Canadian Domestic Homicide Prevention Initiative

Domestic Violence Death Review Committees:
"Speaking for the Dead to Protect the Living"

Domestic Homicide Brief 1

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Acknowledgements

This Domestic Homicide Brief is the first in a series developed by the Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations (CDHPIVP). The CDHPIVP is a five year (2015 -2020) national research project on domestic homicides in Canada. Specifically, the research will identify unique risk factors for domestic homicide within particular vulnerable groups (children exposed to domestic violence; rural, remote, and Northern communities; immigrant and refugee populations; and Aboriginal peoples) and strategies currently utilized to reduce this risk and prevent future violence. The CDHPIVP is built on a national partnership between research centres/universities, government, and community agencies all focused on domestic violence prevention.

This series discusses topics relevant to the CDHPIVP research and includes guest editors with specific expertise in the area. The next brief in the series will be on risk assessment, risk management and safety planning.

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Domestic Violence Death Review Committees:

"Speaking for the Dead to Protect the Living"

Much has been learned about domestic homicides from multidisciplinary death review committees in Canada and around the world. In Ontario, the Office of the Chief Coroner has had such a committee in operation since 2003.[1] The motto of the Chief Coroner is "We speak for the dead to protect the living" which is a stark reminder of the important role that these reviews offer to the community. The extent of this problem is reflected in the fact that from 2003 to 2013, there has been almost one thousand (960) domestic homicides that have occurred in Canada with over three quarters of these deaths involving female victims. The majority of domestic homicides in Canada are committed by a (current or former) married or common-law partner, with almost one quarter committed by a dating partner.[2]

It is important to note that the number of reported domestic homicide cases may be an underrepresentation due to varying definitions or police not recognizing the nature of the relationship between the victim and the perpetrator. Furthermore, these numbers do not reflect other deaths due to domestic violence, such as children or other adult victims (e.g., victim's new partner; extended family members) or women committing suicide or women dying homeless on the streets in order to escape violent relationships.[3]

There have been close to 1,000 ***domestic homicides*** *in Canada over the past decade.*[2]

What is a Domestic Violence Death Review Committee (DVDRC)

A Domestic Violence Death Review Committee (DVDRC), also known as a domestic violence fatality review team or family violence fatality review team, is a multi-disciplinary advisory committee of experts who review deaths that occur in the context of domestic violence with the overall objective of preventing similar deaths from occurring in the future.

The review process is analogous to reviewing deaths that result from a plane crash.[3] Although plane crashes are a rare event, they draw a lot of public attention due to the high number of fatalities that occur. The public looks to organizations responsible for safety in the aviation industry to conduct a thorough review to determine what mechanical, human, and/or systemic problems occurred that may be connected to the crash and to rectify these problems to prevent potential future crashes.

By analogy, death review committees can examine problems in education, training, and coordination of services that may be important to prevent domestic homicides. For example, a domestic violence death review can identify risk factors to help predict potential lethality, better inform risk assessments and reduce missed opportunities for intervention and prevention.[4]

Domestic Violence Death Reviews Around the World

International Reviews

Australia
In 2008, the Australian government commissioned the National Council to Reduce Violence against Women and their Children to help with the development of a national action plan to reduce violence against women and children across the country. In 2009, the Council published the Time for Action report that contained several recommendations including the need to establish domestic homicide review processes in all states and territories.[5] Following the publication of the Time for Action report, domestic homicide review teams have been established in New South Wales, Queensland, South Australia, and Victoria.[6,7]

New Zealand
The Family Violence Death Review Committee (FVDRC) was established in 2008 following a recommendation by the Taskforce for Action on Violence within Families. The FVDRC operates under the New Zealand Public Health and Disability Act 2000 and falls under the responsibility of the Health Quality and Safety Commission.

United Kingdom
In April 2011, it became law (Section 9(3) of the Domestic Violence, Crime and Victims Act 2004) in the United Kingdom that a multi-agency local review be conducted after the occurrence of a domestic homicide. The Advocacy After Fatal Domestic Abuse (AAFDA) organization provides support for professionals and family members who establish and participate in the review. The UK government also provides multi-agency statutory guidance for conducting reviews.

United States
The first domestic violence death review was conducted in San Francisco in 1990 after Joseph Charan killed his wife, Veena, and himself in front of their nine-year old son's school. The review resulted in identifying several key recommendations that would help to predict and prevent similar tragedies. Since the Charan review, approximately 82 DVDRCs have been established across the U.S.[4] Some states have only a state-wide committee while others have committees for individual counties and/or cities. The National Domestic Violence Fatality Review Initiative (NDVFRI) compiles a list and links to all DVDRC reports published in the U.S.[8]

Canadian Reviews

Alberta
The Family Violence Death Review Committee (FVDRC) of Alberta was established in February 2014. The Committee reports to the Minister of Human Services and derives its authority from the Protection Against Family Violence Act. The FVDRC examined 76 incidents of family violence that occurred between 2008 and 2014 and chose six cases for further in-depth review. Results from the 76 case examinations are in the Family Violence Death Review Committee 2014-2015 Annual Report and recommendations stemming from one case review are available in the Case Review Public Report, 2015.[9,10]

British Columbia
In March 2010, the B.C. Domestic Violence Death Review Panel conducted a one-time review of 11 domestic homicides drawn from over 100 coroner case files dating back to 1995. Findings and recommendations from the review are published in the 2010 report to the Chief Coroner.[11]

Manitoba
In 2008, the Manitoba Minister of Family Services and Consumer Affairs, the Minister of Justice and Attorney General and the Minister of Labour and Immigration announced the plan to create a domestic violence death review committee for the province. The Manitoba DVDRC was formally established in 2010. Since its inception, the Manitoba DVDRC has conducted four reviews. Recommendations from the reviews are available in the executive summaries of the annual reports.[12]

New Brunswick
In 2009, New Brunswick established the Domestic Violence Death Review Committee (DVDRC) which serves as an advisory body to the Office of the Chief Coroner. Between 2010 and 2014, the New Brunswick DVDRC reviewed four domestic homicide cases and provided recommendations for prevention. The Recommendations from the Domestic Violence Death Review Committee 2012-2013 report outlines the recommendations that stemmed from the reviews and the responses of government departments and agencies involved with the cases.[13]

Ontario
The first Canadian DVDRC was established in 2002 in Ontario in response to recommendations from two major inquests of the domestic homicides of Arlene May and Gillian Hadley by their estranged intimate partners. The mandate of the Ontario DVDRC is to assist the Office of the Chief Coroner with the investigation and review of deaths involving domestic violence with the purpose of making recommendations aimed at preventing deaths in similar circumstances. Since its inception, the committee has reviewed 199 cases involving 290 deaths.[14]

Saskatchewan
In October 2015, Saskatchewan Justice Minister Gordon Wyant stated that the province will begin to review domestic homicides and will work with police, the coroner's office, community groups and First Nations to determine how to initiate a review process.[15]

Definition of Domestic Homicide

With such a large number of DVDRCs and processes around the world, there is undoubtedly going to be variability in the definition of domestic homicide. Some DVDRCs have a very narrow definition that includes homicides that only involve current or former spousal or common-law intimate partners whereas other DVDRCs have a more expansive definition that may include intimate partners, children, other family members, bystanders, and/or interveners. The following three themes around defining domestic homicide can explain the inconsistencies across definitions: 1) marital versus dating relationships; 2) secondary victims; and 3) intimate partner versus intrafamilial homicide.[16]

1. **Marital vs. Dating Relationships**
   The nature of the victim and offender relationship can cause variability in the definition of domestic homicide. All DVDRCs seem to agree that domestic homicides occur within spousal relationships whether the couple is currently married, separated or divorced. Furthermore, most definitions recognize common-law relationships. However, including dating relationships has been relatively new for some DVDRCs and presents some challenges around defining 'dating'. A definition of a 'dating' relationship may require examining the length of the relationship and/or whether one individual exerted power and control over the other.

   It is important to mention that same-sex relationships are often included in the definition for most DVDRCs.

2. **Secondary Victims**
   Domestic homicide definitions include the intimate partners as the 'primary victim' but in some cases other people are killed in the context of domestic violence. 'Secondary victims' may include children, other family members, bystanders, or the victim's new partner. Because the deaths of 'secondary' victims occur in the context of domestic violence, most DVDRCs consider these homicides as an extension of the domestic homicide and believe they could have been prevented by addressing the missed opportunities for intervention with the primary victim. Therefore, 'secondary' victims are most often included in the definition of domestic homicide.

3. **Intimate Partner vs. Intrafamilial Homicide**
   Variability across definitions can occur if DVDRCs choose to include or exclude intrafamilial homicides. Some committees explicitly state that their definition includes only intimate partner deaths and other family violence deaths are only included if the family member was killed in the context of domestic violence (e.g., family member intervening or child killed out of revenge). Other committees include all family violence deaths (e.g., person killed by a sibling) in their definition. Some DVDRCs are governed through legislation which dictates which homicides are included in the review.

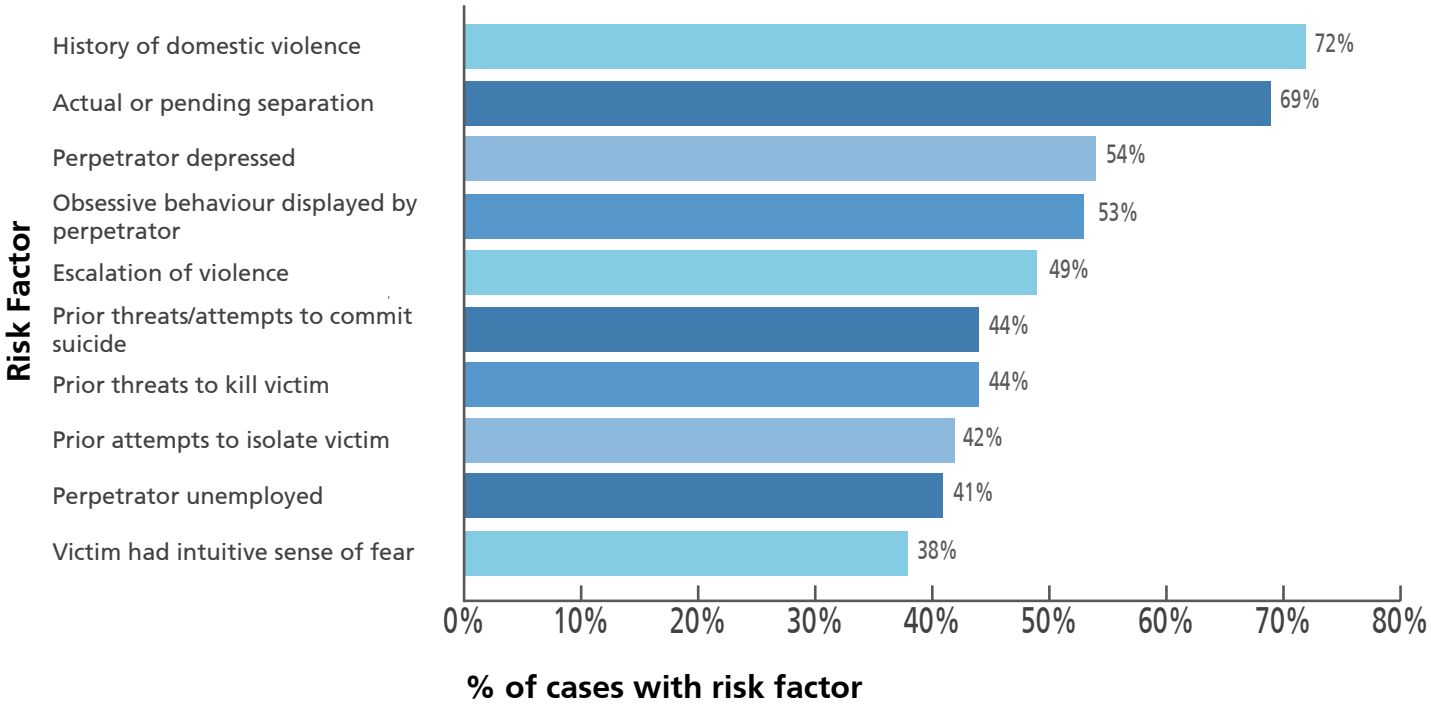
The CDHPIVP defines domestic homicide as the killing of a current or former intimate partner, their child(ren), and/or other third parties. An intimate partner can include people who are in a current or former married, common-law, or dating relationship. Other third parties can include new partners, other family members, neighbours, friends, co-workers, helping professionals, bystanders, and others killed as a result of the incident.

Benefits of a DVDRC[17]

Identifies risk factors for lethality

One of the main goals of a domestic violence death review is to identify common risk factors for lethality in order to inform risk assessment, risk management and safety planning. For instance, the Ontario DVDRC compiled a list of 39 risk factors, based on empirical evidence, that indicate the potential for lethality in a relationship (See Appendix B of 2015 Annual Report). When reviewing a case, the committee looks for the presence of any of these risk factors in order to determine if the homicide was predictable. In all the cases reviewed by the committee since its inception, 80% had seven or more known risk factors present indicating there was a high risk for domestic homicide.[9] The 10 most common factors identified by the Ontario DVDRC include:

Frequency of Common Risk Factors in DVDRC Cases Reviewed (2003-2014)[18]

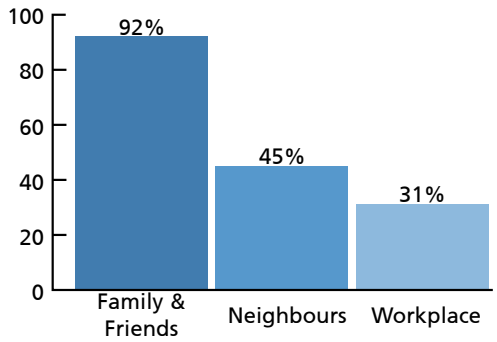


Source: Adapted from Ontario DVDRC Annual Report (2015)

Identifies missed opportunities for intervention and prevention

Often when conducting reviews it is revealed that people, such as family and friends, were aware of the abuse that was occurring but did not know how to intervene. The Washington State Domestic Violence Fatality Review found that in many of the cases they reviewed victims reached out for help. Specifically, in 92% of the cases victims reached out to family and friends; in 45% of the cases victims reached out to neighbours; and in 31% of the cases victims looked for help in their workplace.[19] The BC Domestic Violence Death Review Panel found that in one of the cases they reviewed, family, friends and neighbours were aware of the domestic violence or family distress but only informed investigators after the homicide.[20] Furthermore, a case review can reveal the number of professionals, agencies, or systems the family was involved with who had an opportunity to assess for violence and intervene. The Ontario DVDRC found that in 65% of the cases reviewed, the victim and/or perpetrator had involvement with mental health and counselling professionals and 43% of the cases had police involvement.[21]

Who Victims Sought Help From Regarding Domestic Violence in Cases of Domestic Homicide



Source: Washington State Domestic Violence Fatality Review (2013) http://www.ndvfri.org/reports/washington/Friends_and_Family_DVFR_Issue_Brief_6.2013.pdf.

Identifies barriers and gaps in service

Many victims of domestic violence encounter barriers or gaps in service particularly victims from more vulnerable communities (e.g., immigrant and refugee; Indigenous people; rural, northern, and remote). A domestic violence death review can identify these barriers and gaps and form recommendations to address the issues. For instance, the Washington State Domestic Violence Fatality Review team found that immigrant and refugee victims faced several barriers to safety such as inadequate interpretation, threat of deportation, and isolation from their cultural community.[22]

Advocates for legislative reform

Domestic homicide reviews can identify areas for legislative reform. The Alberta FVDRC made a recommendation for the government to amend the Occupational Health and Safety Act and Code to recognize and include family violence as a workplace hazard.[23] Similarly, a major inquest into the domestic homicide-suicide of Lori Dupont by her ex-partner Marc Daniel that occurred in Windsor, Ontario in 2005 led to recommendations around legislation changes to enhance protections against workplace violence and harassment. Bill 168, an Act to amend the Occupational Health and Safety Act came into effect in 2010 in direct response to these recommendations. Bill 168 requires employers across the province to develop policies, programs, and procedures that protect employees from workplace violence and harassment including domestic violence.

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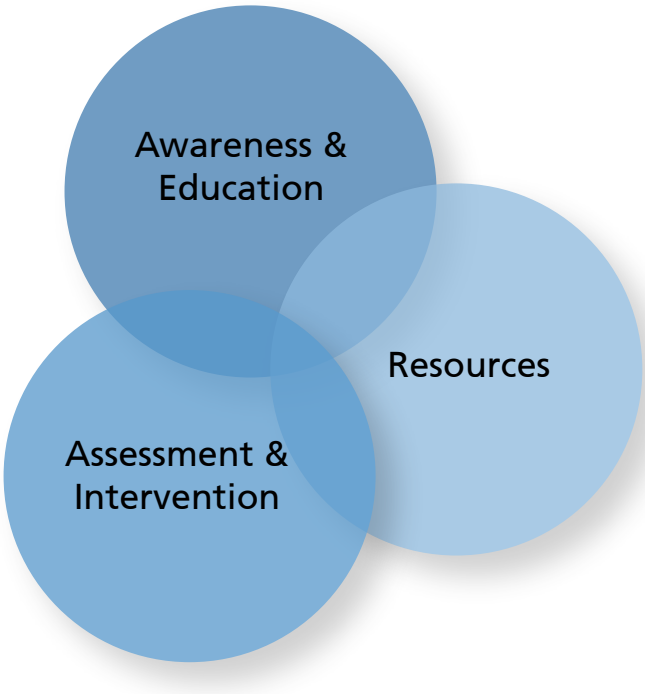
We all have a role to play in addressing Workplace Domestic Violence

Facilitates systemic and inter-agency communication and coordination

Many domestic homicide reviews reveal that at-risk families can be involved with a number of different service providers across multiple sectors (e.g., police, child welfare, victim services). Each of these systems and agencies have valuable information on the couple or family that can indicate the potential risk for further harm. However, in some cases, there is a lack of communication between these systems and agencies resulting in a failure to implement effective risk management and safety planning strategies. The BC DVDRP identified this theme in their 2010 report and recommended that a standardized, collaborative approach to domestic violence by all agencies, ministries, and support networks be developed. In 2010, changes were made to the Violence Against Women in Relationships (VAWIR) Policy in BC to include a protocol for dealing with high-risk domestic violence cases. The policy gave clear direction that information is to be shared across sectors and that all systems involved need to work collaboratively when responding to domestic violence. Since the policy amendment, communities have developed interagency case assessment teams (ICATs) that are comprised of local agencies across multiple systems. The ICATs review and monitor high-risk cases of domestic violence and develop enhanced risk management and safety plans in order to prevent future harm. Recently, the Ending Violence Association of BC developed a protocol that guides ICATs information sharing practices (Interagency Case Assessment Team Best Practices: Working Together to Reduce the Risk of Domestic Violence).

Major Themes in Recommendations

Recommendations made by DVDRCs usually fall under three overarching themes:



Awareness and Education

One of the most common themes that stems from death reviews is the importance of raising awareness and educating the general public and professionals about the dynamics of domestic violence and how to appropriately and effectively intervene. Many committees have made recommendations around developing public awareness campaigns and providing comprehensive training to service providers.

Assessment and Intervention

The theme of assessment and intervention includes several different areas for recommendations by DVDRCs. Risk assessment is a key component in predicting and preventing lethality and committees have made recommendations that different systems/agencies be mandated to use a standardized risk assessment tool that assesses the risk for further violence and homicide. DVDRCs recognize that risk assessment is not an end in itself but rather an ongoing process that requires risk management and safety planning and recommendations have been made around interagency and system collaboration and coordination in managing high-risk cases and developing effective safety plans with victims and children. Furthermore, recommendations have been made for policy and legislative changes for supporting victims of domestic violence in the workplace; firearm registry and safety; bail/probation conditions and counselling services for offenders; and child custody and access.

Resources

A lack of resources is a common concern that has been identified within domestic homicide reviews particularly for marginalized and underserved communities (e.g., Aboriginal; rural, Northern, and remote; immigrant and refugee). DVDRCs often make recommendations around developing and providing more accessible services/resources that are culturally appropriate.

Some major trends that have been identified through committee reviews that are reflected in recommendations within the three overarching themes include:

- Dangers facing children exposed to domestic violence
- Safe separation
- Immigration issues
- Domestic violence in the workplace
- Technology facilitated domestic violence
- Issues with intervention and prevention for rural, Northern, and remote communities
- Depression and domestic homicide
- Older population and domestic homicide
- Women with disabilities and their unique experiences with violence

Research

Another benefit of DVDRCs is the tremendous amount of information available to further research around domestic homicide prevention. Since 2008, there has been a number of Canadian research studies that have been conducted using data from DVDRCs that address the important topics mentioned above. Specifically, domestic homicide research helps to better inform risk assessment by differentiating risk factors within different vulnerable groups. For example, research has looked at particular risks associated with rural communities; older populations; depression among perpetrators; and children exposed to domestic violence.

The Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations (CDHPIVP) will develop a national database comprised of all domestic homicides that have occurred across the country in order to enhance research by providing a comprehensive dataset to identify trends, risk factors, and strategies regarding domestic homicide prevention. Some provinces have a small number of domestic homicide cases and are unable to generalize findings to the whole population but when added to a national dataset going over a decade, common trends and factors start to emerge that can be applicable to all domestic homicide cases and can help to better inform risk assessment, risk management and safety planning strategies.

A Snapshot of Select Research Findings from Domestic Violence Death Review Committee Data

Domestic homicides in rural vs. urban areas[24]

- Perpetrators in rural areas had greater access to firearms
- Firearms were used more often in domestic homicides in rural areas
- Couples in rural areas were less likely to be separated

Risk profiles of male perpetrators of domestic violence and domestic homicide[25]

- Male perpetrators of domestic homicide had higher risk profiles and were more likely to exhibit obsessive and jealous behavior, isolate the victim, threaten suicide, and have access to firearms
- One third of male perpetrators of domestic violence who were attending a PAR program were assessed as being high risk for lethality

Domestic Homicide in the Older Population[26]

- Older couples had less risk factors present
- Homicide-suicides were more common among the older population
- The most prevalent risk factors among the older population included depression, access to firearms, and prior suicide threats/attempts

Depression among perpetrators of domestic homicide[27]

- More risk factors were present in domestic homicide cases where perpetrators were depressed
- Specific risk factors associated with depressed perpetrators include the perpetrator witnessing violence as a child, prior history of hostage-taking, previous suicide threats/attempts, and obsessive behaviour
- Depressed perpetrators and perpetrators who commit domestic homicide-suicide tend to be older than non-depressed perpetrators and perpetrators who commit homicide

Children and domestic homicide[28,29]

- Research has found that there are no unique risk factors associated with domestic homicide cases that involve child victims except for the higher number of agencies involved with the family
- Both domestic homicide cases involving adult victims and those involving child victims were assessed as high risk using common risk assessment tools indicating that if a mother is at risk, the children are also at risk

Online Training

Conducting a domestic homicide review: online learning
This online course is aimed at frontline practitioners who will participate in a local domestic homicide review. The objectives of the course are to provide a better understanding of the domestic homicide review process including roles and responsibilities; highlight the importance of sharing best practices and lessons learned at a local level; outline issues related to disclosure and criminal proceedings; and assist in producing the overview report in line with the statutory guidance for the conduct of domestic homicide reviews. This course was developed by the Home Office in the United Kingdom.

Document, Monitor, Collaborate: A Primer on Domestic Violence Risk Assessment & Management
This one-hour course provides an introduction to domestic violence risk assessment, risk management and safety planning. Topics include identifying warning signs and risk factors for domestic violence, talking with victims and perpetrators to offer support, and learning when to reach out to other resources for collaboration.

Domestic Violence Risk Assessment and Management
This course uses scenario-based learning to learn how to identify high risk situations of domestic violence and collaborate with other organizations and services to provide appropriate monitoring and risk management. The importance of collaboration for effective risk assessment and management is emphasized.

Neighbours, Friends & Families Webinar
This webinar teaches participants about the warning signs of domestic violence and how to recognize high-risk situations. It also outlines ways to support someone who is experiencing domestic violence including how to talk to someone and make appropriate referrals.

Useful Links

Canadian Domestic Homicide Prevention Initiative
The Canadian Domestic Homicide Prevention Initiative (CDHPI) is a knowledge hub on information pertaining to domestic violence death review in order to inform promising practices in prevention. The CDHPI contains information on domestic homicide review processes across Canada and serves as a knowledge mobilization strategy between established DVDRCs. The CDHPI also includes national and international reports, educational materials, and key findings developed through research, inquests, and reviews; information on implementing a death review process in your own community; and current learning opportunities regarding domestic homicide prevention.

National Domestic Violence Fatality Review Initiative
The NDVFRI is a resource centre that provides information and support to communities that plan to implement a domestic homicide review process. The NDVFRI provides technical assistance, training, and a depository of information around domestic homicide review including DVDRC reports from U.S. committees, U.S. domestic violence death review statutes and executive orders, sample data-collection instruments and sample confidentiality agreements. The NDVFRI is funded by the Office on Violence Against Women and is housed at Northern Arizona University.

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