
Office of the Chief Coroner
Province of Ontario

# Domestic Violence Death Review Committee

## 2021 Annual Report

November 2024

# Table of Contents




**This report was prepared by staff in the Office of the Chief Coroner including Dr. Elizabeth Urbantke and Indira Stewart, Co-Chairs of the Domestic Violence Death Review Committee (DVDRC), Hannah Verrips – Senior Policy & Program Advisor and Executive Lead, DVDRC and Debika Burman –Epidemiologist Lead for the DVDRC.**

## Message from the Co-Chairs

This annual report reflects the activities of the Domestic Violence Death Review Committee (DVDRC) in 2021. The multidisciplinary dedicated experts who form the DVDRC are tasked with reviewing all intimate partner violence-related deaths in Ontario. In 2021, 28 cases involving 42 deaths were reviewed, resulting in 55 recommendations.

The DVDRC was established in 2003 in response to recommendations that arose from two inquests into the homicides of Arlene May and Gillian Hadley by their former male partners. From 2003-2021, the DVDRC has reviewed 392 cases involving 563 deaths and has made 492 recommendations.

We were privileged to become the new co-chairs of the DVDRC in early 2024, taking over from Prabhu Rajan, who became the Chair in 2021. We would like to acknowledge the hard work and dedication of Prabhu, the committee members and staff who came before us.

The Committee aims to inform the prevention of further intimate partner violence-related deaths in Ontario through expert review to ensure that these tragic deaths are not overlooked and there is a better understanding of why such deaths occur. Recommendations are identified to contribute to creating systemic change.

A comprehensive review of the committee occurred in 2022-2023, including an examination of the committee mandate, function and composition, with the expectation of diversifying membership, modernizing processes, and implementing innovative approaches to our case reviews. The 2021 annual report reflects work done prior to this renewal process.

Moving forward, we will be incorporating lessons learned from past reviews and supporting the committee in developing new and innovative practices to inform the prevention of intimate partner violence-related deaths in Ontario.

It is an honour to participate in the work of the DVDRC and we are grateful for the commitment of its members, both past and present, to the people of Ontario. We are greatly appreciative of the members' time and enormous contributions to Ontario's understanding of intimate partner violence.

**Dr. Elizabeth Urbantke**
Regional Supervising Coroner
Office of the Chief Coroner
Co-Chair, DVDRC

**Indira Stewart**
Inquest Counsel
Office of the Chief Coroner
Co-Chair, DVDRC

# 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

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

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

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

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

**Rebecca Law**
Crown Attorney

**Nneka MacGregor, LL.B.**
Executive Director, WomenatthecentrE

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

**Dan Pyrah**
Ontario Provincial Police

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

**Eva Zachary**
Executive Director, Muskoka Victim Services

# Executive Summary

### Cases reviewed by the DVDRC in 2021:

In 2021, the DVDRC reviewed 28 cases, resulting in 55 recommendations. Of the 28 cases reviewed, 17 were homicides and 11 were homicide-suicides, resulting in the death of 42 individuals. Among the 31 homicide victims, 26 (84%) were adult females, 2 (6%) were adult males, 2 (6%) were females 18 and under, and 1 (3%) was a male 18 and under. The DVDRC recognizes the tragic loss of each victim to intimate partner violence (IPV) and hopes that the review and analysis of each case identifies areas of intervention that could be actioned to prevent further deaths in Ontario.

Among the 31 homicide victims, 15 (48%) died by firearms, 15 (48%) died as a result of trauma (cuts or stabs, assault, and blunt force), and 1 (3%) from asphyxia. The person who caused the death(s) in these cases, often referred to as the "perpetrator", was male in every case except one, and ranged in age from 29 to 82 years old. The most common risk factors identified were history of IPV (68%); victim vulnerability (57%); and actual or pending separation (54%). Eighty percent (80%) of victim deaths occurred at home/on property; 6% in the urban outdoors, and 5% in the rural outdoors.  For more detailed case data analysis, please see Chapter Two.

### Recommendations in 2021:

In 2021, 55 recommendations were developed focusing on intervention points where systems and communities can come together and take action to prevent intimate partner homicide in Ontario. Of the 55 recommendations, themes included:

- The need for increased education about identifying IPV risk factors and responding accordingly, including for medical professionals, Crown Attorneys, Assistant Crown Attorneys and other legal professionals, law enforcement and other front-line service providers;
- The potential risks associated with access to firearms in IPV situations and the ability for individuals (i.e. victims, family, friends, neighbours etc.) to be able to report concerns related to the storage or ownership of firearms or the behaviour of gun owners;
- The crucial importance of public awareness and education campaigns on how to identify the risks and signs of IPV in friends, family, neighbours, and co-workers, and how to help;
- The importance of Indigenous-led justice practices in Indigenous communities and for Indigenous Peoples, and the need for adequate funding for these practices;
- The significance of adequate funding and resources for essential programs and services such as the Partner Assault Response (PAR) program, mental health and care providers, among others.

For a list of all recommendations made in 2021, please see Appendix D.

# Chapter One: Domestic Violence Death Review Committee Overview

## 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 intimate partner violence, and to make recommendations to help prevent further deaths[1].

## Objectives

1. To provide and coordinate a confidential multidisciplinary review of intimate partner violence deaths pursuant to the *Coroners Act*, R.S.O. 1990 Chapter c.37, as amended ("*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 the person who caused the death(s) in intimate partner violence-related 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 further deaths, based on the aggregate data collected from the intimate partner violence death reviews.

Note: All of the above described objectives and attendant committee activities are subject to the limitations imposed by the *Coroners Act* and the *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. F.31 ("*Freedom of Information and Protection of Privacy Act").*

[1] As noted, a comprehensive review of the committee occurred in 2022-2023, including an examination of the committee's mandate, objectives and scope. This report reflects the language and framework that existed prior to this renewal process.

## History

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

## Membership

The 2021 DVDRC consisted of representatives with expertise in IPV from law enforcement, the criminal justice system, the healthcare sector, social services and other public safety agencies and organizations.

Some members of the 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/Intimate Partner Violence

While the term "domestic violence" has historically been used to describe the violence examined by this committee, "intimate partner violence" (IPV) is now a more commonly used term. As such, these terms have been used interchangeably throughout this report.

In May 2023, the definition and scope of what are considered domestic violence-related deaths for the purposes of the committee was updated based on input from the new members of the DVDRC. The aim of this new definition and scope was to be more inclusive of different relationships and intimate encounters that did not fit within the historically used definition of domestic violence that was utilized by the committee. However, as all reviewed cases in 2021 used the previous definition in their analysis, for the purposes of this report, it remains as follows:

Within the context of the DVDRC, IPV-related 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/s, the DVDRC may review other deaths if they occurred within the context of an incident where the intended victim was the partner/ex-partner of person who caused the death, and the intended victim did not die, or in cases where there was the perception or possibility that the victim and the person who caused the death(s) were involved in an intimate relationship.

## Method for Reviewing Cases

Reviews are conducted by the DVDRC only after all other investigations and criminal justice proceedings – including 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 typically reviewed more expeditiously..

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 actions of the person who caused the death(s), the victim(s) 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 further 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 further deaths and reducing IPV in general. Recommendations are distributed to relevant organizations and agencies through the Chair/s of the DVDRC. The phrase "no new recommendations" indicates that either no issues prompting 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 included 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 them. However, organizations and agencies are asked to respond back to the 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.deathreviewcommittees@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 ("*Coroners Act*"). 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. the person who caused the death(s)) and therefore protected under other privacy legislation.

All information obtained as a result of a coroner's investigation and provided to the DVDRC is subject to confidentiality and privacy limitations imposed by the *Coroners Act* and the *Freedom of Information and Protection of Privacy.* Unless, and until, an inquest is called with respect to a specific death or deaths, the confidentiality and privacy interests of the deceased persons , 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 deaths, question investigative techniques or comment on decisions made by judicial bodies. Furthermore, it is not the mandate nor role of the DVDRC to lay blame, make findings of legal liability or make any legal determinations.

## Annual Report

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

## 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*. 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: Analysis of domestic violence-involved homicides and homicide-suicides

## Collection of Data

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

## Types of Data

Results presented in this report are derived from two sets of data:

### 1. Data collected through coroner death investigations

In Ontario, coroner investigations aim to answer five questions: who (identity of the deceased), when (date of death), where (location of death), how (medical cause of death), and by what means (natural, accident, suicide, homicide, or undetermined). Data collected through death investigations include personal information about the deceased person (e.g., date of death, age, sex, gender, and address) and information describing the circumstances surrounding the death.

### 2. Findings from cases reviewed by the DVDRC

As outlined in the Domestic Violence Death Review Committee Objectives section, reviews include the identification of risk factors, and case-specific and systemic recommendations that may assist in preventing further deaths. Information about the person who caused the death(s) (e.g., sex, age) is also collected through each case review.

In this report, results are presented for three groups:

(1) Cases reviewed by the DVDRC in 2021;
(2) Five Year Trends: Domestic Violence-Involved Cases Investigated by a Coroner Between 2017 and 2021 (reviewed by the committee or not) and;
(3) All cases reviewed by the DVDRC between 2003 and 2021.

## Cases Reviewed by the DVDRC in 2021

In 2021, the DVDRC reviewed 28 cases (17 homicides and 11 homicide-suicides) involving 42 deaths (Table 1). Among the 31 homicide victims, 26 (84%) were adult females, 2 (6%) were adult males, 2 (6%) were females 18 and under, and 1 (3%) was a male 18 and under (Table 2). Victims ranged in age from 11 years to 91 years.

**Table 1:** Number of cases and deaths, by case type, for cases reviewed in 2021

| Case type | Number of cases | Number of deaths |
|---|---|---|
| Homicide | 17 | 18 |
| Homicide-suicide | 11 | 24 |
| **Total** | **28** | **42** |

**Table 2:** Number of homicide victims by age group and sex, among cases reviewed in 2021

| Sex of homicide victim | Age of homicide victim | | Total |
|---|---|---|---|
| | 18 and under | 19 and older | |
| Female | 2 | 26 | 28 |
| Male | 1 | 2 | 3 |
| **Total** | **3** | **28** | **31** |

Among homicide victims, 15 (48%) died by firearms, 15 (48%) died as a result of trauma (cuts or stabs, assault, and blunt force), and 1 (3%) from asphyxia (see Figure 1). Twenty-four victim deaths (77%) occurred at home/on property; 4 (13%) occurred in a motor vehicle, 1 (3%) occurred in the urban outdoors, 1 (3%) occurred in the rural outdoors, and 1 (3%) occurred in a workplace (see Figure 2).

**Figure 1:** Percent of homicide deaths by cause among cases reviewed in 2021

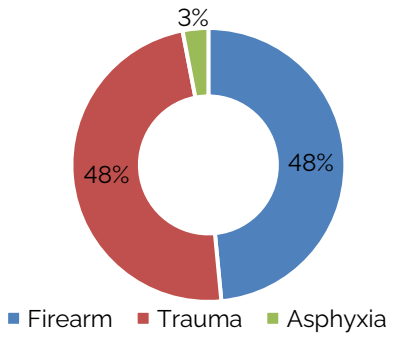
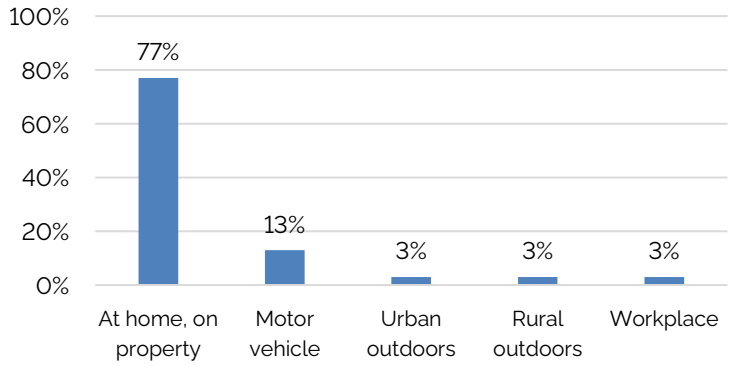



**Figure 2:** Percent of homicides, by location, among cases reviewed in 2021



Among the 28 cases reviewed, the individual who caused the death(s) was male in every case except one. The ages of these individuals ranged from 29 to 82 years. In 8 cases, the victim and person who caused the death(s) were aged 65 or older (two were homicide-suicides).

The most common risk factors identified were history of domestic violence (68%); victim vulnerability (57%); and actual or pending separation (54%) (Figure 3). More than half of the cases reviewed in 2021 had 7 or more risk factors (Table 3).

**Figure 3:** Percent of cases reviewed in 2021, by top 10 risk factors

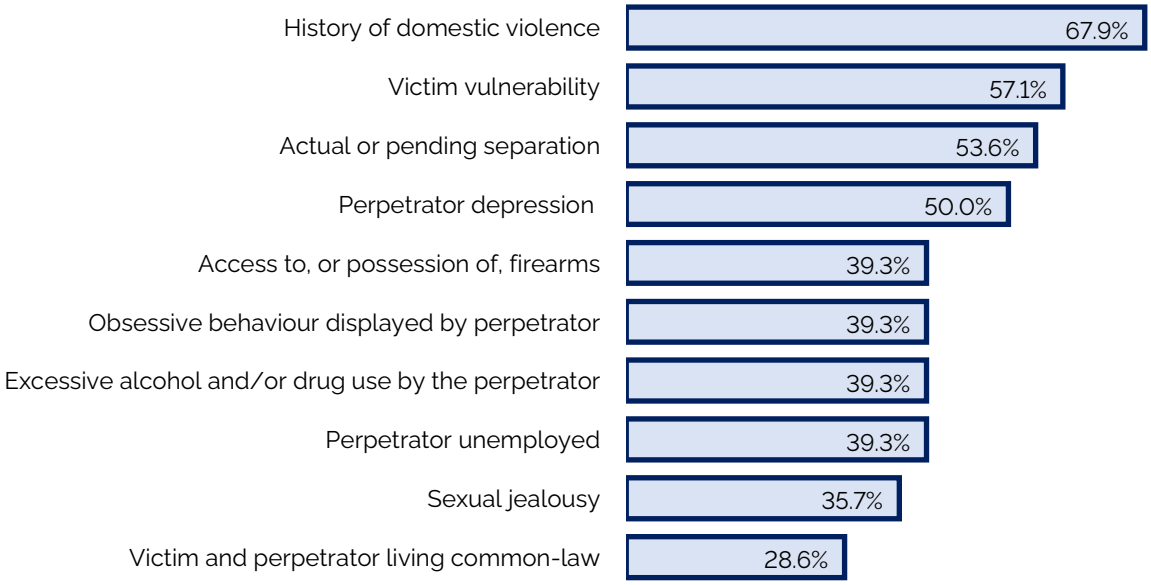



**Table 3:** Number and percent of cases by number of risk factors identified, among cases reviewed in 2021

| Number of risk factors | Number of cases | Percent of cases |
|---|---|---|
| Zero | 0 | 0.0% |
| One to three | 6 | 21.4% |
| Four to six | 7 | 25.0% |
| Seven to 9 | 4 | 14.3% |
| 10 to 19 | 11 | 39.3% |
| 20 or more | 0 | 0.0% |
| **Total** | **28** | **100%** |

A detailed summary, including the type of case (i.e. homicide or homicide-suicide), the age and sex of victims and the individuals who caused the death(s), the number of risk factors and the

number of recommendations is included in **Appendix B**. A brief narrative on the circumstances surrounding the death(s), as well as recommendations towards the prevention of further deaths, is included in **Appendix C** and **Appendix D** respectively.

Full, redacted versions of individual cases reviewed by the DVDRC in 2021 may be requested directly from the DVDRC's Executive Lead at the Office of the Chief Coroner: occ.deathreviewcommittees@ontario.ca

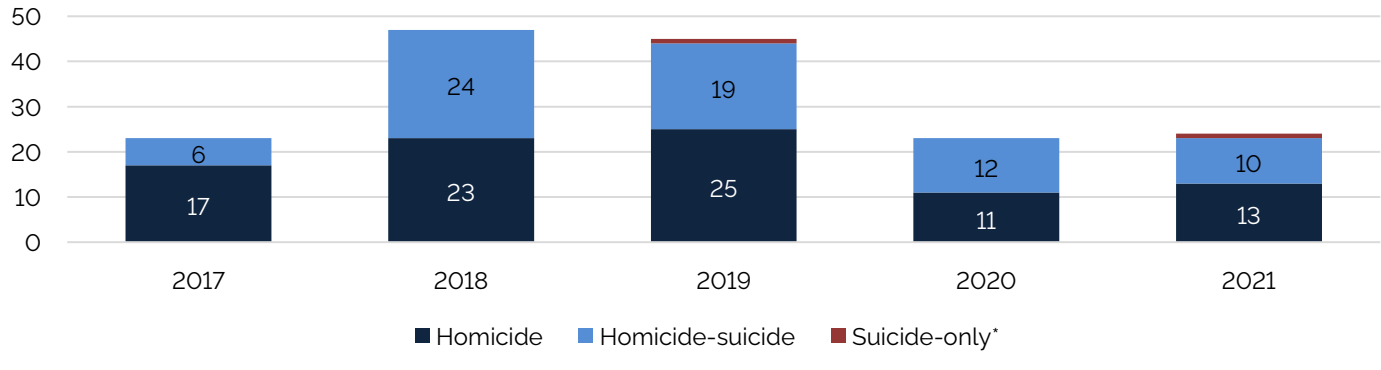
## Five Year Trends: Domestic violence-involved cases investigated by a coroner between 2017 and 2021

Domestic violence-involved cases are defined as homicides where the person who caused the death(s) was a current or former intimate partner (e.g., spouse, partner, boyfriend, girlfriend, etc.) of the victim. Deaths of involved children are also included. If the person who caused the death(s) of their intimate partner or any involved children also dies by suicide, that individual is included as well (i.e., as a homicide-suicide).

Some of these cases may have undergone review by the DVDRC while others are pending review upon completion of legal proceedings (e.g., criminal trials).

These data report on domestic-violence involved deaths over the last five years between 2017 and 2021. Throughout the last five years, 162 deaths across 116 domestic-violence involved cases were investigated by a coroner. Nearly 70% of these cases were homicides and 28% were homicide-suicides. There were also two cases where the individual died by suicide, and had a history of suffering from violence and/or abuse by an intimate partner. Figure 4 below presents the number of deaths, by year, and by case-type.

**Figure 4: Number of domestic violence-involved deaths, by case type, by year, 2017-2021**




*Two cases, one in each of 2019 and 2021, where the individual died by suicide, and had a history of suffering violence by an intimate partner.

Of all domestic-violence related homicide victims from 2017-2021, 85% were female, and 3% of the individuals who caused the death(s) were female.

## Cases Reviewed by the DVDRC from 2003 to 2021

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

From the DVDRC's inception in 2003 until the 2021 review, the DVDRC has reviewed 392 cases involving 563 deaths. Of the cases reviewed, 263 (67%) were homicides and 129 (33%) were homicide-suicides. See Table 4 for a detailed breakdown by year.

In 2015, a dedicated effort was made to address the accumulation of cases awaiting review by the DVDRC. Forty-nine cases underwent an "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 of cases where the relationship between the victim and individual who caused the death(s) was not clearly established and where the intimate partner was not confirmed as the intended victim.

**Table 4:** Number of cases by case type, number of deaths, and number of recommendations, by year of review

| Review year | Review type | Cases | Case type | | Deaths | Recommendations |
|---|---|---|---|---|---|---|
| | | | Homicide | Homicide - Suicide | | |
| **2003** | **Full** | 11 | 2 | 9 | 24 | 18 |
| **2004** | **Full** | 9 | 7 | 2 | 11 | 29 |
| **2005** | **Full** | 14 | 5 | 9 | 19 | 10 |
| **2006** | **Full** | 13 | 5 | 8 | 21 | 35 |
| **2007** | **Full** | 15 | 8 | 7 | 24 | 33 |
| **2008** | **Full** | 15 | 13 | 2 | 19 | 33 |
| **2009** | **Full** | 16 | 6 | 10 | 26 | 11 |
| **2010** | **Full** | 18 | 6 | 12 | 36 | 14 |
| **2011** | **Full** | 33 | 28 | 5 | 41 | 31 |
| **2012** | **Full** | 20 | 14 | 6 | 32 | 18 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **2013** | **Full** | 19 | 17 | 2 | 22 | 9 |
| **2014** | **Full** | 14 | 12 | 2 | 16 | 25 |
| **2015** | **Full** | 21 | 12 | 9 | 30 | 28 |
| | **Executive** | 49 | 46 | 3 | 57 | 0 |
| **2016** | **Full** | 22 | 11 | 11 | 37 | 23 |
| **2017** | **Full** | 22 | 12 | 10 | 35 | 33 |
| **2018** | **Full** | 18 | 15 | 3 | 25 | 28 |
| **2019** | **Full** | 20 | 17 | 3 | 24 | 32 |
| | **Executive** | 2 | 2 | 0 | 2 | 0 |
| **2020** | **Full** | 13 | 8 | 5 | 20 | 27 |
| **2021** | **Full** | 28 | 17 | 11 | 42 | 55 |
| **Total** | | **392** | **263** | **121** | **563** | **492** |

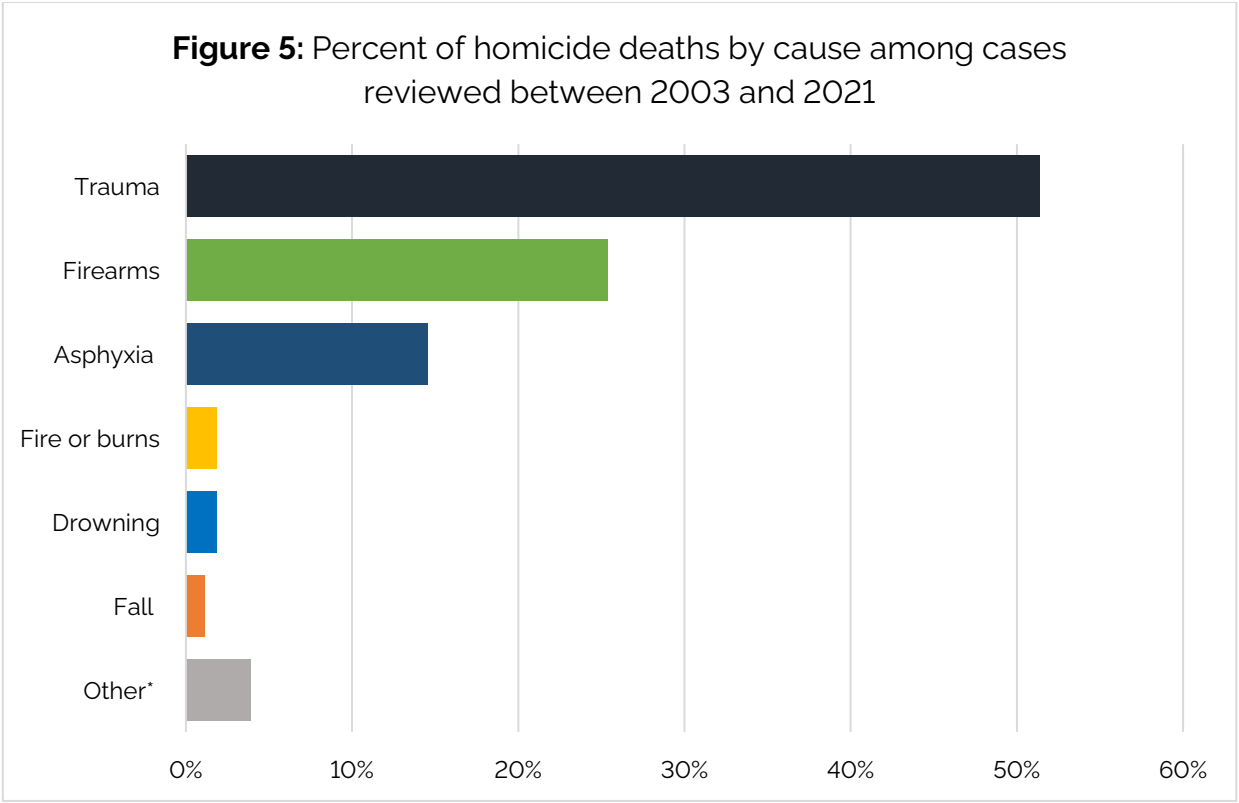
Among the 563 deaths, 434 (70%) were homicide victims, 371 of whom were female. Victims ranged in age from five months to 91 years. Table 5 presents the number of victims by age and sex.

**Table 5:** Number of homicide victims by age group and sex, among cases reviewed between 2003 and 2021

| **Sex of homicide victim** | **Age of homicide victim** | | **Total** |
|---|---|---|---|
| | 18 and under | 19 and older | |
| Female | 28 | 343 | 371 |
| Male | 17 | 46 | 63 |
| **Total** | **45** | **389** | **434** |

From 2003-2021, more than half of the homicide victims whose cases were reviewed by the DVDRC died as a result of trauma; 25% died from firearms, and 15% died from asphyxia (Figure 5).

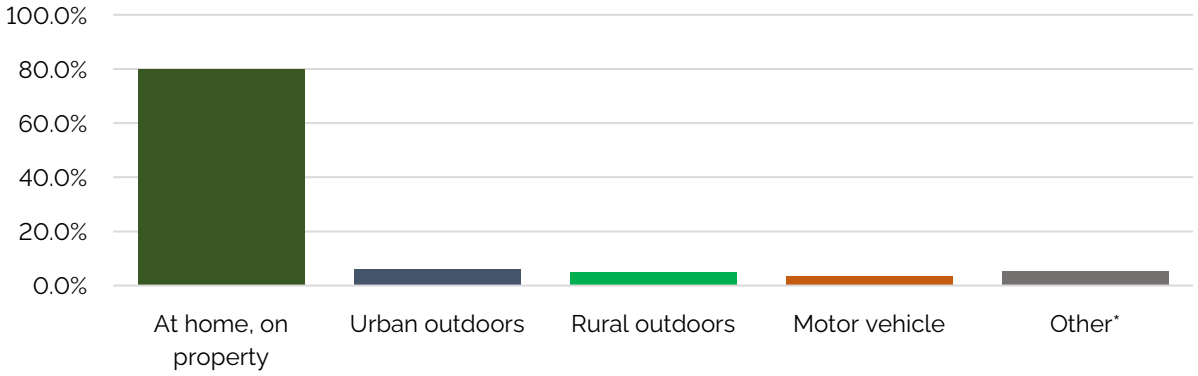
**Figure 5:** Percent of homicide deaths by cause among cases reviewed between 2003 and 2021




*Other includes drug and alcohol toxicity, explosion, and category not ascertained or defined.

Eighty percent of victim deaths occurred at home/on property; 6% in the urban outdoors, and 5% in the rural outdoors (Figure 6).

**Figure 6:** Percent of homicide deaths, by location, among cases reviewed between 2003-2021




*Other includes inside, other than residence, hotel or motel, workplace, railway or subway, long-term care facility, and hospital.

Based on findings from IPV research, the DVDRC has created a list of 41 risk factors which apply to both the victim and/or the person who caused the death(s). These risk factors indicate the potential for IPV-related homicide, and are assessed for in each case reviewed by the committee. Topics covered by the risk factors include history of IPV and/or abuse, prior threats, assault, and/or violence, mental illness and suicide threats, drug and alcohol use, unemployment, separation and/or new partner, and parenting time, decision-making responsibilities, and contact with children. The risk factors carry equal weight, however some risk factors may be more predictive of future harm (e.g., prior assault with a weapon, choked/stranged victim in the past).

A complete list of risk factors and their definitions is included in **Appendix A**.

Our analysis shows that several risk factors are common among most of the cases reviewed by the committee. Among cases reviewed by the DVDRC between 2003 and 2021, 76% identified a history of domestic violence; 65% identified actual or pending separation, and 45% of cases identified obessive behaviour displayed by the person who caused the death(s). See Figure 7 for the top 20 risk factors identified.

In nearly 70% of cases reviewed, seven or more risk factors were identified. In 6% of cases, 20 or more risk factors were identified. Among all cases reviewed, the median number of risk factors was nine. Table 6 presents a count of cases by the number of risk factors flagged. The recognition of multiple risk factors within a relationship may allow for enhanced risk assessment, safety planning, and even prevention of further deaths through appropriate interventions by the justice system, healthcare partners, and others.

**Figure 7:** Percent of cases reviewed between 2003 and 2021, by top 20 risk factors identified

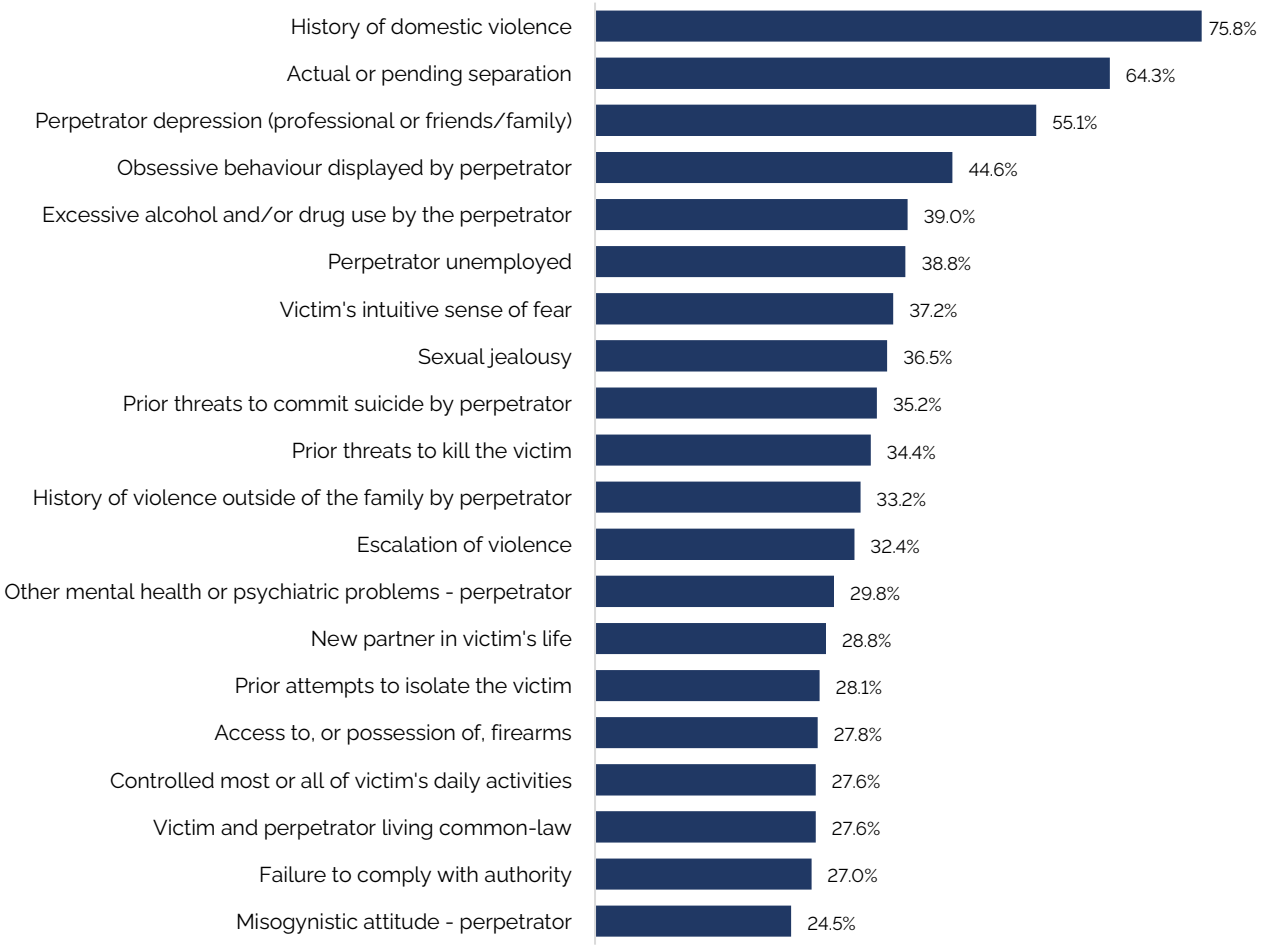



**Table 6:** Number and percent of cases by number of risk factors identified, among cases reviewed between 2003 and 2021

| Number of risk factors | Number of cases | Percent of cases |
|---|---|---|
| Zero | 6 | 1.5% |
| One to three | 55 | 14.0% |
| Four to six | 59 | 15.1% |
| Seven to 9 | 83 | 21.2% |
| **10 to 19** | **164** | **41.8%** |
| 20 or more | 25 | 6.4% |
| **Total** | **392** | **100%** |

# Chapter Three: DVDRC Reviews – Frequently Asked Questions

## Selection of Cases for Review

### 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 after all other investigations and criminal justice proceedings - including trials and appeals - have been completed. As such, DVDRC reviews often take place several years after the actual incident. Deaths involving homicide-suicides are generally reviewed more expeditiously as these deaths typically do not proceed to criminal proceedings.

### 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 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 deaths involving homicide-suicides generally do not result in criminal proceedings, these deaths are reviewed in a more timely fashion.

Once it has been determined that a death is ready for review (i.e., all other proceedings and investigations have been completed), the file is assigned to a reviewer (or reviewers). The 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 review of facts of the individual death and presents their findings to the DVDRC as a whole. Information considered within this examination includes the history, circumstances and actions of individual who caused the death(s), 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 further deaths. In general, the DVDRC strives to develop a comprehensive understanding of why IPV-related deaths occur and how they might be prevented.

**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 IPV-related death(s) took place. Information provided through the course of the initial coroner's investigation will also 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 items seized under the authority of the *Coroners Act* that will contribute to 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 further 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" investigations and does not analyze investigative or judicial findings. The DVDRC may also review documentation from family members, friends, and co-workers submitted to the Office of the Chief Coroner through a regional office.

**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*. 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., individual who caused the death(s)) 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* 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 deceased persons, 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 IPV 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, should be implemented in order to prevent future violence and possibly death. Research has been conducted using data from the DVDRC which suggests the importance of looking at both individual risk factors and multiple risk factors.

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

Risk factors that frequently recur in our case reviews may be illustrative of ongoing 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 and criminal and family courts also miss opportunities for proactive interventions that provide avenues of potential safety for victims, and much needed counselling and supports for the person who caused the death(s).

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

The lack (or small number) 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 recognized as warranted or deemed necessary. Most of the homicide-suicide cases involving elderly individuals had very few risk factors identified. However, there are patterns which are unique with information held by health care professionals and related to declining physical and mental health of both the victim and the person who caused the death(s). These issues have more recently been highlighted by the Ryan and Ryan Inquest in September 2023 (2023 coroner's inquests' verdicts and recommendations | ontario.ca) as well as research in the field. 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 determines that there may be an opportunity to identify gaps, bring awareness to, or encourage change to specific areas identified during the course of the review of the circumstances surrounding IPV-related deaths, recommendations will be made.

One of the primary goals of the DVDRC is to make recommendations aimed at preventing further deaths and to reduce IPV in general. Recommendations are distributed to relevant organizations and agencies through the Chair/s of the DVDRC. The phrase "no new recommendations" indicates 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 included 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 them. However, organizations and agencies are asked to respond back to the 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 IPV.
- 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 IPV 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 within their relationships. [Note: While significant work has already been done to address IPV 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 IPV.
- The recognition and assessment of **risk factors** (particularly the most prevalent risk factors of history of IPV, 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 use** by victims and/or individual who caused the death(s).
- **Parenting time, decision-making responsiblities, contact with children,** family court decisions and child welfare concerns and the implications on IPV.

**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.

At the 2022 inquest into the deaths of Carool Culleton, Anatasia Kuzyk and Nathalie Warmerdam, the jury recommended a provincial implementation committee to monitor recommendations made on domestic homicide deaths: (https://www.ontario.ca/page/2022-coroners-inquests-verdicts-and-recommendations#section-4)

## 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.deathreviewcommittees@ontario.ca.

The most recent annual report from the DVDRC can also be found on the Ontario.ca website. A copy of the DVDRC 2019-2020 Annual Report can be found here.

# Appendix A

## Risk Factor Descriptions

**The person who caused the death(s)** = The primary aggressor in the relationship
**Victim** = The primary target of the person who caused the death(s) abusive/maltreating/violent actions

| | | Definition / Considerations |
|---|---|---|
| | **History of person who caused the death(s)** | |
| 1 | Person who caused the death(s) was abused and/or witnessed DV as a child | As a child/adolescent, the person who caused the death(s) was victimized and/or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment. |
| 2 | Person who caused the death(s) exposed to/witnessed suicidal behavior in family of origin | As a(n) child/adolescent, the person who caused the death(s) was exposed to and/or witnessed any actual, attempted or threatened forms of suicidal behaviour in their family of origin. Or somebody close to the person who caused the death (e.g., caregiver) attempted or committed suicide. |
| | **Family/Economic Status** | |
| 3 | Youth of couple | Homicide victim and person who caused the death(s) 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 person who caused the death(s) living common-law | The victim and person who caused the death(s) were cohabiting. |
| 6 | Actual or pending separation | The victim wanted to end the relationship. Or the person who caused the death(s) 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. Or the person who caused the death(s) believed the homicide victim was going to end the relationship. |
| 7 | New partner in victim's life | There was a new intimate partner in the victim's life or the person who caused the death(s) perceived this to be the case. |
| 8 | Family law disputes related to the children | Any dispute related to parenting arrangements for any children, including formal legal proceedings or any third parties having knowledge of such arguments. |

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| 9 | Presence of step-children in the home | Any child(ren) that is(are) not biologically related to the person who caused the death. |
| 10 | Person who caused the death(s) unemployed | Employed means having full-time or near full-time employment (including self-employment) outside the home. Unemployed means experiencing frequent job changes or significant periods of lacking a source of income. Support from government income assisted programs (e.g., O.D.S.P.; Worker's Compensation; E.I.; etc.) can be considered unemployment. |
| | **Mental Health of the person who caused the death(s)** | |
| 11 | Excessive alcohol and/or drug use by person who caused the death(s) | Within the past year, and regardless of whether or not the person who caused the death(s) received treatment, substance use that appeared to be characteristic of their 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. For example, people described the person who caused the death(s) as frequently intoxicated or claimed that they never saw them without a beer in their hand. This dependence on a particular substance may have impaired the health or social functioning (e.g., overdose, job loss, arrest, etc) of the person who caused the death. Comments by family, friends, and acquaintances that indicate annoyance or concern with a drinking or drug problem and any attempts to convince the person who caused the death to end their substance use may be considered. |
| 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 person who caused the death(s) received treatment, the person who caused the death(s) displayed symptoms characteristic of depression. |
| 13 | Depression – professionally diagnosed* (count as one) | 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 person who caused the death(s) received treatment. |
| 14 | Other mental health or psychiatric problems | For example: psychosis; schizophrenia; bi-polar disorder; mania; obsessive-compulsive disorder, etc. |

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| 15 | Prior threats to commit suicide | Any recent (past six months) act or comment made by the person who caused the death(s) that was intended to convey their 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 | 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. |
| **Attitude/Harassment/Violence of the person who caused the death(s)** | | |
| 17 | Obsessive behaviour | Any actions or behaviours by the person who caused the death(s) that indicate an intense preoccupation with the victim. For example, stalking behaviours, such as following the victim, spying on or making repeated phone calls to them, or excessive gift giving, etc. |
| 18 | Failure to comply with authority | The person who caused the death(s) 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 person who caused the death(s) continuously accuses the victim of infidelity, repeatedly interrogates them, searches for evidence, tests the victim's fidelity, and sometimes stalks them. |
| 20 | Misogynistic attitudes | 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." |
| 21 | Prior destruction or deprivation of victim's property | Any incident in which the person who caused the death(s) intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the person who caused the death(s). This could include slashing the tires of the car that the victim uses, breaking windows or throwing items at a place of residence. Any |

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| | | incident, regardless of charges being laid or those resulting in convictions may be considered. |
| 22 | History of violence outside the family | Any actual or attempted assault on any person who is not, or has not been, in an intimate relationship with the person who caused the death(s). 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 person who caused the death(s). 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 person who caused the death screaming at a previous victim or a co-worker noticing bruises consistent with physical abuse on a previous victim while at work. |
| 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 person who caused the death(s). 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 person who caused the death screaming at the victim or a co-worker noticing bruises consistent with physical abuse on the victim while at work. |
| 25 | Prior threats to kill victim | Any comment made by the person who caused the death(s) 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." |

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| 26 | Prior threats with a weapon | Any incident in which the person who caused the death(s) 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 by the person who caused the death(s) 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.). |
| 28 | Prior attempts to isolate the victim | Any non-physical behaviour by the person who caused the death(s), whether successful or not, that was intended to keep the victim from associating with others. The person who caused the death(s) 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 the victim's daily activities | Any actual or attempted behaviour by the person who caused the death(s), whether successful or not, intended to exert full power over the victim. For example, when the victim was allowed in public, the person who caused the death(s) made them account for where they were at all times and who they were with. Another example could include not allowing the victim to have control over any finances (e.g., giving them an allowance, not letting them get a job, etc.). |
| 30 | Prior hostage-taking and/or forcible confinement | Any actual or attempted behaviour, whether successful or not, in which the person who caused the death(s) physically attempted to limit the movement of the victim. For example, any incidents of forcible confinement (e.g., locking the homicide victim in a room) or not allowing them to use the telephone (e.g., unplugging the phone when they attempted to use it). Attempts to withhold access to transportation should also be included (e.g., taking or hiding car keys). The person who caused the death(s) may have |

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| | | 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 by the person who caused the death(s) to engage the victim in sexual acts (of whatever kind) against their will. Or any assault on the victim, of whatever kind (e.g., biting; scratching, punching, choking, etc.), during the course of any sexual act. |
| 32 | Choked/strangled victim in past | Any attempt (separate from the incident leading to death) to strangle the victim. The person who caused the death(s) could have used various things to accomplish this task (e.g., hands, arms, rope, etc.). This does not include previous attempts to smother the victim (e.g., suffocation with a pillow). |
| 33 | Prior violence against family pets | Any action by the person who caused the death(s) toward a pet of the victim, or a former pet of the person who caused the death, with the intention of causing distress to or instilling fear in the victim. This could range in severity from killing the pet to abducting 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 of physical violence by the person who caused the death(s), 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 person who caused the death(s) was aware of this. |
| 35 | Escalation of violence | The abuse/maltreatment (physical; psychological; emotional; sexual; etc.) inflicted upon the victim by the person who caused the death(s) was increasing in frequency and/or severity. For example; more regular trips for medical attention or an increase in complaints of abuse to/by family, friends, or other acquaintances. |
| 36 | Person who caused the death(s) threatened and/or harmed children | Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual; etc.) by the person who caused the death(s) towards children in the family. This 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). |

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| 37 | Extreme minimization and/or denial of spousal assault history: | At some point the person who caused the death(s) was confronted, either by the victim, a family member, friend, or other acquaintance, and they displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., batterer intervention programs). Or they 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** | |
| 38 | Access to or possession of any firearms | The person who caused the death(s) stored firearms in their place of residence, place of employment, or another nearby location (e.g., friend's place of residence, or shooting gallery). The purchase of any firearm within the past year, regardless of the reason for purchase should be included. |
| 39 | After risk assessment, the person who caused the death(s) had access to the 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 person who caused the death(s) still had access to the homicide victim. |
| | **Victim's Disposition** | |
| 40 | Victim's intuitive sense of fear of the person who caused the death | The victim knows the person who caused the death(s) best and can accurately gauge their level of risk. If the victim discloses to anyone their fear that the person who caused the death will harm them or their children, for example statements such as, "I fear for my life", "I think they will hurt me", or "I need to protect my children". |
| 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 factors that place them at risk (e.g., sex 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 B

# Detailed Summary of Cases reviewed in 2021

| Case # | Year of death | Homicide | Homicide-Suicide | # of victims | Age of Victim(s) | Female Victim | Male Victim | Child Victim | Age of PWCD[2] | Male PWCD[1] | Female PWCD[1] | # of risk factors | # of recs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2018 | 1 | | 2 | 66<br>77 | 1 | 1 | | 56 | 1 | | 7 | 1 |
| 2 | 2019 | | 1 | 1 | 11 | | | 1 | 41 | 1 | | 10 | 2 |
| 3 | 2012 | 1 | | 1 | 41 | 1 | | | 40 | 1 | | 4 | 0 |
| 4 | 2018 | 1 | | 1 | 61 | 1 | | | 62 | 1 | | 11 | 6 |
| 5 | 2017 | 1 | | 1 | 92 | | 1 | | 64 | | 1 | 10 | 3 |
| 6 | 2013 | 1 | | 1 | 72 | 1 | | | 82 | 1 | | 3 | 1 |
| 7 | 2016 | 1 | | 1 | 68 | 1 | | | 73 | 1 | | 1 | 0 |
| 8 | 2019 | | 1 | 1 | 68 | 1 | | | 73 | 1 | | 14 | 1 |
| 9 | 2018 | | 1 | 1 | 30 | 1 | | | 46 | 1 | | 5 | 2 |
| 10 | 2018 | | 1 | 1 | 27 | 1 | | | 30 | 1 | | 5 | 3 |
| 11 | 2019 | | 1 | 1 | 41 | 1 | | | 47 | 1 | | 19 | 4 |
| 12 | 2018 | | 1 | 3 | 34<br>14<br>16 | 1 | | 2 | 37 | 1 | | 5 | 0 |
| 13 | 2018 | 1 | | 1 | 61 | 1 | | | 61 | 1 | | 13 | 2 |
| 14 | 2018 | 1 | | 1 | 27 | 1 | | | 29 | 1 | | 4 | 0 |
| 15 | 2017 | 1 | | 1 | 73 | 1 | | | 78 | 1 | | 3 | 0 |
| 16 | 2017 | | 1 | 1 | 78 | 1 | | | 76 | 1 | | 3 | 1 |
| 17 | 2017 | 1 | | 1 | 30 | 1 | | | 34 | 1 | | 11 | 11 |
| 18 | 2016 | 1 | | 1 | 65 | 1 | | | 66 | 1 | | 19 | 4 |
| 19 | 2018 | | 1 | 1 | 62 | 1 | | | 57 | 1 | | 1 | 0 |
| 20 | 2019 | | 1 | 1 | 30 | 1 | | | 39 | 1 | | 7 | 2 |
| 21 | 2017 | 1 | | 1 | 46 | 1 | | | 51 | 1 | | 5 | 2 |
| 22 | 2017 | 1 | | 1 | 64 | 1 | | | 67 | 1 | | 13 | 2 |
| 23 | 2015 | 1 | | 1 | 29 | 1 | | | 39 | 1 | | 11 | 1 |
| 24 | 2016 | 1 | | 1 | 73 | 1 | | | 78 | 1 | | 3 | 2 |
| 25 | 2018 | 1 | | 1 | 70 | 1 | | | 74 | 1 | | 9 | 1 |
| 26 | 2019 | 1 | | 1 | 57 | 1 | | | 57 | 1 | | 8 | 2 |
| 27 | 2020 | | 1 | 1 | 33 | 1 | | | 44 | 1 | | 13 | 0 |
| 28 | 2019 | | 1 | 1 | 63 | 1 | | | 69 | 1 | | 3 | 2 |

[2] PWCD = Person who caused the death(s)

# Appendix C

## Summary of 2021 Case Reviews

| Case # | Summary |
|---|---|
| **2021-01** | This case involved the homicides of a 66-year-old woman and her 77-year-old husband. The deceased persons were the parents of the intended victim, a 41-year-old woman who was in the process of ending her common-law relationship with her 56-year-old partner. The person who caused the death sexually assaulted the intended victim and killed her parents. There were seven risk factors[3] for intimate partner homicide identified. |
| **2021-02** | The case involved an 11-year-old female victim who was killed by her 41-year-old father who subsequently died by suicide. The victim's mother was the intended victim and was the former intimate partner of the person who caused the death. An Amber Alert was issued several hours after the victim did not return from a scheduled visit with her father. There were ten risk factors[3] for intimate partner homicide identified. |
| **2021-03** | This case involved a 41-year-old woman who was killed by her 40-year-old former partner. The victim and the former partner had been in a relationship for approximately four years. They met when they worked at the same factory. The former partner had lived in the basement apartment but moved out when their relationship ended. It was reported that the victim continued to see the former partner while in a new relationship. There were four risk factors for intimate partner homicide identified. |
| **2021-04** | This case involved the death of a 61-year-old woman by her 62-year-old male common-law partner. The couple had been in a relationship for 13 years. The male partner was alcohol-dependent and there was a history of IPV perpetuated by both individuals. There were 11 risk factors for intimate partner homicide identified. |
| **2021-05** | This case involved the death of a 92-year-old man by his 64-year-old female common-law partner. Both had previously experienced the death of their spouses. They had been in a relationship for approximately five years with the common-law partner being financially dependent on the deceased. It was reported that she had a history of worsening mental health issues. There were ten risk factors for intimate partner homicide identified. |

[3] Risk factors are based on the relationship between the intended victim and the person who caused the death.

| Case # | Summary |
|---|---|
| **2021-06** | This case involved a 72-year-old woman who died after being stabbed by her 82-year-old husband. The husband lived in a long-term care home (LTCH), but was visiting his wife and other family outside of the facility when the homicide took place. The husband had dementia and a history of paranoid delusions. They were deemed unfit to stand trial. There were three risk factors for intimate partner homicide identified. |
| **2021-07** | This case involved the death of a 68-year-old woman by her 73-year-old husband. The couple had been married for 46 years and had been arguing for several months prior to the homicide. There was one risk factor for intimate partner homicide identified. |
| **2021-08** | This case involved the death of a 68-year-old woman by her 73-year-old husband who subsequently died by suicide. There was an unreported history of domestic violence until just prior to the homicide-suicide when then couple had interactions with police. There were 14 risk factors for intimate partner homicide identified. |
| **2021-09** | This case involved the homicide of a 30-year-old woman by her 46-year-old boyfriend who subsequently died by suicide. The couple dated for approximately five months and had been living together for two weeks. The boyfriend was wanted on an immigration warrant. There were five risk factors for intimate partner homicide identified. |
| **2021-10** | This case involved the homicide of a 27-year-old woman by her 30-year-old boyfriend who subsequently died by suicide. He had been charged with the sexual assault of another woman in a different province. Approximately two weeks before he was scheduled to appear in court for the sexual assault charge, he killed his girlfriend, then himself. There were five risk factors for intimate partner homicide identified. |
| **2021-11** | This case involved the homicide of a 41-year-old woman by her 47-year-old husband who subsequently died by suicide. There was a history of domestic violence and both the victim and the husband had a past medical history of mental health issues. The homicide was witnessed by the couple's two children. There were 19 risk factors for intimate partner homicide identified. |
| **2021-12** | This case involved the homicides of a 34-year-old woman (victim 1) and her 14-year-old daughter (victim 2) and 16-year-old son (victim 3). The person who caused the deaths was the husband and father of the two children. There were five risk factors[4] for intimate partner homicide identified. |

[4] Risk factors are based on the relationship between victim 1 and the individual who is believed to have caused the death.

| Case # | Summary |
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| **2021-13** | This case involved the homicide of a 61-year-old woman by her 61-year-old husband. He had a long history of mental health issues and was under significant stress due to financial challenges. There were 13 risk factors for intimate partner homicide identified. |
| **2021-14** | This case involved the homicide of a 27-year-old woman by her 29-year-old common-law husband. The couple were planning to get married and there was no history of domestic violence. He was believed to have used recreational drugs and the victim threatened to end the relationship if the drug use continued. There were four risk factors for intimate partner homicide. |
| **2021-15** | This case involved the death of a 73-year-old woman by her 78-year-old common-law partner. The victim was killed during a dispute between the partners. There was no reported history of intimate partner violence in the couple's relationship. The common-law-partner subsequently died following an altercation while in custody. There were three risk factors for intimate partner homicide identified. |
| **2021-16** | This case involved the death of a 78-year-old woman by her 76-year-old husband, who subsequently died by suicide. There was no history of prior marital problems or domestic violence in their marriage. The motive as reported by the victim's son was the wife's declining health and the husband's inability to care for her. There were three risk factors for intimate partner homicide identified. |
| **2021-17** | This case involved the homicide of a 30-year-old woman by her 34-year-old boyfriend. The couple lived in an isolated First Nation community. The victim and the boyfriend were in a relatively new relationship together which was challenged by substance use and violence. The victim had voiced that she wanted to end the relationship but feared that she may end up getting killed first. There were 11 risk factors for intimate partner homicide identified. |
| **2021-18** | This case involved the homicide of a 65-year-old woman by her 66-year-old partner. The couple had been in a dating relationship for approximately one year. The partner had a long history of domestic violence involving previous partners. There were 19 risk factors for intimate partner homicide identified. |
| **2021-19** | This case involved the homicide of a 62-year-old woman by her 57-year-old husband who subsequently died by suicide. There was no known history of fighting or abuse and the couple was viewed as social and friendly. Both the victim and her husband believed in conspiracy theories and often displayed paranoid behaviour. There was one risk factor for intimate partner homicide identified. |

| Case # | Summary |
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| **2021-20** | This case involved the death of a 30-year-old woman by her 39-year-old boyfriend. The couple had been in a relationship for a short time and were both immigrants. He stabbed the victim, then took his own life. There were seven risk factors for intimate partner homicide identified. |
| **2021-21** | This case involved the death of a 46-year-old woman by her 51-year-old husband. The victim was a recent immigrant, did not speak English well and had a limited social network. The husband was also an immigrant and had been in Canada for several years. The couple experienced financial hardship after unsuccessfully trying to operate, then sell, a restaurant. The victim was in the process of ending the relationship and returning to her home country. There were five risk factors for intimate partner homicide identified. |
| **2021-22** | This case involved the homicide of a 64-year-old woman, by her 67-year-old husband. The victim experienced persistent verbal, psychological, and physical abuse throughout their 50-year marriage. Family and friends were aware and concerned of the ongoing abuse.The husband engaged in a verbal dispute with the victim which escalated to him shooting her on the driveway as she tried to leave. There were 13 risk factors for intimate partner homicide identified in this case. |
| **2021-23** | This case involved the homicide of a 29-year-old woman by her 39-year-old common-law partner. The couple were in the process of separating and the victim had started a new relationship. Friends and family were aware that the common-law partner was despondent about the separation. There were 11 risk factors for intimate partner homicide identified. |
| **2021-24** | This case involved the homicide of a 73-year-old woman by her 78-year-old husband. He had access to firearms, was in declining health and displayed paranoid thoughts. He was found not criminally responsible for the homicide of his wife. There were three risk factors for intimate partner homicide identified. |
| **2021-25** | This case involved the homicide of a 70-year-old woman by her 74-year old husband. The couple had been married for 55 years and the victim was considering ending the relationship. The husband had escalating depression and other stressors as well as access to firearms. There were nine risk factors for intimate partner homicide identified. |
| **2021-26** | This case involved the homicide of a 57-year old woman by her 57-year-old husband. There was a history of domestic violence and both the victim and the person who caused the death suffered from alcohol use disorder, and the victim suffered from mental health issues. The homicide was preceded by arguments, physical assaults and the presence of firearms. The victim was shot and found in |

| Case # | Summary |
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| | the backyard of their residence. There were eight risk factors for intimate partner homicide identified in this case. |
| **2021-27** | This case involved the death of a 33-year-old woman caused by her 44-year-old boyfriend who subsequently died by suicide. He had a history of jealous behaviour with previous intimate partners and had access to firearms. There were 13 risk factors identified in this case for intimate partner homicide. |
| **2021-28** | This case involved the homicide of a 63-year-old woman by her 69-year-old husband who subsequently died by suicide. Both the victim and her husband were in poor health and had significant financial challenges, and they were about to be evicted from their house. There were three risk factors for intimate partner homicide identified in this case. |

# Appendix D

## 2021 Case Review Recommendations

| DVDRC Case Number | Recommendation(s) |
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| **2021-01** | 1. It is recommended that the various campaigns that address the role of neighbours, friends and families in preventing domestic homicide should include information about warning signs related to potential threats made on social media as well as indicators of stalking and harassing behaviour.<br>• The information should encourage victims to reach out to the police to discuss potential risk and safety planning. Many victims and the public believe that they can only call police at the time of a violent incident or imminent risk of harm and don't appreciate that police services have domestic and IPV coordinators who can offer advice and referrals to other agencies. |
| **2021-02** | 1. In cases involving explicit threats of harm to a child or a documented history of child abuse or domestic violence, the Amber Alert should be made immediately upon notification of the police.<br>2. Public and profession-focused education campaigns on domestic violence and domestic homicide should be expanded to include the risks to children in conflicted child custody cases in the context of a history of domestic violence. |
| **2021-03** | No new recommendations. |
| **2021-04** | 1. It is recommended that the RCMP develop a system that alerts them when individuals with a current Possession and Acquisition License (PAL) become known to any police service for alcohol use/poor judgement and/or mental health issues and impulsivity/suicidality and that when alerted, an investigation occur with the potential of revoking the PAL. It is recommended that individuals with current mental health and/or substance use issues not be eligible to obtain a PAL.<br>2. Given the high co-occurrence between addictions and IPV, it is recommended that there be more education and training for counsellors who work with clients with addiction problems and who may disclose IPV. |

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| | 3. It is recommended that there be routine screening in every case where there are indicators of IPV. This would include a thorough assessment of risk and risk management of the case.<br>4. When a counsellor is not trained in risk assessment or does not have the time to complete a thorough risk assessment due to high caseload or lack of resources, the counsellor should refer the client to agencies that specialize in IPV risk assessment and risk management (e.g., victim services).<br>5. Counsellors are encouraged to speak with couples separately to assess risk for IPV prior to seeing the couple together for couples' therapy. This ensures that an appropriate and thorough risk assessment can be conducted where the individuals can be honest and open and where safety is a priority.<br>6. It is recommended that the Office of Women's Issues develop a professional education campaign across ministries involved in front-line services for IPV to raise awareness about historical oppression of Indigenous peoples and how it affects help-seeking with victims. During the development of this educational campaign, reference should be made to the 2019 Report from the National Inquiry into Missing and Murdered Indigenous Women and Girls. |
| **2021-05** | 1. Medical alert call centres should utilize safety screening tools when notifying individuals identified as emergency contacts for clients of the medical alert services. When calls involve possible violence or conditions that might be unsafe, the call centre should immediately notify the relevant police service. Call takers should not instruct emergency contacts to check on a medical alert client if there is any possibility that the situation is unsafe.<br>2. Local health integration networks are encouraged to adopt a "healthcare navigator" system for acute mental health patients in order to promote continuity of care and collaboration of services and treatment between healthcare providers.<br>3. Police services are encouraged to utilize victim services for witnesses and other individuals impacted by violence. |
| **2021-06** | 1. Family members and/or substitute decision makers for long-term care residents with behavioural issues should be given regular status updates, including information and guidance on how to manage behavioral and emotional responses by the resident, including the potential for violence, that may arise during visits while in the long-term care home and while outside the facility. |

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| **2021-07** | No new recommendations. |
| **2021-08** | 1. The Ministry of the Solicitor General and the Ministry of the Attorney General should review, update and expand existing policies, practices, and training for police officers and crown attorneys to recognize the unique issues facing older couples involved in intimate partner violence. |
| **2021-09** | 1. The Ministry of Children, Community and Social Services should develop a professional education campaign across government ministries involved in front-line services for domestic violence and IPV to raise awareness about historical oppression of Black/African descent women and gender diverse peoples, and how it affects help-seeking victims of intimate partner abuse and sexual violence.<br>2. The Canadian Border Services Agency should conduct an internal review of findings and lessons learned for this case, to be submitted back to the DVDRC. |
| **2021-10** | 1. The Ministry of the Attorney General and the Ministry of the Solicitor General should facilitate collaboration between crown prosecutors and police jurisdictions after bail has been posted and a those who are believed to have caused the death has been arrested/charged with a gender-based violence-related offense. As part of the statement-taking, police should inquire about current and former intimate partner relationships of accused persons, including those that may live in another jurisdiction. Partners and/or ex-partners should be advised of arrest/bail conditions.<br>2. The Ministry of the Attorney General should develop a counselling program aimed at supporting accused persons, especially those out on bail, as they navigate the criminal legal system. Such a program would include resources and referrals to culturally relevant supports in the community, where accused persons could get information about what the process entails, as well as strategies to manage anxiety, fears, stress, etc.<br>3. The Office of the Chief Coroner should share this report with Alberta's intimate partner violence death review committee or similar body. |
| **2021-11** | 1. Crown attorneys should carefully consider the implications of peace bonds to resolve domestic violence cases. In particular, the safety of victims and children after separation needs to be a central consideration of policies and practices in resolving these cases. A thorough review of every application for a peace bond or resolution of criminal charges through a peace bond, must be guided by a risk assessment of the matter for adult |

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| | victims and their children. A peace bond that directs a those who are believed to have caused the death to stay away from a victim must include a provision for access to the children that does not depend on the victim and those who are believed to have caused the death having contact. Such peace bonds are contradictory in their direction and may endanger victims and promote ongoing harassment.<br>2. Funding for Partner Assault Response (PAR) programs should be increased for high-risk those who are believed to have caused the deaths with multiple challenges (e.g., employment, housing, financial support, mental health, addictions). This funding should include enhanced group programs from the current 12 weeks to 24 weeks as well as access to crisis support 24/7 and complementary individual counselling if not available in the community elsewhere.<br>3. The Ministry of Children, Community and Social Services should ensure that child protective service policies include the requirement to remain involved with children in high-risk domestic violence cases in order to monitor their safety until there is a family court order detailing parenting arrangements that address the ongoing risks.<br>4. The police service involved should conduct a lessons-learned case review of the circumstances surrounding this homicide-suicide with a view to developing integrated and coordinated policies and services for high-risk IPV cases. |
| **2021-12** | No new recommendations. |
| **2021-13** | 1. Local health integration networks (LHINs) (also called *"Home and Community Care Support Services"*) should create acute care health navigators that would collaborate with patients with acute mental and/or physical health care needs and primary care providers to help ensure a circle of care including the development of care plans where multiple practitioners may be involved.<br>2. The hospital involved should conduct a lessons-learned case review of the circumstances surrounding the care provided to the those who are believed to have caused the death leading up to and immediately prior to the homicide of the victim. The review should include a review of protocols, procedures and risk mitigation processes particularly as they relate to discharge planning of potentially high-risk individuals. |
| **2021-14** | No new recommendations. |

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| **2021-15** | No new recommendations. |
| **2021-16** | 1. It is recommended that the Ministry of Health, the College of Physicians and Surgeons of Ontario (CPSO), and the Canadian Psychiatric Association should:<br>• Ensure that all family doctors and psychiatrists are aware of the dangers of domestic homicide for elderly domestic partners with declining physical and mental health, particularly when one partner is experiencing dementia.<br>• Ensure that all doctors and psychiatrists are able to understand, recognize and treat stress, anxiety, and overwhelm experienced by an elderly domestic partner who is acting as a dedicated caregiver for an elderly domestic partner experiencing declining health.<br>• Ensure all family doctors and psychiatrists enquire about guns in the homes of elderly patients suffering from depression and who are acting as a dedicated caregiver for an elderly partner experiencing declining health. |
| **2021-17** | 1. It is recommended that the Ministry of the Attorney General look to expand and make accessible community-led justice processes (Indigenous restorative justice, Indigenous-specific victim services, Indigenous Bail and Verification Supervision Program, etc.).<br><br>2. Recognizing that all First Nations are unique and that justice service delivery approaches need to reflect this uniqueness, the Ministry of the Attorney General should ensure that funding is available to support integrated services such as justice, health care, housing, etc. For example, in larger communities this may look like a 'hub' setting, while smaller communities may be better served by a specific crisis worker that is adequately resourced to support the needs of community members. First Nations should be supported to implement a service delivery model for mental health and intervention services that reflects their ways of knowing and meets the needs of their individual community.<br><br>3. The Ministry should provide adequate and sustainable support to the community to implement and manage Indigenous-led justice processes.<br><br>4. The Ministry of the Attorney General should appropriately charge individuals, particularly when they have a long history of violent behaviour. |

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| | 5. First Nation communities should be provided with the supports and resources needed to build capacity so they can engage and implement their own solutions to address mental health issues such as substance use in the community. The Ministry of Health and Ministry of the Attorney General should engage with Chief and Council to learn what capacity supports would be needed to make this occur and commit to implementing the learnings with a report-back mechanism also established.<br><br>6. It is recommended that Indigenous child and family well-being agencies be supported by Ministry of Children, Community and Social Services to:<br><br>Provide services that are wholistic with a focus on community driven supports that encompass the whole family and not just the individual. Children and youth are situated within a family and community context and the Ministry should look for ways to support this service delivery approach.<br><br>7. The Ministry of Children, Community, and Social Services should support the development of programs and services by and for First Nations and the need to address the underlying factors that contribute to current challenges faced by individuals, families and communities, including historical, ongoing and intergenerational trauma.<br><br>• Support the First Nation to design holistic approaches to healing and family wellbeing that are grounded in the community's cultural and spiritual practices.<br><br>• Support the First Nation in the implementation of land-based healing as an intervention for healing the whole family.<br><br>8. It is recommended that The Ministry of the Solicitor General (Correctional Services) Probation and Parole Offices review the enforcement of court orders and how to mitigate this concern.<br><br>9. Probation and parole officers should assess clients in a timely fashion and ensure that ongoing reporting to the community is done to ensure that risks and needs are identified and addressed. Critical to this is that the funding of service delivery models that allows for justice services to be |

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| | funded in the community rather than accepting the status quo that services will not be accessible due to the remote nature of the community. Referrals to rehabilitative programs that address the unique needs of Indigenous clients is essential to mitigate risks to victims.<br><br>10. Probation and parole officers should reach out to collateral contacts to confirm or verify the information provided by the client. This will serve to inform supervision and better understand any risks and needs of the perpetrator as well as the victim.<br><br>11. It is recommended that the Office of the Chief Coroner's Domestic Violence Death Review Committee add "history of animal abuse" to the risk factors identified in case reviews. |
| **2021-18** | 1. The municipal housing department, police service and other community resources involved should conduct a lessons-learned case review of the circumstances surrounding this death. The assessment should identify possible missed opportunities to intervene prior to the homicide and existing and potential policies and practices that might help avert future similar deaths.<br>2. The municipal housing department involved should conduct criminal background checks on potential tenants prior to admission to seniors' housing. Potential tenants that are considered high risk should be refused housing and/or police and other residents should be advised.<br>3. The police service involved should review the circumstances of the case for quality assurance purposes to identify if there was sufficient evidence to support criminal harassment or other charges<br>4. The Ministry of the Attorney General should complete a study of chronic domestic violence those who are believed to have caused the deaths with a view to creating a policy to identify repeat domestic violence those who are believed to have caused the deaths who cause significant psychological and physical harm to one or more victims. The policy should address special considerations for dangerous offender or long-term offender designation for domestic violence those who are believed to have caused the deaths who are chronic offenders with multiple victims. |
| **2021-19** | No new recommendations. |
| **2021-20** | 1. In cases where the victim does not want to proceed with charges, the police service involved should refer the individual to Victim Services. This |

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| | should be a mandatory referral to ensure the victim has the necessary supports.<br>2. It is recommended that the police service involved review the "all chiefs" memorandum issued by the Office of the Chief Coroner (2009) which included an Investigative Companion for Domestic Violence Homicides and Homicide-Suicides. This recommendation serves as a reminder of this investigation guidance. |
| **2021-21** | 1. It is recommended that the Financial Consumer Agency of Canada encourage banks and loans companies to provide families, particularly immigrant, refugee, and newcomer families, with information on starting a new business in the province. Information packages should include steps to consider prior to starting or operating a business such as registering the business with the government, permits and licenses, support and financing but also the potential stressors and their impacts on a family, rates of success, and where to go to get advice and support if the business is struggling. Mentorship programs should also be provided to learn from successful and established business owners.<br>2. Newcomers should be provided with resources (e.g., Neighbours, Friends, and Families campaign ), programs and information sessions on IPV and the resources/supports available to families. Immigration, Refugees and Citizenship Canada can also provide resources to newcomers who are interested in starting a business in Canada. These resources should include the steps to take when starting a business and the stressors of running a successful business on families and relationships, success rates, and programs that provide families with financial support and literacy. |
| **2021-22** | 1. Due to the continuing need to educate family members, friends, and colleagues who encounter victims and perpetrators of IPV, about the risk factors and warning signs of IPV, the Ontario Women's Directorate should develop appropriate resources for public dissemination. Public education materials could include safety planning and risk management, community and bystander obligations, and action plans for persons who encounter individuals involved in domestic violence. In particular, the education materials should address the increased risk associated with separation or pending separation. These educational resources should also include a guideto identify the risk factors for potential lethality and the specific steps to take when risk factors for lethality are identified. |

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| | 2. Public information resources should be developed by local police and victim services organization to help individuals, friends, families, and neighbors of victims or potential victims access information when they observe warning signs of IPV in a relationship. These resources could include information about how to confidentially contact police, victim services, or crisis support workers, as well as provide advice and support for those experiencing IPV or other forms of abuse. These resources could include online information, brochures, posters, public restroom signs, and/or public presentations. |
| **2021-23** | 1. The Ministry of Children, Community and Social Service (Women's Issues) should enhance its efforts to reach the public about IPV and the potential risk factors that are associated with it. This recommendation is a two-step process to examine the depth of current public access and understanding of these issues and then based on this study to expand current public education efforts. |
| **2021-24** | 1. The Chief Firearms Office and the Firearms Safety Education Service of Ontario should collaborate on the development of a public education campaign that explains how the public can report public safety concerns relating to individuals with serious mental health problems and/or a history of IPV, who have access to firearms.<br><br>2. The Ministry of Health should develop public education material to assist families of individuals with dementia prepare for potential behavioural and emotional challenges. This should include guidance on identifying potential risks (such as access to firearms) and safety precautions to mitigate these risks. |
| **2021-25** | 1. The Chief Firearms Office and the Firearms Safety Education Service of Ontario should collaborate on the development of a public education campaign that explains how the public can report public safety concerns relating to individuals with serious mental health problems and/or a history of IPV, that have access to firearms. |
| **2021-26** | 1. The Ministry of Health and the Ontario Provincial Police should send a reminder notice to all employers of Ambulance Communications Officers (also known as 911 call-takers and dispatch personnel) to encourage all staff to reach out for support if they suffer from any symptoms of post-traumatic stress disorder, or other mental health issues; and senior management to carefully monitor all Ambulance Communications Officers for symptoms of vicarious trauma given the nature of their jobs. |

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| | 2. Police services should ensure that all police officers when responding to a call involving domestic violence, develop a safety plan with the victim and refer them to victim services. Additionally, officers should ensure that they leave a pamphlet or other information for the perpetrator to offer preventative support resources. |
| **2021-27** | No new recommendations. |
| **2021-28** | 1. Government policies and practices regarding repossessing a home (and eviction of tenants) by sheriffs and/or representatives from financial institutions be reviewed to ensure safeguards are in place that recognize the vulnerability of the homeowners/tenants due to mental and/or physical health.<br>2. The Ontario College of Family Physicians should promote continuing education on the links between aging, declining physical and mental health, access to firearms and intimate partner homicide. |

**For further information, please contact:**

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