Family Violence Death Review Committee

2015/2016 Annual Report
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Message from the Chair

In Alberta, between January 1, 2015 and December 31, 2015, there were 15 deaths due to family violence in Alberta. Alberta’s Family Violence Death Review Committee reviewed each of these deaths, and is currently completing an in-depth examination of six cases. Cases are reviewed by focusing on the identification of trends, risk factors and systemic concerns. The Committee completes in-depth examinations of individual cases and makes recommendations to the Minister of Community and Social Services to help improve services and supports and to prevent future tragedies. In 2015, the Committee released its first Case Review Public Report, which made a number of recommendations to prevent family violence, and to bring the issue of family violence further into the public’s awareness.

In-depth case examinations are rigorous processes, which require dedicated commitment, considerable expertise and time and effort from the Committee members and support staff. The Committee has also benefited greatly from supportive relationships with Government of Alberta ministries and community partners; these relationships are essential to the collective ongoing work of addressing family violence. The Committee would like to thank the Ministries of Health; Children’s Service’s; Community and Social Services; and Justice and Solicitor General. They would also like to thank the Alberta Association of Chiefs of Police and Alberta’s police services, throughout the province, for their excellent work, and for their help, support and cooperation.

As Albertans, we all have a responsibility to prevent family violence, to protect those who need our help and to promote healthy relationships. When you are in a time of need, it is important to seek help. Family, friends and professionals are there to help you. We must continue to make the determined efforts to maintain and continue to create the capacity for all Albertans to have access to all the resources and supports they need when and where they need them. As Albertans we have demonstrated time and time again that, not only do we have a responsibility to help, we have the strength, fortitude and ability to help others in need and to prevent family violence.

Dr. Allen Benson, LLD (Hon.)
Chair
Executive Summary

Alberta’s Family Violence Death Review Committee (the Committee) is an internal arm’s-length, multi-disciplinary, cross-sector group reporting directly to the Minister of Community and Social Services. The Committee derives its authority from the Protection Against Family Violence Act (PAFVA). The Committee has the responsibility to review family violence deaths and make recommendations related to program, policy and service delivery for the prevention of family violence.

First, the 2015/2016 Annual Report provides an overview of the Committee membership, structure and accountability. Secondly, it explains how case reviews are completed, the processes used to complete the reviews and the resulting recommendations. It also includes the results of the first Case Review. Finally, provided is a detailed examination and information of family violence deaths, which occurred in Alberta, from 2008 to 2015.

Last year’s Annual Report (2014/2015 Annual Report) defined the goals for a solid foundation. This year’s report provides more case specific information about the review process and how case reviews are conducted. This edition begins to articulate the foundation that we are building as we move forward.

Introduction and Overview

In 2009, the Ministry of Community and Social Services led a cross-ministry committee to establish a Family Violence Death Review Committee. Subsequently, a working group was formed with community partners and police agencies, to provide options for an operational structure for the Committee in Alberta.

In 2013, legislation was passed that established the Committee under the Protection Against Family Violence Act (PAFVA) [http://www.qp.alberta.ca/documents/Acts/p27.pdf].

The Committee became operational in February 2014. The Committee provides advice and makes recommendations, through the Minister of Community and Social Services, pertaining to the reduction of family violence through the examination of family violence deaths. The Committee reviews cases in a manner that is confidential and makes recommendations – without blame – for systems and societal change. The scope of the work includes examinations of:

- all homicides and homicides/suicides where the victim was a current or former intimate partner of the person responsible for the homicide; and
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.

The Committee is guided by a Code of Conduct and a Mandate and Roles document, http://alberta.ca/ags-ministries.cfm#Human.

Committee Membership

The Committee is a multi-disciplinary group of 11 family violence experts. Members represent various sectors, including legal services, law enforcement, sexual assault services, victim advocacy and research/academia. The members of the Committee are:

- Dr. Allen Benson, LLD (Hon.), Chair (CEO of Native Counselling Services of Alberta)
- Trent Forsberg (Inspector, Edmonton Police Service)
- Gary Gibbens, MA Psychology (Mental Health/Domestic Violence Specialist)
- William Hogle, QC (Family Lawyer)
- Sylvia Kasper, QC (Retired Crown)
- Donnan McKenna (Inspector, RCMP)
- Cliff O’Brien (Inspector, Calgary Police Service)
- Karen Pease (Community and Victim Advocate)
- Kim Sanderson (Assistant Deputy Minister of the Correctional Services Division, Alberta Justice and Solicitor General)
- Debra Tomlinson (CEO of the Association of Alberta Sexual Assault Services)
- Lana Wells (Associate Professor, University of Calgary, Faculty of Social Work)

Organizational Structure

The Committee reports directly to the Minister of Community and Social Services. The following diagram provides a view of the organizational structure since inception.
Case Reviews – Recommendations

Types of Reviews
The Committee completes two types of case reviews, a Summary Report and an in-depth Case Review Report. The Summary Report is a synopsis that is completed soon after the Committee is informed of a family violence death. In preparing the report, the Committee utilizes available information to identify circumstances, eligibility and system involvement. In the last year, 13 Case Summary Reports, that represented 15 deaths, were completed.

Cases are eligible for an in-depth review only after the police investigation is completed and/or all criminal matters are finalized. The cases selected are chosen based on specific criteria, which include:
- reviewing the most recent eligible cases;
- those representing a diversity of ages and other factors;
- geographical locations;
- the status of relationships; and
- ethnicity.

Once an in-depth case review is completed, a publically releasable version is presented to the Minister of Community and Social Services. This version of the report provides very little identifiable information, focusing on the recommendations, as legislation prohibits disclosing the names of the individuals involved or providing any identifying information about the individual whose death is the subject of the review.

Recommendations from the First In-depth Case Review Report

1. The Alberta government amends the Occupational Health and Safety Act and Code to recognize and include family violence as a workplace hazard. Family violence would be defined as it is in the Protection Against Family Violence Act and include direct family violence (where the family violence is at the workplace) and indirect family violence (where the family violence is outside of the workplace), where it directly affects the workplace through employee performance or by creating an unsafe work environment. When family violence as a workplace hazard occurs, policies, procedures, monitoring and accountability mechanisms must be implemented. Collaboration with police services is recommended to develop and implement such mechanisms.
   a. The Alberta government, in consultation with key stakeholders, will develop training, educational and public awareness materials for employers, employees and the public that addresses family violence as a workplace hazard.
2. The Alberta government develop and include a family violence training component into the mandatory Alberta Basic Security Course, offered through Justice and Solicitor General, to ensure that all security workers licensed in Alberta have this training. In addition, it is recommended that all existing licensees and individuals renewing a license be required to complete this training.
   a. The Alberta government work with post-secondary institutions to develop and include family violence response and reporting components into their diploma and certificate programs related to law enforcement, security and investigations.

3. The Alberta government distributes family violence materials at points of public contact.
   - Alberta Registries – Materials provided to individuals when obtaining an application for a marriage licenses, birth certificates, driver’s license applications and renewals, vehicle registration renewals and replacement documentation requests. Family violence materials would also be available online in cases of online applications and renewals.
   - Alberta Family Justice programs and Mediation/Dispute programs targeted towards familial matters and dissolution of intimate partner relationships (married and common-law) and to all individuals applying for protection orders.
   - For people attending court-ordered treatment for mental health and/or addictions treatment.
   - Through Health and Alberta Health Services programs (e.g. Primary Care Networks).
   - To all social service agencies, especially those which partner with the Alberta government, to provide social programs and services to immigrants.

4. The Alberta government, in collaboration with agencies and community partners which serve immigrants, work to identify and enhance existing family violence strategies and educational materials specifically targeted towards new Canadians and newcomers to address key obstacles, such as language barrier, isolation, stigma and cultural differences that prevent new Canadians from seeking assistance regarding family violence issues.
Process for Case Reviews

Family Violence Death Review Process

Receive Notification of Death

Create a Summary Report of the Case

Committee Assigns Sub-Committees Cases For In-Depth Review

Decide Eligibility (Eligible = Legal and Police Investigative Work is Complete)

Sub-Committees Draft Recommendations and Finalize a Case Report

Committee Reviews And Approves Final In-Depth Case Report And Publically Releasable Report

Committee Provides Reports to the Minister of Community and Social Services
Method for In-depth Case Reviews

The structure of the Committee allows more than one case to be reviewed at a time by using three sub-committees. This allows the Committee to work efficiently and effectively as the sub-committees can assist one another as requested, and where an ex-officio member is required, he or she becomes a member of the sub-committee.

In-depth case reviews are “paper reviews,” where information is requested from Justice and Solicitor General; Health; Children’s Services; Community and Social Services; and police services. Information is also requested from other sources, as determined through analysis of the case. When conducting in-depth reviews, the Committee identifies the presence or absence of systemic issues – and makes recommendations to the Minister for interventions to reduce and prevent family violence deaths. The Committee’s recommendations must meet the SMART criteria by being Specific, Measurable, Achievable, Realistic/Reliable and Timely.

In-depth Case Reviews

Three in-depth reviews are being finalized and scheduled to be completed by the next 2016/17 annual reporting period. During this reporting period, one in-depth Case Review Report has been completed. Particulars from that review are:

Incident


Analysis

Up to and at the time of the death, there was very limited intervention in response to the escalation of incidents in the relationship. This reflected reluctance by the individuals to involve outside systems.

Best Practices

Several best practices identified in this case include:
- Referral of the offender to an employee assistance program for psychological and legal assistance;
- Attempts to ban the offender from the victim’s place of employment; and
- Police de-escalation by having the couple limiting their contact with each other.
In order to formulate recommendations, three main themes were examined:
- The role and influence of culture in the responses of the victim and offender and their respective family and support networks;
- Services available to assist families who are relatively new to Canada; and
- The role of the employers and employees in identifying and intervening where there are behaviours indicating possible family violence.
Alberta Statistical Overview

From January 1, 2015 to December 31, 2015, there were 13 family violence incidents that resulted in 15 family violence deaths in Alberta. In total, from January 2008 to December 2015, there were 132 family violence deaths in Alberta. Fifty-eight per cent of victims were killed by someone who was their current partner (spouse/common-law/current boyfriend/girlfriend); 17 per cent were killed by a former intimate partner (ex-spouse/ex-common-law/ex-boy/girlfriend); and another 15 per cent were killed by a family member. Ten percent of the victims were bystanders who were unrelated or unknown to the perpetrator. Seventy-two per cent of the victims are between the ages of 20-49.
Manner of Deaths, Including Perpetrator Suicide, 2008-2015

Manner of Deaths: 2008 - 2015
Including Perpetrator Suicides

<table>
<thead>
<tr>
<th>MANNER</th>
<th>Single Homicide</th>
<th>Multiple Homicide</th>
<th>Single Homicide/Suicide</th>
<th>Multiple Homicide/Suicide</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Female</td>
<td>45</td>
<td>4</td>
<td>14</td>
<td>17</td>
<td>81</td>
</tr>
<tr>
<td>Male</td>
<td>19</td>
<td>2</td>
<td>16</td>
<td>15</td>
<td>52</td>
</tr>
<tr>
<td>Total</td>
<td>64</td>
<td>6</td>
<td>30</td>
<td>32</td>
<td>132</td>
</tr>
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## Percentage of Deaths by Sex, 2008-2015

### Year over Year Comparison, 2008 - 2015

![Graph showing percentage of deaths by sex and year from 2008 to 2015.]

### Detailed Number of Deaths by Gender and Incident Type 2008-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Single Homicide</th>
<th>Multiple Homicide</th>
<th>Homicide/Suicide</th>
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<th>Total</th>
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<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>2008</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>5</td>
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<tr>
<td>2009</td>
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<td>0</td>
<td>4</td>
</tr>
<tr>
<td>2010</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2011</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>2012</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>3</td>
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<tr>
<td>2013</td>
<td>3</td>
<td>5</td>
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<td>0</td>
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<tr>
<td>2014</td>
<td>3</td>
<td>6</td>
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<tr>
<td>2015</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>2</td>
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<tr>
<td>Total</td>
<td>19</td>
<td>45</td>
<td>2</td>
<td>4</td>
<td>21</td>
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### Victim’s Relationship to Perpetrator at Time of Death, 2008-2015

#### Victims relationship to perpetrator at time of Death

<table>
<thead>
<tr>
<th>Relationship to Perpetrator</th>
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<th>Total</th>
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<tbody>
<tr>
<td>Spouse</td>
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<td>26</td>
</tr>
<tr>
<td>Common-Law</td>
<td>17</td>
<td>6</td>
<td>23</td>
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<tr>
<td>Current Boy/Girlfriend</td>
<td>12</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Separated Spouse</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Separated Common-Law</td>
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<td>0</td>
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<tr>
<td>Ex-Spouse</td>
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<td>8</td>
</tr>
<tr>
<td>Ex-Common-Law</td>
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<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ex-Boy/Girlfriend</td>
<td>8</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Family Member</td>
<td>9</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>Unrelated/Bystander</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>81</td>
<td>31</td>
<td>112</td>
</tr>
</tbody>
</table>

#### Table:

<table>
<thead>
<tr>
<th>Sex</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number</td>
<td>81</td>
<td>31</td>
<td>112</td>
</tr>
<tr>
<td>Percentage</td>
<td>72.3</td>
<td>27.7</td>
<td></td>
</tr>
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</table>
*The majority of the victims were between the ages of 20 to 49 (72 per cent). Victims under the age of 19 accounted for 11 per cent of family violence deaths, while those 50 years of age or older accounted for 15 per cent of all family violence deaths. Two percent of victims’ ages were unknown.
Conclusion

The Committee continues to move forward with its mandate to review family violence deaths and to provide advice and recommendations to the Minister with respect to the prevention and reduction of family violence. The Committee’s second Annual Report provides information on family violence deaths that occurred from 2008 to 2015 and gives an overview of the Committee’s current operational structure. Moreover, the report highlights and provides a summary of the findings and recommendations of the Committee’s first in-depth case review that was released in November 2015.

The second Annual Report illustrates how the Committee is organized and conducts its work. The Committee completes two reports: the Summary Report (a synopsis report) and an in-depth Case Review Report. The Summary Report is completed after the Committee receives notification of a family violence death. It typically contains information that identifies the circumstances surrounding the death and the manner of death. The report assists the Committee in determining whether a case is eligible for an in-depth review. The criteria for selecting cases for in-depth reviews includes the diversity of ages, geographical locations, status of relationships and ethnicity.

When a case is selected for an in-depth review, the Committee examines different systems that the victim and perpetrator had contact with in the province (such as health, education, justice, etc.) in order to see what types of involvement there was with these systems, how often they were used, what recommendations/outcomes there may have been, etc. Once the review is complete, the Committee provides the Minister with a Publically Releasable Case Report that contains findings and recommendations. The Committee completed its first Case Review in November 2015.

The four recommendations from the first review were that the Alberta government:

- amend the Occupational Health and Safety Act and Code to recognize and include family violence as a workplace hazard;
- develop and include a family violence training component into the mandatory Alberta Basic Security Course;
- distribute family violence materials at key points of public contact; and
- collaborate with immigrant-serving agencies and community partners to identify and address key obstacles that prevent new Canadians from seeking assistance with family violence issues.

As the Committee moves forward, it will continue to build on the accomplishments of the last year and to refine its case review process to increase operational efficiency and effectiveness. In addition, through case reviews, collection, and analysis of data on family violence deaths, the Committee will continue to contribute to the knowledge base, increase awareness of family violence issues and provide solutions that contribute to the prevention and reduction of family violence and family violence deaths in Alberta.