ACWS Position Statement

THE NEED FOR A DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE IN ALBERTA

In the Fekete case in Red Deer (murder/suicide 2003) and the Cole Harder case in Camrose (murder/suicide 2003), primary risk factors for homicide were present. In 2004, domestic violence murder/suicides occurred in Sundre, Airdrie, and Bonneyville. Again, primary risk factors were present. Friends, family, and the police were aware that each of these situations was potentially explosive, but may not have had the proper tools to assess risk and prevent harm. **There is a growing recognition that these deaths are preventable.** - Domestic Violence Handbook: for Police and Crown Prosecutors in Alberta, Alberta Justice 2008

"Over the last fifteen years, domestic violence fatality review teams have emerged in North America as an innovative and promising means of understanding and preventing domestic violence deaths, homicides and suicides resulting from domestic violence (Websdale, 2003). " Sadly, Alberta often leads in the number of domestic violence homicides and murder suicides. While there have been many strides forward in the last number of years (e.g., increased shelter support; Domestic Violence Courts, increased training, the Integrated Threat and Risk Assessment Centre), what is still missing is a comprehensive review of deaths that we know are predictable and preventable. With the development of a well thought out, thorough and interdisciplinary process, the Alberta Council of Women's Shelters sees the following advantages of domestic violence death review committees as they:

1. Inform and motivate both the public and decision makers to find solutions to end domestic violence

2. Clearly identify systemic changes required within all organizations and agencies involved in responding to domestic violence.

3. Enhance systems accountability of domestic violence responders and service providers through a collaborative review of domestic violence deaths designed to improve systems rather than cast individual blame .

"*The establishment of domestic violence fatality review teams under legislative or statutory authority and executive orders is one very important promising practice that has emerged to allow teams to both share information and maintain the confidentiality of information shared. Domestic violence fatality review teams involve collaboration among stakeholders from a variety of agencies (e.g., law enforcement, health care, social services, education) to identify and review cases of domestic violence deaths and to develop strategies to prevent or reduce future fatalities*."[1]

[1] Domestic Violence Fatality Review Teams: Critical Tensions and Promising Practices. Kelly A. Watt and Nicole E. Allen (Page 1)

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4. Inform and motivate both the public and decision makers to find solutions to end domestic violence.[2]

5. Clearly identify systemic changes required within all organizations and agencies involved in responding to domestic violence.

6. Enhance systems accountability of domestic violence responders and service providers through a collaborative review of domestic violence deaths designed to improve systems rather than cast individual blame .

7. Help to overcome the failure of the current system to hold public inquiries into domestic violence deaths, unless these deaths receive significant media attention.[3]

8. Offer the potential to enhance the safety of children exposed to domestic violence through an examination of risk factors present for children and through collaboration with Children's Fatality Review processes. System failures in child custody and access that result in the death of children and/or their mothers can only be identified and explained by a comprehensive death review process.

9. Examining the circumstances under which domestic violence fatalities occur will enhance our knowledge on informed intervention and prevention resulting in an enhanced quality of life for Albertans and a decrease in the significant systems costs associated with domestic violence homicides and attempted homicides.

At the time of this position statement, the last domestic violence related fatality inquiry was into the deaths of Betty and Alex Fekete. The results of this inquiry spurred improved responses to domestic violence incidents in Alberta. Since that time there have been 81 fatality inquiries in the province, but none of them were related to domestic violence homicides even though in 2008, the RCMP alone reported that domestic violence accounted for more than a quarter of the 53 homicides investigated in their area. We have seen that domestic violence deaths in rural and remote areas in particular tend to be overlooked by the media and hence do not receive a great deal of public attention. If there was an automatic review of all deaths related to domestic violence in the province, these cases (which are quite numerous), would finally get the attention they deserve.

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[2] Even when there is significant media attention, fatality reviews into domestic violence deaths may not be held. For instance, ACWS requested a fatality review into the death of Brenda Moreside. We received confirmation from the Chair of the Review Committee that this would occur following the court proceedings. However, the court found Stanley Willier not guilty of second-degree murder in the death of his common-law wife, Brenda Moreside. Moreside had called 911 on Feb. 13, 2005 to report that her intoxicated common-law husband (and previously convicted murderer) was trying to break into a window of their home. She was told that police could not charge him with damaging his own property, and the RCMP did not dispatch a car to respond to her call. Moreside's body was found in the house 12 days later. She had been stabbed several times. The Court ruled the RCMP hadn't given Willier enough opportunity to have a lawyer present while he was being questioned. The Court of Appeal reversed this decision, which is being appealed to the Supreme Court of Canada. It is now 5 years since she was murdered.

New Zealand was the first country to establish a national approach to family violence death reviews. The National Domestic Violence Fatality Review Initiative is a clearing house and resource centre dedicated to domestic violence death reviews, with local committees initially investigating family violence deaths in their area.

Approximately 20 American states have legislation providing for family violence death reviews, with around 25 states having family violence death review processes. In the United Kingdom, the Domestic Violence, Crime and Victims Act 2004 provides for domestic violence homicide reviews with the aim of learning lessons from previous fatalities so that risk factors can be recognized and preventative steps can be taken.

Here in Canada, the Province of Ontario has had a Death Review Committee in place for the last five years. Both New Brunswick and Manitoba have announced that they will soon be following Ontario's lead. Some positive results arising from the Ontario Death Review Committee reports include:

- the development of the Neighbours, Friends and Family campaign due to the finding that in a number of domestic violence deaths, friends and family saw the risk factors but did not understand their role
- legislative reform to include domestic violence as a type of workplace violence
- enhanced training for medical health professionals given the finding that many of these professionals did not address Domestic Violence (i.e., with depression they asked about suicide but not domestic violence and homicide ideation)

Of course, one can never fully know (and therefore count), the number of deaths and amount of harm that is averted due to an improved community response. What we know for certain is that improved community responses saves lives.

It is the position of the Alberta Council of Women's Shelters that Alberta also needs to implement its own death review committee. We have already benefited from Ontario's Death Review Committee as the current risk factors developed by the Solicitor General for the Family Violence Investigative Response (FVIR) drew heavily upon the risk factors identified in the Ontario reports. However, we cannot just watch from the sidelines. It is critical for Alberta to have its own death review to committee in order to identify areas in our jurisdiction that are working and those that are not . An Alberta Death Review Committee should have the mandate to review all domestic violence related deaths, including the deaths of children and elders. Alberta needs to do its own due diligence thus setting the stage for individual, system and community accountability.