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

December 31

2016

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

TABLE OF CONTENTS

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 2014, or before and 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 2016 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 2016, all but three items have been implemented and closed. Remaining items are expected to close by 1 June 2017, 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 2016 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).

Proposed recommendations resulting from the review are listed below:

- Add policy within AFMAN 31-201v4, *High Risk Response*, making it a tier 0, DODI requirement, to notify FAP immediately of all incidents of child abuse, neglect or domestic abuse as outlined in DODI 6400.06, *Domestic Abuse Involving DOD Military and Certain Affiliated Personnel*
- Include requirement for SF to report suspected child abuse, neglect and/or domestic abuse to FAP in SF AFIs
- [redacted]
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- Provide education about domestic abuse and available resources, including FAP, to the general military population/community
- Air Force should develop a strategic campaign to educate the general military population/community about risk factors for family maltreatment and suicide
- Identify a standardized FAP briefing to be included on the home station for SF to meet the requirement for FAP training for Law Enforcement Officer Safety Act (LEOSA) and DODI 5525.15, *Law Enforcement Standards and Training in the DOD*
- Require that all documentation associated with administrative paperwork/action, to include an Article 15, is maintained in personnel file (member's response, evidence, etc.)

Based on "case-specific" findings this year and number of fatalities (annual average of eight), 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 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 FRB, and "case specific" findings and recommendations and "proposed" 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; defined as a former spouse, person with whom the victim shares a child in common, or a person with whom the victim shares or has shared a common domicile
(4) Dating partners or stalking. 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 2-6 May, 2016 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.

The 2016 review included AF maltreatment-related fatalities that occurred in or before fiscal year 2014, and had been fully adjudicated. Nine deaths, resulting from eight fatal incidents were reviewed. The incidents included three child homicides, three adult partner homicides, a murder/suicide 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 unmarried intimates, as defined above, eligible for FAP assessment and some services, as well as inclusion in the FRB process.

FRB Process

The committee used the following documents/records when available on 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 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 the group with 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 back to 2005. 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, 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 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 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 will be used in 2017. The Board continually works to streamline the review process in order to manage up to 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 Incidents Reviewed in 2016
Including Trends from 2005 - 2016

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[redacted]

[redacted]

[redacted]

[redacted]

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[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Three Fatal Partner/Spouse Maltreatment Incidents:

[redacted]

[redacted]

Statistical Trends: From 2005 – 2016, 30 fatal intimate partner/spouse maltreatment incidents were reviewed by the FRB:

- Subject used a firearm to kill the victim (18/30) or 63%
- Subject is male (21/30) or 70%
- Subject is under 25 years old (10/30) or 33%
- Subject is married (26/30) or 86%
- Subject was trained in firearms/combat (18/30) or 60%
- Verbal argument preceded the incident (17/30) or 56%
- Incident occurred in the shared residence (19/30) or 63%
- Significant relationship conflict between Subject and Victim (29/30) or 96%

[redacted]

Statistical Trends: From 2005 – 2016, 30 fatal intimate partner/spouse maltreatment incidents were reviewed by the FRB:

- Subject is married (26/30) or 86%
- Subject is under 25 years old (10/30) or 33%
- Subject was under the influence of drugs/alcohol (11/30) or 36%
- Subject is female (9/30) 30%
- Subject was trained in firearms/combat (18/30) or 60%
- Incident occurred in the shared residence (19/30) or 63%
- Victim of partner homicide is male (9/30) or 30%
- Significant relationship conflict between Subject and Victim (29/30) or 96%

[redacted]

[redacted]

Statistical Trends: From 2005 – 2016, 30 fatal intimate partner/spouse maltreatment incidents were reviewed by the FRB:

- Subject is married (26/30) or 86%
- Subject was under the influence of drugs/alcohol (11/30) or 36%
- Subject was trained in firearms/combat (18/30) or 60%
- Subject was diagnosed with depression (11/30) or 36%
- Significant relationship conflict between Subject and Victim (29/30) or 96%
- Incident occurred in the shared residence (19/30) or 63%

<u>One Murder/Suicide</u>:

[redacted]

Statistical Trends: From 2005 – 2016, 13 murder-suicides were reviewed by the FRB:

- Subject is under 25 years old (10/30) or 33%
- Subject is male (21/30)
- Victim is under 25 years old (11/30) or 36%
- Victim suspected/accused of infidelity (17/30) or 56%
- Victim threatened to leave Subject (13/30) or 43%
- Couple together less than two years (11/30) or 36%
- Problems with finances (9/30) or 30%

<u>One Suicide Related to Domestic Violence</u>:

[redacted]

[redacted]

- Death by firearm (11/20) or 55%
- Suicide occurred during/immediately after verbal argument (10/20) or 50%
- Deceased feared loss of status/esteem (11/20) or 55%
- Deceased is married (14/20) or 70%
- Deceased is male (13/20) or 65%
- Deceased had a history of suicidal ideation (10/20) or 50%
- Deceased had a history of alcohol/substance abuse (8/20) or 40%
- Deceased was under influence of drugs/alcohol (6/20) or 30%
- Deceased was depressed (11/20) or 55%
- Deceased had history of disciplinary action (LOR, LOC, Article 15) (4/20) or 20%
- Deceased was trained in firearms/combat (11/20) or 55%
- Deceased had a history of psychiatric hospitalization (5/20) or 25%
- Deceased had criminal charges/disciplinary action pending at time of death (8/20) or 40%
- Incident was planned/premeditated (11/20) or 55%
- Incident occurred in shared residence (6/20) or 30%

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 FRB 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.

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[redacted]

The Board identified another continuing trend in adult partner maltreatment deaths, specifically the presence of loaded weapons in easily accessible locations, such as the bedroom nightstand, closet, or kitchen drawer. With easy access to firearms, heated couple disagreements can turn into fatal incidents, especially when alcohol is involved. A similar case was reviewed this year. Subject was drinking heavily and had a loaded hand gun in his back pocket while he waited for his wife to return home. A second concerning trend identified again this year is failure to recognize male victims of domestic abuse. 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:

- No NPSP involvement; home visits might have provided more support for Victim if the child's special needs and Victim's anxiety issues had been identified
- Family member child was not enrolled in the Exceptional Family Member Program (EFMP)

Case Specific Recommendation(s):

- Provide training to medical providers recommending NPSP referral for families with children under age three years with special needs

Partner - 2 Findings:

- No specific findings

Case Specific Recommendation(s):

- Provide education about domestic abuse and available resources, including FAP, to the general military population/community

Actions being taken or already in place:

- AF CVS has recently established positions at several installations called the Specialist for the Primary Prevention of Violence who will be leading a Service-wide prevention effort to reduce the incidence of domestic abuse, child maltreatment and suicide, among other types of interpersonal violence in the Air Force

Partner - 3 Findings:

- Military Family Life Consultant (MFLC) was not an appropriate referral for this family

Case Specific Recommendation(s):

- No specific recommendations

Partner - 4 Findings:

- There should have been more leadership involvement encouraging Subject to seek help and then follow-up regarding whether grief and/or other counseling services were obtained
- Subject should have been placed on a modified duty status to improve his ability to obtain services
- Involvement in chaplain services may have been useful

- Informal support systems (co-workers, family) may not have recognized the risk factors or known the appropriate actions to take to help this couple
- Command could have referred couple to FAP prevention counseling
- Victim's sister had concerns about physical and emotional abuse of Victim by Subject but she did not report them to command or another military POC

Case Specific Recommendation(s):

- Air Force should develop a strategic campaign to educate the general military population/community about risk factors for family maltreatment and suicide
- Identify a standardized FAP briefing to be included on the home station for SF to meet the requirement for FAP training for Law Enforcement Officer Safety Act (LEOSA) and DODI 5525.15, *Law Enforcement Standards and Training in the DOD*

Actions being taken or already in place:

- AF CVS has recently established positions at several installations called the Specialist for the Primary Prevention of Violence who will be leading a Service-wide prevention effort to reduce the incidence of domestic abuse, child maltreatment and suicide, among other types of interpersonal violence in the Air Force

Suicide - 1 Findings:

- Mental Health suicide protocol was not followed by ADAPT. Deceased should not have been deemed an ADAPT treatment failure, however once that was determined there should have been a referral for administrative separation
- Deceased's personnel record does not contain the required documentation regarding demotion
- There was no hand-off with civilian psychiatric hospital and no follow-up after discharge with on base mental health as required in AFI 44-172, *Mental Health*
- ADAPT providers should have offered to continue treatment services to Deceased until he was separated

Case Specific Recommendation(s):

- Require that all documentation associated with administrative paperwork/action, to include an Article 15, is maintained in personnel file (member's response, evidence, etc.)

Potential Recommendations:

- Add policy within AFMAN 31-201v4, *High Risk Response*, making it a tier 0, DODI requirement, to notify FAP immediately of all incidents of child abuse, neglect or domestic abuse as outlined in DODI 6400.06, *Domestic Abuse Involving DOD Military and Certain Affiliated Personnel*
- Include requirement for SF to report suspected child abuse, neglect and/or domestic abuse to FAP in SF AFIs
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Recommended Review Plan

Based on the relatively small number of incidents reviewed annually in the AF (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 "proposed" recommendations to be tracked for future policy considerations. 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 2016 AF Domestic Violence and Child Maltreatment Fatality Review Board Report.

Appendix A: 2016 Air Force Fatality Review Board Members (2-6 May 2016)

Consultant AFOSI ICON	First Sergeant Special Duty Manager
AFMOA Mental Health Branch	HQ Air Force Security Forces Center
Child Abuse Pediatrician	
Mental Health Flight Commander	AFMOA/SGHW

[redacted] Chief, Relief and Inquiries [redacted]	[redacted] AFMOA/SGHW [redacted]
[redacted] Office of the Chief of Chaplains [redacted]	[redacted] AFMOA/SGHW [redacted]
[redacted] HQ AFPC/DPSOR [redacted]	
Fatality Review Administrative Support Members	
[redacted] AFMOA/SGHW [redacted]	[redacted] AFMOA/SGHW [redacted]
[redacted] AFMOA/SGHW [redacted]	