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

December 31

2015

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, or before, FY 2013 involving Air Force members and their family members or intimate partners, as defined by the Department of Defense (DoD), were reviewed by the 2015 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 asked 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 20 November 2015, all but four items have been implemented and closed. Remaining items are expected to close by 1 June 2016, or sooner. 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 2015 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, Judge Advocate (JA), and Security Forces (SF).

Proposed recommendations resulting from the review are listed below:

- [redacted] ts for prevention and
- FAP providers should make ADAPT referrals for alcohol-related incidents in accordance with AF guidance – consistent peer review of FAP records should detect failures to refer
- FAO should notify AF FAP Clinical Director when they identify a pattern of failure to follow the Central Registry Board (CRB) decision tree, so additional training and consultation can be scheduled
- On-base mental health providers have right of first refusal to provide care for family members with open FAP cases to improve continuity of care

- [redacted]
- Require a process of handing off a case from one FAP provider to another FAP provider that requires the transfer summary be completed by losing provider
- [redacted]
- [redacted]
- Before a FAP provider crafts a letter for the court verifying attendance at recommended classes or treatments, clients must provide proof of completion and FAP record must reflect compliance of treatment plan; JA should review letter
- [redacted]
- MOUs between civilian Law Enforcement (LE) and SF to ensure timely notification to SF of domestic violence or child maltreatment arrests
- Ensure every adult victim of partner maltreatment has access to a DAVA or community victim advocate regardless of sex/gender or risk level; even if a victim states they are not afraid of their partner, still refer them to a DAVA
- All allegations of domestic violence should be thoroughly investigated by LE/OSI
- There should be a modification of the Limited Privilege Suicide Protection (LPSP) to allow privileged communication with a therapist even in the absence of suicidality for Active Duty Members (ADM) facing Uniformed Code of Military Justice (UCMJ) action

Based on our "case-specific" findings this year and our small number of fatalities (annual average of eight), we did not identify any 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 our previous year's findings for the purpose of identifying any trends that would shape recommendations for DoD policies.

This concludes the Executive Summary; the following pages provide details on methods used by the AF Fatality Review Board, and "case specific" findings and recommendations and "proposed" recommendations to be tracked over five years.

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; defined as a person with whom the victim shares a child in common, or a person with whom the victim shares or has shared a common domicile

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.

Background

This report details the AF's eleventh annual Domestic Violence and Child Maltreatment Fatality Review. The review convened from 18-22 May, 2015 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 Fatality Review Training arranged by the Department of Defense and the Department of Justice 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 Review. The Chairperson opened the meeting by presenting the 2014 Domestic Violence and Child Maltreatment Fatality Review Board Lessons Learned PowerPoint presentation to help Board members understand the benefits of this review process for the AF and DoD.

The 2015 review included AF maltreatment-related fatalities that occurred in or before fiscal year 2013, and that have been fully adjudicated. Eight deaths were reviewed from eight fatal incidents including five child victims, one partner homicide victim, and two adult suicides related to family maltreatment. 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 unmarried intimates, as defined above, eligible for FAP assessment and some services, as well as inclusion in the Fatality Review process.

Fatality Review Process

The committee used the following documents/records on each member of the immediate family to conduct their reviews:

- Family Advocacy Maltreatment and Prevention Records
- Inpatient and Outpatient Medical Records
- OSI Records
- Mental Health Records (including ADAPT)
- Personnel Records
- Court Records
- Security Forces Records

The review was conducted in compliance with confidentiality and information protection requirements set forth in DoDI 6400.06. Measures employed by the team included maintaining all records under double locks, 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 are 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, the Board conducted comprehensive group reviews of each incident. The Record of Fatality Review Form was used as a guide for these corporate reviews. Board members first reviewed the known Victim and Subject 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 the group with information, insight and feedback from the perspective of their unique specialty. Comprehensive discussions including differing perspectives about 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 the 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 back to 2005. This matrix contains more than 250 correlates and served as a template for the DoD correlates matrix initiated in 2008 (see attachment). Results of the correlates matrix are compiled and included in each 5-year FRB Report. In 2008, the process of collecting the necessary records seven months prior to the Board meeting was instituted, dramatically increasing the amount of information available to the Board. 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 Correlates Matrix. The Board continually works to streamline the review process in order to manage approximately 10 fatal maltreatment incidents annually for the Board's review.

As described above, each review addressed 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 Cases Reviewed in 2015 Including Trends from 2005 - 2015

[redacted]:

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

One Partner Homicide:

[redacted]

[redacted]

Statistical Trends: From 2005 – 2015, 26 intimate partner/spouse victim deaths were reviewed by the FRB:

- 35% of the subjects threatened to kill their victim prior to doing so (9/26)
- 31% of the victims had left the relationship with subject (8/26)
- 27% of the victims and subjects had previously separated (7/26)
- 23% of the victims had expressed fear of subject to others (6/26)
- 36% of the victims were suspected or accused of infidelity by subject (16/45)
- 38% of the subjects used a firearm to kill the victim (17/45)

Two Adult Suicides Related to Domestic Abuse:

- [redacted]
- [redacted]

Statistical Trends: From 2005 – 2015, 19 maltreatment-related suicides (without homicide) were reviewed by the FRB:

- [redacted]
- Fifteen involved the deceased as either the offender or victim in a domestic abuse incident
- In 63% of the suicides, the deceased experienced a recent break-up of relationship (12/19)
- In 58% of the suicides, a firearm was used (10/19)
- In 37% of the suicides, the deceased experienced loss of or limited contact with his/her child(ren) (7/19)

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 to identify needed local improvements and/or AF-wide lessons.

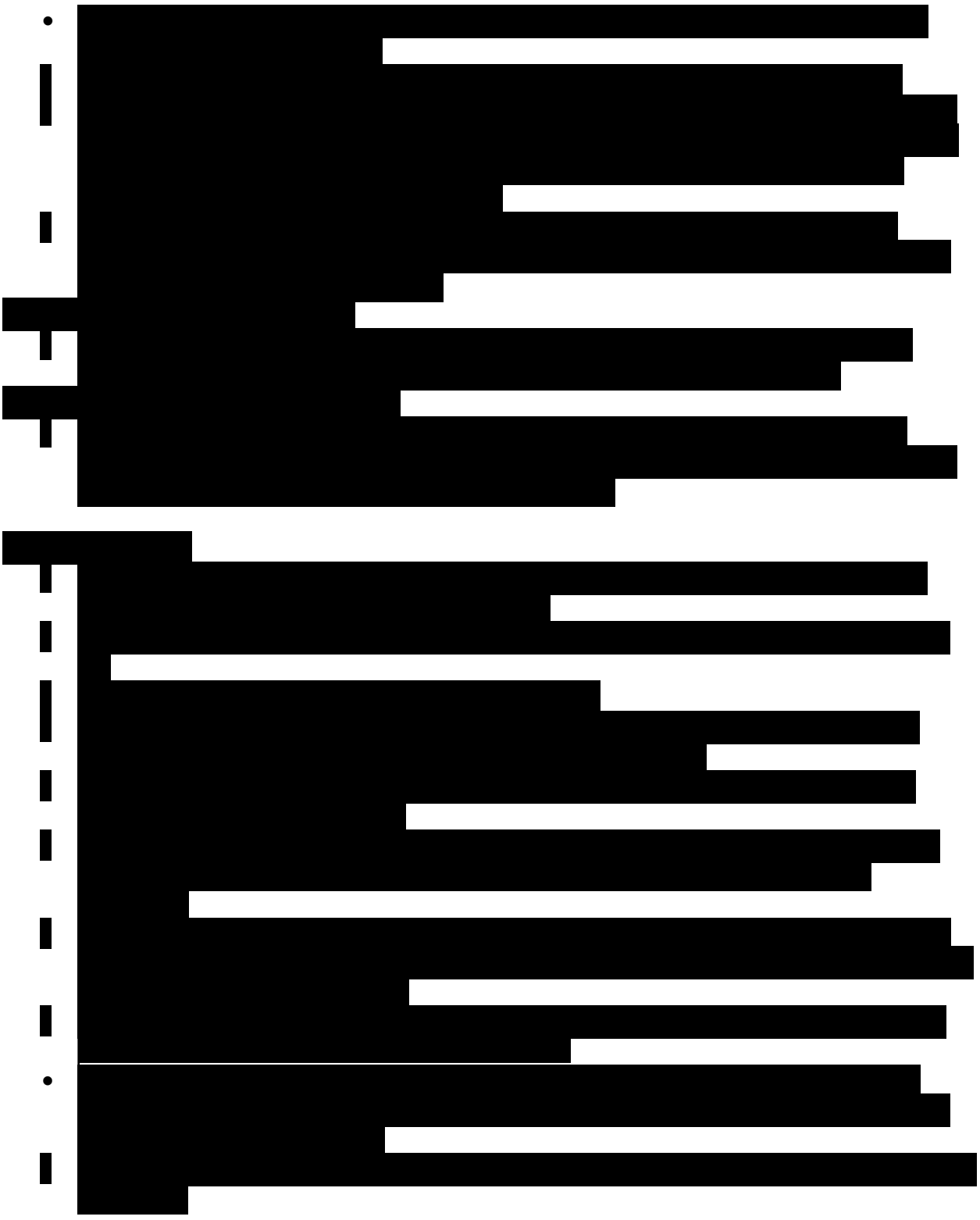
In previous reports the Fatality Review Board has identified the increased risk to military families who are attached to tenant units or GSU's that are supported by a different branch of Service. There appear to be barriers to these families seeking or being referred to supportive services from agencies 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 the bedroom nightstand, closet, or kitchen drawer. Couples in heated disagreements, especially when alcohol is involved, turn arguments into fatal incidents where one or both partners die. We reviewed a similar case this year. A second concerning trend identified again this year is failure to refer male victims of domestic abuse to FAP. This appears to stem from a lack of understanding by the military community that males are also victims of domestic abuse and the abuse males suffer can also be fatal.

Description of Case Findings and Case Specific Recommendations

[redacted]



[redacted]

Partner - 1 Findings:

- Victim should have been offered a DAVA at prior base
- Commander should have directed ADM alleged offender to complete FAP treatment
- FAP failed to follow closure/transfer criteria procedures; FAP case should have been transferred to gaining base or closed unresolved because the ADM did not complete treatment
- Victim's allegation of ADM trying to kill her did not initiate the proper military coordinated response to domestic violence; OSI should have investigated the allegation against ADM when the victim alleged he tried to kill her in accordance with OSI policies
- OSI and First Sergeant at gaining base should have reported allegation to FAP
- ADM was not motivated to change his behavior or engage in FAP treatment
- FATM failed to engage the couple in needed treatment, told victim and ADM they did not have to participate in FAP treatment (FATM resigned after fatal incident)
- Timing of ADM's PCS prompted FAP to close case prematurely
- First responder agencies such as FAP, OSI, and SFS fail to thoroughly document all actions they have taken in response to domestic violence and child maltreatment allegations

Case Specific Recommendation(s):

- Ensure every adult victim of partner maltreatment has access to a DAVA or community victim advocate regardless of sex/gender or risk level; even if a victim says they are not afraid of their partner, still refer them to a DAVA
- All allegations of domestic violence should be thoroughly investigated by LE/OSI

Suicide - 1 Findings:

- Upon review, all systems and agencies followed current protocols

Case Specific Recommendation(s):

- None

Suicide - 2 Findings:

- Deceased had expressed on multiple visits that he was counseled by the Area Defense Counsel (ADC), did not talk to FAP or Mental Health
- Deceased has suffered multiple, significant losses (job, reputation, family, money) which all put him at increased risk of self-harm
- If a program similar to LPSP had been available, the ADM may have been able to talk about these concerns with this therapist and benefited from individual therapy which may have resulted in a different outcome

Case Specific Recommendation(s):

- There should be a modification of the LPSP to allow privileged communication with a therapist even in the absence of suicidality for ADM facing UCMJ action

Potential Recommendations:

- [redacted]
- FAP providers should make ADAPT referrals for alcohol-related incidents in accordance with AF guidance – consistent peer review of FAP records should catch such failures to refer
- FAO should notify AF FAP Clinical Director when a pattern of failure to follow the CRB decision tree occurs so additional training and consultation can be scheduled
- Grant on-base mental health providers the right of first refusal to provide care for family members with open FAP cases to improve continuity of care
- [redacted]
- Require a process of handing off a case from one FAP provider to another FAP provider that requires the transfer summary be completed by losing provider
- [redacted]
- Before a FAP provider crafts a letter for the court verifying attendance at recommended classes or treatments, clients must provide proof of completion and FAP record must reflect compliance of treatment plan; JA should review letter
- [redacted]
- Establish MOUs between civilian LE and SFS to ensure timely notification to SFS of domestic violence or child maltreatment arrests
- Ensure every adult victim of partner maltreatment has access to a DAVA or community victim advocate regardless of gender or risk level; even if a victim says they are not afraid of their partner, still refer them to a DAVA
- All allegations of domestic violence should be thoroughly investigated by LE/OSI

- There should be a modification of the LPSP to allow privileged communication with a therapist even in the absence of suicidality for ADM facing UCMJ action

Recommended Review Plan

Based on the relatively small number of incidents reviewed annually in the USAF (average of 8 per year), it was deemed inadvisable to make policy recommendations on an annual basis. The two types of recommendations contained in this report are "case-specific" and "proposed" recommendations to be tracked for future policy considerations. We will identify reoccurring concerns and trends each year and at the 5-year review we will identify the most potent recommendations as formal AF recommendations. This concludes the 2015 AF Domestic Violence and Child Maltreatment Fatality Review Board Report.

Appendix A: 2015 Air Force Fatality Review Committee Members (18-22 May 2015)	
[redacted]	[redacted] First Sergeant Special Duty Manager
AFOSI/ICON [redacted]	[redacted]
[redacted]	[redacted]
[redacted] ADAPT/DDR Branch	Action Officer, Police Services & SFMIS
AFMOA/SGHW [redacted]	[redacted]
[redacted] Child Abuse Pediatrician	[redacted]
[redacted]	AFMOA/SGHW [redacted]
[redacted] Mental Health Flight Commander	[redacted]
[redacted]	AFMOA/SGHW [redacted]
[redacted]	[redacted]
[redacted]	AFMOA/SGHW

Office of the Chief of Chaplains [redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Chief, Relief and Inquiries [redacted]	[redacted] AFMOA/SGHW [redacted]
[redacted]	
[redacted]	
HQ AFPC/DPSOR [redacted]	
Fatality Review Administrative Support Members	
[redacted]	[redacted]
Air Force Family Advocacy Program Central Registry [redacted]	Air Force Family Advocacy Program Central Registry [redacted]
[redacted]	
Air Force Family Advocacy Program Central Registry [redacted]	

Appendix B

Top 10 Correlates 2005 -2015

ALLEGED OFFENDER (AO) FACTORS 2005-2015 Total 26 Adult Partner Cases	**TOTAL**
AO Conflict with partner	25 of 26
AO Married	22
AO Male	18
AO Low marital/relationship satisfaction	18
AO Jealous obsessive	17
AO Trained in firearms/combat	14
AO Reported anger problems	13
AO Threatened separation/break-up	12
AO Separation from partner	11
AO Past history of disciplinary action i.e. LOR, LOC, Article 15	11
AO Depressed	10
AO Current medical problems	10

VICTIM (V) FACTORS 2005-2015 Total 26 Adult Partner Cases	**TOTAL**
V Female	18 of 26
V Suspected/accused of infidelity	16
V Employed full-time	11
V Threatened to leave assailant	11
V Active duty	10
V Accepts/embraces traditional gender roles	8
V Under age 25	8
V Had left assailant	8
V Has assaulted AO; other than self-defense	7
V And AO have separated before	7

INCIDENT (I) FACTORS **2005-2015** **Total 26 Adult Partner Cases**	**TOTAL**
I Firearm(s) used	17 of 26
I Death by firearm	16
I Murder/suicide	15
I Incident occurred in shared residence	15
I Jealousy precipitated incident	14
I Occurred after 1800	13
I Verbal argument preceded the incident	13
I Occurred between midnight and 0600	11
I Planned/premeditated	11
I Victim/assailant were separated	10

FAMILY (F) FACTORS **2005-2015** **Total 26 Adult Partner Cases**	**TOTAL**
F Family conflict	15 of 26
F Firearms in home	13
F Recurrent verbal arguments between family members	11
F Both partners employed full time	8
F Couple together less than 2 years	8
F Problems with finances	7
F Children not by alleged offender residing in home	6
F Couple married/co-habitating less than 6 months	6
F Hx of “met criteria” partner abuse	6
F Blended family (children from past relationship)	5