Domestic Homicide Policy Responses in Canada:
Exploring the Diversity of Models and their Potential for Tertiary Prevention

By

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Abstract

Despite significant gains in research and programming, domestic violence persists, with domestic homicides remaining a particular concern. Yet, very little has been written about the administrative and policy responses that exist to combat domestic homicide. In Canada, inquiries, inquests, Domestic Violence Death Review Committees, and other models are increasingly being recognized as important policy responses following an intimate partner death. To assess their potential for tertiary prevention, this thesis examines models of inquiry adopted in Ontario, Manitoba, New Brunswick, and British Columbia, using secondary data analysis of relevant literature and reports as well as qualitative interviews with 11 respondents with expertise in one or more of the models. After considering the strengths and limitations of each model of inquiry, the main conclusion drawn is that the models work in complementary fashion such that, in combination, they offer a path forward in combatting the serious problem of domestic homicide.

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Finally, I would like to acknowledge all of the women who have died as a result of domestic homicide. It is my sincere hope that we may continue to learn from their deaths to prevent more families from experiencing the same pain and loss.

> "We speak for the dead to protect the living."
> (Motto of the Ontario Office of the Chief Coroner)

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Introduction

The past thirty years have seen much growth and expansion in the area of domestic violence research and programming.[1] Feminist activists have been successful in their efforts to eliminate long-held beliefs that this form of violence is a private matter by lobbying to increase its political profile and raise public awareness. Although this activism has led to the establishment of much-needed social programs and significant increases in services for families affected by domestic violence, the issue of domestic violence persists throughout Canada. Sixty-seven percent of all Canadians report that they personally know at least one woman who has been physically or sexually assaulted (Canadian Women's Foundation, 2014). While domestic violence and domestic homicides[2] have been an area of concern for feminist theorists, researchers, activists, and policy makers for decades now, one area has not received enough attention. Very little has been written about the administrative and policy responses following a domestic homicide, leaving a significant gap in the literature. Domestic Violence Death Review Committees (DVDRCs), public inquiries, inquests, in-depth reports, and other models are increasingly being recognized as important policy responses following a domestic homicide. The purpose of this thesis is to examine these models of inquiry with a focus on their potential for tertiary prevention.

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[1] As research in this field has expanded, so has the terminology. Early documents use the term 'wife abuse'; however, gender-neutral terms such as 'intimate partner violence,' 'spousal abuse,' 'family violence,' 'domestic violence,' and 'partner violence' have become favoured in recent years. This paper will use the term 'domestic violence' to refer to violence occurring between married, dating, cohabitating, separated, or divorced partners. At times, however, other terms may be used to remain consistent with the language used by other writers.

[2] As with domestic violence, 'domestic homicide' has a variety of terms. This study will use the term 'domestic homicide' to refer to all homicides occurring between married, dating, cohabitating, separated, or divorced partners and will include cases of murder-suicide unless otherwise noted.

Domestic Violence

Despite the development of a continuum of services, domestic violence persists, with women being the predominant victims of intimate partner violence. In 2015, there were 15,055 domestic calls for service[3] in Winnipeg, and domestic disturbances were the top event reported to police that year (Winnipeg Police Service, 2016: 19, 25). Statistics Canada collects data on domestic violence through police-reported data, the Transition Home Survey, and the General Social Survey on Victimization. One limitation of police data measurement is that it only 19 percent of spousal violence victims report these incidents to police (Statistics Canada, 2016: 10). However, recent reports released by Statistics Canada (Sinha, 2013; Statistics Canada, 2016) highlight the continued presence of violence in intimate partner relationships. "In 2014, there were about 19.2 million Canadians who had a current or former spouse or common-law partner. Among them, about 760,000 or 4% reported having been physically and/or sexually abused by their partner during the preceding five years" (Statistics Canada, 2016: 5). While domestic violence may be perpetrated against both men and women, women are nearly four times more likely than men to be the victim of both spousal and dating violence. The rate of police-reported intimate partner violence for women is 542 victims per 100,000 compared to a rate of 139 male victims per 100,000 men (Sinha, 2013: 20).

Although domestic violence is a gendered crime, both women and men are assaulted. However, intimate partner violence against women is quite different from intimate partner violence against men. This is true in terms of the severity of the violence,

[3] "Events where the accused and victim are in a current or past domestic relationship" (Winnipeg Police Service, 2016: 31).

where the victimization occurs, and the types of violence (Johnson and Dawson, 2011; Sinha, 2013). For instance, Statistics Canada (2016: 7) reports that "Women were twice as likely as men to experience being sexually assaulted, beaten, choked or threatened with a gun or a knife (34% versus 16%, respectively)." In terms of overall violence, intimate partners, including spouses and dating partners, were the most common perpetrators in violent crimes against women in 2011, representing 45 percent of all those accused of victimizing women. This is different from violent crimes against men where intimate partners were among the least common perpetrators at 12 percent (Sinha, 2013: 14).

Domestic Homicide

The previous statistics document the continued prevalence of domestic violence in Canada and, tragically, some of these cases end in domestic homicide. In 2015, there were 83 intimate partner homicides in Canada, representing 18 percent of all homicides that year (Mulligan, Axford, and Solecki, 2016: 22). As with domestic violence generally, women have historically been more likely than men to be victims of domestic homicide. In 2014, the rate of intimate partner homicide against women was approximately four times higher than that for men, with one woman being killed every six days by her intimate partner. In that year, there were 83 intimate partner homicides, 67 (80 percent) of which had female victims (Miladinovic and Mulligan, 2015: 34).

Despite small increases in some years, "over the past 20 years, the proportion of intimate partner homicides committed by a legally married spouse (current or former) has been decreasing, from just under 50% in 1994 to 37% in 2014" (Miladinovic and Mulligan, 2015: 11). This overall decline may be attributed to a number of factors, including demographic changes and increased intervention resources. Despite these developments,

however, domestic homicides still occur across Canada and are a cause of great concern. A theme throughout this thesis is that a majority of domestic homicides are potentially predictable and possibly preventable, with many victims having previous involvement with domestic violence services. “Between 2001 and 2011, police reported that about six in ten spousal homicides of women (59 percent) had a history of family violence involving the victim and accused” (Sinha, 2013: 24).

While the prevalence of domestic violence and domestic homicides in Canada is clear, there are regional differences, with some populations and age groups being more vulnerable than others. Among the Canadian provinces, Manitoba and Saskatchewan have the highest rates of police-reported intimate partner violence against women, with rates that are more than double that of Ontario and Quebec, provinces that hold the lowest rates (Sinha, 2013: 21). The rates of intimate partner violence are considerably higher in the Canadian territories than any of the provinces. Nunavut has the highest territorial rate with 7,772 female victims per 100,000, which is four times higher than Yukon’s rate and double the rate for the Northwest Territories (Sinha, 2013: 22). At the census metropolitan level, Thunder Bay, Ontario recorded the highest rate of intimate partner violence against women, followed by Regina and Saskatoon, Saskatchewan (Sinha, 2013: 23).

Beyond regional differences, domestic violence occurs in all cultures, at every age, and in every income group but there are certain groups that are especially at risk. Aboriginal women, who are victims of higher rates of murder in general (Amnesty International, 2004; RCMP, 2014 and 2015), are more than eight times more likely to be killed by their intimate partner than non-Aboriginal women (Status of Women Canada, 2012). As well, young “women aged 15 to 24 are killed at nearly three times the rate for all

female victims of domestic homicide" (Canadian Women's Foundation, 2014: 5). Women with disabilities are also at risk, with persons with disabilities being between 50 and 100 percent more likely to experience spousal violence than those without a disability (DisAbled Women's Network Canada, 2013: 2). Immigrant women may also be more vulnerable due to economic dependence, language barriers, and a lack of knowledge about community resources (Status of Women Canada, 2012).

In addition to regional and demographic variation in domestic violence, the number and type of victims of a domestic homicide also vary. Intimate partner homicides can include a female victim only, a woman and her child(ren), her new partner, other family members, or a domestic homicide/suicide. Separated and divorced women are also at a greater risk of being killed than married women, with women in common-law relationships accounting for the largest proportion of spousal homicide victims between 1997 and 2006 (DeKeseredy, 2011: 24-25).

Several provinces have established Domestic Violence Death Review Committees and death review panels with the purpose of reviewing and investigating deaths that occur as a result of domestic homicide and making recommendations to prevent such deaths in similar circumstances (Office of the Chief Coroner of Ontario, 2015b). Despite the differences in population size and demographics between these provinces, the data produced by these inquiries substantiate an ongoing concern with domestic homicides. Between 1999 and 2008, New Brunswick reported 32 domestic homicide incidents with 28 adult victims and eight children (Gill, 2012). In Ontario, between 2002 and 2009 there were 203 domestic homicide and homicide-suicide cases resulting in the deaths of 295 people. The victims were predominantly adult females, while 12 percent were children and

eight percent were adult males (Office of the Chief Coroner of Ontario, 2012: 5). Manitoba experienced 37 domestic homicides and three murder-suicides between 2006 and 2012, with 28 (70%) of those victims being women (Ursel, 2013: 13). And in British Columbia, there were a total of 147 intimate partner violence-related deaths (homicides, suicides, and undetermined[4]) between 2003 and 2011, with 72 percent of homicide victims being female (BC Coroners Service, 2012).

Domestic Violence Prevention and Intervention

There are three main approaches to domestic violence prevention that draw on clinical public health models: primary, secondary, and tertiary prevention (Wolfe and Jaffe, 2009; Gundersen, 2002; Ward and Belanger, 2011). *Primary prevention* is intended to prevent violence from occurring at all. This includes efforts to address, inform, and educate the public in order to encourage non-violent behaviour. The most common primary interventions are far removed from domestic violence and domestic homicide, with examples including poverty reduction strategies, accessible child care, educating children in schools, public awareness campaigns, and discussions about healthy relationships. *Secondary prevention* is aimed at addressing at-risk populations, both victims and perpetrators, following incidents of violence. These interventions address individuals who have witnessed, experienced, or perpetrated violence with the hope that early intervention will prevent subsequent violent incidents (Murray and Graybeal, 2007: 1251). This includes identifying and working with individuals who have shown certain behaviours associated with domestic violence, such as young people who have witnessed violence at

[4] "The Undetermined case was a death that occurred while evading police custody, which could not be conclusively ruled a Suicide or Accidental" (BC Coroners Service, 2012: 6).

home or first-time offenders. Finally, *tertiary prevention* focuses on victims and perpetrators with recurrent domestic violence incidents. Treatment and interventions include a continuum of services such as shelters, second-stage housing, counselling for survivors, offender programs, and incarceration for perpetrators. Legislative changes, medical assistance, and social services accessible to all members of a family are also part of tertiary prevention strategies. While tertiary interventions attempt to prevent future violence and/or death, in the event that a domestic homicide occurs, tertiary prevention strategies involve inquiries, inquests, in-depth reports, or DVDRCs mandated to identify intervention opportunities, behaviour patterns, and risk factors to assist in the prevention of future homicides.

While there are three recognized levels of prevention outlined in the literature, for the purposes of this thesis, the critical distinction will be between secondary and tertiary prevention. There is a clear demarcation between primary and secondary prevention but there is a lot of overlap between secondary and tertiary and, as such, for the purposes of this study, the various intervention strategies will be dealt with as secondary prevention and all inquiries into domestic homicides as tertiary. Within these definitions, secondary intervention may include a wide range of interventions that have and will continue to grow and evolve over time. The terms 'intervention' and 'secondary prevention' may be used interchangeably when discussing these social services, such as shelters, men's treatment groups, and the child welfare system. Tertiary prevention will be used only as it applies to post-homicide reviews, or the range of inquiries following a domestic homicide death.

The Purpose of the Study

This study examines the diversity of administrative responses that exist in Canada following a domestic homicide, including DVDRCs, inquiries, inquests, and review panels. In all of these inquiry processes, the stated intent of participants has been to acquire information about the circumstances of particular homicides in order to prevent future homicides from occurring. *The main purpose of this thesis is to assess each model in terms of its potential for tertiary prevention.*

The data for this investigation are drawn from two sources: interviews conducted with 11 respondents who have experience with one or more of the models of inquiry in British Columbia, Manitoba, Ontario, and New Brunswick; and a range of secondary data sources, including legislation, government reports, journal articles, news releases, and other publications that shed light on the workings of these models.

This thesis is divided into four chapters. Chapter One provides the theoretical framework for the project as well as a discussion of the growth of social service and criminal justice interventions. Chapter Two examines the different models of inquiry that exist in Canada, with particular attention paid to those operating in four provinces. Chapter Three outlines the methodology, including the main research questions, sampling method, data collection, and analysis. Chapters Four and Five provide the findings and analysis of the investigation into the four different models. Chapter Four focuses on inquiries and inquests, while Chapter Five considers Domestic Violence Review Committees and other models (death review panels), and undertakes a comparative analysis of all four models of inquiry. After considering the strengths and limitations of each model of inquiry, the main conclusion drawn is that the models work in complementary fashion with each other such

that, in combination, they offer a path forward in combatting the serious problem of domestic homicide.

Chapter 1: Review of the Literature

"Feminist theories emphasize how gendered power structures contribute to male violence against women" (Johnson and Dawson, 2011: 34). They recognize that the root causes of domestic violence are tied to gender inequality and the subordination of women, and that using this model—as opposed to simply examining the individual pathologies of abusers and/or victims—is fundamental to creating meaningful interventions that strengthen the social service and criminal justice systems. These interventions, and ultimately the models of inquiry examined in this study, are continually evolving to better meet the needs of victims (and abusers) and combat the systemic patterns that exist to perpetuate violence against women.

Defining the Problem

A theme that underlies this project and its theoretical base is the definition, and continual redefinition, of the problem of domestic violence. Feminist theorizing, research, and advocacy to raise awareness of the issue of domestic violence resulted in changing definitions and an evolution in services initiated by service providers. These changes in practice are in themselves a source of further evolution as they call for new definitions and growth. Indeed, the models of inquiry examined are the result of learning derived from direct service intervention. Anchoring this emphasis on defining the problem and its connection to public policy in the area of domestic violence is the work of Carol Bacchi (2009, 1999).

Bacchi (2009, 1999) offers an approach to analysing policy that focuses on the question of 'What's the Problem Represented to be?' (WPR). She describes her perspective

as a “poststructural approach to policy analysis,” with the intention of digging deeper into the meaning of policies and into the meaning-making that is part of policy formulation (2009: vi). Bacchi (2009) elaborates on her approach to policy analysis by posing six questions for analysts to consider:

1. What’s the ‘problem’ represented to be in a specific policy or policy proposal?
2. What presuppositions or assumptions underlie this representation of the ‘problem’?
3. How has this representation of the ‘problem’ come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the ‘problem’ be thought about differently?
5. What effects are produced by this representation of the ‘problem’?
    a. What is likely to change with this representation of the ‘problem’?
    b. What is likely to stay the same?
    c. Who is likely to benefit from this representation of the ‘problem’?
    d. Who is likely to be harmed?
    e. How does the attribution of responsibility for the ‘problem’ affect those so targeted and the perceptions of the rest of the community about who is to ‘blame’?
6. How/where has this representation of the ‘problem’ been produced, disseminated, and defended? How has it been (or could it be) questioned, disrupted, and replaced?

Given that the evolution of services and research initiate new understandings and new definitions of the problem of domestic violence, Bacchi’s work is particularly well suited to this study.

The way in which a problem is defined is an important determinant of what solutions are put forward. Using the six questions that comprise the WPR approach, the changing definition of the ‘problem’ of domestic violence can be analysed to help understand policy decisions and program development. Bacchi’s first question highlights the first critical definition change regarding domestic violence. Until the mid-1980s, ‘wife

abuse' was perceived by most Canadians as a personal tragedy rather than a serious crime (MacLeod, 1980). In the late 1970s and 1980s, the women's movement across North America redefined violence against women. It was identified as an issue of male violence against women, not a personal tragedy, and defined as a social issue in need of socio-political analysis and social change (Lehrner and Allen, 2009; Johnson and Dawson, 2011). As long as domestic violence was defined as a personal tragedy, there was no scope for social intervention and no basis for service intervention and social policy development. Defining domestic violence as a social problem and a crime opened the doors for social intervention, which began as informal assistance in providing escape and/or a safe place and evolved into major program and policy changes in the social service and criminal justice systems.

Bacchi's second question concerning the presuppositions or assumptions underlying the old definition draws our attention to the permeation of patriarchy in everyday life. It was assumed that women experiencing abuse were unlucky and men who abused were unable to control their behaviour. These assumptions not only served to privatize the problem but they also blamed the victim ("bad choice of partner" or "she must have done something to provoke him") and removed any responsibility from the abuser ("he just couldn't help it"). Bacchi's third question (the source of the old definition) reiterates the deeply embedded patriarchal assumptions in our society while her fourth question concerning who is silenced clearly indicates the importance of the women's movement in giving women a voice. Hearing women's voices was the prerequisite of change.

In aiming to "identify the effects of specific problem representations so that they can be critically assessed" and to "pay attention both to the means through which some problem representations become dominant, and to the possibility of challenging problem representations that are judged to be harmful" (Bacchi, 2009: 19), Bacchi's WPR approach provides a framework for our discussion of the evolution of services and theorizing in the area of domestic violence. Her work reminds us that each proposed program or policy reveals what is implicitly believed to be problematic and encourages researchers to examine *who* is defining the problem and the important implications this has on intervention methods. What is seen to be problematic can, and will, change and may be a reflection of evolving understandings of the dynamic and impact of domestic violence.

The subject of this thesis is domestic homicides and how they came to be redefined (or currently understood). The research identifies how different models of inquiry resulted from the growing understanding that patterns could be identified and detailed knowledge of the homicide could teach us about indicators of risk and hopefully lead to tertiary prevention.

Bacchi's work is important because it provides a framework for the discussion of the changes and evolution of services that have taken place over time. As will be seen, in the social service and criminal justice sectors early interventions were based on early definitions and theories, which have, over time, developed a more sophisticated and nuanced appreciation of the consequences of violence for victims, their family members, and abusers. These evolving definitions have also led to a greater appreciation of the potential for change and the possibility of prevention. Bacchi's work highlights the integral connection between domestic violence theory and domestic violence practice, setting the

context for a review of the literature, which is embedded in a very brief review of the evolution of services for victims and abusers.

Feminist Theories of Domestic Violence

This thesis uses a feminist lens based on two premises: 1) domestic violence is a social, not only a personal problem; and 2) it is an issue of exercising control, not loss of control. This fundamental shift in understanding has important implications for policy development and policy analysis. Feminist theory examines women's experiences with an aim to improving their social conditions by recognizing inequalities, discrimination, social control, and oppression of women (Gill, 2006). Feminist theorists assert that violence results from structural forces tied to gender, race, and class hierarchies (Johnson and Dawson, 2011: 33). It was not until the 1970s and 1980s that domestic violence was truly seen as a social problem gaining the attention of academics, policy makers, and the criminal justice system (Dixon, 2014).

Within the theoretical perspectives on domestic violence, and within feminist perspectives in particular, there is a diversity of views. However, all feminists agree that gender plays a critical role in "how gendered power structures contribute to male violence against women" (Johnson and Dawson, 2011: 34). Beginning in the 1970s, radical feminists such as Kate Millett (1970), Diana Russell (1975, 1984), Catharine MacKinnon (1989), and Andrea Dworkin (1989) examined power and gender relations, focusing on masculinity and the interconnection of sexuality, aggression, and violence. These theorists "identified masculine power and privilege manifested in patriarchy as the root of all forms of inequality" (Johnson and Dawson, 2011: 26). Sylvia Walby (1990: 3) illustrated the connection between domestic violence and patriarchy by showing that men as a group

dominate women as a group and it is these men that benefit from the subordination of women. Patriarchy and structural inequality are seen as the foundation of social roles and domestic violence is seen as a consequence. Rebecca Dobash and Russell Dobash (1979) define patriarchy as being made up of a structure and an ideology that privileges men, referring to the hierarchical nature of social institutions and the widespread acceptance of these structures that are reinforced throughout society. These authors theorized the connection between patriarchy and domestic violence by drawing on the voices and experiences of women and the interventions of practitioners.

As women's experiences were redefined as victimization by male aggression, it necessitated a redefinition of the male role. Men's aggression was reframed from the old assumption of *loss of control* to the understanding that their aggression was an *exercise of control*. This transition is important because perpetrators are now understood as conscious actors in the abuse and thus interventions seek to have them acknowledge their responsibility and hold them accountable for their behaviour. Evan Stark (2007) illustrates some of the theories and beliefs that led up to what he calls the "Coercive Control Model," citing feminist pioneers in the battered women's movement who embraced a definition of woman abuse as controlling behaviour that created and maintained an imbalance of power between the batterer and the battered woman.

Canadian researchers Holly Johnson and Myrna Dawson (2011) use a feminist framework and an ecological model to inform their work on intimate partner violence and domestic homicides. They focus on the commonalities and linkages between different forms of male violence against women in intimate relationships. "Conceptualising perpetration and victimization within the ecological model requires us to think about

prevention at multiple levels, including individual, family, and peer relationships as well as community and societal prevention initiatives" (p. 182). Their work provides insights into prevention efforts as well as some of the themes that emerge from DVDRC reports and recommendations throughout North America. "The concept of prevention of male violence against women has broadened to encompass alterations to the physical environment, individual attitudes, bystander interventions, and community- and societal-level norms" (p. 182). This work illustrates the evolution of the definition of domestic violence—moving beyond a focus on couple dynamics and incorporating a broad range of social relations and physical environments.

Evolution of Services/Interventions

As Johnson and Dawson (2011: 13) note, "How and why violence is understood to occur underpins the directions taken by policy makers, service providers, and community activists to intervene and prevent male violence against women. [Theories] help inform decisions about how to respond most appropriately to prevent or intervene in violent situations." The social historical context in which inquiries, inquests, DVDRCs, and other models are situated is directly tied to the growth and expansion of social service and criminal justice interventions. As well, the development of feminist theories of domestic violence are enmeshed in this evolution of services and policy responses.

Recent decades have seen substantial growth and evolution in social service interventions specific to domestic violence. These services have evolved with an increasing appreciation of the intricate dynamics that exist as practitioners and front-line workers begin to recognize a person's history and the paths that brought them to either victimization or perpetration (or, in some cases, both). Over time, the simplistic and

dichotomized view of women as “helpless victims” and men as one-dimensional “brutes” has transitioned into a deeper appreciation of the personal, social, and historical context that informs their behaviour. Women are now understood as survivors and active agents of change as well as victims of abuse. Conversely, men who abuse may have complex histories that inform their use of violence to control their partner. As Bacchi (1999) illustrates in her work, it is important to understand these changing representations and the potential implications of defining a problem a particular way.

Treatment work has evolved from a standpoint that acknowledging a perpetrator’s past was simply playing into his denial to understanding that acknowledging his past is an important tool in the process of building motivation and developing skills to change abusive behaviour. The evolution of services, therefore, led to a different understanding of domestic violence. While definitions of treatment processes change and evolve, the goal remains the same: accountability and behavioural change. Shelter and victim services, the child welfare system, and treatment programs for abusers are just some areas that are evolving to meet the changing understanding of domestic violence intervention as well as the changing needs of the clients. The literature also points to emerging areas of research, such as the effects on children who witness violence, which may have important policy implications for front-line workers.

Shelter Services

Residential facilities for abused women provide a necessary service for women experiencing violence, and they are an essential component of intervention and secondary prevention efforts. Shelters have been shown to be one of the most effective resources available for women experiencing domestic violence (Johnson and Dawson, 2011; Postmus

et al., 2009; Gordon, 1996). Like other interventions, shelter services emerged out of the women's movement and have grown along with the changing definitions of domestic violence. Before 1975, there were just 18 known shelters operating in Canada; by the time the 2003/2004 Transition Home Survey was conducted there were 543 facilities known to be in operation (Taylor-Butts, 2007). On April 18, 2012, there were 601 shelters for abused women operating across Canada with a total of 11,820 available beds (Mazowita and Burczycka, 2014)—an increase of eight shelters since 2010 and 48 shelters since 2006 (Burczycka and Cotter, 2011). While all types of shelters have seen an increase in recent years, transition and second-stage housing have increased more than any other type. Second-stage housing, in particular, plays an important role in the continued safety for women and their children as they offer long-term, secure housing and support while women search for permanent housing. All shelters offer time away and physical refuge from abuse as well as a range of services, including safety and protection planning, advocacy, transportation, counselling, and culturally-sensitive services (Mazowita and Burczycka, 2014).

A current challenge in this area is that the population and needs of women accessing shelters are changing. In the past, service providers were primarily focused on a woman's need to escape abuse and seek refuge from a partner. Today, service providers are more aware of the complex needs of women using their services—including mental health concerns and addictions—and the importance of meeting their full range of needs. Furthermore, many women with mental health and addiction issues are at substantial risk of homelessness because of restricted access to shelters and transitional housing for abused women (YWCA Canada, 2014). Shelter studies have found that some women

showed "more internal control and more social independence" following their stay in a second-stage facility (McDonald, 1989: 122). Shelters provide the time to think, physical distance from abuse, and access to necessary services—all of which may provide victims with a sense of agency in their lives. Accessing the services provided by shelters is an important first step for women putting their lives back together following victimization.

Front-line workers in direct contact with victims of domestic violence play a critical role in developing safety plans and defining women not only as victims, but also as actors with agency and strengths to build on. The issue of the changing definitions of victims that is so integral to Bacchi's policy analysis has come from the service providers working with women and providing strong secondary prevention efforts. While shelter workers are focused on secondary prevention, keeping women safe and preventing homicides, they have also made significant contributions to tertiary prevention. Shelter staff were among the first people in the field of domestic violence to identify patterns of abuse and risk factors that have informed DVDRCs and other reviews.

Children who Witness Abuse

The best way to protect a child is to protect her mother. Women escaping dangerous situations are not the only vulnerable group in need of effective social service support. While friends, family, or co-workers may be peripherally aware of violence within a home, children can be direct witnesses to it on a regular basis. "Almost six in ten (59 percent) female spousal victims with children reported that their children heard or saw the violent episode. This compares to 43 percent of male spousal victims. Further, when children did witness spousal violence, physical injuries were more than twice as common in spousal violence episodes against the child's mother than those against the child's father (52

percent versus 22 percent)" (Sinha, 2013: 28). This exposure to violence can have long-term emotional, cognitive, social, and behavioural impacts on children, especially the very young (Sinha, 2013; Holt et al., 2008; Kitzmann et al., 2003; Howell and Miller-Graff, 2014; Carpenter and Stacks, 2009). Protecting children from abuse or from witnessing abuse is a common reason that women seek shelter services (Mazowita and Burczycka, 2014), providing further evidence of the interconnectedness in domestic violence prevention efforts. While there seems to be no question that witnessing violence in the home can impact a child, researchers are only beginning to understand the complexities of those impacts (Holt et al., 2008).

Mothers play an important role in keeping their children safe and the increased awareness of the impacts on children has changed the availability of resources within the social services arena. Domestic violence interventions should be linked to a continuum of social services and should acknowledge that a child's welfare is aligned with the protection and empowerment of her mother (Holt et al., 2008; Hendry, 1998; Kelly, 1996). Interventions were previously targeted at the victim, the mother, and services were not available for children. Now, most shelters offer some programming for children, whether it is counselling, childcare, or simply a table for arts and crafts. The way practitioners intervene when children are involved must continue to evolve to address the changing needs of families experiencing abuse. In addition to keeping children safe during times of domestic abuse, this particular area of intervention is especially important to tertiary prevention of domestic homicides. A mother's commitment to keeping her children safe may result in greater exposure to danger if she feels that her partner may gain custody or threaten to harm the children if they leave. Intervention work with children has revealed

the paradox of parenting in an abusive relationship in which the presence of children may be the primary motive to leave and at the same time a major risk factor for escalating violence.

Men's Treatment Programs

A third dimension of social service intervention that is undergoing growth is in the area of men's treatment groups. "Batterer intervention programs [or men's treatment groups] are designed for men arrested for domestic violence and for men who would be arrested if their actions were public" (Bennett and Williams, 2001: 1). Individual groups or programs may be different, but they usually involve some combination of educational classes, treatment groups, counselling, case management, and extensive evaluation. Larry Bennett and Oliver Williams (2001) cite justice and accountability, victim safety, and rehabilitation and behavioural changes as goals of batterer intervention programs. Treatment programs for abusers are an important aspect of secondary prevention that informs tertiary prevention, identifying risk factors and circumstances that can lead to escalation. Most often, men who are in treatment groups first have to come to the attention of the authorities. As such, increasing criminal justice interventions, arrest policies, and specialized courts are associated with the increasing demand for men's treatment groups.

Men's treatment groups of the 1980s and 1990s originated out of the power and control model, which focused on emphasizing men's responsibility. Men's attempts to tell their story or their history were seen to be diversionary, if not victim-blaming. The power and control model silenced men, delegitimized their history, and situated the facilitator as the person in control. William Miller and Stephen Rollnick (2013) describe these earlier program models as utilizing a "righting reflex." This refers to a desire that people have to

fix others' problems and direct them to a better way of doing things. Although this righting reflex comes from well-meant intentions, the natural reaction of the client is to respond defensively—a response that was treated as denial (Miller and Rollnick, 2013). Traditional programs utilized a strategy that centred on pressuring men to acknowledge their abusive behaviour and agree to change through confrontation (Mederos, 2001). Such an approach made individuals feel angry, defensive, uncomfortable, and powerless (Miller and Rollnick, 2013). This situation is the opposite of what treatment facilitators wanted.

Today, treatment strategies have changed. Facilitators have recognized that the simplistic, one-dimensional view of the abuser as "brute" has transitioned into a deeper appreciation of the personal, social, and historical context that informs their behaviour. Facilitators discovered that by listening to men and validating their history, they could become more effective instruments of change (Klostermaier-Starkewski, 2014a, 2014b). By allowing the clients to define their reality and explore past victimization and complexities in their lives, facilitators can create an atmosphere of honesty, collaboration, compassion, respect, care, and acceptance while still acknowledging the high-risk behaviours of the men. Such an atmosphere is more likely to engage men in the difficult process of change and provides valuable information to all service providers about the context of violence and the multiple triggers and risk factors associated with violence. By further examining the reasons men abuse and the complex dynamics that may exist, treatments can provide accountability for abusers and safety for victims.

Treatment programs for men who abuse will continue to be an important component of violence intervention; however, as with shelter services and the child welfare system, these programs must evolve to meet the needs of clients and ultimately

prove effective in preventing domestic violence. Paul Klostermaier-Starkewski (2014b: 2) cautions that, "because these men are such a heterogeneous population, it may never be best practice to use only one approach." In their evaluation of men's batterer treatment groups, Leslie Tutty and her colleagues (2001: 666) point out that "it is essential to see the men's groups as only one aspect of a coordinated community response to woman abuse, one that also provides support and safety planning for partners."

Criminal Justice Interventions

Concurrent with the growth and evolution of social services, the criminal justice system is evolving to better address the needs of victims and perpetrators. Policy changes across North America have led to the criminal justice system intervening in a substantial number of cases of domestic violence (Tutty and Ursel, 2008). While some victims still choose not to involve the police, policy and practice have changed to include putting greater emphasis on victim safety and holding offenders accountable for their assaults (Tutty and Ursel, 2008:1).

Bacchi's work (1999, 2009) emphasizes how the definition of a problem has a determining effect on what is perceived as a solution, and this is evident in the ongoing evolution of criminal justice intervention. Changing the definition of the problem of domestic violence from one of men's lack of control to their deliberate use of violence to control their intimate partner resulted in greater police involvement and the engagement of the justice system.

The criminalization of domestic violence has been an ongoing development over the past few decades. Until the 1980s, criminal justice intervention often occurred only if the woman chose to proceed with charges and, even then, there was no guarantee that a case

would be heard in court or result in a sentence with consequences for the offender. However, service providers and women's organizations began lobbying for greater police accountability and increased criminal justice intervention, which resulted in a number of police policies and practices, referred to as mandatory arrest and "zero-tolerance" (Johnson and Fraser, 2011; Comack and Balfour, 2004; Tutty et al., 2008; Wood, 2001). With mandatory arrest or "no drop" policies, "police were instructed to lay charges if they had reasonable and probable grounds to suspect that a crime had occurred, regardless of the relationship between the complainant and the accused" (Comack and Balfour, 2004: 15). What came to be known as the "zero tolerance" policy, on the other hand, meant that police were to lay charges "whether or not the victim wishes to proceed with the matter, and even in circumstances where there are no visible injuries or independent witnesses" (Winnipeg Police Department cited in Comack and Balfour, 2004: 152). The criminal justice response to domestic violence has also expanded to include assertive prosecution policies and specialized domestic violence courts, each with the goal of encouraging the arrest and prosecution of people charged with domestic violence offences.

The expansion of policies, however, has not come without some debate, particularly among feminist scholars. While some feminists worry that using the law to address domestic violence has led to the "co-optation, institutionalization, accommodation, deradicalization, repackaging and depoliticization of women's issues," others "see potential wedges in the state and law that allow for a meaningful response to issues concerning women" (Wood, 2001: 8). This debate, which centres on whether criminalization creates safety for victims of abuse or whether it actually does more harm than good, is the existing environment within which service providers and policy-makers must work to redefine the

problem and ensure positive growth for domestic violence interventions. The debate is ongoing and will likely continue as jurisdictions establish the best ways to address the issues while ensuring victims are receiving the best treatment possible. Despite these very different opinions of criminalization, there is substantial support for police and criminal justice system intervention among social service providers.

Specialized Domestic Violence Courts

Specialized domestic violence courts are a consequence of increased criminalization of domestic violence and a critical component of secondary prevention. These courts recognize that family violence often requires specialized prosecution and can include a number of services that support or interact with the court system. Specialized courts operate along with victim support programs, government or community treatment programs, specialized police units, Crown prosecutors, and probation officers (Tutty et al., 2008: 75). Because court administration is under provincial jurisdiction, different provinces have adopted different models of specialization. However, there are three basic principles that underlie these programs: early intervention for low-risk offenders; vigorous prosecution for serious and/or repeat offenders; and a commitment to rehabilitation and treatment (Tutty et al., 2008: 76).

The demand for specialized courts came from the belief that the traditional criminal justice system was not able to adequately respond to the unique characteristics of domestic violence. Domestic violence cases "are complex and messy rather than being straightforward evidentiary matters" (Ursel, 2012: 162). Like other interventions in the criminal justice system, specialized courts are not without debate as people struggle to determine whether the process is providing safety and protection or unintentionally re-

victimizing the victim. However, since the introduction of the first specialized domestic violence court in Manitoba in 1990, seven jurisdictions across Canada have implemented various models of specialized domestic violence courts, further expanding the role the criminal justice system plays in domestic violence intervention.

One example of the growth and expansion of intervention strategies is Manitoba, where we can see the evolution of processes used to address domestic violence and domestic homicides (Table 1.1).

Table 1.1 History of Policy Initiatives and Criminal Justice Intervention in Manitoba

1983	Mandatory charging policy
1985	Domestic Violence Prevention Branch, Department of Family Services
1986	Women's Advocacy Program
1990	Specialized Family Violence Court
1992	Specialized corrections programs for offenders
1993	Zero tolerance policy
1999	*Domestic Violence and Stalking Protection, Prevention, and Compensation Act*
2000	Special domestic violence unit in provincial prison
2010	Creation of a Domestic Violence Death Review Committee

Beginning with the implementation of the mandatory charging policy and the creation of the Domestic Violence Prevention Branch two years later, provincial policies were initiated to respond to and contribute to the expanding field of intervention in the social services and criminal justice systems. In the 1990s, specialized courts and zero-tolerance arrest policies brought further interventions into the criminal justice response to cases of domestic violence.

Despite the expansion of social services and criminal justice interventions, domestic homicides continued. While the rate may have decreased over time, the existence of domestic violence homicides provoked a series of inquiries and reviews, which led to

further policy change. The Pedlar Report (1991), the Lavoie Inquiry (Schulman, 1997), and the creation of Manitoba's Domestic Violence Death Review Committee (2010) have led to the publicly expressed need to conduct careful examinations of the context and trajectories of these homicides. Each of these policy initiatives builds on changing definitions of the problem as well as growing recognition that there is much to be learned from examining cases of domestic homicide. DVDRCs, for example, are just the latest process employed by jurisdictions to examine and learn from domestic homicides and ultimately strengthen tertiary prevention efforts.

Risk Assessment/Risk Factors

It is important to note that two parallel and complementary developments are central to the use of risk factors for domestic homicide prevention. Across North America, inquiries and homicide reviews resulted in the understanding that there are patterns that exist in domestic violence and domestic homicide cases. To identify and acknowledge these patterns, the concept emerged that there are certain "risk factors" that may indicate potential lethality in domestic violence cases. Around the same time that DVDRCs were emerging, the changing understanding of men's violence against their intimate partners—from one of loss of control to one of exercising control—gave rise to a literature on risk factors and the creation of risk assessment tools for use by practitioners (Campbell et al., 2003; Campbell, 2004; Komarnicki, 2011; Office of the Chief Coroner of Ontario, 2003; Stark, 2007; Websdale, 1999; Websdale, 2003). These risk factors are seen to identify potentially dangerous situations and behavioural patterns that help to predict and hopefully prevent escalating violence. Each of these developments points to the importance of reviewing domestic homicides as important tertiary prevention methods.

Domestic Violence Death Reviews emerged in the United States in the 1990s. They were seen as a tool that could potentially help reduce the number of domestic homicides. As will be shown in the next chapter, DVDRCs operate differently across jurisdictions, but one central tenet of the reviews is the use of risk factors and the identification of patterns in the hope that future deaths can be prevented. It has been shown that patterns identified in these reviews could contribute to a number of systemic changes and assist in preventing future deaths (Thompson, 2006; Websdale, 2003). Further discussion of DVDRCs and risk factors will come in the following chapters, but it is important to acknowledge the impact of the risk factor literature on the growth of domestic homicide interventions. Peter Jaffe and Myrna Dawson (2002: 52) discuss the importance of risk factors in tertiary prevention and sum it up by saying, "having criminal justice actors, women's advocates and those who routinely provide services to victims, batterers and their families discuss possible risk markers on a regular basis can contribute in important ways to their own understanding of domestic violence and, ultimately, increase the likelihood that such deaths will be prevented in the future."

Jacquelyn Campbell, a prominent researcher in the field of risk factors and femicide, was involved in an eleven-city study to document risk factors for femicide in abusive relationships in the U.S. (Campbell et al., 2003; Campbell, 2004). Significant risk factors included the victim having left for another partner, the perpetrator's use of a gun, stalking, forced sex, and abuse during pregnancy (Campbell et al., 2003). Campbell also points to studies that have found that 65 to 80 percent of victims of intimate partner femicide were previously abused by the partners who killed them (Campbell, 2004: 1466). The multi-city study also showed that the majority of women who were killed had been seen by the

criminal justice, health, social services, or shelter systems during the year before they were killed, suggesting that there had been earlier opportunities to intervene (Campbell, 2004: 1466). Campbell's work suggests that a better understanding of risk factors would yield more effective interventions and hopefully prevent future domestic homicides. Indeed, Campbell's research contributions made risk factors an important part of prevention efforts and highlighted the important impact on service delivery that can result from examining these factors. In the case of domestic homicide, this work on risk factors provides the basis for studying homicides as a means to prevent future deaths.

Risk assessment tools are frequently used to help predict domestic violence and domestic homicide. "Risk assessment instruments are designed to take all items shown empirically to be risks for recidivism and combine them into a scale or checklist to guide assessment and preferably to generate a risk score" (Dutton, 2006: 273). There are a number of risk assessment tools that exist, including the Danger Assessment Scale (Campbell, 1995), the Spousal Assault Risk Assessment Guide (Kropp and Hart, 2000), and the Propensity for Abusiveness Scale (Dutton, 1995).

Johnson and Dawson (2011) have argued that risk assessment tools

> have clear benefits, beyond assessing risk, including the ability to educate and inform those working with abused women as well as the general public about the nature of intimate partner violence and escalation; the ability to highlight when particular care and caution may be required to assess danger (although such tools should never be used on their own or without consultation with the women affected); and the ability to develop a shared language of risk for those working in the field that can enhance communication, lead to greater awareness of the complexities of the situation, and allow for more effective intervention. (Johnson and Dawson, 2011: 169)

Regarding Bacchi's (1999) point that definitions of the problem are fundamental in developing solutions, Campbell's work on risk factors helped to redefine the way we think

about prevention by highlighting that domestic homicides are not random. There are patterns that can be seen across cases and prevention is a reasonable goal for many cases. Her work on risk factors is the reason why it suddenly became feasible to examine domestic homicides and set the stage for one of the models of inquiry examined in this thesis. Without patterns and risk factors, there would be no point in having a DVDRC.

Concluding Remarks

As we have seen, feminist service providers, theorists, and researchers redefined the problem of domestic violence and lobbied social service and criminal justice systems for more responsive and effective services. They have given us a language and analytical tools for the analysis of this serious social problem. They have documented incidents, evaluated programs and policies, and drawn our attention to risk factors and behavioural patterns that are associated with the escalation of violence. In short, feminist service providers, theorists, and researchers have informed our understanding of domestic violence and domestic homicide.

Bacchi's (1999) WPR approach assists in illustrating that how the problem of domestic violence is defined is an important determinant of what solutions are put forward. In that regard, the immense strides that have been made in social service and criminal justice interventions are proof that change can occur and the problem can be redefined while still focusing on keeping women safe from abuse. In the last 20 years, there has been a significant expansion of domestic violence resources such as shelters, men's treatment groups, counselling programs, legislation, and specialized courts. Significantly, we have seen a decline in domestic homicides but domestic violence remains a significant problem. The ongoing incidents of domestic violence and domestic homicide indicate the

need for further research in the area of prevention, specifically around the various models of policy responses. Public inquiries, inquests, DVDRCs, and review panels are some of the ways that jurisdictions are tackling the issue of domestic homicide. The models of inquiry to be addressed in this thesis are important components of the evolution of domestic violence interventions.

Bacchi's work helps to reveal and explain the dynamics that exist in domestic violence theory as definitions are continually changing and interventions are evolving. Throughout this process, however, feminist service providers, theorists, and researchers continue to address the basic principles of safety and accountability. In addition to redefining the issues, the domestic violence movement fought for social change within the criminal justice and social service systems (Lehrner and Allen, 2009), which resulted in many of the primary and secondary interventions that exist today. This historical redefinition and the emphasis on domestic violence as a social problem informs the underlying feminist framework of this thesis as it analyses public inquiries, Coroner's inquests, DVDRCs, and other models for their potential for tertiary prevention. The women's movement throughout North America had a significant social impact, resulting in the criminalization of intimate partner violence, the development of specialized courts, and an expansion of social services for victims and their children as well as treatment programs for abusers.

Despite the debates that exist around intervention and policy, there are two points of consensus among researchers and practitioners. First, the issue is a social and political one, not just a personal one. Second, redefining the issue of abuse as one of control has provided a framework for intervention through the development of men's treatment

programs and the involvement of the criminal justice system, and the understanding that perpetrators must be held accountable for their actions. Bacchi's approach to policy analysis provides a framework for analysis of the continuing evolution of programs and services. These two points of consensus along with the contributions of Bacchi's work will be the focus of continued discussion on models of inquiry and the analysis of the research findings.

Chapter 2: Models of Inquiry

As seen in the previous chapter, there is an ongoing evolution in thinking around domestic violence and domestic homicide. Despite all of the positive developments, however, domestic homicides still occur. In responding to the recognition that interventions must evolve, jurisdictions across Canada, the United States, Australia, New Zealand, and the United Kingdom have established different models of inquiry to examine cases of domestic homicide. In Canada, it is important to note that inquiries, inquests, Domestic Violence Death Review Committees, and death review panels fall within provincial jurisdiction. While every province struggles with the same problem, each takes a different approach to tertiary prevention, designing and using the model(s) that works best for them at the time. This chapter will examine a range of models that exist across Canada, paying particular attention to the models of inquiry pursued in British Columbia, Manitoba, Ontario, and New Brunswick. These provinces were selected because they represent the range of models of inquiry operative in Canada today.

While there is variation in the design of models of inquiry, the goal is consistent: preventing future domestic homicides. The various models (Table 2.1) have some structural similarities. However, they can also be vastly different so it is difficult to situate them in a linear fashion. This variation will be seen in more detail in coming chapters, but it also makes it difficult to describe the models of inquiry as categories rather than individual illustrations. As well, the models of inquiry to be examined here are only some of the ways that governments respond to a domestic homicide, and it is important to understand the connections to intervention efforts such as shelters, men's treatment groups, mandatory charging policies, and early intervention programs. Finally, no jurisdiction in Canada uses

only one method to examine domestic homicides. In most jurisdictions, DVDRCs are the most recent development in a continuum of interventions and there is evidence that they evolve and change over time. The following discussion will look sequentially at the different responses taken by selected jurisdictions across Canada.

Table 2.1 Selected Models of Inquiry in Canada

Year	**Province**	**Model of Inquiry**
1991	Manitoba	Pedlar Report
1996	Manitoba	Lavoie Inquiry
1999	Ontario	May-Iles Coroner's Inquest
2002	Ontario	Hadley Coroner's Inquest
2003	Ontario	DVDRC
2010	New Brunswick	DVDRC
2010	Manitoba	DVDRC
2010	British Columbia	Death Review Panel

Domestic Violence Death Review Committees

Domestic Violence Death Review Committees originated in the United States in the 1990s (Jaffe, Dawson, and Campbell, 2013: 138). One of the first reviews took place in San Francisco after the murder-suicide of Veena Charan at the hands of her ex-husband. This review identified factors that could help prevent future killings in similar situations (Websdale, 1999) and "highlighted the importance of such reviews in domestic homicide prevention" (Johnson and Dawson, 2011: 147). Since that time, DVDRCs have been implemented in over 40 states in the U.S., and other countries have followed suit. In Australia, for instance, the first DVDR team was formed in 2009. As of 2012, four Australian states—Victoria, New South Wales, Queensland, and South Australia—have DVDR teams in operation (Bugeja et al., 2013).

DVDRCs were implemented with the purpose of identifying common risk factors and more effective intervention strategies, with the goal of preventing future deaths in similar circumstances. Early reviews in the United States maintain that, "A preventable death is one in which, with retrospective analysis, it is determined that a reasonable intervention (e.g., medical, social, legal, psychological) might have prevented the death" (Montgomery County Domestic Violence Death Review Committee, 2009: 1). DVDRCs in Canada have similar views and recognize the importance of documenting the circumstances of a domestic homicide (Office of the Chief Coroner of Ontario, 2016).

The primary goal of a DVDRC is to gain a better understanding of why and how domestic homicides occur. This is done through a detailed examination of individual cases and an ongoing analysis of patterns and trends that emerge from these cases. The actual process of examining cases varies with each DVDRC, as does the composition of the committee, but the ultimate goal remains the same. Death review committees help to determine what could have been done differently to prevent the tragedy. Through the investigation, trends may be revealed that could lead to policy changes for the prevention of future deaths as well as enhancing programs and interventions that already exist in the community. Peter Jaffe, Myrna Dawson, and Marcie Campbell (2013) highlight four commonalities that exist among many DVDRCs: 1) identifying common risk factors for domestic homicide; 2) identifying systemic gaps or missed opportunities; 3) making recommendations; and 4) sharing information. It is important to note that most, if not all, DVDRCs in North America review cases involving male and female victims of domestic homicide. The DVDRCs that exist in Canada all review cases regardless of the gender of the victim and/or perpetrator; however, the gendered nature of domestic homicides results in

a majority of case reviews involving female victims.

DVDRCs are still relatively new in Canada, existing in some form in only four provinces: Alberta, Manitoba, Ontario, and New Brunswick. Saskatchewan recently announced plans to initiate a DVDRC (CBC News, 2015). In 2002, Ontario established the first DVDRC in response to recommendations stemming from two domestic homicide inquests (Office of the Chief Coroner of Ontario, 2003). In 1999, the jury in a coroner's inquest made a recommendation to create a DVDRC following the murder-suicide of Arlene May and Randy Isles. A similar recommendation was made in early 2002 by the jury in the coroner's inquest into the murder-suicide of Gillian Hadley and Ralph Hadley (Jaffe and Dawson, 2002). The Ontario DVDRC reviews cases of domestic homicides annually and, as the first Canadian committee, has become a model for other committees in the country.

The Ontario DVDRC operates under the authority of the *Coroner's Act* (1990), which gives the Chief Coroner the ability to convene committees of experts to assist in the investigation of a death. "The purpose of the committee, as outlined in its Terms of Reference, is to assist the Office of the Chief Coroner of Ontario in investigating and reviewing deaths of persons that occur as a result of domestic violence, and making recommendations to help prevent such deaths in the future" (Office of the Chief Coroner of Ontario, 2003: 3). The multi-disciplinary nature of the DVDRC is the result of the recognition that to fully and adequately investigate domestic homicide deaths, the committee would need to have experts and input from people involved in a variety of services and disciplines.

The Ontario *Coroner's Act* (1990) does not pertain solely to DVDRCs, as section 15 can be used to convene any number of necessary committees, but it lays out the legislation

used to establish a coroner's death investigation. Section 15(4) states that, "Subject to the approval of the Chief Coroner, a coroner may obtain assistance or retain expert services for all or any part of his or her investigation or inquest" (*Coroner's Act*, 1990). This *Act* facilitates the use of domestic violence experts and the creation of the Ontario DVDRC. Additionally, all information obtained as a result of the Coroner's investigation and provided to the Domestic Violence Death Review Committee is "subject to the confidentiality and privacy limitations imposed by the Coroners Act of Ontario and the Freedom of Information and Protection of Privacy Legislation" (Office of the Chief Coroner of Ontario, 2003: 6). The Ontario DVDRC continues to refine its process for reviewing cases as well as its process of gathering and presenting information on domestic homicide cases (Office of the Chief Coroner of Ontario, 2010: 3).

In 2008, the Manitoba government announced plans to create its own DVDRC to review domestic homicide cases in the province (Jaffe, Dawson, and Campbell, 2013: 139). This decision came following the April 2008 murder of Shannon Scromeda by her longtime boyfriend. The homicide prompted two back-to-back articles in the *Winnipeg Free Press*, calling for Manitoba to establish a death review committee (Skerritt, 2008; Winnipeg Free Press, 2008). Legislation was tabled through a Private Member's Bill in 2008, which was twice rejected by the Government although it continued to look into the matter and meet with local domestic violence experts.

Manitoba's DVDRC was established on June 16, 2010 (Manitoba Government, 2010) and to date has released four annual reports with recommendations (Manitoba Justice, 2013, 2014, 2015, and 2016). In 2013 a Government of Manitoba News Release stated that work had begun to address the recommendations from the committee and there would be

coordination with the Province's Domestic Violence Strategy (Manitoba Government, 2013). Similar to other DVDRCs, the Manitoba committee will continue to review selected domestic violence homicide cases, identifying trends, risk factors, and patterns by exploring the history, circumstances, and conduct of the perpetrators, victims, and their families and making recommendations to improve the criminal justice and social service systems' efforts to combat domestic violence (Manitoba Government, 2013).

The Manitoba DVDRC is made up of two groups: a working group and an advisory group. The working group consists of six individuals who are directly involved in the criminal justice system, which gives them access to confidential documents. The advisory group is made up of the working group plus six additional members, three of whom are government employees and three representatives from non-governmental organizations (Ursel, 2016). While the Ontario DVDRC falls under existing legislation for the Office of the Chief Coroner, the Manitoba DVDRC was formed without passing new legislation and exists without any specific governing legislation. A Private Member's Bill put forth by the opposition in 2008 and again in 2010 entitled *The Domestic Violence Death Review Committee Act* never passed second reading during either legislative session. However, the Manitoba DVDRC follows specific Terms of Reference and reports to the province's Attorney General.

In New Brunswick, a DVDRC was announced in 2009 and implemented in 2010 to serve as an advisory body to the Office of the Chief Coroner. The 2008 murder of John McKendy by his son-in-law highlighted the need for a committee in the province, which had experienced 54 cases of domestic homicide between 1990 and 2008 involving spouses, children, other family members, and new partners (Gill, 2013). The New Brunswick

Committee's initial work included an examination by the Muriel McQueen Fergusson Centre for Family Violence Research of all of the 32 intimate partner domestic homicides that occurred in the province between 1999 and 2008 (Communications New Brunswick, 2010).

Other provinces have also taken steps to establish a DVDRC. Alberta announced plans to implement a Family Violence Death Review Committee in 2013. The committee was formally established in 2014. Like other DVDRCs, the Alberta committee will review family violence deaths, identify trends, patterns, risk factors, gaps in service, and make recommendations to the Minister of Human Services with the goal of reducing family violence (Alberta Ministry of Human Services, 2015).

Public Inquiries

Another model for examining domestic homicides is the public inquiry, which has a long history in Canada as a means for developing and investigating policy and events of public importance (Carver, 2012; Inwood and Johns, 2016). Ed Ratushny (2009) defines a commission of inquiry as "a body created by a government under Part 1 of the *Inquiries Act* [or comparable act in other jurisdictions] or the corresponding provincial or territorial legislation. Its purpose is to make inquiries and report to the government its findings and any related recommendations" (Ratushny, 2009: 11). Ratushny cites a Law Reform Commission of Canada report that indicates some 400 inquiries have been established by the government under section 2 of the *Inquiries Act* with respect to the "good government" or "public business" of Canada (Ratushny, 2009: 14). These inquiries cover a variety of subjects and function in different ways. While some inquiries hold a largely advisory role, others are primarily investigative. "Broadly speaking, commissions of inquiry are of two

types. There are those that advise. They address themselves to a broad issue of policy and gather information relevant to that issue. And there are those that investigate. They address themselves primarily to the facts of a particular alleged problem, generally a problem associated with the functioning of government. Many inquiries both advise and investigate…" (Law Reform Commission of Canada, 1977: 13). This thesis will focus on investigative inquiries into domestic or family homicides.

Public inquiries in Canada can be held at the federal level, the provincial/territorial level, or jointly between the two with different federal and provincial legislation governing them. Under the Canadian *Inquiries Act*, the Governor-in-Council has the power to call a federal public inquiry "into and concerning any matter connected with the good government of Canada or the conduct of any part of the public business thereof" (*Inquiries Act,* 1985). The *Act* is broad and sets a process for establishing an inquiry as well as some of the powers and responsibilities of the inquiry. Following an inquiry at any level, the commissioner must submit a report, which may include recommendations to the government for policy or program changes.

Unlike DVDRCs, public inquiries are singular events, which respond to a particular concern and terminate when their investigation and report is completed. They are "established for a specific purpose—to investigate and report—and then cease to exist once that purpose has been achieved" (Ratushny, 2009: 2). Inquiries are intended to investigate rather than lay blame and are set up in a manner similar to court proceedings, with each interested party having their own legal representation and cross-examination of witnesses as part of the process. Public inquiries, like DVDRCs, only take place once all criminal proceedings have been completed and they cannot make findings about criminal

wrongdoing.

Throughout Canada, inquiries have been used to investigate a number of deaths. Most recently in Manitoba, there was a public inquiry involving the child welfare system. This inquiry examined the circumstances surrounding the death of a young girl, Phoenix Sinclair, who had been in the care of Child and Family Services but who seemingly fell through the cracks in the system. The Commission of Inquiry into the Circumstances Surrounding the Death of Phoenix Sinclair (Hughes, 2013) raised a number of issues related to the operation of a public inquiry as it was marked by a number of setbacks. Timelines were frequently pushed back, costs increased, and there were a number of issues around witnesses who feared that their reputations and careers would be ruined by their testimony. The hearings for the inquiry concluded in June, 2013 after 85 days of court time, 126 witnesses, 35 lawyers, five major delays, and an estimated cost of $9 million (Bowes, 2013).

With respect to domestic homicides, one high-profile public inquiry was the Manitoba Commission of Inquiry into the 1995 murder-suicide of Rhonda and Roy Lavoie. The inquiry heard from 67 witnesses and produced a substantial document, recommending numerous changes in various government departments to improve their response to domestic violence (Schulman, 1997). Domestic homicides, however, seldom result in a public inquiry, as the Alberta Council for Women's Shelters points out in their position statement calling for the creation of a DVDRC in the province (Alberta Council of Women's Shelters, 2010). In Canada this has been the motivation in many provinces to establish DVDRCs.

Among the Canadian provinces and territories, the legislation is similar. For

example, in Ontario, *The Public Inquiries Act* gives the Lieutenant Governor in Council the power to "establish a commission to conduct a public inquiry into a matter that the Lieutenant Governor in Council considers to be in the public interest" (*Public Inquiries Act*, 2009). Similarly, Part V of the *The Manitoba Evidence Act* grants the Lieutenant Governor in Council the power to call an inquiry. The inquiry is led by a commissioner who has the power to summon witnesses, examine witnesses under oath, view premises, issue a warrant for non-appearance of a witness, receive the services of experts, and search any related instruments, documents, or records without fee or charge (*The Manitoba Evidence Act*, 2011).

Within the literature on public inquiries, the issue of procedural fairness is one that plays an important role when comparing models of inquiry. An area of concern is around fairness and the potential arbitrariness and unfairness of decision-making. There has been some discussion as to the necessity of procedural fairness in public inquiries, as they only make reports rather than decisions. However, it seems that those beliefs are a minority and it is important to hold a public inquiry to the same level of fairness as a court. As Peter Carver has noted:

> There is little doubt … that investigative inquiries are subject to the duty of fairness in administrative law. This follows from three things. First, inquiry statutes authorize inquiries to compel the testimony of witnesses. This extraordinary power exposes witnesses to legal consequences, as well as denying them the right to remain silent in the face of public scrutiny and possible future prosecution. Second, the findings of fact of an inquiry carry with them significant consequences. Inquiry findings may be the closest our society comes to "received truth." Reputations can be made or broken as a result of these findings. Third, public inquiries generally operate like judicial hearings. It is neither difficult nor inappropriate for inquiries to be required to meet standards of fair process. (Carver, 2012: 14-15)

In *Baker*, it was emphasized that the duty of fairness is flexible and variable but that

there are a number of related factors to be considered (*Baker v. Canada*, 1999: 819). With fairness being the ultimate goal, Ratushny states, "in the context of commissions of inquiry, the most relevant [contextual factors to be considered] are the importance of the potential findings to the individual affected and the need for deference to the commissioner in choosing the manner in which fairness [is] sought to be satisfied" (Ratushny, 2009: 285). The basic objective of the principle of fairness is that underlying all of these factors is the notion that "the purpose of the participatory rights contained within it is to ensure that administrative decisions are made using a fair and open procedure, appropriate to the decision being made and its statutory, institutional, and social context, with an opportunity for those affected to put forward their views and evidence fully and have them considered by the decision-maker" (*Baker v. Canada*, 1999: 819).

In *Baker*, Justice L'Heureux-Dubé outlined five non-exhaustive factors for determining the extent of the procedural fairness required in any particular context: 1) the nature of the decision being made and process followed in making it; 2) the nature of the statutory scheme and the terms of the statute pursuant to which the body operates; 3) the importance of the decision to the individual or individuals affected; 4) the legitimate expectations of the person challenging the decision; and, 5) the choices of procedure made by the agency itself (*Baker v. Canada*, 1999: 819). These five factors will be useful when determining fairness in the cases of public inquiries, inquests, DVDRCs, and other models and the specific criteria for assessing their relative merits for tertiary prevention.

Inquests

An inquest is "an inquisitorial process designed to focus public attention on the circumstances of a death" (Office of the Chief Coroner of Ontario, 2015a: 4). In Canada,

inquests into a death are legislated at the provincial level, with different systems for governing proceedings. Similar to other models of inquiry, an inquest is not a court process where one is looking to lay charges or place blame. Instead, "an inquest is designed to be an impartial, non-adversarial and procedurally fair, fact-finding inquiry committed to receiving as much relevant evidence about the facts and issues surrounding the death of a community member as is in the public interest, but without making findings of criminal or civil responsibility" (*Hudson Bay Mining and Smelting Co. v. Cummings*, 2006). Learning from events and preventing similar deaths from occurring in the future remains a goal of this model.

In Manitoba, *The Fatality Inquiries Act* (1990) gives the chief medical examiner the ability to hold an inquest into any death. The inquest is to be conducted by a provincial court judge who, after hearing all evidence and completing the inquest, submits a report. The report must include "when, where and by what means the deceased person dies, the cause of death, the name of the deceased person, if known, and the material circumstances of the death" (s. 33 (1)). The report may also include recommendations that the judge believes "would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest" (s. 33 (1)).

In Ontario, the *Coroner's Act* (1990) empowers the coroner and a jury to investigate the circumstances of a death and make recommendations if they wish. Section 20 of the *Act* states that, "When making a determination whether an inquest is necessary or unnecessary, the coroner shall have regard to whether the holding of an inquest would serve the public interest and, without restricting the generality of the foregoing, shall consider… the desirability of the public being fully informed of the circumstances of the

death through an inquest; and the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances." Flexibility in the model exists allowing the chief coroner to "make additional rules of procedure for inquests" (s. 50 (1)).

As in Manitoba, an inquest in Ontario must answer five questions when investigating a death: who was the deceased, where did the death occur, when did the death occur, how did the death occur, and by what means did the death occur? In addition to considering whether the answers to these five questions are known, the coroner may consider the potential to prevent future deaths when determining whether to hold an inquest. "The preventative function is a very important aspect of inquests because it encourages changes that will result in a safer province. Recommendations from previous inquests have resulted in changes to legislation (e.g. graduated licensing and labour laws, policy (e.g. how the police and courts administer justice), procedures (e.g. how we protect children and how safe medical practices are encouraged) and product development (e.g. safety mechanisms for motorized vehicles and other consumer goods)" (Office of the Chief Coroner of Ontario, 2015a: 4).

The jury in a coroner's inquest consists of five people from the community who, at the end of the inquest, must deliver a verdict answering the five questions. They may also make recommendations based on the evidence presented during the inquest and are encouraged to take an active role in the process by asking relevant questions of witnesses. (s. 37 (2)). In addition to the coroner, a Crown attorney acting as counsel to the coroner, the jury, and witnesses, an inquest may allow parties with standing to take an active role in the process. "On the application of any person before or during an inquest, the coroner

shall designate the person as a person with standing at the inquest if the coroner finds that the person is substantially and directly interested in the inquest" (s. 41 (1)). Parties with standing may call and cross-examine witness and they may present recommendations to the jury for consideration after all evidence has been heard.

There are situations where an inquest is mandatory, for instance, deaths occurring in a psychiatric facility, while the deceased was being held in custody, or a death resulting at a construction site, mining plant, or mine (*Coroner's Act*, 1990). With cases of domestic homicide it is more likely that a discretionary inquest will be called for a particular reason relating to an individual case. In two Ontario inquests into the homicides of Arlene May and Gillian Hadley by their former male partners, the cases were selected for their representative qualities and the recommendations that resulted helped to spark the formation of the Ontario DVDRC.

Other Models of Inquiry

In contrast to the DVDRCs found in a number of provinces, British Columbia took a different route and created a one-time panel to review a number of domestic violence deaths. Over three days in March, 2010, the British Columbia Death Review Panel was convened under the *Coroner's Act* to conduct a one-time review of 11 domestic homicides across the province dating back to 1995 (BC Coroner's Service, 2010). The BC panel was essentially a hybrid of the two main inquiry models. Like a public inquiry, it was a singular event rather than an ongoing committee; however, it was also like a DVDRC in its multidisciplinary approach and its exclusive focus on domestic homicides, with an emphasis on looking at patterns and making connections between a number of cases. While over 100 case files were reviewed for selection, the 11 incidents that were ultimately

selected represent “case illustrations of the most compelling and significant domestic violence risk factors and systemic gaps” (BC Coroners Service, 2010: 1). In this way, the panel was also like an inquiry or inquest, which selects a representative case.

Similar to British Columbia, the province of Quebec established a 17-person Committee of Experts on Domestic Homicides in October, 2011. The purpose of the committee was to “analyze the extent of this issue in the province, identify best practices, services, and tools available to assist in preventing domestic homicide, and form recommendations for the Minister of Health and Social Services” (http://cdhpi.ca/national-provincial-initiatives). The committee submitted its 71-page report to the Quebec Minister of Health and Social Services in November, 2012 (Ministère de la Santé et des Services sociaux, 2012).

In-depth reports are another model for examining domestic homicides. The Pedlar Report in Manitoba was an alternative approach. Submitted to the Minister of Justice in 1991 by Dorothy Pedlar, it was motivated by a domestic homicide. However, its focus was very specific to examining police response to domestic violence calls. It was established as a fact-finding mission and involved province-wide consultations and feedback from women who had been victims of domestic violence. The report also included recommendations to specifically address adequate protection for and sensitive treatment of women by police and more generally the justice system.

Concluding Remarks

This chapter has introduced some of the models of inquiry that exist in Canada following a domestic homicide. While there are certainly more examples in operation, the particular focus of this research will be on an inquiry (Manitoba), two coroner’s inquests (Ontario),

three DVDRCs (Manitoba, Ontario, and New Brunswick), and a death review panel (British Columbia). DVDRCs and death review panels are relatively new to Canada and, overall, there is limited research on the potential of each of these models for tertiary prevention. As such, more information is needed to better understand how each model might contribute to preventing future deaths from occurring. The following chapter outlines the methods used to assess the tertiary prevention potential of these models.

Chapter 3: Methodology

The purpose of this thesis is to assess DVDRCs, public inquiries, inquests, and other models of inquiry in terms of their potential for tertiary prevention. The methodology for this study was comprised of two components meant to complement and enhance each other in order to reach a fuller understanding of the potential of each model of inquiry. The first component involved secondary data analysis of relevant literature and key documents related to domestic homicides, DVDRCs, public inquiries, and inquests. The second component involved qualitative, semi-structured interviews with key informants who have been involved in the various models of inquiry. Using these two strategies for this project meant that data collection and analysis could be carried out concurrently, allowing for flexibility in the research as understanding of the subject grew.

Secondary Research

The secondary data collection involved two stages of document review. The first stage consisted of reviewing prominent documents on domestic homicides, DVDRCs, public inquiries, inquests, and other models of inquiry. This provided general information about the various models through reviewing annual reports, provincial legislation, news releases, committee publications, North American literature on death review committees, journal articles and recent publications, and texts relating to the operation of public inquiries. This stage helped to shape the interview guide and inform the selection of provinces and experts for the interviews. The second stage took place during and following primary data collection. It involved returning to the documents to address and clarify specific issues arising from the interviews throughout the data collection process. There is limited

research on this subject and, as such, the available literature and documents were relied on to guide the major themes of the thesis and the analysis of findings from the primary research.

Primary Research

The second part of data collection involved qualitative, semi-structured interviews with experts who have experience with the various models of inquiry. The use of semi-structured interviews was aimed at gathering specific information about the models of inquiry from those who are closely involved. Given the limited literature in this field and the lack of comparative research, interviews with key stakeholders who are knowledgeable about the subject enabled a more thorough investigation of the topic and the addition of a new perspective to the domestic violence and domestic homicide literature. As well, using a qualitative methodology allowed the respondents to "explain their experiences, attitudes, feelings, and definitions of the situation in their own terms and in ways that are meaningful to them" (Van den Hoonaard, 2012: 78). While the interviews were guided by a series of questions, respondents were free to shift the conversation and the definition of the problem as they talked about their area of expertise.

Sample Selection

In selecting the sample for the interviews, two initial considerations had to be made: the provinces and the people. Given the number of models of inquiry that exist in Canada, it was important to choose a range in terms of public inquiries, inquests, new and established death review committees, and other models. The secondary data analysis was not limited to particular provinces and was able to provide valuable information on models of inquiry

across North America, but for the interviews British Columbia, Manitoba, Ontario, and New Brunswick were selected. These four provinces and the interview respondents were chosen based on two considerations: ensuring that a full range of models would be represented, and the availability and expertise of respondents.

In addition to covering a range of models and expertise, efforts were made to include respondents who are both internal and external to the process to provide further variety in perspectives. Internal respondents were identified as people who work in the government or legal system and who were involved in the DVDRC, death review panel, inquest, or inquiry process in that capacity. External respondents are those involved in the inquiry process from an outside position, such as an academic, a researcher, a social worker, or a domestic violence practitioner. This internal/external designation is significant in that it may impact the perspective individuals bring to the process and their access to information during the process.

Interview respondents were identified and selected by reading annual reports, newspaper articles, membership lists, and websites related to each model of inquiry. To be considered for the study, the participant must have had direct experience participating in one of the following models of inquiry: public inquiry, inquest, DVDRC, or other model of inquiry. All but one of the respondents had direct experience with one or more of the models of inquiry involving domestic homicide cases; this respondent was included based on extensive experience with an inquiry involving the death of a child under the care of the child welfare system. In total, 11 people were interviewed over nine formal interviews (two of the participants were interviewed together) and one informal phone conversation. Four in-person interviews were conducted in Manitoba with five participants, and six

phone interviews were completed: two from British Columbia, three from Ontario, and one from New Brunswick. In terms of the internal/external distinction, five of the participants could be classified as "internal" and six as "external." While I was mindful of ensuring a representation of respondents who were both internal and external to the process during the sample selection, because of the small sample size it was not possible in the reporting of findings to identify each respondent as one or the other without compromising their anonymity.

As with all studies of this nature, limitations exist. As will be discussed further in Chapter Six, this study is limited by its small sample size and the number of models chosen for examination. As well, there are no doubt other inquiries and inquests that could have been explored, and DVDRCs are continually evolving and growing in number, making it difficult to explore fully the range of models in use across Canada.

Method

Prior to beginning the primary data collection, approval was received by the University of Manitoba Psychology/Sociology Research Ethics Board. A significant ethical concern in this project is the possibility for identification of respondents due to the small size of the sample. The consent form, which was signed by all respondents, stated that steps would be taken to ensure that confidentiality would be maintained throughout the data collection process and in written reports using these data. Nevertheless, respondents were also warned: "Despite these precautions, this is a small study involving a limited number of inquiry processes; therefore, there is a possibility that you could be identified by your responses. We will take the necessary procedures to keep the information confidential. If

this concerns you, then you should not participate in an interview" (see Appendix A: Interview Consent Form).

Once potential respondents were identified, those selected were then emailed to determine if they would be interested in participating in the study. These introductory emails outlined the project, issues of confidentiality, and details of participation (see Appendix B: Invitation to Participate). Once confirmation was received that they would be willing to participate, interviews were scheduled and held either in-person or over the phone, depending on the geographical location of the participant. Consent forms were completed by email for participants in British Columbia, Ontario, and New Brunswick and in-person for participants in Manitoba, with verbal agreements recorded at the start of each interview. All interviews were audio recorded and later transcribed for analysis purposes (in the case of the informal phone conversation, notes were taken of what was being said).

The interview guide focused specifically on DVDRCs, public inquiries, inquests, and other models to explore similarities and differences and canvass respondents on the relative merits of these different models of inquiry (see Appendix C: Interview Guide). Following accepted practice for qualitative, semi-structured interviews, the interview guide included questions that were directed in such a way to allow the research question to be answered, but broad enough to allow for further probing of avenues of discussion (Kirby, Greaves, and Reid, 2006: 134). The interview guide was split into three parts, with one set of questions worded specifically for those with experience in DVDRCs and other models, a second set of questions worded for those with experience in inquiries and inquests, and a third section of broader comparison questions for all participants to answer. Questions

explored seven main areas: origins, structure, membership, case selection, finances, reporting and recommendations, and assessment and efficacy for tertiary prevention. These seven areas were selected based on examining secondary data and seeing the main themes that exist in the models of inquiry. It was determined that each of these areas would allow for a thorough discussion of each model of inquiry by ensuring that participants were asked questions in broad areas. The literature points to these factors as being relevant distinctions that would enable thorough exploration of the research question. For example, the literature identifies how a tragic homicide that receives considerable media attention causes the public to be particularly concerned about prevention, often leading to a call for an inquiry/inquest or the development of a DVDRC. Thus, exploring the origins of an inquiry or DVDRC was a necessary component to include in the interview guide.

Data Analysis

All interviews were transcribed (with identifying information removed when possible) and given a code 'P01' to 'P11.' Each transcript was read a number of times to identify themes, both those that were mapped out in the interview guide as well as any emergent themes raised by respondents. As is typical with qualitative research, some transcripts were read before all of the interviews were complete, which helped to identify additional questions or areas to address in subsequent interviews. For instance, a question was added about the extent to which people may be thinking pragmatically when writing recommendations. This question was intended to gather additional insight into the recommendation process and the issue of implementation. This process also involved returning to the secondary data to identify themes for use in analysing transcripts. In addition to the themes outlined

in the interview guide, transcripts were coded to reflect themes relating to Bacchi's WPR approach and the five factors outlined in the *Baker* decision regarding procedural fairness.

In the initial stages of the analysis process, numerous criteria were used to assess and compare the different models of inquiry. These criteria were drawn from the literature on inquiries, inquests, DVDRCs, and domestic homicide risk factors and were also reflected in the interview questions. They relate to a model's overall organization and are different from those that are built into the models, as they are ones that facilitate the actual work of a DVDRC review, inquest, or public inquiry. The criteria include: frequency, costs, timelines, membership, structure, process, recommendations, reporting, implementation, and monitoring.

Frequency has to do with how many cases can be conducted in a given time as well as the ability of the inquest, inquiry, or DVDRC to examine each domestic homicide that occurs. For instance, the 1995 Lavoie Inquiry was the last domestic homicide inquiry in Manitoba, despite there being 79 victims of spousal homicide in the province from 1997 to 2015 (Statistics Canada, n.d.). The 2007 Dupont Inquest is the most recent domestic homicide inquest in Ontario; however, since the provincial DVDRC was created that same year, they have reviewed 267 cases involving 376 deaths that occurred between 2003 and 2015 (Office of the Chief Coroner of Ontario, 2016: 1). *Costs* include both financial and human resources. Financial costs involve the overall costs involved in running an inquiry, inquest, or DVDRC. Human resource costs involve the number of people required as well as the type of people involved and what sort of implications this has for the overall efficiency of the model. *Timelines* include the period from beginning to completion for different inquiries. *Membership, structure, process,* and *recommendations* are all main themes of

analysis concerning the differential operation of DVDRCs, inquiries, inquests, and other models and were examined in terms of how they are used and how they differ between the models. *Reporting, implementation,* and *monitoring* involve the final stages of an inquest, inquiry, DVDRC, or other model, including how any decisions are disseminated and what type of follow-up or monitoring exists for any recommendations made as a result of the case review(s).

In addition to the above criteria, the five factors outlined in the *Baker* decision helped to guide this initial analysis stage of the inquiry models on the subject of procedural fairness. The first factor, *the nature of the decision being made and process followed in making it,* aided in the examination of the different processes involved in inquiries, inquests, DVDRCs, and other models. The second factor, *the nature of the statutory scheme and the terms of the statute pursuant to which the body operates*, was applied to each of the models. For instance, of the three provincial DVDRC models being examined (Manitoba, Ontario, and New Brunswick), one is statutorily embedded while the others are policy-based. Does it make a difference in their potential for tertiary prevention? The third factor, *the importance of the decision to the individual or individuals affected*, raised some interesting questions on the breadth of individuals considered to be affected. Who are they? How are they determined? Are there limitations within inquiries and inquests about individuals who have standing? What implication does this have for the determination of persons considered to be affected? Do DVDRCs have similar challenges? The fourth factor, *the legitimate expectations of the person challenging the decision*, involves a number of expectations for those participating in a DVDRC, inquest, or inquiry, such as fair process, receiving an open hearing about their experiences, expectations for change, and ensuring

compliance with the rules of procedure and practice set out for the specific model. Finally, the fifth factor, *the choices of procedure made by the agency itself*, relates to the fact that inquiries and inquests have the flexibility to choose the individual procedure for each case, while DVDRCs have a set procedure provincially.

In order to make the presentation of the findings and the analysis more manageable, the key criteria that emerged from the initial stage of the analysis process were then organized into three main categories: *representation* (who is being heard during the proceedings); *procedural fairness* (the choice of procedure and the process followed in making decisions and recommendations); and *accountability and oversight* (the provisions for implementation of the recommendations). Each of these categories is used in elaborating on and comparing the different models of inquiry in the next two chapters. Other criteria (for example, frequency or cost) are included where relevant in the discussion of the potential of each model for tertiary prevention.

In addition, examining each of the models in terms of their potential for tertiary prevention involved an assessment of the extent to which known risk factors associated with domestic homicide are brought into account. In that regard, the WPR approach (Bacchi, 1999, 2009) is used to examine how the problem of domestic violence is represented in each of the models. This approach sensitizes policy analysis to the idea that the definition of the problem can shape the policy solution. By questioning the definition of the problem, we can dig deeper into some of the presumptions built into a particular model of inquiry.

Concluding Remarks

A variety of models—inquiries, inquests, Domestic Violence Death Review Committees, and review panels—have been used to respond to the issue of domestic homicide in Canada. These inquiries have the common aim of identifying intervention opportunities, behaviour patterns, and risk factors to assist in the prevention of future homicides. In order to assess their potential for tertiary prevention, the next two chapters outline and assess these models of inquiry, drawing on the insights of the 11 interview respondents as well as information obtained from secondary sources. Chapter Four examines inquiries and inquests, while Chapter Five examines Domestic Violence Death Review Committees and the death review panel that was convened in British Columbia. Chapter Five also includes a comparative analysis of the four models of inquiry, drawing on the three areas of analysis (representation, procedural fairness, and accountability and oversight) as well as Bacchi's WPR approach. The main conclusion reached is that while each model has its particular assets and challenges, in combination they offer a path forward in combatting the serious problem of domestic homicide.

Chapter 4 Findings: Inquiries and Inquests

Inquiries and inquests are two models of inquiry used to investigate domestic homicide deaths. These two models share a number of characteristics: they focus on a singular incident of domestic homicide; they are one-time events; and they are public in nature. The purpose of this chapter is to assess their potential for realizing tertiary prevention, focusing especially on the Lavoie Inquiry in Manitoba and the May-Iles and Hadley Inquests in Ontario. Three main areas of analysis will be considered: representation (who is being heard during the proceedings); procedural fairness (the choice of procedure and the process followed in making decisions and recommendations); and accountability and oversight (the provisions for implementation of the recommendations). Following that, each model will be assessed in terms of its potential for tertiary prevention. Attention will be focused on how the problem of domestic homicide is being represented in each of the models and their strengths and limitations.

Public Inquiries

Public inquiries typically proceed by hearing evidence and statements from witnesses, and then offering recommendations aimed at preventing similar incidents from occurring. The Manitoba inquiry into the deaths of Rhonda and Roy Lavoie sheds light on the inquiry process and provides an opportunity for an analysis of the potential of this model for realizing tertiary prevention of domestic homicide deaths. While the Lavoie Inquiry examined a domestic homicide case, another Manitoba inquiry into the death of Phoenix Sinclair, a little girl who died while in the care of the child welfare system, can also offer insights into the inquiry process and the recommendations that result, especially in

relation to the tertiary prevention potential of the inquiry model. Some of the potential limits of the inquiry process can also be learned from an examination of the Missing Women Commission of Inquiry that was held in British Columbia to investigate the disappearance and murder of dozens of women in Vancouver's Downtown Eastside (Oppal, 2012a).

The Death of Rhonda Lavoie [5]

The bodies of Rhonda and Roy Lavoie were found on January 20, 1995 following a lengthy period of abuse perpetrated on Rhonda by her husband Roy (from whom she was separated at the time of their deaths). The couple started dating when Rhonda was just 14 years old; Roy was 22. They began living together two years later, and were married when Rhonda was 20. At the time of their deaths, Rhonda was 22 and Roy was 30 years old. They left behind three children, aged six, four, and two.

Rhonda experienced escalating abuse and violence in her relationship with Roy with early violence including being pushed and restrained by Roy. Roy also called Rhonda by abusive names, such as "slut," "whore," and "cow." The couple's first involvement with the criminal justice system occurred in November, 1993 when Rhonda phoned the police after Roy threw a pumpkin at her. After Winnipeg Police Service Constables Walls and Santiago attended to the house, Roy was charged with assault and taken into custody. He was released on bail later that same day. The conditions of his release prohibited him from contacting or communicating with Rhonda and from going to their home; he also promised to attend counselling. In December, however, Rhonda agreed to reconcile with Roy and she

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[5] The information on the relationship between Rhonda and Roy Lavoie discussed in this section has been drawn from the Inquiry report (Schulman, 1997).

asked an advocate at the Women's Advocacy Program to notify the Crown that she did not want the charges against Roy to proceed. The charges were stayed and Roy moved back home. The abuse continued, with Roy becoming more physically violent during arguments: pushing her, restraining her with increasing force, and pinning her shoulders to the bed or floor.

In November, 1994 Rhonda told Roy that she wanted to separate. Roy did not want to end their relationship, but agreed to move in with a friend. Instead, without Rhonda's knowledge, Roy took up residence in the garage of their family home. He also installed a device that allowed him to listen in on telephone calls made inside the home. Two days after he moved out, Roy overheard a sexually explicit phone call between Rhonda and a man she met in Grand Forks. The following day, Rhonda went to Grand Forks for the weekend with her friend, Rita Emerson, leaving Roy in the family home with their children and his brother and sister-in-law. When she returned on the Sunday, Rhonda stopped in at her house to see the children, intending to spend the night with Rita.

Roy attempted to interrogate Rhonda about her activities that weekend, following her around the house and preventing her from leaving. Rhonda tried to call for help, but discovered that Roy had removed the phone. Unbeknownst to Rhonda, Roy had also arranged to have his brother and sister-in-law take the children to Beausejour (some 60 kms. away) to stay with his mother. So Rhonda found herself alone in the house with Roy.

Over the next 24 hours Roy terrorized Rhonda, chasing her through the house, ripping off her clothes, pinning her down, binding her hands with a cord, gagging her with a sock and sanitary napkin, beating her repeatedly, and threatening to kill her. At one point Rhonda managed to escape, but Roy caught her and dragged her back into the house by her

hair. Roy then locked Rhonda in the cold room and read her a love poem he had written for her through the door. On releasing her from the cold room, Roy took her to the bedroom and bound her limbs to the bed. "He tried to force Rhonda to swallow Tylenol and other pills. He shaved her pubic hair. He assaulted her with a curling iron and a banana. Finally, he raped her" (Schulman, 1997: 4).

Rhonda's friend Rita, who had been expecting her to stay the night, was worried when she did not show up. She went to the Lavoie home the next morning to find Rhonda. Though she was able to see the shoes Rhonda had been wearing in Grand Forks, Roy refused to open the door and denied that Rhonda was, or had been, in the home. Rita called the police and Constables Walls and Santiago responded, but they left when no one answered at the house or the garage. Inside the garage, Roy was holding Rhonda captive in the car, but she was too terrified to yell for help.

Once the police left, Roy drove Rhonda to an isolated cabin in the Whiteshell Provincial Park. He restrained Rhonda by tying her arms behind the car seat, attached a hose to the exhaust pipe, and ran the other end of the hose into the car through the sunroof. He then wrapped a blanket around the sunroof edges to create a seal, got in the car, and turned on the engine. With exhaust fumes filling the car, Rhonda pleaded with Roy to let her go. When Roy told her that he was doing this because he did not want to go to jail, Rhonda promised not to involve the police if he left her alone and got counselling. Roy turned off the car and promised to get help.

Stopping in Beausejour to see their children on the way back to Winnipeg, Rhonda and Roy learned from Roy's mother and his sister-in-law that the police were looking for them. After calling the police, Roy told Rhonda's friend Rita—who had called to find out if

Roy's mother had heard from the couple—that he had raped Rhonda and he did not want to go to jail. He also told his sister-in-law that he had done terrible things, but no details were shared. The children stayed with Roy's mother in Beausejour, and Roy and Rhonda travelled back to the city.

With a key obtained from Rhonda's mother, Constables Walls and Santiago returned and walked through the home with Rita, making notes on what they saw. Rita returned to the house later that evening with her friend, Mitch, to meet Rhonda and Roy. Rita noticed that Rhonda was wearing a turtleneck that covered her neck and arms and that her lipstick was covering up a swollen lip. Rhonda and Roy told their two friends that they did not want to involve the police and that Rhonda was going to say Rita had misunderstood her plans on their return from Grand Forks. Constables Morrow and Liebrecht, new to the case, then arrived at the house. They asked Rhonda—in Roy's presence—whether she was alright. Rhonda said she was, and that there had been a misunderstanding. Accepting her story, the officers left without any further questioning.

With the police gone, Roy and Rhonda had separate conversations with their two friends about the incidents that had taken place. Roy told Mitch details about tying Rhonda up and raping her with foreign objects and how he had intended to kill them both. Rhonda also told Rita the story but with much greater detail, showing her the foreign objects Roy had raped her with, the clothing he had ripped off her body, the restraints he had used, and the bruises he had inflicted on her arms, neck, and thighs.

A third team, Constables Tyndall and Speirs, got involved in the case after Mitch phoned the police the next day and told them what Roy had said. They met with Mitch in person and took further details, but he was not asked to provide a written statement. When

the two officers went to the Lavoie home and told Rhonda what Mitch had said, she denied the story. The officers left after seeing no signs of injury on her wrists and neck. Following the advice of a Crown attorney, Constables Tyndall and Speirs returned to Mitch's apartment and had him provide a written statement. Rita was also present but she refused to give a statement as Rhonda had chosen not to disclose the events. Neither of them told the police about Roy's attempt to asphyxiate Rhonda in the Whiteshell.

A week later, Rhonda was interviewed by Constables Walls and Santiago, the two officers who had originally attended the home in November, 1993 after Roy had assaulted Rhonda. She initially denied that anything had happened, but she broke down after hearing Mitch's statement and admitted that she had been physically and sexually assaulted by Roy. She gave a lengthy statement outlining the events but did not disclose his attempt to asphyxiate her in the car in the Whiteshell. Rhonda initially declined the offer of medical attention and said she was comfortable staying in her home, but she changed her mind after receiving a call from Roy. A police officer, Constable Siwak, drove her and the children to Rita's home.

When he found out that the police were looking for him, Roy went voluntarily to the police station where he was placed under arrest, charged, and cautioned. Constable Antaya and Sergeant Harrison, both new to the Lavoie case, interviewed Roy and showed him the detailed statement Rhonda had provided. He seemed upset and confused during the interview and, on the advice of his lawyer, refused to give a statement. Roy did, however, acknowledge that there was some truth in what Rhonda had said and he tearfully asked what was going to happen to him. Roy was offered psychiatric assistance and was told by the sergeant that they would oppose an application for interim release.

When she was given an update that Roy had been arrested, Rhonda told the police officers that Roy was a good father, that the sexual assault was out of character, and that she did not want him to go to jail. Rhonda said she was afraid that he would try to kill himself if he ended up in jail. Roy was charged with Assault, Sexual Assault, Unlawful Confinement, Committing a Sexual Assault with a Weapon, and Uttering Threats. They also made a note for the corrections officers at the Remand Centre that he was suicidal. Roy was held in custody for three days and, during that time, made at least one call to Rhonda, offering money for the children if she helped in getting him released.

Roy's application for judicial interim release was heard in Provincial Judges Court on December 5, 1994. While the Crown opposed the application, the court was told by Roy's lawyer that Rhonda supported his application. Roy was subsequently released on his personal recognizance in the sum of $1,500. A number of conditions were also specified: that he reside at a friend's house; that he not contact Rhonda; that he stay at least three blocks from the Lavoie home; that he not consume alcohol and drugs; that he not possess firearms; and that he follow a curfew from 9pm to 7am.

Rhonda and Roy had some contact over the next few days when Rhonda would drop off the children at Roy's new residence or when he would return the children to her home. They spent some time together in both homes and, after decorating the Christmas tree in the Lavoie house, Rhonda drove Roy back and they talked in the car for about half an hour. However, on December 13 Rhonda discovered a tape recorder inside the locked garage and found that it had recordings of calls she had made and received earlier in the day. After playing the tape for Rita, they called the police, but Roy came into the home and removed the equipment from the hallway before the police officers arrived. Constables Kuzma and

Sveinson, a fifth team of officers, arrived at the house and took a written statement from Rhonda. Roy was arrested the next day and charged with three counts of Failure to Comply with Recognizance and one count of House Break and Enter with Intent. He was held in the Remand Centre for two days. On December 16, although the Crown Attorney opposed his release and Rhonda did not support it, the judge released Roy on his personal recognizance of $2,000 with the same conditions as before and further conditions that he not contact or communicate with the children and that he not be near Rhonda's home or work or the children's school. Rhonda and Rita frequently tried to check to make sure Roy was complying with the curfew, and Roy obtained permission to move to his mother's house in Beausejour.

On December 20, Rhonda retained a lawyer to initiate divorce proceedings. She told her lawyer about the physical and sexual assault that had taken place the previous month and about Roy's subsequent criminal charges as a result. Rhonda also told her lawyer about his attempted asphyxiation in the car in the Whiteshell and how she had not given that information to the police. Her lawyer suggested she make a further report to the police. When Rhonda reported this incident to Constable Walls on December 24, he questioned her as to why she had not reported the incident earlier. Rhonda became upset and hung up the telephone. The constable called her back shortly after, asking if she felt she was in danger from Roy. Rhonda responded that she was not afraid for her safety and that things had been going well. A meeting was set up for a few days later. This meeting was rescheduled for the following week because Rhonda was not home when the officers arrived at the house, saying she had misunderstood the date. When Constables Walls and Santiago returned to the home on January 4, 1995 Rhonda was reluctant to let them in.

Although they encouraged her to tell them about the attempted asphyxiation Rhonda refused, saying she did not want to "stir things up."

While Roy was out of the province for a week, Rhonda's lawyer filed for divorce and included an affidavit with a detailed account of the horrific events of the previous month, including what happened in the car. Roy was served the court documents on January 16, which was the first time he learned that Rhonda had filed for divorce and had disclosed the details of the attempted asphyxiation. On January 18, after leaving the children with a babysitter, Rhonda and Rita returned home and saw Roy in his van. When they got in the house everything was in order and Rita left to drive the babysitter home. When she returned, Rhonda was gone and the children were alone in the house.

The police began an extensive search for the couple, which broadened and intensified given their knowledge about Roy's previous attempt to kill Rhonda and commit suicide. Rhonda and Roy were found in the Lavoie van on January 20, 1995 at a farm north of Gimli. Rhonda was restrained with handcuffs and a hose ran from the exhaust pipe into a window. They both died by asphyxiation in a manner almost identical to Roy's earlier attempt.

The deteriorating relationship between Rhonda and Roy Lavoie reflected many of the risk factors that have been highlighted in the research, including a history of domestic violence and escalating violence, prior threats or attempts to commit suicide and/or kill the victim, and an actual or pending separation. The case also exposed several gaps in the system for responding to domestic violence; in particular, the multiple police teams involved with Rhonda and Roy and the apparent miscommunication or lack of

communication within the criminal justice system as well as Roy's release from custody despite documented abuse.

The Lavoie Inquiry

The Order-in-Council for the Commission of Inquiry into the Deaths of Rhonda Lavoie and Roy Lavoie was approved and submitted November, 1995. The Hon Mr. Justice Perry Schulman was appointed as the Commissioner. The Order in Council set a scope beyond the deaths of Rhonda and Roy Lavoie; it set out that the commission of inquiry "inquire into whether there presently exists appropriate processes within the criminal justice system to deal with the issue of domestic violence" (Schulman, 1997: ix).

In terms of representation, seven applications for standing were made at the inquiry. In responding to these applications, Commissioner Schulman cautioned that the inquiry could become "unproductive and wasteful" if every individual and/or entity who may be affected by the matters to be examined were to be granted standing (Schulman, 1997: 217). In determining the "substantial and direct interest" of the applicants, therefore, Commissioner Schulman held that four parties had a direct interest in the outcome of the proceedings and were therefore granted full standing to participate in the inquiry: the Government of Manitoba; the City of Winnipeg; Judith Protosavage, Rhonda Lavoie's mother; and Margaret Lavoie, the mother of Roy Lavoie, and the Lavoie family. Two parties—the Coalition Opposed to Violence against Women and the Manitoba Association of Women's Shelters—were granted limited standing "to be present and monitor the inquiry and to make a submission to the inquiry after all of the evidence has been called" (p. 221). Rita Emerson, Rhonda's friend, was denied standing. Commissioner Schulman noted:

> In denying Ms. Emerson standing at the inquiry I do not intend to minimize the effect that the loss of Rhonda Lavoie has had on Ms. Emerson, or to suggest that the information which Ms. Emerson is able to provide is not significant. On the contrary, I understand that Ms. Emerson has suffered as a result of Rhonda Lavoie's death, and I believe that Ms. Emerson will be an important witness at the inquiry. (Schulman, 1997: 222)

Commissioner Schulman also outlined the practices and procedures to be adopted at the inquiry, with the goal of ensuring "that the inquiry is conducted in a manner which is effective, efficient, practical and expeditious" (p. 222). Nine rules of procedure were outlined, including that the presentation of all evidence would be by oral testimony and the filing of relevant exhibits, and that the Commission counsel was to call and examine all witnesses and then Counsel for parties granted standing would then cross examine them (pp. 222-23). Sixty-seven witnesses appeared before the inquiry, including police officers, social service workers, domestic violence researchers, and members of the Lavoie family. The final report and recommendations were submitted to the Manitoba Minister of Justice in June, 1997.

The Lavoie Inquiry made 91 recommendations. These recommendations included changes and improvements to a number of public and private organizations in Manitoba that deal with cases of domestic violence. Recommendations pertained to the Winnipeg Police Service, the Family Violence Court, Women's Advocacy Program, Community and Youth Corrections, Civil Restraining Orders, Social Services Agencies, Social Allowances, the legal profession, public awareness, as well as six general recommendations. Significantly, the Schulman report recommended the establishment of a committee to oversee the implementation of its recommendations (#88), as well for the government to commit "real dollars" to implement the recommendations of the report (#86) (Schulman, 1997: 115, 116).

On September 19, 1997 the Manitoba Government created a three-person Lavoie Inquiry Implementation Committee mandated to respond to the 73 recommendations directed at the provincial government. The additional 18 recommendations from the report were directed at the Winnipeg Police Department (16), the Law Society of Manitoba (1), and the Faculty of Law at the University of Manitoba (1) and responsibility for implementing those recommendations was with the institutions themselves.

The implementation committee engaged in what it termed "participatory policy making": "that the process of implementation reflect the call for democratizing responsibility by engaging the community in the process of change" (Lavoie Implementation Committee, 1998: 5). To that end, 14 working groups were formed around clusters of recommendations in the Schulman report. The working groups were comprised of 135 individuals; 92 were community representatives (36 of whom were from outside of Winnipeg) and 43 were government staff (p. 6).

The Potential of Inquiries for Tertiary Prevention

The investigation into the Lavoie deaths took one particular case and used it as the backdrop for a larger investigation and conversation about policies and practices and ways to strengthen the system. As noted by Commissioner Schulman, "This Commission of Inquiry sought to find in the murder-suicide of a young married couple the lessons that would save others from their fate" (Schulman, 1997: i).

One interview respondent recalls that the Lavoie Inquiry came "*at a time when we were in the throes of changes to domestic violence…. By the time we got to Lavoie there was a cultural change going on and there was a lot of discussion about whether this was appropriate or not appropriate and what was the correct approach*" (P03). In that regard,

the inquiry occurred in the context of a broader effort to respond to domestic violence in the province. The implementation of a Family Violence Court in 1990 and its accompanying Family Violence Tracking Project aimed at monitoring the processing of cases (Ursel, 1994) as well as the Pedlar review (1991) and subsequent implementation of a comprehensive protocol for police response to domestic violence cases (Winnipeg Police Department, 1993) exemplified that effort.

In terms of the representation of the problem of domestic violence, while the language of “risk” is evident throughout the inquiry report, emphasis was placed more firmly on the cycle of violence in framing the issue of domestic violence. The report noted that Rhonda and Roy Lavoie “were an almost-classic example of the cycle of violence in all its horror” (Schulman, 1997: ii), and an entire chapter of the report was devoted to mapping out the cycle of violence and how it applied in the case.

In spelling out the distinct phases of the cycle of violence—a tension-building phase, an explosive incident, and a honeymoon phase—the focus of this framing was on the dynamics within the couple’s relationship, especially in terms of how their emotional states altered over time as the cycle advanced (Schulman, 1997: 15-19). With this framing, the broader social context in which domestic violence occurs was not brought into focus. Instead, the emphasis was on educating criminal justice personnel and the general public as to the psychological dynamics of the relationship. As Johnson and Dawson (2011) have argued, prevention efforts need to move beyond a focus on couple dynamics and incorporate a broad range of social relations and physical environments that contribute to domestic violence.

In terms of the systemic responses to domestic violence, Commissioner Schulman found "critical shortcomings in the way that organizations interact, in the knowledge among staff about the cycle of violence that is often at the heart of domestic violence cases, in the adequacy of the support provided for those with the responsibility for dealing with these cases, and in public awareness of the issues involved and of the typical signs that friends and family may be at risk" (Schulman, 1997: 131). To address those shortcomings, the inquiry report recommended greater use of computer technology to share information between criminal justice sectors; the establishment of a Vulnerable Persons Investigation Unit in the Winnipeg Police Service to deal with victims and offenders and Auxiliary Domestic Abuse Prevention Teams made up of police officers and social workers to deal with high-risk cases of domestic violence; the use of risk assessments by Crown attorneys and judges when considering applications for judicial interim release or pre-sentence reports; and increased funding for community-based organizations that provide support for victims and offenders of domestic violence. The report also recommended increased training for criminal justice officials "so that they will be aware and able to recognize when offenders and their victims may face increasing risks" and, more broadly, programs to "increase public awareness of the characteristics of the cycle of violence in domestic abuse" (p. 132).

When interviewed, respondents provided several insights as to the perceived limitations of the inquiry model. One respondent noted that governments may be reluctant to call an inquiry: "*Inquiries, once the government has made the appointment and counsel's been retained, they can and at times have wandered so there's a hesitation on governments to appoint inquiries because they're more expensive than inquests and they can take on a life of*

their own" (P03). Another respondent (P07) was aware of the public sentiment with regard to the financial costs incurred by an inquiry, saying, "*I think that sometimes people look at what it costs and think, 'Could that be better spent on direct services?'*" At the same time, this respondent was of the view that "*We are a province that puts a lot of money into service providers and into services, direct services*." S/he was also of the view that "*our network is very strong*" and that "*we have created this culture about caring a lot about domestic violence*" (P07). A third respondent concurred, saying, "*I think it's a facile kind of thing to say, 'Oh we could just take the money and put it into the system'*" (P02).

Respondents saw the implementation committee as a decided strength of the Lavoie Inquiry. As one respondent commented, the committee sent a message that the issue of domestic violence was being addressed:

> *Lavoie was somewhat unusual in the sense of putting together that committee to implement it and, as much as anything, the implementation committee may have been a way to reassure the public—and if not the public in general, a community, the community of people that are particularly interested in that—that it was being dealt with properly.* (P03)

This respondent also talked about how the implementation committee helped to set in motion an ongoing process that continued once its work was completed: "*Once you implement a process in government it's harder to stop than it is not to. So it just goes on because you've hired the people, you've told them what to do, and it's there and then it just goes on*" (P03).

Another respondent remarked on the timeliness of the implementation committee: "*We wrote our terms of reference and [the committee chair's] idea was that we do it all in a year. And we did. And I think it was something to do with 'strike while the iron is hot.' There was lots of political will, they had some money to put behind it*" (P07). This respondent also

talked about how the implementation committee was able to "cluster" the recommendations and involve both government and community participants in the process:

> *It was just the best participatory policy making that I had ever seen. The Crown attorneys would say "Wow, those service providers are really dah, dah, dah, dah, dah, dah, dah." And the service providers would say, "We had no idea the Crown attorneys had so many obstacles they [have to] overcome or how thoroughly they understand the issue or how committed they are." So it was great, it was a great piece.* (P07)

S/he also saw a benefit to inquiries in holding government accountable for making change: "*I think you hold whatever government is in power more accountable if you say, 'Here's the report, here's the 82 recommendations, could you give us the status on them?' And so I became a believer after doing Lavoie. I became a big believer in doing inquiries*" (P07). Based on his/her experience, this respondent concluded: "*Now I'm a big fan of the Lavoie Inquiry. I think that went exceptionally well*" (P07).

One of the interview respondents had close experience with the more recent Phoenix Sinclair Inquiry and so was able to shed further light on the tertiary prevention potential of the inquiry model. The Commission of Inquiry into the Circumstances Surrounding the Death of Phoenix Sinclair (Hughes, 2013) concluded in June, 2013 after hearing from 126 witnesses over 85 days at an estimated cost of $9 million (Bowes, 2013).

One factor that has been raised about public inquiries is their cost. This respondent was aware of not only the financial but emotional costs incurred, saying: "*I don't think a government should be quick to call an inquiry because of the cost, both financial and emotional. It has an emotional toll on the whole society. I think everybody found it difficult every morning to wake up to those news stories*" (P02). Nevertheless, in the case of the Sinclair inquiry, financial cost was taken into consideration:

We're working in the public interest so it's not inquiry at all cost, at any cost. So in the standing hearing, part of how the Commissioner made his determination included those cost considerations, both in terms of time and money and of course time does become money, but also in terms of paying legal fees. So in making his grant of standing that would affect whether, for instance, in some cases he would group several applicants together so they'd have a single lawyer and it would shorten it, they'd have one set of questions, or whether he'd confine them to just one part of the inquiry or confine someone to just being able to make written arguments.

So that kind of, the public cost was very much part of what we considered. We weren't going to call evidence that wasn't relevant a) because it's not going to be relevant and b) because why would you take up the time and money? We tried to be as economical as possible in terms of holding the inquiry, getting as much out of each day as possible, keeping it as short as possible. So those were, without sacrificing content, those were always considerations. (P02)

Representation was also an important consideration at the Sinclair inquiry. Because an inquiry "*has broad powers and has the power to subpoena witnesses*," the inquiry "*heard from a broad range of types of witnesses*" (P02). As the respondent noted, "*If you're going to have a public inquiry and make transparent all that was happening, then the multiplicity of perspectives was very important as a matter of fairness and comprehensiveness*" (P02).

This respondent also spoke to the issue of the process and procedure used in inquiries, especially as they compared to court proceedings. In that regard, inquiries were seen as having a number of advantages over court proceedings:

I mean, a court proceeding is going to have more binding effect than an inquiry or an inquest. So it's just a fact. But an inquiry is much more public and has fewer restrictions in terms of process so it doesn't have to follow, although we did for the most part follow the rules of evidence, but it can be a much more effective way at getting at the factual underpinnings than a formal courtroom proceeding.

So the informality of an inquiry is very useful to making sure that you get a broader picture, I think, than a courtroom proceeding, which has more rules of a narrower nature because the consequences can be more significant. Because in a courtroom proceeding there is going to be a determination of liability with either money or freedom at stake. So because you don't have that responsibility it does free you up to look more broadly at a matter. (P02)

The public nature of the inquiry model was considered to be a decided advantage in terms of its educational value:

> *I think the very fact of holding the hearings, making the matter visible, having the media put it out there, the fact that the public was so interested and followed it, it had an educational value just by virtue of holding the hearings themselves and I think would have caused people to change their actions whether they're professionals or members of the private sector. And I did hear from various people, both professionals and others, that just the fact of holding the hearings was making a difference in their world.* (P02)

In addition, the inquiry model was also seen as performing an important healing role for those who have been affected by the death:

> *One of the roles behind a public inquiry, in addition to making the information public and dispelling myths and learning from what happened, is a healing role and I think that we achieved that healing for a whole bunch of individuals and systems to varying extents. But I think that for a lot of the friends and family it was very helpful for them to come forward and talk about their involvement to the extent that there was involvement. I would hope that ultimately for the social workers there is some healing or closure process because we heard from them that none of them had been talked to about this in any way, shape, or form about their involvement until the inquiry was called and we talked to them.* (P02)

As this respondent noted, however, "*At the end of the day, to use that very time-worn expression, all that you're making are recommendations*" and "*the government doesn't have to follow them*." In that regard, the political will of government becomes a key issue in determining the tertiary prevention potential of the inquiry model. "*Ultimately it's the public, that is, the taxpayer that talks to and should guide the legislators. So the political will is guided by public support. So you need to get at the public. And so an inquiry, because it is so public in its nature, is a very good vehicle for that*" (P02).

While interview respondents in this study were very positive about the potential for inquiries to address significant issues such as domestic homicides and the death of a child in the custody of the child welfare system, not all inquiries have received such positive

endorsements. A case in point is the Missing Women Commission of Inquiry that was held in British Columbia to consider police investigations into cases of women reported missing from the Downtown Eastside of Vancouver between 1997 and 2002. Families and friends of the missing women and several community organizations had alleged that the disappearances "had received inadequate attention and investigative resources" (Houle, 2014: 450). Following Robert Pickton's conviction on six counts of murder in 2007 and the exhaustion of his legal appeals, the BC government, under the provision of the *Public Inquiry Act*, called the Missing Women Commission of Inquiry in 2010 and appointed Wally Oppal as the Commissioner. The inquiry called 86 witnesses over 93 days of hearings between October, 2011 and June, 2012 (Oppal, 2012b: 17). Released in November 2012, its extensive report deemed the police investigations into the missing and murdered women to be "blatant failures" and offered 63 recommendations to address these police failings (Oppal, 2012a: 160).

In terms of representation, the Commissioner received 23 applications for participant status and 13 applications for funding recommendations. "This included several community organizations who provided frontline services to survival sex workers and drugs users in Vancouver's downtown eastside, and who thus possessed unique knowledge of the circumstances surrounding the missing women and a strong capacity to express community experiences, perspectives, and concerns" (Houle, 2014: 450). All of the applications for participant status were granted full or limited standing at the inquiry, and Commissioner Oppal deemed each of the organizations that had applied for standing to merit government funding for counsel. However, while the government "agreed to fund counsel for the coalition of families of the missing and murdered women," it denied support

"to the Aboriginal organizations, women's groups, sex workers' groups, and human rights organizations that had been granted full or limited standing" (Bennett et al., 2012: 23). This decision significantly restricted the ability of groups to participate in the inquiry. As Commissioner Oppal stated in his report,

> The provincial government's decision to deny public funding to the majority of participants to whom I had granted standing was a significant hurdle that the Commission had to overcome, and no doubt made the work of the Commission more difficult. It meant that not all groups, communities and individuals that had an interest in the Inquiry participated in the inquiry process. (Oppal, 2012b: 10)

In the attempt to ameliorate this difficulty, the Commissioner appointed two independent lawyers, one to represent the interests of the Downtown Eastside and the other to represent Aboriginal interests—groups that are diverse in composition and have formed differing views on the issues being considered.

In addition to representational issues, the inquiry was also plagued with procedural issues. In order to hear evidence from marginalized people, the Commissioner established a "Study Commission" to provide a less formal and less threatening venue at which witnesses could tell their stories. However, "those who testified at the Study Commission were told that their evidence, though informative, could not be used in any final findings of fact that came out of the evidentiary hearings because it had not been tested by cross examination" (Bennett et al., 2012: 47).

In terms of accountability and oversight, the representational and procedural problems that plagued the Oppal Inquiry "reduced the credibility of the Commissioner's report among the very individuals and groups whose confidence it was intended to restore" (Houle, 2014: 452). Representatives from the BC Civil Liberties Association, Pivot Legal Society, and West Coast LEAF go so far as to deem the Oppal Inquiry "an absolute

failure" and a lesson in "what should not be done in conducting a public inquiry" (Bennett et al., 2012: 5). The primary lesson to be learned, according to these groups, is that "commissions of inquiry that intend to work with marginalized populations as witnesses, or inquiries that are called in response to the concerns of marginalized communities, must consult thoroughly at every stage with those communities and the organizations that work with those communities" (Bennett et al., 2012: 5).

Inquests

In Ontario, inquests are governed under the *Coroner's Act* (1990). A five-member jury, presided over by the coroner, is tasked with addressing a number of questions: who was the deceased, where did the death occur, when did the death occur, how did the death occur, and by what means did the death occur? In addition, the jury makes recommendations based on the evidence presented during the inquest that have the potential to prevent future deaths. Two Ontario coroner's inquests will be considered here: the inquest into the deaths of Arlene May and Randy Iles and the inquest that examined the deaths of Gillian Hadley and Ralph Hadley.

The Death of Arlene May

Arlene May was a 38-year-old mother of five children ranging in ages from four to 20. Her estranged boyfriend, 36-year-old Randy Iles, murdered her in her home near Collingwood, Ontario on March 8, 1996. Iles' body was also found at the home. He died as a result of a self-inflicted gunshot wound.

Arlene's eldest daughter, Pauline, described her mother as "just a typical mom, always tried to do stuff with us and take us places, when she could afford to" (Adams,

2016a). Arlene and her children lived in poverty, and occasionally relied on food banks in order to make ends meet (Sampson, 2003: 78).

The couple began their relationship in 1994. At the time, Randy was married to his third wife, Arlene's cousin. May started the relationship not realizing that Iles was still with his wife. Randy also had several previous conflicts with the law, including "convictions for indecent exposure, harassing phone calls, breach of probation, possession of stolen property, and a weapons offence for which he received a five year prohibition order." There were also "instances of child abduction, stalking, threatening with a weapon, and child custody disputes in Family Court" relating to his two previous marriages (Porter, 1998).

Arlene May experienced escalating violence throughout her two-year relationship with Randy Iles. The violence began when Arlene became pregnant with their child in July, 1995 (which she miscarried). In November, 1995 Arlene fled to a women's shelter after an assault. The police were contacted and Iles was charged with Assault and Criminal Harassment. Arlene also gave a 90-minute videotaped statement to police, in which she said: "I really thought he was going to kill me because he had that look on his face." During the interview Arlene was crying as she described in detail, "being stalked, beaten, threatened, choked and held captive in her home by Iles" (Waterloo Regional Record, 2011). During the ensuing three months, Randy continued to terrorize Arlene, calling her and leaving messages on her phone, saying they would be together for a "honeymoon in heaven" (Adams, 2016a).

Randy appeared in court 11 times and was released on bail four times in two different jurisdictions for incidents connected to his relationship with Arlene. In late February, a warrant for Randy's arrest had been issued in Simcoe County, connected with

an assault on Arlene earlier that month. On February 29, 1996 he appeared before a Grey County court for charges of Uttering Threats and breaching the conditions of his release. Because the information on his arrest warrant in Simcoe County was not available to the Grey County court, Randy was released on $200 bail with no surety and on condition that he leave the jurisdiction. Randy moved his family to the Oshawa area. However, on March 6, 1996 another warrant was issued in Grey County for breaching his recognizance for communicating with Arlene.

In the face of threats to her own safety, Arlene's primary concern appeared to rest with the security of her children. Two days before her death, Arlene gave her oldest daughter, Pauline, a letter. According to Pauline, "She knew something was going to happen. [The letter said] that if anything was to happen to her I needed to take care of my younger sister and to separate out her belongings" (Adams, 2016a). On the morning of her murder, Arlene went to the hairdresser in the hopes that it would lift her spirits. Her daughter Pauline explained, "Because of everything that had been going on, she was depressed and she wanted to make herself feel better" (Adams, 2016a). On telling her hairdresser that Randy had been released from custody on $200 bail, she rhetorically asked, "Isn't my life worth more than $200?" (Sampson, 2003: 79).

On March 8, 1996 Randy Iles purchased a 20-gauge shotgun and ammunition from the Canadian Tire Store in Oshawa, Ontario, using his Fire Arms Certificate (which had never been confiscated despite a bail condition requiring it to be relinquished). He then rented a van and drove to Arlene's home near Collingwood. Randy waited outside the house for Arlene to return. At approximately 1:00 pm, Randy forced his way into the house and took Arlene and three of her children hostage. He barricaded the children in a bedroom

closet for several hours and then released them, ordering them to go to the corner store and call the police. The children last saw their mother "sitting on the bed, crying and telling them to go" (Porter, 1998).

An emergency response team and local police "in total comprising a force of approximately 50 officers" then surrounded the house for several hours (Sampson, 2003: 79). On entering the house at 11:40 pm, police found Arlene May and Randy Iles dead in Arlene's bedroom. Randy had shot Arlene in the chest at short range. He had apparently then "paused for a cigarette, reloaded, and shot her again before turning the gun on himself" (Adams, 2016a).

Several risk factors were evident in the circumstances leading to the death of Arlene May: obsessive behaviour, abuse during pregnancy, prior and escalating violence, weapon use, and homicidal and suicidal threats (the "honeymoon in heaven"). Arlene also had an intuitive sense of victimization, even going so far as to make plans for her children should something happen to her. System gaps were also starkly evident. Randy had frequent involvement with the criminal justice system connected to domestic incidents with multiple partners as well as non-domestic incidents. He was also repeatedly released from custody in different jurisdictions. There appears to have been an alarming lack of communication and information sharing between jurisdictions where Randy had involvement with police and the justice system. As well, Randy was in possession of his Fire Arms Certificate when he bought the gun that killed Arlene, despite a bail condition that required him to relinquish it.

The May-Iles Inquest

The coroner's inquest into the deaths of Arlene May and Randy Iles "was the first in Ontario to examine the roots of domestic violence and how police and the courts treat victims and perpetrators" (Adams, 2016a). Fiona Sampson (2003: 79) terms it a "super inquest" given that it involved "a broad and systemic inquiry into the issue of domestic violence." As one of the interview respondents explained:

> *One of the responsibilities of the Chief Coroner's Office is to call inquests into matters that require some public attention when they are considered to be preventable deaths. But because of the number of domestic homicides that had been occurring … they couldn't call an inquest into each and every one of them. It was just too time consuming and resource-demanding process. So the decision was made by the Chief Coroner's Office to have a representative case in which we would examine in great detail publicly … The big issue in the May-Iles inquest was the number of times that Randy Iles and Arlene May were involved in the criminal justice system and how he had been charged, basically, repeatedly but yet released on bail and not properly supervised when on bail, committing further offences, and yet still being released and saying and doing things while he was on bail that were alarming and should have triggered greater vigilance in terms of him but also the safety of Arlene*. (P01)

Standing at the inquest was granted to several parties, including the Attorney General of Ontario, the Solicitor General of Ontario, the Town of Collingwood, and the Ontario Crown Attorney's Association. Debbie Iles (Randy's widow) and Pauline May (Arlene's eldest daughter) were also granted standing. Pauline May took an active role in the inquest. As she explained to a reporter: "I wanted to get up there and tell them how things were not done right, between the charges in Grey County and Simcoe County, nobody looked into whether he had an FAC [Fire Arms Certificate]—I couldn't believe that. They basically gave him the key to go and kill my mom. It shouldn't have happened" (Adams, 2016b). In addition, two women's advocacy organizations, the Metro Action

Committee on Violence Against Women (Metrac) and the Ontario Association of Interval and Transition Houses (OAITH) were also granted standing.

The five-member jury heard from 76 witnesses over 51 days of evidence. The evidence was presented in five phases: 1. The history of the background of Arlene May and Randy Iles and their relationship; 2. The issues of domestic violence; 3. The response of the Police Services to the reports of the violence; 4. The response of the Crown Attorneys and the courts to the allegations of the violence; and 5. The community supports available to Arlene (Porter, 1998: 3). While the coroner's counsel entered his case first, other parties were permitted to cross-examine the coroner's witnesses and then those parties with standing called their own witnesses. Jury members were able to question all witnesses (Sampson, 2003: 80-81).

On July 2, 1998, the jury released 213 recommendations for reform, the vast majority of which were directed at the provincial government. According to Sampson (2003: 85), "The jury clearly understood the evidence which confirmed that, despite Arlene May's efforts to assist the criminal justice system in its efforts to hold Randy Iles accountable for his abusive behaviour, the system ultimately failed Arlene." Several of the jury's recommendations pointed to systemic weaknesses, including the need to standardize provincial domestic violence policies and services for police and Crowns to improve coordination between service providers and jurisdictions. In addition, the jury recommended the introduction of an independent women's advocate to provide support and advocacy assistance to victims of domestic violence. It also recommended the introduction of risk assessments for use by all police officers and Crowns; mandatory

training for all police, Crowns, and members of the judiciary in domestic violence issues; and the province-wide extension of the specialized domestic violence court system.

Immediately following the release of the jury's recommendations, the Ontario Ministry of the Attorney General announced that 95 percent of the recommendations relating to the criminal justice system were already being introduced (Sampson, 2003: 88). One of the key recommendations of the jury was the implementation of a steering committee tasked with overseeing the implementation and coordination of the recommendations. This committee was to have equal numbers of government and community representatives. A Joint Domestic Violence Committee was only formed four months after the release of the jury's recommendations and after pressure from opposition parties and women's groups. According to Sampson (2003: 88), "The committee was comprised of a small group of individual experts selected by the Attorney General to advise the Minister on the implementation of the recommendations. There was no representation on the committee of women's advocacy groups with firsthand experience relating to the evidence and submissions heard by the May-Iles jury."

The Joint Domestic Violence Committee released its report in January, 1999, providing 173 recommendations on how to implement the 213 May-Iles recommendations. Sampson (2003: 90), however, maintains that the committee appeared to have little impact or effect. "On July 7, 2000, Madame Justice Lesley Baldwin, chair of the committee, wrote to James Flaherty, then the Attorney General of Ontario, on behalf of the committee. Madam Justice Baldwin wrote that she had not noticed any change in how cases of domestic violence were being approached by lawyers in court."

The Coroner's Office released its report on the May-Iles recommendations in September, 1999. Much of the government's reporting to the Coroner's Office on the implementation of the recommendations, however, "focused on initiatives that were implemented by previous governments, or by the current government prior to the release of the recommendations" (Sampson, 2003: 88). As well, the jury recommendation of an independent advocate for abused women was only implemented in the form of a short-term pilot project in Toronto, and the recommendations relating to community-based support needs for abused women were only being met through the Office for Victims of Crime, a generic, non-gender specific approach that ran counter to the jury's opening statement that "Domestic violence cases are different than other criminal cases" (Sampson, 2003: 89).

The Death of Gillian Hadley

On the morning of June 20, 2000, neighbours spotted 35-year-old Gillian Hadley running naked in the street and then being dragged back into her Pickering, Ontario home by her estranged husband, Ralph Hadley (34 years old). When the neighbours went to the door, Ralph opened it. Gillian, with her 11-month-old son in her arms, was trying to leave but Ralph blocked her way, saying, "She's psychotic and can't leave" (Small, 2001). Gillian managed to hand the baby to one of the neighbours. When two of the neighbours attempted to pull Gillian out the door, they backed off on seeing that Ralph had a gun. Ralph then slammed the door and, moments later, shots were fired inside the house. Police arrived soon afterward. On entering the house several hours later they found Gillian lying inside the front door. She had died from a gunshot wound to the head. Ralph Hadley was found in an upstairs bedroom. He had died from a self-inflicted gun wound.

Gillian and Ralph Hadley had grown up on the same street in Scarborough, Ontario and had known each other since public school. Their parents were close friends. After Gillian separated from her first husband in 1996, the couple began dating. They began living together in July, 1997 and were married in October of that same year. Gillian had two children, Faith Leila and Michael, from her first marriage. Michael was born with severe disabilities due to an intrauterine haemorrhage.

While the couple seemed happy at first, their relationship soon began to deteriorate. After nurses at the Hospital for Sick Children discovered "severe bruising" on Michael's body in February, 1999 a report was made to the Suspected Child Abuse and Neglect (SCAN) unit (Carr, 2001). The investigation led the Children's Aid Society to remove the boy from their home and temporary custody was awarded to his biological father. In April, 1999 Ralph was charged with Criminal Negligence Causing Bodily Harm to Michael.

Gillian was pregnant with Ralph's child and, believing him to be innocent, initially supported him. When the couple's son Chase was born in June, 1999 he was added to the Children's Aid Society supervision order as the charges against Ralph were still before the courts. Ralph also had restricted access to the baby. Meanwhile, Gillian sought counselling to help with family and financial stresses. She also began to doubt Ralph's innocence. In December of that year, Ralph's charges were resolved when he accepted a peace bond to stay away from Michael. The marriage, by that point, had completely broken down.

In late 1999, Ralph moved out of the family home and Gillian began seeing another man. In January 2000, when Ralph discovered this new relationship, he became aggressive, slapping Gillian and slamming her head against a brick wall. Police were called and Ralph

was charged with Assault and Breach of Recognizance (the peace bond). He was released on a Promise to Appear and ordered to have no contact with Gillian or her home.

Ralph, however, broke the conditions of his release, making repeated telephone calls, making threats, and hanging about the house (Coyle, 2001). Gillian called the police. Several more charges—Criminal Harassment, Breach of Recognizance, and Breach of an Undertaking—were laid in February, 2000. Ralph was granted bail and again ordered not to contact Gillian. He was also ordered to reside with his parents. Given his involvement with the Children's Aid Society, Ralph was encouraged to take anger management courses. In anger management counselling he denied he had a problem and saw himself as a victim. Gillian, meanwhile, was attempting to find alternate housing but was hampered by the long wait list and the specific requirements for her children.

On June 19, Ralph attended to his workplace to clean out his locker and pay off debts. Early on June 20, he stuffed his bed to make it look to his parents that he was sleeping and took a cab to a Pickering neighbourhood. Ralph forced his way into Gillian's home through a rear window, surprising her in the bathroom. In addition to a 25-calibre semi-automatic handgun (which was not registered), he had in his possession a satchel filled with "a knife, tools, lighter fluid, duct tape, rope, surgical gloves, a pornographic magazine, 13 pairs of women's underwear and a dog collar attached by a metal loop to a wedding band engraved with the date of the couple's October, 1997 nuptials" (Small, 2001). Police also found a tape recording and transcript of a suicide note, in which Ralph revealed his plan to kill Gillian and then himself, saying it was "done for the sake of his son" (Carr, 2001; Josey and Rankin, 2000).

As with the deaths of Rhonda Lavoie and Arlene May, risk factors and system gaps are evident in the events leading up to the death of Gillian Hadley. Prior violence (towards Gillian and her son), actual or pending separation, stalking, threats, and escalating physical harm were all present. Ralph was also in possession of an unregistered weapon and repeatedly broke the conditions of his release.

The Hadley Inquest

The inquest into the deaths of Gillian Hadley and Ralph Hadley took place in Toronto from October 22, 2001 to February 8, 2002. The jury heard 39 days of evidence from 60 witnesses (including friends and family of Gillian and Ralph, co-workers, police, lawyers, and domestic violence experts), addressing issues such as "the response of the criminal justice system to the incidents between Gillian and Ralph, the role of community support services (children's aid services and counselling services), housing issues and income support" (Porter, 2002: 6). In addition to investigating Gillian and Ralph's deaths, the Hadley Inquest was tasked with examining what progress had been made to implement the 213 jury recommendations stemming from the 1998 May-Iles Inquest.

Eleven parties had standing at the inquest, including the Ministry of the Attorney General, the Regional Municipality of Durham, the Ministry of Correctional Services, the Durham Regional Police, the Durham Children's Aid Society, the Housing Access Centre, the John Howard Society, and the Hadley and McLean families. As in the May-Iles Inquest, OAITH, a women's advocacy organization, was granted standing. So too was a fathers' rights organization called F.A.C.T. (Fathers Are Capable Too).

In her ruling on the application of standing for F.A.C.T., Dr. Bonita Porter, the Deputy Chief Coroner of Inquests, noted that the organization had "no direct involvement with

either Gillian or Ralph Hadley" and therefore did not "meet the private law test normally applied to this criteria." However, in weighing the four principles to be applied in the determination of standing for a "special interest group"—the "potentially significant area" identified by the group that is an issue for the inquest, the nature of the group, the expertise and uniqueness of the expertise of the interest group, and the interest of the group in the preventative recommendations—Dr. Porter held that F.A.C.T. met all of the criteria. Dr. Porter cautioned, however, that she "appreciate[d] the undertaking of counsel to ensure respect for the inquest process by the organization given an earlier demonstration and distribution of literature outside the inquest court." She also cited Campbell J. in *Stanford v. Harris*:

> The danger is not simply that of the busybody or the crank, but also the danger of sincerely motivated groups seeking a public platform for views that are not sufficiently relevant to the subject of the inquest and which will only result in undue delay and inefficiency. (Porter, 2001: 3)

Dr. Porter also commented that one of the duties of the coroner was to "see that the sideshow does not takeover [sic] the circus" (p.3).

The documentation that F.A.C.T. posts on its website (www.fact.on.ca/) regarding the Hadley Inquest reveals the organization's stance on domestic violence. It states that "Ralph Hadley was not a batterer" and that "it would be ignorant and biased to present this as an inquest solely into the death of Gillian Hadley." Walter Fox, a criminal lawyer, represented F.A.C.T. at the inquest. Fox has his own history of marital troubles, including being held in arrears for child support payments when his marriage dissolved. According to journalist Michele Landsberg (2001), Fox "blames feminism" for his troubles. Fox is quoted as saying during a Parliamentary Joint Committee on Custody and Access: "Feminism has come to take on the structure of McCarthyism … The current form of feminism is really a

replay of the side that lost the Second World War … I don't want to equate feminism with Nazism … but …" (Landsberg, 2001).

F.A.C.T. also called on Dr. Harold Merskey to testify at the inquest, "even though Merskey had no special familiarity with the Hadley case and had not read the coroner's brief" (Landsberg, 2001). Merskey was not a domestic violence expert; rather, he was a member of the False Memory Syndrome Foundation board, an organization that maintains almost all recovered memories of past abuse are "false" memories implanted by feminist therapists. Merskey testified at the inquest that "we can never know" if Ralph Hadley was really criminally responsible for the murder. In his view, Hadley must have "snapped" under the extreme stress of "his wife's betrayal." As Landsberg (2001) notes, the coroner asked the jury to disregard Merskey's remarks.

On February 8, 2002 the jury returned a verdict of homicide/suicide and made 58 recommendations aimed at a number of services and systems. A number of recommendations were directed to the provincial government in addition to the federal government, the John Howard Society, the Ontario Association of Interval and Transition Houses (OAITH), the Ontario Association of Children's Aid Societies, the police, and municipal sectors.

Risk factors were featured prominently in the Hadley inquest. One of the interview respondents commented:

> *I guess the role, my role in that particular inquest was to bring some of our findings from the intimate femicide study to the people who were presiding over the inquest to talk about what we didn't know at the time. What we now have through the Death Review Committee, at the time we didn't have. So I was talking about the trends and patterns that we had identified in the intimate femicide, which looked primarily at women killed by intimate partners. So I was talking about those findings and what we knew about some of the risk factors, some of the common characteristics. So my role was just kind of, I guess, it was really filling the hole of what the Domestic Violence*

> *Death Review does now. We didn't have it so it was to say 'This is what we know about it and this is how the Hadley case locates within what we know about it."* (P04)

Similar to the May-Iles Inquest, the jury in the Hadley Inquest recommended that an implementation committee be established by the Ontario government, consisting of government and non-government representatives. The purpose of the committee would be to oversee the recommendations of both the Hadley and May-Iles Inquests, as well as the recommendations arising from the Joint Committee on Domestic Violence that was struck after the May-Iles Inquest. The recommendation also specified: that half of the members of the implementation committee be selected from community-based organizations working with women and children survivors of violence as well as community-based representatives with expertise on issues of domestic violence; and that the work of the implementation committee be funded and not time limited. According to OAITH, however, this recommendation was not followed (OAITH, n.d.).

Potential of Inquests for Tertiary Prevention

Only four years apart, the May-Iles and Hadley Inquests were very similar in their representation of the problem of domestic violence and their attention to the system gaps that existed in addressing that problem. Whereas the Schulman (1997) inquiry report framed the deaths of Rhonda Lavoie and Roy Lavoie in terms of the cycle of violence, the juries in May-Iles and Hadley took a broader view. For example, the jury in May-Iles deemed domestic violence against women to be an equality rights issue and took a more holistic approach to resolving it:

> As we approach the millennium we are faced with the reality of the violence occurring to women and children in our society. Until we as a country stand up and declare a 'Zero Tolerance', this problem will not only continue, but in this jury's

> opinion, will escalate. It is our belief that every person has an equal right to be protected from abuse.
>
> A combined effort must be made by our Government and Communities in order to put an end to family violence. The myths attached to family violence must be dispelled. Domestic violence is a Criminal Offence and must never be viewed as a 'private matter.' (Porter, 1998)

Part of the reason for this framing may be attributed to the role that Metrac and OAITH, the two women's advocacy groups, played during the inquests. In the May-Iles Inquest they called four witnesses, one of whom testified about the social dynamics of violent relationships and the criminal justice response to violence against women. They also put forward 200 recommendations for consideration by the jury and made a closing statement. OAITH also had standing at the Hadley Inquest. While F.A.C.T., the fathers' rights organization, was granted standing in Hadley and called its own witness, the jury's recommendations suggest that the feminist understanding of domestic violence as a gendered issue was the one adopted by the jury.

While inquiries are often criticized for their steep financial cost, inquests are not as problematic because they do not require extra funding. As one respondent noted:

> *In terms of those two in particular [Hadley and May-Iles] there was never any discussion in the Chief Coroner's office about how much it would cost to conduct these inquests and whether there was a cost benefit to doing it. It was just, "This needs to be done, let's do it." Whatever costs the Chief Coroner's office had to bear, of course, came out of its annual budget. There was never any extra funding requested of government to conduct these inquests. It was just operational costs*. (P01)

This same respondent also spoke to the advantages of an inquest model:

> *The two very large advantages to the inquest is that it raises the public profile of the issue—these inquests were covered daily in the print and broadcast media so these became well known circumstances—and the second part was that recommendations would be made directed towards the prevention of deaths based on those particular circumstances. So those are the big advantages, I think, to the inquest. Focusing public attention and, of course, the public also involves people who deal with public policy in government and government services*. (P01)

Another respondent noted that with an inquest, "*You can look at broader systemic issues more freely, especially if you have a good judge and a good jury*" (P05).

Fiona Sampson served as counsel for Metrac and OAITH at the May-Iles Inquest. Based on her experience, Sampson maintains that the inquest model holds the potential to bring about systemic change, especially in regard to equality issues.

> Given the potentially broad subject matter of a coroner's inquest, the forum provides an excellent opportunity to contextualize equality rights arguments to include a consideration of the socio-historic roots of the inequality at issue. The fact that a coroner's inquest operates pursuant to the rule of administrative law means that there is a fair degree of elasticity with respect to the application of the rules of evidence. This allows more flexibility with respect to the determination of relevance and the admission of evidence than would be the case when litigating a similar issue in the criminal or civil law context. (Sampson, 2003: 76)

According to Sampson (2003: 94), "The primary utility of a coroner's inquest with respect to its potential as a human rights mechanism lies in its educational and political value." Interview respondents, however, also saw the May-Iles and Hadley Inquests as producing significant tertiary changes in the criminal justice response to domestic violence:

> *[T]he May-Iles inquest, particularly May-Iles to some lesser degree Gillian and Ralph Hadley, became very significant in instituting domestic violence courts in Ontario and the training of police and prosecutors…. [A]ll the training that went on for prosecutors made reference to May-Iles. And the reason it was significant was because they had so many contacts with the justice system; there are at least a half a dozen Crown attorneys, it was unusual in that. They lived in one area and the occurrence happened in another area so there are a number of police services and there are two different jurisdictions that involve Crowns offices; they went to different court houses. So there's a real need to ensure that the police are investigating these things and the Crowns who are prosecuting them knew about the issues around domestic violence. So it became a real focus on the training of police and Crowns. It still is. You couldn't go to a prosecutors' course dealing with domestic violence or working in the domestic violence courts without hearing the name May-Iles*. (P01)

According to another respondent, both the May-Iles Inquest and the Hadley Inquest had a significant impact on the criminal justice response to domestic violence. The May-Iles Inquest "*really shifted policing in Ontario, major shifting of policing and how forces could talk to one another, kind of a much more integrated model and the curriculum actually was born out of that, the domestic violence training curriculum for investigators*," while the Hadley Inquest, "*spurred the province on to take a much more, I guess, proactive approach to looking at patterns and trends and what's predictable, what's preventable*" (P05).

One of the limitations associated with inquests, however, is their restricted focus on a single case: "*Well, the limitation is that it only focuses on one death and thereby limits the true scope of recommendations, but also a true understanding of what factors should be looked at in any circumstance and the only way you can get to that is if you look at them all*" (P01). Similar to inquiries, another limitation is that the jury's recommendations are not legally enforceable. In that regard, a respondent spoke about the important role that advocacy groups such as OAITH can play in holding the government accountable:

> *They would follow-up themselves, they would make contact. Now, how successful they were I don't really know, but I know they, from time to time through their spokespeople, would say "There's been no meaningful actions in this area, no meaningful action in that area," that sort of thing as affected their interests, shelters.* (P01)

Concluding Remarks

Inquiries and inquests into domestic homicide deaths each have their strengths and limitations. As respondents noted, the public nature of inquiries and inquests has the benefit of drawing attention to the issue of domestic violence and pressuring governments to make changes and address system gaps. Nevertheless, neither of these models is backed by legislation that would make their recommendations enforceable. Respondents also

commented on the singular focus of inquiries and inquests. Significantly, both the May-Iles Inquest (#172) and the Hadley Inquest (#54) recommended the establishment of a Domestic Violence Death Review Committee. As one respondent noted, the experience of the two inquests highlighted "*that we should in fact not just be doing one or two inquests but we should be reviewing every domestic violence related death in the province, which was the beginning then of the Death Review Committee, I believe the first of its kind in Canada if I remember correctly*" (P05). The next chapter explores the potential of these DVDRCs, as well as the BC Death Review Panel, for realizing tertiary prevention of domestic homicides.

Chapter 5 Findings: Domestic Violence Death Review Committees and Other Models of Inquiry

Domestic Violence Death Review Committees are a multidisciplinary approach to examining domestic homicide deaths that bring together a group of experts to examine cases and provide recommendations for tertiary prevention. The DVDRC models that have been adopted in each jurisdiction differ, with no two committees looking exactly the same. Also, since the models are relatively new to Canada, they are continuing to develop as more is learned about the tertiary prevention of domestic homicides (Jaffe, Dawson, and Campbell, 2013). Ontario was the first province in Canada to implement a DVDRC (in 2002). Discussion will focus on the Ontario DVDRC model, as well as those in Manitoba and New Brunswick. The British Columbia Domestic Violence Death Review Panel is somewhat of a hybrid model, with aspects similar to a DVDRC as well as an inquest or inquiry. These two models of inquiry will be examined with respect to the three areas of analysis—representation, procedural fairness, and accountability and oversight—and then assessed in terms of their potential for tertiary prevention. The chapter concludes with a comparative analysis of all four models of inquiry, drawing on the three areas of analysis as well as Bacchi's WPR approach. The main conclusion reached is that while each model has its particular assets and challenges, in combination they offer a path forward in combatting the serious problem of domestic homicide.

Domestic Violence Death Review Committees

The impetus for establishing a DVDRC in Ontario came from a recognition of the need to move tertiary prevention efforts beyond what could be achieved from the inquest model. As one interview respondent explained:

> *[I]t was also recognized in both the May-Iles Inquest and then later in Ralph and Gillian Hadley's that we can't hold these representative inquests, we shouldn't actually be holding these representative inquests on an ongoing basis because there are still many, many, many, many more deaths that occur in intimate partner relationships that should be given the same kind of scrutiny to learn lessons, if they could be learned, but in a way that would not entail the great amount of resources necessary to hold an inquest. You can only do one of those every few years 'cause they take months and months to prepare and months to conduct 'cause they are like inquiries. So that was, the recommendation, one of the recommendations in both those inquests was that the Office of the Chief Coroner create a committee to review all of the domestic-related homicides that occur in the province so that each could be looked at with the same sort of level of scrutiny, not in a public way, but in a concentrated way by individuals who are knowledgeable and representing the various parties in effect that we had at these inquests.* (P01)

The Ontario DVDRC operates under the authority of the *Coroner's Act* (1990). The primary aim of the committee is to assist the Office of the Chief Coroner by providing a more comprehensive understanding of "how and why domestic homicides occur, through a detailed multi-disciplinary examination and analysis of individual cases." The committee collects information "to establish the context of the death(s), including the history, circumstances, and conduct of the abusers/perpetrators, the history and circumstances of the victims and their families, as well as community and systemic responses." The main purpose of this investigation is "to determine the primary risk factors in these cases and identify possible points of intervention, with the goal of preventing similar deaths in the future" (Office of the Chief Coroner of Ontario, 2003: 3-4).

The objectives of the Ontario DVDRC are outlined in its 2013/14 Annual Report:

1. To provide and coordinate a confidential multi-disciplinary review of domestic violence deaths pursuant to Section 15(4) of the Coroners Act, R.S.O. 1990, Chapter c. 37, as amended.
2. To offer expert opinion to the Chief Coroner regarding the circumstances of the event(s) leading to the death in the individual cases reviewed.
3. To create and maintain a comprehensive database about the victims and perpetrators of domestic violence fatalities and their circumstances.

4. To help identify the presence or absence of systemic issues, problems, gaps, or shortcomings of each case to facilitate appropriate recommendations for prevention.
5. To help identify trends, risk factors, and patterns from the cases reviewed to make recommendations for effective intervention and prevention strategies.
6. To conduct and promote research where appropriate.
7. To stimulate educational activities through the recognition of systemic issues or problems and/or:
   - referral to appropriate agencies for action;
   - where appropriate, assist in the development of protocols with a view to prevention;
   - where appropriate, disseminate educational information.
8. To report annually to the Chief Coroner the trends, risk factors, and patterns identified and appropriate recommendations for preventing deaths in similar circumstances, based on the aggregate data collected from the Domestic Violence Death Reviews. (Office of the Chief Coroner of Ontario, 2015b: 1)

Manitoba's committee was formally established in 2010, 13 years after Commissioner Schulman released his report from the Lavoie Inquiry. Unlike the Ontario DVDRC, Manitoba's DVDRC is not legislated. Similar to the Ontario DVDRC, however, the Manitoba committee reviews domestic homicide cases that are no longer before the courts, identifying trends, risk factors, and patterns by exploring the history, circumstances, and conduct of the perpetrators, victims, and their families (Manitoba Justice, 2015). The committee reports to the Manitoba Attorney General, and annual reports with recommendations are available on the Government website.

In New Brunswick, a DVDRC serves as an advisor to the Chief Coroner. The initial work of the New Brunswick committee focused on an examination by the Muriel McQueen Fergusson Centre for Family Violence research of the 32 domestic homicides that occurred in the province between 1999 and 2008. In the 2010-2014 period the committee reviewed four cases of domestic homicide and submitted reports to the Chief Coroner

(Communications New Brunswick, 2010; New Brunswick Office of the Chief Coroner, 2012/13).

In terms of representation, Ontario's DVDRC is currently comprised of 17 members (Office of the Chief Coroner of Ontario, 2016: iii). Over the years, membership has changed but a number of original members are still on the committee. Committee members include coroners, Crown attorneys, victim service workers, law enforcement personnel, healthcare professionals, social workers, and advocates. The Manitoba DVDRC is made up of two groups: a working group and an advisory committee. The working group, which conducts the in-depth review of cases, consists of individuals from the Winnipeg Police Service, the RCMP, Probation Services, the Office of the Chief Medical Examiner, Prosecution Services, and Victim Services (Manitoba Justice, 2016: 2). The advisory group consists of the members of the working group plus representatives from RESOLVE, Education, Status of Women, the Family Violence Prevention Program, the Department of Emergency Medicine/Faculty of Medicine/University of Manitoba, the Special Advisor on Indigenous Women's Issues and the Consortium of Family Violence Service Providers (Manitoba Justice, 2016: 2). The New Brunswick DVDRC is chaired by the Deputy Chief Coroner and includes 10 members from a variety of fields, including "law enforcement, Public Prosecutions, health, academia, research, service provision, interested citizens and government" (New Brunswick Office of the Chief Coroner, 2012/2013).

Involvement by people not on the committee is different across jurisdictions. The Ontario DVDRC may bring in an expert on a particular subject if necessary or hear from friends and family, but this is done on an individual, case-by-case basis and only when the DVDRC believes there is a need (Office of the Chief Coroner of Ontario, 2015b: 2). As one

interview respondent indicated, for the Ontario DVDRC to bring in a family member or friend of the deceased person "*was very rare*" (P01). The same was true for the New Brunswick DVDRC. One respondent offered a rationale for this decision:

> *It would be wonderful sometimes to bring the family to share what they've been through, but at the same time when you have some of those cases and, you know, that it's been totally screwed up, you're not going to get the family again to come and explain how the system has screwed their parents.* (P10)

In contrast, Manitoba's approach extends beyond a "paper-only review" of cases by including interviews with family members, friends, and "other relevant representatives of the victim and offender who are able to share important information about the patterns and trends associated with domestic violence homicides" (Manitoba Justice, 2016: 2). The decision to involve individuals who were directly affected by a domestic homicide was reached after assessing DVDRC models in other jurisdictions. As one respondent explained:

> *[W]e had looked at again the different models and made a decision too that we wanted to go beyond just a paper review and to interview people who were directly affected. Either friends, family members, co-workers, and to conduct more in-depth reviews in that sense that gather as much information as we could right from the, I guess really, the birth of both the victim and the offender and tracking their life history up until the incident.* (P11)

Participation in these reviews is voluntary and those who choose to be involved are asked to sign a confidentiality agreement.

With regard to the process and procedures used, in Ontario cases are assigned to an individual member of the DVDRC, who is responsible for examining the information in the case file. The case file may include information from criminal justice sectors, the Children's Aid Society, and healthcare and counselling professionals that addresses both "the history, circumstances and conduct of the perpetrators, the victims and their families" and the "community and systemic responses" in order to determine primary risk factors and

identify possible points of intervention (Office of the Chief Coroner of Ontario, 2015b: 2-3). After a thorough examination of the file and analysis of the facts, the reviewer will present the information to the entire committee at their next meeting. The Ontario DVDRC meets six to eight times each year for all-day meetings to review the cases being examined and make decisions regarding recommendations. Since the Ontario DVDRC was established in 2003, it has reviewed 267 cases involving 376 deaths (Office of the Chief Coroner of Ontario, 2016: 1). This process has also evolved over time:

> *[I]n terms of in the early years, we were a much smaller process because when a committee is new you're trying to learn the best way to do things. And so we were reviewing cases but it was taking us much longer. And as we evolved we learned the best and most efficient way to review cases so that we could get at all the cases, which is what we're reviewing now. That's our goal, is to review all cases that occur in our province in a way that will capture all types of characteristics from different types of cases. So we have evolved*. (P04)

In contrast to the public nature of inquiries and inquests, DVDRCs are tasked with maintaining confidentiality and privacy. In the case of Ontario,

> All information obtained as a result of coroner's investigations and provided to the DVDRC is subject to confidentiality and privacy limitations imposed by the *Coroners Act* of Ontario and the *Freedom of Information and Protection of Privacy Act*. Unless and until an inquest is called with respect to a specific death or deaths, the confidentiality and privacy interests of the decedents, as well as those involved in the circumstances of the death, will prevail. Accordingly, individual reports, as well as the minutes of review meetings and any other documents or reports produced by the DVDRC, remain private and protected and will not be released publicly. Review meetings are not open to the public. (Office of the Chief Coroner of Ontario, 2016: 5)

Similar to the Ontario DVDRC, the New Brunswick and Manitoba committees engage in confidential reviews of domestic homicide cases. In Manitoba, all members of the Manitoba DVDRC "enter into memorandums of understanding and confidentiality agreements" (Manitoba Justice, 2015); however, because of privacy concerns, the non-government or external members of the committee "*don't have access to the file*

information, they don't have the police information, they don't have the prosecution's file, the victim services file, the Chief Medical Examiner's Office file. Those things to disclose that information to another party would be a breach of our privacy laws here" (P06). The case reviews are therefore conducted by the smaller working group comprised of internal, government representatives on the DVDRC—"*the people that have access to the information already*" (P11). As one member of the working group explained:

> *[W]e get recommendations from the advisory group about the reviews they want us to undertake and then as a smaller working group we take a look at what it is they recommend and we decide as another measure of protection and keeping the review, the case that's under review, confidential.* (P06)

These case reviews include interviews with friends, family, and other relevant parties about the victim and offender.

In terms of accountability and oversight, the Ontario DVDRC makes public a very comprehensive annual report each year, outlining the committee structure and process, case reviews conducted, statistical information, and recommendations. As one respondent described:

> *We have a report that comes out every year that will give a short synopsis of each case that we've reviewed and any recommendations that evolved from that case…. There isn't always recommendations. There are some cases that you just can't think of anything to recommend because it appears that everybody did what they were supposed to do and it happened anyway. But then there will be other cases that there will be ten recommendations or something like that because there just was so much that didn't happen, that there was all these different areas that you can make recommendations for. So those are all included in the annual reports that come out at the end of every year.* (P04)

In contrast, the information Manitoba makes publicly available from its DVDRC is in the form of a short executive summary and recommendations pertaining to the cases reviewed during the particular period. Four such annual reports are available online (2011/12, 2013/14, 2014/15, 2015/16), offering a total of 18 recommendations. No

information is provided about the cases the committee reviewed and no context is given around the recommendations being put forward. It is also unclear from the information that is made publicly available if the recommendations are aimed at a particular sector.

To date, New Brunswick has only made public one report with recommendations. It too is confined by confidentiality and privacy requirements.

> *We have to protect the privacy of individuals. So right now we're at the stage where there's been some reports and this particular one has been rewritten in a way that can provide some recommendations without permitting identifying the individual. But the detail what I'm telling you here, has not been released publicly. It has been prepared for the Chief Coroner.* (P10)

Similar to inquiries and inquests, the recommendations generated by a DVDRC in all three provinces are not legally binding. As an annual report of the Ontario DVDRC notes:

> Similar to recommendations generated through coroner's inquests, the recommendations developed by the DVDRC are not legally binding and there is no obligation for agencies and organizations to implement or respond to them. Organizations and agencies are asked to respond back to the Executive Lead, DVDRC on the status of implementation of recommendations within one year of distribution. (Office of the Chief Coroner of Ontario, 2015b: 4)

In New Brunswick, reports and recommendations are delivered to the Chief Coroner, "*and he's the one who's deciding what he's doing with this. We don't have the power to do anything with those reports*" (P10). This respondent explained further:

> *That's not our role for the implementation because it's going to be in the Chief Coroner's, it will be the Chief Coroner's responsibility to do something. And implementation of recommendations, you can only do so much to recommend, let's say, recommend that the police force do this and this, but you can't force anybody. So we don't know if it's going to be implemented, right?* (P10)

The Potential of DVDRCs for Tertiary Prevention

The Ontario DVDRC annual reports provide a lot of data and information about domestic homicide deaths that have occurred in the province and the work that the committee has done in reviewing cases since its inception. While they have the benefit of being around

longer than other committees in Canada, their first annual report still provided an extensive review of work done, the information and statistics that had been collected, and the risk factors as they pertain to the cases reviewed.

In terms of the representation of the problem of domestic violence, risk factors are a primary consideration within the DVDRC model. The Ontario DVDRC has created a list of 40 risk factors relating to the potential for a domestic homicide. When reviewing a case, the committee identifies whether any of these risk factors were present in the relationship between the victim and the perpetrator. Based on these reviews, the Ontario DVDRC has identified 10 of the most common risk factors:

1. history of domestic violence
2. actual or pending separation
3. obsessive behaviour
4. depressed perpetrator
5. prior threats or attempts to commit suicide
6. escalation of violence
7. prior threats to kill the victim
8. prior attempts to isolate the victim
9. victims who had an intuitive sense of fear
10. a perpetrator who was unemployed

(Office of the Chief Coroner of Ontario, 2015b: 10-11)

The Ontario DVDRC has been able to demonstrate that "the vast majority of cases resulting in domestic homicide or homicide-suicide had a significant number of risk factors (i.e. seven or more) and therefore were potentially predictable and preventable" (Office of the Chief Coroner of Ontario, 2016: 18).

During the interviews, respondents elaborated on a number of strengths of the DVDRC model. One respondent talked about the holistic approach that is taken:

> *You look at it from a different perspective, you're not looking at it through the eyes of a police investigator, you're looking at it from the eyes of all of the different people that are around the table and you're able to pull information from other areas that may not have been included. Our specific focus is that relationship, it's not to investigate*

> *something well enough to get it to prosecution or it's not to prosecute it, to get a conviction and it's not for the purpose of declaring cause of death. Each of the parties around the table have a specific mandate and purpose, the committee, it's all of those mandates together. So it's a more holistic way of looking.* (P06)

Another respondent saw the DVDRC model as not only offering a different perspective, but also having a symbolic benefit:

> *[T]here's no other group out there that's going to look at these cases in the way that Death Review Committees look at them. Police look at it, for criminal justice process purpose for the most part, as an investigation purpose but they don't ask the same questions that we do. And I think symbolically, for me, it means that they're important enough to have their own review committee, it's enough of a concern to the country or to the province that we have it, but also that it's preventable…. We used to think … about them being spontaneous crimes of passion and … [W]ith a Domestic Violence Death Review Committee, it represents the idea that people are now understanding that they can be prevented. So there's a symbolic benefit to it as well.* (P04)

Respondents also believed that the focus of the model on producing knowledge about risk factors was a distinct benefit in terms of formulating evidence-based policy:

> *[E]ven though we know that there's certain things that are common among these cases, we need the evidence-based policy for the government to listen. So with death reviews we have a sustainability in terms of producing risk factors every year that are common. We have reports that publish recommendations and, again, that's another benefit. If you keep publishing the same recommendation and ten years down the road that's still not there, then hopefully somebody is going to start to listen at some point. And getting them to listen is the thing we need to work on.* (P04)

DVDRCs were also seen as providing an important educational experience for the various sectors responsible for responding to domestic violence:

> *I think it's quite an educational experience for the people sitting around the table. And even though there's not a lot of numbers around the table, those people then go back to their agencies to the OPP or to the Crown Attorneys Association and they would learn some of what is going on in the other sectors so that they could talk about it in-house to their own colleagues. So it's about educating the sectors that are responding to domestic violence. How particular sectors are responding and what their constraints are. So that's been a real benefit in terms of creating dialogue I guess is the best way to put it. And hopefully increasing collaboration because there's a greater understanding of the constraints that surround people's responses to domestic violence and that they can't do anything about it until there's change implemented.* (P04)

> *I think that they're a great educating tool. I think that they're good to lay out where we fail as a sector or as a system and I think it's really important, for instance, our development of the risk factors. To be able to say that almost every case had at least seven risk factors and to be able to know what they are is a great educational tool whether you're training doctors or emergency nurses. We wouldn't have been able to do that a few years ago so it has huge implications for training programs.* (P05)

One respondent noted that the DVDRC offers a benefit to the families of domestic violence victims:

> *[T]he families that we work with closely who have had children murdered or loved ones murdered, once the court case ends, there's nothing for them. It's over, it's done, "nobody cares" is kind of the theme you'll hear from them. But to know that it's not really left, people are still going to look at this in a different way, in a more holistic way. It gives, I think, families a bit of satisfaction in knowing. And that's why I think we've seen good participation. Because people don't want to see another family go through what they've been through.* (P06)

On the issue of the impact that the DVDRC reports are having, one respondent believes there has been a definite impact for those working on the front lines:

> *I'm connected with a lot of community groups, as are a lot of the members, and we hear things when the reports come out. We know people are reading them. We know they're saying, "Yes, we do this already" or "No, we don't do this and we could do this." So I think that there is an impact ... out to the services and the sectors. I don't know that it's always getting out to the people that need to read it in order for the change to happen most effectively, but I think it's certainly getting out to the people that are working on the ground. I think it's something that they read quite closely because they can use some of the recommendations to lobby for resources to make changes.* (P04)

Respondents were also aware of some of the challenges encountered with the DVDRC model. One challenge involved the amount of time and energy that goes into conducting the reviews, especially in Manitoba, where interviews with family members and friends are conducted. One respondent noted the challenge of, "*just being able to do them [the reviews] all as thoroughly, so it takes time to develop the right kind of review process to make sure that you're reviewing as many as you can but also as thoroughly as you can*" (P01). Another respondent noted, "*I guess some of the weaknesses too is that you may not ever*

completely know who else may have had involvement with that particular individual that's under review, so you can do as much as you think you can do, but you may be missing, especially when something's anonymous" (P06). A third respondent commented, "*It would be nice to be able to complete more than two reviews a year. Really, we do have often more than two homicides per year so it would be nice to be able to do more. Because the more of a wealth of information we have, the better you can make predictions on trends and patterns and all those things*" (P11).

Some respondents also commented on the composition of the DVDRCs and the need for more diversity in their membership. When asked whether certain groups were missing from the committee membership, one respondent replied: "*Child welfare, people who run the men's program, absolutely activists are missing, people from diverse backgrounds are missing, immigrant women are missing, Aboriginal people are missing*" (P05). Another respondent believed that the committees lack representation from community partners:

> *I think with a lot of the committees there's an overemphasis on the criminal justice partners and not enough emphasis on the community partners because a lot of the information that's held about victims and offenders and children and their families is held within community organizations, whether it be the mental health sector, addictions sector. But then the problem comes down to who do you get that is going to be the best person from that particular sector?* (P04)

This respondent also spoke to the issue of representation of family members and friends on the DVDRC:

> *And there's been lots of debates about whether or not that is a good idea. I'm not sure where I fall on the debate. I think that family and friends obviously hold information, given that in our reports we say that in 75 percent of the cases, family and friends knew what was going on, that they actually hold probably the most crucial information in terms of, at least about the relationship and about the extent of the violence and that type of thing. There's some argument that it would traumatize family members to be involved and others argue that it would be cathartic to have them there.* (P04)

Nevertheless, s/he was also aware of the challenges of maintaining diversity: "*I probably expect that there's no committee that has adequately represented the diversity that they need on these committees. They do the best they can based on the people that are available, but I think there's still a lot of work to be done in that situation*" (P04).

Respondents were also cognizant of the political culture in which their committees operated, and the importance of political will on the part of governments in seeing recommendations implemented.

> *Since this committee has been in existence, this particular government, the Liberal government, has been extremely supportive of our work. Now that doesn't mean they attach dollars, but have always been extremely respectful of our report. Most of the ministries are respectful of the recommendations. They would say they attempt to address them within the constraints of lack of funding.* (P05)

> *And I think in our case in New Brunswick, it's really in line with what's happening at the provincial level because in December 2012, the provincial government launched a provincial strategy on crime prevention and crime reduction. And intimate partner violence is one of the top three priorities. So the work of the Death Review Committee contributes to that. So it's not just a sole entity that is swimming without ever seeing the land [laughs]… There are concurrent activities that are ongoing in the province that are bringing them together, that are connecting them together. So the work of the Death Review Committee is necessary because it can inform some of those activities that are led through this strategy as well.* (P10)

In terms of the implementation of the committees' recommendations, respondents spoke of the need for an accountability mechanism: "*I think recommendations sitting there with nobody doing anything about it means that changes aren't going to happen. So there needs to be an accountability mechanism put in place*" (P04).

Despite their lack of power to implement recommendations, one respondent believed the work of the DVDRCs remained important, making a poignant comparison to the work of Romeo Dallaire:

> *Well, I think a limitation of likely any committee is that they likely don't have a lot of power in terms of implementing recommendations. They can report. It's kind of like*

Dallaire's work in Rwanda. At some point the atrocities were so great all he could do was witness and document. And sometimes that's what it feels like we're doing, documenting atrocities. But better than not, better to bear witness. (P05)

Other Models of Inquiry

Inquiries, inquests, and DVDRCs are not the only models that exist to examine domestic homicide deaths. Other models may arise in a particular jurisdiction that fit their needs at a particular time. In-depth reports, such as the 1991 Pedlar Report in Manitoba, may be used to examine domestic violence and highlight risk factors and system gaps. There are likely many examples of other models employed across the country, but for the purposes of this section I will briefly outline the route taken by British Columbia.

The British Columbia Domestic Violence Death Review Panel

Convened in March, 2010, the British Columbia Domestic Violence Death Review Panel reviewed 11 cases that resulted in 29 deaths. These cases were chosen from over 100 case files going back to 1995. The panel was comprised of 14 people, including a chair and a panel administrator from the BC Coroner's Service. Other panel members included "representatives from the Royal Canadian Mounted Police (RCMP), Victoria City and Vancouver Police Departments, Crown Counsel, Community Corrections, the Representative for Children and Youth, the Ministry of Children and Family Development, the Ending Violence Association of BC, Simon Fraser University Department of Psychology, RCMP Victim Services and the Victim Services and Crime Prevention Division of the Ministry of Public Safety and Solicitor General" (BC Coroners Service, 2010: 1-2). No additional outside experts were brought in during the case review.

The BC panel was convened under the *Coroner's Act* and reported, through the chair, all findings and recommendations to the chief coroner (BC Coroners Service, 2010: 1). This one-time review of cases took place over three days in Burnaby, BC where the panel members reviewed case summaries and created recommendations. The 11 cases reviewed were selected for their representative nature as "compelling and significant domestic violence risk factors and systemic gaps" (BC Coroners Service, 2010: 1). Of the 11 cases, five were previously the focus of public coroner reports and six were the subject of public inquests.

Upon completion, the panel submitted 19 recommendations "for review, consideration and distribution, as deemed appropriate by the chief coroner" (BC Coroners Service, 2010: 7). Recommendations were aimed at a number of provincial government departments, the BC Association of Chiefs of Police, the Law Society of BC, and the Chief Coroner of BC. In addition to creating recommendations, the report highlights a number of recurring themes reported by the panel: collaboration, standardization, resources and training, coordination, information sharing, community involvement, and death investigations. These themes identify gaps in the system and areas where work is needed, and they are consistent with the recommendations put forward.

The BC Coroners Service publicly released a report documenting the findings of the BC Death Review Panel and, as such, recommendations are available to the public and a wider audience. Information is not included in the report about the 11 cases reviewed but some statistics are presented about domestic homicides in British Columbia between 2003 and 2008. Upon completion of the three-day panel, recommendations were submitted to the coroner's office and no provisions were noted in the report about implementation or

follow-up. Also publicly available is a document of response letters from various stakeholders with recommendations aimed at them (BC Coroners Service Death Review Panel, n.d.). These letters outline completed or intended work to address the recommendations made by the panel.

The Potential of the BC Death Review Panel for Tertiary Prevention

The BC Domestic Violence Death Review Panel shares similarities with other models previously discussed. Like an inquest or inquiry, it is a one-time process, although with a much shorter timeframe. The panel of experts examining multiple case files and creating recommendations shares similarities with the DVDRC model. The submission of its report, however, appeared to mark the end of this particular group as there was no formalized legislation that would ensure the panel's work continued into the future.

One of the panel's recommendations (#16) suggests: "The Chief Coroner will convene recurring death review panels comprised of diverse stakeholders from a range of relevant social service, health care and criminal justice agencies, as well as affected private citizens. These panels will be tasked with examining the circumstances related to one or more deaths in specific cases chosen to reflect issues that are of particular interest or concern (e.g. cultural, religious, socioeconomic) and provide recommendations to the Chief Coroner" (BC Coroners Service, 2010: 10). In June, 2016 a two-day panel was convened to review aggregate case data for intimate partner deaths that occurred between 2010 and 2015. This panel released a more comprehensive report in November, 2016, addressing trends and patterns, risk factors, and system gaps that exist. The panel also made three recommendations to increase awareness and education, strengthen safety planning and

early case management, and enhance data access, quality, and collaboration (BC Coroners Service Death Review Panel, 2016).

One respondent (P08) echoes statements made by others that political will is necessary for effective processes and lasting change. S/he also acknowledges the importance of increasing public education. Another respondent suggested that coroner's legislation needed to change before a death review panel could happen. "*I think there were probably a lot of pressures around the need for the Coroner's Office to be able to have the grounds upon which they could hold special inquiries and come up with some solutions*" (P09).

The BC panel may have had the benefit of contributing to the growing need to investigate and learn from domestic homicide deaths, but the limited information provided to the panel may have hindered its recommendations. A more comprehensive examination of cases, including access to files and perhaps witnesses, and a commitment to an ongoing process and implementation may be required to see lasting change.

As with other models, representation is a theme that featured prominently in the interviews. The membership was heavy with government and criminal justice partners. In the view of one respondent, "*I would say that having really, really experienced people and having the fullest, broadest representation is important and so we had some of that. We had really experienced people and we had people that had prior relationships, which is important*" (P09). This respondent went on to say that a weakness of the panel would be the lack of representation from the diverse population that exists in the province: "*It could've been more diverse.*" As well, because the panel membership overemphasized government and criminal justice partners, voices from community advocates were not adequately included.

Similar to other models, this same respondent suggested that a limitation of the model is the inability to ensure recommendations are implemented. *"[T]he recommendations have zero teeth…. [W]e did see some change based on some of the recommendations, but there seems to be something missing in the accountability factor"* (P09).

A strength of the BC panel model is that it brought people to the same table to examine cases from a place of understanding and learning. *"[Y]ou need to be able to [review cases and have conversations] in a way that is like everybody's working toward the common good, which is, let's try to prevent these deaths from happening in the future…. I think it was easier to talk about a sector's shortcomings by having empathy for the individuals in that sector…. [N]obody's out to make anybody feel bad, so you need to kind of have empathy"* (P09). The respondent used an example of a newly minted RCMP officer who has very limited domestic violence training but who is still expected to know all of the risk factors and policies. Engendering empathy, therefore, may ultimately help to address system gaps.

Comparative Analysis

Inquiries, inquests, DVDRCs, and other models such as the BC Domestic Violence Death Review Panel share the common aim of identifying intervention opportunities, behaviour patterns, and risk factors to assist in the prevention of future domestic homicides. Each model of inquiry can be compared and contrasted in terms of representation, procedural fairness, and accountability and oversight. Bringing Bacchi's (1999, 2009) WPR approach into play also enables a consideration of how the problem of domestic violence is represented in each of these models, and the implications for realizing tertiary prevention.

Representation

In terms of representation, respondents who had experience with each of the models talked about the challenge of ensuring that all voices are heard. In the case of inquiries and inquests, representation is dependent, in large part, on the decision of the commissioner to grant standing to parties with a "substantial or direct interest" in the subject matter of the inquiry (Schulman, 1997: 217). In making that determination, there is a need to balance the time it would take to hear all possible witnesses and grant standing to every significant party with the need for an efficient and effective process. Nonetheless, the participants involved in an inquest or inquiry (counsel, parties with standing, witnesses) have the ability to shape the overall tone of the process, which may impact the proceedings as well as the resulting recommendations. In the May-Iles and Hadley Inquests, for instance, the presence of the women's advocacy groups, Metrac and OAITH, appeared to have a decided effect on the outcomes. In contrast, one of the criticisms of the BC Missing Women Commission of Inquiry was that it marginalized the voices of the members of the Downtown Eastside community, "while the 'professional' opinions of police and government officials took centre stage" (Bennet et al., 2012: 5). Although Commissioner Oppal had granted standing to a number of interested parties, the decision of the government to deny funding and the inadequate consultation process adopted by the commission meant that the voices of the very community that was most affected by the Pickton murders were side-lined in the inquiry process. In light of that experience, the *Blueprint for an Inquiry* report makes a number of recommendations aimed at ensuring full and meaningful participation by marginalized groups, including the provision of funded counsel and adequate support systems for potential witnesses (Bennet et al., 2012).

DVDRCs and the BC Death Review Panel face similar issues with representation as they endeavour to balance committee or panel memberships. One issue pertains to the balance of government and non-government (or internal and external) committee members. Ensuring representation from various government sectors on a DVDRC is important since, "Committee members are in a position to take knowledge from the committee and make changes within their own systems" (Jaffe, Dawson, and Campbell, 2013: 145). It would appear, however, that government representatives are in the majority on DVDRCs and the BC Death Review Panel. The current membership of the Ontario DVDRC consists of 12 government and five non-government members (Office of the Chief Coroner of Ontario, 2016). On the Manitoba DVDRC, nine of the twelve members currently on the advisory committee are government representatives; only three are from non-governmental organizations (Ursel, 2016). Of the fourteen members on the BC Death Review Panel, 12 are from government departments and the criminal justice system (BC Coroners Service, 2010). As the interview respondents indicated, external representation from community advocates from a variety of domestic violence sectors is important, as they can bring a perspective to the deliberations that might otherwise be missing.

In addition to balancing internal and external representation, diversity among the members is another consideration. Representation from community, cultural, and minority groups is important to better reflect the experiences of the women who are encountering domestic violence. Ensuring Indigenous representation on DVDRCs is particularly important in provinces with high populations of Aboriginal people, especially given the current climate of reconciliation emanating from the work of the Truth and Reconciliation Commission (TRC, 2015). As one respondent commented, *"In Canada we do know that the*

Aboriginal community has much higher rates, both male and female, of domestic homicides, so having someone there with that perspective is extraordinarily important, particularly when you have cases involving Aboriginals" (P04). In that regard, the inclusion of three Indigenous committee members on the Manitoba DVDRC (two of whom are on the working group) is a positive step (Ursel, 2016).

Process and Procedure

Each model has its own process and procedure, yet all of them have the common goal of examining cases of domestic homicide to prevent future deaths. Inquiries and inquests are typically selected for their representative characteristics and examine one domestic homicide case at a time, allowing for a thorough look into that particular case. As well, there is often flexibility to expand the scope, if necessary, to assess peripheral issues, allowing for a broader system analysis. The process for selecting a case to review by an inquest or inquiry is often the result of substantial media coverage and public pressure on the government to respond to a perceived failure of the system in preventing a domestic homicide. This was the situation with the Lavoie Inquiry in Manitoba, as well as the May-Iles Inquest in Ontario, which was called following a number of deaths in the province with the intention of selecting a representative case to identify trends, patterns, and risk factors.

Recommendations of inquiries and inquests may be limited to one particular case, but they will have been created from a more comprehensive picture of the system gaps that led to the death(s). This was seen in the domestic homicide inquests and inquiries examined here, as the lengthy review process and inclusion of witnesses and expert testimony allowed for a thorough review of the cases considered. Inquiries and inquests are also a public process, with open hearings and media attention, which makes the

transparency of the proceedings more achievable, and may encourage the political will necessary to implement recommendations. Nevertheless, as we saw with the BC Missing Women Commission of Inquiry, the process of inquiries can be limited—and their credibility challenged—when they fail to adequately incorporate the voices of those most affected into the process.

DVDRCs and the BC Death Review Panel, on the other hand, are able to examine a number of cases and create comprehensive recommendations based on risk factors, patterns and trends, and larger system change. However, these models run into concerns around privacy and confidentiality, which may both limit the involvement of external committee members and the amount of information that can be made public. With regard to the former, committee and panel members must sign confidentiality agreements, and they must be cautious about maintaining the confidentiality of victims and their families. In Ontario, all members of the DVDRC sign the same confidentiality agreement and are given access to all necessary files and documents when it is their turn to review a particular case. In Manitoba, however, privacy concerns have been interpreted such that only government employees can serve on the working group, as they already have access to the confidential materials involved in conducting a case review. Community members can only serve on the larger advisory group of the Manitoba DVDRC, and they receive an anonymized case summary compiled by the working group. This process, therefore, potentially limits the diversity of perspectives brought to the review. With regard to the latter, when creating recommendations and a final report, valuable learnings may be left out of what gets released publicly because the group cannot share all of their findings without identifying victims. This is of particular concern for committees (such as the Manitoba DVDRC) that

review a small number of cases each reporting period. Even so, abiding by the privacy rights of victims and their families does not necessarily preclude the ability to maintain transparency in the proceedings. As Nathalie Des Rosiers (2016: 381) notes, "Transparency does not mean that everything has to be in the public sphere at all times, but it does mean that there must be an explanation for the exemption from public scrutiny."

Further to the issue of process and procedure, the commissioners or chairs of each model of inquiry have differing levels of autonomy, which can impact the overall potential for meaningful reviews and recommendations. The Hadley and May-Iles Inquests were presided over by the Chief Coroner, but also involved a five-member jury tasked with hearing the evidence and making recommendations. Public inquiries, although established by government, are independent from government. "After the terms of reference are established, government cannot tell commissioners how to interpret their mandate or what procedure to follow in carrying it out" (Oppal, 2012b: 3). Nevertheless, one of the criticisms of the BC Missing Women Commission of Inquiry was the perceived conflict of interest present, since the commissioner was a "former Attorney General who had suggested there would be little to learn from an Inquiry" (Bennet et al., 2012: 9).

The chairs of the Manitoba, Ontario, and New Brunswick DVDRCs as well as the BC Review Panel are all government employees. In Ontario, for instance, "because the Death Review Committee is located in the Coroner's Office, an employee of the Coroner's Office acts as the chair of the committee and so we have a chair that sort of runs the meeting and has executive lead of the committee that helps him run the meeting, so he's sort of the overseer of the committee" (P04). In addition to the limitations that may arise from having an internal member chairing the committee—and perhaps controlling the process in the

interest of the government of the day—the chairs may not always have expertise in the area of domestic violence as they are selected more on the basis of their government position.

Accountability and Oversight

The challenge of accountability and oversight is one that came up throughout the interviews and the secondary research. None of the recommendations from any of the models have legislated or mandated follow-up mechanisms. In other words, they can just be left to gather dust on a shelf. Even with the establishment of implementation committees and requests for annual follow-up, it seems that implementing recommendations is still fraught with challenges. In Ontario, for example, the Coroner's office is responsible for inquests as well as the DVDRC, and both models lack formal accountability beyond the annual updates on progress that the office provides on all inquests and committees in the province.

Implementation committees are rare as they are not a requirement written into the process of any model of inquiry. Most often, the work of reviewing recommendations is left to individual departments assigned to report to the Minister on the feasibility and possible costs associated with implementing recommendations. The Lavoie Implementation Committee, however, stands out as an exception. Mandated to oversee the implementation of all government-directed recommendations stemming from the Lavoie Inquiry, the committee was provided with the financial support to conduct its work. It also had the benefit of strong community representation (92 of the 135 working group participants were community representatives), which led to the implementation of nearly all of the 73 recommendations (Lavoie Implementation Committee, 1998).

Recommendations stemming from an inquest or inquiry may have more of an immediate impact because of the public attention the model receives. As one respondent remarked:

> *The recommendations that come from the inquest, though, I think have potential for a greater impact than ongoing recommendations through the committee report process only because they're directed as a result of the specific case that's been elevated in the public eye. So I think, yeah, I know for a fact that the recommendations that came out of the May-Iles had a great bearing on the creation of the educational program for prosecutors, the development of standard operating procedures for police across the province. The educational programs that they instituted in the police college in Toronto and the Ontario police college. Just the reference to May-Iles is recognized in the criminal court process because courts were created, domestic violence courts. Why? Because of the May-Iles Inquest. So, yeah, I think that recommendations from an inquest have greater potential to be acted on just because of the very nature of them being made publicly in that process.* (P01)

This is not to say that the work done by a DVDRC will not have an impact. One advantage of the DVDRCs is their ongoing nature, which allows for the potential for greater oversight on recommendations that have been advanced by the committee, even if that means making the same recommendations more than once. As one respondent commented: "*There's something to be said about repeating things because eventually somebody will hear you*" (P04).

There is also some evidence that DVDRCs can have a broad reach, one that extends beyond the criminal justice system to other sectors. As one respondent noted:

> *[Recommendations from a DVDRC] may impact in other areas. Because those inquests largely involved the criminal justice [sector] I know that some of the committee reviews reported on things like what are the educational programs for physicians, for hospital staff in dealing with people who come in with injuries related to domestic abuse, social workers in interviewing people in the home. When there's a child in need of protection, an investigation, is the spouse being abused? Understanding of the fact that abuse of a spouse has an impact on the children who witness and hear the abuse. Those kinds of things. So they all have a role to play.* (P01)

Applying the WPR Approach

While comparing and contrasting the models of inquiry in terms of the issues of representation, procedural fairness, and accountability and oversight provide insights into their potential for tertiary prevention, adopting Bacchi's (1999, 2009) WPR approach enables us to dig deeper with regard to how the problem of domestic violence has been represented in each of the models.

As noted in an earlier chapter, largely as a result of feminist advocacy work, the representation of the problem of domestic violence has shifted over time, from one of a personal tragedy to a social issue requiring social intervention. This shift in representation is evident in the models of inquiry explored here. The Schulman report from the 1995 Lavoie Inquiry framed the problem of domestic violence as a relationship issue rooted in the cycle of violence and the corresponding emotional states of Rhonda and Roy Lavoie. The May-Iles and Hadley inquests, however, adopted a more holistic approach and framed the problem of domestic violence as an equality issue, providing a forum for contextualizing women's equality rights and locating their socio-historical roots (Sampson, 2003). Domestic Violence Death Review Committees extend this framing even further by focusing more comprehensively on the risk factors, system gaps, and the preventable nature of domestic homicide deaths. The assumption or presupposition underlying this representation is that if risk factors can be made known, then prevention can be realized in future cases.

As noted previously, what is left unproblematic in this problem representation (Bacchi's third question) is the issue of accountability or the ability to require that recommendations emerging from the models of inquiry are implemented. While the

specific domestic homicide cases considered in inquiries and inquests are chosen for review and convened by the government (in contrast to some DVDRCs, such as the ones in Ontario and New Brunswick, which aim to examine all deaths), increased efforts to implement recommendations do not necessarily follow. Public attention and scrutiny around the case and interest from advocacy groups may, however, encourage accountability. Nevertheless, no mechanism exists that mandates the government or other parties to respond to an inquiry or inquest report or to implement recommendations. This may happen in some cases—the Lavoie Implementation Committee is a good example—but there are still limits to the process.

In the case of DVDRCs, Jaffe, Dawson, and Campbell (2013: 143) note that, "To date, there is no Canadian domestic homicide review committee that tracks responses to these recommendations." They go on to suggest that, "A committee needs to develop a mechanism that ensures the implementation of recommendations as well as monitors the corresponding systemic changes" (p. 148). As the interview respondents noted, committee members advocating within their professional fields may also help bring attention to unmet recommendations. The fact that committees are examining cases on an ongoing, regular basis also means that reports and recommendations are less likely to be forgotten on a shelf.

In terms of Bacchi's fifth question—what are the effects produced by this representation of the problem?—redefining the issue from one of men's lack of control to their deliberate use of violence to control their intimate partner placed the attribution of responsibility for the problem of domestic violence squarely on the shoulders of the perpetrators. One advantage of this shift in the representation of the problem is that when

domestic homicides do occur, blame remains with the perpetrator, even when gaps in the system become evident. This attribution of responsibility is more conducive to making system changes to rectify those gaps, a point that was not lost on several of the interview respondents, especially with regard to the perspective adopted by the DVDRCs.

> *[W]e're not going to be blaming certain areas of government or police for the death of someone, the death of someone is the person who did it is ultimately responsible, we're working from that perspective where we're trying to make things better. We're not trying to attack those or where we think things fell through the cracks and so everybody from the committee operates from that perspective and we've had good participation as a result.* (P06)

> *[T]en years ago we had all these different sectors that weren't talking to each other, they weren't saying anything, they were blaming each other for everything that was happening and sometimes some people were to blame and other people weren't. Now I see with the Death Review Committees, at least in Ontario, we have a group that sort of doesn't want to blame. We just want to learn. We want to identify the problems that we have and we want to find solutions to the problems.* (P04)

Finally, Bacchi (2009) poses the question of: How/where has this representation of the 'problem' been produced, disseminated, and defended? How has it been (or could be) questioned, disrupted, and replaced? One aspect of this question involves the continuing effort to ensure that the representation of the problem of domestic violence includes a recognition of its gendered nature. As discussed in chapter one, this effort was historically initiated by the feminist movement in its endeavour to transform intimate partner violence from a personal trouble to a public issue meriting a criminal justice response. As we saw in the Hadley Inquest, however, attempts were made by F.A.C.T., the father's rights organization, to disrupt this representation of the problem. In that regard, one respondent spoke about the importance of a feminist standpoint for addressing the issue of domestic homicide: "*You can't do this work without having a voice from the independent women's movement*" (P05). In order for this standpoint to be included in the different models of

inquiry, community organizations need to be provided with the financial resources required to participate in inquiries and inquests, and community advocates need to be well-represented on the DVDRCs.

One strategy that DVDRCs have adopted to enhance the impact of the model in fostering tertiary prevention is through the establishment of the Canadian Domestic Homicide Prevention Initiative, which includes a website (http://cdhpi.ca/) dedicated to disseminating the information from the different DVDRCs to the public. As one respondent noted:

> *Ok, so that is the motivation behind that particular website, is to get the Death Review Committees, because we've had a couple of think tanks on the Death Review Committees so that sort of is to push people forward not only in sharing best practices but for people who haven't implemented these committees to learn from the accomplishments or the mistakes potentially that committees have made already. So that's part of what that initiative is trying to achieve.* (P04)

A respondent also spoke of a need to nationalize the recommendations and bring information together because people are working too much in isolation (P08). Another respondent commented that DVDRCs have the benefit of engendering more cohesion among the various groups working to address domestic violence, saying:

> *The people who respond to domestic violence are so diverse and so far away from each other in many cases that if there isn't a kind of an overarching group that brings them all together, then they just kind of work in their silos, which is what the problem has been. So for me, the Death Review Committees start to make us less a silo and more one cohesive unit. We still work in our silos, but we're paying attention to what's going on in the other silos more than we used to.* (P04)

Disrupting the reluctance of governments to implement recommendations that flow from the models of inquiry also involves capturing the public imagination. Public pressure can engender the political will of governments to take action, which respondents indicated was a significant factor for all of the models of inquiry in terms of their potential for

tertiary prevention. While educating the public is an important feature of primary prevention, it also may be key to increasing the likelihood that recommendations stay front-of-mind for those with the ability to enact change. Inquiries and inquests may be more successful at this because of the media attention they receive. Nevertheless, DVDRCs and death review panels could also give closer consideration to engaging with the public about their work.

While the issue of implementing the recommendations of inquiries, inquests, DVDRCs, and review panels is a significant one, Bacchi (2012) also makes the point that the way in which a problem is represented creates a particular form of knowledge or "truth" of the matter. Nathalie Des Rosiers (2016) makes a similar point with regard to public inquiries (and, arguably, other models of inquiry), suggesting that they are not simply a "truth-finding" body but also a "truth-producing" enterprise. In that regard, irrespective of whether or not the recommendations that emerge from a model of inquiry are adopted, the very process of making public a particular way of framing an issue can create meaningful change. In this sense, according to Des Rosiers, the *process of inquiry* itself becomes the message. As such, "the real measure of their success is whether or not they succeed in transforming the conversation and the power structures that currently define it" (p. 388).

Concluding Remarks

After speaking to respondents from across the country and reading reports from each model, it is clear that no one model is the answer. Each model has challenges and strengths, but it is the combination of models that can lead to tertiary prevention and lasting change. This complementary relationship between the models was evident in the interviews. When asked, respondents could not say whether one model had more overall potential for

tertiary prevention than another. As one respondent noted, *"You can't inquest every [domestic homicide]. It's not possible. And it's not necessary. So I think the combination of inquest and a Death Review Committee are really helpful, they complement each other, … saving [inquests] for the really complex and teachable cases"* (P05). In that regard, the existence of a DVDRC or death review panel in a province does not mean that there will not be a need for an inquest or inquiry in the future.

> *I think it may be at some point that if the Domestic Violence Death Review reports are not being looked at or followed and at some point the Office of the Chief Coroner may say, "We'll have to pick another one of these unfortunate situations to see if we can make recommendations to correct some failings in whatever system the people find themselves in"…. The Office of the Chief Coroner may decide this has some unique features that needs to have the, it's in the public interest to have an inquest.* (P01)

As well, one respondent spoke about the ways in which the models of inquiry could potentially interact with each other:

> *[T]he people that are at an inquiry or inquest … could call everybody who's involved in a Death Review Committee, and maybe that will become a trend over time, I don't know. With the establishment of these Death Review Committees, if there are future inquests you might see members of committees being called to testify about risk factors or the things that they've seen in their work, you might see that happening in tandem, I don't know.* (P06)

For all that has been learned through this research process, it remains that meaningful change will ultimately come from the hard work and dedication of those working with and for victims of domestic violence. Much can be learned from examining deaths, and as long as those voices are being heard, there is hope that system change will follow and lives will be saved. One respondent ended the interview with a call to action for the domestic violence sector and the public, saying: "It's time to start putting the recommendations into place and use what we already know about domestic homicides and the risk factors" (P08).

Chapter Six: Conclusion

Domestic violence is a serious issue in Canada. While many efforts have been made to improve the various and related domestic violence intervention systems and sectors, every province continues to experience deaths resulting from intimate partner violence. The feminist movement worked long and hard to change the way the problem of domestic violence is represented. Meaningful results of those efforts can be seen in the way we talk about the issue of domestic violence and the systems that are in place to help women and their families. However, there is always room for improvement and as long as domestic homicides occur, there is a need to continue working to prevent them.

One thing that is now clear is that domestic homicides are patterned and risk factors can be enumerated and ordered according to degree of risk. This understanding is the product of information from service providers, inquests, inquiries, and ongoing DVDRCs that inform the growing body of research on risk factors involved in intimate partner homicides. As knowledge about risk factors increases there is an evolution of models of inquiry used to examine and learn from domestic homicides. The purpose of this thesis has been to examine inquiries, inquests, Domestic Violence Death Review Committees, and other models of inquiry to assess their potential for tertiary prevention. While it is too late to save the lives of women already lost to domestic violence—including Rhonda Lavoie, Arlene May, and Gillian Hadley—much can be learned from examining their stories and paying attention to the risk factors and system gaps that existed. Each of these models of inquiry endeavours to identify intervention opportunities, behaviour patterns, and risk factors to assist in the prevention of future homicides.

Based on an analysis of interviews conducted with 11 key stakeholders and the secondary data, it is clear that there *is* the potential to prevent future domestic homicides. The potential of a model of inquiry may be dependent on the specifics of how it is constituted in a particular case (in the case of inquiries and inquests) or a particular jurisdiction (in the case of DVDRCs), but the potential is there nonetheless. It is also clear that no one model is the "right" or the "best" model. Each model has its own strengths and limitations with regard to issues of representation, process, and accountability. While inquiries and inquests will likely continue to be convened for particular domestic homicide deaths, the work of Domestic Violence Death Review Committees can play an ongoing and complementary role in compiling a substantial body of analytic data on domestic homicides.

In the case of DVDRCs, there is a dynamic tension when community representatives are brought together with government staff to develop recommendations for service or system change. Government staff are necessarily answerable to their Ministers, who frequently have an interest in containing demands for change, particularly when large expenditures are involved. Community representatives are largely answerable to their community of advocates and service providers, who have a strong interest in change. On a DVDRC, the two groups bring their expertise to the analysis of domestic homicides with the common goal of preventing future homicides. Nevertheless, they are limited in the impact they can have on the implementation of their recommendations. As such, the strength of DVDRCs lies in their analysis; their weakness lies in their lack of control over implementation.

The particular combination of strengths and weaknesses of DVDRCs is complemented by the much less frequent but the much more public occurrence of inquests and inquiries. Inquests and inquiries have time and case limitations to their ability to amass analytic data on domestic homicides. However, their public nature gives them much greater strength for creating "political will," which ultimately determines the prospects of implementation.

While the focus of this thesis has been on tertiary prevention, it is also clear that in the same way that each of the models work together, the different forms of prevention (primary, secondary, and tertiary) also work in combination to prevent domestic homicides. In that regard, the models of inquiry and the recommendations that result can go a long way towards improving work throughout the domestic violence sector, starting with the earliest intervention and prevention programs.

As was shown in the Introduction, domestic violence affects all groups in Canadian society but some groups are more at risk than others. In particular, research has shown that Aboriginal women are especially vulnerable to domestic violence. One respondent, therefore, directed attention to the need for models of inquiry to focus on that issue.

> *I think that the next inquest in [this province] should be an inquest into an Aboriginal death which would allow us … to look at systemic violence, structural violence, legacy of the residential schools, why Aboriginals are so over-represented in the criminal system, the level of racism and colonialism.* (P05)

In that regard, The National Inquiry into Missing and Murdered Indigenous Women and Girls launched September, 2016 may contribute to the work being done across the country in the domestic violence field and bring attention to particular recommendations that each of the models have made over the years. The mandate for the five commissioners is to "examine and report on the systemic causes of all forms of violence against Indigenous

women and girls in Canada by looking at patterns and underlying factors" (http://www.mmiwg-ffada.ca/en/), a mandate similar to the goals of the various models examined here.

Ultimately, the potential of the models of inquiry for tertiary prevention depends on the political will of governments to review a case or cases in the first place, and to ensure that the appropriate stakeholders act on the recommendations. Advocacy work, public awareness, and the right political climate are what can translate into action and real, meaningful change.

Strengths and Limitations of the Study

As with all research, there are limitations that exist in this project. One significant limitation is that it is a small study with a limited number of interviews. This was due, in part, to the limited number of domestic homicide inquiry processes that exist in Canada and the relatively small number of stakeholders who are involved in those processes. While the aim was to interview respondents with a breadth of knowledge from across the country, all of the expertise that exists could not be captured. Some difficulties were also experienced in recruiting people to take part in an interview. For instance, additional stakeholders in British Columbia were contacted but they were unable to participate in the study, in part because of a confidentiality agreement that prohibited them from speaking about their involvement in the death review panel process.

Another limitation pertains to the varying developmental stages of the Domestic Violence Death Review Committees. Ontario's DVDRC has the most experience, having been in operation for over ten years, while the committees in other provinces are much newer and have fewer public resources available for examination. While, ideally, more people

from each committee could have been interviewed, it would not change the fact that there are few committees to choose from and that each is at a different stage of development and operation. Every effort has been made in conducting this study, however, to be mindful of the specific circumstances of each DVDRC.

Because of the small sample size, it was not possible to separate respondents who were internal and external to the DVDRC process in the reporting of the findings. It should be noted, however, that this designation was not a theme that emerged during the interviews, as the standpoints of respondents on the issues considered were not significantly different based on whether they were internal or external committee members.

This study was also limited with respect to the other models of inquiry that exist. Six people were interviewed with experience related to inquiries and inquests, all of whom were from Manitoba or Ontario. Additional interviews with more people from across the country with experience with inquiries and inquests may have provided a more complete picture. As well, while the study sample included respondents from the BC Death Review Panel, it did not include individuals who were involved in other in-depth reviews that have been conducted across the country, and so there is a chance that there are other models of inquiry into domestic homicides that may have been missed.

Interviews with friends and/or family members of the victims or perpetrators of domestic homicides were intentionally excluded from the study. This is a group that likely could have provided additional narratives on these inquiry processes, especially in terms of the issue of representation and the extent to which the models served their interests. Nevertheless, given the limits of time and resources, the decision was made to focus the

study on the experts who have played key roles in conducting the reviews and the official documents and research that exist on the subject.

A final limitation pertains to the changing field of domestic homicide prevention in Canada. With DVDRCs existing in only a few provinces to date and for a relatively short time period, it is likely that much will change around the use and implementation of DVDRCs and other inquiry models in Canada over the coming decades. In the last few years alone, Alberta and Saskatchewan have begun the process of implementing a DVDRC, British Columbia convened a second death review panel, and other provinces have made modifications to their review process or reporting method. Such change is positive, however, and research such as the present study may be able to offer guidance and suggestions to models of inquiry into domestic homicide as they continue to grow and evolve.

Despite its limitations, this study does have an important contribution to make. The subject of domestic homicide prevention is a relatively under-investigated area. By bringing together what is known about the different models of inquiry and showcasing the voices of people who have a wealth of knowledge on the topic, the study takes us one step further in the important project of addressing the serious issue of domestic violence.

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Appendix A: Interview Consent Form

UNIVERSITY OF MANITOBA

Informed Consent Form

Exploring a Continuum of Policy Responses to Domestic Homicides in Canada

Principal Investigator: Mariah Baldwin, Department of Sociology

Research Supervisor: Dr. Jane Ursel, Department of Sociology, RESOLVE Research Centre

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Project Description

"Exploring a Continuum of Policy Responses to Domestic Homicides in Canada" examines the different models of inquiry that exist in Canada following a domestic homicide. These models include inquiries, inquests, Domestic Violence Death Review Committees (DVDRCs), in-depth reports, and review panels. DVDRCs, in particular, are relatively new in Canada and this research will provide important information on an understudied topic. As part of this project, I am interviewing key stakeholders who have expertise in one or more of these models of inquiry to gather firsthand information about the policy responses that exist. Although this research is primarily directed toward the completion of a Master's degree, I hope it will also provide practical suggestions for policymakers and practitioners in the field of domestic violence.

What Participation Involves

Your voluntary participation will involve an open-ended interview. During the interview, I will be asking questions about your experience with models of inquiry related to domestic homicide deaths. The interview may take about 1 hour of your time; however, it could be longer if you have a great deal of information to share. The interview will be recorded with your consent using a digital device and later transcribed by for analysis.

Confidentiality

Any information gathered in this research will be kept confidential. All recorded and transcribed data will be identified only by code number and kept in a locked cabinet in my home office or on my password-protected computer. Steps will be taken to remove not only names from the data, but any other potentially identifying information.

The Principal Investigator and the Research Supervisor will be the only ones to have access to the data. You will not be named or identified in any study reports, presentations, or publications (meaning statements you make will be attributed to an anonymous source). Information containing personal identifiers (e.g. this consent form, audio recordings) will be deleted or destroyed by shredding five years after the project is completed (approximately 09/2019).

Despite these precautions, this is a small study involving a limited number of inquiry processes; therefore, there is a possibility that you could be identified by your responses. We will take the necessary procedures to keep the information confidential. If this concerns you, then you should not participate in an interview.

Communication of Results

Results from this research will be communicated in aggregate form. It will be presented to my thesis committee as well as any members of the public who wish to attend the presentation. It may also be published as academic papers in refereed journals or presented at professional conferences. Again, your personal confidentiality will be maintained throughout.

Risks and Benefits

There is no expected risk to you from participating in this research. There may be a short-term benefit of having the opportunity to talk about your experience in the field of domestic homicide policy responses. In the long-term, this research will contribute to a growing body of research on the subject and may help strengthen prevention policies for responding to domestic homicides.

Consent

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Psychology/Sociology Research Ethics Board. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 204-474-7122. A copy of this consent form has been given to you to keep for your records and reference.

If you agree to each of the following, please place a check mark in the corresponding box. If you do not agree, leave the box blank:

I have read or had read to me the details of this consent form. ( )

My questions have been addressed. ( )

I, ______________________________ (print name), agree to participate in this study. ( )

I agree to have the interview audio-recorded. ( )

I agree to have the findings (which may include quotations) from this project published or presented in a manner that does not reveal my identity. ( )

Do you wish to receive a summary of the findings? ( ) Yes ( ) No

How do you wish to receive the summary? ( ) E-mail ( ) Surface mail

Email or mailing address: ____

Participant's Signature ____________________________________ Date ______________________________

Researcher's Signature ____________________________________ Date ______________________________

Appendix B: Invitation to Participate

Hello,

My name is Mariah Baldwin. I am a Master's student in the Department of Sociology at the University of Manitoba. My thesis research, entitled Exploring a Continuum of Policy Responses to Domestic Homicides in Canada, is examining the different models of inquiry that exist in Canada following a domestic homicide. I am contacting you to see if you would be willing to participate in this research.

When a domestic homicide occurs, it raises questions about whether the couple had prior involvement with criminal justice or social service agencies and, if so, how their case was handled. Inquiries, inquests, Domestic Violence Death Review Committees (DVDRCs), review panels, and in-depth reports are among the policy responses that exist in Canada. In all of these processes, it has been the stated intent of reviewers to acquire information about the circumstances of a particular homicide in order to prevent subsequent deaths.

The research question for this project asks: *which model of inquiry for addressing domestic homicides has the greatest potential for tertiary prevention?* Tertiary prevention in the case of a domestic homicide is based on the idea that new information can be gathered from each case in which a domestic partner or family member attacks and kills a victim – murders which are considered highly preventable.

As part of the data collection process for my thesis, I will be conducting interviews with experts who have experience with the various models of inquiry. Participation is completely voluntary and will involve an in-person interview lasting between 1-2 hours. Where an in-person interview is not possible, efforts will be made to accommodate a Skype conversation or a phone interview. During the interview (which will be audio-recorded), I will ask you questions about your experiences with one or more of the models of inquiry. Every effort will be made to ensure your participation is confidential and your name will never be used in any reports or presentations resulting from the study. However, this is a small study involving a limited number of inquiry processes in Canada and there is a potential that you may be identified based on your responses. If you are uncomfortable with the possibility of being identified, you should not participate in an interview. Attached is a copy of the interview guide so you can see what you will be asked and determine if you are comfortable answering the questions.

If you are interested in participating in this project, please contact me and we can set up an interview time and begin the consent process. As well, please do not hesitate to contact me if you have any questions about this project or your participation in it.

Take care,

Mariah Baldwin

Appendix C: Interview Guide

Exploring a Continuum of Policy Responses to Domestic Homicides in Canada

Mariah Baldwin, MA student, Department of Sociology

- Interview Guide -

This project is examining different models of inquiry into cases of domestic homicide in Canada. To date, there have been different procedures utilized to inquire into the circumstances that led to domestic homicides. The range of inquiry processes has included inquiries, inquests, review panels, in-depth reports (such as the Pedlar Report), and Domestic Violence Death Review Committees (DVDRCs). In some cases, a province may choose to employ a hybrid of two models (for example the BC Death Review Panel). In all of these processes, it has been the stated intent of reviewers to acquire information about the circumstances of a particular homicide in order to prevent future homicides. The purpose of this study is to examine different review processes to assess their potential for tertiary prevention.

You have been selected for this interview because of your experience with one or more of these inquiry processes.

1. What experience have you had with the range of models of inquiry into domestic homicides? Please explain.

DVDRCs and Other Models

Origins

2. Can you talk about the origins of the DVDRC/review panel/in-depth report that you have been involved with?
    a. What factors led to the development of the DVDRC/review panel?
    b. Why was this particular model chosen to address a specific domestic homicide or domestic homicides in the province?

Structure

3. How is the DVDRC structured?
    a. Is there flexibility in that structure?
    b. Do you know how and/or why that structure was chosen?
    c. Are there any changes to the structure that you would suggest?

Membership

4. Who makes up the membership of the DVDRC? (areas of expertise, etc.)
    a. What is the process of selecting the members? Who does this? How is this done? Any specific requirements?
    b. What involvement is there from people in the social services?
    c. What, if any, is the role of family and/or friends of the victim(s)?

d. How open is the Committee to people outside of government?
e. Is there room for involvement by people not on the committee during the review?
f. Is there a set term for membership on the DVDRC?
g. In your opinion, is anyone (or any particular area of expertise) missing from the membership?

Case Selection

5. How are cases selected for review? Who selects them? Criteria?
    a. How does the Committee review a domestic homicide case?
    b. What is the average length of time to review a case? How is this time spent?

Finances

6. In your experience, what costs are associated with a DVDRC review?
    a. Where does the funding come from?

Reporting and Recommendations

7. What sort of reporting structure exists for the DVDRC? (annual reports, etc.)
    a. Who does the committee report to?
8. Are recommendations made for all cases reviewed by the DVDRC?
    a. Who drafts the recommendations?
    b. Who are recommendations submitted to?
    c. Are recommendations and final reports released publicly?
    d. Is there a process for implementing recommendations?
    e. What about monitoring and follow-up of recommendations and long-term effects?
    f. In your opinion, are recommendations being followed? Ignored?
        i. Which ones? Why? By whom?

Assessment and Efficacy for Tertiary Prevention

9. What do you see as some of the strengths and/or benefits of a DVDRC, review panel, or in-depth report?
10. What do you see as some of the limitations and/or weaknesses of a DVDRC, review panel, or in-depth report?
    a. Are there things that you are not getting out of this model?
11. How do you see the role of DVDRCs in domestic homicide prevention and policy?
12. How could the work of DVDRCs better lead to changes or positive improvements for women and victims?

Inquiries and Inquests

Origins

13. What were the circumstances that led to the domestic homicide inquiry or inquest(s) you were involved with?

Membership

14. Can you talk about the people involved in the inquiry process you experienced? (areas of expertise, etc.)
    a. Can you talk about the process of granting standing?
    b. What, if any, is the role of family and/or friends of the victim(s)?
    c. In your opinion, is anyone missing from the inquiry/inquest process? (e.g. particular areas of expertise, social services, etc.)

Case Selection

15. What was it about the particular domestic homicide that prompted an inquiry/inquest to take place?
16. How long did the inquiry/inquest take?
    a. How was the time spent? (e.g. preparation, hearings, etc.)

Finances

17. What costs are associated with an inquiry/inquest?
    a. How crucial is the issue of finances in balancing the costs and benefits of an inquiry?
    b. Are there any implications of this? (positive or negative)

Reporting and Recommendations

18. With the inquiry/inquest you were involved in, were recommendations generated?
    a. Who was involved in drafting recommendations?
    b. What was the nature of the recommendations?
    c. Were they implemented?
    d. What about monitoring and follow-up of recommendations and long-term effects?
    e. In your experience, are recommendations being followed? Ignored?
        i. Which ones? Why? By whom?

Assessment and Efficacy for Tertiary Prevention

19. What do you see as some of the strengths and/or benefits of an inquiry or inquest?
20. What do you see as some of the limitations and/or weaknesses of an inquiry or inquest?
    a. Are there things that you are not getting out of this model?
21. How do you see the role of inquiries in domestic homicide prevention and policy?
22. How could the work of inquiries better lead to changes or positive improvements for women and victims?

<u>DVDRCs, Inquiries, Inquests and Other Models</u>

23. Are you aware of any of the different models of inquiry having an impact on domestic violence crime?
    a. What kind of an impact? (positive or negative)

24. In your opinion, what is the best way/structure to examine domestic homicide cases with the goal of prevention?
25. Given your expertise, with the ultimate goal of prevention, can you speak to which model of inquiry may be better?
26. Is there anything else you would like to add or clarify?