

**MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT  
INFORMATION BRIEFING NOTE**

**CLIFF # 229718**

**PREPARED FOR:** Stephanie Cadieux, Minister – **FOR INFORMATION**

**TITLE:** BC Coroners Service Death Review Panel Report 2016

**PURPOSE:** To provide an update on the status of the BC Coroners Service Death Review Panel Report 2016

**BACKGROUND:**

- On June 8-9, 2016, a death review panel appointed under the *Coroners Act* was held to better understand intimate partner violence-related deaths and identify prevention opportunities.
- The review panel was comprised of professionals with an expertise in law, intimate partner violence, victim services, child welfare, Aboriginal health, public health, education, and law enforcement.
- From January 2010 to December 2015, 75 fatal Intimate Partner Violence (IPV) incidents occurred in BC, resulting in 100 deaths. The circumstances of the people who died were reviewed in aggregate. Current research and statistics were assessed and key themes identified.
- During this review the panel identified that:
  1. Few victims reach out to disclose IPV, and those that do disclose may be met with family, friends and even professionals who do not yet understand the risk and what to say or do to help.
  2. There is lack of public awareness about IPV, how to help and refer victims to community support and services. There is also a lack of IPV reporting to police.
  3. There is a need for collaborative risk assessment and safety planning and the need for improved sharing of risk factor information so that courts can properly assess risk and set conditions as opportunities to reduce intimate partner violence deaths.
- In relation to the deaths reviewed the panel identified three key areas to reduce intimate partner violence deaths:
  - IPV awareness and education;
  - Safety planning and collaborative case management; and
  - Data access, quality and information sharing.

**DISCUSSION:**

- The death review panel has developed a set of recommendations; considering the current research and applying this knowledge to intimate partner violence case findings.
- The recommendations address systemic issues with policies and practices and are intended to prevent future deaths. Details for each of these recommendations are located in Appendix A:

- Recommendation 1: s.13  
s.13
- Recommendation 2: s.13  
s.13
- Recommendation 3: s.13  
s.13
- While drafts of the report have been submitted to panel members for review an embargoed report has not yet been submitted to the ministries involved. The date for this is unknown, but is expected to be fall 2016.

**ADVICE:**

s.13

Attachment (Appendix A)

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**Drafter:** Clark Russell, Director, Provincial Office of Domestic Violence

**Date:** October 6, 2016

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