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Exploring Dimensions of Vulnerability in Victims of Domestic Homicide

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Abstract

Gender-based violence is rooted in a network of multidimensional constructs encompassing personal, situational, social and cultural elements, as well as the intersectionality of these elements. Current research on victims of domestic homicide has not incorporated the use of this lens and has had a tendency to focus on a singular construct as independent and autonomous. The present study explored 20 dimensions of victim vulnerability. Cases from the Ontario Domestic Violence Death Review Committee were analyzed to examine the presence and frequency of these dimensions within the sample. Using two-step cluster analysis, different profiles of vulnerable victims were determined. Relationships between these profiles were explored in relation to the following variables; age, number of agencies involved, number of homicide risk factors, separation from an intimate partner, and various perpetrator-related factors. The results demonstrated distinct constellations of vulnerability. Implications and recommendations are discussed.

Keywords: victim vulnerability, domestic violence, intimate partner violence, domestic homicide, Domestic Violence Death Review Committee, intimate partner homicide, intimate partner femicide, uxoricide,

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Finally, I would like to recognize both the victims and the survivors of this horrific crime. May we never forget the importance of the work in this field and that behind each statistic there is a person. “We speak for the dead to protect the living”.

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Exploring Dimensions of Vulnerability in Victims of Domestic Homicide

Intimate partner violence (IPV) is a serious and pervasive public health concern; an issue of human rights that constitutes a global social problem (Coker, Smith, Thompson, McKeown & Bethea, 2002; Kuijpers, Van der Knaap & Lodewijks, 2011). The term IPV recognizes any deliberate and calculated threat, attempt or actual harm of a physical, sexual, emotional or psychological nature, that is directed towards a partner in an intimate relationship (World Health Organization, 2012; Krug, Dahlberg, Mercy, Zwij & Lozano, 2002). Within the literature, numerous terminologies have been employed to characterize intimate partner violence such as domestic violence (DV), spousal violence, dating violence and battering. These terms are reflective of the diversity of the intimate relationships affected as intimate partner violence does not distinguish between married, separated/divorced, dating and co-habiting relationships, of both former (ex-partners) and current partners. The terms intimate partner violence and domestic violence (DV) will be employed interchangeably throughout this paper.

Domestic violence victimology is not exclusive of male victims. However, the disproportionate and overwhelming prevalence of women is staggering as they represent 80% of all victims (Statistics Canada, 2013). This form of violence against women occurs universally in unique, patterned ways that are stable and irrespective of factors such as race, class, and ethnicity. Domestic violence is recognized as a gendered crime (Hunnicut, 2009). A woman's risk of domestic violence is four times greater than that of a male (Statistics Canada, 2013), and women are more likely to experience higher levels of victimization, increased severity of abuse and injury, as well as risk becoming victims of lethal violence (Black, 2011). Domestic violence seldom occurs as an isolated incident and is often a re-occurring and patterned form of abuse (Kuijpers, Van der Knaap & Winkel, 2012). The consequences of this form of violence may be

deeply damaging and affect all aspects of a victim's life; social, physical, psychological, emotional, and economic (World Health Organization, 2012). The devastating ramifications of this crime are a cause for concern and a call to action.

In extreme cases, domestic violence culminates in domestic homicide; "the killing of a current or former intimate partner, their child(ren) and/or other parties killed as a result of the incident" (Dawson & Jaffe, n.d). According to Statistics Canada, six out of ten uxoricides (the act of killing one's wife) are preceded by a history of intimate partner violence (Sinha, 2013). Although the overall proportion of male to female victims of homicide is greater amongst males, there are distinct demographics between them. Males are at an increased likelihood of victimization by strangers and acquaintances whereas, women are more likely to be killed by their intimate partner (Johnson & Dawson, 2011). As femicide (intentional killing of a woman due to gender identity), occurs in current and former intimate partner settings, research has been devoted to exploring lethal risk factors for intimate partner homicide (IPH).

A history of domestic violence has been identified as the most crucial and pressing risk factor for IPH (Campbell, Glass, Sharps, Laughon & Bloom, 2007). In such cases, domestic homicide is often preceded by persistent relationship violence (Dawson, Bunge & Balde, 2009) in which the occurrence of domestic homicide is the pinnacle of violence in that relationship (Dugan, Nagin & Rosenfeld,1999). Domestic homicides (DH) account for 20% of homicides in Canada (Boyce & Cotter, 2013), and though rates have been decreasing since the 1990s (Dawson, Bunge & Balde, 2009), like DV, it continues to be a gender-specific trend. On average, every six days a woman is killed by an intimate partner in Canada (Statistics Canada, 2014) and Canadian women represent nearly 80% of domestic homicide victims (Beaupré 2014; DVDRC, 2015). Globally, women represent two thirds of domestic homicide victims (UNODC, 2013).

The exploration of risk factors and homicide reviews conducted in hindsight posit that domestic homicide is a preventable crime.

Over the last decade, research and practice in domestic violence and domestic homicide, has witnessed a dramatic shift in moving from reactive measures in response to violence, towards violence prevention. Considerable focus has been dedicated towards improving intervention and preventative measures through the transformation in dialectic, highlighting the necessity of inter-agency collaboration, the expansion of competency and comprehension in both practice and research capacities and enhanced, empirically validated strategies in the domains of risk assessment, risk management and safety planning. Despite these advances, most of this work has concentrated on the violent offender or perpetrator of homicide to delineate what characteristics or offender/perpetrator-related factors can predict or increase the risk of these crimes (Kuijpers et al., 2012). To date, there is scant research aimed at exploring risk as it pertains to victim-related factors.

Traditional risk assessment and risk management protocols appraise the risk that the perpetrator poses but many do not address unique victim-related factors that may place victim at a greater risk of harm or lethality. In large, this is attributed to the cautious approach of researchers in avoiding the inadvertent possibility of blaming the victim for the horrific outcomes (Krause, Kaltman, Goodman & Duton, 2006). In recognition of this delicate boundary, it is critical to highlight and clarify the position of the present study. The researcher acknowledges that women are victims of the crimes committed against them, and no characteristic or action on behalf of the victim merits or claims responsibility for the tragic aftermath. An exploration of victim-related factors does not diminish culpability and it is clear that accountability rests with the perpetrator. The researcher contends that it is however, essential

to learn more about the victim's context to inform and improve efforts on keeping her safe. Acknowledging the avertible nature of both DH and DV, it is imperative that victim factors bear weight in decisions concerning risk assessment, risk management and safety planning.

In recognition of the heterogeneity of victims of domestic violence and domestic homicide, the researcher explored a myriad of factors that are specific to victims and may contribute to increasing vulnerability. "Vulnerable victim" is the present term applied to individuals who may be considered vulnerable due to the position, circumstance or problems presenting in their situational context. Vulnerability is not to be confused with weakness of character but rather, as put forth by Few & Rosen (2005), "a state of susceptibility to negative outcomes in decision making when a culmination of risk factors overshadow protective factors" (pg. 266). They posit that a large quantity of risk factors in the absence of meaningful protective factors, amplify a vulnerable state (Few & Rosen, 2005). The term *victim vulnerability* has been employed in recognition of particular constituents that may decrease a woman's ability to engage in self-protection as well as, augment violence or opportunities for violence (Storey & Strand, 2017). It has been incorporated into a handful of risk assessment tools with the premise that including both victim and perpetrator characteristics and circumstances is essential to a well-rounded assessment of the situation (Belfrage & Strand 2008; Belfrage & Strand, 2008). Though correlational in nature, research supports that an increase in victim vulnerability factors and risk factors is associated with an increased risk of violence (Belfrage & Strand, 2008).

The Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER) (Kropp, Hart & Belfrage, 2005) is one of the few risk assessment tools that incorporates victim vulnerability. Within this measure, five items have been dedicated to this construct and are considered within the present timeframe and not in a retrospective/historical manner; *Item 11-Inconsistent*

attitudes/behaviour; Item 12-Extreme fear of the perpetrator; Item 13- Inadequate support/resources; 14-Unsafe living situation and *Item 15- Health problems.* These factors may propagate a victim's appearance of being vulnerable, diminish capacity to protect herself, decrease motivation and increase perceived helplessness (Storey & Strand, 2017). While the term is gaining momentum within the growing body of literature on domestic violence and domestic homicide, there are various gaps in terms of a holistic representation/conceptualization of vulnerability and the dynamics of these factors. The current research tendency has focused on exploring singular constructs that may be related to vulnerability as autonomous and independent. This narrow approach has failed to address as well as understand, their dynamic overlap and interplay.

The Present Study

The purpose of this study was to identify the percentage of cases from the Ontario domestic homicide sample that involve victims who meet the suggested criteria for vulnerability. Characteristics of vulnerability were selected based on literature review and are outlined below. Through this exploration, the researcher wanted to develop an understanding of which dimensions of vulnerability are the most common, the occurrence of these dimensions in the present sample, their relationship to actions taken by the victim concerning the number of agencies involved and leaving a violent relationship, and how they relate to risk factors for homicide and perpetrator-related factors.

In order to deconstruct the unique dynamics of domestic homicide within the context of victim vulnerability, it is essential to develop a clear understanding of the framework to work within. The views cultivated through the proposed lens are important not only in terms of

conceptualization, but are indicative of direction as each approach informs laws, action and policies (DeKeseredy, 2011).

Theoretical Framework

Ecological Model of Domestic Violence. Decades of research have yielded various theoretical conceptualizations of domestic violence offering explanations across political and cultural spheres however, the majority have proposed a singular stream of thought to explain the occurrence of domestic violence. More recently, the dialectic has expanded to a more comprehensive exploration of DV as a multidimensional phenomenon comprised of numerous intersecting factors and levels, as is proposed by the Ecological Model (Heise, 1998). According to this model, the etiology of gender-based violence is rooted in the notion that there is no single cause of this type of violence, but rather it can be understood as a complex combination of compounding and contributing factors (Heise, 2011). The Ecological Model was first conceptualized by Bronfenbrenner through the Ecological Theory of Human Development (1979) and since, has seen many adaptations and variations of this framework. This model is based in a contextual understanding of an individual; that a person can only be fully understood in terms of their context (Bronfenbrenner, 1994; Obajasu, Palin, Jacobs, Anderson & Kaslow, 2009). The dominant adaptation that will be discussed here is Heise's ecological framework for conceptualizing the etiology of gender-based violence (1998), adapted from Belsky's model (1980) on the etiology of child maltreatment.

Within this structure, context refers to the personal, interpersonal, social and cultural factors that make up the various components of the ecological system. An individual is infixed within a network of varying systems. The first level, referred to as *ontogenic development*, or the individual level, encompasses an individual's personal history and biological factors that play a

role in behaviour. The *microsystem* refers to an individual's inner social networks and relationships between family, friends, peers, and the intimate relationship within which/where the violence occurs. At the community level, the *exosystem* consists of formal and informal structures and institutions that for example, could include the victim's neighbourhood and workplace. Finally, there is the *macrosystem*, the societal level capturing the greater sociocultural context and norms of culture such as support of patriarchal views and a culture of victim-blaming (Heise, 1998; Grauerholz, 2000; Alaggia, Regehr & Jenney, 2012).

The ecological framework looks at the causality of domestic violence through superimposed layers. By means of the synthesized organization of this model, predictive, pre-disposing and perpetuating factors of violence can be examined at each level, as well as in their interplay and interaction across varying levels (Heise, 1998). The use of an ecological lens may elucidate a more complete picture of both protective and risk factors for domestic violence (Obajasu et al., 2009). In addition, it moves the conversation of domestic violence away from victim-blaming as intimate partner violence is conceptualized as a broader, multi-level and systemic phenomenon operating on the interaction between various levels (Obajasu et al., 2009). An additional strength of this model is its ability to address the limitation of the feminist framework that does not account for why not all men perpetrate violence (Heise, 1998). The leading theory used to conceptualize gender-based violence comes from feminist theories. The feminist paradigm is a criticism of the patriarchal construction of society that favours males on both micro and macro levels (Hunnicut, 2009). Through this construct, men hold power over females and exercise this power through the use of violence as it serves to keep women in subordinate status and constrained to their patriarchal-defined roles (Tracy, 2007). Various aspects of this theory are incorporated within the ecological approach. Although the ecological

model is rooted in empiricism, caution must be maintained in drawing firm conclusions as critical factors may be overlooked that are not included within this framework and factors may be correlational in nature. This highlights the necessity of further research in this domain (Heise, 1998).

Intersectionality Theory. Crenshaw's theory of intersectionality contends that the crossover of multiple identities creates discrimination and oppression of particular societal groups (Crenshaw, 1993). This framework distinguishes how multiple systems and dynamics both create and reinforce marginalization and injustice against women. Within the context of domestic violence, this is explored through the interaction of gender (being a woman) with other identities such as age, sexual orientation, race, social class, mental illness, physical illness and disability, that places women at the forefront of victimology. These identities are not mutually exclusive and function systemically in a negative manner. It is argued that the present social infrastructure is not equipped to handle the complexity of intersectionality and its role thus, creating additional oppressive systems and barriers to seeking help.

Victim vulnerability will be explored through the intersectionality of the female identity with multiple other identities that when compounded, create increased vulnerability as victims of violence and formulate a hindrance to pursuing help. Drawing on these two frameworks, it is of essence to probe into the various contributing factors to victim vulnerability on all levels within the ecological framework, as well as their intersecting relationships.

Review of Selected Literature

Social Support Versus Isolation. Within the context of domestic violence, social support systems, networks of family and friends, are integral to victim support in reducing the risk of re-victimization and lethality. Social support serves as a protective factor against impending

violence and empowers victims towards an efficacious pursuit to access resources (Goodman, Dutton, Vankos & Weinfurt, 2005). The risk of re-victimization for victims of domestic violence with low levels of social support exceeds that of victims with greater levels of social support (Bybee & Sullivan, 2002). The fabric of social support is consistent in safeguarding victims from violence regardless of severity of past violence. In their work Goodman et al. (2005), concluded that social support was critical for 75% of cases in their sample. Within these cases, the risk of re-victimization dropped to 20% for victims with high social support from 60%, in victims with low social support. Social support may offer a moderating relationship between domestic violence and a myriad of mental health consequences, specifically through rendering emotional support (Coker et al., 2002). In their study, Coker et al. (2002), found that victims with high levels of emotional support reported less adverse outcomes related to mental health and were less likely to attempt suicide. It is believed that social support increases psychological well-being and supports positive coping (Coker et al., 2002). Family and friends may serve key roles through providing financial assistance, housing, accommodation, transportation, and child care. In addition, they may offer emotional support through empowerment and navigating the challenges of various intervention systems and agencies, or help in leaving an abusive relationship (Goodman, et al., 2005). Perpetrators often strive to isolate victims from social supports and interaction with others, particularly as violence increases (Bybee & Sullivan, 2005). Victim isolation diminishes opportunities for the victim to escape and increases opportunity for re-abuse and dependency on the perpetrator. Perpetrators may monitor a victim's whereabouts, screen their calls, forbid them to see friends or take measures such as moving them to a remote location and restricting phone access.

The social networks of female victims of domestic violence are characterized by distinguishing dynamics such as decreased size of the social network or increased isolation from close supports (Jasinski, 2004). Alternatively, some researchers posit that these social networks may have been smaller to begin with (Weisbart, Thompson, Pelaez-Merrick, Kim, Wike, Brigg, English & Dubowitz, 2008). Social isolation is a tremendous barrier as it increases opportunities for violence and control, while decreasing opportunities for support, intervention or ending a violent relationship.

Mental Health. There is an overwhelming amount of literature supporting the devastating impacts of domestic violence on the mental health of victims. Research suggests that the presence of a mental illness may both provoke and increase a victim's risk of DV (Kuijpers et al., 2011). Although the mechanism is not completely understood, a victim experiencing mental illness may be perceived as more vulnerable to her perpetrator and may have, or may appear to have a diminished capacity to protect herself thus, facilitating the exertion of control over her (Nurius, Macy, Nwabuzor & Holt, 2011; Kuijers et al., 2012). Mental illness can be both a product of violence or may be a pre-existing condition exacerbated by victimization. The prevailing mental health concerns for victims of DV are depression and post-traumatic stress disorder (PTSD) (Campbell, 2002); which often carry high levels of co-morbidity in females who regularly experience violence (Dutton, Green, Kaltman, Roesch, Zeffior & Krause, 2006). Other concerns include increased levels of suicide, anxiety, insomnia and substance use (Dutton et al., 2006). In samples of domestic violence survivors, prevalence rates are at 50% for meeting the criteria for Major Depressive Disorder (Riggs, Caufield & Street, 2002) and PTSD has been linked to increased levels of re-victimization over extended periods of time (Krause et al., 2006). A review conducted by Golding (1999) depicted that females enduring violence showed a greater

likelihood of negative mental health consequences that was 3 to 5 times greater than those women who were not victims of violence. Internationally, individuals seeking help for issues concerning mental health are more likely to have recently experienced violence with the rate being 11 times higher than that of individuals without mental health concerns. Within this population, individuals with serious mental illness have the most elevated risk of violence (Khalifeh & Dean, 2012). Mental health concerns can interfere with and reduce quality of life and functioning, thus decreasing a sense of self-efficacy and independence and increasing social isolation (Helfrich, Fujiura & Rutkowski-Kmitta, 2008).

Physical Health/Disability. The impact of physical violence itself has multiple negative consequences on the well-being and health of victims. Female victims of domestic violence have increased rates of health problems as a direct result of the trauma inflicted upon the body (Dutton et al., 2006). This may range from minor to severe and include, but is not limited by gastrointestinal complications, gynaecological problems, chronic pain, various physical complications, lowered immunity, disability and several neurological and cognitive consequences (Campbell, 2002; Coker, Smith & Fadden, 2005). Research suggests that DV victims may be less likely to pursue care and many injuries may go undiagnosed, particularly those resulting from traumatic head inquiry and strangulation (Coker et al., 2005; Black, 2011).

The risk of domestic violence victimization for females with a disability is far more pronounced in this population than for females without a disability, and is attributed to the intersectionality of two vulnerable identities (Ballan & Burke Freyer, 2012; Shah, Tsitsou & Woodlin, 2016). In a Canadian research sample, Ballan, Burke & Freyer (2012) observed that the threat of domestic violence for females with a disability was 40% greater. Females with a disability are two times more likely to report grave abuse, and abuse in this population endures

for longer periods of time (Ballan & Burke Freyer, 2012). In a sample of females with a disability seeking medical aid, 54% reported experiencing some form of partner violence (Coker et al., 2005). Individuals living with a disability may be victims of distinct forms of violence that are unique to their condition. This may include neglect, denial of care and medication, and limited or restricted access to medical aids (Platt, Powers, Leotti, Hughes, Robinson-Whelen, Osburn, Ashkenazy, Beers, Lund & Nicholaidis, 2017). Physical injuries sustained as a result of domestic violence may also lead to disability and therefore, increased violence (Coker et al., 2005). Although there is some variability in the definition of disability, it generally encompasses chronic pain, chronic diseases, disabilities resulting from trauma, learning and cognitive difficulties, as well as mental illness. Disability may increase a victim's state of vulnerability and the perception of dependency, thus increasing the possibility of perpetrator exploitation (Shah, Tsitsou & Woodlin, 2016). The perpetrator may take advantage of the power differential and the victim's dependency on him or other aids (Ballan & Burke Freyer, 2012). Moreover, individuals with a disability are more likely to exhibit lower levels of self-esteem and perceive themselves as a less valuable partner because of the disability. Survivors with a disability face various physical, institutional and systemic barriers such as those pertaining to a lack of accessibility to spaces and materials, limited substitute options and professionals' ignorance of the unique dynamics of disability (Shah, Tsitsou & Woodlin, 2016). Taking into account the various possible limitations and barriers as a result of disability, many victims may be much more reliant on their intimate partner, increasing opportunities for social isolation and exclusion (Ballan & Burke Freyer, 2012). These unique challenges and circumstances increase risk of victimization and may impede support, intervention or separation from an abusive relationship.

Living Context: Rural & Remote. Community cohesion is a term used to characterize the level of coherence, union, mutual support and communication between members of a community (Obajasu et al., 2009). At high levels, community cohesion serves as a protective factor increasing social power and resources, thus decreasing risk of re-victimization (Obajasu et al., 2009). Alternatively, high levels of neighbourhood disorder (poor conditions, increased rates of crime and drug use) can lead to poorer health outcomes amongst its members, a lack of cohesion, and increased feelings of mistrust in those around, thus increasing re-victimization. This can be aggravated for individuals living in lower economic status or who are victims of systemic marginalization (Obajasu et al., 2009). Research has also explored victimization comparing urban to rural and remote settings as these regions have striking dynamics in their relation to domestic violence.

Almost one-third of Canadians reside in rural areas (Kulig & Williams, 2011). Although there is a lack of agreement on what constitutes rurality and limited literature concerning this topic (Lanier & Maume, 2009), much of the existing consensus concentrates on regions with a small population and low population density (Sandberg, 2013). Remote regions witness similar characteristics to rural areas, however there is a recognizable disparity in terms of isolation. The Registered Nurses' Association of Ontario defines remote as "communities without year-round road access, or which rely on a third part (e.g. train, airplane, ferry) for transportation to a larger centre" (McNeil & Paquette, 2015, p.12). Distinct demographics exist in rural and remote areas; an increased number of elderly individuals and children, increased visibility of Indigenous populations, higher rates of unemployment and decreased education rates (Hart, Larson & Lishner, 2005; Bollman & Clemenson, 2008). In addition, these populations witness higher rates of suicide, disability, chronic disease and mortality (Bollman & Clemenson, 2008). In large this

distinguishing portrait is attributed to less availability of health care services, increased costs and a lack of targeted and specialized services as the rarity of these structures calls for more general and universal services (Hart, Larson & Lishner, 2005).

Rurality and remote living contribute to risk of victimization due to geographic isolation, which may further exacerbate various characteristics unique to these regions (Campo & Tayton, 2015). Victims living in small communities are less likely to disclose violence for fear of revealing private matters and a lack of anonymity. In addition, those living in these regions may experience a scarcity, or decrease in community resources, which is compounded by low socioeconomic status. These regions often encounter increased rates of poverty and are more susceptible to economic decline, which by consequence increases victim rates of financial dependency (Shepard and Hagemeister, 2013; Hart, Larson & Lishner, 2005). Geographical distance acts as an additional barrier to service access and may create a delay in both safety and intervention response. Victims living in rural and remote regions also face additional accessibility barriers such as a lack of transportation, road closures or absence of roads, and hindrances due to weather conditions (Sandberg, 2013).

It is argued that social networks may be the most vital protective factor for victims living in rural and remote regions since women who receive help from social networks have a lowered risk of violence (Lanier & Maume, 2009) this is however contrasted by concerning evidence that rural victims are less willing to disclose to intimate networks (Sandberg, 2013). For many of these reasons, perpetrators may forcefully relocate their victim to more remote regions with the intention to isolate victims in a social, emotional and physical manner, thus further decreasing support and opportunities for intervention (Sandberg, 2013).

Some literature supports the conservation of traditional views in rural regions, often conceptualized as rural patriarchy/masculinity, or idiosyncratic beliefs affiliated with religion (Campo & Tayton, 2015). These communities may be less willing to intervene as family conflicts may be viewed as private affairs, traditional gender roles are often conserved and males hold superior authority over family issues (Sandberg, 2013; Shepard & Hagemeister, 2013). These attitudes may further hinder domestic violence intervention or disclosure of violence and lead to increased levels of violence and re-victimization.

Living Context: Homelessness & Subsidized Living. The etiology of homelessness is not rooted in a single factor or occurrence in an individual's life, but is the result of multiple, compounding factors attributed to structural elements, systemic shortcomings and complex individual situations. The term homeless is employed in situations where an individual or family lacks permanent/secure housing or where there is limited likelihood of obtaining secure housing. Within this definition, there are various typologies of homelessness; *unsheltered homelessness* where individuals have no accommodation and therefore are forced to live in conditions that do not meet the standards for human habitation, *the emergency sheltered* who rely on shelters for accommodation as they do not have secure housing, *provisionally accommodated* are individuals in transient housing without long-term security that may be living in motels or couch-surfing and finally, *the at risk for homelessness* which are individuals at imminent risk of becoming homeless due to various interpersonal factors (Canadian Observatory on Homelessness, 2014).

Violence is both a precipitating factor of and root of cause homelessness (Clough, Draughon, Nije-Carr, Rollins, & Glass, 2013). Individuals fleeing interpersonal violence are a common and increasing demographic amongst homeless populations. Women who are marginalized, ethnic minorities, individuals with mental health concerns and low socioeconomic

status are at the highest risk of becoming homeless (Homeless Hub, 2017). The decision to leave a violent relationship presents many barriers and insecurities around finances, loss of home, isolation and fear of future violence and is further exacerbated with a lack of accommodation. Canada has witnessed a shift from shelter use to bed nights which consequently has emergency shelters working at 90% over capacity, often turning away many individuals. Emergency shelters designed for survivors of domestic violence offer resources and unique safeguards geared towards this population however, research supports that mental health concerns can be exacerbated by the instability and insecurity of homelessness, and that homeless individuals are more susceptible to violence (Meinbresse, Brinkley-Rubinstein, Benson, Hamilton, Malott & Jenkins, 2014; Homeless Hub, 2017). Given the lack of options due to limited availability of temporary housing, and the lack of affordable, secure, safe and long-term housing, many survivors return to their abuser (Yamawaki, Ochoa-Shipp, Pulsipher, Harlos, & Swindler, 2012; Homeless Hub 2014; Clough, Draughon, Nije-Carr, Rollins, & Glass, 2013). Although individuals living in subsidized housing may not meet the criteria for homelessness, by virtue of low socioeconomic status or poverty, they are at risk for violence and may fall into the category of at risk for homelessness. Low socioeconomic status individuals are eligible for government subsidy to supplement their rent which on average hovers around 30% of their monthly income (Settlement.Org, 2015). This financial strain may cause economic dependence on the perpetrator and pose a barrier to help-seeking or leaving the relationship.

Dependant Others. Following the ecological model, there may be additional barriers in a female victim's immediate context (microsystem) creating obstacles to intervention and help-seeking. Females may have dependent others who are in their care or residing with them such as children or older adults, thus increasing the difficulty of leaving a violent relationship and adding

additional financial constraints. Children in the context of domestic violence create a dual relationship to risk, as they may be both a deterrent to leaving an abusive relationship or may be the motivation to do so (Zink, Elder & Jacobson, 2003). The child is often used as a weapon and accessory for harassment, intimidation, and threats against the mother (Jaffe, Scott, Jenney, Dawson, Straatman & Campbell, 2014). Work conducted by Beeble, Bybee & Sullivan (2007) found of 156 battered women, over 50% of the perpetrators used their children to harass or intimate the mother. Given that mothers often place children's safety and needs ahead of their own, this might hinder the woman's ability to leave the relationship as she may be fearful of the safety of her child or the possibility of the offender gaining custody (Beeble et al., 2007). Separation and guardianship arrangements are subject to offender violation or negligence. The abuser may use alienation from his children as a legal argument and capitalizes on these situations using the child to exert control and authoritative behaviour that in reality, is targeted at the mother. In extreme situations, children may be victims of domestic homicide as a form of retaliation against the mother (Jaffe, Campbell, Hamilton & Olszowy, 2014).

Prior Victimization. Domestic violence usually presents as a repetitive pattern of abuse (Riggs et al., 2002). Prior violence of any nature has been linked to an increase in future violence, and both verbal and emotional violence are supported as predictors of future physical domestic violence (Riggs et al., 2002). Although emotional, psychological and physical abuse are distinct forms of violence, they are often connected and co-exist (Kuijpers et al., 2011). Emotional abuse occurs more frequently and increases a victim's risk of physical violence due to the experience of psychological difficulties (Kuijpers et al., 2012). In the case of both physical and emotional abuse, recency and severity of violence, are strong predictors of re-victimization (Kuijpers et al., 2011). Alarmingly, rates for re-abuse are quite high even after an intervention.

Krause et al. (2006) observed that 36.7% of victims experienced re-abuse even after an intervention that was uniquely designed to target domestic violence.

Prior violence can refer to previous violence in an intimate partner setting, but additionally encompasses early/childhood experience of trauma or abuse (both physical, sexual and emotional) which can increase future adult victimization (Carbone-Lopez & Kruttschnitt, 2010; Obajasu, 2009). Childhood maltreatment augments a female's risk for dating violence as early as in adolescent relationships (Iratzoqui, 2016; Iratzoqui, 2017), and a history of dating violence increases risk for violence in a marital setting or adult relationship (Riggs et al., 2002; Iratzoqui, 2017; Bensley, Van Eenqyk & Simmons, 2003). Iratzoqui (2016) presents Cohen and Felson's model to explain this phenomenon, arguing that past childhood trauma (abuse, neglect) may lead to engagement in maladaptive coping strategies and entering into high-risk relationships. Additionally, witnessing violence in the family can also increase future victimization due to transmission of expectations that violate the norms around what constitutes a healthy relationship (Riggs et al., 2002). It is proposed that the phenomenon of re-victimization is pervasive and may impact an individual throughout the life course trajectory (Iratzoqui, 2016). Females enduring chronic victimization have much poorer outcomes with respect to mental and physical health (Weisbert et al., 2008).

Economic dependence. Research on victim economic dependence in relation to domestic violence is quite scant however, the consensus highlights that this phenomenon occurs much more often in female victim populations (Postmus, Plumer, McMahon, Murshid & Kim, 2012). Within the literature it is sometimes referred to as economic abuse; a term used to encompass a variety of situations in which the victim becomes economically dependent on the perpetrator. This includes the perpetrator's control of a victim's funds, demands for proof of purchases,

sabotaging credit scores, the perpetrator's dominance over financial decisions, persecuting and harassing behaviours that cause disturbances in workplace attendance, and decreased hours of work which ultimately may lead to loss of employment (Postmus et al., 2012; Fawole, 2008; Stylaniou, Postmus & McMahon, 2013). Limited or lack of access to economic resources increases barriers to leaving a violent, abusive relationship (Postmus et al., 2012) and decreases the victim's economic self-sufficiency and autonomy. Economic abuse may also continue after separation or divorce from a violent relationship, causing the victim additional stress and further keeping a degree of control over the victim (Fawole, 2008). Postmus et al. (2012) references work conducted by Adams, Sullivan, Bybee & Greeson (2008) which posits that through the removal of economic means (securing, gathering, using), the perpetrator is able to exert control over the victim, placing them in a subordinate position and financial dependency on the perpetrator. Various conditions such as a disability, dependent children and poverty can increase a victim's vulnerability and exacerbate economic dependence, creating a trap to leaving (Postmus et al., 2012). Economic independence in DV victims can serve as a protective factor offering increased access to safety, resources, information, flexibility and increasing the ability to exiting a violent relationship (Goodman, et al., 2005). Additionally, a female's occupational status can have significant weight on leaving/staying behaviours, specifically females in occupations with lower wages may be less likely to leave violent relationships, as are females who are economically dependent (Bornstein, 2006).

Risk Employment & Substance Addiction- A victim's involvement in high-risk employment such as prostitution and substance trafficking also poses an increased risk of victimization. Research suggests that individuals engaging in these behaviours are more likely to associate with high risk, anti-social individuals. Through affiliation with these groups, risk and

exposure to potential violence increases (Carbone-Lopez & Kruttschnitt, 2010). Iratzoqui (2016) offers work conducted by Sterk (1999), that posits risky behaviours such as selling drugs, may provide victims with a sense of maladaptive empowerment, escape and financial independence.

Women employed in the sex industry are at heightened risk of violence due to their stigmatization and increased subjection to numerous potential perpetrators (Doherty, 2005). Violence may be employed to coerce women into the industry or to continue within the industry. Though some women may choose to work in the sex trade, a significant number of women find themselves in the industry without choice, and may be fleeing violence or are exploited while trying to acquire financial autonomy (Doherty, 2005; Thaller & Cimino, 2016). Of the industry, prostitution has the highest rate of homicide (Thaller & Cimino, 2016). Due to their marginalized status and the illegality of prostitution, these women are more likely to work in secluded areas, heightening the risk of violence and are less likely to seek help due to stigmatization. Women working in the sex trade may experience a variety of different forms of violence ranging from sexual assault, physical and psychological aggression, as well as controlling behaviours (Thaller & Cimino, 2016). Thaller and Cimino (2016) criticize research approaches that separate the phenomenon of IPV from sex work, as their intersectionality merits detailed attention, arguing that both constructs operate on blurred boundaries around consent. Substance use disorders are often concurrent with prostitution as individuals may seek employment to gain financial means to maintain the use of a substance or use drugs as a form of coping with psychological pain (Young, Boyd & Hubbell, 2000).

Substance use amongst female victims of domestic violence has been cautiously explored and information is often limited to samples derived from incarcerated victim populations. In domestic violence, substance use has been linked to increased risk of becoming a victim of

violence and this relationship is argued to be positive; when violence increases, so does the use of a substance (Riggs et al., 2002; Cunradi, Caetano & Schafer, 2002). Female victims of domestic violence are five times more likely to use substances than non-victims (Dutton et al., 2006) and a female's risk of violence under the influence is believed to range from moderate to severe (Carbone-Lopez & Kruttschnitt, 2010). Current use of a substance is associated with risk of re-victimization as the female appears increasingly vulnerable to her perpetrator, creating a disparity in power. The victim may have an impaired ability to defend herself or predict the victimization (Kuijpers et al., 2011; Iratzoqui, 2016 & Kilparick, Acierno, Resnick, Saunders & Best, 1997). Although it may be difficult to delineate whether substance use is a precursor or response to violence, it is critical to discern that victim substance use if often linked to a traumatic history and is viewed as a maladaptive method of coping (Kuijpers, et al., 2011; Riggs et al., 2002). Moreover, it appears that victim substance use in itself is not a precipitating factor to domestic violence, but is dependent on substance use of the abusive partner (Carbone-Lopez & Krusttchnitt, 2010). Perpetrator intoxication has been highlighted in the research as a major risk factor for violence and re-victimization (DVDRC, 2015; Carbone-Lopez & Kruttschnitt, 2010). Females may therefore find themselves entrapped in a vicious cycle of violence where substance use is employed as a coping response to abuse but its use increases risk of victimization (Kilpatrick et al., 1997). Victim substance use may constitute a major barrier to help-seeking given the negative stigma associated with this behaviour and victims under the influence may appear unreliable, causing them to be turned away.

Intuitive Sense of Fear. A woman's sense of fear of the perpetrator and her perception of personal risk level are rich sources of information for domestic violence intervention and case planning, however the importance of these victim statements has only received recent

acknowledgement and consideration. Victim disclosures provide a first-hand account of violence, and can articulate factors that are difficult to conceptualize empirically that may not have representation within actuarial risk assessments. Dismissing how a victim gauges their own risk could omit critical information, although research findings indicate variability in the accuracy of a victim's ability to predict risk and little is understood in terms of the mechanism through which survivors appraise their level of risk (Weisz, Tolman and Saunders, 2000).

In a national study conducted with 465 victims of femicide or attempted femicide, roughly half of the women discerned their risk of homicide by their partner (Campbell, 2004). The literature offers possible reasons for this such as the woman's doubt in her abilities due to coercive minimization, the possible use of minimization as a coping strategy for violence or a diminished capacity to perceive threat, as consequences of endured trauma (Weisz, Tolman & Saunders, 2000; Sherill, Bell & Wyndgarden, 2015). Nonetheless, the consensus is that a victim's appraisal of risk is a crucial element that should be used in conjunction with risk assessment tools, as their fusion fosters improved risk prediction (Connor-Smith, Henning, Moore & Holdford, 2011). Both components are autonomously important however, when used in conjunction, they provide critical and complimentary information (Weisz, Tolman & Saunders, 2000; Connor-Smith, Henning, Moore & Holdford,2011).

Within actuarial and empirically validated risk assessment tools, the primary focus is dedicated to static factors that can be conceptualized and measured, as is inherent with an empirical approach. These factors usually concern the history of interpersonal violence in the relationship, weapons and recent occurrences of violence, criminal background, employment history and substance use (Connor-Smith, Henning, Moore & Holdford, 2011). There is some variance in content between risk assessment tools but generally these domains are covered. A

survivor's account of their awareness of risk allows a unique opportunity to attend to dynamic factors that are arguably immeasurable in an empirical setting. Victims are often able to attest to changes in the perpetrator's behavior, and the importance of certain events in the life of the perpetrator as opposed to the sole occurrence of an event captured by the presence or absence of a factor. Studies suggest that individuals are generally poor at predicting their risk of victimization, although it would appear that survivors of IPV do not fall subject to optimism bias on account of their experience with breached and violated expectations and may have an increased awareness of possible menace or risk due to hypervigilance (Connor-Smith, Henning, Moore & Holdford,2011; Sherill, Bell & Wydgarden, 2015). Though limited, there is compelling support for differences in victim appraisal of risk when compared to statistical risk assessments, furthering the claim that the two should be used in tandem.

In a large study conducted by Connor-Smith, Henning, Moore & Holdford, 2011), over half of their population sample (70%) experienced notable violence, however, roughly 50% reported that the likelihood of a subsequent incident of violence was improbable. The victim's statements were contrasted with results on the Ontario Domestic Assault Risk Assessment (ODARA). Although agreement was similar between the two sources and some overlap was observed between the statistical measure and victim perceptions, important differences were noted though the two measures did not always correspond. Women rated their situation as high-risk when the following perpetrator-related factors were present; issues with employment, substance use, criminal history, jealousy, controlling behaviours, threats, as well as, an escalation of violence, how accessible they are to their perpetrator, ending a violent relationship, the perpetrator's avenging fantasies, mental health issues and personality factors (Connor-Smith, Henning, Moore & Holdford, 2017). Surprisingly, factors that have significant representation in

the literature such as non-criminal history, family constellations, the presence of children, marital status or age, were not found to be significant in terms of victim risk-perceptions (Connor-Smith, Henning, Moore & Holdford, 2011). There is some overlap between the two, for example a history of violence seems to be an important indicator in both victim-perception and actuarial tools, however it appears that women attend to more emotionally salient indicators to assess their risk (Connor-Smith et al., 2011). These results, although hampered in terms of research representation, offer support that these two sources of information are complimentary but equally important and victims should be an active player in risk assessment. It should be noted that these studies are often limited to survivors of sexual assault, women who are involved with agencies and have engaged in help-seeking, and may not be generalizable to other samples (Connor-Smith et al., 2011; Sherill, Bell & Wyngarden, 2015). A victim's intuitive sense of fear has been labelled as a risk factor for lethality and continues to be one of the top 10 risk factors in cases reviewed by the Ontario Domestic Violence Death Review Committee (DVDRC, 2015).

Fear/Mistrust in the Justice System. A woman's prior experience with the justice system may be dependent on future pursuit of support (Cerulli, Kothari, Dichter, Marcus, Wiley & Rhodes, 2015). This finding is not based solely on the outcome determined but the treatment of the survivor and the handling of the case throughout the process. Police serve an integral role in the process as they are the first point of contact with the criminal justice system (Tutty, Wyllie, Abbott, Mackenzie, Ursef, & Koshan, 2008). As domestic violence gained further recognition as a social problem and moved away from a diffusion of responsibility caused by a label of it being a "private matter", changes were reflected in the social sphere through amendments and corrections to policies, protocols and procedures governing justice and proactive systems. Amidst these strides, domestic violence remains highly underreported (Tutty et al., 2008). It is

estimated that around seventy-percent of cases of domestic violence are not reported to authorities (Sinha, 2013). Variability in police response has been attributed to a victim's willingness to disclose, as well as desire to pursue future contact or help. Women report satisfaction with police response when they are approached with respect, listened to, not criticized or blamed, when they are connected with resources, arrests are made and when they are empowered throughout the process and their opinions are not discounted (Russel & Light, 2006). In contrast, attitudes of victim-blaming, criticisms of the victims or dismissing victim statements are associated with less satisfaction. Trujillo and Ross (2008) argue that police response is influenced by three factors; personal beliefs or assumptions about intimate relationships and the alleged incident, situational factors of the incident and prior reports. Studies have demonstrated that victim-blaming attitudes and the personal beliefs around domestic violence of police officers are barriers to victim help-seeking (Gover, Pudrzynska, Dodge & Dodge, 2011; Tutty et al., 2008; Myhill & Johnson, 2016). It is argued that the criminal justice itself is intrinsically rooted in masculinity, sexism and patriarchal values and that current procedures undermine victims and perpetuate stereotypes and victimization (Leung, 2013; Huisman, Martinez, and Wilson, 2005; Ragusa, 2012). Police express frustration with repeat calls to the same residence, women who choose to remain with their abuser, the time-intensive nature of response to domestic violence calls and the accompanying paperwork, a lack of training on response and the inner dynamics of domestic violence, inadequate staffing, difficultly identifying the primary aggressor, and recanted victim statements (Gover, Pudrzynska, Dodge & Dodge, 2011; Russel & Light, 2006; Ruff 2012; Myhill & Johnson, 2016). Women may also be apprehensive in reporting violent incidents for fear of child protection involvement or what may happen to their children, the victim herself has employed violence, the victim wishes for the

violence to end but fears rupture of the relationship or fear around finances, stigmatization and shaming (Cerulli, Kothari & Dichter, 2015; Cerulli, Kothari, Dichter, Marcus, Wiley & Rhodes, 2014; Fugate, Landis, Riordan, Naureckas & Engel, 2005). Women may also fear reprisal from their partner as a consequence of violence disclosure, may doubt agency response, may question whether the incident merits reporting, may be physically obstructed from contacting authorities, may anticipate criticism from their social networks, breaches of privacy, further isolation and systemic barriers such as time, money and transportation, (Maxwell, 2002; Fleury, Sullivan, Bybee & Davidson, 1998; Kang & Lynch, 2010; Fugate et al., 2005). Additionally, victims living marginalized lifestyles such as having a criminal history or substance use problems, may feel further disinclination to do so. An increased level of education is found to decrease reporting (Kang & Lynch, 2010; Fleury et al., 1998) and increased levels of reporting were observed amongst younger victims (Kang & Lynch, 2010). Interestingly, a victim's sense of fear appears to have a large impact, increasing police action and pursuit of charges (Trujillo & Ross, 2008).

Within the legal system, cases of domestic violence are often renounced (Gauthier, 2010). Similar concerns amongst legal professionals are echoed such as a lack of training in domestic violence and a lack of victim cooperation throughout the process leading to burnout and compassion fatigue (Bettinson, 2012; Gauthier, 2010). A common discourse of conflict exists within the justice system in which professionals articulate increasing frustration with victim actions and proceeding in a manner that it does not encroach on the victim's autonomy and personal sense of efficacy (Gauthier, 2010). Victim's express a lack of confidence in the justice system, doubting its ability to ensure their safety or a lack of confidence that the pursuit of charges will be successful in promoting change. Furthermore, criminal proceedings are often long, arduous processes and are both time and resource intensive. Cases that do not produce

successful outcomes may produce skepticism in the justice system, further propagating victimization and dismissing the violence that occurred as unworthy of proceedings (Gauthier, 2010). Interestingly, work by Cerulli et al. (2015) observed that women may continue to pursue criminal proceedings even when the prosecution was inconsistent with their desires. This contrasts the common belief and stereotype of victims as powerless and helpless individuals. However, in cases which the prosecutor's stance was to drop charges, women who experienced lower levels of violence were more likely to proceed despite difference in opinions. Cases in which the perpetrator had prior offenses were more likely to be pursued by both the prosecution and the victim, while first time offenses were more likely to be dropped. Some important differences were highlighted such as victims of higher socioeconomic status were more likely to pursue charges, minority victims were more likely to drop charges and women who used substances at the time of the incident were less likely to proceed due to shame and fear of potential repercussions and lower credibility (Cerulli et al., 2015)

Immigrant Status. Ontario is one of the most culturally distinct provinces, as over one-fourth of its population is composed of foreign-born individuals (Ontario Immigration, 2016). Annually, an estimated 100,000 immigrants chose Ontario as their intended destination. In the context of domestic violence, immigrant women face a unique set of challenges attributed to the intersectionality of their immigrant status and their identity as a woman, in addition to multiple factors such as cultural background, race, class, religious beliefs, and social positioning (Abraham & Tatsoglou, 2016).

A lack of language proficiency is a barrier to service access and mediates the comprehension level of existing policies and laws. Language interpretation services are not always available as they are resource-intensive and in cases where they are an option, are often

deemed to be insufficient (Abraham, 2000). Furthermore, special consideration must be employed in the selection of an interpreter as they may belong to the same cultural community of the client and impact a victim's willingness to disclose or pursue help for fear of judgement, cultural shame or the perpetrator finding out. This is further compounded by a lack of knowledge of the woman's rights and accessible services. As the perpetrator is often the sponsor, their dependant status is used against them as a coercive tactic, impeding help-seeking. Women are financially dependent on their spouse and live in constant trepidation of deportation (Alaggia, Regehr & Rishchynski, 2009; Abraham & Tatsoglou, 2016). Victims may be less likely to disclose or report violence for fear of systemic repercussions. In many cases, laws and policies are misinterpreted and victims are hesitant to involve services such as Child Protection for fear of losing their children (Alaggia, Regehr & Rishchynski, 2009). Immigrant women may also be reluctant to report violence to police due to prior negative experiences with authority in their homeland, creating a general mistrust in the systems whose mandate is their protection.

Isolation has been linked to severity of abuse (Raj & Silverman, 2003). Newcomers may have smaller social networks and may fear that violence disclosure may alter their reputation and bring cultural shame, resulting in isolation from an already intimate social circle (Abraham, 2000). Various cultures do not acknowledge separation from a partner and there is an expectation of preserving the family unit and private matters (Alaggia, Regehr & Rishchynski, 2009). This is difficult to manage as immigrants are immersed in a Canadian context where violence is not tolerated and punishable. Disclosures may have consequences within the intimate relationship and may further increase isolation of the victim. These contrasting dynamics and various cultural differences are not taken into account in various domestic violence approaches, representing systemic shortcomings. A lack of cultural sensitivity and awareness from professionals has been

supported in the research as an additional barrier to help-seeking. Furthermore, research on immigrants and newcomers, specifically in the context of domestic violence, has been difficult to carry out due to the above-mentioned barriers and fear of stereotyping (Alaggia, Regehr & Rishchynski, 2009).

Risk Factors and the Domestic Violence Death Review Committee. The DVDRC is a multi-disciplinary team composed of professionals from different sectors including policing, prosecution, research, health sectors and social services that was created within the Office of the Chief Coroner based on the inquests of two domestic homicide cases. Since the advent of the committee in Ontario in 2003, Domestic Violence Death Review Committees have formed in several other provinces in Canada. The committee operates as one of the six expert committees under the Ontario Office of the Chief Coroner (OCC) and has reviewed 367 deaths to date (DVDRC, 2015). The DVDRC conducts a thorough review of domestic homicide reports to identify trends, risk factors, patterns and death factors in each case, and elements that may be common amongst cases. Reports provide a comprehensive picture based on history, circumstances, interventions and victim/perpetrator information. The committee assesses what warning signs were present and what actions could have been taken to prevent the reviewed homicide (DVDRC, 2015). Recommendations derived from these case reviews are shared to inform institutions that may be involved (criminal justice, victim centres, health care providers, government) in the hopes of prevention of death in similar circumstances in the future. Seventy-four percent of these recommendations are made with respect to victim risk and safety (Dawson, Jaffe, Campbell, Lucas & Kerr, 2017) and operate within the exposure reduction framework.

Based on the current research in the field, the DVDRC has assembled a list of 40 risk factors for lethality in cases of domestic homicide. In 72% of the cases reviewed, there were at

least 7 or more listed risk factors (DVDRC, 2015). A risk factor can be described as a characteristic, context or attribute that increases the likelihood for lethality; domestic homicide. Risk factors concern the history of the perpetrator, family and economic status, perpetrator mental health, perpetrator attitude/violence, and perpetrator access and disposition. The two most common risk factors in the DVDRC are history of domestic violence (74% of cases) and intimate partner separation (68%), and other top risk factors include obsessive behaviour on behalf of the perpetrator, perpetrator depression, and an escalation of violence. An understanding of these risk factors can inform risk assessment, as well as safety planning and intervention for victims. In the majority of cases, the DVDRC found that family, friends, co-workers and various other agencies were aware of these factors (DVDRC, 2015). Within the DVDRC, risk factors related to victim vulnerability have not yet been incorporated. This research would provide a novel contribution and be complimentary to the ongoing hard work and dedication of the DVDRC research team.

Purpose and Rationale of the Current study

This study explored dimensions of vulnerability amongst victims of domestic homicide. The purpose of the study was binary in nature; to determine the prevalence of vulnerability dimensions in the sample of cases and the different profiles of vulnerability and second, to investigate the relationship between these profiles and the number of agencies involved, separation, the number of homicide risk factors and perpetrator factors. Research on victim-related factors is scarce and is often conducted by the exploration of isolated variables. Domestic violence and domestic homicide are both considered to be a multi-dimensional phenomenon propagated by the intersectionality of multiple factors and levels that are intertwined with oppressive systems. This study explored the intersectionality of multiple, and compounding vulnerabilities and its contribution to creating distinct profiles of vulnerability.

Hypothesis

On account of a multitude of factors, the extent of the inter-relationships between multiple dimensions of vulnerability, their diverse nature and a lack of homogeneity of experience, the researcher hypothesized the emergence of distinct profiles of vulnerability. It was expected that the present sample would identify more than one cluster of vulnerability and that variance would be observed between clusters, with respect to the victim's age, number of homicide risk factors, agency involvement, and separation from an intimate partner. Through an ecological approach, it was expected that correlates between victim factors and factors related to the perpetrator would be observed. Due to the exploratory nature of this study, detailed hypotheses were not identified.

Method

Procedure

This study employed the use of a pre-existing database of domestic homicide case files and additional file review was conducted for the dimensions of victim vulnerability. Material from case files and reports reviewed by the DVDRC are amassed into a large database. To ensure confidentiality cases are protected under a unique identifier code. Information regarding risk factors, demographic information, information concerning details of the homicide, data regarding the perpetrator, the couple and their history, as well as agency intervention, was collected and coded by a team of researchers. Using a standardized coding system, researchers assigned numeric values to cases to summarize the presence or absence of specific factors in those cases. The absence of a risk factor was marked as "1", the presence of a risk factor was assigned a "2", if the presence of the risk factor was unknown, or not mentioned directly in the files it was coded as a "3". As many of the dimensions utilized in this study were not part of this existing database, additional coding and file review was carried out. A team of graduate students

independently reviewed all case summaries and coded each of the case files for the presence of the vulnerability dimensions in a manner that was consistent with the previous coding system. To ensure homogeneity and consensus, each researcher coded the same 30 cases on a pilot basis. An inter-rater reliability check was conducted using a Microsoft Excel formula. Differences in opinion on ratings in these 30 cases were flagged and discussed between the researchers, refining definitions and criteria. Once consensus was reached and an agreement above 80% was established between raters, the rest of the cases were evenly allocated between students and coded.

Dimensions for victim vulnerability were derived from a literature search outlined in the introduction of this study based on key words such as, “victim vulnerability”, “vulnerable victim”, “victim-related” and “victim-influenced” factors. It is important to discern that the factors employed in this study are not independently causal to domestic violence nor do they comprise an exhaustive list. Following the coding scheme outlined above, the following 20 dimensions of vulnerability were coded:

Addiction: The case files explicitly stated that a victim had an addiction or substance abuse issue. Cases including recreational substance use were not included under this categorization.

Dependent: Elderly Adult in the Home- If there was an older (65+) dependant adult residing with or in the care of the victim.

Dependent: Children- This risk factor was coded for any child living with the victim under the age of 18. This operationalization captured only the presence of a dependent child and not the number of dependent children.

Disability: The case file explicitly stated the victim had a disability or made note of the victim being on disability support. Mental illness was excluded from this category and was coded for separately.

Economic Dependence: The case file explicitly stated that the victim was economically dependent on the perpetrator through unemployment or the perpetrator's control over victim's finances.

Fear/Mistrust in the Justice System: The case file explicitly mentioned the victim's mistrust in the justice system or the victim had a history of criminal behaviour and involvement with the justice system.

High-Risk Occupation: Was coded for victims working in the sex or drug trafficking industry.

Immigrant Status: Involved any newcomer and non-Canadian born individuals. The case file explicitly stated that the victim was not born in Canada and/or stated the country of origin. Individuals immigrating from English-speaking countries, such as the United States or England were excluded for simplified analysis purposes. This is further discussed in the limitations section.

Intuitive Sense of Fear: The victim disclosed fear of the perpetrator or potential lethal outcomes.

Lack of Family Support: Was based on explicit statements made in the case files. A range of support was identified, from no family support (1), (2) if the family was present (there was contact), (3) if unknown or family was not mentioned, (4) if the family provided active support and (5) if the family actively supported and provided/pursued intervention relative to the violence.

Living Context- Homeless: Two categories of homelessness were recognized in coding; the emergency sheltered, characterized as victims who did not have secure/permanent housing and

relied on emergency shelters as well as the provisionally accommodated, those in transient housing seeking temporary shelter with family, friends, transitional housing or motels/hostels (Canadian Observatory on Homelessness, 2014)

Living Context- Remote: Remote living encapsulated geographically isolated regions that cannot be accessed year-round.

Living Context- Rural: Rural was defined as any town in which the total population is less than 1,000 as defined by Census Canada (Statistics Canada, 2009).

Living Context- Subsidized: Subsidized housing needed to be explicitly stated within case files to be coded at present.

Mental Health Diagnosis: The presence of a mental health diagnosis was explicitly stated within the cases or the victim was prescribed psychiatric medication.

Mental Health Suspected: No formal mental health diagnosis was stated but statements from family and friends are present indicating the possibility of an undiagnosed condition, or evidence supporting the presence, opinion or inclination of an undiagnosed mental health concern.

Poor Physical Health: The victim had an illness or a physical health condition explicitly stated that did not qualify as a disability.

Prior Abuse in Childhood: The case file explicitly stated that the victim witnessed or experienced abuse (physical, emotional, sexual, neglect) in her childhood.

Prior Abuse in Previous Relationship: If the victim endured previous violence in an intimate relationship, prior to the current abusive one.

Social Isolation: The case file explicitly stated that the victim was isolated from friends and family due to perpetrator's secluding actions or through moving the victim to an isolated area.

Given the large presence of unknown information, cases were recoded to omit unknown variables to provide a more concrete analysis. Cases that did not mention specific dimensions were coded as not present. The limitations of this are discussed further in this paper.

Statistical Analysis

Descriptive statistics regarding counts for the various dimensions of vulnerability were computed. Initially, vulnerability variables were examined on a continuum. Given the range of dimensions, three categories were formed; *no vulnerability* (0 dimensions), *low vulnerability* (1-3 dimensions), and *high vulnerability* (4 or more dimensions). Cut-offs were established using quartiles and were based on the sample's distribution. The researcher recognized that not all dimensions could be assumed as being of equal weight, suggesting subtypes of victims that are distinct from each other. As such, a two-step cluster analysis was employed instead to determine natural groupings within the set of data. Following cluster analysis, cluster membership was used to predict other variables: age, number of homicide risk factors, the number of agencies involved, separation and perpetrator-related factors.

Results

Sample Characteristics

The initial sample comprised 219 cases of domestic homicide. Cases that did not meet the criteria for inclusion (cases with female perpetrators, same-sex couples, primary, or intended victims under age 18) were removed as sample sizes were too small to allow for meaningful analysis. In addition, cases where all variables were marked as unknown were removed, yielding a final sample of 183 cases of domestic homicide that occurred between 2002-2012. These cases represent a total of 201 deaths as a result of domestic homicide of which 169 are females aged

18-85 (*M* = 40.65*, SD* = 14.68) and 17 child homicide victims. The rest of the sample includes partners, ex-partners, witnesses, perpetrators and others at the scene. There are fourteen female survivors of attempted-homicide amongst the sample.

Cases were classified into the following types; homicide (48.1%), attempted homicide-suicide (9.8%), homicide-suicide (32.2%), multiple homicides (3.8%), multiple homicide-suicide (5.5%) and attempted homicides (0.5%). A multitude of different types of relationships between the victim and the perpetrator are depicted within the sample; legal spouse (36.1%), estranged legal spouse (21.3%), common-law partner (19.1%), estranged common-law partner (5.5%), boyfriend/girlfriend (6.0%), estranged boyfriend/girlfriend (12.0%). The majority of these relationships were between 1-10 years in length (49.7%). Fifty-three percent of cases included children in common with the perpetrator and in 2.6% (*n* = 5) of cases, the victim was pregnant at the time of the homicide.

The number of vulnerability dimensions for each case ranged from 0-11 (*M* = 3.3 *SD* = 2.01), out of a possible 20 dimensions. As seen in Table 1, the top three dimensions of vulnerability that were identified were the victim having an intuitive sense of fear (50.3%), having (dependent) children (49.7%), and social isolation (32.2%). The breakdown of these dimensions is represented in Table 2. Interestingly, only 2.7% of cases did not have at least one dimension of vulnerability.

Table 1

Dimensions of Victim Vulnerability

Dimension of Vulnerability	**Percentage of Sample with Identified Dimension**
Intuitive Sense of Fear	50.3
Dependants: Children in the Home	49.7
Mental Health- Suspected Concerns	37.2
Immigrant Status	30.6
Lack of Family Support	23.5
Poor Physical Health	19.7
Economic Dependence	17.5
Mental Health Diagnosis	16.4
Addiction to a Substance	13.7
Disability	12.6
Prior Abuse in Previous Relationship	9.8
Prior Abuse in Childhood	9.8
High Risk Occupation	6.0
Fear/Mistrust in the Justice System	5.5
Living Context: Homeless	3.8
Living Context: Rural Housing	2.7
Living Context: Subsidized Housing	2.2
Dependants: Older Adult in the Home	2.2
Living Context: Remote	0.5

Table 2

Distribution of Vulnerability Dimensions across the sample

Number of Vulnerability Dimensions	Number of Cases	Percentage of Cases
0	5	2.7
1	28	15.3
2	39	21.3
3	38	20.5
4	26	14.2
5	24	13.1
6	11	6.0
7	5	2.7
8	3	1.6
9	2	1.1
10	1	0.5
11	1	0.5

Independence of variables. Given that 97.3% percent of the sample identified at least one dimension of vulnerability, the researcher wanted to conceptualize different profiles of vulnerability via two-step cluster analysis. Two-step cluster analysis is a statistical technique that depicts any naturally occurring groups within a set of data and can be employed with both categorical and continuous data (IBM, 2012). Cluster analysis assumes independence of variables used for clustering. To check this assumption, Pearson chi-square tests of independence were conducted between vulnerability dimensions and each dimension was tested against all twenty dimensions. As depicted in Table 3, there was a large number of variables that were statistically related and therefore could not be used as criteria for creating clusters. Variables that met the assumption of independence, had a lot of support within the literature and had large

enough counts (sample sizes allowing for analysis) were selected for the cluster analysis; victim mental health diagnosis, social isolation and victim intuitive sense of fear.

A two-step cluster analysis was conducted to find natural groupings in the data using these three dimensions. In order to be deemed a good solution, various requirements needed to be met; the silhouette measure of cohesion (indicating the quality of the clusters), surpassed the threshold of 0.5, had a ratio of the smallest to the largest cluster that was less than 2 (1.97) and made sense conceptually. Based on the satisfaction of these requirements, a four-cluster solution was elected. Analysis of variance testing was conducted using the four-cluster solution and the variables of age, number of homicide risk factors and the number of agencies involved, to explore differences between clusters. Chi-square tests of independence were also conducted using the four profiles employing several perpetrator-related factors and separation.

Table 3

Pearson Chi-Square Tests and Phi Coefficients for Dimensions of Victim Vulnerability

Vari-able	1	2	3	4	5	6	**7**	**8**	9	10	11	12	13	14	15	16	17	18	19	20
1	-																			
2	.45 (.05)	-																		
3	2.18 (-.11)	1.00 (-.07)	-																	
4	1.46 (.09)	.59 (-.06)	.06 (.02)	-																
5	.13 (.03)	.16 (.03)	.18 (.03)	3.06 (.13)	-															
6	.36 (.04)	.24 (-.04)	3.79 (.15)	2.93 (.13)	.41 (-.05)	-														
7	**5.11* (.17)**	.26 (-.04)	.84 (-.07)	.13 (-.03)	.78 (.07)	3.66 (.14)	-													
8	**4.72* (-.16)**	.73 (.06)	1.02 (.08)	.97 (-.07)	.01 (.01)	.00 (-.00)	.85 (-.07)	-												
9	.06 (-.02)	4.13 (-.15)	2.0 (-.10)	.41 (.05)	1.29 (.08)	.40 (.05)	.91 (-.07)	.00 (-.00)	-											
10	2.61 (.12)	1.28 (.08)	1.61 (.09)	.05 (.02)	.55 (.06)	4.24 (.15)	6.93 (.20)	**7.87* (.21)**	3.48 (.14)	-										
11	.01 (.00)	.16 (-.03)	3.77 (.14)	.02 (.01)	3.25 (.13)	1.20 (.08)	6.56 (.20)	.52 (.05)	1.30 (.08)	.46 (.05)	-						-			
12	.16 (-.03)	.02 (-.01)	1.02 (.08)	.15 (-.03)	.21 (-.03)	.58 (-.02)	.06 (-.02)	.44 (-.05)	1.02 (-.08)	.82 (.07)	.04 (-.02)	-						-		
13	.18 (.03)	.12 (-.03)	.20 (-.03)	.26 (.04)	.02 (.01)	.30 (-.04)	.33 (-.04)	2.27 (-.11)	.22 (-.03)	1.08 (.08)	.20 (-.03)	.03 (-.01)	-						-	
14	.65 (-.06)	.09 (-.02)	1.05 (.08)	.59 (-.06)	.16 (.03)	.24 (-.04)	.26 (-.04)	.73 (.06)	.00 (-.00)	1.17 (.08)	4.98 (.17)	.02 (-.01)	.12 (-.03)	-						-
15	**8.12* (.21)**	.80 (-.07)	**3.86* (-.15)**	**18.96** (.32)**	.16 (.03)	.10 (.02)	.03 (.01)	**7.17* (-.20)**	.59 (.06)	2.11 (.11)	.02 (-.01)	.20 (-.03)	.05 (.07)	.22 (.04)	-					

16	**31.90** ** **(.42)**	.01 (.01)	1.39 (-.09)	**15.96** ** **(.30)**	.06 (-.02)	1.60 (.10)	1.08 (.08)	**9.53** * **(-.23)**	.32 (-.04)	1.78 (.10)	.34 (-.04)	.31 (-.04)	.04 (-.01)	.01 (.01)	**79.65** ** **(.66)**	-				
17	1.27 (.08)	1.00 (.07)	2.11 (-.11)	**48.98** ** **(.52)**	.12 (.03)	.00 (.00)	2.87 (-1.25)	.00 (.00)	.00 (-.00)	1.80 (.10)	.13 (-.03)	.25 (-.04)	1.34 (.09)	1.00 (-.07)	**25.73** ** **(.38)**	**14.03** ** **(.28)**	-			
18	**29.71** ** **(.40)**	1.06 (.08)	.27 (.04)	4.20 (.15)	.31 (.04)	1.23 (.08)	.92 (.07)	**5.90** * **(-.18)**	.01 (-.00)	**6.84** * **(.19)**	1.6 (.03)	.11 (-.02)	.60 (.06)	.45 (-.05)	1.89 (.10)	**11.41** * **(.25)**	.11 (-.03)	-		
19	.15 (.03)	.45 (-.05)	1.04 (.08)	1.69 (.20)	.31 (.04)	1.23 (.08)	.92 (.07)	**5.90** * **(-.18)**	.27 (-.04)	.965 (.07)	1.6 (.03)	.11 (-.02)	.56 (-.06)	.45 (-.05)	.50 (.05)	2.63 (.12)	.93 (-.07)	3.45 (.14)	-	
20	.24 (-.04)	.59 (.06)	.28 (.04)	**7.10** ** **(.20)**	.80 (.14)	**11.05** ** **(.25)**	.13 (-.03)	.45 (.05)	2.85 (.123	2.79 (.12)	**5.12** ** **(.17)**	.48 (-.05)	.35 (-.04)	.10 (-.02)	.32 (.04)	.00 (.00)	3.06 (.13)	2.88 (.13)	1.36 (.09)	-

Note: Significant findings are represented in bold type. Pearson's chi square and Fisher's Exact Test were used, where appropriate. Fisher's Test was used if any expected frequencies were less than five.

* denotes $p < .05$

** denotes $p < .01$

1-Addiction, 2-Dependents: Adult, 3-Dependents: Children, 4-Disabilty, 5-Economic Dependence, 6-Fear/Mistrust in the Justice System, 7-High-Risk Occupation, 8-Immigrant Status, 9-Intutive Sense of Fear 10-Lack of Family Support, 11-Living Context: Homeless, 12-Living Context: Remote, 13-Living Context: Rural, 14-Living Context-Subsidized, 15-Mental Health Diagnosis, 16-Mental Health Suspected, 17-Poor Physical Health, 18-Prior Abuse in Childhood, 19-Prior Relationship Abuse, 20-Social Isolation

Main analysis

The solution depicted four distinct profiles of victims. Cluster one (n = 30), named *mental health diagnosis,* was the only profile in which victims had a documented diagnosis of a mental health concerns. In addition, the majority of victims in this cluster were not socially isolated (less than half were), but the majority were fearful. Cluster two (n = 46), the *fearful* cluster, represented victims who did not have a diagnosis of mental health or an indication that they were socially isolated, but they did describe an intuitive sense of fear of the perpetrator. Cluster 3 (n = 48), *socially isolated,* encompassed victims who did not have a mental health diagnosis, but were all socially isolated and the majority had a sense of fear. Finally, cluster 4 (n = 59), *low vulnerability/risk*, depicted victims that had no mental health diagnosis, no social isolation and no identified sense of fear. A diagnosis of mental health issues was the main predictor variable in the creation of clusters. These breakdowns are depicted in Table 4. The two-step cluster analysis was run multiple times wherein the cases were reordered using the sort function. As each consecutive analysis provided the same solution, the researcher concluded that it was a robust estimation of cluster membership.

Table 4

Breakdown of Vulnerability Clusters

Cluster	**1**	**2**	**3**	**4**
Size *(n)*	30	46	48	59
Mental Health	Yes 100%	No 100%	No 100%	No 100%
Social Isolation	No 63.3%	No 100%	Yes 100%	No 100%
Victim Fear	Yes 56.7%	Yes 100%	Yes 60.4%	No 100%

Additional analyses. In employing this new cluster membership variable, further analyses were carried out. It was expected that cluster membership would predict the victim's age, the number of domestic homicide risk factors, as well as the number of agencies that the victim was involved with, and that variance between clusters would be observed. The data was tested to check if it met the between-subjects ANOVA assumptions: independence of observations, the outcome is an interval or ratio and normally distributed, and homogeneity of variance. Homogeneity of variance was evaluated using Levene's test.

Victim's age. A one-way between-subjects ANOVA was conducted wherein the cluster membership predicted victim's age. Welch's Test of Equality of Means was used to correct for the violation of the assumption of homogeneity of variance. As seen in Table 5, there was a significant difference in victims' age depending on cluster membership. Post-hoc tests using the Bonferroni correction for multiple comparisons determined a statistical difference between the *mental health diagnosis* and *fearful* clusters. The *fearful* victims were younger ($M = 36.63$, $SD = 12.3$) than victims with a *mental health diagnosis* ($M = 46.73$, $SD = 14.90$).

Number of DVDRC risk factors. The relationship between the total number of DVDRC risk factors present in each case and the four clusters was tested using a one-way ANOVA. As the list of homicide risk factors from the DVDRC includes victims' intuitive sense of fear, this variable was recoded and fear was excluded from the list to avoid confounds. Both the Shapiro-Wilk test of normality and the Kolmogorov-Smirnov tests demonstrated that the data violated normality assumptions ($p = .020$, $p = .006$) thus the bootstrap correction for confidence intervals was employed to address this. The ratio of the skewness statistic compared to the standard error was less than two times the value and therefore deemed acceptable. In addition, Q-Q plots and box plots indicated no significant outliers.

The analysis of variance test showed that cluster membership significantly predicted the number of risk factors (Table 5). Post-hoc tests using the Bonferroni correction depicted differences between the following clusters; *fearful* (M = 11.87, SD = 5.13) and *low vulnerability/risk* (M = 7.78, SD = 4.43) as well as, *socially isolated* (M = 11.95, SD = 5.38) and *low/vulnerability/risk*. Victims in the *fearful* and *socially isolated* clusters had more homicide risk factors, than those in the *low vulnerability/risk* cluster.

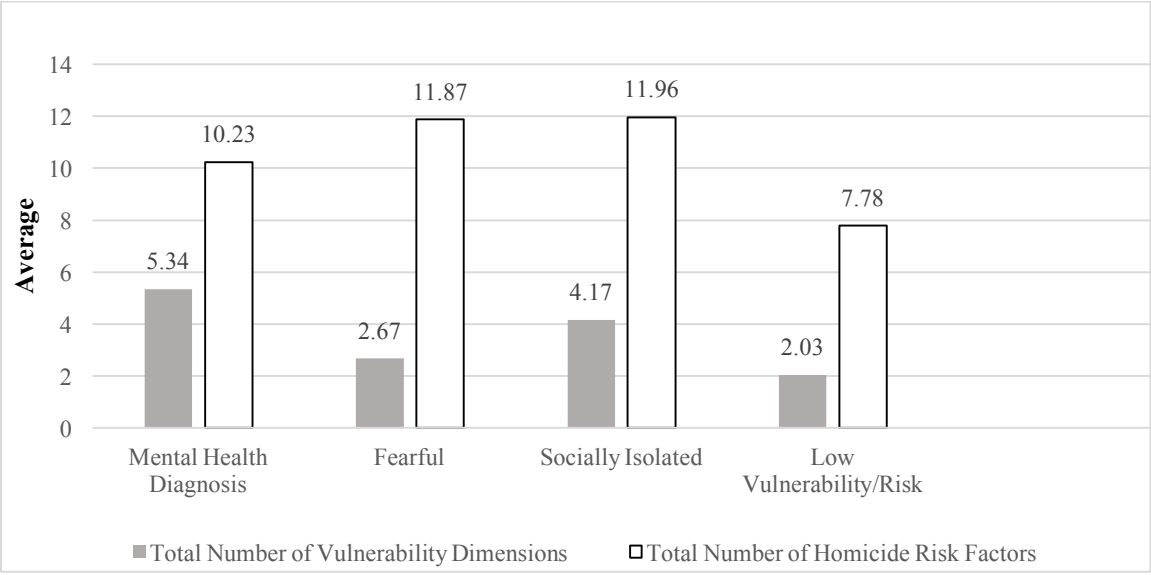

Figure 1. Average Number of Victim Vulnerability Dimensions Versus Homicide Risk Factors by Cluster

Number of agencies. Homogeneity of variance for the variable number of agencies was violated. In addition, both the Kolmogorov-Smirnov and the Shapiro-Wilk tests were significant (p = .020, p = .006) and statistic values were notably larger than the standard error, indicating non-normality and skewness. This was confirmed using Q-Q plots and box plots, which depicted outliers in the data. To account for this, a univariate ANOVA was employed with the bootstrap

correction to compensate for assumption violations, followed by post-hoc tests with the Bonferroni correction.

Bootstrap pairwise comparisons using bias correction revealed that the *mental health diagnosis* cluster and *low vulnerability/risk* clusters were different, as well as the *socially isolated* cluster and *low vulnerability/risk cluster*, but the overall model was not significant (refer to Table 5). In this first test, all mental health agencies were excluded to avoid potential confounds. A second analysis was conducted including all agencies (inclusive of mental health agencies) and was significant. Post-hoc test with the Bonferroni correction recognized a difference between the *mental health diagnosis* cluster and the *low vulnerability/risk* cluster.

Table 5

Descriptive Statistics (M, SD) and Analysis of Variance for Age, Number of Risk Factors and Number of Agencies

Dependent Variable	**Mental Health Diagnosis** ***M (SD)***	**Fearful** ***M (SD)***	**Socially Isolated** ***M (SD)***	**Low Vulnerability/ Risk** ***M (SD)***	***F (df)***	***p***	η^2
Age	46.73 (14.90)	36.63 (12.30)	41.48 (15.50)	40.02 (13.91)	3.186 (3,88)	.025	.051
Number of Homicide Risk Factors	10.23 (6.42)	11.87 (5.13)	11.96 (5.38)	7.78 (5.50)	7.585 (3,179)	.000	.113
Number of Agencies (Excluding Mental Health)	3.00 (2.49)	2.48 (3.14)	2.98 (2.38)	1.86 (2.10)	2.208 (3,179)	.089	-

Number of Agencies (Including Mental Health)	4.10 (2.99)	2.80 (3.48)	3.25 (2.68)	2.15 (2.44)	3.306 (3, 179)	.021	.021

Separation from the intimate partner. A chi-square test of independence was conducted between the four victim profiles and separation from the intimate partner (actual or pending at the time of the homicide), and was not found to be significant, X^2 (3, N = 177) = 4.50, $p < .05$. A history of separation was significant, X^2 (3, N = 127) = 8.34, p =.040 with an effect size of 0.256. Post-hoc analyses determined a difference between *fearful* victims and *low vulnerability/risk* victims, but not between *mental health diagnosis* or *socially isolated* victims.

Perpetrator-Related Factors: Further chi-square tests of independence were carried out between the four clusters and variables related to the perpetrator. All unknowns were removed from the analysis. The significant findings and post-hoc comparisons are reported in Table 6. It should be noted that a number of these perpetrator factors are also found on the list of homicide risk factors released by the Ontario Domestic Violence Death Review Committee.

Additional analyses were carried out with the following variables, but were not significant: perpetrator employment status, perpetrator criminal history, perpetrator made threats with a weapon, perpetrator access to weapons, perpetrator threatened suicide, perpetrator attempted suicide, hostage-taking, forced sexual acts with the victim, violence against pets, perpetrator choked the victim in the past, perpetrator childhood exposure or domestic abuse, perpetrator obsessive behaviours, perpetrator substance use, perpetrator access to victim after risk assessment, a history of violence against the children, a new partner in the victim's life (real or perceived), the perpetrator's mental health- professional diagnosis of depression, perpetrator's

mental health- other psychiatric problems, the perpetrator blamed the victim for the abuse and the perpetrator's education.

Other. Additional analyses were carried out with the following variables: victim employment status, child custody, common-law relationship, and presence of step-kids, and were not significant.

Table 6

Significant Findings for Chi-Square Analysis with Perpetrator Factors

Dependent Variable (% of Total Cluster)	**Cluster 1 %**	**Cluster 2 %**	**Cluster 3 %**	**Cluster 4 %**	***x^2 (df=3)***	***p***	***Cramer's v***	***n***
Controlling the Victim's Daily Activities	48 $_{a,b}$	47.2 $_{a,b}$	55.6 $_{b}$	21.2 $_{a}$	13.48	.004	.292	65
Escalation of Violence	52.2$_{a,b}$	70 $_{b}$	65.1 $_{b}$	36 $_{a}$	12.79	.005	.286	86
Extreme Minimization/Denial of Spousal Assault	8.3 $_{a}$	41.2 $_{b}$	35 $_{a,b}$	12 $_{a}$	15.18	.002	.320	36
History of Domestic Violence in Current Relationship	76 $_{a,b}$	95.3 $_{b}$	91.5 $_{b}$	66 $_{a}$	17.65	.001	.327	136
Misogynistic Attitudes of Perp.	20.8 $_{a}$	48.3 $_{ab}$	61.3 $_{b}$	31 $_{a,b}$	11.73	.008	.305	51
Perpetrator Abused Victim in Public	22.2 $_{a}$	32.6 $_{b}$	35.9 $_{b}$	10.2 $_{a}$	9.69	.021	.248	39
Perpetrator Failure to Comply with Authority	35.7 $_{a,b}$	43.2 $_{b}$	46.7 $_{b}$	17.9 $_{a}$	11.11	.011	.259	57
Perpetrator Monitored the Victim's Whereabouts	33.3 $_{a,b}$	56.4 $_{b,c}$	73.8 $_{c}$	28.8 $_{a}$	22.28	.000	.373	77
Perpetrator Prior Substance Abuse Treatment	27.6 $_{a}$	5.3 $_{a}$	7.3 $_{a}$	12.8 $_{a}$	9.01	.029	.241	19
Perpetrator Violently & Constantly Jealous	27.6 $_{a}$	69.4 $_{b}$	58.5 $_{a,b}$	31.1 $_{a}$	18.42	.000	.349	71

of Victim								
Prior Attempts to Isolate Victim	34.6 $_{a,b}$	56.8 $_{b,c}$	70.5 $_{c}$	12 $_{a}$	36.80	.000	.484	67
Prior Threats to Kill Victim	43.5 $_{a,b}$	63.2 $_{b}$	65 $_{b}$	32.7 $_{a}$	12.50	.006	.289	75

Note. p-values were evaluated using Pearson's statistic, *df*=3
Each subscript letter denotes a subset of Two-Step Cluster Number categories whose column proportions do not differ significantly from each other at the .05 level.

Discussion

The present study employed retrospective case analyses using 2002-2012 domestic homicide cases from the Ontario Domestic Violence Death Review committee, to analyze a plethora of factors relating to victim vulnerability. The purpose of this study was to explore the various dimensions of victim vulnerability in domestic homicide cases and the relation of these dimensions to help-seeking and leaving actions taken by the victim, as well as homicide risk factors and other perpetrator-specific factors. A list of 20 vulnerability dimensions was created as a result of a thorough literature review. In recognition of the diversity in experience and multitude of factors, it was hypothesized that different profiles of vulnerability would be generated and that these profiles would demonstrate different relationships to homicide risk factors, perpetrator factors, as well as agency involvement and separation behaviours. The findings demonstrated that 97.4% of the sample had at least one dimension of vulnerability, highlighting its ubiquity amongst victims of domestic homicide. However, there was a degree of variability with respect to the identified dimensions of vulnerability and the results derived from cluster analysis demonstrated unique groupings of these vulnerability dimensions. These discrepant victim typologies denote differences in age, the number of homicide risk factors, agency involvement and risk/perpetrator factors.

The present sample indicated the striking prevalence of vulnerability across victims of domestic homicide. Whilst almost all victims were recognized as vulnerable, the cases depicted a range of dimensions (M = 3.3, SD = 2.0), with the majority of cases exhibiting between one to five dimensions. Cross-tabulations between all 20 dimensions indicated that a significant number of vulnerability factors are co-occurring and not independent of each other. Given the inability to conclude that all variables are autonomous, the researcher selected three independent variables (diagnosis of mental health, social isolation and intuitive sense of fear) and conducted a two-step cluster analysis to find naturally-occurring profiles of vulnerability within the data set. This yielded four distinct constellations of victims and the following clusters; *mental health diagnosis*, *fearful*, *socially isolated* and *low vulnerability/risk*. These clusters were further subjected to statistical analyses that demonstrated different relationships amongst the investigated variables.

The results demonstrated that victims with a diagnosis of mental health were significantly older than victims who were fearful by an average of ten years. When compared to *low vulnerability/risk* victims, victims who are *fearful* and *socially isolated* had more homicide risk factors, an average of four more. Although the number of agencies was not significant when agencies addressing mental health were excluded, an analysis between all agencies (including mental health) demonstrated that victims with a *mental health diagnosis* are involved with an additional agency when compared to *low vulnerability/risk* victims.

In exploring comparisons between various risk/perpetrator-related factors and victim profiles, various significant relationships were determined. Overall, the greatest observed differences were between the three clusters and the *low vulnerability/risk* profile. Important differences in relationships between clusters were noted. Victims who are *fearful* and *socially*

isolated, are different than victims with *low vulnerability/risk* on the following dimensions: escalation of violence, history of domestic violence, perpetrator failure to comply with authority and the perpetrator's prior threats to kill the victim. This indicates a greater presence of the aforementioned factors in situations which the perpetrator's conduct was violent and threatening towards the victim. Both of these clusters expressed some degree of an intuitive sense of fear of the perpetrator while *low vulnerability/risk* victims did not. Between victims who are *socially isolated* and *low vulnerability/risk victims,* those who were *socially isolated* experienced significant differences in the perpetrator monitoring their whereabouts, and prior isolation. These findings are consistent with a socially isolated profile and these factors exist within a social space. Victims who were *fearful*, experienced greater fear-instilling behaviours from the perpetrator; minimization of abuse, abuse in public and the perpetrator's violent jealousy when compared to victims with a *mental health diagnosis.* Finally, victims who were *socially isolated*, experienced increased levels of the perpetrator's misogynistic attitudes, public abuse, having their whereabouts monitored and prior isolation attempts than victims with a *mental health diagnosis.* These behaviours are socially nuanced, and foreseeably have greater prevalence in victims who are *socially isolated*, than those who are not. To the surprise of the researcher, separation from the abusive partner was not significant amongst the different profiles of vulnerability as this is a common risk factor for lethality. However, a history of separation was significant for victims who expressed an intuitive sense of fear of the perpetrator (*fearful*).

Relevance to Existing Literature

Research has dedicated itself to deconstructing and understanding the phenomenon of domestic violence and domestic homicide to inform improved victim safety and intervention strategies however, traditionally these efforts have focused on factors related to the perpetrator

and predictions of risk of lethality and recidivism related to the abuser. Extant efforts in studying victim-related factors place emphasis on a single factor and do not take into account the presence of multiple factors therefore, little is understood with respect to the amalgamation and intersection of several variables and their impact. This study presents a novel contribution, as dimensions of vulnerability have not been explored in a manner considering their compounding and intersectional nature. Within the explored sample, only a small percentage of vulnerable homicide victims (16%) had a solitary dimension of vulnerability however, the predominant discourse in the literature has centered on single factors. The inclusion of multiple dimensions of vulnerability demonstrated a range across cases, and various combinations of factors thus, yielding different profiles of vulnerability. Ninety seven percent of the sample was determined to fit the criteria for vulnerability, indicating the prevalence of vulnerability across domestic homicide victims and highlighting the importance of attending to this construct. The diversity amongst the vulnerability clusters speaks to some differences in victims' experience and presentation of dimensions; the implications of this are discussed further on. This inordinate representation calls for the consideration of these factors with respect to risk assessment, risk management and safety planning.

Vulnerability in the context of intimate partner homicide, may decrease the victim's capacity for self-defense and increase perceived helplessness, thus making her more vulnerable to violence. Furthermore, these vulnerabilities may act as barriers to help-seeking, disclosure of violence or agency involvement, thus hindering opportunities for intervention or separation from a violent relationship. The importance of attending to victim vulnerabilities is necessary to not only recognize, but to understand the different needs and barriers faced by victims and how they relate to risk. As aforementioned, a paucity of risk assessment tools incorporates victim-related

factors and characteristics. The majority of these assessments focus on statistic factors and risk as it relates to the perpetrator, his actions, and behaviours and does not consider how vulnerability ties into that risk. The level of risk may change with respect to a victim's level of vulnerability. However, the exploration of these factors must not diminish the culpability of the abuser, and the critical importance of perpetrator risk assessment and risk management, as this is key to homicide prevention. The primary and pivotal step to addressing, preventing and managing the risk of lethality in domestic violence, is conducting an effective, and accurate risk assessment. Risk assessment involves the collection and examination of information to distinguish the level of risk of violence in terms of degree of risk, frequency, length, and likelihood of recidivism and future offences (Storey & Strand, 2017). Given the multifarious representation of these factors, it may highlight a need for more well-rounded assessments that incorporate factors specific to victims and their relationship to perpetrator predictors of risk and recidivism.

Acknowledging the ecological framework that encapsulates the phenomenon of intimate partner homicide, this study explored how perpetrator risk factors related to the dimensions of vulnerability. To the knowledge of the researcher, few studies have explored the relationship between victim vulnerability factors and perpetrator risk. Correlational research conducted by Belfrage & Strand (2008) depicted that an increase in both these constructs, increases the risk of violence. The perpetrator factors investigated through this study pertain to threatening tactics and intimidation behaviours exhibited by the abuser, that may ignite or increase a victim's sense of fear and insecurity. Out of the four clusters, three indicated an intuitive sense of fear of the perpetrator. This finding further speaks to the importance of considering a victim's intuitive sense of fear within or in conjunction to risk assessment and other interventions and safety

planning strategies. Out of the entire sample, 50% of the victims reported an intuitive sense of fear of the perpetrator (*n*=92) though in each case the outcome was homicide. This is consistent with previous literature findings that roughly half of victims are aware of their risk of homicide (Campbell, 2004). Similarly, a sense of fear was also the most common dimension of vulnerability, replicating findings by Belfrage & Strand (2008), that determined an intuitive sense of fear, as the most common risk factor recognized in B-SAFER assessments. It has also been named a domestic homicide risk factor by the Ontario Domestic Violence Death Review Committee (2015). At present, victim vulnerability is not recognized as a risk factor for lethality.

Implications

These findings support the importance of attending to victim vulnerability in cases of domestic violence, as various intersecting and compounding vulnerabilities may increase risk of lethality. Furthermore, these results point to the conspicuous presentation of victim vulnerability as a risk factor for lethality, although further research is required to improve its conceptualization and to further understanding of its unique dynamics. Though the notion of victim vulnerability is very much in its infancy, this study points to the importance of this construct. The heterogeneity in dimensions of vulnerability and the four distinct profile point out that there is no singular typology for victims of intimate partner homicide however, there are common factors such as a sense of fear, that are detectable an can be responded to within intervention. These cases present diversity and various contributing and compounding dimensions of vulnerability. It is imperative to recognize that these dimensions are not causal of violence but are circumstances and barriers that may make women more susceptible to violence and risk of lethality. Although this study is exploratory in nature, it implies the importance of attending to victim-related factors and has

important implications for risk assessment, risk management and victim safety planning. As vulnerability is related to heightened risk of homicide, there is a necessity for intervention and support agencies to consider the following in creating plans to keep women safe. This study can provide some insight into both dynamic (factors that can be changed, ameliorated) and static factors (constant and cannot be changed/improved) and their dynamic interplay. Information on victim vulnerability can inform risk assessment and safety protocols as well as potentially aid in the improvement of victim services through the identification of what factors to screen/look for. These results may highlight a need to explore specific strategies to reach out to victims who appear more vulnerable and isolated, and even those with low vulnerability. As a consequence of the multifaceted experience and presentation of vulnerability, unique approaches may need to be generated to meet the acute needs of victims as well as well-rounded risk assessments exploring various factors. This could emphasize a need for a more holistic approach and the need to push for collaboration due to intersectionality and multiple systemic levels. It may also highlight a need for the recognition of the relationship between perpetrator risk and victim vulnerability, as his actions and behaviours may create vulnerability or exacerbate existing vulnerability. Perhaps collaboration and dual management of perpetrator risk alongside management of victim vulnerabilities is required.

Agencies and service providers should take into account various dimensions of vulnerability, as well as how their compounding nature may impede a victim's ability to seek help or leave a violent relationship. These dimensions act as barriers and may escalate violence and increase a woman's risk. It is critical for agencies to attend to these to understand how dimensions may play into risk assessment and safety plans, as well as risk management with the perpetrator.

Furthermore, this study highlights the need for further research in the domain of victim vulnerability within an intersectional and ecological lens. Studies should explore how these dimensions relate to the risk posed by the perpetrator, whether there is a relationship to risk recidivism or risk prediction. Various other possible dimensions, ones not included in this study, should be taken into account.

This study also supports the imperative nature of attending to a victim's self-reported intuitive sense of fear of the perpetrator. Cases where victims expressed fear had an increased number of homicide risk factors, which should indicate increased opportunities for intervention and that distinct dynamics of threat and coercion govern these relationships, increasing risk. This emphasizes that risk of homicide is far more influenced by perpetrator-related factors which need to be addressed in both risk assessment and risk management, in conjunction with exploration of the victim's context.

Limitations

Caution should be maintained when interpreting the results of this study. The researcher has identified the following limitations that should be taken into consideration when drawing conclusions:

*Sampl*e. Firstly, the cases explored in this study are limited to the province of Ontario, Canada which may have distinct geographical and population demographics, as well as cultural, systemic, social and political entities that are unique to this region and therefore do not generalize to other populations. Furthermore, domestic homicide is a rare occurrence and the dynamics of this specific phenomenon may not extrapolate to other populations. Domestic homicide data is often limited to retrospective reports and case analyses. Researchers are forced to rely on the accuracy in record-keeping and collection of these documents by third parties.

Thus, it is possible that the data is subject to various biases such as recall and selection bias, and there may be errors in reporting, documenting, collection or missing information. Although the data for this sample from the DVDRC review is extremely informative, reports are created for the purpose of the Coroner's review which is an inherent limitation. Important information and detail that may be pertinent to understanding the dynamics of domestic homicide may have been omitted or missed as it was outside of the scope of Coroner's report. In many cases, limited information is available or is missing and analysis could not be carried out. Furthermore, it cannot be confirmed whether missing information is due to purposeful collection (excluded because it did not meet the criteria for the report) or whether it was not present in a particular case. This renders drawing conclusions difficult, may skew the data or provide both an incomplete and inaccurate picture. In addition, the limited data in case reports is often subject to the researcher's interpretation and may not be an accurate reflection as researchers are forced to draw conclusions. Such interpretation may also be subject to possible biases in coding. In order to provide a more concrete depiction, cases that did not mention a particular dimension of vulnerability or where the presence of a dimension was unknown, were coded as not present. This is a limitation as there is no way to confirm whether the dimension was in fact absent in a case or whether there was not enough information to confirm its absence or presence, and thus there may be discrepancies between the cases in actuality and how information was captured. Furthermore, inter-rater reliability was established at 84%. Although a value over 80% has been determined as an appropriate cut-off within the literature, as consensus was not unanimous, this may account for some variability and differences in coding.

Sample Size. As domestic homicide is characterized as a rare occurrence and a deviation from the norm, sample sizes are often too low to carry out meaningful analyses. In the present study, the

application of exclusion criteria and the removal of missing cases, further diminished the size of the sample. Furthermore, various dimensions of vulnerability have low representation, for example there were only seven cases in which a victim was identified as homeless, leading this variable to be insufficient for statistical testing and reducing statistical power. Cases with a female perpetrator and same-sex couples have even lower representation within the sample, thus a subset of victims were excluded from this analysis as findings would not be generalizable to other groups due to distinct dynamics. In addition, due to limitations in material reporting, differences in cultural context are not accounted for. The present study included the dimension of immigrant status but failed to address the unique cultural context for Indigenous populations and Francophone populations residing in Ontario, as well as newcomers from English-speaking countries.

In this instance, as the majority of victims were identified as vulnerable, there was no opportunity to compare differences, whether they existed or not, between profiles that would be identified as "non-vulnerable" and "vulnerable". It may be that the particular conceptualization and operationalization of the definition of vulnerable that was employed here limited analysis.

Problem Definitions: As aforementioned, due to the scant information available in reports, the presence or absence of various dimensions is subject to the interpretation of the researcher. The particular wording in a case may have had influence over a researcher's decisions to mark a dimension as absent or present and thus may not provide an accurate reflection of the sample. The narrow criteria may disregard pertinent information.

Rural: According to Census Canada (2009) the current definition of rurality is a population of less than 1,000. This definition was employed in the present study. This particular construct was difficult to operationalize and there is much debate on the most suitable definition as there is no

comprehensive and global understanding of rurality (Hart, Larson, & Lishner, 2005). Conceptions of rurality can range from the geographical distance from urban centres, degree of isolation, divergent settlement arrangements, particular economic activities, economic enterprise, or distinct cultural contexts, to variations in population size and density (Hart, Larson & Lishner, 2005). Some argue that it may be more appropriate to employ a definition that reflects a conceptualization created by the residents of the area themselves (Kulig, Andrews, Stewart, Pitblado, MacLeod, Bentham, D'Arcy, Morgan, Forbes, Remus & Smith, 2008). This inability to create a universal conceptualization, results in a high degree of variance in definitions and proves difficult for researchers to incorporate in empirical studies. A different conceptualization of rurality may have increased sample sizing of this dimension and provided more information. This particular definition of rurality is limited as it does not speak to the context of different areas, nor does it account for self-defined rural areas or individual differences in rurality. This concern poses a problem that is not solely geared at researchers but a lack of a proper definition inhibits the ability to address the needs of this population pertaining to the barriers and limitations of victims living in rural areas. The Rural and Small Town Analysis Bulletin (2001) recommends an amendment to this definition until a better one is created. They propose populations of 10,000 that reside outside commuting zones of urban and population centres. This adjustment alone would have increased the sample from 1 to 24 cases.

Dependent Children: Aside from missing information about the age of children, children were defined as living in the home and under the age of 18. This does not take into account the number of dependent children, or children living in foster care or in the care of another adult, as well as children with special needs, disabilities or illnesses. In addition, the researcher recognizes that the "dependency" of a young child differs vastly than that of an older child, and therefore

has different implications for risk and safety planning. Furthermore, eighteen-year old individuals are often excluded as children and are viewed as young adults. The present definition may be too broad and a more precise conceptualization is required to account for these differences.

Immigrant Status: Cases of individuals immigrating from English-dominant and English-speaking countries (ex: United States, England) were omitted from the analysis as it is believed that these groups do not face the same barriers to language that would deter or reduce help-seeking, service access, or law and policy comprehension, in comparison to individuals that do not have any knowledge of the English-language. However, they are still newcomers and face other non-language related barriers that and are not represented within this sample.

Vulnerability: The definition of vulnerability was quite broad in the present study, including a large range of dimensions however, there may be other dimensions that have not been explored, accounted for or may be undocumented within the files. Although the researcher accounted for this in statistical testing, not all dimensions can be assumed to be of equal weight and many are overlapping or compounded in cases. The presence of the number of dimensions in a case does not necessarily speak to their additive effect. Various dimensions may be influencing another, and it is difficult to explore them autonomously and separately. For example, individuals who identify as immigrants have distinct factors such as language barriers, cultural barriers, etc. that are not accounted for in the present study.

Directionality: The researcher is limited to the information present in each case and cannot draw conclusions on whether the dimensions of vulnerability within a case are a consequence of domestic violence, or whether these factors preceded relationship violence.

Future Directions

Future research exploring victim vulnerability in domestic homicide should address the limitations alluded to by the researcher. In order to gain more statistical power and develop an understanding of non-vulnerable versus vulnerable victims of domestic violence, sample sizes must be increased. Research efforts should be focused on exploring these dimension in a national domestic homicide database or with a larger sample size. This would be an excellent opportunity to explore victim vulnerability on a national level, and confirm the validity and reliability of these results through replication on a larger scale. Further research should be conducted using distinct samples to determine whether these results can be replicated in a different setting and to determine their generalizability. In addition, the populations excluded from this analysis should be included in future studies to further understanding of unique dynamics or discrepancies.

In addition, subsequent research should examine what agencies victims are involved in, and who knew about the presence of violence in the relationship. Agencies where the victim was involved should be explored alongside those implicated in perpetrator assessment and management, as agencies may be implicated with one or both partners, and may have pertinent information in terms of risk assessment, management and safety planning, though it may be outside of the scope or mandate of their organization. Further exploration into each of the clusters would help augment an understanding of the dynamics that are present within each profile. This is especially important for the low risk/vulnerability cluster, where signs of risk appear to be less overt. This is a concern as the victims in this cluster may be less perceptible to service providers and agencies and may have unique needs.

Further efforts should be dedicated to exploring victim vulnerability through empirically validated studies, particularly their role in risk assessment. Risk assessments exploring factors

related to victims should undergo rigorous statistical testing and efforts should be geared towards an improved understanding of their relationship to lethality and violence risk, and should recognize intimate partner violence with an ecological framework.

Conclusions

This study observed differences between clusters of vulnerability amongst victims of domestic homicide, supporting heterogeneity in experience. The study explored how dimensions of vulnerability play into separation and agency involvement, as well as risk factors for homicide and perpetrator-influenced factors. Half of the victims in the sample population were unaware of their risk of lethality and victims with an intuitive sense of fear and social isolation had more risk factors for homicide. As vulnerability factors increase susceptibility to risk it is essential to attend to, as the majority of victims in this study had at least one dimension of vulnerability. Preliminary findings highlight the need to further explore victimology and vulnerability in the context of domestic violence and homicide and improving identification of vulnerable victims. Risk assessment, risk management and safety planning should take into account victim vulnerability to ensure the victim's protection and safety, and ultimately to save lives.

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Appendix A

Data Summary Form

OCC Case #(s): _____ OCC Region: Central
OCC Staff: _____
Lead Investigating Police Agency:
Officer(s):
Other Investigating Agencies: _
Officers: __

VICTIM INFORMATION

***If more than one victim, this information is for primary victim (i.e. intimate partner)*

Name

Gender	
Age	
Marital status	
Number of children	
Pregnant	
If yes, age of fetus (in weeks)	
Residency status	
Education	
Employment status	
Occupational level	
Criminal history	
If yes, check those that apply…	____ Prior domestic violence arrest record ____ Arrest for a restraining order violation ____ Arrest for violation of probation ____ Prior arrest record for other assault/harassment/menacing/disturbance ____ Prior arrest record for DUI/possession ____ Juvenile record

____ Total # of arrests for domestic violence offenses ____ Total # of arrests for other violent offenses ____ Total # of arrests for non-violent offenses ____ Total # of restraining order violations ____ Total # of bail condition violations ____ Total # of probation violations
Family court history
If yes, check those that apply… ____ Current child custody/access dispute ____ Prior child custody/access dispute ____ Current child protection hearing ____ Prior child protection hearing ____ No info
Treatment history
If yes, check those that apply… ____ Prior domestic violence treatment ___ Prior substance abuse treatment ____ Prior mental health treatment ____ Anger management ____ Other – specify _____ ____ No info
Victim taking medication at time of incident
Medication prescribed for victim at time of incident
Victim taking psychiatric drugs at time of incident

Victim made threats or attempted suicide prior to incident	
Any significant life changes occurred prior to fatality?	
Describe:	
Subject in childhood or Adolescence to sexual abuse?	
Subject in childhood or adolescence to physical abuse?	
Exposed in childhood or adolescence to domestic violence?	

-- END VICTIM INFORMATION --

PERPETRATOR INFORMATION

***Same data as above for victim*

Gender	
Age	
Marital status	
Number of children	
Pregnant	
If yes, age of fetus (in weeks)	
Residency status	
Education	
Employment status	
Occupational level	
Criminal history	

If yes, check those that apply… ____ Prior domestic violence arrest record ____ Arrest for a restraining order violation ____ Arrest for violation of probation ____ Prior arrest record for other assault/harassment/menacing/disturbance ____ Prior arrest record for DUI/possession ____ Juvenile record
____ Total # of arrests for domestic violence offenses ____Total # of arrests for other violent offenses ____ Total # of arrests for non-violent offenses ____ Total # of restraining order violations ____ Total # of bail condition violations ____ Total # of probation violations
Family court history
If yes, check those that apply… ____ Current child custody/access dispute ____ Prior child custody/access dispute ____ Current child protection hearing ____ Prior child protection hearing ____ No info
Treatment history
If yes, check those that apply… ____ Prior domestic violence treatment ___ Prior substance abuse treatment ____ Prior mental health treatment ____ Anger management ____ Other – specify _____ ____ No info

Perpetrator on medication at time of incident	
Medication prescribed for perpetrator at time of incident	
Perpetrator taking psychiatric drugs at time of incident	
Perpetrator made threats or attempted suicide prior to incident	
Any significant life changes occurred prior to fatality?	
Describe:	
Subject in childhood or Adolescence to sexual abuse?	
Subject in childhood or adolescence to physical abuse?	
Exposed in childhood or adolescence to domestic violence?	

-- END PERPETRATOR INFORMATION --

INCIDENT

Date of incident	
Date call received	
Time call received	
Incident type	
Incident reported by	
Total number of victims ***Not including perpetrator if suicided*	

Who were additional victims aside from perpetrator?	
Others received non-fatal injuries	
Perpetrator injured during incident?	
Who injured perpetrator?	

Location of crime

Location of incident	
If residence, type of dwelling	
If residence, where was victim found?	

Cause of Death (Primary Victim)

Cause of death	
Multiple methods used?	
If yes be specific …	
Other evidence of excessive violence?	
Evidence of mutilation?	
Victim sexually assaulted?	
If yes, describe (Sexual assault, sexual mutilation, both)	
Condition of body	
Victim substance use at time of crime?	
Perpetrator substance use at time of crime?	

Weapon Use

Weapon use	
If weapon used, type	
If gun, who owned it?	
Gun acquired legally?	
If yes, when acquired?	
Previous requests for gun to be surrendered/destroyed?	
Did court ever order gun to be surrendered/destroyed?	

Witness Information

Others present at scene of fatality (i.e. witnesses)?	
If children were present:	
Matthew Jr.	
Michelle	
Andrea	
What intervention occurred as a result?	

Perpetrator actions after fatality

Did perpetrator attempt/commit suicide following the incident?	
If committed suicide, how?	
Did suicide appear to be part of original homicide?	

How long after the killing did suicide occur?	
Was perpetrator in custody when attempted or committed suicide?	
Was a suicide note left? *If yes, was precipitating factor identified*	
Describe: *Perpetrator left note attached to envelope and within the envelope were photos of the victim and her boyfriend and correspondence regarding the purchase of a house in North Dakota and money transfers etc.*	
If perpetrator did not commit suicide, did s/he leave scene?	
If perpetrator did not commit suicide, where was s/he arrested/apprehended?	*(At scene, turned self in, apprehended later, still at large, other – specify)*
How much time passed between the fatality and the arrest of the suspect:	*(Hours, days, weeks, months, unknown, n/a – still at large)*

-- END INCIDENT INFORMATION --

VICTIM/PERPETRATOR RELATIONSHIP HISTORY

Relationship of victim to perpetrator	
Length of relationship	
If divorced, how long?	
If separated, how long?	
If separated more than a Month, list # of months	

Did victim begin relationship with a new partner?	

If not separated, was there evidence that a separation was imminent?	
Is there a history of separation in relationship?	
If yes, how many previous separations were there?	*(Indicate #, unknown*
If not separated, had victim tried to leave relationship	
If yes, what steps had victim taken in past year to leave relationship? (Check all that apply)	____ Moved out of residence ____ Initiated defendant moving out ____ Sought safe housing ____ Initiated legal action ____ Other – specify

Children Information

Did victim/perpetrator have children in common?	
If yes, how many children in common?	
If separated, who had legal custody of children?	
If separated, who had physical custody of children at time of incident?	
Which of the following best describes custody agreement?	
Did victim have children from previous relationship?	
If yes, how many?	*(Indicate #)*

History of domestic violence

Were there prior reports of domestic violence in this relationship?

Type of Violence? *(Physical, other)* _____
If other describe: _____
_____
_____

If yes, reports were made to: (Check all those that apply)
____ Police
____ Courts
____ Medical
____ Family members
____ Clergy
____ Friends
____ Co-workers
____ Neighbors
____ Shelter/other domestic violence program
____ Family court (during divorce, custody, restraining order proceedings)
____ Social services
____ Child protection
____ Legal counsel/legal services
____ Other – specify _____

Historically, was the victim usually the perpetrator of abuse? _____
If yes, how known? _____
Describe: _____
_____
_____

Was there evidence of escalating violence?
If yes, check all that apply:
____ Prior attempts or threats of suicide by perpetrator
____ Prior threats with weapon
____ Prior threats to kill
____ Perpetrator abused the victim in public
____ Perpetrator monitored victim's whereabouts
____ Blamed victim for abuse
____ Destroyed victim's property and/or pets
____ Prior medical treatment for domestic violence related injuries reported
____ Other – specify _____

-- END VICTIM-PERPETRATOR RELATIONSHIP INFORMATION --

SYSTEM CONTACTS

Background

Did victim have access to working telephone? _____

Estimate distance victim had to travel to access helping resources? (KMs)
_____

Did the victim have access to transportation? _____

Did the victim have a Safety Plan? _____

Did the victim have an opportunity to act on the Plan? _____

Agencies/Institutions
Were any of the following agencies involved with the victim or the perpetrator during the past year prior to the fatality? _____

***Indicate who had contact, describe contact and outcome. Locate date(s) of contact on events calendar for year prior to killing (12-month calendar)*

Criminal Justice/Legal Assistance:

Police (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Crown attorney (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Defense counsel (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Court/Judges (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Corrections (Victim, perpetrator or both)
Describe:_____
_____
Outcome:_____

Probation (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Parole (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Family court (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Family lawyer (Victim, perpetrator, or both)
Describe_____
_____
Outcome:_____

Court-based legal advocacy (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Victim-witness assistance program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Victim Services (including domestic violence services)

Domestic violence shelter/safe house (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Sexual assault program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Other domestic violence victim services (Victim, perpetrator, or both)
Describe:_____

_____
Outcome:_____

Community based legal advocacy (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Children services

School (Victim, perpetrator, children or all)
Describe: (Did school know of DV? Did school provide counseling?)
_____
_____
Outcome:_____

Supervised visitation/drop off center (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Child protection services (Victim, perpetrator, children, or all)
Describe:_____
_____
Outcome:_____

Health care services

Mental health provider (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Mental health program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Health care provider (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
_____
Outcome:_____

Local hospital (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Ambulance services (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Other Community Services

Anger management program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Batterer's intervention program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Marriage counselling (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Substance abuse program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Religious community (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Immigrant advocacy program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Animal control/humane society (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Cultural organization (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Fire department (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Homeless shelter (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

-- END SYSTEM CONTACT INFORMATION --

RISK ASSESSMENT

Was a risk assessment done?
*If yes, by whom?*_____

When was the risk assessment done?_____

What was the outcome of the risk assessment?_____

DVDRC COMMITTEE RECOMMENDATIONS

Was the homicide (suicide) preventable in retrospect? (Yes, no)

If yes, what would have prevented this tragedy?

_____
_____
_____
_____
_____
_____
_____
_____
_____

What issues are raised by this tragedy that should be outlined in the DVDRC annual report?

_____

Future Research Issues/Questions:

Additional comments:

Appendix B

Risk Factor Coding Form

A= Evidence suggests that the risk factor was not present
P= Evidence suggests that the risk factor was present
Unknown (Unk) = A lack of evidence suggests that a judgment cannot be made

Risk Factor	Code (P,A, Unk)
1) History of violence outside of the family by perpetrator/	
2) History of domestic violence- past partners	
3) History of domestic violence- current partner	
4) Prior threats to kill victim	
5) Prior threats with a weapon	
6) Prior assault with a weapon	
7) Prior threats to commit suicide by perpetrator*	
8) Prior suicide attempts by perpetrator*(if check #6 and/or #7 only count as one factor)	
9) Prior attempts to isolate the victim	
10) Controlled most or all of victim's daily activities	
11) Prior hostage-taking and/or forcible confinement	
12) Prior forced sexual acts and/or assaults during sex	
13) Child custody or access disputes	
14) Prior destruction or deprivation of victim's property	
15) Prior violence against family pets	
16) Prior assault on victim while pregnant	
17) Choked victim in the past	

18) Perpetrator was abused and/or witnessed domestic violence as a child	
19) Escalation of violence	
20) Obsessive behaviour displayed by perpetrator	
21) Perpetrator unemployed	
22) Victim and perpetrator living common-law	
23) Presence of stepchildren in the home	
24) Extreme minimization and/or denial of spousal assault history	
25) Actual or pending separation	
26) Excessive alcohol and/or drug use by perpetrator*	
27) Depression – in the opinion of family/friend/acquaintance - perpetrator*	
28) Depression – professionally diagnosed – perpetrator* (If check #26 and/or #27 only count as one factor)	
29) Other mental health or psychiatric problems – perpetrator	
30) Access to or possession of any firearms	
31) New partner in victim's life*	
32) Failure to comply with authority – perpetrator	
33) Perpetrator exposed to/witnessed suicidal behaviour in family of origin	
34) After risk assessment, perpetrator had access to victim	
35) Youth of couple	
36) Sexual jealousy – perpetrator*	
37) Misogynistic attitudes – perpetrator*	
38) Age disparity of couple*	

39)	Victim's intuitive sense of fear of perpetrator*	
40)	Perpetrator threatened and/or harmed children*	

Risk Factor Descriptions

Perpetrator = The primary aggressor in the relationship
Victim = The primary target of the perpetrator's abusive/maltreating/violent actions

1) Any actual or attempted assault on any person who is not, or has not been, in an intimate relationship with the perpetrator. This could include friends, acquaintances, or strangers. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.).

2) Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who has been in an intimate relationship with the perpetrator. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; coworkers; counsellors; medical personnel, etc.). It could be as simple as a neighbour hearing the perpetrator screaming at the victim or include a co-worker noticing bruises consistent with physical abuse on the victim while at work.

3) Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who is in an intimate relationship with the perpetrator. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; coworkers; counsellors; medical personnel, etc.). It could be as simple as a neighbour hearing the perpetrator screaming at the victim or include a co-worker noticing bruises consistent with physical abuse on the victim while at work.

4) Any comment made to the victim, or others, that was intended to instill fear for the safety of the victim's life. These comments could have been delivered verbally, in the form of a letter, or left on an answering machine. Threats can range in degree of explicitness from "I'm going to kill you" to "You're going to pay for what you did" or "If I can't have you, then nobody can" or "I'm going to get you."

5) Any incident in which the perpetrator threatened to use a weapon (e.g., gun; knife; etc.) or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.) for the purpose of instilling fear in the victim. This threat could have been explicit (e.g, "I'm going to shoot you" or "I'm going to run you over with my car") or implicit

(e.g., brandished a knife at the victim or commented "I bought a gun today"). Note: This item is separate from threats using body parts (e.g., raising a fist).

6) Any actual or attempted assault on the victim in which a weapon (e.g., gun; knife; etc.), or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.), was used. Note: This item is separate from violence inflicted using body parts (e.g., fists, feet, elbows, head, etc.).

7) Any recent (past 6 months) act or comment made by the perpetrator that was intended to convey the perpetrator's idea or intent of committing suicide, even if the act or comment was not taken seriously. These comments could have been made verbally, or delivered in letter format, or left on an answering machine. These comments can range from explicit (e.g., "If you ever leave me, then I'm going to kill myself" or "I can't live without you") to implicit ("The world would be better off without me"). Acts can include, for example, giving away prized possessions.

8) Any recent (past 6 months) suicidal behaviour (e.g., swallowing pills, holding a knife to one's throat, etc.), even if the behaviour was not taken seriously or did not require arrest, medical attention, or psychiatric committal. Behaviour can range in severity from superficially cutting the wrists to actually shooting or hanging oneself.

9) Any non-physical behaviour, whether successful or not, that was intended to keep the victim from associating with others. The perpetrator could have used various psychological tactics (e.g., guilt trips) to discourage the victim from associating with family, friends, or other acquaintances in the community (e.g., "if you leave, then don't even think about coming back" or "I never like it when your parents come over" or "I'm leaving if you invite your friends here").

10) Any actual or attempted behaviour on the part of the perpetrator, whether successful or not, intended to exert full power over the victim. For example, when the victim was allowed in public, the perpetrator made her account for where she was at all times and who she was with. Another example could include not allowing the victim to have control over any finances (e.g., giving her an allowance, not letting get a job, etc.).

11) Any actual or attempted behaviour, whether successful or not, in which the perpetrator physically attempted to limit the mobility of the victim. For example, any incidents of forcible confinement (e.g., locking the victim in a room) or not allowing the victim to use the telephone (e.g., unplugging the phone when the victim attempted to use it). Attempts to withhold access to transportation should also be included (e.g., taking or hiding car keys). The perpetrator may have used violence (e.g., grabbing; hitting; etc.) to gain compliance or may have been passive (e.g., stood in the way of an exit).

12) Any actual, attempted, or threatened behaviour, whether successful or not, used to engage the victim in sexual acts (of whatever kind) against the victim's will. Or any assault on the victim, of whatever kind (e.g., biting; scratching, punching, choking, etc.), during the course of any sexual act.

13) Any dispute in regards to the custody, contact, primary care or control of children, including formal legal proceedings or any third parties having knowledge of such arguments.

14) Any incident in which the perpetrator intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the perpetrator. This could include slashing the tires of the car that the victim uses. It could also include breaking windows or throwing items at a place of residence. Please include any incident, regardless of charges being laid or those resulting in convictions.

15) Any action directed toward a pet of the victim, or a former pet of the perpetrator, with the intention of causing distress to the victim or instilling fear in the victim. This could range in severity from killing the victim's pet to abducting it or torturing it. Do not confuse this factor with correcting a pet for its undesirable behaviour.

16) Any actual or attempted form physical violence, ranging in severity from a push or slap to the face, to punching or kicking the victim in the stomach. The key difference with this item is that the victim was pregnant at the time of the assault and the perpetrator was aware of this fact.

17) Any attempt (separate from the incident leading to death) to strangle the victim. The perpetrator could have used various things to accomplish this task (e.g., hands, arms, rope, etc.). Note: Do not include attempts to smother the victim (e.g., suffocation with a pillow).

18) As a child/adolescent, the perpetrator was victimized and/or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment.

19) The abuse/maltreatment (physical; psychological; emotional; sexual; etc.) inflicted upon the victim by the perpetrator was increasing in frequency and/or severity. For example, this can be evidenced by more regular trips for medical attention or include an increase in complaints of abuse to/by family, friends, or other acquaintances.

20) Any actions or behaviours by the perpetrator that indicate an intense preoccupation with the victim. For example, stalking behaviours, such as following the victim, spying on the victim, making repeated phone calls to the victim, or excessive gift giving, etc.

21) Employed means having full-time or near full-time employment (including self-employment). Unemployed means experiencing frequent job changes or significant periods of lacking a source of income. Please consider government income assisted programs (e.g., O.D.S.P.; Worker's Compensation; E.I.; etc.) as unemployment.

22) The victim and perpetrator were cohabiting.

23) Any child(ren) that is(are) not biologically related to the perpetrator.

24) At some point the perpetrator was confronted, either by the victim, a family member, friend, or other acquaintance, and the perpetrator displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., batterer intervention programs). Or the perpetrator denied many or all past assaults, denied personal responsibility for the assaults (i.e., blamed the victim), or denied the serious consequences of the assault (e.g., she wasn't really hurt).

25) The partner wanted to end the relationship. Or the perpetrator was separated from the victim but wanted to renew the relationship. Or there was a sudden and/or recent separation. Or the victim had contacted a lawyer and was seeking a separation and/or divorce.

26) Within the past year, and regardless of whether or not the perpetrator received treatment, substance abuse that appeared to be characteristic of the perpetrator's dependence on, and/or addiction to, the substance. An increase in the pattern of use and/or change of character or behaviour that is directly related to the alcohol and/or drug use can indicate excessive use by the perpetrator. For example, people described the perpetrator as constantly drunk or claim that they never saw him without a beer in his hand. This dependence on a particular substance may have impaired the perpetrator's health or social functioning (e.g., overdose, job loss, arrest, etc). Please include comments by family, friend, and acquaintances that are indicative of annoyance or concern with a drinking or drug problem and any attempts to convince the perpetrator to terminate his substance use.

27) In the opinion of any family, friends, or acquaintances, and regardless of whether or not the perpetrator received treatment, the perpetrator displayed symptoms characteristic of depression.

28) A diagnosis of depression by any mental health professional (e.g., family doctor; psychiatrist; psychologist; nurse practitioner) with symptoms recognized by the DSM-IV, regardless of whether or not the perpetrator received treatment.

29) For example: psychosis; schizophrenia; bi-polar disorder; mania; obsessive-compulsive disorder, etc.

30) The perpetrator stored firearms in his place of residence, place of employment, or in some other nearby location (e.g., friend's place of residence, or shooting gallery). Please include the perpetrator's purchase of any firearm within the past year, regardless of the reason for purchase.

31) There was a new intimate partner in the victim's life or the perpetrator perceived there to be a new intimate partner in the victim's life

32) The perpetrator has violated any family, civil, or criminal court orders, conditional releases, community supervision orders, or "No Contact" orders, etc. This includes bail, probation, or restraining orders, and bonds, etc.

33) As a(n) child/adolescent, the perpetrator was exposed to and/or witnessed any actual, attempted or threatened forms of suicidal behaviour in his family of origin. Or somebody close to the perpetrator (e.g., caregiver) attempted or committed suicide.

34) After a formal (e.g., performed by a forensic mental health professional before the court) or informal (e.g., performed by a victim services worker in a shelter) risk assessment was completed, the perpetrator still had access to the victim.

35) Victim and perpetrator were between the ages of 15 and 24.

36) The perpetrator continuously accuses the victim of infidelity, repeatedly interrogates the victim, searches for evidence, tests the victim's fidelity, and sometimes stalks the victim.

37) Hating or having a strong prejudice against women. This attitude can be overtly expressed with hate statements, or can be more subtle with beliefs that women are only good for domestic work or that all women are "whores."

38) Women in an intimate relationship with a partner who is significantly older or younger. The disparity is usually nine or more years.

39) The victim is one that knows the perpetrator best and can accurately gauge his level of risk. If the women discloses to anyone her fear of the perpetrator harming herself or her children, for example statements such as, "I fear for my life", "I think he will hurt me", "I need to protect my children", this is a definite indication of serious risk.

40) Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual; etc.) towards children in the family. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family; friends; neighbours; co-workers; counselors; medical personnel, etc).

Curriculum Vitae

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