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

December 31

2018

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 4*, 26 May 2017, 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. The fatalities reviewed by the 2018 Air Force Fatality Review Board (FRB), were those fatalities which occurred in FY 2016, or before and were not yet reviewed by this board prior to FY 2018. All fatalities reviewed involved Air Force members and their family members or intimate partners, as defined by the Department of Defense (DOD).

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 2018, all but one item has been implemented and 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 2018 FRB conducted individual and group reviews of available records from the following agencies and organizations: FAP, Maltreatment Intervention, Domestic Abuse Victim Advocacy (DAVA), 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 2018 Domestic Violence and Child Maltreatment Fatality Review Board:</u>

- [redacted]
- Units need better coordination and utilization of key spouse and other deployment support to family members when they reside on an installation of a different branch of Service.
- Better training for command regarding requiring an active duty alleged offender's completion of all FAP treatment recommendations, fully investigating the active duty member's alleged gang activity, and referrals/consultation with JA/OSI/FAP.
- Anger Management training is not sufficient for domestic abuse offender treatment: each alleged offender must be referred to domestic abuse treatment if the incident meets criteria at the Central Registry Board.
- Mental health leadership should be more vigilant when assigning a mental health provider to particular cases, taking into account the mental health provider's rank and level of experience compared to the case complexity and rank of the patient

- Command should be as aggressive as legally allowed in ensuring weapons are removed from a suicidal service member's possession.
- Consider allowing dependents to be seen in MH when also being treated by other flight providers in Family Advocacy or Alcohol Drug Abuse Prevention and Treatment (ADAPT).

Based on "case-specific" findings this year and the number of family maltreatment related fatalities among AD AF personnel and their families and/or unmarried intimate partners (average of eleven 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 4*, 26 May 2017, 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 fourteenth annual Domestic Violence and Child Maltreatment Fatality Review. The review was conducted 21-25 May 2018 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 Investigations

- 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 2018 review included AF maltreatment-related fatalities that occurred in or before fiscal year 2016, and had been fully adjudicated. Twelve deaths (plus one fetal death at 34 weeks gestation) resulting from ten fatal incidents were reviewed. The incidents included three child homicides, five adult homicides, an adult suicide related to child maltreatment, and three adult suicides 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.

Fatality Review Board 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 fatal incident.

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 350 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 Board instituted a process which required the collection of necessary records seven months prior to the review Board meeting. This process dramatically increased 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 2018
Includes Trends from 2005 - 2018

[redacted]:

[redacted]

[redacted]

[redacted]

[redacted]

Five Fatal Domestic Violence Incidents:

[redacted]

[redacted]

Statistical Trends: From 2005 – 2018, 36 fatal intimate partner/spouse maltreatment incidents were reviewed by the FRB:

Abuser Factors (A):
A conflict with partner, 34/36 or 94%
A married, 29/36 or 81%
A is male, 28/36 or 78%
A low marital/relationship satisfaction, 24/36 or 67%
A jealous obsessive, 20/36 or 56%
A trained in firearms/combat, 20/36 or 56%
A reported anger problems, 16/36 or 45%
A threatened separation/break-up, 16/36 or 45%
A past history of disciplinary action (i.e. LOR, LOC, Article 15), 16/36 or 45%
A involved in known or suspected infidelity, 14/36 or 39%
A alcohol/substance abuse, 13/36 or 36%
A current medical problems, 13/36 or 36%
A current financial problems, 13/36 or 36%
A separation from partner, 12/36 or 33%

Victim Factors (V):
V female, 26/36 or 72%
V suspected/accused of infidelity, 18/36 or 50%
V employed full-time, 17/36 or 47%
V threatened to leave assailant, 15/36 or 42%
V accepts/embraces traditional gender roles, 13/36 or 36%
V active duty, 12/36 or 33%
V under age 25 years old, 12/36 or 33%
V has assaulted Abuser, 10/36 or 28%
V and assailant have separated before, 10/36 or 28%
V is male 10/36 or 28%
V had separated from assailant 9/36 or 25%

Family Factors (F):
F family conflict, 22/36 or 61%
F firearms in home, 18/36 or 50%
F recurrent verbal arguments between family members, 16/36 or 44%
F both partners employed full time, 15/36 or 42%
F couple together less than 2 years, 13/36 or 36%
F problems with finances, 10/36 or 28%
F children not by abuser residing in home, 9/36 or 25%
F blended family (children from past relationship/s), 9/36 or 25%

F couple married/co-habit after less than 6 months, 9/36 or 25%
F history of substantiated partner abuse, 8/36 or 22%

Incident Factors (I):
I firearm(s) used, 26/36 or 72%
I incident occurred in shared residence, 25/36 or 69%
I death by firearm, 25/36 or 69%
I occurred between midnight and 0600, 20/36 or 56%
I verbal argument preceded the incident, 20/36 or 56%
I occurred after 1800, 17/36 or 47%
I planned/premeditated, 17/36 or 47%
I children in the home during incident, 17/36 or 47%
I murder/suicide, 15/36 or 42%
I jealousy precipitated incident, 15/36 or 42%
I abuser attempt to hide/alter evidence, 15/36 or 42%
I abuser under influence of drugs/alcohol, 13/36 or 36%
I victim and assailant alone in the house, 13/36 or 36%
I victim threat to leave precipitated incident, 12/36 or 33%

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

[redacted]

[redacted]

Statistical Trends: From 2008 – 2018, 24 suicides were reviewed by the AF FRB (6 child maltreatment-related adult suicides and 18 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:

Deceased Factors (D) Incident Factors (I)
D had conflict with partner, 17/24 or 71%
D was married, 16/24 or 67%
D is male, 16/24 or 67%
I death by firearm, 14/24 or 58%
D left Suicide Note, 13/24 or 54%
I occurred during/immediately after verbal argument, 13/24 or 54%
D experienced a recent separation, 13/24 or 54%
D feared loss of status/esteem, 12/24 or 50%
I verbal argument preceded the incident, 12/24 or 50%
D had low marital/relationship satisfaction, 11/ 24 or 46%
D depressed, 11/24 or 46%
D trained in firearms/combat, 11/24 or 46%
D had history of suicidal ideation, 11/24 or 46%
D had prior suicide attempts, 10/24 or 42%
I was planned/premeditated, 10/24 or 42%

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. 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, 28% of partner homicide victims were male. [redacted]

Description of Case Findings and Case Specific Recommendations

[redacted]

Partner - 1 Findings: None
Case Specific Recommendation(s): None

Partner - 2 Findings: None
Case Specific Recommendation(s):

- None

Partner - 3 Findings:

- Command should have been more involved regarding first egregious domestic violence incident in 2012 and Subject's known affiliation with a motorcycle gang. There should have been more engagement with Family Advocacy with that incident which was closed unresolved because Subject did not complete treatment. Subject should have been moved to the dorms for better supervision. Administrative action should have been taken when command became aware of Subject's association with the motorcycle gang.
- Regarding the domestic violence incident in 2012, anger management was not an appropriate intervention. Subject should have been referred to a batterer's intervention program.

Case Specific Recommendation(s):

- Better training for command regarding requiring an active duty alleged offender's completion of all FAP treatment recommendations, fully investigating the active duty member's alleged gang activity, and referrals/consultation with JA/OSI/FAP.

Partner - 4 Findings:

- Title 32 status limits command's ability to direct subject to engage in services.

Case Specific Recommendation(s): None

Partner - 5 Findings:

- Regarding the domestic violence incident in 2012, anger management was not an appropriate intervention.

Case Specific Recommendation(s):

- Subject should have been referred to a batterer's intervention program after the first domestic violence incident.

Suicide -1 (Related to Domestic Violence) - Findings: None
Case Specific Recommendation(s): None

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

- More senior and experienced mental health clinicians should have been assigned earlier. Deceased discussed weekly as a high interest case with history of suicidal ideation and his care was not elevated.

Case Specific Recommendation(s):

- Mental health leadership should be more vigilant in assignment of mental health providers matching level of client's case complexity and rank to level of experience of the mental health provider.
- Command should be as aggressive as legally allowed in ensuring weapons are removed from a suicidal service member's possession.

Suicide - 3 Findings:

- It is unclear whether the CC had a list of weapons and briefed Deceased on weapon safety and storage and signed Lautenberg form.
- Collateral information suggests deceased refused to seek MH due to stigma/fear of loss of career.

Case Specific Recommendation(s):

- Consider allowing dependents to be seen in MH when also being treated by other providers in the flight.

Potential Recommendations:

- [redacted]
- Units need better coordination and utilization of key spouse and other deployment support to family members when they reside on an installation of a different branch of Service.
- Better training for command regarding requiring an active duty alleged offender's completion of all FAP treatment recommendations, fully investigating the active duty member's alleged gang activity, and referrals/consultation with JA/OSI/FAP.
- Anger Management training is not sufficient for domestic abuse offender treatment: each alleged offender must be referred to domestic abuse treatment if the incident meets criteria at the Central Registry Board.
- Mental health leadership should be more vigilant when assigning a mental health provider to particular cases, taking into account the mental health provider's rank and level experience compared to the case complexity and rank of the patient
- Command should be as aggressive as legally allowed in ensuring weapons are removed from a suicidal service member's possession.
- Consider allowing dependents to be seen in MH when also being treated by other flight providers in Family Advocacy or Alcohol Drug Abuse Prevention and Treatment (ADAPT).

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 eleven 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 2018 AF Domestic Violence and Child Maltreatment Fatality Review Board Report.

Appendix A

2018 Air Force Fatality Review Team Members

[redacted] Air Force Security Forces Center [redacted]	[redacted] AFOSI HQ/XR [redacted]
[redacted]	[redacted]
[redacted] Air Force Medical Operations Agency (AFMOA) [redacted]	[redacted] Medical Director, Mental Health Flight [redacted]
[redacted]	[redacted]
[redacted] First Sergeant Special Duty Manager [redacted]	[redacted] NCOIC, Special Programs [redacted]
[redacted]	[redacted]
[redacted] Office of the AF Chief of Chaplains [redacted]	[redacted] Child Abuse Pediatrician [redacted]
[redacted]	[redacted]

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