Department of the Navy

Domestic Violence and Child Abuse Fatality Review

Sixth Annual Report
October 2010

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FY10 DON Fatality Review Report

1. Background:

a. To support the implementation of service wide fatality reviews, Public Law 108-136 directed the service secretaries to conduct a multidisciplinary, impartial review of each fatality known or suspected to have resulted from domestic violence or child abuse. Fatality reviews are conducted for the purpose of formulating lessons learned as a means of decreasing the risk of child abuse and domestic violence homicides and suicides.

b. In February 2004, the Department of Defense (DoD) directed each military department to establish a fatality review team sufficient in size and capability to complete its mission. In July 2004, the Assistant Secretary of the Navy (Manpower and Reserve Affairs) directed the establishment of a Department of the Navy (DON) multidisciplinary fatality review team in lieu of separate United States Navy (USN) and United States Marine Corps (USMC) teams.

c. DoD Instruction 6400.06 (issued August, 2007) details the responsibilities of the Military Departments as it relates to the formation, function, and reporting of required Fatality Review Teams.

d. Navy Instruction 1752.2B (issued in April, 2008) directs the USN Family Advocacy Program (FAP) Manager to coordinate with the USMC FAP Manager to meet DON Fatality Review requirements.

2. Purpose:

a. Fatality reviews are deliberative examinations of the systemic interventions into the lives of the deceased and are conducted after related law enforcement investigations, autopsies, and court trials have ended. The purpose of the fatality review is to formulate lessons learned from agency or system responses and failures; identify trends and patterns to assist in developing policy recommendations for earlier and more effective interventions; and foster better communication and cooperation among participating agencies.

3. Requirement:

a. Each military department is directed to conduct fatality review for any fatality (suicide or homicide) known or suspected to have resulted from domestic violence or child abuse against any of the following:

(1) A member of the military department on active duty;

(2) A current or former dependent of a member of a military department on active duty; or

(3) A current or former intimate partner who has a child in common or has shared a common domicile with a member of a military department on active duty.

b. The annual report is due to the Office of the Deputy Under Secretary of Defense for Military, Community and Family Policy by 1 November 2010. This report covers fatalities occurring in FY08 or fatalities carried over from prior years that have been fully investigated or legally adjudicated since FY09 fatality review concluded.

c. The DON Fatality Review Team records a comprehensive set of data elements on each fatality reviewed. The Report Form used to capture data during the FY08 review was redesigned and formatted during FY09 to facilitate data capture in an active database. This database was further refined during FY10 to incorporate additional reporting features. The database has the capability to better analyze and evaluate trends over time and related variables.

4. Significant Findings:

a. Case Exclusion: Included in the initial pool of cases for possible review were 48 incidents that resulted in 52 fatalities. Of the 52 deaths, 11 were subsequently excluded. In five of the excluded deaths, there was no military affiliation. Four of those deaths were perpetrated by former military, with Naval Criminal Investigative Services (NCIS) providing investigative assistance to local law enforcement; while one accidental child death occurred in military housing. Of the remaining six deaths, there was no known history of domestic or child abuse in three suicides; a current or intimate partner relationship could not be established in two homicides; and one accidental Sudden Infant Death Syndrome (SIDS) death did not meet DON Fatality Review criteria for unsafe sleeping practices inclusion. Enclosure (1) provides a summary of incidents excluded for review and the reason for exclusion. Of the remaining 41 deaths, 21 were deferred for review due to pending adjudication or open investigation. Notably, 10 of these 21 deaths occurred prior to FY08

b. Case Inclusion: A total of 20 incidents resulting in 20 fatalities met criteria and were reviewed in FY10. This included four prior year fatalities that were not adjudicated or closed prior to conclusion of the FY09 review (i.e., 1 from FY04, 3 from FY07). Enclosure (2) provides a summary of the 20 fatalities reviewed in FY10. The fatalities reviewed include 10 homicides, 3 suicides, and 7 of other manner of death (i.e., 1 of undetermined and 6 of accidental manner). Enclosure (3) depicts the manner of death by age of decedent for deaths reviewed this year. Of the 20 deaths reviewed, 16 were USN fatalities (i.e., 6 homicides, 3 suicides and 7 of other manner). Four deaths reviewed were USMC fatalities, all of which were child homicides.

c. Child Abuse Related Fatalities Reviewed in FY10:

(1) Of the 20 fatalities reviewed, 10 were related to child abuse and neglect (i.e., 9 homicides and 1 suicide). The youngest child homicide victim was 2 months, while the oldest was 11 years, with an average age of 27 months. Child victims tended to be older than in prior year reviews where child decedents were often under six months of age. Three children were less than 6 months, 1 was less than a year, 3 children were between 2 and 3 years of age, 1 was 6, and the oldest was 11. Also in contrast with prior year reviews, seven of the child victims were female, while two were male.

(2) Notably, five of the nine child homicides involved the adjudication of two identified offenders. In one additional death, the DON Fatality Review team identified the biological mother as also culpable in the circumstances leading up to the child's death, although she was never charged. It was notable to the team that Child Protective Services (CPS) removed the surviving child from the mother's custody. While the identification of more than one offender has occurred occasionally in the past, it was not a frequent finding in past year reviews. Five of these six cases were USN cases. In three of the four USMC cases, the offender acted alone. Thus, 15 offenders were identified in the 9 child homicides. The average age of offender was 27 years. Seven offenders were female, leaving eight males. Ten of the 15 offenders were active duty (i.e., 4 USMC, 6 USN), 4 were family members, and one was the civilian intimate partner of a family member spouse.

(3) Deployment in the six months prior to the child's death was noted in two of the homicides. In the USMC case (FY08-10), the active duty offender returned from his third deployment to Iraq about 6 weeks prior to the child's death. In the Navy case (FY08-02), the active duty member was deployed aboard ship in the Persian Gulf prior to the child's death in December, 2003. In another case, the active duty spouse of the family member offender was deployed as an Individual Augmentee at the time of the child's death by the hands of the mother's civilian intimate partner.

(4) Consistent with findings from previous years, a biological parent was identified as at least one of the responsible parties in all of the 9 homicides reviewed. Biological mothers represented 5 of the 15 identified offenders, while 6 of the identified offenders were biological fathers. Step-parents represented 3 (2 stepmothers and 1 stepfather) of the 15 identified offenders.

(5) The cause of death by age of decedent is represented in Enclosure (4). Blunt force trauma was the cause of death in 6 of the 10 child homicides. These findings are even more compelling in that one additional death was caused by shaking with impact. The two remaining deaths were caused by dehydration/malnutrition and shaking without impact. Blunt force trauma to the head was more common among younger decedents (average age of 17 months), while children who died of blunt force trauma to the body were older (average age of 80 months).

(6) In general, the child deaths reviewed this year were excessively violent and heinous. Extensive and recurrent brutality was noted in several of the cases leading up to the fatal injury. One child had been tied up and left in a garage with over 100 points of injury identified on her body at the time of autopsy. Another child was "stomped" to death by her father, while another one was pushed and punched so severely and repeatedly that an impression of her head was left in the wall. In a fourth case, the stepsister described discipline of the victim by the stepmother that included holding her by the neck against the wall until she turned blue and recurring discipline by the father that included hitting her with various objects, making her hold a push up or squat, depriving her of all food but bread and water, and grabbing her by the forearms and thrusting her up until she hit her head on the ceiling. The latter act led to her death.

(7) In one case, the active duty member received custody of his five-year-old daughter, who had been living with her mother in Africa. He brought the child to live with him and his

spouse in an overseas location. She had difficulty assimilating to the DoD school because English was not her native language and she was subsequently removed from first grade and placed back in kindergarten. The service member, displeased with her lack of progress in new school and adaptation to her new life, used physical force and discipline to change her behavior. The child developed encopresis as a result of this discipline.

(8) On the day of the fatal injury, the family attended a multicultural fair. The member viewed the child's behavior as disobedient because she was reluctant to leave the event at the time he had designated. His level of physical force escalated when the family returned home. While scolding her, the child defecated in her clothing. He ordered her to strip and wash out her clothing in the bathtub. When she did not wash the clothing according to his specifications, he struck her in the face. When she took her clothes outside to dry on the balcony, she was struck again for not hanging the clothes correctly. Upon falling to the ground, the service member began stomping the child's abdomen, continuing to scold her. When it eventually became apparent to him that the child was unconscious, he transported her to the Emergency Department. She succumbed to her injuries one week after her sixth birthday, after being with her father and stepmother for only 4 weeks.

(9) The list of the child's injuries were extensive and included bruising to the forehead, scalp, nose, and lower face, subdural hematoma to the base of the skull, bruises on the back and chest, fracture to the ninth rib, lacerated liver, lacerated bladder, hemorrhaging of the large organs and adrenals. The service member was cooperative with authorities and provided several statements. He described some but not all of the behavior that would have resulted in the documented injuries. The service member, who had 3 deployments in the previous 5 years, was adamant that his downrange assignments were unrelated to his actions.

(10) In the one child abuse/neglect related suicide, the USN active duty member was alleged to have been sexually abusing the 12-year-old niece of his girlfriend. The child's mother discovered the abuse from explicit text messages between the girl and the member. The victim's mother made a report to the local police, who contacted the service member to obtain a statement. Later the same day, the member pulled his car to the side of a highway, exited the vehicle, waited until a truck was approaching over a hill, and walked out into the highway. The driver was unable to stop or avoid hitting him. Witnesses reported the service member raised both hands over head before the truck hit him.

(11) Of the seven deaths ruled of other manner of death during FY10 review, all of the decedents were children. Six of these deaths were ruled of accidental manner, while one was of undetermined manner. In one of the accidental deaths, a 14-month-old child drowned in the private pool of an unlicensed child care provider. Despite the accidental manner of death, the responsible party was charged, ultimately pleading guilty to contributing to the delinquency of a minor and receiving a 12 month suspended sentence. There was considerable public attention to the drowning of this child, as well as pressure to close her unlicensed day care. These factors appear to have contributed to her being charged, while the manner of death being ruled accidental may have contributed to the suspended sentence. In the one death of undetermined manner, the medical examiner identified the cause of death as Sudden Unexplained Death (SUDS) with positional asphyxiation a contributing factor. This 14-day-old child was found to

be unresponsive after falling asleep with his father in a recliner. A number of risk factors were noted by the DoN Fatality Review Team in this family, including a history of chronic mental illness and suicide attempts by the mother, law enforcement involvement because of domestic violence by the mother toward the father, and marital infidelity. This was also the only child death during the FY10 review with prior FAP involvement.

(12) In the five remaining accidental child deaths reviewed in FY10, asphyxia was identified as the cause of death in all of them. Unsafe sleeping practices were noted in 4 of these deaths; with co-sleeping present in three and improper bedding present in the remaining incident. These children varied from 14 days to 5 months of age.

(13) The one asphyxia death ruled of accidental manner in which unsafe sleeping was not clearly indicated bears further discussion. The case was investigated extensively, in part because of the active duty father's inconsistent statements. He originally indicated that he found his one-month-old son home alone and crying as if in pain. He called 911. Upon reporting on the scene, emergency personnel found the child in cardiac arrest. Child protective services placed the couple's 17-month-old child into temporary protective custody. Subsequently, the service member indicated that he and his spouse were both home at the time. He had arrived home from work and fell sleep. The wife asked him to watch the baby while she bathed their other child. He reported hearing the child cry and checking on him. The baby was breathing shallowly, gasping for breath sporadically, and eventually stopped breathing. He began CPR, which was continued by emergency personnel upon arrival. The service member was questioned extensively by CPS and law enforcement regarding co-sleeping or accidentally rolling over on the child, which he denied. No specific evidence existed to indicate that he had been sleeping with the child and the case was subsequently closed by FAP, law enforcement and CPS.

c. Domestic Abuse Fatalities Reviewed in FY10:

(1) Three domestic abuse related fatalities were reviewed in FY10 (i.e., 1 homicide and 2 suicides). All three were Navy cases. Two of the three decedents were female (i.e., 1 Suicide; 1 Homicide). The two female decedents were family member spouses; while the male decedent was on active duty at the time of his death. Causes of death in the suicides were carbon monoxide poisoning and gunshot, while the homicide victim succumbed following blunt force trauma to the head. Prior FAP involvement was noted in one of the suicides. The other suicide occurred within the context of a domestic abuse incident. Marital discord, impending marital dissolution and alleged infidelity were present in all three deaths.

(2) In the one incident with prior FAP involvement, the active duty husband and his family member spouse first became known to authorities when presenting for marital counseling with recurring periods of legal separation. Both acknowledged marital infidelity, but expressed a desire to keep the marriage together to maintain a home for their daughter. They missed their second appointment, reportedly due to the spouse not wanting to continue counseling. Shortly after the missed appointment, a Chaplain contacted the FAP to report that the parents had left their 8-year-old daughter alone in their hotel room while they attended the Navy Ball. When the mother did not return to the Ball after the child called her and she went to check on her, the active duty member returned to the room and assaulted the mother, strangling her. The family

member spouse reported to police that she had numerous bruises and scratches after the incident. She initiated charges through local police, the service member was arrested, a Military Protective Order was issued and a Civilian Order of Protection was served three days later. The service member began counseling with the Chaplain and was scheduled for a 26-week intervention program. Eight days after the Civilian Order of Protection was served, the family member spouse left home and did not return. The service member became concerned when his spouse's employer (a Real Estate Company) reported to him that she had stolen a credit card, used it, and charges had been filed against her. Local police had surveillance video in which the family member spouse was using the stolen credit card at a local business. When the police report was filed, it became a missing person case and an arrest warrant was issued. Her body was found in the garage of a vacant condominium three weeks after she left the family home. The cause of death was carbon monoxide poisoning. Her approximate date of death was 11 days after the assault. After extensive investigation to rule out the active duty spouse as a potential suspect, the fatality was ruled a suicide. This is the second year in a row in which a female domestic violence victim's death was ruled a suicide.

(3) In the circumstances leading up to the other suicide, the couple was arguing about his drinking and the family member spouse's alleged infidelity with another woman. The argument escalated when the service member accused her of changing his password, after which he broke the computer in half. When he came toward her in an aggressive manner, she attempted to call 911 and he wrestled her to the ground and broke the phone. She ran downstairs and heard him enter the bathroom and shut the door. She heard a gunshot and called the police. After breaking down the bathroom door, the police found the service member dead from one self-inflicted gunshot wound. A post-death interview conducted by the police with the service member's father revealed that the service member had been arrested in the past for domestic violence against his sister. His father surmised that the service member chose death over a repeat of that situation.

(4) In the one domestic violence homicide, marital infidelity was a precipitating factor. Divorce was imminent after the wife discovered that the service member had been unfaithful with one of her female friends. The service member feared his spouse might disclose his long-term homosexual relationship. In actuality, the family member spouse was reported to have accepted the homosexual relationship but was angered about his infidelity with another woman. The active duty husband reported to police that his wife dropped him off at convenience store the day before she was reported missing and he did not see her again. He participated in the search and located her vehicle himself, off a wooded embankment. The wife was found deceased in the woods, some distance from her vehicle. The active duty spouse was arrested two days later. The death investigation revealed that the service member struck his wife in their home, loaded her into the vehicle, and drove to the woods. He dragged her out of the vehicle thirty feet into the brush. She had been struck at least 4 times in the head. A side-view truck mirror covered in her blood was found nearby and believed to be one of the instruments used to facilitate her death. When the service member's ex-wife was interviewed by investigators, she described an incident in which he drove her to a secluded area, straddled her, attempted to pin her hands behind her back, and place a plastic bag over her face. She was able to escape and exited the van. The service member then apologized to her and attributed his behavior to being under considerable stress at the time.

d. General Trends in Cases Reviewed in FY10:

(1) Prior system involvement was noted in 9 of the 20 fatalities reviewed this year. Enclosure (5) identifies the specific agencies or organizations involved with these 9 families prior to the fatal injury. Where prior system involvement was noted in the documents reviewed, general medical and Command involvement were most common. Notably, 59% of all prior system involvement was noted in 3 of these 9 deaths.

(2) The presence of prior system involvement does not necessarily mean that an agency or organization failed to act in a manner that might have prevented the fatal outcome. In addition to recording agency involvement, the time that elapsed between the latest contact for each system and the date of the fatal injury is also recorded. In the nine deaths with prior documented system involvement, elapsed time varied from 1 day to over one year, with an average of 150 days. In the case with system involvement on the day before the death, the 14-day-old child was evaluated by a physician for pneumonia, which was seen as potentially contributing to his death that was ultimately characterized by the civilian medical examiner as Sudden Unexplained Death. Notably, specific system lapses were not identified in any of the incidents reviewed in FY10.

(3) The legal disposition of cases reviewed this year is provided in Enclosure (6). Of the 11 fatalities that were legally adjudicated, 7 USN and 2 USMC incidents were resolved in civilian courts, while 2 USMC incidents were resolved in military court. In contrast with previous years, 10 of the 11 deaths criminally adjudicated resulted in plea agreements or convictions. Sentences during this year's review ranged from dismissal to Life plus 40 years. As noted above, child homicides reviewed in FY10 were striking in that more than one offender was identified and charged in five of the nine deaths. In three of those cases, both identified offenders pled or were convicted of murder. In the four most violent child deaths reviewed this year, legal dispositions included Acquittal/Dismissal for the 2-year-old child whose head left an impression in the wall, Felony Murder for both offenders who tortured the 11-year-old child in the garage, Second Degree Murder for both offenders of the 3-year-old child who died after she was thrust several times upward striking her head on the ceiling, and Involuntary Manslaughter for the offender who stomped his 6-year-old daughter.

e. Temporal Trends in All Deaths Reviewed to Date:

(1) As annual fatality review has continued, it has become increasingly apparent that cases are often deferred for several years because of pending legal or investigatory action. Under these circumstances, analysis by the fiscal year of death and not the year of review is necessary to identify temporal trends that may be related to system or situational issues such as combat operations. Continued development and implementation of the DON Fatality Review database has made more detailed analysis of trends over time feasible for the first time since DON fatality review began.

(2) Since the first fatality review in FY05, 115 deaths have been reviewed. The number of deaths to date for each fiscal year reviewed is shown in Enclosure (7). The highest number of fatalities occurred in FY04 (26) while the lowest number reviewed occurred in FY05 (12).

While it appears that fatalities declined from FY06 to FY08, it is important to remember that the number of deaths will change over time as carryover cases are resolved and reviewed. Furthermore, the number of deaths held over is likely to be greatest for the fiscal years most recently reviewed, with the number of deaths eventually remaining static as the time between the year of death and year of review increases. There have been 5 homicide-suicide incidents reviewed to date, 4 of which were USN and 1 was USMC, that resulted in 11 deaths. The manner of death by type of associated abuse is found in Enclosure (8). Of all deaths reviewed over the past 6 years, 70% (80) were fatalities related to child abuse and neglect, while 30% (35) were related to domestic violence. Homicide represented 75% of the child abuse related deaths reviewed to date, while suicide was by far the most common manner of death in domestic violence related deaths, representing 76% of domestic violence related deaths reviewed to date. It is important to remember that the type of associated abuse does not always correspond to the age of the decedent because child deaths can be associated with domestic violence and vice versa. In the latter case, we have reviewed a number of adult suicides associated with allegations of child abuse. Children have more commonly suffered fatal outcomes, representing 66% (76) of the deaths reviewed, while adults represented 34% (39) of the deaths reviewed to date.

(3) To review the geographic distribution of deaths, the location of each fatality was captured in 10 geographic areas. The Navy's regional organizational structure was used to define the geographic area for both USN and USMC deaths. Enclosure (9) reflects the geographic distribution of deaths reviewed to date. The greatest number of deaths (38%) occurred in the Mid-Atlantic geographic area, which runs from Maine to South Carolina, excluding the National Capitol Area. This geographic area includes force concentrations for both USN and USMC. The next greatest number of deaths (17%) occurred in the Southwest, which is another concentration area for USN and USMC personnel. Fourteen percent of deaths reviewed to date occurred outside the continental United States, with almost half of those occurring in Japan. In future years, active duty USN and USMC population numbers from Defense Manpower Data Center will be used to determine if the rates of fatality differ from one geographic area to another. When the geographic distribution of fatalities is broken out by the type of associated abuse, as reflected in Enclosure (10), interesting trends emerge. Hawaii, Japan and Guam stand out in that all deaths reviewed to date have been related to child abuse and neglect, whereas no child abuse and neglect related deaths have been reviewed in the National Capitol area. In contrast with other regions, domestic violence deaths are disproportionately represented in the Southwest.

(4) Whether the fatality occurred on or off a military installation is shown in Enclosures (11) and (12). Over the six years of review, 35% of all fatalities occurred on an installation. The frequency of on-base fatalities has been fairly consistent, ranging from 3 to 7 deaths per year, with the exception of 17 deaths in FY04. Of the deaths that occurred off a military installation, 36% occurred from FY03 to FY05, while 64% occurred from FY06 to FY08. To what extent this represents a change over time in the location of DON deaths or is due to secondary factors such as improved case capture in deaths handled by civilian law enforcement or greater collaboration between military and civilian law enforcement is unknown at this time. When the location of the fatality by the manner of death is reviewed, 74% of all homicides occurred off base, in contrast with 66% of all deaths. The distribution of suicides occurring on or off base

mirrored the distribution of all deaths. Accidental, natural and undetermined deaths were more equally distributed between on and off-base locations, in contrast with homicide and suicide.

(5) Enclosure (13) provides a breakdown of deaths each fiscal year by branch of service. USN deaths represent 77% (89) of all death reviewed to date and, as such, mirror the overall trends described above. USMC deaths represent 23% (26) of all deaths reviewed, with the lowest number of deaths (2) in FY04 and the highest number of deaths (i.e., 7 each) in FY06 and FY07. Drilling down further, Enclosure (14) reflects the manner of death by branch of services. When examined in this manner, the distribution of homicide and suicide is similar across the USN and USMC. Homicide represents 54% of USN deaths and 50% of USMC deaths reviewed to date, while suicide represents 22% and 19% of USN and USMC deaths, respectively. Fewer USMC deaths have been ruled of accidental manner, while proportionately more USMC deaths have been ruled of undetermined manner of death.

(6) Enclosure (15) provides the manner of death by associated abuse for the fatalities reviewed to date. Homicide is the most frequent manner of death overall (53%; 61), with suicide representing 22% (25) of deaths, followed by accidental (14%; 16), undetermined (10%, 11), and natural manner of deaths (2%; 2). When the type of associated abuse is considered, homicide was the most common manner in child abuse and neglect related deaths, while suicide has been the most common manner of death for domestic violence related deaths. Manner of death also differs for the age of the decedent. Enclosure (16) reflects the manner of death for child decedents for each year reviewed. Specifically, children were victims of homicide 62% of the time, followed by accidental and undetermined deaths. Only one child suicide in FY04 has been reviewed to date. It is important to remember that accidental/natural/undetermined deaths have been included since the FY07 Review, when those deaths are associated with unsafe sleeping practices. This is likely to increase the number of accidental/natural/undetermined deaths accordingly beginning in FY05 and after. Child homicides have seemingly decreased since FY06, although the inclusion of carryover cases in future year reviews may alter this observed trend. Accidental deaths showed a sharp increase in FY08. Among adult decedents, the most common manner of death is suicide, representing 62% of the deaths reviewed to date, followed by homicide 6%), as shown in Enclosure (17). One accidental adult death has been reviewed to date. Adult suicides appear at this point to be trending downward since FY04.

(7) The cause of death for domestic violence related homicide is shown in Enclosure (18). Gunshot is the leading cause of death in domestic violence homicide, representing 46% of the homicides reviewed to date, followed by blunt force trauma and asphyxiation. A drowning and a stabbing stand out as atypical at this point. Enclosure (19) shows the Cause of Death for the 46 child abuse and neglect related homicides reviewed to date. Blunt force trauma is the most frequent cause of death, representing 54% of death reviewed, with spikes noted in FY06 and FY07. Shaking and asphyxia were the next most common causes, each representing 16% of deaths reviewed. The cause of death for suicides is represented in (Enclosure (20). Death by gunshot represents 60% of all suicides reviewed to date, followed by hanging and toxicity, each of which occurred 16% of the time.

(8) Consistent with the civilian literature, the youngest children in DON families are most at risk for fatal outcomes. Enclosure (21) reflects the age of children across the six years of

fatality review. Of the 76 child decedents, 54% (41) of these children were six months or younger. Only 4 children were over the age of 5. The age of adult decedents is found in Enclosure (22). When the manner of death and associated abuse are considered, domestic violence homicide victims were the youngest with an average age of 27 years, followed by domestic violence suicide victims, where the decedent was 30 years on average. Adults who commit suicide in the context of child abuse and neglect were 37 years on average. This would not be unexpected, given the cluster of more senior ranking Navy members who committed suicide soon after allegations of child sexual abuse come to light. Given current Navy policies regarding mandatory administrative processing for members who are substantiated for child sexual abuse, it is important for command and FAP personnel to aggressively screen alleged offenders for suicidal risk soon after such allegations come to light. The average age of adult USN decedents was 31, in contrast with USMC decedents who were 28 years on average. Offenders who perpetrated homicide within the context of child abuse and neglect were younger (25 years on average), in contrast with those who perpetrated domestic violence related homicide (30 years). Marine Corps offenders tended to be younger, with an average age of 24 in child abuse homicides and 23 in domestic violence homicides.

(9) Gender trend analyses were conducted to examine the role gender played in domestic violence or child abuse related fatalities. Enclosure (23) shows the distribution of male and female homicide offenders by type of associated abuse. Males were significantly more likely to be offenders than females for both domestic violence and child abuse, when a chi square analysis was run. Chi square analysis is used to determine whether there is a statistically significant relationship between categorical variables. Enclosure (24) shows the gender distribution for the 35 victims of domestic violence related homicide, suicide or accident. A chi-square analysis was conducted to test whether gender was related to domestic violence homicide and suicide. That analysis indicated that, within the context of domestic violence, men were significantly more likely than women to commit suicide, while women were significantly more likely to be victims of homicide. The one accidental death is an anomaly over the six years of fatality review. Similar analysis was done for child abuse and neglect related deaths. Enclosure (25) shows the gender differences for the 80 victims of homicide, suicide, or other manners of death. There were no gender differences in child abuse related homicide (i.e., females were just as likely as males to be victims of homicide). However, victims of child abuse related suicide and other manners of death were more likely to be male, although not significantly so in this small sample.

(10) Enclosures (26), (27) and (28) reflect the race/ethnicity of homicide offenders, homicide victims, and suicide victims, respectively. Forty-one percent of homicide offenders were White, 37% were Black/African-American, 6% were Asian, 11% were Hispanic/Latino/Spanish, and 4% were of other or unknown race/ethnicity. When associated abuse is considered, Blacks perpetrated 60% of the domestic violence homicides, in contrast with 31% of the child abuse homicides. Whites perpetrated 33% of domestic violence related homicides and 44% of child abuse related homicides. Whites represented 44% of all homicide victims, with Blacks, Asians, and Hispanics/Latinos/Spanish representing 36%, 5%, and 10% of victims, respectively. In contrast with homicide offenders and victims, 60% of all suicide victims were White and 20% were Black, followed by Asians and Hispanics/Latinos/Spanish who each represented 4% of suicide victims. Suicide victims of other race/ethnicity represented 12% of suicide victims.

(11) The status of the victim by manner of death for child abuse and domestic violence related deaths is found in Enclosure (29). Active duty members represented 83% of all suicides related to child abuse and neglect. The cluster of suicides among USN members related to allegations of child sexual abuse has already been discussed. Domestic violence homicide victims were relatively equally distributed between active duty, family members and unaffiliated civilians. In contrast, active duty represented 74% of domestic violence related suicide victims. Enclosure (30) provides offender status for child abuse and domestic violence deaths. Active duty represented 57% of all offenders, and 67% of all domestic violence homicide offenders. Family members represented 35% of offenders who perpetrated child abuse homicide, while civilian offenders represented 14% of all offenders and 27% of offenders who perpetrated domestic violence homicide.

(12) The pay grade of active duty offenders and victims is found in Enclosure (31). The most frequent pay grade for victims was E-5, with the remainder of victims being equally distributed among E-3, E-4, E-6 and E-7. E-3 represented 38% of the active duty offenders, followed by E-5, which represented 25% of active duty offenders.

(13) Select family background variables present in the deaths reviewed to date are found in Enclosure (32). As has been noted during several years of fatality review, multiple indicators of disharmony in marital/interpersonal relationships were the most commonly occurring family background variable across all six years of review. Financial stress and prior law enforcement contact are fairly consistently found over the six years of review.

5. System Interventions and Recommendations:

(a) DON Fatality Review personnel have begun contacting local and state Fatality Review Teams in areas where DON personnel are concentrated to explore opportunities for sharing information and system response recommendations. Navy personnel in Hampton Roads, Virginia have recently reactivated their Death Review Team and their collaboration with civilian teams in the community. In FY10, DON Fatality Review team members were invited to participate in the Florida Attorney General's newly established Domestic Violence Fatality Review Team. The collaborative relationship developed as the Florida team develops guidance for the 26 local Florida teams both improves the DON Fatality Review process and increases the likelihood of collaboration with local teams should deaths involving military members occur in Florida in the future.

(b) While DON policies and procedures pertaining to family violence response are generally sound, FAP staff could benefit from continuing educational opportunities regarding effective psychosocial assessment in family violence cases. Vigilance by command and Navy FAP personnel about suicide potential in members when allegations of child sexual abuse first come to light is also recommended.

(c) The DON Fatality Review Team will continue to monitor increased tracking and reporting of suicides and suicide attempts across the DoD. While sufficient data is not yet available to determine whether or not suicides associated with family violence are increasing, it

is of concern that these cases are being identified and reviewed with some frequency. The presence of domestic violence related suicide not associated with homicide has occurred with sufficient frequency to be noteworthy in the six years of DON Fatality Review. To improve the quality of the reviews, the DON Fatality Review Team continues to build partnerships with the USN and USMC Suicide Prevention Program Coordinators. These partnerships create opportunities to share relevant information, better identify trends and warning signs, and identify opportunities for implementation of targeted prevention efforts.

(d) The information NCIS agents collect at the initial death report have been identified as critical to conducting a comprehensive review. NCIS however, most frequently assists local law enforcement and then generates reports for information only. These "information only" investigations do not provide the data necessary for comprehensive review, whereas when NCIS serves as the primary investigative body, the investigation results in comprehensive information. The DON Fatality Review team will engage with NCIS to develop a checklist for field agents that will serve as an instrument for ensuring the collection and maintenance of information on cases in which they have limited involvement. The NCIS agent providing assistance is most likely to obtain police reports, crime scene photos, CPS reports, autopsies, and other critical information at the time of the assist request, rather than at the time of review.

(e) The DON Fatality Review Team has identified the need for additional representation on the Team from military medicine behavioral health and general medical specialties and potentially from stakeholders as well. The addition of these representatives will increase the breadth of perspective about the cases as well as forge an active partnership in the timely development of early identification and prevention tools.

(f) The recent DON Fatality Review database redesign will allow for more robust evaluation of trends over time. The effects of various family background variables and factors (e.g. deployment, pregnancy, mental and physical health) may be examined more closely to determine their relationship to domestic violence and child abuse and neglect fatalities in the Navy and Marine Corps.

(g) There are some fatalities in which a survivor, either a family member or non family member, may be able to provide the DON Fatality Review Team with valuable information about the circumstances surrounding the death that is not otherwise available in official documentation. Interviewing select survivors who agree to such an interview, in compliance with a developed protocol, will be explored by the DON Fatality Review team in the upcoming review year in consultation with DoD FAP personnel.

Summary of Fatalities Excluded from Review in FY10

Case #	Manner of Death	Victim Gender	Branch of Service	Rationale for Exclusion
FY08-21	Suicide	M	USN	Auto-erotic asphyxiation with marital discord, but no known or suspected history of domestic violence or child abuse.
FY08-22	Homicide	F	N/A	Offender former military. Child victim had no military affiliation.
FY08-23	Suicide	F	USN	Active duty member with a history of depression. No known or suspected history domestic violence or child abuse.
FY08-24	Suicide	M	N/A	Former military.
FY08-25	Homicide	F	N/A	Offender former military. Adult victim had no military affiliation.
FY08-26	Homicide	F	N/A	Offender former military. Adult victim had no military affiliation.
FY08-27	Suicide	M	USN	Active duty member with a history of martial discord and dysphoria related to being passed over for promotion. No known or suspected history of domestic violence or child abuse.
FY08-28	Accidental	M	N/A	Dog mauling death. Dog's owner had no military affiliation. Decedent was the child of an active duty member's intimate partner.
FY08-29	Homicide	F	USMC	Murder of active duty member by active duty member. No known intimate partner relationship prior to death.
FY08-30	Homicide	F	USN	Rape/murder of family member child of active duty member by acquaintance. No known intimate partner relationship prior to death.
FY08-31	SIDS	F	USMC	No known or suspected history of domestic violence or child abuse. Did not meet DON Fatality Review Team criteria for inclusion on the basis of unsafe sleeping practices.

Note: Shaded, consecutively numbered deaths denote one incident; in this incident murder-suicide involving 3 decedents.

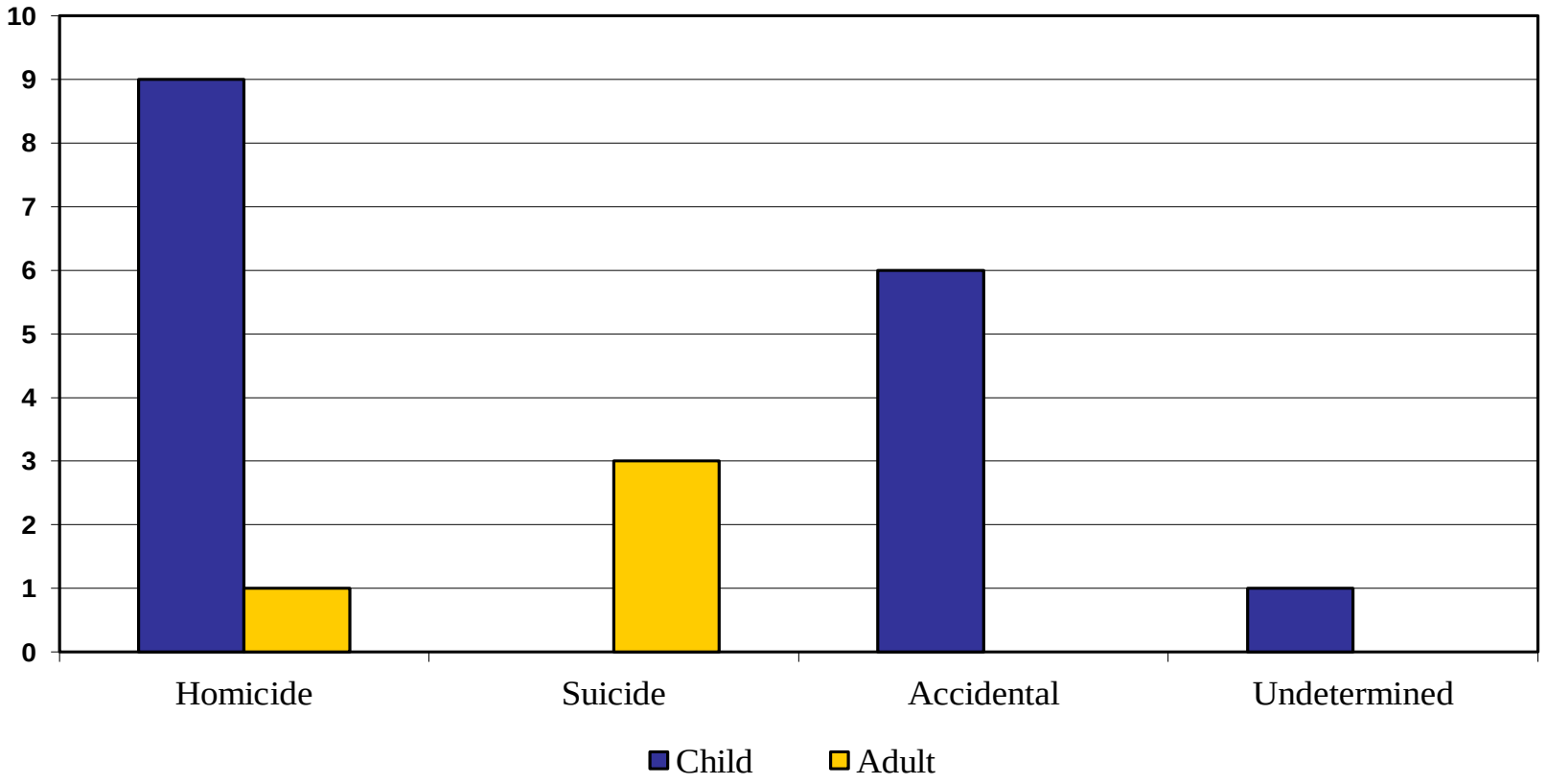
Summary of Cases Reviewed in FY10

Case #	FY of Death	Manner of Death - Context	Victim Gender	Victim Age	Offender Status/ Relationship to Victim	Cause of Death	Branch of Service
FY08-01	FY07	Homicide – DV	F	41 years	Active Duty/ /Spouse	Blunt Force Trauma Head	USN
FY08-02	FY04	Homicide – CAN	F	11 years	Off1: Active Duty/ Biological Father; Off2: Family Member/ Stepmother	Blunt Force Trauma Body	USN
FY08-03	FY07	Homicide – CAN	M	3 Months	Active Duty/ Biological Father	Blunt Force Trauma Head	USMC
FY08-04	FY07	Homicide – CAN	F	2 years, 5 months	Off1: Civilian/ Intimate Partner of Biological Mother; Off2: Family Member/ Biological Mother	Blunt Force Trauma Head	USN
FY08-05	FY08	Suicide – DV	M	25 years	N/A	Gun Shot	USN
FY08-06	FY08	Accidental	M	5 months	N/A	Asphyxiation	USN
FY08-07	FY08	Homicide – CAN	F	3 years	Off1: Active Duty/ Stepfather; Off2: Family Member/ Biological Mother	Blunt Force Trauma Body	USN

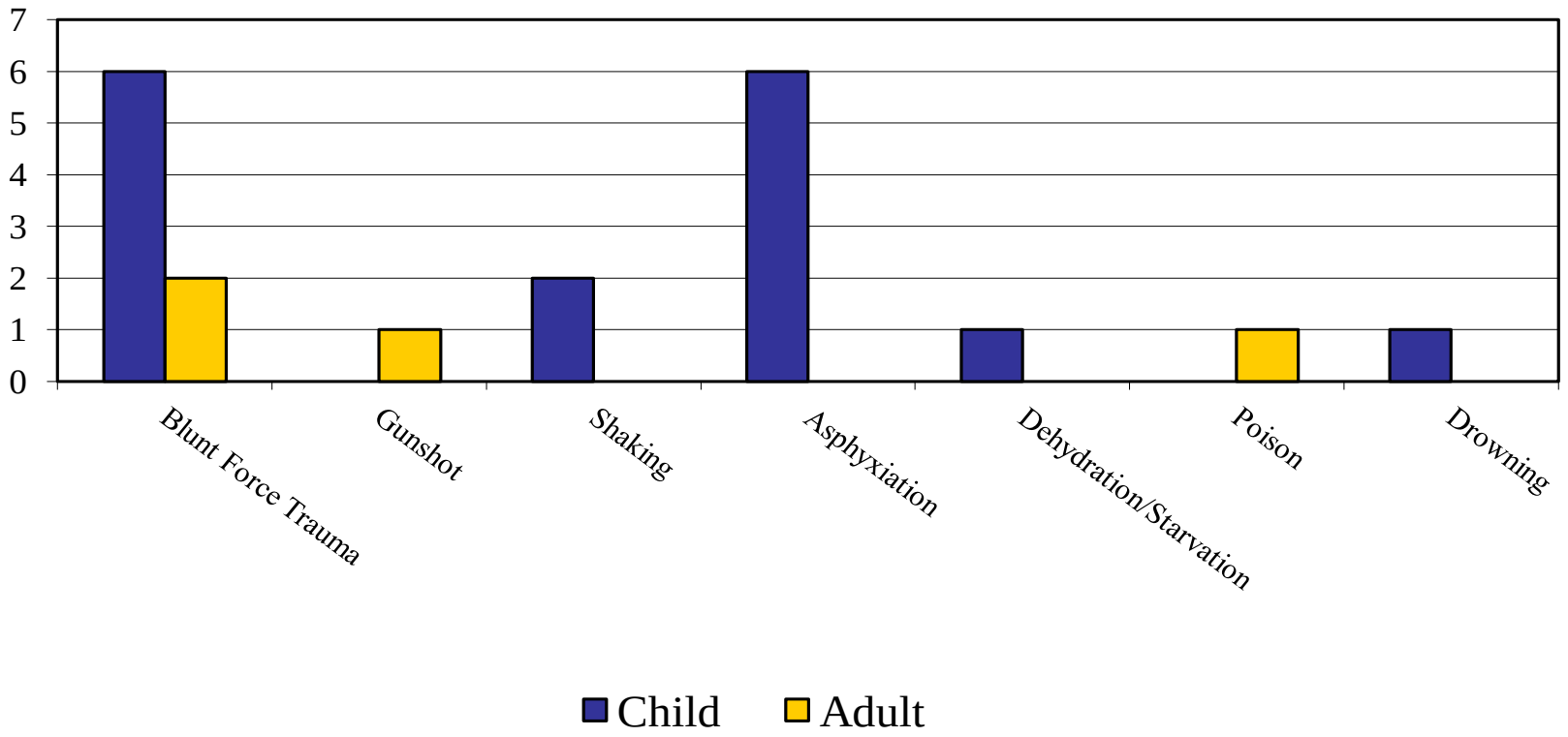
Case #	FY of Death	Manner of Death – Context	Victim Gender	Victim Age	Offender Status/ Relationship to Victim	Cause of Death	Branch of Service
FY08-08	FY08	Homicide – CAN	M	2 months	Off1: Family Member/ Biological Father; Off2: Active Duty/ Biological Mother	Shaken Baby without Impact	USMC
FY08-09	FY08	Homicide – CAN	F	3 years	Off1: Active Duty/ Biological Father; Off2: Family Member/ Stepmother	Blunt Force Trauma Head	USN
FY08-10	FY08	Homicide – CAN	F	6 years	Active Duty/ Biological Father	Blunt Force Trauma Body	USMC
FY08-11	FY08	Homicide – CAN	F	10 months	Off1: Active Duty/ Biological Mother; Off2: Active Duty/ Biological Father	Starvation /Dehydration	USN
FY08-12	FY08	Accidental	M	4 months	N/A	Asphyxiation	USN
FY08-13	FY08	Accidental	F	14 days	N/A	Asphyxiation	USN
FY08-14	FY08	Accidental	M	18 days	N/A	Asphyxiation	USN
FY08-15	FY08	Undetermined	M	14 days	N/A	Asphyxiation	USN
FY08-16	FY08	Suicide – DV	F	31 years	N/A	Carbon Monoxide Poisoning	USN

Case #	FY of Death	Manner of Death – Context	Victim Gender	Victim Age	Offender Status/ Relationship to Victim	Cause of Death	Branch of Service
FY08-17	FY08	Accidental	F	14 months	Civilian/ Caregiver	Drowning	USN
FY08-18	FY08	Suicide – CAN	M	30 years	N/A	Impact Injury (truck)	USN
FY08-19	FY08	Homicide – CAN	F	2 months	Active Duty/ Biological Mother	Shaken Baby with Impact	USMC
FY08-20	FY08	Accidental	M	1 month	N/A	Asphyxiation	USN

Manner of Death by Age of Decedent
FY10 Review



Cause of Death by Age of Decedent
FY10 Review



Documented System Involvement Prior to the Fatality
FY10 Review

Case Number	CPS	Command	FAP/ Family Center	Mental Health	Base Security	NCIS	Civilian Courts	Civilian Police	Navy Pediatrics	General Medical Services	School	Child Development Center	Total
FY08-02				X							X		2 (9%)
FY08-03									X			X	2 (9%)
FY08-04										X			1 (5%)
FY08-09	X	X	X		X	X							5 (23%)
FY08-12										X			1 (5%)
FY08-13	X			X					X	X			4 (18 %)
FY08-15		X	X				X			X			4 (18%)
FY08-16		X						X					2 (9%)
FY08-20				X									1 (5%)
Total	1 (5%)	3 (14%)	2 (9%)	3 (14%)	1 (5%)	1 (5%)	1 (5%)	1 (5%)	2 (9%)	4 (18%)	1 (5%)	1 (5%)	22 (100%)

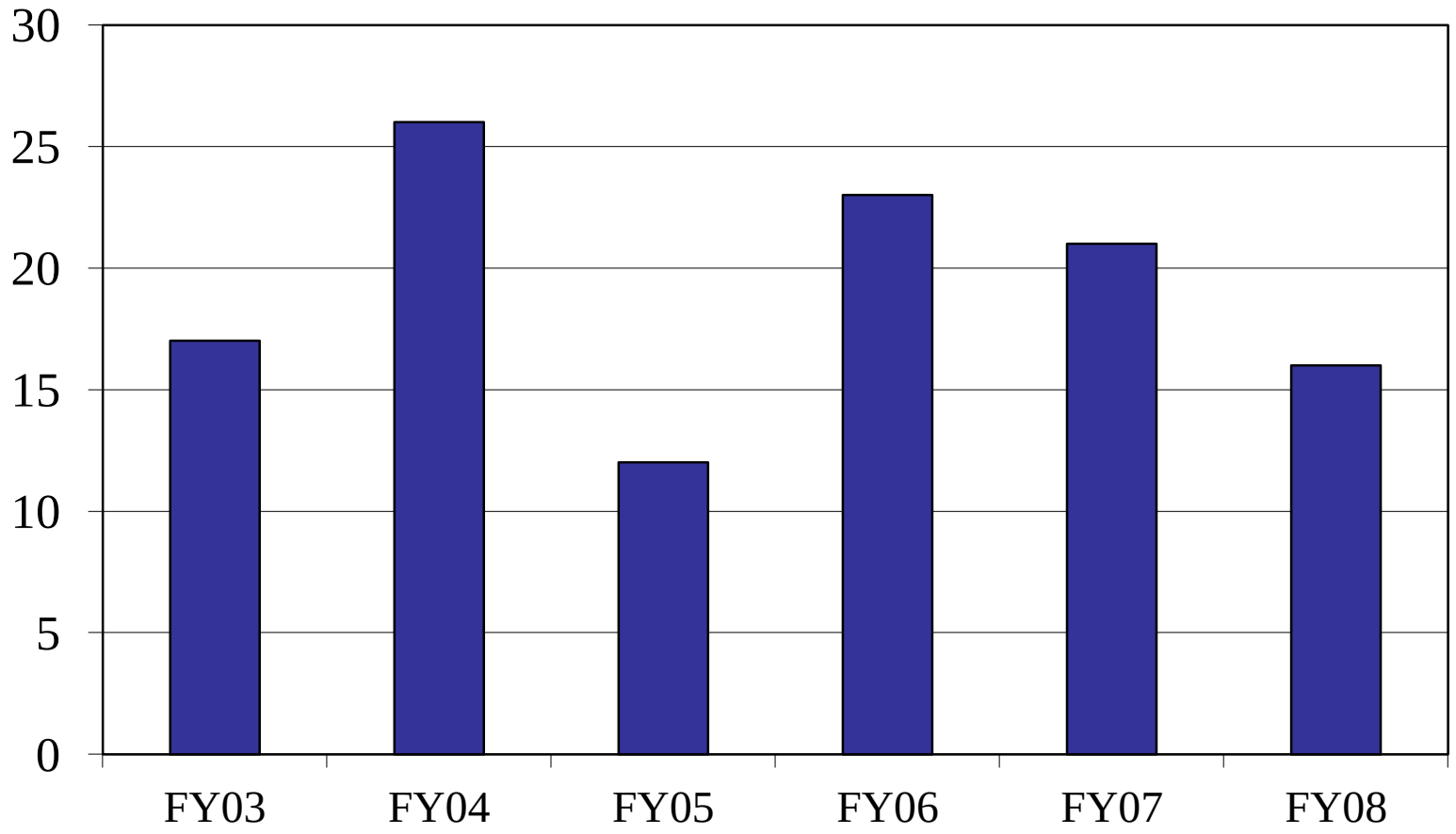
Legal Disposition
FY10 Review

The chart below provides an overview of the final legal dispositions. In cases that were prosecuted by civilian authorities, the legal dispositions were verified with the clerk of courts of the cognizance jurisdiction. The below sentences reflect the "adjudged sentence" without regard to subsequent clemency.

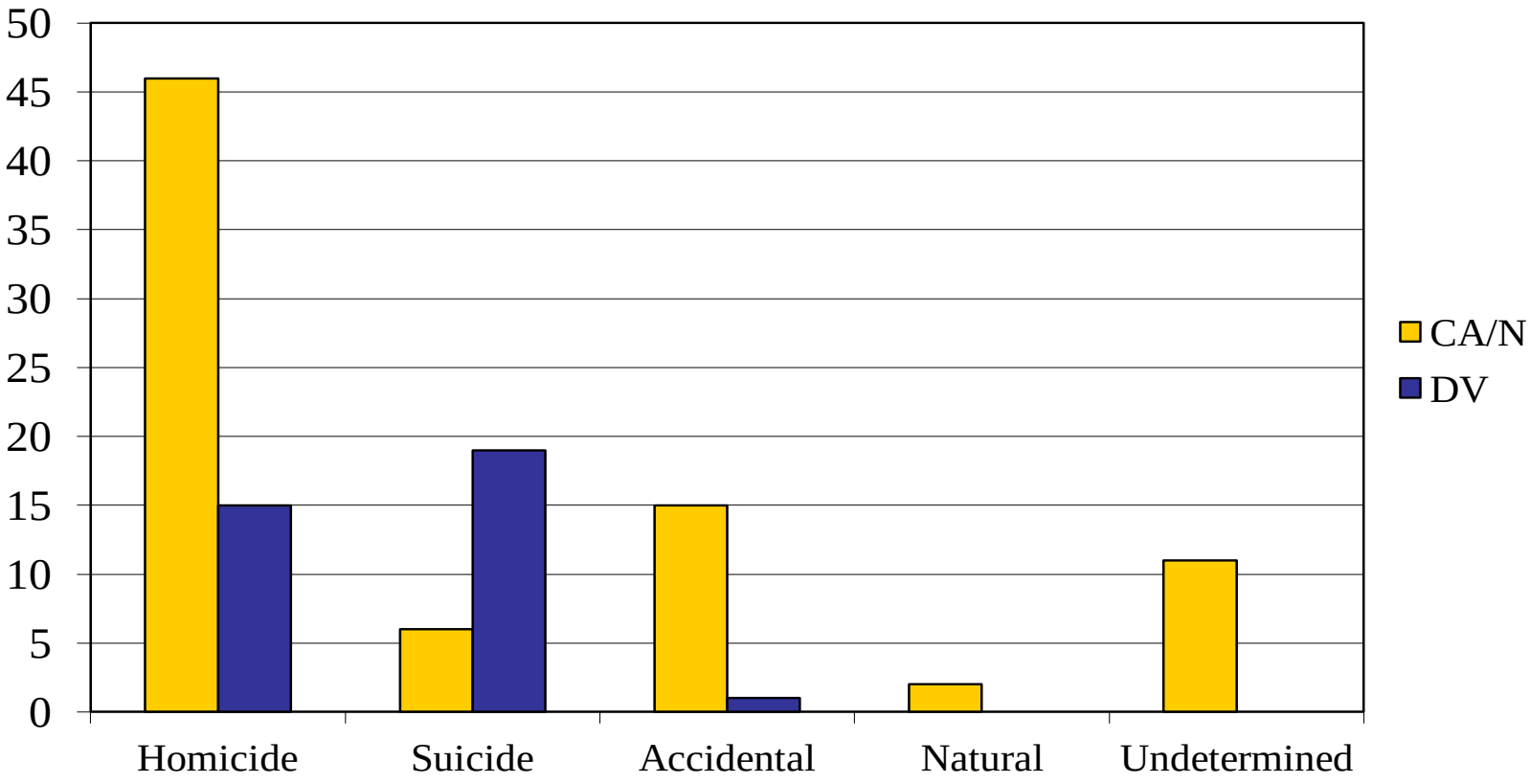
Case #	Branch of Service	Forum	Sentence
FY08-01	USN	Civilian	Conviction: Murder; 28 years/3 years suspended, $6656 fine, indefinite supervised probation
FY08-02	USN	Civilian	Offender 1: Conviction: Felony Murder; Aggravated Battery; Cruelty to Child; Life plus 40 years Offender 2: Conviction: Felony Murder; Aggravated Battery; Cruelty to Child; Life plus 40 years
FY08-03	USMC	Civilian	Conviction: Involuntary Manslaughter; 16-20 months; Acquittal: Child Abuse
FY08-04	USN	Civilian	Offender 1: Acquittal: Murder and Assault. All other charges dismissed or stricken. Offender 2: Dismissed: Abuse/Endangering a Child
FY08-05	USN	N/A	N/A – Suicide
FY08-06	USN	N/A	N/A – Accidental
FY08-07	USN	Civilian	Offender 1: Conviction: Second Degree Murder; 15 years to Life Offender 2: Plea Agreement: Felony Child Abuse; 8 years with no probation
FY08-08	USMC	Civilian	Off1: Plea Agreement: Involuntary Manslaughter; Intentional Child Abuse/Bodily Harm; 44-62 months Off2: Not charged. Child protective services founded the case and removed the surviving child from this offender's custody.
FY08-09	USN	Civilian	Offender 1: Conviction: Second Degree Murder; 15 years to life; $14,000 restitution Offender 2: Plea Agreement: Second Degree Murder; 15 years with credit for 630 days, $7500 restitution

Case #	Branch of Service	Forum	Sentence
FY08-10	USMC	Military	Guilty at General Courts Martial: Involuntary Manslaughter; 8 years confinement subsequently reduced by Convening Authority; Forfeiture all pay and allowances, Reduction in Rank, Dishonorable Discharge.
FY08-11	USN	Civilian	Offender1: Plea Agreement: Second Degree Murder; 25 years/15 suspended with 15 years probation, $753 fine ; Child Neglect; 10 years; 2 suspended Offender 2: Conviction: Second Degree Murder: 15 years/8 suspended; Child Neglect: 10 years/6 suspended
FY08-12	USN	N/A	N/A – Accidental
FY08-13	USN	N/A	N/A – Accidental
FY08-14	USN	N/A	N/A – Accidental
FY08-15	USN	N/A	N/A – Undetermined
FY08-16	USN	N/A	N/A – Suicide
FY08-17	USN	Civilian	Plea Agreement: Contributing to the Delinquency of a Minor: 12 months/12 months suspended. Court costs.
FY08-18	USN	N/A	N/A – Suicide
FY08-19	USMC	Military	Guilty at General Courts Martial: Involuntary Manslaughter; 6 years confinement, Forfeiture all pay and allowances, Reduction in Rank, Dishonorable Discharge.
FY08-20	USN	N/A	N/A – Accidental

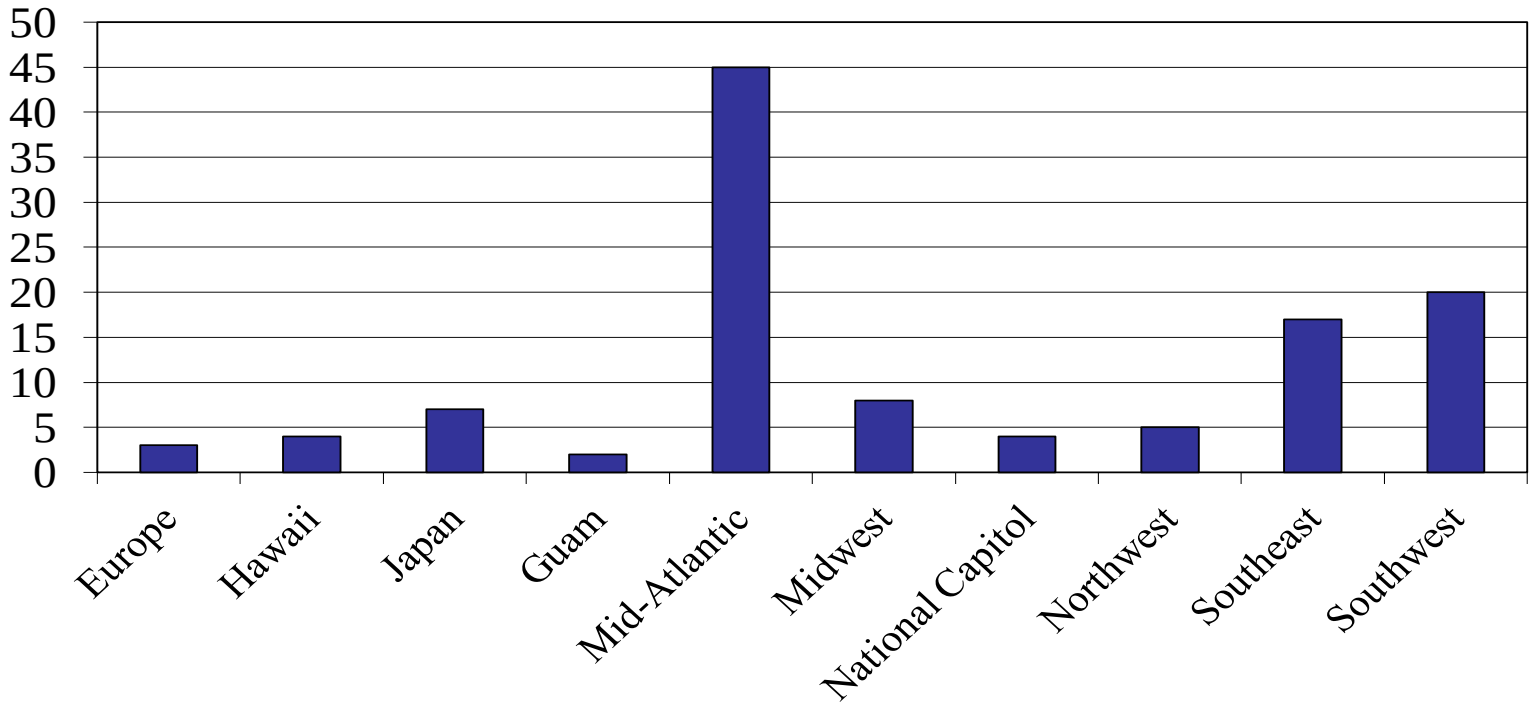
Fiscal Year of Death



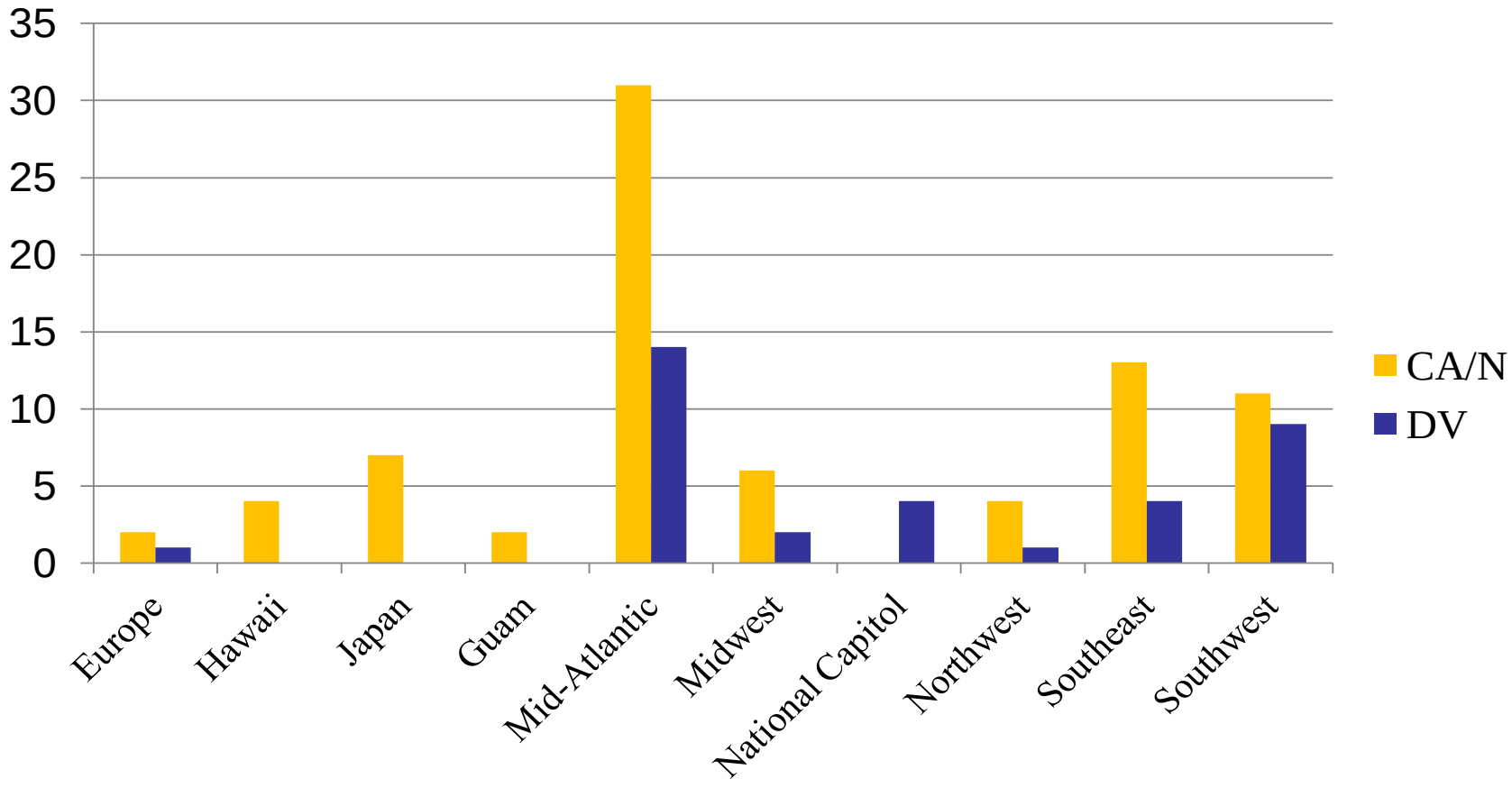
Manner of Death by Associated Abuse



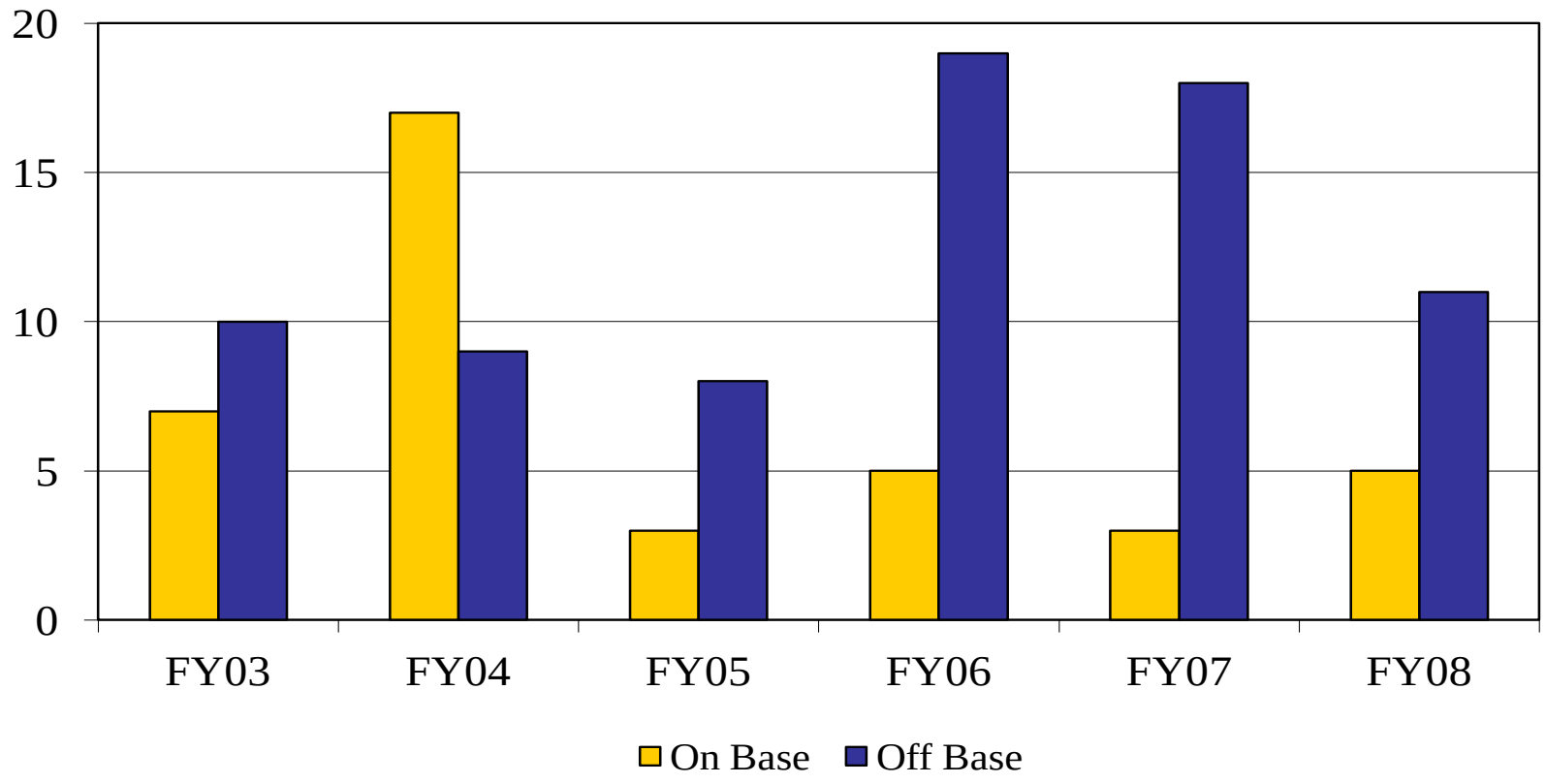
Geographic Distribution of Deaths



Geographic Distribution by Type of Associated Abuse



Location of the Fatality



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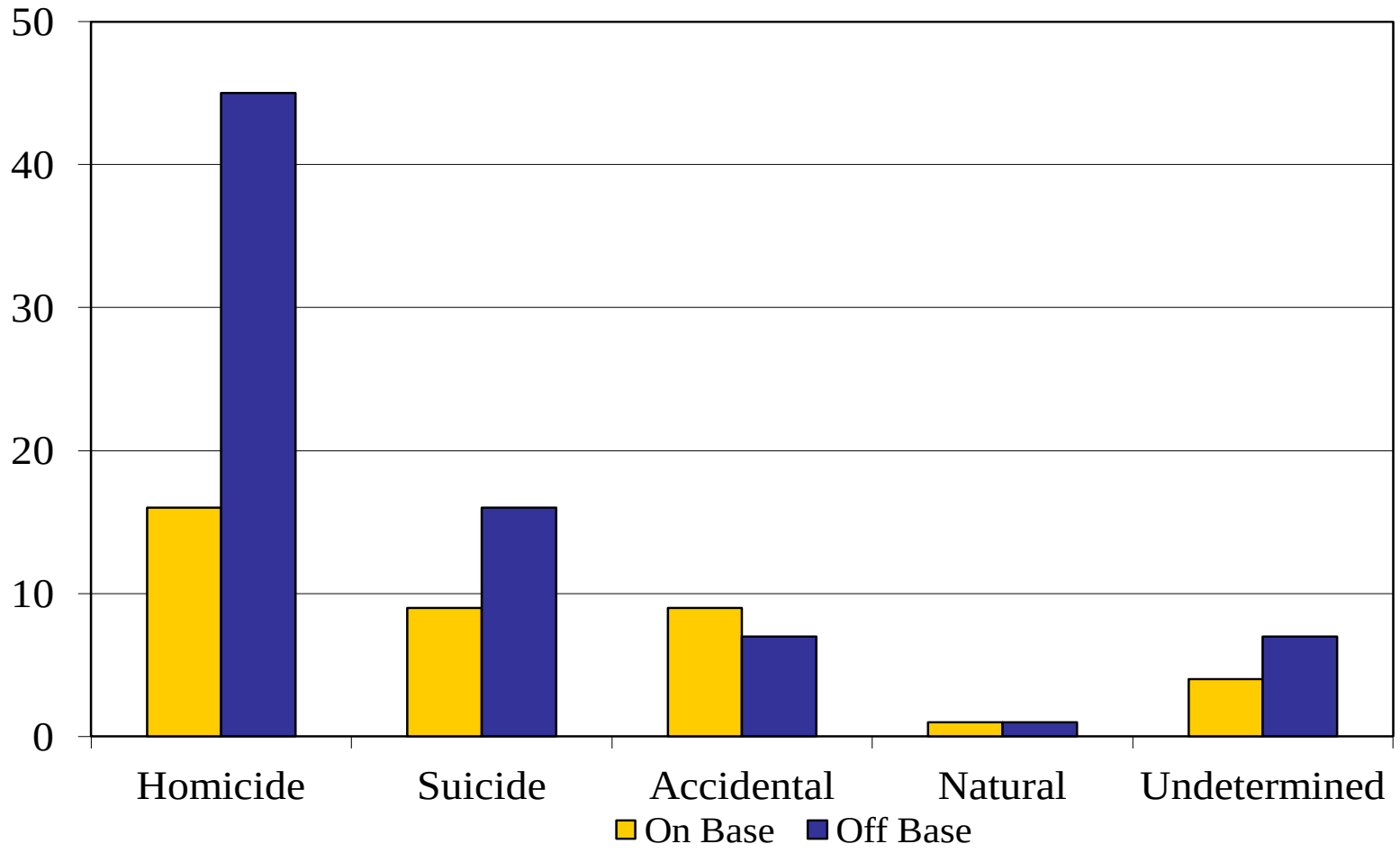
Location of Fatality by Manner of Death



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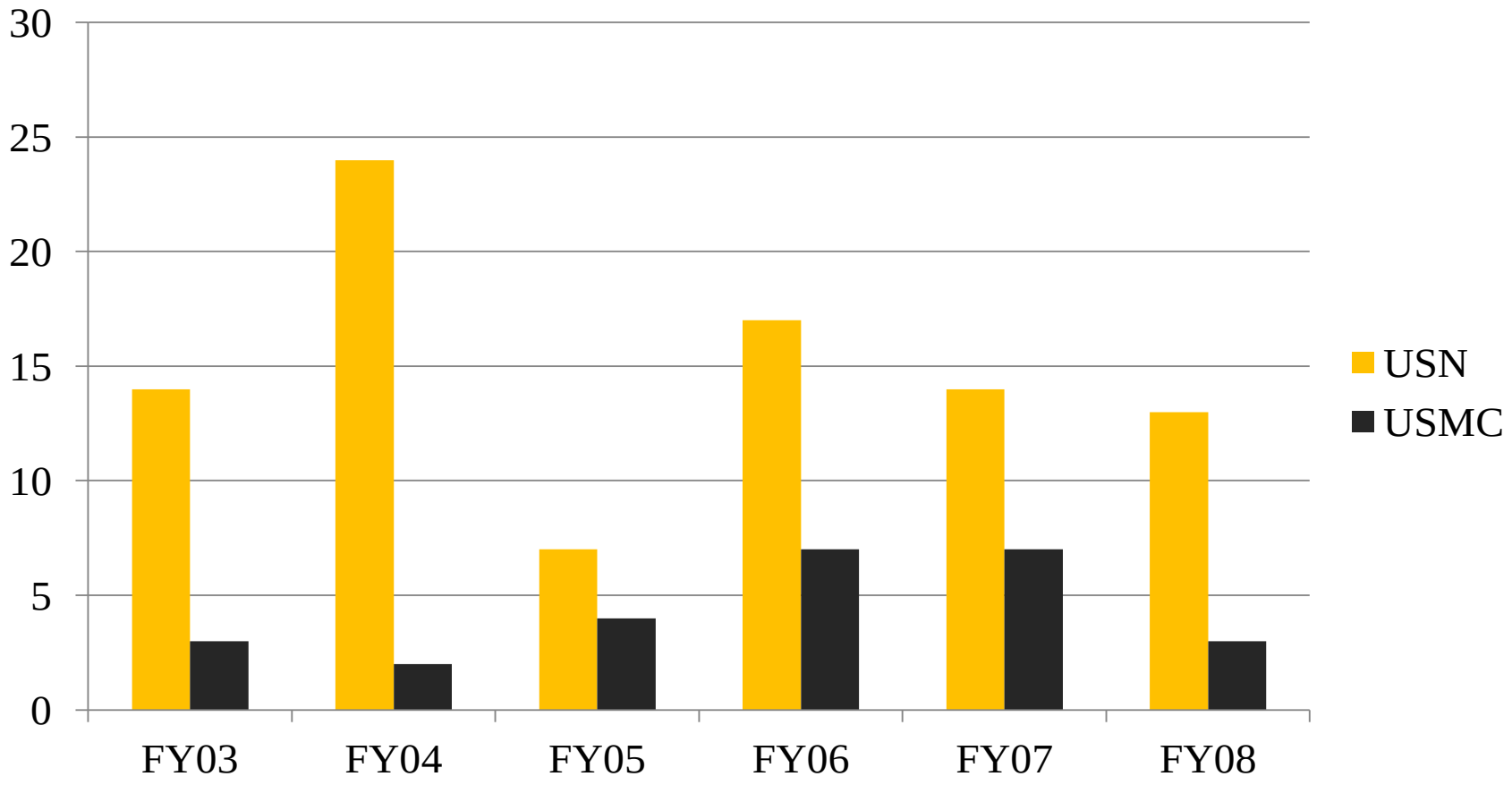
Fatalities by Branch of Service



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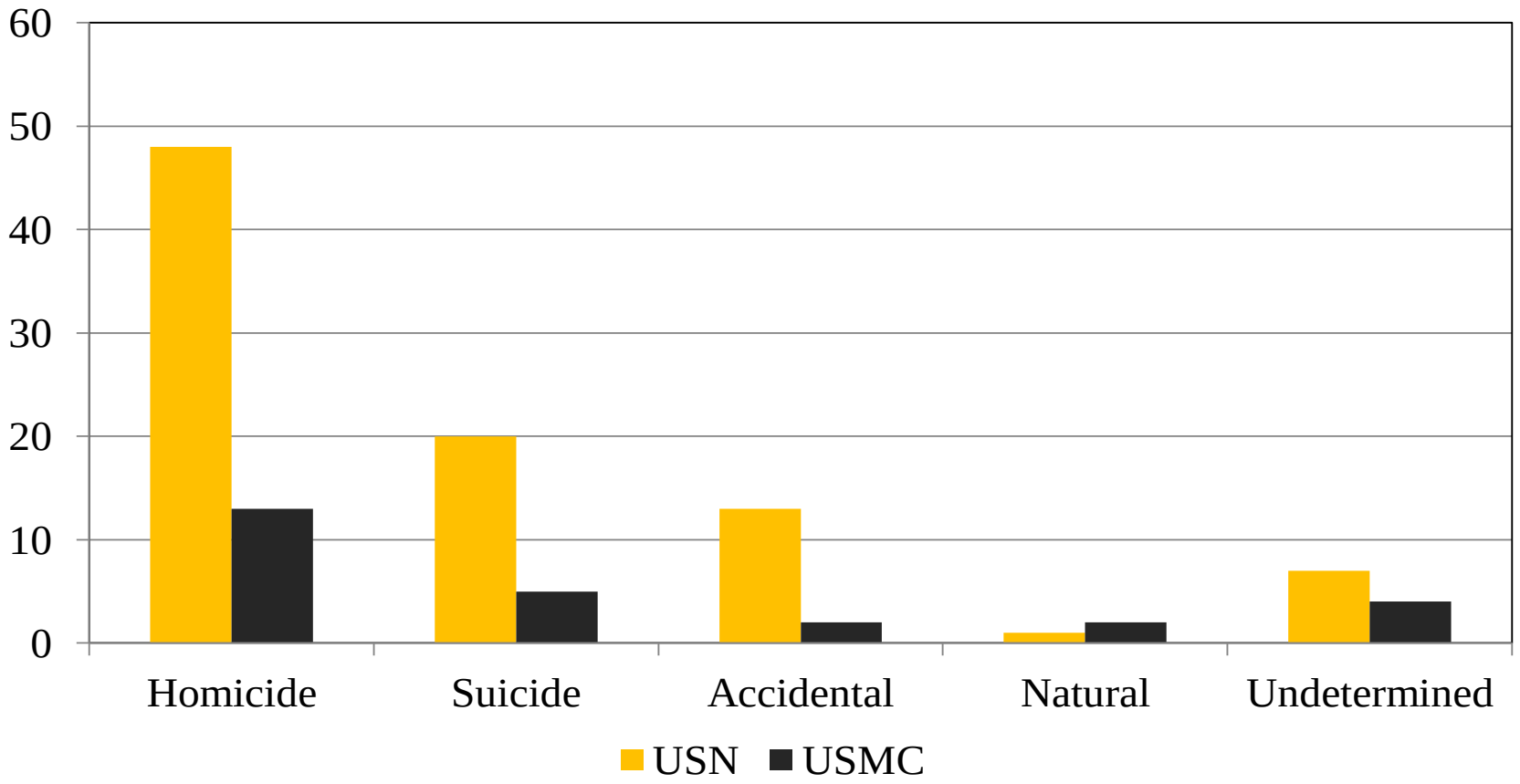
Manner of Death by Branch of Service



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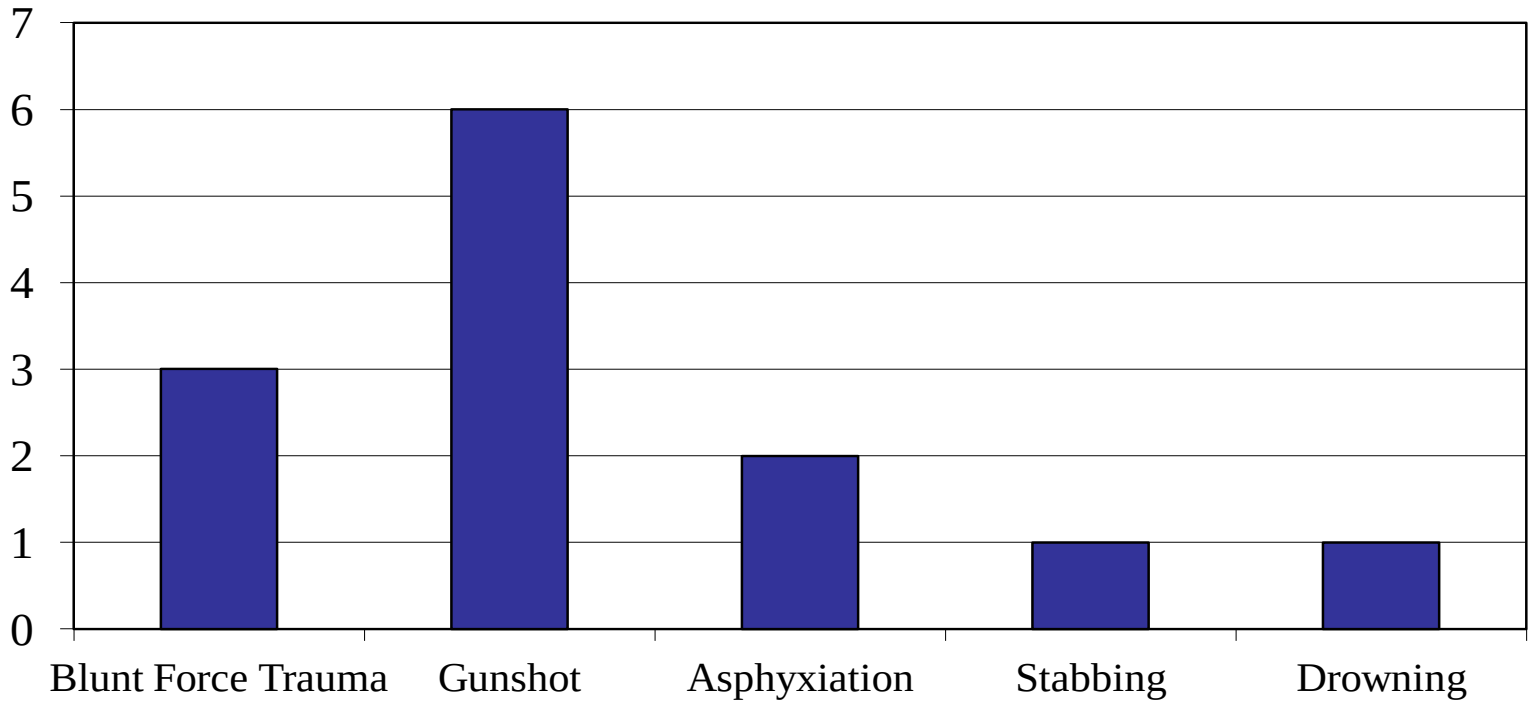
Cause of Death
Domestic Violence Homicide



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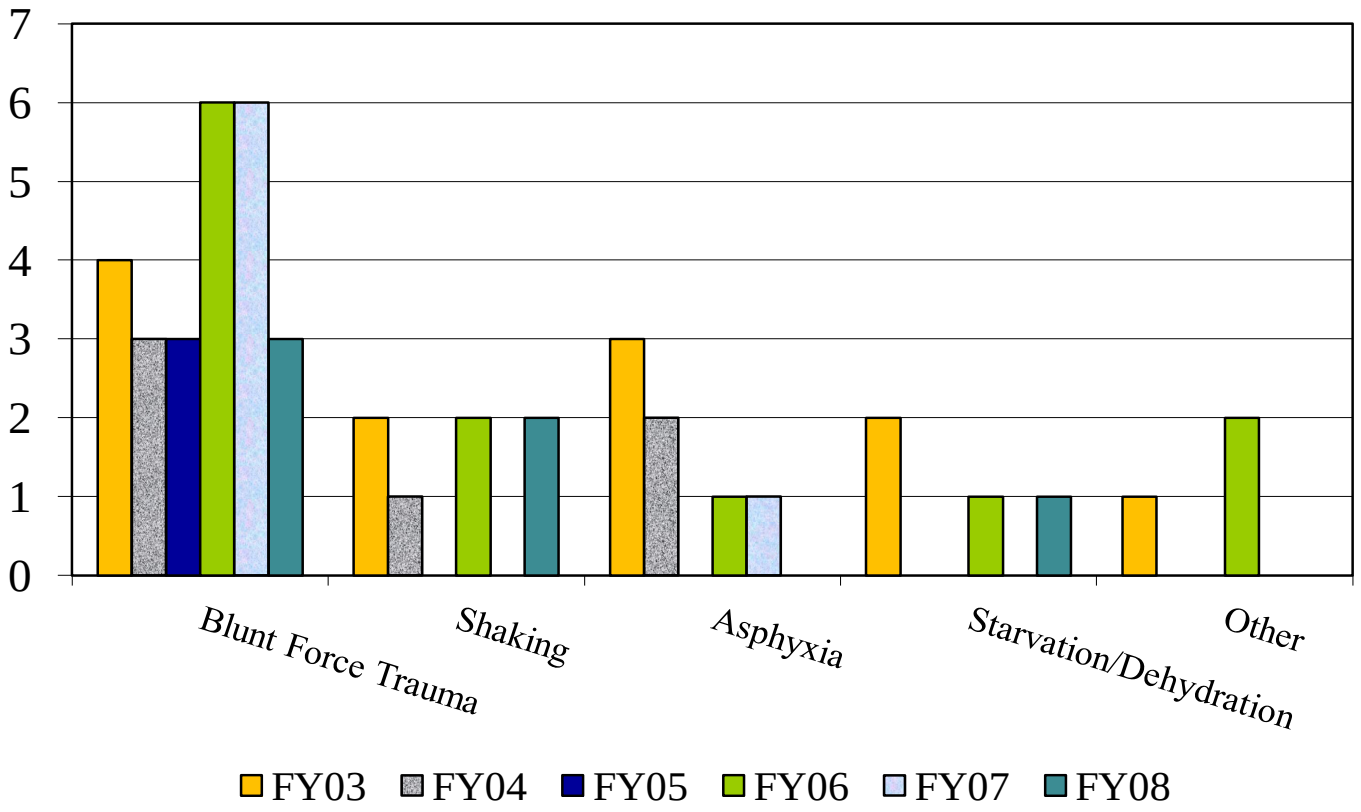
Cause of Death

Child Abuse & Neglect Homicide



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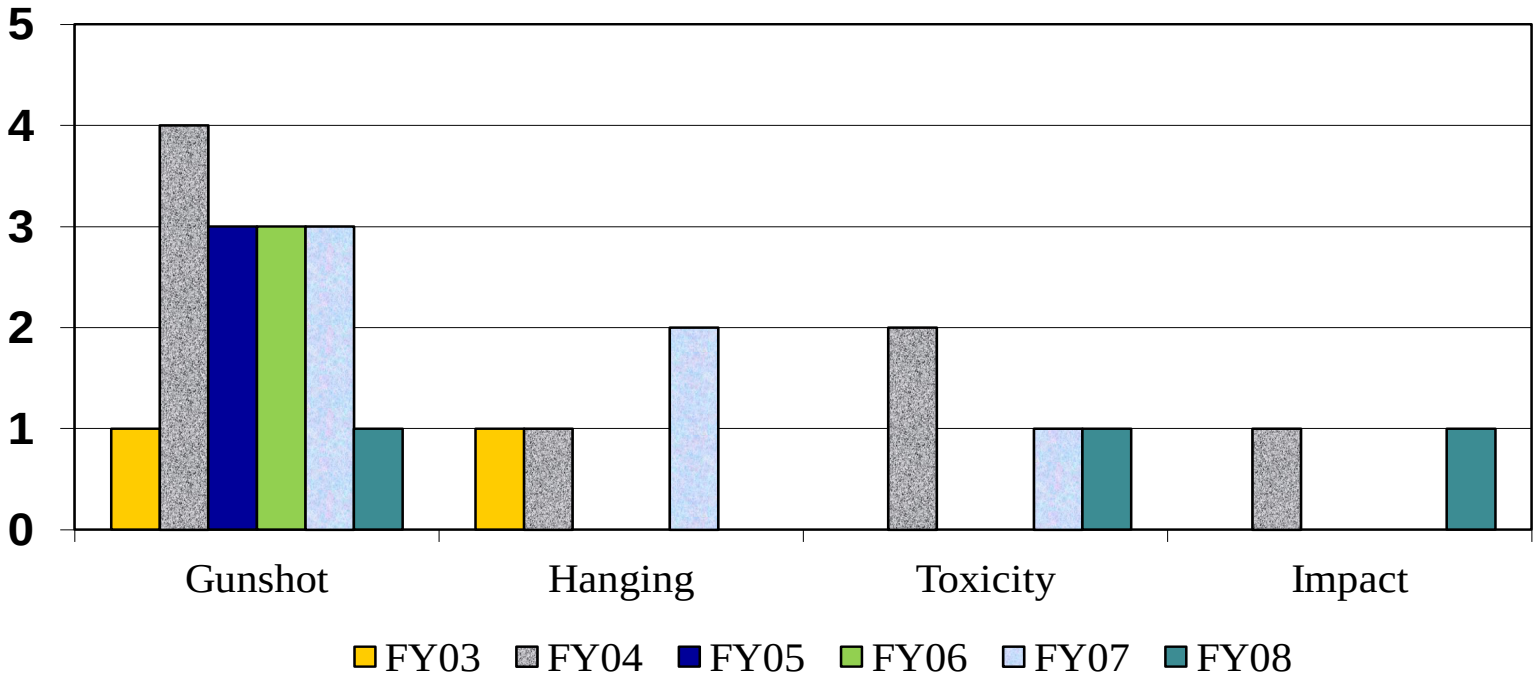
Cause of Death

Suicide



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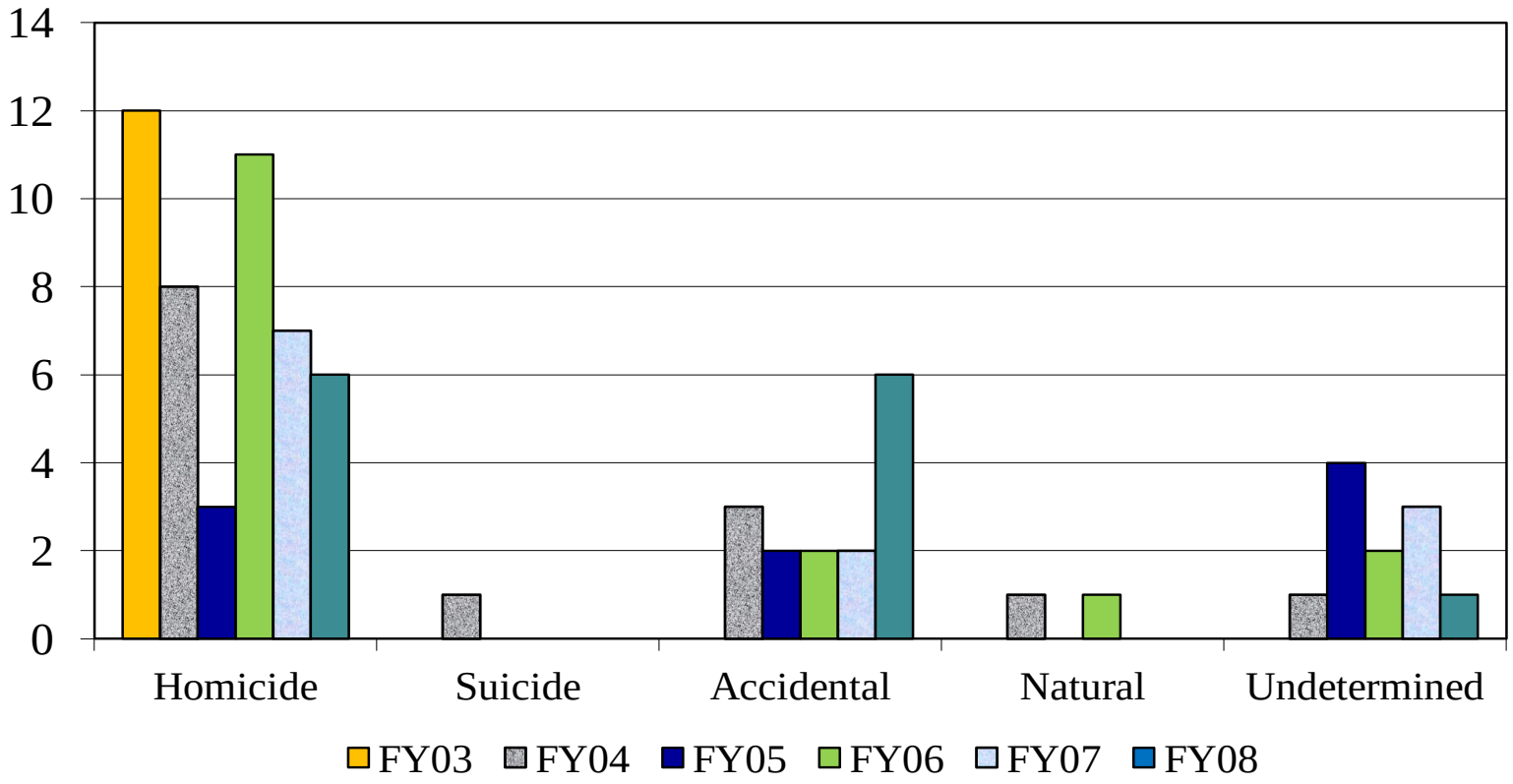
Child Decedents

Manner of Death by Year of Death



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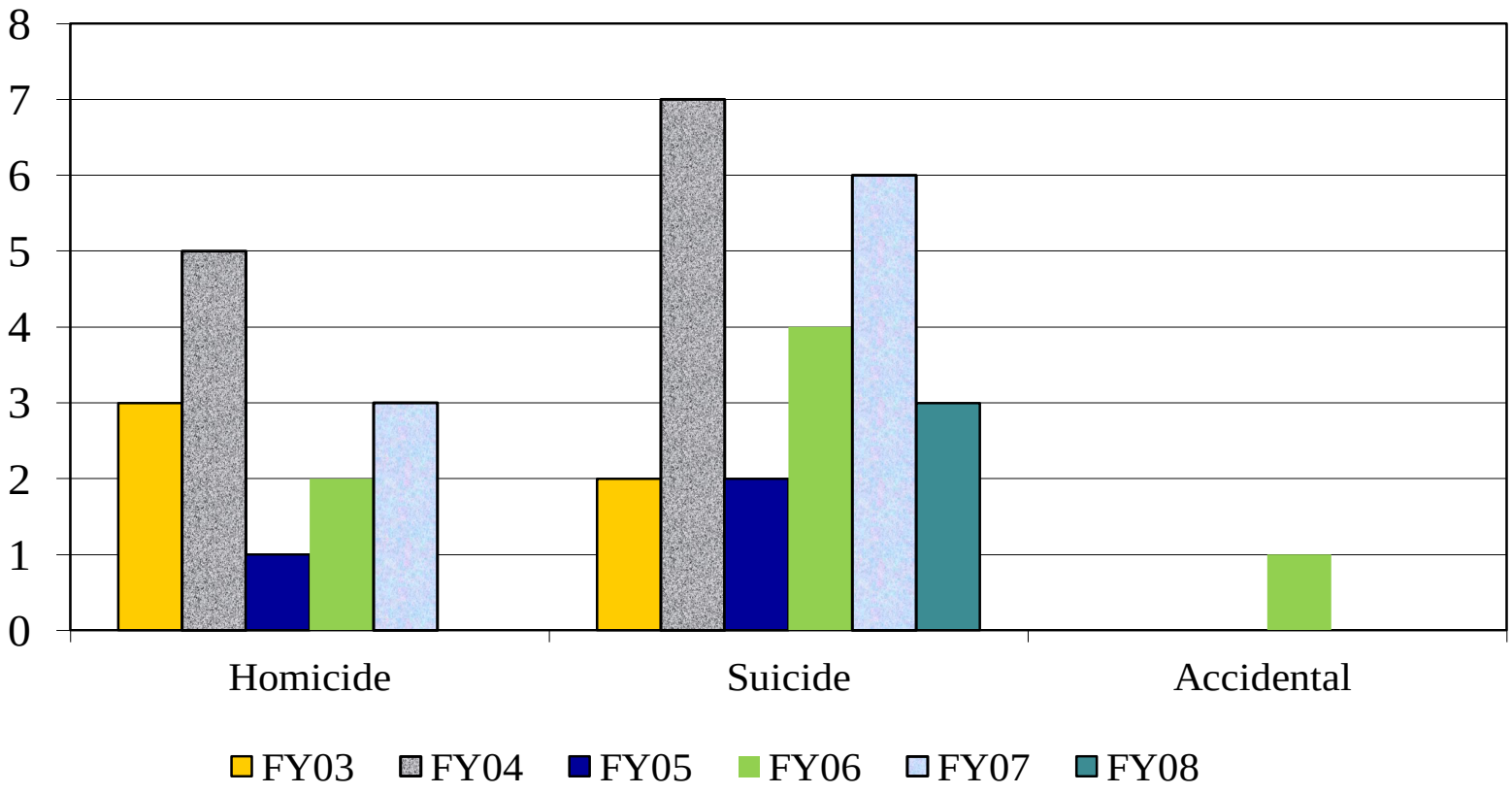
Adult Decedents
Manner of Death by Year of Death



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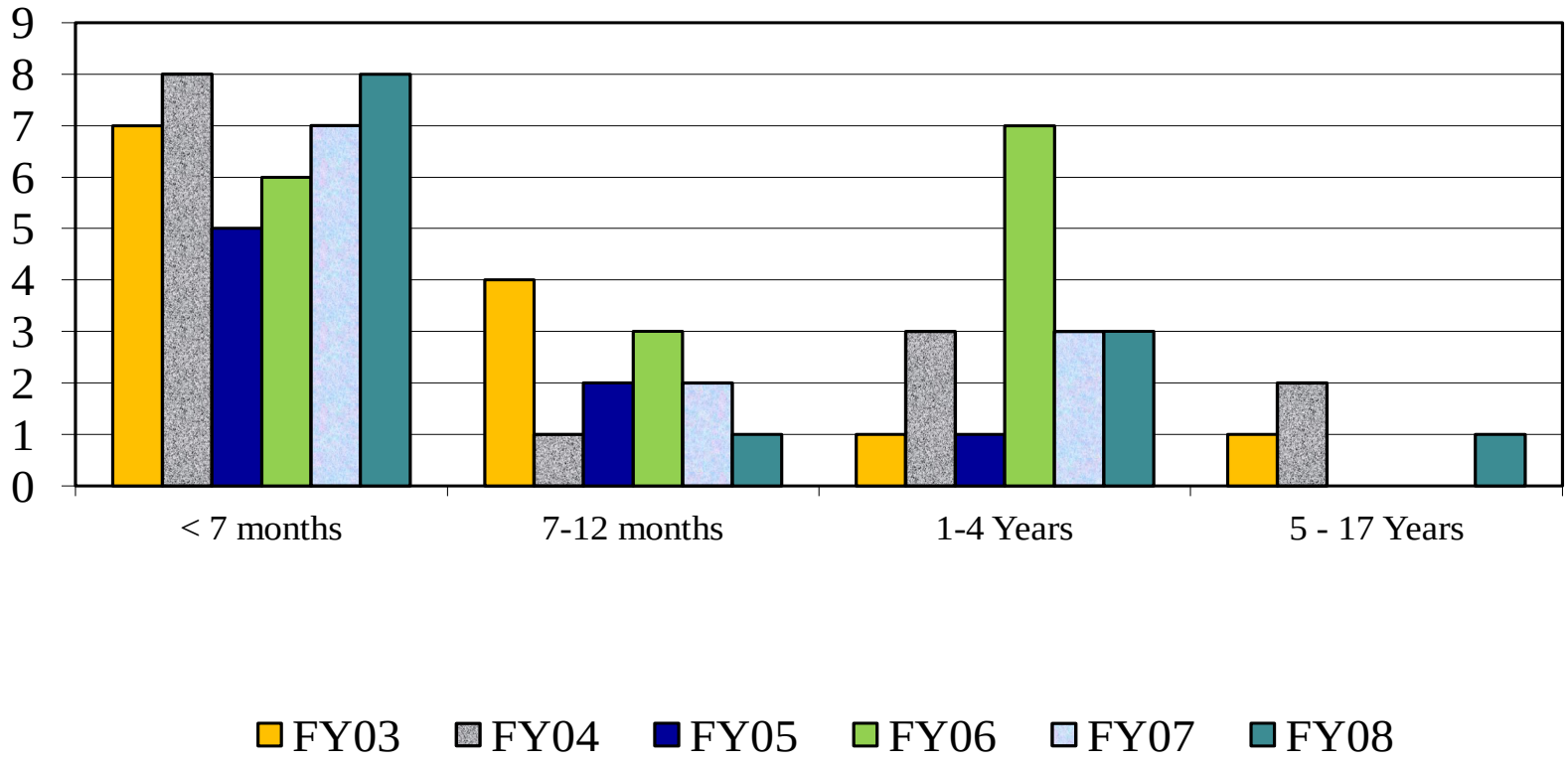
Age of Child Decedents



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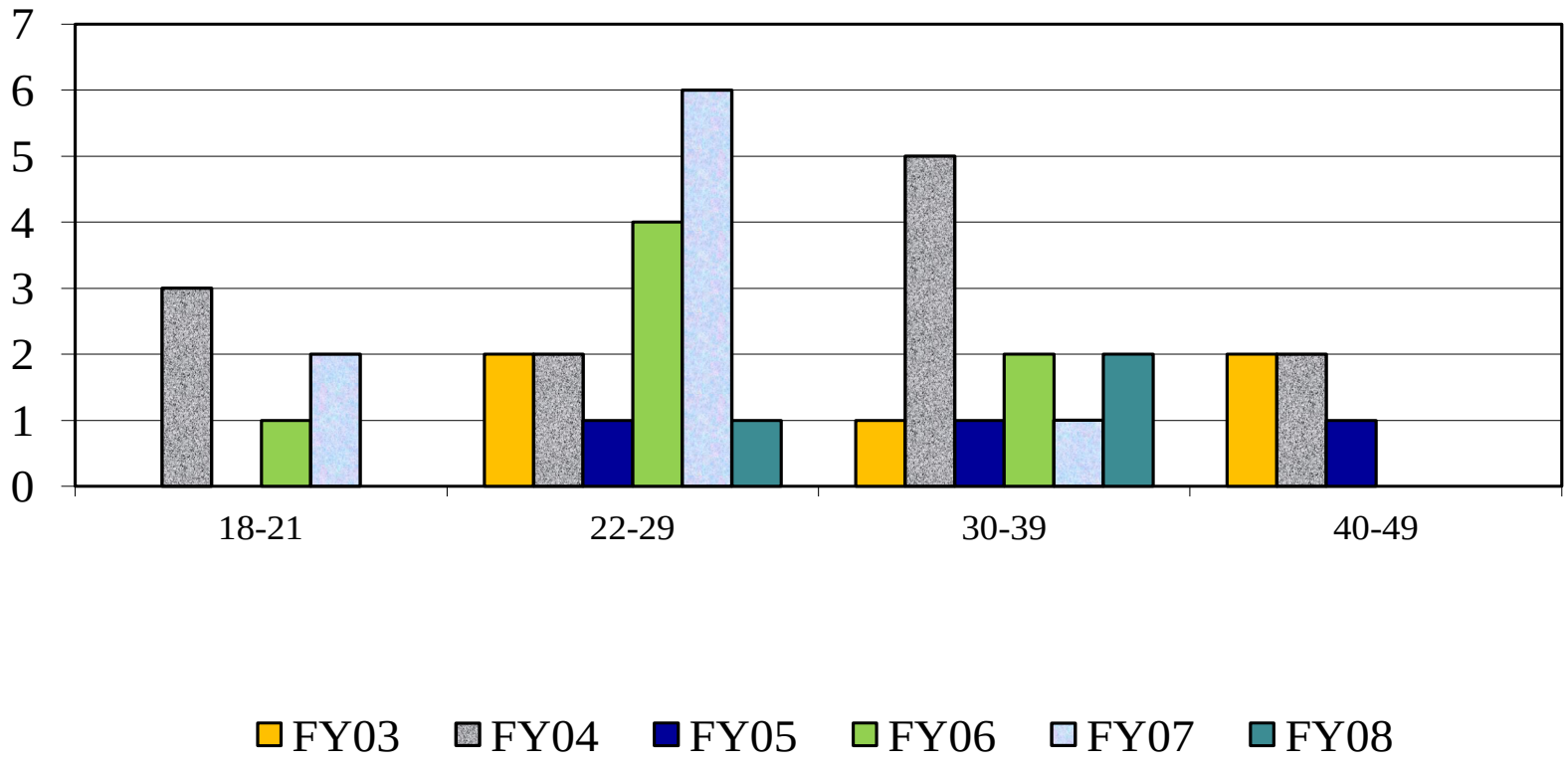
Age of Adult Decedents



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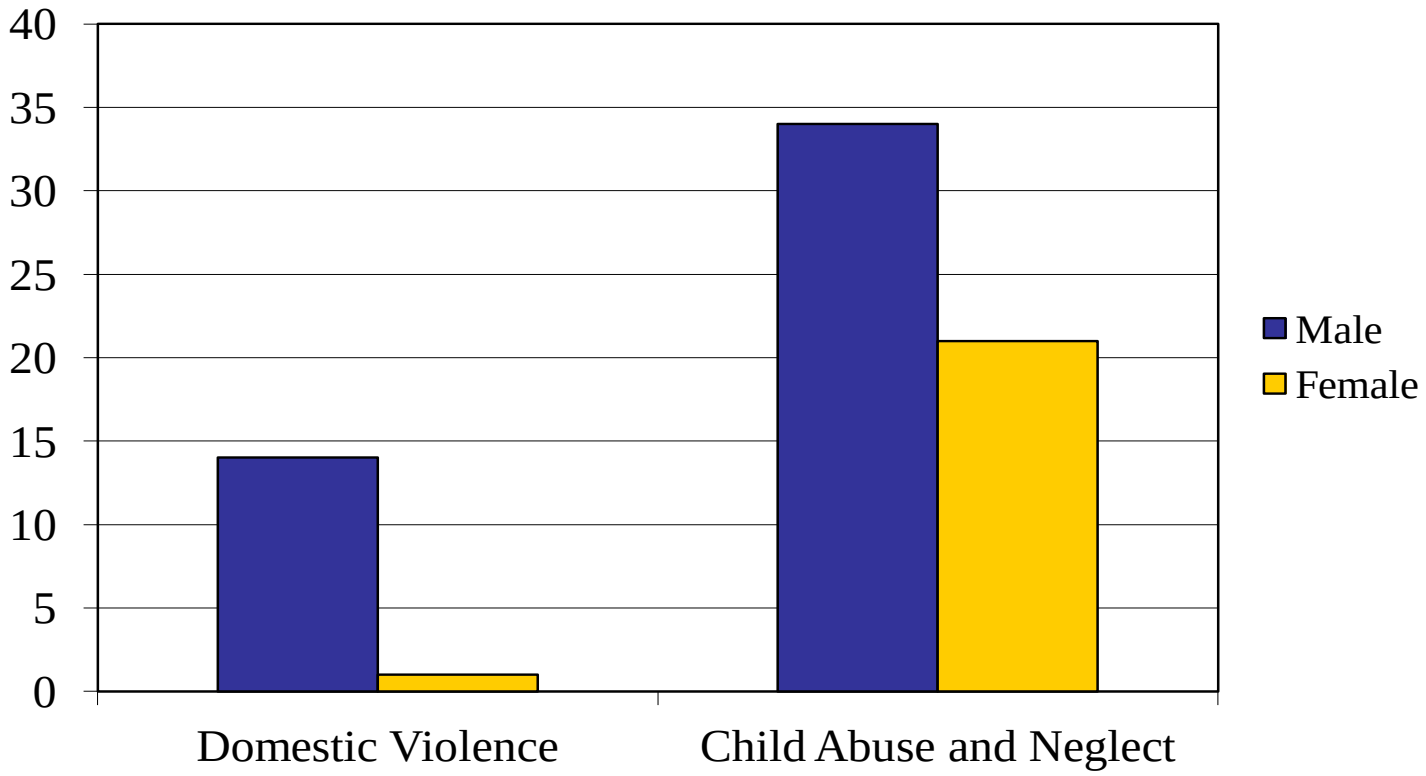
Gender of Homicide Offenders



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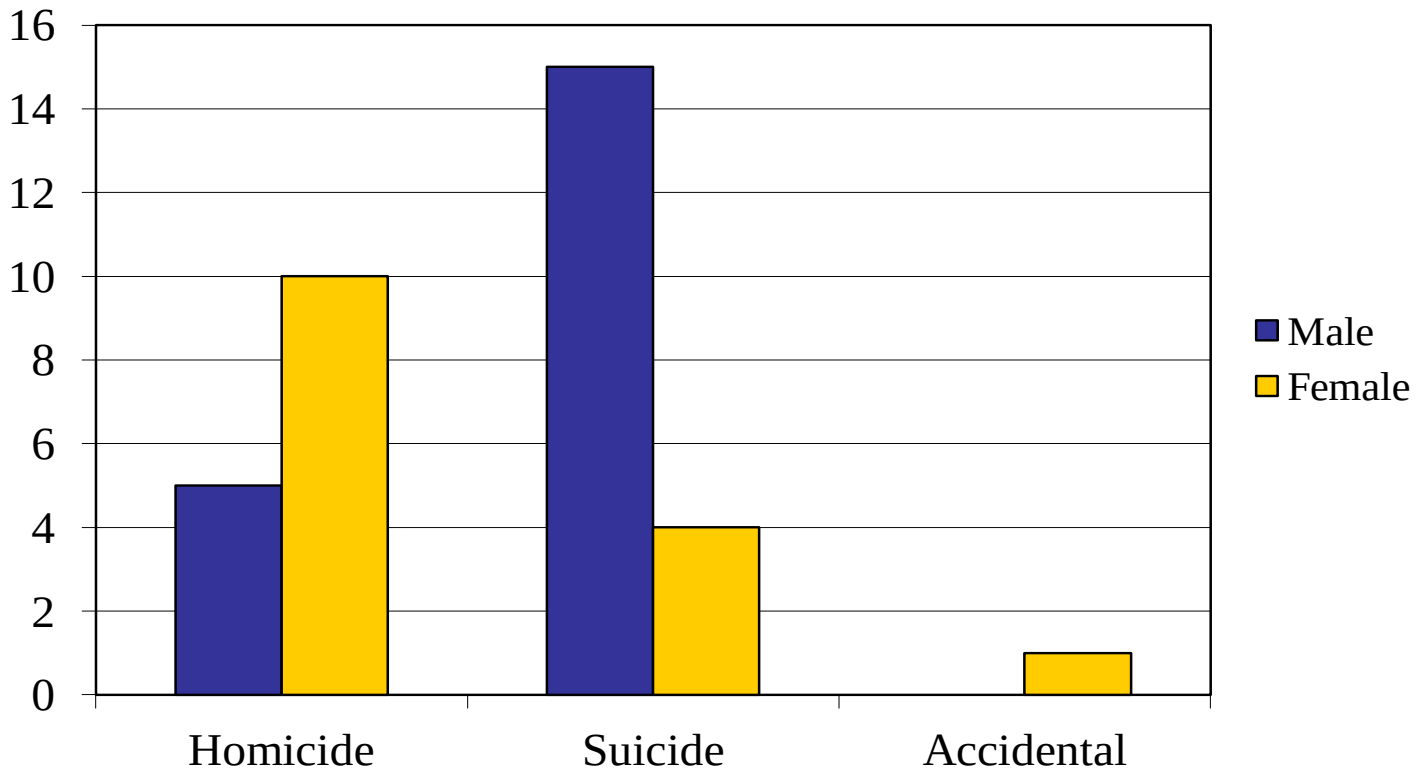
Victim Gender by Manner of Death
Domestic Violence



Enclosure (23)

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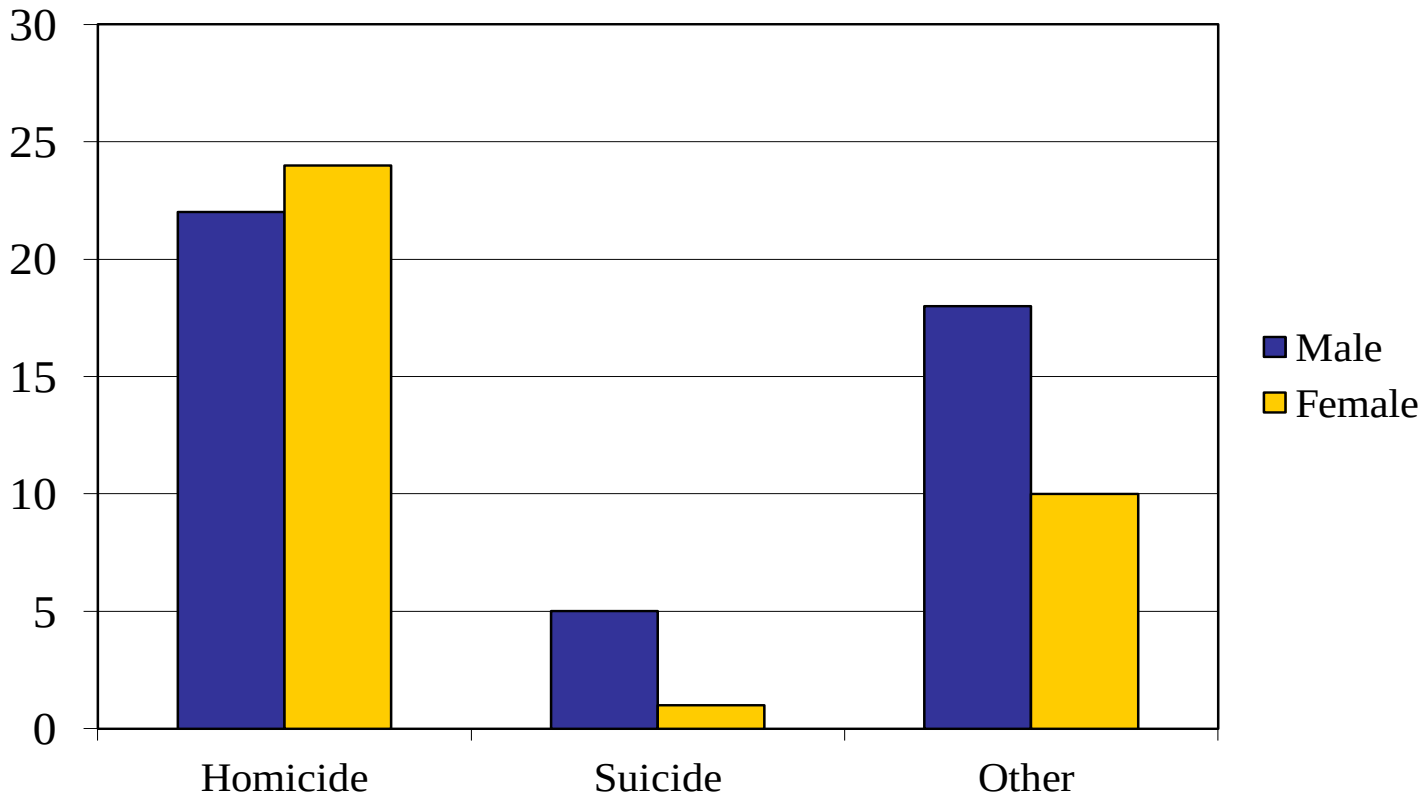
Victim Gender by Manner of Death

Child Abuse & Neglect



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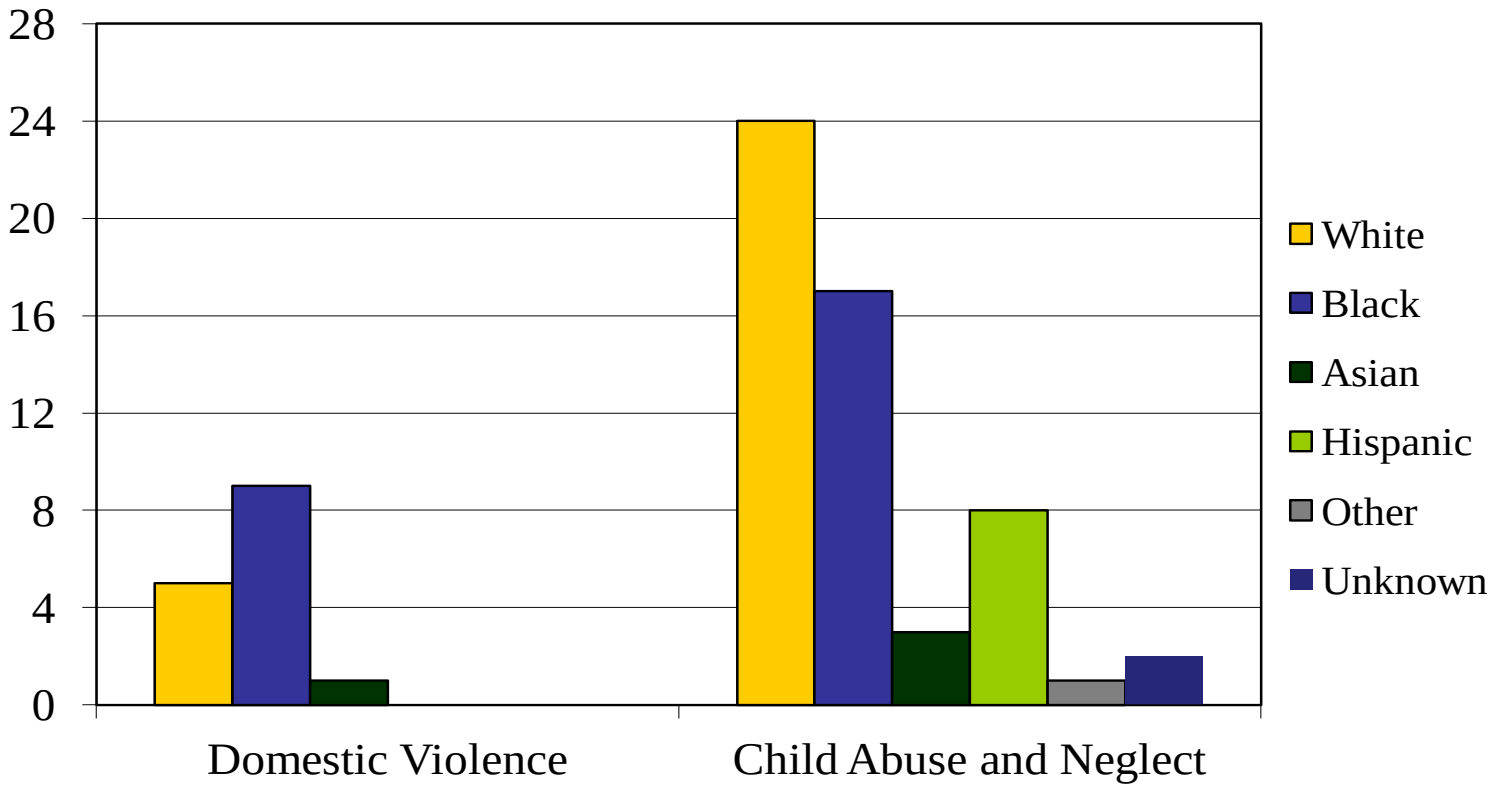
Race/Ethnicity of Homicide Offenders



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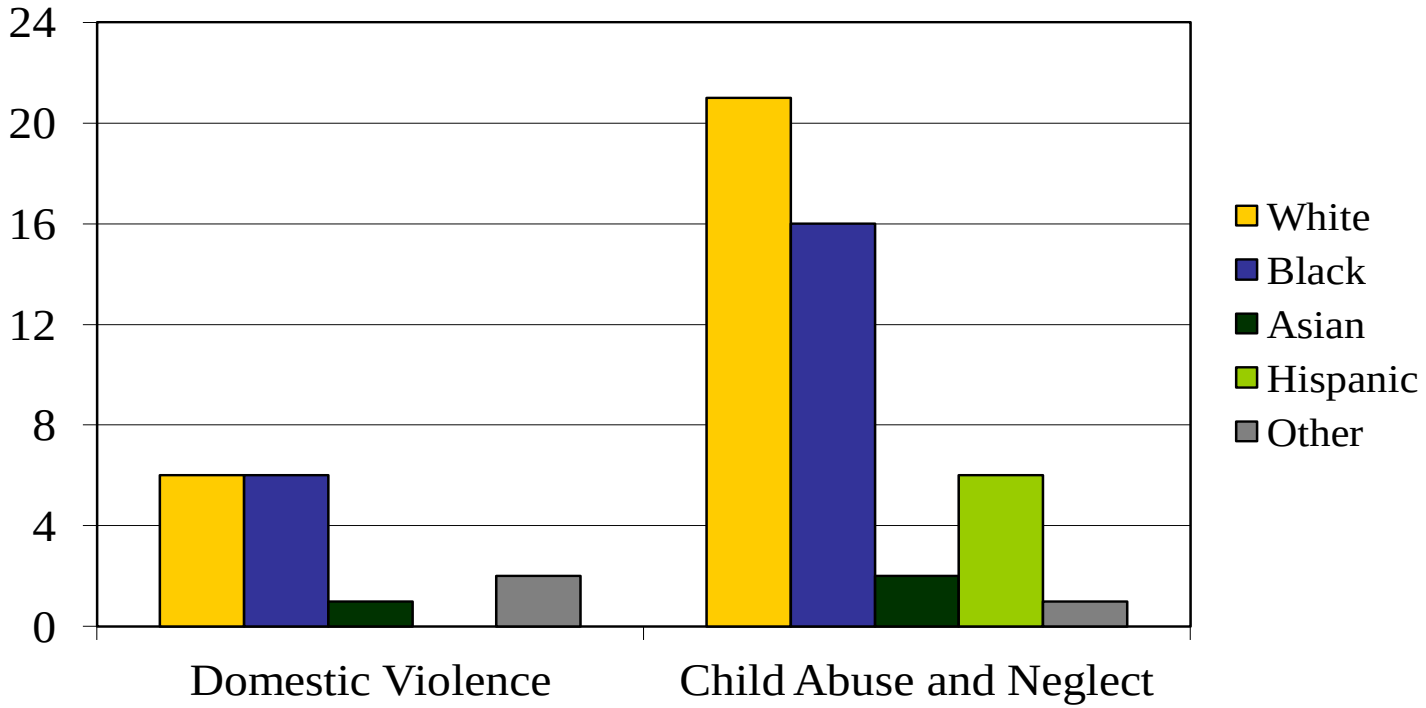
Race/Ethnicity of Homicide Victims



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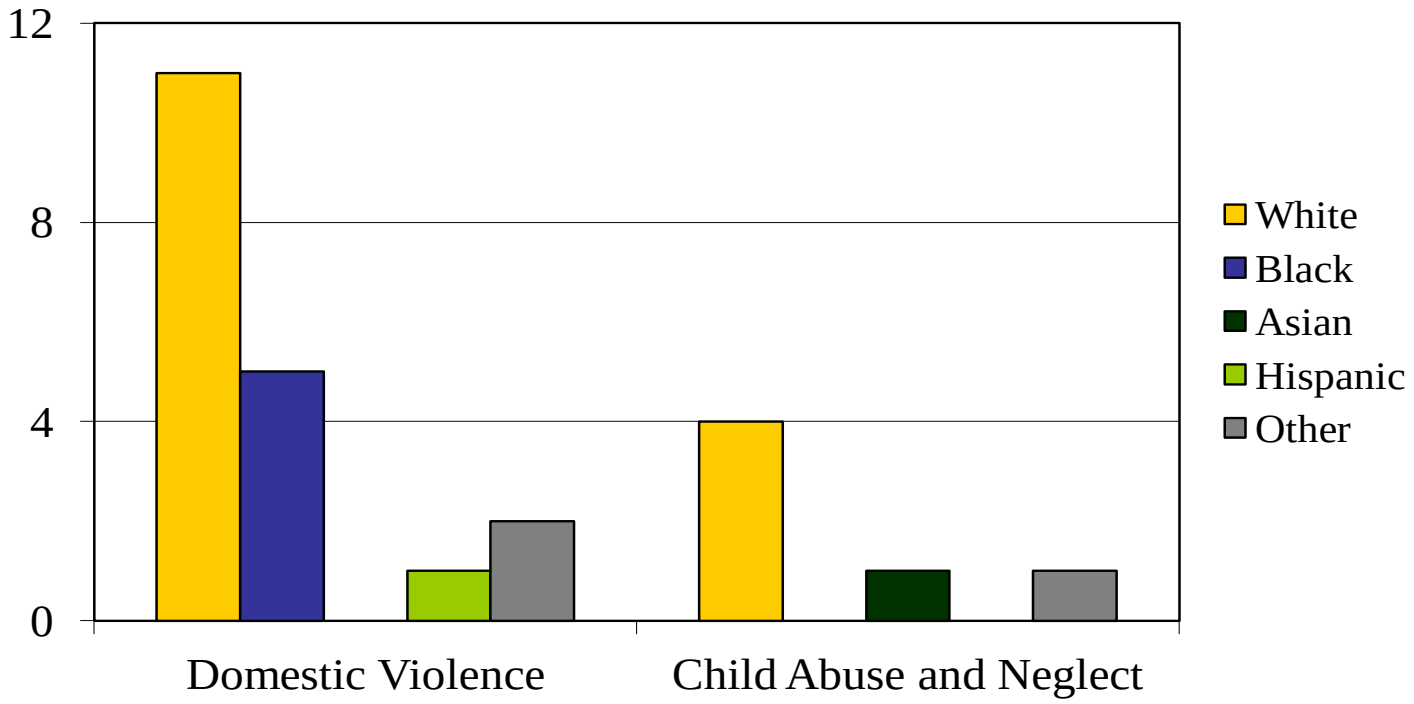
Race/Ethnicity of Suicide Victims



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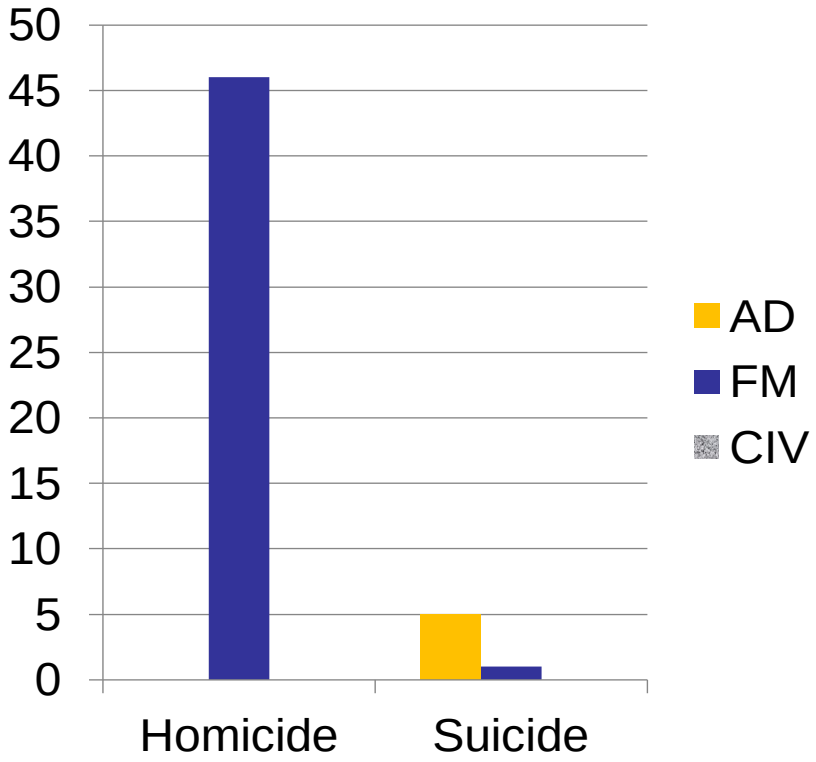
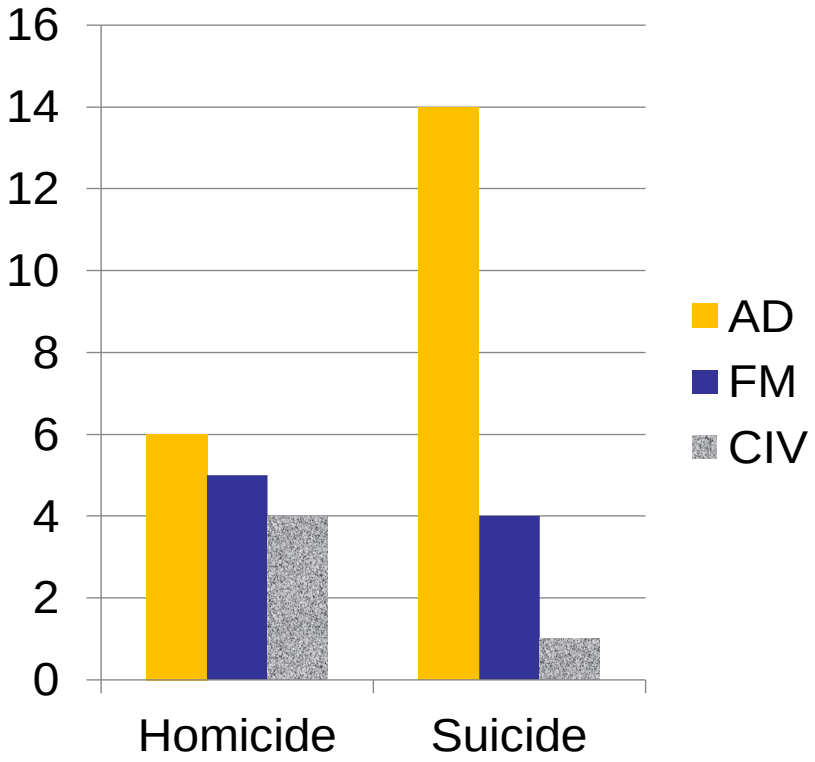
Victim Status by Manner of Death

Child Abuse & Neglect



Domestic Violence



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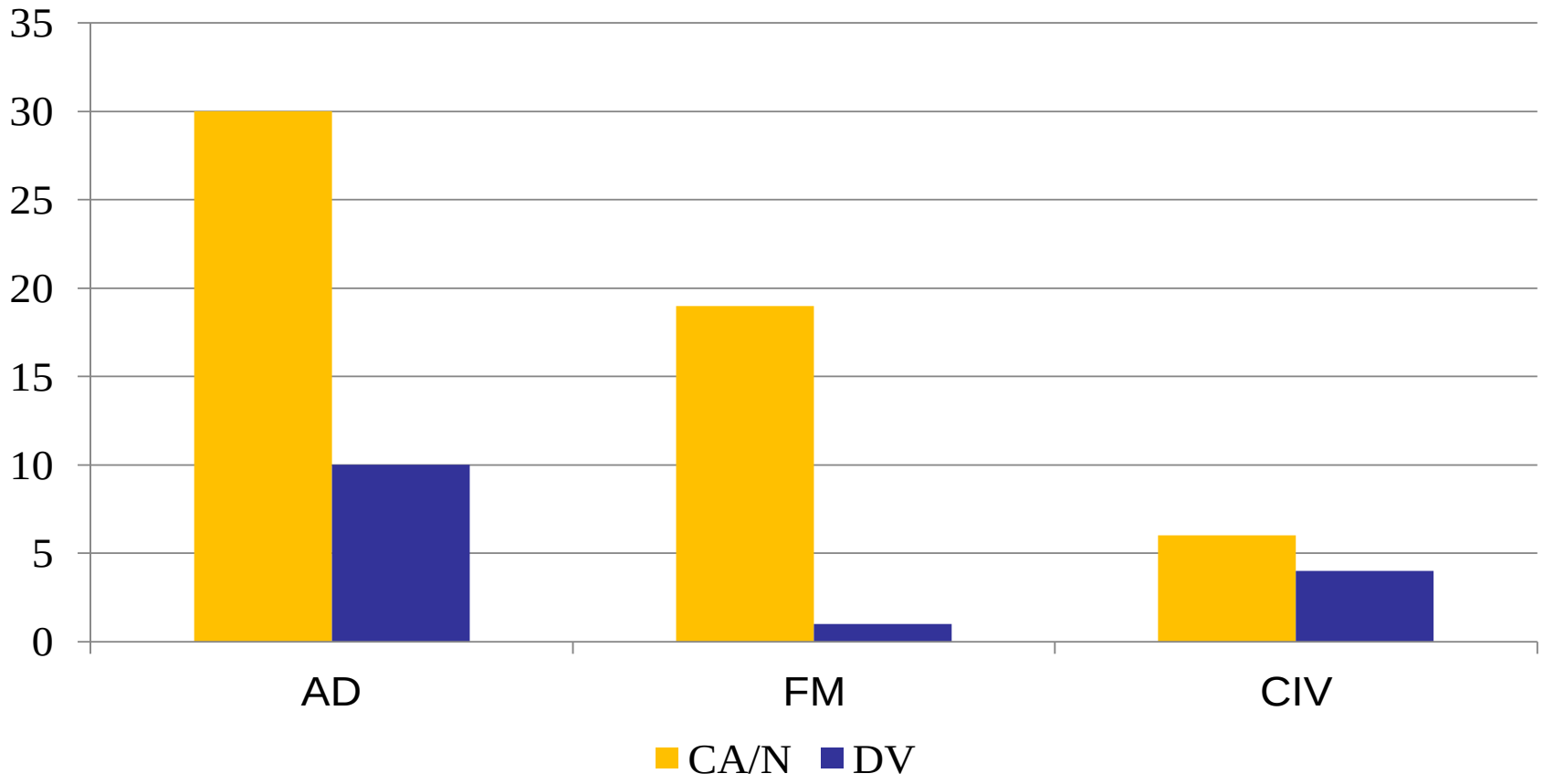
Offender Status



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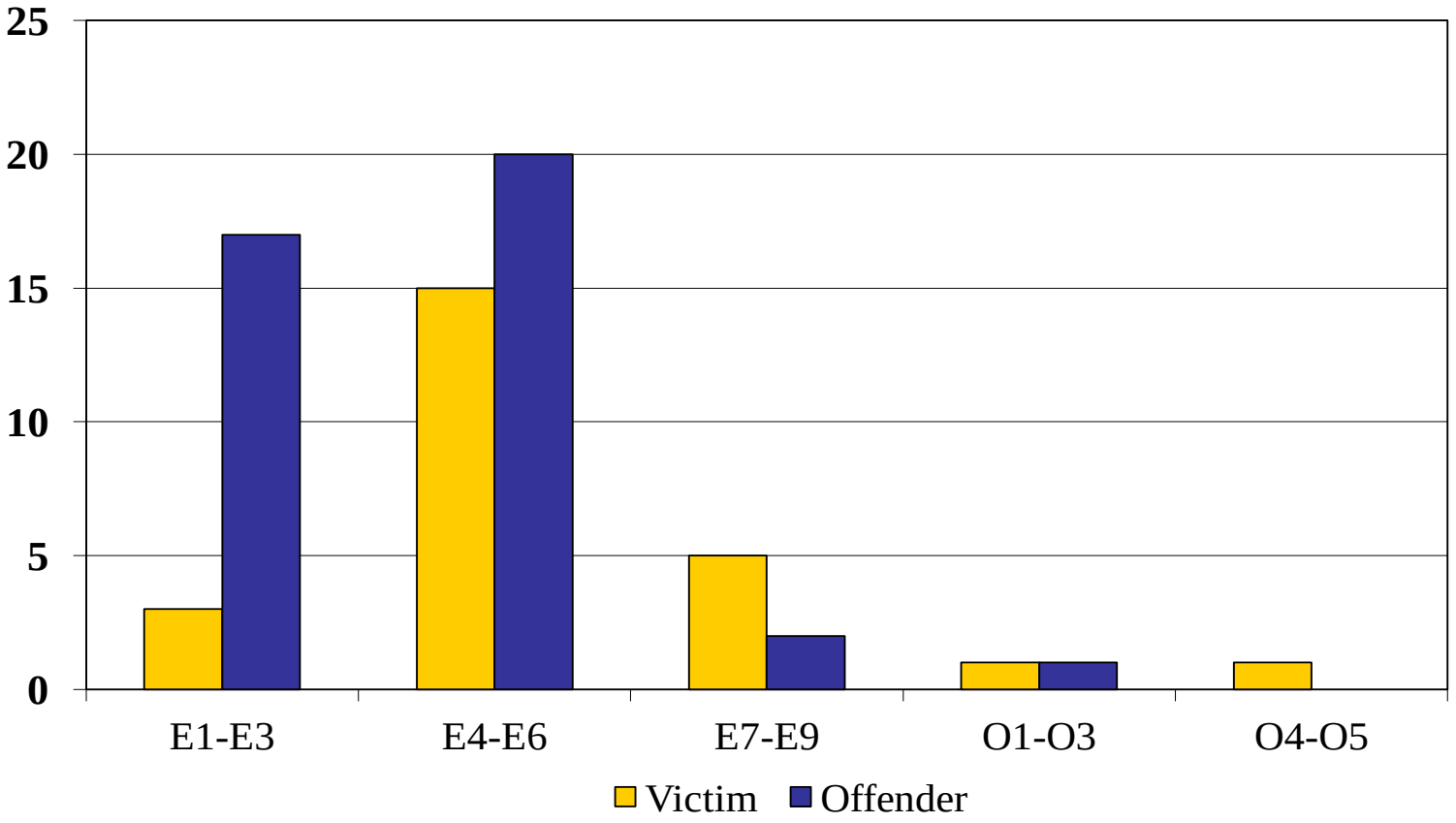
Pay Grade of Victims and Offenders



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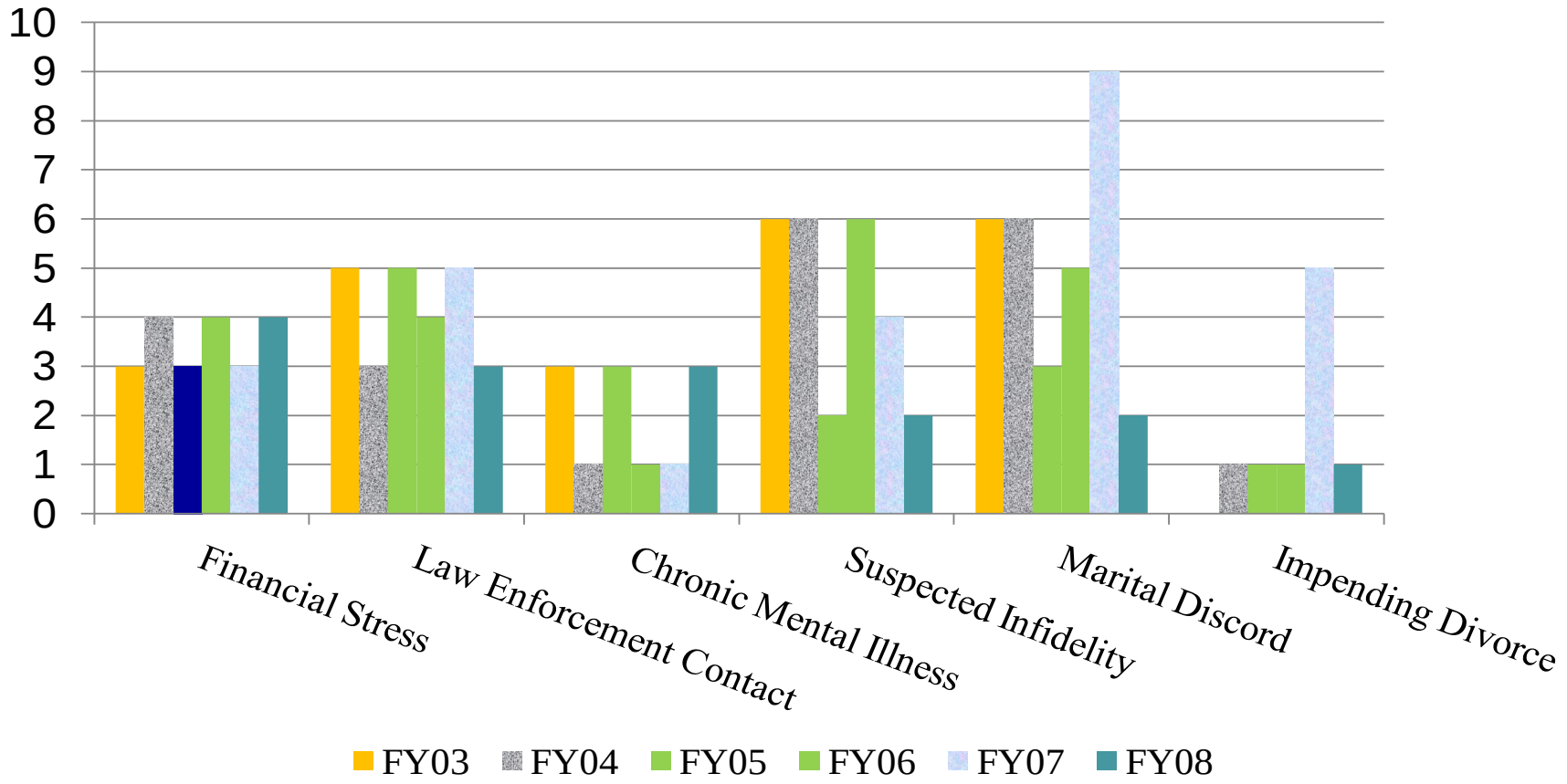
Select Family Background Variables



Enclosure (31)

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