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Alberta's Family Violence Death Review Committee: Recent Reports, Recommendations and Reflections

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Reports Commented On: Family Violence Death Review Committee, Annual Reports and Case Reviews, available here.

Alberta's *Protection Against Family Violence Act*, RSA 2000, c P-27 (*PAFVA)* was passed in 1999 and has as its primary focus the provision of protection orders for persons experiencing family violence. The *PAFVA* was amended in 2013 to empower the government to establish a Family Violence Death Review Committee (FVDRC) with the mandate to review fatal incidents of family violence and to advise and make recommendations to the government on preventing and reducing family violence (*PAFVA*, s 16). The FVDRC was established in 2013, and its most recent annual report, released in May 2017, provides statistics on the 132 family violence deaths in Alberta between January 2008 and December 2015 (see Family Violence Death Review Committee, 2015/2016 Annual Report at 12). In a series of more in-depth case reviews released between May 2017 and May 2018, the FVDRC makes several recommendations related to legislation, policy and legal processes that I review in this post. For a good resource on domestic violence death review committees in other jurisdictions in Canada and internationally, see the website of the Canadian Domestic Homicide Prevention Initiative.

The FVDRC's Case Reviews

The FVDRC's first case review report has a publication date of November 2015 but was released with the 2015/16 annual report in May 2017. It involved the homicide of a female adult in 2011 by her male partner. Generally, few details of the relationship and death are made available in this first case report, a pattern that is repeated in subsequent death review reports. However, it appears that the couple were new Canadians and that violence had occurred in the workplace of the victim. In speaking to the media after the release of this report, FVDRC Chair Allen Benson noted that the offender had told his co-workers "that a serious, violent crime would take place" but nothing was done by his employer, nor by the victim's employer, who "did very little to protect the employee at the workplace site, and knew about the violence and knew about the potential threat, and did nothing about it." The FVDRC report highlighted several best practices from the case – although based on Benson's comments, it is unclear whether these are practices that should have happened or that did happen. Best practices were said to include referral of the offender to an employee assistance program for psychological and legal assistance, and attempts to ban him from the victim's place of employment (at 3).

In its recommendations, the FVDRC advocated amendment of the *Occupational Health and Safety Act* to recognize family violence as a workplace hazard (at 3), a change that was

implemented in June 2018 (see *Occupational Health and Safety Act*, SA 2017, c O-2.1 (*OHSA*)). The amendments impose obligations on employers and supervisors to ensure that their workers are not subjected to nor participate in harassment or violence at the work site, and violence is defined to include domestic and sexual violence (see *OHSA* ss s 1(yy)), 3(1)(c), 4(a)(v)). The report also recommended that the government develop a family violence training component for the Alberta Basic Security Course for security workers and that post-secondary institutions develop family violence response and reporting components into their programs on security and investigations; that the government distribute family violence materials at various points of public contact; and that it enhance existing strategies and educational materials on family violence targeted at new Canadians and newcomers (at 4). In its response to the report, released in May 2017, the Ministry of Community and Social Services indicated that it had shared these recommendations with the ministries of Labour, Justice and Solicitor General, Advanced Education, Service Alberta, and Health, showing the complexity involved in implementing the recommendations.

The second FVDRC case review report was published in September 2016 and concerns a 2013 murder of a woman by her estranged husband who then killed himself. According to the report, the couple had lived together for about nine years and had one child together. The victim and offender are described as having had mental health and drug and alcohol abuse issues, and they "had come to the attention of police on a number of occasions related to family violence, dating back to 2008" (at 3). A number of other service providers were also involved with the family: child intervention, health services, mental health and a women's emergency shelter's outreach program. The FVDRC noted the "lack of communication between intersecting systems" in the case, and found that "had there been a mandated, coordinated effort to address their needs, it could have potentially changed the course for this couple" (at 3). It identified the women's shelter as "probably the service provider who had the clearest picture of the severity of risk to the victim" but noted that "the victim was unwilling to accept assistance by leaving the home for a shelter", perhaps "due to the effects of trauma she experienced as a result of multiple adverse childhood experiences, including her own childhood experience of staying in a women's shelter" (at 3). This observation illustrates the difficulty many women face in leaving situations of violence, as well as the intergenerational effects of abuse.

In its recommendations flowing from this case review, the FVDRC advocated the amendment of the *PAFVA* to allow for the delivery of services and supports to family violence victims through voluntary service agreements and to allow professionals to obtain and/or disclose victims' information (with their consent) in order to increase collaboration and coordination between professionals for safety planning and intervention purposes (at 4). These amendments have not been implemented, and, as I discussed in a previous post, current privacy legislation may restrict the sort of information-sharing recommended here. The Minister's March 2018 response to the report notes that "the local police services have implemented new processes and staffing models related to family violence situations by making greater connections with intersecting systems, such as women's shelters" (at 3). It also commits to investigating policy changes and evaluating the *PAFVA* "to address concerns and identify opportunities to strengthen coordination and communication among service providers who support individuals and families affected by family violence" (at 4).

The FVDRC's third in-depth case report reviewed the 2010 murder of two children during a court-authorized, unsupervised weekend visit (presumably by one of their parents, but the offender is not specified). Published in March 2018, the report states that the parents of the children were "in an on and off-again common-law relationship for more than eight years" with "continual disputes related to the custody, access, supervision, and parental discipline of the children" (at 3). It also describes "a long-standing history of mental health issues that raised concerns, at times, for the safety and well-being of the children" as well as drug abuse and related criminal activity, although it is not clear on the part of whom (at 3). A number of service providers were involved with the family over the years, including Children's Services, Child and Family Services, and Justice and Solicitor General (the courts), as well as various health care professionals.

One of the key findings of the FVDRC from this case review is that the risk of harm for potential victims of family violence should be assessed via independent evidence – i.e. information from professionals, family members and colleagues – rather than on the basis of self-reporting (at 3). The report recommends that under the *Child, Youth and Family Enhancement Act*, RSA 2000, c C-12, every child intervention case that requires a safety assessment should use an actuarial risk assessment tool "to determine if preventative safety measures and services are required" (at 4). Where the risk assessment indicates that further intervention is required, the FVDRC recommends several mandatory checks as a matter of standard practice, including criminal record checks on the parents and court system checks for protection orders granted under the *PAFVA*, as well as for restraining orders, peace bonds and similar court orders. It also recommends that the Minister of Justice and Solicitor General develops or upgrades software in the Provincial Court and Court of Queen's Bench systems to "allow the civil and criminal systems to share information and identify proceedings and orders, especially with cases involving family violence, custody issues, and child protection concerns" (at 5). Short of these software developments, the report recommends "mandatory manual searches for multiple proceedings and previous orders in all court systems" and "a mandatory formal information-sharing arrangement between court systems … so that this information is provided for judicial consideration in advance of proceedings" (at 5). Lastly for the justice sector, the FVDRC recommends "the widespread implementation of integrated family violence courts in Alberta, in consultation with the Family Court Intersection Committee regarding the implementation of the integrated courts" (at 5).

In its response to the third case review, also released in March 2018, the Minister indicates that since the incident, it has implemented "improved supports to help frontline staff critically consider risk assessments" (at 3). The Minister accepts the recommendations for better information sharing between courts, and interestingly, states that the government "accepts the recommendation to adopt the widespread implementation of integrated family violence courts in Alberta," noting that, "there are currently several courthouses throughout Alberta that have Integrated Family Violence Courts" (at 4). Unfortunately, this is a potentially misleading statement. Integrated Domestic (or Family) Violence Courts are typically understood to be those that hear criminal and family matters in the same courtroom in a one judge-one family model, and to my knowledge the only such court in Canada at present is in Toronto (see here; for an evaluation of the Toronto court see Rachel Birnbaum, Michael Saini and Nicholas Bala, "Canada's first integrated domestic violence court: Examining family and criminal court outcomes at the Toronto IDVC" (2017) 32:6 Journal of Family Violence 621). Alberta currently

has eight Domestic Violence Courts (in Calgary, Edmonton, Fort McMurray, Grand Prairie, Lethbridge, Medicine Hat, Pincher Creek, and Red Deer), which are specialized criminal courts that do not hear family law matters. While greater integration and/or information sharing between criminal and family courts in domestic violence cases may be beneficial – for example, to avoid conflicting protection orders – information sharing may also have unintended consequences for some victims and requires careful investigation and implementation.

The reports for the fourth, fifth and sixth in-depth case reviews were all released, along with the government's responses, in May 2018.

In the fourth report, the FVDRC reviewed a case from 2011 involving an Indigenous couple who had a 7 year relationship and a blended family with 6 children; the couple is also described as having had alcohol, prescription drug addiction and mental health issues. The male was fatally stabbed by his female partner in their home during a heated argument. Government agencies were previously involved with the family in relation to two previous complaints of domestic violence, including Child and Family Services and the RCMP. The male partner appears to have been the alleged offender in at least one of these instances, although the report is not entirely clear about this. It does note that the female partner claimed to have stabbed her husband in self-defence when she called police following the stabbing, but she was convicted of second-degree murder – an opportunity to note that FVDRC reviews are carried out only after all other investigations and proceedings have been completed (see the FVDRC FAQ at 2).

The report recommends that various government departments work in partnership with Indigenous experts to develop training tools for staff working with Indigenous communities and curricula for social services disciplines on the effects of colonialism, the residential school system and intergenerational trauma on Indigenous individuals, families and communities (at 4). It also recommends that the government "identify and increase support for successful programs aimed at reducing family violence in Indigenous communities" which "must be community-based, culturally relevant, led by Elders and incorporate a collaborative community development approach" (at 4), and that it, "in collaboration with relevant Indigenous partners, develop an action plan to prevent family violence in Aboriginal communities in Alberta" which "needs to complement and inform the provincial Framework to end family violence and be published and be made publicly accessible" (at 4; for a link to the Framework see here). With respect to child protection services more specifically, the report recommends that the Alberta government "engage the federal government with the goal of adequately resourcing designated First Nation's agencies in Alberta" (at 4), and that the Ministry of Children's Services, in partnership with Indigenous experts in child welfare, "ensure that child welfare standards are adhered to when dealing with Indigenous families and communities" including by regularly auditing and evaluating child interventions and by working with Indigenous partners and communities "to improve and enhance practice standards and risk assessment tools to ensure child welfare practice standards are being complied with" (at 4). The Minister's response to the report states that the government is "committed to working with Indigenous communities and community partners to address family violence and build healthy communities for all Albertans" and accepts all of the report's recommendations (or at least the intent behind them) (at 3).

The fifth report concerns a case where a woman was killed by blunt force trauma at the hands of her husband in their family home in 2014. The couple and their children had immigrated to

Canada in 2000 (their country of origin is not specified). The husband was diagnosed with dementia around 2010, leading to a decline in his cognitive abilities and intellectual capacity and to hallucinations and paranoia, which the FVDRC notes "may have caused him to make threats towards his wife" (at 3). It reports that about a month before her death, the wife contacted family members several times, concerned about her husband and fearing for her own safety. A week before the incident, the police were called to the home after the husband threatened to harm her, and although the family asked police to take the husband to the hospital, police suggested that he be relocated to another family member's home. The report notes that "no additional information is available as to what other advice, strategies or information the responding officers may have provided to the family" (at 3). Following the death, the husband was charged with second degree murder and possession of a weapon, but he was found unfit to stand trial due to a permanent cognitive impairment after a court-ordered psychiatric evaluation, and the charges against him were stayed. The FVDRC recommendations relate only to Alberta Health and not to the Ministry of Justice and the Solicitor General concerning the actions (or lack thereof) of the police in this case. The Minister's response also focuses on Alberta Health and the importance of "increas[ing] the awareness among health care providers of family violence as it relates to the provision of care for patients" (at 3).

The FVDRC's sixth report involved a victim killed by their same-sex partner, both of whom were refugees under Sexual Orientation and Gender Identity claims. The gender and country(s) of origin of the victim and perpetrator are not disclosed, but the report indicates that "both individuals were from a country where being in a same-sex relationship is a criminal activity that is punishable by law" (at 3). The couple is said to have had "ongoing relationship difficulties" for which they did not seek assistance from social services, police or mental health services (at 3). The offender was diagnosed with a neurological disorder which was later determined to result from emotional stress and trauma. The key findings of the FVDRC included the point that "many newcomers do not want members of their cultural community in Canada to know of their orientation, and are faced with a difficult 'choice' – to freely express their identity at the expense of their cultural connections, or to keep their orientation private and maintain connections to their cultural community, at the expense of being able to live authentically, without fear of discrimination" (at 3). Following consultations with agencies providing services to LGBT newcomer populations in Alberta, it also found that newcomer, LGBT, and newcomer-LGBT groups "have a harder time accessing services because they are under-represented in the scope of services available to victims of family violence" (at 3).

The FVDRC made several recommendations, including that the Ministry of Alberta Community and Social Services should update Alberta's *Framework to End Family Violence* to provide "more information specifically targeted towards diverse communities, and … specific provisions for newcomer and LGBT populations" (at 4). The Ministry was also advised to update and modernize family violence public resource materials and to develop an information hub for the public to easily access these materials along with current family violence research and best practices from other jurisdictions. The report also recommended that the government collaborate with immigrant-serving agencies and community partners to establish "a coordinated and culturally sensitive approach to increase awareness of and services to address family violence in newcomer-LGBT populations" (at 4). For Alberta Health Services, recommendations included "continued family violence screening at hospitals and points-of-care" and "ongoing family violence education … for health-care professionals concerning specific risks to the LGBT

community." The Minister's response to the sixth case review report states that the government "is committed to ensuring supports and resources are available for all Albertans, especially those at higher risk of relationship violence" and that it will be updating its resource materials and website to make them "more responsive to the needs of diverse communities" (at 3). The Minister also commits to "work[ing] with newcomer, multicultural and LGBTQ2S+ communities to share learnings, identify gaps, and explore ways to further improve our response to family violence" (at 3).

Commentary

The FVDRC plays an important role in responding to domestic violence in the most serious of cases, those resulting in deaths. Its work is reactive by nature; but, as seen in its recommendations in the in-depth case reviews, the FVDRC also advises various government departments on how they might develop laws, policies and processes that can prevent violence. The criteria used by the FVDRC for selecting cases for in-depth review include looking for the most recent eligible cases and those that represent a diversity of ages and other factors, geographical locations, relationship statuses, and ethnicity (see the FVDRC 2015/16 annual report at 7). The cases discussed here represent a broad range of relationships in terms of family status, gender, sexual identity, immigration / refugee status and Indigeneity, and the FVDRC considers the impact of these factors in explaining the response of the parties and state actors to the violence and its recommendations. At the same time, it is frustrating that more details are not provided about these cases so that readers can evaluate the FVDRC's findings and recommendations with more context. At the very least, the FVDRC should provide the gender and region of origin for the parties, make it clear who the victims and perpetrators were, and clarify which parties engaged in risk factors such as drug and alcohol abuse and prior acts of violence. These sorts of details can be added without raising confidentiality concerns and would facilitate the evaluation of the FVDRC's recommendations and the government's responses. More importantly, the failure to provide details about matters such as who was responsible for prior violence and the death(s) being reviewed may tend to reinforce false assumptions that both parties are to blame for domestic violence.

Another observation is that the in-depth case reviews illustrate the breadth of laws, policies and government departments that are engaged in domestic violence cases, as well as the potential complexity of the intersections between them. A future post will describe these intersections in Alberta, and I am pleased to report that my research team has acquired funding from the Law Foundation of Ontario's Access to Justice Fund to develop a website to disseminate our research on these intersections in each jurisdiction in Canada. One of the overarching recommendations from the FVDRC is the need for better access to information and resources about family violence and our forthcoming website is intended to make a contribution in this respect.

Also of particular interest are the FVDRC's recommendations in the second and third case reviews that government agencies and courts should develop better information sharing methods. As noted earlier, information sharing by criminal and family courts may assist in avoiding conflicting protection orders, and information sharing amongst government agencies may facilitate risk assessments for victims and children. However, information sharing can have unintended consequences for some victims, placing them at risk of adverse outcomes in child protection, immigration and other matters and facilitating ongoing harassment by their abusers

(see e.g. Janet Mosher, "Grounding Access to Justice Theory and Practice in the Experiences of Women Abused by Their Intimate Partners" (2015) 32 Windsor Yearbook of Access to Justice 149 at 176-177). Similarly, my research on Integrated Domestic Violence (IDV) courts (see here and here) suggests that although integration of criminal and family matters in one courtroom can result in some access to justice advantages, there has been scant attention given to the impact of IDV courts on parental disputes about access to children. Some studies suggest that IDV courts may actually increase parental contact – including unsupervised access – and hence the potential for safety issues to arise. The risks associated with unsupervised access in a case where concerns were expressed for the safety and well-being of the children are tragically illustrated in the third case review, and this case is by no means an isolated incident (see e.g. here).

Finally, although only some of the FVDRC's recommendations are linked to the *PAFVA*, the reports make clear that it is time for a review of this legislation. The last evaluation of the *PAFVA* was published in 2005, and there have been several changes to the Act since then – including the addition of the FVDRC – that have not been evaluated. Previous recommendations for the reform of the *PAFVA* have not been implemented and merit consideration by the government, including recommendations that the scope of the *PAFVA* be broadened to include intimate relationships where the parties have never resided together and emotional and financial abuse (see here) and that the *PAFVA* make provision for enforcing conflicting and extra-jurisdictional protection orders (see here). In addition, it would be useful to know how often the legislation is used, where and by whom, and to what extent breaches of the *PAFVA* are being enforced under new provisions added in 2011 (see *PAFVA* s 13.1). A *PAFVA* review should also include the mandate of the FVDRC and review whether the government has followed up on its responses to the death review reports I have discussed here (and any subsequent reports of the FVDRC).

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