



**Family Violence Death Review Committee:  
Case Review Public Report No. 8**

**July 2019**

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## Incident

A man was shot in rural Alberta.

## Background

The man, a father, was shot in self-defence as a mother and her children were trying to protect themselves. The family had experienced years of severe physical and emotional abuse, including regular death threats from the father.

The father had an extensive criminal record involving violent crimes, and had been released into the community on bail and was awaiting trial at the time of the incident.

## Key Findings / Analysis

### Main Themes That Emerged

Individuals and agencies from the family's community that had contact with the family were aware of the violence perpetrated against the mother and her children, yet the perpetration of violence against them rarely received the attention of the proper authorities, especially considering the frequency and severity of abuse the mother and children suffered.

In Alberta, if a person has reasonable and probable grounds to believe that a child is in need of intervention they must report the matter to a director under *the Child, Youth and Family Enhancement Act*. Child Intervention Services and local authorities, including the police, should be contacted if anyone has concerns that a child or youth has been abandoned, is being neglected, physically or emotionally injured, or sexually abused, or subjected to cruel and unusual treatment or punishment by their parent or guardian.

In this case, the information and records reviewed indicate that the ongoing violence perpetrated against the mother and children had been normalized, and as a result, appears not to have been reported to the proper authorities by the systems which had contact with the family.

Additionally, continuity of services and follow up for the mother and her children was also impacted by jurisdictional barriers, which led to an overall lack of communication between service providers.

### Challenges Accessing Services in Rural and Remote Communities

Characteristics that can lead to victims of domestic and family violence in rural and remote communities being more vulnerable include: physical/geographical isolation, social isolation, under-resourcing of support services, being unable to seek locally-based professional advice due to conflict of interest (e.g. where there is only one local legal practitioner), lack of privacy, lack of anonymity, heightened visibility, transportation costs and the prevalence of guns. All of these factors can compromise the options for people in rural and remote areas to seek help and escape domestic and family violence.

Access to supports and services is limited for those living in rural and remote communities, and often requires travelling long distances to obtain necessary services. Ensuring that services and supports are available to victims of domestic and family violence who live in geographically isolated areas is challenging where service availability and accessibility are limited.

Victims of family violence also have additional social and economic challenges to overcome. Seeking supports and services can mean that a person must leave their home and familiar surroundings, including their social supports, close family and friends to be safe. In the absence of dedicated, resourced and accessible services to support victims or respond to perpetrators of domestic and family violence, it is likely that opportunities for interventions are missed, and the victims of domestic and family violence who are attempting seek help or to leave an abusive relationship may not be able to access necessary supports in a timely manner.

### **Family and Friends as Informal Supports**

Extended family, friends and community members were aware of the abuse that this family suffered, but did not appear to intervene, or to assist the family with seeking family violence services. This meant that the family was left on their own with very limited resources.

It also appears that none of these informal supports contacted the police, law enforcement or child intervention authorities to alert them that the family were in danger, in spite of being aware that the father repeatedly threatened to kill his wife and his family, and demonstrated the means to do so, with firearms stored in the home.

Records indicate that the family came to the attention of the authorities only after some of the children sought help from RCMP after being seriously injured by their father, only months prior to the father's death.

### **Key Systems for Review**

In the years prior to the incident, the mother had contact with the police, health services, women's emergency shelter workers, Alberta Child Intervention Services (CIS) and the Delegated First Nation Agency (DFNA) providing intervention services on reserve. She accessed each of these systems during periods when the physical abuse and threats from the father had been at their most extreme.

#### Health

The mother and children were frequent visitors to the doctor and emergency room. The mother had been treated for severe injuries, many of which were unmistakably the result of physical abuse. The children were also treated for various injuries commonly indicative of abuse. There is no information from health, police, CIS or the DFNA records indicating that these incidents were reported by medical staff to the proper authorities for intervention and/or follow-up, or that the mother and children were identified as family violence victims and referred to an appropriate family violence service provider.

Emergency departments, physicians and nurses are in a critical position to provide support and appropriate referrals to victims of family violence, and to report suspected abuse to the authorities when victims are seeking medical attention and presenting with abuse related injuries.

### Shelter Services

The mother and her children went to a women's emergency shelter twice within a nine year period. Shelter staff are credited with reporting the family's situation to CIS, and with assisting the family with obtaining appropriate supports and services.

### Police / Criminal Justice

Months before the father's death, RCMP arrested the father for assaulting and threatening to kill the children, after the children contacted RCMP for protection. The father was granted bail, which police vigorously opposed, on the grounds that the father posed a significant threat to the family. As part of his bail condition, a no-contact order was imposed to limit the father's contact with his wife and children.

Despite the father's significant violent criminal history and threat of harm to the mother and children if the father were released, the courts still granted the father bail. Once released on bail, the father went to live with a relative, approximately an hour away. He repeatedly violated the no contact order, constantly telephoning the mother and threatening to harm her family if she did not visit with the children. The mother did not report the breaches to the RCMP.

Recidivism among offenders is relatively common and often occurs soon after the previous offence (Kingsnorth, 2006; Gondolf, 2000; Hanson, Helmus, & Bourgon, 2007; Hendricks, Werner, Shipway, & Turinetti, 2006; Ventura and Davis, 2004) particularly among those who have an extensive history of violence and reoffending. Bail restrictions alone are often not enough to keep victims safe, as in this case, where the bail conditions were repeatedly violated.

The circumstances surrounding this family demonstrate the need to identify whether criminal justice system responses can be strengthened to ensure that sufficient consideration is given to the appropriate assessment and management of risk by violent repeat offenders of family/domestic violence, particularly in cases where the perpetrator has an extensive and violent criminal record history, or in cases where there are other factors present that are indicative of a heightened risk of harm.

### Child Intervention Services

Over an approximately nine year period, CIS had been alerted on several occasions by shelter staff and police to the abuse of the mother and children. Limited information was available regarding whether intervention actions were taken or services provided by CIS or the DFNA, what the extent of the interventions were, or the outcome.

Considering the small size of the community where the family lived and the proximity of the families that live there, coupled with the longstanding severity and frequency of abuse that occurred in the home, there appears to have been very limited involvement of child intervention authorities.

Shortly after the father's arrest and in the months prior to his death, there was no information available indicating whether CIS or the DFNA provided the family with safety strategies or whether supports had been put in place to help improve the family's safety over the long-term. Though incarceration provides an immediate respite for victims by removing the perpetrator and reducing the immediate risk of harm, it is not effective as a prevention strategy and does not necessarily reduce recidivism rates on its own (Dunford, 1992; Dunford, Huizinga, & Elliott, 1989; Hanson and Wallace-Capretta, 2006).

### Education

Information reviewed for this case suggests that the children attended school in their community; however, school attendance records could not be obtained. It could not be confirmed whether teachers at the school noticed signs or had information of the children being abused.

The school division overseeing the children's school has a clear administrative policy on the duty to report child abuse, and references section 4(1) of the *Child, Youth and Family Enhancement Act*, identifying the responsibility to report children in need of intervention. Under the school division's policies, staff suspecting abuse or neglect are required to fulfill their legal obligation and immediately report suspected child abuse or neglect to CIS, informing the Principal once the report is made. It is unknown whether teachers or school officials reported the children's situation to CIS, the DFNA or police, as records were not available.

### Lack of Coordination Between Service Providers

There is no indication among the agencies that were notified of the family's situation that there was a coordination of services to assist the family. Records indicate the majority of service providers acted largely on their own, without consultation among other agencies, and without involving police.

Had the agencies coordinated their efforts or worked together, more awareness of the potential danger to the family would have been evident, and additional measures could have been put in place to assist the family. It is also unknown whether any agency was monitoring the father's court appearances or had been in contact with police to determine what release conditions had been placed on the father in the month prior to his death.

## Recommendations

The Family Violence Death Review Committee (FVDRC) would like to commend the professional conduct and timely response by RCMP in this case. Their response resulted in the immediate assistance and prevention of further harm and danger coming to the children. Such conduct and response represents the preventative and forward looking response that is a best practice in policing. The FVDRC would also like to recognize the work of the women's emergency shelter staff, and their work to coordinate services to assist the family.

1. To the Ministry of Alberta Health and Alberta Health Services:

- a. The FVDRC recommends that Alberta Health and Alberta Health Services require hospitals and medical professionals to complete family/domestic violence screening at all health care facilities and centres.
- b. The FVDRC also recommends that Alberta Health and Alberta Health Services work in concert with Alberta Community and Social Services to make available training for medical staff and professionals that addresses the importance of screening for abuse in clinical settings, and that the training on screening is made part of all employees' annual training requirements.
- c. The FVDRC recommends that Alberta Health and Alberta Health Services expand the best practice model of the Calgary Domestic Violence Coordinator to be scaled up to the provincial level.

2. To the Ministry of Alberta Education:

All teachers in Alberta have a responsibility to report abuse or suspected abuse of children to the proper authorities. It is recommended that Alberta Education work with Alberta School Boards to educate members of the duty to report under Alberta's *Child, Youth and Family Enhancement Act*.

- a. The FVDRC recommends that Alberta Education work with Alberta educators, school boards and divisions in the province to develop a consistent policy which outlines a clear process for where and how to report suspected child abuse/and or neglect and the professional sanctions imposed on those who fail to act.

### **Past Recommendations That Apply to This Case**

As this case shared similar circumstances with Case Four, the FVDRC recommends the Government of Alberta take steps to implement, regularly audit and report publicly on the following recommendations that were previously stated in Case Four.

1. Alberta Children's Services, in partnership with Indigenous expertise in child welfare, develop an online training tool for staff of all agencies that work or deal with Indigenous communities in order to increase the knowledge and skills required to respond to the effects of intergenerational trauma and the residential school system on Canadian Indigenous individuals, families and communities.

The ministry must make services and supports available to Indigenous persons working in agencies to ensure that they also have the supports available to them to heal from the trauma they have experienced in their lives so that they are healthy and effective community leaders.

The ministries of Alberta Advanced Education, Alberta Children's Services and Alberta Indigenous Relations, in partnership with Indigenous expertise in child welfare, work with post-secondary institutions to develop, implement and evaluate core curricula for all social services disciplines on the history of colonialism in Canada; and the effects of intergenerational trauma on Indigenous individuals, families and communities.

2. Government of Alberta identify and increase support for successful programs aimed at reducing family violence in Indigenous communities. Programs must be community-based, culturally relevant, led by Elders and incorporate a collaborative community development approach. The lessons learned need to be disseminated and shared.
3. In partnership with Indigenous expertise in child welfare, Alberta Children's Services must ensure that child welfare standards are adhered to when dealing with Indigenous families and communities. The ministry must regularly audit and evaluate interventions and work with relevant Indigenous partners and communities to improve and enhance practice standards and risk assessment tools to ensure child welfare practice standards are being complied with.
4. Taking into consideration the history of colonialism and the effects of intergenerational trauma, it is recommended that the Government of Alberta, in collaboration with relevant Indigenous partners, develop an action plan to prevent family violence in Indigenous communities in Alberta, with the action plan focusing on the root causes of family violence in Alberta's Indigenous communities. The action plan needs to complement and inform the provincial framework to end family violence and be published and be made publicly accessible.
5. Given the findings from the Truth and Reconciliation Commission, and recent reports and recommendations by the Auditor General of Alberta and the Office of the Child and Youth Advocate regarding child welfare practice in Indigenous communities, the Committee recommends that the Government of Alberta engage the federal government with the goal of adequately resourcing designated First Nation's agencies in Alberta.