Office of the Chief Coroner
Province of Ontario

Domestic Violence Death Review Committee

2015 Annual Report

November 2016

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Message from the Chair

The publication of the 2015 Annual Report of the DVDRC represents the thirteenth year that the Office of the Chief Coroner has reported on its reviews and on the incidence of domestic homicide and domestic homicide-suicide in Ontario.

In 2015, a dedicated effort was made to address the accumulation of pending cases awaiting review by the DVDRC. In many instances, the cases had been pending review as criminal court proceedings were ongoing. Gradually, and after several years delay, the cases were processed through the courts and were ready for review by the DVDRC. D/Sgt. Monica Denreyer from the Ontario Provincial Police was instrumental in determining the status of outstanding cases and assisting with the coordination and compilation of materials for cases that were suitable for review by the DVDRC. Many of the cases at this point, were several years old.

It was recognized that many of the systems and organizations involved with the cases had undergone significant change over the years. As such, all of the pending cases (49 in total), underwent "executive review" by a core team of representatives of the DVDRC. The executive review included a thorough analysis of the circumstances surrounding the deaths and compilation of risk factors identified in each case. None of the executive reviews conducted resulted in recommendations.

The DVDRC also conducted 21 full case reviews in 2015. Together with the 49 executive reviews, the DVDRC reviewed a total of 70 cases in 2015. This included 58 homicide and 12 homicide-suicide cases, resulting in a total of 87 deaths (75 homicide victims and 12 perpetrator suicides).

Since its inception in 2003, the DVDRC has now reviewed 267 cases involving 376 deaths. Seventy-four percent of all cases reviewed involved a couple where there was a history of domestic violence. The top risk factors for intimate partner homicide have been consistently identified as actual or pending separation, perpetrator depression, obsessive behaviour and the victim's intuitive sense of fear. Eighty-one percent of the homicide victims were adult females.

On average, there have been 28 cases of domestic homicide per year, from 2002-2014. While this number appears to be on the decline since 2011, there is still significant work to be done on reducing intimate partner homicide in the province.

It is hoped that the continued work of the DVDRC, together with the compilation of a more robust database and recommendations, will assist policy-makers, healthcare professionals, legal and judicial professionals, victims and policing services, academics and the public a large, with addressing the many

issues involved with the reduction of intimate partner violence within our province.

For readers interested in receiving full, redacted versions of individual DVDRC cases, please contact the Office of the Chief Coroner at occ.inquiries@ontario.ca.

I would like to take this opportunity to thank D/Sgt. Monica Denreyer, Ms. Tara McCord (A/Executive Lead) and Ms. Kathy Kerr (Executive Lead) for their assistance with the additional task of assessing and compiling the executive reviews conducted in 2015, together with the ongoing administration and management of DVDRC activities and data.

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

Committee Membership

William Lucas, MD, CCFP.
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Regional Supervising Coroner – Central West

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

Gail Churchill, M.D.
Investigating Coroner

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Donna Northeast
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National Manager, Family Violence Prevention Programs, Correctional Service Canada

Mark Gauthier
Detective Sergeant, Ontario Provincial Police

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

Executive Summary

Cases reviewed from 2003-2015:

- From 2003-2015, the DVDRC has reviewed 267 cases, involving 376 deaths
- Of the cases reviewed, 67% were homicides and 33% were homicide-suicides.
- Approximately 74% of all cases reviewed from 2003-2015 involved a couple where there was a history of domestic violence and 68% of the cases involved a couple with an actual or pending separation.
- The other top risk factors were:
    - obsessive behaviour by the perpetrator (48%)
    - a perpetrator who was depressed (50%)
    - an escalation of violence (34%)
    - prior threats or attempts to commit suicide (44%)
    - prior threats to kill the victim (39%)
    - excessive alcohol and/or drug use (39%)
    - a victim who had an intuitive sense of fear towards the perpetrator (43%)
    - a perpetrator who was unemployed (39%)
- In 72% of the cases reviewed, seven or more risk factors were identified.

Cases reviewed in 2015:

- There were 21 full case reviews and 49 executive reviews, for a total of 70 cases reviewed by the DVDRC in 2015. These included 58 homicide cases and 12 homicide-suicide cases, resulting in 87 deaths (75 homicide victims and 12 perpetrator suicides).
- There were 28 recommendations generated through these reviews.
- Of the 75 victims in the cases reviewed, 64 (85%) were female and 11 (15%) were male.
- Of the 70 cases reviewed, 63 (90%) involved male perpetrators and seven (10%) involved female perpetrators
- The victims ranged in age from six months to 88 years.
- The average age for victims was 35.5 years.
- The perpetrators ranged in age from 18 to 88 years.
- The average age for perpetrators was 40.3 years.
- The average number of risk factors identified in the cases reviewed was 8.2.
- The number of risk factors ranged from zero to 24.
- Seven or more risk factors were identified in 61% of the cases reviewed.

Domestic Violence Death Review Committee Aims and Objectives:

Purpose

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

Objectives

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

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

Chapter One: Introduction and Overview

History

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

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

Membership

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

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

Definition of Domestic Violence

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

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

Method for Reviewing Cases

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

When a domestic violence homicide or homicide-suicide takes place in Ontario, the relevant Regional Supervising Coroner notifies the Executive Lead of the DVDRC and the basic case information is recorded in a database. The Executive Lead, together with a police liaison officer

assigned to the DVDRC, periodically verify the status of judicial and other proceedings to determine if the review can commence. Since cases involving homicide-suicides generally do not result in criminal proceedings, those cases are reviewed in a more timely fashion.

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

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

Recommendations

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

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

Review and Report Limitations

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

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

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

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

Annual Report

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

Disclaimer

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

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

Chapter Two: Statistical Overview

Collection of Data

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

Types of Data

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

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

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

Statistics generated for the purposes of this annual report reflect a 13-year period of cases occurring from 2002-2014 where: 'homicide' has been identified as the manner of death for at least one victim; 'abuse – domestic violence' has been identified and coded as an involvement; *and* the case meets the DVDRC's definition of a domestic violence death. Some cases, where the manner of death is 'undetermined' and where there is involvement of domestic violence, are included in the data set.

It is important to note that some homicide cases identified with the 'abuse – domestic violence' involvement code occurring between 2002-2014 may still be pending review by the DVDRC. In many cases, DVDRC reviews have not commenced because legal or other proceedings are still underway or pending. The number of pending cases has been significantly reduced through the executive review of several cases that were outstanding as of 2015.

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

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

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

Statistical Overview: Homicides with Domestic Violence Involvement (2002-2014)

The following statistics relate to homicides in Ontario occurring between 2002-2014 where 'abuse – domestic violence' has been identified as an involvement code, and that meet the DVDRC's definition of a domestic violence death. Some of these cases may have already undergone review by the DVDRC while others are pending review upon completion of other proceedings (e.g. criminal trials).

Chart One: Homicides in Ontario with Domestic Violence Involvement Code (2002-2014)

Table A: Total number of homicides/homicides-suicides

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Totals 2002-2014
Number of cases	30	22	22	29	33	27	20	20	26	32	24	21	17	**323**
Homicides	19	18	13	21	26	17	15	15	20	25	15	17	11	**232 (72%)**
Homicide-Suicides	11	4	9	8	7	10	5	5	6	7	9	4	6	**91 (28%)**
Total number of Deaths	**46**	**26**	**32**	**37**	**52**	**44**	**29**	**29**	**33**	**39**	**31**	**28**	**27**	**453**

Table B: Age/Gender of homicide victims

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Totals 2002-2014
Total number of Homicide Victims	**35**	**22**	**23**	**29**	**45**	**34**	**24**	**25**	**27**	**30**	**24**	**24**	**21**	**363**
Female (adult)	26	19	21	29	28	27	20	20	22	28	19	21	13	**293 (81%)**
Female (child)	4	1	1	0	8	1	0	3	1	0	0	0	2	**21 (6%)**
Male (adult)	4	1	1	0	3	4	4	2	4	2	4	3	2	**34 (9%)**
Male (child)	1	1	0	0	6	2	0	0	0	0	1	0	4	**15 (4%)**
Average age of Homicide Victim	**37.8**	**34.9**	**40**	**38.2**	**28**	**34.7**	**43.3**	**37.2**	**36.1**	**45.6**	**44.8**	**38.8**	**36.3**	**38.1**

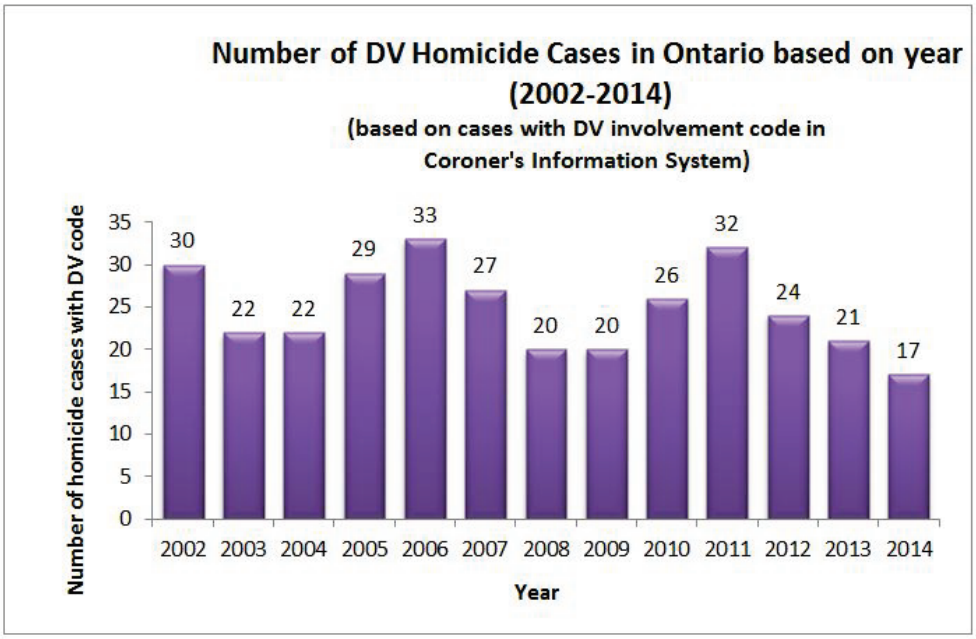
Table C: Perpetrator deaths

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Totals 2002-2014
Total number Perpetrator deaths (suicide or other)	11	4	9	8	7	10	5	4	6	9	7	4	6	**90 (20%)**
Female (adult)	0	0	1	0	0	1	0	0	0	0	0	0	0	**2 (2%)**
Male (adult)	11	4	8	8	7	9	5	**4**	6	9	7	4	6	**88 (98%)**
Average age of Deceased Perpetrator	**42.5**	**45.5**	**42.2**	**45**	**51.1**	**45.2**	**43.8**	**60**	**44.7**	**45.1**	**76.6**	**41**	**48.7**	**48.6**

Chart One: Summary

- There were 323 domestic homicide and/or homicide-suicide cases that occurred in Ontario between 2002-2014 (based on cases investigated by the Office of the Chief Coroner for Ontario, where domestic violence was identified as an involvement code).
- Of those 323 cases, 232 (72%) were homicides and 91 (28%) of the cases were homicide-suicides.
- The 323 cases resulted in a total of 453 deaths.
- Of the 453 deaths, 363 (80%) were homicide victims and 90 (20%) were perpetrators who committed suicide or were otherwise killed (e.g. shot by police).
- There was an average of 25 domestic homicide and/or homicide-suicide cases per year from 2002-2014.
- There was an average of 28 domestic homicide victim deaths per year from 2002-2014.
- Of the 363 homicide victims, 293 (81%) were adult females, 36 (10%) were children and 34 (9%) were adult males.
- Of the 90 perpetrator deaths, 88 (98%) were adult males.
- The average age of homicide victims was 38.1 years.
- The average age of perpetrators who died was 48.6 years.

Graph One: Number of DV cases based on year (2002-2014) in Ontario – based on cases with DV involvement code in Coroner's Information System



Graph One shows the number of domestic violence cases that occurred per year from 2002-2014. The number of case occurrences per year has varied from 16 cases in 2014 to 33 cases in 2006.

Graph Two: Number of DV Homicide Victims (2002-2014)

Graph Two shows the number of domestic violence homicide victims per year from 2002-2014. The number of homicide victims per year has varied from 20 in 2014 to 45 in 2006.

Death Factors

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

Chart Two illustrates the death factors most commonly cited in domestic violence deaths (homicides and perpetrator deaths) identified in the CIS from 2002-2014.

Chart Two: Top Death Factors in Domestic Violence Deaths (2002-2014)

Death Factor	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Total number and percentage of DV deaths 2002-2014
Trauma – cuts, stabs	15	8	11	9	21	14	8	11	16	15	7	12	13	160 (35%)
Trauma – beating, assault	5	4	4	5	6	2	0	0	3	3	2	4	0	38 (8%)
Shooting - handgun	8	5	2	4	1	9	1	3	3	1	6	4	2	49 (11%)
Shooting - rifle	2	0	3	5	5	3	3	2	1	2	0	0	0	26 (6%)
Shooting - shotgun	7	1	2	2	2	2	1	2	6	0	5	5	2	37 (8%)
Shooting – weapon (not spec.)	0	0	1	0	0	0	1	0	0	0	0	0	0	2 (0%)
Asphyxia – airway obstruction	0	1	1	0	0	1	0	1	1	2	1	0	0	8 (2%)
Asphyxia – strangulation	0	3	4	5	6	4	4	0	0	3	3	1	1	34 (8%)
Asphyxia – neck compression	0	0	0	1	2	0	2	3	0	0	0	1	1	10 (2%)
Other	9	4	4	6	9	9	9	7	3	13	7	1	8	89 (20%)
Total	46	26	32	37	52	44	29	29	33	39	31	28	27	453

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

Summary of Chart Two: Top Death Factors in Domestic Violence Deaths (2002-2014)

- Trauma (i.e. cuts/stabs and beating/assault) was a death factor in 44 % of the deaths.
- Shooting (i.e. handgun, rifle, shotgun or gun not specified) was a death factor in 25% of the deaths.
- Asphyxia (i.e. airway obstruction, strangulation and/or neck compression) was a death factor in 12% of the deaths.
- Other death factors such as: trauma by motor vehicle, train/vehicle or blunt force, asphyxia from hanging, anoxic environment and carbon monoxide, drug toxicity, jump/fall, fire with smoke inhalation or thermal injury, and burns–thermal drowning, were present in 19% of the deaths.

Statistical Overview: Cases Reviewed by the DVDRC (2003-2015)

From 2003-2015, the DVDRC has reviewed 267 cases that involved a total of 376 deaths. This includes 178 homicide and 89 homicide-suicide cases, some of which may have involved multiple victims.

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

In 2015, a dedicated effort was made to address the accumulation of pending cases awaiting review by the DVDRC. In many instances, the cases took several years to be processed through the criminal court system and were now ready for review. It was recognized that many of the systems and organizations involved with the cases had undergone significant change over the years. As such, all of the pending cases (49 in total), underwent "executive review" by a core team of representatives of the DVDRC. The executive review was a focused analysis of the circumstances surrounding the deaths and identification of risk factors present. Executive reviews provided a process that was similar to full reviews (as described on p. 3 method for reviewing cases), but was completed in a more expeditious manner in order to address the accumulation of pending cases.

The following statistics relate to all cases reviewed by the DVDRC from 2003-2015 inclusive.

Chart Three: Number of Cases Reviewed by the DVDRC (2003-2015)

Year	# of cases reviewed	# of deaths involved	Type of Case: Homicides	Type of Case: Homicide - Suicides
2003	11	24	3	8
2004	9	11	5	4
2005	14	19	5	9
2006	13	21	4	9
2007	15	25	7	8
2008	15	17	13	2
2009	16	25	6	10
2010	18	36	6	12
2011	33	41	27	6
2012	20	32	14	6
2013	19	22	17	2
2014	14	15	13	1
2015	Full: 21 Executive:49	Full: 29 Executive:57	Full: 12 Executive: 46	Full: 9* Executive: 3
Total	**267**	**374**	**178 (67%)**	**89 (33%)**

* One case involved a perpetrator that was shot by police following the homicide. For the purposes of this review, this case will be considered a homicide-suicide.
* One case involved a victim where it could not be determined if the death was a suicide or homicide, followed by the suicide of the possible perpetrator. For the purposes of this review, the case will be considered a homicide-suicide.

Summary of Chart Three: Number of Cases Reviewed by the DVDRC (2003-2015)

- In the period between 2003 and 2015, the DVDRC reviewed 267 cases, involving 374 deaths.
- Of the 267 cases, 178 (67%) were homicides and 89 (33%) were homicide-suicides.

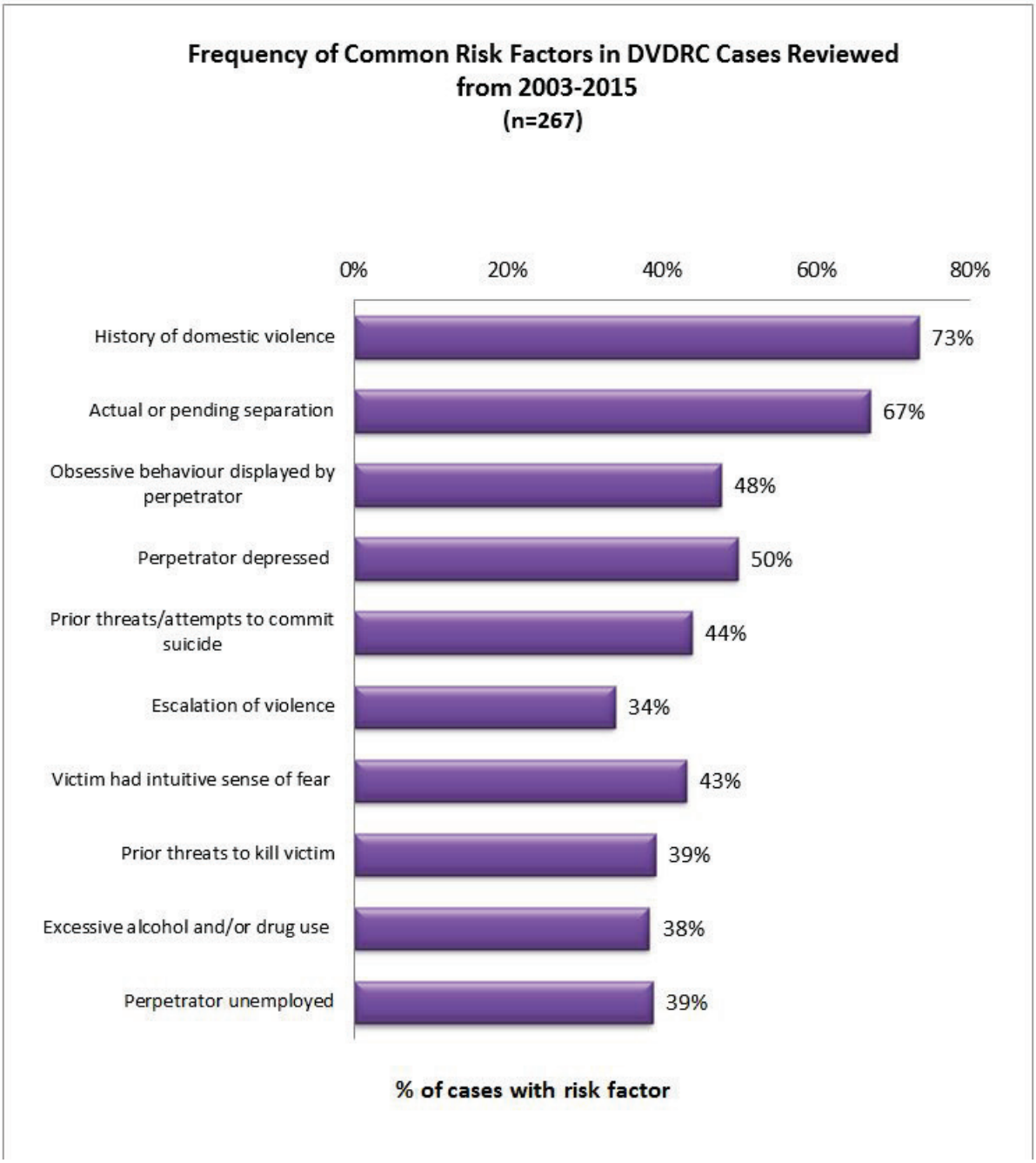
Analysis of Risk Factors: Common Risk Factors

Based on extensive research, the DVDRC has created a list of 40 risk factors that indicate the potential for lethality within the relationship examined. Prior to 2015, cases were assessed based on 39 risk factors. In 2015, the risk factor of history of domestic violence was broken down into past history vs. current history (involving the victim). The recognition of multiple risk factors within a relationship potentially allows for enhanced risk assessment, safety planning and possible prevention of future deaths related to domestic violence through appropriate interventions by criminal justice system and healthcare partners, including high risk case identification and management.

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

When reviewing a case, the DVDRC identifies which, if any, of the 40 risk factors were present in the relationship between the victim and the perpetrator.

Graph Three: Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2015)



*includes all reviews, including executive reviews in 2015

Summary of Graph Three: Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2015)

- When reviewing a case, the DVDRC identifies which of the 40 established risk factors were present in the relationship between the perpetrator and the victim.
- In 73% of all cases reviewed from 2003-2015, there was a history of domestic violence (past and/or present).
- In 67% of the cases, the couple had an actual or pending separation.
- In 50% of the cases, the perpetrator that was depressed (diagnosed and/or undiagnosed).
- In 48% of the cases, obsessive behaviour was displayed by the perpetrator.
- In 44% of the cases, the perpetrator had threatened or attempted at suicide.
- In 43% of the cases, the victims had an intuitive sense of fear.
- In 39% of the cases, there were prior threats to kill the victim.
- In 38% of the cases, excessive alcohol and/or drug use was involved.
- In 39% of the cases, the perpetrator was unemployed.
- In 34% of the cases, there was an escalation of violence.

Analysis of Risk Factors: Number of Risk Factors per Case

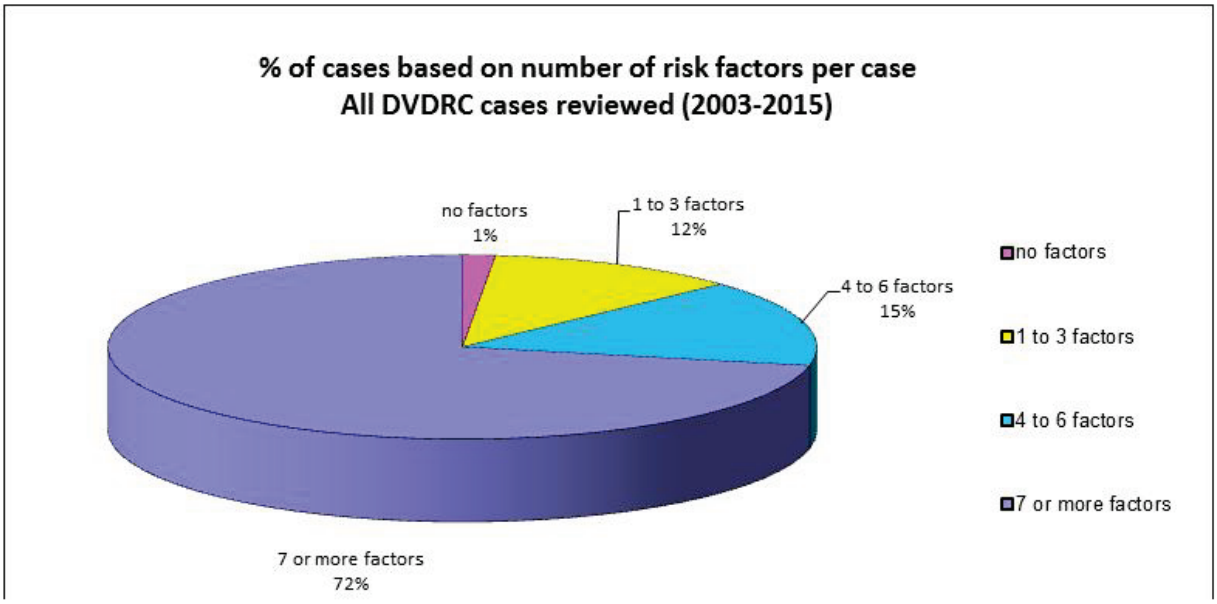
Chart Four: Number of Risk Factors per Case – All DVDRC cases reviewed (2003-2015), demonstrates that almost three quarters of all cases reviewed by the DVDRC had seven or more risk factors identified. The significance of this finding is that many domestic homicides may have been predicted and prevented with earlier recognition and action towards identified risk factors for future lethality.

The percentage of total cases based on number of risk factors is shown in a pie graph in **Graph Four: Percent (%) of cases based on number of risk factors per case – All DVDRC cases reviewed (2003-2015).**

Chart Four: Number of Risk Factors per Case – All DVDRC Cases Reviewed (2003-2015)

# of risk factors per case	2003-2014 (n=197)	2015 (n=21)	Executive Reviews 2015 (n=49)	2003-2015 (n=267)	% of total cases
no factors	1	0	3	4	1%
1 to 3 factors	25	3	3	31	12%
4 to 6 factors	23	5	13	41	15%
7 or more factors	148	13	30	191	72%

Graph Four: Percent (%) of cases based on number of risk factors per case – All DVDRC cases reviewed (2003-2015)



Summary of Chart Four and Graph Four: Number of Risk Factors per Case – All DVDRC cases reviewed (2003-2015)

- In 72% of the cases reviewed from 2003-2015, seven or more risk factors were identified.
- In 15% of the cases reviewed from 2003-2015, four to six risk factors were identified.
- The combined proportion of cases with four or more risk factors was 87%.
- In 12% of the cases reviewed from 2003-2015, one to three risk factors were identified.
- In 1% of the cases reviewed from 2003-2015, no risk factors were identified.
- The recognition of multiple risk factors within a relationship allows for enhanced risk assessment, safety planning and possible prevention of future deaths related to domestic violence.

Statistical Overview: Cases Reviewed by the DVDRC in 2015

In 2015, a dedicated effort was made to address the accumulation of pending cases awaiting review by the DVDRC. In many instances, the cases had been pending review as criminal court proceedings had been ongoing. Gradually, and after several years delay, the cases were processed through the courts and were now ready for review by the DVDRC.

It was recognized that many of the systems and organizations involved with the cases had undergone significant change over the years. As such, all of the pending cases (49 in total), underwent "executive review" by a core team of representatives of the DVDRC. The executive review included an analysis of the circumstances surrounding the deaths and compilation of risk factors identified in each case. None of the executive reviews conducted resulted in recommendations.

The DVDRC also conducted 21 full case reviews in 2015. Together with the 49 executive reviews, the DVDRC reviewed a total of 70 cases in 2015. This included 58 homicide and 12 homicide-suicide cases, resulting in a total of 87 deaths (75 homicide victims and 12 perpetrator suicides).

A detailed summary, including the type of case (i.e. homicide or homicide-suicide) age and sex of victims and perpetrators, number of risk factors and relevant themes for each, is included in Appendix C.

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

Full, redacted versions of individual cases reviewed by the DVDRC in 2015 may be requested directly from the Executive Lead, Committee Management at the Office of the Chief Coroner: occ.inquiries@ontario.ca

Chart 5 – Summary of Cases reviewed in 2015

	Full	Executive	Total
Total number of cases reviewed:	**21**	**49**	**70**
Total number of deaths reviewed:	**30**	**57**	**87**
Homicide deaths:	**21**	**54**	**75**
Female	18	46	64
Male	3	8	11
Child deaths:	1	**2**	**3**
Average age of victim:	39.1	**34.1**	**35.5**
Suicide deaths:**	9	3	12
Female	0	0	
Male	9	3	12
Average age of all perpetrators:	43.8	38.8	40.3
Average age of deceased (suicide/other) perpetrator:	54.7	50.7	53.7
# of male perpetrators	19	44	63
% of perpetrators - male	90.5%	89.8%	90.0%
# of female perpetrators	2	5	7
% of perpetrators - female	9.5%	10.2%	10.0%
Total # of homicide cases:	**12**	**46**	**58**
Total # of homicide-suicide cases:	**9**	**3**	**12**
# of cases with less than 7 risk factors:	8	19	27 (39%)
# of cases with 7 or more risk factors:	13	30	43 (61%)
Average number of risk factors:	8.5	8.1	8.2
# of cases involving age 65 or older:	3	2	5
Homicide-suicides w/elderly	2	1	3
# of recommendations made:	28	0	28

* includes one case where it could not be determined if the victim was murdered, or whether she committed suicide. While the manner of death was undetermined, for the purposes of this review, it will be considered a homicide.
** includes one case where the perpetrator was shot by police. For the purposes of this review, the death will be considered a suicide.

Chart 5 – Summary of Cases reviewed in 2015, demonstrates that:

- There were 21 full case reviews conducted by the DVDRC in 2015. This included 12 homicide cases and nine homicide-suicide cases, resulting in 30 deaths (21 homicide victims and nine perpetrator suicides).
- There were 49 executive case reviews conducted by the DVDRC in 2015. This included 46 homicide cases and three homicide-suicide cases, resulting in 57 deaths (54 homicide victims and three perpetrator suicides).
- In total, the DVDRC conducted 70 reviews (i.e. executive + full) in 2015. This included 58 homicide cases and 12 homicide-suicide cases, resulting in 87 deaths (75 homicide victims and 12 perpetrator suicides).
- As a result of these reviews, 28 recommendations were made towards the prevention of future similar deaths.
- Of the 75 victims in the cases reviewed, 64 (85%) were female and 11 (15%) were male.
- Of the 70 cases, 63 (90%) involved male perpetrators and seven (10%) involved female perpetrators.
- The victims ranged in age from six months to 88 years.
- There were three child victims: two male children (ages six months and six years) and one female child (age 3 years).
- The average age of victims was 35.5 years.
- The perpetrators ranged in age from 18 to 88 years.
- The average age of perpetrators (deceased and living) was 40.3 years.
- In 43 (61%) of the cases, seven or more risk factors were identified.
- The average number of risk factors identified in cases reviewed in 2015 was 8.2.
- The number of risk factors for individual cases ranged from zero to 24.
- Of the 70 cases reviewed, five (7%) involved individuals aged 65 or older; three of these cases were homicide-suicides.

Analysis of Risk Factors: Number of Risk Factors per Case

The data in **Chart Six: Number of Risk Factors Identified in Cases Reviewed (2015**), are consistent with the findings of the previous cases reviewed (2003-2014) which clearly demonstrate that the vast majority of cases resulting in domestic homicide or homicide-suicide, had a significant number of risk factors (i.e. seven or more) and therefore were potentially predictable and preventable (see Chart 4). It is important to again stress that the recognition of multiple risk factors within a relationship allows for enhanced risk assessment, safety planning and possible prevention of future deaths related to domestic violence.

Chart Six: Number of Risk Factors Identified in Cases Reviewed (2015)

# and % of risk factors per case	Full Reviews 2015 (n=21)	Executive Reviews 2015 (n=49)	Total reviews 2015 (n=70)	2003-2015 (n=267)
no factors	0	3	3	4
%	0	6%	4%	1%
1 to 3 factors	3	3	6	31
%	14%	6%	9%	12%
4 to 6 factors	5	13	18	41
%	24%	27%	26%	15%
7 or more factors	13	30	43	191
%	**62%**	**61%**	**61%**	**72%**

Chart Six breaks down the number of identified risk factors in the cases reviewed in 2015 and compares them to the number of risk factors for all cases reviewed from 2003-2015.

The chart indicates that:

- In 2015, 3 (4%) of all cases reviewed (i.e. executive and full reviews) had no risk factors identified. This compares to 1% of *all* cases reviewed from 2003-2015.
- In 2015, 6 (9%) of all cases reviewed (i.e. executive and full reviews) had one to three risk factors identified. This compares to 12% of *all* cases reviewed from 2003-2015.
- In 2015, 18 (26%) of all cases reviewed (i.e. executive and full reviews) had four to six risk factors identified. This compares to 15% of *all* cases reviewed from 2003-2015.
- In 2015, 43 (61%) of all cases reviewed (i.e. executive and full reviews) had seven or more risk factors identified. This compares to 72% of *all* cases reviewed from 2003-2015.
- The number of risk factors for cases reviewed in 2015 ranged from zero to 24.

- The risk factor findings for cases reviewed in 2015 is consistent with the findings shown in Chart Four and Graph Four which indicate that the majority of *all* cases reviewed from 2003-2015 have seven or more risk factors.

Analysis of Death Factors

Chart Seven: Death factors for cases reviewed in 2015 shows that 57% of the cases reviewed in 2015 involved some type of trauma (including cuts, stabs, beatings, assaults). Of the cases reviewed, 13% involved the use of a firearm, 13% were due to asphyxia (i.e. hanging, airway obstruction, strangulation or neck compression) and 17% were due to other factors such as jump/fall, burns, drowning or not ascertained.

Chart Seven: Death factors for cases reviewed in 2015

Death Factor	2015 Full Reviews	2015 Executive Reviews	Total
Trauma - cuts, stabs	12	28	40
Trauma - beating, assault	3	5	8
Trauma - blunt force	1	1	2
Shooting - handgun	5	3	8
Shooting - rifle		1	1
Shooting - shotgun		2	2
Asphyxia - hanging	2	1	3
Asphyxia - airway obstruction	1		1
Asphyxia - strangulation	1	6	7
Asphyxia - neck compression	1	3	4
Jump/Fall	3	3	6
Burns - heat		1	1
Drowning	1		1
not ascertained		3	3
Total Deaths	**30**	**57**	**87**

* Death factors as coded within the Coroner's Information System (CIS) - the database of all cases investigated by the Office of the Chief Coroner for the Province of Ontario.

- Deaths by trauma: 57%
- Deaths by shooting: 13%
- Deaths by asphyxia: 13%
- Deaths by jump/fall, burns-heat, drowning, not ascertained: 17%

Recommendations made from 2015 Case Reviews

In 2015, 28 recommendations were made from reviews conducted by the DVDRC.

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

Recommendations focused on:

- Training and education to healthcare providers (specifically obstetrical, geriatric and psychiatric service providers) on domestic violence
- Training and education on risk assessment to family court lawyers and marriage counsellors
- Interaction between child welfare and domestic violence services
- Funding for Partner Assault Response services
- Risk assessments

A summary of all recommendations made in 2015 is included in Appendix D.

Discussion and Significant Findings for Cases Reviewed in 2015

The findings from reviews conducted in 2015 are consistent with the overall results from reviews conducted from 2003-2014. More specifically:

- The majority of domestic violence homicide victims were female.
- The age range of victims is broad (six months to 88 years). The average age of a victim is mid-thirties.
- The age range for perpetrators is also broad (18 years to 88 years). The average age of a perpetrator is early-forties.
- The majority of cases reviewed had seven or more risk factors identified. The implication of numerous risk factors associated with these cases is that there was likely significant opportunity to predict (and prevent) future lethality in these cases.
- Trauma (e.g. stabs, beating, blunt force injury) was a factor in approximately half of the cases reviewed.

Chapter Three: DVDRC Reviews – Frequently Asked Questions

Mandate and Selection of Cases for Review

What is the mandate of the DVDRC?

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

How does the DVDRC define "domestic violence?"

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

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

What cases are reviewed by the DVDRC?

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

Review Process

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

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

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

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

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

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

Who is on the DVDRC?

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

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

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

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

What information is reviewed by the DVDRC?

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

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

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

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

Risk Factors

Why is identifying risk factors important?

Risk factors identified in case reviews are risk factors for **lethality** and are not limited to being predictive for recurrent domestic violence of a non-lethal nature. The trends in risk factors identified from case reviews conducted from 2003-2015 were demonstrated in Graph Three and Chart Four. In 74% of all cases reviewed over the past 13 years, the couple had a history of domestic violence. In 68% of the cases, there was an actual or pending separation. The other most common risk factors were obsessive behaviour by the perpetrator, a perpetrator who was depressed (diagnosis by a physician and/or observed by others), an escalation in violence, prior threats or attempts to commit suicide, prior threats to kill the victim, a victim who had an intuitive sense of fear of the perpetrator and a perpetrator who was unemployed.

Are some risk factors more important than others?

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

What is the importance of multiple risk factors?

In 72% of the cases reviewed from 2003-2015, seven or more risk factors were identified in the relationship between the victim(s) and the perpetrator.

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

What is the significance of the trends in risk factors?

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

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

Of the cases reviewed, 13% (see Chart Four) involved three or less risk factors. The lack of risk factors may impact the ability to predict or foresee lethality in the relationship and as a result, preventative or mitigating actions may not have been warranted or deemed necessary. Most of the homicide-suicide cases involving elderly individuals had very few risk factors identified. With minimal risks identified, it likely would have been difficult to predict, and therefore prevent, the tragic outcome.

Recommendations

How are recommendations developed and distributed?

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

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

Are recommendations binding?

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

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

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

The DVDRC has now reviewed a total of 267 cases since its inception in 2003. Upon analysis of those cases, the following general themes have emerged:

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

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

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

Is there follow-up to recommendations?

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

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

DVDRC Reports

Are DVDRC reports available to the public?

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

Chapter Four: DVDRC - Looking forward

The DVDRC has now been collecting, analyzing and interpreting data on domestic violence homicides in Ontario for 13 years. Our understanding of the complex relationship dynamics and issues that contribute to domestic homicides continues to be enhanced through both qualitative and quantitative validation of trends and themes. The data collected by the DVDRC provides a unique and comprehensive opportunity for academic researchers to access detailed information pertaining to victims and perpetrators of domestic violence homicides that may not routinely be collected or analyzed by other agencies or organizations.

The DVDRC continues to explore the many societal, legal and cultural implications of domestic violence in Ontario. As the database of information continues to evolve and develop, the opportunity for further analysis and interpretation will guide academic researchers, policy-makers, legal and medical practitioners and the public at large, towards the development of initiatives to reduce domestic violence homicides in Ontario.

The first 13 years of the DVDRC has demonstrated that positive change is possible and that with a collaborative and multi-disciplinary effort, we can continue to learn from the past in order to make Ontario a healthier and safer place in the future.

Appendix A: DVDRC – Terms of Reference

Purpose

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

Definition of Domestic Violence Deaths

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

Objectives

1. To provide and coordinate a confidential multi-disciplinary review of domestic violence deaths pursuant to Section 15(4) of the Coroners Act, R.S.O. 1990, Chapter c. 37, as amended.
2. To offer expert opinion to the Chief Coroner regarding the circumstances of the event(s) leading to the death in the individual cases reviewed.
3. To create and maintain a comprehensive database about the victims and perpetrators of domestic violence fatalities and their circumstances.
4. To help identify the presence or absence of systemic issues, problems, gaps, or shortcomings of each case to facilitate appropriate recommendations for prevention.
5. To help identify trends, risk factors, and patterns from the cases reviewed to make recommendations for effective intervention and prevention strategies.
6. To conduct and promote research where appropriate.

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

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

Appendix B

Risk Factor Descriptions (updated 2015)

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

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

	Family/Economic Status	Definition
3	Youth of couple	Victim and perpetrator were between the ages of 15 and 24.
4	Age disparity of couple	Women in an intimate relationship with a partner who is significantly older or younger. The disparity is usually nine or more years.
5	Victim and perpetrator living common-law	The victim and perpetrator were cohabiting.
6	Actual or pending separation	The partner wanted to end the relationship. Or the perpetrator was separated from the victim but wanted to renew the relationship. Or there was a sudden and/or recent separation. Or the victim had contacted a lawyer and was seeking a separation and/or divorce.
7	New partner in victim's life	There was a new intimate partner in the victim's life or the perpetrator perceived there to be a new intimate partner in the victim's life

8	Child custody or access disputes	Any dispute in regards to the custody, contact, primary care or control of children, including formal legal proceedings or any third parties having knowledge of such arguments.
9	Presence of step children in the home	Any child(ren) that is(are) not biologically related to the perpetrator.
10	Perpetrator unemployed	Employed means having full-time or near full-time employment (including self-employment). Unemployed means experiencing frequent job changes or significant periods of lacking a source of income. Please consider government income assisted programs (e.g., O.D.S.P.; Worker's Compensation; E.I.; etc.) as unemployment.

	Perpetrator Mental Health	Defintion
11	Excessive alcohol and/or drug use by perpetrator	Within the past year, and regardless of whether or not the perpetrator received treatment, substance abuse that appeared to be characteristic of the perpetrator's dependence on, and/or addiction to, the substance. An increase in the pattern of use and/or change of character or behaviour that is directly related to the alcohol and/or drug use can indicate excessive use by the perpetrator. For example, people described the perpetrator as constantly drunk or claim that they never saw him without a beer in his hand. This dependence on a particular substance may have impaired the perpetrator's health or social functioning (e.g., overdose, job loss, arrest, etc). Please include comments by family, friend, and acquaintances that are indicative of annoyance or concern with a drinking or drug problem and any attempts to convince the perpetrator to terminate his substance use.
12	Depression – in the opinion of family/friend/acquaintance	In the opinion of any family, friends, or acquaintances, and regardless of whether or not the perpetrator received treatment, the perpetrator displayed symptoms characteristic of depression.

13	Depression – professionally diagnosed	A diagnosis of depression by any mental health professional (e.g., family doctor; psychiatrist; psychologist; nurse practitioner) with symptoms recognized by the DSM-IV, regardless of whether or not the perpetrator received treatment.
14	Other mental health or psychiatric problems – perpetrator	For example: psychosis; schizophrenia; bi-polar disorder; mania; obsessive-compulsive disorder, etc.
15	Prior threats to commit suicide by perpetrator	Any recent (past 6 months) act or comment made by the perpetrator that was intended to convey the perpetrator's idea or intent of committing suicide, even if the act or comment was not taken seriously. These comments could have been made verbally, or delivered in letter format, or left on an answering machine. These comments can range from explicit (e.g., "If you ever leave me, then I'm going to kill myself" or "I can't live without you") to implicit ("The world would be better off without me"). Acts can include, for example, giving away prized possessions.
16	Prior suicide attempts by perpetrator	Any recent (past 6 months) suicidal behaviour (e.g., swallowing pills, holding a knife to one's throat, etc.), even if the behaviour was not taken seriously or did not require arrest, medical attention, or psychiatric committal. Behaviour can range in severity from superficially cutting the wrists to actually shooting or hanging oneself.

	Perpetrator Attitude/ Harassment/ Violence	**Defintion**
17	Obsessive behavior displayed by perpetrator	Any actions or behaviours by the perpetrator that indicate an intense preoccupation with the victim. For example, stalking behaviours, such as following the victim, spying on the victim, making repeated phone calls to the victim, or excessive gift giving, etc.
18	Failure to comply with authority	The perpetrator has violated any family, civil, or criminal court orders, conditional releases, community supervision orders, or "No Contact" orders, etc. This includes bail, probation, or restraining orders, and bonds, etc.

19	Sexual jealousy	The perpetrator continuously accuses the victim of infidelity, repeatedly interrogates the victim, searches for evidence, tests the victim's fidelity, and sometimes stalks the victim.
20	Misogynistic attitudes – perpetrator	Hating or having a strong prejudice against women. This attitude can be overtly expressed with hate statements, or can be more subtle with beliefs that women are only good for domestic work or that all women are "whores."
21	Prior destruction or deprivation of victim's property	Any incident in which the perpetrator intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the perpetrator. This could include slashing the tires of the car that the victim uses. It could also include breaking windows or throwing items at a place of residence. Please include any incident, regardless of charges being laid or those resulting in convictions.
22	History of violence outside of the family by perpetrator	Any actual or attempted assault on any person who is not, or has not been, in an intimate relationship with the perpetrator. This could include friends, acquaintances, or strangers. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.).
23	History of domestic violence - **Previous** partners	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person **who has been in** an intimate relationship with the perpetrator. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.). It could be as simple as a neighbour hearing the perpetrator screaming at the victim or include a co-worker noticing bruises consistent with physical abuse on the victim while at work.

24	History of domestic violence - **Current** partner/victim	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who **is in an** intimate relationship with the perpetrator. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.). It could be as simple as a neighbour hearing the perpetrator screaming at the victim or include a co-worker noticing bruises consistent with physical abuse on the victim while at work.
25	Prior threats to kill victim	Any comment made to the victim, or others, that was intended to instill fear for the safety of the victim's life. These comments could have been delivered verbally, in the form of a letter, or left on an answering machine. Threats can range in degree of explicitness from "I'm going to kill you" to "You're going to pay for what you did" or "If I can't have you, then nobody can" or "I'm going to get you."
26	Prior threats with a weapon	Any incident in which the perpetrator threatened to use a weapon (e.g., gun; knife; etc.) or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.) for the purpose of instilling fear in the victim. This threat could have been explicit (e.g, "I'm going to shoot you" or "I'm going to run you over with my car") or implicit (e.g., brandished a knife at the victim or commented "I bought a gun today"). Note: This item is separate from threats using body parts (e.g., raising a fist).
27	Prior assault with a weapon	Any actual or attempted assault on the victim in which a weapon (e.g., gun; knife; etc.), or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.), was used. Note: This item is separate from violence inflicted using body parts (e.g., fists, feet, elbows, head, etc.).

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

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

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

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

	Victim's Disposition	Defintion
40	Victim's intuitive sense of fear of perpetrator	The victim is one that knows the perpetrator best and can accurately gauge his level of risk. If the women discloses to anyone her fear of the perpetrator harming herself or her children, for example statements such as, "I fear for my life", "I think he will hurt me", "I need to protect my children", this is a definite indication of serious risk.

Appendix C: Detailed Summary of Cases reviewed in 2015

Full Reviews (2015)

Case #	Year of death	Homicide	Homicide-Suicide	# of victims	Age of Victims	Female Victim	Male Victim	Child Victim	Age of Perp	Male Perp	Female Perp	# of risk factors	# of recs	Themes
1	2011	1		1	26	1			28	1		9	3	Safe separation, immigrants,
2	2012	1		1	27		1		24		1	9	0	Mental health, substance abuse,
3	2011	1		1	19	1			22	1		20	7	Mental health, financial, unity of family
4	2011	1		1	46	1			56	1		13	3	Family/friends, risk management, strategies for men
5	2011	1		1	43	1			46	1		5	0	Mental health
6	2012		1	1	88	1			88	1		4	5	Mental health, elderly
7	2012		1	1	52	1			65	1		7	0	Safe separation, access to firearms
8	2011		1	1	43	1			46	1		14	1	Mental health, substance abuse, risk assessments, family/friends
9	2011		1	1	51	1			54	1		13	0	Financial, substance abuse, safe separation
10	2011	1		1	27	1			27	1		16	0	Mental health, financial, safe separation
11	2011		1	1	43	1			47	1		10	0	Safe separation, workplace
12	2010	1		1	25		1		24		1	2	0	History of DV
13	2011	1		1	42	1			41	1		7	0	Mental health, substance abuse, safe separation, cultural friction
14	2012		1	1	43	1			43	1		9	4	Safe separation, friends/family
15	2011	1		1	41	1			43	1		5	0	Safe separation, mental health

16	2012		1	1	70	1			74	1		2	2	Elderly, mental health
17	2012		1	1	6		1	1	43	1		6	0	Safe separation
18	2011	1		1	29	1			25	1		6	0	Family/friends, pornography
19	2011		1	1	29	1			32	1		12	0	Family/friends, substance abuse, mental health
20	2012	1		1	41	1			40	1		3	0	Safe separation
21	2011	1		1	31	1			51	1		8	0	Substance abuse, vulnerable victim

Executive Reviews (2015)

Case #	Year of death	Homicide	Homicide-Suicide	# of victims	Age of Victims	Female Victim	Male Victim	Child Victim	Age of Perp	Male Perp	Female Perp	# of risk factors	# of recs	Themes
EX-01	2002		1	1	77	1			87	1		0	0	Elderly
EX-02	2004	1		1	51	1			57	1		6	0	Repeat DV, mental health
EX-03	2004	1		1	34		1		36		1	3	0	Financial issues, child custody and public/family/friends intervention opportunities.
EX-04	2005	1		1	24	1			36	1		24	0	Public/family/friends intervention opportunities, mental health issues, probation, immigration, previous domestic violence.
EX-05	2006	1		1	55	1			70	1		7	0	Public/family/friends intervention opportunities.
EX-06	2006				0.5		1							Mental health issues
		1		3	3	1		1	40	1		6	0	
					38	1		1						
EX-07	2006	1		1	29	1			19	1		7	0	Public\Friends\Family Intervention Opportunities and Safe Separation

EX-08	2006	1		1	34	1			45	1		13	0	Public/Family/Friends Intervention Opportunities, Mental Health Issues, History of Domestic Violence and Cultural Differences/Stressors.
EX-09	2006	1		1	19	1			18	1		12	0	Jealousy, policing, public/family/friends intervention opportunities
EX-10	2006	1		1	18		1		19		1	9	0	Jealousy and public/family/friend intervention opportunities
EX-11	2006	1		1	35	1			45	1		9	0	Issues of bail, restraining orders, and the responsibilities of sureties.
EX-12	2006	1		1	31	1			35	1		16	0	
EX-13 EX-13	2006 2011	1		2	32 28	1 1			49	1		11		
EX-14	2006	1		1	36		1		34		1	0	0	Financial Issues, Perpetrators who were previous victims of domestic violence and Public\Family\Friends Intervention Opportunities.
EX-15	2006		1	2	25 35	1	 1		35	1		4	0	Jealousy, safe separation
EX-16	2007	1		1	32	1			34	1		4	0	Financial issues, substance abuse, perpetrators who were previous victims of domestic violence.
EX-17	2007	1		1	22	1			38	1		6	0	
EX-18	2007		1	1	27	1			30	1		5	0	Financial issues, jealousy, public/family/friends intervention opportunities
EX-19	2007	1		1	25	1			29	1		3	0	Financial issues, health concerns or mental health issues
EX-20	2007	1		2	22 24	1	 1		27	1		10	0	Safe separation and public/friends/family intervention opportunities.
EX-21	2010	1		1	32	1			35	1		13	0	Child Custody, Public/Family/Friends Intervention Opportunities, Immigration/Safe Separation

EX-22	2008	1		1	32	1			48	1		11	0	Child custody issues, access to firearms
EX-23	2008	1		1	53	1			60	1		10	0	Cultural differences/stressors, mental health issues, safe separation.
EX-24	2008	1		1	42	1			38	1		3	0	Child Custody Issues, Family Lawyer Education and Safe Separation
EX-25	2008	1		1	44	1			50	1		8	0	Public, family/friends intervention opportunities
EX-26	2008	1		1	31	1			22	1		7	0	Public/family/friends intervention opportunities
EX-27	2008	1		1	58	1			56	1		10	0	Public/friends/family intervention, family lawyer education and police
EX-28	2008	1		1	53	1			52	1		6	0	Public/Family/Friends Intervention Opportunities, Safe separation and Mental Health Issues
EX-29	2009	1		1	41	1			39	1		10	0	Child Custody Issues, Policing (us of the DVSR), Immigration, and Incongruent Criminal and Family Contact Conditions.
EX-30	2009	1		1	28	1			30	1		0	0	
EX-31	2009	1		1	52	1			40	1		10	0	Public/Family/Friends Intervention Opportunities, Financial Issues, Substance, and Previous Domestic Violence.
EX-32	2009	1		1	47	1			46	1		8	0	Safe Separation, Public/Family/Friends Intervention Opportunities
EX-33	2009	1		1	45	1			46	1		18	0	Mental Health Issues, Substance, Public/Family/Friends Intervention Opportunities, Probation, Education for Health Care Worker, High Risk Offender Significant History of Domestic Violence, Monitoring of High Risk Offenders, Education for Family Physician.
EX-34	2009	1		1	53	1			57	1		4	0	Cultural Difference/Stressors, Victim Vulnerability and Safe Separation.

EX-35	2009	1		1	36		1		21		1	11	0	Substance, Probation, Mutual Violence, Rural/Aboriginal Communities, and Policing.
EX-36	2009	1		1	33	1			33	1		14	0	Policing
EX-37	2009	1		1	19	1			23	1		7	0	Jealousy and Safe Separation
EX-38	2009	1		1	29	1			30	1		14	0	Public/Family/Friends Intervention Opportunities and Safe Separation
EX-40	2010	1		1	46	1			43	1		5	0	Substance, Safe Separation
EX-41	2010	1		1	25		1		23		1	6	0	Public/Family/Friends Intervention Opportunities, Substance and Mutual Violence
EX-42	2010	1		1	27	1			39	1		10	0	Public/Family/Friends Intervention Opportunities
EX-43	2010	1		1	38	1			45	1		5	0	Public/Family/Friends Intervention Opportunities, Safe Separation and Mental Health Issues
EX-44	2010	1		1	28	1			26	1		12	0	Public/Family/Friends Intervention Opportunities, Victim Vulnerability and Probation
EX-45	2010	1		1	23	1			27	1		7	0	Mental Health Issues, Substance Abuse, Public/Family/Friends Intervention Opportunities
EX-46	2010	1		1	21	1			29	1		4	0	Educating Physicians, Firearms, Mental Health Issues, Public/Family/Friends Intervention Opportunuties
EX-47	2010	1		1	48	1			48	1		8	0	Safe Separation, Physician and Public/Family/Friends Intervention Opportunities
EX-48	2010	1		1	44	1			51	1		8	0	High Risk Offender with a Significant History of Domestic Violence, Monitoring of High Risk Offenders, Mutual Violence, Substance Abuse, Aboriginal Community, Probation.

EX-49	2010	1		1	29	1			31	1		7	0	Child Custody and Victim Vulnerability

Appendix D

Summary of Cases and Recommendations – 2015 Full Case Reviews

Case #	Summary	Recommendation(s)
2015-01	This case involved the homicide of a 26-year-old female victim by her 28-year-old husband. The couple, originally from Sudan, had emigrated from Egypt to Canada. The victim was six months pregnant at the time of her death. Nine risk factors.	To obstetrical care providers (College of Midwives, College of Family Physicians, College of Nurses, Society of Obstetricians and Gynecologists, Ontario Medical Association), Ministry of Health and Long Term Care, Ontario Medical Schools and Ontario Schools of Nursing: **1. The curriculum for prenatal programs should include a presentation and resource material regarding violence against women. (Reference: Talk to Me Program – Mount Sinai Hospital).** To the Ontario Ministry of Citizenship, Immigration and International Trade and Citizenship and Immigration Canada: **2. The issue of violence against women should be discussed as part of any programs provided to newcomers to Canada who are attempting to adjust to new cultural and societal values, along with resources available to support victims.** To the Ministry of the Attorney General: **3. When a perpetrator completes the intake assessment with the Partner Assault Response (PAR) provider, and there is evidence of high risk to the victim, the PAR agency should immediately notify the police, the referral source, the victim and the perpetrator.**

2015-02	This case involved the homicide of a 27-year-old male victim by his 24-year-old female common-law spouse. Both the perpetrator and victim had a history of substance abuse. Nine risk factors.	No new recommendations.

2015-03	This case involved the homicide of a 19-year-old female victim by her 22-year-old boyfriend. There was a history of domestic violence and mental health issues. 20 risk factors.	To the Children's Aid Society involved: **1. The Children's Aid Society (CAS) involved with this family should conduct an internal review to examine its assessment of risk, not only for child abuse or neglect, but also for intimate partner violence.** To the Ministry of Children and Youth Services and Ontario Association of Children's Aid Societies: **2. All Children's Aid Societies should be strongly encouraged to conduct an internal review whenever a domestic violence death occurs in a family that had received services of the Society within the preceding 12 months of the death, and where potential domestic violence issues had been identified.** To the Ministry of Children and Youth Services: **3. It is recommended that the Ministry of Children and Youth Services update and enhance the training available to all CASs regarding assessing potential for domestic and intimate partner violence and ensure that it reflects the most recent literature and best practices. It is recommended that the training of front line CAS workers and supervisors include training on issues related to intimate partner violence.** To Medical Schools in Ontario: **4. It is recommended that all medical schools and their departments of psychiatry ensure that domestic violence, as well as risk assessment, safety planning, and risk management, are a mandated part of their training programs and certification processes. Safety is a top priority, therefore, it must be ensured that trainees at all levels obtain competency in risk assessment and risk management techniques.** To the Canadian Professional Counsellors Association: **5. It is recommended that the facts and circumstances of the case be used to assist in the education of members of the Canadian Professional Counsellors Association (CPCA) about the dynamics of domestic violence and the risk factors of lethality so that they can adequately assess and counsel clients with relationship problems.** **6. It is recommended that continuing education of CPCA members include an emphasis on the importance of understanding the dynamics of domestic violence and the risk factors of lethality so that they can adequately assess and counsel clients with relationship problems.** To the Police Service involved: **7. It is recommended that the Domestic Violence Coordinator of the Police Service review the Service's**

2015-04	This case involved the homicide of a 46-year-old woman by her 56-year-old husband. The couple had a history of domestic violence and the perpetrator had recently been charged with assaulting the couple's 18-year-old daughter. The victim was in the process of ending the marriage at the time of the homicide. 13 risk factors.	To the Ministry of the Attorney General **1. Partner Assault Response (PAR) services across the province should receive special funding for crisis assessment and interventions, including provision of support and risk management on a voluntary basis to support men charged with assaults in the family pending court intervention.** To the Ministry of Community Safety and Corrections Services (MCSCS) and Police Services in Ontario: **2. Police services are reminded that when intervening in incidents involving violence against children where there is also a history of domestic violence, the perpetrator should be referred to Partner Assault Response (PAR) programs for risk assessment and risk management on a voluntary basis.** To the Ministry of Community Safety and Correctional Services (MCSCS) and Police Services in Ontario: **3. Police services are reminded that as part of their domestic violence policies and protocols, and in collaboration with MAG/Crowns, when an offender is released to a location where they are able to observe or be close to the victim and/or children, the police service should conduct safety planning at the victim's residence and that full victim services are offered. The Victim Quick Response Program (VQRP) should be utilized to change locks and provide other necessary safety precautions**. **4.**
2015-05	This case involved the homicide of a 43-year-old female victim by the perpetrator, her 46-year-old husband. The perpetrator was diagnosed with mental health issues and was non-compliant with his medications. Five risk factors.	No new recommendations.

2015-06	This case involved the homicide-suicide of an elderly couple who had been married for 62 years. The victim had significant health concerns and the perpetrator was under significant stress as the primary care provider. Four risk factors.	To the Ministry of Health and Long Term Care and Ontario Association of Community Care Access Centres: **1. All health care providers who work with the elderly population should be educated on the risk factors related to domestic violence and potential domestic homicides.** To the Ministry of Health and Long Term Care and the Ontario Hospital Association: **2. The Ministry of Health and Long Term Care, in collaboration with the Ontario Hospital Association, should develop information materials on structured risk assessment and risk management strategies as part of a care plan to deal with domestic violence in the elderly population similar to their efforts on suicide prevention.** **3. The accreditation process for Ontario hospitals should include policies and procedures directed toward the assessment and management of domestic violence in the elderly population. This should include red-flagging potential high risk cases and ongoing information sharing amongst the multiple health professionals involved within the hospital and community including nurses, doctors, mental health professionals and personal support workers. An overall coordinated and integrated approach by geriatric services is essential.** To the Ontario Women's Directorate: **4. The Ontario Women's Directorate should extend their public education efforts on domestic violence to ensure that the general public is aware of domestic violence in the elderly population.** **5.** To the hospital and Community Care Access Centre (CCAC) involved: **6. The hospital and CCAC providing care to the victim in this case should conduct internal reviews to determine what safeguards should be in place to prevent future similar deaths. The facts from this case could be used as an educational opportunity for staff.**

2015-07	This case involved the homicide of a 52-year-old female victim by her 65-year-old husband who subsequently committed suicide. The couple was in the process of separating at the time. Seven risk factors.	No new recommendations.
2015-08	This case involved the homicide of a 43-year-old female victim and subsequent suicide by her 46-year-old husband, the perpetrator. 14 risk factors.	To Police Services in Ontario, Ontario Association of Chiefs of Police and Ministry of Community Safety and Correctional Services: **1. Police risk assessment should be mandatory for every domestic violence call, regardless of whether there is a prior history of domestic violence, and should not be dependent upon a charge being laid or not.**
2015-09	This case involved the homicide of a 51-year-old female victim by her 54-year-old husband who subsequently committed suicide. The couple and their three children had significant stressors including gambling and alcohol issues and prior attempted suicides within the family. 13 risk factors.	To the Ontario Association of Children's Aid Societies: **1. Staff of Children's Aid Societies should be made aware of the links between domestic violence and domestic homicides that may impact their clients and place families at risk, with a view to supporting evidence-informed practice in this area. The OACAS should consider integrating knowledge about this link into training materials for new and ongoing staff training.** To the Ontario Association of Marriage and Family Therapy and the Ontario Association of Social Workers: **2. The Ontario Association of Marriage and Family Therapy and the Ontario Association of Social Workers should be encouraged to promote professional development related to preventing domestic homicide including a review of DVDRC annual reports and the links between domestic violence and domestic homicide.** To the Ontario Women's Directorate and the Ministry of Children and Youth Services: **3. The Ontario Women's Directorate and the Ministry of Children and Youth Services should jointly direct funding to an appropriate body to undertake a research study to determine the factors that may contribute to an increased risk of lethality to adults and children where domestic violence is a verified child protection concern.**

2015-10	This case involved the homicide of a 27-year-old female victim by her 27-year-old boyfriend. The perpetrator had a significant history of mental health issues. 16 risk factors.	No new recommendations.
2015-11	This case involved the homicide of a 43-year-old female victim by her 47-year-old husband who subsequently committed suicide. The couple had recently separated. 10 risk factors.	No new recommendations.
2015-12	This case involved the homicide of a 25-year-old male victim by his 24-year-old female partner. There was a significant history of domestic violence in the relationship, although the victim was the instigator of most of the violence. There was a history of Children's Aid Society involvement. Two risk factors.	No new recommendations.

2015-13	This case involved the homicide of a 42-year-old female victim by her 41-year-old husband. The couple was in the process of separating at the time of the homicide and both had sought advice from legal counsel. The perpetrator had significant mental health and substance abuse issues. Seven risk factors	No new recommendations.

2015-14	This case involved the homicide of a 43-year-old female victim by her 43-year-old husband. The perpetrator was subsequently shot and killed by police. The couple was in the process of separating and there had been a lengthy family law dispute at the time of the homicide. Nine risk factors.	To the Ministry of the Attorney General: **1. Existing public education campaigns and programs for divorcing couples and their friends and family should highlight the potential for escalating violence in these circumstances, and should encourage help-seeking for individuals experiencing high conflict divorce, as well as risk assessment and risk management for individuals expressing suicidal or homicidal thoughts.** To the Law Society of Upper Canada: **2. The Law Society of Upper Canada should ensure that family law lawyers who may be engaged in high conflict litigation in regards to child custody and access cases receive appropriate legal education on the links between suicidal thinking and risk for homicide.** To universities offering programs in social work, psychology and medicine; College of Physicians and Surgeons of Ontario, Ontario College of Social Workers and Social Services Workers, College of Psychologists, College of Nurses, Ontario Association of Marriage and Family Therapists: **3. The Deans or Chairs of Departments of Social Work, Psychology and Medicine should ensure courses are provided on domestic violence and risk assessment and risk management. Professional Colleges for these professional groups should share information on the links between depression, suicidal ideation and domestic homicide.** To the Ministry of the Attorney General: **4. The Ministry of the Attorney General should convene an interdisciplinary committee to review and revise Family Law rules to provide that each litigant must complete and file with the court as part of the regular court documents an "Assessment of Conflict Form" that asks questions that will elicit information that can be measured by risk assessment tools in regards to risk of harm to any of the parties.**

2015-15	This case involved the homicide of a 41-year-old female victim by her 43-year-old husband. The couple was in the process of separating. Five risk factors	No new recommendations.
2015-16	This case involved the homicide of a 70-year-old woman by her 74-year-old husband who subsequently committed suicide. The couple had been married for 42 years. The perpetrator had a history of depression and previous suicide attempts. Two risk factors.	To the Ministry of Health and Long Term Care, Ministry of Community Safety and Correctional Services, Ministry of the Attorney General (Victim Services), Ontario Seniors Secretariat, Ontario Association of Community Care Access Centres, Ontario Women's Directorate and College of Physicians and Surgeons of Ontario: **1. Health care providers, police services, victim services, community care access centres, Ontario Women's Directorate, and families should receive enhanced education and training about aging couples' increased risk of intimate partner homicide-suicide, particularly if they are experiencing declining or poor health, and/or some other major life change.** To the Ministry of Health and Long Term Care, College of Physicians and Surgeons of Ontario, Ontario Association of Community Care Access Centres and the Ontario Seniors Secretariat: **2. Health care providers should emphasize or discuss the importance of aftercare options or mechanisms for aging couples and work with their families to identify appropriate mechanisms when one partner is being treated for depression or other related mental health issues and, in particular, if there is evidence of suicidal ideation, previous suicide attempts, and/or subsequent hospitalization.**
2015-17	This case involved the homicide of a seven-year-old boy by his 43-year-old father who subsequently committed suicide. At the time of the incident, the perpetrator and his wife (the victim's mother) were in the process of separating. Six risk factors.	No new recommendations.

2015-18	This case involved the homicide of a 29-year-old woman by her 25-year-old husband. Six risk factors.	No new recommendations.
2015-19	The case involved the death of a 29-year-old female and the suicide of her 32-year-old boyfriend. It could not be determined whether the deceased female committed suicide or whether she was a victim of homicide. The manner of death for the female has therefore been noted as undetermined. 12 risk factors.	No new recommendations.
2015-20	This case involved the homicide of a 41-year-old woman by her 40-year-old on-again/off-again boyfriend. The victim was involved in a new relationship. Three risk factors.	No new recommendations.
2015-21	This case involved the homicide of a 31-year-old female victim by her 51-year-old boyfriend. The victim was addicted to drugs and worked in the sex trade industry. The perpetrator provided drugs to the victim. Eight risk factors.	No new recommendations.

For further information, please contact:

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