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

2010

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

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Executive Summary

As directed by the Under Secretary of Defense for Personnel and Readiness (USD P&R), the Air Force has conducted a 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 2008 involving Air Force members and their family members or intimate partners, as defined by the Department of Defense (DOD), were reviewed by the 2010 Air Force Fatality Review Board.

The review team conducted individual and group reviews of available records from the following agencies and organizations: Family Advocacy, military medical treatment facilities (MTFs), Office of Special Investigations (OSI), Mental Health, including Alcohol and Drug Abuse Prevention and Treatment (ADAPT) personnel, Air Force Personnel Center (AFPC), Judge Advocate, and Security Forces.

Significant findings and proposed recommendations resulting from the review are listed below:

2010 Fatality Review Proposed Recommendations

1. **Finding:** FAP failed to develop an adequate safety plan for the victim. FAP provider:
    - Did not pursue a full explanation from the parents about all of the victim's injuries
    - Did not directly confront the parents' minimization of the injuries
    - Allowed alleged offender to deny causing some of the injuries and remain in the home
    - Failed to separate alleged offender from victim after the second physical abuse incident in a short period of time
    - Did not interview the children separately from the parents to inquire about continued abuse during the follow-up session, nor did the provider ever contact DoD school personnel to inquire about continued safety concerns

2. **Finding:** FAP providers make independent decisions about lowering risk status on moderate or high risk cases without clinical staffing or consultation.

Recommendations from Findings 1 and 2: Train new FAP providers in effective safety planning and ensure adequate supervision.

Actions taken or underway: FAP Treatment Managers were trained in August 2010, and AF FAP Standards were amended to include:

- Providers must consult a clinical supervisor prior to lowering risk status.

- When high risk status is established, clients will remain on high risk status (and managed that way) for no less than 30 days.
- Alleged offenders and victims on high risk status will have weekly FAP contact, and the FAP provider must also contact the Commander or First Sergeant at least weekly on high risk cases.
- Follow-up with victims/other family members, to determine whether abuse is continuing, will be done individually and prior to family or couple sessions.

3. **Finding:** Air Force does not have foster homes in OCONUS locations making it difficult to separate child victims from offenders.

Recommendation: Written/integrated AF guidance is needed for emergency stabilization of families at high risk for maltreatment, and for procedures to enhance access to services not available in OCONUS areas. These options include Early Return of Dependents, reassignment under Exceptional Family Member Program, and Humanitarian reassignments involving high risk family maltreatment situations.

Actions Taken or Underway: AFMOA/SGHW has conducted a survey of installation FAP offices regarding delays in returning high-risk families to the CONUS. AFMOA will coordinate a concise reference on management of high-risk family maltreatment incidents in OCONUS areas for dissemination to all AF MTFs.

4. **Finding:** Many young, at-risk families are not being referred to/enrolled in AF prevention programs such as New Parent Support Program (NPSP).

Recommendation: Commanders and First Sergeants should refer all expectant parents/parents of young children to FAP/NPSP for prevention services and provide active duty members time to meet with prevention staff for education and support.

Actions Taken or Underway: AF FAP developed an enhanced data system for tracking FAP's educational contacts with unit leaders; enhancement released to MTFs in Oct 2010. AFMOA/SGHW will track MTF compliance with requirement to brief all Commanders and First Sergeants on the benefits of participation in NPSP.

5. **Finding:** Airmen who report to duty with body odor, unkempt appearance, and other personal hygiene issues and who have small children in the home, frequently have serious problems with unsanitary living conditions and other risk factors associated with child neglect and/or infant deaths. Commanders and First Sergeants do not consistently recognize the association between poor personal hygiene and unsanitary living conditions to risks for children of these airmen. Units do not consistently

provide adequate follow-up and appropriate referrals when airmen are identified with unsanitary living conditions.

Recommendation: Increase Commander and supervisor awareness of the significant risk involved with airmen displaying disheveled and unkempt appearance/poor hygiene and the importance of assessing and reassessing the home environment in these situations, especially when children are in the home.

Actions Taken or Underway: AFMOA/SGHW trained MTF-level FAP staff (outreach, prevention and intervention staff) on the findings of this Fatality Review during summer 2010, and is incorporating these considerations in ongoing trainings and unit outreach materials.

6. **Finding:** Airmen with financial problems, problems securing appropriate childcare, and/or establishing reliable dependent care plans are at risk for child neglect by leaving their children with unsuitable and sometimes dangerous caregivers.

Recommendation: Commander or First Sergeant's support and assistance in locating appropriate child care is key to helping Airmen keep their children safe.

Actions Taken or Underway: AFMOA/SGHW to incorporate this information in standardized training materials and guidance for outreach/prevention staff. MTF FAP staffs participate in installation Community Action Information Boards where local shortcomings in affordable childcare may be addressed.

7. **Finding:** FAP provider's intervention plan for domestic abuse was limited to an anger management class which does not meet standard of care for treatment of domestic abuse alleged offenders IAW AF FAP Standards.

8. **Finding:** FAP provider did not conduct the required home visits when a child less than 12 months resided in the home where domestic abuse allegedly occurred; nor did he document attempts to conduct a home visit or explain why this was not accomplished.

9. **Finding:** IAW AF suicide management policies, any person on an anti-depressant must be assessed for mood and safety at every medical encounter. This alleged offender's medical record indicates he was not properly assessed by his physician.

10. **Finding:** Family Advocacy provider failed to make child protective services referrals regarding the two domestic abuse incidents where the infant was clearly present in the home.

Recommendation: FAP providers must follow AF FAP clinical practice standards, and medical providers must adhere to AF suicide management

protocols to meet standard of patient care and maintain clinical privileges in the MTF.

Actions Taken or Underway: Failures of any credentialed provider to follow AF requirements for standards of client/patient care are referred to the MTF Chief of the Medical Staff for credentialing/privileging review.

11. **Finding:** Medical providers and FAP nurse failed to effectively communicate concerns about mother's potential post-partum depression.

12. **Finding:** A new NPSP case should have been opened for the second pregnancy and attempts should have been made to contact parents.

13. **Finding:** AF Child Development Center were aware of parents' inadequate parenting of older child and therefore should have reported to FAP their concerns about older child's current diaper rash and hygiene issues, as well as parents' hygiene issues, especially knowing a new baby was in the home.

14. **Finding:** Unit leaders should have looked into the home environment, given they knew Subjects had two small children and Subject 2 had such poor hygiene.

Recommendations:

- Positive post partum depression screeners should be placed in AHLTA or provider have some way to flag the medical record as high risk and have increased follow-up or tracking.
- Increase wingmen/unit awareness of the significance of disheveled, unkempt appearance/poor hygiene and the importance of assessing the home environment in these situations especially when children are in the home. Also significant changes or deterioration of personal hygiene or behavior should be evaluated.
- In required leadership orientation and annual training given by Family Advocacy Outreach Managers, include training concerning common risk factors that would indicate a need to look closer at similar situations and refer to services.

Actions Taken or Underway: AFMOA/SGHW has increased collaboration with AF/A1S to enhance standardized child-care personnel training on identification of risk factors for infants and toddlers. As mentioned previously, FAP staff have been trained on results of the Fatality Review and standardized trainings are under revision to incorporate this material in outreach/prevention contacts.

15. **Finding:** It is important to educate personnel assigned to sensitive duty positions (e.g., PRP, flight status) about the potential

temporary nature of being removed from their special status when participating in FAP services.

Recommendation:

- Examine the process of ensuring medical or mental health treatment records or summaries are sent to the assigned MTF to be placed in the beneficiary's outpatient or mental health record.
- Recommend that special attention be given to units that have sustained high-ops tempo such as prevention briefings from ADAPT, FAP Outreach Manager, Mental Health, etc.
- Increase awareness of the dangers of not accessing care for personal/family matters for fear of impacting career or unit.

Actions Taken or Underway: AFMOA has established a Resiliency Branch, and publication of a new AFI (Mental Health) is pending that directs the establishment of a Resilience Element at every MTF. The Resilience Elements/Branch will focus on building unit capacity for resilience despite unit-specific stressors. AFMOA continues to balance activities designed to reduce stigma with necessary vigilance for conditions that potentially jeopardize the AF mission.

Recommendation Review Plan

Based on the small number of incidents reviewed annually in the USAF (Average 6.5), it was deemed inadvisable to make formal recommendations with widespread policy impact on an annual basis. Recommendations contained in this report include "case-specific" and "proposed" recommendations. The potential policy recommendations derived from the annual review will be considered for inclusion in formal policy recommendations made on the basis of a 5-year comprehensive review. The AF submitted the first formal policy recommendations in the 5-year Fatality Review Report in 2009.

Introduction

The Under Secretary of Defense for Personnel and Readiness (USDP&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 Military and Certain Affiliated Personnel," August 21, 2007, 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 against any of following:

(1) An active duty military member.
(2) A current or former family member of an active duty member.
(3) A current or former intimate partner; defined as a person of the opposite sex 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 2 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.

This report details the Air Force's sixth Domestic Violence and Child Maltreatment Fatality Review. The review was convened from 12-16 April, 2010 in San Antonio, Texas and was chaired by the Air Force Family Advocacy Treatment Program Manager. 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 (OSI)
- Air Force Medical Operations Agency: Family Advocacy/New Parent Support, Psychiatry, Family Practice, and Forensic Pediatrics
- Air Force Chief of Chaplains
- Air Force Security Forces
- Air Force Domestic Abuse Victim Advocate
- Air Force Chief Master Sergeant Representative (First Sergeant)

Some participants completed Fatality Review Training arranged by DoD 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 Fatality Review. The review covered Air Force fatalities that occurred in fiscal year 2008. Seven deaths were reviewed from six incidents including four child victims and three adults, two adults were suicides related to child maltreatment. Based on DoD policy, all fatalities involving a current or former intimate partner must be included in the review. This policy took effect in CY 2006. Prior to this, only married partners were defined as victims of domestic violence. The policy change rendered unmarried intimates, as defined above, eligible for FAP assessment and services as well as inclusion in the fatality review.

Fatality Review Board Process

The committee used the following documents to conduct their reviews:

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

The review was conducted in compliance with confidentiality and information protection requirements set forth by the USD P&R in DoDI 6400.06, "Domestic Abuse Involving DoD Military and Certain Affiliated Personnel," August 21, 2007. Measures employed by the team included maintaining all records under double locks, briefing all members about DoD and state privacy and confidentiality policies, and conducting all proceedings as closed meetings. All hard copies of the documents used by the Board were destroyed at the conclusion of the review.

Board members first completed extensive individual reviews of all available records using standardized Fatality Timeline Forms. 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 Deceased and Subject demographics. Second, a detailed case timeline was constructed documenting all known facts about the Deceased, the Subject, and

their interactions with families, friends, supervisors, co-workers, and organizations or agencies, leading up to 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 deaths from maltreatment, 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. 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. This year the Board recommended eliminating some items on the worksheet that were redundant and assigned Board members to complete specific items. The Board focused on streamlining the review process in order to manage the increasing numbers of maltreatment incidents to be reviewed.

Fatality Summaries

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

CASE REVIEW SUMMARY:
Case Designation: C1-2010

SUBJECT 1: 25-year-old, Hispanic Male, Civilian, Stepfather of Victim
SUBJECT 2: 29-year-old, Caucasian Female, ADAF E-5, Mother of Victim
VICTIM: 8-year-old, Male, Family Member-Son
OTHER HOUSEHOLD MEMBERS: 10-year-old Family Member-Daughter

Brief Summary of Events and Relevant History:

The victim was transported to the emergency room not breathing and could not be resuscitated. Death was determined to be homicide due to blunt force abdominal trauma. Injuries included a lacerated liver, extensive abdominal and pelvic hemorrhage, and multiple contusions – left forehead, left scalp, lateral to left eye, left face/mandible, right mandible, left upper lip, neck, chest, suprapubic

area, back, buttocks, arms, and legs. There was a history of two substantiated child physical maltreatment cases of Subject 1 against victim (Nov 06, and Jan 07) involving bruises to the forehead, leg, back, buttocks and marks on the neck. There were reports of excessive physical discipline and both Subjects reported spanking victim. The sister reported that the most recent punishment for victim was that he had to stand and take punches to the abdomen delivered by Subject 1. In Nov 06 victim attempted to run away. He went to town and told Japanese civilians that he wanted to get to the airport to go back to the states. Victim reported that Subject 1 hit him, that no one wanted him at home, and that he was afraid of Subject 1. Victim did not disclose abuse to the Japanese police and was returned to the family. There was some physical maltreatment directed at the sister but not to the same extent or severity as victim.

Systems, Agency and Unit Contact Interventions:

FAP had two substantiated child physical maltreatment cases that were open at the time of the child's death. Both referrals were by school personnel. The family was in therapy at the time of the death. The last session was on 4 April 07, a week prior to his death. AF medical personnel were involved in the examinations for both alleged maltreatment incidents.

Legal Disposition:

On 22 Oct 09, Subject 1 was found guilty by federal jury of murdering 8-year-old stepson. On 6 Jan 10, he was sentenced to 30 years in prison, followed by 5 years supervised release.

Lessons Learned:

- FAP provider conducted psychosocial assessments with all family members but never got a full explanation from the Subjects about all of Victim's injuries, did not directly confront the Subjects' minimization of the injuries, and allowed Subject 1's denial of causing some of the injuries to allow Subject 1 to remain in the home.
- FAP did not interview the children separately from the Subjects to inquire about continued abuse during the April 07 session.
- There is no documentation that this case was clinically staffed with a supervisor (except for FMCMT discussions), even though the risk of maltreatment was changed from high to moderate by the provider.
- Inadequate safety plan for Victim and failure to separate Subject 1 from Victim after the second physical abuse incident in a short period of time
- Closer observation of progress and follow-up with victim, sibling, teachers, and school nurses may have identified more risk factors. Third parties are more likely to be objective.

Case Specific Recommendation(s):

• FAP Providers should not be allowed to lower risk level without consulting a clinical supervisor. High risk clients must remain high risk and managed that way for no less than 30 days. High risk alleged offenders and victims must have weekly FAP contact and FAP must also contact the CC/CCF weekly on high risk cases.
• Air Force does not have any foster homes in some OCONUS locations (e.g. Japan) making it difficult to separate child victims from civilian alleged offenders. Written policy is needed for emergency Early Return of Dependents, Exceptional Family Member Program, and Humanitarian Reassignments for high risk abuse situations.
• Follow-up with victims/other family members to determine whether abuse is continuing should be done individually and prior to family or couple sessions.

CASE REVIEW SUMARY:
Case Designation: C2-2010

SUBJECT 1: 26-year-old, Hispanic Male, Civilian, Stepfather of Victim
SUBJECT 2: 27-year-old, Hispanic Female, ADAF E-4, Mother of Victim,
VICTIM: 2-year-old, Caucasian Male, Family Member-Son

Brief Summary of Events and Relevant History:

Victim was found unresponsive by Subject 2 at approximately 1830 on 14 August 2007. Like most days, Subject 1 was home alone with Victim while Subject 2 was at work. Emergency personnel transported Victim to an off-base hospital and noted that he had bruises to his face, cheeks, inside thighs of both legs, and a possible broken clavicle. Hospital personnel also noted the bruising and possible broken clavicle. Doctors diagnosed Victim with a subdural hematoma, fractured clavicle, and limited brain activity. Subject 1 claimed Victim had fallen. On 14 August 2007, skeletal surveys of Victim disclosed multiple healing fractures, including fractures on Victim's anterior ribs, humerus, and fibula.

On 15 August 2007, Subjects were told Victim's injuries were too severe to survive. Four hours later, Subject 1 jumped off a freeway overpass and was transported to the hospital with a ruptured spinal column and other severe injuries to his extremities. On 16 August 2007, Victim was pronounced brain dead. An autopsy listed the cause of death as multiple blunt-force injuries and the manner of death was listed as homicide. On 23 August 2007, Subject 1 confessed to injuring and killing Victim by shaking him "severely" and hitting his head against a wall. On 1 November 2007, Subject 1 died while undergoing surgery related to the injuries sustained during his suicide attempt. Subject 1's death certificate listed his death as a suicide. Subject 2 later admitted in court that she knew Subject 1 was abusing Victim.

Systems, Agency and Unit Contact Interventions:

During 18-month well baby check, medical group personnel noted developmental delay and growth chart with concerning decline in weight percentiles from 6 to 18 months. Referral was made to First Connections Early Intervention, but no appointment was made by Subject 1 or 2. Subject 2 was counseled for her poor hygiene/dress and appearance. Subject 2 did not engage in any FAP services and did not have any contact with NPSP.

Legal Disposition:

Cause of death was homicide by blunt force trauma. Subject 1 died before he could be prosecuted; Subject 2 pled guilty to assault of a child under 16 as part of a plea bargain. Subject 2 was sentenced to five years' probation, $1,000 fine, and anger management and parenting classes. In addition, Subject 2 was involuntarily separated from the Air Force with a general (other than honorable conditions) discharge.

Lessons Learned:

• Enrollment in NPSP or other prevention programs may have resulted in a better outcome.
• Commander should refer new or expectant parents to FAP/NPSP and other prevention services.

Case Specific Recommendations:

• Increase wingmen/unit awareness of disheveled, unkempt appearance/poor hygiene and the importance of assessing the home environment in the situations especially when children are in the home.
• Increase wingmen/unit awareness of financial issues and childcare problems, particularly when an Airman seemingly impulsively marries.

CASE REVIEW SUMMARY:
Case Designation: C3-2010

SUBJECT 1: 22-year-old, Caucasian Male, ADAF E-3, Father of Victim
SUBJECT 2: 23-year-old, Caucasian Female, Civilian, Mother of Victim
VICTIM: 5-month-old, Caucasian Female, Family Member-Daughter
OTHER HOUSEHOLD MEMBERS: 28-month-old, Family Member-Daughter

Brief Summary of Events and Relevant History:

The victim was found unresponsive in her crib under a large pile of stuffed animals presumably placed there by her 28 month old sibling. The 2 children had been left alone in the bedroom for 5 to 6 hours without being checked.

Death was determined to be accidental suffocation. There was a pattern of significant parental neglect. Friends identified concerns of lack of supervision and proper attention to the needs of the children. Some concerns were also relayed to the supervisor and/or First Sergeant who believed the family had taken the child to the doctor. At the time of death, the house was unsafe and unsanitary with filthy living conditions, numerous open partially filled containers of alcohol, potential choking items on floor and medications within reach, animal feces and partially eaten food on floor, smell of urine, dirty diapers throughout the home, broken glass, etc. This was a pattern with the family as the house had been in this condition before and command was aware of past issues. Medical care was lacking with failure to follow-up with routine well child care and victim behind in immunizations. Victim was noted to have dirt and debris on her body at autopsy, and dehydration and moderate diaper rash was noted. Diaper rash was a recurrent problem for both children to the point of being considered neglectful in past though referral to FAP or CPS not done. There were reports of depression in Subject 2.

Systems, Agency and Unit Contact Interventions:

FAP was involved with family due to domestic violence since April 2007. There were three cases that met criteria for partner physical abuse prior to death of victim. Subject 1 completed anger management course twice; Subject 2 refused counseling. CPS was notified due to the domestic violence, but the case was unfounded. The unit was aware of the unsafe/unsanitary house issues. The house did pass two known re-inspections.

Legal Disposition:

Subject 1 was discharged on 14 Nov 08, with a General discharge. Both subjects pled guilty to Child Abuse and Neglect (Category B Felony) in violation of NRS 200.508. Subjects received 5 years probation/60 month jail sentence which was suspended time served. They were also charged $150.00 for DNA analysis and $25.00 for processing.

Lessons Learned:

- FAP did not treat DV appropriately (Anger Management alone is insufficient) and they did not conduct home visit for the last two DV referrals where a child under one year was in the home.
- Any person on an anti-depressant must be assessed for mood and safety at every medical encounter and Subject 2 was not assessed.
- CPS was not notified of the first two DV incidents.

Case Specific Recommendation(s):

• Enhance outreach/standardized training to emphasize the significance of the housing situation when assessing risk to children, and importance of follow-up
• Enhance communication between FAP and command/unit
• FAP must educate wingmen/units regarding the significance of risk factors such as poor hygiene, unsanitary living conditions, financial stress, and significant marital discord or domestic abuse

CASE REVIEW SUMARY:
Case Designation: C4-2010

SUBJECT 1: 18-year-old, Caucasian Female, Civilian, Mother of Victim
SUBJECT 2: 22-year-old, Caucasian Male, ADAF E-3, Father of Victim,
VICTIM: 5-week-old, Caucasian Male, Family Member-Son
OTHER HOUSEHOLD MEMBERS: 16-month-old, Caucasian Male, Family Member-Son

Brief Summary of Events and Relevant History:

Victim was found unresponsive by Subject 1 at approximately 1400 on 9 June 2008. Victim had been placed in his crib the night before and was last checked on at 0030 on 9 June 2008 by Subject 2. Subject 2 left for work on 9 June 2009 at 0600 but did not check on Victim. Subject 2 returned to his on-base home at 1130 for lunch, at which time he woke Subject 1. Subject 2 left at approximately 1230 to return to work. Subject 1 began playing the online fantasy game "World of Warcraft" after Subject 2 returned to work. At approximately 1400, Subject 1 checked on Victim and discovered that a blanket was covering his mouth and he was not breathing. Emergency personnel responded but could not resuscitate Victim and declared him dead at the scene. Subject 1 initially told authorities that she had checked on and fed Victim at 1130 and laid him in his crib for a nap. First responders and OSI agents noted that the residence was in disarray and extremely dirty, to include numerous insects and rat feces scattered throughout the home and even inside Victim's crib. Subject 2 informed authorities that he and Subject 1 had recently started playing World of Warcraft extensively and, as a result, many household chores had been neglected. Co-workers, friends, and neighbors indicated that Subjects were not clean people and their residence was regularly filthy. Personnel at the Child Development Center stated that Subjects' 16-month-old son was often dirty and had chronic severe diaper rash that would be healed by Friday; however, on Mondays the rash would reappear. During a well baby check for Subjects' older son, Subject 1—a high school dropout and teenage mother—was screened positive for post-partum depression. Prior to

Victim's death, Subject 1 told a neighbor that both children may not have been Subject 2's biological offspring.

Systems, Agency and Unit Contact Interventions:

Subject 1 enrolled in NPSP and received several visits while older son was an infant. Family Advocacy Nurse (FAN) referred Subject 1 to Mental Health, WIC, and the local school district (for completion of high school/GED). Case was closed due to loss of contact after numerous attempts by FAN to contact her. Subject 1 contacted FAN briefly for pregnancy test referral. Subject 1 completed NPSP paperwork during second pregnancy. No documentation of subsequent contact with client due to FAN vacancy. Subject did not access Mental Health services until after Victim's death.

Legal Disposition:

Cause of death was inconclusive; civilian and military authorities declined to prosecute.

Lessons Learned:

- Medical providers need to improve communication with each other whenever potential post-partum depression is identified.
- Unit leaders should refer expectant and young families to NPSP and give them time off to participate. While participation is voluntary, encouragement and support from units is likely to enhance participation.
- A new NPSP case should have been opened for the second pregnancy and attempts should have been made to contact clients.
- CDC should have reported their concerns about older child's diaper rash and hygiene issues, as well as parents' hygiene issues, especially knowing a new baby was in the home.
- Unit leaders should have looked into the home environment, given they knew Subjects had two small children and Subject 2 had such poor hygiene.

Case Specific Recommendations:

- Positive post partum depression screeners should be placed in AHLTA or provider have some way to flag the medical record as high risk and have increased follow-up or tracking.
- Increase wingmen/unit awareness of the significance of disheveled, unkempt appearance/poor hygiene and the importance of assessing the home environment in these situations especially when children are in the home. Also significant changes or deterioration of personal hygiene or behavior should be evaluated.
- In required leadership orientation and annual training given by Family Advocacy Outreach Managers, include training concerning common risk factors that would indicate a need to look closer at similar situations and refer to services.

CASE REVIEW SUMMARY:
Case Designation: P1-2010

VICTIM: 33-year-old, Caucasian Male, ADAF E-6, Victim of Shooting by Wife
SUBJECT: 32-year-old, Caucasian Female, Civilian, Alleged Offender of Domestic Abuse to Husband
OTHER HOUSEHOLD MEMBERS: 14-year-old, Stepdaughter; 11-year-old, Son

Brief Summary of Events and Relevant History:

On 8 Mar 07, Subject advised Victim that she planned to move with children from the area to get specialized educational services for her hearing impaired daughter. On 9 Mar 07, Subject allegedly received one threatening phone call and two unanswered phone calls from Victim; therefore, she loaded her gun "just in case" and laid down. Subject walked down the hall and saw Victim standing in the house. Victim allegedly called Subject several names, punched her in the face, slammed her against the wall and cut her with a knife telling her she wasn't going anywhere. Subject ran into the bedroom retrieved the gun and locked herself in the bathroom. Subject stated she told Victim that she had a gun, and the Victim "busted into the bathroom". Victim called her a "bitch" and she shot him with .357 Magnum handgun. Victim moved the knife in her direction and she shot him. A total of four gunshots were fired. Subject took the knife from Victim, dropped the gun, apologized, checked his pulse and called 911.

Background Information: On 29 Aug 04, FAP received initial allegation of spouse physical abuse where Victim allegedly assaulted Subject. Subject was seen for intake interview on 30 August 04. She confirmed allegation and she was referred to a Victim Advocate for "direct services". Victim did not go to FAP for initial interview until 23 June 2005 on advice of ADC. During interview Subject stated Victim pulled her from the car, hit her near her kidneys because she was having treatment for renal cancer. She reported that she had a hysterectomy in the past due to beatings from Victim. Victim was the alleged offender in a FAP partner maltreatment incident for physical abuse that met criteria. It remained open until 10 February 2005.

Systems, Agency and Unit Contact Interventions:

FAP had contact with Victim and Subject in Aug/Sep 2004. Couple was non-compliant with treatment and the case was appropriately closed "unresolved" in Feb 2005.
Victim's unit issued a No Contact order in Sep 2004. Subject received a restraining order that was later amended by Subject to allow for non-violent contact. Victim was seen in Mental Health for three sessions following a domestic abuse incident in Aug 2004.

Legal Disposition:

Civilian authorities have dropped the case. AFOSI case remains open as they continue to investigate.

Lessons Learned:

Case is still open

Case Specific Recommendations:

None at this time

CASE REVIEW SUMMARY:
Case Designation: C/Su1-2010

SUBJECT (DECEASED): 37-year-old, Caucasian Male, ADAF E-6, Suicide by Gunshot
OTHER HOUSEHOLD MEMBERS: 36-year-old, Caucasian Female, Civilian Wife of Deceased and 16-year-old, Family Member-Stepdaughter

Brief Summary of Events and Relevant History:

Subject had recently returned from deployment on 7 Dec 2007. While he was at home on 3 Jan 08, he and the FM/SD had a conversation. The FM/SD reported that the Subject has offered her money for sex. FM/SD reported that the Subject entered her bedroom and asked her what she could do to earn her driving and cell phone privileges and $300.00. During the conversation Subject said "sex" and told her not to tell her mother about the conversation. FM/SD refused the offer and told the Subject he needed serious help. The Subject then telephoned the FM/W to inform her that FM/SD was going to tell her that he had solicited her for sex. Upon interview FM/SD said prior to deployment Subject told her he was attracted to her, and approximately a week before his death he made open-ended, vague innuendos about his desires and needs.

The Subject left at 1400 on 3 Jan 08 for a post deployment physical examination appt. He denied any suicidal/homicidal ideation at this appointment. He told his Primary Care Manager that he was doing well. The Subject and the FM/W had a heated argument when she got home from work. The FM/SD had been seeing a civilian mental health provider, and the couple agreed to go to FM/SD's counselor. They made an appointment for 1800 that evening.

In 2006, prior to his deployment, FM/W reported that the Subject had told her that he felt depressed and worthless. He alluded to something he had said that would get him fired or put in jail, but he never provided an explanation of what it was.

After the argument with FM/W and FM/SD, Subject went to a neighbor's house to wait until the counseling appointment. The Subject returned shortly thereafter, grabbed the car keys, and proceeded to the master bedroom. The FM/W followed him to the master bedroom and noticed the gun case had been removed. The Subject was in the bathroom with the door shut. The FM/W reported that she asked if the Subject had the gun and he replied he did. The FM/W reported that she asked the Subject if he was "going to do anything stupid with it." The Subject is reported as replying, "No." He then told her he loved her. At approximately 1630 on the same day, Subject, while in the bathroom, shot himself.

Systems Agency and Unit Contact and Interventions:

CPS was contacted the day of the incident. FM/SD removed from the home and placed with biological father's sister. Civilian counselor provided individual counseling for the FM/SD. FAP was involved after the fact. FAP also assessed the FM/W for potential physical abuse to the FM/SD due to the fight they had about the allegation. The incident did not meet criteria.

Legal Disposition:

None - Subject completed suicide

Lessons Learned:

It is important to educate personnel assigned to sensitive duty positions about the potential temporary nature of being removed from their special status when services are being received.

Case Specific Recommendation(s):

- Examine the process of ensuring medical/mental health treatment records/summaries are sent to the assigned MTF to be placed in the beneficiary's outpatient/mental health record.
- Recommend that special attention be given to units that have sustained high-ops tempo. Preventive briefings from ADAPT, FAP Outreach Manager, Mental Health, etc.
- Increase awareness of the dangers of not accessing care for personal matters for fear of impacting career or unit.

2010 Fatality Review Findings and Proposed Recommendations

1. **Finding:** Inadequate safety plan for the victim. FAP provider:
    - Never got a full explanation from the parents about all of the victim's injuries
    - Did not directly confront the parents' minimization of the injuries
    - Allowed alleged offender to deny causing some of the injuries and still remain in the home
    - Failed to separate alleged offender from victim after the second physical abuse incident in a short period of time
    - Did not interview the children separately from the parents to inquire about continued abuse during the follow-up session, nor did the provider ever contact DoD school personnel to inquire about continued safety concerns

2. **Finding:** FAP providers appear to be routinely making independent decisions about lowering risk status on moderate or high risk cases without clinical staffing or consultation.

Recommendation: New FAP providers will be trained in effective safety planning and adequately supervised. AF FAP Standards were amended to include:

- Providers must consult a clinical supervisor prior to lowering risk status.
- When high risk is established, clients will remain on high risk status (and managed that way) for no less than 30 days.
- High risk alleged offenders and victims will have weekly FAP contact and the FAP provider must also contact the Commander or First Sergeant weekly on high risk cases.
- Follow-up with victims/other family members, to determine whether abuse is continuing, will be done individually and prior to family or couple sessions.

3. **Finding:** Air Force does not have foster homes in OCONUS locations making it difficult to separate child victims from offenders.

Recommendation: Written AF guidance is needed for emergency early return of dependents, Exceptional Family Member Program, and humanitarian reassignments involving high risk family maltreatment situations.

4. **Finding:** Many young, at risk families are not being referred to/enrolled in AF prevention programs such as New Parent Support Program (NPSP).

Recommendation: Commanders and First Sergeants should refer all expectant parents to FAP/NPSP for prevention services and give active duty members time off to meet with prevention staff for education and support.

5. **Finding:** Airmen who report to duty with body odor, unkempt appearance, and other personal hygiene issues and who have small children in the home, frequently have serious problems with unsanitary living conditions and other risk factors associated with child neglect and/or infant deaths. Commander doesn't always provide adequate follow-up and appropriate referrals when airmen are identified with unsanitary living conditions.

Recommendation: Increase Commander and supervisor awareness of the significant risk involved with airmen displaying disheveled and unkempt appearance/poor hygiene and the importance of assessing and reassessing the home environment in these situations, especially when children are in the home.

6. **Finding:** Airmen with financial problems and problems securing appropriate childcare and/or establishing reliable dependent care plans are at risk for child neglect by leaving their children with unsuitable and sometimes dangerous caregivers.

Recommendation: Commander or First Sergeant's support and assistance in locating appropriate child care is key to helping Airmen keep their children safe.

7. **Finding:** FAP provider's intervention plan for domestic abuse was limited to an anger management class which does not meet standard of care for treatment of domestic abuse alleged offenders IAW AF FAP Standards.

8. **Finding:** FAP provider did not conduct the required home visits when a child less than 12 months resided in the home where domestic abuse allegedly occurred; nor did he document attempts to conduct a home visit or explain why this was not accomplished.

9. **Finding:** IAW AF suicide management policies, any person on an anti-depressant must be assessed for mood and safety at every medical encounter. This alleged offender's medical record indicates he was not properly assessed by his physician.

10. **Finding:** Family Advocacy provider failed to make child protective services referrals regarding the two domestic abuse incidents where the infant was clearly present in the home.

Recommendation: FAP providers must follow AF FAP clinical practice standards, and medical providers must adhere to AF suicide management protocols to meet standard of patient care and maintain clinical privileges in the MTF.

11. **Finding:** Medical providers and FAP nurse failed to effectively communicate concerns about mother's potential post-partum depression.

12. **Finding:** A new NPSP case should have been opened for the second pregnancy and attempts should have been made to contact parents.

13. **Finding:** AF Child Development Center were aware of parents' inadequate parenting of older child and therefore should have reported to FAP their concerns about older child's current diaper rash and hygiene issues, as well as parents' hygiene issues, especially knowing a new baby was in the home.

14. **Finding:** Unit leaders should have looked into the home environment, given they knew Subjects had two small children and Subject 2 had such poor hygiene.

Recommendation:

- Positive post partum depression screeners should be placed in AHLTA or provider have some way to flag the medical record as high risk and have increased follow-up or tracking.
- Increase wingmen/unit awareness of the significance of disheveled, unkempt appearance/poor hygiene and the importance of assessing the home environment in these situations especially when children are in the home. Also significant changes or deterioration of personal hygiene or behavior should be evaluated.
- In required leadership orientation and annual training given by Family Advocacy Outreach Managers, include training concerning common risk factors that would indicate a need to look closer at similar situations and refer to services.

15. **Finding:** It is important to educate personnel assigned to sensitive duty positions about the potential temporary nature of being removed from their special status when services are being received.

Recommendation:

- Examine the process of ensuring medical or mental health treatment records or summaries are sent to the assigned MTF to be placed in the beneficiary's outpatient or mental health record.
- Recommend that special attention be given to units that have sustained high-ops tempo such as prevention briefings from ADAPT, FAP Outreach Manager, Mental Health, etc.
- Increase awareness of the dangers of not accessing care for personal matters for fear of impacting career or unit.

Recommendation Review Process

Based on the relatively small number of incidents reviewed annually in the USAF (Average 6.5), 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. The proposed recommendations are derived from the annual review and will be considered for inclusion in formal policy recommendations made on the basis of a 5-year comprehensive review.

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