



**Office of the Chief Coroner  
Province of Ontario**

# **Domestic Violence Death Review Committee**

**2016 Annual Report**

**September 2017**

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## Message from the Chair



The publication of the 2016 Annual Report of the DVDRC represents the fourteenth year that the Office of the Chief Coroner has reported on its reviews and on the incidence of domestic homicide and domestic homicide-suicide in Ontario.

As we strive to make our data and information more readily available and more current, we have changed our policy and expectations for responses to recommendations. In keeping with the government's "go green" initiatives, commencing in 2017, all reports and recommendations are being distributed electronically.

We will also be requesting responses within six months, rather than one year and have abandoned our system of requesting respondents to self-rate their responses using a standardized set of codes. We will be expecting a narrative response which will provide more clarity in terms of how the response will be effected.

After eleven years as Chair of the Committee, it is now time for me to take my leave. The experience has been both stimulating and educational. I am greatly appreciative of the support and assistance I have received from the very dedicated and committed Committee members, support staff and the entire investigative team of coroners, pathologists and Regional Supervising Coroners at the Office of the Chief Coroner.

A handwritten signature in black ink that reads "W. J. Lucas". The signature is written in a cursive, flowing style.

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

## Committee Membership (2016)

### **William Lucas, MD, CCFP.**

#### **Committee Chair**

Regional Supervising Coroner – Central West

### **Jessica Diamond**

Executive Lead, Child Welfare, Office of the Chief Coroner

### **Marcie Campbell, M.Ed**

Centre for Research & Education on Violence Against Women & Children, Western University

### **Gail Churchill, M.D.**

Investigating Coroner

### **Jade Harper**

President, Ontario Network of Victim Services Providers

### **Myrna Dawson, Ph.D.**

Professor, Department of Sociology & Anthropology, University of Guelph

### **Monica Denreyer**

Detective Sergeant, Ontario Provincial Police, Threat Assessment Unit

### **Donna Northeast**

Safety Coordinator, Halton Regional Police

### **Barb Forbes**

(A) Regional Director  
MCSCS – Probation & Parole Western Region

### **Jim Glena**

Sergeant, Thunder Bay Police Service

### **Craig Harper**

Crown Attorney

### **Anita Hass**

Sergeant, Greater Sudbury Police Service

### **Peter Jaffe, Ph.D., C.Psych.**

Professor, Centre for Research & Education on Violence Against Women & Children, Western University

### **Leslie Raymond**

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

### **Deborah Sinclair, MSW, PhD(c), RSW**

Independent Practice

### **Lynn Stewart, Ph.D., C.Psych.**

Senior Research Manager, Correctional Service Canada

### **Mark Gauthier**

Sergeant, Ontario Provincial Police

### **Kathy Kerr, M.A.**

Executive Lead, Committee Management, Office of the Chief Coroner

## Executive Summary

### Cases reviewed from 2003-2016:

- From 2003-2016, the DVDRC has reviewed 289 cases, involving 410 deaths.
- Of the cases reviewed, 65% were homicides and 35% were homicide-suicides.
- Approximately 73% of all cases reviewed from 2003-2016 involved a couple where there was a history of domestic violence and 67% of the cases involved a couple with an actual or pending separation.
- The other top risk factors were:
  - a perpetrator who was depressed (50%)
  - obsessive behaviour by the perpetrator (47%)
  - prior threats or attempts to commit suicide (46%)
  - a victim who had an intuitive sense of fear towards the perpetrator (43%)
  - perpetrator displayed sexual jealousy (42%)
  - prior threats to kill the victim (39%)
  - excessive alcohol and/or drug use (39%)
  - a perpetrator who was unemployed (39%)
  - history of violence outside the family (35%)
  - an escalation of violence (34%)
- In 71% of the cases reviewed, seven or more risk factors were identified.

### Cases reviewed in 2016:

- There were 22 cases reviewed by the DVDRC in 2016. These included 12 homicide cases and 10 homicide-suicide cases, resulting in 36 deaths (26 homicide victims and 10 perpetrator suicides).
- There were 23 recommendations generated through these reviews.
- Of the 26 victims in the cases reviewed, 22 (85%) were adult females, two (8%) were adult males and two (8%) were male children.
- Of the 22 cases reviewed, 21 (95%) involved male perpetrators and one (5%) involved a female perpetrator.
- The victims ranged in age from eight to 83 years.
- The average age for victims was 37.8 years.
- The perpetrators ranged in age from 19 to 78 years.
- The average age for perpetrators was 43.5 years.
- The average number of risk factors identified in the cases reviewed was 10.5.
- The number of risk factors ranged from two to 23.
- Seven or more risk factors were identified in 15 (68%) of the cases reviewed in 2016.

## Domestic Violence Death Review Committee Aims and Objectives:

### Purpose

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

### Objectives

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

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

# Chapter One: Introduction and Overview

## History

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

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

## Membership

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

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

## Definition of Domestic Violence

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

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

## Method for Reviewing Cases

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

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

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

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

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

## Recommendations

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

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

## 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 14-year period of cases occurring from 2002-2015 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 2002-2015 may still be pending review by the DVDRC. In many cases, DVDRC reviews have not commenced because legal or other proceedings are still underway or pending. The number of pending cases has been significantly reduced due to a concerted effort by the DVDRC to review outstanding cases.

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

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

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

### Statistical Overview: Homicides with Domestic Violence Involvement (2002-2015)

The following statistics relate to homicides in Ontario occurring between 2002-2015 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 (2002-2015)

*Table A: Total number of homicides/homicides-suicides*

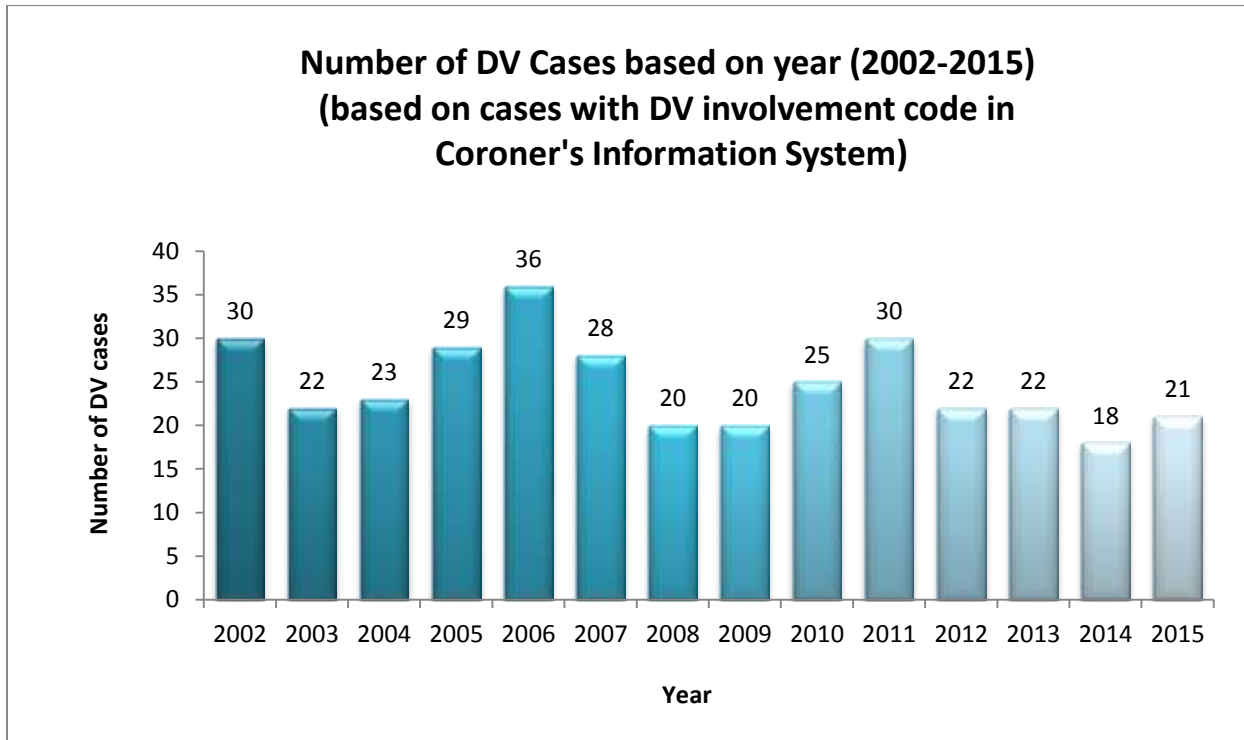
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Totals 2002-2015
<b>Number of cases</b>	30	22	23	29	36	28	20	20	25	30	22	22	18	21	<b>346</b>
<b>Homicides</b>	19	18	14	21	29	18	15	15	19	22	13	17	11	14	<b>245</b> 71%
<b>Homicide-Suicides</b>	11	4	9	8	7	10	5	5	6	8	9	5	7	7	<b>101</b> 29%
<b>Total number of Deaths</b>	<b>46</b>	<b>26</b>	<b>33</b>	<b>37</b>	<b>53</b>	<b>45</b>	<b>29</b>	<b>30</b>	<b>32</b>	<b>38</b>	<b>32</b>	<b>29</b>	<b>29</b>	<b>30</b>	<b>489</b>
<b>Total number of Homicide Victims</b>	<b>35</b>	<b>22</b>	<b>24</b>	<b>29</b>	<b>46</b>	<b>35</b>	<b>24</b>	<b>25</b>	<b>26</b>	<b>30</b>	<b>23</b>	<b>24</b>	<b>22</b>	<b>23</b>	<b>388</b>
<b>Female victim (adult)</b>	26	19	21	29	28	29	20	20	21	27	19	21	13	21	<b>314</b> 81%
<b>Female victim (child)</b>	4	1	1	0	8	0	0	3	1	0	0	0	2	0	<b>20</b> 5%
<b>Male victim (adult)</b>	4	1	1	0	3	4	4	2	4	3	3	3	3	2	<b>37</b> 10%
<b>Male victim (child)</b>	1	1	0	0	7	2	0	0	0	0	1	0	4	0	<b>16</b> 4%
<b>Average age of Homicide Victim</b>	<b>35.9</b>	<b>34.9</b>	<b>39.8</b>	<b>38.2</b>	<b>27.4</b>	<b>34.9</b>	<b>43.3</b>	<b>37.2</b>	<b>36.5</b>	<b>44</b>	<b>45.3</b>	<b>37.7</b>	<b>29.4</b>	<b>38.8</b>	<b>37.4</b>
<b>Total number Perpetrator</b>	11	4	9	8	7	10	5	5	6	8	9	5	7	7	<b>101</b>

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Totals 2002-2015
<b>deaths (suicide or other)</b>															<b>21%</b>
<b>Female perpetrator (adult)</b>	0	0	1	0	0	1	0	0	0	0	0	0	0	0	<b>2</b>
															<b>2%</b>
<b>Male perpetrator (adult)</b>	11	4	8	8	7	9	5	5	6	8	9	5	7	7	<b>99</b>
															<b>98%</b>
<b>Average age of Deceased Perpetrator</b>	<b>48.5</b>	<b>45.5</b>	<b>42.2</b>	<b>45</b>	<b>51.1</b>	<b>45.2</b>	<b>43.8</b>	<b>60</b>	<b>44.7</b>	<b>50.8</b>	<b>59.6</b>	<b>41</b>	<b>47.1</b>	<b>58</b>	<b>48.8</b>

### Chart One: Summary

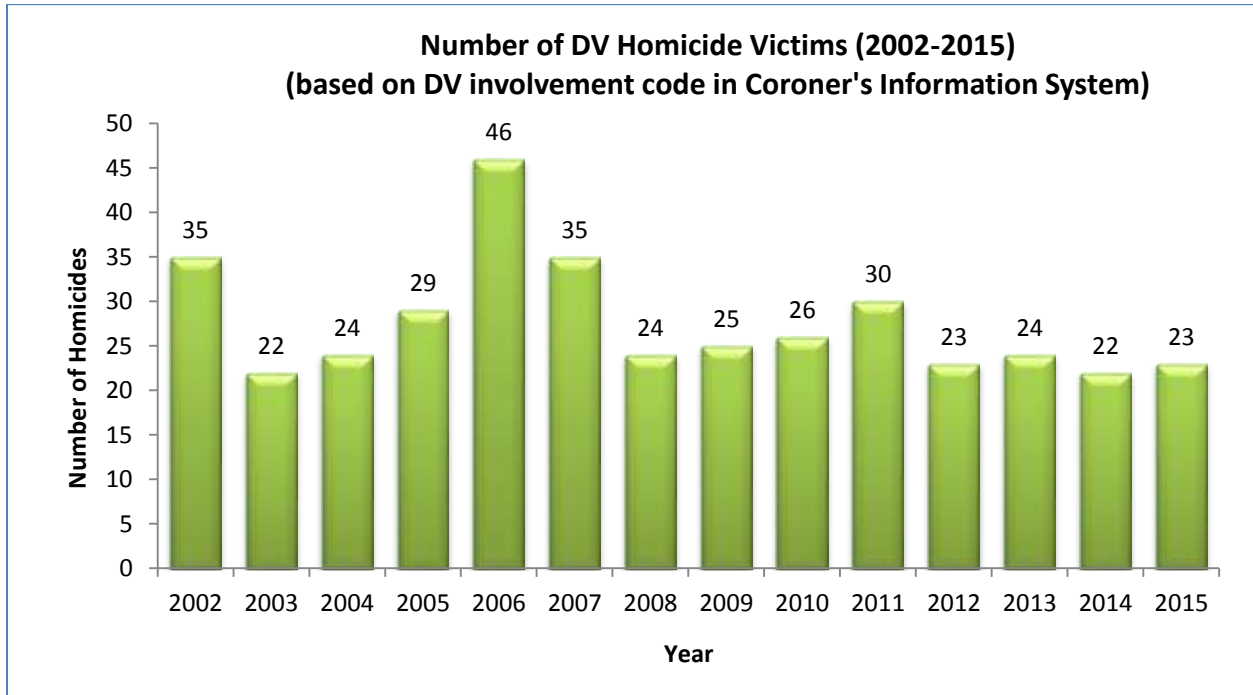
- There were 346 domestic homicide and/or homicide-suicide cases that occurred in Ontario between 2002-2015 (based on cases investigated by the Office of the Chief Coroner for Ontario, where domestic violence was identified as an involvement code).
- Of those 346 cases, 245 (71%) were homicides and 101 (29%) of the cases were homicide-suicides.
- The 346 cases resulted in a total of 489 deaths.
- Of the 489 deaths, 388 (79%) were homicide victims and 101 (21%) were perpetrators who committed suicide or were otherwise killed (e.g. shot by police).
- There was an average of 25 domestic homicide and/or homicide-suicide cases per year from 2002-2015. Some of these cases may have included multiple victims.
- There was an average of 28 domestic homicide victim deaths per year from 2002-2015.
- Of the 388 homicide victims, 314 (81%) were adult females, 36 (9%) were children and 37 (10%) were adult males.
- Of the 101 perpetrator deaths, 98 (97%) were adult males.
- The average age of homicide victims was 37.4 years.
- The average age of perpetrators who died was 48.8 years.

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



**Graph One** shows the number of domestic violence cases that occurred per year from 2002-2015. 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.

**Graph Two: Number of DV Homicide Victims (2002-2015)**



**Graph Two** shows the number of domestic violence homicide victims per year from 2002-2015. The number of homicide victims per year has varied from 22 in 2003 and 2014 to 46 in 2006.

### 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 2002-2015.

**Chart Two: Top Death Factors in Domestic Violence Deaths (2002-2015) based on CIS data**

Death Factor	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total DV Deaths (2002-2015)	% of Total DV Deaths (2002-2015)
Trauma - cuts, stabs	15	8	11	9	21	14	8	11	16	15	6	12	13	9	168	34%
Trauma - beating, assault	5	4	4	5	6	2	0	0	3	3	2	4	0	2	40	8%
Shooting - handgun	8	5	2	4	1	9	1	3	3	1	6	4	2	2	51	10%
Shooting - rifle	2	0	3	5	5	3	3	2	1	2	0	0	0	5	31	6%
Shooting - shotgun	7	1	2	2	2	2	1	2	6	0	5	6	2	4	42	9%
Shooting - weapon (not spec.)	0	0	1	0	0	0	1	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	11	2%
Asphyxia - strangulation	0	3	5	5	6	4	4	0	0	3	3	1	1	1	36	7%
Asphyxia - neck compression	0	0	0	1	2	0	2	3	0	0	0	1	1	0	10	2%
Other	9	4	4	6	10	10	9	8	2	12	9	1	10	4	98	20%
<b>Total</b>	<b>46</b>	<b>26</b>	<b>33</b>	<b>37</b>	<b>53</b>	<b>45</b>	<b>29</b>	<b>30</b>	<b>32</b>	<b>38</b>	<b>32</b>	<b>29</b>	<b>29</b>	<b>30</b>	<b>489</b>	

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

**Summary of Chart Two: Top Death Factors in Domestic Violence Deaths (2002-2015)**

- Trauma (i.e. cuts/stabs and beating/assault) was a death factor in 42 % of the deaths.
- Shooting (i.e. handgun, rifle, shotgun or gun not specified) was a death factor in 26% of the deaths.
- Asphyxia (i.e. airway obstruction, strangulation and/or neck compression) was a death factor in 12% 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 (2003-2016)**

From 2003-2016, the DVDRC has reviewed 289 cases that involved a total of 410 deaths. This includes 189 homicide and 100 homicide-suicide cases, some of which may have involved multiple victims.

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

The following statistics relate to all cases reviewed by the DVDRC from 2003-2016 inclusive.

**Chart Three: Number of Cases Reviewed by the DVDRC (2003-2016)**

Year	# of cases reviewed	# of deaths involved	Type of case: Homicides	Type of case: Homicide - Suicides
2003	11	24	3	8
2004	9	11	5	4
2005	14	19	5	9
2006	13	21	4	9
2007	15	25	7	8
2008	15	17	13	2
2009	16	25	6	10
2010	18	36	6	12
2011	33	41	27	6
2012	20	32	14	6
2013	19	22	17	2
2014	14	15	13	1
2015	21	29	12	9
2015 - Full Executive*	49	57	46	3
2016	22	36	11	11
<b>Total</b>	<b>289</b>	<b>410</b>	<b>189</b>	<b>100</b>

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



### **Summary of Chart Three: Number of Cases Reviewed by the DVDRC (2003-2016)**

- In the period between 2003 and 2016, the DVDRC reviewed 289 cases, involving 410 deaths (including perpetrator suicides)
- Of the 289 cases, 189 (65%) were homicides and 100 (35%) were homicide-suicides.

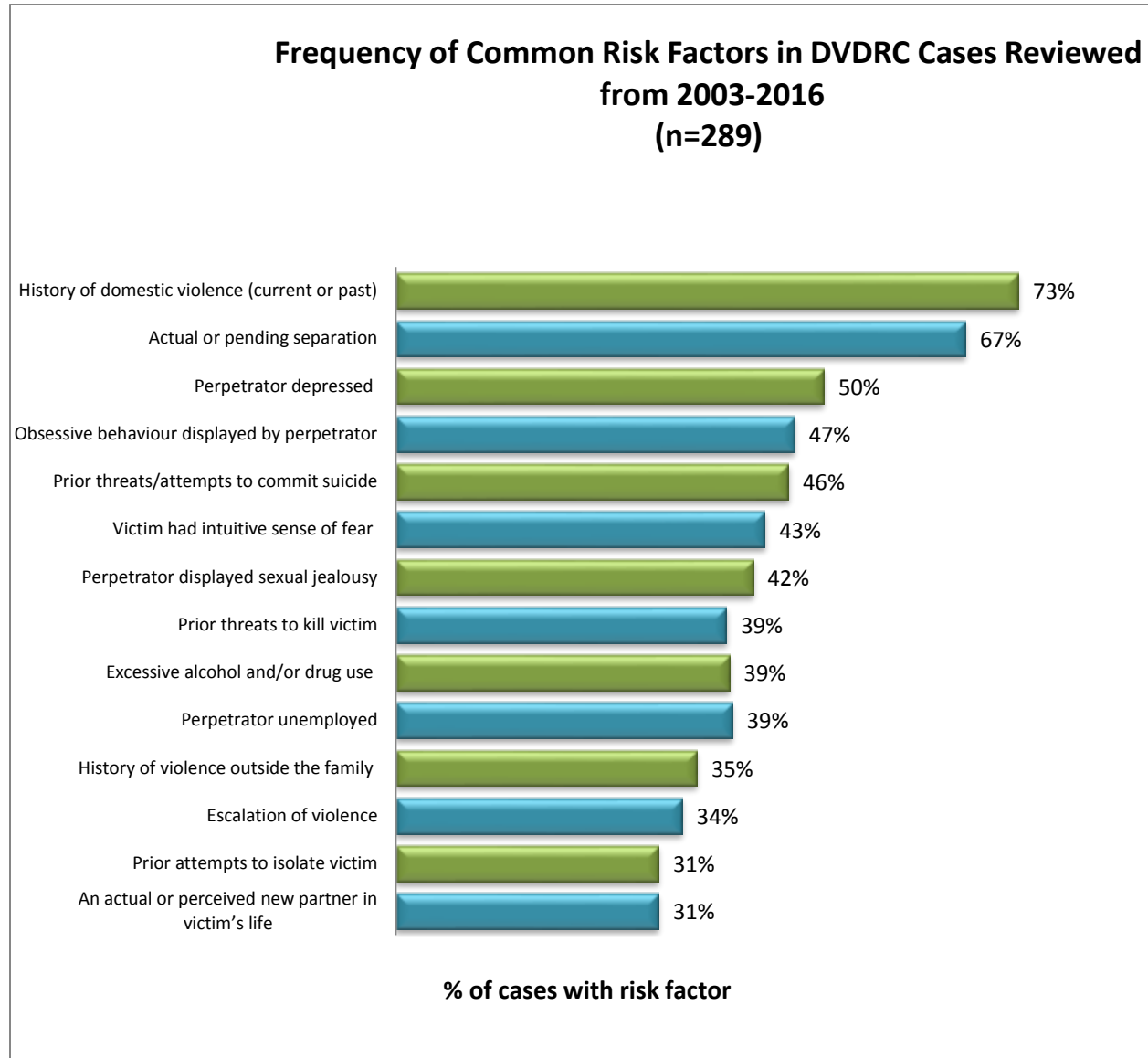
### **Analysis of Risk Factors: Common Risk Factors**

Based on extensive research, the DVDRC has created a list of 40 risk factors that indicate the potential for lethality within the relationship examined. 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 40 risk factors were present in the relationship between the victim and the perpetrator.

**Graph Three: Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2016)**



\*includes all reviews, including executive reviews in 2015

**Summary of Graph Three: Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2016)**

- When reviewing a case, the DVDRC identifies which of the 40 established risk factors were present in the relationship between the perpetrator and the victim.
- In 73% of all cases reviewed from 2003-2016, there was a history of domestic violence (past or present).
- In 67% of the cases, the couple had an actual or pending separation.
- In 50% of the cases, the perpetrator that was depressed (diagnosed and/or undiagnosed).

- In 47% of the cases, obsessive behaviour was displayed by the perpetrator.
- In 46% 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 42% of the cases, the perpetrator displayed sexual jealousy.
- In 39% of the cases, there were prior threats to kill the victim.
- In 39% of the cases, excessive alcohol and/or drug use was involved.
- In 39% of the cases, the perpetrator was unemployed.
- In 35% of the cases, there was a history of violence outside of the family.
- In 34% of the cases, there was an escalation of violence.
- In 31% of the cases there was an attempt to isolate the victim.
- In 31% of the cases there was an actual or perceived new partner in the victim’s life.

### Analysis of Risk Factors: Number of Risk Factors per Case

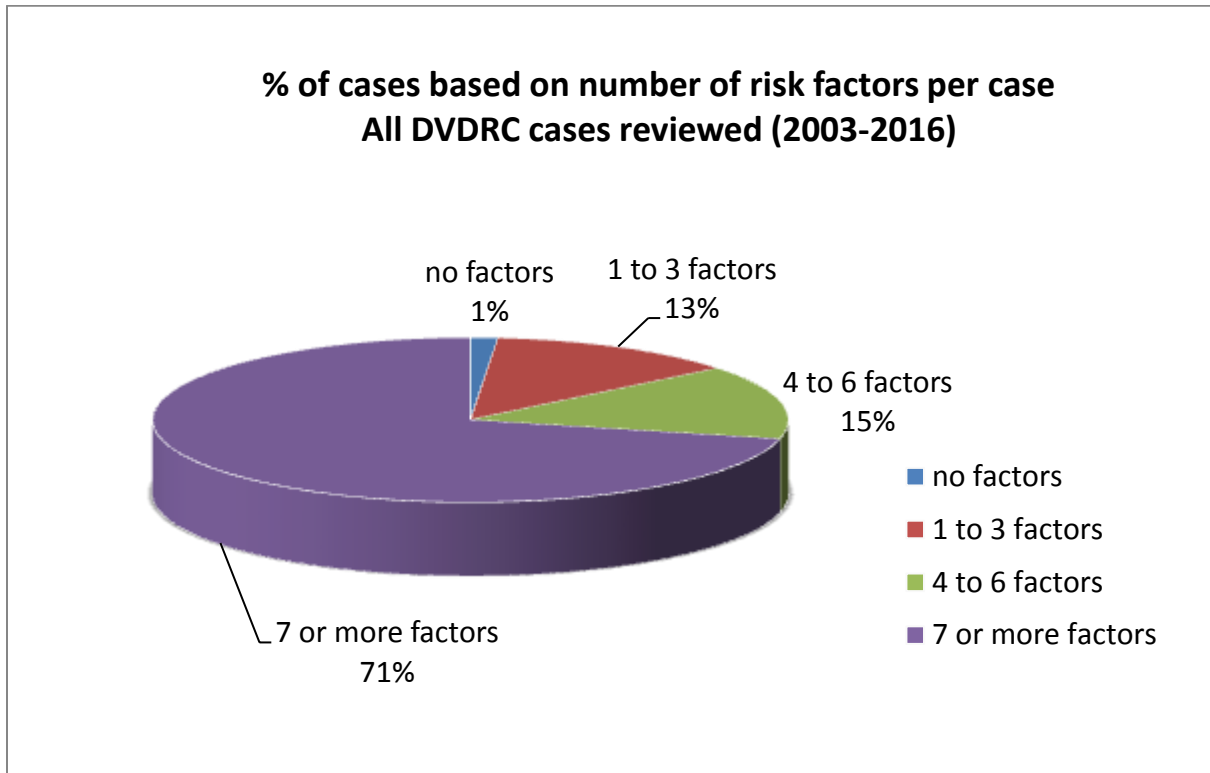
**Chart Four: Number of Risk Factors per Case – All DVDRC cases reviewed (2003-2016),** demonstrates that almost three quarters of all cases reviewed by the DVDRC had seven or more risk factors identified. The significance of this finding is that many domestic homicides may have been predicted and prevented with earlier recognition and action towards identified risk factors for future lethality.

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 (2003-2016).**

**Chart Four: Number of Risk Factors per Case – All DVDRC Cases Reviewed (2003-2016)**

# of risk factors per case	2003-2015 (n=267)	2016 (n=22)	2003-2016 (n=289)	% of total cases
no factors	4	0	4	1%
1 to 3 factors	31	6	37	13%
4 to 6 factors	41	1	42	15%
7 or more factors	191	15	206	71%

**Graph Four: Percent (%) of cases based on number of risk factors per case – All DVDRC cases reviewed (2003-2016)**



**Summary of Chart Four and Graph Four: Number of Risk Factors per Case – All DVDRC cases reviewed (2003-2016)**

- In 71% of the cases reviewed from 2003-2016, seven or more risk factors were identified.
- In 15% of the cases reviewed from 2003-2016, 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 2003-2016, one to three risk factors were identified.
- In 1% of the cases reviewed from 2003-2016, 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 2016

The DVDRC conducted 22 full case reviews in 2016 – 12 homicide and 10 homicide-suicide cases, resulting in a total of 36 deaths (26 homicide victims and 10 perpetrator suicides). A detailed summary, including the type of case (i.e. homicide or homicide-suicide) age and sex of victims and perpetrators, number of risk factors and relevant themes for each, is included in **Appendix C**.

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

Full, redacted versions of individual cases reviewed by the DVDRC in 2016 may be requested directly from the Executive Lead, Committee Management at the Office of the Chief Coroner: [occ.inquiries@ontario.ca](mailto:occ.inquiries@ontario.ca)

**Chart 5 – Summary of Cases reviewed in 2016**

		<b>% of 2016 reviews</b>
<b>Total number of cases reviewed:</b>	<b>22</b>	
<b># of homicide cases</b>	<b>12</b>	55%
<b># of homicide-suicide cases</b>	<b>10</b>	45%
<b>Total number of deaths reviewed:</b>	<b>36</b>	
<b>Homicide deaths:</b>	<b>26</b>	
Female (adult)	22	85%
Female (child)	0	0%
Male (adult)	2	8%
Male (child)	2	8%
Child deaths:	<b>2</b>	8%
Average age of victim:	<b>37.8</b>	-
<b>Suicide deaths:</b>		-
Female	0	-
Male	10	-
Average age of all perpetrators:	43.5	-
# of male perpetrators	21	95%
# of female perpetrators	1	5%
Total # of homicide cases:	<b>12</b>	55%
Total # of homicide-suicide cases:	<b>10</b>	45%
# of cases with less than 7 risk factors:	7	32%
# of cases with 7 or more risk factors:	15	68%
Average number of risk factors:	10.5	-
# of cases involving age 65 or older:	2	9%
Homicide-suicides w/elderly	1	5%
# of recommendations made:	23	-

### **Chart 5 – Summary of Cases reviewed in 2016, demonstrates that:**

- There were 22 full case reviews conducted by the DVDRC in 2016. This included 12 homicide cases and 10 homicide-suicide cases, resulting in 36 deaths (26 homicide victims and 10 perpetrator suicides).
- As a result of these reviews, there were 23 recommendations made towards the prevention of future similar deaths.
- Of the 26 homicide victims in the cases reviewed, 22 (85%) were adult females, two (8%) were adult males and two were children (both males).
- Of the 22 cases, 21 (95%) involved male perpetrators and one (5%) 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 2016 was 10.5.

Further analysis of the cases reviewed in 2016 demonstrated that:

- The victims ranged in age from eight to 83 years.
- The average age of victims was 37.8 years.
- The perpetrators ranged in age from 19 to 78 years.
- The average age of perpetrators (deceased and living) was 43.5 years.
- The number of risk factors for individual cases ranged from two to 23.

## Analysis of Risk Factors: Number of Risk Factors per Case

The data in **Chart Six: Number of Risk Factors Identified in Cases Reviewed (2016)**, are consistent with the findings with all cases reviewed by the DVDRC from 2003-2016 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 2016 ranged from two to 23.

**Chart Six: Number of Risk Factors Identified in Cases Reviewed (2016)**

# and % of risk factors per case	2016 Reviews (n=22)	Total Reviews 2003- 2016 (n=289)
no factors	0	4
%	0%	1%
1 to 3 factors	3	34
%	14%	12%
4 to 6 factors	5	45
%	24%	16%
7 or more factors	13	204
%	<b>62%</b>	<b>71%</b>

**Start Chart Six** breaks down the number of identified risk factors in the cases reviewed in 2016 and compares them to the number of risk factors for all cases reviewed from 2003-2016.

The chart indicates that:

- In 2016, no cases had zero risk factors identified. This compares to 1% of *all* cases reviewed from 2003-2016.
- In 2016, 3 (14%) cases reviewed had one to three risk factors identified. This compares to 12% of *all* cases reviewed from 2003-2016.
- In 2016, 5 (24%) cases reviewed had four to six risk factors identified. This compares to 16% of *all* cases reviewed from 2003-2016.
- In 2016, 13 (62%) of cases reviewed had seven or more risk factors identified. This compares to 71% of *all* cases reviewed from 2003-2016.
- The risk factor findings for cases reviewed in 2016 is consistent with the findings shown in Chart Four and Graph Four which indicate that the majority of *all* cases reviewed from 2003-2016 have seven or more risk factors.



## Analysis of Death Factors

**Chart Seven: Death factors for cases reviewed in 2016** shows that 42% of the cases involved some type of trauma (including cuts, stabs, beatings, assaults). Of the cases reviewed, 30% involved the use of a firearm, 15% were due to asphyxia (i.e. hanging, airway obstruction, strangulation or neck compression) and 14% were due to other factors such as jump/fall, or smoke inhalation.

**Chart Seven: Death factors for cases reviewed in 2016**

Death Factor	Victim	Perpetrator	Total	%
Trauma - cuts, stabs	11	1	12	33%
Trauma - beating, assault	2	-	2	6%
Trauma - blunt force	1	-	1	3%
Shooting - handgun	5	2	7	19%
Shooting - shotgun	2	1	3	8%
Shooting - gun not specified	-	1	1	3%
Asphyxia - hanging	-	2	2	6%
Asphyxia - airway obstruction	2	-	2	6%
Asphyxia - strangulation	1	-	1	3%
Jump/Fall		3	3	8%
Fire - smoke inhalation	2	-	2	6%
<b>Total Deaths</b>	<b>26</b>	<b>10</b>	<b>36</b>	

\*percentages are rounded off

## Recommendations made from 2016 Case Reviews

In 2016, 23 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:

- Screening of applicants for Possession and Acquisition of Firearms Licenses (PALs)
- Training on domestic violence risk factors to mental health professionals, pharmacists and Justices of the Peace
- Expansion of collaborative family violence centres in the province
- Enhanced public education campaigns in Indigenous and Muslim communities
- Further discussion and public education about domestic violence involving the elderly

- Conducting lessons-learned case reviews for organizations involved with domestic violence homicides.

A summary of all recommendations made in 2016 is included in Appendix D.

### **Discussion and Significant Findings for Cases Reviewed in 2016**

The findings from reviews conducted in 2016 are consistent with the overall results from reviews conducted from 2003-2015. More specifically:

- The majority of domestic violence homicide victims were female.
- The age range of victims is broad (eight to 88 years). The average age of a victim is mid-thirties.
- The age range for perpetrators is also broad (19 years to 78 years). The average age of a perpetrator is early-forties.
- 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 a factor in 42% of the cases reviewed. Shooting was a factor in 30% of cases reviewed. Asphyxia was a factor in 15% cases reviewed.

## Chapter Three: DVDRC Reviews – Frequently Asked Questions

### Mandate and Selection of Cases for Review

#### **What is the mandate of the DVDRC?**

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

#### **How does the DVDRC define “domestic violence?”**

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

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

#### **What cases are reviewed by the DVDRC?**

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

### Review Process

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

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

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

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

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

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

## **Who is on the DVDRC?**

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

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

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

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

## What information is reviewed by the DVDRC?

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

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

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

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

## Risk Factors

### Why is identifying risk factors important?

Risk factors identified in case reviews are risk factors for **lethality** and are not limited to being predictive for recurrent domestic violence of a non-lethal nature. The trends in risk factors identified from case reviews conducted from 2003-2016 were demonstrated in Graph Three and Chart Four. In 73% of all cases reviewed over the past 14 years, the couple had a history of domestic violence. In 67% of the cases, there was an actual or pending separation. The other most common risk factors were a perpetrator who was depressed (diagnosis by a physician and/or observed by others), obsessive behaviour by the perpetrator, prior threats or attempts to commit suicide, a victim who had an intuitive sense of fear of the perpetrator and sexual jealousy by the perpetrator. Other key risk factors included an escalation in violence, prior threats to kill the victim, and a perpetrator who was unemployed.

### **Are some risk factors more important than others?**

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

### **What is the importance of multiple risk factors?**

In 71% of the cases reviewed from 2003-2016, seven or more risk factors were identified in the relationship between the victim(s) and the perpetrator.

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

### **What is the significance of the trends in risk factors?**

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

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

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

## Recommendations

### How are recommendations developed and distributed?

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

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

### Are recommendations binding?

Similar to recommendations generated through coroner’s inquests, the recommendations developed by the DVDRC are not legally binding and there is no obligation for agencies and organizations to implement or respond to them. Organizations and agencies are asked to respond back to the Executive Lead, DVDRC on the status of implementation of recommendations within one year of distribution. Commencing in January 2017, organizations are asked to respond back within six months.

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

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

The DVDRC has now reviewed a total of 289 cases since its inception in 2003. Upon analysis of those cases, the following general themes have emerged:

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

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

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

### **Is there follow-up to recommendations?**

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

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

## **DVDRC Reports**

### **Are DVDRC reports available to the public?**

Redacted versions of individual final reports are available by contacting the Office of the Chief Coroner at [occ.inquiries@ontario.ca](mailto:occ.inquiries@ontario.ca).



## Chapter Four: DVDRC - Looking forward

As part of its current Five Year Strategic Plan, the Office of the Chief Coroner is exploring new ways and means to allow the wealth of information gathered from our death investigations to assist with future death prevention and enhancement of public safety. Part of the review process has included looking at our committee structure from a perspective of “how can we be more effective?” It is likely that we are at a cross-road, where innovative approaches to collaborate more broadly with community partners and stakeholders, as well as other intergovernmental bodies, may mean revisions to how we have traditionally approached our case reviews, and how we will apply our knowledge and developed expertise going forward. Importantly, our data and information must continue to drive change with the ultimate goal of reducing the frequency of domestic homicides in Ontario in the future.

## Appendix A: DVDRC – Terms of Reference

### Purpose

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

### Definition of Domestic Violence Deaths

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

### Objectives

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

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

## Appendix B

### Risk Factor Descriptions (updated 2015)

**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.

	<b>Family/Economic Status</b>	<b>Definition</b>
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.

	<b>Perpetrator Mental Health</b>	<b>Definition</b>
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.

	<b>Perpetrator Mental Health</b>	<b>Definition</b>
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 6 months) suicidal behaviour (e.g., swallowing pills, holding a knife to one's throat, etc.), even if the behaviour was not taken seriously or did not require arrest, medical attention, or psychiatric committal. Behaviour can range in severity from superficially cutting the wrists to actually shooting or hanging oneself.

	<b>Perpetrator Attitude/ Harassment/ Violence</b>	<b>Definition</b>
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 - <b>Previous</b> partners	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person <b>who has been in</b> 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 - <b>Current</b> partner/victim	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who <b>is in an</b> 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.).

	<b>Perpetrator Attitude/ Harassment/ Violence</b>	<b>Definition</b>
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.



	<b>Perpetrator Attitude/ Harassment/ Violence</b>	<b>Definition</b>
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).

	<b>Perpetrator Attitude/ Harassment/ Violence</b>	<b>Definition</b>
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).

	<b>Access</b>	<b>Definition</b>
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.

	<b>Victim's Disposition</b>	<b>Definition</b>
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 woman 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.

## Appendix C: Detailed Summary of Cases reviewed in 2016

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	2013	-	1	1	26	1	-	-	32	1	-	16	3	firearm registration, NFF
2	2011	1	-	1	56	1	-	-	48	1	-	18	2	mental health and addictions
3	2012	-	1	1	46	1	-	-	43	1	-	6	2	mental health
4	2012	1	-	1	45	1	-	-	46	1	-	3	0	Financial troubles
5	2014	-	1	3	43	1	-	-	-	-	-	-	-	separation, cultural
		-	-	-	13	-	1	1	-	-	-	-	-	-
		-	-	-	8	-	1	1	-	-	-	-	-	-
		-	-	-	-	-	-	-	50	1	-	20	2	cultural
6	2013	1	-	1	24	1	-	-	19	1	-	16	1	FN, bail, NFF
7	2013	1	-	1	27	1	-	-	30	1	-	21	2	bail, NFF
8	2012	1	-	1	50	1	-	-	53	1	-	11	1	mental health
9	2014	-	1	1	25	1	-	-	-	-	-	23	2	FN, CAS, NFF
		-	-	-	-	-	-	-	38	1	-	-	-	-
10	2013	-	1	2	42	1	-	-	-	-	-	3	0	immigration
		-	-	-	21	1	-	-	-	-	-	-	-	-
		-	-	-	-	-	-	-	43	1	-	-	-	-
11	2013	-	1	1	31	1	-	-	30	1	-	2	0	safe separation
12	2013	1	-	1	28	1	-	-	42	1	-	10	0	mental health, substance abuse
13	2011	1	-	1	27	-	1	-	21	-	1	13	1	female perp
14	2015	-	1	1	40	1	-	-	44	1	-	7	0	safe separation
15	2012	1	-	1	37	1	-	-	41	1	-	7	1	911, firearms, substance abuse
16	2013	-	1	1	71	1	-	-	71	1	-	3	0	elderly
17	2012	1	-	1	40	1	-	-	41	1	-	13	0	separation
18	2016	-	1	1	46	1	-	-	57	1	-	14	2	cultural
19	2015	1	-	1	83	1	-	-	78	1	-	11	2	elderly, NFF
20	2915	-	1	1	33	1	-	-	43	1	-	3	1	other mental health (PTSD)
		-	-	-	48	1	-	-	60	1	-	8	0	FN, alcohol
21	2012	1	-	2	53	-	1	-	-	-	-	-	-	-
22	2011	1	-	1	21	1	-	-	27	1	-	3	0	cultural, separation
<b>Total/Avg.</b>		12	10	26		22	4	2		21	1	10.5	22	

## Appendix D

### Summary of Cases and Recommendations – 2016 Case Reviews

Case #	Summary	Recommendation(s)
<p><b>2016-01</b></p>	<p>This case involved the homicide of 26-year-old woman by her 32-year-old former boyfriend who subsequently committed suicide. Both died of shotgun wounds. The perpetrator had a license for the possession and acquisition of a firearm despite his criminal and mental health history. There were 16 risk factors for intimate partner homicide identified.</p>	<ol style="list-style-type: none"> <li>1. Screening of individuals applying for, or renewing, Possession and Acquisition Licenses (PALs) should be improved to include: <ul style="list-style-type: none"> <li>• interviewing of applicants and their references, particularly those applicants who have been previously convicted of a crime against a person or convicted of a firearms offence;</li> </ul> </li> <li>2. A public education campaign should be developed to encourage victims of domestic abuse/violence to contact police and victim services agencies to obtain advice and support in difficult domestic situations. Victims should be encouraged to utilize non-emergency numbers rather than 911, when appropriate and safe to do so, whenever seeking information that may assist them with prioritizing steps to be taken to enhance their safety, including referral to other agencies. Victim services agencies have the skills and resources to provide victims of domestic violence with free and confidential supportive services aimed at early intervention.</li> <li>3. Friends, family and neighbours of victims, or potential victims, should be encouraged to reach out to police and victim services agencies whenever they observe warning signs of domestic violence in a relationship. Public information should include ways to contact police or victim services for advice and support in non-emergency situations, and could be communicated through online sources, brochures and public presentations.</li> </ol>
<p><b>2016-02</b></p>	<p>This case involved the homicide of a 56-year-old woman by her 48-year-old common-law husband. Both the victim and perpetrator had a long history of drug and/or alcohol</p>	<ol style="list-style-type: none"> <li>1. The Ministry of Health and Long Term Care should require that all mental health and addictions services in the province mandate training for all staff on the co-occurrence of domestic violence, mental health problems and</li> </ol>

Case #	Summary	Recommendation(s)
	<p>addiction. 18 risk factors for intimate partner homicide were identified.</p>	<p>substance abuse. Existing training that is currently available on-line could be used (<a href="http://dveducation.ca/makingconnections/">http://dveducation.ca/makingconnections/</a>). The Ministry should also encourage the development of memoranda of understanding between program managers or executive directors of services for violence against women, counselling, and addictions to facilitate referrals across programs.</p> <p>2. The Ontario College of Pharmacists should encourage basic training in domestic violence for all pharmacists in order to raise awareness of the problem and to create a comfort level in addressing these issues with clients with obvious warning signs so that appropriate referrals can be made when appropriate.</p>
<p><b>2016-03</b></p>	<p>This case involved the homicide of a 46-year-old woman by her 43-year-old husband who subsequently committed suicide. The perpetrator had mental health issues and the couple was in the process of separating. There were six risk factors for intimate partner homicide identified.</p>	<p>1. The hospital involved should conduct an internal review of the services provided to the perpetrator. This review should include, but not be limited to:</p> <ul style="list-style-type: none"> <li>• An evaluation of the psychiatric assessment conducted on the perpetrator particularly as it relates to his history of domestic violence and suicidal/homicidal ideation</li> <li>• An evaluation of the discharge process and whether the history of domestic violence was considered and whether safety planning for the family could have been completed.</li> </ul> <p>2. The police service involved should conduct an internal review of the circumstances surrounding the deaths of the victim and perpetrator, particularly as it relates to the response provided in relation to previous incidents of domestic violence between the couple. The review should include, but not be limited to:</p> <ul style="list-style-type: none"> <li>• An evaluation of the response to the report of domestic violence in March 2012, including what information was collected and documented, whether the perpetrator’s mental health history was considered, what follow-up was conducted on the victim’s report of previous domestic violence, the process of “closing” reports and</li> </ul>

Case #	Summary	Recommendation(s)
		requiring victims to initiate action and safety planning for the family.
<b>2016-04</b>	This case involved the homicide of a 45-year-old woman by her 46-year-old common-law partner. The perpetrator had a history of fraud and was considered a “con man.” Three risk factors for intimate partner homicide were identified.	No recommendations.
<b>2016-05</b>	This case involved the homicides of a 43-year-old woman and her two sons, ages eight and 13 years. Their homicides were discovered during the course of a police investigation of an apparent suicide by the 50-year-old husband/father. There were 20 risk factors for intimate partner homicide identified.	<ol style="list-style-type: none"> <li>1. The Ministry of the Attorney General, Ministry of Community Safety and Correctional Services and the Ministry of Children and Youth Services should consider expanding collaborative family violence resource centres throughout the province where victims would have a choice to access services at a single location.</li> <li>2. The Ministry of the Attorney General, Ministry of Community Safety and Correctional Services and the Ministry of Children and Youth Services should develop joint training initiatives across ministries, professionals and grass-root advocates that highlight this case as an illustration of the need for a collaborative case management model within an integrated service approach.</li> </ol>
<b>2016-06</b>	This case involved the homicide of a 24-year-old woman by her 19-year-old boyfriend. There were 16 risk factors for intimate partner homicide identified.	<ol style="list-style-type: none"> <li>1. Enhanced public education programs should be targeted to victims of domestic violence in First Nations communities to reduce or eliminate the stigma which leads to non-reporting of domestic violence to authorities or to agencies able to assist with victims in a domestic violence crisis. Currently available programs, such as the Kanwayhitowin Campaign, are a valuable resource that can assist in education of both victims and their friends and family who may witness the violence in their communities. Where required, additional funding should be provided to ensure that such programs are in place and/or are effective.</li> </ol>

Case #	Summary	Recommendation(s)
<b>2016-07</b>	This case involved the homicide of 27-year-old woman by her 30-year-old intermittent boyfriend. The perpetrator had a history of domestic violence with both the victim and previous partners. There were 21 risk factors for intimate partner homicide identified.	<ol style="list-style-type: none"> <li>1. It is recommended that there be a province-wide review of cases deemed to be at high-risk for further domestic violence and how they are treated at bail hearings. High-risk cases include those that involve accused persons who have demonstrated mental instability, actual or pending separation, failure to comply with prior supervision orders, suicidal ideation, and a history of violence, including threats to kill.</li> <li>2. It is recommended that the Ontario Court of Justice consider annual education and training sessions for Justices of the Peace to enhance their understanding and skills in risk assessment and risk management on issues surrounding high-risk domestic cases. This education and training is especially important when these cases involve accused individuals who have demonstrated mental instability, actual or pending separation, and failure to comply with supervision orders, suicidal ideation and a history of domestic violence. In particular, it is recommended that Ontario Court of Justice consider using some of the high risk cases reviewed by the Domestic Violence Death Review Committee (DVDRC) where judicial interim release was granted in high-risk domestic cases, and a homicide subsequently ensued.</li> </ol>
<b>2016-08</b>	This case involved the homicide of a 50-year-old woman by her 53-year-old husband. The perpetrator had a history of mental health issues and was not compliant with his medications. There were 11 risk factors for intimate partner homicide identified.	<ol style="list-style-type: none"> <li>1. Mental health professionals are encouraged to review the common risk factors for intimate partner homicide that have been identified in the annual reports of the Domestic Violence Death Review Committee. The presence of these risk factors should trigger efforts for risk assessment, safety planning and risk management with perpetrators. Breaches of court conditions should be taken seriously as part of assessment and treatment of domestic violence victims and perpetrators.</li> </ol>
<b>2016-09</b>	This case involved the homicide of a 25-year-old female by her 38-year-old common-law partner who subsequently committed suicide. The	<ol style="list-style-type: none"> <li>1. It is recommended that Kanawayhitowin, a public awareness campaign launched in 2007 to raise awareness on the signs of woman abuse in First Nations communities, include information</li> </ol>

Case #	Summary	Recommendation(s)
	<p>couple had been separated, but reconciled about a week before the homicide-suicide. There were 23 risk factors for intimate partner homicide identified.</p>	<p>on the potential risk of lethal violence at the time of relationship breakdown and recommendations on how to engage in and/or support a “safe” break-up/separation for couples experiencing domestic violence.</p> <ol style="list-style-type: none"> <li>2. It is recommended that Kanawayhitowin collaborate with Indigenous communities to promote the campaign on reserve websites and other online sites that include resources for Indigenous communities (e.g., the <a href="http://www.anishinabek.ca/">Union of Ontario Indians or Anishinabek Nation</a> <a href="http://www.anishinabek.ca/">http://www.anishinabek.ca/</a>).</li> <li>3. It is recommended that the Ontario Association of Children’s Aid Societies (OACAS) work with the Association of Native Child and Family Service Agencies of Ontario to ensure that all child welfare workers that may work with Indigenous families receive training on how to effectively respond to Indigenous families that have experienced and/or are experiencing domestic violence. The training should be offered on a regular basis to ensure that all relevant staff can receive it.</li> </ol>
<p><b>2016-10</b></p>	<p>This case involved the homicides of a 42-year-old woman and her 21-year-old disabled daughter by their 43-year-old husband/father. The family was under significant stress regarding their immigration status and financial situation. There were three risk factors for intimate partner homicide identified.</p>	<p>No new recommendations.</p>
<p><b>2016-11</b></p>	<p>This case involved the homicide of a 31-year-old woman by her 30-year-old former boyfriend. The couple had recently broken up and both were involved with new partners. There were two risk factors for intimate partner homicide identified.</p>	<p>No new recommendations.</p>
<p><b>2016-12</b></p>	<p>This case involved the homicide of a</p>	<p>No new recommendations.</p>



Case #	Summary	Recommendation(s)
	28-year-old woman by a 42-year-old man that she was intimately involved with in a casual relationship. There were 10 risk factors for intimate partner homicide identified.	
<b>2016-13</b>	This case involved the homicide of a 28-year-old man by his 21-year-old former girlfriend. The perpetrator had previously been a victim of domestic violence with another partner. There were 13 risk factors for intimate partner homicide identified.	1. The Ministry of Advanced Education and Skills Development should ensure that dating violence prevention programs in schools and post-secondary institutions include the links between mental health problems and intimate partner violence and should include discussion on how these problems may result in future violence by both males and females.
<b>2016-14</b>	This case involved the homicide of a 40-year-old woman by her 44-year-old common-law partner who subsequently committed suicide. There was no history of domestic violence. There were seven risk factors for intimate partner homicide identified.	No new recommendations.
<b>2016-15</b>	This case involved the homicide of a 37-year-old woman by her 41-year-old husband. The couple argued frequently over the perpetrator's drug use. Several family members were aware of the tension in the relationship and had been warned by the perpetrator not to interfere or call police. There were seven risk factors for intimate partner homicide identified.	1. If not already completed, the police service involved should conduct a quality review of the incident with particular focus on the call to 911 to determine if there are opportunities for improvement.
<b>2016-16</b>	This case involved the homicide of a 71-year-old woman by her 71-year-old husband, followed by his suicide. Both the victim and perpetrator had significant health issues. There was no prior history of domestic violence. There were three risk factors for intimate partner homicide identified.	No new recommendations.

Case #	Summary	Recommendation(s)
<b>2016-17</b>	This case involved the homicide of a 40-year-old woman followed by the suicide of her 41-year-old on-again off-again boyfriend. The victim was in the process of ending the relationship. The perpetrator was scheduled to go to court for charges related to extorting the victim after he distributed nude photos of her. There were 13 risk factors for intimate partner homicide identified.	No new recommendations.
<b>2016-18</b>	This case involved the homicide of a 46-year-old woman by her 57-year-old husband, followed by his suicide. The perpetrator controlled most of the victim's daily activities and there was a history of violence within the family. The family dynamics were influenced by culture, religion and language. There were 14 risk factors for intimate partner homicide identified.	<ol style="list-style-type: none"> <li>1. Individuals and organizations providing services and support to Muslim communities are reminded that the Neighbours, Friends and Family program is a valuable resource to provide information and education on addressing the issue of domestic violence involving the Muslim community in Ontario.</li> <li>2. Curriculum in English as a Second Language (ESL) courses and in cultural centres, should include information regarding victim's rights in Canada. The issue of domestic violence and violence in the home should be discussed, as well as resources available to support victims, families and others who may be impacted or aware of the violence.</li> </ol>
<b>2016-19</b>	This case involved the homicide of an 83-year-old woman by her 78-year-old husband. There were 11 risk factors for intimate partner homicide identified.	<ol style="list-style-type: none"> <li>1. The Domestic Violence Action Plan (administered by the OWD) should be updated to include reference to domestic violence in older couples. Ageism is a particular problem with respect to the apparent invisibility, or lack of awareness, of domestic violence in older couples. All government Ministries involved with funding and prevention initiatives regarding violence against women (VAW) and domestic violence, should ensure that provisions specific to aging adults are addressed.</li> <li>2. The Ontario Senior's Secretariat, the Ontario's Women's Directorate and the Ministry of Community Safety and Correctional Services, should address intimate partner violence</li> </ol>

Case #	Summary	Recommendation(s)
		<p>involving the elderly. This may include consultation with experts in elder abuse and domestic violence to create resources and educational materials that specifically target domestic violence involving the elderly. This would expand the focus on elder abuse beyond that of abuse by caregivers only, and enhance the elder abuse awareness program currently under development.</p>
<p><b>2016-20</b></p>	<p>This case involved the homicide of 33-year-old woman by her 43-year-old husband who subsequently committed suicide. The couple had been married for approximately one month. The victim was pregnant at the time of her death. There were three risk factors for intimate partner homicide identified.</p>	<p>1. The Canadian Armed Forces (CAF), through the CAF Family Violence Advisory Committee and other specialized units, should conduct a lessons-learned case review of this homicide-suicide with particular focus on the following areas:</p> <ul style="list-style-type: none"> <li>• Services and supports to address domestic violence involving serving members and their families</li> <li>• Review of the current policies and practices (as documented in <a href="http://www.forces.gc.ca/en/about-policies-standards-defence-admin-orders-directives-5000/5044-4.page">DAOD 5044-4, Family Violence</a> - <a href="http://www.forces.gc.ca/en/about-policies-standards-defence-admin-orders-directives-5000/5044-4.page">http://www.forces.gc.ca/en/about-policies-standards-defence-admin-orders-directives-5000/5044-4.page</a>)</li> <li>• Services and supports for post-traumatic stress disorder</li> <li>• Services and support for mental health and life stressors (e.g. relocation, pregnancy, marriage counselling, etc.)</li> </ul>
<p><b>2016-21</b></p>	<p>This case involved the double homicide of a 48-year-old woman and her 52-year-old male friend by the woman's 52-year-old boyfriend. There were eight risk factors for intimate partner homicide identified.</p>	<p>No new recommendations.</p>
<p><b>2016-22</b></p>	<p>This case involved the homicide of a 21-year-old woman by her 27-year-old husband. The couple was in the process of separating at the time and there was significant cultural pressure on the victim to not leave</p>	<p>No new recommendations.</p>

<b>Case #</b>	<b>Summary</b>	<b>Recommendation(s)</b>
	the relationship. There were three risk factors for intimate partner homicide identified.	

**For further information, please contact:**

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