Office of the Chief Coroner
Province of Ontario

Domestic Violence Death Review Committee

2019-2020 Annual Report

February 2023

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Message from the Chair

This annual report reflects the activities of the Domestic Violence Death Review Committee (DVDRC) in 2019 and 2020. In mid-2021, I became Chair of the DVDRC and joined a team of knowledgeable and dedicated experts tasked with reviewing all intimate partner violence-related homicides in Ontario. In the two-year period, 35 cases were reviewed resulting in 59 recommendations.

The committee members' sensitive and expert analyses ensure that these tragic deaths are not overlooked and that actions are identified to prevent further deaths. I am greatly appreciative of the members' time, commitment and enormous contributions to Ontario's understanding of intimate partner violence with a goal to reducing, and hopefully, eliminating such terrible violence and death. Thank you!

I believe the committee's work makes a significant positive impact on Ontario society. However, we can always do better; we must be proactive in improving the committee's processes and outcomes to better serve Ontarians and improve safety for intimate partners predominantly women, and children. Therefore, under the Chief Coroner's leadership, we are embarking on a comprehensive review of the committee, including an examination of the committee's mandate, function and composition, with the expectation of diversifying membership, modernizing processes, and implementing innovative approaches to our case reviews.

A call for rejuvenated committee membership is underway in early 2022. It is our hope that we identify intimate partner violence experts from different geographical, racial, cultural, social, academic and occupational backgrounds. We believe that such diversity in life and experience will surely enhance our understanding and review of intimate partner violence.

As we move forward, I look forward to embracing the lessons learned from past reviews and guiding the committee towards new and innovated practices to significantly reduce intimate partner violence-related homicide in Ontario. As a first step, we intend on renaming the committee by replacing "domestic violence" with "intimate partner violence."

On a final note, I'd like to thank Kathy Kerr for her many years of service as the Executive Lead for Committee Management. She has retired after 35 distinguished years of service, 12 of which she was responsible for the OCC's many death review committees, including the DVDRC. I believe I speak for all the other committee chairs in saying that our important work has been greatly enhanced by Kathy's dedication and expertise. I wish Kathy all the best in the next phase of her life.

Prabhu Rajan
Chief Legal Counsel
Office of the Chief Coroner
Chair, Domestic Violence Death Review Committee

Committee Membership (2019 - 2020)

Deidre Bainbridge, NP
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

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

Barb Forbes
Regional Director
Ministry of the Solicitor General
Probation and Parole Western Region

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

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

Eva Zachary
Executive Director, Muskoka Victim Services

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

Committee Membership (2021)

Prabhu Rajan
Chair
Chief Legal Counsel
Office of the Chief Coroner

Tope Adefarakan, PhD
Director, Black Women, Girls and Gender Diverse Peoples (B-WGGD) Initiative

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

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

Barb Forbes
Ministry of the Solicitor General
Regional Director, Probation and Parole
Western Region

Peter Jaffe, Ph.D., C.Psych.
Professor Emeritus,
Western University

Rebecca Law
Crown Attorney

Nneka MacGregor, LL.B.
Executive Director, WomenatthecentrE

Rebecca Miller-Small
Detective Sergeant, Peel Regional Police
Intimate Partner Violence Unit

Deborah Sinclair, MSW, Ph.D, RSW
Independent Practice

Eva Zachary
Executive Director, Muskoka Victim Services

Julie Erbland
Executive Lead,
Child Youth Death Review Analysis
Office of the Chief Coroner

Dan Pyrah
Ontario Provincial Police

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

Executive Summary

Cases reviewed from 2003-2020:

- From 2003-2019, the DVDRC has reviewed 364 cases, involving 515 deaths.
- Of the cases reviewed, 67% were homicides and 33% were homicide-suicides.
- Approximately 71% of all cases reviewed from 2003-2020 involved a couple where there was a history of domestic violence and 66% of the cases involved a couple with an actual or pending separation.
- The other top risk factors were:
    - a perpetrator who was depressed (49%)
    - obsessive behaviour by the perpetrator (45%)
    - prior threats or attempts to commit suicide (42%)
    - a victim who had an intuitive sense of fear towards the perpetrator (43%)
    - victim vulnerability (45%)[1]
    - perpetrator displayed sexual jealousy (40%)
    - prior threats to kill the victim (36%)
    - excessive alcohol and/or drug use (41%)
    - a perpetrator who was unemployed (40%)
    - history of violence outside the family (34%)

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

Cases reviewed in 2019:

- There were 22 cases reviewed by the DVDRC in 2019. There were 20 full reviews and two executive reviews. This included 19 homicide cases and three homicide-suicide cases, resulting in 26 deaths (23 homicide victims and three perpetrator suicides).
- There were 32 recommendations generated through these reviews.
- Of the 23 homicide victims in the cases reviewed, 18 (78%) were adult females, four (17%) were adult males and one (4%) was a female child.
- Of the 22 cases, 18 (82%) involved male perpetrators and four (18%) involved a female perpetrator.
- In 15 (68%) of the cases, seven or more risk factors were identified.
- The average number of risk factors identified in cases reviewed in 2019 was 9.
- The victims ranged in age from six to 70 years.
- The average age of victims was 39 years.
- The perpetrators ranged in age from 19 to 71 years.
- The average age of perpetrators (deceased and living) was 40 years.
- The number of risk factors for individual cases ranged from zero to 20 (out of 41).

[1] This risk factor has been tracked since 2017.

Cases reviewed in 2020:

- There were 13 cases reviewed by the DVDRC in 2020. This included 9 homicide cases and four homicide-suicide cases, resulting in 19 deaths (15 homicide victims and four perpetrator suicides).
- There were 27 recommendations generated through these reviews.
- Of the 15 homicide victims in the cases reviewed, 12 (80%) were adult females, two (13%) were adult males and one (7%) was a male child.
- Of the 13 cases, all of them (100%) involved male perpetrators.
- In 12 (92%) of the cases, seven or more risk factors were identified.
- The average number of risk factors identified in cases reviewed in 2020 was 12.
- The victims ranged in age from seven to 88 years.
- The average age of victims was 42 years.
- The perpetrators ranged in age from 25 to 83 years.
- The average age of perpetrators (deceased and living) was 47 years.
- The number of risk factors for individual cases ranged from one to 23 (out of 41).

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 18-year period of cases occurring from 2002-2019 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 2002-2019 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.

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 (2002-2019)

The following statistics relate to homicides in Ontario occurring between 2002-2019 where 'abuse – domestic violence' has been identified as an involvement code, and that meet the DVDRC's definition of a domestic violence death. Some of these cases may have already undergone review by the DVDRC while others are pending review upon completion of other proceedings (e.g. criminal trials).

Chart One: Homicides in Ontario with Domestic Violence Involvement Code (2002-2019)

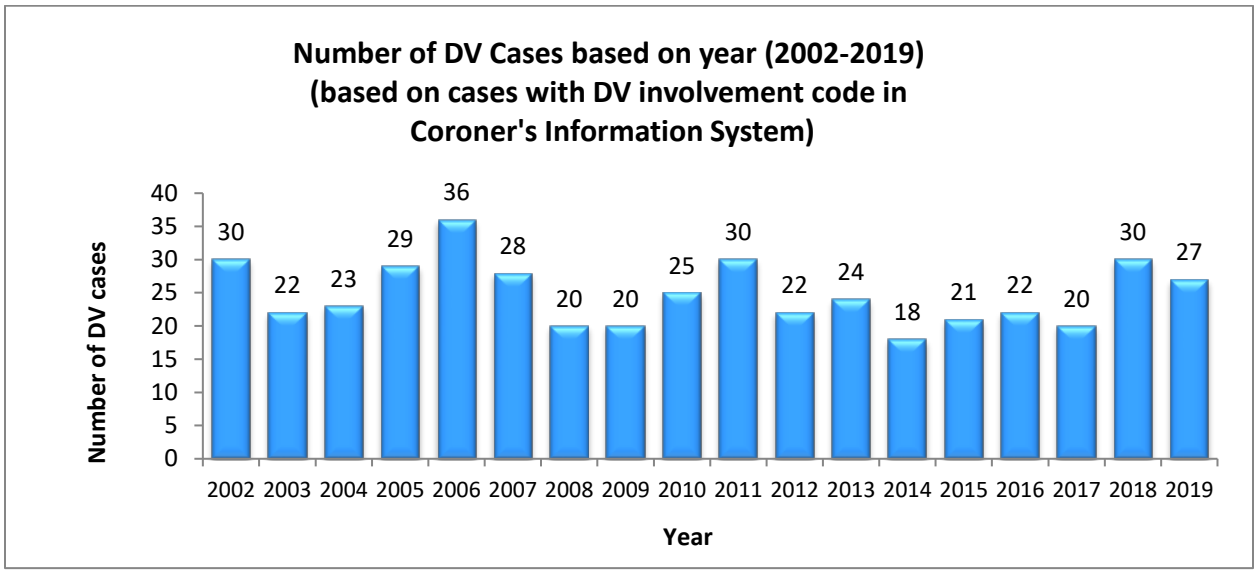
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Totals 2002-2020
Number of cases	30	22	23	29	36	28	20	20	25	30	22	24	18	21	22	20	30	27	**447**
Homicides	19	18	14	21	29	18	15	15	19	22	13	19	11	14	16	17	20	20	**320**
																			72%
Homicide-Suicides	11	4	9	8	7	10	5	5	6	8	9	5	7	7	6	3	10	7	**127**
																			28%
Total number of Deaths	**46**	**26**	**33**	**37**	**53**	**45**	**29**	**30**	**32**	**38**	**32**	**30**	**29**	**30**	**30**	**23**	**48**	**39**	**630**
Total number of Homicide Victims	**35**	**22**	**24**	**29**	**46**	**35**	**24**	**25**	**26**	**30**	**23**	**25**	**22**	**23**	**24**	**20**	**38**	**32**	**503**
																			80%
Female (adult)	26	19	21	29	28	29	20	20	21	27	19	22	13	21	17	17	30	24	**403**
																			80%
Female (child)	4	1	1	0	8	0	0	3	1	0	0	0	2	0	2	0	2	3	**27**
																			5%
Male (adult)	4	1	2	0	3	4	4	2	4	3	3	3	3	2	5	1	4	3	**51**
																			10%
Male (child)	1	1	0	0	7	2	0	0	0	0	1	0	4	0	0	2	2	2	**22**
																			4%
Average age of Homicide Victim	**36**	**35**	**40**	**38**	**27**	**35**	**43**	**37**	**37**	**44**	**45**	**38**	**29**	**40**	**44**	**43**	**44**	**43**	**38.8**
Total number Perpetrator deaths (suicide or other)	11	4	9	8	7	10	5	5	6	8	9	5	7	7	6	3	10	7	**127**
																			20%
Female (adult)	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	**3**
																			2%

Male (adult)	11	4	8	8	7	9	5	**5**	6	8	9	5	7	7	5	3	10	7	**124**
																			98%
Average age of Deceased Perpetrator	**49**	**46**	**42**	**45**	**51**	**45**	**44**	**60**	**45**	**51**	**60**	**41**	**47**	**58**	**43**	**68**	**50**	**53**	**49.8**

Chart One: Summary

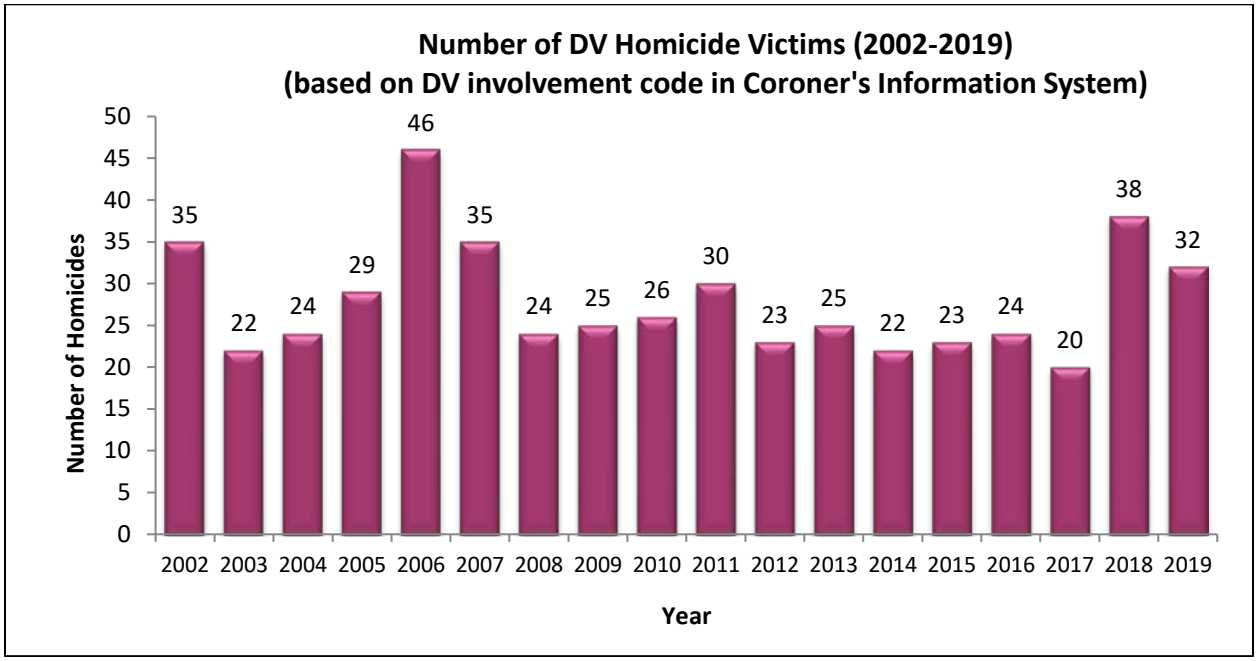
- There were 447 domestic homicide and/or homicide-suicide cases that occurred in Ontario between 2002-2019 (based on cases investigated by the Office of the Chief Coroner for Ontario, where domestic violence was identified as an involvement code).
- Of those 447 cases, 320 (72%) were homicides and 127 (28%) of the cases were homicide-suicides.
- The 447 cases resulted in a total of 630 deaths.
- Of the 630 deaths, 503 (80%) were homicide victims and 127 (20%) were perpetrators who died by suicide or were otherwise killed (e.g. shot by police).
- There was an average of 25 domestic homicide and/or homicide-suicide cases per year from 2002-2019. Some of these cases may have included multiple victims.
- There have been 503 domestic homicide victims from 2002-2019.
- There was an average of 28 domestic homicide victim deaths per year from 2002-2019.
- Of the 503 homicide victims, 403 (80%) were adult females, 49 (9%) were children and 51 (10%) were adult males.
- Of the 127 perpetrator deaths, 124 (98%) were adult males.
- The average age of homicide victims was 38.8 years.
- The average age of perpetrators who died was 49.8 years.

Graph One: Number of DV cases based on year (2002-2019) 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 2002-2019. The number of case occurrences per year has varied from 18 cases in 2014 to 36 cases in 2006. Some cases may involve multiple victims. There was an average of 25 domestic homicide and/or homicide-suicide cases per year from 2002-2018.

Graph Two: Number of DV Homicide Victims (2002-2019)



Graph Two shows the number of domestic violence homicide victims per year from 2002-2019. The number of homicide victims per year has varied from 20 in 2017 to 46 in 2006. There was an average of 28 domestic homicide victim deaths per year from 2002-2019.

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 2002-2019.

Chart Two: Top Death Factors in Domestic Violence Deaths (2002-2019) based on CIS data

Death Factor	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total DV Deaths (2002-2019)	% of Total DV Deaths (2002-2019)	
Trauma - cuts, stabs	15	8	11	9	21	14	8	11	16	15	6	12	13	9	8	7	9	19	211	33%	
Trauma - beating, assault	5	4	4	5	6	2	0	0	3	3	2	4	0	3	0	3	4	3	51	8%	**42%**
Shooting - handgun	8	5	2	4	1	9	1	3	3	1	6	4	2	2	7	6	7	0	71	11%	
Shooting - rifle	2	0	3	5	5	3	3	2	1	2	0	0	0	5	3	0	9	2	45	7%	
Shooting - shotgun	7	1	2	2	2	2	1	2	6	0	5	6	2	4	0	1	9	2	54	9%	**27%**
Shooting - weapon (not spec.)	0	0	1	0	0	0	1	0	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	0	0	12	2%	
Asphyxia - strangulation	0	3	5	5	6	4	4	0	0	3	3	1	1	1	1	1	2	1	41	7%	**11%**
Asphyxia - neck compression	0	0	0	1	2	0	2	3	0	0	0	1	1	0	1	0	1	2	14	2%	
Other	9	4	4	6	10	10	9	8	2	12	9	2	10	3	10	4	7	10	129	20%	**20%**
Total	46	26	33	37	53	45	29	30	32	38	32	30	29	30	30	23	48	39	630		

* percentages are rounded off

**includes all deaths, including perpetrator suicides

Summary of Chart Two: Top Death Factors in Domestic Violence Deaths (2002-2019)

- 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 27% 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 20% of the deaths.

Statistical Overview: Cases Reviewed by the DVDRC (2003-2020)

From 2003-2020, the DVDRC has reviewed 364 cases that involved a total of 515 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 2003-2020 inclusive.

					Type of Case	
Year		# of cases reviewed	# of deaths involved	# of recs	Homicides	Homicide - Suicides
2003		11	24	18	3	8
2004		9	11	29	5	4
2005		14	19	10	5	9
2006		13	21	35	4	9
2007		15	25	33	7	8
2008		15	17	33	13	2
2009		16	25	11	6	10
2010		18	36	14	6	12
2011		33	41	31	27	6
2012		20	32	18	14	6
2013		19	22	9	17	2
2014		14	15	25	13	1
2015	**Full** **Executive**	21 49	29 57	28	12 46	9 3
2016		22	36	23	11	11
2017		22	35	33	12	10
2018		18	25	28	15	3
2019	**Full**	20	24	32	17	3
	Executive	2	2		2	0

2020		13	19	27	9	4
Total		**364**	**515**	**437**	**244**	**120**

Chart Three: Number of Cases Reviewed by the DVDRC (2003-2020)

* 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 resulted in recommendations.

** In 2019, executive reviews were conducted on cases where the relationship between the victim and perpetrator was not clearly established and where the intimate partner was the unintended victim.

Summary of Chart Three: Number of Cases Reviewed by the DVDRC (2003-2020)

- In the period between 2003 and 2020, the DVDRC reviewed 364 cases, involving 515 deaths (including perpetrator suicides).
- Of the 364 cases, 244 (67%) were homicides and 120 (33%) were homicide-suicides.

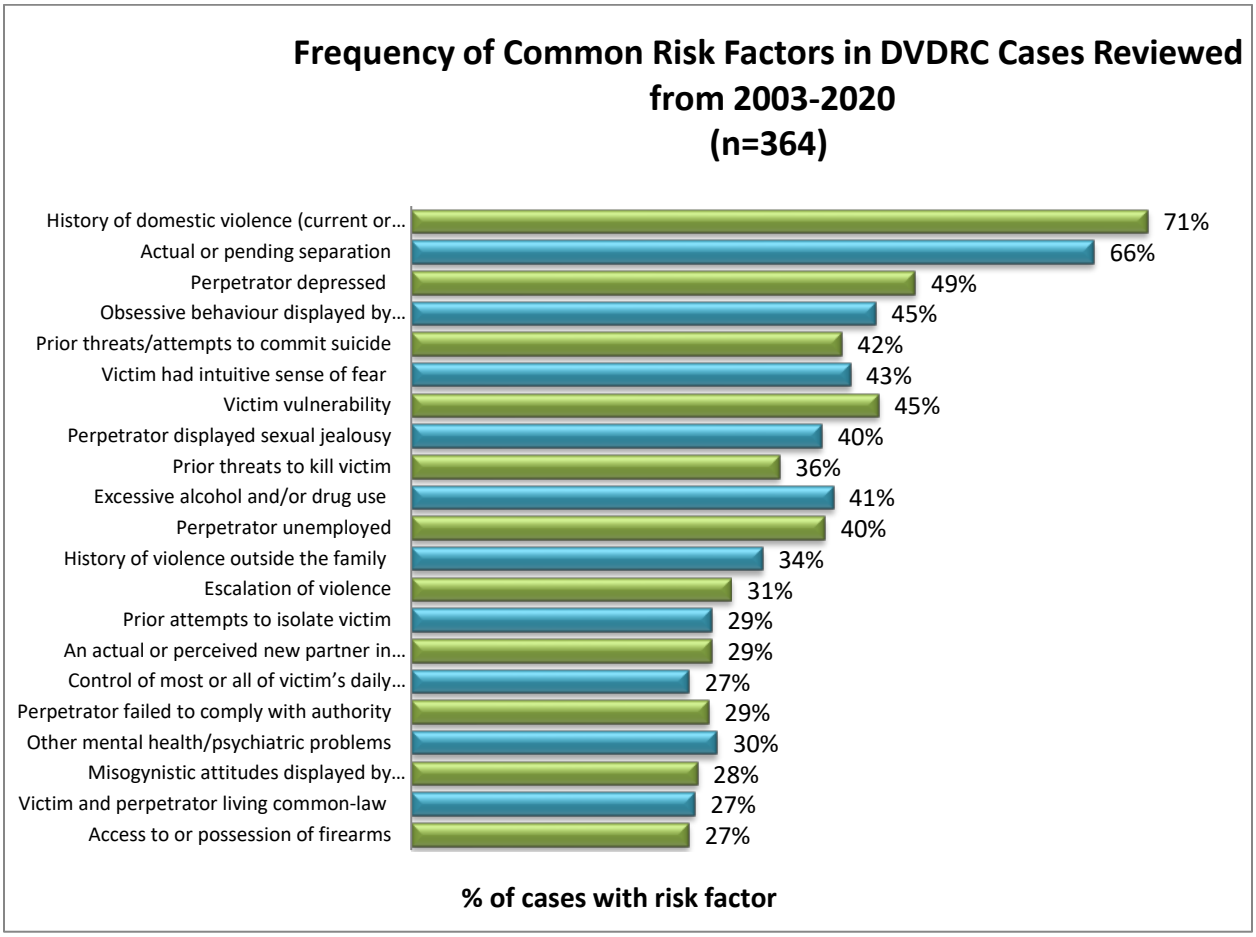
Analysis of Risk Factors: Common Risk Factors

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. The victim is considered the primary target of the perpetrator's abusive/maltreating/violent actions. In some cases, the person(s) killed may not have been the intended victims.

Graph Three: Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2020)



*includes all reviews, including executive reviews in 2015 and 2019
** Victim vulnerability was added as a risk factor in 2017.

Summary of Graph Three: Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2020)

- 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 2003-2020, there was a history of domestic violence (past or present).
- In 66% of the cases, the couple had an actual or pending separation.
- In 49% of the cases, the perpetrator was depressed (diagnosed and/or undiagnosed).
- In 45% of the cases, obsessive behaviour was displayed by the perpetrator.

- In 45% of the cases[2], victim vulnerability was identified as a risk factor.
- In 42% 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 40% of the cases, the perpetrator displayed sexual jealousy.
- In 36% of the cases, there were prior threats to kill the victim.
- In 41% of the cases, excessive alcohol and/or drug use was involved.
- In 40% of the cases, the perpetrator was unemployed.
- In 34% of the cases, there was a history of violence outside of the family.
- In 31% of the cases, there was an escalation of violence.
- In 29% of the cases there was an attempt to isolate the victim.
- In 29% 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 (2003-2020), 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.

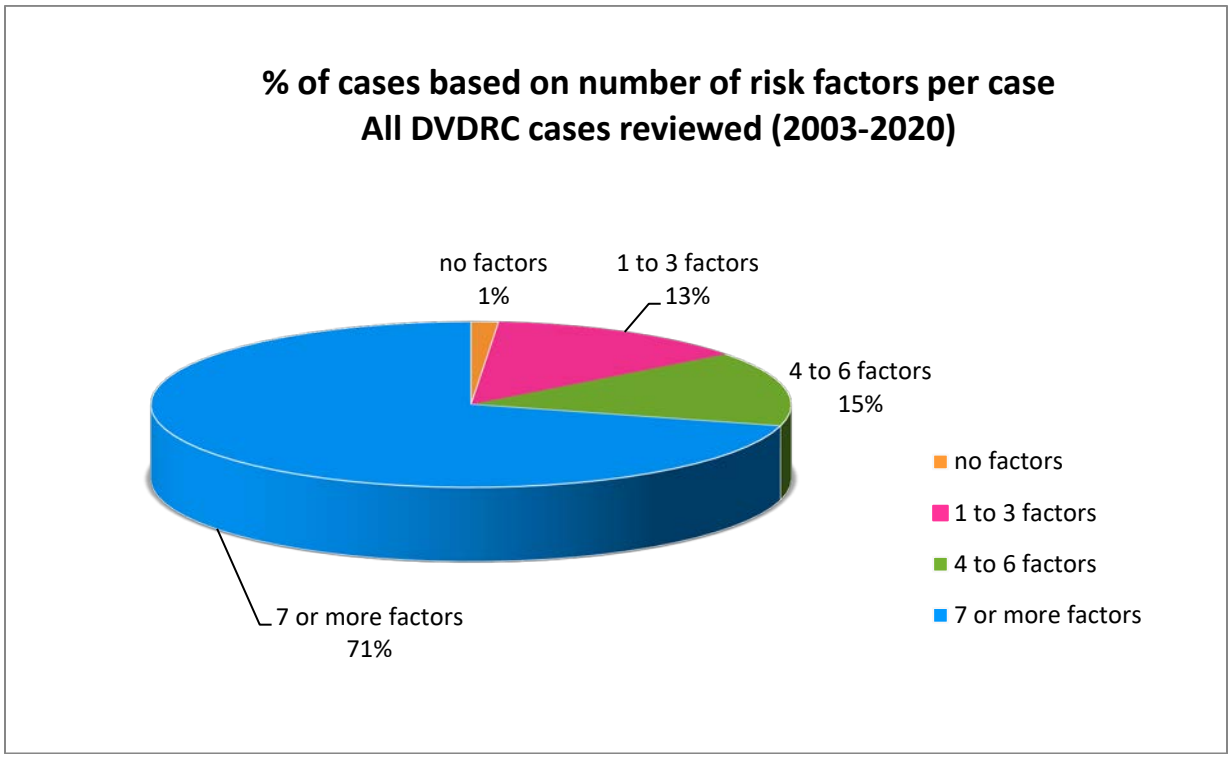
Chart Four: Number of Risk Factors per Case – All DVDRC Cases Reviewed (2003-2020)

# of risk factors per case	2003-2019 (n-351)	2020 (n=13)	2003-2020 (n=364)	% of total cases
no factors	5	0	5	1%
1 to 3 factors	47	1	48	13%
4 to 6 factors	53	0	53	15%
7 or more factors	246	11	257	71%

The percentage of total cases based on number of risk factors is shown in a pie graph in **Graph Four: Percent (%) of cases based on number of risk factors per case – All DVDRC cases reviewed (2003-2020).**

[2] Victim vulnerability was added as a risk factor in 2017. This percentage is based on cases reviewed from 2017-2019.

Graph Four: Percent (%) of cases based on number of risk factors per case – All DVDRC cases reviewed (2003-2020)



Summary of Chart Four and Graph Four: Number of Risk Factors per Case – All DVDRC cases reviewed (2003-2020)

- In 71% of the cases reviewed from 2003-2020, seven or more risk factors were identified.
- In 15% of the cases reviewed from 2003-2020, four to six risk factors were identified.
- The combined proportion of cases with four or more risk factors was 86%.
- In 13% of the cases reviewed from 2003-2020, one to three risk factors were identified.
- In 1% of the cases reviewed from 2003-2020, 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 2019 and 2020

The DVDRC conducted 20 full case reviews and two executive review in 2019. This included 19 homicide and three homicide-suicide cases, resulting in a total of 26 deaths (23 homicide victims and three perpetrator suicides).

In 2020, the DVDRC reviewed 13 cases. This included nine homicides and four homicide-suicides, resulting in 19 deaths (15 homicides and four 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 2019 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 2019

Total number of cases reviewed:	***22***
# of homicide cases	*19*
# of homicide-suicide cases	*3*
Total number of deaths reviewed:	***26***
Homicide deaths:	***23***
Female (adult)	*18*
Female (child)	*1*
Male (adult)	*4*
Male (child)	*0*
Average age of victim:	*39*
Suicide deaths:	*3*
Female	*0*
Male	*3*
Average age of all perpetrators:	*40*

# of male perpetrators[3]	*18*
# of female perpetrators	*4*
# of cases with less than 7 risk factors:	*7*
# of cases with 7 or more risk factors:	*15*
Average number of risk factors:	*9*
# of cases involving age 65 or older:	*3*
Homicide-suicides w/elderly	*1*
# of recommendations made:	*32*

Chart 5 – Summary of Cases reviewed in 2019, demonstrates that:

- There were 22 case reviews conducted by the DVDRC in 2019. This included 19 homicide cases and three homicide-suicide cases, resulting in 26 deaths (23 homicide victims and three perpetrator suicides).
- As a result of these reviews, there were 31 recommendations made towards the prevention of future similar deaths.
- Of the 23 homicide victims in the cases reviewed, 18 (78%) were adult females, four (17%) were adult males and one (4%) was a female child.
- Of the 22 cases, 18 (82%) involved male perpetrators and four (18%) involved a female perpetrator.
- In 15 (68%) of the cases, seven or more risk factors were identified.
- The average number of risk factors identified in cases reviewed in 2019 was 10.

Further analysis of the cases reviewed in 2019 demonstrated that:

- The victims ranged in age from six to 70 years.
- The average age of victims was 39 years.
- The perpetrators ranged in age from 19 to 71 years.
- The average age of perpetrators (deceased and living) was 40 years.
- The number of risk factors for individual cases ranged from zero to 21 (out of 41).

[3] Three cases were reviewed that involved the same male perpetrator.

Analysis of Risk Factors: Number of Risk Factors per Case

The data in **Chart Six: Number of Risk Factors Identified in Cases Reviewed (2019**), are consistent with the findings with all cases reviewed by the DVDRC from 2003-2019 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 2019 ranged from zero to 20.

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 (2019)

# and % of risk factors per case	2019 Reviews (n=22)	Total Reviews 2003-2019 (n=351)
no factors	1	5
%	(5%)	(1%)
1 to 3 factors	3	47
%	(14%)	(13%)
4 to 6 factors	3	53
%	(14%)	(15%)
7 or more factors	15	246
%	(68%)	(70%)

Chart Six breaks down the number of identified risk factors in the cases reviewed in 2019 and compares them to the number of risk factors for all cases reviewed from 2003-2019.

The chart indicates that:

- In 2019, one case (5%) had no risk factors identified. This compares to 1% of *all* cases reviewed from 2003-2019.
- In 2019, three (14%) cases reviewed had one to three risk factors identified. This compares to 13% of *all* cases reviewed from 2003-2019.
- In 2019, three (14%) cases reviewed had four to six risk factors identified. This compares to 15% of *all* cases reviewed from 2003-2019.

- In 2019, 15 (68%) of cases reviewed had seven or more risk factors identified. This compares to 70% of *all* cases reviewed from 2003-2019.

- The risk factor findings for cases reviewed in 2019 is consistent with the findings shown in Chart Four and Graph Four which indicate that the majority of *all* cases reviewed from 2003-2019 have seven or more risk factors.

Analysis of Death Factors

Chart Seven: Death factors for cases reviewed in 2019 shows that 54% of the cases involved some type of trauma (including cuts, stabs, beatings, assaults). Of the cases reviewed, 27% involved the use of a firearm, 8% were due to asphyxia (i.e. hanging, airway obstruction, strangulation or neck compression) and 11% were from fire-related injuries, drug toxicity or undetermined.

Chart Seven: Death factors for cases reviewed in 2019

Death Factor	Victim	Perp	Total	
Trauma - cuts, stabs	9	0	9	54%
Trauma - beating, assault	4	0	4	
Trauma - blunt force	1	0	1	
Shooting – handgun, rifle or shotgun	5	2	7	27%
Asphyxia – strangulation/airway obstruction	1	0	1	8%
Asphyxia - hanging	0	1	1	
Other or undetermined	3	0	3	11%
Total Deaths	**23**	**3**	**26**	

Recommendations made from 2019 Case Reviews

In 2019, 31 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:

- Awareness and training on risk factors for intimate partner homicide by physicians, nurses, mental health care providers, addiction counsellors, family law lawyers, crown attorneys and probation officers
- Access to information by victims/families regarding history of intimate partner violence
- Lessons learned case reviews for organizations involved
- Public education campaigns and culturally appropriate intervention programs

- Management of high-risk offenders.

A summary of all recommendations made in 2019 is included in Appendix D.

Discussion and Significant Findings for Cases Reviewed in 2019

The findings from reviews conducted in 2019 are consistent with the overall results from all reviews conducted from 2003-2019. Specifically:

- The majority of domestic violence homicide victims were female.
- The age range of victims is broad. In 2019, the range was from six to 70 years.
- The age range for perpetrators is also broad. In 2019, the range was from 19 to 71 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:

Guiding Future Direction

Intimate partner homicide statistics for Ontario have remained largely unchanged over the past 20 years. Although the committee continues to develop valuable evidence-based recommendations, many of which have led to important changes to various systems, the numbers have not decreased. Now is an opportune time to critically review the activities of the committee and begin exploring other approaches and strategies to reduce intimate partner homicide in Ontario.

By using the term "intimate partner violence" in place of "domestic violence" in the name of the committee, we acknowledge and recognize broader issues present in all types of intimate relationships, not just those of a domestic nature. This change also reflects the first step towards re-imagining and exploring opportunities for innovation relating to the membership of the committee, how the committee reviews cases, how recommendations are created and distributed, and how responses to those recommendations are analyzed and reported.

The process to revitalize the committee will be measured and deliberate in an inclusive, accessible and transparent manner. Our aim is to explore innovative approaches at addressing this complex and multi-faceted societal challenge, and to embrace and nurture collaboration while engaging diverse perspectives and better promoting our work and recommendations.

We welcome feedback and input from interested stakeholders as our transformation commences. Comments may be sent to: occ.deathreviewcommittees.com.

Thank you for your interest in our work.

Chapter Four:

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.

The DVDRC endeavours to be reflective of Ontario's diverse population and vast geography. Efforts will be made to broaden representation on the committee and refresh membership regularly.

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 2019

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	2016		1	1	6			1	45		1	7	5	court process
2	2013	1		1	28		1		33		1	9	2	Indigenous, alcohol
3	2013		1	1	56	1			59	1		0	0	suicide pact
4	2016		1	1	65		1		33	1		13	2	safe separation
5	2012	1		1	40	1			39	1		7	1	safe separation
6	2015	1		1	26	1			37	1		14	1	alcohol misuses, history of DV
7	2014	1		1	32	1			42	1		17	1	BDSM
8	2017	1		1	39	1			43	1		12	3	
9	2015	1		1	39	1			42	1		1	0	
10A 10B 10C	2015 2015 2015	1 1 1		1 1 1	66 36 48	1 1 1			57	1		13 16 20	4 6	safe separation, gun, history of DV
11	2016	1		1	20		1		20		1	5	0	youth, alcohol misuse
12	2015	1		1	54	1			45	1		5	4	healthcare, alcohol, Indigenous
13	2015	1		1	21	1			19	1		13	1	child welfare, Indigenous
14	2013	1		2	42 35	1 1			47	1		10	0	history of DV
15	2014	1		1	41	1			39	1		1	0	vulnerable victim
16	2015	1		1	39	1			38	1		8	1	mental health
17	2017	1		1	70	1			71	1		13	1	safe separation, mental health
18	2016	1		1	44		1		32		1	6	0	alcohol abuse and history of DV
EX 1	2016	1		1	24	1			23	1		3	0	guns, safe separation
EX 2	2013	1		1	28	1			41	1		7	0	unwanted relationship

Appendix D

Summary of Cases and Recommendations – 2019 Case Reviews

Case #	Summary	Recommendation(s)
2019-01	This 2016 case involved the homicide of a six-year-old female child by her 45-year-old mother who subsequently died by suicide. The perpetrator and her husband were separated. Just prior to the homicide-suicide, the perpetrator had received notification from the family court that she would no longer have custody of the victim and that her husband had been granted sole custody. There were seven risk factors for intimate partner homicide identified.	1. A funding envelope and guidelines should be developed for the family court to appoint an Amicus Curiae (lawyer as friend of the court) for cases with a self-represented litigant in a child custody trial that might impact significant parenting outcomes such as a change in custody or termination of access. 2. An expert panel should be convened on the process to change custody from one parent to another after a trial of the matter. The panel should include experts from the field of family law, child protection, judicial officers, police and mental health. Issues to be discussed should include, but not be limited to: • notification of parents • transition plans • having children in a safe place before transfer • required counselling • safety planning/risk management. 3. The Office of the Children Lawyer (OCL) should complete an internal review of their initial assessment of the individuals involved in this case to see if there were missed opportunities to provide a more comprehensive and acceptable report for the family court. 4. The regional supervising coroner for the area where this homicide-suicide occurred should conduct a review of the circumstances surrounding these deaths with the local agencies involved. 5. The Canadian Radio-television and Telecommunications Commission (CRTC) should consider studying the possibility of the reduction, management or elimination of web-sites that are published to inform people how to kill themselves or others.
2019-02	This case involved the homicide of a 28-year-old male by his 33-year-old girlfriend. The couple had been in an abusive relationship for approximately three years before the incident that resulted in the victim's death. The victim and perpetrator were homeless	1. Police services are encouraged to work more closely with culturally-appropriate healthcare and social services systems in order to address alcohol and substance abuse issues in a more holistic manner. Such an approach may include inviting community elders to assist with the process.

Case #	Summary	Recommendation(s)
	and had severe alcohol and drug problems. Both had a lengthy criminal record including assault, uttering threats, theft, public intoxication and failing to comply with probation orders and recognizance. There were nine risk factors for intimate partner homicide identified.	2. Healthcare providers are encouraged to refer patients to culturally-appropriate mental health services (e.g. healing programs).
2019-03	This case involved the death of a 56-year-old woman followed by the suicide of her 59-year-old husband. The couple had been charged with fraud in the United States and prosecution procedures were forthcoming. While the couple may have had a suicide pact, it is believed that the perpetrator assisted in the death of his wife, then killed himself. There were no risk factors for intimate partner homicide identified.	No recommendations.
2019-04	This case involved the death of a 65-year-old male victim by a 33-year-old male perpetrator. The victim was the father of the intended victim, who was the former female common-law partner of the perpetrator. The perpetrator was attempting to attack the intended victim when the victim intervened and was killed. The intended victim was injured and the perpetrator subsequently took his own life. There were 13 risk factors for intimate partner homicide identified.	1. It is recommended that lawyers in family law practice receive mandated continuing education on understanding and recognizing the dynamics of domestic violence and the risk factors for lethality associated with separation, divorce, and custody and access. 2. It is recommended that family law lawyers consider the risks and benefits of different strategies for communicating and serving family court documents, and in cases of domestic violence they consider serving papers in person.
2019-05	This case involved the homicide of a 40-year-old woman by her 39-year-old husband. The couple were in the process of separating at the time of the homicide. The perpetrator suffered a stroke two years prior and was dependent on the victim for his financial, emotional and physical needs. The perpetrator was depressed and had other mental health concerns. There were seven risk	1. Hospital systems and health care models are reminded of the impact of major life changes to a patient's mental health in addition to the physical health changes, and consider a mandatory mental health/psychological evaluation as part of the rehabilitation process prior to discharge from hospital based services.

Case #	Summary	Recommendation(s)
	factors for intimate partner homicide identified.	
2019-06	This case involved the death of a 26-year-old woman who was killed by her 37-year-old partner. Both the victim and perpetrator misused alcohol, had a history of domestic violence with other partners and were unemployed. There were 14 risk factors for intimate partner homicide identified.	1. Social Assistance (Ontario Works and Ontario Disability Support Program) case workers should receive specialized training in the dynamics of domestic violence. Case workers should ask evidence-based probing/screening questions if a client verbalizes wanting to kill or harm someone, particularly an intimate partner, and refer the client to other professional services (including the police) as necessary.
2019-07	This case involved the homicide of a 32-year-old woman by her 42-year-old male partner. The couple were involved in a sadistic sexual relationship where the perpetrator dominated most aspects of the victim's life. There were 17 risk factors for intimate partner homicide identified.	1. Public health and other sex educators should develop public awareness campaigns and informational resources on safe practices and warning signs for risk of non-consensual sexual and physical activity between partners involved in BDSM.
2019-08	This case involved the homicide of a 39-year-old woman by her 43-year-old husband. The couple were in the process of separating when the perpetrator killed the victim while their children were present in the house. There were 12 risk factors for intimate partner homicide identified.	1. Domestic violence public education materials created by the Office of Women's Issues should include information on the potential harm of exposure to domestic violence on children. Public service announcements (PSAs) should highlight the negative impact of domestic violence on children and encourage broader public awareness, particularly with friends, family, neighbours and co-workers. 2. Education on the dynamics of domestic violence, including coercive controlling abuse and post-separation violence, risk assessment, safety planning and risk management strategies should be part of mandatory education and continuing education for law students and family law lawyers. 3. The federal government should consider possible amendments to the Criminal Code of Canada to include homicide of a domestic or intimate partner as automatic first degree murder when there is a prior conviction of domestic/intimate partner violence or a pattern of abuse with that partner in the past five years, with the exception of behaviour that constitutes self-defense.
2019-09	This case involved the homicide of a 39-year-old woman by her 42-year-old husband. The victim went missing in July 2014 and her remains were	No recommendations.

Case #	Summary	Recommendation(s)
	located a year later. The perpetrator had started a new relationship prior to the victim's disappearance. There was one risk factor for intimate partner homicide identified.	
2019-10A	This case involved the death of a 66-year-old female by a former intimate partner that had a lengthy history of intimate partner violence. Victim 1 was one of three women killed by the same perpetrator within the span of several hours. There were 13 risk factors for intimate partner homicide identified in the relationship between Victim 1 and the perpetrator.	(recommendations applicable to cases 10A, 10B and 10C): 1. Justice partners, health professionals and counsellors should better utilize case conferencing systems that share information and action plans to address safety issues and "high risk" cases. 2. When information is received regarding assignment of a mobile tracking system (MTS) alarm to a victim or potential victim, there should be a special interest police CPIC entry linking the offender to the victim. 3. Protocols and provincial standards should be established for the administration, funding and procedures for use of mobile tracking system alarms across all victim services in the province.
2019-10B	This case involved the death of a 36-year-old female by a former intimate partner that had a lengthy history of intimate partner violence. Victim 2 was the second of three women killed by the same perpetrator within the span of several hours. There were 16 risk factors for intimate partner homicide identified in the relationship between Victim 2 and the perpetrator.	4. The Ministry of the Attorney General should provide funding for alarms for victims. The victim quick response program (VQRP), provided through victim service organizations across the province, should receive additional funding to cover mobile tracking system alarms. 5. Police and victim services organizations should establish a standard provincial policy regarding the use of mobile tracking system alarms. 6. Crown counsel are encouraged to share information with other justice stakeholders and victims, as to why charges against a perpetrator are stayed or withdrawn.
2019-10C		Above recommendations, in addition to the following: 1. Justice partners, health professionals and counsellors should better utilize case conferencing systems that share information and action plans to address safety issues and "high risk" cases. 2. When information is received regarding assignment of a mobile tracking system (MTS) alarm to a victim or potential victim, there should be a special interest police CPIC entry linking the offender to the victim.

Case #	Summary	Recommendation(s)
		3. Protocols and provincial standards should be established for the administration, funding and procedures for use of mobile tracking system alarms across all victim services in the province. 4. The Ministry of the Attorney General should provide funding for alarms for victims. The victim quick response program (VQRP), provided through victim service organizations across the province, should receive additional funding to cover mobile tracking system alarms. 5. Police and victim services organizations should establish a standard provincial policy regarding the use of mobile tracking system alarms. 6. Crown counsel are encouraged to share information with other justice stakeholders and victims, as to why charges against a perpetrator are stayed or withdrawn.
2019-11	This case involved the death of a 20-year-old male by his 20-year-old girlfriend. The couple had a child together and both consumed alcohol. There were five risk factors for intimate partner homicide identified.	No recommendations.
2019-12	This case involved the death of a 54-year-old Aboriginal woman by her 45-year-old male common-law partner. The perpetrator had a history of substance abuse and mental health issues. There were five risk factors for intimate partner homicide identified.	1. Hospital A should conduct a lessons-learned case review of the circumstances surrounding this case particularly as they relate to the initial assessment and discharge of the perpetrator from the emergency department. 2. It is recommended that the College of Physicians and Surgeons ensure that educational interventions for family physicians, emergency department physicians and medical residents on mental illness highlight the way that such problems elevate the risk for lethality in situations of ongoing intimate partner violence. 3. All emergency departments in hospitals should have access to mental health crisis support workers that can engage with patients involved with substance abuse. Engagement with patients should also consider the safety of support people and intimate partners and/or family members. This would likely require more liaisons with external agencies, and more allocation for mental health resources and services across the province. 4. The Ministry of Health should increase community initiatives and public education to build awareness of substance abuse issues and

Case #	Summary	Recommendation(s)
		resulting implications for intimate partners, families, friends and co-workers.
2019-13	This case involved the death of a 21-year-old Indigenous woman by her 19-year-old boyfriend. Both the victim and perpetrator had been involved with the child welfare system when younger. The couple had an on-again off-again relationship. There were 13 risk factors for intimate partner homicide identified.	1. A meeting, co-chaired by the regional supervising coroner and senior officials in the Ministry of Indigenous Affairs and Indigenous Services Canada (Ontario Region), should be held with service providers involved in this case across all sectors including Indigenous and non-Indigenous police services, court-related professionals, Indigenous and non-Indigenous social services and child protection services, mental health and education to address the need to provide culturally appropriate services for victims and perpetrators of domestic violence.
2019-14	This case involved the deaths of a 42-year-old woman and a 35-year-old woman (victim 1 and victim 2), who were both in dating relationships (at the same time) with the 47-year-old perpetrator. There was a total of ten risk factors for intimate partner homicide identified in the relationships the perpetrator had with victims 1 and 2.	No recommendations.
2019-15	This case involved the homicide of a 41-year-old woman by her 39-year-old husband. The victim had progressive Multiple Sclerosis and was dependent on her husband for all her care needs. The perpetrator struck the victim after becoming frustrated with her crying. There was one risk factor for intimate partner homicide identified.	No recommendations.
2019-16	The victim was a 39-year-old woman who was killed by a 38-year-old man who she had an open intimate relationship with. The perpetrator had a long history of mental health issues and domestic violence and was found not criminally responsible for the victim's death. There were eight risk factors for intimate partner homicide identified.	1. The Ministry of the Attorney General should consider developing legislation that would allow potential domestic violence victims and their family members to apply for access to information about intimate partners where there is a concern that they may have a history of violence and abuse in other relationships and present a serious risk. Albert and Saskatchewan have enacted similar legislation that is known as Clare's Law named after a domestic homicide victim in the UK whose family advocated for this

Case #	Summary	Recommendation(s)
		reform after their daughter was killed by a serial offender.
2019-17	This case involved the homicide of a 70-year-old woman by her 71-year-old husband. The couple had been married for 48 years and had been separated (although living in the same residence) for five years. There were 13 risk factors for intimate partner homicide identified.	1. It is recommended that the police service involved conduct a lessons-learned case review of the circumstances of this death, particularly as it relates to the victim presenting to the police station, her interaction with civilian staff and the assessment and action taken regarding threats that had been made.
2019-18	The victim was a 44-year-old man who was murdered by his 32-year-old common-law spouse. Both the victim and perpetrator had a history of alcohol abuse and domestic violence. In many instances, the victim had been the instigator of the violence. There were six risk factors for intimate partner homicide identified.	No recommendations.
2019-EX-01	This case involves the homicide of 24-year-old female victim by her 23-year-old former boyfriend. There were three risk factors for intimate partner homicide identified.	No recommendations.
2019-EX-02	This case involved the death of 28-year-old female victim by her 41-year-old male acquaintance. The victim and the perpetrator described their relationship as like “brother and sister.” The perpetrator indicated that he had wanted to pursue a relationship, the victim was not receptive. There were seven risk factors for intimate partner homicide identified.	No recommendations.

Appendix E: Detailed Summary of Cases reviewed in 2020

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	2016	1		1	25	1			29	1		19	2	Dangerous offender
2	2017	1		1	31	1			31	1		18	4	online dating
3	2012	1		1	26	1			33	1		13	4	marginalized, race, mental health
4	2014	1		1	26	1			27	1		7	0	mental health
5	2017	1		1	7		1	1	43	1		10	1	child, financial, safe separation
6	2015	1		1	31	1			52	1		23	0	safe separation
7	2017	1		1	26	1			25	1		14	3	safe separation
8	2018		1	3	55	1			58	1		12	3	police response, victim
					28		1							
					88	1								
9	2017	1		1	76	1			70	1		8	4	shot by police, elderly, poor health, firearms
10	2018		1	1	51	1			63	1		14	1	safe separation, financial
11	2018		1	1	52	1			53	1		11	2	firearms
12	2015	1		1	84	1			83	1		1	0	Alzheimers, unfit to stand trial
13	2018		1	1	35		1		46	1		8	3	firearms, public education

Appendix F

Summary of Cases and Recommendations – 2020 Case Reviews

Case #	Summary	Recommendation(s)
2020-01	This case involved the death of a 25-year-old woman by her 29-year-old boyfriend. The perpetrator had a long history of violent and criminal activity and had been declared a violent offender. At the time of the homicide, the perpetrator lived in a half-way house and was allowed out on weekends to visit with the victim and their child. There were 19 risk factors for intimate partner homicide identified.	To Correctional Services Canada: 1. Correctional Services Canada should conduct a lessons-learned case review of the circumstances surrounding this case including: • reviewing their policies related to this case with a view to enhance counselling and monitoring of high-risk offenders, especially those deemed "dangerous offenders" involved in intimate relationships including random visits to the home, drug and alcohol testing and interviews with their intimate partners regarding their safety • role of child welfare services with a registered dangerous offender • protocols to alert police in the community, and alert CAS when a person with dangerous offender status has access to children. To the federal Minister of Justice: 2. The federal Minister of Justice could consider if the first-degree murder definitions in the criminal code should be expanded to include murder committed by individuals that had been declared a dangerous offender, under long-term supervision and in violation of the terms of their supervision.
2020-02	This case involved the death of a 31-year-old woman by her 31-year-old boyfriend. The perpetrator had a history of domestic violence. The couple had recently split up and the victim had started a new relationship. There were 18 risk factors for intimate partner homicide identified.	To the Ministry of the Solicitor General: 1. Police referrals to victim services should be strongly considered for all domestic violence calls – even when victims may be reluctant to disclose enough information for charges to be laid. To the Ministry of Government and Consumer Services and the Ministry of Children, Community and Social Services (Children's and Women's Issues): 2. The Ministry of Government and Consumer Services and the Ministry of Children, Community and Social Services should ensure that all dating sites in the province have

Case #	Summary	Recommendation(s)
		warnings about abuse in dating relationships based on current material developed by provincial campaigns such as Neighbours, Friends and Family that remind consumers the extent of violence in dating relationships, definitions, warning signs, safe separations and where to seek help. Currently, the only warnings on government web-sites relate to financial and personal information matters (see https://www.ontario.ca/page/dating-services-before-you-sign) To the Ministry of Children, Community and Social Services (Children's and Women's Issues): 3. The Ministry of Children, Community and Social Services (Children's and Women's Issues) should develop public education material related to violence against women for bars/drinking establishments and should be considered as part of licensing these establishments. 4. The Ministry of Children, Community and Social Services should undertake a study to explore the extent to which children living with the aftermath of domestic homicide have counselling and trauma support in place across the province.
2020-03	This case involved the homicide of a 26-year-old Black woman by her 33-year-old White common-law partner. The couple were in a relationship for four years. The victim was a sex worker and the perpetrator was reportedly her pimp. The victim went missing in 2010 and her remains were located in 2012. There were 13 risks factors for intimate partner homicide.	To the Ministry of Children, Community and Social Services 1. It is recommended that the Ministry of Children, Community and Social Services develop a public and professional education campaign to address the harm to children living with intimate partner violence. The campaign should also provide education and resources on individuals' duty to report to child protection services when they know or suspect that a child has been exposed to intimate partner violence. 2. It is recommended that the Ministry of Children, Community and Social Services consult with experts in non-fatal strangulation and the gender-based violence sector, develop training and create culturally responsive resources and materials on the warning signs, dangers and risks of strangulation, and safe intervention strategies and make such materials available and accessible across all workplaces and communities.

Case #	Summary	Recommendation(s)
		To the Ministry of Labour: 3. As part of the domestic violence in the workplace initiatives under the Occupational Health and Safety legislation, the Ministry of Labour should give employers responsibilities to protect victims and co-workers, as well as address the behaviour of abusers using a progressive accountability framework (see resource developed by Western University, FETCO, and the Canadian Labour Congress). It is also recommended that the Ministry of Labour adapt culturally responsive resources and materials on the warning signs, dangers and risks of intimate partner violence and homicide developed by the University of Western Ontario, the Ontario Council of Agencies Serving Immigrants, and the Rexdale Women's Centre (http://rapworkers.com/), and make such materials available and accessible across all workplaces. To the Human Resources Professionals Association: 4. It is recommended that the Human Resources Professionals Association consider creating a template regarding a "Progressive Accountability" policy pertaining to intimate partner violence leading to violence in the workplace that can be shared with their members.
2020-04	This case involved the death of a 26-year-old woman by her 27-year-old male common-law partner. The perpetrator had no criminal history and had legal access to firearms. The victim was considering ending the relationship just prior to her death. There were seven risk factors for intimate partner homicide identified.	No new recommendations.
2020-05	The case involved the death of a seven-year-old male child by his 43-year-old stepfather. The victim's mother was in a common-law relationship with the perpetrator and was in the process of separating. The perpetrator was unemployed and	To the Ministry of Children, Community and Social Services: 1. The Ministry of Children, Community and Social Services should develop a public and professional education campaign to improve public awareness of the psychological and physical harm for children living with domestic violence.

Case #	Summary	Recommendation(s)
	experiencing financial hardship. There were 10 risk factors for intimate partner homicide relating to the relationship between the perpetrator and the victim's mother.	
2020-06	This case involved the death of a 31-year-old woman by her 52-year-old on-again off-again boyfriend. The perpetrator had a history of domestic violence with previous partners. The victim had tried to end the relationship. There were 23 risk factors for intimate partner homicide identified.	No new recommendations.
2020-07	This case involved the death of a 26-year-old female by her 25-year-old husband. At the time of her death, the victim was pregnant and full-term. There was a history of domestic violence in the couple's relationship. There were 14 risk factors for intimate partner homicide identified.	To College of Physicians and Surgeons, College of Nurses Ontario, College of Midwives Ontario, Society of Obstetricians and Gynaecologists, Ontario College of Family Physicians and Public Health Ontario: 1. Obstetrical care providers are encouraged to utilize this case report and information contained within the DVDRC annual report for educational opportunities to reflect the significant risk that pregnant mothers face with domestic violence and domestic homicide. Although Ontario has a perinatal guide (Ontario Perinatal Record OPR) that was created to standardize the documentation of perinatal care, it is difficult to readily find resources on domestic violence including a focus on the warning signs, screening, and appropriate responses for women experiencing domestic violence. Ongoing reminders and training in this area is essential. To the Ministry of the Solicitor General: 2. Policy, procedures and training for Ontario police services should continue to outline strategies to deal with reluctant victims of domestic violence who may recant statements or refuse to support charges, especially in circumstances that reflect an ongoing pattern of abuse and high risk, based on a mandatory risk assessment required for all domestic violence occurrences. To the Ontario College of Social Workers:

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		3. Social workers should recognize the risk of domestic homicide for victims of domestic violence. Members should be mandated to complete a risk assessment when clients disclose violence and provide safety planning. Training should be offered to members to increase awareness and skills to appropriately address domestic violence when disclosed by clients. For social workers without training or competence in this area, they should refer victims to others who can provide appropriate risk assessment and safety planning services.
2020-08	This case involved the homicides of the 55-year-old primary victim (victim 1), her 28-year-old son (victim 2) and her 88-year-old mother (victim 3). The perpetrator was a 58-year-old man who had been involved in an intimate relationship with victim 1. There were 13 risk factors for intimate partner homicide identified.	To the Ministry of the Solicitor General: 1. The Ministry of the Solicitor General should review its policy and training materials for police services to ensure a broad definition of domestic violence/intimate partner violence that captures the diverse nature of intimate relationships, especially in the context of dating relationships, on-line relationships and intimate relationships that may be of brief duration and more one-sided. The existing Provincial Intimate Partner Violence Coordinating Committee could be helpful in reviewing definitions as well as their consultation with experts in the field. 2. The Ministry of the Solicitor General should develop clear policy and procedures as well as training at the Ontario Police College, on managing sexual assault victims who are reluctant to proceed with criminal charges, but may require additional time and counselling to recognize the risks they face from the perpetrator and the potential benefits of engaging in the criminal justice process. 3. The Ministry of the Solicitor General, through the Ontario Police College, should utilize this review as a case study to illustrate the complexity of investigating domestic/intimate partner violence, dating violence and sexual assaults as multiple forms of gender-based violence.
2020-09	This case involved the homicide of a 76-year-old woman by her 70-year-old husband. The couple were in a hospital emergency department when the perpetrator shot and killed the victim. Police responded and subsequently shot and killed the perpetrator. The couple's health was	To the Ministry of Labour, Training, and Skills Development; College of Nurses Ontario; Ministry of Health (Emergency Health Services Branch); Ontario Personal Support Workers Association; Health Shared Services Ontario: 1. It is recommended that elder abuse and intimate partner violence be a mandatory component of courses and training for personal support workers, emergency medical services and nurses.

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	in decline and the perpetrator had a history of suicidal and homicidal ideation. There were eight risk factors for intimate partner violence identified.	To the Ministry of the Solicitor General: 2. It is recommended that elder abuse and risk assessment be a mandatory part of police training at the pre-service and ongoing professional development levels. To the Ministry of Health: 3. It is recommended that the Ministry of Health establish communication policies and protocols to enhance coordination of assessments and intervention by personal support workers, emergency medical services, police and nursing, particularly around attendance at hospital emergency departments. To the hospital involved, Local Health Integration Network and police service involved: 4. The hospital, Local Health Integration Network and police service involved should conduct a lessons-learned case review of the circumstances surrounding these deaths to identify system challenges and identify opportunities for developing or amending policy and practice guidelines.
2020-10	This case involves the homicide of a 51-year-old woman followed by the suicide of her 63-year-old husband. The couple were in a very unhappy marriage and the victim was in the process of separating. The couple had significant financial issues and lived in rural Ontario. There were 14 risk factors for intimate partner homicide identified.	To the Office of Women's Issues, Ministry of Children, Community and Social Services: 1. The Office of Women's Issues, Ministry of Children, Community and Social Services should review their policies and training materials to ensure a comprehensive definition of domestic violence that integrates both a historical context as well as a current analysis of the nature of the abusive tactics used against victims. It is critical to emphasize the dangers of non-physical forms of violence such as verbal, emotional, psychological and financial abuse as forms of coercive control. It is recommended that the differential impact on victims, their families and communities depending on the intersections between the family's social location and their access to resources, be identified.

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2020-11	This case involved the homicide of a 52-year-old woman by her 53-year-old husband who subsequently died by suicide. The perpetrator used illicit drugs and developed an opioid dependency while taking medications for his back pain. The perpetrator had firearms but did not have a license. There were 11 risk factors for intimate partner homicide identified.	To the government of Canada and Chief Firearms Office for Ontario: 1. It is recommended that educational materials be prepared and widely distributed to the public regarding how to report and dispose of firearms in the home, particularly when residents of the home are not licensed and/or have mental health issues and/or where there is violence. To the College of Physicians and Surgeons Ontario and the College of Family Physicians Canada: 2. Family physicians are reminded to consider the links between addiction, mental health and suicidality when managing patient's needs.
2020-12	This case involved the death of an 84-year-old woman by her 83-year-old husband. There was no history of violence in the couple's relationship. The perpetrator was on medication for Alzheimer's disease and was becoming more forgetful. The perpetrator was charged with first degree murder but was found unfit to stand trial. The perpetrator subsequently died while in custody. There was one risk factor for intimate partner homicide identified.	No new recommendations.
2020-13	This case involved the homicide of a 35-year-old man who died while intervening in a dispute between his 59-year-old mother (the intended victim) and the 46-year-old perpetrator that she was in an intimate relationship with. Based on the relationship between the intended victim and the perpetrator, there were eight risk factors for intimate partner homicide identified.	To the government of Canada: 1. The government of Canada should amend the Firearms Act to ban the sale or transfer of a firearm from one person to another without proof of the recipient having a valid firearm license. To the government of Canada and Chief Firearms Office for Ontario: 2. The government of Canada and the Chief Firearms Office for Ontario should enhance training and public education regarding the proper transfer of firearms.

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		To the Office of Women's Issues, (Ministry of Children, Community and Social Services): 3. The Office of Women's Issues should raise awareness on the multiple risk factors that may be associated with an abuser's heightened risk to harm their partner including a history of growing up with violence and child abuse, mental health problems including depression and addictions and acquired brain injury.

For further information, please contact:

Office of the Chief Coroner
Domestic Violence Death Review Committee
25 Morton Shulman Avenue,
Toronto, ON
M3M 0B1
occ.inquiries@ontario.ca