Ministry of Justice

Exhibit: *National Inquiry into Missing and Murdered Indigenous Women and Girls*
Location/Phase: Part 11: Calgary
Witness: Betty Ann Pothruff
Submitted by: Meredith Porter (Commission)
Add'l info: P02 P01 P0201
Date: MAY 29 2018

Intials	I/D	Entered
63		22

Saskatchewan Domestic Violence Death Review Report

Released May 24, 2018

"We all own community safety."

A Review Panel member

Review Panel Members

The Ministry of Justice would like to thank the members of the Saskatchewan Domestic Violence Death Review Panel who shared their multi-disciplinary expertise in the area of domestic violence. Their collaborative discussion produced thought provoking observations that led to actionable recommendations.

Mary Aspinall
Domestic Violence Court Caseworker
Family Service Regina

Kelly Baxter
Manager, Child and Family Program
Ministry of Social Services

Angie Bear
Cultural Counsellor
Pinegrove Correctional Centre

Karol Douglas
Policy Analyst
Corporate Initiatives, Performance and Planning
Ministry of Justice

Jo-Anne Dusel
Executive Director
Provincial Association of Transition Houses and Services of Saskatchewan

Deb Fehr
Psychologist
Saskatoon Health Region

Brent Mackey
Inspector
Moose Jaw Police Service

Elizabeth Hilts
Director of Prosecutors
Public Prosecutions
Ministry of Justice

Frankie Jordan
Corporate Initiatives, Performance and Planning
Ministry of Justice

Leonard Keshane
Aboriginal Resource Officer
Parkland Victim Services

Carmela Schneider
Staff Sergeant – North District Management Team
RCMP

Shelley Gibson
Deputy Chief Coroner
Ministry of Justice

Rod Watson
Social Worker
Sun Country Health Region

Executive Summary

This is the final report of the pilot in the Saskatchewan Domestic Violence Death Review initiative. The information contained in this report will lead to an increased awareness of the factors that contribute to these deaths in Saskatchewan. Other jurisdictions that have conducted domestic violence death reviews regularly have implemented changes to make communities and homes safer for individuals and their families.

Saskatchewan has the highest rate of police-reported interpersonal and domestic violence of all provinces across all relationships. This affects the wellbeing of Saskatchewan citizens, communities, and businesses and generates high costs to human service systems, workplaces, individuals, and families.

This report provides detailed information about domestic homicides in Saskatchewan from 2005 to 2014. In that time frame Saskatchewan had 48 domestic homicides with nine related suicides. The majority of the victims were female; the majority of the perpetrators were male. One third of the victims were under age 21 and almost two thirds of the victims were attacked in their own home.

The five domestic violence death cases and two related suicides that took place in 2015 were not included in this review because at the time the review began the majority of these cases were open. In total ten individuals died. Four victims were under age 20, one male and three females. The adult victims were female and ranged in age from 27 to 48 years. One was Indigenous; the remaining Caucasian.

Recommendations

The Saskatchewan Death Review Panel identified common themes among the selected cases and agreed that these themes can be identified across most cases of domestic violence deaths:

- Escalation;
- Mental health and substance abuse issues;
- History of violence, particularly domestic violence;
- Multiple system failure;
- Awareness by family and friends about existing domestic violence and abuse between the perpetrator and victim;
- Lack of education on prevention and intervention;
- Financial issues; and
- Impact of colonization and residential schools in cases involving Indigenous people.

The recommendations were developed with consideration given to current research as well as risk factors identified in specific cases of domestic violence deaths. Review Panel members worked collaboratively, focusing on issues of public safety and domestic violence prevention and intervention. They were unanimous in the belief that domestic violence deaths can be prevented.

The Panel felt strongly that an integrated comprehensive process must be implemented across government and community to reduce incidents of domestic violence and abuse, prevent future domestic violence deaths, and interrupt the impact of intergenerational violence. While some of these recommendations may be viewed as cost generating they should be seen as an investment in the future.

Awareness and education

- Develop a comprehensive program that focuses on building education and awareness about healthy relationships and how to prevent and respond to situations of domestic violence and abuse.

- Investigate ways to use social media to raise awareness and educate all sectors about this issue.

- Educate employers about the need for employees to have training in responding to actual or suspected incidents of domestic violence, about providing victims of domestic violence with time to heal, protection and understanding in the workplace, and about the need for perpetrators to have support to enable them to access and attend programming such as domestic violence treatment prevention and addictions.

- Educate front-line service providers about domestic violence and other issues such as substance abuse and mental health.

- Encourage social agencies (e.g., SUMA, SARM, industry leaders, health, First Nations, sports organizations, and law enforcement agencies) to take an action-oriented, visible stand against domestic violence.

- Encourage justice partners to develop a systems approach to managing cases involving victims at high risk for domestic violence.

- Develop an evaluation plan that crosses all sectors and identifies common outcomes from a variety of actions to achieve common objectives.

Assessment and intervention

- Implement the use of common validated instruments to assess potential reoccurrence and lethality in situations involving domestic violence.

- Develop a first responder team in all communities across the province with expertise in domestic violence.

- Implement domestic violence programs for perpetrators, victims, and families that are available in all communities.

- Establish a provincial central call line that provides information about and support for victims and perpetrators in situations of domestic violence and abuse.

- Investigate the implementation of a protocol similar to the Saskatchewan Child Abuse Protocol that requires reporting domestic violence situations.

- Develop a protocol for front-line service providers including doctors and hospitals dealing with situations of domestic violence and mental health issues that allows for better collaboration and information sharing between agencies in cases where domestic violence and personal safety is a factor.

Children in domestic violence situations

- Improve communication and disclosure between provincial and family courts in domestic violence criminal cases and custody and access cases.

- Mandate parents involved in domestic violence situations and custody and access cases to attend parent education courses before allowing the abusive parent access to the children.

- Improve the oversight of programs for children in care on reserve.

Resources

- Provide funding and personnel to ensure prevention and intervention services are available across the province to match the demand.

- Establish a governance structure external to government to coordinate and oversee actions initiated to reduce domestic violence.

- Investigate ways to reduce financial stress in families.

Table of Contents

Introduction 1
- Intimate Partner Violence 1
- Saskatchewan Domestic Violence Death Review 3
  - The process 3
- Limitations and Confidentiality 4

The Saskatchewan Context 5
- Case Data 2005 to 2014 5
  - Location 6
  - Age 7
  - Ethnicity 9
  - Relationship 9
  - Method of death 11

Panel Findings, Recommendations and Observations 13
- Cases Reviewed 13
- Recommendations 14
  - Awareness and education 15
  - Assessment and intervention 17
  - Children in domestic violence situations 18
  - Resources 19
- Observations About the Current Domestic Violence Death Review Process 19

Saskatchewan Policy and Legislation 22
- Legislation 22
- Policy 22
- Services, Interventions and Supports Available 24

Appendix A: Saskatchewan Domestic Violence Death Review Process 26
Appendix B: Cross-jurisdictional Summary 29
Appendix C: Information for the Review Panel 34
Appendix D: Risk Factor Matrix and Descriptions 35
Appendix E: Victim Considerations 39
Appendix F: Further Information on Saskatchewan's Legislative and Policy Response to Domestic Violence 40

Introduction

Between 2004 and 2014 police reported 967 intimate partner homicides in Canada (Statistics Canada, 2014). In 74% of these deaths the perpetrator was a spouse; in 23% the perpetrator was a dating partner. In 2014 there were 83 intimate partner homicides, 11 more than in 2013.

Although the intimate partner homicide rate has decreased for female and male victims over the past 20 years, females continue to be murdered at a rate four times greater than males (Statistics Canada, 2014). Female victims represented more than 75% of the attempted murders and 83% of murders resulting from intimate partner violence (Statistics Canada 2015).

From 2004 to 2014, females between the ages of 25 and 29 were at the highest risk of intimate partner homicide, followed by females 35 to 39 years. Female victims 15 to 19 years were more than 13 times more likely to be victims of intimate partner homicide than males in the same age range.

Statistics Canada (2014) reported that the most frequently reported reason for incidents of homicide were arguments or quarrels followed by frustration, anger, or despair.

Intimate Partner Violence

Results from the 2014 General Social Survey (GSS) on victimization showed that self-reported spousal violence has declined over the past decade. However, spousal violence continued to impact the lives of 4% of those with current or former spouses, with serious consequences for victims.[1]

While the most common form of spousal violence reported to the GSS was having been pushed, grabbed, shoved, or slapped (35%), a quarter of victims reported having experienced the most severe types of abuse (sexual assault, beating, choking, or threatening with a gun or a knife). Women were twice as likely as men to report these most severe forms of violence, while men were more than three and one-half times more likely than women to be the victim of kicking, biting, hitting, or being hit with something.

About a third of victims of spousal violence frequently sustained physical injuries with women more likely to report being injured than men. Hospital care was required by 16% of spousal violence victims who reported physical injuries. Aside from physical injuries, most victims of spousal violence reported some form of negative emotional consequences resulting from the abuse. New measures of long-term psychological harm show that 16% of spousal violence victims often suffer symptoms consistent with Post Traumatic Stress Disorder, with women being more likely to report these effects than men.

[1] Statistics Canada (2014). **Family Violence in Canada: A Statistical Profile 2014**.

Analysis of victims' experiences of childhood maltreatment indicate links between abuse suffered during childhood, abuse witnessed during childhood, and experiences of spousal violence later in life. Among individuals with current or former spouses or common-law partners, 8% reported having been both sexually and physically abused during childhood. They were more than twice as likely to report spousal violence as those who had not experienced abuse as children. Twenty-one percent of those individuals who had experienced spousal violence in the previous five years reported having witnessed violence committed by a parent, step-parent, or guardian as a child.

Most victims of spousal violence (70%) indicated that police were never contacted. More often, victims turned to other formal sources of support in their communities (36%), such as shelters or social workers, or sought help from informal sources such as family and friends (68%).

Aboriginal peoples across the provinces reported spousal violence more frequently (9%) than their non-Aboriginal counterparts (4%) and experienced more severe types of spousal violence. Aboriginal women reported experiencing intimate partner violence at a rate 2.5 times higher than non-Aboriginal women. People identifying as Aboriginal were also more likely than non-Aboriginals to report having witnessed violence committed by a parent, step-parent, or guardian as a child (21% versus 10%, respectively).

Saskatchewan has had the highest police-reported provincial violent crime rate in Canada since 1997, nearly double the national rate. From children to teenagers to adults and seniors, our interpersonal violence rates are the highest across all age groups and relationships. For example, Saskatchewan has the highest intimate partner homicide rate and sexual and physical violence rate against children (1.7 and 2.3 times the national rate respectively). As well, six of the 10 communities in Canada with the highest rates of violence against Indigenous women and girls are in northern Saskatchewan. National research shows Indigenous women are three times more likely to be victims of interpersonal violence than non-Indigenous women and five times more likely to be victims of homicide.

This violence affects the wellbeing of Saskatchewan citizens, communities, and businesses and generates high costs to human service systems, workplaces, individuals, and families. It causes trauma to victims and family members and holds lifelong implications. These include physical injuries and ongoing disabilities, medical conditions such as heart disease and diabetes, mental health and substance abuse problems, lost education or employment opportunities, and financial costs for individuals, businesses, and communities. Research conducted in Regina, Saskatchewan by a community-based organization estimated the financial cost of one domestic violence incident at about $112,000 in the justice, social services, and health systems and to the victim[2]. Interpersonal violence is estimated to cost over $450 million annually in Saskatchewan across systems and for individuals.

[2] The Circle Project Assoc. Inc. (2016). **Economic Impact: The Cost of One Incident of Domestic Violence.**

Saskatchewan Domestic Violence Death Review

In October 2015, the Minister of Justice announced that Saskatchewan would undertake a domestic violence death review process to gain a better understanding of why perpetrators of domestic violence kill their intimate partners and other familial members and why victims of violence are vulnerable. Refer to Appendix A for a detailed description of the process.

Definition
Domestic Violence Death

Within the context of the Saskatchewan Domestic Violence Death Review process domestic violence death is defined as a homicide or a related suicide that occurs in circumstances involving persons in an intimate relationship and their families. It often involves conflict between intimate partners or ex-partners, including situations which lead to the death of a child or familial member.

A steering committee with representation from ministry divisions that deal with domestic violence situations and the police was identified. This committee oversaw the development of the review process. It agreed that the domestic violence review process would examine specific cases to:

- Identify trends, risk factors and patterns in order to inform risk assessment, risk management and safety planning;
- Identify possible barriers, gaps and points of intervention in community and systemic responses;
- Recommend domestic violence prevention and intervention strategies; and
- Facilitate systemic and inter-agency communication and coordination.

Definition
Intimate Partner Relationship

- current or former dating relationships
- current or former common-law relationships
- current or former marriage relationships
- persons who are parents of one or more children regardless of their marital status or whether they have lived together at any time.

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. It is intended to add value to existing knowledge about domestic violence deaths and inform related policy and practice.

The process

The Ministry of Justice compiled a list of domestic violence deaths in Saskatchewan between 2005 and 2014 by examining closed files from the Office of the Chief Coroner. The creation of a spreadsheet detailing this information facilitated the selection of six cases for a pilot of the review process.

Three tools were developed to guide the review: a set of research questions (Appendix C), a risk assessment matrix (Appendix D), and a victim consideration matrix (Appendix E).

A multi-disciplinary Review Panel met for seven days over a number of months. The Panel collectively demonstrated expertise, knowledge, and skills related to domestic violence and its impact in the following areas: medical issues, justice system response, societal issues, mental health, substance abuse, and child protection. The Panel tested a standardized assessment process that used risk and victim consideration matrices to examine cases.

The review investigated how the characteristics of the case, actions, and/or responses contributed to the death(s) using information obtained from coroners, police, health, and social service sources. The Panel used the information provided to make evidence-based recommendations that reflected systemic gaps, changes, and improvements in the areas of policy, procedure, program, training, services, and protocols that, when acted on, would prevent or reduce such deaths.

Limitations and Confidentiality

A limitation of the process was the length of time it took to develop information sharing protocols with agencies holding personal information and personal health information about the individuals in the selected cases – for example, when more information was needed about the incident, the history of domestic violence in current and past relationships, and the presence of mental health and addictions issues. Throughout the design and implementation of this initiative, attention to the privacy and confidentiality of individuals involved in the cases as well as data accuracy were paramount. Details that could identify cases have been removed.

The Saskatchewan Context

In December 2015 the Office of the Chief Coroner in Saskatchewan reviewed its files from January 1, 2005 to December 31, 2014 in order to identify all deaths that were related to domestic violence. Forty-eight of 331 homicides (14.5%) were found to be domestic-related.

The data that follows in this section was aggregated from information in the Office of Chief Coroner 2005 to 2014 files.

Case Data 2005 to 2014

Table 1 shows the annual and gender breakdown of Saskatchewan's 48 domestic-related homicides with nine related suicides. These 57 domestic-related deaths occurred within 45 cases.

Definitions

In this section victim and perpetrator are defined as follows:
Perpetrator = A person who committed domestic homicide(s). The perpetrator may not be the primary aggressor in the relationship.
Victim = A person who was killed in the domestic homicide. The victim may not be the primary or usual target of the perpetrator or primary aggressor in the relationship.

Domestic Violence Deaths 2015 and 2016

In 2015 there were five cases of domestic homicide with two related suicides. In total ten individuals died. Four victims were under age 20, one male and three females. The adult victims were female and ranged in age from 27 to 48 years. One was Indigenous; the remaining Caucasian.

In 2016 there were three confirmed cases of domestic homicide. The three victims ranged in age from 22 years to 38 years. Of the remaining four open cases, in May 2017 none had been confirmed. One of these cases had a related suicide.

To May 2017 there were three open homicide cases that may have been domestic related, all adult female victims.

Table 1: Number of domestic-related homicides and suicides in Saskatchewan 2005 to 2014 by gender

Homicides (victims)

	Female	Male	Total
2005	4	1	5
2006	4	4	8
2007	2	2	4
2008	2	5	7
2009	3	3	6
2010	0	2	2
2011	2	2	4
2012	4	3	7
2013	1	1	2
2014	3	0	3
Total	**25**	**23**	**48**

Source: Office of the Chief Coroner, December 2015

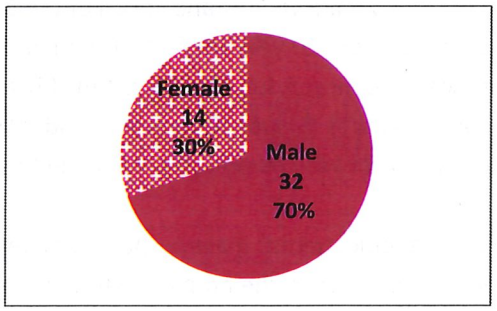
Suicides (perpetrators)

	Male	Female	Total
2005	1	0	1
2006	1	0	1
2007	1	0	1
2008	1	0	1
2009	1	0	1
2010	0	0	0
2011	0	1	1
2012	2	0	2
2013	0	0	0
2014	1	0	1
Total	**8**	**1**	**9**

Of the adult victims of domestic-related homicide, 19 were female and 14 were male. One female was under age 20 but was a partner of the perpetrator. This is consistent with findings across Canada that females are more likely to be killed in a domestic-related homicide than males.

Of the perpetrators of domestic-related homicide 32 (70%) were male and 14 (30%) were female (Figure 1).

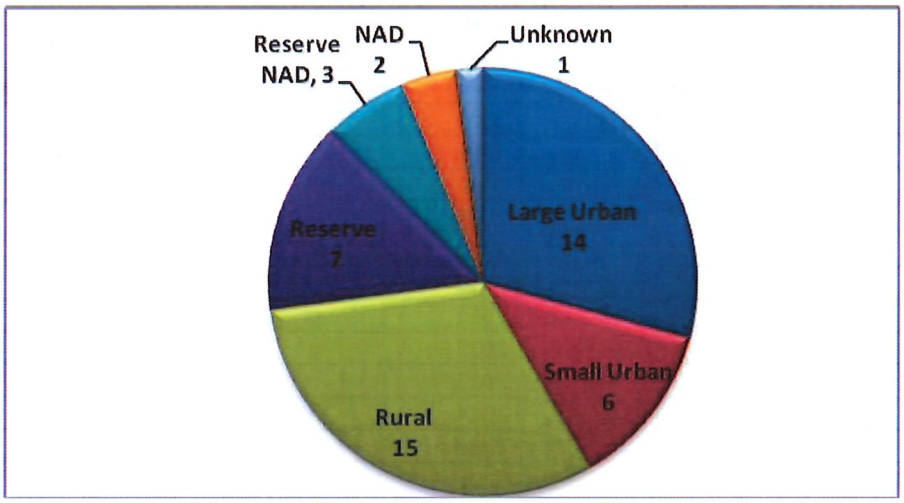
Figure 1: Perpetrators by gender (2005-2014)



Location

As shown on Figure 2, 44% of the victim incidents took place in an urban setting – 14 in Regina and Saskatoon and six in small urban centres. Fifteen of the incidents were in rural areas; ten on reserve and two in the Northern Administration District (NAD). In total, five incidents took place in the NAD, three on reserve.

Figure 2: Victim geographical location of injury



About two thirds of the victims were attacked in their own homes and eight in their home area. The majority (60%) of the victims died where they were attacked.

Age

The ages of the victims of homicide and the perpetrators who committed suicide are shown on Table 2. Nine of the 23 male victims and seven of the 25 female victims were under 21. Five female and nine male victims were 10 years or less. The male child victims were all three years old or less. The age range with the most adult female victims (6) was between 21 and 30 years; the age range with the most male adult victims (5) was between 41 and 50 years. No one over age 60 was either a victim of homicide or a perpetrator who committed suicide in this time period.

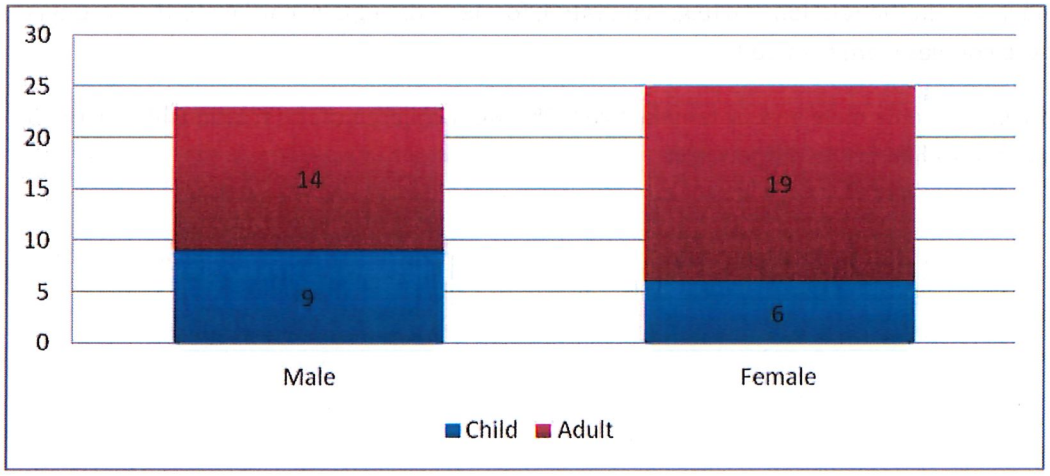
These data indicate that male perpetrators between the ages of 41 and 60 are more likely to commit suicide in response to the homicide they committed.

Table 2: Ages of victims of homicide and perpetrators who committed suicide (2005-2014)

Age range	Number of female victims	Number of male victims		Number of male perpetrators	Number of female perpetrators
0-10 years	5	9			
11-20 years	2				
21-30 years	6	4		1	
31-40 years	4	4			
41-50 years	5	5		4	
51-60 years	3	1		3	1
61-70 years					
70+ years					
Total	**25**	**23**		**8**	**1**

Figure 3 shows the breakdown of adult and child victims. Approximately half of the victims were children. One female victim was the intimate partner of the perpetrator and, although under 20, is classified as an adult in these data.

Figure 3: Number of adult and child victims (2005-2014)



Ethnicity

Over half (27/48) of the victims of homicide were Indigenous[3]; 19 Caucasian and two unknown. Thirteen of the Indigenous victims and seven of the Caucasian victims were male. Fourteen of the Indigenous victims were female[4] and twelve of the Caucasian victims were female (Table 3).

Table 3: Ethnicity of victims by gender

	Male	Female
Caucasian	7	12
Indigenous	13	14
Unknown	2	0

Of the nine perpetrators who committed suicide two were Indigenous and seven were Caucasian.

Relationship

More victims were killed by their current spouse (18) than by a former spouse (2). As well, more victims were killed by their current dating partner (6) than by a former dating partner (2).

Of the 33 adult victims, 30 were or had been in an intimate relationship with the perpetrator (10 male - 33% and 20 female - 67%). Of these, 18 (60%) were living together at the time of the incident (Figure 4). A fifth were no longer in the relationship (e.g., separated, formerly dating). According to the Coroners' data none of the couples were divorced.

Of the 15 child victims, nine male and six female, five (33%) were children of the relationship (Figure 5). Ten (67%) were not a child of the perpetrator.

[3] In 2011 16% of Saskatchewan's population and 4% of Canada's population identified as Indigenous. (Statistics Canada, **National Household Survey**, 2011)

[4] In 2011 16% of Saskatchewan's population and 4% of Canada's population identified as female Indigenous. (Statistics Canada, **National Household Survey**, 2011)

Figure 4: Relationship between perpetrator and adult victim by victim gender (2005-2014)

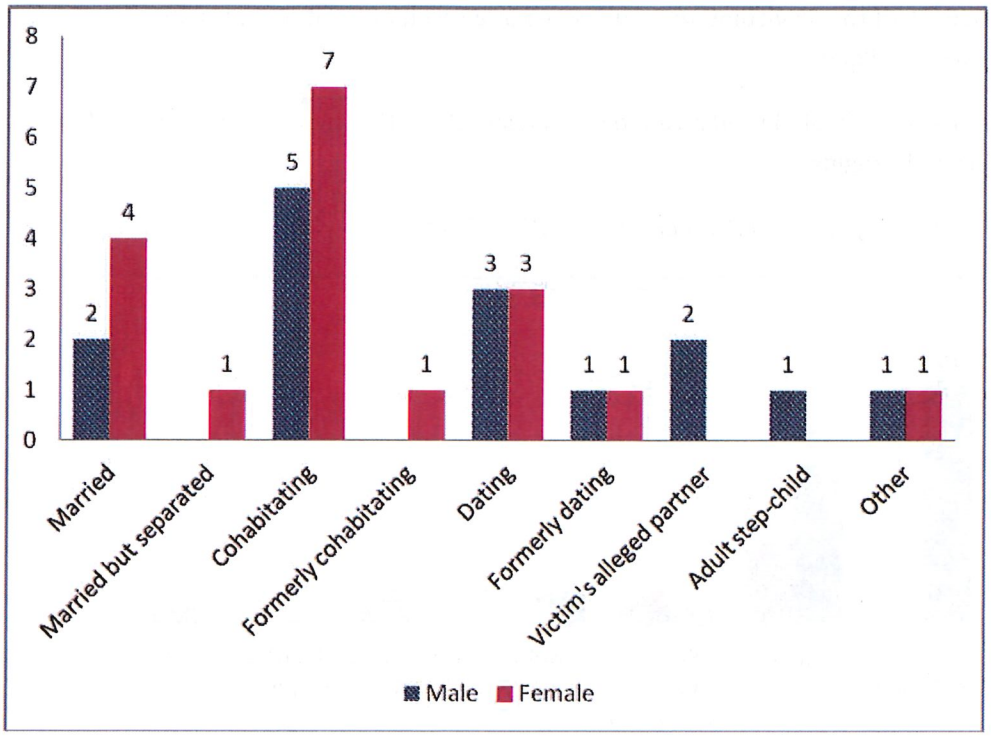
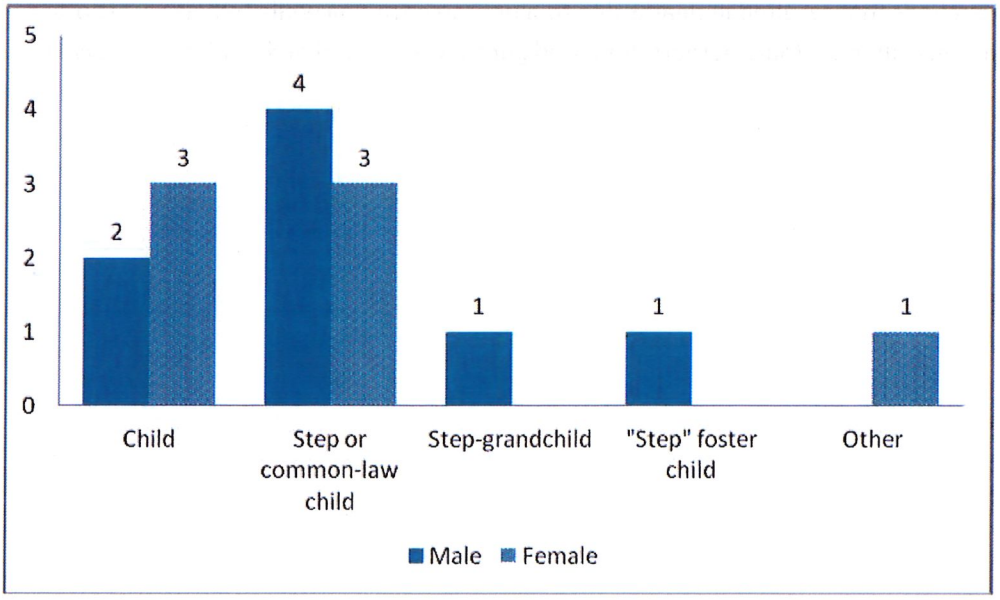


Figure 5: Relationship between perpetrator and child victim by victim gender (2005-2014)



Note: One adult victim was a step-child of the perpetrator and is not included on this table.

Method of death

As shown on Figure 6, 18 of the 48 victims were murdered as a result of blunt force trauma; 15 with a sharp implement such as a knife.

The majority of perpetrators (5 of 9) used a gun to commit suicide. Other methods included carbon monoxide poisoning and hanging.

Figure 6: Method of death of victim and of perpetrator (2005-2014)

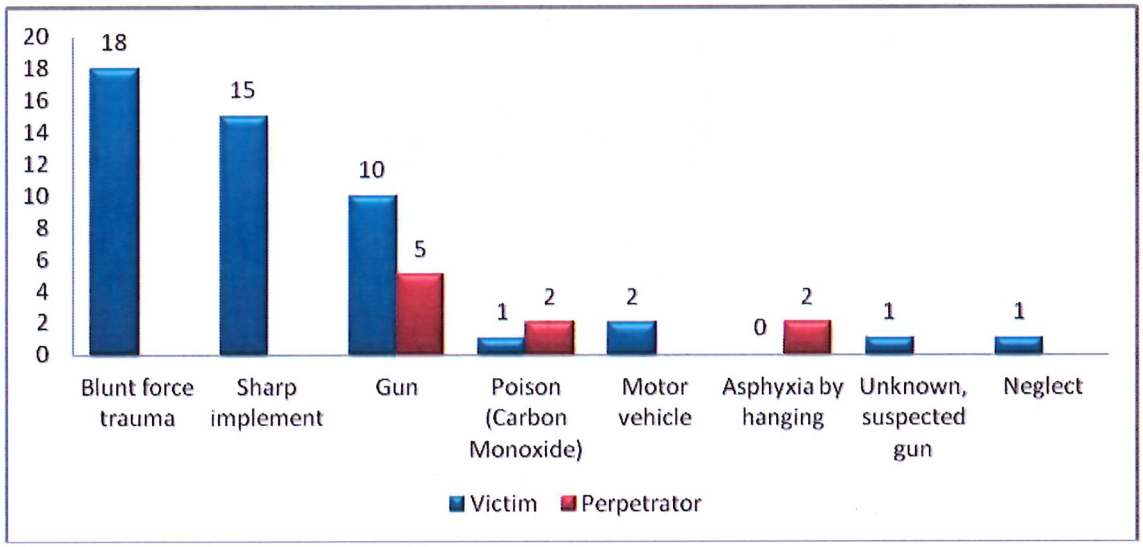
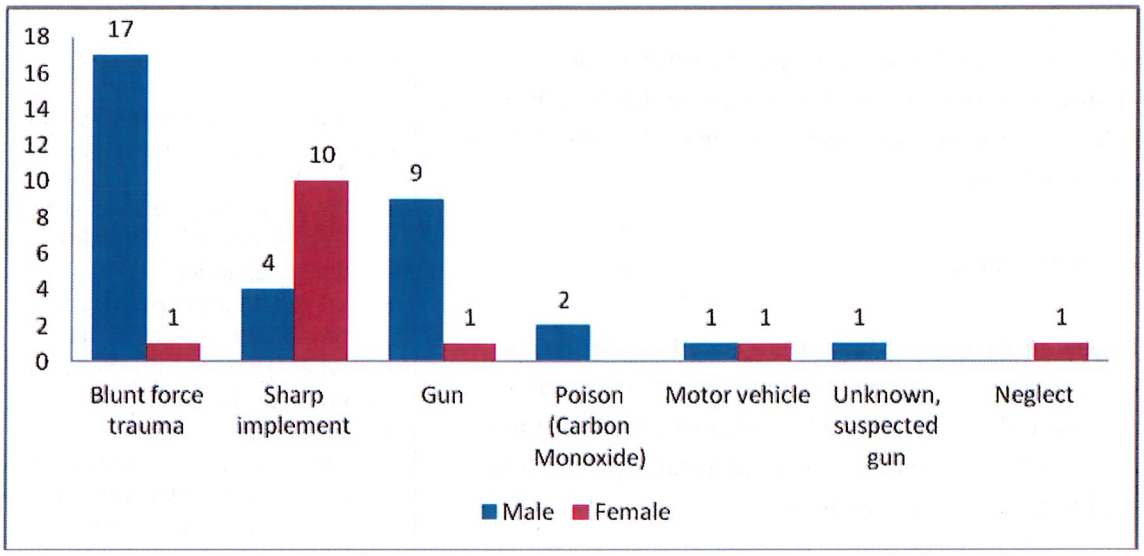


Figure 7 shows the differences by gender in choice of weapon used by perpetrators. Male perpetrators more often used methods that resulted in deaths due to blunt force trauma while females most often chose to use a sharp instrument. Male perpetrators used guns more often than females (9 versus 1).

Figure 7: Method of death used by perpetrator by gender (2005-2014)



Panel Findings, Recommendations and Observations

This section includes case findings, recommendations for change to prevent and better respond to situations involving domestic violence, and observations of the Review Panel about the review process.

In examining the cases the Review Panel considered the following questions:

- What was the timeline of events leading up to the homicide or homicide/suicide?
- What risk factors and victim considerations were present?
- What systems or agencies were involved with the family?
- What was the degree of communication and coordination among these systems and agencies?
- What were some missed opportunities that could have improved the systemic and/or community response to the family?
- What went well?

Cases Reviewed

The Review Panel used the factors presented in six domestic violence death cases to develop recommendations to various sectors. The cases were selected to ensure a variety of situations including gender of the victim and perpetrator, age of victim, and geographic location of the homicide.

The following summarizes common risk factors found across the cases. The case descriptions below show that each case had more risk factors present than those listed.

- All cases shared one common risk factor: #18 – escalation of violence[5].
- Five cases showed three additional common risk factors:
  - #4 – history of domestic violence
  - #23 – after risk assessment, perpetrator had access to victim
  - #36 – perpetrator unemployed or underemployed
- Four cases[6] showed nine more common risk factors:
  - #3 – history of violence outside of the family by perpetrator
  - #5 – prior assault with a weapon
  - #10 – prior threats to kill victim
  - #21 – presence of other family members in the home
  - #30 – depression in the opinion of family/friend/acquaintance (perpetrator)
  - #32 – other mental health or psychiatric problems (perpetrator)
  - #33 – excessive alcohol and/or drug use by perpetrator
  - #34 – failure to comply with authority (perpetrator)

Identification of the risk factors combined with the basic information provided to the Panel shows that many domestic violence deaths can be predicted and could be prevented. The presence of multiple risk

[5] Risk factor descriptions are in Appendix D.

[6] Two cases involved single deaths of a child; several risk factors did not apply in those cases.

factors in a case may be interpreted as "red flags" that require direct intervention and response by a specific system (e.g., safety planning, child protection). If risk factors appear across cases, this may indicate that a response gap exists that should be addressed.

Recommendations

This section contains recommendations made by the Review Panel to improve the Saskatchewan response by government and community to domestic violence deaths. The Panel feels strongly that an integrated comprehensive process must be implemented across government and community to reduce incidents of domestic violence and abuse, prevent future domestic violence deaths, and interrupt the impact of intergenerational violence. While some of these recommendations may be viewed as cost generating they should be seen as an investment in the future. As stated previously in this report the financial costs of responding to situations involving interpersonal and domestic violence in Saskatchewan are extremely high across systems and for individuals. Investment in prevention and intervention will reduce future financial costs and develop healthy families who are able to contribute to society.

The Review Panel identified common themes among the selected cases and agreed that these themes can be identified across most cases of domestic violence deaths.

- Escalation
- Mental health and substance abuse issues
- History of violence, particularly domestic violence
- Multiple system failure
- Awareness by family and friends about existing domestic violence and abuse between the perpetrator and victim
- Lack of education on prevention and intervention
- Financial issues
- Impact of colonization and residential schools in cases involving Indigenous people.

The Panel highly supported government, community, and individuals working together to address this issue and was critical of the current "piecemeal" approach.

The following recommendations have been divided into four categories that connect and overlap.

- Awareness and education
- Assessment and intervention
- Children and domestic violence and abuse
- Resources required to facilitate change in these areas

Awareness and education

For the public

- Develop a comprehensive program that focuses on building education and awareness about healthy relationships and how to prevent and respond to situations of domestic violence and abuse.

  The cases reviewed showed that often family and friends knew domestic violence and abuse existed in the relationship. It appeared that they were not sure what to do or how they could help the victim. In most cases the victim appeared to be unaware of the lethality risk.

  This program should provide a continuum of education from pre-natal to school age to adult and demonstrate individual and community responsibility in changing the issue. It should also provide information about where to go for help for families and the public. As part of school curriculum all children should learn how to respond to conflict. Providing information to the public could take place at various entry points – for example, marriage license and preparation courses, birth certificate applications, driver license renewals. The program should define what is meant by domestic violence and ensure understanding that it is not only physical or chargeable acts but often involves other forms.

  Consider using the term "partner abuse" as the actions are much broader than domestic violence. Consideration should be given to examining the impact of culture and belief systems on the issue.

- Investigate ways to use social media to raise awareness and educate all sectors about this issue.

  It is important to invest in ways to reach all sectors over a significant period of time (e.g., five to ten years). Research shows that "one offs" are not effective long term. A communication strategy should be designed to build on what exists and reinforce key messages. Social media is a relatively inexpensive way to provide messages about building positive relationships and promoting non-violence. As well, perpetrators may be invited to self-identify and access programming.

For professionals

- Educate employers about the need for employees to have training in responding to actual or suspected incidents of domestic violence, about providing victims of domestic violence with time to heal, protection and understanding in the workplace, and about the need for perpetrators to have support to enable them to access and attend programming such as domestic violence treatment prevention and addictions.

  Actions involving domestic violence external to the workplace are a hazard to and may create unsafe environments for employees. They influence relationships at work and affect productivity. Ignoring the impact of domestic violence on workplaces endangers all employees

and sends a message that survivors of domestic violence do not deserve compassion and support. Employers need to develop policies, protocols, and training for employees affected by domestic violence.

- Educate front-line service providers about domestic violence and other issues such as substance abuse and mental health.

  Staff, programs, and services within the justice and other systems need to be given the knowledge, skills, and tools to identify domestic violence risk factors. They need to understand the impact of culture, mental health issues, and substance abuse on domestic violence situations in order to respond and make appropriate referrals. Clients – whether victims or perpetrators – may have attitudes and behaviors that require specialized assessment and intervention practices.

For systems

- Encourage social agencies (e.g., SUMA, SARM, industry leaders, health, First Nations, sports organizations, and law enforcement agencies) to take an action-oriented, visible stand against domestic violence.

  Having organizations recognize that domestic violence is a public health issue by taking a stand against it will broadly influence public thought, attitudes, and behaviour.

- Encourage justice partners to develop a systems approach to managing cases involving victims at high risk for domestic violence.

  Using a systems approach to case management allows coordination, collaboration, and information sharing that supports clients effectively and fills gaps that currently exist. It is interactive and considers the interdependence of external and internal factors. The Saskatchewan domestic violence courts are an example of a systems approach.

- Develop an evaluation plan that crosses all sectors and identifies common outcomes from a variety of actions to achieve common objectives.

  Conduct rigorous evaluations of program effectiveness and changes in societal attitude and behaviour with respect to domestic violence. Consider using a participatory collective impact model for the evaluation. The evaluation plan will identify required data to conduct the evaluation that may need to have processes developed to identify and collect data not currently available. The plan may also include research components on specific issues such as the impact on families when workers are required to work away from home for significant periods of time to determine if there are correlations between domestic violence and the risk factors of mental health/substance abuse, misogynistic culture, and financial stress.

Assessment and intervention

Risk assessment

- Implement the use of common validated instruments to assess potential reoccurrence and lethality in situations involving domestic violence.

  All systems need a common reliable tool to use when suspicions of domestic violence exist. It should include checklists and have an associated protocol that assesses the safety of the victim and children. The analysis of instruments used in other jurisdictions conducted several years ago by the Ministry of Justice would be an excellent starting place.

- Develop a first responder team in all communities across the province with expertise in domestic violence.

  This model has worked well in medical and trauma crisis situations. A person with knowledge and experience in domestic violence could be added to the team to assist with victims, perpetrators, and children in domestic violence incidents.

Programming

- Implement domestic violence programs for perpetrators, victims, and families that are available in all communities.

  Currently alternatives to violence programs for perpetrators are provided in some health regions; other regions do not identify these programs as a priority. Effective, consistent domestic violence programming for perpetrators (and victims) should be considered to be a core service within each of the integrated service areas in the emerging Saskatchewan Health Authority. The Saskatchewan Health Authority or community-based counselling agencies, or both, should be encouraged and supported to prioritize and to provide a broad range of domestic violence programming/counselling for children, adult victims, perpetrators, schools, places of work, and communities.

  Opportunities for the service providers to learn from each other should be established.

  Some communities have programs for children exposed to violence; many do not. In order to stop the intergenerational violence cycle and address safety issues with children, programs should be expanded so all families have access to them. As well, adult victims need to be encouraged to attend support programs to enable access to information such as safety planning and healthy relationships.

  In order for programs to meet individual needs, research into culture and domestic violence and what is needed to change belief systems and characteristics to enable change should be undertaken.

Intervention

- Establish a provincial central call line that provides information about and support for victims and perpetrators in situations of domestic violence and abuse.

  A central number such as 711 would be accessible across the province and allow for anonymity. Consideration should be given to providing timely access to a video connection to professional resources through this number.

- Investigate the implementation of a protocol similar to the Saskatchewan Child Abuse Protocol that requires reporting domestic violence situations.

  While barriers exist to implementing a protocol that requires reporting domestic violence, consideration should be given to messaging the need to report and providing anonymous options for reporting. It is critical to reduce the stigmatizing public attitude, especially in small communities.

- Develop a protocol for front-line service providers including doctors and hospitals dealing with situations of domestic violence and mental health issues that allows for better collaboration and information sharing between agencies in cases where domestic violence and personal safety is a factor.

  Knowledge of assessment histories is critical when dealing with clients who have suspected domestic violence. Establishing common guidelines and processes to allow information sharing and support among community agencies is critical in situations of personal safety. This would enable agencies to direct their clients to specific services and share information that would assist these services to better serve the clients and perhaps influence timeliness of response. Front-line service providers such as doctors and hospitals need to be encouraged to ask questions about injuries, have protocols for asking in a safe manner, and have a plan in place for reporting suspected domestic abuse.

Children in domestic violence situations

- Improve communication and disclosure between provincial and family courts in domestic violence criminal cases and custody and access cases.

  Both courts should be encouraged to take a child centred approach in all cases. The rights of the child should come before the right of access and the right to safety should be a priority. The judiciary needs to better understand the impact of domestic violence on children. As well, in situations involving non-contact conditions the judiciary, Crown prosecutors, and victim services must take responsibility for educating victims about possible outcomes when changes are made to non-contact conditions. Part of this education may include a common assessment process used by police-based victim services personnel across all courts when a request for change to non-contact conditions occurs.

- Mandate parents involved in domestic violence situations and custody and access cases to attend parent education courses before allowing the abusive parent access to the children.

In cases where custody and access and domestic violence are issues early attendance at high risk parenting classes is critical. It is important to rebuild the sense of belonging and self-worth by teaching parenting and relationship skills. If criminal charges are in provincial court, access by the offending parent, if allowed, should be supervised.

- Improve the oversight of programs for children in care on reserve.
  There appears to be a breakdown in the relationship between the Ministry of Social Services and Child and Youth Services on reserve. Indigenous leadership and the Ministry should establish clear roles and responsibilities and implement changes to ensure safety for all children in care.

Resources

- Provide funding and personnel to ensure prevention and intervention services are available across the province to match the demand.
  Changing attitudes and behaviour is difficult and actions must take place in a timely manner. Research has shown through the cycle of violence that being put on a wait list is not an effective response to domestic violence.

- Establish a governance structure external to government to coordinate and oversee actions initiated to reduce domestic violence.
  To support the implementation of actions by government and community across the province to reduce domestic violence, the Panel was adamant that an oversight body is required to ensure effectiveness and efficiency.

- Investigate ways to reduce financial stress in families.
  Financial stress appears to be a common factor in domestic violence cases and a primary reason for victims to return to unsafe situations. The government needs to pilot initiatives such as a guaranteed annual income and the provision of employment following training initiatives on and off reserve to reduce financial stress for families in vulnerable situations.

Observations About the Current Domestic Death Review Process

The Review Panel appreciated the group process used to review the cases. They stated that the different backgrounds of the Panel members were important to the process and that they used the knowledge from others on the Panel to assist in analyzing the cases. The Panel was asked to think about the following questions during the discussion about changes to the domestic violence death review process:

- What would you change to improve the process?
- What should we pay more attention to?
- How often should a review take place?

Panel members identified the following to improve the domestic violence death review process:

- Every domestic violence death case should be reviewed using this process. The Panel agreed that the review should be mandated through legislation or amendments to existing legislation or that it should be established as a study commission under the *Public Inquiries Act*. This would enable a unit in the Ministry of Justice to be assigned the mandate through legislation or other means to receive the required information in all domestic violence death cases to enable a timely review of the case.
- Consider expanding the domestic death review process to include suicides that result from domestic violence and abuse.
- Risk factors and victim considerations provided an important common framework for assessing cases. Consider adding the following risk factors and victim considerations:
    - Culture
      This may assist in assessing the impacts on behaviour of actions such as colonization, residential school attendance, or belief systems learned and experienced in other countries.
    - Primary aggressor
      In examining the cases the Panel identified the need to know the relationship history with respect to domestic violence and abuse in order to know if the perpetrator was actually the primary aggressor or was s/he the victim in the relationship who eventually retaliated. Or, were the individuals both?
    - Victim requests for help
      This information may indicate the history of domestic violence between the victim and perpetrator. It may also add critical information about the involvement of family and agencies.
    - Misandrist attitude
      Misogynistic attitude (#39) should be expanded to capture hating or having a strong prejudice against men.
- Availability of the following information assists in "telling the story" but obtaining privacy agreements with ministries and agencies takes a significant length of time. Consideration should be given to establishing a process that provides the following information without the need for individual privacy agreements with information sources:
    - List of available resources in the community
    - Criminal history and details of the incident
    - Interactions with police-based victim services and victim/witness programs
    - Health history including emergency room visits and mental health and substance abuse issues
    - Social history of the relationship as well as the life history of the victim and perpetrator (e.g., child abuse, family violence present as a child, attendance at residential school)
    - Information from shelters used by victims.
- Inclusion of child victims when the child is the only victim in an incident may be considered a component of a domestic violence death review process depending on the family history. However,

different interventions occur with children in domestic violence situations. Better assessment may occur if child deaths are considered separately from partner domestic violence deaths. Different assessment tools are needed as several of the current categories do not apply when a child is the only victim (e.g., victim's fear of perpetrator, age disparity, actual or pending separation). As well, determining whether the child death is related to domestic violence in the home may not be possible given existing information. Changes would have to be made to include these details in police and coroner reports and would require an in-depth review of each case. Recommendations in situations of child deaths may be different from those associated with partner deaths. Consideration should be given to improving and expanding existing child death review processes to ensure child deaths in domestic violence situations are assessed appropriately.

- Although police and media reports sometimes contain information about the circumstances of the relationship according to neighbours, friends, and family, important social history information may be gleaned by inviting these individuals to contribute their perceptions directly to the Panel. Balancing this with differing views among family members about their participation and about their perceptions of the relationship, potential revictimization of families and the value it has to the process should be assessed. Participation should be voluntary; protocols would need to be put in place; and an individual with knowledge and skill in interviewing individuals in vulnerable circumstances and in conducting case studies would be required.

Saskatchewan Policy and Legislation

Appendix F provides a more detailed description of legislation and policy related to domestic violence in Saskatchewan[7].

Legislation

Domestic-related crimes fall within the federal *Criminal Code of Canada* that defines the type of conduct that constitutes criminal offences and establishes the type of sentence that may be imposed upon conviction.

Saskatchewan legislation that applies to incidents involving domestic violence includes:

- *The Child and Family Services Act* - Chapter C-7.2 of the *Statutes of Saskatchewan*
  The purpose of this Act is to promote the well-being of children in need of protection by offering services that are designed to maintain, support and preserve the family. It may allow the removal of the children from the situation of intimate partner violence.

- *The Victims of Interpersonal Violence Act, 2015*
  Formerly the Victims of Domestic Violence Act (1995) this revised Act is civil legislation that protects victims of domestic violence by providing immediate protection to the victim in a number of ways (e.g., exclusive residency, non-contact provisions).

Policy

When the Saskatchewan Domestic Violence Death Review was initiated Saskatchewan did not have a provincial policy on or approach to interpersonal violence and abuse, including domestic violence. Although some sectors such as Public Prosecutions, Child Protection, and some police services had operational protocols in place there was no common government policy, protocol, or direction.

[7] In 2017 the federal government announced a program called *It's Time: Canada's Strategy to Prevent and Address Gender-Based Violence* with targeted funding for a whole government approach to prevent domestic violence and other forms of gender-based violence. *It's Time* builds on federal initiatives already underway and coordinates existing programs. It lays the foundation for greater action and is based on three pillars that will improve Canada's overall response to gender-based violence: prevention, support for survivors and their families, and promotion of responsive legal and justice systems.

Examples of existing policy in Saskatchewan include:

- Victims of Crime Regulations
  These regulations govern the eligibility and distribution of financial compensation for victims of violent crimes that were reported to police. In 2014 amendments allowed for compensation for counselling for children exposed to interpersonal violence when a parent has reported the incident to police.

- Declaration of Principles Respecting the Treatment of Victims of Crime (updating the Victims of Crime Act, 1996)
  This list of principles addresses how victims of crime should be treated by individuals working in the criminal justice system including consideration of the safety and security of victims at all stages of the criminal justice process.

- The Saskatchewan Child Abuse Protocol (revised 2015)
  The purpose of this Protocol is to describe what constitutes child abuse under the law, to describe roles and responsibilities of service providers, and to describe the process by which they must respond. Responding to child abuse is a challenge in every community.

- Police charging policy
  Police must lay charges in all cases of domestic violence when investigation indicates a crime has taken place against an intimate partner. The policy removes responsibility for the decision to lay charges from the victims.

- Public Prosecution policy
  The Justice Public Prosecutions Policy Manual establishes a consistent approach to the prosecution of domestic violence cases.

- Corrections
  Risk assessment is a critical tool in planning offender programming and victim safety. In domestic violence cases Saskatchewan uses the Saskatchewan Provincial Risk Assessment (SPRA) and the Ontario Domestic Assault Risk Assessment (ODARA) to assess risk.

Services, Interventions and Supports Available

Although at the time of the initial domestic violence death review Saskatchewan lacked a policy framework to address interpersonal and domestic violence, ministries continued to work to provide services for victims, offenders, and their families. Examples of this include:

- Financial support to community agencies for direct services and initiatives for adults at risk of violence and their children (e.g., sexual assault services, family violence outreach, residential crisis services for women and their children, children exposed to violence programs);
- Domestic violence prevention and intervention programs for men and women who are violent towards their partners;
- Caring and Respectful Schools initiatives with school divisions;
- Implementation of action items that address child mistreatment; and
- Annual provincial violence prevention week to raise public awareness about the issue.

Victim services

Victim Services in the Ministry of Justice offers a range of services to meet the needs of victims of crime throughout Saskatchewan, including victims of domestic violence. Services include:

- Access to police-based victim services in all police services;
- Support for victims/witnesses involved in the criminal justice system in six regional prosecution offices;
- Support for bereaved families through a funded community agency; and
- Compensation for eligible victims.

Domestic violence courts

The provincial court system includes domestic violence courts in the Battlefords (2003), Saskatoon (2005) and Regina (2008) that operate using a collaborative partnership model. They offer an early intervention program to offenders who accept responsibility for their actions and also provide intense support for victims. For more information refer to www.sasklawcourts.ca.

At this time there is little coordination between the provincial courts that deal with criminal law issues and Court of Queen's Bench that deals with family law issues. This may result in overlapping orders at a time when research has shown there is a heightened danger to the victim.

Family justice services

The Family Justice Services Branch of the Ministry of Justice provides a variety of services for people dealing with family law matters. This branch does not provide legal services or legal advice. As part of its services:

- The Maintenance Enforcement Office registers and enforces support orders and agreements (both child and spousal support).

- The Social Work Unit prepares court-ordered custody and access assessments. This unit also manages the Supervised Access and Exchange Program.
- The Parent Education Unit is responsible for the delivery of the Parent Education Program across Saskatchewan. It is aimed at providing parent education and information to people dealing with family breakdown. The unit also provides information on options for resolving family disputes.
- The Family Law Information Centre and Support Variation Project is a public information resource center on family law and the Child Support Guidelines. It also provides assistance and information on varying child support.

For more information refer to http://www.sasklawcourts.ca/home/court-of-queen-s-bench/family.

Community-based services

The Ministry of Justice funds a number of community-based organizations to provide services to victims involved in domestic violence situations, including crisis and sexual assault centres and shelters. It also funds programs focused on interpersonal violence in families, the Aboriginal Family Violence Program, and the Children Exposed to Violence Program.

Appendix A: Saskatchewan Domestic Violence Death Review Process

In October 2015 the Minister of Justice announced that Saskatchewan would undertake a domestic violence death review process to gain a better understanding of why perpetrators of domestic violence kill their intimate partners and other familial members and why victims of violence are vulnerable. This was intended to provide a firm basis for effective action to address domestic violence in Saskatchewan.

A steering committee with representation from ministry divisions that deal with domestic violence situations and the police was identified: Office of the Chief Coroner, Victim Services Branch, Community Justice Division, Saskatchewan Police Commission, Children's Counsel, RCMP, and municipal police.

That committee, chaired by the Corporate Initiatives, Performance and Planning Branch:

- reviewed practices in other jurisdictions;
- drafted the Review Panel mandate and membership, and identified other resources as required;
- consulted with stakeholders;
- developed review policy and procedures, including identifying criteria for selecting and prioritizing cases for review, and parameters of information sharing and confidentiality;
- established timelines, process for review and reporting;
- selected files for the pilot according to criteria developed;
- assisted in developing the review matrix and assessment instruments;
- reviewed the interim and final reports; and
- assessed the efficacy of the review process and proposed changes.

Definition
Domestic Violence Death

Within the context of the Saskatchewan Domestic Violence Death Review process domestic violence death is defined as a homicide or a related suicide that occurs in circumstances involving persons in an intimate relationship and their families. It often involves conflict between intimate partners or ex-partners, including situations which lead to the death of a child or familial member.

The goal of the domestic violence review process is to help prevent deaths related to domestic violence in the future. The objectives are to:

- Identify trends, risk factors and patterns in order to inform risk assessment, risk management and safety planning;
- Identify possible barriers, gaps and points of intervention in community and systemic responses;
- Recommend domestic violence prevention and intervention strategies; and
- Facilitate systemic and inter-agency communication and coordination.

Definition
Intimate Partner Relationship

- current or former dating relationships
- current or former common-law relationships
- current or former marriage relationships
- persons who are parents of one or more children regardless of their marital status or whether they have lived together at any time.

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. It is intended to add value to existing knowledge about domestic violence deaths and inform related policy and practice.

The Process

Prior to developing the process for the Saskatchewan review, the Ministry of Justice conducted a cross-jurisdictional review of processes used elsewhere in Canada and in other countries (Appendix B). This review identified the common benefits of the review process listed above as objectives of the Saskatchewan Domestic Violence Death Review process.

The Ministry of Justice compiled a list of domestic violence deaths in Saskatchewan between 2005 and 2014 by examining closed files from the Office of the Chief Coroner. The following information was available on most files:

- perpetrator and victim
    - name
    - gender
    - date of birth
    - relationship
    - ethnicity
    - address
- incident
    - date
    - location
    - police service and police identification number
    - type of weapon used
    - witnesses and relationship
- death
    - date
    - location
    - cause
    - contributing factors (e.g., evidence of substance abuse, mental health issues, previous domestic violence)
- other information (e.g., evidence of substance abuse, mental health issues, previous domestic violence)

A spreadsheet detailing this information was created to facilitate the identification of six cases for a pilot of the review process. The following criteria were considered in choosing pilot cases:

- geographic location (urban or rural)
- homicide
- homicide/suicide
- male perpetrator
- female perpetrator
- child victim

Three tools were developed to guide the review: a set of research questions (Appendix C), risk assessment matrix (Appendix D), and a victim consideration matrix (Appendix E).

Review Committees

The Review Panel

A multi-disciplinary Review Panel was selected to collectively demonstrate expertise, knowledge, and skills related to domestic violence and its impact in the following areas:

- Medical issues
- Justice system response in domestic violence cases
- Societal issues related to domestic violence
- Mental health
- Substance abuse
- Child protection.

In the pilot the Saskatchewan Domestic Violence Death Review Panel examined six closed domestic violence death cases where a homicide or a homicide/suicide occurred in circumstances involving persons in an intimate relationship and their families. Examination included determining how the characteristics of the case, actions, and/or responses contributed to the death(s). Additional information from police, health, and social services sources was required to inform the analysis. The Panel used the information provided to make recommendations that reflect systemic gaps, changes, and improvements that would prevent or reduce such deaths in the areas of policy, procedure, program, training, services, and protocols.

As part of the pilot the Review Panel tested a standardized assessment process that used risk factors and victim consideration matrices to examine cases.

Ad Hoc Individuals

Subject matter experts were accessed when questions arose about policies and procedures (e.g., individuals with specialized knowledge in northern issues or mental health diagnoses).

Interpretation Panel

The findings and proposed recommendations were presented to an Interpretation Panel made up of financial and policy representatives from the ministries who respond to situations involving domestic violence in order to provide additional context and understanding.

Appendix B: Cross-jurisdictional Summary

A domestic violence death review brings together community agencies, service providers, and government representatives with expertise in domestic violence to investigate and review homicides and/or homicide-suicides that involve domestic violence. The purpose of the review is to create recommendations aimed at preventing deaths in similar circumstances and reducing domestic violence in general. By conducting a thorough and detailed examination and analysis of the facts within domestic homicide cases, the review strives to develop a comprehensive understanding of why domestic homicides occur and how they might be prevented. The recommendations are created through the examination of the risk factors identified in the cases and the responses to these factors by different community and government systems. The recommendations are generally aimed at public education, professional development in many service sectors, enhanced legislation, better coordination of services and resource development. The importance of these death review teams has been recognized across North America and they have been implemented in other countries including Canada, Australia, New Zealand and the United Kingdom (Wilson & Websdale, 2006)[8].

The first domestic violence death review in North America occurred in San Francisco, California after a 1990 homicide-suicide involving Veena and Joseph Charan (Websdale, 1999)[9]. The results of the investigation identified several key elements that would help to predict and prevent similar deaths. Specifically, it was noted that crucial gaps in service delivery needed to be rectified, such as providing better communication and coordination between government agencies, providing better mechanisms for data collection by institutions investigating domestic homicides, providing better access to services for victims and perpetrators and implementing more thorough training programs for frontline workers.

In Canada, in 2002, the formation of the first Canadian domestic death review committee (Ontario Domestic Violence Death Review Committee - Ontario DVDRC) was in response to recommendations that arose from two separate, major inquests into the domestic homicides of Arlene May and Gillian Hadley by their former male partners. These inquests generated several key recommendations that identified the need for education, training, and prevention programs; coordination of services and sharing information; risk assessment, risk management, and safety planning; modification and reconstruction of justice programs (e.g., bail hearings) and police procedures; conducting further research into domestic violence and homicide prevention; and the formation of a domestic violence death review committee.

---

[8] Centre for Research and Education on Violence Against Women and Children, Western University (2012). **Report of the Risk Assessment, Risk Management and Safety Planning Knowledge Exchange.**

[9] Canadian Domestic Homicide Prevention Initiative (2016). **Brief 1: Domestic Violence Death Review Committees.**

A number of years later other provinces implemented domestic violence death review processes:

- In 2008 the Manitoba Minister of Family Services and Consumer Affairs, the Minister of Justice and Attorney General and the Minister of Labour and Immigration (responsible for the Status of Women) announced the creation of a domestic violence death review process to examine and review domestic homicides in that province. The Manitoba Domestic Violence Death Review Committee was formally established in 2010 and has generated several reports.
- In March 2010 the British Columbia Domestic Violence Death Review Panel conducted a review of 11 domestic homicides from over 100 coroner case files across the province dating back to 1995. Findings and recommendations were published in the 2010 report to the Office of Chief Coroner. In 2016 a second report was presented to the Chief Coroner reviewing aggregated data on intimate partner deaths between 2010 and 2015 within the context of existing legislation, services, intervention and supports.
- New Brunswick formed a domestic violence death review team as an advisory body to the Office of the Chief Coroner. This team commissioned a study on all domestic homicides that occurred in the province between 1999 and 2008 (Office of Chief Coroner, 2012). Between 2010 and 2014 the committee submitted reports on four cases to the Chief Coroner.
- In 2014 Alberta established the Family Violence Death Review Committee. It completed a retrospective ten-year review of 76 cases of domestic violence death and selected six cases for in-depth review. This information was contained in the 2014-15 annual report submitted to the Minister of Human Services.

Recommendations made by domestic violence death review committees are typically classified under common themes such as education and awareness; assessment and intervention; resources; and enhancing system response (Websdale, 1999). Since its inception, the Ontario DVDRC has made recommendations around the importance of risk assessment, risk management and safety planning in domestic violence cases. Specifically, between 2003 and 2009, 72% of the recommendations were targeted at assessment and intervention (Ontario DVDRC, 2009). In their first annual report, the Ontario DVDRC made the following recommendation:

> *There is a need to have appropriate assessment tools available to those who work with victims and perpetrators of domestic violence to better assess the potential for lethal violence in their lives. Correspondingly, once the risk is identified, victims and perpetrators of domestic violence need access to appropriate services and programs. The person at risk requires access to:*
>
> - *a specialized and comprehensive risk assessment by an appropriate agency;*
> - *skilled assistance to engage the victim in developing a safety planning process; and*
> - *risk management, for both the victims and the perpetrator (Ontario DVDRC, 2003, recommendation #10).*

In addition to this general information, specific information was collected on the domestic violence death review process in each province that established an ongoing review process (Table 3).

Table 3: Domestic violence death review processes in Canada

	Ontario	Manitoba	Alberta	New Brunswick
Established	2003	2010	2013	2010
Statute	*Coroner's Act*	Not legislated	*Protection Against Family Violence Act*	
Definition of "domestic violence death"	All homicides that involve the death of a person, and/or his or her child(ren) committed by the person's partner or ex-partner from an intimate relationship.	A death resulting from domestic violence (*The Domestic Violence and Stalking Act* defines 'domestic violence' as an act committed on someone by another person who is cohabiting or has cohabited with him or her in a spousal, conjugal, intimate, family or dating relationship; or is the other parent of his or her child, regardless of their marital status or whether they have ever lived together).	All homicides/suicides and homicides in which the victim was a current or former intimate partner or immediate family member of the person responsible for the homicide. Homicides of people other than the intimate partner that occur in the context of intimate partner violence, or in the midst of a perpetrator's attempt to kill an intimate partner or an immediate family member.	A homicide, a suicide or other death that results from conflict between intimate partners or ex-partners and may include the death of a child or other familial members.
Administration	Office of the Chief Coroner	Report to Attorney General - Justice	Report to Minister of Human Services	Office of the Chief Coroner
Membership	No term Evolves as needed External expertise may be contracted	Advisory Committee and subcommittee working group (government only)	11 appointed by Cabinet Experts in family violence Term unknown	
Coroner/medical examiner representatives	Chair of committee 3 representatives from Office of Chief Coroner	Chief Medical Examiner		Coroner
Justice ministry representatives	Pediatric Death Review Committee Public prosecutions Community Safety and Correctional Services	Victim Services Public prosecutions Probation Services	Community Corrections and Release Programs	Public prosecutions
Other government representatives	Social worker Family Violence Prevention	Family Violence Prevention Program Status of Women	Calgary Domestic Violence Unit, City of Calgary	Women's Equality Department

	Ontario	Manitoba	Alberta	New Brunswick
	Program Correctional Services Canada	office Women's Advisory Council		
Police representatives	Ontario Provincial Police (3) Thunder Bay Police	Winnipeg Police Service RCMP	RCMP Edmonton Police Service Calgary Police Service	Fredericton Police Force
Academia representatives	Western University University of Guelph		University of Calgary	St. Thomas University Muriel McQueen Fergusson Centre for Family Violence Research
Community-based organisations and other representatives	John Howard Society (Toronto) Ontario Network of Victim Services providers	RESOLVE (a tri-provincial family violence research and evaluation network)	YWCA Sherriff King Home, Calgary (women's shelter) Alberta Council of Women's Shelters Native Counselling Services of Alberta Family Law Lawyer Association of Alberta Sexual Assault Services	Eel Ground First Nation Quispamsis (Town of) Fredericton Sexual Assault Crisis Centre Dr. Mary Goodfellow Dr. Barbara Fisher-Townsend
Methodology				
Cases reviewed	Any case after <u>all</u> criminal justice system proceedings including appeals concluded May be done before or without a coroner's inquest	No cases older than 2006 No longer before the courts		Commissioned analysis of deaths (1999-2008) as baseline
Access to information	Only accesses information available to Coroner Chair assigns files to reviewers Appears to be paper-based (i.e., no interviews)	Paper-based and interviews Membership split to balance privacy issues	Legislation allows access to all information (including personal and health)	
Procedure	Chair from Office of Chief Coroner Regional coroner identifies case Risk factors identified in cases		3 staff review cases researchers assigned	

	Ontario	Manitoba	Alberta	New Brunswick
Budget	Within coroner's budget Annual cost $14-26K 20% of 2 FTEs	Within regular ministry budget – no separate budget	Within ministry budget 3 researchers and .75 FTE manager from Ministry	
Recommendations directed to	Agencies given one year to respond - no legal obligation	Attorney General - intervention and prevention strategies	Ministry of Human Services	

Other Domestic Violence Death Review Processes in Canada	
British Columbia	- One-off committee in 2010, examined 11 cases, made recommendations - Has regular Death Review Panels, average cost per Panel of $2-3,000 to cover travel, meeting and printing costs - Produced a retrospective study of intimate partner deaths 2010-2014 - No additional staffing costs incurred
Quebec	- One-off committee in 2011 - Examined the overall situation in Quebec rather than reviewing any specific cases
Northwest Territories	- Tabled a motion to create a DVDRC under the authority of the Chief Coroner March 2015

Appendix C: Information for the Review Panel

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 domestic violence in the relationship?
13. What information was available to / shared among agencies? What interagency communication took place?

Services and Supports

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)
22. What changes are required to legislation, intervention, prevention, interagency communication?

Appendix D: Risk Factor Matrix and Descriptions

Perpetrator = The person who committed the domestic homicide(s). Please note that the perpetrator may not be the primary aggressor in the relationship.
Victim = The person who was killed in the domestic homicide. This includes intimate partners or ex-partners and/or other familial members who die as a result of the incident. Please note that the victim may not be the primary or usual target of the perpetrator.

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 his 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 include 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.
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, arms, 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., 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).
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.
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 disparity of couple: An intimate relationship where partners are significantly older or younger. The disparity is usually nine or more years.
20. Presence of step children 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 is one that knows the perpetrator best and can accurately gauge his level of risk. If the woman 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".
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.
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 actually 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 or not 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 or not 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 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 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 his 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.*
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 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., she 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 subtler with beliefs that women are only good for domestic work or that all women are "whores".

Appendix E: Victim Considerations

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/maltreatment.

2. Victim had history of victimization from persons other than family of origin members:

- 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, 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 that the relationship would improve, the perpetrator involved in an abuse prevention or addictions 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: Further Information on Saskatchewan's Legislative and Policy Response to Domestic Violence

	Date	Name	Description	Outcome
Legislation	1989-1990	*The Child and Family Services Act* Chapter C-7.2 of the Statutes of Saskatchewan	Promote the well-being of children in need of protection by offering services that are designed to maintain, support, and preserve the family. Child deemed to be in need of protection when he/she has been exposed to domestic violence or severe domestic disharmony that is likely to result in physical or emotional harm to the child (*The Child and Family Services Act, 2006*).	Protection of children with perhaps removal of the children from the situation of intimate partner violence.
	1995	*The Victims of Interpersonal Violence Act* Chapter V-6.02 of the Statutes of Saskatchewan, 1994 (effective February 1, 1995) as amended by the Statutes of Saskatchewan, 2010, c.15; and 2015, c.24	Assist victims of domestic violence; 3 components of the Act: a) Emergency Intervention Order (EIO) - granted when interpersonal violence occurs to provide immediate protection to the victim; may include granting the victim exclusive ownership of the residence, removing the offender from the residence, allowing the victim or offender to return to the residence to retrieve personal belongings on a specific date and time, preventing the offender from communicating with the victim including electronic communication, preventing the offender from attending at or near or entering any specified place that is attended by the victim or other family members,	Two formal program evaluations. Amendment to the Act (2015) included changes to enhance the types of circumstances that constitute IPV and other items for the Designated Justice of the Peace to consider when deciding to grant an order (EIO). Harassment and deprivation of necessities was

			including the residence, property, business, school or place of employment, and any other provisions necessary to provide immediate protection to the victim. b) Victim's Assistance Order - used in non-emergency situations and may include granting the victim ownership of the residence, restraining the offender from attending any specified place that is regularly attended by the victim, preventing the offender from any form of communication with the victim, removing the offender from the residence, allowing the victim to return to the residence to retrieve belongings, requiring the offender to pay victim compensation (e.g., loss of earnings), allowing either the offender or victim temporary possession of personal property (e.g., vehicle), preventing the offender from taking, converting, or damaging property that the victim may have an interest in, recommending counselling, and requiring the offender to post any bond for securing compliance with the order, and finally, any other provisions considered necessary. c) Warrant Permitting Entry - issued by a designated justice of the peace and is to be used when a person cannot act on their own. The order may only be made when the potential abuser has refused to give a police officer access to a	added to section (2) (e.1) outlining what constitutes IPV within this legislation. In section 3 (2) of the Act additional factors were added to the list of factors that the JP should consider when determining to grant an order. They are: the exposure of any child to IPV; a recent change in circumstances for the respondent such as loss of employment or release from incarceration; controlling behaviour by the respondent; and a particular vulnerability of the victim. In section 3 (2.1)(NEW) a number of factors were added that must not preclude a designated JP from making an order (EIO).

			person who may be a victim of interpersonal violence. The warrant authorizes a police officer to enter, search and examine the place and any connected premises, assist or examine the victim, and seize anything that may provide evidence of domestic violence (Victims of Interpersonal Violence Act, 1995 as amended by the Statutes of Saskatchewan, 2010, c.15; and 2015, c.24).	
Policies	1997	Victims of Crime Regulations Chapter V-6.011 Reg 1	Financial compensation may be granted for loss which result from a victim's injury or death including medical, dental, chiropractic, and other services provided by health care professionals, loss of earnings, funeral costs, cost of counselling, and any other expenses considered reasonable *(Victims of Crime Act, 1997).* The legislation was amended in October 2014 to allow for compensation for counselling for children exposed to IPV where a parent has reported the incident to police and applied for compensation whose injury is the result of domestic violence.	Financial compensation for victims of violent crime.

	2006	Declaration of Principles Respecting the Treatment of Victims of Crime – updating the Victims of Crime Act, 1995	Individuals working within the justice system shall: 1) treat victims with courtesy, compassion, and respect 2) take measures to minimize inconvenience to victims 3) consider the safety and security of victims at all stages of criminal justice process and take appropriate measures to protect victims from intimidation and retaliation 4) provide information to victims about the justice system, status of investigations, and progress and outcome of proceedings and status of offender in the correctional system 5) provide victims with information regarding available victim services and programs and obtaining financial reparation 6) consider the views and concerns of victims in justice processes 7) take into account diversity in the development and delivery of programs and services.	