

Efforts to Understand and Prevent Intimate Partner Femicide in British Columbia

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Magnitude of Problem

- Violence against women and children is a serious problem with immense personal, social, medical, and legal costs
- There were 10,273 incidents of spousal assault reported to police in BC in 2005, a 9% increase from 2004
- An average of 13 women per year are killed by their current or former partner in BC between 1992 and 2002

Aftermath of Tragedies

- Greatest change follows the aftermath of a tragedy
- Through collective efforts we know what services, training, policies, and resources are needed to increase safety of women and children
- But we must do better to create a culture of accountability with an emphasis on specialised resources, increased risk management, information sharing, and coordination at senior levels

B.C. Tragedies

- 1996 Gakhal and Saran families in Vernon
- 2002 Tammy Miller in Victoria
- 2002 Rosella Centis in Nanaimo
- 2003 Denise Purdy in Nanaimo
- 2004 Sherry Heron and Anna Adams in Mission
- 2006 William Bethell and Seth Thornett in Nanaimo
- 2006 Navreet Waraich in Surrey
- 2006 Manjit Panghali on Delta
- 2007 Sunny Yong Sun Park, Christian, and Sunny's parents in Victoria

Critical Action Taken: Policy

- RCMP operational policy *Violence in Relationships/ Violence Against Women in Relationships/Criminal Harassment*
- Referral Bulletin issued in January 2007 to all police departments and victim service program that clarifies policy directives regarding referrals of victims from police and police-based victim service programs to community based victim services

Critical Action Taken: Operations

- Created specialized Domestic Violence Units in Vancouver and New Westminister and created Protective Measures Unit with VPD for high risk
- Developed the Victim Safety Unit in response to the need for improved notification of offender release
- Developed strategies to link police computer data systems and increase information sharing
- Coordinated and Implemented risk and safety assessment instruments BSAFER and ASAP

Critical Action Taken: Training

- Developed and implemented sector specific and inter-sectoral training for justice system
 - Dynamics on violence against women
 - Investigation and interviewing skills
 - Criminal harassment
 - Police release
 - Risk assessment and victim safety
 - Facing diversity
 - Dispatch operator training

Critical Action Taken: Community

- Ongoing work with community agencies at a local, provincial, and ministry executive level (e.g., VAWIR Committees and Community Coordination for Women's Safety)
- Published information resources for abused women "Help Starts Here"

Critical Action Taken: Research

- Conducted community safety audits of police response to VAWIR in New Westminster
- Partnered with experts in the field to conduct evidence based research on violence risk, safety planning, empowerment, and police release
- Partnered with BCIFV to review the literature on fatality reviews and intimate partner homicide

Future Action: Evidence Based Policy Framework

- Critical Elements of An Effective Specialised Justice Response to Violence Against Women
- Collaboration with community and private bar to review literature and models of service delivery to improve effectiveness of justice system responses to violence against women and children

Critical Components

1. Managing risk and victim safety

- A comprehensive, coordinated approach to risk and safety assessment and victim safety planning

2. Offender accountability

- Appropriate and consistent sentencing, consistent enforcement of protection orders, and accessible treatment for abusers

Critical Components

3. Specialized victim support

- Comprehensive, proactive, and timely support that includes outreach and access for marginalized groups

4. Information-sharing

- Consistent, timely, information-sharing between agencies and the victim, with particular emphasis on high-risk cases

Critical Components

5. Coordination

- Coordination and collaboration at all levels among all relevant sectors, including senior level leadership, and resources to adequately support a coordinated approach

6. Domestic violence policy

- A comprehensive justice system policy that includes all justice system components and takes a proactive approach to charging, prosecution, and offender accountability

Critical Components

7. Use of specialized expertise

- Dedicated justice system personnel and dedicated court time, a carefully considered and principled approach to domestic violence courts, and adequately funded specialized training

8. Monitoring and evaluation

- An integral part of all the foregoing critical components and a systematic, comprehensive approach to collection, analysis, and publication of statistics across all justice system components

Critical Questions

- How can we build on what we are doing right in a more focused way to prevent further tragedies?
- What can we learn from the our reviews and discussions on fatalities and from other communities that have established Domestic Violence Fatality Review Teams?

Intimate partner femicide (IPF)

- The homicide of woman by her current or former partner
- The single most common form of homicide perpetrated against women
- Preventable tragedies following many opportunities for intervention
- Critical to identify ways to increase understanding and prevention

Domestic Violence Fatality Review Teams (DVFRT)

- A collaboration among domestic violence related professionals to *understand* and *prevent* cases of IPF
- Anecdotal evidence suggests that DVFRT could reveal patterns contributing to IPF that may lead to system changes
- However, little is known about the nature of these committees or what they accomplish

Provincial study of IPF

- In 2000, the British Columbia Institute Against Family Violence was contracted to:
 - Review intimate partner femicides in British Columbia from 1997
 - Conduct a literature on fatality reviews
 - Evaluate the feasibility of establishing a domestic violence fatality review team in the province

Methods

- Cases

- 13 cases of IPF from 1997 in British Columbia, Canada

- Information reviewed

- Coroners reports and police investigations

- Data coding

- Information was collected about risk factors related to the perpetrator, the victim, their relationship, and the community response

Findings related to IPF

- Evidence of risk factors for IPF consistent with previous research
- Critical to understand the dynamic and contextual nature of risk factors
- Important to examine information from multiple sources using multiple methods

Findings related to DVFRT

- Several strategies could be used to review cases of IPF each with strengths and weaknesses
 - Agency reviews, judicial reviews, public inquests, and DVFRT
- A recommendation was made for the establishment of a DVFRT in BC
 - Prevention focus, member expertise, multiple cases, review process

National Study of DVFRT

- In 2005, began dissertation on DVFRT to examine:
 - How DVFRT attempt to promote change by describing their goals, structures, processes, and outcomes
 - What critical issues or tensions underlie their efforts to promote change that may account for how they operate and what they achieve

Methods

■ Recruitment

- At least 1 “active” team in each state/province
- At least 1 member familiar with history/operations

■ Participants

- 35 DVFRT (M = 6 yrs)
- 42 Members (M = 5 yrs)

■ Measures

- In-depth interview
- Document review

Findings

- The goals, structures, processes, and outcomes of DVFRT are diverse across teams and dynamic within teams
- DVFRT navigate several important tensions or issues in their efforts to promote change that may account for their diverse and dynamic nature

Implications of Context

■ Authority

- 69% Legislation
- 22% Interagency agreement
- 6% Executive order
- 3% Coroner's act

(Freedom of Information vs. Confidentiality)

■ Funding

- 51% Funding
- 41% No funding

Implications of Structure

- Jurisdiction
 - 43% State/province wide teams
 - 57% County/regional teams
- Membership
 - 100% Professionals
 - 17% Religious community
 - 11% Victims
 - 1% Family

(Betterment vs. Empowerment)

Implications of Process

- Breadth and Depth

- Breadth of cases
- Depth of review

(Biography vs. Epidemiology)

- Recommendations

- 91% Make recommendations
- 51% Monitor recommendations
- 46% Implement recommendations

(Understanding vs. Action)

(No Blame or Shame vs. Accountability)

Future Directions

■ Research

- Longitudinal research to measure change
- Program evaluations to assess outcomes

■ Practice

- Develop a working group to foster the establishment of a DVFRT in BC
- Determine proximal goals to inform what model is best suited for BC
- Conduct ongoing evaluation of process and outcomes

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