	15	8	11	9	21	14	8	11	16	15	6	12	13	9	8	7	183	34%	**42%**
Trauma - beating, assault	5	4	4	5	6	2	0	0	3	3	2	4	0	3	0	3	44	8%	
Shooting - handgun	8	5	2	4	1	9	1	3	3	1	6	4	2	2	7	6	64	12%	**26%**
Shooting - rifle	2	0	3	5	5	3	3	2	1	2	0	0	0	5	3	0	34	6%	
Shooting - shotgun	7	1	2	2	2	2	1	2	6	0	5	6	2	4	0	1	43	8%	
Shooting - weapon (not spec.)	0	0	1	0	0	0	1	0	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	1	12	2%	**11%**
Asphyxia - strangulation	0	3	5	5	6	4	4	0	0	3	3	1	1	1	1	1	38	7%	
Asphyxia - neck compression	0	0	0	1	2	0	2	3	0	0	0	1	1	0	1	0	11	2%	
Other	9	4	4	6	10	10	9	8	2	12	9	2	10	3	10	4	112	21%	**21%**
Total	**46**	**26**	**33**	**37**	**53**	**45**	**29**	**30**	**32**	**38**	**32**	**30**	**29**	**30**	**30**	**23**	**543**		

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

Summary of Chart Two: Top Death Factors in Domestic Violence Deaths (2002-2017)

- 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 (2003-2018)

From 2003-2018, the DVDRC has reviewed 329 cases that involved a total of 470 deaths. 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 2003-2018 inclusive.

Chart Three: Number of Cases Reviewed by the DVDRC (2003-2018)

				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
2018		18	25	15	3
Total		329	470	216	113
				66%	34%

* 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 (2003-2018)

- In the period between 2003 and 2018, the DVDRC reviewed 329 cases, involving 470 deaths (including perpetrator suicides).
- Of the 329 cases, 216 (66%) were homicides and 113 (34%) were homicide-suicides.

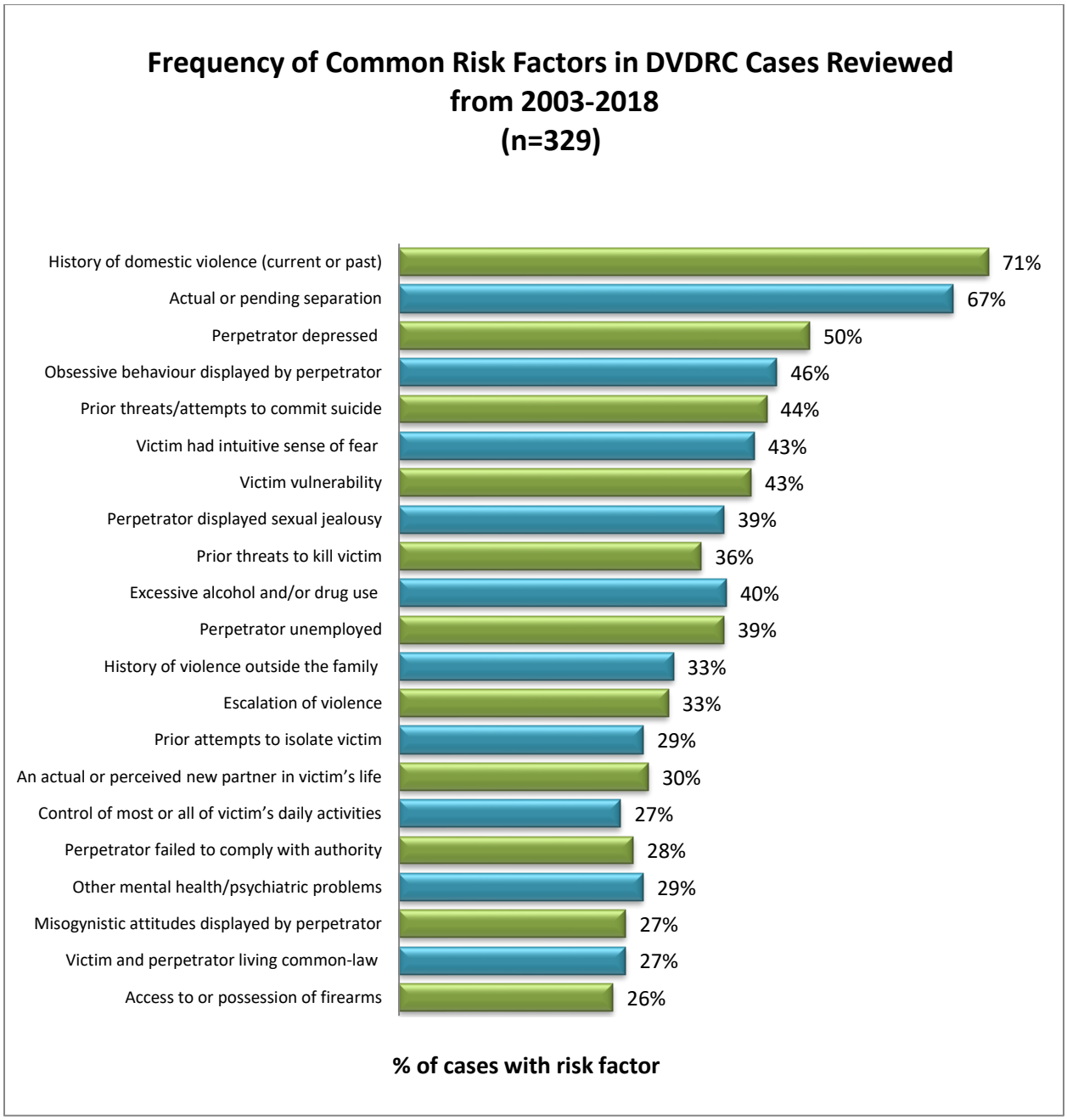
Analysis of Risk Factors: Common Risk Factors

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 (2003-2018)



*includes all reviews, including executive reviews in 2015

Summary of Graph Three: Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2018)

- 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 71% of all cases reviewed from 2003-2018, 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 was depressed (diagnosed and/or undiagnosed).
- In 46% of the cases, obsessive behaviour was displayed by the perpetrator.
- In 44% of the cases, the perpetrator had threatened or attempted at suicide.
- In 43% of the cases, the victims had an intuitive sense of fear.
- In 39% of the cases, the perpetrator displayed sexual jealousy.
- In 36% 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 39% of the cases, the perpetrator was unemployed.
- In 33% of the cases, there was a history of violence outside of the family.
- In 33% of the cases, there was an escalation of violence.
- In 29% of the cases there was an attempt to isolate the victim.
- In 30% 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

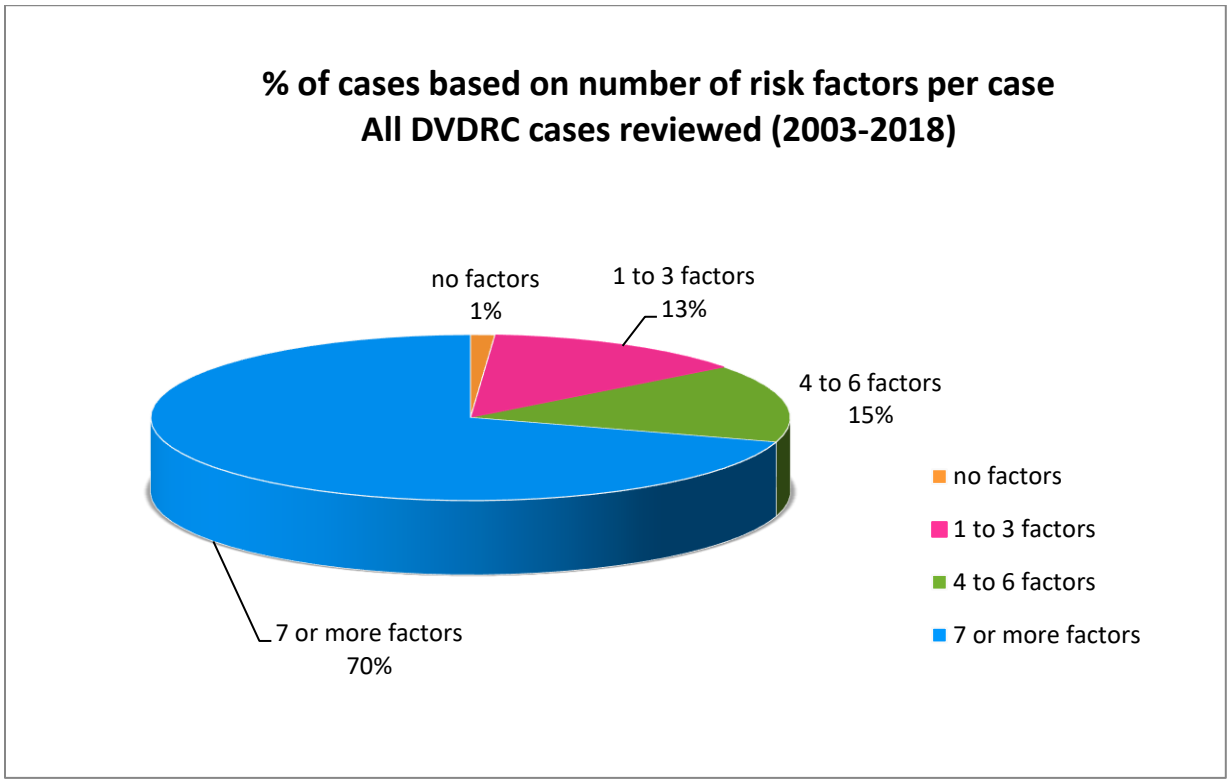
Chart Four: Number of Risk Factors per Case – All DVDRC cases reviewed (2003-2018), demonstrates that 70% of all cases reviewed by the DVDRC had seven or more risk factors identified. The significance of this finding is that many domestic homicides may have been predicted and prevented with earlier recognition and action towards identified risk factors for future lethality.

Chart Four: Number of Risk Factors per Case – All DVDRC Cases Reviewed (2003-2018)

# of risk factors per case	2003-2017 (n=311)	2018 (n=18)	2003-2018 (n=329)	% of total cases
no factors	4	0	4	1%
1 to 3 factors	41	3	44	13%
4 to 6 factors	46	4	50	15%
7 or more factors	220	11	231	70%

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 (2003-2018).**

Graph Four: Percent (%) of cases based on number of risk factors per case – All DVDRC cases reviewed (2003-2018)



Summary of Chart Four and Graph Four: Number of Risk Factors per Case – All DVDRC cases reviewed (2003-2018)

- In 70% of the cases reviewed from 2003-2018, seven or more risk factors were identified.
- In 15% of the cases reviewed from 2003-2018, four to six risk factors were identified.
- The combined proportion of cases with four or more risk factors was 85%.
- In 13% of the cases reviewed from 2003-2018, one to three risk factors were identified.
- In 1% of the cases reviewed from 2003-2018, 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 2018

The DVDRC conducted 18 full case reviews in 2018 – 15 homicide and three homicide-suicide cases, resulting in a total of 25 deaths (22 homicide victims and three 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 2018 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 2018

Total number of cases reviewed:	***18***
# of homicide cases	*15*
# of homicide-suicide cases	*3*
Total number of deaths reviewed:	***25***
Homicide deaths:	***22***
Female (adult)	*13*
Female (child)	*2*
Male (adult)	*5*
Male (child)	*2*
Average age of victim:	*39.3*
Suicide deaths:	*3*
Female	*0*
Male	*3*
Average age of all perpetrators:	*44*
# of male perpetrators	*14*

# of female perpetrators	*4*
# of cases with less than 7 risk factors:	*7*
# of cases with 7 or more risk factors:	*11*
Average number of risk factors:	*7.5*
# of cases involving age 65 or older:	*2*
Homicide-suicides w/elderly	*1*
# of cases involving Indigenous peoples	*3*
# of recommendations made:	*28*

Chart 5 – Summary of Cases reviewed in 2018, demonstrates that:

- There were 18 case reviews conducted by the DVDRC in 2018. This included 15 homicide cases and three homicide-suicide cases, resulting in 25 deaths (22 homicide victims and three perpetrator suicides).
- As a result of these reviews, there were 28 recommendations made towards the prevention of future similar deaths.
- Of the 22 homicide victims in the cases reviewed, 13 (59%) were adult females, five (23%) were adult males, two (9%) were female children and two (9%) were male children.
- Of the 18 cases, 14 (78%) involved male perpetrators and four (22%) involved a female perpetrator.
- In 11 (61%) of the cases, seven or more risk factors were identified.
- The average number of risk factors identified in cases reviewed in 2018 was 7.5.

Further analysis of the cases reviewed in 2018 demonstrated that:

- The victims ranged in age from four to 82 years.
- The average age of victims was 39.3 years.
- The perpetrators ranged in age from 23 to 82 years.
- The average age of perpetrators (deceased and living) was 44 years.
- The number of risk factors for individual cases ranged from one to 17.
- There were three cases involving individuals (either victims and/or perpetrators) that identified as Indigenous.

Analysis of Risk Factors: Number of Risk Factors per Case

The data in **Chart Six: Number of Risk Factors Identified in Cases Reviewed (2018**), are consistent with the findings with all cases reviewed by the DVDRC from 2003-2018 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 2018 ranged from one to 17.

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 (2018)

# and % of risk factors per case	2018 Reviews (n=18)	Total Reviews 2003-2018 (n=329)
no factors	0	4
%	(0)	(1%)
1 to 3 factors	3	44
%	(17%)	(13%)
4 to 6 factors	4	50
%	(22%)	(15%)
7 or more factors	11	231
%	(61%)	(70%)

Chart Six breaks down the number of identified risk factors in the cases reviewed in 2018 and compares them to the number of risk factors for all cases reviewed from 2003-2018.

The chart indicates that:

- In 2018, no cases had zero risk factors identified. This compares to 1% of *all* cases reviewed from 2003-2018.
- In 2018, three (17%) cases reviewed had one to three risk factors identified. This compares to 13% of *all* cases reviewed from 2003-2018.
- In 2018, four (22%) cases reviewed had four to six risk factors identified. This compares to 15% of *all* cases reviewed from 2003-2018.

- In 2018, 11 (61%) of cases reviewed had seven or more risk factors identified. This compares to 70% of *all* cases reviewed from 2003-2018.

- The risk factor findings for cases reviewed in 2018 is consistent with the findings shown in Chart Four and Graph Four which indicate that the majority of *all* cases reviewed from 2003-2018 have seven or more risk factors.

Analysis of Death Factors

Chart Seven: Death factors for cases reviewed in 2018 shows that 32% of the cases involved some type of trauma (including cuts, stabs, beatings, assaults). Of the cases reviewed, 28% involved the use of a firearm, 12% were due to asphyxia (i.e. hanging, airway obstruction, strangulation or neck compression), 16% were from drowning and 12% from fire-related injuries.

Chart Seven: Death factors for cases reviewed in 2018

Death Factor	Victim	Perp	Total	
Trauma - cuts, stabs	6		6	32%
Trauma - beating, assault	1		1	
Trauma - blunt force	1		1	
Shooting - handgun	2		2	28%
Shooting - rifle	2	1	3	
Shooting - shotgun	1	1	2	
Asphyxia - strangulation	3		3	12%
Drowning	4		4	16%
Fire - smoke inhalation	1	1	2	12%
Fire - thermal	1		1	
Total Deaths	**22**	**3**	**25**	

Recommendations made from 2018 Case Reviews

In 2018, 28 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:

- Services and resources for new immigrants living in Ontario
- Risk assessment, safety planning and risk management in Indigenous communities
- Probation services and safety planning
- Workplace strategies for addressing domestic violence

- Awareness and training on risk factors for intimate partner homicide by physicians, nurses, mental health care providers, addiction counsellors, family law lawyers and crown attorneys
- The impact of intimate partner violence on children.

A summary of all recommendations made in 2018 is included in Appendix D.

Discussion and Significant Findings for Cases Reviewed in 2018

The findings from reviews conducted in 2018 are consistent with the overall results from all reviews conducted from 2003-2018. Specifically:

- The majority of domestic violence homicide victims were female.
- The age range of victims is broad. In 2018, the range was from four to 82 years.
- The age range for perpetrators is also broad. In 2018, the range was from 23 to 82 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.

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 (i.e. intimate partner homicide), and to make recommendations to help prevent future deaths.

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.

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?

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?

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?

Upon analysis of cases reviewed since inception of the DVDRC in 2003, 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.

DVDRC reports and responses to recommendations

Are DVDRC reports and responses to recommendations available to the public?

Redacted versions of individual final reports and responses to recommendations are available upon request to the Office of the Chief Coroner at occ.inquiries@ontario.ca.

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 and the Freedom of Information and Protection of Privacy Act.

Appendix B

Risk Factor Descriptions

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. Indigenous).

Appendix C: Detailed Summary of Cases reviewed in 2018

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	2007	1		1	42	1			36	1		11	0	mental health
2	2009	1		4	51 19 17 13	1 1 1 1		 1 1	56	1		9	3	cultural integration
3	2013	1		1	31	1			29	1		11	1	cultural integration
4	2015	1		1	82	1			82	1		1	0	firearm
5	2014	1		1	61		1		39		1	13	4	Alcohol, previous DV
6	2014	1		1	35		1		41		1	5	0	Alcohol, previous history
7	2013	1		1	37	1			34	1		7	2	Alcohol, previous history
8	2012	1		1	40		1		36		1	1	2	Recent immigrants
9	2013	1		1	26	1			28	1		8	1	Alcohol, PAR
10	2013	1		1	50	1			49	1		11	2	Safe separation, access to firearms, depression
11	2012	1		1	22	1			23	1		17	4	Mental health, youth
12	2014	1		1	63	1			60	1		7	3	Depression, firearms
13	2015		1	1	77		1		62	1		3	0	Same sex, suicide.
14	2014	1		1	51	1			46	1		6	1	Immigration.
15	2015	1		1	35		1		28		1	10	1	Substance abuse, safe separation
16	2015	1		1	36	1			43	1		4	2	Immigration, mental health
17	2014		1	2	4 10		1 1	1 1	36	1		7	2	Children, safe separation
18	2015		1	1	62	1			64	1		5	0	Safe separation, access to firearms
	Total	**15**	**3**	**22**		**15**	**7**	**4**		**14**	**4**		**28**	

Appendix D

Summary of Cases and Recommendations – 2018 Case Reviews

Case #	Summary	Recommendation(s)
2018-01	This case involved the homicide of a 42-year-old woman by her 36-year-old common-law husband. Police had been involved with the couple on several occasions prior to the homicide. Mental health concerns pertaining to both the victim and perpetrator may have played a role. There were 11 risk factors for intimate partner homicide identified.	No new recommendations. Relevant recommendations from previous reviews: 2003-05 - Police and other front-line workers (health/educational/social) need to be made aware of the resources available in their respective communities to address issues of family breakdown, conflict, and mental health, and to make referrals when necessary. 2008-07 - 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. 2010-04 - The DVSR should be used not only to indicate the presence of risk-enhancing factors towards violence, but also to identify those areas where case management could mitigate the risk for future violence. When risk factors such as substance abuse, mental health concerns, employment issues etc. are identified, efforts should be made to provide appropriate references or involve appropriate services to alleviate those risk factors. 2014-01 - Social Assistance (Ontario Works & Ontario Disability Support Program) Case Workers should receive specialized training in the dynamics of domestic violence. This training should include recognizing the signs and symptoms of domestic violence and how to effectively respond in the event they suspect a client is being abused. It is important that the training focuses on: all aspects of domestic violence including the psychological/emotional/verbal abuse that many victims experience; recognizing high risk cases such as when there is a recent or pending separation between the couple and depression on the part of the perpetrator; and education about supports in the community for victims and their children (e.g., women shelters). 2014-07 - It is recommended that there be ongoing training for police on the appropriate response to

Case #	Summary	Recommendation(s)
		domestic violence cases that involve victims with disabilities (in the current case, the victim had a speech impediment). Cases involving women with disabilities often involve less obvious forms of domestic violence (e.g. withholding a wheelchair; holding back medication) because of the victim's potential reliance on her abuser and/or her increased vulnerability to the abuser because of his/her disability. 2014-08 - It is recommended that the Ontario Women's Directorate develop and implement public education programs about domestic violence with a specific focus on women with disabilities and their increased risk of domestic violence, less obvious forms of violence that they may be experiencing, and the various agencies that are available to help this population. 2014-09 - It is recommended that agencies or organizations who work with women living with disabilities receive training about their increased risk of violence, including domestic violence, such as the various ways that women with disabilities may experience violence because of their increased vulnerability in some cases.
2018-02	This case involved the homicides of Victim 1 (51-year-old first wife of Perpetrator 1), Victim 2 (19-year-old daughter of Perpetrators 1 and 2), Victim 3 (17-year-old daughter of Perpetrators 1 and 2) and Victim 4 (13-year-old daughter of Perpetrators 1 and 2) by Perpetrator 1 (the husband of Victim 1 and father to Victims 2, 3 and 4 and Perpetrator 3), Perpetrator 2 (second wife of Perpetrator 1 and mother to Victims 2, 3 and 4 and Perpetrator 3) and Perpetrator 3 (the son of Perpetrators 1 and 2 and brother to Victims 2, 3 and 4). The perpetrators were not pleased that the victims were adapting western values that were not "honourable" and contrary to the strict religious values and behaviours that were expected of them.	**To the Ministry of Citizenship and Immigration; Ministry of Children, Community and Social Services, and Immigration and Citizenship Canada:** 1. Individuals involved in the immigration process (before and after) should be provided with resources/programs and information sessions in order to educate them about potential problems associated with cultural integration and/or perceived transgression of norms or values as their families become exposed to the Canadian culture (i.e. Westernization). They should also be provided with appropriate assistance and support (e.g. resources/family counselling) when experiencing conflict within the family. 2. New immigrants and their homeland families should be provided with resources (including contacts, shelters, resource centres, etc.) that can assist them with understanding Canadian law (e.g. immigration, domestic violence), equality, women's rights, employment and education. New immigrants should also be made aware of and encouraged to initiate contact with police and/or other resources.

Case #	Summary	Recommendation(s)
		To the Ministry of Citizenship and Immigration; Ministry of Children, Community and Social Services; Ministry of Education; Ministry of Health and Long Term Care and Ministry of Community Safety and Correctional Services. 3. Police and other agencies (e.g. schools, healthcare institutions, community resources, children's aid societies) dealing with new immigrants should be educated about potential problems of cultural integration and/or perceived transgression of norms or values, cultural beliefs/diversity and honour violence when involved with these families.
2018-03	This case involved the homicide of a 31-year-old woman by her 29-year-old husband from an arranged marriage. The perpetrator was a recent immigrant and had difficulty adjusting to Canadian culture. There were 11 risk factors for intimate partner homicide identified.	**To the Office of the Status of Women:** 1. The importance of safe separation should be reinforced in public education campaigns dealing with violence against women and issues associated with the role of culture should be considered in the educational material.
2018-04	This case involved the homicide of an 82-year-old woman by her 82-year-old husband. The perpetrator killed his wife after she berated him for causing injury to their grandson following a lawn mower accident. There was one risk factor for intimate partner homicide identified.	No new recommendations.
2018-05	This case involved the homicide of a 61-year-old man by his 39-year-old former girlfriend and the 31-year-old male that she was now in a relationship with. There was a long history of domestic violence between the victim and the female perpetrator. Alcohol was a contributing factor to the previous incidents and in the homicide. There were 13 risk factors for intimate partner homicide identified.	**To the Ministry of Community Safety and Correctional Services:** 1. The Ministry of Community Safety and Correctional Services should engage and work with the community to develop guidelines to assist First Nations Police Services in responding to chronic domestic violence. **To the First Nation Police Service involved:** 2. The First Nation police service involved should conduct an internal review of their involvement with this case to examine potential missed opportunities to prevent the homicide with a particular focus on risk assessment, safety planning and risk management of chronic domestic violence. 3. The police service involved should organize a community review of the homicide with appropriate professionals and community members to examine

Case #	Summary	Recommendation(s)
		strategies to prevent a death in similar circumstances in the future including enhanced collaboration with friends, family, neighbours as well as professionals in social service, health and corrections. **To the Ministry of Community Safety and Correctional Services:** 4. Probation services should review this case as part of an examination of community corrections' strategies in dealing with chronic offenders with problems related to domestic violence, addictions and poverty.
2018-06	This case involved the homicide of a 35-year-old man by his 41-year-old female common-law partner. There had been a history of domestic violence between the couple, including instances where the victim assaulted the perpetrator. Alcohol was a significant factor in their relationship. There were five risk factors for intimate partner homicide identified.	No new recommendations. Previous relevant recommendation: 2011-24 - All police services should receive annual training/education on programs and services offered by Victim Services in order to assist officers in responding more effectively to the criminal and non-criminal issues victims face following an incident of domestic violence. Police should be reminded to immediately refer all victims of domestic violence (male and female) to Victim Services to ensure timely intervention and assistance.
2018-07	This case involved the homicide of a 37-year-old woman by her 34-year-old boyfriend. The victim had been the perpetrator of intimate partner violence with previous partners. Both the victim and perpetrator abused alcohol. There were seven risk factors for intimate partner homicide identified.	**To the Ministry of Community Safety and Correctional Services:** 1. It is recommended that conditions of probation should include regular monitoring of the domestic violence offender's compliance with conditions, specifically reporting requirements and counseling conditions. Supervision would benefit from ongoing collateral contacts to confirm the status of the offender's situation and the credibility of self-reported information. When the offender has failed to meet the terms, progressive enforcement must align with level of risk. When repeated verbal or written cautions fail to bring about change, a fail-to-comply charge should be pursued. 2. It is recommended that probation officers consider the development of safety planning for suitable probation candidates.
2018-08	This case involved the homicide of a 40-year-old man by his 36-year-old wife. The couple had recently emigrated from China and had a daughter together. There was no history of domestic violence and the homicide may have	**To the Ontario Ministry of the Status of Women:** 1. Encourage the Neighbours, Friends and Families Campaign for Immigrant and Refugee Communities (http://www.immigrantandrefugeenff.ca/) to develop specific outreach campaigns for several

Case #	Summary	Recommendation(s)
	been financially motivated. There was one risk factor for intimate partner homicide identified.	cultural groups (e.g., ethno-specific websites, newspapers, radio, television, social media, etc.) **To the Ministry of Labour:** 2. It is recommended that all workplaces design and implement a policy to address domestic violence as it relates to the workplace. The policy should include: • educating employees about the issue of domestic violence to help them identify an abusive relationship in which they may be involved and about how to reach out to co-workers; • training employers and managers to identify the signs of abuse and respond appropriately to employees who are victims and perpetrators of domestic violence; • providing a resource list of appropriate referral agencies; • providing an organized response to direct threats of domestic violence that occur in the workplace; • developing and implementing a safety plan for the victim to ensure that a number of security measures are in place for her protection. • developing and implementing a plan for those staff who demonstrate well-known red flags of DV in the workplace of potentially abusive and bullying behaviours by a perpetrator • assisting managers to learn ways of dealing with angry and abusive staff, and the impact it has on their staff.
2018-09	This case involved the homicide of a 27-year-old woman by her 28-year-old male common-law partner. The couple had been in a relationship for approximately five years. There were eight risk factors for intimate partner homicide identified.	**To the Ministry of the Attorney General:** 1. Partner Assault Response (PAR) programs should be promoted to voluntary referrals in addition to court mandated referrals through the Ministry or a partner Ministry in order to promote early intervention and prevention efforts for perpetrators of domestic violence.
2018-10	This case involved the homicide of a 50-year-old woman by her 49-year-old husband. The victim was in the process of ending the marriage. The perpetrator had access to firearms and was known to be depressed. The victim was more concerned that the perpetrator would harm himself and	**To the College of Physicians and Surgeons of Ontario:** 1. It is recommended that the College of Physicians and Surgeons of Ontario develop a mandatory course on domestic violence and homicide. The course curriculum should highlight the dynamics and/or warning signs of domestic violence and the potential for lethality, especially when working with patients who have a history of depression and/or are

Case #	Summary	Recommendation(s)
	was less concerned about her own safety. There were 11 risk factors for intimate partner homicide identified.	experiencing problems in their intimate relationship. The course should highlight the risks associated with patients who are depressed, may be experiencing a possible separation from their intimate partner, and have access to firearms. The course should include ways for physicians to raise awareness with patients about the risk of homicide and suicide with firearms in the home and potential strategies for relinquishing firearms or working with the police to remove firearms from the home where there is a risk of harm. 2. It is recommended that the College of Physicians and Surgeons of Ontario provide information on how physicians' can begin the process of encouraging patients to relinquish firearms or collaborating with police to remove firearms from a patient's home when they are experiencing depression and/or suicidal/homicidal ideation and/or if they are experiencing conflict within their intimate relationship (e.g., pending or actual separation). The information should include assessing risk, how to talk with patients about the risk of firearms in the home, and protocols for how to work with police to remove firearms when risk is assessed. Previous relevant recommendations: 2003 – 01, 02, 08 – It is recommended that every effort be made by family members, friends, and community professionals to have firearms removed from individuals who are going through a separation in their relationships and showing signs of depression or suicidal or homicidal ideation. 2005 – 08 - It is recommended that family members, friends, and community professionals be educated to contact police immediately and report their concerns when they are aware of individuals who have potential access to firearms and who are in a relationship where domestic violence is suspected. This is particularly important when the couple is through a separation or the individual is showing signs of depression or suicidal or homicidal thoughts. 2003 – 05 - Public education should target potential victims and perpetrators of domestic violence. The education should: • Include the fact that risk of violence increases substantially during the time that a partner is leaving the relationship;

Case #	Summary	Recommendation(s)
		• Address the needs of depressed and suicidal men who require counselling and risk reduction interventions, such as the removal of firearms from the home to prevent the escalation of the circumstances that result in the tragedies we have reviewed; • Be directed towards persons of all cultures, languages, and faiths; and • Address the need to overcome cultural barriers and the feeling "shame" as related to mental health issues, with the goal of reducing stigma. 2009 – 09 - It is recommended to the federal Minister of Public Safety that applications for a firearm Possession Acquisition Licence (PAL) should include a medical waiver signed by the applicant. This would allow investigators access to information pertaining to the mental health of the applicant. There should also be higher standards and more restrictions for individuals applying for a firearms PAL when they have had previous licenses revoked or removed. 2016-01 - Screening of individuals applying for, or renewing, Possession and Acquisition Licenses (PALs) should be improved to include: • interviewing of applicants and their references, particularly those applicants who have been previously convicted of a crime against a person or convicted of a firearms offence 2015-14 - The Deans or Chairs of Departments of Social Work, Psychology and Medicine should ensure courses are provided on domestic violence and risk assessment and risk management. Professional Colleges for these professional groups should share information on the links between depression, suicidal ideation and domestic homicide.
2018-11	This case involved the homicide of a 22-year-old woman by her 23-year-old boyfriend. Both the victim and perpetrator had a long history of mental health issues. The couple met and resided for a time, at a homeless shelter for youth. There were 17 risk factors for intimate partner homicide identified.	**To the Ministry of Community Safety and Correctional Services (MCSCS):** 1. The MCSCS probation and parole domestic violence protocol should apply as soon as a client is charged with a domestic violence offence, as opposed to after conviction. 2. The MCSCS should develop a policy that in all cases where an offender is being released from custody after a domestic offence (even if the domestic violence protocol does not yet apply), probation

Case #	Summary	Recommendation(s)
		and parole officers be required to contact the domestic violence victim to inform of release, offer supports, discuss safety planning and collect risk assessment information. 3. The MCSCS training for probation and parole officers should address the synergistic risk created by the combination of mental health issues, domestic violence and victim vulnerability. **To the Board of Directors for the shelter involved and to the Ministry of Children, Community and Social Services:** 4. Youth shelters are encouraged to examine counselling and other evidenced-based interventions for residents that may be victims or perpetrators of intimate partner violence.
2018-12	This case involved the homicide of a 63-year-old woman by her 60-year-old husband. The perpetrator had physical and financial challenges which lead to depression. The perpetrator had access to firearms. There were seven risk factors for intimate partner homicide identified.	**To the College of Physicians and Surgeons, College of Nu of Ontario, College of Psychologists of Ontario and Ontar Psychiatric Association:** 1. Mental health professionals are encouraged to review the common risk factors for intimate partner homicide that have been identified in the annual reports of the Domestic Violence Death Review Committee. The presence of risk factors such as access to firearms and depression should trigger efforts for risk assessment, safety planning and risk management with patients as potential perpetrators/victims. 2. When an individual is diagnosed with depression, efforts should made by the mental health professionals to encourage families to remove the individual's access to firearms. **To the College of Physicians and Surgeons, College of Nurses of Ontario, Ministry of Health and Long Term Care (Local Health Integration Networks – Home and Community Care):** **3.** Healthcare providers should emphasize or discuss the importance of care options or mechanisms for couples experiencing declining health or disabilities and work with their families to identify appropriate mechanisms when one partner is being treated for depression or other related mental health issues and, in particular, if there is evidence of depression, suicidal ideation, previous suicide attempts and access to firearms.

Case #	Summary	Recommendation(s)
2018-13	This case involved the homicide of a 77-year-old male by his 62-year-old male common-law partner. The couple had been in a committed relationship for over 40 years and there was no history of domestic violence. Both the victim and perpetrator had recently been charged with a historical sexual assault. It is believed that couple had originally planned on committing suicide together, but when that failed, the perpetrator shot the victim, then himself. There were three risk factors for intimate partner homicide identified.	No new recommendations.
2018-14	This case involved the homicide of a 51-year-old woman by her 46-year-old husband. The victim's business partner was injured during the incident that resulted in the victim's death. There were six risk factors for intimate partner homicide identified.	**To the Ministry of Attorney General:** 1. It is recommended that Crown Attorneys receive enhanced training and education about why victims of domestic violence may recant and/or fail to appear for trials against their abusers and to review policies laid out in Ontario's Domestic Violence Court Program that recognize special procedures are to be followed in these cases, where possible, so that that they may proceed with charges against an accused even when a victim does not subsequently cooperate with the proceedings.
2018-15	The case involved the death of a 35-year-old man by his 28-year-old common-law wife; the couple lived in a remote community. Both the victim and perpetrator had substance abuse issues and a history of domestic violence. The perpetrator had previously experienced domestic violence inflicted on her by the victim. There were 10 risk factors for intimate partner violence identified. Charges against the perpetrator relating to the death of the victim were subsequently withdrawn as it was felt that she was acting in self defence.	**To the Ministry of Health and Long Term Care (MOHLTC), College of Physicians and Surgeons and College of Nurses:** **1.** Health professionals (including addiction counsellors and nurses) who are involved with Indigenous communities should receive additional training and education on the issue of domestic violence and how it may be impacted by substance abuse, mental health and other factors within the community. Previous relevant recommendations: 2016 - Enhanced public education programs should be targeted to victims of domestic violence in First Nations communities to reduce or eliminate the stigma which leads to non-reporting of domestic violence to authorities or to agencies able to assist with victims in a domestic violence crisis. Currently available programs, such as the Kanwayhitowin Campaign, are a valuable

Case #	Summary	Recommendation(s)
		resource that can assist in education of both victims and their friends and family who may witness the violence in their communities. Where required, additional funding should be provided to ensure that such programs are in place and/or are effective. 2016- It is recommended that Kanawayhitowin, a public awareness campaign launched in 2007 to raise awareness on the signs of woman abuse in First Nations communities, include information on the potential risk of lethal violence at the time of relationship breakdown and recommendations on how to engage in and/or support a "safe" break-up/separation for couples experiencing domestic violence. 2007 -Kanawayhitowin is an Aboriginal public awareness campaign that was launched in the fall of 2007 to raise awareness about the signs of woman abuse in First Nations communities, so that people who are close to at-risk women or abusive men can provide support. It reflects a traditional and cultural approach to community healing and wellness. Educational materials include brochures, public service announcements, a training video and CD-ROM. We recommend that the OWD consider making this campaign available to all Aboriginal communities across the province. 2007 - We recommend that First Nation communities be prioritized by government to address enormous lack of resources available to them, including making available culturally appropriate service providers that would be adequately trained in providing an effective response to the complex issues facing Aboriginal families. These issues include the impact of intergenerational trauma on families with the consequence of high rates of mental health issues, addictions, domestic violence, unemployment and living in chronic states of poverty.
2018-16	This case involved the death of a 36-year-old woman by her 43-year-old husband. The couple had been experiencing marital problems since immigrating to Canada from Iran. The	**To the Ontario Ministry of Citizenship and Immigration and the Ontario Council of Agencies Serving Immigrants (OCASI):** 1. The Ministry of Citizenship and Immigration and OCASI are encouraged to continue outreach with

Case #	Summary	Recommendation(s)
	perpetrator had a history of mental health issues and a history of suicide attempts. There were four risk factors for intimate partner homicide identified.	new immigrants who may be experiencing mental health, physical health and social consequences arising from their recent immigration to Canada. **To the Ministry of Health and Long-Term Care (MOHLTC):** **2.** The MOHLTC is encouraged to establish more dedicated long-term mental health resources to support patients who have been admitted as mental health inpatients.
2018-17	This case involved the deaths of two children (ages 4 and 10), followed by the suicide of their 36-year-old father. The perpetrator and his wife (the intended victim) had been seeking to adopt a foster child, however they also appeared to be in the process of ending their relationship. The perpetrator lived part of the time in another city and appeared to have a "secret" life there. There were seven risk factors identified for intimate partner homicide identified.	**To The Ministry of the Status of Women and Ministry of Children and Youth Services:** 1. It is recommended that the Ministry of the Status of Women and the Ministry of Children and Youth Services develop initiatives that will enhance a broader public and professionals' awareness about the risk of lethal violence for children living with domestic violence, particularly at the time of a pending or actual parental separation. Information on how to support a "safe" separation should include safety measures for children. **To The Ministry of Children and Youth Services and the Ontario Association of Childrens Aid Societies:** 2. It is recommended that this case be shared with child protection services across the province to highlight the risks of domestic violence to children and the need to verify employment and education background of potential adoptive parents.
2018-18	This case involved the homicide of a 62-year-old woman by her 64-year-old husband who subsequently died by suicide. The couple had been married for 40 years and was in the process of separating. The perpetrator had a valid firearms license. There were five risk factors for intimate partner homicide identified.	No new recommendations.

For further information, please contact:

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