Domestic Violence Death Review
Report

Released January, 2025

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Saskatchewan

Minister's Message

Saskatchewan recognizes the need to take action to address the issue of interpersonal violence and domestic violence deaths in our province.

As part of its commitment to reduce interpersonal violence, the province initiated its first Domestic Violence Death Review in 2016 to expand our provincial understanding of domestic violence deaths and inform future policies and practices. The first Domestic Violence Death Review released its findings in 2018, which went on to inform the development of a wide variety of programs and legislation to combat domestic violence in Saskatchewan.

The second Domestic Violence Death Review, the results of which are in this report, was initiated in 2022. While a significant amount of progress has been made since the first review, there is more to do. Domestic violence remains a deeply pervasive issue that can affect anyone in the province regardless of their location, socio-economic status, or demographic.

The recommendations contained in this report are intended to contribute to the ongoing discourse surrounding domestic violence in Saskatchewan. As a province, we need to enhance our understanding of the complex dynamics of domestic violence to make informed and targeted efforts to break the cycle of abuse and protect individuals, families, and communities from domestic violence and its terrible impacts.

On behalf of the Ministry of Justice and Attorney General, I would like to express my sincere gratitude to everyone who participated in the Domestic Violence Death Review. It is through the collective expertise and collaborative spirit of individuals like you that we can achieve our goals and drive positive change.

Thank you for your dedication and commitment to addressing this critical issue. Your contributions are invaluable and will help shape future actions to combat domestic violence in our province.

Trigger Warning: This document includes discussions about homicide, suicide, child abuse, mental health and substance misuse. If this content affects you, you are encouraged to reach out to a local mental health resource or visit https://sk.211.ca to find a list of resources in Saskatchewan.

Land Acknowledgement

Saskatchewan is located on the traditional home of the Dene, nêhiyawak (nay-hi-yuh-wuk), Anihšināpēk (uh-nish-i-naa-payk), Nakota, Lakota, Dakota and Métis people. The writers of this report acknowledge and recognize the immense contributions Indigenous people have made to what we now call Saskatchewan. We acknowledge past harms and reaffirm our commitment to partnership and reconciliation.

Executive Summary

The 2024 Domestic Violence Death Review Report (the Report) for Saskatchewan addresses the deeply pervasive issue of domestic violence, which continues to affect individuals across the province. Saskatchewan has one of the highest rates of domestic violence and domestic homicide in Canada. This Report includes background, highlights and learnings from the province's most recent Domestic Violence Death Review. The Domestic Violence Death Review (the Review) was conducted by a multi-ministry steering committee and three multidisciplinary case review teams who completed an analysis of 31 domestic violence-related death cases that occurred in Saskatchewan between 2015 and 2020. The purpose of the review was to uncover systemic issues and offer recommendations to prevent future tragedies, while honouring the experiences and voices of victims and their families.

The recommendations contained in this Report were developed by two key groups: the families and loved ones of victims and the three multidisciplinary case review teams. To ensure important context regarding the recommendations was maintained, each recommendation includes actionable opportunities for governments, communities, advocates, and Saskatchewan residents to respond to the recommendations. The recommendations are ordered based on their prevalence and potential impact, as determined by both key groups. Importantly, these recommendations aim to shift the responsibility for change onto individuals who use violence and societal systems, rather than placing blame or responsibility on victims.

Key Findings:

- **Victims and Perpetrators:** The majority of victims were female (83%), and most perpetrators were male (82%). Most victims were killed by current intimate partners, with a significant number of deaths occurring in rural areas.
- **Case Review Insights:** Detailed reviews of 11 domestic homicide cases revealed common factors such as: the perpetrators' history of childhood abuse, substance misuse, and escalating violence prior to the homicide. Many victims had reached out for support before their deaths but often faced barriers in receiving adequate help.
- **Family Perspectives:** Interviews with family members and loved ones provided critical insights into their experiences with systems with a mandate to help victims, including insufficient shelter space, lack of professional understanding, and lack of police protection. Families emphasized the need for greater awareness and education on the signs of domestic violence to prevent such tragedies.

Recommendations:

1) **Education and Awareness:** Implement ongoing public awareness campaigns to educate communities about domestic violence. Develop youth-focused educational programs on healthy relationships and provide parents with tools to guide their children's online activities safely.
2) **Intervention for Perpetrators:** Create programs focused on behaviour change for those who perpetrate domestic violence, offering self-referral options and ensuring cultural responsiveness in program delivery.

3) **Victim-Centered Approaches:** Enhance counseling support for children and families affected by domestic violence. Improve risk assessment tools for police and ensure clear communication with victims about the legal process and available supports.
4) **Legislation and Policy:** Advocate for longer sentences for repeat offenders, implement a mandatory healthy relationships curriculum in schools, and provide standardized training on domestic violence for professionals across various sectors.
5) **Services in Rural and Northern Areas:** Develop tailored methods for service delivery in isolated communities, establish domestic violence police officers, and expand mental health education programs.
6) **Infrastructure Development:** Expand cellular and internet services in remote areas, create emergency transportation solutions, and increase the availability of specialized courts in rural and remote locations.

The review emphasized the need for a comprehensive and coordinated approach to address domestic violence in Saskatchewan. Collective action from government agencies, communities, and individuals is required to strengthen support systems, enhance preventive measures, and ultimately reduce the incidence of domestic violence-related deaths in the province. Through a trauma-informed approach[1], the review aimed to honour the voices of victims and their families that have been impacted by these tragedies. Change is required to create a safer and more supportive society that stands against domestic violence.

[1] https://www.saskhealthauthority.ca/our-organization/our-direction/engagement/sha-engagement-framework/trauma-informed-engagement

Contents

Introduction

The term spousal or domestic violence, also known as intimate partner violence (IPV)[2] is a prevalent form of gender-based violence. It refers to multiple forms of harm caused by a current or former intimate partner or spouse. Statistics continually identify Saskatchewan as having one of the highest per capita rates of domestic violence[3]. Additionally, Saskatchewan has one of the highest rates of gender-related homicide of women and girls[4]. The rate of gender-related homicide of women and girls in rural areas is noted as being more than twice the rate compared to urban areas[5].

Domestic violence death reviews serve as a critical tool for understanding fatal incidents of domestic violence to prevent similar tragedies and increase our understanding of the specific circumstances leading up to the loss of life caused by violence between intimate partners or ex-partners. Understanding the circumstances surrounding a domestic violence death assists in identifying systemic failures and missed opportunities along with ways to increase prevention and intervention.

The completion of the 2024 Saskatchewan Domestic Violence Review was led by a multi-ministry steering committee and three multidisciplinary case review teams. The case review teams reviewed incidents of intimate partner violence resulting in deaths between 2015–2020 and provided advice and recommendations respecting the prevention and reduction of similar deaths. The cases reviewed involved current or former spouses, common-law relationships, dating relationships, and the death of children or bystanders as a result of violence in intimate partner relationships. The steering committee reports to the Minister of Justice and Attorney General.

The 2024 report is the second Domestic Violence Death Review Report released by the province.

The review process was informed by ongoing conversations with experts in domestic homicide, domestic violence, as well as advocates, service providers and community leaders. The review process included:

- inviting family members and loved ones of victims to participate and provide recommendations;
- implementing regional domestic violence case review teams to ensure the needs of rural and remote communities were considered; and,
- increasing the number of cases reviewed in detail from the previous review.

The review process centered around 31 cases that included 34 homicides and four related suicides identified by the Saskatchewan Coroners Service between 2015 and 2020. The majority of the victims were female; the majority of the perpetrators were male. It should be noted that these cases may not be the only domestic homicides in the province for the period identified. For example, between 2015 and 2020 the Native Women's Association of Canada reported eight cases of unresolved missing persons, suspicious deaths, or unidentified remains in Saskatchewan. This review did not identify possible links between missing persons cases and domestic violence.

[2] Intimate partner violence and abuse by the Royal Canadian Mounted Police (2019).
[3] The Daily — Trends in police-reported family violence and intimate partner violence in Canada, 2022 (statcan.gc.ca) by Statistic Canada, 2023
[4] Stats Can report released in Nov 2023 Gender-related homicide of women and girls in Canada (statcan.gc.ca)
[5] Stats Can report released in Nov 2023 Gender-related homicide of women and girls in Canada (statcan.gc.ca)

"Reviewing domestic violence deaths is an essential step in informing recommendations to improve agency and community responses and working toward preventing future deaths. Saskatchewan's second DVDR took an innovative approach in examining northern, rural, and urban cases. The inclusion of collateral victims of domestic homicide (family members) and professionals from a variety of sectors and geographic locations in the review was invaluable. This DVDR is an important step in addressing Saskatchewan's high rates of intimate partner and domestic violence and domestic homicide/femicide and must continue to be built upon in future reviews."
– Case Review Team Member

Saskatchewan's 2024 Domestic Violence Death Review

The 2020-21 provincial budget included an announcement that the Ministry of Justice and Attorney General would undertake Saskatchewan's second domestic violence death review. The announcement included a commitment to bring together community agencies, service providers, and government representatives with relevant expertise to analyze and review deaths that involve domestic violence in the province. The goal of the process was to identify systemic issues and gaps in services, make recommendations for improving responses to domestic violence cases and prevent future deaths. The Domestic Violence Death Review process does not re-open or re-investigate cases, question investigative techniques or comment on decisions made by judicial bodies and the Crown. It is intended to expand existing knowledge about domestic violence deaths and inform related policies and practices.

"Although we provide comprehensive and well-serving services in our respective regions, I believe we need to look for direct and sustainable ways in which to better serve our communities and improve safety for women, children and men living with domestic violence. Education and intervention strategies being of the utmost importance." – Case Review Team Member

The Government of Saskatchewan released its first Domestic Violence Death Review in June 2018. That review resulted in a number of actions and legislation to reduce domestic violence in Saskatchewan, which can be found in Appendix A of this report.

Methodology

The methodology for the 2024 Domestic Violence Death Review was informed by experts in the field including other Domestic Violence Death Reviews completed by Dr. Peter Jaffe, a leading expert in the field of domestic violence. Dr. Jaffe is a psychologist and professor in the Faculty of Education at Western University and the Director Emeritus of the Centre for Research & Education on Violence Against Women & Children[6].

The approach used by the case review teams and based on this work included the following components:

- Conducting comprehensive case analyses to understand the history of violence, risk assessments, and responses by relevant agencies.
- Using an ecological perspective, considering individual, relationship, community, and societal factors, assisting reviewers to identify systemic issues and develop relevant recommendations.
- Promoting multidisciplinary collaboration by engaging professionals from diverse sectors to facilitate a comprehensive understanding of domestic violence dynamics and the need for coordinated responses.
- Utilizing evidence-based tools for risk assessment and management to enhance safety for victims and families.
- Addressing intersectionality by considering factors like race, ethnicity, gender, and socioeconomic status to ensure a nuanced understanding of victims' experiences.

The integration of this methodology allowed the case review teams to use a consistent standard to effectively identify underlying factors contributing to domestic violence-related fatalities and develop targeted strategies for prevention and intervention.

Through the Saskatchewan Coroners Service, the Ministry of Justice and Attorney General compiled a list of the 31 domestic violence death cases in Saskatchewan between 2015 and 2020. This process identified 34 homicides and four related suicides[7]. These 34 homicides represent 12%[8] of total reported homicides in the province over the same period. The Ministry observed trends and patterns from these 31 cases and identified 11 cases for a more comprehensive review. The 11 cases were selected with a goal of reviewing cases that were representative of Saskatchewan's unique context.

In 2022, three multi-disciplinary case review committees were established to represent the urban, rural, and northern regions of Saskatchewan (Appendix B) and to perform a detailed review of between four to six cases each. The review committee members were selected based on their demonstrated expertise, knowledge, and skills related to the impact of domestic violence in the following areas: medical issues, justice system response, societal issues, mental health, substance abuse, and child protection. The review committees used three standardized tools to guide their reviews: a set of research questions (Appendix C), a risk assessment matrix (Appendix D), and a victim consideration matrix (Appendix E).

[6] https://www.learningtoendabuse.ca/resources-events/jaffe-lectures.html
[7] Several cases included multiple deaths and/or suicides.
[8] Number, rate and percentage changes in rates of homicide victims (statcan.gc.ca)

The reviews investigated how the characteristics of the case, actions, and/or responses contributed to the death(s) using information obtained from the:

- Saskatchewan Coroners Service;
- Regina Police Service;
- Saskatoon Police Service;
- Ministry of Corrections, Policing and Public Safety;
- Ministry of Social Services; and
- Royal Canadian Mounted Police (RCMP).

The case review teams used the information provided to make evidence-based recommendations that reflected systemic gaps, changes, and improvements in the areas of legislation, policy, protocols, programs, and training that could prevent or reduce future deaths.

In addition to the case review committees, a trauma-informed psychotherapist conducted interviews with families and loved ones of the victims that were analyzed in this review. (Appendix E).

Respecting Privacy

Protecting people's privacy means respecting their rights under provincial and federal legislation, as well as those protections defined in each agency's privacy and confidentiality policies. To respect those protections, the bulk of the effort and time invested in the Domestic Violence Death Review centered around creating a process to facilitate the exchange of information between government, agencies, and law enforcement. These agreements enabled privacy-sensitive sharing of information.

For example, of the 11 cases reviewed in Saskatchewan, seven fell under RCMP jurisdiction. While the RCMP was unable to provide full access to their homicide files due to the *Privacy Act* and their privacy policies, the RCMP did provide responses to questions identified in the workbooks to the case review teams to assist in the review process.

Limitations

While this review contributed valuable insights into how Saskatchewan could better prevent future domestic violence-related tragedies, it is important to acknowledge limitations in the data that follows which may have impacted the outcome of the review.

The availability and accuracy of data limited the ability to infer insights. Homicides are identified as domestic violence-related by the Saskatchewan Coroner Service, based on information provided by first responders. It was not always clear how the accused and the victim were connected. This was mitigated at the case selection phase by attempting to select cases where the relationship was evident.

Further, the sample size made it a challenge to be both fully representative, and statistically relevant, to Saskatchewan's context, which includes urban, rural and northern communities. Saskatchewan boasts a diversity of culture, race, multi-generational residents, and new immigrants. Further, individuals and their relationships are complex. Violence is complex. Finding commonalities across these cases to fairly represent Saskatchewan's diverse context was challenging.

While these limitations warrant consideration, every effort was made to mitigate the limitations to reduce any impact they may have had on the outcome of the review.

Additional Information

Prior to starting this Domestic Violence Death Review, the Ministry engaged on scope and process with community experts, police, academics, and other Ministry officials.

These conversations resulted in a decision to include family members of victims as well as perpetrators, if possible, in this review.

A trauma-informed approach that respected privacy was used in making contact with family members and with perpetrators. A number of family members were contacted and were able to participate in the review and the art memorial.

If you are a family member of a victim of domestic homicide between 2015 and 2020 who was not contacted, and you would like to speak with the Ministry, please reach out to **IVA@gov.sk.ca.**

Efforts were made to reach perpetrators through provincial and federal correctional staff. The Ministry was not able to contact any perpetrators.

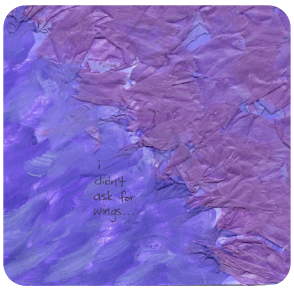
Memorial Page

It is with honour that as part of the 2024 Domestic Violence Death Review family members and loved ones of those impacted were invited to participate in the development of a piece of art to act as a reminder and memorial for those lost. The project was completed using a collaborative approach that used individual paintings from family members and loved ones and curated into a hive that aims to reflect their shared experiences. This memorial depicts their loss, their grief, and their memories. It also depicts their hope that change will occur so that no other family member will experience the same loss they have experienced.

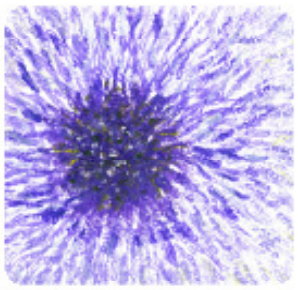
Creating a Saskatchewan free of violence, where everyone is safe at home, requires a collective effort where everyone works in unison to strengthen communities. Members of the Domestic Violence Death Review hope that this memorial provides the opportunity for readers of this report to reflect on all the individuals who have been impacted by these deaths and the collective effort required to create a society free from domestic violence.

We want to acknowledge the family members who lost loved ones to domestic violence between 2015 and 2020.

We honour all of you.



Note: 2024 Domestic Violence Death Review Members made efforts to contact a family member of all the victims of domestic homicide considered in the scope of this report and provide them with an opportunity to participate in the review and this art project. If you are a family member reading this report and you would like to connect about your experiences, or this art project please email the Ministry of Justice and Attorney General at ***IVA@gov.sk.ca****.*








The Saskatchewan Context – Case Data from 2015-2020

In November 2022, the Saskatchewan Coroners Service reviewed files from January 2015 to December 2020, in order to identify deaths that occurred in that time frame related to domestic violence. Thirty-one cases were identified that involved 34 homicides and four related suicides. Eleven of these cases were reviewed in detail.

The information contained in this section of the report includes statistical information about the 31 cases and more detailed information from the 11 cases that were reviewed in detail. Victims in this section include any person who was killed in a domestic homicide. The victim may or may not be the primary target of the perpetrator. Perpetrators in this section include any person who committed domestic homicide(s). The perpetrator may or may not be the primary aggressor in the relationship.

Case Occurrences by Geographic Location

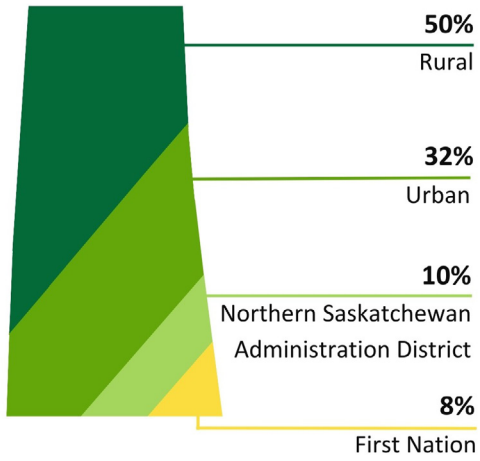


Figure 1: Geographic location where the case of domestic homicide took place.

Domestic Violence-Related Deaths by Year

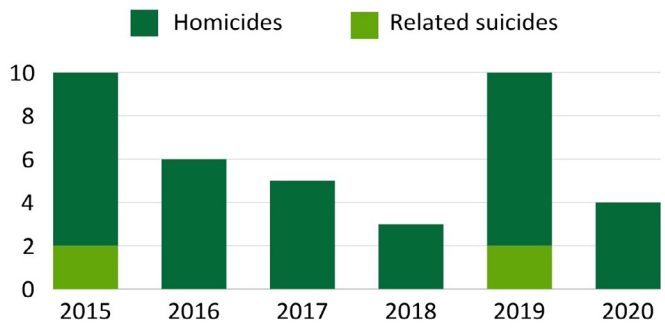


Figure 2: Number of homicides and associated suicides in each year from 2015-2020.

As illustrated by Figure 1, half of all deaths (50%) took place in rural settings and thirty-two percent (32%) took place in urban communities. Ten percent (10%) took place in the Northen Saskatchewan Administration District (NSAD) and eight percent (8%) were on a First Nation. The years 2015 and 2019 saw the highest number of recorded deaths related to domestic violence, with 10 deaths each, while the lowest was in 2018 with 3 deaths (Figure 2).

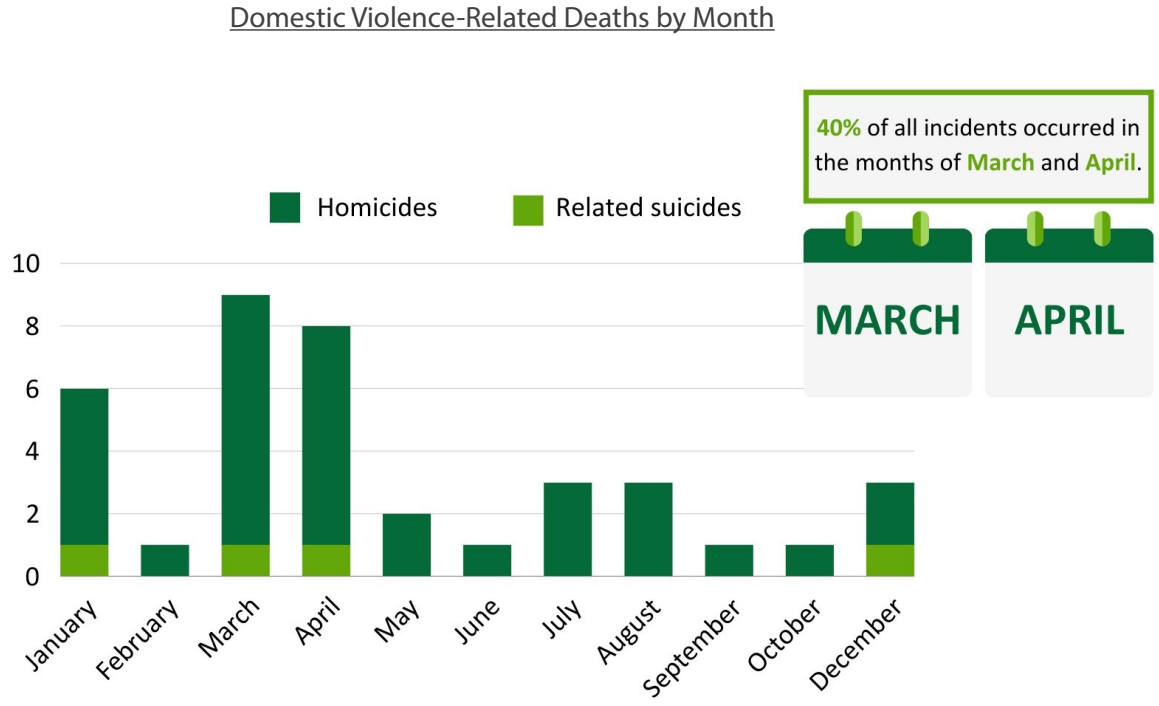


Figure 3: 2015-2020 domestic violence-related deaths by month

Approximately forty percent (40%) of deaths recorded over the five-year review period occurred during the months of March and April as shown in Figure 3.

Domestic Homicide Victims

Between 2015 and 2020, there were 30 adults and four children who were victims of domestic homicide. Among the adult victims of domestic homicide, 25 (83%) were female and five (17%) were male (Figure 4). As noted in Figure 5, forty-three percent (43%) of all adult victims were between the ages of 30 and 39.

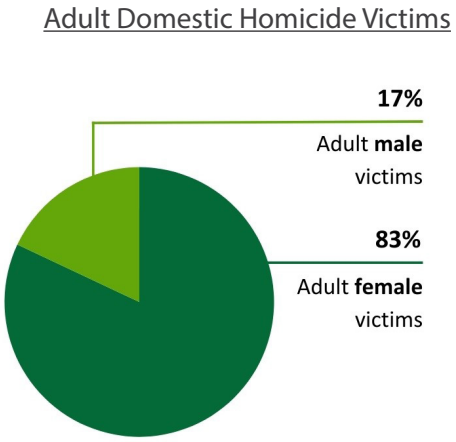


Figure 4: 2015-2020 adult domestic homicide victims

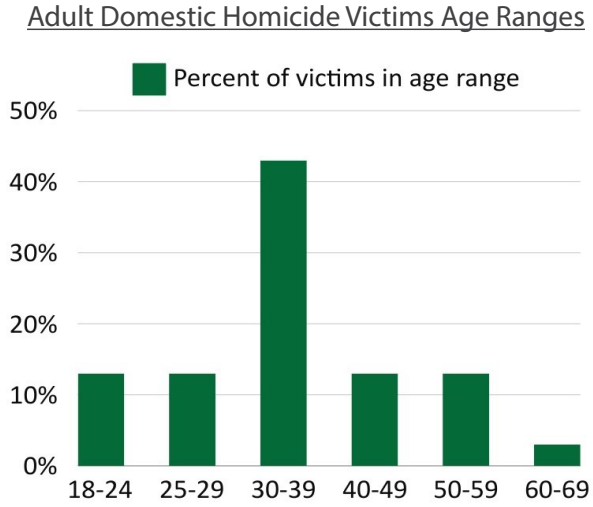


Figure 5: 2015-2020 victims by age range

Ethnicity of Domestic Homicide Victims

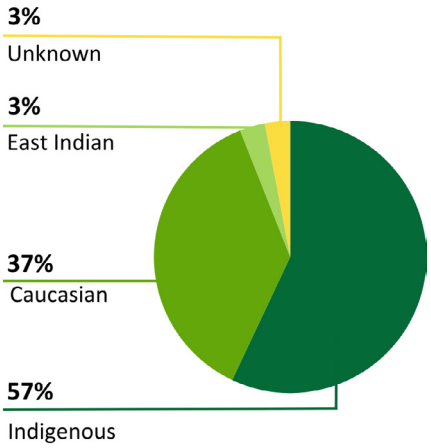


Figure 6: 2015-2020 victims ethnicity

In all adult victims, fifty-seven percent (57%) were identified as Indigenous, thirty-seven percent (37%) as Caucasian, three percent (3%) as East Indian, and in three percent (3%) of the cases the victim's ethnicity was unknown (Figure 6).

Relationship Status to the Perpetrator

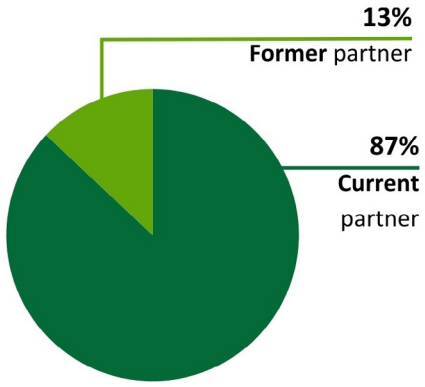


Figure 7: Victim's relationship status to the perpetrator

Of all adult victims, eighty-seven percent (87%) were killed by their current intimate partners (including those in dating, married, and common-law relationships), while thirteen percent (13%) were killed by former intimate partners who were either separated or divorced (Figure 7).

Suicide Deaths in Domestic Homicide Cases

Out of the 38 deaths recorded between 2015 and 2020, four were suicides that took place after a domestic homicide. Fifty percent (50%) of these individuals were in a current relationship with the victim, seventy-five percent (75%) used a firearm to commit suicide (Figure 8), and fifty percent (50%) were between the ages of 18 and 24.

"To create meaningful change, we must address the cultural norms and systemic issues that allow domestic violence to remain normalized in our communities." – Steering Committee Member

Use of Firearm in Suicide

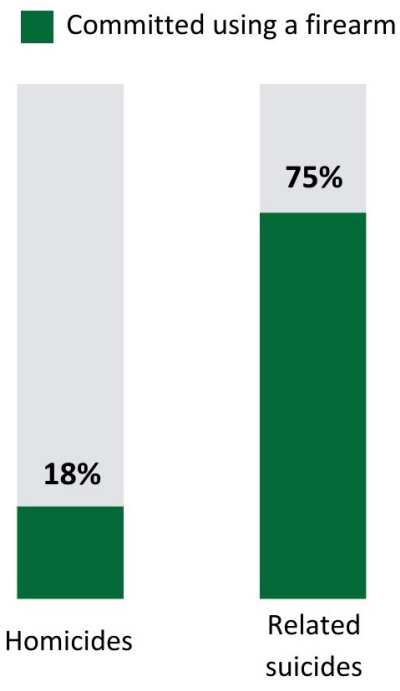


Figure 8: Comparison between gun use in homicides and post homicide suicides

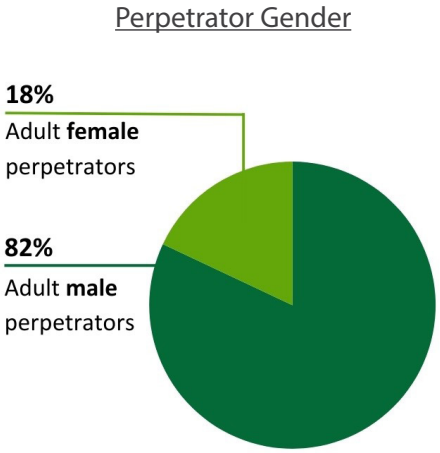


Figure 9: 2015-2020 adult domestic homicide perpetrators

Domestic Homicide: Further Insights from Cases

Between 2015 and 2020, the 11 cases reviewed in detail show eighty-two percent (82%) of perpetrators identified as male and eighteen percent (18%) of perpetrators identified as female (Figure 9).

Blunt force trauma and the use of a knife or sharp object were the most common methods and weapons used by the perpetrator to commit domestic homicide (Figure 10). Most perpetrators were between the ages of 40 and 49 (36%).

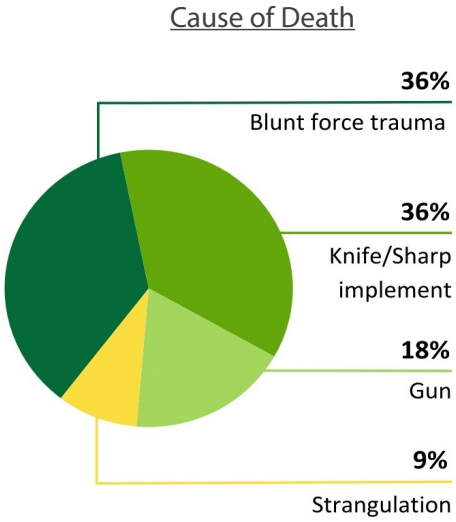


Figure 10: Cause of death

Prevalence of Risk Factors identified in Saskatchewan Cases

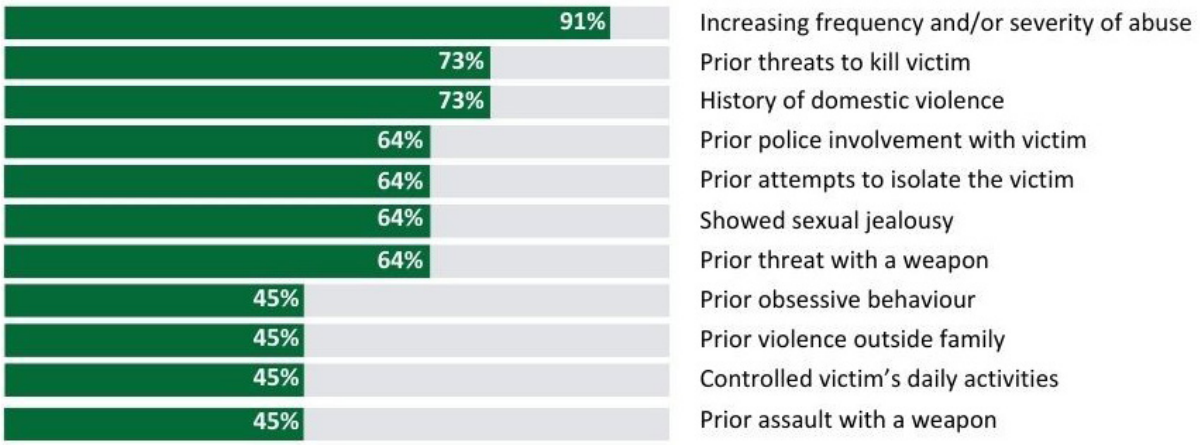
Case review teams collected information on the number and type of risk factors present in each case. This information was then used to look for gaps in service, missed opportunities for interventions, and trends or patterns. This section identifies risk factors that case review teams identified as significant themed into five areas:

1. Perpetrator's history of violence
2. Perpetrator's childhood history
3. Victim considerations
4. Perpetrator and victim relationship status
5. Perpetrator's socio-economic and mental status

A full description of the risk factors can be found in the workbook used by the case review teams (Appendix C). In almost all cases reviewed (91%) there was a pattern of escalating violence by the perpetrator. More than half of perpetrators (55%) were victims of abuse or maltreatment and/or exposed to family violence as children or youth. In forty-five percent (45%) of cases perpetrators continued to have access to the victim after the completion of a formal risk assessment by a service provider. Most perpetrators were experiencing financial stress (82%), had depression in the opinion of friends and family members (73%), and/or were using alcohol or drugs excessively (55%). Half of victims (50%) were previous victims of abuse or maltreatment and/or exposed to family violence as children or youth. Seventy percent (70%) of victims did not share the full extent of the violence with family or friends.

Perpetrators' History of Violence

Percent of cases where the following risk factors were observed.



Perpetrator's Childhood History

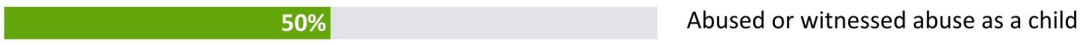
Percent of cases where the following risk factors were observed.

Victim Considerations

Percent of cases where the following risk factors were observed.

Victim's Childhood History

Percent of cases where the following risk factors were observed.

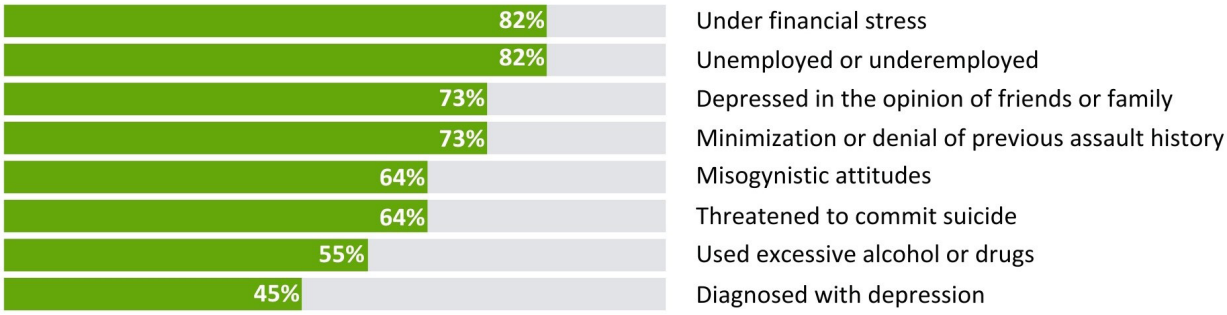


Perpetrator and Victim Relationship

Percent of cases where the following risk factors were observed.

Perpetrator's Socio-economic and Mental Status

Percent of cases where the following risk factors were observed.



"We need to stop simply labelling this a complex issue and get to work. There are real issues in this province with alcohol, poverty, views on gender roles, and a lack of proactive solutions addressing root causes. This report highlights those gaps, provides real solutions, and encourages us to challenge the idea of waiting until after the violence happens." – Case Review Team Member

Family Members of Victims

Domestic violence, with its challenges and complexities, extends far beyond the primary victims. It ripples through families and communities, leaving a permanent mark on those left behind. Family members have a deeper understanding of the shortcomings and challenges within existing systems that is integral to identifying areas that require reform.

By listening to the voices of family members and loved ones, we can hope to create a more empathetic, responsive, and supportive society that stands against domestic violence. In 91% of the cases, an escalation in violence occurred, and each of the victims reached out for support prior to the homicide. A system that meets victims with understanding and empathy will support connection, and that connection is what will reduce risks in victims' lives.

Approach

The Saskatchewan Ministry of Justice and Attorney General commissioned a report that involved conducting interviews with families and loved ones affected by domestic violence-related deaths. The primary objective of this report was to enhance awareness of the contributing factors behind these tragic incidents and to propose policy and support changes based on the insights provided by the family members.

Kerrie Moore, Quest Endeavors Inc., was contracted to conduct interviews with family members due to her expertise in culturally trauma-informed practice. Ms. Moore collaborated with the Ministry to develop interview questions that would accurately capture the family members' perspectives. Following the interviews, a debrief session was held with each family member interviewed to mitigate negative impacts of participating in the process.

Quest Endeavors Inc.'s report encompassed eight cases, with seven of the victims being female and one male. Nineteen family members were interviewed, sharing their concerns and recommendations. It was identified that some of the concerns discussed were historic in nature and some have been addressed since 2020. Quest Endeavor's report was submitted to the Ministry on July 21, 2023, and reviewed by the steering committee and the case review teams to inform their work. A summary is included in this report as Appendix F.

Interview Findings and Observations

Loved Ones History

In alignment with trauma-informed practices and to honour the stories shared, the word victim has been replaced with "loved one/ones" for this section.

Many of the family members characterized their loved ones as self-assured and self-reliant individuals. In all cases, the family members observed controlling behaviour exhibited by the perpetrators. One family member described the isolation that the perpetrator created made it difficult for family members and those close to their loved one to be aware of the abuse. Even telephone and text messages were being monitored by the perpetrator. The loved ones appeared to have developed a traumatic bond with their abusers and were reluctant to leave the relationship.

Family members noted that their loved ones either denied the existence of any issues or made justifications for the abuser's behaviour, holding onto the belief that the abuse would eventually stop. During the interviews, all family members expressed a lack of awareness regarding indicators of domestic violence. The family members mentioned seeing the isolation but failed to recognize it as a potential sign of domestic violence. Every family member asserted that had they known the signs of domestic violence, they would have taken action earlier. The primary concern raised by the family members was the urgent need for an ongoing awareness campaign to educate people about the signs of domestic violence. Such awareness, the family members believed, would enable families to intervene at an earlier stage, potentially preventing severe outcomes such as death. *"We were able to really cut down on drunk driving through ongoing advertising about drunk driving and the outcomes. Why don't we do that with domestic violence?"* (Family member)

> *"Alcohol and addiction play a huge role in domestic violence." – Family Member*

Family members noted that prior to the current relationship, many of the loved ones had children from their previous relationships. Financial difficulties were reported in numerous instances. Multiple risk factors were present, including substance misuse, alcohol dependency, a party-oriented lifestyle, mental health issues, fetal alcohol spectrum disorder (FASD), prior involvement in criminal activities, and past abusive relationships.

Tragically, family members noted that each of their loved ones had reached out to law enforcement, shelters, or other support services prior to their death. Their loved ones sought out the safety they needed; however, they did not receive the necessary supports and services. In several cases, family members noted the police permitted the perpetrator to remain in the home or return the following day.

Family Concerns and Perspectives

The family members spoke about a need for public awareness and failures of the justice system, including the court process and law enforcement. The family members commented that many of their loved ones faced inadequate protection from violent partners and that police measures need to be strengthened to ensure immediate safety is a priority. Family members would like to see a more rigorous safety-focused approach that prioritizes victims' protection and prevents the escalation of violence in homes to protect children and the families of potential victims.

In addition to concerns with the justice system, family members noted there is insufficient shelter space, which endangers the lives of victims and their children. Expanding the number of shelters would assist in providing victims with safe refuge. Family members highlighted there is an overall lack of understanding from frontline professionals to take the concerns of victims of domestic violence seriously. In one incident, a loved one called emergency response to report the perpetrator's aggressive behaviour. No support was provided to the loved one. Shortly after that, the loved one was murdered by the perpetrator. The family members recommend that training be intensified for anyone dealing with domestic violence in a professional setting including police, social workers, teachers, and hospital staff.

"The systems need to come together and work on all these issues together. You can't just fix one system. It requires working together." – Family Member

Some of the concerns and insights shared by the family members center on supporting children after a domestic violence-related death. Family members identified a need for a more responsive system that prioritizes the needs of surviving children. Children process trauma in different ways. Young children do not have the ability to verbalize their feelings. As they get older, unresolved trauma manifests itself as mental health issues, behavioural issues, conduct issues, learning disabilities and many other high-risk behaviours[9]. Family members described the court process as traumatic and said that it exacerbated the negative impact on surviving children and family members. The family members identified that perpetrator sentencing for the homicide was not adequate and that perpetrators were sometimes released without notice to their family. Further, in some cases the perpetrator was provided access to the children upon release.

Overall, families identified the need for more immediate wrap-around resources and supports and improved inter-agency communication to assist victims of domestic violence.

"He only got 13 years. He will be out in less time than that. We are so scared for ourselves and the children. He murdered our daughter, and he gets less time in jail for murdering his partner than if he murdered someone else." – Family Member

"I am an old man and now I have two children to raise." – Family Member

[9] Quest Endeavors Inc, Kerrie Moore

Recommendations

The recommendations in this report were developed by two key groups: the families and loved ones of victims, and the 35 members of three case review teams. Six (6) high level recommendations emerged from the groups. To ensure that important context was preserved, each recommendation includes opportunities for action for governments, communities, advocates, and Saskatchewan residents to consider. The recommendations in the report were ordered based on their prevalence and potential impact identified by both key groups.

These recommendations are intended to put the onus of change on societal systems and individuals who use violence.

These recommendations are not intended to place the blame or responsibility on victims.

Recommendation #1

Prioritize education and awareness initiatives aimed at supporting all Saskatchewan residents to recognize, address, and prevent domestic violence in all its forms.

Opportunities for action:

- Continue to expand and ensure there are ongoing public awareness campaigns highlighting the prevalence of domestic violence in Saskatchewan and the need for community engagement to reduce it.
    - Engage community leaders in tailoring messaging to address specific local needs and preferences.
    - Enhance campaign effectiveness through multilingual advertisements, regionally targeted outreach, and age-appropriate presentations in educational institutions.
- Develop a comprehensive public awareness campaign on the 211-service line highlighting domestic violence services to ensure that those that witness or experience domestic violence know how to access services and support.
- Develop education and public awareness for youth highlighting the connection between social media use and relationship violence. The campaign should include topics such as sexting, bullying, grooming and how to respond when youth witness or experience relationship abuse online.
- Create and offer tools and resources to parents, empowering parents to better understand and guide their children and youths' online activities to prevent relationship violence and abuse for the next generation.
- Review, increase awareness, and audit the current healthy relationship curriculum to ensure it is mandatory and standardized for K-12 education. This curriculum should address domestic violence prevention and ensure that every Saskatchewan child knows what a healthy relationship is.

Recommendation #2:

Focus efforts on evidence-based interventions and programs that target people who perpetrate domestic violence, with an emphasis on accountability and behaviour change.

Opportunities for action:

- Create justice system interventions for those who take accountability for their actions and want to change their violent behaviour.
- Develop self-referral program options that provide tools and support for behaviour change for people who use violence that are not currently involved in the criminal justice system.
- Ensure all programs aimed at changing the behaviour of people who use violence consider the link between domestic violence and alcohol and drug use.
- People who use violence need to be able to access supports that include de-escalation, conflict resolution, skill building, and alcohol use supports outside of regular business hours and through a variety of access points (in person, phone and online).
- Ensure programming is culturally responsive and considers the unique needs of communities in northern and rural Saskatchewan to increase its effectiveness.

Recommendation #3

Broaden victim-centered approaches in systems to better support individuals affected by domestic violence, including family members of victims.

Opportunities for action:

- Provide increased accessibility to counseling support for children who have been exposed to violence, including long-term support for those who have witnessed the homicide of a parent or caregiver.
- Develop, track, and audit the use of a risk assessment tool that can be administered by police at domestic violence calls for service with the person using violence and abuse to better inform decision making related to victim safety.
- Establish additional supports dedicated specifically to:
    - consistently offer, track, and audit the use of a risk assessment tool such as the Ontario Domestic Assault Risk Assessment with a victim on any police-involved domestic violence calls for service;
    - create a process within organizations to ensure any professional working with victims and their families have regular training on the Victims' Bill of Rights and trauma-informed approaches;
    - ensure assistance is available to navigate the court process for adult and child victims in all domestic violence court cases;

- increase opportunities to communicate with victims and their families about the legal process including ensuring updates are provided when perpetrators are released in all domestic violence cases; and,
- develop a process to increase system level accountability by having police and domestic violence community experts review police domestic violence calls for service.

Recommendation #4

Enhance legislation and policies to strengthen domestic violence prevention efforts and improve support for victims.

Opportunities for action:

- Lobby for federal legislative changes for longer sentences for repeat offenders.
- Work with Federal/Provincial/Territorial partners to review potential changes to sentencing in the *Criminal Code of Canada* to see repeat offenders sentenced to longer periods.
- Conduct a legislative review to identify and address gaps and barriers in *The Victims of Interpersonal Violence Act*, ensuring enhanced support for emergencies and immediate protection for victims.
- Further to recommendation #3, develop mandatory domestic violence training for human service sectors, including courts, judges, police agencies, healthcare, social services, and community-based organizations.

Recommendation #5:

Prioritize accessibility, availability, and appropriateness of domestic violence services in northern, rural, and isolated communities.

Opportunities for action:

- Identify appropriate evidence-based methods for delivering services in rural and northern communities, where traditional service delivery methods may be limited.
- Establish provincially funded domestic violence police officers to ensure all aspects of domestic violence cases are thoroughly reviewed for adherence to investigation and interview practices, including follow-up with victims.
- Increase accessibility to mental health and wellness education by offering the Saskatchewan Indian Institute of Technologies' two-year Mental Health and Wellness diploma program in northern Saskatchewan.

Recommendation #6:

Enhance accessibility and support for victims of domestic violence through infrastructure development initiatives.

Opportunities for action:

- Continue to expand cellular coverage and internet services to the north.
- For communities with no road access, create transportation solutions, including infrastructure for emergency flights, to help domestic violence victims leave isolated areas and reach support services.
- Expand domestic violence courts or domestic violence options in existing courts in rural and remote locations.

Recommendations Related to Further Domestic Violence Death Reviews

The case review teams indicated that they appreciated the group process used to review the cases. The review committee highlighted the positive impact of the diverse backgrounds of the review members, noting that they leveraged each other's knowledge to aid in analyzing the cases.

The case review teams identified the following opportunities to improve the domestic violence death review process:

- Consider legislative or policy changes to collect the information needed to review every domestic violence death. New legislation or amendments to existing legislation or the establishment of a study commission under the *Public Inquiries Act* could enable the collection and receipt of required information in all domestic violence death cases, enabling more robust and timely reviews.
- Domestic violence death reviews should occur more frequently than every five years.
- Should there be a third Domestic Violence Death Review, RCMP suggests introducing legislation that would allow for the disclosure of information by the RCMP under *Privacy Act* S(8)(2)(f). This may allow the RCMP to provide more detailed information to the case review teams.

Acknowledgements

Family Members of Loved Ones

Family members affected by domestic homicides are navigating a clutter of adversity. The inadequacies and systemic failures described by those who participated in this review cast a long shadow over the lives of those who have experienced the trauma of domestic violence.

Family members identified numerous challenges, including insufficient support for children and their caregivers, inadequate protective measures, and in some cases, a lack of understanding and compassion from professionals. Yet, within this narrative of adversity, there is an undercurrent of hope. The collective strength of these family members advocating for change, seeking solutions, and raising their voices against injustice is a testament to their determination.

Let us recognize the spirit of these and any family member who has endured and continues to fight for a more compassionate, responsive, and supportive society. It is in their stories, their advocacy, and their shared determination that we find the seeds of change. The path ahead may be difficult, but with the courage and resilience of these family members, we can hope for a brighter and safer future for all who have been affected by domestic violence.

Northern Case Review Team

The Northern Case Review Team dedicated seven full days to comprehensively review three cases from the northern region. This group exhibited a commitment for change. They were deeply passionate about the well-being of the northern communities, Indigenous perspectives, and the crucial task of ensuring that the distinct requirements of northern residents were acknowledged and addressed throughout this process. For instance, northern Saskatchewan residents experience unique challenges that often stem from geographical isolation, with limited access to essential services. Indigenous communities often face challenges related to preserving their cultural identity and traditions.

Urban Case Review Team

The Urban Case Review Team committed eight full days to the review of four cases from urban centres in Saskatchewan. This team was defined by a strong sense of ideology and a clear vision for bringing change. Their approach encompassed a thorough examination of every facet, system, and aspect of the issue, examining every possibility on how Saskatchewan could improve its response to domestic violence.

Rural Case Review Team

The Rural Case Review Team committed eight full days to the review of four cases from the rural regions of Saskatchewan. This team had a unique challenge related to the nature of cases in rural areas, particularly the occurrence of homicide-suicides. In such cases, the perpetrators not only took their own lives after committing the homicide but also often had no prior criminal history, making it challenging to gather information to review. Despite this challenge, the rural team approached the task with dedication to drive meaningful change.

Conclusion

The friends and family members, case review teams, and government officials who worked on the report provide it as an instrument to help the province develop future programs and strategies to reduce the rates of domestic violence and domestic homicides.

The responsibility to prioritize change lies in the hands of Saskatchewan as a whole, including agencies, government bodies, communities, and individuals. It is incumbent upon all residents of Saskatchewan to create the cultural shift that makes reducing domestic and interpersonal violence in our province a priority. Without prioritizing the issue, we risk perpetuating the status quo as the province with the highest rates of intimate partner violence. Action is necessary to reduce incidents of domestic violence, prevent future deaths, and interrupt the impact of intergenerational violence.

"It has been a privilege to be a member of the Domestic Violence Death Review Steering Committee. Each circumstance discussed has been deeply impactful to me. I am grateful for the opportunity to be involved in proposing opportunities to improve circumstances for the communities and citizens of this province." – Steering Committee Member

Appendix A – Government of Saskatchewan Responses to the 2018 Domestic Violence Death Review

There has been notable progress made across the province by the Government of Saskatchewan in response to the recommendations identified in the initial Domestic Violence Death Review report released in 2018.

The Government of Saskatchewan implemented the following changes after the release of the 2018 report:

1. **Legislative Changes**

   - ***The Victims of Interpersonal Violence Amendment Act*** was amended in July, 2017, to allow renters to end fixed-term tenancy agreements with 28 days' notice without penalty if they are victims of interpersonal violence or victims of sexual violence and continue to be at risk.
   - ***The Privacy Act*** was amended in September, 2018, to allow a person whose intimate image has been distributed without their consent to sue the person who distributed the image. It also shifts the onus of proof to the person who circulated the image, requiring them to show that they had a reasonable basis to conclude consent had been granted to do so.
   - ***The King's Bench Rules*** were amended in February, 2019, to require family law service providers, such as mediators and collaborative lawyers, to have 14 hours of family violence training.
   - ***The Interpersonal Violence Disclosure Protocol (Clare's Law) Act*** came into force in the province on June 29, 2020. It authorizes a police service to disclose certain risk-related information to a current or former intimate partner in cases where such information can help them make informed decisions about their safety and relationships. Saskatchewan was the first province in Canada to implement Clare's Law.
   - ***The Children's Law Act*** was amended in March 1, 2021, to align with the federal *Divorce Act* amendments requiring family violence and its effects to be considered when making parenting arrangements.
   - ***The Enforcement of Maintenance Orders Act, 1997*** was amended in November, 2021 to allow the Maintenance Enforcement Office to begin enforcement procedures after a payor is one month in arrears and there are reasonable grounds to believe the payor is acting in bad faith.
   - ***The Privacy (Intimate Images – Additional Remedies) Amendment Act, 2021*** was amended in November 2021 to add additional remedies for victims of non-consensual distribution of intimate images.

- ***The Saskatchewan Employment Act*** was amended in January, 2022 to provide survivors of interpersonal violence with five days' paid leave and a further five days' unpaid leave. This provides survivors with more financial and job security as they leave violent relationships.
- ***The Protection From Human Trafficking (Coerced Debts) Amendment Act, 2023*** was introduced in November 2023, to protect victims and survivors of human trafficking from debts incurred as a result of human trafficking.

2. New Programs and Services

- **Expansion of the Children Exposed to Violence program** – The program provides children who have been exposed to domestic violence with support designed to reduce their risk of becoming a victim or offender. The program has expanded to Black Lake, Onion Lake, and Peter Ballantyne Cree Nation.
- **Second Stage Housing** – These programs provide safe, affordable, longer-term support (between 18 and 24 months) for individuals and their children to break the cycle of violence. In 2023, the Ministry of Justice and Attorney General began a three-year pilot to provide operational support to seven Second Stage Housing providers.
- **Transportation** – The Ministry of Justice and Attorney General implemented a program to provide transportation for individuals leaving violence. A transportation fund, administered by the Ministry of Justice and Attorney General, reimburses agencies that provide transportation to individuals fleeing situations of interpersonal violence.
- **Provincial Call Line** – The Ministry of Justice and Attorney General funded 211 Saskatchewan to enhance its existing 211 call line, provide staff with additional training to support victims of interpersonal violence and enhance its web portal. Additionally, the Ministry expanded the Crisis Line services through 211 Saskatchewan to provide brief intervention counselling to individuals at risk of perpetrating violence.
- **Family Intervention Rapid Support Teams (FIRST)** – The Ministry of Justice and Attorney General established four Family Intervention Rapid Support Teams (FIRST). Using a continued outreach approach, FIRST supports families at risk of violence to increase safety through early intervention.
- **Multi-Year Public Awareness Campaign** – The Ministry of Justice and Attorney General and the Status of Women Office developed a multi-year public awareness campaign called "Face the Issue," with the specific goal of changing attitudes and beliefs about interpersonal violence and abuse in the province.
- **Seeking Safety Benefit** – The Ministry of Social Services offers the Seeking Safety program under the Saskatchewan Housing Benefit, providing a flat-rate monthly benefit to assist individuals escaping interpersonal violence with rent and utility expenses.

3. Policy and Protocol Changes

- **Family Law Screening Officers** - In Regina and Saskatoon, these officers are trained to screen for family violence and to identify risk factors and warning signs in family court documents.

These changes aim to have both immediate and long-term positive impacts for those that experience domestic violence. In addition to initiatives led by the Government of Saskatchewan, residents, businesses, community-based organizations and other levels of government have made steps towards addressing the recommendations from the first Domestic Violence Death Review.

Appendix B – Case Review Team Membership

Northern Case Review Team	Urban Case Review Team	Rural Case Review Team
Elder	Executive Director Prince Albert Safe Shelter for Women	Victim Services Coordinator Weyburn Victim Services
Executive Director North Saskatchewan Victim Services	School Counselor Regina Public Schools	Manager Program Design and Policy Social Services
Senior Policy Analyst Indigenous and Northern Relations Government Relations	Clinical Director Community Corrections Offender Services	Family Violence Coordinator North West Friendship Centre
Consultant Indigenous Services Social Services	Director of Research and Communications Provincial Association of Transition Houses and Services of Saskatchewan	Director of Restorative Justice File Hills Qu'Appelle Tribal Council
Wakaw Primary Health	Supervisor Yorkton Community Corrections	Principal North East School Division
Coordinator Primary Health Care	Manager Family Service Regina	Executive Director SIGN Yorkton (Society for the Involvement of Good Neighbours)
Manager Athabasca Health Authority	Victim Services Coordinator Saskatoon Victim Services	Supervisor Offender Services
Executive Director Piwapan Women's Centre	Executive Director Prince Albert Mobile Crisis and Sexual Assault Centre	Mental Health and Addictions Saskatchewan Health Authority
	Manager Child Life Program Saskatchewan Health Authority	Estevan Police Service
	Regina Police Service	Clinical Director Community Corrections Offender Services

Appendix C – Case Review Research Questions

Case Context

1. What was the nature and history of the violence and abuse in the relationship between the victim, the perpetrator, and the children?
2. Who (family members, friends, neighbours, co-workers, schools, agencies) knew of or suspected domestic violence? How did they know?
3. What actions were taken as a result of that awareness?
4. What risk indicators were present?
5. What victim factors were present?
6. What is the victim's/perpetrator's medical and behaviour history? Substance abuse history?
7. What is the victim's/perpetrator's history of domestic violence in childhood and adulthood?
8. What protection orders were or had been in place?
9. To what extent was the victim/perpetrator involved with the criminal and family justice systems?

Agency Involvement

10. What agencies were available in the community?
11. What agencies were contacted by victim/perpetrator?
12. What agencies had contact with the individuals, family, co-workers and others related to domestic violence in the relationship?
13. What information was available to/shared among agencies? What interagency communication took place?

Services and Support

14. What services were offered? When?
15. What services were declined? When?
16. What services appeared to make a difference, even temporarily?

Policies and Protocols

17. To what extent are policies and protocols in place in the community to prevent domestic violence deaths? In the province?
18. What measures are in place to ensure policies and protocols are followed?
19. What else is needed?

Review Panel Considerations

20. What may have worked if…?
21. What were the barriers to obtaining services and supports for victim/perpetrator/children? (e.g., language, cost, cultural, access) What changes are required to legislation, intervention, prevention, interagency communication?

Appendix D – Case Review Risk Assessment Matrix

Perpetrator = The primary aggressor in the relationship.

Victim = The target of the perpetrator's abusive/maltreating/violent actions that includes intimate partners or ex-partners and/or other familial members who die as a result of the incident.

RISK FACTORS
Perpetrator's Childhood History
1. Perpetrator was abused and/or witnessed domestic violence as a child: As a child/adolescent, the perpetrator was victimized and/or exposed to any actual, attempted or threatened forms of family violence/abuse/maltreatment.
2. Perpetrator exposed to/witnessed suicidal behaviour in family of origin: As a(n) child/adolescent, the perpetrator was exposed to and/or witnessed any actual, attempted or threatened forms of suicidal behaviour in their family of origin. Or somebody close to the perpetrator (e.g., caregiver) attempted or committed suicide.
Perpetrator's History of Violence
3. History of violence outside of the family by perpetrator: Any actual or attempted assault on any person who is not or has not been, in an intimate relationship with the perpetrator. This could include friends, acquaintances, or strangers. This incident did not have to necessarily result in charges or convictions. It 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.).
4. History of domestic violence: 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 or is a familial member (e.g., children, parents). This incident did not have to necessarily result in charges or convictions. It 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 a neighbour hearing the perpetrator screaming at the victim or a co-worker noticing bruises consistent with physical abuse on the victim while at work. It may include situations when the victim denied that the abuse took place. *Note: Strangulation, biting, forced sex, use of weapons, blows to the head, and obsessive or stalking behaviour are lethality indicators.*
5. Prior assault with a weapon: Any actual or attempted assault on the victim in which a weapon (e.g., gun, knife, etc.) or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.) was used. *Note: This item is separate from violence inflicted using body parts (e.g., fists, feet, elbows, head, etc.).*
6. Prior assault on victim while pregnant: Any actual or attempted form of physical violence, ranging in severity from a push or slap to the face, to punching or kicking the victim in the stomach. The victim was pregnant at the time of the assault and the perpetrator was aware of this fact.
7. Prior forced sexual acts and/or assaults during sex: Any actual, attempted or threatened behaviour, whether successful or not, used to engage the victim in sexual acts (of whatever kind) against the victim's will. Or any assault on the victim of whatever kind (e.g., biting, scratching, punching, choking, etc.) during the course of any sexual act.

RISK FACTORS
8. Strangled victim in past: Any attempt (separate from the incident leading to death) to strangle the victim. The perpetrator could have used various things to accomplish this task (e.g., hands, rope, etc.). *Note: Do not include attempts to smother the victim (e.g., suffocation with a pillow).*
9. Prior threats with a weapon: Any incident in which the perpetrator threatened to use a weapon (e.g., gun, knife, etc.) or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.) for the purpose of instilling fear in the victim. This threat could have been explicit (e.g., "I'm going to shoot you" or "I'm going to run you over with my car") or implicit (e.g., brandished a knife at the victim or commented "I bought a gun today"). *Note: This item is separate from threats using body parts (e.g., raising a fist).*
10. Prior threats to kill victim: Any comment made to the victim, or others, that was intended to instill fear for the safety of the victim's life. These comments could have been made verbally, in the form of a letter or through texts, email or social media. 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."
11. Prior attempts to isolate the victim: Any non-physical behaviour, whether successful or not, that was intended to keep the victim from associating with others. The perpetrator could have used various psychological tactics (e.g., guilt trips) to discourage the victim from associating with family, friends or other acquaintances in the community (e.g., "if you leave, then don't even think about coming back" or "I never like it when your parents come over" or "I'm leaving if you invite your friends here"). The perpetrator may have denied the victim access to critical documents such as passports, visas and health cards or restricted financial resources. The perpetrator could have kept children isolated by demanding they return directly home after school and not allowing participation in extra-curricular activities.
12. Controlled most or all of victim's daily activities: Any actual or attempted behaviour on the part of the perpetrator, whether successful or not, intended to exert full power over the victim. For example, when the victim was allowed in public, the perpetrator demanded an account for where the victim was at all times and who was there. Another example could include not allowing the victim to have control over any finances (e.g., providing an allowance, restricting employment, etc.).
13. Prior physical restriction and/or forcible confinement: Any actual or attempted behaviour, whether successful or not, in which the perpetrator physically attempted to limit the mobility of the victim. For example, any incidents of forcible confinement (e.g., locking the victim in a room) or not allowing the victim to use the telephone (e.g., taking a cellphone 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).
14. Sexual jealousy - perpetrators: Continuously accuses victim of infidelity, repeatedly interrogates victim, searches for evidence, tests the victim's fidelity and sometimes stalks the victim.
15. Repetitive harassment / pre-occupation / obsessive behaviour displayed by perpetrator: Any actions or behaviours by the perpetrator that are unwanted by the victim. For example, stalking behaviours, such as following or spying on the victim, making repeated phone calls, texts or social media contact with the victim, excessive gift giving, watching, following, making false reports (to the police, child protection, Revenue Canada, etc.), spreading damaging information, tracking the victim's activities electronically or through information obtained from others, etc.

RISK FACTORS
16. Prior violence against family pets and other animals: Any action directed toward a pet of the victim, a former pet of the perpetrator, or other animals (e.g., horses, sheep, etc.) associated with the victim 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 or other animal to abducting or torturing it. Do not confuse this factor with correcting a pet for its undesirable behaviour.
17. Prior destruction or deprivation of victim's property: Any incident in which the perpetrator intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the perpetrator. This could include slashing the tires of the car that the victim uses. It could also include breaking windows or throwing items at a place of residence. This includes any incident, regardless of whether charges were laid or finding of guilt resulted.
18. Escalation of violence: The abuse/maltreatment (physical, psychological, emotional, sexual, etc.) inflicted upon the victim by the perpetrator was increasing in frequency and/or severity. For example, this can be evidenced by more regular trips for medical attention or include an increase in complaints of abuse to/by family, friends, or other acquaintances. *Note: Record in comments if there was an unexplained de-escalation of violence.*
Relationship
19. Age difference of couple: An intimate relationship where partners are significantly older or younger. The disparity is usually nine or more years.
20. Presence of stepchildren in the home: Child(ren) who is (are) not biologically related to the perpetrator and living in the home.
21. Presence of other family members in the home: Individuals who are related biologically to either the perpetrator or the victim (e.g., parents) and are living in the home.
22. Victim's intuitive sense of fear of perpetrator: The victim knows the perpetrator best and can accurately gauge the level of risk. If the victim discloses fear of the perpetrator harming oneself or children. For example, statements such as "I fear for my life," "I think he will hurt me," "I need to protect my children."
23. After risk assessment, perpetrator had access to victim: Despite apparent risk determined by 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, the perpetrator still had access to the victim.
24. Actual or pending separation: The intimate relationship had ended or was ending as a result of break-up, separation, or divorce. The perpetrator wanted to continue or renew the relationship.
25. High-conflict break-up, separation, or divorce: The intimate relationship has ended but high levels of conflict or tension continue, demonstrated through disputes over property, children, or other issues.
26. Child custody or access disputes: Former intimate partners were in dispute regarding the custody, contact, primary care, or control of children. Include formal legal proceedings or any third parties' information about such arguments. This may include evidence in the conditions of an order or agreement that indicate attempts to prevent parental child abduction such as a restriction on moving children out of the jurisdiction or retention of passports.
27. New partner in victim's life: New intimate partner in the victim's life or the perpetrator perceived there to be a new intimate partner in the victim's life.

RISK FACTORS
Perpetrator
28. Prior suicide attempts by perpetrator: Any 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 shooting or hanging oneself.
29. Prior threats to commit suicide by perpetrator: Any 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 through text, email, or social media. 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"). *Note: An example of an act is giving away prized possessions.*
30. Depression – in the opinion of family/friend/acquaintance: In the opinion of any family, friends, or acquaintances, and regardless of whether the perpetrator received treatment, the perpetrator displayed symptoms characteristic of depression. *Note: a significant loss (of job, status, family member, support, etc.) in the perpetrator's life is a lethality indicator.*
31. Depression – professionally diagnosed: The perpetrator received a diagnosis of depression from a mental health professional (e.g., family doctor, psychiatrist, psychologist, nurse practitioner), regardless of whether the perpetrator received treatment.
32. Other mental health or psychiatric problems – perpetrator: For example, psychosis, schizophrenia, bi-polar disorder, mania, obsessive-compulsive disorder, personality disorder such as antisocial or paranoid behaviour, etc.
33. Excessive alcohol and/or drug use by perpetrator: Within the past year, and regardless of whether 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 the perpetrator without a beer. This dependence on a particular substance may have impaired the perpetrator's health or social functioning (e.g., overdose, job loss, arrest, etc.). Include comments by family, friends and acquaintances that are indicative of annoyance or concern with a drinking or drug program and any attempts to convince the perpetrator to terminate the substance use.
34. Failure to comply with authority: Perpetrator has violated 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.
35. Access to or possession of firearms: The perpetrator stored firearms in their place of residence, place of employment or in some other nearby location (e.g., friend's place of residence). Include the perpetrator's purchase of any firearm within the past year, regardless of the reason for purchase. *Note: Access to firearms should not be considered an indicator of a risk of violence occurring; however, it may indicate that should violence occur there may be an increased risk of a resulting fatality.*

RISK FACTORS
36. Perpetrator unemployed or underemployed: Employed means having full-time or near full-time employment (including self-employment). Unemployed means experiencing frequent job changes, layoffs, or significant periods of lacking a source of income. Underemployed means employees with high education, skill levels or experience are working in jobs that do not require such abilities. Consider government income assisted programs (e.g., Worker's Compensation, E.I., etc.) as unemployment.
37. Financial stress: This is brought about by the difficulty that an individual or household may have in meeting basic financial commitments due to a shortage of money. This may include the stress of the possibility of unemployment.
38. Extreme minimization and/or denial of spousal assault history: At some point the perpetrator was confronted either by the victim, a family member, friend or other acquaintance and the perpetrator displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., domestic violence 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., the victim wasn't really hurt).
39. Misogynistic attitudes – perpetrator: Hating or having a strong prejudice against women. This attitude can be overtly expressed with hate statements or can be more subtle with beliefs that women are only good for domestic work or that all women are "whores."

Appendix E – Case Review Victim Consideration Matrix

1. **Victim abused and/or witnessed domestic violence as a child:**
    - As a child/adolescent, the victim was victimized and/or exposed to any actual, attempted or threatened forms of family violence/abuse/mistreatment.
2. **Victim abused and/or witnessed domestic violence as a child:**
    - As a child, adolescent or adult, the victim experienced at least one incident of physical and/or sexual assault committed by a stranger, extended family member, acquaintance or previous intimate partner.
    - The incident did not have to necessarily result in a charge or a conviction but can be verified by a record (e.g., police reports or medical records) or witness (e.g., family members, friends, neighbours, co-workers, counsellors, medical personnel, etc.).
3. **Victim vulnerabilities and/or lack of supports:**
    - The victim faced social or physical isolation, language or cultural barriers, mental health issues, ability or health struggles, financial dependence, addictions, and/or immigration concerns.
    - The victim lacked a formal or informal support network of family, friends, service providers, etc. due to isolation, embarrassment, absence or shortage of accessible services, no means of connecting with services and supports (telephone, computer, etc.), and/or fear or mistrust of authority (police, child protection, service providers, justice system, etc.).
    - The victim's social condition was not stable due to homelessness, street life, gang affiliation, involvement in criminal activity, etc.
4. **Victim minimized and/or denied violence:**
    - The victim tended to deny the perpetrator's violence, and/or minimized the severity or frequency of the perpetrator's violence.
    - The victim was oblivious to, or underestimated, the degree of danger presented by the perpetrator's violence.
5. **Victim stayed in violent relationship and/or returned to the relationship for specific reasons:**
    - At some point, the victim provided a reason, or reasons, for staying in the relationship, and/or returning to the relationship, to a family member, friend, acquaintance or service provider.
    - This may have included hope that the relationship would improve, promises from the perpetrator involved that the relationship would improve, the perpetrator involved in an abuse prevention or addiction program, wanting the children to grow up with both parents, fear of losing custody or access to the children, fear that the perpetrator would abduct the children, financial dependence on the perpetrator, not wanting the children to do without financially, concern for the children's safety, ties to the community or family business, conformity to religious/spiritual or cultural beliefs, blames self for the violence, feels sorry for the perpetrator, etc.

Appendix F – Summary of Quest Endeavour's Interview Report

Family members' Concerns

- Lack of support for children and the families who raise them afterwards.
- Lack of police protection from violent partners.
- Lack of understanding by professionals.
- Lack of shelter availability.
- Lack of victim support.
- Lack of resources, knowledge about resources and access to resources.
- Lack of efficient communication between agencies.
- Lack of domestic violence awareness.
- The court process was very traumatic.
- Children were distraught when in court.
- Sentencing the perpetrator was not adequate - it was too short.
- Families are frightened for when the perpetrator leaves prison.
- The court allowed the perpetrator access to the children.
- Lack of crisis support for abusers.

Family members' Recommendations

- *Safety*. Focus should be on immediately ensuring the victims' safety.
- *Education*. Domestic violence education should start at an early age. Children in junior high school should know how to recognize the signs and how to get help.
- *Shelters*. More shelters, especially in small communities.
- *Support for Public*. A support line available 24/7 for youth and adults.
- *Support for Families of Victims*. Agencies must reach out to families of victims on an ongoing basis. Make accessing support more convenient - a helpline for support information and assistance with completing necessary forms. Financial help for families taking care of the victim's children and/or going through the adoption process, specifically for court and lawyer costs.
- *Support for Victims*. An evaluation process to determine needs for families experiencing domestic violence.
- *Training*. Increase domestic violence training for police, social workers, teachers, and hospital staff.
- *Counselling*. Trauma awareness for families of victims by qualified and culturally aware professionals. Immediate access to counselling for children of victims. No financial or time restrictions for counselling the victim's children.

- *Justice System*. No access to children by domestic violent offenders unless requested by the children themselves. Young children should not testify in court; instead, a trained counsellor could gather the necessary information in a separate place. Policy that views domestic abuse as a serious offence should be written.

Family members were very willing to participate in the interviews. They are supportive of the changes the government is making to help support families of victims and prevent further episodes of domestic violence ending in homicide. They have requested a copy of the government's review of this report. They are hopeful that information on support will become more accessible to them, especially those on the Reserve. They believe that public awareness is a key factor to ending domestic violence and it should be done in a direct and consistent manner.

INNOCENCE – A POEM BY A DOMESTIC HOMICIDE VICTIM

Submitted by a family member of a loved one

Once upon a time there was an innocence in me
I cannot describe
There was a perfection in my life every time the
morning flooded my eyes
when I climbed the tall poplar tree in the front yard
To watch the red sky swallow an orange-colored sun
when I ran through the woods and fields or gazed
at the river on a long evening.
My romantic childhood twisted with age and
I only looked away once
But I might as well have dropped it in the sea,
vines that wither, waters that calm, fields
that rust.
I try to re-awaken my past, try to feel it again,
but it is like getting blood from a stone.
Still though, when the moon wakes in a deep
velvet sky, when I cast a line on the lake,
or smell a new season, a part of me slides
back to the child, which haunts me, and I
catch a sudden glimpse of life and beauty,
for a moment, and it slips away when the riddle defects me again.

Back when happiness was not looked for, because it was all I knew. There is no description of the greatness of legs that could run forever.