Eighth Annual Report

Domestic Violence Death Review Committee

Office of the Chief Coroner
Province of Ontario
2010

Annual Report of the Domestic Violence Death Review Committee - 2010

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Ontario

Message from the Chair

In 2010, the Domestic Violence Death Review Committee continued to refine the process by which domestic violence homicides and homicide-suicides were reviewed. In particular, the process and methods used for gathering, calculating and presenting statistical information pertaining to the cases reviewed by the DVDRC are being re-examined in order to ensure consistency, accuracy and reliability. As such, all data collected to date will undergo further analysis and refinement, as necessary. For this reason, this 2010 Annual Report of the Domestic Violence Death Review Committee will only contain statistical information pertaining to the actual cases reviewed in 2010.

The historical review of our data collection processes and resulting statistical compilations for cases reviewed since 2003 is expected to be completed and presented in next year's annual report of the DVDRC. Readers are referred to the last Annual Report (2009) in the interim.

In 2010, a total of 18 cases, involving 36 deaths, were reviewed. Two-thirds of the cases reviewed involved homicide-suicides or multiple homicide-suicides. While the number of homicide-suicide cases may appear extraordinarily high, the number reflects a concerted effort by the DVDRC to review cases where judicial procedures were not outstanding or pending. Due to the "closed" nature of homicide-suicide cases, the reviews can generally be done in an expeditious manner.

From the cases reviewed in 2010, a total of 14 recommendations towards the prevention of future domestic violence related deaths, were made. Much like recommendations made from coroner's inquests, these recommendations were distributed to organizations and agencies that were in a position to effect implementation and these organizations were requested to indicate the status of implementation of recommendations within one year's time.

As with previous reports, a very brief summary of the circumstances of each case is provided with the expectation that it will provide some context for any recommendations that arise.

Chapter Four of this annual report touches on some of the recurring themes that emerged from the cases reviewed in 2010. The following themes are examined in further detail: domestic violence in the workplace, the utilization of information and communication technologies to further abuse victims of domestic violence and safe separation.

W.J. Lucas

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

Committee Membership

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Committee Chair
Regional Supervising Coroner

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Child Welfare Specialist
Paediatric Death Review Committee

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Executive Summary of Cases Reviewed by the DVDRC in 2010

- 18 cases, involving 36 deaths were reviewed by the DVDRC in 2010;
- 24 of the deaths were victims of homicides and 12 of the deaths were suicides by perpetrators;
- Two-thirds of the cases reviewed in 2010 involved homicide-suicides or multiple homicide-suicides;
- More than half of the cases involved couples that were legally married and in a relationship for over 10 years;
- Half of the couples had children in common;
- The majority of victims were female. There were two male victims in 2010 reviewed cases;
- All of the perpetrators were male;
- The most common cause of death for victims was stabbing;
- The top risk factors identified were: actual or pending separation, history of domestic violence, obsessive behaviour by the perpetrator and a perpetrator that was identified as being depressed;
- Most common themes of cases reviewed in 2010 were: awareness and education (for the general public and professionals), training for professionals and assessment and intervention;
- 14 new recommendations towards the prevention of future deaths were made.

Chapter One: Introduction & Overview

Mandate

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 mandate of the DVDRC is to assist the Office of the Chief Coroner with the investigation and review of deaths involving domestic violence with a view to making recommendations aimed at preventing deaths in similar circumstances and reducing domestic violence in general.

The DVDRC consists of representatives with expertise in domestic violence from law enforcement, criminal justice, healthcare sector, social services and other public safety agencies and organizations. By conducting a thorough and detailed examination and analysis of facts within individual cases, the DVDRC strives to develop a comprehensive understanding of why domestic homicides occur and how they might be prevented. Information considered within this examination includes the history, circumstances and conduct of the abusers/perpetrators, the victims and their respective families. Community and systemic responses are examined to determine primary risk factors and to identify possible points of intervention that could assist with the prevention of similar deaths in the future.
The Terms of Reference for the DVDRC are included in Appendix A.

Since its inception, the DVDRC has reviewed 111 cases that involved a total of 178 deaths.

Year	# of cases reviewed	# of deaths involved
2003	11	24
2004	9	11
2005	14	19
2006	13	21
2007	15	25
2008	15	17
2009	16	25
2010	**18**	**36**
Total	**111**	**178**

Each review includes an assessment of risk factors. The definition of these risk factors is included in Appendix B.

The summaries and recommendations resulting from each of the 18 cases reviewed in 2010 are presented in Chapter 3 of this report.

Chapter 4 touches on common themes and issues that were identified in the review of cases in 2010.

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 were distributed to relevant organizations and agencies through the Chief Coroner.
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 were asked to respond back to the Chief Coroner on the status of implementation of recommendations within one year of distribution.

A summary of recommendations made from cases reviewed in 2010 is included in Appendix C.

Review and Report Limitations

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 review meetings and any other documents or reports produced by the DVDRC, remain private and protected and will not be released publicly. Each member of the Committee has entered into, and is bound by, the terms of a confidentiality agreement that recognizes these interests and limitations.

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.

The case summaries included in Chapter 3 are intended to provide a general sense of the circumstances that led to the deaths and subsequent issues that were considered by the committee when formulating recommendations. The summaries are an overview of key elements of the case and do not necessarily include all details or issues examined by the DVDRC.

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(4) 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: Looking Back and Moving Forward

Introduction

The purpose of the Domestic Violence Death Review Committee 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.

Within the context of the DVDRC, domestic violence deaths are defined as "*all homicides that involve the death of a person, and/or his 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 definition and criteria of domestic violence deaths utilized by other organizations and agencies, including Statistics Canada, may be different than that used by the DVDRC.

Reviews conducted by the DVDRC are completed only after all other investigations and proceedings – including inquests, criminal trials and appeals – have been completed. As such, DVDRC reviews often take place several years after the actual incident. DVDRC reviews completed within any given calendar year may relate to previous deaths that occurred years before.

Collection of Data

Since its inception in 2003, a variety of data has been collected from the cases reviewed by the DVDRC. As the Committee has evolved, so too have the processes for reviewing, collecting and analyzing information that has been gathered. The DVDRC strives to provide information and analyses that is accurate, valid and useful to relevant stakeholders.

To this end, a comprehensive and rejuvenated analysis and examination of all data collected by the DVDRC since its inception in 2003 is now being undertaken by the Office of the Chief Coroner.

The current Annual Report of the Domestic Violence Death Review Committee includes information pertaining to the cases reviewed in 2010 only. All historical data, analyses and charts that were produced in previous Annual Reports will be reviewed and amended as required and will be included in future publications distributed by the DVDRC.

Table 1 – Domestic Homicide Information for cases reviewed in 2010

		# of cases$_{n = 18}$	Actual Deaths n=36	
			Victim (homicide) n=24	Perpetrator (suicide) n=12
Gender of deceased	Female Male		22 2	0 12
Type of Case	Homicide	6	6	
	Homicide-suicide	8	16	
	Multiple homicide-suicide	4	14	
	Multiple homicide	0	0	

Table 1 shows that in the 2010 reviews, the vast majority (22 out of 24) of homicide victims were female. Two victims were males and both of these were the children (one was an adult) of the perpetrator. In 2010, two-thirds of the cases reviewed involved homicide-suicides or multiple homicide-suicides. The high number of homicide-suicide cases reviewed reflects the logistical ability of the DVDRC to promptly examine cases that do not require processing through the criminal justice process prior to review.

Table 2 – Relationship between Victim and Perpetrator for cases reviewed in 2010

Category	Variable	2010 n = 18	
Type of Relationship	Legal Spouse Common-law Boyfriend/girlfriend (incl. same sex)	11 5 2	61% 28% 11%
Length of Relationship	<1 year 1 – 10 years 11 – 20 years Over 20 years	2 6 8 2	11% 33% 44% 11%
Children in Common	0 1-2 3+	9 6 3	50% 33% 17%

Table 2 shows that just over half the domestic homicides reviewed in 2010 occurred with couples who were legally married for a period of ten years or more. Half of the couples had children in common.

Table 3 - Cause of Death – Cases reviewed in 2010

	Total number of deaths = 36	
Cause of Death	**Victim n=24**	**Perpetrator n=12**
Asphyxia (airway obstruct)	0	1
Asphyxia (hanging)	0	2
Asphyxia (neck comp)	1	0
Asphyxia (strangulation)	2	0
Fall/Jump	0	1
Shooting (handgun)	4	2
Shooting (rifle)	2	2
Trauma (beating/assault)	2	0
Trauma (cuts, stabs)	10	2
Trauma (motor vehicle)	1	1
Trauma (train/vehicle)	0	1
Unascertained	2	0

Table 3 shows that in 2010, the main causes of death for the victims of the cases reviewed were trauma (cuts, stabs) and shooting. The causes of death for perpetrator suicides were varied and included asphyxia, shooting and trauma (cuts, motor vehicle and train).

Table 4 - Top Risk Factors from 2010 Reviews

Risk Factors	**2010**	
	n n=18	**%**
Actual or pending separation	14	77%
History of domestic violence	13	72%
Obsessive behaviour displayed by perpetrator	10	56%
Perpetrator depressed in the opinions of professionals (e.g., physician, counsellor) and/or non-professionals (e.g., family, friends, etc)	9	50%
Victim had intuitive sense of fear	8	44%
Prior threats/attempts to commit suicide	7	39%
Perpetrator unemployed	7	39%
Prior threats to kill victim	6	33%
Prior attempts to isolate victim	6	33%
Access to or possession of firearms	6	33%
Control of most or all of victim's daily activities	6	33%
An actual or perceived new partner in victim's life	6	33%

Table 4 indicates that in 2010, the top risk factors identified in the cases reviewed were: actual or pending separation, history of domestic violence, obsessive behaviour displayed by the perpetrator and a perpetrator that was depressed. Most cases had several identified risk factors.

Figure 1: Number of Risk Factors Identified in DVDRC Cases Reviewed In 2010

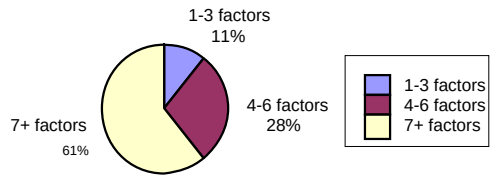

Figure 1 indicates that 11 of the 18 (61%) cases reviewed in 2010 had 7+ risk factors identified. The recognition of multiple risk factors within a relationship allows for enhanced risk assessment, safety planning and possible prevention of future deaths related to domestic violence.

Top Themes/Issues from DVDRC Reviews in 2010

As the DVDRC reviews cases each year, recurring issues, themes, and potential points of intervention are frequently identified.

In 2010, several cases reviewed by the DVDRC identified concerns pertaining to awareness and education of domestic violence issues to both the general and professional public. The majority of recommendations made in 2010 were aimed at educating professionals and the general public on specific issues such as:

- how victims can separate safely;
- the increased danger with perpetrators that have substance abuse issues and a history of domestic violence;
- awareness around firearms in the home particularly when there is the presence of depression and/or a pending or actual separation.

Just under half of the cases reviewed in 2010 involved the need for training professionals in recognizing, assessing, and intervening in domestic violence situations. In many domestic homicide cases reviewed by the Committee, the violence and abuse in the relationship entered the workplace.

It was also noted that a variety of communication and information technologies were utilized within the relationships that were reviewed. Some of these technologies were used to harass and stalk victims prior to the homicide(s).

Additional information pertaining to themes arising from cases reviewed in 2010 is included in Chapter 4.

Chapter Three: Case Summaries & Recommendations

Case DVDRC-2010-01: OCC file numbers: 2007-453 and 2007-2819

On January 19, 2007 the perpetrator (age 42) phoned the victim (age 40) while she was out with some friends. The victim told her friends that the perpetrator was upset and jealous, and he wanted to know what she was doing and who she was with. The victim's phone lost power and the call was disconnected. The victim returned home and she and the perpetrator had a verbal dispute. At some point, the perpetrator phoned a friend of the victim's and asked if she knew if the victim was with another guy.

Later that evening, the perpetrator called his sister and said that he was all messed up and stressed out. He spoke to his daughter and told her to take care of her brother. He called another sister and again said he was stressed out and that he had messed up his life.

On January 20, 2007 at 3:30 a.m. the perpetrator called a tenant upstairs and told her he had killed the victim and that her body was downstairs. He told the tenant that the victim brought it on herself.

The victim's body was found on the bed with multiple stab wounds to the upper torso area. The perpetrator subsequently committed suicide by jumping in front of a train.

3 risk factors were identified.

Common theme: public education (Neighbours, Friends and Families).

No new recommendations.

Case DVDRC-2010-02: OCC file numbers: 2004-6152 and 2005-5333

On May 21, 2004, the victim (age 25) telephoned her husband, the perpetrator (age 33), at his work and advised him that she wanted a divorce. She told him that she had purchased plane tickets for her sister and the children to fly home to be with her parents while they worked on the separation. A short time later, the perpetrator returned home from work where he engaged in a verbal argument with his wife. The victim told him that she and her sister would pick up the tickets at the travel agent. He told her that they were his children too, and that he would attend the travel agent with her to pick up the tickets. This argument was witnessed by the victim's sister. The couple left the apartment and attended at the travel agent where they picked up the plane tickets. They returned to the apartment and a short while later, video surveillance monitors captured the perpetrator leaving the apartment alone. The victim's body was found a few days later decomposing in the bedroom closet. It is believed that the perpetrator had strangled her with a shoelace.

It was suspected that the perpetrator left the apartment and proceeded to a secluded wooded area outside the city, where he committed suicide by hanging. Despite aggressive searches, his body was not found until 11 months after the homicide.

6 risk factors were identified.

Common theme: public education/ awareness – (Neighbours, Friends and Families).

No new recommendations.

Case DVDRC-2010-03: OCC file numbers: 2007-7789, 2007-7790 and 2007-7788

The victims were Ms. Y, (age 77) and her adult daughter Ms. I (age 46). The perpetrator was Ms. I's common law spouse, Mr. B (age 32). The perpetrator stabbed both victims to death, and then stabbed himself to death.

Ms. I had two children, a son (age 17) and a daughter (age 13), from a previous relationship. Ms. I, Ms. Y and Mr. B and the two children, resided together for approximately five years.

The perpetrator had been physically and sexually abusing Ms. I's 13-year-old daughter for approximately three years prior to the homicides. The sexual abuse had created significant tension in the family. The 13-year-old daughter often stayed in her grandmother's (Ms. Y) bedroom for protection.

On the evening of the homicides, June 25, 2007, the 13-year-old daughter had attended her grade 8 graduation ceremony with her mother (Ms. I) and step-father (Mr. B). The grandmother (Ms. Y) had stayed at home. Shortly after returning home from the graduation, there was an argument between the grandmother and perpetrator. The argument was focused on protecting the 13-year-old from further sexual and physical abuse from the perpetrator. The perpetrator got a knife and proceeded to stab the grandmother multiple times. When Ms. I tried to intervene, he stabbed her multiple times too. The 13-year-old girl tried to intervene and was injured, but managed to escape to a neighbour's home where police were notified. Both women succumbed to their injuries and the perpetrator subsequently took his own life.

Both victims were born in Hong Kong, spoke Cantonese and were of the Buddhist faith. English was not their first language.

Both victims were aware that the perpetrator was sexually abusing Ms. I's daughter. The grandmother tended to be very protective of the girl and often encouraged her to stay in her room for protection. The girl had confided in friends about the nature and source of the sexual and physical abuse. As the abuse escalated, the girls' mother (Ms. I) intervened more. This caused additional tension between the victims and the perpetrator. The perpetrator had threatened to kill the victims in the past.

Seven risk factors were identified. It is recognized that the deceased's daughter, although not a homicide victim, was a victim of sexual assault by the perpetrator. When the victimization of the daughter is considered, 12 risk factors are identified.

Common theme: public education/ awareness – (Neighbours, Friends and Families).

Recommendation 1:

To Ontario Women's Directorate:

Public education campaigns need to provide information on the co-occurrence of domestic violence and child maltreatment and emphasize to both professionals and community members the importance of notifying Child Protective Services (CPS) if either form of abuse is identified. Research has indicated that there is a substantial overlap between domestic violence and child abuse.[1] CPS professionals are trained to assess both types of abuse and provide the necessary supports to help the family.

[1] Jouriles, E.N., McDonald, R., Smith Slep, A. M., Heyman, R.E., & Garrido, E. (2008). Child abuse in the context of domestic violence: Prevalence, explanations, and practice implications. Violence and Victims, 23, 221-235.

Case DVDRC-2010-04: OCC file numbers: 2006-14185, 2006-14186 and 2006-14184

On November 3, 2006, the perpetrator (age 39) arrived back to Canada after visiting relatives in Germany for three weeks. His wife (one of the victims), picked him up at the airport on that date.

On November 5, 2006, the perpetrator went to his brother-in-law's apartment. He barged into the apartment and went directly to the balcony. While on the balcony, he was talking to police on his cell phone. He told police that he had just killed his wife (age 36) and daughter (age 14) and that he was about to kill himself. He screamed out that he was "mental", then jumped off the balcony to his death.

The wife and daughter of the perpetrator were found by police deceased in their residence. The wife died from sharp force injuries to the neck and the daughter from asphyxia due to neck compression. Two other younger daughters who were in the residence at the time were not injured.

The wife of the perpetrator was originally from Sri Lanka. Her family did not live far away from her.

The deceased daughter of the perpetrator was the eldest of the couple's three children.

The perpetrator was born in Sri Lanka and came to Canada in 1992. He was known to have mental health issues and was diagnosed with schizophrenia in 2001. He was often seen talking to himself. He lost his trucking license about six months prior to the deaths due to his mental health condition.

The couple had been married for approximately 14 years. The couple had three daughters, aged 14 (victim), 12 and 9 years.

There was a history of domestic violence between the couple. In October 2001, the perpetrator assaulted his wife after he formed the belief she was poisoning him. This incident was not reported to police.

In March 2002, the perpetrator again assaulted his wife. The victim was hit in the head several times and suffered a fractured nose, cuts and a swollen face. The perpetrator was arrested and charged with assault causing bodily harm. He was given a "no contact" order, although it appears that he remained in regular contact, and likely was still living with his wife.

The couple's three daughters were present during the incident in March 2002. The CAS were not involved with this family.

4 risk factors were identified.

Common themes: public education/ awareness – (Neighbours, Friends and Families); mental health of perpetrator.

No new recommendations.

Case DVDRC-2010-05: OCC file numbers: 2008-14470, 2008-14471, 2008-14469 and 2008-14472

The elder female victim (age 64) and the perpetrator (age 66), her husband, were planning to leave on a trip to Mexico on November 19, 2008. The couple's adult daughter (the other female victim, age 41), went to see them on November 18 to help them prepare for the trip. The couple's adult son (age 38) was also home that evening.

The daughter's husband attempted to contact her by telephone on the evening of November 18, 2008. When he still could not get in contact with her the next morning, he went to his wife's parent's home. When he arrived, there was a note on the door that stated, "Do not enter. Call Police."

The bodies of two female victims (mother and daughter), as well as the adult son, were found in the residence. Autopsy results indicated that all of the victims were stabbed to death.

The perpetrator was found deceased from a self-inflicted gunshot wound to the head. The family dog was also killed.

In 1992, the perpetrator was diagnosed with depression.

There were no previous reports of domestic violence and no forewarning of anticipated violence.

2 risk factors were identified.

No common themes identified.

No new recommendations.

Case DVDRC-2010-06: OCC file number: 2005-15631

This case was deemed to be a homicide perpetrated by the intimate partner. On November 11, 2005, partial remains were found at a waste transfer station. Over the ensuing days, other partial remains were located in four separate sites. Police investigation linked these to be from the victim.

The victim's common-law spouse, when arrested, claimed he struck her on the back of the head with a wrench after she had discovered him using crack cocaine. An apparent argument ensued and the victim (age 46) told him she was calling police. She had threatened to leave him in the past due to his drug use and he had made a promise to discontinue the habit.

Due to the dismemberment, the cause of death was "unascertained" as death could not be definitively attributed to the head injury alone.

The perpetrator had chronic anxiety, depression, and a possible personality disorder. There was no history of parasuicide (i.e. self-injurious behaviour). He was on medication and had been on antidepressants at various times during his life. He had attended rehabilitation in the past for his drug addiction.

11 risk factors were identified.

Common themes: public education/ awareness – (Neighbours, Friends and Families); safe separation; mental health and addictions.

No new recommendations.

Case DVDRC-2010-07: OCC file number: 2006-5416

The victim (age 20) died from sharp force injuries to her neck sustained while in her room at a student housing residence. The victim's boyfriend, who was the perpetrator (age 30), was quickly apprehended on a bridge where he was reportedly contemplating suicide.

The victim and perpetrator met in August 2004 and continued to have a relationship until the time of her death in 2006.

A reported assault on the victim occurred in January 2005. The location of the assault was in a different geographic jurisdictional police division than the one that the victim actually lived in. There was no communication between the initial investigating police division and the police division where she lived. As

such, police in the division where the victim lived were not aware that a No Contact Order between the perpetrator and victim had been previously made.

Due to an unfortunate misplacement of paperwork, a recharge summons for an arrest order on the perpetrator was issued in May. In June, the courts allowed the victim to act as a surety for the perpetrator for an impaired driving charge stemming from an incident in March.

A further assault on the victim in July, combined with the earlier assault in January, as well as an assault on the victim's friend and the impaired driving conviction, resulted in the perpetrator being incarcerated for 75 days. He pled guilty to the charges in September 2005.

The perpetrator was described as being controlling and possessive. The victim and her friends (as well as acquaintances of the perpetrator), feared him. On the night of the homicide, May 15, 2006, the victim was in the company of two friends and the perpetrator. Her plan was to communicate to him that she was breaking off their relationship as she was in love with someone else. She was also planning to go away on a summer cruise with friends. The perpetrator planned to spend the night with her. His claim following the homicide was that she was arranging to have him harmed while she was away. He described delusional thoughts of her being evil.

The victim was in her third year of a hospitality management program at a post secondary institution. The victim was sociable, had friends and often spent holidays and special occasions with her family.

The perpetrator was born in Ethiopia. His family was geographically separated due to his father's political views.

It is reported that the perpetrator was married in 1999, a year prior to emigrating to Canada. His wife emigrated a few months ahead of him. His wife reported that he was very jealous and attempted to smother her with a pillow. She did not report this to police.

The perpetrator had a history of mental illness with paranoid delusions and suicidal ideation. He was admitted to a psychiatric facility for a one month period in February 2006. The psychiatrist had been alerted to the No Contact Order between the perpetrator and victim, but the victim apparently visited the perpetrator repeatedly during his hospitalization. The perpetrator was discharged from hospital to a support unit with the Salvation Army - Judicial / Mental Ambulatory Centre. A follow-up appointment with a psychiatrist was arranged.

21 risk factors were identified.

Common themes: public education/ awareness – (Neighbours, Friends and Families), mental health; communication/sharing of information.

Recommendation 1:

To the Police Service involved:
It is recommended that Police Services compel Domestic Violence Coordinators to facilitate the liaison and information sharing between case managers in Domestic Violence occurrences that cross divisional and jurisdictional boundaries within their service.

Comment: There were several domestic violence related occurrences filed with police involving the perpetrator that preceded the homicide of the victim. A systemic disconnect contributed to an apparent lack of awareness by police, resulting in a breakdown of communication throughout the judicial process.

Recommendation 2:

To Police Services in Ontario:
Incidents reported to, or investigated by police as domestic violence, regardless of whether a verbal incident only or whether criminal charges are laid, should result in the completion of the Domestic Violence Supplementary Report (DVSR).

Comment: Physical violence is only one risk factor in relation to the risk of future domestic violence when there is conflict within a relationship. The fact that there was police contact indicated an elevated concern for safety by the victim and the incident required closer scrutiny through the use of the DVSR.

Recommendation 3:

The DVSR should be used not only to indicate the presence of risk-enhancing factors towards violence, but also to identify those areas where case management could mitigate the risk for future violence. When risk factors such as substance abuse, mental health concerns, employment issues etc. are identified, efforts should be made to provide appropriate references or involve appropriate services to alleviate those risk factors.

Recommendation 4:

To the Ontario Association of College and University Security Administrators (OACUSA):
The OACUSA should develop a consistent and comprehensive plan, in collaboration with health and counselling services available on campus, to educate students on the nature and risks of violence in dating relationships through public education campaigns and outreach programs to students dealing with intimate violence.

Recommendation 5:

To the National Judicial Institute, Ministry of the Attorney General, and Faculties of Law in Ontario:
The details and facts from this case should be used as a training aid for the education of law students, continuing education for practicing lawyers (e.g. Crown attorneys, family law and criminal law) and the judiciary regarding the issues and concerns facing victims of domestic violence. In particular, this case demonstrates the need for the timely and accurate sharing of information not just within the police service itself, but also between the police, judiciary, probation services and health care providers.

Recommendation 6:

To acute care hospitals and psychiatric institutions in Ontario:
It is recommended that health care facilities consider formulating (and/or reviewing and revising as necessary) protocols, policies and procedures to provide specific practice guidelines, in order to ensure an immediate and proactive response to information reported to them of a "No Contact Order" between a patient and a visitor.

Comment: The perpetrator was hospitalized on a psychiatric unit of an acute care hospital. The perpetrator's probation officer had informed an attending physician of the past assault with a No Contact Order between their patient and the victim. Although the physician documented this data in the medical progress notes, effective communication with other members of the health care team did not seem to occur as it is believed that the victim frequently visited the patient/perpetrator over the duration of his month-long admission.

Mental illness is considered to be a risk factor for potential lethality. The psychological dynamics of a violent domestic relationship are complex and the individuals may continue to associate with each other,

regardless of a court order prohibiting such contact. All persons, (including health care professionals) are encouraged to seize an opportunity to assist in the efforts to monitor and alert law enforcement of failure to comply with No Contact Orders.

Case DVDRC-2010-08: OCC file number: 2003-18286

The victim was killed in his home by the perpetrator, his stepfather, who was separated from the victim's mother. The perpetrator was charged and convicted (pleaded guilty to second degree murder, received life sentence with no eligibility for parole for 14 years).

The home where the victim and his mother lived had an alarm system. The perpetrator had entered through a window that was not part of the alarm system. When a door was opened, the alarm was activated and the alarm company was notified. The alarm company called the house and someone picked up the phone, then hung up. When the company called back, there was a busy signal. A security guard was dispatched, walked around the house, missed the jimmied window, tried the back door and concluded that everything was fine. Neighbours heard the alarm, but did not respond.

The perpetrator, who was intoxicated at the time, entered the home through a "taped" basement window and assaulted and killed his stepson, the victim. The perpetrator then fled the scene.

The victim's mother arrived back home after her night shift. She did not see any lights on in the house, so she went in looking for her son. She noticed that the alarm system was broken and she found her son lying on the couch with a pillow over his head. The victim died from blunt force trauma to the head and ligature strangulation.

The perpetrator was later apprehended by police.

The victim (age 14), lived with his mother. The victim's mother was born in Russia and came to Canada in February 1999. The perpetrator (age 35), was born in Russia and came from a large, poor family.

The perpetrator intended to come to Canada on a visitor's visa and meet a Russian woman (Woman A) for a marriage arranged through a church organization. After two previous unsuccessful visa applications, the perpetrator was granted a visitor's visa in 1994 after Woman A turned to her employer as well as her local Members of Parliament (MP) and Provincial Parliament (MPP) for letters of recommendation to support the visa application and acknowledge that Woman A was a responsible citizen.

The visitor's visa granted to the perpetrator in 1994 expired in early 1995. In late November 1994, he submitted a claim for refugee status.

The perpetrator apparently sexually assaulted Woman A in November 1994, but she did not report the incident to police until March 1995. Police informed immigration officials about the sexual assault allegation. Woman A was not pleased with the police investigation and decided to tell her story to the media with the hopes that she would gain public support to have the perpetrator removed from the country.

The mother of Woman A felt that the perpetrator was being deceitful and wrote a letter to the MP asking him to deny the refugee claim. In mid-1995, the refugee claim was turned down after ministerial intervention. The perpetrator appealed the decision and in 1997, the appeal was denied. The perpetrator remained in Canada however.

After the perpetrator left Woman A, he met, and married Woman B in 1999. Woman B had a son from a previous marriage. The marriage was never considered legal because Woman B had not filed the proper paperwork. Towards the end of their relationship, the perpetrator drank heavily and talked about suicide. Woman B had called the police on several occasions after the perpetrator became violent. The

perpetrator was abusive to Woman B and threatened to kill her and her son. Woman B reported these threats to police and the children's aid society were notified.

When the police arrived to arrest the perpetrator, a chase ensued. He was caught and brought to jail, but escaped custody. He was subsequently apprehended and received 20 days in jail and two years probation.

The perpetrator and Woman B ended their relationship and she subsequently married another man. Several years after the relationship ended, Woman B's new husband felt that the perpetrator was following him and had slashed his car tires.

The perpetrator had an extensive criminal record with offences of domestic assault, sexual assault, assault, and harassment.

In 2000, a motion was made to re-open the claim for refugee status. An immigration departure order became enforced, but the perpetrator was not removed from Canada because no country (i.e. Uzbekistan, Kazakhstan or Russia), were willing to concede that he was a citizen of their respective countries.

In early 2002, the perpetrator's application for Permanent Resident status was refused. At that time, the perpetrator was living common-law with the victim's mother and had five convictions involving incidents (i.e. assault, threatening death/bodily harm, failure to comply with court order), with Woman B.

In March 2003, the perpetrator's application for permanent resident status was again refused.

The perpetrator and the victim's mother were married in March 2002. The victim was born during a previous relationship that his mother was involved in. The perpetrator was verbally and physically abusive to both his wife and her son from the start of the relationship. The victim and his mother had gone to police and asked them to speak to the perpetrator, but not to charge him. The victim was afraid of the perpetrator and thought that he would hurt his mother. The victim sometimes stayed home from school in order to protect his mother.

In August 2003, the perpetrator was arrested and charged with assaulting the victim's mother. He was held in custody until November 2003, at which time he pled guilty to assault and was placed on two years probation.

In early December 2003, the perpetrator breached his probation by showing up in the victim's mother's backyard and trying to break into her house while intoxicated. The victim's mother, who was home at the time, called police. When police arrived, they could not verify the perpetrator's probation conditions and let him go. No charges were laid. A few days later, the perpetrator began calling the house.

In mid-December 2003, the victim called immigration officials to tell them that the perpetrator was in the country illegally and that he feared for the safety of his mother and himself.

On December 22, 2003, the victim's mother telephoned police to report the earlier probation violation by the perpetrator. She presented the probation order that outlined the conditions that had been breached. She indicated that she was afraid for her safety. The police suggested the victim's mother consider a "place of safety", but she declined. Warrants were issued for the perpetrator's arrest due to his breaches of probation.

The police contacted the local children's aid society (CAS) after-hours on December 23, 2003 to report a domestic violence referral. The case was assigned on December 24, 2003 with a 7-day response time (to occur after the Christmas holiday). The perpetrator killed the victim on December 26, 2003 while awaiting the services of the CAS.

The local children's aid society had previous contact with the perpetrator in 1999 due to a domestic violence incident involving a different partner.

15 risk factors were identified.

Common themes: public education/ awareness – (Neighbours, Friends and Families); immigration; role of school system in risk assessment; communications.

Recommendation 1:

It is recommended that the Regional Supervising Coroner responsible for the area where this incident took place conduct a Regional Coroner's Review into the death of the victim. In particular, the review should address the following questions:

a. **Given the introduction of a high risk team for the police service in this jurisdiction, how would this incident be managed differently if it happened now? Would the incident be flagged and managed differently? Would a case like this result in early notification of CAS/CCAS?**
b. **How would the CAS or CCAS deal with this type of incident under current policies and guidelines?**
c. **Would the PAR (Partner Assault Program) play a role if this incident were to occur now?**
d. **What role would the local school system play in identifying and assisting students who may be exposed to domestic violence in the home? Are there current policies for investigating absences or behaviours that may be a result of domestic violence?**
e. **Are there protocols for police and CAS to work collaboratively with Citizenship and Immigration Canada (CIC)? How would Citizenship and Immigration Canada presently deal with a "tip" indicating that somebody's life and/or safety was at risk? Does CIC have policies that would include notification of local CAS/CCAS?**
f. **What is the policy for Citizenship and Immigration Canada for dealing with applicants who have been convicted of serious criminal offences or who have criminal charges pending?**
g. **What role could probation and parole play in preventing future similar incidents? What would be done differently if this incident were to occur today?**
h. **What role could the crown attorney/judicial system have played in preventing this death from happening? How would the case be handled differently if it were to happen today?**

Case DVDRC-2010-09: OCC file numbers: 2008-6418 and 2008-6419

This case involves a homicide–suicide. The victim and the perpetrator (both age 28) were involved in a common-law relationship and were engaged to be married. The victim was in the process of terminating the engagement and ending the relationship. The couple had previously lived together in Ottawa, but the perpetrator had recently moved back to Calgary to find employment.

On the day of the homicide-suicide, the perpetrator traveled back to Ottawa to visit with the victim. The victim picked the perpetrator up at the airport and transported him back to her residence. The perpetrator subsequently strangled the victim, and then hanged himself.

There was no previous history of domestic violence.

When the victim eventually initiated a break up with the perpetrator, the perpetrator reportedly had a very difficult time accepting the situation.

The victim was employed and busied herself and expanded her social networking with her work friends. She was described as an extrovert. Both the victim and the perpetrator were university educated, although the perpetrator had a difficult time securing satisfactory employment.

5 risk factors were identified.

No common themes.

No new recommendations.

Case DVDRC-2010-10: OCC file numbers: 2007-14788, 2007-14787, 2007-14786 and 2007-14789

This case involves the homicide of a mother (the primary victim, age 46) and her two adult daughters (ages 20 and 22) by their husband/father (age 44), in November 2007.

The primary victim and her husband, the perpetrator, arrived in Canada from India in 1990. Some time in early 2007, the primary victim and her daughters became aware that the perpetrator was involved in an extra-marital affair. This caused a major rift in their relationships, with mother and daughter making plans to leave the household. The perpetrator may have perceived that he was losing his control and influence over his spouse and daughters, and was contemplating returning the family to their native land.

On November 16, 2007, the perpetrator called in sick to work, went to a local store and purchased a semi-automatic rifle and 500 rounds of ammunition. According to the police investigation, it is believed that the perpetrator may have already killed his wife and was purchasing the firearm and ammunition in order to kill his daughters. The cause and manner of death for the primary victim, the perpetrator's wife, was undetermined. The cause and manner of death for the daughters were gunshot wounds and homicide. After shooting his daughters, the perpetrator took his own life with a self-inflicted gunshot wound.

On November 21, 2007, the victim's family from India contacted local police to indicate that they were concerned because they had not heard from the victims for several days. Upon investigation by police, the victims were found deceased in their residence.

There was no previous involvement with police or other agencies.

The perpetrator and his wife, the primary victim, were together as a result of an arranged marriage. The relationship was apparently troubled from the beginning, and the perpetrator reportedly left the victim with his parents in India for a period of time.

The perpetrator had a valid license to purchase firearms. The current license was set to expire in December 2007. The perpetrator had also held previous licenses. There was documentation that the victim had applied for a Firearms Acquisition Certificate in 1996, but there is no record indicating that she ever owned a firearm.

6 risk factors were identified.

No common themes.

No new recommendations.

Case DVDRC-2010-11: OCC file number: 2002-16121

This case involves a homicide by the victim's husband. The victim (age 39) disclosed to a friend about a week prior to her death, that her husband (the perpetrator), had "threatened" her with a dumbell weight by putting it against her face. It is unknown what he said to her at the time. There are no reports of any prior incidents of physical assault, although the perpetrator was known to display controlling behaviour over his wife.

The victim had gone to her parent's house on Christmas Eve with her husband and son. They later returned back to their house. Sometime Christmas morning, the perpetrator drove his two daughters, both from a previous relationship, back to their mother's house. While the perpetrator was away, the victim spoke on the telephone with a friend and she left a message for a male friend. During her conversation with the male friend, the perpetrator apparently arrived back home. The victim told her friend that the perpetrator, "gave her that look." At some point after that, the perpetrator struck the victim on the head several times with a dumbbell. The victim was transported to the hospital where she succumbed to her injuries the next day.

The victim worked full-time and had recently completed a 14 week program for anxiety at a local hospital that she reportedly had attended on her own volition.

The perpetrator had been previously married and worked in information technology.

The victim and perpetrator had dated for approximately 18 months prior to getting married in 1995. Their son was born in 1999 and was 3 years old at the time of his mother's death. Initially, the victim seemed happy in the marriage, however after the birth of her son, she reported to a relative that things started to deteriorate.

The victim disclosed to several of her friends, family and co-workers that the perpetrator was controlling, jealous and possessive, and that they argued frequently.

At some point prior to her death, the victim told the perpetrator that she wanted a trial separation. She was waiting until after Christmas to come to a firm decision. The victim was attacked by the perpetrator on Christmas Day and died the following day.

10 risk factors were identified.

Common themes: public education/ awareness – (Neighbours, Friends and Families); safe separation.

No new recommendations.

Case DVDRC-2010-12: OCC file number: 2002-1332

In the weeks prior to her death, the victim (age 36) began to seek information about how she could leave her marriage to her abusive husband (the perpetrator) and keep herself and her children safe. She wanted to remove the perpetrator from the family home they shared with their four children.

On the morning of May 1, 2002, the couple's two eldest children left for school independently. The victim drove the two younger children to their respective schools while the perpetrator remained at home.

According to police reports, the victim returned home at approximately 9:00 a.m. At approximately 9:11 a.m. neighbours observed the perpetrator leaving the home. It is reported that the perpetrator went to see a friend who is a lawyer, who then escorted him to another lawyer's office. The police were subsequently notified by the perpetrator's lawyer of the victim's death.

Upon investigation by police, the victim was found deceased in the residence. She had been shot several times in the head and chest. It is also believed that the perpetrator flicked a live cigarette into the hair of the victim.

The victim was a homemaker and mother to four children ages 18, 16, 14 and 8 years. At the time of her death, the victim was not employed outside the home because she suffered from a disability.

According to medical records and the police interview with her doctor, the victim had spoken openly about the abusive nature of her relationship with her husband. The doctor encouraged the victim to leave the relationship as she felt she was in danger. The victim was also fully open about the nature of the abuse in her marriage with her family, friends and neighbours. She had suffered broken ribs, a broken nose, many bruises and several assaults over the course of the marriage.

The victim was terrified to approach police as the perpetrator had threatened on many occasions to kill her and her family if she reported the abuse. On one such occasion, when her parents intervened to assist, the perpetrator assaulted the victim's father. The victim's father met with the perpetrator and his brothers a few days later to try and resolve the dispute. At that time, the perpetrator promised to treat his wife better. This informal family intervention was effective temporarily. The couple sought and received marital counselling from their clergy.

The victim had utilized the counselling services of a women's shelter in April 2002, one month prior to the homicide. The victim fully disclosed her history of abuse to the shelter workers. She was given information pertaining to her rights and requested a referral to a lawyer. The victim was scheduled to attend a follow up meeting with the shelter, but had to cancel when directed to do so by her husband.

It is believed that the pivotal event for the victim was the realization that her husband, who was known to have extra-marital relationships, had infected her with a sexually transmitted disease (STD). One day prior to the death, the presence of an STD was confirmed. The victim may have felt that this positive test result would give her more credibility in having the perpetrator removed from the family home and obtaining a financial settlement.

The perpetrator (age 45), was part of a large, close-knit family. He immigrated to Canada as a young boy and subsequently started a business with two of his brothers.

In 1997, the perpetrator was charged with assaulting his wife. The perpetrator had been drinking at the time of the assault. The victim suffered a cut lip and other head injuries. The children, as well as the perpetrator's brothers, were present during the assault The perpetrator was fined $500, entered into a six month peace bond and was instructed to turn over his firearms.

The perpetrator owned a number of guns and carried a revolver on a daily basis, reportedly for personal protection.

The victim and perpetrator were married for 18 years. There was a long-standing history of verbal, psychological and physical abuse that was well-known to the whole family. The perpetrator had a history of infidelity and extreme financial control over his wife.

21 risk factors were identified.

Common Themes: Neighbours, Friends and Family; risk assessment; school intervention.

No new recommendations.

Case DVDRC-2010-13: OCC file number: 2004-16235

The victim (age 47) had been thinking for a while about leaving her husband because of an abusive relationship. She had contacted a lawyer to start separation proceedings. She had found an apartment and planned to move in the weekend before her husband returned from a trip abroad.

The victim discussed her plans to separate with many of her friends and colleagues. She was afraid of the perpetrator and felt that he would come after her. Her co-workers were concerned and attempted to make her work environment (a secondary school), safe. The victim also spoke with her doctor, a police officer (who was assigned to the school where she worked) and the school principal about her plans to separate and her fears of her husband. The police officer provided her with safety tips to use at her new home.

While the perpetrator was away, the victim moved into her new apartment. She took several precautions to ensure that her husband would not be able to find where she lived.

When the perpetrator arrived home from being abroad, he became aware that his wife had left him. On the day before the homicide, the perpetrator left messages on the victim's cell phone saying that he missed her and wanted her to come home.

The perpetrator obtained a rental van the day before the homicide. On the day of the homicide, the perpetrator drove the van to the victim's workplace. When the victim appeared in the parking lot, the perpetrator ran up to her car and shot her in the head. The perpetrator then fled the scene.

The victim was born in Turkey and her parents and brother lived there. She had no family in Canada. When she came to Canada, she obtained a job working part-time in retail, and subsequently went to university where she obtained a teaching certificate. She taught English as a Second Language (ESL) and special education at a secondary school.

The perpetrator (age 62), received his engineering degree from a university in Germany. His mother came to Canada and lived with him and the victim for a period of time, until his mother committed suicide in 2000.

Three years prior to the homicide, the perpetrator was forced to retire from his job and he was not happy.

The perpetrator had been married once before and had a son. He was known to be abusive to his first wife and his son. At one point, his first wife had to go to a women's shelter and he stalked and harassed her while she was there.

Approximately 15 years prior to the homicide, the perpetrator was diagnosed with depression and anxiety. He also suffered from several medical issues stemming from a car accident.

The perpetrator did not have many friends. He also owned a firearm.

The victim and perpetrator met in Turkey by way of an arranged marriage.

The perpetrator was verbally, economically and emotionally abusive towards the victim. There are some reports from the victim's friends that the perpetrator was also physically abusive.

The victim became very unhappy in the marriage. She told friends that she would have left her husband before, but that she was new to Canada and did not have any family or friends. She also confided to friends that she feared her husband would come to the school and shoot her if she ever left him.

10 risk factors were identified.

Common Themes: Neighbours, Friends and Families; safe separation; domestic violence in the workplace; safety planning process.

Recommendation 1

All employers in Ontario should be required to develop policies on measures they can take in their workplace(s) to prevent and/or provide effective responses to workplace domestic violence. Employers should also be required to provide training to all employees on recognizing the warning signs of domestic violence, as well as initiating the appropriate responses when they do recognize warning signs or witness incidents. Managers and supervisors should receive additional training in providing appropriate assistance to victims or co-workers who report concerns.
Comment: Through the provisions of Bill 168, employers in Ontario are now mandated by the Occupational Health and Safety Act (OHSA) to have policies on workplace violence and harassment and to provide training to employees on workplace violence and harassment. Bill 168 also makes employers responsible for taking reasonable precautions to protect the workers from domestic violence likely to expose a worker to physical injury in the workplace. Although most employers have little or no experience preventing or responding to workplace domestic violence, the OHSA does not lay out specific requirements for policy development or training in this area.

Recommendation 2

The Ministry of Labour and the Ontario Women's Directorate is encouraged to work with domestic violence experts, Health and Safety Ontario and the Ontario Federation of Labour to establish a non-profit initiative to engage employers in the work of preventing and responding to domestic violence. The new non-profit initiative should provide workplace specific information, resources and advice for employers.
Comment: Examples for such promising practices exist in other jurisdictions. In the U.S., two non-profit initiatives involve corporate partners in efforts to protect employees from domestic violence: The Corporate Alliance to End Partner Violence (www.caepv.org/), and Workplaces Respond to Domestic and Sexual Violence: A National Resource Center (www.workplacesrespond.org/) . The latter was launched by President Barack Obama and Vice President Joe Biden in November 2010.

Case DVDRC-2010-14: OCC file numbers: 2010-1197 and 2010-1198

The perpetrator (age 39) had been experiencing anxiety and paranoia that was possibly triggered by an unknown event at his workplace in November 2009. At that time, the perpetrator was also laid off from his place of employment.

The perpetrator's psychological ailment manifested as jealousy concerning his wife, the victim (age 36), and evidence from family reveals that he was convinced that she had been having an affair. The victim accompanied the perpetrator to a naturopathic doctor. The naturopath suggested that the victim take her husband to a medical doctor as he suspected the perpetrator was suffering some form of schizophrenia. The naturopath further advised that the victim should not leave the perpetrator alone.

The victim took time off work to assist and care for her husband.

The perpetrator spoke of suicide and stabbing two or three times prior to the murder and the victim's brother remarked that he did not think the perpetrator was mentally stable. The perpetrator had telephoned the victim continually at her workplace, which prompted the victim to believe that his mental/emotional state had declined.

The victim could not cope with the perpetrator's paranoid behaviour. They became involved in a verbal argument and she told him that she wanted him to leave. The perpetrator was emotionally distraught and begged the victim not to leave him. The couple's two children were present at the time, and the son told them to stop arguing. The son further disclosed that there had been discussion of separation two weeks prior to the tragedy.

The next day, while the children were at school, the perpetrator stabbed the victim to death, then stabbed himself to death.

The couple had no known or reported history of domestic violence. The victim was aware of, and was becoming frustrated by her husband's declining mental state and the fight is believed to have resulted from the perpetrator's paranoid and deteriorating mental state.

11 risk factors were identified.

Common themes: public education/ awareness – (Neighbours, Friends and Families); mental health.

Recommendation 1:

To Ontario Women's Directorate:
Public education campaigns (e.g. Neighbours, Friends, and Families) should address the increased risk for domestic homicide when there co-exists a history of domestic violence and the presence of mental illness in a potential perpetrator. The campaign should stress the seriousness of the risk posed by a mentally ill individual who is threatening to harm his/her partner and/or is threatening self-harm. Specifically, the campaign should outline the steps to be taken when attempting to obtain help for a mentally ill family member, including treatment options and referrals to support services.

Case DVDRC-2010-15: OCC file numbers: 2008-3179 and 2008-3178

The couple was separated, but still shared a residence with their three children. Prior to separating, the couple had what was described as an "open" relationship and dated other people. The perpetrator reportedly tended to be very jealous and controlling and was not pleased with the separation. He had threatened to kill himself because he felt he could not live without the victim.

On March 20, 2008, the perpetrator (age 41) made arrangements for the children to be looked after by a babysitter. The babysitter was given very detailed information regarding the children, including their birthdates, medical histories and various contact numbers. It was most unusual for the perpetrator to provide this level of detail to the babysitter. The babysitter was also paid in advance, which was not the normal practice.

When the victim (age 36) arrived home from work she was surprised by the rather unexpected arrangements with the children and babysitter, and she engaged in a brief argument with the perpetrator. At approximately 6:30 p.m., although it was not clear why, the victim accompanied by the perpetrator, left the house travelling in the same vehicle.

Less than 18 minutes later, the vehicle was driven into a concrete bridge support. The victim was pronounced dead at the scene and the perpetrator died later in the hospital.

The investigation determined that the collision was intentional as there were no skid marks and there was no evidence to suggest swerving or attempts at braking. The perpetrator was driving the vehicle and the impact was fully on the front passenger side where the victim was sitting. The victim was determined to be not wearing her seat belt at the time of the collision; she was reported to always wear her seat belt. The perpetrator however was wearing his seat belt and this was reportedly out of character for him. The

fuse for the airbags and ABS brakes was subsequently discovered to have been removed. The neighbours reported seeing the perpetrator working on the van earlier in the day.

The victim was known to have extramarital affairs, and was involved in a relationship with another man at the time of her death. Since 1994, the perpetrator had not been employed full-time. At the time of the deaths, he was attending college on a part-time basis and he delivered newspapers part time. He often looked after the children and he was described as a stay-at-home father.

The perpetrator was noted to be very jealous, manipulative and controlling. In 2004, the victim started a new job and the perpetrator would frequently call the office to ensure that she was at work.

In the fall 2006, the victim began working at a new company. The perpetrator would telephone several times every day to ensure she was at work. He would also call every extension to determine who she may have been with. He would show up unexpectedly at the company with the children and walk straight into the main office area, bypassing the receptionist. In order to stop him from entering the offices, the company installed a security door.

The couple had three children together. There were no child welfare issues and no involvement of CAS.

9 risk factors were identified.

Common themes: public education/ awareness – (Neighbours, Friends and Families), domestic violence in the workplace.

No new recommendations.

Case DVDRC-2010-16: OCC file numbers: 2009-11636 and 2009-11797

On September 10, 2009 the victim (age 39) told the perpetrator (age 42), her husband, that they should get a divorce. The couple had been apparently amicably separated and living apart for the prior year. The next day, the perpetrator went to the victim's house to pick up their son. The victim reiterated their conversation from the night before and the perpetrator became very upset. The couple had two teenaged children together.

At 11:37 p.m. on September 11, police attended the victim's house in response to a domestic assault call. The victim told police that the perpetrator had been at her residence and had assaulted her. She indicated that the perpetrator had grabbed her around her neck, strangled her, and forced her to the ground. He then threatened her as he left the house. The victim phoned her mother to report what had happened. She said that the perpetrator had been drinking. She told her mother that she was terrified and that she felt she had to call the police.

When the police arrived, the victim refused medical treatment and told the police that she did not want to pursue the matter with charges, stating that the behaviour was out of character for the perpetrator and that she believed he would never hurt her. She declined to go to the police station. The police advised the victim that they would proceed with charges even without her cooperation.

At 11:56 p.m., the perpetrator called the victim on her cell phone while police were still present in her home. One of the officers spoke to the perpetrator and he agreed to meet the officers at the police station. At 12:11 a.m., the officers returned to the station to continue their investigation. The police contacted the victim to let her know that the perpetrator had not attended the police station as he said he would. The police left a message with the perpetrator advising him to contact them.

At 12:28 a.m., the victim called the police to report that the perpetrator had called her and told her he would not be going to the police station and was staying home because he had been drinking. The victim

told the perpetrator that she was proceeding with charges of domestic assault, and in response, the perpetrator reportedly became very upset.

The victim was talking on the phone with her mother when the perpetrator returned to her residence. Both the victim and her mother called the police. Police immediately responded to the call and while en route, were advised by dispatch of shots fired.

At 12:41 a.m., officers arrived at the victim's residence and after a brief search, located the victim inside the residence next door, suffering from three gunshot wounds to her chest. The victim subsequently died in surgery at the hospital.

Police officers traveled to the perpetrator's residence and upon arrival, heard a gunshot. The perpetrator was subsequently found dead of a self-inflicted gunshot wound. Police found several guns in the perpetrator's home. Police also found a letter written by the victim to the perpetrator discussing their relationship and how she had taken the key to his gun locker because she feared he would harm himself.

Suicide letters addressed to the victim, her parents, the perpetrator's parents, and each of their children, were also found. It appeared the letters may have been written eight months earlier, in January 2009.

The perpetrator was reportedly not dealing well with the separation and appeared to be depressed. He was not performing well at his job and appeared distracted. The perpetrator seemed concerned about losing money after he separated from his wife. He was apparently in debt and he was concerned about the victim's spending habits. The perpetrator was dealing with financial stress, employment concerns, and the death of the family dog.

7 risk factors were identified.

Common theme: safe separation.

Recommendation 1:

To the Ministry of Community Safety and Correctional Services.
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.

Comment: This case was high risk at the time of the initial call to police. Although there was no prior history of domestic violence, the risk was substantial due to the strangulation attempt on the victim, relatively recent separation, depression and suicidal ideation by the perpetrator and his access to firearms. More subtle factors included the perpetrator's unstable employment and financial status. A risk assessment could have lead to an immediate safety plan and arrest of the perpetrator.

Recommendation 2:

Police training should include instruction on how to deal with resistant or reluctant victims of domestic violence.

Comment: Historically, many victims have ambivalent feelings that may contribute to their unwillingness to cooperate with police or have charges laid. The facts of this case demonstrate this well, and could be used in police training on domestic violence to educate officers in how to deal with reluctant and/or resistant victims.

Recommendation 3:

It is recommended that the Working Group co-chaired by the Ministry of Community Safety and Correctional Services and the OPP, expedite the process to distribute a modified Domestic Violence Supplementary Report (DVSR) to police in Ontario.

Comment: A Working Group has been meeting in an effort to improve upon the current DVSR utilized by police, modifying the Risk Factor portion to include more recent, empirically validated factors and supplying a Risk Management portion to assist police officers to more immediately identify high risk domestic violence cases and appropriately manage those cases. Widespread adoption of this modified DVSR would provide increased victim safety and more appropriate offender management and assistance

Case DVDRC-2010-17: OCC file numbers: 2010-260 and 2010-398

The victim and perpetrator (both age 20) had dated on and off for a period of time in 2005-2006. They began dating again for two weeks in the spring of 2009, but the relationship ended as a result of the perpetrator's continuous obsessive, controlling and jealous behaviour. The victim was casually dating other men. Prior to Christmas 2009, the perpetrator began to contact the victim on a more frequent basis under the auspices that they were "just friends." It appears however, that his intent was to rekindle their past relationship.

In early December 2009, the victim became more seriously involved with another man. On December 21, 2009, the perpetrator sent a gift certificate for horseback riding and a card to the victim.

On January 2, 2010, the victim attended the perpetrator's residence to view family photographs. On January 9, 2010, the victim and perpetrator together used the gift certificate for horseback riding, then the victim drove the perpetrator home. The perpetrator sent a text message to the victim after she dropped him off, asking her to come back to his residence so they could talk "as friends", or to meet him somewhere. The victim refused. The perpetrator persistently requested to attend the victim's residence and after declining, the victim eventually agreed to allow him to visit. She said she had "moved on" and discussed her new relationship. They engaged in a series of messages about their relationship and the perpetrator concluded with a message indicating that he no longer wanted to visit her at her residence.

The following day, on January 10, 2010, the perpetrator attended the victim's residence and was turned away by her mother. The mother had previously asked the victim why she did not want to talk to the perpetrator any longer and the victim stated that while he had never threatened her, she had a "bad vibe" about him and felt that he wanted to kill her.

Approximately an hour later, the perpetrator began sending text messages to the victim indicating that he wanted to talk to her. The victim responded by text, telling the perpetrator that she did not want to talk any further. Approximately 15 minutes later, the perpetrator attended the victim's residence and shot her in the back and the head. The victim died at the scene.

The perpetrator sent a text message to his mother telling him he loved her, then fled to a park where he shot himself in the head while sitting in his vehicle. He was found alive by emergency personnel and transported to hospital. He was removed from life support and died on January 12, 2010.

9 risk factors were identified.

Common themes: safe separation; harassment using telecommunications.

No new recommendations.

Case DVDRC-2010-18: OCC file numbers: 2010-544 and 2010-545

On January 7, 2010 the tenant who lived in the apartment above the male perpetrator called the police to report a fight between two people in the apartment below. The tenant stated that she had been woken up by the fight which had been going on for approximately 3 or 4 hours. She later told police that she witnessed the female (now known to be the victim) hitting the male (the perpetrator) with a long stick. The male fell and the female ran over to him and asked if he was okay and told him that that she was sorry and that she loved him. The male pushed the female onto the couch.

Police attended the residence, however they did not speak to the complainant or any of the involved parties. The police knocked on the door and nobody answered. They stayed on scene for about 10 minutes, heard no disturbance, then left.

On January 8, 2010 the perpetrator was noted to be “freaking out” when he called a female friend. The friend went to the perpetrator’s residence where they sat in the stairwell in the common area and talked. She did not go inside the apartment. She described the perpetrator as dazed, disorientated and teary. He told her that on January 4, while on his way home from work, someone had tried to kill him. He supposedly hit the unknown assailant and reported that he feared he may have killed him. He told the female friend that if he did not call her within the next few days, he would either be gone, or in police custody. He also told the friend that he had last seen the victim a few days prior.

A friend of the victim called the police on January 10, 2010 to report the victim missing, indicating that she had not spoken to the victim since January 6, 2010. The friend was advised to check the residence and advise police if she had any problems. The friend did not attend the residence.

On January 12, 2010 a male friend attended the residence and was met by the perpetrator outside the apartment. This friend observed cuts on the perpetrator’s neck, but he did not ask about them. The perpetrator told this friend about the fights that he had with the victim, and that one fight involved a knife. No other details were provided. The friend did not enter the residence.

It is believed that the perpetrator stabbed and killed the victim on January 7, 2010 soon after they had been observed fighting, then killed himself on, or around January 12, 2010. The perpetrator was found with a plastic bag over his head and the cause of death was asphyxia. The bodies were not located until January 16, 2010. There was evidence of crack/cocaine use in the apartment.

As a child, the victim had been involved with local child protective services. She had difficulty with school and there was a high level of conflict within her home. She had been placed in numerous foster homes, but was a persistent runaway. The victim had allegedly been sexually assaulted by a family friend when she was eight years old. The victim had been hospitalized on several occasions for suicidal gestures and was known to use drugs and alcohol. Child protective services ended involvement with the victim once she turned 16 years of age.

At the time of her death, the victim (age 24) had 39 incidents on record with the local police service. The incidents involved substance abuse, violence and prostitution. She also had a criminal record for assault. She had been held in detention, as a youth, in 2001 for stealing a car. The victim was employed as an escort and she was known to use crack/cocaine and to be a heavy drinker.

The perpetrator (age 34), had 11 incidents (mostly alcohol and driving related) on record with the local police service. He worked with heavy machinery.

The victim and the perpetrator had known each other for approximately three years prior to their deaths. Although they were not considered a couple, they did spend time together and engaged in sexual relations. The victim had recently moved in with the perpetrator while she was waiting for her own rental apartment in the same building to be ready.

6 risk factors were identified.

Common theme: public education/ awareness – (Neighbours, Friends and Families).

No new recommendations.

Chapter Four: Common Themes in 2010 Case reviews

In 2010, the Domestic Violence Death Review Committee (DVDRC) reviewed a total of 18 cases involving 36 deaths. 4 of these cases involved multiple homicide victims and 12 of the 18 cases were homicide-suicides. After reviewing these cases, and considering other cases reviewed in previous years, several themes, patterns or trends have been identified. These themes included:

1. Domestic violence and its impact on the workplace;
2. The utilization of information and communication technologies to harass or stalk victims of domestic violence;
3. Increased risks to victims while separating or ending a relationship.

1. Domestic Violence and its impact on the Workplace

The issue of domestic violence within the workplace was examined in the 2007 inquest into the deaths of Lori Dupont and Marc Daniel. On November 12, 2005, Lori Dupont was stabbed to death by her ex-partner, Marc Daniel, who committed suicide shortly thereafter.[2] Ms. Dupont worked as a nurse at Hotel Dieu Hospital in Windsor, Ontario. Dr. Daniel was an anesthesiologist at the same hospital. The inquest explored several missed opportunities and system failures of the workplace when there was an obvious presence of domestic violence between co-workers. Several of the 65 recommendations made by the inquest jury pertained to workplace violence and/or domestic violence.

In response to the Dupont-Daniel inquest, the Ontario legislature passed amendments to the Occupational Health and Safety Act (OHSA) that incorporated initiatives to address workplace violence and harassment.[3] In June 2010, Bill 168 introduced significant amendments to the Occupational Health and Safety Act towards preventing violence and harassment in the workplace. Section 32.0.4 of the amended Act specifically addresses the issue of domestic violence by stating that:

If an employer becomes aware, or ought reasonably to be aware, that domestic violence that would likely expose a worker to physical injury may occur in the workplace, the employer shall take every precaution reasonable in the circumstances for the protection of the worker.

The Bill requires that employers address workplace violence by: implementing a workplace violence prevention policy; conducting a risk assessment; and providing information and instruction for employees on the workplace policy and information disclosure.[4] Bill 168 states that if an employer becomes aware of domestic violence occurring in the workplace, s/he must take every precaution to protect their employee.

Several cases reviewed by the DVDRC in 2010 involved incidents where the victim was threatened or harmed while at their place of employment. In many cases, it was apparent that co-workers and employers were often aware that the victim experienced, or was at risk of experiencing, violence initiated by their domestic partner. In several cases, the violence and/or risk of violence, often followed the victim to work which in turn posed potential safety concerns to others in the workplace. Depending on the

[2] Office of the Chief Coroner. Inquest into the deaths of Lori Dupont and Marc Daniel. (2007).
[3] Bill 168, Occupational Health and Safety Act Amendment (Violence and Harassment in the Workplace) 2010. Retrieved April 26, 2011 from: http://www.labour.gov.on.ca/english/hs/sawo/pubs/fs_workplaceviolence.php.

[4] Fonseca, Hon. P.. (2009). *Bill 168, Occupational Health and Safety Amendment Act (Violence and Harassment in the Workplace) 2009*. Legislative Assembly of Ontario. Retrieved October 15, 2010 from: http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=2181.

workplace, other individuals that could be impacted may include: the employer, co-workers, clients, students and the general public.

Some employers and employees may consider domestic violence as a "personal issue" that does not enter or impact the workplace. Perpetrators of domestic violence however, may engage in abusive behaviours that extend outside of the home environment to interfere and impact with a victim's work and place of employment.[5] Perpetrator behaviours that may impact a victim while in their place of employment could include:

- Interfering or obstructing the victim's ability to attend work, or look for employment;
- Attending and/or entering the victim's workplace without permission or authorization;
- Repeatedly phoning, texting, emailing or contacting the victim while at work;
- Physically or verbally abusing the victim (or others) while at work.

It is recognized that perpetrator behaviours may also, as an unfortunate consequence, impact upon other individuals present within the workplace who could become unintended victims. Victims may also experience reduced productivity and increased rates of absenteeism which may in turn lead to psychological distress and detrimental economic repercussions.[4]

It is recognized that domestic violence does not just occur within a residential environment and that violence and abuse may follow a victim to their place of employment. As such, employers and fellow employees could play an important role in intervening and diffusing potentially harmful or lethal situations that may impact not only the victim, but also others that are present within or near the work location.

In the most tragic of cases, domestic violence that is experienced by a victim within their workplace may result in lethal outcomes. Of the 111 cases reviewed by the DVDRC since 2003, 5 domestic homicides occurred within the victim's actual workplace. In 2010, the DVDRC reviewed two cases where the victim was either killed or exposed to violence within their work environment:

Case 2010-13 - The victim, a teacher at a secondary school, was in the process of separating from her abusive husband. She discussed with both the police officer who was assigned to the school, and the school principal her plans to separate and voiced her concerns and fears of her husband. The victim had made appropriate safety plans around preventing her husband from finding out where she lived and she was fearful that he would come after her at the school where she worked. Colleagues of the victim were aware of the potential threat posed by the perpetrator and would engage in protective behaviours with the victim, like walking her to her car.

The perpetrator was observed in the parking lot of the school where the victim worked and at one point, attempted to gain entry into the school, but was denied access because he did not have proper identification.

On the day of the homicide, the perpetrator had sent the victim an email stating that he would die without her. The victim showed this email to her colleagues at the school. Later that day, the victim left the school and the perpetrator followed her. As the victim returned to the school, the perpetrator ran up to her car in the school parking lot and shot her. The perpetrator fled the scene and was later apprehended by police.

The two recommendations from Case 2010-13 focused on the intervening role employers may play when domestic violence impacts the workplace.

[5] Ontario Safety Association for Community & Healthcare (OSACH). (2009). Addressing domestic violence in the workplace: A handbook. Second edition. (ISBN: 1-894878-77-9). Health Force Ontario. Retrieved March 24, 2011 from: http://www.osach.ca/products/resrcdoc/PH-MWVP0-E-100109-TOR-001.pdf.

Case 2010-15 - The perpetrator in this case frequently called the victim's office to ensure she was at work. The perpetrator also made several hang-up and harassing calls to a co-worker of the victim with whom he suspected she was having a relationship. Even when the victim changed employers, the perpetrator called other telephone extensions in the office in order to determine where his wife was and who she was with. The perpetrator showed up with the children at the victim's workplace and would enter the work area without permission. In order to stop the perpetrator from continuing to do this, the company installed a security door.

The perpetrator subsequently killed the victim, then himself, in an intentional motor vehicle collision.

Recognizing the legislative requirements of Bill 168 and the role that employers may play in intervening or ending domestic violence, several resources have been developed. These include:

- Make it our Business (www. makeitourbusiness.com) - *Make It Our Business* is a campaign of the Centre for Research & Education on Violence against Women & Children (CREVAWC). The information and training provided through *Make It Our Business* is intended to help employers meet their new obligations under the Ontario Occupational Health and Safety Act.
- Occupational Health and Safety Council of Canada – Workplace Violence Preventions Series http://www.labour.gov.on.ca/english /hs/pdf/wvps_guide.pdf
- Ontario Ministry of Labour Preventing Workplace Violence and Workplace Harassment http://www.labour.gov.on.ca/ english/hs/sawo/pubs/fs_workplaceviolence.php)

2. The utilization of information and communication technologies to further abuse victims of domestic violence

According to Statistics Canada, in 2009, 81% of individuals in Ontario had access to the Internet (from all locations including: home, work, school, public library or other) [6] and 77.2 % of Canadian residents had cellular phones. [7] With the rapid development and consumption of information and communication technologies, perpetrators of domestic violence have potentially more opportunities to abuse and control victims[8] and the "rapid expansion and availability of new information technologies poses new threats to both victims of domestic violence and victim service providers." [9]

Perpetrators of domestic violence are increasingly using a variety of technologies, including telephone, surveillance and the Internet, to harass, terrify, intimidate, coerce and monitor their victims. It is likely that, "the growing use of the Internet in the population and the ready availability and extensive use of other technologies such as cell phones, video cameras and Global Positioning Systems (GPS), will result in an increase in the use of technology related to intimate partner violence." [8]

High-tech stalking, often referred to as "cyberstalking," is a relatively new concept which has no universally accepted definition, but includes "the unsolicited use of electronic mail, Internet chat rooms, message boards or guest books, commercial service user profiles, Internet websites and Internet news groups to pursue and/or harass a specific individual." [7]

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[6] Statistics Canada. Internet use by individuals, by location of access by province. 2009. Retrieved April 27, 2011 from http://www40.statcan.gc.ca /l01/cst01/comm36g-eng.htm.
[7] Statistics Canada. Selected dwelling characteristics and household equipment. 2009. Retrieved April 27, 2011 from http://www40.statcan. gc.ca/l01/cst01/famil09b-eng.htm?sdi=cellular).
[8] Hand, T., Chung, D., & Peters, M. (2009). The use of information and communication technologies to coerce and control in domestic violence and following separation. Stakeholder paper 6. Australian Domestic & Family Violence Clearinghouse. Retrieved March 6 2011 from: http://www.adfvc.unsw.edu.au/PDF%20files/Stakeholder%20Paper_6.pdf.
[9] Finn, J. and Atkinson, T. (2008). Promoting the Safe and Strategic Use of Technology for Victims of Intimate Partner Violence: Evaluation of the Technology Safe Project. *Journal of Family Violence* (2009) 24:53-59.

This “high-tech” or “cyber-stalking” may include:

- Sending multiple or unwanted email, text or other online messages to the victim and/or their family, employer, etc.
- Monitoring a victim’s computer usage through “spyware.”
- Tracking a victim’s whereabouts using GPS technology (on telephones, cameras and other devices).
- Watching/listening to a victim through hidden cameras and listening or monitoring devices.
- Intercepting telephone calls, text messages or e-mails.
- Impersonating the victim online.
- Creating websites or other online forums (e.g. blogs) with harassing messages about/to the victim.
- Sending or installing viruses on the victim’s computer. [10] [11]

There is increasing evidence that perpetrators of domestic violence use the medium of the Internet to harass, stalk, and abuse victims. “Perpetrators can monitor and harass victims by way of: computer monitoring software; keystroke logging; instant messaging and chat rooms; checking browser history; and email tampering.”[7] Spyware technology can be downloaded onto a computer to monitor and record all activities and keystroke loggers are devices that record every typed key on the keyboard. Chat rooms, instant messaging services, and Internet browsers record conversations or websites visited and this information may be accessed by perpetrators or potential perpetrators.

Email tampering is another way for perpetrators to monitor the online activities of victims. Perpetrators may threaten violence in order to force victims to disclose passwords. Perpetrators may read, intercept, redirect, delete or otherwise manipulate a victim’s emails, without their knowledge or consent.[7] The Neighbours, Friends and Families public education program has identified the high risk associated with a perpetrator listening into telephone calls and intercepting emails from victims. [12]

The use of information and communication technologies continues to be a major theme of cases reviewed by the DVDRC. Some cases involved victims that met through online dating forums. The perpetrator in one case, used the dating site to threaten and harass his victim(s). In other cases reviewed, perpetrators were known to tamper with the victim’s email, including the dissemination of slanderous messages to individuals on the victim’s address list and the distribution of threatening, abusive and/or excessive messages to the victim and others using email and text services. Other cases reviewed by the DVDRC identified perpetrators that downloaded tracking devices and/or “spyware” to monitor their victim’s activities. Additional cases reviewed by the DVDRC identified perpetrators who monitored their victim’s online journal and other social networking activities.

[10] Department of Justice Canada. Family Violence Initiative. *Criminal Harassment – A Handbook for Police and Crown Prosecutors.* Retrieved April 27, 2011 from http://www.justice.gc.ca/eng/pi/fv-vf/pub/har/part1.html

[11] National Network to End Domestic Violence, Safety Net Project. High-Tech Stalking. (2009). Retrieved on April 27, 2011 from http://nnedv.org/docs/SafetyNet/NNEDV_HighTechStalking_TipsForAgencyPartners.pdf.

[12] Neighbours, Friends and Families. Signs of High Risk. Retrieved on April 27, 2011 from http://www.neighboursfriendsandfamilies.ca/helping-abused-women/signs-of-high-risk.html

In 2009, the DVDRC recommended that:

The Ministry of Community Safety and Correctional Services provide public education on the risks involved with online dating sites and other social networking applications. The information should focus on what is considered to be criminal and/or harassing conduct and provide guidance on what safety measures should be undertaken and/or reported to police. Students in Ontario schools receive this type of information as part of the current awareness of cyber-bullying and inappropriate use of the Internet, but many adults may not be aware of Internet safety precautions. [13]

The following cases reviewed in 2010 had information and communication technology implications:

Case 2010-15 – The perpetrator was known to make excessive telephone calls to the victim and her colleagues at work. He accessed the victim's cell phone and retrieved messages from another individual that had "sexual overtones." The perpetrator harassed the victim and her new partner by telephone when they were on vacation together.

Case 2010-17 - The victim told a friend that the perpetrator was jealous and that he was stalking her, sending her excessive text messages and was behaving like a "cyber-bully." The perpetrator was sending text messages to the victim indicating that he wanted to talk to her. The victim responded by text, telling the perpetrator that she did not want to talk any further. Approximately 15 minutes later, the perpetrator attended the victim's residence and shot her.

The increased use of information and communication technologies against domestic violence victims has implications for the development and implementation of effective safety plans and in the general safety practices of individuals utilizing the various technologies. Victim advocates should remember that the motive for stalking is not affected by technological advancements; the motive of the perpetrator is to maintain power and control over the victim. With this in mind, "safety planning with survivors about technological methods used to stalk her may have a similar format to other non-technology related safety planning approaches and advocacy."14 Recognition and education of the available technologies and the implications they have on the victim's well-being should be part of the larger safety planning process.

It should also be recognized that some victims may have heightened risks of stalking through technology and as such, may require additional information and support. Additional factors, such as geographic location, ethnicity, income, accessibility, age or sexual orientation, could impact a victim's access to, or reliance on, various communications or technologies. [13] All of these factors should be considered when preparing safety plans.

While information and communication technologies may be used for nefarious purposes by perpetrators, victims (and their advocates) should educate themselves on the positive benefits of emerging technology tools that can enhance and promote their safety. This may include educating victims on safer practices and behaviours when utilizing the available technologies. Victims and advocates should develop an understanding of available technologies, including the potential risks and benefits of the various tools. It is recognized that, "victims of domestic violence are especially in need of technology safety education to protect their safety and promote their interaction with the larger community." [8]

One such project that was designed to increase awareness and knowledge of technology safety issues for domestic violence victims, survivors and advocacy staff was the Technology Safety Project of the

[13] Office of the Chief Coroner. 2009 Annual Report of the Domestic Violence Death Review Committee. Case 2009-09, p. 17-18.
[14] Southworth, C., Dawson, S., Fraser, C and Tucker, S. (2005) A High-Tech Twist on Abuse: Technology, Intimate Partner Stalking, and Advocacy. Violence Against Women Online Resources. Retrieved on April 27, 2011 from http://www.vaw.umn.edu/categories/3

Washington State Coalition Against Domestic Violence. The goals of the program were to: "1) increase safe computer and Internet access for domestic violence survivors in Washington; 2) reduce the risk posed by abusers by educating survivors about technology safety and privacy; and 3) increase the ability of survivors to help themselves and their children through information technology." [8]

The results of the Washington project indicate that technology issues "should be a regular part of assessment and safety training for women both in shelters and those seeking community services" and that "the program is needed, useful and effective in raising the consciousness of domestic violence victims as they plan for their safety and the safety of their children."[8] Participants in the program found the training about technology safety to be, "empowering, both in terms of personal safety and meeting post-shelter needs, such as finding employment, social services, and the establishment of a social network." [8]

3. Safe separation

Victims experiencing intimate partner violence are often forced to make life-altering and complex decisions to keep themselves and their families safe. In many cases, the most difficult decision is whether or not to separate by ending the relationship and leaving the perpetrator. Victims of domestic violence are at risk staying in the relationship and they are also at risk when separating. Research has indicated that leaving a relationship can lead to further, more extreme abuse and possibly death for the victim and children. A Canadian survey found that 19% of victims who experienced intimate partner violence and subsequently left the relationship, experienced further abuse during the separation.[15] A 1990 study conducted in Toronto found that divorced or separated women experienced more violence compared to married or cohabitating women.[16] In a study conducted by Crawford and Gartner that looked at intimate partner homicides in Ontario from 1974 to 1990, 31% of the homicides involved estranged couples.[17]

The most common risk factor identified in the cases reviewed by the DVDRC from 2003-2010 was an actual or pending separation; 78% of all domestic homicides reviewed by the DVDRC during this time involved a perpetrator and victim who were separated, or in the process of separating.

In 2010, 14 of the 18 cases reviewed involved an actual or pending separation.

Research has indicated that the period immediately after separation is most dangerous for abuse victims.[18] [19]

Several cases reviewed in 2010 demonstrate the increased risk that victims are exposed to when initiating a separation or divorce. During the time of separation or impending separation, additional stressors may include the perpetrator's realization that the relationship is over and in many cases, the recognition that the victim has a new partner in their life and has "moved on."

The following cases reviewed by the DVDRC in 2010 demonstrate the significant impact that separation (or pending separation) has on increasing the risk of lethality for victims of domestic violence:

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[15] Johnson, H., & Sacco, V.F. (1995). Researching violence against women: Statistics Canada's national survey. Canadian Journal of Criminology, 37(3), 281-304.
[16] Smith, M.D. (1990). Sociodemographic risk factors in wife abuse: Results from a survey of Toronto women. Canadian Journal of Sociology, 15(1), 39-58.
[17] Crawford, M., & Gartner, R. (1992). Woman killing: Intimate femicide in Ontario 1974-1990. Toronto: Women We Honour Action Committee. As cited in Brownridge, D.A. (2006). Violence against women post-separation. Aggression and Violent Behavior, 11, 514-530.
[18] Brownridge, D.A. (2006). Violence against women post-separation. *Aggression and Violent Behavior*, 11, 514-530.
[19] Gartner, R., Dawson, M., & Crawford, M. as cited in Brownridge, D.A. (2006). Violence against women post-separation. *Aggression and Violent Behavior*, 11, 514-530.

Case 2010-02 – This case involved the homicide of the victim and the suicide of her husband. The victim telephoned her husband at his work and advised him that she wanted a divorce. The victim had purchased plane tickets for her sister and her children to fly to be with her parents in another country while she and the perpetrator worked on their separation/pending divorce. The perpetrator returned home after work and engaged in a verbal argument with the victim. The victim's body was found a few days later; she had been strangled. The perpetrator committed suicide by hanging and was found at a secluded wooded area.

Case 2010-04 - This case involved the suicide of the perpetrator and homicide of his wife and daughter. There was a history of domestic violence and mental health issues.

Case 2010-06 – This case involved the homicide of the victim by her common-law partner. The perpetrator was known to abuse drugs and the victim had informed him that if she caught him using drugs again she would leave him. The perpetrator, when arrested, claimed he struck the victim on the back of the head with a wrench after she had discovered him using crack cocaine. An apparent argument ensued and the victim told him she was calling police. She had threatened to leave him in the past due to his drug use and he had made a promise to discontinue the habit.

Case 2010-07 - This case involved the homicide of the victim by her boyfriend. The victim and perpetrator had a history of domestic violence and on the night of the homicide, the victim had planned on breaking off her relationship with the perpetrator as she had fallen in love with someone else.

Case 2010-08 – The 14 year old victim was killed by his step-father. The victim's mother was separated from the perpetrator and there were probation conditions forbidding him to be in or near her residence.

Case 2010-09 – This case involved the homicide of the victim and the suicide of her common-law partner. The victim and perpetrator were involved in a long-distance relationship and they were engaged to be married. The victim told the perpetrator that she was not happy in the relationship and they made an agreement to break off the engagement. A few weeks later, the perpetrator flew to visit the victim with the hope of salvaging the relationship. The victim picked the perpetrator up at the airport and drove him back to her residence where the perpetrator subsequently strangled her, then hanged himself.

Case 2010-10 - This case involved the homicide of a mother (the primary victim) and her two adult daughters by their husband/father. The primary victim was planning on leaving the perpetrator and moving out with her daughters. The perpetrator may have perceived that he was losing control and influence over his spouse and daughters.

Case 2010-11 – This case involved the homicide of the victim by her husband, the perpetrator. At some point, the victim had told the perpetrator that she wanted a trial separation. She was apparently waiting until after Christmas to come to a firm decision about the separation. The victim was attacked by the perpetrator on Christmas Day and succumbed to her injuries the following day.

Case 2010-12 – In the weeks prior to her death, the victim began to seek information about how she could leave her marriage to her abusive husband (the perpetrator) and keep herself and her four children safe.

Case 2010-13 – The victim had been thinking for a while about leaving her husband because of an abusive relationship. She had contacted a lawyer to start separation proceedings.

Case 2010-14 – This case involved the homicide of the victim and suicide of the perpetrator. The victim could not cope with the perpetrator's paranoid behaviour. They became involved in a verbal argument and she told him that she wanted him to leave. The perpetrator was emotionally distraught and begged the victim not to leave him.

Case 2010-15 – This case involved the homicide of the victim and suicide of the perpetrator. The couple were separated, but still shared the same residence with their three children. Prior to separating, the couple had an "open" relationship and dated other people. The perpetrator was very jealous and was not pleased with the separation. He had threatened to kill himself because he felt he could not live without the victim.

Case 2010-16 - This case involved the homicide of the victim and the suicide of her estranged husband. The couple had been amicably separated and living apart for the past year. While out celebrating their daughter's birthday, the victim informed the perpetrator that they should get a divorce. The next day, the victim reiterated their conversation from the night before and the perpetrator became very upset. Later that evening, the perpetrator went to the victim's residence and assaulted her, including attempting to strangle her. The perpetrator left and the victim called police. Police responded and the victim decided to remain at home. Shortly after midnight, the perpetrator returned to the victim's residence and shot her, then retreated and killed himself at his residence.

Case 2010-17 – This case involved the homicide of the victim and the suicide of her boyfriend following a break-up. The victim had ended the relationship with the perpetrator but maintained contact with him with the intention of "being friends" and cushioning the blow of the break-up for him. The victim had a new partner in her life and had informed the perpetrator that she had "moved on." The following day the perpetrator attended the victim's residence and shot her.

Additional information on separation as a critical risk factor can be found in the Sixth Annual Report of the Domestic Violence Death Review Committee (2008), Chapter Four, p. 29. This report can be viewed online at:
http://www.mcscs.jus.gov.on.ca/stellent/groups/public/@mcscs/@www/@com/documents/webasset/ec080176.pdf

Appendix A: DVDRC Terms of Reference & Mandate

Purpose:

The purpose of this committee 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 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 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: DVDCR Risk Factor Coding Form

A= Evidence suggests that the risk factor was not present
P= Evidence suggests that the risk factor was present
Unknown (Unk) = A lack of evidence suggests that a judgment cannot be made

Risk Factor	Code (P,A, Unk)
1. History of violence outside of the family by perpetrator	
2. History of domestic violence	
3. Prior threats to kill victim	
4. Prior threats with a weapon	
5. Prior assault with a weapon	
6. Prior threats to commit suicide by perpetrator*	
7. Prior suicide attempts by perpetrator* (if check #6 and/or #7 only count as one factor)	
8. Prior attempts to isolate the victim	
9. Controlled most or all of victim's daily activities	
10. Prior hostage-taking and/or forcible confinement	
11. Prior forced sexual acts and/or assaults during sex	
12. Child custody or access disputes	
13. Prior destruction or deprivation of victim's property	
14. Prior violence against family pets	
15. Prior assault on victim while pregnant	
16. Choked/Strangled victim in the past	
17. Perpetrator was abused and/or witnessed domestic violence as a child	
18. Escalation of violence	
19. Obsessive behaviour displayed by perpetrator	
20. Perpetrator unemployed	
21. Victim and perpetrator living common-law	
22. Presence of stepchildren in the home	
23. Extreme minimization and/or denial of spousal assault history	
24. Actual or pending separation	
25. Excessive alcohol and/or drug use by perpetrator*	
26. Depression – in the opinion of family/friend/acquaintance - perpetrator*	
27. Depression – professionally diagnosed – perpetrator* (If check #26 and/or #27 only count as one factor)	
28. Other mental health or psychiatric problems – perpetrator	
29. Access to or possession of any firearms	
30. New partner in victim's life*	
31. Failure to comply with authority – perpetrator	
32. Perpetrator exposed to/witnessed suicidal behaviour in family of origin	
33. After risk assessment, perpetrator had access to victim	
34. Youth of couple	
35. Sexual jealousy – perpetrator*	
36. Misogynistic attitudes – perpetrator*	
37. Age disparity of couple*	
38. Victim's intuitive sense of fear of perpetrator*	
39. Perpetrator threatened and/or harmed children*	
Other factors that increased risk in this case? Specify:	

* Revised or new item

Risk Factor Descriptions

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

1. 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.).
2. Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who has been in, or 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.
3. 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."
4. 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).
5. 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.).
6. 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.
7. 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.
8. 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").
9. 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.).
10. 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).

11. 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.
12. 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.
13. 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.
14. 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.
15. 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.
16. 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).
17. As a child/adolescent, the perpetrator was victimized and/or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment.
18. 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.
19. 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.
20. 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.
21. The victim and perpetrator were cohabiting.
22. Any child(ren) that is(are) not biologically related to the perpetrator.
23. 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).
24. 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.
25. 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.

26. 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.
27. 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.
28. For example: psychosis; schizophrenia; bi-polar disorder; mania; obsessive-compulsive disorder, etc.
29. 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.
30. 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
31. 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.
32. 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.
33. 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.
34. Victim and perpetrator were between the ages of 15 and 24.
35. 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.
36. 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."
37. Women in an intimate relationship with a partner who is significantly older or younger. The disparity is usually nine or more years.
38. 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.
39. 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).

Appendix C: Summary of Recommendations – 2010 Case Reviews

2010-03	**Recommendation 1:** To Ontario Women's Directorate: Public education campaigns need to provide information on the co-occurrence of domestic violence and child maltreatment and emphasize to both professionals and community members the importance of notifying Child Protective Services (CPS) if either form of abuse is identified. Research has indicated that there is a substantial overlap between domestic violence and child abuse.[20] CPS professionals are trained to assess both types of abuse and provide the necessary supports to help the family.
2010-07	**Recommendation 1:** To the Police Service involved: It is recommended that Police Services compel Domestic Violence Coordinators to facilitate the liaison and information sharing between case managers in Domestic Violence occurrences that cross divisional and jurisdictional boundaries within their service. *Committee Comment:* There were several domestic violence related occurrences filed with police involving the perpetrator that preceded the homicide of the victim. A systemic disconnect contributed to an apparent lack of awareness by police, resulting in a breakdown of communication throughout the judicial process. **Recommendation 2** To Police Services in Ontario: Incidents reported to, or investigated by Police as Domestic Violence, regardless of whether a verbal incident only or whether criminal charges are laid, should result in the completion of the Domestic Violence Supplementary Report (DVSR). *Committee Comment:* Physical violence is only one risk factor in relation to the risk of future domestic violence when there is conflict within a relationship. The fact that there was police contact indicated an elevated concern for safety by the victim and the incident requires closer scrutiny through the use of the DVSR. **Recommendation 3** The DVSR should be used not only to indicate the presence of risk-enhancing factors towards violence, but also to identify those areas where case management could mitigate the risk for future violence. When risk factors such as substance abuse, mental health concerns, employment issues etc. are identified, efforts should be made to provide appropriate references or involve appropriate services to alleviate those risk factors.

[20] Jouriles, E.N., McDonald, R., Smith Slep, A. M., Heyman, R.E., & Garrido, E. (2008). Child abuse in the context of domestic violence: Prevalence, explanations, and practice implications. Violence and Victims, 23, 221-235.

	Recommendation 4 To the Ontario Association of College and University Security Administrators (OACUSA). The OACUSA should develop a consistent and comprehensive plan, in collaboration with health and counselling services available on campus, to educate students on the nature and risks of violence in dating relationships through public education campaigns and outreach programs to students dealing with intimate violence. **Recommendation 5** To the National Judicial Institute, Ministry of the Attorney General, and Faculties of Law in Ontario. The details and facts from this case should be used as a training aid for the education of law students, continuing education for practicing lawyers (e.g. Crown attorneys, family law and criminal law) and the judiciary regarding the issues and concerns facing victims of domestic violence. In particular, this case demonstrates the need for the timely and accurate sharing of information not just within the police service itself, but also between the police, judiciary, probation services and health care providers. **Recommendation 6** To acute care hospitals and psychiatric institutions in Ontario. It is recommended that health care facilities consider formulating (and/or reviewing and revising as necessary) protocols, policies and procedures to provide specific practice guidelines, in order to ensure an immediate and proactive response to information reported to them of a "No Contact Order" between a patient and a visitor. *Committee Comment:* The perpetrator was hospitalized on a psychiatric unit of an acute care hospital. The perpetrator's probation officer had informed an attending physician of the past assault with a No Contact Order between their patient and the victim. Although the physician documented this data in the medical progress notes, effective communication with other members of the health care team did not seem to occur as it is believed that the victim frequently visited the patient/perpetrator over the duration of his month-long admission. Mental illness is considered to be a risk factor for potential lethality. The psychological dynamics of a violent domestic relationship are complex and the individuals may continue to associate with each other, regardless of a court order prohibiting such contact. All persons, (including health care professionals) are encouraged to seize an opportunity to assist in the efforts to monitor and alert law enforcement of failure to comply with No Contact Orders.
2010-08	**Recommendation 1:** It is recommended that the Regional Supervising Coroner responsible for the area where this incident took place conduct a Regional Coroner's Review into the death of the victim . In particular, the review should address the following questions: a. Given the introduction of a high risk team for the police service in this jurisdiction, how would this incident be managed differently if it happened now? Would the incident be flagged and managed differently? Would a case like this result in early notification of CAS/CCAS?

	b. How would the CAS or CCAS deal with this type of incident under current policies and guidelines? c. Would the PAR (Partner Assault Program) play a role if this incident were to occur now? d. What role would the local school system play in identifying and assisting students who may be exposed to domestic violence in the home? Are there current policies for investigating absences or behaviours that may be a result of domestic violence? e. Are there protocols for police and CAS to work collaboratively with Citizenship and Immigration Canada? How would Citizenship and Immigration Canada (CIC) presently deal with a "tip" indicating that somebody's life and/or safety was at risk? Does CIC have policies that would include notification of local CAS/CCAS? f. What is the policy for Citizenship and Immigration Canada for dealing with applicants who have been convicted of serious criminal offences or who have criminal charges pending? g. What role could probation and parole play in preventing future similar incidents? What would be done differently if this incident were to occur today? h. What role could the crown attorney/judicial system have played in preventing this death from happening? How would the case be handled differently if it were to happen today?
2010-13	**Recommendation 1** All employers in Ontario should be required to develop policies on measures they can take in their workplace(s) to prevent and/or provide effective responses to workplace domestic violence. Employers should also be required to provide training to all employees on recognizing the warning signs of domestic violence, as well as initiating the appropriate responses when they do recognize warning signs or witness incidents. Managers and supervisors should receive additional training in providing appropriate assistance to victims or co-workers who report concerns. *Committee Comment:* Through the provisions of Bill 168, employers in Ontario are now mandated by the Occupational Health and Safety Act (OHSA) to have policies on workplace violence and harassment and to provide training to employees on workplace violence and harassment. Bill 168 also makes employers responsible for taking reasonable precautions to protect the workers from domestic violence likely to expose a worker to physical injury in the workplace. Although most employers have little or no experience preventing or responding to workplace domestic violence, the OHSA does not lay out specific requirements for policy development or training in this area. **Recommendation 2** The Ministry of Labour and the Ontario Women's Directorate is encouraged to work with domestic violence experts, Health and Safety Ontario and the Ontario Federation of Labour to establish a non-profit initiative to engage employers in the work of preventing and responding to domestic violence. The new non-profit initiative should provide workplace specific information, resources and advice for employers. *Committee Comment:* Examples for such promising practices exist in other jurisdictions. In the U.S., two non-profit initiatives involve corporate partners in efforts to protect employees from domestic violence: The Corporate Alliance to End Partner Violence

	(www.caepv.org/), and Workplaces Respond to Domestic and Sexual Violence: A National Resource Center (www.workplacesrespond.org/). The latter was launched by U.S. President Barack Obama and Vice President Joe Biden in November 2010.
2010-14	**Recommendation 1** To Ontario Women's Directorate: Public education campaigns (e.g. Neighbours, Friends, and Families) should address the increased risk for domestic homicide when there co-exists a history of domestic violence and the presence of mental illness in a potential perpetrator. The campaign should stress the seriousness of the risk posed by a mentally ill individual who is threatening to harm his/her partner and/or is threatening self-harm. Specifically, the campaign should outline the steps to be taken when attempting to obtain help for a mentally ill family member, including treatment options and referrals to support services.
2010-16	**Recommendation 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. *Committee comment:* This case was high risk at the time of the initial call to police. Although there was no prior history of domestic violence, the risk was substantial due to the strangulation attempt on the victim, relatively recent separation, depression and suicidal ideation by the perpetrator and his access to firearms. More subtle factors included the perpetrator's unstable employment and financial status. A risk assessment could have lead to an immediate safety plan and arrest of the perpetrator. **Recommendation 2** Police training should include instruction on how to deal with resistant or reluctant victims of domestic violence. *Committee comment:* Historically, many victims have ambivalent feelings that may contribute to their unwillingness to cooperate with police or have charges laid. The facts of this case demonstrate this well, and could be used in police training on domestic violence to educate officers in how to deal with reluctant and/or resistant victims. **Recommendation 3** It is recommended that the Working Group co-chaired by the Ministry of Community Safety and Correctional Services and the OPP, expedite the process to distribute a modified Domestic Violence Supplementary Report (DVSR) to police in Ontario. *Committee Comment:* A Working Group has been meeting in an effort to improve upon the current DVSR utilized by police, modifying the Risk Factor portion to include more recent, empirically validated factors and supplying a Risk Management portion to assist police officers to more immediately identify high risk domestic violence cases and appropriately manage those cases. Widespread adoption of this modified DVSR would provide increased victim safety and more appropriate offender management and assistance.

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