OUR TIME TO ACT: A REVIEW OF INTIMATE PARTNER VIOLENCE-RELATED DEATHS IN BRITISH COLUMBIA, 2016-2024

Report to the Chief Coroner of British Columbia

We acknowledge with humility and gratitude the people of the
sḵwx̱wú7mesh úxwumixw, xʷməθkʷəy̓əm, səlilwətaɬ peoples, known today as Vancouver,
on whose territories the death review panel was convened.

We further acknowledge that the people whose lives were lost lived and loved
in territories throughout British Columbia.

This report is dedicated to the families, friends and communities grieving the loss of loved ones,
and is a call to action to prevent similar deaths in the future.

MESSAGE FROM THE CHIEF CORONER

On behalf of my colleagues at the BC Coroners Service, and with a deep sense of gratitude to the death review panelists, I am honoured to endorse the following report.

Intimate partner violence (IPV) continues to take the lives of far too many people in British Columbia. Between 2016 and 2024, at least 135 people—partners, children, family members, friends, and perpetrators themselves—died as a result of IPV-related violence. Behind every number is a person whose life was cut short, and a community that will carry that loss forever.

This Death Review Panel's findings are unequivocal: IPV-related deaths are overwhelmingly preventable. Across sectors, British Columbians interacted with health care providers, police, community supports, and other public systems in the months and years before they died. Too often, the warning signs were present; too often, systems were uncoordinated, overburdened, or unable to respond in ways that meaningfully enhanced safety. The responsibility to prevent future deaths rests with all of us.

The report shows that rural, remote, and northern communities experience disproportionately high rates of IPV-related deaths. Limited access to safe housing, health and forensic services, transportation, and timely law enforcement response sharply reduces opportunities for intervention. These conditions reflect longstanding inequities that require targeted, sustained investment—not temporary or one-size-fits-all solutions.

The recommendations in this report offer a practical and necessary path forward: a coordinated provincial strategy, a standing IPV death review committee, enhanced and consistent training for frontline responders, support for community-led and culturally grounded approaches, and a province-wide public awareness campaign. Taken together, they represent the action required to prevent future deaths and improve safety across all regions of B.C.

We owe it to every person whose life was taken by intimate partner violence—and to every person who fears it today—to act decisively, collaboratively, and without delay.

With gratitude,

Dr. Jatinder (Taj) Baidwan,
Chief Coroner, Province of British Columbia

The decedent and her spouse were living in a township of about 10,000 people in rural B.C. They had been together for more than 30 years.

The spouse was known to struggle with substance use and had related contact with police within the previous year. The decedent had left the relationship several times in the past due to their spouse's substance use.

The spouse had recently told a neighbour that he was depressed and had thoughts of suicide, but he had not shared this with health care providers. The decedent's coworkers were aware that she was experiencing marital problems; while most were not concerned about violence, one had noticed bruising on her arm that appeared as though it could have been caused by someone grabbing her.

Approximately two months before her death, the decedent had left her spouse again and had been living with a family member. Days before she was killed, the decedent advised her family member that she would be moving back in with her spouse, who had been unemployed, but recently obtained a new job and had attended a detox centre. The decedent was killed by her spouse in their home in the early morning hours before he ended his life as well. They were discovered later the same day as a coworker called police when the decedent did not attend work.

There was no police-involved history of intimate partner violence in their relationship, and family members were also unaware of any violence.

PREFACE

As part of its mandate, the BC Coroners Service (BCCS) investigates all unnatural, sudden and unexpected, unexplained, and unattended deaths in British Columbia. This includes all deaths believed to be homicides.

Between January 1, 2016, and December 31, 2024, a total of 253 suspected homicides in which the victim was identified as biologically female were reported to the BCCS. Of those homicides, at least 87 (34%) were deemed to have been caused by an act of intimate partner violence (IPV). As many investigations into these deaths remain open, the number of homicide deaths attributed to IPV will increase as individual files are completed.

On September 17, 2025, the Chief Coroner convened a Panel on the territories of the sḵwx̱wú7mesh úxwumixw, xʷməθkʷəy̓əm, səlilwətaɬ peoples, known today as Vancouver. This group of subject matter experts reviewed data collected through coroner investigations of the 135 confirmed IPV-related deaths, with the goals of identifying systemic gaps and creating meaningful, actionable recommendations intended to prevent IPV-related deaths.

This report is dedicated to the memory of those who have been lost, and to the families, friends and communities forever altered by their grief.

It also serves as an urgent call to action. We can, and must, do better.

I am deeply grateful to the Panel for their willingness to share their expertise, wisdom and guidance throughout the process. The insights and recommendations that follow are a direct result of the collective efforts of the following members:

Alisia Adams, Director, Policy & Justice Issues, BC Prosecution Service, Ministry of Attorney General
Dr. Evan Adams, Deputy Chief Medical Officer, First Nations Health Authority
Dr. Daniéle Behn Smith, Deputy Provincial Health Officer, Office of the Provincial Health Officer
Asha Bhat, Assistant Deputy Minister, Gender Equity Office, Ministry of Finance
Dr. Jennifer Charlesworth, Representative, Representative for Children and Youth
Christina J. Cook, KC, Senior Policy Counsel, First Nations Justice Council
Paul Craven, Assistant Deputy Minister, Justice Services Branch, Ministry of Attorney General
Dr. Natasha DeSousa, Emergency Medicine Physician,
Northern Health and Rural Coordination Centre of BC
Amy FitzGerald, Executive Director, BC Society of Transition Houses
Erin Gunnarson, Assistant Deputy Minister, BC Corrections
Dr. Balbir Gurm, Executive Director, Network to Eliminate Violence (NEVR); Adjunct Faculty,
Simon Fraser University
Bal Hansra, Superintendent, Major Crime, BC RCMP

Dalya Israel, Executive Director, Salal Sexual Violence Support Centre
Ninu Kang, Executive Director, Ending Violence Association of BC
Dr. Charuka Maheswaran, Physician, Rural Coordination Centre of BC
Dr. Amanda McCormick, Associate Professor, School of Criminology and Criminal Justice, University of the Fraser Valley
Holly Mikesh, Investigating Coroner, BC Coroners Service
Jane Murdoch, Stopping the Violence Counsellor, Northern Society for Domestic Peace
Amanda Parnham, Director, Women's Transition Housing & Supports Program, BC Housing
Mike Procyk, Deputy Chief Constable, Surrey Police Service
tyler redskye, Executive Director, Restorative Justice Victoria
Lucie Vallieres, Director, Standards and Training, Police Services Branch, Ministry of Public Safety and Solicitor General
James Wale, Deputy Director of Child Welfare, Ministry of Children and Family Development
Taryn Walsh, Assistant Deputy Minister, Community Safety and Victim Services, Ministry of Public Safety and Solicitor General

I am also appreciative of the panel support offered by my colleagues, Aubrey Baldock, Tej Sidhu, Vince Stancato, and Andrew Tu, and all of the BC Coroners Service whose immense efforts to support grieving families and improve the public safety of all British Columbians is reflected throughout this report.

Finally, I acknowledge with thanks that this death review panel was funded through a Canada-British Columbia bilateral agreement as part of the National Action Plan to End Gender-Based Violence.[1] Support for the Panel and its processes furthers the ongoing work under Safe and Supported: B.C.'s Gender-Based Violence Action Plan.[2]

On behalf of the Panel, I submit this report and recommendations to the Chief Coroner of B.C.

Ryan Panton (he/him)
Chair, Child Death Review Unit
Territory of the Lekwungen-speaking Peoples

TABLE OF CONTENTS

EXECUTIVE SUMMARY **9**
Terminology and Language 12
INTRODUCTION **17**
Decedent Narratives 19
PART 1: BC CORONERS SERVICE REVIEW FINDINGS **21**
Key Findings 21
Overview 23
Age and Biological Sex 25
Indigeneity (First Nations/Métis/Inuit) 27
Residing with Perpetrator 28
Residing with Child 28
Relationship Status 28
Health Authority (HA) of Residence 29
Population Size of Resident Township 30
Resident Neighbourhood Deprivation 30
Biological Sex of Perpetrator 32
Means of Death 32
Injury Location 33
Criminal History of Perpetrator 34
RCMP "E" Division Data 34
Medical/Mental Health History 36
Chronic Disease Registry 36
Hospitalizations 37
Medical Service Plan (MSP) Billings 38
PART 2: LITERATURE FINDINGS **41**
Prevalence 41
COVID-19 Pandemic 42
Barriers to Reporting 42
Age and Biological Sex 43
Homicide-Suicide 44
Indigeneity (First Nations/Métis/Inuit) 45
Race, Ethnicity, and Immigration Status 45
Relationship Status and Living Arrangement 47

Geography 47
Means of Violence 48
Criminal History 49
Health Care 49
PART 3: CONTEXT 51
Understanding Risk 51
Education 52
Survivor Supports 52
Legal System 53
Perpetrator-Focused Interventions 54
Restorative Justice 54
PART 4: PROVINCIAL RESPONSE 56
Safe and Supported: B.C.'s Gender-Based Violence Action Plan (2023)[2] 56
Independent Systemic Review (2024–2025)[14] 56
Don't Look Away (2024)[15] 57
Government's Current Actions & Commitments 58
Strategic Implications 58
PART 5: PANEL DISCUSSIONS 60
Early Prevention and Education 60
Integrated Data Infrastructure 61
Standardized and Specialized Training and Supervision 61
Narrative Change and Storytelling 62
Community-Led Response Models 62
Rural and Remote Communities 63
Forensic and Medical Response 64
Legislative and Judicial Reform 64
Firearm Access in IPV Cases 64
Standing IPV Death Review Committee 65
PART 6: RECOMMENDATIONS 67
APPENDIX 1: GLOSSARY 73
APPENDIX 2: DATA SOURCES 75
APPENDIX 3: REFERENCES 76

EXECUTIVE SUMMARY

Between 2016 and 2024, at least 135 people in British Columbia died as a result of intimate partner violence (IPV). These deaths occurred in 107 separate incidents and included intimate partners, family members, friends, and perpetrators who died during the event. Because many investigations remain open, the total number of IPV-related deaths during this period is expected to increase.

Each death represents a profound loss to families and communities, and underscores the urgent need for coordinated, evidence-supported action to prevent further harm.

In late 2025, the Chief Coroner convened a death review panel to examine the circumstances of IPV-related deaths reported between January 1, 2016, and December 31, 2024. The Panel included experts in medicine, public health, Indigenous health, rural health, law enforcement, justice, gender equity, child welfare, victim services, and community-based supports. Their work was grounded in a distinctions-based approach and aligned with the Province of British Columbia's commitments to Reconciliation and Indigenous self-determination.

The Panel reviewed aggregated coronial investigative findings, linked administrative datasets, police records, and contextual information provided by panel members. The review identified several consistent themes and systemic gaps that contribute to IPV-related harm and limit opportunities for prevention.

Key Findings

- **IPV-related deaths remain persistent and mostly preventable.** An average of 15 people died each year as a result of IPV-related violence between 2016 and 2024.
- **Women are disproportionately impacted.** 65% of all decedents were biologically female, and 76% of victims killed by an intimate partner were female. These proportions remained relatively consistent throughout the review period.
- **Indigenous peoples are significantly over-represented.** Although Indigenous peoples represent 5.9% of B.C.'s population, they accounted for 24% of IPV victims.
- **Rural and northern communities face elevated risk.** Northern Health had the highest rate of IPV-related deaths, and rural communities were over-represented.
- **Firearms and sharp objects were the most common means of death.** Firearm related deaths were more prevalent in rural communities.
- **Most victims were killed in their homes.** 74% of intimate partners who died in a private residence were killed where they lived.
- **A known history of violence was common but not universal.** 36% of victim–perpetrator relationships had at least one prior incident of police-reported IPV and, of these, 29% of incidents occurred within one month of the death. Over half of perpetrators had a history of assault.

These findings reinforce that IPV is a complex, multi-system issue requiring coordinated, sustained, and culturally safe responses across government, health care, justice, and community sectors.

Context and Contributing Factors

The Panel's discussions and literature review identified several systemic contributors to IPV-related harm:

- Persistent stigma and misconceptions that frame IPV as a private matter rather than a public health and criminal issue.
- Barriers to reporting, including fear of retaliation, shame, and distrust of police, courts, and health care systems.
- Indigenous-specific racism – both actual and perceived – and the continuing impacts of colonialism, which limit access to culturally safe supports.
- Fragmented data systems that impede the identification of trends, evaluation of interventions, and distinctions-based approaches.
- Lack of clarity about roles and responsibilities for intervention and follow-up across service providers.
- Inconsistencies in application of training and supervision across law enforcement, health care, and frontline services.
- Gaps in firearm monitoring and enforcement, even when risk factors were known.
- Limited access to community-led, culturally grounded prevention and intervention models, particularly in rural and remote communities.

The Panel emphasized that IPV is preventable, but only through coordinated, multi-sector action that addresses both immediate safety needs and the broader social and structural conditions that enable violence.

Panel Recommendations

The Panel identified five priority areas for action:

1. **Establish a coordinated provincial response** to align ministries, standardize policy, and ensure accountability for IPV-related work.
2. **Create a standing IPV death review committee** to provide continuous oversight, identify systemic gaps, and support timely intervention.
3. **Enhance training for law enforcement, first responders, and health care providers** to improve identification of IPV and strengthen survivor-centred responses.
4. **Develop and resource community-led, evidence-supported models** that reflect local needs and support culturally safe, trauma-informed prevention and intervention.
5. **Implement a province-wide public awareness campaign** to dispel myths, identify risk factors, and promote pathways to support survivors, perpetrators, and communities.

The Panel also reaffirmed a recommendation made from a previous panel[3] to improve data collection, information sharing, and reporting, particularly regarding race, ethnicity, gender identity,

and disability, and to strengthen distinctions-based data governance with First Nations, Métis, and Inuit partners.

The vast majority of intimate partner violence-related deaths are preventable when met with an urgent, coordinated, and sustained response. The findings of this review demonstrate that many victims had contact with systems that could have intervened, yet opportunities for prevention were missed. The recommendations in this report provide a roadmap for strengthening B.C.'s response to IPV, improving safety for survivors, and preventing future deaths.

The Panel acknowledges the lives lost, the families and communities forever changed, and the responsibility shared across systems to do better. Preventing intimate partner violence-related deaths is both possible and necessary—and requires collective commitment, accountability, and action.

Terminology and Language

> *"This [GBV] is a complex social issue rooted in patriarchal political, social and economic systems, meaning that many parts of daily life are subject to male dominance and control. Existing institutions, laws, policies and social norms can perpetuate gender-based violence and sustain gender inequity and other inequalities that contribute to the challenges facing survivors – due to the harmful legacies of systemic racism, colonialism, toxic masculinity, homophobia and transphobia."*[2]

Intimate partner violence (IPV), also referred to as spousal or domestic violence, is the most prevalent form of gender-based violence globally.[4]

Gender-based violence (GBV) is defined as "violence based on gender norms and unequal power dynamics, perpetrated against someone based on their gender, gender expression, gender identity, or perceived gender. It takes many forms, including physical, economic, sexual, as well as emotional (psychological) abuse".[5]

IPV is specifically caused by a current or former intimate partner, at any time during a relationship or following its end, regardless of the gender and sexual orientation of the partners and/or whether the partners cohabitate or are sexually intimate.[6] Harm may take the form of coercive control, criminal harassment (also referred to as stalking), emotional/psychological abuse, financial abuse (also referred to as economic abuse), physical abuse, reproductive coercion, sexual violence, spiritual abuse, and/or technology-facilitated violence (also referred to as cyberviolence).[6]

For the purposes of this review, IPV deaths include instances where the decedent is:

- A current or former intimate partner of the perpetrator;
- A child, other family member, or unrelated person who died in an incident targeting the perpetrator's current or former intimate partner; and/or
- A perpetrator who died during the incident targeting the current or former intimate partner.

Not included in this review are deaths that fall within the broader category of gender-based violence, including:

- Family violence deaths where the perpetrator killed their intimate partner and additional family members, but the investigation could not conclude that their intimate partner was the primary target;
- Deaths where the decedent was the victim of non-lethal intimate partner violence prior to their death, but their manner of death was by suicide, unintentional injury, or other undetermined or natural causes; or
- Deaths that occurred in the context of sex work.

The use of the terms "victim" and "perpetrator" within this review are not intended to assign fixed or distinct identities, but are descriptors intended to clarify action within the context of the IPV incidents being reviewed This is done to appoint responsibility to the person enacting harm, which is often done strategically to suppress victim resistance, but not without awareness that perpetrators of IPV may have also experienced victimization in other contexts.

BCCS findings only represent data regarding the perpetrators who died during the incident targeting their current or former partner; this review is unable to include demographic and risk factor data for perpetrators who were alive at the time of the victim's death.

The term **perpetrator** is used with recognition that parallel criminal investigations are at varied stages of completion and is not tied to conviction of charge(s).

The term **victim** is also used with intent, not to obscure a decedent's resistance to violence or dishonour the ability for others to survive, heal and thrive following violence, but to acknowledge that violence is unilateral oppression deliberately enacted "against the will and well-being of another" within a specific relational dynamic.[7]

Death Review Panels

The *Coroners Act*[8] provides the Chief Coroner with the discretion to establish death review panels to review the facts and circumstances of deaths to provide the Chief Coroner with advice on medical, legal, social welfare and other matters that may impact public health and safety and prevention of deaths. A death review panel may review one or more deaths before, during or after a coroner's investigation or inquest.

Members of the panel were appointed by the Chief Coroner under Section 49 of the *Coroners Act* and included professionals with expertise in intimate partner violence, medicine, rural medicine, public health, First Nations health, Métis health, Indigenous-specific anti-racism, education, health administration, child and family development, law enforcement, restorative justice, gender equity, victim services, policy, and research.

Regardless of their employment or other affiliations, individual panel members were asked to exercise their mandate under the *Coroners Act* and express their personal knowledge and professional expertise. The findings and recommendations contained in this report need not reflect, or be consistent with, the policies or official position of any organization.

While considering intimate partner violence-related deaths, the Panel reviewed and discussed:

- Coroners' aggregated investigative findings;
- Information provided by panel members;
- Environmental, social, geographic and medical factors associated with the deaths;
- Possible trends or themes;
- The current state of related public policy and strategies; and,
- Existing challenges.

Data Limitations and Confidentiality

The BC Coroners Service (BCCS) is mandated to investigate and review all unnatural and unexpected deaths in the province. This may include attending the location of the death, completing a physical examination of the decedent, conducting interviews with family, friends and persons or service providers involved in the decedent's life, arranging necessary post-mortem examinations, obtaining medical records, and documenting the investigation findings in a coroner's report. These investigative findings provide insight into the circumstances of a decedent's life and may also identify issues or challenges, opportunities for preventing similar deaths, and areas for program or policy improvement.

The BCCS operates in a live database environment. Decedent information, investigative notes, case details and findings are regularly updated during a death investigation. The data presented within the case review is based on open and closed BCCS case files. It includes analysis of BCCS investigative

notes, police reports, medical records and other documents collected, or protocols completed during the investigation. Many cases are still under investigation and information may be partial and hence incomplete.

Linkages were made to other data sources; however, due to incomplete or incorrect information, not all cases were linked successfully and therefore the data cannot be considered exhaustive. Where possible, the best available data was used for analysis; however, discrepancies can still occur. Additionally, chronic disease information was obtained from the Chronic Disease Registry.

As part of the investigative process for homicides and intimate partner violence-related deaths, coroners complete an investigative protocol, a questionnaire which details decedent characteristics, circumstances of death, and potential risk factors. The information gathered from family and witness interviews, scene findings, medical records, police reports and other information gathered over the course of the investigation is used to answer the questions. The investigative protocol was last updated in 2021; for deaths that occurred prior, investigations may have contained less contextual information.

Due to parallel criminal investigations that occur in the context of homicides and the imperative to avoid jeopardizing those investigations, coroners may be limited in their ability to obtain some information regarding the context of a death in a timely manner. As information cannot be collected directly from the decedent, responses to certain questions (e.g. risk factors, etc.) from the protocol questionnaire may be considered speculative or anecdotal in nature.

Provisions under the *Coroners Act* and *Freedom of Information and Protection of Privacy Act*[9] allow for the BCCS to disclose information to meet its legislative mandate and support the findings and recommendations generated by the review process. For the purposes of this report, information is presented in aggregate. The BCCS is sensitive to the privacy of individuals and families that it serves and proceeds with caution when reporting findings. Details that could identify individuals have been omitted to respect the privacy of the person who died and their family.

Data contained within the case review findings includes information collected from all relevant open and closed coroner investigations. Data for this review was extracted on May 22, 2025, and, at the time of extraction, about 20% of the death investigations had been completed by the coroner. Because data collection and protocol completion begins as soon as a coroner attends the scene of death, the data contained within this report is much more robust and complete than the closed percentage would suggest.

The decedent lived in a town of 25,000 and had been in an on again, off again relationship for approximately two years.

Police had responded to incidents involving violence on several occasions in the six months preceding her death. The decedent's partner had been convicted of charges relating to one incident and was placed on probation for one year and instructed to not have contact with her without prior written consent and not possess weapons, among other conditions. He was arrested for failure to comply with these conditions when he and the decedent had contact that became violent again a month prior to her death.

The decedent and her partner resumed contact and made plans for an outing together. Shortly before the outing, she cancelled those plans and did not respond to her partner's repeated and increasingly frequent attempts to contact her. In the early morning hours, the partner arrived at her home with a firearm, intending to end his life, but upon realizing that a male friend of the decedent's was present, he forced his way into the residence and killed the decedent's friend before killing her.

An investigation revealed that the firearm used in the homicides belonged to the partner and was not required to be registered in the Canadian Firearms Registry. The partner was not registered as having a Possession and Acquisition License, and neither police nor his probation officer was aware that he was in possession of a firearm, despite a Domestic Violence Risk Factors form acknowledging the belief that firearms were stored in his parents' home where he also resided.

INTRODUCTION

> *"Intimate partner violence and sexual violence are forms of gender-based violence. Gender-based violence is a global epidemic with complex root causes. This means that no single department, branch, ministry, sector, system, or government can cure it alone."*[14]

Intimate partner violence – also known as IPV – is a global **pandemic**. In the last 12 months, an estimated 316 million women worldwide were subjected to physical or sexual violence by an intimate partner.[10]

Across Canada, almost half of women and girls older than age 15 who have ever been in an intimate partner relationship report having experienced some form of IPV-related violence in in their lifetime.[4]

Despite its prevalence, police reported data tells us that it is also among the most underreported crimes nationally, with as many as 80% of survivors not reporting their experience to law enforcement.[11]

There are many reasons for this. For some, intimate partner violence is seen as a personal matter, not a criminal one. For others, the stigma and shame associated with IPV, the blame inappropriately appointed to them, or distrust in either or both the legal or criminal justice systems, for historical and modern-day reasons, may be barriers to disclosing the incident. Pervasive Indigenous specific-racism and lack of culturally safe and trauma-informed supports may further prevent Indigenous survivors of IPV from disclosing their injuries, which compounds issues of inter-generational trauma and the ongoing legacy of colonialism and colonial violence.

The reasons for choosing whether to disclose an experience of intimate partner violence are as unique as the victims themselves. But regardless of the justification, the fact that such a decision must even be contemplated is proof that the support and safeguards in place are simply not as effective as they need to be.

And our own province is by no means immune.

In 2016, the BC Coroners Service convened a panel of subject matter experts to review the circumstances of 100 IPV-related deaths reported to the agency between January 2010 and December 2015.[12] That Panel forwarded three recommendations to government aimed at reducing such deaths in the future. This followed a panel of subject matter experts convened in 2010 that reviewed 29 domestic violence deaths dating back to 1995 and forwarded 19 recommendations[13] to government.

In the time between the report released in 2016 and today, at least 135 intimate partner violence-related deaths have occurred in B.C. Because many deaths remain under open investigation, that number is all but certain to increase.

Consequently, in early 2025 the Chief Coroner of British Columbia convened a third death review panel to examine IPV deaths between 2016-2024, determine what has changed between the last report and now, and identify ways that address this ongoing pandemic with the urgency that it demands.

In many ways, this report is intended to build upon, supplement, and amplify previous work and recommendations made over the course of the last several years. Recent examples of this work include:

- The British Columbia Legal System's Treatment of Intimate Partner Violence and Sexual Violence[14]
- Don't Look Away – How one boy's story has the power to shift a system of care for children and youth[15]
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls[16]

Evidence-supported decision-making demands that we follow the data to ensure that proposed approaches are grounded in what we *know*, not by what we *think*. However, as noted throughout this report, one of the primary challenges with such an approach in the current climate is that the data required to underpin it is fragmented in some cases, and incomplete or even non-existent in others.

The quote at the top of this section reflects another reality discussed throughout the panel process: that because its impacts are so wide-ranging and pervasive, any effective response to IPV requires coordinated efforts from across society. But it also demands an implementation strategy that is cohesive, consistent, broadly understood and vigorously prioritized.

Intimate partner violence is a complex problem and, as a consequence, there are no simple solutions to address and resolve it. But there are lessons we can learn from the journeys and experiences of the lives lost to IPV violence in the hopes of closing the gaps through which others are at risk of lethal harm.

We owe it to the memories of those we have lost to try.

Decedent Narratives

The data contained within this report only tell part of a much larger, more complex story. It is critical to remember that behind every data point is a person with a story and a journey that was cut short by a horrific act of violence.

The four narratives included in these pages are intended to illustrate risks and gaps related to IPV prevention and intervention that have been known for decades. More importantly, they serve as an urgent call to action to support ongoing cross-sector work to disrupt violence in relationships, and to increase the safety of all British Columbians. The decedents were people whose identities and life experiences were rich and diverse, far beyond what can be adequately captured by aggregate review. Each death has created a void that family, friends and communities will grieve forever.

Coroner investigations capture certain demographics and known risk factors, but lack in their capacity to honour the accomplishments, aspirations and resilience of decedents, or the ways their losses are grieved by families and communities. While there are overlapping experiences in the journeys of many decedents, there is no singular profile that represents who has died by intimate partner violence, or under which circumstances.

The relationship between decedent and perpetrator varied in length and legal commitment, from days and months of dating to decades of marriage. Some relationships were characterized as "off and on," and other decedents were killed during the process of separation; others still were killed while the partnership was seemingly intact and untroubled.

Some decedents had children, either from previous relationships or with their current partners, while others did not. Multiple minor children were killed when their mother was assaulted or killed. Multiple adult male decedents were killed simply because of their proximity to the current or former female partners of the perpetrators.

While most decedents were killed while alone with their current or ex-partner, the presence of another person was not always a deterrent to violence. Some friends or family members were killed in the same incident, others were injured in attempts to intervene, and still others were helpless witnesses to rapidly unfolding violence.

The existence of licensing and registration legislation appeared to have limited deterrence for the firearms-related homicides, as multiple perpetrators did not have a license to own a firearm, or owned non-restricted firearms that did not require registration. One perpetrator with a criminal history of intimate partner violence lived in the same home where firearms were stored; this was documented in risk assessment forms but not recognized by police and probation officers.

Some decedents had disclosed abuse by their partner to friends, family or coworkers, while others are grieved by loved ones who were entirely unaware of any previous instances of violence. Many people didn't think the perpetrator was capable of what they had done. There were instances where service providers were known to have been involved with the couple in some capacity, from police and hospital staff to MCFD and community-based victim services. Multiple investigations suggested that the potential for lethal violence was simply underestimated, and further intervention was not explored.

While this review includes perpetrators who killed themselves after killing their partners, or who were killed by police during the course of the violence they were inflicting, most perpetrators are still alive.

Perpetrators displayed a range of behaviour in the weeks, months and years before killing their partners. There is little known about the full extent of coercive, controlling and jealous behaviours inflicted behind closed doors. Some perpetrators displayed signs of physical or mental health challenges, but the subsequent risk for violence was not considered. When police were involved, many perpetrators alleged that there was mutual violence or that their partners' injuries were the result of them defending themselves.

PART 1: BC CORONERS SERVICE REVIEW FINDINGS

Key Findings

The following data summarizes information contained within BC Coroners Service intimate partner violence-related death case investigations. In reviewing these deaths, the following findings emerged:

- There were 135 identified intimate partner violence-related deaths from 2016-2024. This included decedents who were victims of intimate partner violence-related homicide and perpetrators who subsequently died during the incident targeting their current or former intimate partner.
    - Where BCCS data represents perpetrators in demographic counts, this does not include perpetrators who were alive at the time of the incident targeting their current or former intimate partner.
- 76% (102) of decedents were the current or former intimate partner of the perpetrator. According to family or friends, 73 (72%) were current partners, and 29 (28%) had discussed or threatened separation or were recently separated.
    - 83 (81%) of these decedents were biologically female, and 19 (19%) were biologically male.
    - For comparison, in the previous review of IPV-related deaths, there were 54 female decedents and 11 male decedents identified as the intimate partner of the perpetrator.
- 10% (13, including 7 children under age 19) of decedents were family members or acquaintances.
    - 4 (31%) of these decedents were biologically female, and 9 (69%) were biologically male.
- 15% (20) of decedents were identified as the perpetrator who died during the incident targeting their current or former partner
    - 19 (95%) of these decedents were biologically male, and 1 (5%) was biologically female.
- 47% (63) of decedents were between the ages of 30-49.
- Indigenous peoples were over-represented as they make up 5.9% of the population in B.C., but 21% of decedents were identified as Indigenous (25% of victims and 0% of perpetrators who died during the incident targeting their current or former partner).
- There were higher rates of death in the Northern (8.5 per million person-years) and Interior Health (3.5 per million person-years) authorities.

- Townships with fewer than 10,000 residents and materially deprived neighbourhoods[i] were over-represented.
- Sharp/bladed objects (38%), firearms (29%) and blunt force (14%) were the most commonly identified means of death.
- 74% (66) of victims were injured in their own home.
- 58% (59) of decedents who were killed by their intimate/ex-partner resided with the perpetrator at the time of their death.
- 27% (27) of decedents who were killed by their intimate/ex-partner resided with a child at the time of their death.
- RCMP "E" Division linked data found that 36% of victim-perpetrator relationships had an IPV-related police-reported incident between the decedent and perpetrator, and that over half of the perpetrators had a history of assault (either towards their intimate partner or another person).
- 57% of intimate/ex-partners or perpetrators met the criteria for at least one mental health condition (55% of intimate or ex-partners and 65% of perpetrators who died during the incident targeting their current or former intimate partner).
- 3% of intimate/ex-partners had a prior hospitalization related to injury or assault in the year prior to death.
- 35% of intimate/ex-partners had an MSP billing related to injury or assault in the year prior to death.

[i] The material and social deprivation index (MSDI) was created with the aim of characterizing and highlighting deprivation at a small area level by combining three indicators from the Canadian census. Institut National de Santé Publique du Québec. Material and social deprivation index. https://www.inspq.qc.ca/en/deprivation/material-and-social-deprivation-index

Overview

For the nine-year period of January 1, 2016, to December 31, 2024, 135 persons were identified through coroner investigations as having died as a result of intimate partner violence in B.C. from 107 incidents.

Of the 107 incidents:

- 84 (79%) were single homicides;
- 3 (3%) were multiple homicides that resulted in 7 deaths;
- 18 (17%) were related to homicide-suicides that resulted in 41 deaths; and
- 2 (2%) were related to a police shooting after a domestic incident that resulted in 3 deaths.

Of the 135 deaths:

- 102 (76%) were current or former intimate partners;
- 13 (10%) were family members or acquaintances; and
- 20 (15%) were deaths by suicide of the suspected perpetrator.

Table 1: IPV Deaths by Classification, 2016-2024

	Intimate/Ex-partner	Family/Friend	Perpetrator	Total
Homicide	102	13	2	117
Suicide	0	0	18	18
Total	**102**	**13**	**20**	**135**

On average, there were 15 IPV deaths per year, or about 13 homicide and 2 suicide deaths annually (Figure 1). There was an increase in homicide deaths in 2021 (17) and 2022 (18) which corresponded with an increase in homicide deaths in B.C.[17] overall (Table 2, Figure 2). On average, IPV homicide deaths represent 11% of all homicides that occur in B.C.

The rate of IPV-related homicide death for this nine-year review period equates to 2.5 per million population. This rate is slightly below the rate identified in the last IPV review of 2.7 per million population (2010-2015).

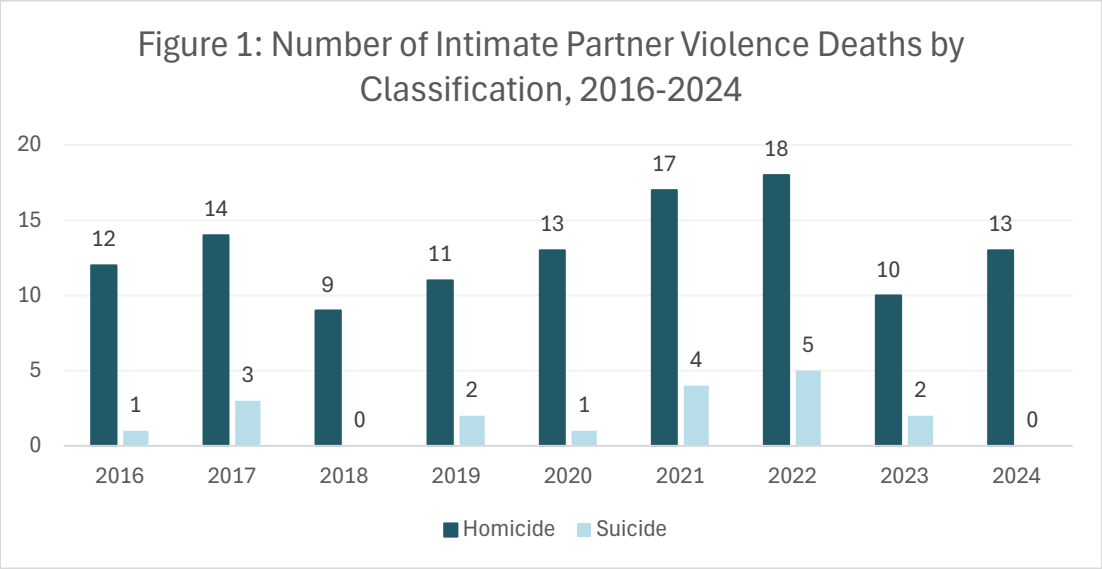
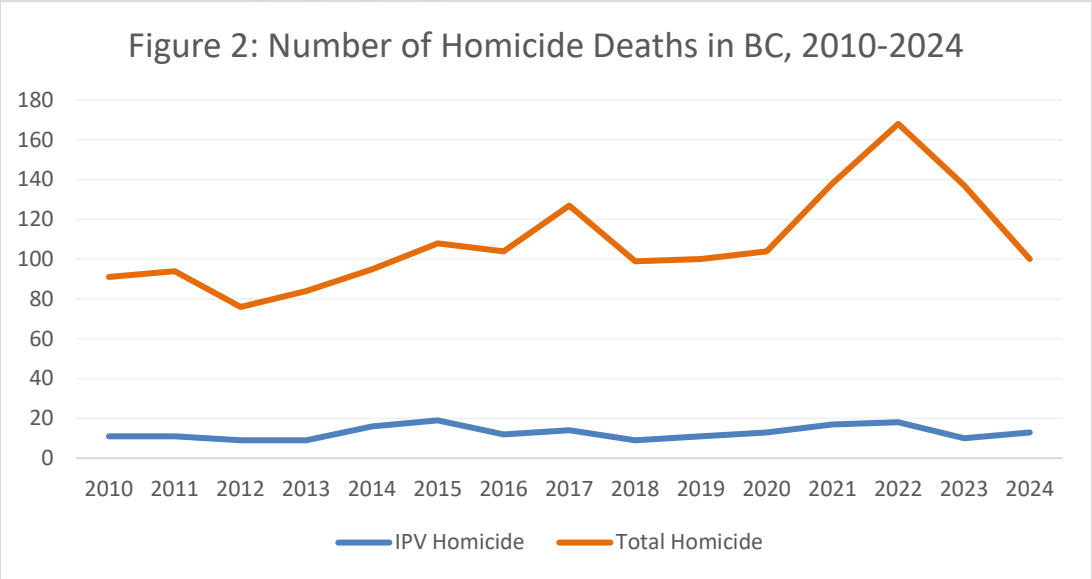


Table 2: Number of Homicide Deaths in B.C., 2016-2024

	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total
IPV Homicides	12	14	9	11	13	17	18	10	13	117
Total Homicides	104	127	99	100	104	138	168	137	100	1077
% IPV Homicide	11.5	11.0	9.1	11.0	12.5	12.3	10.7	7.3	13.0	10.9



Age and Biological Sex

This review follows definitions established in the Province of British Columbia's Gender and Sex Data Standard.[18] The standard confirms sex and gender as distinct concepts, with terminology that cannot be interchanged.

> *"**Sex** is a category used to classify people based on physical and physiological features including chromosomes, genetic expression, hormone levels and function, and reproductive/sexual anatomy. Sex is most often assigned at birth based on a visual examination of genitalia by a doctor or other health care provider. Based on this examination, the child is assigned as Female, Intersex, or Male.*
>
> ***Gender** involves a personal, deeply held, internal sense of self as man or woman, a blend of both, or neither. Broadly speaking, gender includes self-identification as well as socially and culturally constructed roles, behaviours, and expressions. The current gender of a person (e.g., Man, Non-binary person, Woman) may or may not align with social or cultural expectations based on their sex assigned at birth (e.g., Female, Intersex, Male). People for whom this is true may identify as transgender."* [18]

BCCS did not collect information regarding decedent gender, so the data presented is based on biological sex.

In reviewing deaths related to intimate partner violence:

- Almost half (47%) of decedents were between the ages of 30-49 (48% of the victims);
- 7% of decedents were under 19 (8% of the victims) (Table 3); and
- 65% of decedents were assigned female at birth (76% of victims and 5% of perpetrators) (Table 4).

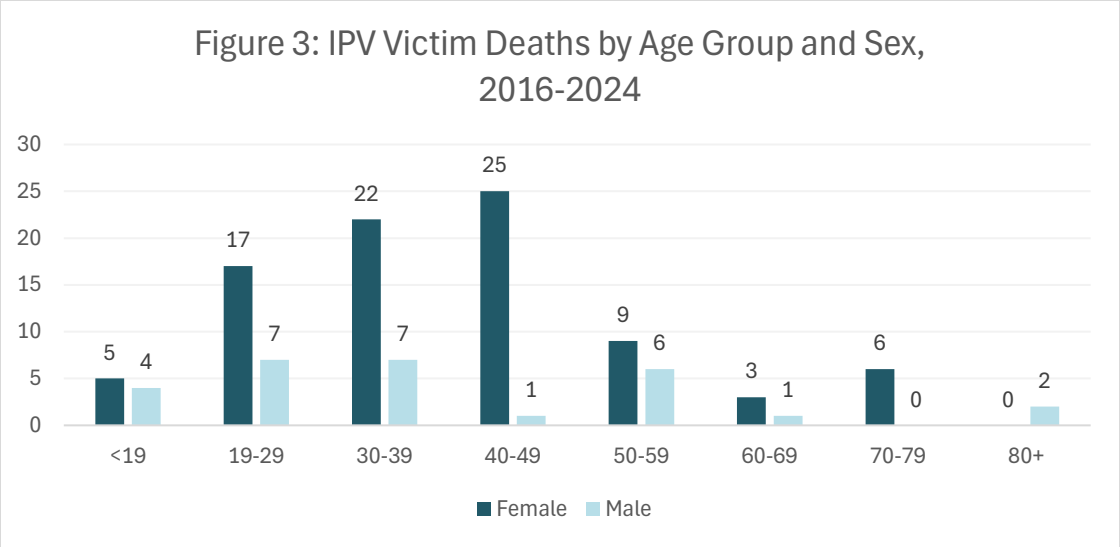
Table 3: IPV Deaths by Age Group, 2016-2024

	Intimate/Ex-partner	Family/Friend	Perpetrator	Total
<19	2 (2.0%)	7 (53.9%)	1 (5.0%)	10 (7.4%)
19-29	22 (21.6%)	2 (15.4%)	1 (5.0%)	25 (18.5%)
30-39	28 (27.5%)	1 (7.7%)	1 (5.0%)	30 (22.2%)
40-49	24 (23.5%)	2 (15.4%)	7 (35.0%)	33 (24.4%)
50-59	14 (13.7%)	1 (7.7%)	5 (25.0%)	20 (14.8%)
60-69	4 (3.9%)	0	3 (15.0%)	7 (5.2%)
70-79	6 (5.9%)	0	1 (5.0%)	7 (5.2%)
80+	2 (2.0%)	0	1 (5.0%)	3 (2.2%)
Total	**102**	**13**	**20**	**135**

Table 4: IPV Deaths by Sex, 2016-2024

	Intimate/Ex-partner	Family/Friend	Perpetrator	Total
Female	83 (81.4%)	4 (30.8%)	1 (5.0%)	88 (65.2%)
Male	19 (18.6%)	9 (69.2%)	19 (95.0%)	47 (34.8%)
Total	**102**	**13**	**20**	**135**

Among the 115 victims (intimate/ex-partner and family/friend), there were more female than male decedents in each age group except for the 80+ age group (Figure 3).



Indigeneity (First Nations/Métis/Inuit)

Distinctions-based First Nations, Métis and Inuit data are necessary, however due to data limitations, this report is limited to pan-Indigenous data. Data governance protocols for First Nations, Métis and Inuit data are required to ensure good stewardship and prevent harms (i.e., stereotyping, lack of contextualization etc.).

As of June 1, 2016, the BCCS implemented the Aboriginal Administrative Data Standard (AADS); this was done to improve the data quality and completeness of Indigenous identity on BCCS case files. For this review, Indigenous identity was based on information gathered during the coroner's investigation from family and friends, or service agencies. Vital Statistics Certificate of Death forms and BCCS case files of all decedents were reviewed for Indigenous identifiers.

Specifically, the following process was used to identify decedents as Indigenous people:

- The Aboriginal identifier on the Vital Statistics Certificate of Death was yes; and,
- Includes any one of the following:
    - The decedent was a resident of a reserve;
    - Case file documentation indicated Indigenous identity; or,
    - The decedent was interred on a reserve.

The BCCS acknowledges that this is an area of data collection that requires review and improvement. As this process has yet to be realized, the death review panel relied on the insights and opinions of three First Nations panelists and one First Nations & Métis reviewer with specific expertise in Indigenous health, public health, justice and medicine.

Using the above-noted methodology, of the IPV deaths in this review, 25% of victims of intimate partner violence-related death were identified as Indigenous (Table 5).

According to Statistics Canada, 5.9% of the BC population in 2021 identified as Indigenous (First Nations/Métis/Inuit).[19]

Table 5: IPV Deaths by Indigenous Identity, 2016-2024

	Intimate/Ex-partner	Family/Friend	Total
Indigenous female	18	1	19
Indigenous male	7	2	9
% Indigenous	24.5%	23.1%	24.3%

There were no deaths of perpetrators who died during the incident targeting their current or former intimate partner and were identified as Indigenous.

Residing with Perpetrator

This review found that among the deaths of the intimate/ex-partner:

- 58% of decedents resided with the perpetrator;
- 21% did not reside with the perpetrator; and
- In 22% of investigations, it was unknown whether the decedent resided with the perpetrator (Table 6).

Table 6: Intimate/Ex-Partner Deaths by Whether They Reside with the Perpetrator	
	Number (%)
Residing with perpetrator	59 (57.8%)
Not residing with perpetrator	21 (20.6%)
Unknown	22 (21.6%)
Total	**102**

Residing with Child

In 27% of deaths of the intimate/ex-partner, a child was residing at the home of the decedent (Table 7).

Table 7: Intimate/Ex-Partner Deaths by Whether They Reside with a Child	
	Number (%)
Reside with child	27 (26.5%)
Not residing with child	59 (57.8%)
Unknown	16 (15.7%)
Total	**102**

Relationship Status

Of the 102 decedents identified as intimate or ex-partners, coroners determined through interviews with family or friends that 29 (28%) had discussed or threatened separation or were recently separated.

Health Authority (HA) of Residence[ii]

Fraser Health (n=44) recorded the largest number of IPV deaths between 2016-2024 (Table 8). Among the victims, Northern Health had the highest rate of death (8.3 per million person-years), (Table 9).

Table 8: IPV Deaths by Health Authority of Residence, 2016-2024

	Intimate/Ex-partner	Family/Friend	Perpetrator	Total
Fraser	35 (34.3%)	3 (23.1%)	6 (30.0%	44 (32.6%)
Interior	24 (23.5%)	2 (15.4%)	6 (30.0%)	32 (23.7%)
Island	11 (10.8%	1 (7.7%)	3 (15.0%)	15 (11.1%)
Northern	15 (14.7%)	7 (53.9%	3 (15.0%)	25 (18.5%)
Vancouver Coastal	17 (16.7%)	0	2 (10.0%)	19 (14.1%)
Total	**102**	**13**	**20**	**135**

Table 9: Number and Rate of IPV Victims by HA of Residence, 2016-2024

	2016-2024	Rate (per million person-years)
Fraser	38 (33.0%)	2.2
Interior	26 (22.6%)	3.5
Island	12 (10.4%)	1.5
Northern	22 (19.1%)	8.3
Vancouver Coastal	17 (14.8%)	1.5
B.C.	115	2.5

[ii] Health authority of death was used in 7 cases of unknown or undetermined health authority of residence.

Population Size of Resident Township

Information regarding the size of resident township was derived from Census data. The Panel acknowledges that using a single population cut-off oversimplifies the diversity of rural communities, which differ widely in density, proximity to services, transportation links, and economic structures.

No single classification can adequately represent rural communities, because rurality involves multiple dimensions beyond population size. More work is required to better stratify this information in a manner that better represents the distinctions of individual communities.

Among all IPV deaths:

- 71% of decedents resided in townships with ≥10,000 population (see Table 10); and
- 29% of decedents resided in townships <10,000 population; and
- The proportions were the same when accounting solely for victims (Table 11).

In comparison, 84% of the B.C. population live in townships ≥10,000 population and 16% live in townships with under 10,000 population in 2021.

Table 10: IPV Deaths by Population Size of Resident Township, 2016-2024

	Intimate/Ex-partner	Family/Friend	Perpetrator	Total
≥10,000 population	74 (72.6%)	8 (61.5%)	14 (70.0%)	96 (71.1%)
< 10,000 population	28 (27.5%)	5 (38.5%)	6 (30.0%)	39 (28.9%)
Total	**102**	**13**	**20**	**135**

Table 11: IPV Victim Deaths by Population Size of Resident Township, 2016-2024

	Number (%)	2021 % for B.C.[iii]
≥10,000 population	82 (71.3%)	83.8%
< 10,000 population	33 (28.7%)	16.2%
Total	**115**	

Resident Neighbourhood Deprivation

The material and social deprivation index (MSDI) was created with the aim of characterizing and highlighting deprivation at a small area level.[iv] The material and social dimensions of the index each combine three indicators from the Canadian census.

[iii] B.C. Stats. Population Estimates. https://www2.gov.B.C.ca/gov/content/data/statistics/people-population-community/population/population-estimates

[iv] Institut National de Santé Publique du Québec. Material and social deprivation index. https://www.inspq.qc.ca/en/deprivation/material-and-social-deprivation-index

- The **material dimension** reflects the deprivation of goods and conveniences and includes the proportion of employed people aged 15 or older, their average income, and the proportion without a secondary school diploma.
- The **social dimension** reflects the deprivation of relationships among individuals in the family and includes the proportion of people aged 15 or older living alone, the proportion separated, divorced or widowed, and the proportion of single parent families. The residential addresses of the decedents were linked to the material and social deprivation index quintile of the corresponding dissemination area from the 2021 census. Each quintile represents 20% of the population.

A higher percentage of IPV decedents lived in the most materially deprived neighbourhoods compared to the general population (34% vs. 20%) and a lower percentage lived in the least materially deprived neighbourhoods (9% vs. 20%) (Table 12). The percentage breakdown of decedents living in each social deprivation quintile was more aligned with the general population, with slightly more living in more socially deprived neighbourhoods (26%) (Table 13).

Table 12: IPV Deaths by Neighbourhood Material Deprivation, 2016-2024

	Intimate/Ex-partner	Family/Friend	Perpetrator	Total
Least deprived quintile	10 (9.8%)	0	2 (10.0%)	12 (8.9%)
Less deprived quintile	11 (10.8%)	1 (7.7%)	2 (10.0%)	14 (10.4%)
Average quintile	20 (19.6%)	1 (7.7%)	5 (25.0%)	26 (19.3%)
More deprived quintile	18 (17.7%)	5 (38.5%)	4 (20.0%)	27 (20.0%)
Most deprived quintile	36 (35.3%)	5 (38.5%)	5 (25.0%)	46 (34.1%)
Data not available	7 (6.9%)	1 (7.7%)	2 (10.0%)	10 (7.4%)
Total	**102**	**13**	**20**	**135**

Table 13: IPV Deaths by Neighbourhood Social Deprivation, 2016-2024

	Intimate/Ex-partner	Family/Friend	Perpetrator	Total
Least deprived quintile	16 (15.7%)	4 (30.8%)	4 (20.0%)	24 (17.8%)
Less deprived quintile	20 (19.6%)	0	3 (15.0%)	23 (17.0%)
Average quintile	14 (13.7%)	1 (7.7%)	2 (10.0%)	17 (12.6%)
More deprived quintile	24 (23.5%)	3 (23.1%)	8 (40.0%)	35 (25.9%)
Most deprived quintile	21 (20.6%)	4 (30.8%)	1 (5.0%)	26 (19.3%)
Data not available	7 (6.9%)	1 (7.7%)	2 (10.0%)	10 (7.4%)
Total	**102**	**13**	**20**	**135**

Biological Sex of Perpetrator

Among the victims of IPV-related deaths:

- 83% of deaths were identified as committed by a male perpetrator; and
- 17% of deaths were identified as committed by a female perpetrator (Table 14).

In two instances, deaths were identified as committed by a same sex perpetrator.

Table 14: IPV Victim Deaths by Sex of Perpetrator	
	Number (%)
Male	95 (82.6%)
Female	20 (17.4%)
Total	**115**

Means of Death

This review found that the most common means of IPV-related death (Table 15) were:

- Firearm (36%);
- Sharp/Bladed object (34%);
- Blunt force (13%); and
- Strangulation/Suffocation (7%).

Among victims, sharp/bladed object (38%), firearm (29%) and blunt force (14%) were the most common means of death. Among perpetrators, three-quarters died by firearm.

Table 15: IPV Deaths by Means of Death, 2016-2024				
	Intimate/Ex-partner	**Family/Friend**	**Perpetrator**	**Total**
Firearm	27 (26.5%)	6 (46.2%)	15 (75.0%)	48 (35.6%)
Sharp/Bladed object	41 (40.2%)	3 (23.1%)	2 (10.0%)	46 (34.1%)
Blunt force	16 (15.7%)	0	1 (5.0%)	17 (12.6%)
Strangulation/ Suffocation	7 (6.9%)	2 (15.4%)	1 (5.0%)	10 (7.4%)
Unregulated drugs	5 (4.9%)	0	0	5 (3.7%)
Other	1 (1.0%)	0	1 (5.0%)	2 (1.5%)
Undetermined	5 (4.9%)	2 (15.4%)	0	7 (5.2%)
Total	**102**	**13**	**20**	**135**

**Note: For cases still under investigation, means of death are based on preliminary information and may change as investigations are concluded.*

Firearm deaths were more common among IPV decedents living in communities with population size <10,000 (44% vs. 32% of those living in communities ≥10,000 population) (Table 15a).

Table 15a: IPV Deaths by Means of Death and Population Size of Resident Township, 2016-2024		
	≥10,000 population	**<10,000 population**
Firearm	31 (32.3%)	17 (43.6%)
Sharp/Bladed object	34 (35.4%)	12 (30.8%)
Blunt force	12 (12.5%)	5 (12.8%)
Strangulation/ Suffocation	5 (5.2%)	5 (12.8%)
Unregulated drugs	5 (5.2%)	0
Other	2 (2.1%)	0
Undetermined	7 (7.3%)	0
Total	96	39

**Note: For cases still under investigation, means of death are based on preliminary information and may change as investigations are concluded.*

Injury Location

In most cases, the incident leading to death(s) happened at one location. In two incidents, a suicide occurred at a different location from the homicide(s).

This review found that among IPV deaths:

- 76% of decedents were injured at a private residence (Table 16);
- 11% were injured outdoors; and,
- 6% were injured at a hotel/motel or business site.
- Where intimate partner homicides occurred at a private residence, 74% (66) occurred in the victim's own home.

Table 16: IPV Deaths by Place of Injury, 2016-2024				
	Intimate/Ex-partner	**Family/Friend**	**Perpetrator**	**Total**
Private Residence	78 (76.5%)	11 (84.6%)	14 (70.0%)	103 (76.3%)
Outdoors	8 (7.8%)	2 (15.4%)	5 (25.0%)	15 (11.1%)
Hotel/Motel	4 (3.9%)	0	0	4 (3.0%)
Business site	3 (2.9%)	0	1 (5.0%)	4 (3.0%)
Unknown/Found outdoors	9 (8.8%)	0	0	9 (6.7%)
Total	**102**	**13**	**20**	**135**

Criminal History of Perpetrator

Because the BC Coroners Service's mandate is to establish the facts surrounding a death, and not assign blame, perpetrator-specific information collected by the coroner in IPV-related deaths is variable. In some instances, details may be revealed through investigations anecdotally, but not in a manner consistent enough to identify or report on trends. Notable exception(s) would be in instances where the perpetrator of the violence also died in a manner that meets the criteria established in Part 2 of the *Coroners Act*[8], and therefore required a coroner's investigation.

RCMP "E" Division Data

BC RCMP ("E" Division) provides service to all but 11 communities in B.C. "E" Division services 99% of the geographical area of B.C., and 72% of British Columbians live within RCMP jurisdiction.

The RCMP Data Analysis Unit conducted a manual review of available data sources of the list of intimate or ex-partners in this review. These data sources included PRIME-BC (police general occurrence reports), CPIC (criminal record information) and homicide surveys.

Due to time constraints, the Vancouver Police Department (VPD) was not engaged for this review. As a result, information for eight victims whose deaths fall under VPD jurisdiction were excluded, as was one victim where no records were found. Therefore, data was available for 93 of the 102 intimate or ex-partner victims (91%).

Of the 93 intimate/ex-partners linked with RCMP data:

- 37% had some police-reported incidents between the victim and perpetrator;
- 8% had no police-reported incidents but homicide surveys indicated a history; and
- 56% had no police-reported incidents (Table 17).

In 11 (12%) of the victim and perpetrator relationships, conditions were in place to restrict contact between the decedent and their intimate/ex-partner at the time of the homicide.

- In 7 of those relationships, conditions were given to the perpetrator by the court as part of a conviction for another criminal offence (e.g., assault, breach of probation, breach of bail violations, uttering threats, etc.);
- In 3 of those relationships, conditions were given to the victim by the court as part of a conviction for another criminal offense (e.g., assault, breach of probation, breach of bail violations, uttering threats, etc.);
- In one relationship, a family law protection order was in place.

Table 17: Intimate/Ex-Partner Deaths by Police Incidents between the Victim and Perpetrator	
	Number (%)
No/Unknown police incidents	52 (55.9%)
No police incident but history of IPV mentioned in homicide survey	7 (7.5%)
Yes, police-reported incidents	34 (36.6%)
Total	**93**

Of the 34 police-reported incidents:

- 74% had at least one violent incident;
- 26% had only non-violent incidents;
- 29% of the incidents occurred within one month of the death; and
- Half of the incidents that occurred within one month of death were violent (Table 18).

In over two-thirds of the relationships that had a police-reported incident, there were multiple incidents over the course of the relationship. In 10 (29%) of the relationships, there were 5 or more police-reported incidents.

Table 18: Intimate/Ex-Partner Deaths by Time Since Most Recent Police Incident		
	Most Recent Incident	**Most Recent Violent Incident**
Within 1 month	10 (29.4%)	5 (20.0%)
1-3 months	8 (23.5%)	5 (20.0%)
4-6 months	6 (17.7%)	4 (16.0%)
7-9 months	2 (5.9%)	2 (8.0%)
10-12 months	2 (5.9%)	1 (4.0%)
1+ years	6 (17.7%)	8 (32.0%)
Total	**34**	**25**

Of the 93 perpetrators, RCMP analysis found that:

- More than half had a history of assault (not just related to the intimate/ex-partner);
- 23% had a history of uttering threats; and
- 1% had a history of criminal harassment (Table 19).

Table 19: Criminal History of Perpetrator			
	History of Assault	**History of Uttering Threats**	**History of Criminal Harassment**
Yes	47 (50.5%)	21 (22.6%)	1 (1.1%)
No	46 (49.5%)	72 (77.4%)	92 (98.9%)
Total	**93**	**93**	**93**

**Perpetrators can fall under multiple categories.*

Medical/Mental Health History

The full BCCS investigation list was matched to the chronic disease registry, hospital records (**Discharge Abstract Database [DAD]**), and physician billings (**Medical Services Plan [MSP]**), to determine the medical/mental health history of the decedent and their health service utilization over the year preceding death.

Linkage with the datasets was successful for 134 of the decedents (99%), 121 of whom were intimate/ex-partner victims and perpetrators.

Chronic Disease Registry

The BCCS case list was linked to the Chronic Disease Registry to determine the percentage of deaths that had ever met the case definition for a mental health condition.

Data matched with the Chronic Disease Registry found that:

- 57% of decedents met the criteria for at least one mental health condition (55% of intimate or ex-partners and 65% of perpetrators);
- 51% had anxiety and mood disorders (51% of intimate or ex-partners and 55% of perpetrators);
- 26% had substance use disorders (30% of intimate or ex-partners and 10% of perpetrators); and
- 3% had schizophrenia and delusional disorders (Table 20).

Table 20: IPV Deaths by Chronic Disease, 2016-2024

	Intimate/Ex-partner	Perpetrator	Total
Depressive Disorders	42 (41.6%)	9 (45.0%)	51 (42.1%)
Mood & Anxiety Disorders (incl. depressive disorders)	51 (50.5%)	11 (55.0%)	62 (51.2%)
Schizophrenia & Delusional Disorders	3 (3.0%)	0	3 (2.5%)
Substance Use Disorders	30 (29.7%)	2 (10.0%)	32 (26.4%)
Total Cases Linked	**101**	**20**	**121**

Hospitalizations

The Discharge Abstract Database (DAD) captures all discharges, transfers and deaths occurring in acute care hospitals in BC. Any hospitalization associated with the death was excluded in the linkage. Hospitalizations include all admissions to hospitals but does not include emergency department visits. Of the 121 intimate/ex-partner or perpetrators linked to the DAD:

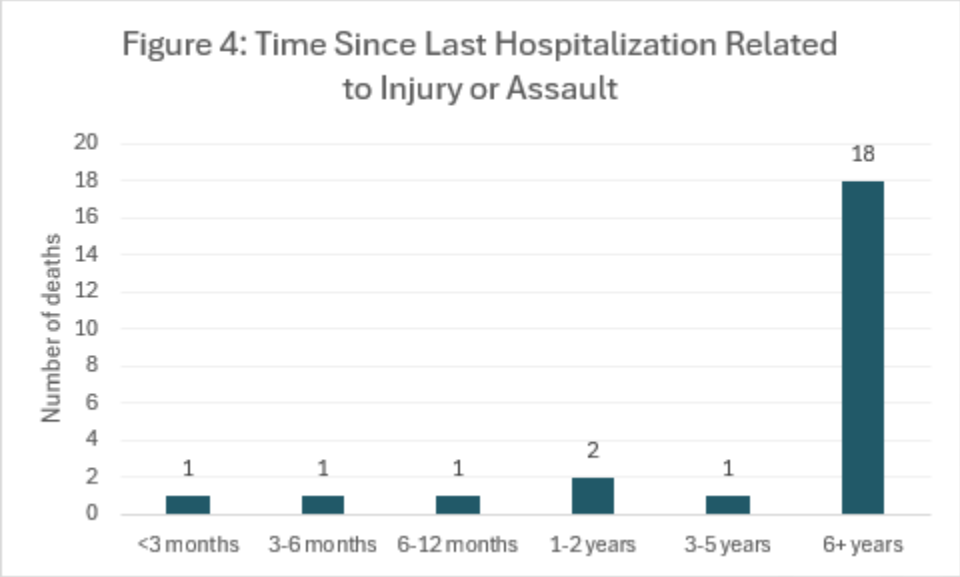
- 21% had a hospitalization in the year prior to death (21% of intimate/ex-partners and 20% of perpetrators);
- 20% had a prior hospitalization related to injury or assault (ICD 10 – S00-T32, T74, T76, T79, T90-T95, T98; X85-Y09) in their lifetime (20% of intimate/ex-partners and 20% of perpetrators); and
- 3% had a prior hospitalization related to injury or assault in the year prior to death (3% of intimate/ex-partners) (Table 21).

Hospitalizations related to injury or assault does not necessarily reflect the harms associated with intimate partner violence. These injuries could be the result of accidents, self-infliction, or caused by someone other than the intimate partner. However, as intimate partner violence tends to be underreported and with the lack of any further qualitative context of the injuries, all injuries or assaults are included in the results.

Table 21: IPV Deaths by Hospitalizations, 2016-2024

	Intimate/Ex-partner	Perpetrator	Total
Hospitalization within 12 months of death	21 (20.8%)	4 (20.0%)	25 (20.7%)
Prior hospitalization related to injury or assault	20 (19.8%)	4 (20.0%)	24 (19.8%)
Prior hospitalization related to injury or assault within 12 months of death	3 (3.0%)	0	3 (2.5%)
Total Cases Linked	**101**	**20**	**121**

Of the three intimate/ex-partners that had a hospitalization related to injury or assault within 12 months of death, one had their admission within 3 months of death, one between 3-6 months, and one between 6-12 months (Figure 4).



Medical Service Plan (MSP) Billings

Data on medical services provided by fee-for-service practitioners to individuals covered by the Medical Services Plan (MSP) were linked to our study cohort. MSP billings include all fee-for-serve practitioners, including laboratory and diagnostic procedures, and dental and oral surgery performed in hospital. It does not include services provided through alternative payment plans, such as salaried, sessional, and service agreement contracts. MSP data includes Indigenous decedents when such information could be confirmed by the First Nations Health Authority.

The linkage found that:

- 85% had an MSP billing within 12 months of death (86% of intimate or ex-partners and 80% of perpetrators);
- 31% of decedents had an MSP billing related to injury or assault (ICD 9 – 800-959, 995; E960-E969) within 12 months of death (35% of intimate or ex-partners and 15% of perpetrators); and
- 9% of decedents had a psychiatrist visit within 12 months of death (10% of intimate or ex-partners and 5% of perpetrators) (Table 22).

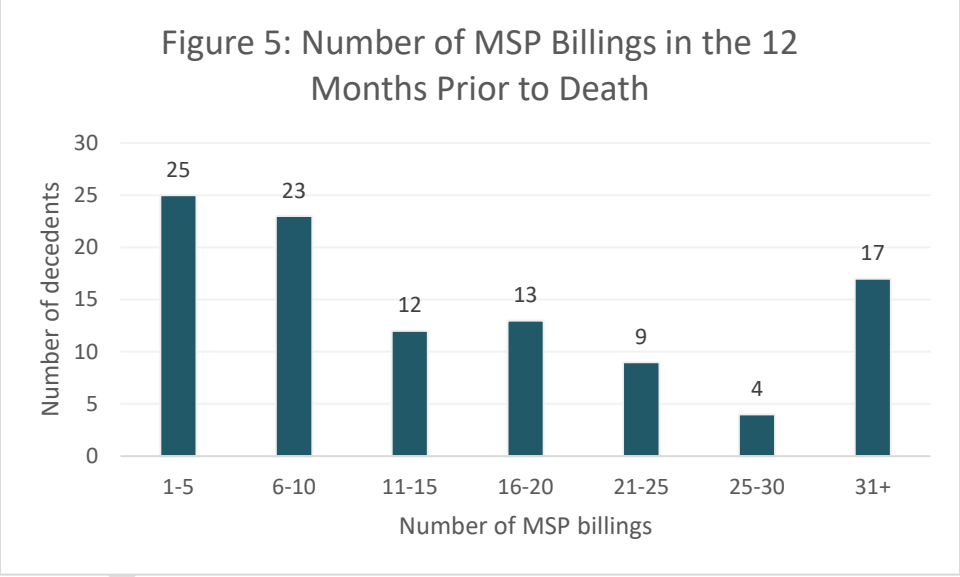
As with hospitalizations, billings for injury or assault may not accurately reflect the harms associated with intimate partner violence. However, without any further qualitative details of the circumstance of the billing, all injury or assault billings were included in the analysis.

Table 22: IPV Deaths by MSP Billings, 2016-2024			
	Intimate/Ex-partner	**Perpetrator**	**Total**
MSP billing within 12 months of death	87 (86.1%)	16 (80.0%)	103 (85.1%)
MSP billing related to injury or assault within 12 months of death	35 (34.7%)	3 (15.0%)	38 (31.4%)
Psychiatrist visit within 12 months of death	10 (9.9%)	1 (5.0%)	11 (9.1%)
Total Cases Linked	**101**	**20**	**121**

The 103 decedents that had an MSP billing within 12 months of death had, in total, 2044 billings which is an average of 17 billings per person.

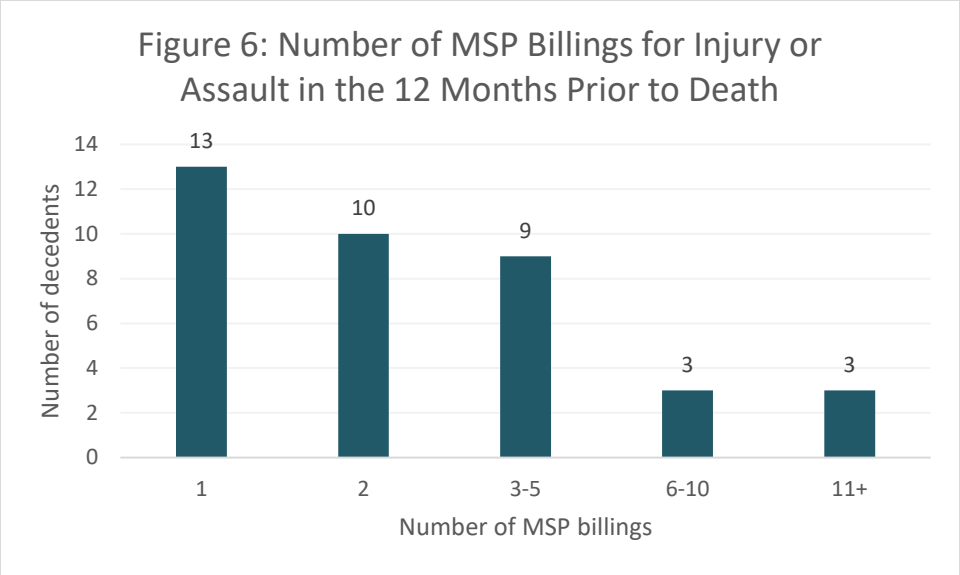
Among the decedents that had an MSP billing within 12 months of death:

- 24% had 1-5 MSP billings;
- 22% had 6-10 MSP billings; and
- 12% had 11-15 MSP billings (Figure 5).



Of the 38 decedents that had an MSP billing for injury or assault in the 12 months prior to death:

- 34% had one injury or assault related billing;
- 26% had two injury or assault related billings; and
- 24% had 3-5 injury or assault related billings (Figure 6).



PART 2: LITERATURE FINDINGS

The magnitude of harmful health and social consequences of IPV on survivors and children who experience abuse has been well documented, as have the economic costs to society.[4] The full scope of IPV harm, the context in which it exists, and the multisectoral approaches to IPV prevention and intervention are critical for understanding the complexity of IPV, and yet extend beyond what can be captured within this death review. The following literature is intended to provide context for the BCCS findings but cannot be considered an exhaustive review on this topic.

It is well documented that one of the most significant risk factors for intimate partner homicide is a previous history of intimate partner violence, so it is imperative to recognize the prevalence of and risk that non-lethal violence presents, while also acknowledging the impossible task of predicting lethal risk. Nevertheless, "(Intimate partner homicide) is rarely an isolated act of violence, and most IPV cases do not end in homicide, so it is necessary to understand '*why certain relationships end in lethal violence and others do not*"'.[20]

Prevalence

- As of 2018, 44% of women in Canada who had been in an intimate relationship had experienced intimate partner violence[4];
- As of 2019, an estimated 80% of Canadians who had experienced IPV did not report it to the police[11] ; and
- In British Columbia, 48% of women over age 15 are estimated to have experienced IPV.[14]

The global prevalence of **intimate partner homicide (IPH)** is 13.5%; 38.6% of homicides of women and 6.3% of homicides of men are committed by an intimate partner.[21]

Between 2011 and 2021, police reported 1,125 homicides of women and girls in Canada; 66% of these were perpetrated by a current or former intimate partner.[22] While the national police-reported homicide rate decreased from 1.99 homicides per 100,000 population in 2023 to 1.91 homicides per 100,000 population in 2024, intimate partner homicides rose from 72 in 2023 to 100 in 2024.[23]

> *"While global rates of homicide have declined since the 1990s, global rates of intimate partner homicide (IPH) have remained relatively stable."*[21]

COVID-19 Pandemic

In March 2020, the World Health Organization declared a pandemic regarding coronavirus SARS-CoV-2 (COVID-19), an infectious disease that was first detected in China in December 2019.

Among its impacts, measures related to self-isolation and social distancing kept people experiencing or at risk of experiencing IPV violence in closer contact with their abusers and further entrenched existing barriers to interpersonal and community supports intended to increase survivor safety.

The Office of the Provincial Health Officer reported that mental health, suicide and violence crisis lines experienced a significant increase in call volume since the onset of the pandemic; many stressors related to poor mental health and an increased risk for suicide, like housing instability, employment loss, and increased substance use, are also associated with a higher risk for IPV.[24]

Indigenous, racialized and gender-diverse populations that already experienced marginalization and discrimination prior to the pandemic reported a generalized increase in violence, both with respect to onset and intensity, since the pandemic began.[25]

Globally, the World Health Organization declared IPV a public health crisis from data in 2018[4]; since the outbreak of COVID-19, UN Women has labelled IPV the "Shadow Pandemic" as rates in many countries around the world have increased at the same time access to supports have decreased.[26]

> *The COVID-19 pandemic and response measures to limit the spread of COVID-19 increased the risk, and likely also the prevalence and severity, of gender-based violence (GBV) in B.C., while reducing access to related support services.[24]*

Barriers to Reporting

It has been estimated that as many as 80% of Canadians who have experienced intimate partner violence do not report it to police.[11]

Violence is more likely to come to the attention of police when there is a higher frequency and/or severity of abuse. Fear of shame and stigma, ineffectiveness of police response, and lack of trust in the criminal justice system to provide justice and safety are among survivors' most commonly self-reported reasons for not reporting IPV to law enforcement authorities.[11,27] These concerns can be particularly acute in rural and remote areas, where there is a much greater likelihood that a survivor would know the authority to whom they would be required to report.

Some survivors have reported privacy concerns (including the belief that IPV is a personal matter), fear of reprisal, fear of the perpetrator, a desire to protect the perpetrator, and a belief that the incident is not important enough to report as reasons not to report IPV.[11,27] Similarly, a meta-analysis

of survivors of attempted intimate partner homicide has highlighted their general underestimation of the potential danger or capability of their partner to use lethal violence.[21]

Indigenous (First Nations/Métis/Inuit) women face additional barriers, resulting from Indigenous-specific racism and colonization, with respect to obtaining supports intended to increase safety from IPV. "Systemic racism contributes to barriers that may further prevent many Indigenous women from seeking help following violent or traumatic experiences, such as cultural barriers to accessing resources, inaccessibility of supports and services, and the mistrust in the police, criminal justice system, and institutions intended to protect".[28]

The over-policing, racial profiling, and discriminatory use of force towards Indigenous peoples, and the failure to adequately respond to missing and murdered Indigenous women and girls has been nationally documented.[29] Additionally, the structure and governance of colonial policing, both with respect to its historical involvement in enforcing child apprehension and residential schools and its modern day approaches to policing in Indigenous communities, has upheld racism.[29]

Furthermore, "disproportionate apprehension of Indigenous children continues today, and fears of child apprehension have the added effect of dissuading Indigenous women from reporting IPV victimization".[30] When Indigenous (First Nations/Métis/Inuit) women do come forward, criminal justice system bias contributes to a tendency to disbelieve their experiences of IPV, "further victimizing them through criminalization, increased surveillance, and inaction."[30]

Age and Biological Sex

National police-reported data indicates that there were 128,175 victims of police-reported IPV over age 12 in 2024, with 78% of victims being women and girls.[31] Women experienced a higher rate of IPV than men, and women are considerably more likely than men to experience the most severe forms of IPV. [11,32] While local police data may include the identification of victims as non-binary, all victims have nationally been coded as either "women and girls" or "men and boys" to ensure the protection of confidentiality and privacy.

B.C.'s Office of the Provincial Health Officer has acknowledged that gender diverse and non-heterosexual persons are at higher risk of gender-based violence due to intersections of oppression including sexism, racism, colonialism, homophobia, transphobia and ableism.[24] Overall, there is a lack of literature examining gender, sexual orientation, and men's experiences of IPV.[4] The frequent utilization of binary language does not acknowledge the reality of IPV experienced by gender diverse people.

Between 2014 and 2019, 75% of female intimate partner homicide victims in Canada were killed by a current or former spouse or common-law partner, and 65% of male intimate partner homicide victims were killed by a spouse or common-law partner.[11]

Based on police-reported data in Canada, most IPV is perpetrated by males.[22] While previous experience of IPV victimization is unknown for the perpetrators in this review, "research has found previous IPV victimization is a risk factor for female-perpetrated intimate partner homicide, which supports a theory that female-perpetrated intimate partner homicide may be the result of self-defense".[21,33] In the US and Canada, there has been a decline in female-perpetrated intimate partner homicide since the 1990's but not for male-perpetrated intimate partner homicide.[21]

Possessing less than a high school education has been identified as a risk factor that increases the likelihood of male-perpetrated intimate partner homicide by 70%, and being employed has been associated with a 50% decrease in the likelihood of male-perpetrated intimate partner homicide.[21] However, when compared to non-IPV homicide, perpetrators of IPV homicide are more likely to have completed high school and be employed, which suggests that additional factors mediate the likelihood of intimate partner homicide occurrence.[2021]

Homicide-Suicide

Between 2011 and 2021 in Canada, 21% of "persons accused of a gender-related homicide [66% of which were perpetrated by an intimate partner] where at least one woman or girl was killed resulted in the suicide of the accused, seven times higher than what was found among persons accused of committing a non-gender-related homicide".[34] Suicide following an IPV homicide is more common among males, and rare among females.[20] A review of intimate partner homicide-suicide has identified that suicide is typically a secondary decision that is related to control as an alternative to criminal justice consequences.[33]

Furthermore, "…it can be assumed that perpetrators of homicide-suicide have an inability to successfully cope with life disappointments, such as a terminated relationship, financial issues, illness, functional disability, depression, or shame", and that they are primarily suicidal but choose to kill their partners and children because they are viewed as property or part of an 'extended self'.[33]

Indigeneity (First Nations/Métis/Inuit)

The erasure of inherent rights to self-determination, land, family, community and health through systematic colonization and racism has resulted in lasting and ongoing impacts on the wellbeing of Indigenous communities.

> *The significant, persistent, and deliberate pattern of systemic racial and gendered human rights and Indigenous rights violations and abuses – perpetrated historically and maintained today by the Canada state, designed to displace Indigenous Peoples from their land, social structures, and governance and to eradicate their existence as Nations, communities, families, and individuals – is the cause of the disappearances, murders, and violence experienced by Indigenous women, girls, and 2SLGBTQQIA people, and is genocide. This colonialism, discrimination, and genocide explains the high rates of violence against Indigenous women, girls, and 2SLGBTQQIA people.*[16]

Indigenous (First Nations/Métis/Inuit) youth and women age 15 and older are 61% more likely to experience IPV in their lifetime when compared to their non-Indigenous peers.[30] As of 2019, 7.5% of Indigenous people who were married or in common-law relationships reported IPV within the previous five years compared with 3.4% of non-Indigenous people.[35]

Furthermore, "IPV against Indigenous women is frequent, overtly violent, and more often fatal"; data from 2019 noted that approximately 25% of victims killed by a spouse or partner in Canada were Indigenous, despite Indigenous women making up only 3% of the Canadian female population as of 2016.[11,30,35]

Race, Ethnicity, and Immigration Status

On January 29, 2026, the Province of British Columbia released The Racial Identity Data Standard to support "a consistent and culturally safe approach to collecting racial identity data." However, as of the convening of the Panel, there was no provincial data standard for collection and reporting of race-based information.

The *Anti-Racism Data Act*, which was introduced on May 2, 2022, and before being passed unanimously through the legislative assembly and receiving royal assent on June 2, 2022, has allowed the Province to begin the work to collect intersectional demographic data, such as age, gender identity and ethnic origin. This will align B.C. with all jurisdictions in Canada, helping break down barriers and better identify interconnected issues, such as economic status, employment and outcomes in health care. BCCS recognizes the importance of aligning its work with provincial data standards in a manner that recognizes and addresses systemic racism and other prejudice.

BC Coroners Service investigative protocols do not include comprehensive questions related to a decedent's racial, ethnic or cultural identity, or immigration status, but the BCCS acknowledges that these demographics are critical to consider in the context of IPV.

Self-reported Canadian data indicates that 29% of women belonging to an ethno-cultural group that is a visible minority have experienced IPV in their lifetime, but visible minority women and non-visible minority women were equally likely to have experienced physical and/or sexual IPV within the past 12 months.[36]

Singh (2010) warned against 'culturalized' explanations of violence, as they can perpetuate the image of the oppressed, non-Western woman.[37]

Studies regarding the experiences of immigrant women in Canada have focused on one specific subculture within each study rather than attempting cross-cultural research, which highlights the fact that, much like other variables related to experiences of IPV, cultural beliefs and experiences are not homogenous, and the needs of people seeking safety must be acknowledged individually.[37] Furthermore, non-Western cultures should not be pathologized as the source of beliefs that sustain intimate partner violence.

Immigration increases vulnerability for people with respect to IPV given challenges with the processes of acculturation, "…such as learning the language, laws, and rights of the host country; social isolation due to the physical distance away from their family, friends, and community; and nonrecognition of their educational credentials, which often limits their access to gainful employment".[37] Additionally, racialized communities experience heightened levels of discrimination by police in Canada, which may exacerbate the isolation of racialized immigrants due to warranted mistrust of law enforcement.[29]

Sociocultural factors like patriarchal beliefs about women's submission to men, believing that children should grow up with married parents, and believing that marriage is a lifelong commitment can be shared by both Canadian-born and immigrant populations. Ultimately, the structural barriers related to economic and citizenship requirements are what leave immigrant women with less power and fewer resources than Canadian-born women who experience IPV.[37]

It is not merely the originating culture's beliefs and ways of life that block individuals' paths towards more egalitarian relationships between men and women; exclusionary and inferiorizing practices in the host country need to be considered as we try to understand the occurrence of gender-based violence in postmigration contexts.[37]

Relationship Status and Living Arrangement

In 2019, there was a higher prevalence of police-reported IPV for current partners compared with former partners, and for unmarried partners compared with married partners.[11]

Studies have identified that separation, or even a threat of separation, is a risk factor for intimate partner homicide due to the perpetrator's loss of control over their victim; the risk increases for women who are separated after having lived with their partner.[38]

Research has also determined that residing with a child presents a clinically (but not statistically) significant risk factor for IPV.[39] While this review does not further identify the circumstances related to a child residing with the decedent with respect to the age and number of children in the home, whether the decedent was pregnant, or the child(ren)'s relationship to the perpetrator, systematic reviews have identified unplanned pregnancy and experiencing IPV while pregnant as risk factors for non-lethal female IPV victimization, and having children from a previous relationship as a risk factor for intimate partner homicide.[20,21,39]

Additionally, one study suggests that "as many as one in five cases of homicides of children aged 2 to 14 years in the U.S. may be related to IPV".[40] An international review of children killed in the context of IPV indicates that fathers are more likely to kill their children as an act of revenge towards their intimate partner in the context of separation, and following a prior history of domestic violence.[41] Children who live following the homicide of their parent have been referred to as the hidden victims of intimate partner homicide due to the traumatic stress experienced from witnessing IPV, sometimes witnessing intimate partner homicide, and loss of one parent because of intentional harm inflicted by the other parent.[42]

> *"Children's exposure to and experiences of IPV and family violence and the associated harms are well documented in research yet, in practice, the safety, well-being, and needs of children who are exposed to violence are often overlooked, with the focus remaining on the adults involved."*[15]

Geography

Geography has a significant impact on the prevalence of IPV in Canada, as well as on the ability for people to escape violence. In 2023, Statistics Canada reported that the rate of IPV in rural communities was nearly double that of urban communities, with rates being nearly four times higher in the rural North than in the rural South.[43]

As of 2016, Indigenous (First Nations/Métis/Inuit) women and girls accounted for 72% of the female population living in the most remote communities in Canada, and this population has previously been identified as experiencing higher rates of IPV compared with their non-Indigenous peers.[44] "In 2021, the rate of gender-related homicide in Canada was more than 2.5 times greater in rural areas compared to urban areas."[6]

While some of the challenges related to escaping IPV are similar for women in remote communities and urban centres, including intergenerational trauma, patriarchal values and the normalization of IPV, limited finances, unaffordable and unsafe housing, these challenges are compounded in remote communities. In fact, in many rural communities, the infrastructure and resources required to effectively support survivors are simply not available.

Women in rural communities have reported barriers to seeking support or leaving relationships related to limited transportation, having a responsibility to care for farm animals, and being concerned about confidentiality in a small community where everyone is known to one another.[45] Smaller communities more often operate under fluctuating economies that can create increased stress in times of economic hardship, and residents of rural communities also have 2 to 3 times longer travel distance to medical care compared with residents in urban communities.[45,46]

Means of Violence

In 2019, 72% of Canadian victims of police-reported IPV were assaulted using physical force, with 54% experiencing a physical injury.[11] The pattern of the method used to cause death for gender-related homicides [66% of which were perpetrated by an intimate partner] of women and girls in Canada between 2011 and 2021 differs according to urban and rural locations; the largest proportion of victims in urban locations died by stabbing (39%), followed by beating (19%) or strangulation (19%), whereas the largest proportion of victims in rural locations died by firearm (33%), followed by beating (25%) and stabbing (22%).[34]

While there are psychological and behavioural factors associated with intimate partner homicide risk, "the risk factor that increased the odds of intimate partner homicide occurring the *most* was the perpetrator's direct access to guns, meaning that the perpetrator had guns in their home or could readily access a gun". This factor increased the risk of intimate partner homicide compared with IPV by 11 times.[21] This meta-analysis was limited to male perpetration and female victimization of intimate partner homicide, and while 11 of the 17 studies originated from the United States where firearms are more widely available, the remaining 6 studies were international samples that included Canada and European countries with similar firearms restrictions.

In 2024, there were 2,425,627 firearms license holders and 1,269,076 registered firearms in Canada; 368,433 of those licenses were provided to individuals in B.C., which represents 15.2% of all licenses.[47]These numbers do not account for individuals who have access to firearms but do not hold a license, or for firearms that are not registered. Across Canada, a firearm was present and relevant to the commission of the offence against 1.6% of all victims of police-reported IPV in rural communities compared with 1.0% of all victims of police-reported IPV in urban areas.[43]

Between 2011 and 2021 in Canada, "about four times as many victims of gender-related homicide [66% of which were perpetrated by an intimate partner] died of strangulation, smothering or

drowning (17%) compared to victims of non-gender-related homicides (4%)".[34] A previous history of non-fatal strangulation has been identified as a risk factor for intimate partner homicide, increasing the risk by over 7 times.[21,48]

Criminal History

A meta-analysis examining risk factors for male perpetration of and female victimization in intimate partner homicide noted that "one of the most recognized predictors of completed intimate partner homicide is a previous history of intimate partner violence", where up to 75% of intimate partner homicide had a known history of IPV.[21] Furthermore, this review emphasized that "…intimate partner homicide often occurs after prolonged violence in a relationship", which occurs at the end of a spectrum of escalating violence behaviours.[21]

Other significant risk factors include previous threats with a weapon, nonfatal strangulation, stalking, sexual violence, separation (both the day of and the first three months after), and jealous and controlling behaviours.

> *A criminal or violence history in general is not a statistically significant risk factor, so it's important not to presume that (intimate partner homicide) is less likely to happen if these factors are absent.*[21]

Health Care

Women who experience IPV present to health care professionals more frequently than women who do not experience IPV. It is estimated that between 38 and 59 percent of women who present to health care professionals have experienced IPV.[49]

IPV screening can identify IPV experiences and inform interventions to improve survivor health outcomes. Despite the use of IPV screening in health care settings, due to a lack of standardization and evaluation of effectiveness, it is unknown whether screenings result in interventions that prevent future IPV.[49] One review of resources developed to support physician knowledge and readiness to respond to disclosures of IPV suggested that physicians may be ill-equipped to address the complexity of patient needs related to IPV after disclosure.[50]Furthermore, research regarding IPV screening is predominantly focused on referrals and treatment for victims rather than perpetrators.

Another review of patient and emergency care provider experiences with IPV "demonstrated a lack of [trauma-informed care] contributing to decreased care-seeking behaviors. This may lead to increased morbidity and mortality, as highlighted by studies demonstrating a link between social isolation and IPV-related injury and death".[51] That review recommended that trauma-informed care and resourcing be in place for both patients and practitioners, particularly given the likelihood that practitioners may have experienced IPV themselves, prior to implementing screening for IPV in order to avoid causing harm by prompting disclosure without appropriate support available.

A review of Indigenous-specific racism in B.C. health care has also highlighted the widespread stereotyping and discrimination that exists within this system, particularly in emergency departments, and disproportionately experienced by Indigenous women and girls; a trauma-informed health care system must include standards and training for anti-racism and cultural safety.[52]

PART 3: CONTEXT

There are two streams of focus with respect to prevention and intervention-based initiatives related to intimate partner violence: those intended to prevent the initial occurrence of IPV, and those meant to prevent future harm when IPV has already occurred. These approaches are not necessarily distinct, and there is recognition that multiple interventions to address IPV-related harms are required.

Furthermore, because there are a multitude of meaningful outcomes that arise from interventions for IPV, it can be difficult to measure which outcomes have a direct impact on IPV reduction; regardless, they are no less valuable for the potential to change the trajectory of a victim's experience and safety and a perpetrator's accountability.

Understanding Risk

Risk factors are characteristics or conditions that may increase the likelihood that someone experiences or perpetrates intimate partner violence, whereas **protective factors** are characteristics or conditions that may decrease that likelihood. Neither are causal or predictive.

Risk and protective factors are complex, dynamic across time, and influenced by personal, social and environmental factors. As such, individuals aren't inherently "vulnerable" or "at-risk" but instead may experience stressors that increase the likelihood that they require support to navigate their unique needs, may be targeted or may experience systemic oppression that results in the overrepresentation of some communities.

Violence risk assessment involves identification, measure and combination of risk factors, and results in the production of a final risk assessment.[53] The primary goal of risk assessment is to prevent further harm to survivors of IPV, but increased transparency and consistency in decision-making as it relates to the accused's rights are also considered goals.[54] Multiple risk assessment tools exist; some are survivor-focused whereas others are perpetrator-focused, and different assessments may be utilized for IPV and intimate partner homicide.[54]

It has been recognized that IPV lethality may increase with the number of risk factors, but the relationship is not linear; "for example, a case with two risk factors that regularly co-occur may be as or more lethal than a case with multiple different risk factors".[55] An international review of the predictive validity of IPV risk assessments has been evaluated as low to moderate, but the influence of many variables makes it difficult to compare results from different studies. For example, assessments may be conducted by different professionals, in different settings, with different tools, with or without supervision, measuring different outcomes, and with varied protective actions and follow-up time for evaluation of recidivism.[53,56]

Furthermore, risk has been defined "as a hazard that by definition is unknown and therefore can only be predicted with uncertainty".[56] As such, risk must be contextualized as a dynamic variable that can

change across time and circumstance. Literature also acknowledges that it is difficult to infer risk causality given that studies do not always account for participants' experiences of IPV prior to exposure to risk or protective factors.[39] The lack of reliable processes for risk assessment and coordinated safety planning has been highlighted as an ongoing challenge in B.C. for decades.[14]

Education

> *The importance of exposure to violence as a child or witnessing parental abuse as a child in shaping both the risk of victimization of women and for perpetration by men highlights the need to take a life course perspective, particularly in examining interventions that are aimed at preventing or addressing violence against children.* [36]

Exposure to violence in childhood has been identified as a risk factor for both the victimization of women and the perpetration by men of intimate partner violence in heterosexual relationships.[57] Similarly, experiencing IPV and/or sexual assault as an adolescent, either as victim or perpetrator, increases the risk of experiencing and/or perpetrating future violence. Interventions that disrupt cycles of violence early in a person's developmental trajectory are imperative for long term change.

There is some evidence that parenting programs targeting social and emotional skill building in high-income countries, including Canada and the United States, can prevent child maltreatment and reduce antisocial behaviour in children.[57] While this modifies known risk factors for adolescent IPV, there is no known longitudinal follow-up to prove their efficacy in IPV prevention.[47]

School-based education programs directed at high school and university students that help shape healthy relationship beliefs and behaviours to prevent IPV before it occurs have shown promise, indicating that it is more beneficial to create environments that make violence unacceptable than to place the onus on individuals to protect themselves.[57]

Community-based sports and parenting programs for males have shown changes in attitudes related to violence but have not shown reductions in violence perpetration. Many of these studies were also implemented in high-income countries, including Canada and the United States, but any further socioeconomic or geographic analysis was not available.[57]

Survivor Supports

A systematic review of 57 articles has highlighted that empowerment-based advocacy and cognitive clinical interventions are most effective for improving mental and physical health outcomes and reducing revictimization.[58] **Cognitive Behavioural Therapy (CBT)** interventions for survivors of IPV have shown greater potential in reducing revictimization compared with other clinical interventions given its particular focus on problem-solving, facilitating choice making, and techniques for altering distorted self-thinking.[58] Additionally, CBT has been associated with reductions in depression, anxiety, and post-traumatic stress symptoms for survivors.[58]

A core focus of services offered, which has been highlighted for immigrant populations but applies to Canadian-born women as well, should be the empowerment of survivors' decision-making processes instead of the imposition of solutions that may not meet their needs.[37]

Empowerment theory is focused on increased autonomy, the gaining or regaining of control, and the ability to create individual opportunities and decision-making".[58] This is the foundation of advocacy-based interventions that are focused on providing support for violence, safety planning, and community referrals, which have been shown to be useful for improving safety and quality of life following an acute violence event or upon leaving shelters.[58]

Additionally, a recent qualitative study of Indigenous women's experiences of utilizing IPV supports highlighted the importance of including Indigenous-specific approaches, as well as implementing efforts to improve the cultural safety and availability of services at large so that women have choice in what approaches best meet their needs.[59]

The literature has also identified the importance of basic life needs and safety being met, both as a direct contributing factor to improved mental and physical health outcomes, and before women are able to focus on interventions targeting those needs.[58]

Ultimately, continued exposure to violence moderated outcomes for both promising approaches, which speaks to the need for interventions that target perpetrator behaviour, as well as safe exits from violence in order to decrease long-term risk.[58]

Legal System

Recidivism is the likelihood that an individual who has already committed a crime will re-offend. Most interventions that target recidivism are only available to perpetrators once an act of intimate partner violence has come to the attention of law enforcement, and subsequently, the criminal justice system.

Canadian data indicates that, while 65% of IPV survivors who reported their experiences to police were satisfied with the response, they were likely to be dissatisfied with the court process due to the lack of control and feeling re-victimized over the process.[27] Their experiences with officers, counsel and judges varied greatly based on the individual; the concept of feeling "lucky" was identified as a key driver in whether survivors experienced safe and helpful responses to their report of IPV, suggesting that confidence in the response may play a role in whether, when, or how survivors seek help.[27]

Perpetrator-Focused Interventions

Behavioural Intervention Programs (BIP) are interventions that target perpetrators to prevent further incidents of IPV. Systematic reviews and meta-analyses have highlighted challenges with respect to identifying the effectiveness of recidivism prevention interventions as variable treatment characteristics, populations, study design, and outcome measures ultimately impact the ability to compare and replicate research.[60–62]

Where evidence for behaviour change interventions have pointed to a reduction in IPV, there may be limitations to attributing that reduction to a particular variable:

> *Evidence that points to a reduction in [domestic family violence]/IPV during a perpetrator's participation in a behaviour change intervention may be closely related to the scrutiny of [domestic family violence]/IPV-related behaviour offered by the program, or the duration of a protection order, rather than the impacts of the intervention itself. It may also be related to the fact that many perpetrators mandated to the majority of behaviour change interventions are more likely to be further entrenched in the criminal justice system. Conversely, the evidence that finds an increase in recidivism as a result of a perpetrator's participation in a program may not necessarily be due to actual increased prevalence of [domestic family violence]/IPV, but rather because a perpetrator's partner may be more confident to report the violence experienced.*[61]

Rather than relying on stand-alone standardized treatment programs, there is recognition of the need to tailor interventions based on a risk-need-responsivity approach whereby evidence-based intervention components are utilized to target relevant risk factors for IPV offending, with particular attention paid to comorbid substance use and trauma-related conditions.[60,61]

One review noted that "…where criminal sanctions were not forthcoming, and a perpetrator was not responding to intervention, empowerment of the victim and survivor may be the only route to safety."[61]

It is clear that we need to be guided by rigorous research in helping us set our course. While better research is needed to determine the effectiveness of court-mandated BIPs, the results from the meta-analysis do not provide confidence that these programs will be found to be effective. Therefore, it would prove beneficial for the criminal justice system to begin looking at other types of interventions for addressing the problem of intimate partner violence. But these interventions must be tied to rigorous evaluations to determine their full impact. [40]

Restorative Justice

Restorative justice (RJ) is an alternative approach to the criminal justice system that is intended to elevate survivor and perpetrator engagement in response to crime, viewing crime "…not as a depersonalized breaking of the law but as a wrong against another person as well as the

community".[63] It is intended to offer a relational opportunity for change through dialogue about impact, accountability, and problem solving with all impacted parties following crime.[64] There are multiple methods of restorative justice practices, some of which have originated from Indigenous communities in North America, some of which are integrated with court processes, and with varying levels of voluntary survivor participation. [63,64]

The application of restorative justice in the context of IPV has been controversial due to the perception that it delegitimizes the seriousness of IPV and gets used as diversion for the perpetrator, and like the criminal justice system, focuses more on the outcome from the perpetrator than on the needs of the survivor to the detriment of victim safety.[63]

While the literature is inconclusive about what methods of RJ work; under which circumstances of IPV; for which perpetrators, victims and communities; and how efficacy is defined, there is emerging evidence of its utility to address violence and promote healing when combined with traditional interventions.[63] Additionally, given the shortcomings of the criminal justice system, RJ approaches that address existing critiques and centre survivors' needs have "the potential to develop more radical, nuanced and transformative remedies than we currently have".[64]

PART 4: PROVINCIAL RESPONSE

British Columbia has undertaken a major, system-wide effort to reform how the province responds to acts of intimate partner violence. This includes implementing a gender-based violence action plan, commissioning an independent review of the legal system's response to IPV, updating IPV-related prosecution policies, and shifting toward a more coordinated, survivor-centred approach.

Safe and Supported: B.C.'s Gender-Based Violence Action Plan (2023)[2]

- The province's primary framework for preventing, reducing, and responding to gender-based violence, including IPV.
- The plan takes a multi-sector, survivor-centred, prevention-focused approach that includes housing, justice reforms, crisis supports, and Indigenous-led initiatives

Key Actions

- Increasing safety and supports for survivors of IPV by establishing new crisis lines, offering free virtual counselling, and adding new sexual assault support programs, 22 of which specifically serve Indigenous women;
- Improving access to safe housing for women and children leaving violence;
- Strengthening justice system responses to IPV, including new policing standards, stronger victim supports, and enhanced training;
- Addressing gaps identified by survivors and community partners, including longer waitlists, lack of culturally safe and community-based services, and inadequate access for Indigenous, racialized, newcomer and gender-diverse populations;
- Supporting Indigenous-led responses to IPV;
- Expanding prevention and awareness campaigns.

Independent Systemic Review (2024–2025)[14]

- Commissioned by the Attorney General in May 2024 to examine how the legal system handles IPV and sexual violence.
- Led by Dr. Kim Stanton, the review gathered input from survivors, frontline workers, police, Crown counsel, and community organizations.
- The Final Report (June 2025) identified IPV as a serious, pervasive, and systemic problem requiring urgent reform.

Key Findings

- Survivors face major barriers, including:
    - Siloed services;
    - High financial and procedural costs;
    - Lack of intersectional supports;

- Victim-blaming and re-traumatizing processes; and
- Community-based support workers (CBSWs) are essential but under-resourced.

Major Recommendations

- Declare gender-based violence an epidemic.
- Create an independent Gender-Based Violence Commissioner.
- Reform court processes and safety planning.
- Strengthen community-based supports.
- Expand public education and institutional training.
- Deepen cross-sector collaboration – including funding and support.
- Improve accountability mechanisms across ministries.

Don't Look Away (2024)[15]

- Report from B.C.'s Representative for Children and Youth demonstrates that family violence is a systemic issue, not an isolated tragedy.
- The report calls for deep structural reform—including stronger violence prevention mechanisms, better inter-agency coordination, enhanced oversight, improved family supports, and Indigenous-led approaches—to prevent future harm and ensure children grow up safe, connected, and protected.

Key IPV- and Family Violence-related Findings

- High prevalence of family and caregiver violence.
- Existing systems failed to identify or respond to warning signs.
- Inter-agency fragmentation contributes to unsafe conditions.
- Indigenous children are at heightened risk due to colonial/systemic inequities.

Major Recommendations Related to Addressing Family Violence

- Strengthen violence prevention and early risk detection.
- Improve cross-sector and cross-government coordination.
- Strengthen accountability and oversight to ensure safety.
- Increase supports for families and kinship caregivers.
- Prioritize indigenous-led, culturally grounded approaches.

Government's Current Actions & Commitments

- Reviewing all recommendations from the Independent Systemic Review.
- Acknowledged IPV and sexual violence as urgent, underreported, and systemic issues.
- Committed to improving coordination across justice, health, and social services sectors.
- Engaging with survivors and community organizations as part of implementation planning.

Strategic Implications

For Government

- Need for cross-ministry coordination and long-term funding.
- Potential creation of new oversight structures (e.g., GBV Commissioner).
- Requirement to modernize justice processes and reduce systemic barriers.
- Enable the gathering of meaningful data
-

For Community Organizations

- Increased recognition of the role of CBSWs.
- Potential for expanded funding and integration into justice pathways.

For Survivors

- Potential for safer, more accessible, and more trauma-informed services.
- Improved communication and accountability from the justice sector.

The decedent and her spouse were not from Canada, but they met in B.C. and had been together for approximately ten years. They lived in the Lower Mainland and did not have children.

A coroner's investigation revealed a significant history of escalating violence, control, isolation and dominance by the spouse. In the months preceding her death, the decedent had communicated with family about her spouse's threats to kill her and the weapons he had purchased. She was encouraged to go to a transition house, which she did for several weeks approximately two months before she was killed. On the day that she attended the transition house, the spouse called police and alleged that she assaulted him. She called the police later that day as the spouse was refusing to give her the keys to her vehicle so she could leave. Police attended, and both parties indicated they would be initiating divorce proceedings.

Two days before she was killed, the decedent attempted to find space at a transition house again, but her spouse found out and advised the transition house not to admit her. There is no indication that police were notified of this.

In the early morning hours of the day the decedent was killed, her spouse called 911 to request an ambulance, alleging that she attacked him, that he defended himself, and that she was now unconscious. He was later convicted of second-degree murder.

When EHS and police had attended the scene, they found a packed suitcase with women's clothing, the decedent's passport, and laptop nearby. The laptop's browser history indicated that the decedent had been searching for rental housing the day before and the morning that she was killed.

PART 5: PANEL DISCUSSIONS

The Panel considered aggregate findings from coronial investigations, a review of relevant literature, and the insights and experiences of fellow panel members to guide its discussions.

Panelists acknowledged that both the number of intimate partner violence-related deaths and the number of British Columbians at risk of experiencing violence and death remain unacceptably high. It further acknowledged that large-scale, systemic changes can take time to realize, and that some smaller, more acute interventions should be urgently considered to support the population(s) at immediate risk while larger opportunities for change are being implemented.

Early Prevention and Education

Panel conversations repeatedly emphasized that intimate partner violence should be recognized as both a preventable public health and public safety issue AND a crime.

This positionality is complicated by the reality that systemic normalization permits IPV to often be seen as a family issue, and not a criminal act. This directly perpetuates harm and, as such, must be challenged through social, cultural, and legislative change.

The Panelists also discussed the importance of ensuring that public education not be focused only on victims but also focused on men and boys to encourage non-violent behaviours, to encourage and educate on healthy ways to deal with anger, and to communicate the social unacceptability of IPV.

Prevention efforts must begin early—ideally at conception—through targeted parenting education focused on healthy relationships, communication, and conflict resolution. Education campaigns, particularly those leveraging social media, were proposed to shift societal norms and reduce the normalization of violence. Schools play a key role in prevention, with programs like Respectful Futures[65] and Violence is Preventable (VIP)[66] promoting age-appropriate awareness and resilience among youth.

Panelists agreed that a focus on inviting men into solutions to end GBV is important as currently men who care deeply about this issue don't always know how to get involved or be part of the solution. The Be More than a Bystander[67] program was mentioned as a well-recognized initiative that invites boys and men to become leaders in getting involved to end GBV.

It was acknowledged that prevention should be localized, as such an approach would best ensure the issues specific to individual communities are effectively addressed. Men's circles were identified as examples of successful preventive measures created and implemented by Indigenous communities in response to their unique challenges.

The Panel further stressed the importance of training and supervision for frontline workers, ensuring consistent, culturally safe, trauma-informed responses. Prevention must also include support for individuals at risk of causing harm, with emotional health screening, appropriate supports and interventions when positive screening occurs, and accountability measures. Finally, better data collection—as well as qualitative and community-sourced—was seen as vital to understanding both survivor and perpetrator journeys and informing effective, localized interventions.

Integrated Data Infrastructure

The Panel acknowledged the urgent need for a more integrated and coordinated data infrastructure to support effective responses to intimate partner violence.

Current data systems are fragmented, siloed, and often fail to capture the full scope of experiences, particularly from rural, Indigenous, and marginalized communities. There was strong advocacy for de-siloing data collection, pooling resources across agencies, and creating a centralized, accessible portal for information sharing. Such an approach would allow for more comprehensive understanding of the issue and assist with evidence-supported decision making. Panelists also emphasized the importance of qualitative data, including lived experiences and community-sourced stories, to complement quantitative metrics and further inform policy and decision-making.

The Panel discussed the potential of standardized forms and platforms for community organizations to collect and contribute to data collection measures, while at the same time respecting privacy and prioritizing cultural safety and trauma-informed practices. There was also recognition of the need to collect data regarding perpetrators to better understand root causes of violence and intervene earlier.

Finally, the panel called for distinctions-based data governance, especially for Indigenous identity data, and stressed that data must be used ethically, avoiding surveillance while enabling targeted, culturally safe interventions.

It should also be noted that the de-siloing discussion was not limited to data and should also apply to delivery of services.

Standardized and Specialized Training and Supervision

B.C.'s provincial policing standards mandate training for all frontline police and supervisors on investigations involving IPV as well as training on trauma-informed practices and Indigenous cultural safety. Panelists stressed the need for standardized, ongoing, and sector-specific training across child welfare, victim services, community social services, health, and education systems as well. The training must evolve with changing societal dynamics and include practical application support, such as mentorship and supervision. Frontline staff often feel unequipped or unsupported, leading to

missed opportunities for intervention. Supervisors across all sectors play a critical role in ensuring quality and accountability, especially in reviewing IPV files and guiding staff through complex cases.

The Panel also discussed the importance of cross-sector collaboration and interdisciplinary training, particularly in rural and remote areas where there is an overrepresentation of IPV-related deaths and resources are limited. There was strong support for embedding supervision and training into system structures, not relying solely on individual relationships or temporary programs. Sustainable, trauma-informed, and culturally safe training models that empower frontline workers, especially those working in law enforcement and child welfare, and supervisors to respond effectively and consistently must be considered as an important part of any such response.

Narrative Change and Storytelling

The Panel continually emphasized the importance of shifting public understanding about intimate partner violence from a narrative that too often directly or indirectly implies blame on the part of the survivor to one that clearly identifies systemic and cultural contributions to violence.

Storytelling was identified as a powerful tool to humanize data, elevate lived experiences, and inform more responsive and compassionate policy. Panelists advocated for collecting and sharing survivor and family stories to complement quantitative data and highlight missed opportunities for intervention. There were calls to reframe IPV as a public health issue and a preventable death, challenging normalized attitudes and promoting cultural societal change.

The Panel also stressed the need to include diverse narratives—especially from Indigenous, rural, and marginalized communities—to avoid reinforcing stereotypes and ensure inclusive representation. Ultimately, storytelling was seen as essential for understanding the full impact and context of IPV, and for guiding meaningful, community-informed solutions.

Community-Led Response Models

The Panel strongly supported appropriately funded development and implementation of community-led responses to address intimate partner violence, particularly in Indigenous, rural, and remote communities. These models prioritize local autonomy, cultural safety, and responsiveness to community-specific needs.

There is a need to identify and resource local co-ordination tables that currently exist at the community level across B.C., including Violence Against Women in Relationship (VAWIR) and Integrated Case Assessment Teams (ICAT). Some of these tables have existed for more than 30 years and are mandated to ensure that survivors don't "fall through the cracks" in existing systems and that we are all working together to improve best outcomes for survivors.

Panelists emphasized that solutions should not be engineered centrally (e.g., in Victoria or Vancouver) and then imposed elsewhere; instead, communities should be empowered to review created solutions and self-develop their own safety and wellness plans, drawing on local leadership, elders, and knowledge keepers. Examples included Indigenous-based healing approaches and locally guided interventions that reflect Indigenous legal orders and laws. All solutions should be evaluated for immediate and longer-term impact, using Western and Indigenous evaluative approaches as appropriate.

The Panel also advocated for the creation of "one-stop-shop" service hubs to simplify access to support for families experiencing IPV. These hubs would consolidate housing, health, counselling, and legal services in a single, easily navigable location, reducing the burden on survivors to seek out specialized services across disconnected systems.

Additional suggestions included embedding awareness of services across multiple systems, including education, and developing an online portal to provide accessible, up-to-date information tailored to user needs.

The Panel also discussed the importance of flexible funding, respect for community governance, and avoiding colonial replication in program design. Community-led models were seen as potentially more sustainable, intuitive, and effective, especially when supported by urban resources and infrastructure without overshadowing local decision-making.

Rural and Remote Communities

Panel discussions emphasized that rural and remote communities face distinct challenges that heighten the risk of intimate partner violence and limit opportunities for prevention and intervention. These communities were disproportionately represented in IPV-related deaths, reflecting longstanding inequities in access to services and supports.

Limited availability of transition housing, counselling, forensic medical services, and specialized IPV programs restricts survivors' ability to seek timely help. Long travel distances, lack of public transportation, and seasonal weather conditions further delay access to care and complicate safety planning. Confidentiality concerns are heightened in small communities, where survivors may fear being recognized or worry about information circulating informally, reducing trust in systems and willingness to report.

Panel members noted that many rural and remote communities—particularly Indigenous communities—lack community-led, culturally grounded IPV prevention and response models. Data gaps and fragmented information systems further obscure rural realities and hinder evidence-informed planning. Addressing these challenges requires sustained investment, coordinated action, and approaches that reflect local context and community leadership.

Forensic and Medical Response

Significant gaps exist regarding medical and forensic responses to IPV, especially in rural areas. Forensic nurses were identified as a useful resource for survivors who do not wish to report to police at the time but wish to proceed with evidence collection. However, distribution of these services is uneven and restricted in most cases to the largest urban centres. As a consequence, most regions lack access to such supports entirely.

The Panel noted that some survivors experience strangulation and brain injury, which can go undetected due to inadequate training among service providers. There was a call for improved screening, data collection, and training in the medical field to recognize and respond to these injuries, which can have serious long-term health consequences.

Legislative and Judicial Reform

Concerns were raised about the limitations of current legal frameworks, particularly in family law, which does not address IPV directly, instead leaving consideration to criminal proceedings. This can be frustrating for survivors who are forced to navigate the two legal systems simultaneously.

The Panel discussed the need for judicial training on IPV risk assessment and culturally safe, trauma-informed practices. Integrated courts and single-judge models were proposed to reduce fragmentation and improve consistency in handling IPV-related cases.

There was also interest expressed toward legislative changes, such as creating a specific offence for assaulting an intimate partner and ensuring that IPV-related murders are treated as first-degree offences. The weaponization of the court system by abusers and the lack of accessible legal aid were also flagged as areas needing reform.

Firearm Access in IPV Cases

Firearms were identified as a key risk factor for lethality in IPV cases. The Panel discussed existing mechanisms for firearm seizure and prohibition, such as court orders and police enforcement, but noted gaps in awareness and enforcement.

Discussions included improving access for law enforcement and other relevant entities to protection order registries for police, increasing awareness of legal tools to restrict firearm access, and streamlining processes.

Standing IPV Death Review Committee

In 2024, the Attorney General of British Columbia commissioned an independent review[14] of the B.C. legal system's response to IPV and sexual violence. The final report, released in June 2025, was frequently cited throughout panel discussions.

Among its findings, the review identified that, while multiple ministries, units, branches and programs are involved in IPV-related work, there is no clear outline regarding their varied responsibilities or how they relate to one another.[14] It further highlighted the continuing need for improved data collection and information sharing practices, including case outcomes by police, Crown and courts, as well as survivor engagement. Many prior reviews have provided recommendations intended to improve all aspects of understanding and preventing IPV, but with limited response.

Additionally, the review highlights the lack of monitoring regarding implementation of previous recommendations regarding IPV violence and death. The final report includes 21 overarching recommendations that address the need for collaborative oversight and evaluation of initiatives

> *If there are places where actionable solutions have been presented but remain unimplemented, we need to understand the reasons for delay and to reflect on how those hurdles can be overcome. Might the challenges be due simply to limited budgets? Or is there resistance to change embedded in institutional cultures? Are the recommendations perceived as unworkable? Is it a combination of these factors, or are there other barriers to addressing these forms of violence?*[14]

intended to respond to IPV, as well as updated training, funding, and policy guidance across the sector.

The Panel agreed that the recommendations contained within the review were of great value and endorsed the notion of using the DRP platform to further amplify its findings. It endorsed the desirability of having the BC Coroners Service (or another such entity) perform regular reviews of existing recommendations made through both the independent review and previous IPV-, family- and gender-based violence-related initiatives.

One specific recommendation that generated significant panel support advocated for the creation of a Gender Based Violence Death Review Committee. Such committees are not novel and exist in other jurisdictions including Ontario and some U.S. states.

Panel consensus was that a standing panel would allow for identification of systemic challenges and shortfalls regarding support offered to decedents and would allow for direct change immediately. There was discussion about the ways that a cross-sectoral analysis would help reduce silos and increase the ability of the multiple systems that offer support to survivors of IPV- and gender-based violence to respond in a coherent, cohesive, timely manner.

The decedent had been in a long-term common law relationship that ended less than six months prior to her death. They had been living in a small rural community in B.C.

The decedent's spouse and his child had moved out of the home about a month before her death, but he continued to attend the home to work on his vehicles or take care of the family pet. Around the same time, the decedent began dating someone new; her former spouse became aware of this relationship a couple of weeks before her death.

The decedent was discovered when she failed to arrive for work and police attended the home. A coroner's investigation revealed that her former spouse had attended her home the evening prior and assaulted her before killing her and their pet; he had intended to kill himself as well but was unable to follow through. He pleaded guilty to second degree murder.

There was no police-involved history of intimate partner violence in the decedent's relationship with her former spouse. The firearm used in her death belonged to her former spouse and was not a restricted weapon, so there was no requirement for its registration, nor was her former spouse registered as having a license required to possess or acquire a firearm in Canada.

PART 6: RECOMMENDATIONS

Following its discussions, the death review panel has developed a set of recommendations it feels will increase public health and safety and positively impact the lives of all British Columbians. In considering the scope of its work, the Panel sought to develop recommendations that were:

- Collaborative;
- Supported by the death investigation-related data and supporting literature that was reviewed;
- Focused on increasing the public health and safety of all affected communities;
- Targeted to specific parties; and
- Measurable.

It should be noted that many recommendations were proposed by panelists during the course of discussions. Due to the prevalence of intimate partner violence, and its wide-spread and pervasive impact, the number of vulnerable and/or at-risk populations is substantial. The recommendations are not intended to address all social, legal, and medical circumstances related to intimate partner violence-related deaths. This is because the data that is currently available is not comprehensive enough to identify all related issues or address all case-specific gaps.

Death review panels are convened in order to identify areas of need for which there is significant potential to reduce deaths and increase public health and safety. Recommendations are intended to address issues that arise from many, if not all, of the deaths reviewed in aggregate. In no way should this imply that other recommendations ought not also be considered.

The Panel identified five key areas to prevent IPV-related deaths and support those experiencing, or at risk of experiencing, intimate partner violence.

All recommendations are made within the context of the Government of British Columbia's commitments to Reconciliation and using a distinctions-based approach that acknowledges the inherent right to self-determination of Indigenous communities throughout B.C.

PANEL RECOMMENDATIONS

RECOMMENDATION 1: Implement a clear, transparent and measurable strategy that ensures a centrally coordinated provincial response to addressing intimate partner-related violence and deaths in British Columbia.

Rationale: Intimate partner violence is a complex, multi-sector issue that intersects with health care, policing, justice, housing, social services, and community-based supports. The Panel's review identified significant fragmentation across these systems, resulting in inconsistent practices, uneven service delivery, and limited accountability for outcomes. Previous death review panels have issued recommendations intended to strengthen the provincial response; however, the absence of a centralized coordinating structure has impeded implementation and monitoring of progress.

A coordinated provincial framework with a clearly identified responsibility and reporting matrix is required to ensure alignment across ministries, reduce duplication, identify and address service gaps, and support culturally safe and trauma-informed approaches. Such a framework would also enhance transparency through public reporting and strengthen the province's capacity to respond to intimate partner violence as a public health and public safety priority. It could (and should) also be extended to addressing all aspects of family violence, as the Panel further acknowledge the impact that IPV has on children and other family members.

Priority actions identified are:

- By January 1, 2027, the Panel requests that the Ministry of Attorney General, with support from the Gender Equity Office and all responsible ministries, conduct a comprehensive gap analysis of all provincially operated and funded IPV-related initiatives, interventions, and programs, and publicly report recommendations to address identified gaps.
- By January 1, 2027, the Panel requests that all ministries with responsibilities related to intimate partner violence review and update all relevant policies and directives to ensure they prioritize culturally safe, trauma-informed support for survivors, and that these materials be publicly accessible.
- By June 1, 2027, the Panel requests that all ministries with responsibilities related to intimate partner violence be required to participate in creating a cross-ministry accountability framework overseen by the Ministry of Attorney General. The results of this framework should be posted publicly and regularly updated.
- By September 1, 2027, the Panel requests that the Province of British Columbia publicly release an updated, data-driven strategy that clearly demonstrates how IPV-related supports are appropriately coordinated, including metrics to evaluate efficacy and ensure initiatives are evidence-supported, scalable, and iterative.

RECOMMENDATION 2: Create and resource a standing committee mandated to individually review all intimate partner violence-related deaths in an effort to identify existing systemic gaps and enhance the province's response.

Rationale: The Panel's review demonstrates that intimate partner violence-related deaths continue to occur at a concerning rate, with at least 135 confirmed deaths between 2016 and 2024. Despite this, British Columbia does not currently have a permanent mechanism to examine these deaths on an ongoing basis. Existing reviews are episodic and dependent on the convening of time limited panels, which limits the province's ability to identify emerging trends, respond to systemic risks, identify barriers and enablers of progress on recommendations, and implement timely prevention strategies.

A standing committee dedicated to reviewing all IPV-related deaths would support real time learning and ensure that systemic issues are identified and addressed promptly. This structure would also enhance accountability for implementing recommendations and align British Columbia with leading practices in other jurisdictions.

Priority actions identified are:

- By January 1, 2027, the Panel requests that the Ministry of Attorney General review relevant existing legislation and identify any necessary amendments that may be required to allow a review of this type to take place.
- By January 1, 2027, the Panel requests that the BC Coroners Service conduct an environmental scan to identify existing initiatives currently being utilized in other jurisdictions and identify the necessary resources required to successfully conduct a standing committee.
- By June 1, 2027, the Panel requests that the BC Coroners Service, in coordination with the Ministry of Attorney General and with the support of the Province of British Columbia, implement a process that includes representation from responsible ministries, front line service providers, advocates, and survivors of intimate partner violence.

RECOMMENDATION 3: Enhance training for law enforcement, first responders, Emergency Department staff and front-line service providers to ensure that instances of intimate partner-related violence are more readily identified, and that survivors are more consistently supported.

Rationale: The data reflects circumstances in which victims have had contact with health care providers and/or police prior to their deaths, yet key risk indicators are not recognized or acted upon. These include visible injuries, escalating patterns of violence, breaches of court ordered conditions, and the presence of firearms. Variability in training, supervision, and investigative practices contribute to inconsistent identification of risk and missed opportunities for intervention.

Enhanced, evidence-supported training is required to strengthen the capacity of frontline responders to recognize IPV, conduct thorough risk assessments, and provide trauma-informed and culturally safe support. Improved supervisory oversight is also necessary to ensure investigative quality and consistency across the province. While data could not exhaustively identify victim involvement with child welfare and/or community based social services, there is recognition that these sectors also require evidence-supported training, policy, and supervisory practices.

Priority actions identified are:

- By January 1, 2027, the Panel requests that the BC RCMP and the BC Association of Chiefs of Police, in coordination with the Ministry of Public Safety and Solicitor General, and with input from front line service providers and other partners, review related policies and procedures for clarity regarding the role of the supervisor during IPV investigations to provide guidance, support and direction to frontline investigating officers, including ensuring a supervisor review during and prior to closing an IPV investigations file.
- By January 1, 2027, the Panel requests that the Ministry of Public Safety and Solicitor General, in coordination with the BC RCMP, the BC Association of Chiefs of Police, and other responsible law enforcement entities, review and update practices regarding the ability of law enforcement to recognize and respond to IPV-related presentations.
- By January 1, 2027, the Panel requests that the Ministry of Health, in coordination and partnership with the College of Physicians and Surgeons of BC and the BC College of Nurses and Midwives, review and update practices regarding the ability of health care professionals to recognize and respond to IPV-related presentations.
- By January 1, 2027, the Panel requests that the Ministry of Children and Family Development, in coordination and partnership with the BC College of Social Workers, review and update practices regarding the ability of child welfare professionals to recognize and respond to IPV-related presentations.

RECOMMENDATION 4: Establish and resource an evidence-supported model that promotes grassroots and community-led approaches to preventing intimate partner-related death and supporting survivors of IPV-related violence.

Rationale: The Panel's review underscores that the experience and impact of intimate partner violence vary significantly across communities, particularly in rural, remote, and Indigenous contexts. Community-based organizations often possess the strongest relationships with survivors and the most nuanced understanding of local needs, yet they face chronic under resourcing and inconsistent support.

Community-led, evidence-supported models are essential to ensure that prevention and intervention strategies are culturally grounded, responsive to local circumstances, and aligned with distinctions-

based approaches to Indigenous self determination. Strengthening community capacity will enhance early intervention, improve survivor safety, and support more effective, sustainable responses to intimate partner violence across British Columbia.

Priority actions identified are:

- By January 1, 2027, the Panel requests that the Ministry of Attorney General, in coordination with the Ministry of Public Safety and Solicitor General and with the input of frontline service providers and survivors of intimate partner violence, review all existing government-funded, community-based initiatives to objectively identify the projects that are creating the greatest impact and consider what is contributing to those successes.
- By April 1, 2027, the Panel requests that the Ministry of Attorney General, in coordination with all other responsible ministries and with the support of frontline service providers and survivors of intimate partner violence, create an evidence-supported strategy to support communities in creating and responding to their unique needs regarding intimate partner violence. This approach must be scalable and responsive to the unique needs of rural and remote communities.
- By September 1, 2027, the Panel requests that the above noted parties present their vision to Indigenous partners for review, endorsement, and partnership.

RECOMMENDATION 5: Create and implement a public awareness campaign to increase knowledge of intimate partner violence and pathways to support for people who experience and use violence.

Rationale: Despite its prevalence, intimate partner violence remains significantly underreported, with many survivors choosing not to disclose due to stigma, shame, fear of retaliation, fear of child welfare intervention, or distrust of systems. The Panel identified a need for improved public understanding of IPV as both a public health and criminal issue, as well as greater awareness of risk factors associated with lethality.

A province-wide public awareness campaign would help dispel misconceptions, reduce stigma, and promote help seeking among survivors, perpetrators, and community members. Clear, accessible messaging across multiple platforms would support earlier intervention, increase community engagement, and strengthen overall public safety.

Priority actions identified are:

- By January 1, 2027, the Panel requests that the Ministry of Finance, with support and input from frontline advocates and survivors of intimate partner violence, conceive and execute a province-wide awareness campaign specifically intended to:
    - Dispel myths about IPV;
    - Identify IPV as a public health emergency and criminal problem;

- Identify risks known to increase the severity and potential lethality of IPV; and
- Promote pathways to support for victims, perpetrators, and community members at large.

Messaging should be appropriately tailored and distributed across all available media platforms, and metrics for evaluating the efficacy of the campaign should be built into its design.

In addition to the above recommendations, the Panel reaffirms and requests an update regarding progress on the below recommendation, which was included in the 2025-issued death review panel report on deaths by suicide of youth and young adults:[3]

RECOMMENDATION: Improve data collection, information sharing and reporting processes to better understand and support diverse communities throughout British Columbia.

Rationale for Reaffirmation: *The Panel identified substantial limitations in the availability, completeness, and consistency of data related to intimate partner violence-related deaths. These include gaps in demographic information, challenges linking datasets across ministries, and limited capacity to identify race, ethnicity, gender identity, and disability. Such limitations impede the province's ability to identify inequities, understand risk patterns, evaluate interventions, and support distinctions-based approaches for Indigenous, Métis, and Inuit communities.*

Improved data collection and information sharing practices are essential to support evidence informed decision making, enhance accountability, and ensure that prevention strategies are equitable, culturally appropriate, and responsive to the needs of diverse populations.

Priority actions identified by the Panel are:

- *By September 1, 2026, the BC Coroners Service, in collaboration with the Ministry of Health, will create and implement information sharing strategies with Métis Nation British Columbia and provincial Inuit Leadership to ensure that patient/decedent data relevant to these Nations are appropriately collected and shared.*
- *By September 1, 2026, the BC Coroners Service, in collaboration with the Ministry of Health and the Ministry of Attorney General, will finalize plans to document information including but not limited to the race and ethnicity, gender orientation and ability of all patients and decedents. The approach should be designed in a manner that recognizes the uniqueness of communities within B.C. and that allows for communities to embrace data-driven approaches to increasing public health and safety initiatives.*

APPENDIX 1: GLOSSARY

The following terms are used within this report to mean:

Behavioural Intervention Programs (BIP): Interventions that target perpetrators of intimate partner violence to prevent further incidents of intimate partner violence.

Biological Sex: A category used to classify people based on physical and physiological features including chromosomes, genetic expression, hormone levels and function, and reproductive/sexual anatomy. Sex is most often assigned at birth based on a visual examination of genitalia by a doctor or other health care provider. Based on this examination, the child is assigned as Female, Intersex, or Male.

Cognitive Behavioural Therapy (CBT): A type of psychotherapy that focuses on the relationship between thoughts, feelings and behaviours, and how changing unhelpful patterns within one domain can have a positive impact on other domains and overall well-being.

Decedent: A person who has died.

Distinctions-Based Approach: A distinctions-based approach, and appropriate respect for Indigenous laws and jurisdictions, means that the scope of rights enjoyed by an Indigenous People is contextual and that the Province's relations and dealings with First Nations, Métis, and Inuit will be conducted in a manner that is appropriate for the specific context, recognizing and respecting the distinct and different rights, laws, legal systems, and systems of governance of each.

Empowerment Theory: The theoretical foundation of advocacy-based interventions for victims of IPV which focus on increasing autonomy, gaining or regaining of control, and creating individual opportunities and decision-making.

Gender: A personal, deeply held, internal sense of self as man or woman, a blend of both, or neither. Broadly speaking, gender includes self-identification as well as socially and culturally constructed roles, behaviours, and expressions. The current gender of a person (e.g., Man, Non-binary person, Woman) may or may not align with social or cultural expectations based on their sex assigned at birth (e.g., Female, Intersex, Male). People for whom this is true may identify as transgender.

Gender-based violence (GBV): Violence based on gender norms and unequal power dynamics, perpetrated against someone based on their gender, gender expression, gender identity, or perceived gender. Violence may include physical, economic, sexual, technology-facilitated, and/or emotional (psychological) abuse.

Intimate partner violence (IPV): Violence that is caused by a current or former intimate partner or spouse, at any time during a relationship or following its end, regardless of the gender and sexual orientation of the partners and whether the partners cohabitate or are sexually intimate. Violence

may include physical, economic, sexual, technology-facilitated, and/or emotional (psychological) abuse.

Material and Social Deprivation Index (**MSDI):** A tool used to measure the degree of deprivation experienced by individuals or groups using Canadian census data.

Pandemic: The worldwide spread of a disease.

Perpetrator: A person who has committed intimate partner violence.

Restorative Justice (RJ): An alternative approach to the criminal justice system that offers a relational opportunity for change through dialogue about impact, accountability, and problem solving with impacted parties following crime.

Risk Factors: Individual, relational, or systemic factors that increase the likelihood that a person will experience or perpetrate intimate partner violence.

Survivor/Victim: A person who has experienced intimate partner violence.

APPENDIX 2: DATA SOURCES

Multiple data sources were used for this review. A full description of each data source can be found below.

BCCS Data – Includes all suspected and confirmed deaths involving acts of intimate partner violence. Data includes dates of injury and death, age, biological sex, and Indigeneity of the decedent, and the place of injury and death.

BCCS Protocol Data – A set of questions completed by the investigating coroner to provide more insight into the decedent and the circumstances surrounding the death.

Chronic Disease Registry – Chronic disease registries are derived from administrative data sources maintained by the B.C. Ministry of Health. There are 26 conditions with registries and registries include date up to 2020/21 fiscal year. People on the registries are not identified by clinical diagnoses but through their healthcare service utilization matching specific case definitions for each condition. Case definitions for each registry can be found at: http://www.bccdc.ca/health-professionals/data-reports/chronic-disease-dashboard.

Discharge Abstract Database (DAD) – All Canadian hospitals (except those in Quebec) submit their separations records directly to the Canadian Institute of Health information (CIHI) for inclusion in the Discharge Abstract Database (DAD). The database contains demographic, administrative and clinical data for hospital discharges (inpatient acute, chronic, rehabilitation) and day surgeries. A provincial data set, including various CIHI value-added elements (such as case mix groups, and resource intensity weights) is released on a monthly basis to the respective Ministries of Health.

Medical Services Plan (MSP) – MSP data includes all medically necessary services provided by fee-for-service practitioners, including laboratory and diagnostic procedures, to individuals covered by the MSP, B.C.'s universal insurance program. Practitioners include physicians, supplementary benefit practitioners, and out-of-province practitioners.

RCMP "E" Division Data – Prime and CPIC Databases – The RCMP Data Analysis Unit conducted a manual review of available data sources of the list of intimate or ex-partners in this review. These data sources included PRIME-BC (police general occurrence reports), CPIC (criminal record information) and homicide surveys.

APPENDIX 3: REFERENCES

1. Government of Canada. The National Action Plan to End Gender-based Violence - Canada.ca. Accessed January 22, 2026. https://www.canada.ca/en/women-gender-equality/gender-based-violence/intergovernmental-collaboration/national-action-plan-end-gender-based-violence.html

2. Government of British Columbia. Safe and Supported: British Columbia's Gender-Based Violence Action Plan. Published online 2023. Accessed July 8, 2025. https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/services-policies-for-government/gender-equity/safe-and-supported-gender-based-violence-action-plan-december-2023.pdf

3. BC Coroners Service. *Creating Connection, Supporting Strengths: A Review of Youth and Young Adult Deaths by Suicide in British Columbia, 2019-2023*. 2025. Accessed January 22, 2026. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/creating_connection_supporting_strengths.pdf

4. Wathen CN, MacGregor JCD, Burd C, Naeemzadah N, Ogunpitan YA, Canie J. A Scoping Review of Intimate Partner Violence Research in Canada. *Trauma Violence Abuse*. 2025;26(1):73-85. doi:10.1177/15248380241275979,

5. Government of Canada. Gender-based violence glossary. Website. October 2025. Accessed July 8, 2025. https://www.canada.ca/en/women-gender-equality/gender-based-violence/gender-based-violence-glossary.html

6. Government of Canada. Fact sheet: Intimate partner violence. Website. August 2025. Accessed July 8, 2025. https://www.canada.ca/en/women-gender-equality/gender-based-violence/intimate-partner-violence.html

7. Coates L, Wade A. Language and Violence: Analysis of Four Discursive Operations. *J Fam Violence*. 2007;(22):511-522. doi:10.1007/s10896-007-9082-2

8. British Columbia. *Coroners Act*. Accessed January 22, 2026. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/07015_01

9. British Columbia. *Freedom of Information and Protection of Privacy Act*. Accessed January 22, 2026. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96165_00

10. World Health Organization. Lifetime toll: 840 million women faced partner or sexual violence. Website. November 2025. Accessed January 1, 2026. https://www.who.int/news/item/19-11-2025-lifetime-toll--840-million-women-faced-partner-or-sexual-violence

11. Conroy S. Family violence in Canada: A statistical profile, 2019. Published online 2019. Accessed July 8, 2025. www.statcan.gc.ca

12. BC Coroners Service. BC Coroners Service Death Review Panel: A Review of Intimate Partner Violence Deaths. Published online November 2016. Accessed November 3, 2025. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/intimate-partner-violence2010-2015.pdf

13. BC Coroners Service. Report to the Chief Coroner of British Columbia: Findings and Recommendations of the Domestic Violence Death Review Panel. Published online May 2010. Accessed January 22, 2026. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/domestic-violence.pdf

14. Stanton K. Independent Systemic Review: The British Columbia Legal System's Treatment of Intimate Partner Violence and Sexual Violence: Final Report. Published online June 2025. Accessed July 10, 2025. https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/about-bc-justice-system/justice-reform-initiatives/systemic-review/dr_kim_stantons_june_2025_final_report_-_independent_systemic_review__the_british_columbia_legal_systems_treatment_of_intimate_partner_violence_and_sexual_violence.pdf

15. Representative for Children and Youth. Don't Look Away: How one boy's story has the power to shift a system of care for children and youth. Published online July 2024. Accessed January 6, 2026. https://rcybc.ca/wp-content/uploads/2024/07/RCY-Dont-Look-Away_July2024.pdf

16. National Inquiry into Missing and Murdered Indigenous Women and Girls. Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1b. 2019;1b. Accessed July 8, 2025. https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1b.pdf

17. BC Coroners Service. Homicide Deaths in B.C. 2012-2022. Published online 2023. Accessed January 22, 2026. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/homicide_deaths_knowledge_update_2012-2022.pdf

18. Province of British Columbia. Province of British Columbia Gender and Sex Data Standard. Published online January 2023. Accessed July 20, 2025. https://www2.gov.bc.ca/assets/gov/government/services-for-government-and-broader-public-sector/information-technology-services/standards-files/312_gender_and_sex_data_standard.pdf

19. Statistics Canada. Focus on Geography Series, 2021 Census - British Columbia. Website. December 2025. Accessed August 17, 2025. https://www12.statcan.gc.ca/census-recensement/2021/as-sa/fogs-spg/page.cfm?lang=E&topic=8&dguid=2021A000259

20. Matias A, Gonçalves M, Soeiro C, Matos M. Intimate partner homicide: A meta-analysis of risk factors. *Aggress Violent Behav*. 2020;50:101358. doi:10.1016/J.AVB.2019.101358

21. Spencer CM, Stith SM. Risk Factors for Male Perpetration and Female Victimization of Intimate Partner Homicide: A Meta-Analysis. *Trauma Violence Abuse*. 2020;21(3):527-540. doi:10.1177/1524838018781101,

22. Burczycka M. Section 2: Police-reported intimate partner violence in Canada, 2018. Website. December 2019. Accessed July 8, 2025. https://www150.statcan.gc.ca/n1/pub/85-002-x/2019001/article/00018/02-eng.htm

23. Statistics Canada. Homicide in Canada, 2024. Website. December 2025. Accessed January 1, 2026. https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2025060-eng.htm

24. Office of the Provincial Health Officer, B.C. Centre for Disease Control. Examining the Societal Consequences of the COVID-19 Pandemic. Published online December 2024. Accessed July 8, 2025. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/annual-reports/pho-annual-report-examining-societal-consequences-of-covid-19.pdf

25. BC First Nation's Justice Council. Indigenous Women's Justice Plan: Final Draft. Published online April 2025.

26. UN Women. The Shadow Pandemic: Violence against women during COVID-19. Website. Accessed July 8, 2025. https://www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response/violence-against-women-during-covid-19

27. Saxton MD, Olszowy L, MacGregor JCD, MacQuarrie BJ, Wathen CN. Experiences of Intimate Partner Violence Victims With Police and the Justice System in Canada. *J Interpers Violence*. 2021;36(3-4):NP2029-2055NP. doi:10.1177/0886260518758330,

28. Statistics Canada. Intimate partner violence: Experiences of Indigenous First Nations, Métis and Inuit women in Canada, 2018. Website. May 2021. Accessed July 8, 2025. https://www150.statcan.gc.ca/n1/pub/85-002-x/2021001/article/00007-eng.htm

29. Mckay HJ. SYSTEMIC RACISM IN POLICING IN CANADA Report of the Standing Committee on Public Safety and National Security. Accessed January 5, 2026. www.ourcommons.ca

30. Kaye J, Glecia A. "Why Do We Have to be Almost Dead to Qualify for Help?": Criminal Legal and Protection System Responses to Intimate Partner Violence Against Indigenous Women in Canada. *Canadian Review of Sociology*. Published online 2025. doi:10.1111/CARS.12492

31. Statistics Canada. The Daily — Trends in police-reported family violence and intimate partner violence in Canada, 2024. October 2025. Accessed January 1, 2026. https://www150.statcan.gc.ca/n1/daily-quotidien/251028/dq251028a-eng.htm

32. Statistics Canada. The Daily — Trends in police-reported family violence and intimate partner violence in Canada, 2023. Website. October 2024. Accessed July 8, 2025. https://www150.statcan.gc.ca/n1/daily-quotidien/241024/dq241024b-eng.htm

33. Salari S, Sillito CLF. Intimate partner homicide–suicide: Perpetrator primary intent across young, middle, and elder adult age categories. *Aggress Violent Behav*. 2016;26:26-34. doi:10.1016/J.AVB.2015.11.004

34. Sutton D. Gender-related homicide of women and girls in Canada. Website. April 2023. Accessed January 5, 2026. https://www150.statcan.gc.ca/n1/pub/85-002-x/2023001/article/00003-eng.htm#n24-refa

35. Perreault S. Victimization of First Nations people, Métis and Inuit in Canada. Website. July 2022. Accessed July 8, 2025. https://www150.statcan.gc.ca/n1/pub/85-002-x/2022001/article/00012-eng.htm

36. Savage L. Intimate partner violence: Experiences of women with disabilities in Canada, 2018. Website. April 2021. Accessed July 8, 2025. https://www150.statcan.gc.ca/n1/pub/85-002-x/2021001/article/00006-eng.htm

37. Okeke-Ihejirika P, Yohani S, Muster J, Ndem A, Chambers T, Pow V. A Scoping Review on Intimate Partner Violence in Canada's Immigrant Communities. *Trauma Violence Abuse*. 2020;21(4):788-810. doi:10.1177/1524838018789156

38. Sheehan BE, Murphy SB, Moynihan MM, Dudley-Fennessey E, Stapleton JG. Intimate Partner Homicide. *Violence Against Women*. 2015;21(2):269-288. doi:10.1177/1077801214564687

39. Yakubovich AR, Stöckl H, Murray J, et al. Risk and protective factors for intimate partner violence against women: Systematic review and meta-analyses of prospective–longitudinal studies. *Am J Public Health*. 2018;108(7):e1-e11. doi:10.2105/AJPH.2018.304428

40. Adhia A, Austin SB, Fitzmaurice GM, Hemenway D. The Role of Intimate Partner Violence in Homicides of Children Aged 2–14 Years. *Am J Prev Med*. 2019;56(1):38-46. doi:10.1016/J.AMEPRE.2018.08.028

41. Jaffe P, Campbell M, Reif K, Fairbairn J, David R. Children Killed in the Context of Domestic Violence: International Perspectives from Death Review Committees. *Domestic Homicides and Death Reviews: An International Perspective*. Published online January 1, 2017:317-343. doi:10.1057/978-1-137-56276-0_11

42. Jaffe P, Bala N, Medhekar A, Scott K. Making appropriate parenting arrangements in family violence cases: Applying the literature to identify promising practices, 2023. Website. February 2023. Accessed July 15, 2025. https://www.justice.gc.ca/eng/rp-pr/jr/mapafvc-cbapcvf/review-analyse.html

43. Statistics Canada. Characteristics of police-reported crime in rural areas in the Canadian provinces, 2023. April 29, 2025. Accessed January 4, 2026. https://www150.statcan.gc.ca/n1/pub/85-002-x/2025001/article/00005-eng.htm

44. Bleakney A, Melvin A. Indigenous women and girls: Socioeconomic conditions in remote communities compared with more accessible areas. Website. June 2022. Accessed August 17, 2025. https://www150.statcan.gc.ca/n1/pub/75-006-x/2022001/article/00005-eng.htm#a16

45. Letourneau N, McBride DL, Barton SS, Griggs K. Service Providers' Perspectives: Reducing Intimate Partner Violence in Rural and Northern Regions of Canada. *Canadian Journal of Nursing Research*. 2023;55(2):165-175. doi:10.1177/08445621221128857

46. Rush KL, Seaton CL, Burton L, Smith MA, Li EPH. The healthcare experiences of rural-living Canadians with and without a primary care provider: a qualitative analysis of open-ended cross-sectional survey responses. *Prim Health Care Res Dev*. 2025;26:e1. doi:10.1017/S1463423624000677

47. Government of Canada. Firearms, Accidental Deaths, Suicides and Violent Crime: An Updated Review of the Literature with Special Reference to the Canadian Situation. Website. August 2022. Accessed January 4, 2026. https://www.justice.gc.ca/eng/rp-pr/csj-sjc/jsp-sjp/wd98_4-dt98_4/p2.html

48. Glass N, Laughon K, Campbell J, et al. Non-fatal strangulation is an important risk factor for homicide of women NIH Public Access. *J Emerg Med*. 2008;35(3):329-335. doi:10.1016/j.jemermed.2007.02.065

49. Sprague S, Slobogean GP, Spurr H, et al. A scoping review of intimate partner violence screening programs for health care professionals. *PLoS One*. 2016;11(12). doi:10.1371/JOURNAL.PONE.0168502

50. Cavanagh A, Kimber M, MacMillan HL, Ritz SA, Vanstone M. Conceptualizing Physicians' Roles in Addressing Intimate Partner Violence: A Critical Discourse Analysis of Resources for Canadian Physicians. *Violence Against Women*. 2022;29(9):1640. doi:10.1177/10778012221114922

51. Duchesne E, Nathoo A, Walker M, Bartels SA. Patient and Provider Emergency Care Experiences Related to Intimate Partner Violence: A Systematic Review of the Existing Evidence. *Trauma Violence Abuse*. 2023;24(5):2901-2921. doi:10.1177/15248380221118962

52. Turpel-Lafond ME. In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care. Published online November 2020. Accessed January 5, 2026. https://baseline.bchumanrights.ca/wp-content/uploads/2022/08/In-Plain-Sight-Addressing-Indigenous-specific-Racism-and-Discrimination-in-B.C.-Health-Care.pdf

53. Svalin K, Levander S. The Predictive Validity of Intimate Partner Violence Risk Assessments Conducted by Practitioners in Different Settings—a Review of the Literature. *J Police Crim Psychol*. *Springer*. 2020;35(2):115-130. doi:10.1007/s11896-019-09343-4

54. Government of Canada. Introduction - Intimate Partner Violence Risk Assessment Tools: A Review. Website. December 2021. Accessed July 10, 2025. https://www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/rr12_8/p1.html

55. Dawson M, Piscitelli A. Risk Factors in Domestic Homicides: Identifying Common Clusters in the Canadian Context. *J Interpers Violence*. 2021;36(1-2):781-792. doi:10.1177/0886260517729404

56. Nicholls TL, Pritchard MM, Reeves KA, Hilterman E. Risk Assessment in Intimate Partner Violence: A Systematic Review of Contemporary Approaches. *Partner Abuse*. 2013;4(1):76. doi:10.1891/1946-6560.4.1.76

57. Lundgren R, Amin A. Addressing intimate partner violence and sexual violence among adolescents: Emerging evidence of effectiveness. *Journal of Adolescent Health*. 2015;56(1):S42-S50. doi:10.1016/j.jadohealth.2014.08.012

58. Trabold N, McMahon J, Alsobrooks S, Whitney S, Mittal M. A Systematic Review of Intimate Partner Violence Interventions: State of the Field and Implications for Practitioners. *Trauma Violence Abuse*. 2020;21(2):311-325. doi:10.1177/1524838018767934

59. Ogden CL, Tutty LM. "We Get Our Healing Through Traditional Ways": Canadian Indigenous Women's Use of Violence Against Women Shelters, Mainstream Counseling, and Traditional Healing. doi:10.1177/10778012241230327

60. Travers Á, McDonagh T, Cunningham T, Armour C, Hansen M. The effectiveness of interventions to prevent recidivism in perpetrators of intimate partner violence: A systematic review and meta-analysis. *Clin Psychol Rev*. 2021;84. doi:10.1016/j.cpr.2021.101974

61. Bell C, Coates D. *The Effectiveness of Interventions for Perpetrators of Domestic and Family Violence: An Overview of Findings from Reviews*. 2022. Accessed January 11, 2026. https://anrows-2019.s3.ap-southeast-2.amazonaws.com/wp-content/uploads/2021/12/08091000/ANROWS-OofR-Perpetrator-Interventions.pdf

62. Wilson DB, Feder L, Olaghere A. Court-mandated interventions for individuals convicted of domestic violence: An updated Campbell systematic review. *Campbell Systematic Reviews*. 2021;17(1). doi:10.1002/CL2.1151

63. Barocas B, Avieli H, Shimizu R. Restorative Justice Approaches to Intimate Partner Violence: A Review of Interventions. *Partner Abuse*. 2020;11(3):318-349. doi:10.1891/PA-2020-0010

64. Evans J. Restorative Justice and Gender-Based Violence: A Look at the Literature. Website. November 2021. Accessed July 13, 2025. https://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd14-rr14/p2.html

65. Surrey Schools. Respectful Futures. Accessed January 22, 2026. https://www.surreyschools.ca/respectful-futures

66. BC Society of Transition Houses. Violence is Preventable (VIP) Program. Accessed January 22, 2026. https://bcsth.ca/program/vip/

67. Ending Violence Association of BC. Be More Than a Bystander. Accessed January 22, 2026. https://endingviolence.org/bystander/