Department of the Air Force Domestic Violence and Child Maltreatment Fatality Review Report

December 31

2017

Air Force Family Advocacy Program
Mental Health Division
Air Force Medical Operations Agency

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Executive Summary

In accordance with DODI 6400.06, *Domestic Abuse Involving Department of Defense Military and Certain Affiliated Personnel*, 21 August 2007, Incorporating Change 2, 9 July 2015, and as directed by the Under Secretary of Defense for Personnel and Readiness (USD P&R), the Air Force conducts an annual comprehensive multidisciplinary review of all fatalities known or suspected to have resulted from domestic violence or child maltreatment, including related suicides. All such fatalities which occurred in FY 2015, or before and were not yet reviewed, involving Air Force members and their family members or intimate partners, as defined by the Department of Defense (DOD), were reviewed by the 2017 Air Force Fatality Review Board (FRB).

The Air Force submits an annual report to USD P&R containing case specific findings and "proposed" recommendations. Every five years the Air Force submits a 5-year report with summary findings and "formal" recommendations. The 2014 report contained the summary findings and "formal" recommendations from the FRB's review of family maltreatment fatalities from 2010 to 2014. The Board reviewed 44 maltreatment incidents which resulted in 50 deaths. The Air Force Surgeon General directed the Family Advocacy Program (FAP) to develop a FRB Action Plan (AP) to implement the Board's "formal" recommendations. There were 24 actionable items on the AP with OPRs and OCRs assigned. As of 31 December 2017, all but one item has been implemented and closed. It is unclear when the final item will be closed. Because annual fatality reviews produce "proposed" recommendations, findings and trends will be tracked from 2015 – 2019 when "formal" recommendations will again be included in a 5-year report and an AP developed.

The 2017 FRB conducted individual and group reviews of available records from the following agencies and organizations: FAP, New Parent Support Program (NPSP), military treatment facilities (family medicine and pediatrics), Mental Health, including psychiatry and Alcohol and Drug Abuse Prevention and Treatment (ADAPT), Office of Special Investigations (OSI), Air Force Personnel Center (AFPC), Judge Advocate (JA), and Security Forces (SF).

<u>Potential recommendations resulting from the 2017 Domestic Violence and Child Maltreatment Fatality Review Board:</u>

- [redacted]
- [redacted]
- Provide education to command regarding recognition of stressors in Airmen and providing tools to aid in intervention
- Educate military and civilian community about risk factors for domestic violence and child maltreatment and who to call with concerns
- [redacted]
- Develop a protocol to increase medical monitoring for patients who are prescribed opioids

Based on "case-specific" findings this year and the number of family maltreatment related fatalities among ADAF personnel and their families and/or unmarried intimate partners (average of eight per year), we did not identify trends that could support formal recommendations for widespread (DOD) policy or systemic changes. The recommendations contained in this report are "case-specific" and aimed at internal AF programs and policies. We will continue to review each year's significant findings in light of previous years' findings for the purpose of identifying any trends that would shape recommendations for DOD policy.

This concludes the Executive Summary; the following pages provide details on methods used by the AF FRB, "case specific" findings and recommendations, and "potential" recommendations to be tracked over five years. The next 5-year report will be submitted in 2019.

Department of the Air Force
Domestic Violence and Child Maltreatment Fatality Review Report

Introduction

Background: The Under Secretary of Defense for Personnel and Readiness (USD P&R), pursuant to implementation of Section 576 of Public Law 108-136, the National Defense Authorization Act for Fiscal Year 2004, and IAW DODI 6400.06, *Domestic Abuse Involving Department of Defense Military and Certain Affiliated Personnel*, 21 August 2007, Incorporating Change 2, 9 July 2015, directed the Secretaries of each of the military departments to conduct a multidisciplinary, impartial review of each fatality known or suspected to have resulted from domestic violence or child maltreatment, including related suicides, involving any of the following:

(1) Active duty member
(2) Current or former family member of an active duty member
(3) Current or former intimate partner of an active duty member; defined as a former spouse, person with whom the active duty member shares a child in common, or a person with whom the active duty member shares or has shared a common domicile
(4) Dating partners or stalkers. Note: In November 2015, in the interest of victim safety, the Air Force expanded the DOD intimate partner definition to include dating partners, defined as victims in an ongoing relationship with the alleged offender who were engaged in sexual intercourse or other sexual acts in the course of a romantic relationship prior to the incident, or demonstrated potential for an ongoing relationship, or if the alleged offender has engaged or is engaged in stalking behaviors.

Fatality reviews are deliberative examinations of the systemic interventions into the lives of the deceased conducted only after related law enforcement investigations, autopsies, and court proceedings have ended, which is normally a period of approximately two years. Reviews are conducted by multidisciplinary teams for the purpose of formulating lessons learned, and identifying trends and patterns that assist in developing policy recommendations designed to prevent future fatalities.

Background

This report details the AF's twelfth annual Domestic Violence and Child Maltreatment Fatality Review. The review was conducted 15-19 May 2017 in San Antonio, Texas and was chaired by the AF Family Advocacy Program Clinical Director. Representatives from each of the following organizations participated in the review:

- Air Force Personnel Center
- Air Force Judge Advocate
- Air Force Office of Special Investigation

- Air Force Medical Operations Agency: Family Advocacy/New Parent Support, Family Medicine, Psychiatry, ADAPT and Forensic Pediatrics
- Air Force Chief of Chaplains
- Air Force Security Forces
- Air Force Chief Master Sergeant Representative (First Sergeant)

Some participants completed FRB training arranged by the DOD and the DOJ Office on Violence Against Women in cooperation with the National Domestic Violence Fatality Review Initiative (NDVFRI). All members were oriented to their roles, responsibilities, and the review process at the opening of the FRB. When possible, Board members scheduled to transition from the Board bring their replacement to their final meeting to orient the new member to their role on the Board the following year.

The 2017 review included AF maltreatment-related fatalities that occurred in or before fiscal year 2015, and had been fully adjudicated. Nine deaths resulting from eight fatal incidents were reviewed. The incidents included five child homicides, a murder/suicide, an adult suicide related to child maltreatment, and an adult suicide related to domestic violence. In accordance with DODI 6400.06., *Domestic Abuse Involving Department of Defense Military and Certain Affiliated Personnel*, all maltreatment-related fatalities involving a spouse or an unmarried intimate partner must be included in the review. The policy change rendered civilian unmarried intimates, as defined above, eligible for FAP assessment, safety planning and DAVA services until connected to community resources, as well as inclusion in the FRB process.

FRB Process

The committee used the following documents/records when available for each member of the immediate family of the victim, offender or both to conduct reviews:

- Family Advocacy Maltreatment and Prevention Records
- Domestic Abuse Victim Advocacy Records
- Inpatient and Outpatient Medical Records
- OSI Reports of Investigation
- Mental Health Records (including ADAPT)
- Personnel Records
- Court Records
- Security Forces Records

The review was conducted in compliance with confidentiality and information protection requirements required by DODI 6400.06. Measures employed by the team included maintaining all records under double lock, briefing all members regarding DOD and state privacy and confidentiality policies, and conducting all proceedings as closed meetings. All hard copies of the documents used by the Board will be destroyed once this report is approved as written.

Board members first completed extensive individual reviews of all available records using the standardized AF Fatality Timeline Form. Members were instructed to review records in their respective areas of expertise and to identify "red flags", system failures and potential recommendations for discussion during the group review.

After completion of individual reviews, comprehensive group reviews of each incident were conducted by the Board. The Record of Fatality Review Form was used as a guide for these corporate reviews. Board members first reviewed the known Victim and Subject (Offender) demographics. Second, a detailed case timeline was constructed documenting all known facts about the Victim, the Subject, and their interactions with families, friends, supervisors, co-workers, and organizations or agencies, from the time the active duty member entered the AF until the time of the fatality.

Throughout the group review, Board members provided information, insight and feedback from the perspective of their unique specialty. Comprehensive discussions including differing perspectives regarding specific circumstances, recommendations and conclusions were conducted for each incident and throughout the entire review process. The Board ended each case review by identifying case-specific lessons learned and recommendations.

In addition to conducting case reviews, the Board continually evaluates the review process focusing on opportunities for improvement. In 2007, a fatality review correlates matrix was developed to identify trends and patterns associated with partner and child maltreatment-related deaths, and was completed retrospectively on reviews completed from 2005 forward. This matrix has been expanded in recent years and now contains more than 300 correlates. It served as a template for the DOD correlates matrix initiated in 2008. Results of the matrix are compiled and included in the 5-year FRB Report, and trends are reported from it annually. In 2008, the process of collecting necessary records seven months prior to the review Board meeting was instituted, dramatically increasing the amount of information available for review. In 2010, the Board eliminated some less useful items on the worksheet. In 2011, the chairperson assigned Board members to complete specific items on the worksheet and several suicide-specific items were added to the matrix. In 2015 eight New Parent Support Program-specific items were added to the matrix. In 2016 the Board identified the need to update the Record of Fatality Review Form with the most current lethality and other risk factors. The updated form was used in 2017. The Board continually strives to streamline the process to ensure optimal review of up to 10 fatal maltreatment incidents annually.

As described above, each review addresses an extensive amount of information about the Victim(s) and the Subject(s) as well as their family members, friends, and work and home environments. Based on the Board's mandate and objectives, case-specific detail in the report is limited.

Statistical Summary of FAP-related Fatal Incidents Reviewed in 2017
Includes Trends from 2005 - 2017

[redacted]:

[redacted]

[redacted]

One Child Maltreatment-related Adult Suicide and One Domestic Violence-related Adult Suicide:

[redacted]

Statistical Trends: From 2008 – 2017, 22 suicides were reviewed by the AF FRB (7 child maltreatment-related adult suicides and 15 domestic violence-related adult suicides). The following correlates were identified in one or more of the above incidents and are listed with their frequency since 2009:

SU = Suicide-Only (DV or child abuse-related) Factors
SU Deceased had conflict with partner in 17/22 or 77%
SU Deceased is married in 16/22 or 73%

SU Deceased is male in 16/22 or 73%
SU Deceased committed suicide due to domestic violence in 15/22 or 68%
SU Recent break-up of marriage or relationship in 14/22 or 63%
SU Deceased was depressed 13/22 or 59%
SU Deceased was trained in firearms/combat in 13/22 or 59%
SU Deceased made prior suicide attempts in 12/22 or 55%
SU Deceased feared loss of status/esteem in 12/22 or 55%
SU Deceased had a history of suicidal ideation in 11/22 or 50%
SU Occurred during or immediately after verbal argument in 11/22 or 50%
SU Deceased last OPR = 5 in 10/22 or 45%
SU Deceased had history of alcohol/substance abuse in 10/22 or 45%
SU Deceased had criminal charges/disciplinary action pending at time of incident in 9/22 or 41%
SU Deceased had current financial problems in 9/22 or 41%
SU Deceased was separated from partner in 9/22 or 41%
SU Loss of or limited contact with children in 9/22 or 41%
SU Deceased was involved in known or suspected infidelity in 7/22 or 32%
SU Deceased committed suicide due to child maltreatment in 7/22 or 32%
SU Deceased reported anger problems in 7/22 or 32%
SU Deceased was threatened by spouse with separation/break-up in 7/22 or 32%
SU Deceased had open FAP case in 6/22 or 27%
SU Deceased had past history of disciplinary action i.e. LOR, LOC, or Article 15 in 6/22 or 27%
SU Deceased was under 25 years old in 5/22 or 23%
SU Deceased had history of psychiatric hospitalization in 5/22 or 23%
SU Deceased seen in Mental Health prior 30 days 5/22 or 23%
SU Deceased first tour of duty (after training/tech school) in 5/22 or 23%
SU Deceased had current medical problems in 5/22 or 23%
SU Deceased had prior criminal charges/conviction (military/civilian) in 3/22 or 14%
SU Deceased pending separation from AF in 2/22 or 9%
SU Deceased had dependency/attachment issues in 2/22 or 9%
SU Deceased had history of problems in duty performance in 2/22 or 9%
SU Deceased had history of prescription drug misuse in 1/22 or 5%
SU Deceased last EPR 3 or lower in 1/22 or 5%
SU Deceased had childhood history of physical or emotional abuse in 1/22 or 5%

<u>I = Incident Factors</u>
I Deceased planned/premeditated the suicide in 12/22 or 55%
I Deceased was under the influence of drugs/alcohol at the time of death in 7/22 or 32%
I Victim and Deceased were separated in 5/22 or 23%
I Deceased was on leave during the suicide incident 4/22 or 18%
I Suicide occurred outside in 3/22 or 14%
I Mechanism of death = other (hanging) in 3/22 or 14%
I Deceased had secondary offender involved in child abuse incident in 1/22 or 5%
I Death by drugging/poisoning in 1/22 or 5%

One Adult Murder/Suicide:

[redacted]

Statistical Trends: From 2005 – 2017, 14 adult murder-suicides were reviewed by the FRB. The following correlates were identified in the above incident and are listed with their frequency since 2005:

DA = Deceased Assailant Factors
DA had conflict with partner in 14/14 or 100%
DA is male in 13/14 or 93%
DA is married in 12/14 or 86%
DA jealous obsessive in 11/14 or 79%
DA low marital/relationship satisfaction in 11/14 or 79%
DA past history of disciplinary action i.e. LOR, LOC, Article 15 in 10/14 or 71%
DA trained in firearms/combat in 10/14 or 71%
DA threatened separation/break-up in 9/14 or 64%
DA was depressed in 8/14 or 57%
DA reported anger problems in 8/14 or 57%
DA had history of suicide attempt in 7/14 or 50%
DA alcohol/substance abuse in 7/14 or 50%
DA had history of suicidal ideation in 6/14 or 43%
DA belief in male domination/privilege in 5/14 or 36%
DA had problems in duty performance in 5/14 or 36%
DA deployed in past 12 months in 4/14 or 29%
DA experienced (was a victim of) Physical/emotional abuse in current relationship in 4/14 or 29%
DA last EPR = 5 in 4/14 or 29%
DA prior criminal charge(s)/conviction (military/civilian) in 3/14 or 21%
DA history of partner abuse (prior relationship(s)) in 3/14 or 21%
DA worked shiftwork/extended duty hours in 3/14 or 21%
DA had history of exposure to combat trauma in 3/14 or 21%
DA had problems with absence/lateness in 2/14 or 14%

V = Victim Factors
V female in 13/14 or 93%
V suspected/accused of infidelity in 11/14 or 79%
V threatened to leave assailant in 9/14 or 64%
V expressed fear to others in 4/14 or 29%
V accepts/embraces traditional gender roles in 4/14 or 29%
V emotionally abused by DA in 4/14 or 29%
V has assaulted DA (other than self-defense) in 3/14 or 21%

V was depressed in 3/14 or 21%
V had history of suicide attempt in 1/14 or 7%
V history of criminal charges/conviction in 1/14 or 7%
V current alcohol abuse in 1/14 or 7 %
V expressed fear for children in 1/14 or 7%

F = Family Factors
F family conflict in 10/14 or 71%
F firearms in home in 9/14 or 64%
F recurrent verbal arguments between family members in 8/14 or 57%
F couple together less than 2 years in 6/14 or 43%
F active duty family member deployment past 12 months in 5/14 or 36%
F couple married/co-habit after less than 6 months in 4/14 or 29%
F children not by assailant residing in home in 3/14 or 21%
F blended family (children from past relationship/s) in 3/14 or 21%
F recent change in family composition (90 days) in 2/14 or 14%
F father (step) failure to bond with child(ren) in 2/14 or 14%
F extra-familial residents in home in 1/14 or 7%

I = Incident Factors
I murder/suicide in 14/14 or 100%
I occurred in shared residence in 10/14 or 71%
I jealousy precipitated incident in 9/14 or 64%
I deceased assailant under influence of drugs/alcohol in 8/14 or 57%
I occurred between midnight and 0600 in 8/14 or 57%
I verbal argument preceded the incident in 8/14 or 57%
I victim threat to leave precipitated incident in 8/14 or 57%
I occurred after 1800 in 7/14 or 50%
I victim under influence of drugs/alcohol in 6/14 or 43%
I children in the home during incident in 5/14 or 36%
I spontaneous suicide attempt after murder (complete or failed) in 4/14 or 29%
I deceased assailant left a note (documented intent via, e-mail, diary etc.) in 4/14 or 29%
I children witnessed/heard incident in 3/14 or 21%
I deceased assailant expressed remorse in 3/14 or 21%
I deceased assailant on leave during incident in 3/14 or 21%
I deceased assailant attempt to hide/alter evidence in 2/14 or 14%
I deceased assailant damaged victims property i.e. wrecked the house/apt in 1/14 or 7%
I homicide by strangulation anything around neck in 1/14 or 7%

Additional Trends Identified since 2005

This AF-level annual review is conducted in addition to focused quality reviews (Root Cause Analysis or Medical Incident Investigation) of each fatality involved in medical care (including FAP) to identify needed local improvements and/or AF-wide lessons.

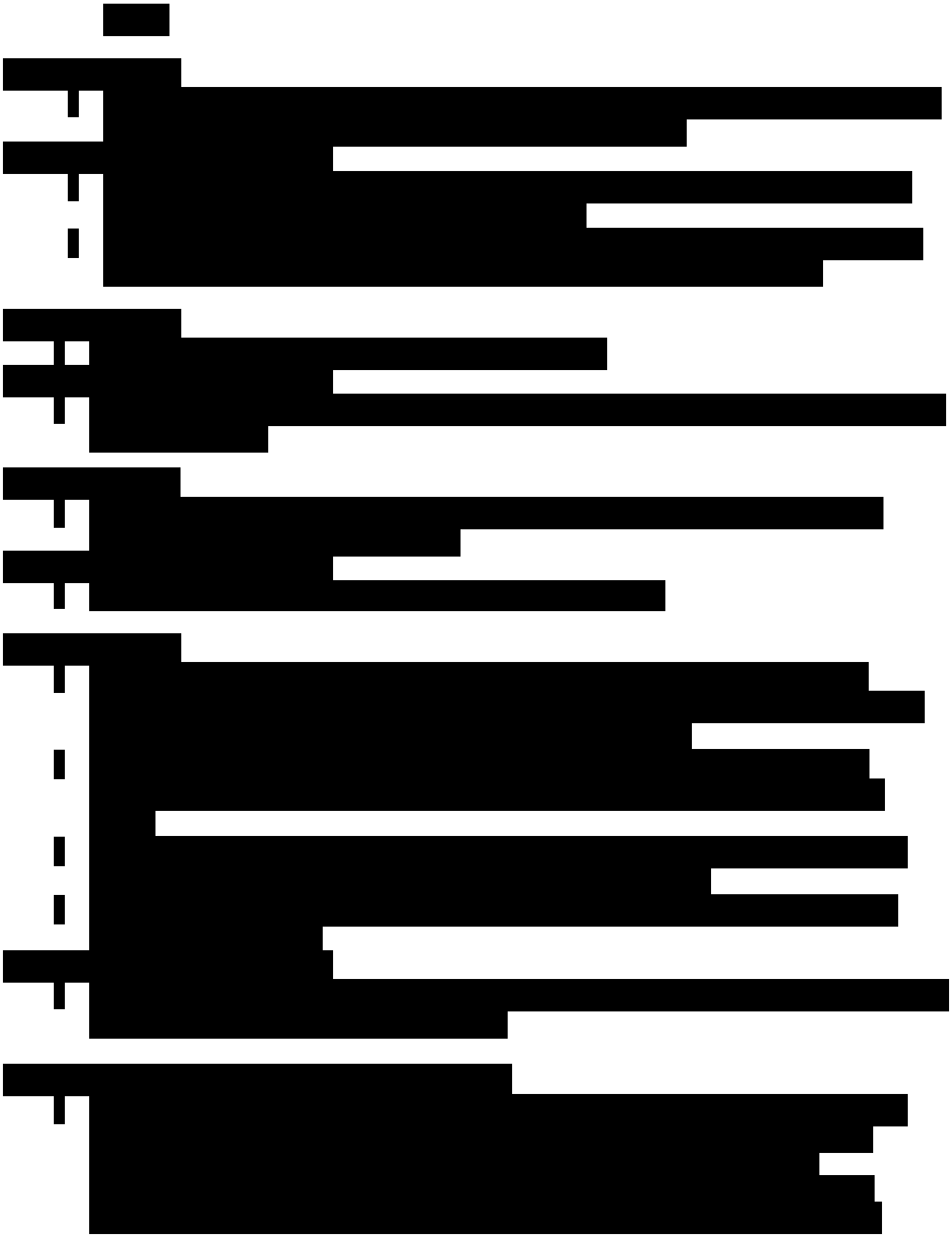
In previous reports the FRB has identified the increased risk to military families who are attached to tenant units or Geographically Separated Units (GSUs) that are supported by a different branch of Service. There appear to be barriers to these families seeking or being referred to supportive services from agencies of a different branch of Service. AF prevention and resilience activities should target installation tenant units and GSUs from a different Branch of Service.

[redacted]

The Board identified another continuing trend in adult partner maltreatment deaths, specifically the presence of loaded weapons in easily accessible locations, such as bedroom nightstands, closets, or kitchen drawers. With easy access to firearms, heated couple disagreements can lead to fatal incidents, especially when alcohol is involved. A similar case was reviewed in 2016; the offender was drinking heavily and had a loaded hand gun in his back pocket while he waited for his wife to return home. Another concerning trend identified again in 2016 was failure to recognize male victims of domestic abuse. This appears to stem from a lack of understanding by the community that males are also victims of domestic abuse, and that the abuse males suffer can be fatal. Of the domestic violence homicides reviewed by AF FRB, 25% of partner homicide victims were male. [redacted]

Description of Case Findings and Case Specific Recommendations

[redacted]



[redacted]

Suicide -2 (Related to Domestic Violence) - Findings:

- Command failed to notify ADAPT of Deceased's emergency leave.
- CPS was notified that FM/S was in the room during the domestic violence incident when Deceased threw an object and CPS did not open an investigation. FAP did not take a child neglect (exposure to physical hazards/DV) case to CRB.
- AWOL procedures limit the ability to reach out to local Law Enforcement for help. Members can't be declared AWOL until after 24 hrs. Command used FM/W to conduct a welfare check rather than LE despite a no contact order.

Case Specific Recommendation(s):

- Develop a protocol for medical monitoring of patients on opioids.

Murder - Suicide - 1 Findings:

- Friends and co-workers were aware of ADAF Assailant's and Victim's drinking habits, though no one reported concerns to leadership and, therefore, no ADAPT referral was made.
- Friends and co-workers were aware of ADAF Assailant's and Victim's marital discord, though no one reported concerns to leadership and, therefore, no referral for marital counseling or other prevention services was made.

Case Specific Recommendation(s):

- None

Potential Recommendations:

- [redacted]
- Education to command regarding recognition of stressors in Airmen and providing tools to

aid in intervention.

- Educate military and civilian community about risk factors for domestic violence and child maltreatment and who to call with concerns.
- [redacted]
- Develop a protocol for medical monitoring of patients on opioids.

Recommended Review Plan

Based on the number of maltreatment-related fatalities that occur annually among ADAF personnel and their families and/or their unmarried intimate partners (average of 8 per year), it was deemed inadvisable to make policy recommendations on an annual basis. The types of recommendations contained in this report are "case-specific" and "potential" recommendations to be tracked for future policy consideration. We will identify reoccurring concerns and trends each year and at the 5-year review will identify the most potent recommendations as "formal" AF recommendations. This concludes the 2017 AF Domestic Violence and Child Maltreatment Fatality Review Board Report.

Appendix A:

2017 Air Force Fatality Review Team Members 15-19 May 2017

[redacted]	[redacted]
Action Officer, Force Protection Integration Air Force Security Forces Center [redacted]	Action Officer, Force Protection Integration Air Force Security Forces Center [redacted]
[redacted] AFOSI [redacted]	Air Force Office of Special Investigation [redacted]
[redacted]	[redacted]
ADAPT [redacted] Air Force Medical Operations Agency (AFMOA) [redacted]	[redacted] Mental Health Flight Medical Director [redacted]
[redacted]	[redacted]
First Sergeant Special Duty Manager [redacted]	NCOIC, Special Programs [redacted]
[redacted]	[redacted]
Office of the Chief of Chaplains [redacted]	[redacted]
[redacted]	[redacted]
[redacted]	Child Abuse Pediatrician
Air Force Family Advocacy Program/AFMOA/SGHW [redacted]	[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Air Force Family Advocacy Program/AFMOA/SGHW [redacted]	Air Force Family Advocacy Program/AFMOA/SGHW [redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
United States Air Force Judiciary	[redacted]
[redacted]	Air Force Family Advocacy Program/AFMOA/SGHW [redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Fatality Review Administrative Support Members	
[redacted]	[redacted]
Central Registry	Central Registry
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Central Registry	Information Technology Specialist
[redacted]	[redacted]
[redacted]	[redacted]