Centre for the Study of
Social and Legal Responses to Violence

UNIVERSITY OF GUELPH

Preventing Intimate Partner Violence - Related Domestic Homicide in Atlantic Canada: Looking back to see our way forward

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In collaboration with:
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GLOSSARY

AAFDA	Advocacy After Fatal Domestic Abuse
ADHRN	Atlantic Domestic Homicide Review Network
CMA	Census Metropolitan Area
CME	Coroner and Medical Examiners
CSSLRV	Centre for the Study of Social and Legal Responses to Violence
DFVH	Domestic and family violence-related homicide
DHR	Domestic Homicide Review
DV	Domestic violence
DVDR	Domestic violence death review
DVDRC	Domestic violence death review committee
IPV	Intimate partner violence
IPV-DH	Intimate partner violence-related domestic homicide
IPV/DV	Intimate partner violence/domestic violence
MMIWG	(National Inquiry into) Missing and Murdered Indigenous Women and Girls
NB	New Brunswick
NL	Newfoundland and Labrador
NLHC	Newfoundland and Labrador Housing Corporation
NON-DH	Non-domestic homicide
NS	Nova Scotia
PDHAC	Preventing Domestic Homicide in Atlantic Canada
PE	Prince Edward Island
2SLGBTQI+	Two-spirit, lesbian, gay, bisexual, transgender, queer, intersex, and + representing the many other diverse sexual orientations and gender identities not specifically listed.
SPSS 30	Statistical Package for the Social Sciences, version 30.0
TCPS-2	Tri-Council Policy Statement, 2nd edition
UNODC	United Nations Office on Drugs and Crime
WAGE	Women and Gender Equality Canada

EXECUTIVE SUMMARY

In 2020, the Atlantic Domestic Homicide Review Network (hereafter referred to as the ADHRN) was established by The Council of Atlantic Premiers to address and prevent domestic homicides in the Atlantic provinces (New Brunswick, Newfoundland and Labrador, Nova Scotia, and Prince Edward Island). This regional review network – the first of its kind in Canada – was launched in advance of the National Day of Remembrance and Action on Violence Against Women, underscoring their commitment to combatting sex- and gender-based violence and fostering safer communities across the Atlantic provinces.[1]

In 2022, the ADHRN launched a three-year research project, *Preventing Domestic Homicide in Atlantic Canada* (hereafter referred to as PDHAC) in conjunction with the Centre for the Study of Social and Legal Responses to Violence (CSSLRV), and funded by Women and Gender Equality Canada (WAGE). The following report outlines the findings of this project, with the overall goal of identifying potential avenues for moving forward to enhance prevention of domestic homicide in Atlantic Canada by:

(1) documenting trends and patterns in domestic homicide in Atlantic Canada (2012-2022);
(2) identifying priority areas of focus for the prevention of domestic homicide, including identifying data which are required to help achieve prevention; and, ultimately,
(3) helping to inform the future direction of the ADHRN.

In the full report that follows, the broader research context of the PDHAC is first outlined, including previously-documented domestic homicide trends in Atlantic Canada, a region where approximately 2.4 million residents of Canada call home. Next, we summarize the limited prior literature which has examined patterns in domestic homicide in this region as well as legislative responses which have informed regional prevention policy and practices. Next, we describe the study's research design which includes the definitional focus on intimate partner violence-related domestic homicide (IPV-DH), *the killing of a current or former intimate partner, their child(ren) and/or other third parties, which is the result of violence between current or former intimate partners.* This is followed by the results of the PDHAC for which highlights are provided below in this Executive Summary and expanded upon in the full report:

Results – Part I, **II**, and **III** describe patterns in killings that occurred in the Atlantic region between and including 2012 and 2022 – an 11-year period. First, to set the larger context, **Part I** reports on general patterns for the total population of 384 homicide victims in Atlantic Canada. **Part II** focuses specifically on trends for the 75 intimate partner violence-related domestic homicide (IPV-DH) victims during the same period. **Part III** discusses the 39 other domestic and family violence-related homicide victims (DFVH) in Atlantic Canada (for which IPV did not appear to play a factor based on files reviewed). All patterns below are based on available information and should be considered minimum estimates.

Some highlights for each section are:

Part I: Homicide in Atlantic Canada – Setting the larger context

- ✓ Between and including 2012 and 2022, there were a total of 384 homicide victims. There were 124 homicide victims in New Brunswick (NB), 53 victims in Newfoundland and Labrador (NL), 194 victims in Nova Scotia (NS), and 13 victims in Prince Edward Island (PE).

1 https://www.gov.nl.ca/releases/2020/exec/1204n03/

- ✓ In New Brunswick, 27% of all homicide victims were IPV-DH (N=33) and 6% were other DFVH (N=8). The remaining were non-domestic homicide (non-DH) victims (49%; N=61), 10% were missing information on the victim-accused relationship (N=12) and 8% were unsolved (N=10), meaning an accused was not identified in the files.

- ✓ In Newfoundland and Labrador, 26% of all homicide victims were IPV-DH (N=14) and 17% were other DFVH (N=9). The remaining were non-domestic homicide (non-DH) victims (47%; N=25), 4% were missing information on the victim-accused relationship (N=2) and 6% were unsolved (N=3).

- ✓ In Nova Scotia, 13% of all homicide victims were IPV-DH (N=25) and 9% were other DFVH (N=17). The remaining were non-domestic homicide (non-DH) victims (51%; N=98), 13% were missing information on the victim-accused relationship (N=26) and 14% were unsolved (N=28).

- ✓ In Prince Edward Island, 23% of all homicide victims were IPV-DH (N=3) and 38% were other DFVH (N=5). The remaining were non-domestic homicide (non-DH) victims (38%; N=5). No cases were unsolved or missing information on the victim-accused relationship.

Part II: Intimate partner violence-related domestic homicide (IPV-DH)

- ✓ From 2012 to 2022, there were 75 IPV-DH victims in Atlantic Canada, representing 71 cases. More specifically, 73% of victims were intimate partners of the accused (N=55), 8% of victims were children of the victim and/or accused (N=6), 16% were third parties killed by the accused (N=12), and 3% were other family members of the victim or accused (N=2).

- ✓ The number of IPV-DH victims killed each year ranged from two to 11 victims, with an average of six victims per year.

- ✓ Atlantic Canada had an average annual IPV-DH rate of 0.26 per 100,000 per year during the study period. New Brunswick had the highest average annual rate of IPV-DH (0.35) among the Atlantic provinces.

- ✓ The majority of IPV-DH victims were killed in rural areas (57%) or small town/cities (31%). The remaining 12% of IPV-DH victims were killed in an urban area.

- ✓ The majority of IPV-DH victims killed in New Brunswick (73%), Newfoundland and Labrador (79%), and Nova Scotia (76%) were intimate partners of the accused.

- ✓ Most adult IPV-DH victims were female victims (75%) in Atlantic Canada and 25% were male victims. Most individuals accused were male (92%) and 8% were female accused.

- ✓ When children were killed in IPV-DHs, 67% of the victims were female victims and 33% were male victims. Two-thirds of the accused in IPV-DH involving children were male (67%) and 33% of the accused were female.

- ✓ When female victims were killed in IPV-DHs, 98% were killed by male accused (N=53). When male victims were killed, 89% were killed by male accused (N=16). In IPV-DHs, there was often an overlap between victim and perpetrator status, especially for female perpetrators, who were often the primary victims in the events leading up to the IPV-DHs.

- ✓ The majority of IPV-DH victims (91%) killed by an intimate partner were female victims. When IPV-DH victims were killed by their parents, two-thirds were female (N=4). There was one female and one male IPV-DH victim killed by other family members (50%, respectively) and all third parties killed as a result of intimate partner violence were male (100%).

- ✓ The age of IPV-DH victims ranged from four years old to 77 years of age, with a mean age of 39 years. Victims aged 18 to 54 years were overrepresented as victims of IPV-DH.

- ✓ The accused ranged in age from 18 years old to 90 years of age, with a mean age of 43 years. Accused aged 25 to 54 years were overrepresented as perpetrators of IPV-DH.

- ✓ When information was known (83%), most of the victims were White for all four provinces (67%), 9% were Indigenous, 7% were Black, and 1% were East Asian, with the remaining 16% of victims missing adequate information to identify race. Similarly, most accused with available information (44%) were White (73%).

- ✓ When citizenship status was known (76% for victims, 52% for perpetrators), all victims were Canadian citizens (100%), and most accused were Canadian citizens (97%). When place of birth was known (65% for victims, 32% for perpetrators), most victims (94%) and accused (92%) were born in Canada.

- ✓ Where information was known (12%), five victims were identified as living with a disability; all victims with a disability were women who were killed by their intimate partners.

- ✓ The most common method of killing in IPV-DHs was stabbing (36%), followed by shooting (31%), beating (13%), and strangulation (12%).

- ✓ Patterns in IPV-DH varied by province and across rural or urban regions where information was available. In Nova Scotia, shootings were slightly more common than stabbings, while in New Brunswick, stabbings were more common. Shootings and stabbings were equally represented in both Newfoundland and Labrador and Prince Edward Island.

- ✓ In shootings, 61% of firearms used were long guns, 35% were handguns, and 4% were an unspecified type of firearm. When information was available on ownership, 70% of firearms used were acquired legally (N=7) and 30% were acquired illegally (N=3) (i.e., accused did not have a Possession and Acquisition License or their restricted firearm was not registered).

- ✓ Looking at relationship status, most victims shared a current or former common-law relationship with their accused (38%), followed by dating relationships (31%), and legal marriages (29%). The intimate partner relationship type could not be determined for 2% of the cases.

- ✓ Looking at relationship state, more than one half of the victims were in a current relationship with the accused (60%; 33) and 27% were separated (N=15). Evidence that separation was imminent or pending was present for 42% of victims who were in a current relationship with the accused (N=14).

- ✓ Combining both relationship status and state, when information was available, the largest proportion of victims were killed by a current common-law partner (25%), followed by a current legal spouse (22%), a current dating partner (13%), a former dating partner (11%), a former common-law partner (11%), and an ex-legal spouse (5%).

- ✓ Three victims of IPV-DH were killed by male same-sex intimate partners.

- ✓ When information was available, 67% of victims were a parent and had at least one child. At least 94 children were left without their parent following the killings.

- ✓ Most IPV-DH (84%) involved single victims killed by a single accused. Two cases of IPV-DH were familicide.

- ✓ While risk factors were not always documented in the files reviewed, where information was available, the most common risk factors documented were actual or pending separation (38%) and access to/possession of firearms (38%). Other risk factors commonly noted were victim vulnerability (34%), unemployment status of accused (33%), history of domestic violence by the accused (29%) and mental illness of the accused according to family or friends (29%).

- ✓ Where information on prior police, legal, and/or social service contact was described for victims and/or their accused (73%), 23% had prior contact police, 10% with the courts, and 10% with mental health providers.

Part III: Other domestic and family violence-related homicide (DFVH)

- ✓ There were 39 victims of DFVH, for which there was no documented evidence that intimate partner violence played a role.

- ✓ Eight victims were children killed by their parents outside of the context of intimate partner violence, ranging in age from newborns to 9 years old.

- ✓ There were 31 victims identified as other family members killed by someone other than a parent. The most common relationship types were parents killed by their children (48%), stepparents killed by stepchildren (10%), siblings (10%), and grandparents killed by grandchildren (10%).

In **Part IV – Comparing CME and Public Data**, we compared data collected from Coroner and Medical Examiners (CMEs) with data collected from public sources to determine the relative strengths of the CME data and public data (*see full discussion and results, Appendix D*). It should be noted here that the

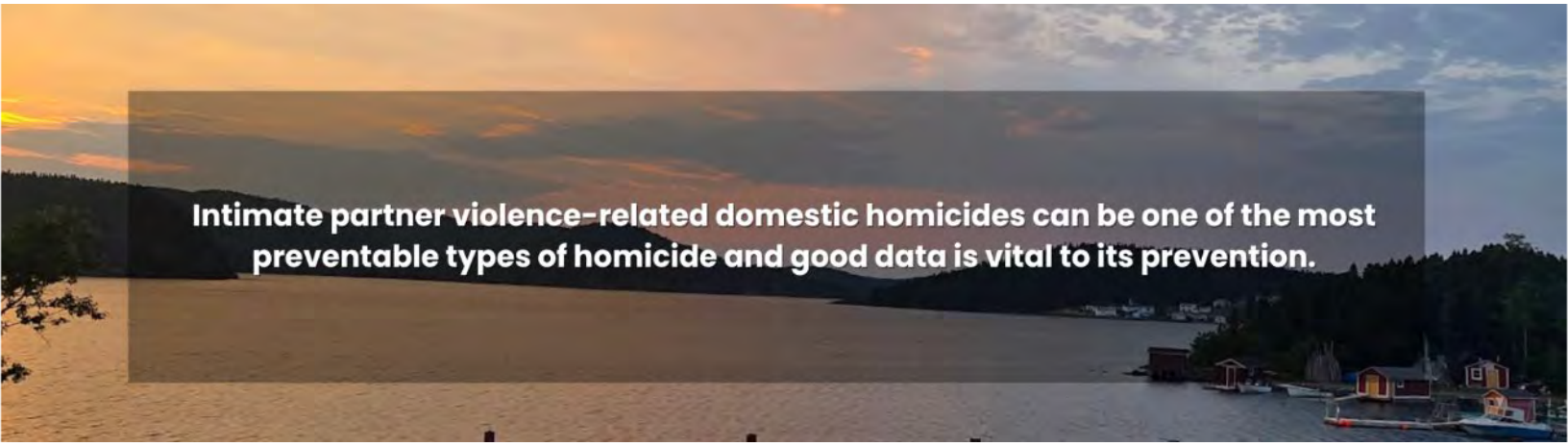
expectation was that the public database would have more information than the CME data because the former were collected on an ongoing basis as the homicide progressed through the criminal justice system whereas the CME data were collected at one point in time, early in the investigation. The one exception to this would be New Brunswick where a domestic violence death review committee was operational during this period.

Compared to the public database, the CME data had more complete data across all situational variables, including the address of the homicide, firearms, evidence of mutilation, and disposal of the victim's body. It also had more information on the certain victim characteristics, such as date of birth, ethnicity, and use of substances at the time of their death. Compared to the CME database, the public data had more information for the majority of victim variables, accused variables, victim-accused relationships, motive variables, criminal justice variables, and risk factors and service contacts.

In **Part V – Comparing Jurisdictions with and without DVDRCs**, we compared the CME databases obtained from each Atlantic province to better understand the extent, patterns, and types of missing data across the four provinces (*see full discussion and results, Appendix E*). Initial results found that New Brunswick CME data sources had more available data than other provinces which was, again, expected given the existence of their domestic violence death review committee at the time of data collection.

In **Part VI – Discussion and Recommendations**, the importance of data in informing violence prevention efforts is discussed. Domestic violence death review initiatives can offer the most comprehensive data on intimate partner violence-related domestic homicide, especially in cases involving the suicide of the accused, though their methods and definitions vary widely. This variability, along with gaps in basic data collection, limits the ability to apply an intersectional lens to prevention, harming efforts to understand and address the risks faced by marginalized victims. The ADHRN's initiative to examine what is known and unknown about IPV-DH in Atlantic Canada represents a critical step towards improving data collection and guiding more equitable and effective prevention efforts.

The Recommendation Section outlines 14 key proposals aimed at strengthening data collection and related processes and practices to support more effective responses to victims of IPV-DH in the Atlantic region. In remembrance of the 75 lives lost to preventable domestic homicides, this work looks back to illuminate the path forward in Atlantic Canada, committing to meaningful change to ensure such tragedies are not repeated. In doing so, this is the first study of its kind to be conducted in Atlantic Canada and, arguably, the first of its kind nationally in terms of depth and focus, regional cooperation, and multi-sector collaborations.



INTRODUCTION

The most recent global estimates provided by the United Nations Office on Drugs and Crime (UNODC) estimated that there were 85,000 female victims of homicide in 2023 (UNODC & UN Women, 2024). Of these, 51,100, or 60% of the total number of women and girls, were killed by their intimate partners or family members. While men and boys represent the vast majority of victims of homicide overall (80%), compared to women, men are much less likely to be killed by intimate partners or family members (11.8%). When individuals are killed in these contexts, such deaths are often referred to as domestic homicides or domestic violence-related killings. Globally, however, femicide, intimate femicide or intimate partner femicide are terms increasingly being used to capture the fact that women are disproportionately the victims in such killings and men most often the perpetrators (Dawson and Mobayed, 2023). However, the impacts of these killings also impact men and boys as both direct and indirect victims. Men and boys are often also killed in these contexts as third-party victims, for example. Indirectly, they are also impacted through the loss of family and friends, especially as children, when they are left orphaned with one or both parents dead or incarcerated. As a result, there has been much attention to this type of homicide because of its negative and far-reaching impacts for individuals, communities and society.

Domestic violence and domestic homicide are not new social problems, however. There have been significant legal and social transformations during past decades in an effort to reduce this type of violence. This has been both preceded, and paralleled, by substantive bodies of literature documenting its incidence and prevalence, risk and protective factors, as well as legal and social responses (Devaney et al. 2021). Globally, however, there has been little significant improvement as a result of these efforts and, with the rise of COVID-19 in 2020, any progress made has largely diminished with the ongoing impacts of the pandemic which continue to reverberate. For example, research shows that the pandemic exacerbated already-existing inequalities and created many other worsening societal conditions (Mooi-Reci and Risman, 2021; Tomsick and Smith, 2022; United Nations, 2020), each a contributor separately, and in combination, to the documented rising levels of domestic violence and domestic homicide. The situation prompted local and global institutions to refer to this violence as the “shadow pandemic” (UN Women, 2021).

Canada was no exception. With lockdowns and other pandemic-related measures, official agencies and researchers documented the increasing frequency and severity of intimate partner violence (IPV) and domestic violence (DV) (Nelson et al. 2022). This, in turn, impacted already overburdened response and support systems operating on increasingly scarce resources and supports. Specifically, research in Canada showed that there were increases in the number of police calls related to IPV, increased severity of IPV, increases in risk factors associated with IPV including financial stressors, caregiver burnout/stress, lack of resources, and negative impacts on healthcare professionals (for more details, see Nelson et al. 2022). During this period and to present day, gradual and consistent increases in the rates of femicide, which includes many domestic homicides involving female victims, have also been documented (Dawson et al. 2023).

Perhaps foreseeing the additional challenges to come, the Atlantic Domestic Homicide Review Network (ADHRN) was formally established in July 2020 by The Council of Atlantic Premiers (The Council of Atlantic Premiers Memorandum of Understanding, 2020). The ADHRN was officially announced just prior to the National Day of Remembrance and Action on Violence Against Women on Dec. 6, 2020. The first regional review network of its kind in Canada, the ADHRN works to “leverage regional expertise to analyze with a diversity lens aggregate data, policies and practices relevant to domestic homicide in the Atlantic Region

and will make joint recommendations to provincial governments for system improvements" (The Council of Atlantic Premiers Memorandum of Understanding, 2020). ADHRN members are appointed by the Premier of each Atlantic province. In its official release, The Council of Atlantic Premiers stated:

> "Domestic violence and domestic homicide are gendered crimes in which the majority of victims are women. Understanding the context in which domestic homicides occur in Atlantic Canada is critical to the development of preventative measures that are aligned with the region's unique culture. Reviewing these deaths recognizes that many are preventable and may require different system responses and community supports. Each province has its own unique systems for how to respond, prevent and learn from deaths when they occur."

The release also stated that the ADHRN would apply a human rights-based approach to its work which would help to ensure that the specific needs of higher risk and marginalized populations made vulnerable to domestic violence and domestic homicide would be reflected in its work, identifying specifically the following groups: Indigenous communities, persons with disabilities, racialized and 2SLGBTQI+[2] populations.

As one of its key activities, the ADHRN launched a three-year project entitled, *Preventing Domestic Homicide in Atlantic Canada* (PDHAC), in conjunction with the Centre for the Study of Social and Legal Responses to Violence (CSSLRV) at the University of Guelph, and funded by Women and Gender Equality (WAGE). The overall goals of the project were:

(1) To document trends and patterns in domestic homicide in Atlantic Canada from 2012 up to and including 2022;
(2) To identify priority areas of focus for the prevention of domestic homicide;
(3) To identify data gaps and research priorities which need to be addressed; and,
(4) To help inform the future direction of the ADHRN.

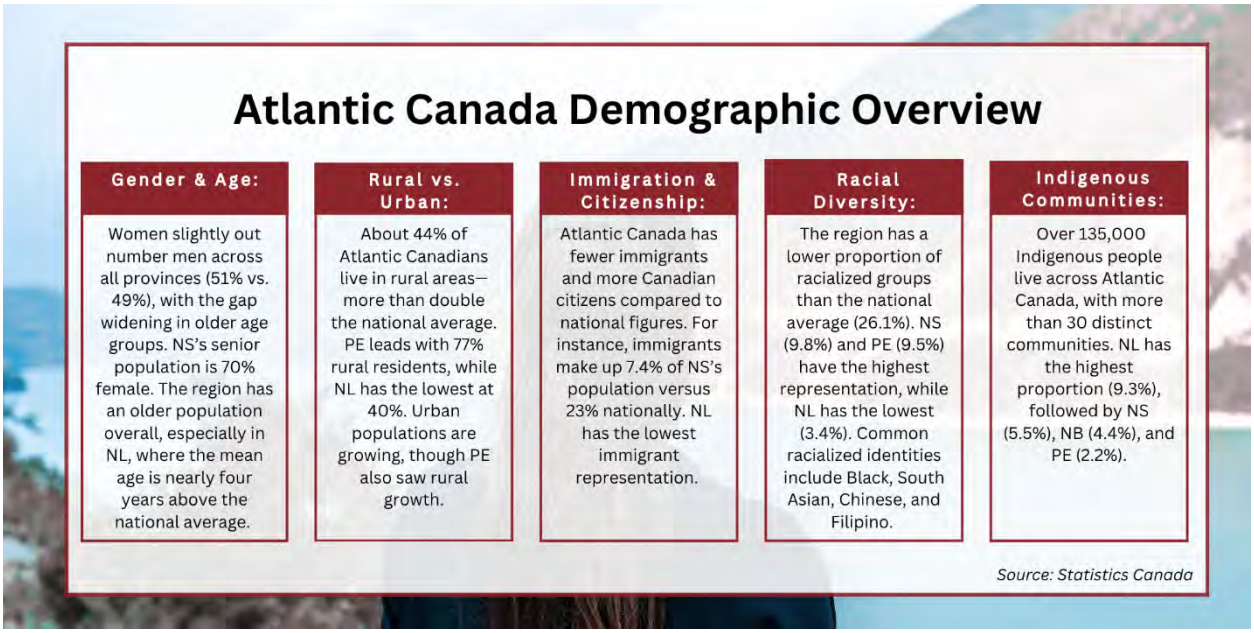
The PDHAC project comprises collaborative, multi-sectoral partnerships with the involvement of the departments of Justice, Public Safety, Health, Social and Family services, and Medical Examiner or Coroner services (*see Appendix A for ADHRN membership*). The primary aim was to improve prevention efforts for domestic homicide within the Atlantic Region recognizing that one key mechanism for doing so is to enhance the consistency of data collected on a routine basis so that more informed and nuanced prevention initiatives could be developed.

The PDHAC project is described in further detail below, beginning with some basic information about the research setting – the Atlantic provinces – followed by the project's research design, including data sources, data collection processes, coding, and analyses. The detailed results' sections that follow provide the foundation upon which the discussion, including recommendations, was generated. Focusing on one region of the country, this project responds to the recommendation of the United Nations Special Rapporteur on violence against women, its causes, and consequences, following her visit to Canada in 2018 to adopt a more comprehensive human rights-based approach to the prevention of gender-based violence, including comparable data collection (UNSRVAW, 2019). Specifically, she stated: "Data on gender-based violence against women in Canada are collected but are fragmentary and, in general, incomparable throughout the provinces and territories, owing to differences in what is captured, counted, and reported" (p. 7). This project aims to address this situation in Atlantic Canada. The PDHAC project also supports the findings of the National Inquiry into Missing and Murdered Indigenous Women and Girls

[2] Various acronyms are used to refer to sexual minority populations. This report adopts the acronym used by WAGE which is 2SLGBTQI+, however, when citing specific material, we remain true to the acronym used by those authors.

(MMIWG) which have repeatedly called on the federal government "to amend data collection and intake-screening processes to gather distinctions-based and intersectional data about Indigenous women, girls, and 2SLGBTQQIA people" (MMIWG, 2019: 72).

THE PDHAC RESEARCH SETTING



The current study focused on homicides that occurred in the four Atlantic provinces – New Brunswick (NB), Newfoundland and Labrador (NL), Nova Scotia (NS), and Prince Edward Island (PE). This region of the country comprises approximately 2.4 million residents of Canada or about six percent of the country's total population.[3] When examining the demographics of the Atlantic region, several key factors such as sex, age, rurality, immigration/citizenship status, race/ethnicity, and Indigeneity, play a crucial role in shaping the identity of each province's population.

First, sex distributions demonstrate slightly higher female populations in each province (49% males and 51% female), a trend that becomes more pronounced in older age groups (Statistics Canada, 2022). For example, in Nova Scotia, the population aged 65 years and older is 30 percent male (N=215,325) and 70 percent female (N=497,650; Statistics Canada, 2022). The mean ages are slightly older for each province, indicating that the Atlantic provinces have an older population on average[4] (Statistics Canada, 2022; Statistics Canada, 2025). This trend is most prominent in NL, where the mean age exceeds the overall Canadian figure by almost four years.

[3] Figures are based on 2022 Statistics Canada data, the last year examined in the PDHAC project. The total population of Canada that year was 38.94 million.
[4] The mean age is 44.7 years in NB, 45.5 years in NL, 44.2 years in NS, and 43.1 years in PE, compared to Canada's mean age of 41.6 years (Statistics Canada, 2022; Statistics Canada, 2025).

Second, according to Statistics Canada, as of 2021, about 44 percent of the residents of the Atlantic region lived in rural communities[5], which is over twice the national average (17.8% of national population live in rural areas; Statistics Canada, 2022b). PE has the highest population living in rural areas (77%), followed by NB (49%), NS (41%) and NL with the lowest (40%; Statistics Canada, 2022c). The most recent Census indicated that urban populations are steadily increasing for all provinces in Atlantic Canada, although PE demonstrated notable increases in its rural population as well.[6]

Third, when focusing on immigration/citizenship status, compared to national figures, Atlantic Canada has a lower proportion of immigrants and a higher proportion of Canadian citizens residing in each province (Statistics Canada, 2023). For example, immigrants counted for just over 23 percent of Canada's population in 2021, with a further 2.5 percent of the population constituting non-permanent residents. However, in NS, immigrants made up 7.4 percent of the population, with a further 2.3 percent being non-permanent residents (Government of NS, 2022). All Atlantic provinces have a lower representation of immigrants and non-permanent residents compared to other provinces in Canada, with the fewest residing in NL (Government of Nova Scotia, 2022).

Fourth, Atlantic Canada has a lower proportion of racialized groups[7] when compared to the total Canadian population (26.1%; Statistics Canada, 2022c). Specifically, 9.8 percent of NS residents, 9.5 percent of PE residents, 5.8 percent of NB residents, and 3.4 percent of NL residents belong to a racialized group (Statistics Canada, 2022). Of those belonging to racialized groups in Atlantic Canada, most residents identified their race/ethnicity as Black, South Asian, Chinese, or Filipino (Statistics Canada, 2022).

Finally, collectively, the Atlantic provinces are home to over 135,000 First Nations, Métis or Inuk (Inuit) people, with over 30 Indigenous communities across the four provinces (Statistics Canada, 2022). As of 2021 in Atlantic Canada, NL had the highest proportion of Indigenous peoples (9.3%), while PE had the lowest (2.2%). Indigenous people made up 5.5% of the population of NS and 4.4% of NB (Statistics Canada, 2022). These demographic factors shape the social, economic, and cultural landscape of Atlantic Canada.

Domestic Homicide in Atlantic Canada

According to the *Juristat* "Homicide in Canada" published annually by Statistics Canada, the Atlantic provinces experience the lowest homicide rates in the country. This trend has been consistent over time from 1961 to 2022, the period covered by the yearly reports analyzed. Specific data on domestic homicide[8] in the Atlantic provinces is not available, however. Considering that 44 percent of Atlantic Canada is rural (Rural Secretariat Atlantic Region, 2005), it is worth noting that Canadians living outside of a Census Metropolitan Area (CMA) are considered at a slightly higher risk of homicide than those living within a CMA and that a higher rate of intimate partner homicides occurred in rural communities compared with urban ones (David & Jaffrey, 2021). *Appendix B* provides the number and rates of homicides annually for each of the four provinces from 1961-2022.

[5] Where rural is defined as an area with less than 1,000 inhabitants and a population density less than 400 people per square kilometre. This definition differs from that used in this study which is discussed in more detail below. It is acknowledged that various regions of the country will have different perceptions of what is rural, remote and/or northern.
[6] Population growth in urban areas is increasing at a faster pace than rural areas due to strong immigration levels and because most immigrants settle in large urban areas of Atlantic Canada (Statistics Canada, 2022b).
[7] 'Racialized groups' is the term used to replace visible minorities by Statistics Canada in their most recent Census report.
[8] These reports also use the term spousal homicide or intimate partner homicide at various points in time.

Legislative Responses to Domestic Violence in Atlantic Canada

New Brunswick: In an unanimous vote in June 2025, the New Brunswick legislature declared gender-based violence an epidemic and systemic crisis following an open call from 20 organizations that the province make this declaration.[9] New Brunswick was also the first province in Atlantic Canada to implement a Domestic Violence Death Review Committee (DVDRC) in 2009, which remains active.[10] This province also saw two reports which documented patterns of domestic homicide from 1999 – 2018, identifying challenges when gathering data that could inform prevention initiatives. The first study (Gill, 2012) examined a total of 32 domestic homicides over a 10-year period (1999-2008) and noted that the majority of victims were between the ages of 30-49 and that the majority of domestic homicides occurred in the home where the victims were living at the time. Results also demonstrated that children were at risk of being killed when living in a home where adults were experiencing domestic violence and that, when the perpetrator died by suicide following the homicide, it usually also involved the killing of children. Gill (2012) also found that the information gathered in coroners' files was not systematic across cases, making it difficult to identify common risk factors and to make recommendations for future prevention. Specifically, it was noted that there was a lack of information about the history of violence in the relationship. Following the implementation of the NB DVDRC, the second study (Gill and Aspinall, 2021) examined 52 domestic homicides from 1999-2018, pre- and post-DVDRs in that province. Trends were similar to the first report; however, the authors found that the creation of a DVDRC facilitated better data related to domestic homicides with all files gathered in a centralized way. They also noted that an important component of the DVDRC was coroner training on data collection about domestic homicide, improving the ability to develop a more comprehensive picture of the events leading up to the homicide and to identify lethality factors. Of the 41 risk factors, the most common were a history of violence in the relationship, escalation of violence, and actual or pending separation.

Legislation relating to domestic violence, intimate partner and sexual violence in the province includes: the *Family Law Act, the Family Services Act,* the *Intimate Images Unlawful Distributions Act,* the *Intimate Partner Violence Intervention Act,* the *Victim Services Act,* the *Residential Tenancies Act,* the *Insurance Act,* and the *Employment Standards Act*, which outlines provisions for domestic or sexual violence leave. New Brunswick has a Domestic Violence Court in Moncton, and a Unified Family Court System in place to deal with divorce and family law matters, including situations where a child's security could be compromised due to a situation of domestic violence.[11] It also

[9] See: https://globalnews.ca/news/11215156/new-brunswick-intimate-partner-violence-epidemic-2/
[10] See: https://www2.gnb.ca/content/gnb/en/departments/public-safety/law-enforcement-and-inspections/content/coroner-services/domestic-violence-death-review-committee.html.
[11] See: https://www2.gnb.ca/content/gnb/en/news/news_release.2011.03.0376.html.

introduced and passed into law Bill 17, the Disclosure to Protect Against Intimate Partner Violence Act (Clare's Law) in 2024. Led by Justice and Public Safety, New Brunswick is developing the regulations, policies, and procedures required to implement the *Act* to establish Clare's Law services. Women's Equality was created in part to oversee implementation of the government's actions and initiative related to gender-based violence and the Department of Justice and Public Safety established the Roundtable on Crime and Public Safety as a venue for community agencies, police, the private sector, academia, First Nations groups, municipal and federal governments, and several provincial departments to collaborate on improvements to New Brunswick crime prevention policy and practice in three priority areas: vulnerable youth, intimate partner violence, and persistent offending.

Newfoundland and Labrador: Newfoundland and Labrador passed several pieces of legislation related to domestic violence. This includes the *Interpersonal Violence Disclosure Protocol Act (Clare's Law*), the *Children's Law Act*, the *Children, Youth, and Families Act*, the *Victims of Crime Services Act*, and the *Intimate Images Protection Act*. On January 2, 2019, NL implemented changes to the Labour Standards Act mandating access to family violence leave for a period of three days paid, or seven days unpaid after 30 days of uninterrupted service with the same employer (Gender-Based Violence Directorate, Women and Gender Equality Canada, 2021). Presently, there is no provincial strategy addressing domestic violence in the province (Grzetic & Nolan, 2020). There is also no provincial strategy addressing women's homelessness, which can be an effective strategy in addressing domestic violence in the province, given the number of women who become homeless as a result of having to flee violence (Cardigan, 2024). Despite this, the 2023 - 2026 Newfoundland and Labrador Housing Corporation (NLHC) listed victims of intimate partner violence as being a distinct population requiring a special focus, and on September 19, 2024, the Government of NL and the Federal Government of Canada announced a joint investment of 17.12 million over the next five years specifically for housing for victims of intimate partner violence (Government of Newfoundland and Labrador, 2024). Additionally, an Intimate Partner Violence Intervention Court exists in St. Johns, Grand Falls-Windsor, and Stephenville as a voluntary service for accused. The Royal Newfoundland Constabulary also has a specialized domestic violence investigations unit (Government of Newfoundland and Labrador, n.d.).

Nova Scotia: In 2024, Nova Scotia officially declared domestic violence an epidemic.[12] In October of 2021, NS made amendments to the *Fatalities Investigations Act*, which also included the creation of a Domestic Violence Death Review Committee. Other legislation relating to domestic violence includes: the *Child and Family Services Act*, *Child Pornography Reporting Act*, and the *Domestic Violence Intervention Act*. On April 18, 2018, changes to the Labour Standards Code also took effect, adding a leave of absence available for victims of domestic violence and for those whose child is a victim of domestic violence and mandating three days of paid domestic violence leave. Employers are also mandated to cooperate in providing any requested information to employees in support of their entitlement to domestic violence leave. In September 2024, following the release of the Mass Casualty Commission Inquiry final report[13], the Government of NS declared intimate partner violence an epidemic (Gender-Based Violence Directorate, Women and Gender Equality Canada, 2021). A Domestic Violence Court is in place in Sydney and Halifax, with elements of domestic violence intervention in the Wellness Court in Amherst, Bridgewater, and Truro (Nova Scotia Courts, n.d.). Beginning in 2018, NS launched "Standing Together", a provincial initiative aimed at preventing domestic violence, supporting victims of domestic violence, and shifting policies and interventions to better respond to domestic violence in the province (Crocker & Ternaway, 2022; 2). Since

[12] See: https://www.cbc.ca/news/canada/nova-scotia/ndp-bill-declares-domestic-violence-epidemic-1.7321627
[13] See *Turning the Tide Together: Final Report of the Mass Casualty Commission* at: https://masscasualtycommission.ca/files/documents/Turning-the-Tide-Together-Executive-Summary.pdf.

2018, "Standing Together" has funded over 80 programs, projects, and collaborations to test new and innovative ideas to prevent and respond to domestic violence (Crocker & Ternaway, 2022: 4). Several feedback sessions have also taken place since its inception, and notably, participants shared that African Nova Scotians, Indigenous women, women with disabilities, and women in rural areas are less served by systems and supports (Crocker & Ternaway, 2022: 5). Since 2001, the province has had a "High Risk Case Coordination Protocol" for high-risk situations of domestic violence in order to intervene prior to a domestic homicide occurring).[14]

Prince Edward Island: Legislation in Prince Edward Island pertaining to domestic violence includes: the *Child, Youth, and Family Services Act*, the *Family Law Act*, the *Children's Law Act*, the *Intimate Images Protection Act*, the *Post-Secondary Institutions Sexual Violence Policies Act*, the *Victims of Crime Act*, and the *Victims of Family Violence Act*. On November 1, 2019, amendments to the Employment Standards Act took effect, mandating access to three days of paid leave or seven days leave without pay to deal with the consequence of domestic violence, intimate partner violence, or sexual violence (Gender-Based Violence Directorate, Women and Gender Equality Canada, 2021). In early 2024, PE established a therapeutic court for perpetrators of domestic violence.[15] Offenders who plead guilty, take responsibility for their actions, and agree to engage in domestic violence intervention programs can choose to participate in this therapeutic court. PE also maintains a "Bridge Model" where service providers (including police) can identify situations where a person is at "a very high risk of harm" (which can include domestic violence) to coordinate a rapid response in order to mitigate and prevent the harm from occurring.

THE PDHAC RESEARCH DESIGN

Definitional parameters

During the past several decades the terminology used to capture various forms of violence among victims and perpetrators who share intimate relationships (e.g., spouse, parent, child) has undergone significant shifts. For example, at one time, wife abuse, spousal abuse, and family violence were regularly used to capture violence within the home and among those who were married or related. More recently, the terms intimate partner violence and domestic violence, including homicide, have been used, although not always capturing the same types of relationships, depending on the jurisdiction and purpose for collecting data. For example, in regular reporting of homicide, Statistics Canada shifted its language in 2010 from spousal homicide to intimate partner homicide to capture the broader and shifting forms of intimate partner relationships (Hotton Mahony, 2011). Most recently, the umbrella term 'gender-based violence' has increasingly been used to capture all of the above, and sexual violence outside the context of intimate relationships, as evidence by Canada's *National Action Plan to End Gender-Based Violence*.[16] These varying descriptive terms and shifting language shape data collection and prevention efforts as well as our understandings of violence (Fairbairn et al., 2019). As such, clarity in the use of terms is crucial.

[14] See: https://masscasualtycommission.ca/files/pd-source-materials/COMM0001046.pdf?t=1701182573

[15] As described in the Justice & Public Safety Annual Report 2023-2024, it is "overseen by the Therapeutic Court Steering Committee, planning continued for the province's first Therapeutic Court, focused on Domestic Violence. The Domestic Violence Court is a voluntary court that utilizes the risk-need-responsivity approach, together with an integrated, inter-sectoral case management table and judicial accountability. Service providers and court officials formulate individualized case plans responsive to assessed risk and need and offer increased opportunity for victim input."https://docs.assembly.pe.ca/download/dms?objectId=9989025c-b539-42b5-a82d-5bfd7e26dfbf&fileName=JPS.Thompson.01242025.2023-24%20Justice%20and%20Public%20Safety%20Annual%20Report.pdf

[16] See: https://www.canada.ca/en/women-gender-equality/gender-based-violence/intergovernmental-collaboration/national-action-plan-end-gender-based-violence.html.

Each of the four provinces forming the ADHRN and participating in this study had varying definitions of domestic homicide. For NB, "a domestic violence death is a homicide that results from conflict between intimate partners or ex-partners and may include the death of a child or other familial members."[17] For NL, "It is intimate partner homicide including spouse, children, siblings, other family members [will not always be of a sexual nature], as well as sex trade workers." Finally, for NS and PE:

> (c) a "domestic violence death" means (i) a homicide that involves the death of (A) a person, the person's child, or other family member, or (B) any other person present at a domestic violence incident involving a person; that is committed by the person's current or former intimate partner, or (ii) a homicide-suicide where, in addition to a death referred to in subclause (i), the current or former intimate partner commits suicide; (d) "intimate partner" means, with respect to a person, an individual who is or was a spouse, common-law partner, dating partner or sexual partner of the person or in a similar relationship with the person.[18]

To bring together each of these definitions, the PDHAC retrospective study used the following definition to identify domestic homicide cases that stemmed from or were related to intimate partner violence: *the killing of a current or former intimate partner, their child(ren) and/or other third parties, which is the result of violence between current or former intimate partners* (hereafter referred to as intimate partner violence-related domestic homicide or IPV-DH).

Other Domestic and Family Violence-related Homicides (referred to as DFVHs), which did not involve prior or current IPV, were also examined in this study and are reported on in a separate section. These killings involve victim-accused relationships in which the victim and accused shared a familial relationship (e.g., blood relatives or relatives by marriage), but the homicide did not appear to stem from intimate partner violence based on the records reviewed. Distinguishing IPV-DH and other DFVH highlights that the majority of domestic homicides are, in fact, IPV-DHs. This, in turn, underscores that the focus on IPV-DH as a research priority is warranted for enhancing intervention and prevention initiatives and, therefore, is the primary focus of this report.

Data sources and transfer

Coroner and medical examiner files: This retrospective study focuses on IPV-DH, as defined above, which occurred in the Atlantic region between and including 2012 and 2022 – an 11-year period. In doing so, to provide the broader context, general patterns in homicide are discussed as well as other domestic and family homicides. Coroner and Medical Examiners (CMEs) in each of the four provinces provided the CSSLRV research team access to existing homicide records. Before data were accessed, separate research agreements were finalized and signed by representatives in each of the four provinces and the University of Guelph between April 2022 and August 2023. During this period, the CSSLRV research team applied for and received research ethics approval from the University of Guelph in January 2023. In NL, research ethics approval was also applied for and approved by the NL Health Research Ethics Board.

To address concerns about data security when transferring files, Brightsquid, which is a secure email system using end-to-end email encryption was used to ensure privacy and confidentiality for files sent to, and from, the research team and CME offices.[19] Data transfer from CME files to the CSSLRV research team occurred from August 2023 to December 2023. Once data was received by the CSSLRV team, it was stored

[17] See: https://www2.gnb.ca/content/gnb/en/departments/public-safety/law-enforcement-and-inspections/content/coroner-services/domestic-violence-death-review-committee.html.
[18] See: https://nslegislature.ca/legc/bills/63rd_2nd/3rd_read/b180.htm.
[19] See: https://brightsquid.com/. End-to-end email encryption effectively secures data sent through email so that it is only accessible and legible to the sender and the recipient. This prevents third parties from accessing data while it is transferred from one device to another as only the intended recipient can decrypt it.

on password-protected, encrypted laptops as well as on a secure server managed by the University of Guelph. Recognizing the high level of security required, the CSSLRV research team followed the guidelines outlined in the University of Guelph's Guidelines for Categorization and Security of Research Data and Information. Data management was performed in accordance with the requirements of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – 2nd edition*. All project team members working with PDHAC retrospective data completed the TCPS-2 Core Certificate (i.e., research ethics training).

A master list of victim names was kept as a separate entity from the dataset itself. The CME office generated the list of victim names containing a corresponding institutional code used within their offices to identify individual files. This list of institutional codes was used for the following purposes: (1) to update cases in the dataset as future information became available or known; and, (2) to merge the CME data with the publicly-sourced data (discussed below). Members of the CSSLRV team used the list of institutional file codes to retrieve the appropriate CME files for coding. Data collection and coding from CME files was completed between September 2023 and March 2024.

Public data sources: While various national mechanisms are in place to document homicides in many countries, including Canada, research has shown that these official records often underestimate the extent of homicides and lack important information about the characteristics of those involved and the events leading up to the killings (Parkin & Gruenewald, 2017). Furthermore, CME files are primarily victim-focused and conducting research is not the mandate for data collection; thus, these files may contain only basic information, especially if provinces did not have a domestic violence death review initiative, which was the case for all provinces except New Brunswick as discussed above. Therefore, using publicly-available digital documents, the CSSLRV team generated its own list of homicides for the same period and collected information from public data sources, creating a second database. Publicly-accessed, digitized data sources included court documents accessed through legal databases (e.g., CanLii, Lexus Nexus) such as sentencing remarks, appeal decisions, and other court decisions. Other public sources included media coverage of the initial incident and court proceedings as well as obituaries of the victims. Data collection and coding from other public data sources was completed between September 2023 and June 2024 with periodic updates for new case information continuing throughout the remainder of the year. Further details on the utility of public data sources compared to official sources is provided in Appendix C.

In summary, data collection from CME files were coded and housed in the primary database. Data from public sources as described above were coded and housed in a separate, secondary database. This approach allowed the researchers to, first, identify a baseline set of data which was regularly collected by CMEs. Second, using the unique, deidentified case number, the two databases were merged, allowing for analyses of the overall trends and patterns in IPV-DH in the Atlantic provinces. The additional supplemental information from other data sources provided a more comprehensive picture of IPV-DH in the Atlantic region, including information that became public during ongoing police investigations and criminal trials.[20] Given that information for CME files is often collected and recorded earlier in homicide investigations, the public data sources allowed for emerging information that became available through the course of the criminal justice process if applicable.

Data coding, variables, and analyses

The CSSLRV research team identified IPV-DHs by reviewing and coding the total sample of homicides. Coding was performed on an encrypted laptop using the Statistical Programming Software for the Social

[20] When information conflicted between CME files and public data sources, data from the CME files were prioritized as this information represents the official record.

Sciences (SPSS) 30. A coding instrument was developed in conjunction with the ADHRN.[21] The goals in the development of the instrument were to ensure that the interests and needs of the Atlantic region were reflected while also drawing from best practices in Canada (Giesbrecht et al., 2023; Jaffe et al., 2013) and globally (Bender, 2017). Briefly, variables captured sex and age of the victim and the accused/perpetrator, type of relationship (e.g., legal spouses, dating), location and cause of death. Additional variables also sought to capture information describing the circumstances leading up to the homicide, victim and accused profiles, risk factors, and criminal justice outcomes. It was recognized that information for many of the variables would not likely be available, but the overall goal in developing the instrument was to determine what was desired and, in turn, to find out what was possible. In short, we wanted to determine what information would be beneficial to have with respect to prevention and what was available in reality.

Data analyses primarily involved descriptive frequencies for the Atlantic Region and then separately for the four individual provinces where appropriate. The results section begins with a brief overview of trends in homicides more generally in the region, followed by patterns in IPV-DHs and then DFVHs, relying on data from the primary and secondary databases. This is followed by two sections focusing more on data availability comparing, first, the CME database to the public database (*see Appendix D*) and, second, comparing data available in New Brunswick where a DVDRC operates to the other three provinces who, at the time of data collection, did not have a DVDRC (*see Appendix E*).[22] Throughout the results' sections, for many variables, we indicate what proportion of data were missing. In the discussion section, we highlight some of the implications of this missing information. It is important to note here that missing information in homicide research is common internationally (Stöckl et al. 2013; UNODC, 2023) and not unique to the Atlantic provinces or Canada as a whole. These and other study limitations are expanded upon below.

STUDY LIMITATIONS

Various study limitations are worth noting which have been documented by other research on homicide using similar data sources (Cullen et al., 2021; Giesbrecht et al., 2023). First, none of the data sources accessed by this project nor the data collected was done so with the purpose of research in mind. For example, in the course of collecting data after a homicide occurs, it is not the mandate of the CME offices to do so for the purposes of research. Second, given the above fact, it is important to note that data collected from such sources primarily captures information known at one point in time. Third, information captured by the data collected represents only what has been recorded in the data sources accessed. While similar to most research, it is worthy of note in terms of limitations of the data presented as follows:

(1) If the data on a characteristic is not recorded, it cannot be assumed that it is not present. For example, if records do not mention that a perpetrator had a prior criminal record or that the victim sought help from an official agency, we cannot assume that a prior record was absent or that a victim did not seek

[21] The ADHRN data collection instrument drew from early research and related instruments developed by the report's first author which began with the *Woman Killing: Intimate Femicide in Ontario 1974-1994* project (Dawson & Gartner, 1998; Gartner et al., 1999), followed by the *Canadian Geography of Justice Initiative* (Dawson 2003, 2004, 2005, 2012, 2016; Dawson & Carrigan, 2021; Dawson et al., 2023; Johnson & Dawson, 2023). These earlier projects also informed the development of the data collection instrument for the *Canadian Domestic Homicide Prevention Initiative for Vulnerable Populations* (Giesbrecht et al., 2023; Jaffe et al., 2013), for which the first author was Co-Director. The ADHRN coding manual is available upon request.

[22] During the project, Nova Scotia implemented a domestic violence review committee (see: https://www2.gnb.ca/content/gnb/en/departments/public-safety/law-enforcement-and-inspections/content/coroner-services/domestic-violence-death-review-committee.html.

help. Thus, when distributions show a certain proportion of perpetrators have a prior record or a certain number of victims touched base with a specific service, those figures must be interpreted as a minimum estimate (i.e., based only on records that included this information). Only if the data specifically documents that a characteristic was absent can we code the characteristic as absent.

(2) Relatedly, if information is not recorded in a data source, that does not mean the data source is faulty. As discussed above, research is not the mandate of CME offices; as such, they may not note the prior criminal record of the accused. However, it may be that this information is recorded in another data source (e.g., police incident reports) not accessed for this research. We return to this issue below in our recommendations.

(3) Given common critiques of media framing of violent crime, it may seem counter-intuitive to rely on them as one of the public data sources used to generate the second database. However, since increasing availability and use of publicly-accessible data sources, and most commonly the media, the question of their legitimacy has been examined. This research has primarily been conducted in the United States; however, findings are relevant for the Canadian context as well (*for full discussion and references, see Appendix C*). Results show that when collecting factual information (e.g., sex of victim and/or perpetrator, ages of those involved, location of homicide, and method of killing), the media is as reliable as data sources often seen as more official (e.g., police, statistical agencies). In addition, this research shows that more comprehensive information may also be available in the media given their coverage often continues from the initial homicide incident through to the culmination of the criminal justice process. In contrast, police and/or CME files may not be updated as often or as late in the criminal justice process. Therefore, while we do compare the data available in the primary (i.e., CME) and secondary (i.e., public) databases, it is expected that, for some variables, the public database will have more information. The question of why the media may have more information than official data sources is one that needs to be grappled with when working to shift our conceptualization of the goals of data collection from administrative to prevention in purpose. We return to this issue in the recommendation section later in the report.

(4) Throughout the report, focusing on only four provinces which often have lower numbers of homicide, small numbers may mean that it is possible for someone to identify the cases that are included. As such, disaggregation of the data will depend on the numbers being examined and the province being focused upon. Furthermore, when dealing with small numbers, slight shifts can lead to what often appear as significant percentage changes. In those instances, patterns should be interpreted with caution.

(5) It is well known that there is often overlap along the continuum of victimization and perpetration; that is, the individual who identified as the perpetrator may also be the victim. This is especially relevant when examining victimization and perpetration in IPV-DH. This fact, coupled with the difficulty of documenting key contextual variables (i.e., prior violence in the relationship) often makes it difficult to accurately identify perpetrators who were primarily the victims and victims who were primarily perpetrators before the killings. It is a well-documented fact that when someone ends up dead in IPV-DH, it is typically a woman and that when a man ends up dead, often the perpetrator was his victim (e.g., for recent overview of global research, Dawson & Mobayed, 2023; for Canada, Jaffe et al., 2020).

Keeping the above factors in mind, this is the first study of its kind to be conducted in Atlantic Canada and, arguably, the first of its kind nationally in terms of depth and focus, regional cooperation, and multi-sector collaborations.

RESULTS – PART I: Homicide in Atlantic Canada – Setting the larger context

Between 2012 and 2022, there were a total of 384 homicide victims. This total and the provincial breakdown by year are shown in Table 1. During the study period, there were 124 homicide victims in NB, 53 victims in NL, 194 victims in NS, and 13 victims in PE. The average annual number of homicide victims during the 11-year period was 35 victims per year. The year with the fewest homicides recorded was 2014 with 25 homicides whereas the year with the most homicides recorded was 2020 with 59 homicides. All but one year – 2020 – had between 25 and 43 homicide victims. The increase in homicide victims in 2020 can be explained, in part, by the Portapique, NS, mass killing, in which 22 victims were killed.[23]

Table 1. *Overview of all homicide victims in Atlantic Canada, 2012-2022 (N=384).*

Year	Province				Total
	NB	NL	NS	PE	
2012	9	2	18	0	29
2013	8	7	10	1	26
2014	10	3	8	4	25
2015	12	4	14	2	32
2016	10	5	18	1	34
2017	10	3	22	0	35
2018	13	4	14	1	32
2019	18	5	10	2	35
2020	15	5	38	1	59
2021	10	10	22	1	43
2022	9	5	20	0	34
Total	**124**	**53**	**194**	**13**	**384**

Of the 384 homicide victims, 21 percent were missing information on their relationship with the accused. Specifically, 10 percent (N=40) had an unspecified or unknown relationship[24] with their accused and 11

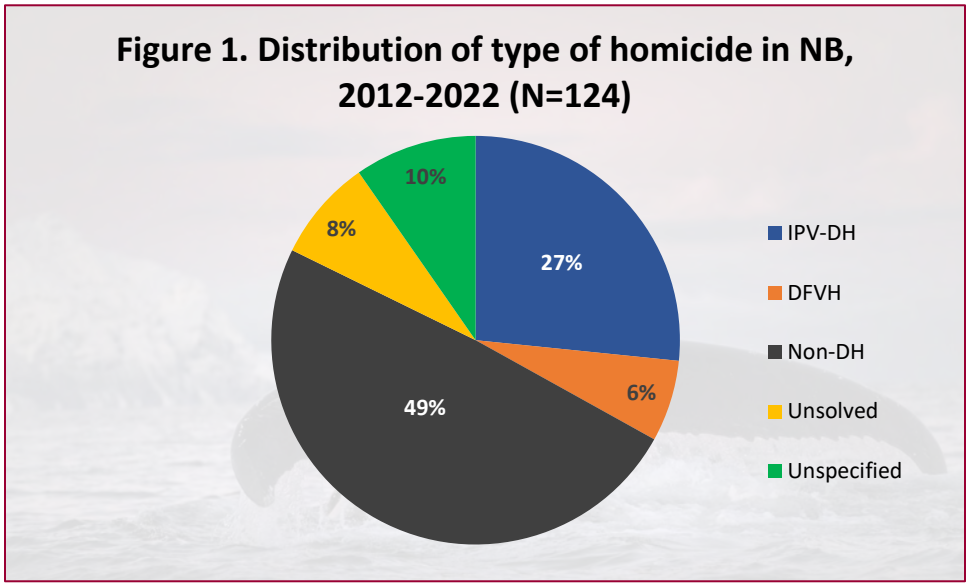
[23] See *Final Report of Mass Casualty Commission*: https://masscasualtycommission.ca/final-report/.
[24] Unspecified or unknown victim-accused relationship refers to homicides in which the identity of both the victim and accused were known, but there was not enough information in the file(s) to determine their relation to one another or the files indicated the relationship was unknown.

percent of victims' homicides (N=41) remained unsolved.[25] The remaining victims were killed in an IPV-DH (20%; N=75), a DFVH (10%; N=39), or a non-domestic homicide (non-DH; 49%; N=189). Table 2 provides a breakdown by province followed by a separate discussion (and a related pie chart) for each province (*see Figures 1-4*). The numbers for each type of homicide are minimum estimates given that, as noted, some homicides remain unsolved or have unspecified/unknown relationships. Atlantic Canada has a lower percentage of unsolved homicides than Canadian as a whole (11% vs 33% respectively; David and Jaffray, 2021).

Table 2. *Distribution of homicide victim-accused relationship by province in Atlantic Canada, 2012-2022 (N=384).*

Homicide classification	Province								Total N	%
	NB	%	NL	%	NS	%	PE	%		
IPV-DH	33	27	14	26	25	13	3	23	75	20
DFVH	8	6	9	17	17	9	5	38	39	10
Non-DH	61	49	25	47	98	51	5	38	189	49
Unsolved	10	8	3	6	28	14	0	-	41	11
Unspecified/unknown	12	10	2	4	26	13	0	-	40	10
Total	124	100	53	100	194	100	13	100	384	100

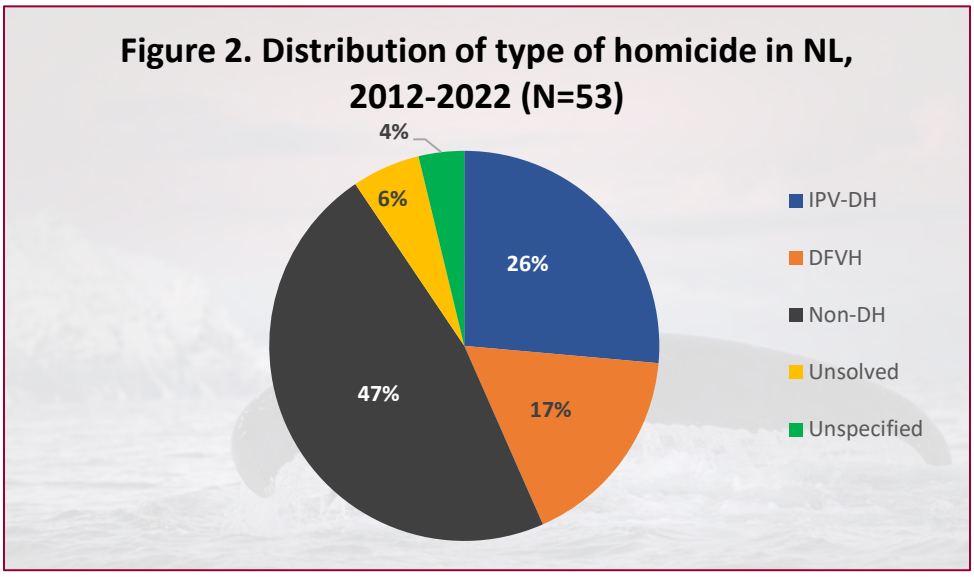
New Brunswick: Figure 1 shows that in NB, 49 percent of all homicide victims were non-domestic homicide victims (N=61). Just over one-quarter (27%) were IPV-DH (N=33) and six percent were other DFVH (N=8). Eight percent of all homicides were unsolved (N=10) and 10 percent were unspecified/unknown victim-accused relationships (N=12).



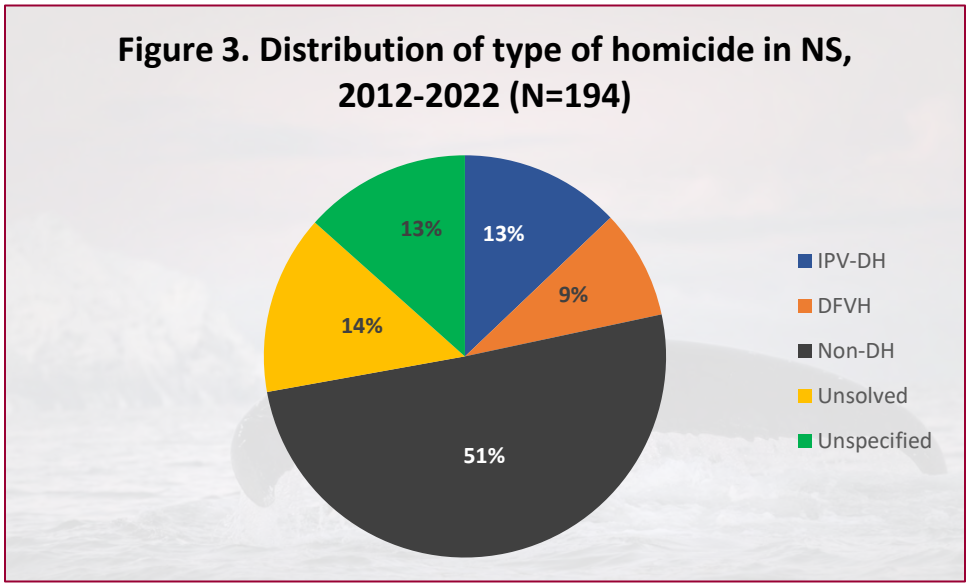
Newfoundland and Labrador: Figure 2 shows that almost one half of all homicide victims in NL were non-DH victims (47%; N=25). Just over one-quarter (26%) were IPV-DH (N=14) and 17 percent were other DFVH

[25] For those victims whose homicides were designated as unsolved, none of the sources identified an accused at the time of review.

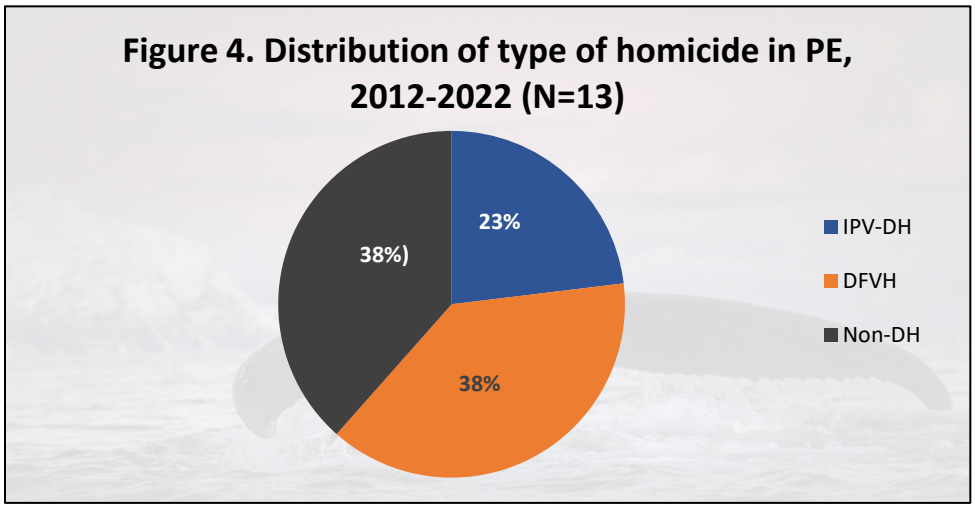
(N=9). Six percent (N=3) were classified as unsolved and four percent (N=2) were missing information on the victim-accused relationship.



Nova Scotia: Figure 3 shows that in NS more than half of all homicide victims were non-DH victims (51%; N=98). Thirteen percent (N=25) of victims were IPV-DH and nine percent were other DFVH (N=17). Fourteen percent (N=28) of all homicides during the study period were unsolved and 13 percent (N=26) were missing information on the victim-accused relationship.



Prince Edward Island: Figure 4 shows that in PE, five homicide victims were non-DH victims (38%). Three victims were IPV-DH (23%) and five victims were other DFVH (38%). Victim-accused relationship was available for all victims and no cases remained unsolved.



RESULTS – PART II: Intimate Partner Violence-Related Domestic Homicide (IPV-DH)

From 2012 to 2022, there were 75 IPV-DH victims in Atlantic Canada, representing one quarter (25%) of all homicides for which the victim-accused relationship was known. The 75 victims were killed in 71 cases of IPV-DH.[26] Specifically, 73 percent (N=55) of victims were intimate partners of the accused, eight percent (N=6) of victims were children of the victim and/or accused, 16 percent (N=12) were third parties killed by the accused, and three percent (N=2) of victims were other family members of the victim or accused (see Figure 5). In this section, those cases with an unspecified relationship or for which no accused was identified were excluded because we were unable to classify whether the cases were an IPV-DH, a DFVH, or a non-DH.

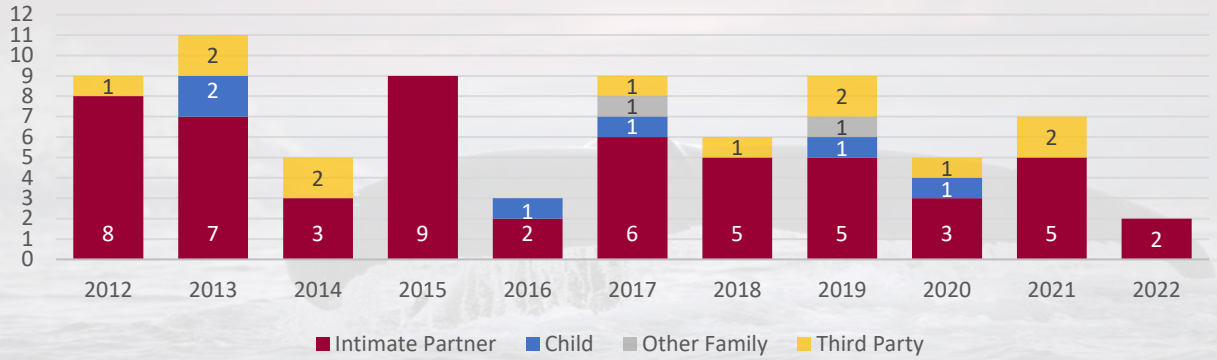
The killing of current/former intimate partners comprised majority of IPV-DHs

Annual distribution: The number of IPV-DH victims killed each year in Atlantic Canada during the study period ranged from two to 11, with an average of six IPV-DH victims per year.[27] Specifically, Figure 5 shows that 2013 had the highest number of IPV-DH while the most recent year, 2022, had the fewest. As shown in the bar chart, the killing of a current or former intimate partner comprised the majority of overall IPV-

[26] The number of victims exceeds the number of cases because some cases involved multiple victims.
[27] The victims of the 2020 attack in Nova Scotia, are not included in this analysis. Although the killings were intimate partner violence-related given the mass killings began with the perpetrator's violence against his female partner who survived, the numbers were identified as a high outlier that can skew the results of the intimate partner violence-related domestic homicide distributions in Nova Scotia. This does not indicate the view that IPV was not associated with this mass killing event.

DHs (73%; N=55), with the distribution of intimate partner victims ranging from 55% (N=5) in 2019 to 100% (N=9) in 2015.

Figure 5. Annual distribution of intimate partner violence-related domestic homicide victims, Atlantic Canada, 2012-2022 (N=75)



Note. *True counts of IPV-DH victims could be higher as unsolved cases and cases with unknown victim-accused relationships were excluded.*

New Brunswick had higher IPV-DH rate than rest of Atlantic Canada

Geographic distribution: Table 3 provides a provincial breakdown of the number and percentage of victims killed in an IPV-DH context over the 11-year period in Atlantic Canada. To adjust for population size, the table provides the number of Atlantic Canadians living in each jurisdiction and calculates the average annual rate of IPV-DH for each province[28]. Atlantic Canada had an average annual IPV-DH rate of 0.26 per 100,000 population per year during the study period. NL (0.23), NS (0.21), and PE (0.15) had average IPV-DH rates lower than the rate for the region as a whole, while NB's average IPV-DH rate (0.35) was higher than the rate for Atlantic Canada.

Table 3. *Geographic distribution of IPV-DH victims, Atlantic Canada, 2012-2022 (N=75).*

Province	Number of IPV-DH victims	Percent of IPV-DH victims	Provincial Population	Average annual rate of IPV-DH per 100,000
NB	33	44	854,355	0.35
NL	14	19	545,247	0.23
NS	25	33	1,076,374	0.21
PE	3	4	178,550	0.15
TOTAL – ATLANTIC CANADA	75	100	2,654,526	0.26

Source: *Statistics Canada, Population Estimates on July 1, by age and gender, Table: 17-10-0005-01 (formerly CANSIM 051-0005), released September 25, 2024.*

Note. *True counts of IPV-DH victims could be higher as unsolved cases and cases with unknown victim-accused relationships were excluded.*

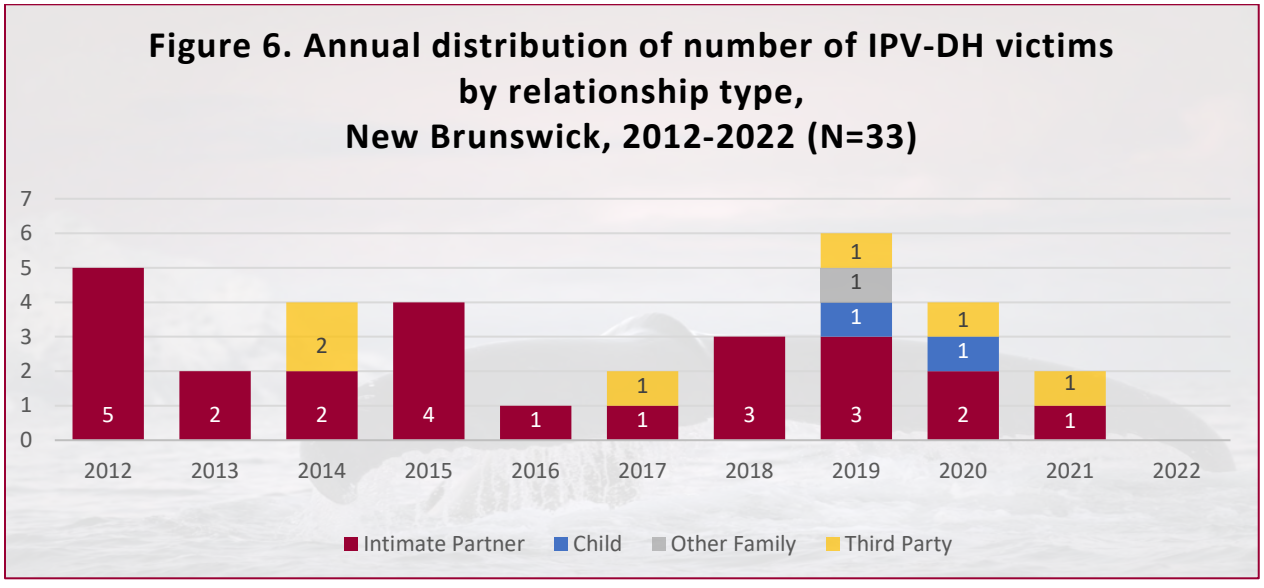
[28] Average annual rate of IPV-DH per 100,000 is based on the population of residents in Atlantic Canada from 2012-2022 (75 victims/2,654,526 population x 100,000 /11 years = 0.26).

The majority of IPV-DH victims and gun-related IPV-DH in rural areas

Rural/urban distribution: Of the 75 IPV-DH victims, the majority were killed in a rural area (less than 10,000 population) (57%; N=43) or a small town/city (31%; N=23; between 10,000 and 49,999 population).[29] Twelve percent of IPV-DH victims (N=9) were killed in an urban area (50,000 population or more). Atlantic Canada has a higher proportion of IPV-DHs in rural areas compared to the proportion nationally (57% vs 33% respectively; Dawson et al., 2021). Most gun-related IPV-DH, discussed further below, occurred in rural areas (74%; N=17), and small town/cities (22%; N=5). One (4%) gun-related IPV-DH victim was killed in an urban area. All IPV-DH Indigenous victims were killed in rural settings compared to 60 percent of Black and 50 percent of White IPV-DH victims. Where information was available, two Indigenous victims of IPV-DH were killed on reserves. Due to small numbers, this study did not capture whether the homicides occurred in remote or northern communities or distinguish such communities from rural regions.

Below, we describe the trends in IPV-DH for each Atlantic jurisdiction (see also Figures 6-8).

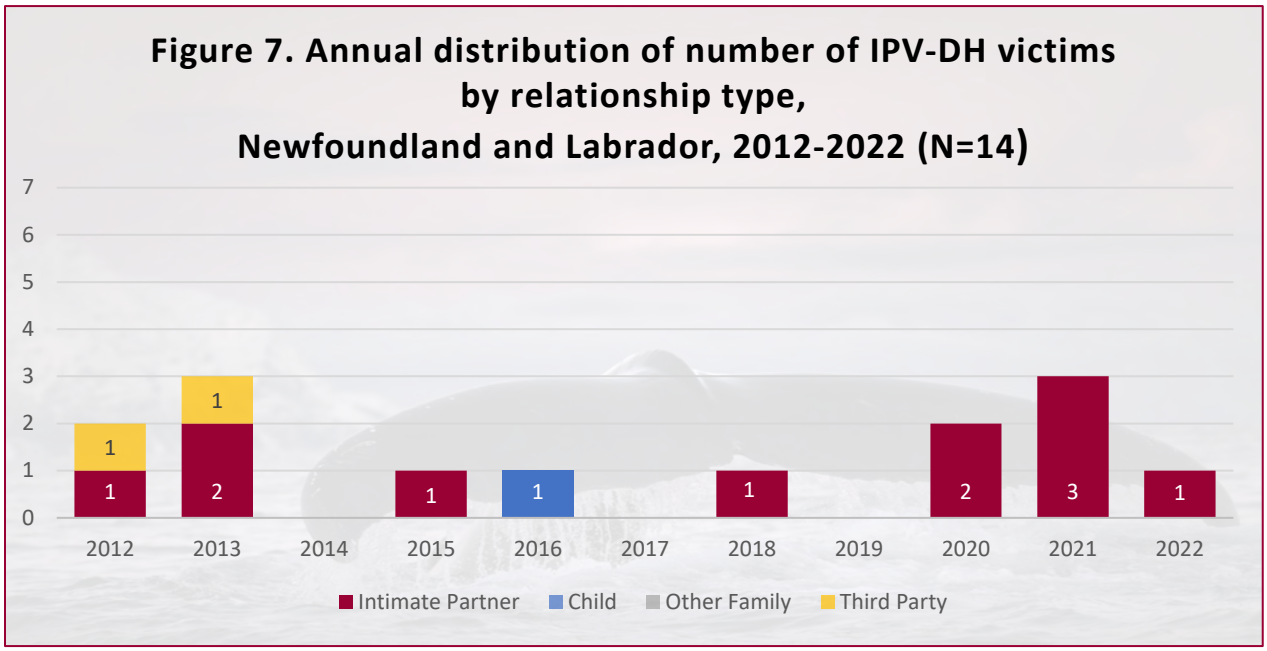
New Brunswick: From 2012 to 2022, there were a total of 33 cases of IPV-DH in NB, involving 33 victims. Figure 6 shows that nearly three-quarters of victims killed were intimate partners of the accused (73%; N=24), followed by third parties (18%; N=6), children of the accused (6%; N=2), and other family members of the accused (3%; N=1).



Note. *True counts of IPV-DH victims could be higher as unsolved cases and cases with unknown victim-accused relationships were excluded.*

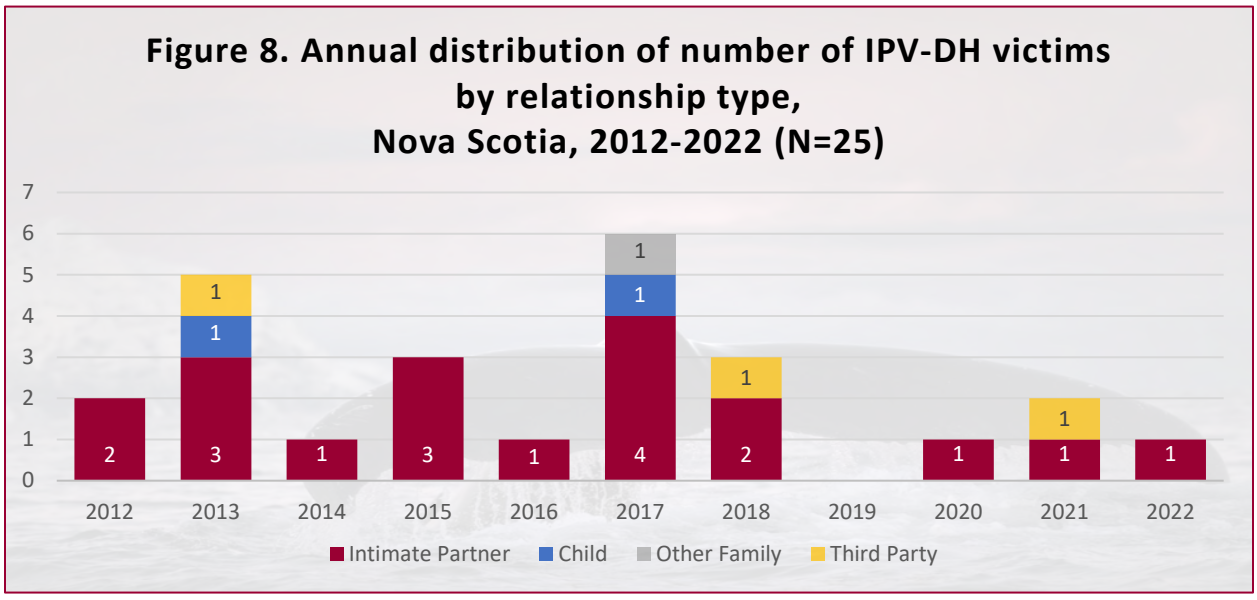
[29] This definition aligns with the definition of rural used in the Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations (Jeffery et al., 2019; see also Bollman, 2016; Statistics Canada, 2016).

Newfoundland and Labrador: From 2012 to 2022, there were a total of 13 cases of IPV-DH in NL, involving 14 victims. Figure 7 shows that the majority of victims killed were intimate partners of the accused (79%; N=11), followed by third parties (15%; N=2), and children of the accused (7%; N=1).



Note. True counts of IPV-DH victims could be higher as unsolved cases and cases with unknown victim-accused relationships were excluded.

Nova Scotia: From 2012 to 2022, there were a total of 22 cases of IPV-DH in NS, involving 25 victims. Figure 8 shows that over three-quarters of victims killed were intimate partners of the accused (76%; N=19), followed by third parties (12%; N=3), children of the accused (8%; N=2) and other family members of both the victim and accused (4%; N=1).

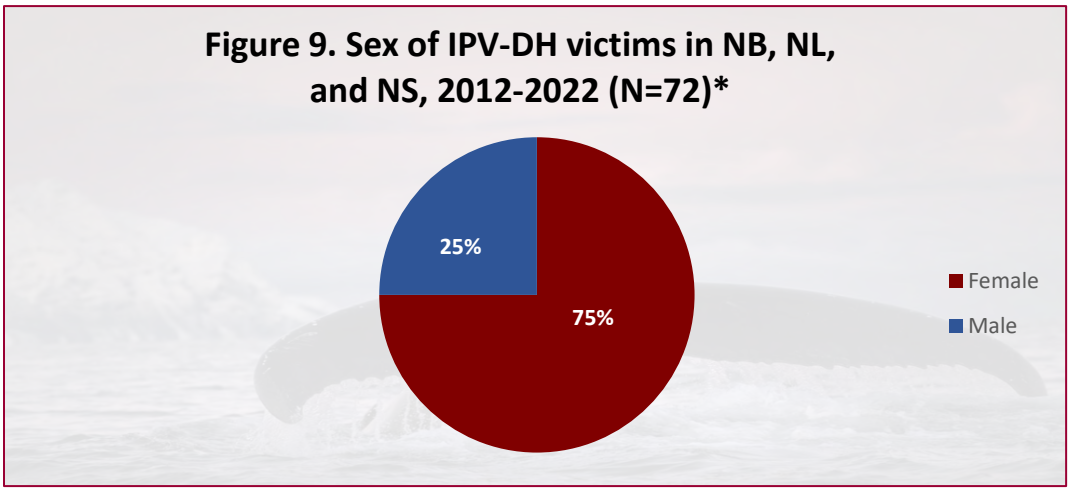


Note. True counts of IPV-DH victims could be higher as unsolved cases and cases with unknown victim-accused relationships were excluded

Prince Edward Island: From 2012 to 2022, there were a total of three cases of IPV-DH in PE, involving three victims. One victim killed was an intimate partner of the accused (33%), one victim killed was a child of the accused (33%), and one victim was a third party (33%).

Female victims comprised the majority of IPV-DH victims

Victim sex: Information on the victim's sex was available for all IPV-DH victims in the Atlantic region; however, due to small numbers distributions for PE are not provided. In the three remaining provinces, as seen in Figure 9, 75 percent were female victims (N=54) and 25 percent were male victims (N=18).



**Due to small numbers, distributions for PE are not provided or included in the totals.*

Table 4 provides the provincial numbers and distributions for the three provinces. The majority of IPV-DH victims were female in NB, NL, and NS (70%, 79%, 80%, respectively).

Table 4. *Overview of victim sex in intimate partner violence-related domestic homicide victims in New Brunswick, Newfoundland and Labrador, and Nova Scotia, 2012-2022 (N=72) **

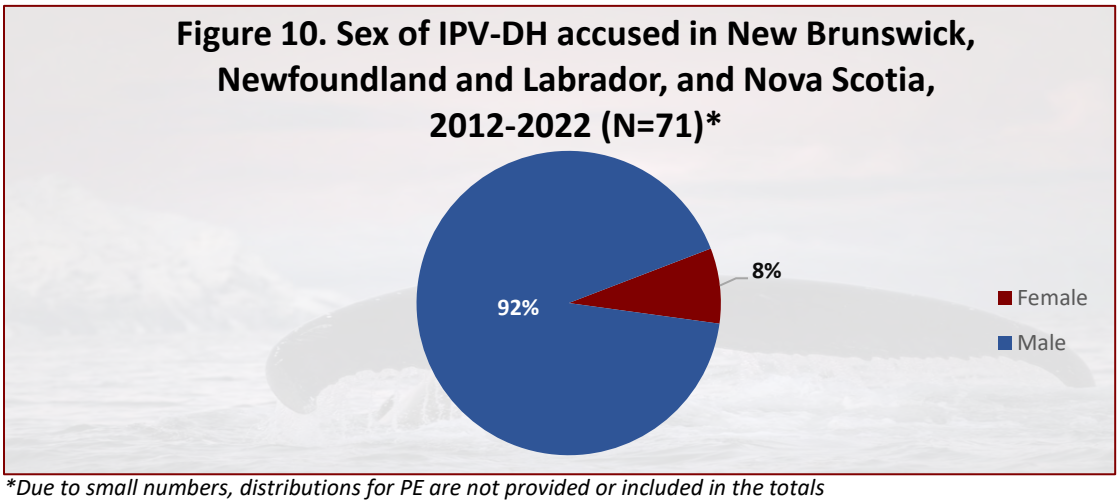
Victim sex	Province						Total	%
	NB	%	NL	%	NS	%		
Female	23	70	11	79	20	80	54	75
Male	10	30	3	21	5	20	18	25
Total	33	100	14	100	25	100	72	100

**Due to small numbers, distributions for PE are not provided or included in the totals.*

Male accused comprised the majority of IPV-DH perpetrators

Accused sex: A total of 74 individuals were accused during the study period.[30] Figure 10 presents the breakdown of male and female accused in NB, NL, and NS (N=71). The majority of IPV-DH accused were male (92%; N=65) with six female accused (8%). Table 5 provides an overview of the accused's sex in three provinces.

[30] The deaths of 75 victims involved 74 individual accused (i.e., one accused killed 2 victims).



Due to small numbers, distributions for PE are not provided or included in the totals

Table 5. *Sex of accused in intimate partner violence-related domestic homicides in New Brunswick, Newfoundland and Labrador, and Nova Scotia, 2012-2022 (N=71) **

Accused sex	Province						Total	%
	NB	%	NL	%	NS	%		
Female	4	11	1	8	1	4	6	8
Male	31	89	12	92	22	96	65	92
Total	35	100	13	100	23	100	71	100

Due to small numbers, distributions for PE are not provided or included in the totals.

Victim and accused sex: Table 6 outlines the victim-accused sex combination for each province (excluding PE). When women and girls were killed, 98 percent (N=53) were killed by male accused and two percent (N=1) were killed by female accused. When men and boys were killed, 89 percent (N=16) of male victims were killed by male accused and 11 percent were killed by female accused (N=2). Victims killed by a male accused comprised 96 percent (N=69) of all IPV-DHs. As noted in the *Study Limitations* section, in IPV-DH, there is often an overlap between victim and perpetrator status, especially for women. That is, even though they are the perpetrator in the killing, they are often the primary victim in the events leading up to the homicide (Suonpää & Savolainen, J., 2019). This detail is lost when data are missing and/or aggregate quantitative data only is presented. The distribution of the sex of both victims and accused is in line with national trends (Dawson et al., 2021).

Table 6. *Victim-accused sex combination of IPV-DH in New Brunswick, Newfoundland and Labrador, and Nova Scotia, 2012-2022 (N=72) **

Victim and Accused Sex	Province						Total	%
	NB	%	NL	%	NS	%		
Female victim-female accused	1	3	-	-	-	-	1	1
Female victim-male accused	22	67	11	79	20	80	53	74
Male victim-male accused	9	27	2	14	5	20	16	22
Male victim-female accused	1	3	1	7	-	-	2	3
Total	33	100	14	100	25	100	72	100

**Due to small numbers, distributions for PE are not provided or included in the totals.*

Table 7 provides a detailed breakdown of the sex of the victim for each category of IPV-DH. The vast majority of IPV-DH victims killed by an intimate partner were female victims (91%; N=50). Two-thirds of IPV-DH victims killed by their parents were female (67%; N=4). There was one female and one male IPV-DH victim killed by other family members (50%, respectively). All third parties killed as a result of intimate partner violence were male (100%; N=12).

Table 7. *IPV-DH victim-accused relationship type by sex of the victim, Atlantic Canada, 2012-2022 (N=75).*

Victim Sex	IPV-DH Victim-Accused Relationship								Total	%
	Intimate Partner	%	Child	%	Other Family	%	Third Party	%		
Female	50	91	4	67	1	50	-	-	55	73
Male	5	9	2	33	1	50	12	100	20	27
Total	55	100	6	100	2	100	12	100	75	100

2SLGBTQI+: Of the 55 IPV-DH victims killed by intimate partners, three victims (5%) were killed by their same-sex partner. All victims were male killed by their male partner (100%; N=3). Specifically, one victim was killed by his sexual companion, one by his common-law partner, and one by an intimate partner for which the exact type of intimate relationship was unknown. Based on files reviewed, Atlantic Canada had the same proportion of reported same-sex IPV-DH as Canada as a whole (5%; Ibrahim, 2019). There were no reported homicides involving transgender IPV-DH victims.

IPV-DH victims in Atlantic Canada tended to be older than rest of Canada

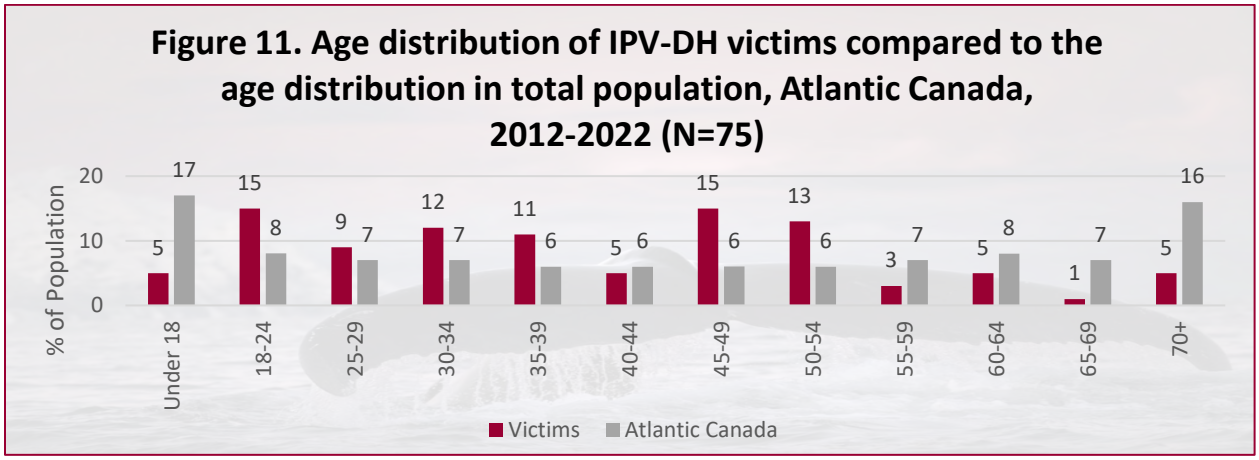
Victim age: Information on age was available for all IPV-DH victims in Atlantic Canada (100%; N=75). The age of victims ranged from four years to 77 years, with a mean age of 39 years. Five percent of the victims were less than 18 years old (N=4), 15 percent were 18-24 (N=11), 21 percent were 25-34 (N=16), 16 percent were 35-44 (N=12), 28 percent were 45-54 (N=21), eight percent were 55-64 (N=6), and six percent were 65 and older (N=5) (see Table 8). IPV-DH victims in Atlantic Canada tended to be older, on average, than IPV-DH victims throughout Canada (45-54 years old vs 25-34 years respectively; Conroy et al., 2019). This may be due to Atlantic Canada's older population (Statistics Canada, 2024), or it could represent a true divergence from the national trend.

IPV-DH victims aged 18-54 years were overrepresented in Atlantic Canada

The largest groups of victims were those aged 18-24 and 45-54 years old. This was fairly consistent across the Atlantic provinces except for PE, where one-third of the victims were under 18 years of age (33%; N=1). In the remaining provinces, the largest age group were those aged 18-24 years (21%; N=7) in New Brunswick; those aged 45-49 years (29%; N=4) in Newfoundland and Labrador; and those aged 30-34 years (20%; N=5) in Nova Scotia. When compared to representation in the Atlantic Canadian population, victims aged 18 to 39 years and victims aged 45-54 years were overrepresented (see Figure 11).

Table 8. *Age distribution of IPV-DH victims, Atlantic Canada, 2012-2022 (N=75).*

Victim age category	Province								Total	%
	NB	%	NL	%	NS	%	PE	%		
Under 18	1	3	1	7	1	4	1	33	4	5
18-24	7	21	1	7	3	12	-	-	11	15
25-29	2	6	2	14	2	8	1	33	7	9
30-34	4	12	-	-	5	20	-	-	9	12
35-39	2	6	3	21	3	12	-	-	8	11
40-44	2	6	-	-	1	4	1	33	4	5
45-49	3	9	4	29	4	16	-	-	11	15
50-54	5	15	2	14	3	12	-	-	10	13
55-59	-		1	7	1	4	-	-	2	3
60-64	4	12	-	-	-	-	-	-	4	5
65-69	1	3	-	-	-	-	-	-	1	1
70+	2	6	-	-	2	8	-	-	4	5
Total	33	100	14	100	25	100	3	100	75	100



Source: Statistics Canada, Table 17-10-0005-01, Population estimates on July 1, by age and gender.

Table 9 provides age distributions for each IPV-DH victim-accused relationship type. The age categories 30-34 years (N=9; 16%) and 45-49 years (N=9; 16%) constitute almost one-third of the victims in the intimate partner relationship category. There were five intimate partner homicide victims aged 65 years and older (9%). There were no intimate partner homicide victims under the age of 18 years. Most victims killed by their parents were under 18 years (67%; N=4) and the remaining victims were 18-24 years (17%;

N=1) or 25-29 years (17%; N=1). Victims killed by other family members were aged 18-24 years (50%) or 50-54 years (50%). Third parties to intimate partner violence ranged in age from 18 to 64 years (N=12).

Table 9. *IPV-DH relationship type by victim age, Atlantic Canada, 2012-2022 (N=75).*

Victim age category	IPV-DH Victim-Accused Relationship								Total	%
	Intimate Partner	%	Child	%	Other Family	%	Third Party	%		
Under 18	-	-	4	67	-	-	-	-	4	5
18-24	6	11	1	17	1	50	3	25	11	15
25-29	4	7	1	17	-	-	2	17	7	9
30-34	9	16	-	-	-	-	-	-	9	12
35-39	8	15	-	-	-	-	-	-	8	11
40-44	3	5	-	-	-	-	1	8	4	5
45-49	9	16	-	-	-	-	2	17	11	15
50-54	8	15	-	-	1	50	1	8	10	13
55-59	-	-	-	-	-	-	2	17	2	3
60-64	3	5	-	-	-	-	1	8	4	5
65-69	1	2	-	-	-	-	-	-	1	1
70+	4	7	-	-	-	-	-	-	4	5
Total	55	100	6	100	2	100	12	100	75	100

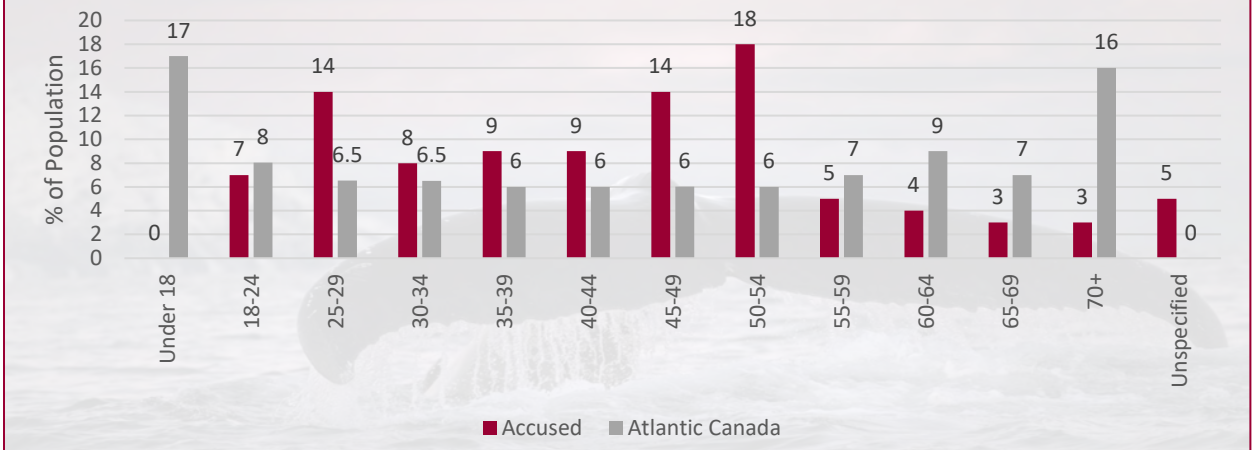
Accused aged 25-54 years overrepresented in Atlantic Canada

Accused age: Of the total 74 accused in IPV-DHs, information on age was available for 95 percent of accused (N=71) (see Table 10). The accused ranged in age from 18 years to 90 years, with a mean age of 43 years. As shown in Figure 12, accused aged 25 to 54 years were overrepresented compared to the age representation in the population in the Atlantic Canada.

Table 10. *Age distribution of accused in IPV-DHs, Atlantic Canada, 2012-2022 (N=74).*

Accused age	Province								Total	%
	NB	%	NL	%	NS	%	PE	%		
Under 18	-	-	-	-	-	-	-	-	-	-
18-24	4	11	-	-	2	9	-	-	6	8
25-29	4	11	1	8	5	22	-	-	10	14
30-34	2	6	-	-	3	13	1	33	6	8
35-39	2	6	3	23	1	4	1	33	7	9
40-44	4	11	1	8	2	9	-	-	7	9
45-49	4	11	1	8	4	17	1	33	10	14
50-54	7	20	3	23	3	13	-	-	13	18
55-59	2	6	1	8	1	4	-	-	4	5
60-64	3	9	-	-	-	-	-	-	3	4
65-69	2	6	-	-	-	-	-	-	2	3
70+	1	3	-	-	1	4	-	-	2	3
Unspecified	-	-	3	23	1	4	-	-	4	5
Total	35	100	13	100	23	100	3	100	74	100

Figure 12. Age distribution of IPV-DH accused compared to age distribution in total population, Atlantic Canada, 2012-2022 (N=74)



Source: Statistics Canada, Table 17-10-0005-01, Population estimates on July 1, by age and gender

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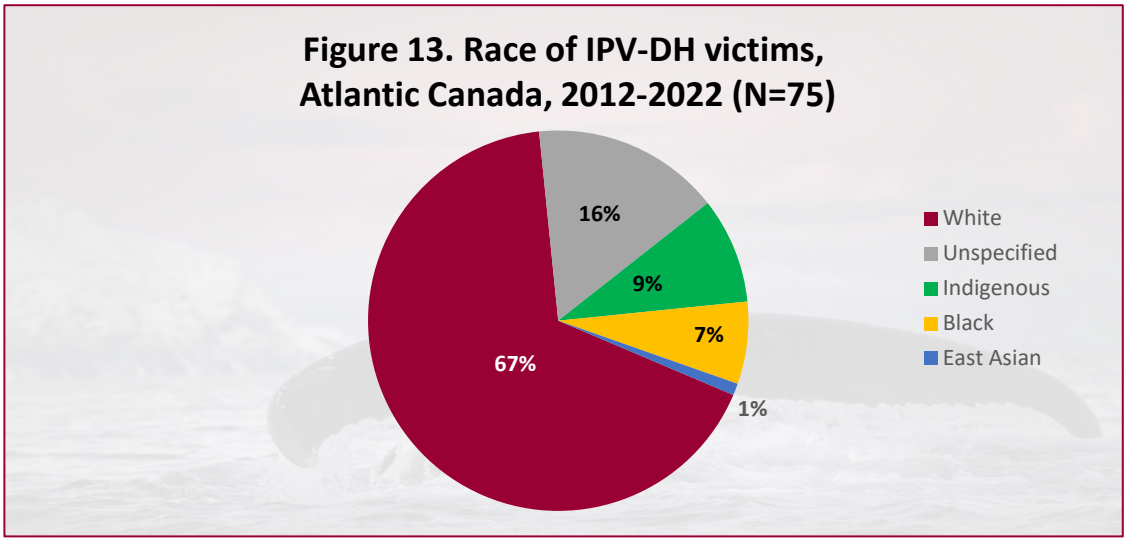
Most IPV-DH victims were white for all four provinces

Victim race: Of the 75 victims, 84 percent had information on race (N=63), while 16 percent were missing this information (N=12). As shown in Table 11, most of the victims whose race was identified were White for all four provinces (67%; N=50). For the remainder, 16 percent were unspecified (N=12), nine percent were identified as Indigenous (N=7), seven percent were identified as Black (N=5), and one percent was identified as East Asian (N=1; see Figure 13).

Table 11. *Race of IPV-DH victims, Atlantic Canada, 2012-2022 (N=75).*

Victim's race	Province								Total	%
	NB	%	NL	%	NS	%	PE	%		
Black	1	3	-	-	4	16	-	-	5	7
East Asian	-	-	1	7	-	-	-	-	1	1
Indigenous	2	6	4	29	1	4	-	-	7	9
White	23	70	9	64	15	60	3	100	50	67
Unspecified	7	21	-	-	5	20	-	-	12	16
Total	33	100	14	100	25	100	3	100	75	100

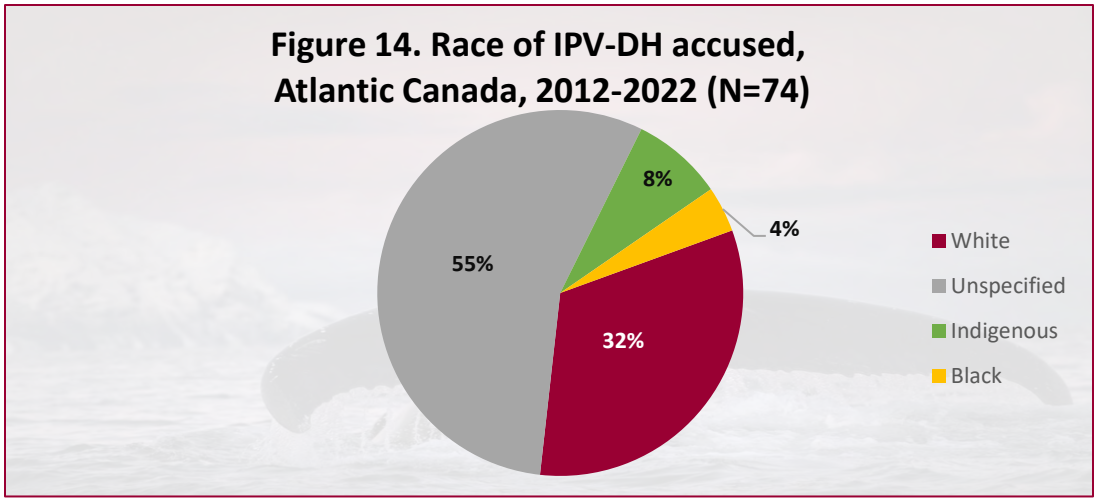


Perpetrator race missing for over one-half of the cases

Accused race: Information on race was available for 44 percent of accused (N=33) and missing for 55 percent (N=41). Focusing on available data, Table 12 shows that 73 percent were White (N=24), 18 percent were Indigenous (N=6), and nine percent were Black (N=3). Distributions across the four provinces are also shown. Figure 14 presents the visual distribution for race of the accused.

Table 12. *Race of IPV-DH accused, Atlantic Canada, 2012-2022 (N=74).*

Accused's Race	Province								Total	%
	NB	%	NL	%	NS	%	PE	%		
Black	2	6	-	-	1	4	-	-	3	4
Indigenous	2	6	3	23	1	4	-	-	6	8
White	16	46	1	8	5	22	2	67	24	32
Unspecified	15	43	9	69	16	70	1	33	41	55
Total	35	100	13	100	23	100	3	100	74	100



Immigration and citizenship status: More victims (76%; N=57) than accused (52%; N=39) had information available on their citizenship status (see Table 13). When citizenship status was known, all victims were Canadian citizens (100% or N=57) and most accused (97% or N=38) were Canadian citizens. As shown in Table 14, there was less information on place of birth for victims and accused (65% and 32%, respectively). When known, most victims (93%; N=46) and accused (92%; N=22) were born in Canada.

Table 13. *Citizenship status for IPV-DH victims and accused, Atlantic Canada, 2012-2022 (N=75).*

Citizenship Status	Victims				Total	Accused				Total
	NB	NL	NS	PE		NB	NL	NS	PE	
Canadian citizen	28	9	17	3	57	18	7	10	3	38
Non-permanent resident	-	-	-	-	-	1	-	-	-	1
Unspecified	5	5	8	-	18	16	6	13	-	35
Total	33	14	25	3	75	35	13	23	3	74[31]

Table 14. *Place of birth for IPV-DH victims and accused, Atlantic Canada, 2012-2022 (N=75).*

Place of Birth	Victims				Total	Accused				Total
	NB	NL	NS	PE		NB	NL	NS	PE	
Canada	24	5	14	3	46	10	3	8	1	22
Europe	-	-	1	-	1	-	-	1	-	1
South America	1	-	-	-	1	-	-	-	-	-
Caribbean	-	-	-	-	-	1	-	-	-	1
Not in Canada	-	1	-	-	1	-	-	-	-	-
Unspecified	8	8	10	-	26	24	10	14	2	50
Total	33	14	25	3	75	35	13	23	3	74[15]

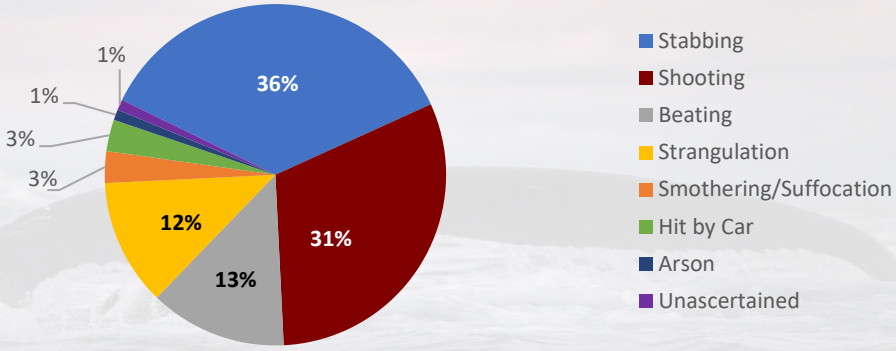
Disability status: Information on disability status was known for nine IPV-DH victims (12%). Five victims (56%) were identified as living with a disability and four victims did not have evidence of a disability (44%). All IPV-DH victims living with a disability were women (N=5). Two victims were older than 60 years and three were between the ages of 22 and 45 years. All victims living with a disability were killed by a current male intimate partner (N=5), such as their husbands[32] (N=2), boyfriend (N=1), and common-law partners (N=2). Of the 74 IPV-DH accused, evidence of a disability was known for eight accused (11%); seven accused had a disability, while one accused did not.

[31] For Table 13 and Table 14, the 75 total victims and 74 total accused were analyzed separately.
[32] Separation was imminent for one victim, who was planning to leave the accused the following day.

Most common method of killing was stabbing except in rural areas where shooting more common

Method of killing: The most common primary[33] method of killing in IPV-DHs was stabbing (36%; N=27), followed by shooting (31%; N=23), although this pattern did vary by province and across rural and urban regions. For example, in NS, shootings were slightly more common than stabbings whereas shootings and stabbings were equally represented in NL and PE. In NB, stabbings were more common than shootings. Similarly, while the overall pattern remained consistent for urban areas (e.g., stabbings more common than shootings), it was the opposite in rural areas (i.e., 37% were shootings and 28% were stabbings). Long guns were more common in rural IPV-DH (76%) compared to urban IPV-DH (33%). These patterns are consistent with other research that show firearms are more common in IPV-DHs in rural regions (Wood et al., 2024; Mancik et al., 2020; Doherty and Hornosty, 2008). Beating (13%; N=10) and strangulation (12%; N=9) were also frequently identified as a primary method. There were several other methods of killing used and, for one victim, the primary method could not be ascertained (see Figure 15). Methods of killing for IPV-DHs in Atlantic Canada are in line with national trends (Dawson et al., 2021).

Figure 15. Method of killing used in IPV-DH, Atlantic Canada, 2012-2022 (N=75)



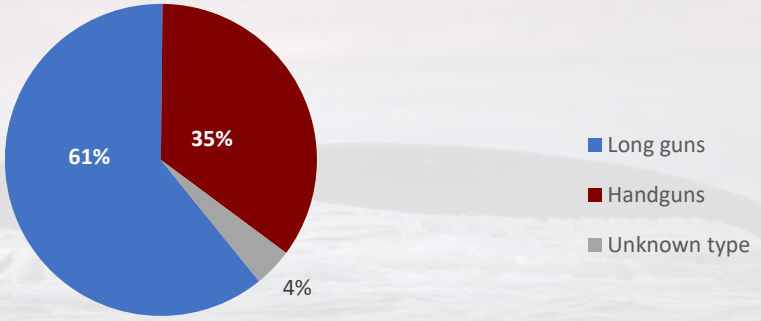
Firearm use: Of the 23 IPV-DH victims (31%) killed by shooting, information on type of firearm used was known for 97 percent of victims (N=22). Specifically, Figure 16 shows that 61 percent were long guns (N=14; 9 rifles and 5 shotguns), 35 percent were handguns (N=8; 7 pistols and 1 revolver), and four percent was unspecified (N=1). Where ownership information was known (N=12), all firearms used were possessed by the accused (100%) and information on whether the gun used was legally owned by the accused was known for 10 victims (43%). Focusing on victims' cases where information was known, 70 percent of firearms used (N=7) were acquired legally and 30 percent (N=3) were acquired illegally (i.e., accused did not have a Possession and Acquisition License or their restricted firearm was not registered). There was a court order in place for one accused to surrender or destroy their firearms.[34] The use of guns,

[33] Primary method of killing refers to the action of the accused identified as having caused the victim's death, or that was most likely to have caused the victim's death. For example, the methods "beating", "single blunt injury", "pushed from height", "pushed, not from height", and "child abuse" could all result in a cause of death of "blunt force trauma", however "cause of death" does not provide as much insight into the killing itself as "method of killing".

[34] The gun was not surrendered and was used to commit murder-suicide.

and specifically the use of long guns, in IPV-DHs in Atlantic Canada is in line with national trends (Dawson et al., 2021).

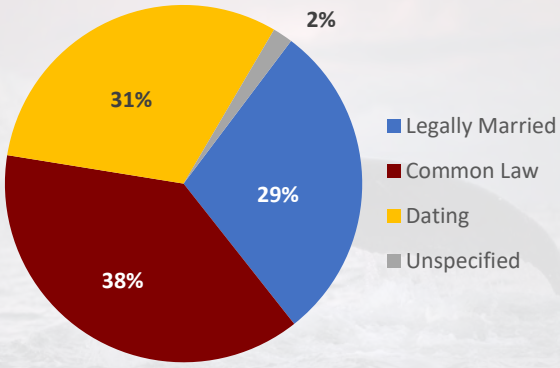
Figure 16. Type of firearm used in firearm-related IPV-DH, Atlantic Canada, 2012-2022 (N=23)



Most common IPV-DH relationship was current/former common-law

Below, we focus specifically on the 55 victims of IPV-DH who were in an intimate partner relationship with the accused to examine their relationship in greater detail, focusing on relationship status and relationship state (Dawson and Gartner, 1998; Johnson and Hotton, 2003).

Figure 17. Relationship status in IPV-DH, Atlantic Canada, 2012-2022 (N=55)



Relationship status: Relationship status captures whether the victim and accused were legally married, living common-law, or dating. Figure 17 focuses only on the 55 IPV-DH victims killed by intimate partners and excludes those victims who shared other relationship types with the accused. The greatest proportion of victims had a current or former common-law relationship with their accused (38%; N=21), followed by dating relationships (31%; N=17) and legal marriages (29%; N=16). One victim was in an intimate partner relationship with their accused (2%) but the relationship status was not specified.

Couples who were separated/imminently separating most common in IPV-DH

Relationship state: Relationship state captures whether the victim and accused were currently in a relationship or separated at the time of the killing. Figure 18 shows that over one half of the victims were in a current relationship with their accused when they were killed (60%; N=33). However, of the 33 victims who were in a current intimate partner relationship with the accused when they were killed, evidence

that separation was imminent or pending was present for 42 percent of victims (25% of total IPV-DH victims; N=14). Some indicators for pending separation included the victim had shared with friends or family their desire to leave the relationship; the victim had told the accused their plans to separate; the accused had begun moving out and/or searching for alternative residences, and/or changing the locks on the home. Over one-quarter of victims were separated from their accused at the time of the killing (27%; N=15). Relationship state was unknown for 13 percent of the victims (N=7). Given that that pending separation would not always be known or recorded, separation as a risk factor remains underestimated.

Figure 18. Relationship state in IPV-DH, Atlantic Canada, 2012-2022 (N=55)

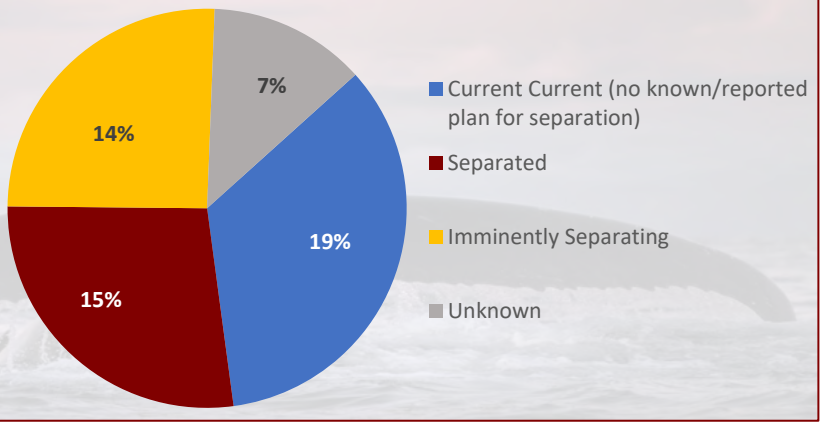
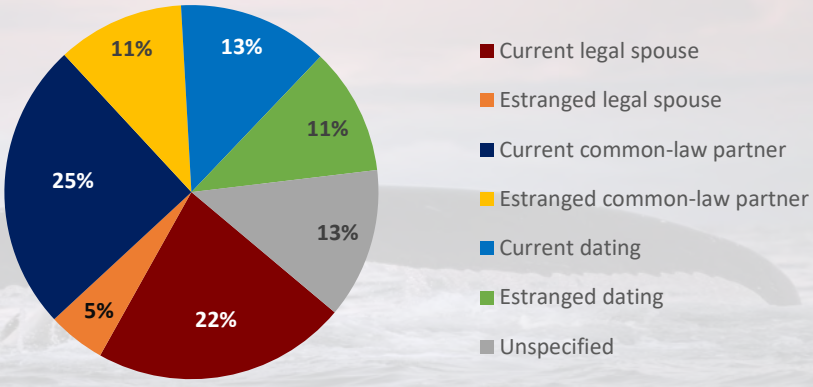


Figure 19 provides a breakdown of the distribution of both relationship status and relationship state for intimate partner IPV-DH victims (N=55) where this information was available (87% of the victims; N=48). The largest proportion of victims were killed by a current common-law partner (25%; N=14), followed by a current legal spouse (22%; N=12), a current dating partner (13%; N=7), a former dating partner (11%; N=6), and a former common-law partner (11%; N=6). The lowest proportion of intimate partners were killed by ex-legal spouses (divorced or separated, 5%; N=3). Seven victims shared an intimate partner relationship with the accused, but no further information was available (13%). The distribution of relationship state for IPV-DH victims in Atlantic Canada is in line with national trends (Dawson et al., 2021).

Figure 19. Distribution of relationship status and state for IPV-DH, Atlantic Canada, 2012-2022 (N=55)

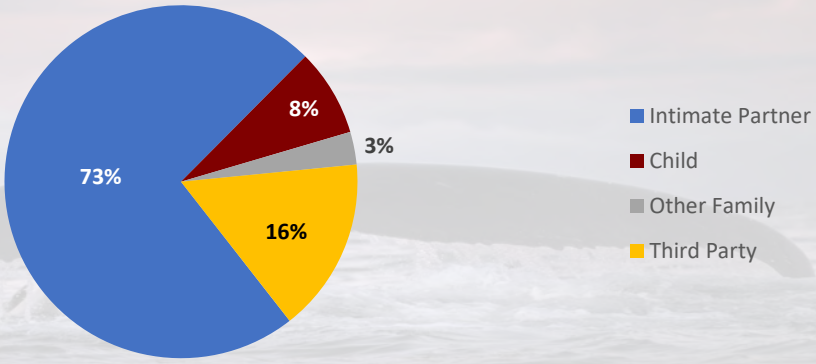


Source: Statistics Canada, 2021 Census, Table: 98-10-0127-01 released March 29, 2023.

Children and third-party victims also often killed in IPV-DHs

As shown in Figure 20, twelve victims were third parties killed in an incident related to IPV (16%). In addition, six IPV-DH victims were children killed by a parent[35] (8%): four victims (67%) were killed by their fathers and two victims (33%) were killed by their mothers. Another two victims were killed by a family member other than a parent (3%).

Figure 20. IPV-DH victim-accused relationship type, Atlantic Canada, 2012-2022 (N=75)



Children killed and left behind: Of the 75 IPV-DH victims, as shown in Figure 20, six victims (8%) were the child(ren) of the accused and/or victim. Of these victims, four (67%) were the biological children of the accused and two (33%) were stepchildren. Of those victims killed by a parent, two (33%) were killed by their biological mother, two (33%) were killed by their biological father, and two (33%) were killed by their stepfather. Three IPV-DH child victims were killed alongside their mothers.

Almost 100 children left without a parent from IPV-DH

For 87 percent of IPV-DH victims, we were able to determine whether they had children. Of these victims, 67 percent (N=44) were a parent and had at least one child. Focusing on this group specifically, 32 percent had one child (N=14), 34 percent had two children (N=15), 20 percent had three children (N=9), seven percent had four children (N=3), five percent had five children (N=2), and two percent had at least one child (N=1), but the exact number of children was not specified. This means that at least 94 children were left without their parent following their killing, and most often their mothers.

Other family members: Of the 75 IPV-DH victims identified as having been killed in Atlantic Canada during the study period, three percent (N=2) were other family members of the accused. One victim was the biological parent of the accused and one victim who was the adult child of the common-law partner of the accused. Both victims were killed by male accused.

Third parties: Of the 75 IPV-DH victims, 16 percent (N=12) were third parties killed as a result of IPV, excluding those listed above. Two-thirds of the victims (67%; N=8) were male third parties, such as new

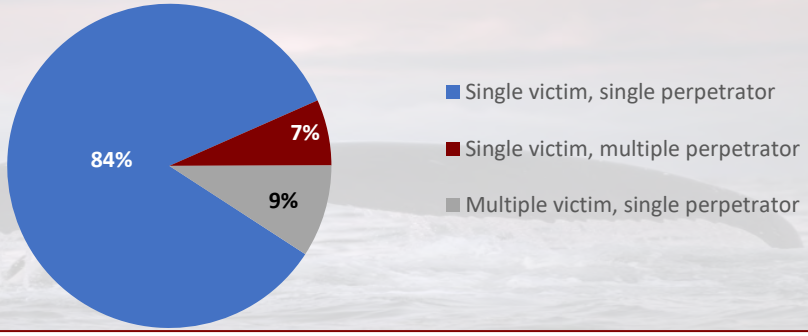
[35] The child category includes any victim of IPV-DH killed by their parent or step-parent, regardless of age.

partners of the victims. Two of the victims (N=17%) were friends of the accused or friends of the accused's intimate partner. Two of the victims (N=17%) were strangers killed in the context of IPV perpetrated by the accused.[36]

Most IPV-DHs involve single victims and single perpetrators

Figure 21 shows that, of the 75 IPV-DH victims, 84 percent involved single victims killed by a single accused (N=63). Nine percent of cases involved multiple victims killed in the same location at the same time by a single accused (N=7). For example, there were two cases in which two victims were killed by a single accused and one case in which three victims were killed by a single accused. Seven percent of victims were single victims killed by multiple perpetrators (N=5; 4 victims killed by two accused and one victim killed by three accused). Multiple perpetrators in these cases often involved additional perpetrators who became involved after the killing (e.g., helped to dispose of the body) by the primary perpetrator.

Figure 21. Distribution of multiple victim and single victim in IPV-DH, Atlantic Canada, 2012-2022 (N=75)



Familicide: Familicide, in which an accused kills multiple close family members in quick succession, including a combination of their children, spouses, parents, and/or grandparents, also occurred during the study period. Two cases of IPV-DHs were familicide. In these two cases, there were five victims of familicide and all familicide victims were killed by a male accused (100%; N=5).

When known, the majority of victims had reported prior IPV

Prior reports of intimate partner violence: As shown in Figure 22, information on whether the victim had previously reported intimate partner violence perpetrated by the accused was available for 45 percent (N=34) of the IPV-DH victims. Of these, the majority of victims (85%; N=29) had at one point reported at least one prior incident of intimate partner violence by the accused. Most were female victims killed by male accused (93%; N=27). The remaining seven percent (N=2) were male victims killed by female accused. When information on prior reporting of DV was available, victims of IPV-DH in Atlantic Canada were more likely to have reported past instances of IPV by the accused than victims of IPV-DH across Canada (85% vs 60% respectively; Conroy et al., 2019).

[36] For example, one accused assaulted his female partner and then drove his car into a stranger, killing him.

Separation and access to firearms most common risk factors for IPV-DH

A voluminous body of literature has documented various risk factors or red flags for IPV-DH, especially as it relates to female victims and male perpetrators (see e.g., Dawson, 2017; Devaney et al., 2021; Jaffe et al., 2020). Various tools or checklists have been adopted across different sectors to assess risk and safety for those involved. In the context of domestic violence death reviews, one such checklist was developed by the Office of the Chief Coroner of Ontario's Domestic Violence Death Review Committee which was incorporated into the coding instrument for this study. Below, Table 15 documents the proportion of IPV-DH cases for which each of the risk factors were identified as present in the files reviewed. As discussed in the *Study Limitations* section, these figures must be considered minimum estimates since the risk factor in question may not always have been known, reported, and/or recorded.

Actual or pending separation was one of the most commonly documented risk factors (38%) in the Atlantic region, although tied with access to firearms (38%). Victim vulnerability was documented in 34 percent of the cases which captures those victims who were living with a disability, language and/or cultural barriers, mental health and/or addiction issues, economic dependence, and/or living in rural or remote locations. Unemployment status of the accused (33%) and a history of domestic violence by the accused (29%) were the next most common risk factors. Accused mental illness or depression, as identified by family and friends, (28% and 26% respectively) and excessive alcohol/drug use by the accused (28%) were also among the top 10 risk factors identified. Victim and accused who were living common-law was also a common risk factor (26%) followed by three risk factors tied at 20 percent each, including stepchildren living in the home, accused had a medical diagnosis for depression, and accused had failed to comply in the past with authorities.

Underscoring that some risk factors may vary by regional context, when comparing the above distributions to the top 10 risk factors identified by the Ontario DVDRC (2003-2021), some similarities and differences were evident. For example, actual or pending separation was among the top two risk factors for both regions, however, access to firearms ranked much higher for Atlantic Canada (tied for top position) than for Ontario where access to or possession of firearms did not make the top 10 risk factors. In addition, a history of domestic violence by the accused was the top risk factor for Ontario and the fifth most commonly documented for the Atlantic Region. It should be noted that only one of the four provinces in the Atlantic region had a domestic violence death review initiative during the period of this

study whereas all of Ontario's findings are based on findings of death reviews which could produce these differences. As such, more systematic comparisons would be required in future research when both regions have data compiled by death reviews or a similar comprehensive initiative.

Table 15. *Risk Factor Documented, IPV-DH, Atlantic Canada, 2012-2022.*

Risk factors	% Cases with risk factor reported
Actual or pending separation	38%
Access to firearms	38%
Victim was in some way vulnerable	34%
Accused unemployed	33%
History of accused's domestic violence	29%
Accused had other mental illness- opinion of family/friends	29%
Excessive alcohol/drug use by accused	28%
Accused depressed- opinion of friends/family	26%
Victim/accused lived common law	26%
Accused depressed- diagnosed	20%
Stepchildren in home	20%
Failure to comply with authority	20%
Controlled victim's daily life	18%
Violence escalation	18%
History of accused's violence outside the family	16%
Accused's obsessive behaviour	16%
Accused displayed sexual jealousy	16%
Prior threat of suicide by accused	15%
Victim had intuitive fear of accused	13%
Accused had other mental illness- diagnosed	12%
Prior threats to kill victim	11%
Prior attempt to isolate victim	11%
Misogynistic attitude	11%
Age disparity of couple (9+ years)	11%
Prior destruction of victim property	9%
Prior suicide attempt by accused	8%
Prior child custody or access disputes	8%
Accused minimized spousal abuse history	8%
Prior threats with a weapon	5%
Threatened/harmed children	5%
Youth of couple (15-24)	5%
Choked victim in past	4%
Prior assault with a weapon	4%
Access to victim after risk assessment	3%
Prior sexual assault	3%
Prior threats to kill non-victim	3%
Prior violence against pets	1%
Prior hostage taking/forcible confinement	1%
Accused witnessed/exposed to suicidal behaviour from family of origin	1%
Prior assault of victim while they were pregnant	-

Most common prior contacts were with police

Some information on prior contacts with various agencies before the homicide was available for 73 percent of the victims (N=55) and/or their accused. Again, as noted above, these numbers are underestimations because they only represent what was recorded in the files reviewed. All service contacts may not have been documented or known. Keeping this in mind, Table 16 shows that the largest proportion of known prior agency contacts for victims and/or the accused was with police (23%; N=45), followed by the courts (10%; N=20), mental health providers (10%; N=20), health care providers (8%; N=16), and hospitals (8%; N=16). The latter three types of agency contacts, focused on health, collectively represent the highest proportion of service contacts (26%) where known. Other agencies identified as points of intervention are also noted in Table 16.

Table 16. *Intimate partner violence-related domestic homicide victims' and accused agency contacts in Atlantic Canada, 2012-2022 (N=75)* [37]

Agency Contacted	Number of Contacts by Victims	%	Number of Contacts by Accused	%	Number of Contacts by Both Victims and Accused	%
Police	14	25	31	22	45	23
Court and/or Judge	2	4	18	13	20	10
Mental Health Provider	5	9	15	11	20	10
Health Care Provider	10	18	6	4	16	8
Local Hospital	8	15	8	6	16	8
Probation	-	-	12	9	12	6
Mental Health Program	1	2	9	6	10	5
Substance Abuse Program	2	4	6	4	8	4
Family Court	3	5	5	4	8	4
Child Protection Services	3	5	5	4	8	4
Corrections	-	-	8	6	8	4
Parole	-	-	3	2	3	2
Anger Management Program	-	-	3	2	3	2
Marriage Counselling	1	2	3	2	4	2
Witness Assistance Program	1	2	1	1	2	1
School	1	2	1	1	2	1
Ambulance Services	1	2	1	1	2	1
Crown	1	2	1	1	2	1
Defense Counsel	-	-	2	1	2	1
Family Lawyer	-	-	1	1	1	<1
IPV Shelter/Safe House	1	2	-	-	1	<1
Sexual Assault Program	-	-	1	1	1	<1
Other IPV Victim Services	-	-	1	1	1	<1
Religious Community	1	2	-	-	1	<1
Total	55	100	141	100	196	100

[37] The categories are not mutually exclusive, meaning that the victim or the accused could have reached out to more than one agency and this is captured in Table 16.

Timing of service contacts varied from 1 year to over 1 year prior to IPV-DH

Information was available on the time frame of the service contact prior to the killings for 51 percent of victims and/or the accused who had contacted police (N=23), 75 percent who had contact with courts (N=15), 35 percent who had contacted mental health providers (N=7), 25 percent who had contacted health care providers (N=4), and 43 percent of those who had contact with a hospital (N=7). Focusing solely on this group where information was available, most victims and/or accused last previous service contact was more than one year before the killing (54%; N=30) whereas 25 percent had a service contact between one month and one year prior to death (N=14), and 21 percent had contact with services in the month prior to the homicide (N=12).

When information was known, 57 percent of victims and/or accused had prior police contact more than one year before the killing (N=13), 26 percent had police contact between one month and one year prior (N=6), and 17 percent had police contact in the past month (N=4). When information was known on prior court contact, two-thirds of victims and/or accused had contact more than one year ago (N=10), 27 percent had court contact between one month and one year prior (N=4), and seven percent had court contact within the past month (N=1).

Of the seven victims and/or accused with known mental health provider contact timing, 57 percent had contact with mental providers in the past month leading up to the killing (N=4), while 43 percent had contact more than one year prior (N=3). Fifty percent of victims and/or accused had contact with health care providers more than one year prior (N=2), 25 percent had contact between one month and one year prior (N=1), and 25 percent had contact within the past month (N=1). Where information was known for the victims and/or accused prior contact with local hospitals, 43 percent had prior contact between one month and one year prior to death (N=3), 29 percent had contact more than one year prior (N=2), and 29 percent had contact within the past month (N=2).

RESULTS – PART III: Other domestic and family violence-related homicide

This section examines other domestic and family violence-related homicides (or DFVH) for which there was no evidence that they were the result of intimate partner-related violence, at least according to the records reviewed. Below, we provide an overview of these killings (N=39), focusing on children and other family members separately.

Domestic and family violence-related homicides involving children

Table 17 shows that eight child victims were killed by their parents outside the context of intimate partner violence. Of these, three were newborns, four were infants aged 1 week to 1 year old, and one child was nine years old. Over half of the children were killed by their mothers (62.5%; N=5) and 37.5 percent were killed by their fathers (N=3). Specifically, three male children were killed by their fathers (37.5%), three male children were killed by their mothers (37.5%), and two female children were killed by their mothers (25%).

Table 17. *Victim and accused sex in DFVH involving child victims killed by a parent, Atlantic Canada, 2012-2022 (N=8).*

Victim and Accused Sex	Province								Total	%
	NB	%	NL	%	NS	%	PE	%		
Female victim-Female accused	-	-	-	-	-	-	2	50	2	25
Female victim-male accused	-	-	-	-	-	-	-	-	-	-
Male victim-male accused	-	-	1	100	2	67		-	3	37.5
Male victim-female accused	-	-	-	-	1	33	2	50	3	37.5
Total	-	-	1	100	3	100	4	100	8	100

Domestic/family violence-related homicides involving other family members

Table 18 describes 31 victims who were other family members killed by someone other than a parent (covered above). One male victim was killed by a female family member (3%). The remaining 30 victims were killed by a male family member (96%). Specifically, 15 female victims were killed by male family members (48%) and 15 male victims were killed by male family members (48%). Table 18 provides a further breakdown of victim and accused sex by province.

Table 18. *Victim and accused sex in DFVH involving other family members, Atlantic Canada, 2012-2022 (N=31).*

Victim and Accused Sex	Province								Total	%
	NB	%	NL	%	NS	%	PE	%		
Female victim-female accused	-	-	-	-	-	-	-	-	-	-
Female victim-male Accused	6	75	2	25	7	50	-	-	15	48
Male victim-male accused	2	25	6	75	6	43	1	100	15	48
Male victim-female accused	-	-	-	-	1	7	-	-	1	3
Total	8	100	8	100	14	100	1	100	31	100

Table 19 outlines in more detail the familial relationship of victims and accused in DFVHs. The most common relationship types were parents killed by their children (48%; N=15), followed by stepparents killed by stepchildren (10%; N=3), siblings (10%; N=3) and grandparents killed by grandchildren (10%; N=3).

Table 19. *Victim-accused relationship type in other family member DFVHs, Atlantic Canada, 2012-2022 (N=31).*

Relationship Type	Province								Total	%
	NB	%	NL	%	NS	%	PE	%		
Biological Parent	7	88	1	12	7	50	-	-	15	48
Stepparent	-	-	2	25	1	7	-	-	3	10
Sibling	-	-	2	25	1	7	-	-	3	10
Grandparent	-	-	1	12	2	14	-	-	3	10
Uncle	1	12	1	12	-	-	-	-	2	6
Cousin	-	-	-	-	1	7	1	100	2	6
Parent-In-Law	-	-	1	12	-	-	-	-	1	3
Child-In-Law	-	-	-	-	1	7	-	-	1	3
Other Kin[38]	-	-	-	-	1	7	-	-	1	3
Total	8	100	8	100	14	100	1	100	31	100

RESULTS – PART IV: Comparing Coroner/Medical Examiner & Public Data

CME and public databases were initially kept separate to allow for a comparison of the data collected from each source. A full set of results and discussion of this comparison is in Appendix D which are highlighted briefly here. The public database had more variables with information available for at least 50 percent of the victims compared to the CME database. The CME database had more information regarding the victim's date of birth, race, and drug use prior to death, as well as details on firearms used during the homicide and specific forms of violence present in the homicide. This was expected given the mandate of the CME offices. The public database had more information on victims' children, immigration/citizenship status, whether the accused committed suicide, dynamics of the victim-accused relationship, the accused's motive, any witnesses present, and criminal justice system outcomes. This was also expected given that information in the public database was tracked through to the culmination of the criminal justice process, where appropriate.

Each database has its strengths and weaknesses. The CME database includes details that are often not included in public documents, either due to confidentiality issues, an ongoing investigation, or a lack of interest from the public. However, CME data tends to be collected at a single point in time early in the investigation, limiting the information collected. If an accused is not identified until long after the CME office has completed their work, the CME files are unlikely to contain any accused, victim-accused relationship, or criminal justice system related information, which is outside their mandate for the most part. Conversely, the public database captures information collected as a case progresses rather than at a specific point in time, allowing new information to be added as it comes to light. However, it may be

[38] Other kin include grandchildren.

lacking in details that are not released to the public. [*Again, for a full set of results and discussion of this comparison, see Appendix D*.]

RESULTS – PART V: Comparative analysis of the New Brunswick CME database with the other CME databases

When comparing the CME database data completeness of Atlantic provinces with a DVDRC (NB) against provinces without a DVDRC (NL, NS, PE), it was found that provinces with a DVDRC tend to have more complete IPV-DH CME data than provinces without a DVDRC. This was the case across nearly all major variables related to the victim, the accused, the victim-accused relationship, the details of the homicide, the criminal justice system outcome, the service contacts preceding the homicide, and the risk factors preceding the homicide. The only major variable where NB had slightly less complete data than another province was Date of Homicide, where NB had data for 97% (N=33) of victims, whereas NS and PE had Date of Homicide data in 100% of cases (N=4 and N=25 respectively). [*For full results and discussion, see Appendix E*.]

PART VI – Discussions and Recommendations

Data matters to violence prevention. Intimate partner violence-related domestic homicides can be one of the most preventable types of homicide and good data is vital to its prevention. Intervention and prevention initiatives which build on incomplete or inaccurate data may be flawed because they are based on a partial – and possibly incorrect – picture of what has occurred. Significant data gaps remain when documenting these killings as documented by national and global research (Cullen et al., 2021; Giesbrecht et al., 2023; Troung et al., 2022). A key reason for these ongoing data gaps stems from the underlying rationale and goals of data collection by statistical, criminal justice, and other official agencies, whose efforts are not designed with research – or prevention – in mind (Dawson and Carrigan 2020). Rather, like Statistics Canada data, they are largely administrative in purpose and the types of data collected reflect these administrative goals and not those of research or prevention.

One exception to this situation may be domestic violence death review initiatives whose primary focus is largely the prevention of future similar deaths (Dawson, 2017; Toledo Vasquez, 2023). Data collected by these initiatives may provide the most complete information on IPV-DH, particularly those that end in the suicide of the accused, which are often not investigated as fully when there are no pending criminal justice proceedings. However, research shows that there is significant variability across these initiatives (Dawson,

2017, 2021; Sheehy, 2017; Toledo Vasquez, 2023), including how such homicides are defined and identified, the volume and type of materials reviewed across cases, the voices heard, and the stakeholders or experts represented at the review table (see also, Troung et al., 2022). Therefore, data collected will, and does, vary significantly across these initiatives which, in turn, impacts what is known and what will inform intervention and prevention in specific jurisdictions.

One key outcome of the difficulties of collecting even the most basic information on homicide is that our ability to understand risk and improve safety, particularly for marginalized and vulnerable populations, is hampered. For example, our ability to apply an intersectional lens to prevention is precluded because of the lack of data required to examine the combination of social identities (e.g., disability, race/ethnicity, sexual minority status, socio-economic status) that may increase a person's risk or safety at both the individual and structural levels. Consequently, differential group risk remains constant for many and, more worrisome, is that this is further exacerbated by our inability to understand the varying challenges and obstacles that particular groups face due to oppression, colonization, discrimination, sexism, racism, ableism, and so on (Toledo Vasquez, 2023).

This situation has the long-term and negative consequences of making some groups of victims (e.g., Indigenous or racialized, poor women, women living with disabilities) less visible than other groups of victims (e.g., white, urban, able-bodied, professional women). This is particularly pertinent in the era and aftermath of the COVID-19 pandemic because the pandemic has, in many cases, exacerbated existing inequities and illuminated more clearly these inequities, including experiences of violence. On the one hand, this makes issues of interpersonal and structural violence more difficult for members of the public, and particularly governments, to ignore. Yet it also underscores the critical need to have access to robust and timely data that continues to accurately represent who is made most vulnerable by dominant social structures and where prevention efforts have been ineffective or misguided, sometimes reinforcing existing structural oppressions and exclusions.

Given the above situation, the goals of the ADHRN to investigate in detail what information is currently known about IPV-DH and, more importantly, what is not known in one of the first regional reviews in Canada is a crucial and positive step forward. Below, building on the data collected as well as ongoing discussions with the ADHRN over the course of the past three years, a series of recommendations are outlined. While they are most relevant to the Atlantic region given this is the geographic site for this research, the recommendations and their implications have much broader and far-reaching impacts for all jurisdictions and stakeholders who are working to prevent intimate partner violence-related domestic homicides. The order of the recommendations does not denote importance of the recommendation; rather, they build on and complement one another and each are required for effective prevention of IPV-DH.

RECOMMENDATION #1:
Prioritize Prevention Data

The purpose of official data collection by CMEs and other similar organizations (e.g., Statistics Canada) be reconceptualized from the primarily administrative focus to prioritize the collection of Prevention Data which can inform the development of effective intervention and prevention initiatives.

In announcing the establishment of the ADHRN, the Council of Atlantic Premiers stated:

"*Domestic violence and domestic homicide are gendered crimes in which the majority of victims are women. Understanding the context in which domestic homicides occur in Atlantic Canada is critical to the development of preventative measures that are aligned with the region's unique culture. Reviewing these deaths recognizes that many are preventable and may require different system responses and community supports. Each province has its own unique systems for how to respond, prevent and learn from deaths when they occur*."

This study identified various gaps in what is known about IPV-DH which precludes adequately 'understanding the context' underscored above as necessary. For example, in order to determine if a homicide was, in fact, an IPV-DH, information on the victim-accused relationship is required. In this study, even when both CME and public data were combined, 21 percent of the victims were still missing information on their relationship with the accused; that is, information was not available for more than one in five victims of IPV-DH. This stemmed from an inability to find information in the files that identified their relationship or the fact that the accused had not yet been identified, according to the files reviewed. In addition, one key aspect of enhancing prevention – and Prevention Data – is to understand the various points of system or service contacts that occurred prior to the homicide. What were the key touch points for victims, accused, and families prior to the killing at which point risk may have been decreased or safety enhanced? As discussed, it is only possible to document these touch points if they are recorded consistently and routinely in the data collected. This requires a mandate to do so which can only be driven by political will. Until then, the frequency with which services were accessed, by whom, and when remain relatively unknown as shown in Table 16. In terms of Prevention Data, this is a significant gap in our knowledge precluding effective intervention in these cases.

It is recognized that conducting research is not the primary goal of many agencies that collect and hold these data but this recommendation asks us to consider the fact that it should be a primary goal. At the very least, these agencies have a collective interest in working together to prevent IPV-DH, including prioritizing the collection of Prevention Data. To achieve this goal, it will be necessary to examine the reasons for, and principles guiding, data collection and to build buy-in for collecting data that informs prevention. While facing their own challenges as discussed above, domestic violence death review initiatives have shown some positive outcomes in enhancing Prevention Data. These initiatives are the focus of the next recommendation.

RECOMMENDATION #2a:
Implement IPV-Related Death Reviews in All Provinces

All provinces must implement a domestic violence death review initiative to improve Prevention Data by better documenting the context in which these homicides occur.

Much research has discussed both the benefits and challenges of DVDRs (for review see, Dawson, 2017, 2021; Toledo Vasquez, 2023). While these mechanisms continue to evolve, there is no question that their focus is prevention, including the collection of Prevention Data, and the work of these reviews have significantly improved knowledge about IPV-DHs. One key way that they have done so is by identifying the key pieces of information that need to be collected in order to enhance prevention, drawing on decades of research which has examined just those questions (Devaney et al., 2021; Jaffe et al., 2020). Until this process is put into place, those responsible for collecting IPV-DH data must incorporate a flag in their general data collection system which identifies IPV-DHs when they occur which, in turn, automatically moves those collecting data to an electronic, pre-populated instrument where the necessary prevention data for IPV-DH is identified and gathered. In doing so, similar to those working in violence prevention fields overall, there must be supports put in place for those working as members of death reviews and similar types of spaces to recognize the role of vicarious trauma.

For example, the results of the comparison of data compiled from New Brunswick where such a review initiative is operating to CME data in the other three provinces. New Brunswick's database had significantly more information than the other provinces for all categories of variables, including general case details, victim and accused characteristics, including, relationship information, situational factors as well as criminal justice outcomes. This was expected given research on these initiatives; however, those with the power to make change need to see this clearly demonstrated in their own jurisdictions before it can drive home the need to make structural and cultural changes to how processes and practices have occurred for decades. The beginning of such change occurred during the course of this project when Nova Scotia implemented a domestic violence death review committee.

RECOMMENDATION #2b:
Address Data Gaps in IPV-Related Death Review Initiatives

Identify and address data gaps in provinces with domestic violence death review initiatives to improve Prevention Data by better documenting the context in which these homicides occur.

Where review processes are already operating, reflecting on what data remain elusive, but are important to effective prevention should be identified and strategies put into place to collect. This recommendation is supported by this report and other research that shows that the depth and quality of data can be improved significantly in jurisdictions with such review bodies. While DVDRs can improve the situation, and enhance prevention efforts, there remains room for improvement in all jurisdictions even with such initiatives. For example, how can such initiatives ensure that the provinces remain accountable to the recommendations made by these committees. In addition, two other factors often continue to impede prevention efforts, including those focused on data collection, from optimally achieving their goals. Nationally and globally relevant, these factors are addressed in the following two recommendations.

RECOMMENDATION #3:
Remove Obstacles to Data Sharing

Obstacles to data sharing must be identified and addressed so that issues of privacy and confidentiality across sectors do not preclude the collection of adequate Prevention Data.

The first two recommendations above emphasize the need to reorient the goal of data collection to prioritize a prevention focus – Prevention Data – and to implement initiatives whose mandate is exactly that – preventing future deaths by reviewing those which have already occurred to identify areas across systems in need of improvement. Even with DVDRs, however, the ability of either of these steps to be successful depends on data sharing across the multitude of sectors involved in responding to victims, perpetrators, and their families, both before and after an IPV-DH. The breadth of sectors includes, but may not be limited to, Child Protection, Victim Services, Mental Health and Addictions, Shelter systems, Community Organizations that support victims of GBV, Probation Services, Correctional Centres, Family Law and Court services (e.g., Maintenance Enforcement, Child Support, Parenting Programs, Family Court Assessors, Office of the Children's Lawyer, etc.), hospital settings, Chief Firearm Office, Indigenous Government offices.

This is necessary, not only to achieve the comprehensive data required to enhance prevention, but also because even with review initiatives in place, 'pieces of data' are housed in various systems responding to these crimes, which are not always accessible to those who need this information the most. Without those pieces, only a partial picture of the events leading up to the killing can be constructed and, consequently, only a partial and incomplete response to future, similar deaths. Issues surrounding data sharing may also be particularly relevant in the Atlantic Region where victims, perpetrators and/or families may move from one province to another, touching base with systems in different jurisdictions.

At times, data sharing is prevented by constraints that relate to privacy and confidentiality which is beyond the scope of this report, but arguably, can be addressed if avenues to do so were investigated and, more importantly, there was the will to do so by those involved in 'gatekeeping' such data. At times, however,

there are no such obstacles. In those situations, we need to ask why there is resistance to data sharing, where this resistance originates, and how it can be addressed.

For example, in the *Study Limitations* section of this report, it was noted that only CME data and publicly-available data were accessed for the current study. However, crucial prevention data could come from any number of sources or systems which are not always made public nor even part of the mandate of CME data collection. For example, an emerging issue in prevention research is the role of family court as a prior contact point for many cases of IPV-DH given the frequent breakdown of relationships and related child custody and access issues. If a review initiative is in place, it may be that these data are collected from family court, although that may not always be the case. If there is no review initiative, these data are often absent even though such data are available across systems, in both formal and/or informal ways. Therefore, it is also possible that family court data could be collected although the consistency of doing so would have to be examined further.

As stated in the introduction of this report, the Council of Atlantic Premiers stated that the ADHRN came together to "leverage regional expertise to analyze with a diversity lens aggregate data, policies and practices relevant to domestic homicide in the Atlantic Region and will make joint recommendations to provincial governments for system improvements." Similar to the memorandum signed to facilitate the ADHRN, memorandums of understanding could also be developed across sectors in the same jurisdiction to share data for the prevention of IPV-DH. The PDHAC project comprised collaborative, multi-sectoral partnerships with the involvement of departments of Justice, Public Safety, Health, Social and Family services, and Medical Examiner or Coroner services. These same individuals could develop a memorandum of understanding which could work to share data that would complement each other's data collection and prevention efforts.

For example, in Prince Edward Island, the Bridge Situation Table is a collaborative, risk-driven, intervention model that is based on situation tables/hub models used across the country. Prince Edward Island's approach is unique as there is only one Situation Table for the entire province. The Situation Table includes representatives from the three levels of government (i.e., federal, provincial and municipal), and non-government organizations with links across the province. All human service providers who sit at the table have entered into an Information Sharing Agreement which allows, through the 4 Filter Process, progressive information sharing for those deemed to be at Acutely Elevated Risk. In doing so, they have also added a flag to capture cases where there was suspected or confirmed IPV/DV.[39] If data sharing can be done here, it can be done in other situations as well. Governments could contribute by providing templates for data sharing. Privacy legislation is not new. Issues that prevent the sharing of crucial prevention data should have been addressed at this point in time. If they have not, we have to ask why that is the case?

[39] See: https://www.princeedwardisland.ca/sites/default/files/publications/bridgebrochure.pdf.

RECOMMENDATION #4:
Develop Sustainable Research Collaborations

Address obstacles to sustainable research collaborations, including as they relate to the availability and accessibility of prevention data.

It is recognized that the time and resources for many official agencies are committed to the mandates of their offices which are not typically focused on prevention research or the collection of Prevention Data. As such, collaborations with local and regional researchers would help to develop data collection practices which are sustainable over time, building historical and contemporary databases which can document trends and patterns, as well as emerging research and prevention priorities unique to particular provinces or the Atlantic region. Across the four provinces are established researchers and research institutions with which such collaborations could be developed. However, this requires institutional recognition that unused (and inaccessible) data, regardless of how comprehensive it is, will never contribute to violence prevention. Data can be used for a variety of purposes and to answer multiple research questions which requires time and resources. If data housed by various official bodies is made more accessible to researchers, the next generation of violence prevention researchers can be trained and equipped with the knowledge they need to continue develop Prevention Data that impacts the lives of those experiencing violence.

Before data were accessed for this research, separate research agreements were finalized and signed by representatives in each of the four provinces and the University of Guelph. During this period, the CSSLRV research team applied for and received research ethics approval from the University of Guelph in January 2023. In Newfoundland and Labrador, research ethics approval was also applied for and approved by the NL Health Research Ethics Board. Similar, more streamlined, processes can be followed to develop established, ongoing collaborations going forward given that researchers are also held to a high standard when it comes to research ethics, which includes privacy and confidentiality concerns. In doing so, a variety of approaches and research strengths can be secured which would allow for the value of all data to be recognized, as discussed next.

RECOMMENDATION #5:
Recognize the Value of All Prevention Data

The triangulation of all available data should be emphasized with both qualitative and quantitative data collected to provide for greater context surrounding IPV-DH.

Funders and policymakers use data to identify priorities for research, policy and practice. When data provide only a partial picture, as discussed above, the potential for research, policy and practice to be flawed, misguided, and even dangerous to those populations they were meant to help increases. As such, there have been greater efforts and demands for more and better data on IPV-DH in recent years – what we refer to as Prevention Data. It is arguably problematic, however, that the data being prioritized is more quantitative than qualitative given that both types of data are required to adequately answer any research question or to develop better prevention and intervention initiatives.

The data in this report also emphasized quantitative rather than qualitative data. However, it is recognized and underscored that this report is only the first step in moving the Atlantic region forward in developing

more effective responses to IPV-DH, including the building of Prevention Data. Aligning with the previous recommendations, next steps require identifying what data is needed, why it is needed, where and who is collecting and housing it, as well as how sustainable collaborations and data sharing can be built into future prevention efforts. This would include the recognition that qualitative data is also part of these files, often documenting the nuances that are lost when data is quantified and aggregated. Thus, innovative data collection strategies that, not only triangulate all possible data sources, but incorporate deeper and richer qualitative data, is required if we are to move from the emphasis on quantitative data, which often misses more information than it captures (Dawson and Carrigan, 2020), as documented in this study. Related to IPV-DH prevention, "the limits of a narrow view of data in relation to questions of gender (in)equality" are captured in Fuentes and Cookson's (2020) article on the 'gender data revolution' which calls for a valuing of all forms of knowledge. They state:

> While quantitative data about the scope and scale of women's experiences with poverty or violence are necessary…as it currently stands, qualitative renderings of gender inequality-and of women's experiences navigating the social and institutional manifestations of that inequality-exist at the peripheries of more privileged forms of knowing, such as statistical data sets (p. 898).

If Prevention Data is to be prioritized and developed, the recognition of both the individual and complementary approaches to data collection and analyses must occur, including the continuum of approaches across qualitative and quantitative methodologies. In doing so, the voices of those involved – whether it be victims, perpetrators, their families, first-responders, frontline service providers and so on – need to be part of that Prevention Data, as highlighted in the next recommendation.

RECOMMENDATION #6:
Incorporate the Knowledge of Family and Friends

The voices of surviving family members and friends of victims and/or accused of IPV-DH need to be considered when developing Prevention Data.

Family members and friends of those involved in IPV-DHs often hold valuable insight on the conditions leading up to an IPV-DH which cannot be captured using other data sources. This is because knowledge and expertise are often assumed to be held by those with credentials (e.g., PhDs), training and/or education related to a specific topic or issue (e.g., police, shelter workers). Therefore, the crucial information often held by those closest to victims, perpetrators, and their families can often be overlooked, especially with family and friends of those involved in IPV-DHs. Such individuals are often interviewed as witnesses by police immediately following the killing and/or prior to any criminal proceeding and they may even testify at trials. However, they are often not

viewed as data sources more broadly in understanding the lives of those involved in the killings whether it be those closest to the victims or the perpetrators. In addition, while it varies across review initiatives, many teams do not include the voices of family and friends in the review process for various reasons (see Mullane, 2017).

In the reconceptualization of data as preventative rather than merely administrative, a key question is what role can family members and friends play, if any, in enhancing what is known about IPV-DHs when they occur. This could entail reviewing the role of these groups in any of the domestic violence death review initiatives who incorporate these voices, including the pros and cons of doing so. For example, in the Domestic Homicide Reviews (DHRs) in the United Kingdom, families often play a significant role in reviews and are supported by an organization called Advocacy After Fatal Domestic Abuse (AAFDA) established and run by the brother of a woman and her son who were killed (Mullane, 2017). Understanding when and how family members and friends can contribute to future prevention of these deaths is crucial to recognizing the value of their voices if they wish to participate. Such considerations, however, must be trauma-informed to recognize that these individuals are also co-victims or living victims of these killings.

RECOMMENDATION #7:
Establish Clear Definitions for IPV-DH

It is crucial that clear definitional parameters and related criteria are established to determine the types of homicides to be examined, including the various types of IPV-DH.

To bring together the variations in definitions across the four provinces in this study, a definition was established for the PDHAC project as follows: *the killing of a current or former intimate partner, their child(ren) and/or other third parties, which is the result of violence between current or former intimate partners* (or IPV-DH). This distinguished IPV-DH from other domestic and family violence-related homicides (or DFVHs), which did not involve prior or current IPV. Even with these parameters clearly identified, it was not always straightforward whether a case adhered to the definition of IPV-DH; thus, transparency is also vital. For example, on April 18-19, 2020, a man killed 13 women and 9 men in Nova Scotia (Mass Casualty Commission, 2023). It has been documented that this mass killing event began with an incident of intimate partner violence in one location perpetrated by the accused against his female partner, who managed to narrowly escape death. This incident was followed by incidents in multiple locations with victims who were known and unknown by the perpetrator. For the purposes of this report, it was decided that even though IPV and GBV was clearly relevant to this case, these deaths did not fall within the parameters of the definition above. While others may argue that these deaths were IPV-DH, being transparent about the fact that we did not include it in IPV-DH here allows researchers to continue to discuss how IPV-DH is defined.

As definitions continue to evolve, it will become even more crucial to always be clear about the focus of prevention, its parameters, and related criteria or indicators. This will allow for more structured and transparent approaches to the collection of Prevention Data which increase reliability and validity. As discussed in the introductory section on research design, during past decades there have been shifts in the terminology used to capture what is commonly referred to as domestic homicide or IPV-DH as referred to in this report. These varying descriptive terms and the shifting language shape data collection and prevention efforts as well as our understandings of these forms of violence (Fairbairn et al., 2019). As

such, establishing clear definitional parameters as to the scope of homicides which are to be included in any Prevention Data is vital.

RECOMMENDATION #8:
Develop Prevention Data Collection Processes

Structured data collection processes and tools should be developed collaboratively across sectors, which will also allow for each province's unique needs.

In recent decades, data collection instruments capturing various forms of violence, including those stemming from intimate partner violence, have improved considerably, but much work remains for those who collect these data at the global, national, regional, and provincial/territorial levels. For the purpose of this project, a data collection instrument and coding manual were developed, drawing considerably on previous such tools from the Canadian context. However, such tools are often more of a wish list of desired information rather than what is actually available as documented in this study. Given this, and increasingly scarce resources, multi-sector discussions are recommended that can identify what Prevention Data needs to be collected, why, who and how, as noted above, with an emphasis on qualitative and quantitative data as discussed in Recommendation #5. These discussions can also allow for the unique needs of particular provinces or regions while also maintaining some consistency across regions for what is routinely collected and the processes in place to ensure this collection occurs. For example, some provinces in this study were more worried about small numbers that would allow for the identification of those involved in the cases whereas other provinces were not. In doing so, a checklist of information sources should be developed and data sharing practices developed that allow for these types of concerns to be addressed. While this may be inherent in domestic violence death review processes (and should be), it must be inherent in all systems which collect data that feed into the Prevention Data collection processes. In short, these data and their origins should be clear and accessible. For example, when police-conducted interview transcripts were included in files, the origin of case-related information was clear and was transparently communicated. This should be the norm across all data included for review.

RECOMMENDATION #9:
Prioritize Underserved and Underrepresented Communities

Develop mechanisms to capture data on underserved and underrepresented communities who are often made most marginalized by society and experience multiple axes of oppression and exclusion.

The concept of intersectionality is regularly used by researchers, policymakers, and others when discussing various social issues, including violence (Davis, 2008; Etherington and Baker, 2016). Intersectionality, in theory and in practice (Hill Collins and Bilge, 2026; Crenshaw, 1989, 1991), recognizes that victims, perpetrators and families experiencing violence cannot be viewed through a one-dimensional lens by focusing on single identities (e.g., as a woman, or an immigrant/refugee, or someone who lives in poverty) when determining how best to respond to their experiences of violence. Rather their identities need to be considered simultaneously (e.g., a poor, immigrant woman) to comprehensively assess risk and to understand how these identities might work together, not just separately, in compounding the level of risk and/or decreasing safety.

While a comprehensive review is beyond the scope of this report, the lens of intersectionality has been applied to Indigenous, Black, Asian, and other racialized populations, people living with disabilities, 2SLGBTQI+ populations, rural/remote/northern communities, immigrant and refugee populations and so on. Thus, it has moved far beyond the aim of its early application to address sex/gender, race and class, especially as it related to Black women. In line with its original intention, the concept of intersectionality is effectively demonstrated in the National Action Plan on Missing and Murdered Indigenous Women, Girls, and 2SLGBTQQIA+ people, with a particular emphasis on data collection on cases involving Indigenous victims and/or offenders (MMWIG Inquiry, 2019).

Despite the growing use and understanding of the importance of adopting this intersectional lens, it is not clear how it is actually being used and applied in practice, especially as it relates to data collection. In other words, have we asked how often and for whom have data collection practices addressed the issue of intersectionality and how was this achieved? One way to examine this question is by reviewing available information on each of these social identities which is necessary before we can examine their intersections. Focusing on IPV-DHs only, and drawing from both CME and public information, we can see that data was available for some, but certainly not all of these social identities. Beyond social class which is rarely available, data on sex of the victims and their accused was available for all cases and data on race was available for 83 percent of the victims, and 44 percent of the accused. Of the IPV-DH victims killed by intimate partners, five percent were killed by their male same-sex partner which is consistent with their representation in the total population (Jaffray, 2021).[40] Information on age was available for all victims and 95 percent of the accused. Immigration and citizenship status was available for 76 percent of the victims and 53 percent of the accused. Finally, information on disability status was available 12 percent of the victims of which 56 percent identified as living with a disability which is disproportionate to their representation in the total population (27%).[41] From this preliminary examination, data on these social identities is more often available for victims than perpetrators (e.g., race, immigration/citizenship status) and victims of IPV-DH living with disabilities are overrepresented in the Atlantic region. Concerted efforts to apply the intersectional lens to data collection processes and analysis can only improve what is known about the impact of overlapping identities and oppressions on experiences of violence. The benefit of doing so has been shown in research on geographic social identities and, more specifically, how living in urban and rural regions can impact one's victimization and perpetration experiences, discussed next.

RECOMMENDATION #10:
Prioritize addressing IPV-DH in rural regions

Rural populations are higher in Atlantic Canada compared to some other regions of Canada and, thus, require greater attention, including to the community and societal level contributors to IPV-DH.

Victims of IPV-DH, especially women and girls, living in rural, remote, and northern areas – non-urban regions – face a heightened risk of such violence in Canada and globally compared to their counterparts living in other, more urban areas. Familicides also occur more frequently in rural Canada, with typically see female partners as the primary target of male accused (Boyd et al., 2022; Gallup-Black, 2005). The findings of this report mirror these trends, showing that the majority of IPV-DH victims were killed in rural areas (57%) or small towns (32%) with only 12 percent of victims killed in an urban area. Since only 44

[40] No cases were identified that involved lesbian victims and perpetrators which suggests an undercounting of this population group which bears further examination.
[41] See *New Data on Disability in Canada, 2022* at: https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2023063-eng.htm.

percent of the Atlantic population lives in rural areas of the country, yet we recorded at least 57 percent of victims living in rural areas (not including small towns) in Atlantic Canada, our findings suggest that rural victims continue to be overrepresented compared to their representation in the overall population.[42,43]

Drawing from prior literature, several factors may explain why femicides are more common in non-urban areas of the country. Living in rural regions often involve greater physical and social isolation, greater access to firearms, and more precarious employment, all recognized contributors to intimate partner and family violence (Doherty, 2012; Doherty & Hornosty, 2008; Gallup-Black, 2005; Jeffrey et al., 2019). In fact, as shown in this report, although overall across the Atlantic Region, stabbings (36%) outpaced shootings (30%) in the method of killings for IPV-DH, the pattern was opposite in rural areas where 37 percent involved shootings and 28 percent involved stabbings. The research literature also demonstrates that rural women may be less likely to seek help and can experience community shame or stigma if they pursue a protective order against their abuser, and/or his gun relinquishment (Doherty, 2012; Doherty & Hornosty 2008; Lynch & Jackson 2018; Lynch & Logan 2018). Rural women may also experience barriers to help-seeking due to concerns about police response times, a lack of trust in the police to protect them, a fear of a lack of anonymity or confidentiality, a lack of reliable transportation, and a lack of follow-up from service providers (Kasdorff & Erb 2010; Doherty & Hornosty 2008). Though not exhaustive, these factors point to several challenges when reporting crime or in safety planning for rural women, which may allow violence to continue, escalate, and turn lethal.

These challenges experienced by rural women escaping violence have also been underscored by the Mass Casualty Commission[44] inquiry where the dynamics of rural living and gender-based violence were at the core of the public inquiry (MCC, 2023). Speaking at the inquiry, Dr. Karen Foster noted that the community closeness and social cohesion apparent in rural communities “has a double edge” where community members may minimize intimate partner violence to avoid the involvement of authorities (Armstrong, 2022).

Given that the Atlantic region has a higher proportion of the population living in rural regions, rurality as a community- and societal-level contributor to IPV-DH must be emphasized and examined further. In addition, variations in how rurality is defined within the Atlantic region and across Canada must be more frequently recognized and discussed. For example, do rural farming communities face the same risks or contributors to violence as rural areas dominated by forestry and mining industries.

[42] See: https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=CA,
[43] See: https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-x/2021002/98-200-x2021002-eng.cfm.
[44] See: https://www.publicsafety.gc.ca/cnt/cntrng-crm/plcng/2020-nsir-en.aspx.

RECOMMENDATION #11:
Address knowledge gaps about perpetrators of IPV-DH

The characteristics and role of perpetrators in IPV-DH is of significance so greater efforts to gather data on perpetrators, including motivations, is necessary.

Throughout the results described in this report, it is clear that we know more about victims than about the accused, including the dynamics of their relationships. This may be expected, as already discussed, given CME data are more focused on the victims than perpetrators. We need to ask, however, who holds the necessary data on perpetrators then? This question reflects the growing recognition of the significant gaps in perpetrator information which need to be addressed given they are one-half of the prevention equation. For example, in a global review of research on perpetrators, especially in cases of IPV-DH, Evans et al. (2023) underscored the paucity of data on perpetrators, and specifically their motivations. Specifically, they identified only 14 papers on the perspectives of male perpetrators of intimate partner femicide, spanning 11 countries. None were in Canada. While broader research on perpetrators of non-lethal intimate partner violence is available, it is important to distinguish what moves such individuals to perpetrate killings.

Other research has underscored how female-perpetrated IPV-DH is often a form of self-defence (Harden et al., 2019; Spencer and Stith, 2020) which is fundamentally different to the motives of male-perpetrated IPV-DH. Given such data was not available in the files reviewed, it was difficult to determine the role of self-defence in cases that involved female perpetrators. It is not expected that our sample would differ from others' research, however.

Overall, the global review underscores some priorities for this focus including: (1) more research on perpetrator engagement with formal social systems or structural factors; (2) better understanding the intergenerational and societal/social transmission of violence; (3) examining perpetrator rationalizations for their actions, including their sense-making and self-narratives (e.g., distancing themselves for the act, presenting themselves as victims); and (4) the need to understand contextual particularities without obscuring commonalities across settings, especially as this relates to community- and societal-level contributors to IPV-DH. Summarizing the importance of such a focus, Evans et al. write: "As perpetrators are the main drivers of femicide, information about their risk factors, motivations, and rationalisations is necessary for effective policy and programmatic intervention to prevent dangerous behaviours by men and actions to save women's lives (p. 551). Such efforts require sustainable collaborations (*see Recommendation #4*) as well as new and innovative approaches to data collection and research, discussed next.

RECOMMENDATION #12:
Develop innovative training on data collection for IPV-DH

Innovative practices and approaches to training need to be explored that will allow for the collection of Prevention Data to, first, improve the basic information collected and, second, to move beyond the almost exclusive focus on individual and relationship factors to community and societal contributors to IPV-DHs.

This report has demonstrated, similar to research in other countries, that even the most basic information on IPV-DH is difficult to capture in official or public sources. This means that a complete picture of events leading up to and surrounding such killings is largely unknown. Death review initiatives have begun to address these Prevention Data gaps; however, some data still remain elusive. As such, effective intervention and prevention will also remain elusive until these knowledge gaps are addressed. What data we do have largely focuses on individual and relationship factors which are necessary, but not sufficient, to understand these killings. Victims, perpetrators and their families cannot be separated from the communities and societies in which they live nor from how these communities and societies respond to their singular or combined social identities.

To achieve Prevention Data requires that we discuss how to incorporate community-level characteristics as well as societal attitudes and beliefs which may face victims, perpetrators, and/or families experiencing violence when seeking help or when thinking about whether they should do so. How do structural processes that are inherently sexist, racist, homophobic, transphobic and so on deter victims from seeking help? How do they further victimize some groups of victims, perpetrators, and their families when responding to their requests for help? The emphasis on individual and relational factors precludes the necessary attention to community and societal-level contributors. This provides only a partial picture of the violence, particularly for some groups who suffer various types of discrimination (UNODC, 2023). In Canada, as discussed above, such groups may be Indigenous or Black, living in rural regions, living with disabilities, migrants or refugees, or belong to sexual minority groups. Only by examining individual and relationship factors within the context of the communities and societies in which victims and perpetrators live will a complete picture be able to inform prevention.

RECOMMENDATION #13:
Enhancing professional/public education and awareness

Various organizations should consider taking a more public-facing role with the purpose of enhancing professional and public education and awareness.

Improving data and knowledge about IPV-DH is only the first step in effective prevention of IPV-DH. Prevention Data needs to be actioned. That is, communication needs to occur between stakeholders and broader audiences which work to increase education and awareness about IPV-DH which, in turn, can lead to social change through enactment of appropriate policies. While the findings in this report are one avenue for doing so, jurisdictions with domestic violence death reviews need to more actively communicate their findings and broaden awareness about what they are finding about risk factors and needed improvements for prevention. This cannot occur if those organizations largely responsible for collecting these Prevention Data do not take a more active role in doing so, either on their own or with researchers, policymakers, and organizations involved in the prevention of this form of violence. In fact,

many of the above recommendations depend on just that – more communication, cooperation and collaboration (Dawson, 2008) across all those sectors and groups who are actively working to prevent IPV-DH. In short, the goals are three-fold: (a) to expand public confidence and relationships with stakeholders, (b) to raise awareness of intimate partner violence-related domestic homicides, and (c) to enact policy change, particularly with reference to this report's findings and actionable recommendations.

RECOMMENDATION #14:
Identify key research/practice priorities to move forward

The ADHRN identify research and practice priorities moving forward to address data and knowledge gaps related to IPV-DH prevention.

Given the above 13 recommendations, the next steps for the ADHRN are clear and provide an opportunity to address key issues that have precluded adequate knowledge about the prevention of IPV-DH that plague, not only the other provinces and territories (Jaffe et al., 2020), but countries globally (Devaney et al, 2021). The ADHRN has taken its first step, by coming together as a region, to determine how they can address these killings in a more effective manner, recognizing that there are improvements to be made. This project allowed them to share knowledge and to enhance dialogue among the four provinces which provided them an opportunity to self-reflect on what they are doing well and what they need to improve. This provides the space to also think about next steps to address IPV-DH which is a preventable form of violence. In doing so, they systematically documented with available data what they know about IPV-DH in their region and what they need to know to more adequately help victims, perpetrators and their families.

In moving forward, to develop better responses which includes collecting Prevention Data (*Recommendation #1*), the ADHRN will need to assess if they have all the key stakeholders at the table, representing all sectors and organizations working to prevent IPV-DH, and have removed the obstacles to communication, cooperation, and collaboration (*Recommendations #2, #3, #4, #5, and #6*). This will also require being clear about what type of violence is being examined with the goal of prevention (*Recommendation #7*) and what types of data and data collection processes must be put in place to achieve Prevention Data (*Recommendation #8*). In doing so, it will be key to emphasize those groups who have remained largely invisible to date (*Recommendation #9 and #10*), including IPV-DH perpetrators on which little systematic attention has focused thus far (*Recommendation #11*). This cannot occur without attention to community- and societal level contributors to IPV-DH (*Recommendation #12*) and more public-facing work by the organizations with data and knowledge about IPV-DH (*Recommendation #13*) so there is crucial transfer of this knowledge to professionals and the public alike, including those directly living with such violence. This final recommendation recognizes these as the next steps for the ADHRN which can continue to move them ahead of other regions in addressing IPV-DH.

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APPENDIX A
ADHRN Membership

List of Membership for the Atlantic Domestic Homicide Review Network

New Brunswick

- ✓ Anne Arseneault, Department of Health
- ✓ Emily Caissy, Coroner Services, Department of Justice and Public Safety
- ✓ Jay Michaud, Women's Equality
- ✓ Martine Stewart, Women's Equality
- ✓ Sarah Gilliss, Justice and Public Safety

Newfoundland and Labrador

- ✓ Adam Fitzpatrick, Medical Examiner Office
- ✓ Joshua Cole, Families and Affordability
- ✓ Dr. Nebojsa Denic, Medical Examiner Office
- ✓ Shane Randell, Public Health

Nova Scotia

- ✓ Dr. Matthew Bowes, Medical Examiner Office
- ✓ Emily Schleihauf, Medical Examiner Office
- ✓ Meredith Naylor, NS Office of Status of Women
- ✓ Michelle Tomchuk, Medical Examiner Office
- ✓ Tracy Embrett, Department of Opportunities and Social Development
- ✓ Phong Vu Hong, NS Office of Status of Women

Prince Edward Island

- ✓ Dawn Wilson, Interministerial Women's Secretariat
- ✓ Denise Walsh-Lyle, Justice and Public Safety
- ✓ Jayelee Grady, Justice and Public Safety
- ✓ Michelle Harris-Genge, Interministerial Women's Secretariat
- ✓ Brandon Webber, Office of the Chief Coroner

APPENDIX B

Number and Rate of Homicides, Atlantic Canada, 1961-2022

Table 20: Homicide Numbers, Atlantic Provinces, 1961 – 2022

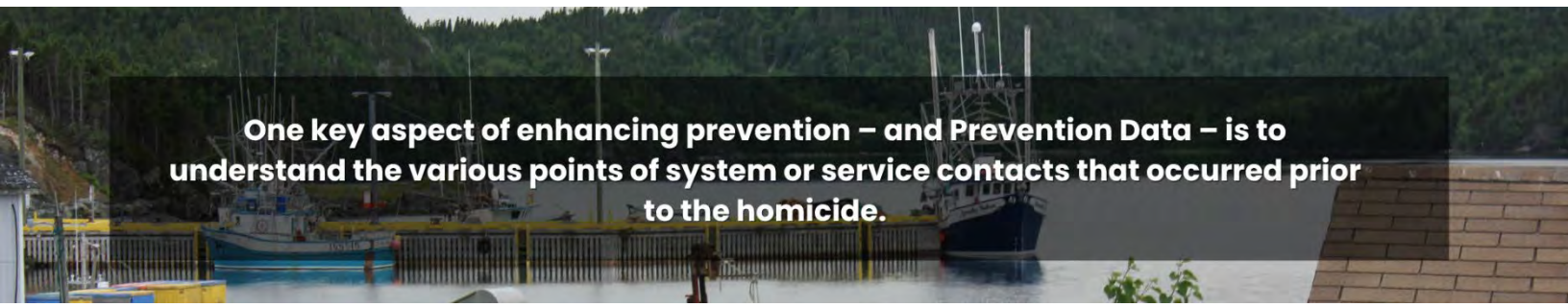
Year	Newfoundland and Labrador	Prince Edward Island	Nova Scotia	New Brunswick
1961	1	1	6	2
1962	0	1	10	8
1963	0	1	6	5
1964	5	0	13	5
1965	6	4	10	5
1966	3	1	9	6
1967	1	0	10	5
1968	5	0	9	5
1969	5	1	12	1
1970	1	1	15	8
1971	2	0	16	10
1972	2	2	14	11
1973	3	0	19	17
1974	3	2	8	21
1975	4	0	14	12
1976	6	2	25	14
1977	8	1	14	38
1978	9	4	13	27
1979	5	0	17	11
1980	3	1	12	9
1981	4	1	11	17
1982	6	0	12	12
1983	6	0	13	11
1984	6	0	15	14
1985	5	1	26	14
1986	4	0	15	12
1987	5	0	14	20
1988	7	1	11	8
1989	5	1	16	18
1990	0	1	9	12
1991	11	2	21	11

1992	2	0	21	11
1993	7	2	19	11
1994	4	1	19	15
1995	5	1	16	14
1996	7	1	18	9
1997	6	0	24	8
1998	7	0	24	5
1999	2	1	13	9
2000	6	3	15	10
2001	1	2	9	8
2002	2	1	9	9
2003	5	1	8	8
2004	2	0	13	7
2005	9	0	20	9
2006	7	1	16	7
2007	3	0	13	8
2008	5	5	12	3
2009	1	0	15	12
2010	4	0	21	9
2011	4	1	22	8
2012	3	0	17	6
2013	7	1	13	7
2014	2	3	6	9
2015	3	1	12	11
2016	7	0	13	11
2017	4	0	21	10
2018	2	0	11	13
2019	5	2	6	15
2020	4	1	35	14
2021	8	0	23	11
2022	3	0	19	15

Table 21: Homicide Rates, Atlantic Provinces, 1961 – 2022.

Year	Newfoundland and Labrador	Prince Edward Island	Nova Scotia	New Brunswick
1961	0.22	0.96	0.81	0.33
1962	0.00	0.93	1.38	1.32
1963	0.63	0.00	0.80	0.82
1964	1.04	0.00	1.72	0.82
1965	1.23	3.67	1.32	0.81
1966	0.61	0.92	1.19	0.97
1967	0.20	0.00	1.32	0.81
1968	0.99	0.00	1.32	0.81
1969	0.97	0.90	1.55	0.16
1970	0.19	0.91	1.92	1.28
1971	0.38	0.00	2.00	1.28
1972	0.37	1.76	1.74	1.69
1973	0.55	0.00	2.33	2.58
1974	0.54	1.72	0.98	3.15
1975	0.72	0.00	1.69	1.77
1976	1.06	1.68	2.99	2.02
1977	1.41	0.83	1.66	5.45
1978	1.58	3.28	1.54	3.85
1979	0.88	0.00	2.00	1.56
1980	0.52	0.81	1.40	1.27
1981	0.69	0.81	1.28	2.40
1982	1.04	0.00	1.39	1.83
1983	1.03	0.00	1.49	1.53
1984	1.03	0.00	1.71	1.94
1985	0.86	0.78	2.93	1.93
1986	0.69	0.00	1.68	1.65
1987	0.87	0.00	1.56	2.74
1988	1.21	0.77	1.22	1.09
1989	0.87	0.77	1.76	2.44
1990	0.00	0.76	0.99	1.62
1991	1.90	1.53	2.29	2.27
1992	0.34	0.00	2.27	1.46
1993	1.20	1.50	2.04	1.46
1994	0.69	0.74	2.03	1.98

1995	0.87	0.73	1.71	1.84
1996	1.25	0.74	1.93	1.20
1997	1.27	0.00	2.57	1.06
1998	1.30	0.74	2.58	0.67
1999	0.37	0.73	1.39	1.20
2000	1.14	2.20	1.61	1.33
2001	0.19	1.46	0.97	1.07
2002	0.38	0.73	0.96	1.20
2003	0.96	0.73	0.85	1.07
2004	0.39	0.00	1.49	0.93
2005	2.14	0.00	2.13	1.20
2006	1.37	0.73	1.71	0.94
2007	0.59	0.00	1.39	1.07
2008	0.98	1.44	1.28	0.40
2009	0.19	0.00	1.60	1.60
2010	0.77	0.00	2.23	1.20
2011	0.76	0.69	2.33	1.06
2012	0.57	0.00	1.80	0.79
2013	1.33	0.69	1.38	0.92
2014	0.38	2.08	0.64	1.45
2015	0.57	0.69	1.28	1.45
2016	1.32	0.00	1.38	1.44
2017	0.76	1.33	2.21	1.30
2018	0.38	0.00	1.15	1.69
2019	0.96	1.27	0.62	2.19
2020	0.77	0.62	3.77	1.79
2021	1.54	0.61	2.32	1.39
2022	0.57	0.00	1.86	1.85



APPENDIX C
Research Comparing Public and Official Data Sources

To track and describe various forms of homicide, including intimate partner violence-related domestic homicide (IPV-DH), researchers now commonly use publicly-accessible, digitized data sources such as court documents and media reports to document the initial incident, subsequent investigation and court processing of an accused if arrested. Additional information is often drawn from public court records when they become available upon the resolution of the criminal case. To collect data for the secondary database in the Preventing Domestic Homicide in Atlantic Canada (PDHAC) project, these data sources were also used given the increasing recognition of their legitimacy for some types of data, as described in more detail below.

With the growth of information technology, various data sources are now easier to access and retrieve, either for free or for a small, monthly subscription fee. Given increasing reliance on media sources, the quality of information documented in the media has been compared to information contained in official sources (e.g., those gathered by statistical agencies, police, etc.). Although this research has largely been conducted in the United States, similarities to the Canadian situation are likely.

This research has shown that:

1. Demographic information, such as the sex/gender and age of the victim and accused/perpetrator, is often reported accurately in newspapers, aligning with national database statistics (Heide & Boots, 2007; Parkin & Gruenewald, 2017).
2. Race/ethnicity can be more difficult to determine based on newspaper articles alone due to editorial restrictions or inherent biases on how and when race/ethnicity can be reported. However, when comparing information extracted from newspapers to official US statistics, one study showed that it was possible to correctly identify the race/ethnicity of the victim in 90 per cent of cases based on newspapers alone (Parkin & Gruenewald, 2017). The authors argued that one reason for this may be that official statistics do not record race/ethnicity if not easily available. It is also unlikely that police and other actors within various systems are trained to accurately record the race/ethnicity of those involved in homicides.
3. Information can also be found on education, employment, prior criminal record, and whether the victim and/or perpetrator had children, but this information may not be consistently reported. In fact, most news coverage only reports affirmative characteristics (e.g., whether the victim/perpetrator had a particular characteristic, such as a prior criminal record, children, etc. rather than whether they did not possess this characteristic). However, this is also typically the case with official statistics.
4. Newspapers were found to be more informative than official data in determining the victim perpetrator relationship. The relationship was specified in 80 percent of cases reported in the media compared to only 55 percent of cases included in official data (Parkin & Gruenewald, 2017).
5. Newspapers were also demonstrated to be useful for providing situational context. For example, information extracted exclusively from police files may not provide the bigger picture because information is not recorded for research purposes, but rather to fulfil organizational requirements (Shon & Lee, 2016). It is also often recorded early in the investigation and may not be updated following any relevant legal proceedings. Thus, a more complete picture of events may not be known at the time some official reports are generated. For example, the circumstances of the homicide may not be known early in the investigation, especially if no suspect has not been immediately identified, and the initial report may not be updated when the investigation has

concluded. This might be particularly problematic if the accused commit suicide following the homicide and no trial follows.

Newspapers, on the other hand, are more likely to report the social and contextual details of the homicide as the investigation unfolds to construct an interesting story for their audiences (Shon & Lee, 2016). Another study by Genovesi et al. (2010) found that newspaper articles provided more context on the homicide circumstances than what was noted in medical examiner files.

The exact location (e.g., address) and the type of location (e.g., residence, outdoors) is often reported consistently across news sources (Heide & Boots, 2007; Huff-Corzine et al., 2014; Parkin & Gruenewald, 2017). This is an advantage compared to official data in which exact location is rarely specified and instead is reported at the census level.

In summary, there is general agreement in the literature that newspapers identify just as much, or more, information about the circumstances surrounding a homicide than what is included in official data sources (Genovesi et al., 2010; Huff-Corzine et al., 2014; Parkin & Gruenewald, 2017; Shon & Lee, 2016). In addition, there were similarities between the two data sources in terms of the information and circumstances listed, highlighting a high level of agreement and, as a result, lending legitimacy to media/newspaper accounts.

While research examining the legitimacy of court documents was not available, it is likely that the situation is at least as good as media reports, and likely better, given that this is an official body that is constructing the events at a later point in time with various sources contributing to this construction (e.g., court actors, witnesses).

Some limitations were also noted, however, again drawing primarily from US research:

1. Certain homicides may not receive much (or any) coverage while other homicides are sensationalized (Parkin & Gruenewald, 2017; Salari & Sillito, 2016). For example, racialized homicide victims and accused/perpetrators residing in low socio-economic communities were less likely to receive media coverage (Parkin & Gruenewald, 2017). However, it is important to recognize that these limitations are drawn from US-based literature. It is possible that Canadian news outlets report on most homicides given their relative infrequency compared to US homicide rates; however, the level of detail will likely vary by the characteristics of the victim and accused and the region of the country. This has been documented in research on femicide, for example, where Indigenous women and girls and other racialized victims often do not receive the same amount of cover as Caucasian female victims.
2. Journalists typically rely on police sources and may not interview those who knew the victim/perpetrator personally or contact violence against women agencies who may have been working with the victim, accused and/or the family (Fairbairn & Dawson, 2013; Richards et al., 2014; Taylor, 2009). Therefore, the information shared by police may not be an accurate reflection of the interpersonal history of those involved, especially when there was a limited amount of police contact prior to the homicide (Taylor, 2009). However, this limitation may be corrected at a later point if the case proceeds through the criminal justice system where coverage would be more comprehensive as details emerge during the trial. This would not be the case, however, for those victims whose perpetrators died by suicide or who pleaded guilty and no trial occurred.

APPENDIX D
Comparing CME Data to Media & Court Data Sources

As discussed earlier in the report, the CME database and public database were kept separately initially to allow for a comparison of available information on the extent, patterns, and types of homicide in both databases. Specifically, the research team explored what variables had information for more than 50 percent of the victims of homicide, including IPV-DH victims, other domestic and family violence-related homicides (DFVH), and non-domestic homicides (non-DH). Using SPSS 30, missing data frequencies were tabulated for each variable in both databases. Below, the first set of results focuses on those variables for which the CME database had more information than the public database. The second set of results highlights the variables for which the public database had more information than the CME database.

Comparative Results – Part I: Strengths of CME data

Variables reaching the 50 percent threshold for information availability in the CME database are listed in Table 22 with the proportion of data available for the same variables in the public database. Compared to the public database, the CME database had more information available on the person who discovered the victim or reported the homicide (56% versus 36%), the victim's date of birth (53% versus 38%), the victim's ethnicity (70% versus 33%), and the victim's use of substances at the time of their death (67% versus 22%). The CME database was also more likely to have information available on the address at which the homicide occurred.

Also shown in Table 22, the CME database had more complete data across situational variables, including firearms, evidence of mutilation, and disposal of the victim's body. First, with respect to firearms, the CME database had more information on the owner of the gun used to commit the homicide (63%) than the public database (44%). Information regarding the legality of gun acquisition (whether the accused had a Possession and Acquisition License and/or the gun was registered if it was restricted) was also more available in the CME database compared to the public database (62% versus 43% respectively). The CME database also contained a higher percentage of data available regarding previous requests for gun destruction or surrender (59%) compared to the public database (41%). Second, the CME database provided more comprehensive information on whether mutilation occurred during the homicide, with the majority of records containing relevant data (61% versus 22% in public database). Third, there was also significantly more information regarding the disposal of the bodies in public spaces in the CME database compared to the public database (94% versus 37%).

Table 22. Comparative analysis of variables reaching 50% threshold for information in the CME database compared to available information in the public database (N=384).

Variables	% Data for CME Database	% Data for Public Database
General case variables		
The person who discovered/reported victim's death	56%	36%
Victim variables		
Victim date of birth	53%	38%
Victim race/ethnic group	70%	33%
Victim used drugs/alcohol at time of death	67%	22%
Situational variables		
Address of crime scene	63%	37%
Postal code of crime scene	65%	38%
Who owned the gun?	63%	44%
Was the gun acquired legally?	62%	43%
Previous requests for gun to be destroyed/surrendered	59%	41%
Did a court ever order gun destroyed/surrendered?	59%	39%
Mutilation during the homicide	61%	22%
Body disposed of in public space	94%	37%

Comparative Results – Part II: Strengths of public database

In this section, the variables reaching the 50 percent threshold for information availability in the public database are listed with the corresponding proportion of available information in the CME database. The public database had more information for the majority of victim variables, accused variables, victim-accused relationship, violence-related variables, criminal legal system, and risk factors and service contacts. A partial, but not complete, explanation for this difference is that the public data were collected on an ongoing basis as the homicide progressed through the criminal justice system (if the accused did not die by suicide) and more information emerged. This would not have been the case for CME data.

Victim variables

Table 23 outlines the victim variables which reached the 50 percent threshold for information in the public database. The public database had more comprehensive demographic data than CME data, such as victim's country of birth (55% versus 24%), number of years in Canada (54% versus 22%), residency status (56% versus 24%), and migrant group membership (54% versus 6%). Information regarding the victim's children was also more available in the public database, including more data on the number of victim's children (76% versus 27%), whether their children were present in the home at the time of the homicide (64% versus 29%), witnessed the homicide (64% versus 28%), were injured (70% versus 30%), or were killed (80% versus 36%) during the homicide of their parent. The public database also offered a more thorough record of additional non-fatal victims than the CME database (63% versus 44%).

Table 23. Victim-focused variables reaching the 50% threshold for information in the public database versus the CME database (N=384).

Variables	% Data For CME Database	% Data For Public Database
Victim-focused variables		
Number of victim's children	27%	76%
Was the victim's child present?	29%	64%
Was the victim's child also killed?	36%	80%
Did the victim's child witness their killing?	28%	64%
Was the victim's child injured?	30%	70%
Victim country of birth	24%	55%
Victim number of years residing in Canada	22%	54%
Victim residency status	24%	56%
Victim belonged to a migrant group	6%	54%
Non-fatal victims injured	45%	73%

Accused variables

For accused variables, the public database also provided better documentation of specific characteristics of the accused than the CME database (see Table 24). First, the age of the accused was more often available in the public database (81% versus 19%). Second, there was greater data completeness in the public database for accused suicide-related variables, including the accused's suicide attempts (86% versus 22%), time of committed/attempted suicide (86% versus 24%), suicide or attempted suicide method (86% versus 20%), suicide plans (77% versus 13%), whether suicide was in custody (75% versus 14%), or whether a suicide note was left by the accused (75% versus 14%). Third, there was more data available on whether the accused was injured by another person (57% versus 31%) and by whom (57% versus 29%).

This was expected since the CME data are more victim-focused and because CME files may be prepared before the accused is officially tried or charged in court and some of details of the accused may emerge in later stages of court proceedings. It does beg the question, however, that if CME data does not capture accused information than what organization/agency does collect such data for the purposes of prevention which is an issue discussed in the final section of the report.

Table 24. Accused variables reaching the 50% threshold for information in the public database versus available information in the CME database (N=384).

Variables	% Data for CME Database	% Data For Public Database
Accused variables		
Accused age	19%	81%
Did the accused commit/attempt suicide?	22%	86%
Time of committed/attempted suicide	24%	86%
Method of suicide	20%	86%
Method of attempted suicide	22%	86%
Was suicide part of accused's plan?	13%	77%
Was the suicide/attempt done in custody?	21%	86%
Was suicide note left by the accused?	14%	75%
Was the accused injured by others in homicide?	31%	57%
Who injured the accused?	29%	57%

Victim-accused relationship variables

The public database provided more comprehensive information on victim-accused relationship compared to the CME database (see Table 25). For example, most public records better indicated whether the homicide was intimate partner violence-related (78% versus 39%) or family-related (76% versus 37%). There was more public data on whether the relationship was current or estranged, whether the victim declined attempts to establish a relationship, the total length of their relationship, length of separation, and length of time divorced. In contrast, the CME database had clear data gaps, especially in documenting whether the relationship was current and the length of the relationship.

There was also more information in the public database than the CME database on other variables related to separation/estrangement, such as whether separation was imminent (71% versus 33%), whether the victim had a new intimate partner (68% versus 31%), whether there was a history of separations in the relationship (67% versus 31%), and prior attempts by the victim to leave the relationship (70% versus 32%). The public database also better documented the presence of stepchildren, presence of the couple's biological children, and disputes related to the custody agreement.

Table 25. Victim-accused relationship variables reaching the 50% threshold for information in the public database versus the CME database (N=384).

Variables	% Data for CME Database	% Data for Public Database
Victim-accused relationship variables		
Was it an intimate partner homicide?	39%	78%
Was it a family-related homicide?	37%	76%
Intimate partner relationship was current/estranged	36%	77%
Victim declined attempts to establish relationship	31%	57%
Length of relationship	33%	70%
Time separated	33%	74%
Time divorced	34%	76%
Was a separation imminent?	34%	71%
Evidence that a separation was imminent	33%	71%
Did the victim have a new intimate partner?	31%	68%
History of separation	31%	67%
How many previous separation(s)?	29%	67%
Did the victim try to leave?	32%	70%
Victim's steps taken to leave	27%	70%
Stepchildren present in the home	33%	74%
Accused and victim had children	35%	74%
Number of victim and accused's children	34%	74%
Child custody	33%	73%
Who had physical custody of children?	33%	74%
Type of child custody agreement	33%	73%
Problems related to child custody	25%	61%
The killing of a child by a parent	44%	97%

Situational variables

Table 26 shows the situational variables that were more available in the public database compared to the CME database. There was much more information about primary and secondary motives in the public

records compared to CME records (63% versus 32%). This is expected, considering that motivations are an important element of the criminal justice process and may not be the focus of CME investigations. The public database also recorded more witness information (55% versus 35%), and whether any witnesses tried to intervene in the homicide (55% versus 31%).

Table 26. Situational-focused variables reaching 50% threshold for information in public database versus CME database (N=384).

Variables	% Data for CME Database	% Data for Public Database
Situational-focused variables		
Room in dwelling where the victim was found	38%	52%
Primary motive for the killing	32%	63%
Secondary motive for the killing	32%	61%
Circumstances of homicide	32%	67%
Homicide incident type (i.e., multiple homicide)	21%	100%
Witnesses to the crime?	35%	55%
Did any witnesses intervene?	31%	55%

Criminal justice variables

It was expected that the public records would have more information on criminal justice outcomes (which often included court documents) than the CME records, given the latter are more focused on determining cause of death early in the investigation. This proved to be the case. The public database was more likely to have data available for the following variables: arrest date, arrest time, arrest location, primary criminal charge, whether the charge was first degree murder, the number of charges, any plea by the accused, type of trial (if any), primary conviction, number of convictions, and length of sentence (see Table 27).

Table 27. Criminal justice variables reaching 50% threshold for information in public database versus CME database (N=384).

Variables	% Data for CME Database	% Data for Public Database
Criminal justice variables		
Date accused was arrested	19%	60%
Amount of time between crime and arrest	21%	82%
Did accused remain at the scene?	40%	87%
Primary charge	37%	100%
Was the primary charge murder?	36%	86%
Was the murder charge first degree?	33%	85%
Were there multiple charges?	23%	86%
Other charges	23%	85%
How many total charges?	16%	86%
Accused plea	21%	65%
Type of trial	23%	72%
Primary conviction	26%	71%
Number of convictions	23%	71%
Additional convictions	23%	71%
Sentence type	24%	69%
Sentence length	24%	69%

APPENDIX E
Comparing Jurisdictions With and Without DVDRCs

Background

In addition to comparing the CME database with the public database, information available in each of the provincial CME databases was also examined to determine the extent, patterns, and types of missing data across the four provinces. Initial results demonstrated that New Brunswick CME data sources had more available data than the other provinces. In large part, this can likely be attributed to the fact that New Brunswick has a Domestic Violence Death Review Committee and while the other Atlantic provinces did not have such a committee at the time of data collection. Missing data frequencies were tabulated for each variable in all provincial CME databases. Below, the results focus on variables in which the New Brunswick CME database had significantly more information for IPV-DH victims than Newfoundland and Labrador, Prince Edward Island, and Nova Scotia.

Results

New Brunswick's CME database stood out in terms of data completeness for several key variables, when compared to the CME database for Newfoundland-Labrador, Prince Edward Island, and Nova Scotia (see Table 28). First, New Brunswick's database had significantly more information than the other provinces in documenting the following general case details: the time of the homicide (55% versus 9%), who reported the homicide (97% versus 58%), whether the homicide was reported by another victim (100% versus 58%), and whether the homicide was reported by whomever found the victim (100% versus 58%).

Table 28. General case variable information availability for IPV-DH victims in New Brunswick's CME database compared to the other Atlantic province's CME databases (N=75).

Variables	% NB Victims (N=33)	% NL Victims (N=14)	% PE Victims (N=3)	% NS Victims (N=25)	% NL, PE, and NS Victims (N=43)
General case variables					
Date of homicide	97%	93%	100%	100%	98%
Official date of death	100%	100%	100%	100%	100%
Military time of homicide	55%	14%	-	8%	9%
Time category of homicide	70%	57%	-	36%	40%
Date homicide reported	100%	79%	33%	72%	70%
Time homicide reported	82%	71%	-	28%	40%
Who reported the homicide?	97%	71%	33%	56%	58%
Homicide reported by another victim?	100%	71%	33%	56%	58%
Homicide reported by perpetrator?	88%	71%	33%	52%	56%
Homicide reported by person who found the victim?	100%	71%	33%	56%	58%

Victim variables:

New Brunswick also had more IPV-DH victim-focused information for most variables when compared to the other provincial CME databases, as shown in Table 29. For example, the victim's residency status was documented for 70 percent of NB victims, compared to 9 percent of victims in the other provinces. New Brunswick files also typically had slightly more information on the victim's country of birth, years living in Canada, and membership in a migrant group. Second, New Brunswick often had more information on the victim's children, such as whether they were present, injured or witnessed in the killing. Third, New Brunswick had more information related to the victim's mental and physical health compared to the other provinces. For example, the victim's mental health treatment history, the victim's mental health-related medication prescriptions, and the victim's disability status, were more often documented in New Brunswick database compared to the other provinces. New Brunswick was the only province to have information on the victim's history of counselling.

Table 29. Victim variable information availability for IPV-DH victims in the New Brunswick CME database compared to the other Atlantic provinces' CME databases (N=75).

Variables	% NB Victims (N=33)	% NL Victims (N=14)	% PE Victims (N=3)	% NS Victims (N=25)	% NL PE, NS Victims (N=43)
Victim-focused					
Total number of victim's children	52%	36%	-	40%	35%
Was the child present?	61%	36%	33%	40%	40%
Did the child witness the homicide?	61%	36%	33%	36%	37%
Was the child injured?	61%	36%	33%	40%	40%
Country of birth	55%	36%	-	-	12%
Years in Canada	52%	29%	-	-	9%
Residency status	70%	29%	-	-	9%
Belonged to migrant group	30%	7%	-	-	2%
Counseling history	18%	-	-	-	-
Mental illness treatment history	27%	14%	-	-	5%
Medication prescribed when killed	24%	7%	-	-	2%
Disability status	21%	-	-	4%	2%

Accused variables:

Table 30 outlines that for many accused-focused variables, New Brunswick had a higher proportion of data than the other provinces. First, New Brunswick had more information on the employment status of the accused (67% versus 9%), employment type (64% versus 9%), and the residency status of the accused (39% versus 5%). Second, New Brunswick was the only province to report on the criminal arrest record of the accused (27%) and criminal conviction, if any (21%). Third, New Brunswick had more information on the accused's health history, with more data available on the history of substance abuse (52% versus 5%) and disability status (21% versus 0%) than other provinces. New Brunswick was also the only province with files that discussed the counselling history of the accused (15%).

Table 30. Accused variable information availability for IPV-DH victims in the New Brunswick CME database compared to the other Atlantic provinces' CME databases (N=75).

Variables	% NB Victims (N=33)	% NL Victims (N=14)	% PE Victims (N=3)	% NS Victims (N=25)	% NL, PE, NS Victims (N=43)
Accused-focused					
Date of birth	45%	21%	-	12%	14%
Employment status	67%	21%	-	4%	9%
Employment type	64%	14%	-	4%	7%
Residency status	39%	14%	-	-	5%
Criminal record	27%	-	-	-	-
Criminal conviction record	21%	-	-	-	-
List of multiple criminal charges	18%	-	-	-	-
Counselling history	15%	-	-	-	-
Disability status	21%	-	-	-	-
History of substance abuse	52%	14%	-	-	5%

Victim-accused relationship variables:

The New Brunswick CME files contained more detail on the relationship between the victim and the accused compared to the other provinces (see Table 31). For example, New Brunswick had information on the whether the accused had children from a previous relationship (45%) while the other provinces had a combined availability of data for five percent of the victims. The remaining variables focusing on previous domestic violence within the relationship were also better documented in New Brunswick as follows: prior threats made against the victim (30% versus 0%), protection or restraining orders in place (33% versus 0%), prior domestic violence in the relationship (52% versus 7%), the type of violence in their relationship (48% versus 7%), police intervention in the relationship (39% versus 5%), whom the domestic violence was reported to (42% versus 5%), and the type of escalating violence against the victim (45% versus 2%).

Table 31. Victim-accused relationship variable information availability for IPV-DH victims in the New Brunswick CME database compared to the other Atlantic provinces' CME databases (N=75).

Variables	% NB victims (N=33)	% NL victims (N=14)	% PE victims (N=3)	% NS victims (N=25)	% NL, PE, NS victims (N=43)
Victim-accused relationship					
Accused had child from previous relationship	45%	7%	-	4%	5%
Prior violence against victim	36%	21%	-	-	7%
Prior threats towards victim	30%	-	-	-	-
History of violence against victim	39%	21%	-	-	7%
Gender/sex-based domination in relationship	21%	-	-	-	-
Accused oppressed victim's sexual liberty	18%	-	-	-	-
Protection/restraining order in place	33%	-	-	-	-
Prior domestic violence in relationship	52%	21%	-	-	7%
Type of violence in prior domestic violence	48%	21%	-	-	7%
List of multiple violence types	30%	14%	-	-	5%
Prior police intervention in relationship	39%	14%	-	-	5%
Prior domestic violence reported	42%	14%	-	-	5%
Victim was historically the accused	30%	7%	-	-	2%
Prior violence by victim against accused	21%	7%	-	-	2%
Prior threat by victim against accused	21%	-	-	-	-
Type of escalating violence	45%	7%	-	-	2%
Victim had access to a phone	15%	-	-	-	-

Situational variables:

Table 32 outlines the few variables related to the killing where the New Brunswick CME database contained more information than the other CME databases. New Brunswick had more information on whether the killing was related to gang activity or had multiple accused (76% versus 26%), whether the killing was due to cultural practices (i.e., honour killings; 42% versus 12%), and whether the accused stalked the victim prior to the killing (30% versus 7%). Nova Scotia and Newfoundland and Labrador did have information for some of these variables, albeit to a lesser degree.

Table 32. Situational-focused variable information availability for IPV-DH victims in New Brunswick's CME database compared to the other Atlantic province's CME databases (N=75).

Variables	% NB victims (N=33)	% NL victims (N=14)	% PE victims (N=3)	% NS victims (N=25)	% NL, PE, NS victims (N=43)
Situational-focused					
Street number	94%	71%	33%	60%	60%
Postal code	94%	71%	33%	60%	60%
Killing was due to cultural practices/rituals	42%	-	-	20%	12%
Killing related to gangs, multiple accused	76%	-	-	44%	26%
Accused had stalked the victim	30%	7%	-	-	2%

Criminal justice variables:

Table 33 shows the variables for which New Brunswick had more information related to the criminal justice process when compared to the other provinces. As noted in the above section, many CME databases are missing information on the criminal justice process because their investigations are not typically updated as the accused undergoes the criminal justice trial process.

Table 33. Criminal justice variable information availability for IPV-DH victims in New Brunswick's CME database compared to the other Atlantic province's CME databases (N=75).

Variables	% NB victims (N=33)	% NL victims (N=14)	% PE victims (N=3)	% NS victims (N=25)	% NL, PE, NS victims (N=43)
Criminal justice variables					
Arrest date	33%	21%	-	12%	14%
Accused confessed	42%	-	-	16%	9%
Date sentence imposed	18%	-	-	-	-

Risk factors and service contact variables:

New Brunswick has more information on risk factors and service contacts than the other Atlantic provinces. Three risk factors for IPV-DH which had the largest differences were whether the perpetrator was unemployed (58% versus 0%), whether there were stepchildren in the home (55% versus 0%), and the youth of the couple (both between 15 and 24 years old) (70% versus 0%). New Brunswick also typically had more information on other IPV-DH risk factors such as prior attempts by the accused to isolate the victim, the accused controlling the victim's daily life (i.e., coercive controlling behaviours), the accused's prior destruction of the victim's property or violence against pets, the escalation of violence, previous threats/harm towards the couples' children, the accused's misogynistic attitudes, and whether the victim had an intuitive fear of the accused (see Table 34). There was one variable related to service contacts with a large difference between New Brunswick and the remaining Atlantic provinces: health care provider involvement (30% versus 0%).

In summary, for the vast majority of variables in the CME databases, New Brunswick had more comprehensive information compared to other provinces, often by a wide margin. However, across all four provinces, there were only a few variables for which the 50 percent threshold was reached, indicating overall issues with consistent available prevention data. The more consistent data available for New Brunswick offers valuable insights into the victim's background and circumstances leading up to the homicide, which may be attributable to the existence of the Domestic Violence Death Review Committee.

Table 34. Risk factor and service contacts variable information availability for IPV-DH victims in New Brunswick's CME database compared to the other Atlantic provinces' CME databases (N=75).

Variables	% NB victims (N=33)	% NL victims (N=14)	% PE victims (N=3)	% NS victims (N=25)	% NL, PE, NS victims (N=43)
Risk factors and service contacts					
Police involvement	36%	21%	-	-	7%
Court/judge involvement	18%	7%	-	-	2%
Probation involvement	15%	-	-	-	-
Mental health program involvement	15%	-	-	-	-
Health care provider involvement	30%	-	-	-	-
Outcome of health care provider contact	21%	-	-	-	-
Risk assessment done	24%	-	-	-	-
Who completed risk assessment?	24%	-	-	-	-
Risk assessment outcome	24%	-	-	-	-
Action after risk assessment	24%	-	-	-	-
History of accused's violence outside the family	30%	-	-	-	-
Prior threats to kill victim	24%	-	-	-	-
Prior threats to kill non-victim	18%	-	-	-	-
Prior threats with a weapon	21%	-	-	-	-
Prior assault with a weapon	24%	-	-	-	-
Prior threat of suicide by perpetrator	21%	-	-	-	-
Prior attempt to isolate victim	39%	-	-	-	-
Controlled victim's daily life	36%	7%	-	-	2%
Prior hostage taking/forcible confinement	24%	-	-	-	-
Prior sexual assault	24%	-	-	-	-
Prior destruction of victim property	33%	-	-	-	-
Prior violence against pets	33%	-	-	-	-
Choked victim in past	24%	-	-	-	-
Violence escalation	39%	-	-	-	-
Perpetrator's obsessive behaviour	24%	-	-	-	-
Perpetrator unemployed	58%	-	-	-	-
Victim/perpetrator lived common law	67%	14%	66%	-	9%
Stepchildren in home	55%	-	-	-	-
Minimize spousal abuse history	30%	-	-	-	-
Excessive alcohol/drug use by perpetrator	52%	14%	-	-	5%
Access to firearms	48%	-	-	-	-
Fail to comply with authority	30%	-	-	-	-
Access to victim after risk assessment	27%	-	-	-	-
Youth of couple (15-24)	70%	-	-	-	-
Age disparity of couple (9+ years)	61%	7%	66%	-	7%
Misogynistic attitude	27%	-	-	-	-
Victim had intuitive fear of perpetrator	33%	7%	-	4%	5%
Threatened/harmed children	30%	-	-	-	-
	24%	-	-	-	-