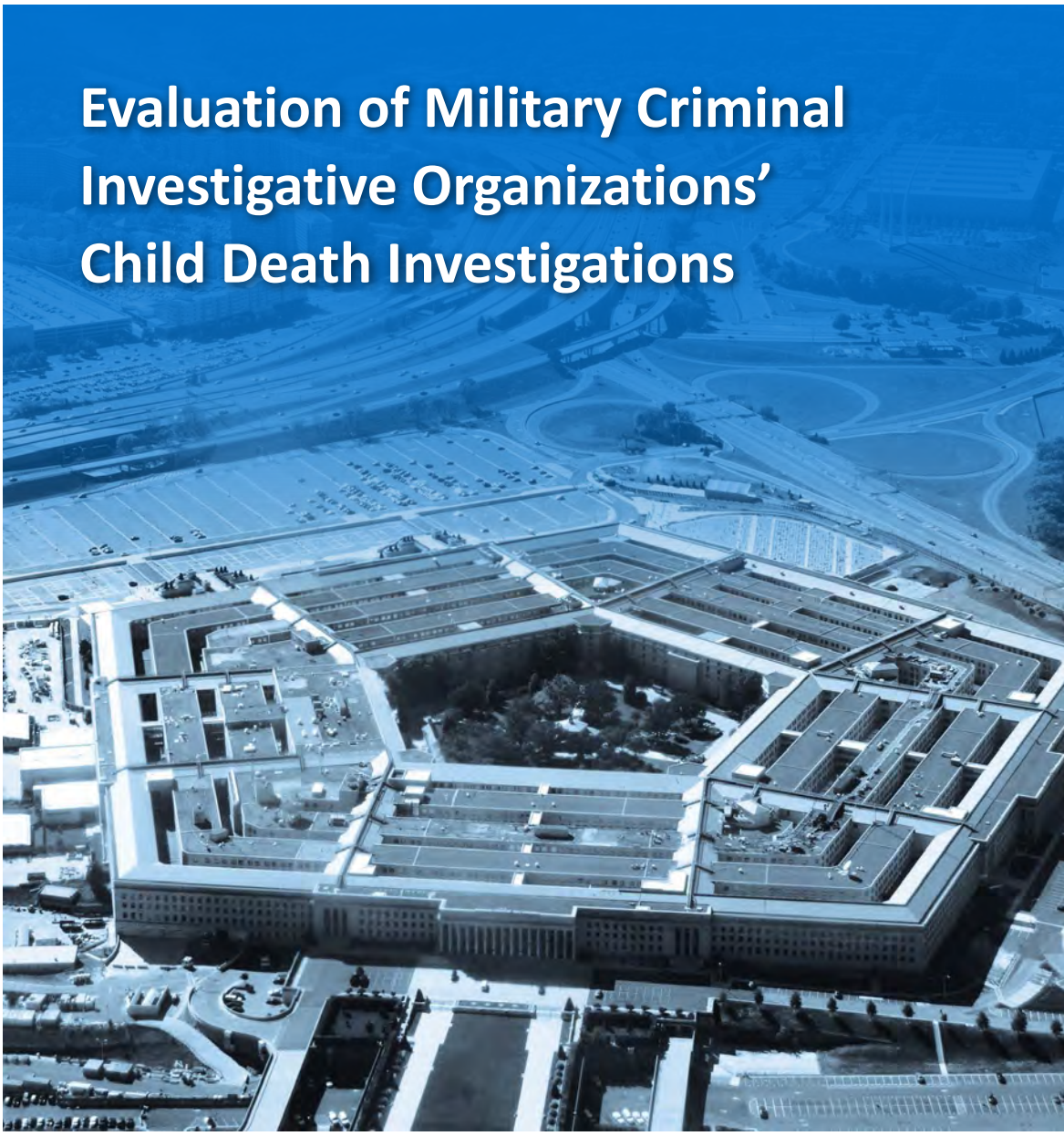
Report No. DODIG-2015-055

INSPECTOR GENERAL

U.S. Department of Defense

DECEMBER 22, 2014

Evaluation of Military Criminal Investigative Organizations' Child Death Investigations



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Results in Brief

Evaluation of Military Criminal Investigative Organizations' Child Death Investigations

December 22, 2014

Objective

We evaluated 82 Military Criminal Investigative Organization (MCIO) investigations of child deaths closed (completed and adjudicated) in Fiscal Years (FYs) 2012 and 2013, to determine whether the MCIOs completed each investigation as required by guiding DoD, Military Service and MCIO policies.

Findings

- 76 of 82 or 93 percent of MCIO investigations met investigative standards. A total of 18 cases had no investigative deficiencies. A total of 58 cases had minor deficiencies.
- We returned six cases which did not meet standards (7 percent) to the MCIOs for corrective action.
- The MCIOs conducted subject and witness interviews; obtained evidence needed to gather case facts; and used various forensic assets in almost all investigations.
- Suspect, subject, and witness interviews were well documented and contained detail supporting manner of death determinations.

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Findings (cont'd)

- Some MCIO death scene documentation revealed inconsistencies from Service and MCIO regulatory guidance in the use of techniques such as evidence triangulation and descriptive narratives of the decedent's stages of decomposition.
- 4 of 43 or 9 percent of U.S. Army Criminal Investigation Command (CID) investigations contained required documentation of quality assurance reviews of final reports.

Recommendations

- The Director and Commanders of the MCIOs

  Continue to ensure thorough child death investigations.

  Ensure thorough death scene documentation as well as evidence identification and collection, and forensic identification and documentation of post-mortem decomposition in all child death scene processing, through increased supervisory reviews, and internal oversight.

- The Commander, U.S. Army Criminal Investigation Command

  Ensure documentation of all headquarters-level quality assurance reviews of final reports.

Management Comments

The MCIOs concurred with our recommendations and management comments were responsive.

Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
The Director and Commanders of the Military Criminal Investigative Organizations	1a., 1b	1a., 1b
The Commander, U.S. Army Criminal Investigation Command	2	2

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
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December 22, 2014

MEMORANDUM FOR COMMANDER, U.S. ARMY CRIMINAL INVESTIGATIONCOMMAND
DIRECTOR, NAVAL CRIMINAL INVESTIGATIVE SERVICE
COMMANDER, AIR FORCE OFFICE OF SPECIAL INVESTIGATIONS

SUBJECT: Evaluation of Military Criminal Investigative Organizations Child Death Investigations (DODIG-2015-055)

We evaluated Military Criminal Investigative Organization (MCIO) child death investigations to determine whether they met DoD, Military Service, and MCIO investigative standards. This was a self-initiated project to meet statutory obligation to provide policy, oversight, and performance evaluation of all DoD activities relating to criminal investigation programs. We conducted this evaluation in accordance with the Council of the Inspectors General on Integrity and Efficiency (CIGIE) "Quality Standards for Inspection and Evaluation."

We determined that nearly all (93 percent) of the MCIOs' child death assault investigations evaluated met investigative standards or had only minor deficiencies. We returned cases with significant deficiencies to the responsible MCIOs for corrective action. Significant deficiencies include key evidence not being collected, crime scenes not examined, and witness or subject interviews not conducted or not thorough. We commend the MCIOs for their high compliance rate and determined approach to solving such heinous crimes against children.

We considered management comments on a draft of this report when preparing the final report. Management concurred with our recommendations therefore additional comments are not required. We appreciate the courtesies extended to the evaluation staff during the project. For more information on this report, please contact Mr. John K. Dippel at (703) 604-9294 (DSN 664-9294) or john.dippel@dodig.mil.

Randolph R. Stone
Deputy Inspector General
Policy and Oversight

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INSPECTOR GENERAL
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Introduction

Objective

We evaluated 82 Military Criminal Investigative Organization (MCIO)[1] investigations of child deaths[2] closed (completed and adjudicated) in FYs 2012 and 2013 to determine whether the MCIOs conducted investigations as required by the guiding DoD, Military Service, and MCIO policies.

Background

The DoD Inspector General [IG] is authorized, pursuant to §8(c)(5) of the Inspector General Act of 1978, as amended, 5 U.S.C. App., to "develop policy, monitor and evaluation program performance, and provide guidance with respect to all Department activities relating to criminal investigation programs." This statutory authority is implemented through paragraph 5.h. of DoD Directive [DoDD] 5106.01, "Inspector General of the Department of Defense [IG DoD]," April 20, 2012, and paragraph 5.a. of DoD Instruction [DoDI] 5505.03, "Initiation of Investigations by Defense Criminal Investigative Organizations," March 24, 2011.

The MCIOs are responsible to investigate unattended deaths of children within their jurisdiction.[3] The MCIOs also conduct inquiries when deaths involve a non-active duty decedent and occurs on a military installation within the United States and no other Federal, State, or local law enforcement agency assumes lead agency status to investigate the death.[4] The MCIOs generally define unattended deaths as any death not resulting from combat or pre-existing and previously diagnosed medical conditions, which most often stem from natural causes, such as children in hospice care. MCIOs investigate attended deaths, generally defined as a death that occurs when a child is hospitalized, but normally do so only when foul play is suspected.

The purpose of an unattended death investigation is to establish the cause, mechanism, and manner of death, as well as to collect evidence to support judicial proceedings when appropriate. In equivocal deaths[5] investigators work as a team

[1] The MCIOs are the U.S. Army Criminal Investigation Command, Naval Criminal Investigative Service, and Air Force Office of Special Investigations.

[2] For the purpose of this evaluation, a "child" is defined as a person under the age of 18 and the person was not emancipated or a member of the Armed Forces.

[3] All unattended deaths are classified by a "manner of death" of natural, accidental, homicide, suicide, or undetermined. Child homicides generally encompass offenses under Article 118, Article 119, Article 119a, and Article 134 (Negligent Homicide) of the Uniform Code of Military Justice, 2008 or 2012 Editions, or similarly framed Federal, State, local, or foreign statutes.

[4] DoDI 5505.10, "Criminal Investigations of Noncombat Deaths," August, 10, 2013 and DoDI 5505.10, January 31, 1996.

[5] "Equivocal" deaths allow for the possibility of more than one meaning or interpretation of the death. In *Merriam-Webster's Dictionary*. Retrieved June 26, 2014, from http://www.merriam-webster.com/dictionary/equivocal

with other professionals, for example, a medical examiner, to resolve medico-legal investigations of death. See Appendix B, Table B-1 for a manner of death breakdown of the 82 child death cases evaluated.

Although many elements of child death investigations are similar in any unattended death investigation, child death investigations require unique knowledge by the agents, such as childhood psychological and physical development, and skill sets, such as child interviews and examining family history, acquired through specialized training and experience, particularly when the manner of death is in question.

DoDI 5505.10, "Criminal Investigations of Noncombat Deaths" (paragraph E.1 (January 10, 1996) and 4.a. (August 15, 2013[6])) requires the DoD IG establish policy and evaluate program performance related to criminal investigations. We initiated this project to determine whether MCIO child death investigations were investigated as required by guiding policies and standards.

[6] DoDI 5505.10 was reissued on August 15, 2013. The 1996 edition of the DoDI was in effect during the course of the investigations that we reviewed for this evaluation.

Finding

Nearly all MCIO Child Death Investigations Complied with Guiding Policies and Standards

A total of 76 of 82 (93 percent) MCIO child death investigations met investigative standards or had only minor deficiencies.

Results of Child Death Investigations

Of the cases evaluated, 76 of 82 (93 percent) met investigative standards or had only minor deficiencies. A total of 6 of 82 cases (7 percent) contained significant deficiencies. Appendix B depicts numerical breakdowns by MCIO for deficiencies noted during our evaluation. Table 2 reflects a breakdown of the total incidents each MCIO investigated and the number of sample cases evaluated.

Table 2. Child Death Investigations during FY 2012 and FY 2013

Child Death Cases	Total	CID	NCIS	AFOSI
Case Population *	87*	46	19	22
Sample Cases Evaluated	82	43	19	20

* Of the 87 cases evaluated 5 did not meet the scope of the evaluation, as outlined in Appendix A, and were excluded from review.

Cases with No Deficiencies or Minor Deficiencies

Of the 82 cases evaluated, 18 cases (22 percent) had no investigative deficiencies. The remaining 58 cases (71 percent) had 1 or more minor deficiencies. Appendix B, Table B-3, depicts a breakdown by MCIO of the number of cases, with and without deficiencies.

A "minor deficiency" is a task or investigative step the MCIO did not perform or did not perform in conformity with DoD, Service, and MCIO policies and standards. A minor deficiency is not likely to affect the outcome nor have a negative impact on the investigation.

Examples of minor deficiencies include:

- appropriate medical records not collected or reviewed[7],
- routine supervisory or other required operational reviews not conducted, and/or
- record fingerprint impressions, mug photographs, and sample deoxyribonucleic acid (DNA) of subjects not obtained.

Cases with Significant Deficiencies

Of the 82 cases evaluated, 6 cases (7 percent) had significant deficiencies. A "significant deficiency" is one or more deficiencies, or series of minor deficiencies, resulting from a failure or failures in execution of elements of DoD, Service, and MCIO policies and standards of investigations. A significant deficiency indicates a breakdown in practices, programs, or policies having actual notable adverse impact on, or a likelihood of materially affecting the integrity of the investigation or adversely affecting, or having a high probability of adversely affecting, the outcome of an investigation. Examples of significant deficiencies include:

- key evidence not collected from the death scene, the subject, or the remains of the decedent; and/or
- scene examinations not conducted, not conducted thoroughly, or not conducted before the loss of crucial evidence.

We provided information on the six investigations with significant deficiencies to the respective MCIOs. We asked the MCIOs to consider our findings and evaluate those cases to conduct additional investigative activity, where practicable, to address the deficiencies. In some instances, reopening the investigation would not be a prudent use of investigative resources due to the length of time elapsed or judgment that additional efforts would be futile.

Of the six cases returned, the MCIOs agreed to reopen two cases for additional investigative work. For the remaining cases, the MCIOs determined, and we agreed, additional investigative activity was not practicable. The DoD IG will oversee results of the reopened investigations. We provided detailed explanations regarding the deficiencies including the guiding policies not followed. See Appendix B, Table B-4 for a breakdown by MCIO of the number of cases with significant deficiencies.

[7] If medical records were necessary to make a cause and manner of death determination the failure to collect them could be considered a significant deficiency; however, in nearly all cases the determination does not rest solely on the review of medical records.

Analysis of Investigative Deficiencies

Our analysis of the 82 cases included the evaluation of a combined 318 investigative steps[8] which apply to unattended death investigations in the following 8 categories: 1) actions upon receipt of death notification, 2) death scene response and scene security, 3) death scene documentation and processing, 4) documentation and evaluation of decedent remains, 5) collection of ante-mortem and postmortem records, 6) autopsy protocols, 7) multidisciplinary approach towards the investigation, and 8) supervisory reviews.

Of the 318 investigative steps, 175 were applicable to nearly all of the MCIO death investigations. The remaining 143 investigative steps were "mechanism of death"[9] specific questions to account for some of the variances among deaths, and how they may be investigated. For instance, different investigative steps will be conducted in a suicide investigation than those investigative steps conducted in a blunt-force trauma injury homicide investigation. The information that follows provides the results of how well each MCIO complied with the standards related to each of the above-listed eight categories of investigative steps applicable to unattended death investigations:

Actions Upon Receipt of Death Notification

With respect to actions required upon receipt of the death notification, the MCIOs completed 99 percent of their cases as required by established standards. The MCIOs documented how the complaint was received, to include circumstances surrounding the discovery of the victim, how the complainant was notified of the death, background information of the incident immediately conveyed to the MCIO, and information of other responding law enforcement and medical units.

The MCIOs employ agents with advanced education and training in the Forensic Sciences, referred to as Forensic Science Officers (FSO) by CID and Forensic Science Consultants (FSC) by NCIS and AFOSI. NCIS also employs major case response teams (MCRT) that respond to reported deaths. Our evaluation disclosed the following relative to actions upon receipt of death notification:

1. CID policies do not require, but recommend, consulting the FSO for assistance.

[8] The investigative steps were derived from multiple MCIO regulations, field guides, and manuals used for reference and guidance by MCIO special agents in the field.

[9] "Mechanism of death" is defined as the process that causes one or more vital organs or organ systems to fail when a fatal disease, injury, abnormality, or chemical insult occurs; it is the functional–physiologic or structural change that makes independent life no longer possible after a lethal event has occurred. Mechanism of Death. (2002). Concise Dictionary of Modern Medicine. Retrieved on May 19, 2014 from http://medical-dictionary.thefreedictionary.com/mechanism+of+death

2. As required by NCIS policy, NCIS notified MCRTs,[10] which subsequently processed the death scenes in 19 child death investigations we evaluated. However, for 14 of 19 (74 percent) investigations, due to a lack of documentation, we could not assess whether NCIS agents coordinated with FSC agents.
3. As required by AFOSIMAN 71-122 V.1, AFOSI coordinated all child death investigations with their responsible FSC, without exception.

The AFOSI policy requirement to contact FSCs in death investigations enhanced the thoroughness of evidence collection efforts. The NCIS MCRT concept allowed for task-dedicated agents to respond to death scenes and provide evidence collection, scene photography and sketches.

Death Scene Response, Scene Security, and Search Authority

The MCIOs responded to child death scenes in a manner that best preserved evidence. Upon arrival, MCIO agents established or adjusted scene security, and documented, photographed, and collected visible fragile evidence in 81 of 82 (99 percent) investigations. Additionally, when a witness potentially contaminated an item of evidence, elimination DNA and/or fingerprints were obtained in 81 of 82 (99 percent) of affected cases.

Obtaining Search Authorization or Search Warrant when Required

Of the 82 cases evaluated, legal authorization, either through an authorization to search[11], a search warrant[12], or a consent to search[13], was obtained in 79 of 82 (96 percent) of the investigations. In the three remaining investigations, authorizations may have been obtained; however, the coordination was not documented in the investigative file.

Death Scene Documentation and Processing

In total, MCIOs processed 86 death scenes in the 82 investigations. The difference in scenes processed and total investigations indicates MCIOs processed more than one scene per investigation. Death scene documentation and processing includes: scene photography; scene sketches; collection of evidence; scene description and

[10] An NCIS MCRT is made up of experienced field agents with specialized experience and specific roles (such as photography, interviews, evidence collection, and sketches) at the incident scene.

[11] An authorization to search is "express permission, written or oral, issued by competent military authority to search a person or an area for specified property or evidence or for a specific person and to seize such property, evidence, or person." Manual for Courts Martial 2012, Military Rules of Evidence, Rule 315, "Probable Cause Searches"

[12] A search warrant is "an express permission to search and seize issued by competent civilian authority." Manual for Courts Martial 2012, Military Rules of Evidence, Rule 315, "Probable Cause Searches"

[13] "A person may consent to a search of his or her person or property, or both, unless control over such property has been given to another. A person may grant consent to search property when the person exercises control over that property." Manual for Courts Martial 2012, Military Rules of Evidence, Rule 314, "Searches Not Requiring Probable Cause"

specialized scene techniques; documentation and evaluation of decedent remains; general decedent processing; and documenting signs and indicators of death. The results noted are as follows:

Death Scene Photography

The MCIOs obtained death scene photographs in 84 of 86 (98 percent) of the scenes processed. The photography exposure quality was sufficient in 83 of 86 (97 percent) of scenes. MCIO agents used video to record 37 of 86 scenes (43 percent). Although there is no DoD, Military Service, or MCIO mandate to video record death scenes, we determined scenes which were video recorded added another fact-based visual perspective to the scene documentation which is not always captured by sketches or still photography alone.

Death Scene Sketches

The MCIOs provided written descriptions of items of scene evidence in 81 of 86 (94 percent) examinations, and we discovered corresponding death scene sketches were completed in accordance with MCIO standards in 81 of 86 (94 percent) scene examinations. Those sketches deemed inadequate included those with features missing, such as triangulation measurements or evidence not annotated.

Collection of Evidence

Evidence was collected from death scenes; however, we identified 6 of 86 (7 percent) death scenes where additional items of evidence could have been collected that may have provided further insight into the circumstances surrounding the death. Examples of evidence not collected included clothing and bed linens. Agents collected electronic media evidence as required in 80 of 86 (93 percent) investigations. In the remaining six cases we could not determine whether electronic media evidence was, or was not available. If MCIOs required evidence to be submitted to the Defense Forensic Science Center (DFSC),[14] or other appropriate forensics facilities, evidence was submitted in 99 percent of investigations.

[14] Located within the Defense Forensic Science Center in Forest Park, Georgia, the US Army Criminal Investigation Laboratory (USACIL) provides forensic laboratory services to DoD investigative agencies and other Federal law enforcement agencies. USACIL

Death Scene Description and Specialized Scene Techniques

Agents responding to death scenes used specialized scene processing techniques, when necessary, including: alternate light sources[15] to search for bodily fluids and stains, and an electrostatic dust lifter[16] used to lift dust impressions.

Additionally, MCIO agents described the scene environment; such as, details of temperature and unusual odors, and described signs of a lack of a nurturing environment for a child in 81 of 86 (94 percent) scene examinations. Further, responding agents conducted interviews in areas surrounding the death scene, at daycare centers, and with family, friends, and co-workers in 81 of 86 (94 percent) of death scenes.

Documentation and Evaluation of Decedent Remains

We determined there were 116 opportunities an investigator logically had to view, photograph, and collect potential evidence from the decedent in the 82 investigations. The locations of these opportunities included the death scene, body recovery scene, hospital emergency rooms, or during autopsy.

General Decedent Processing

Agents accomplished the following as required in 100 percent of the cases:

- protected the decedent's remains before transport to the morgue;
- secured or inventoried personal effects from the body;
- facilitated secure transport of the decedent to the morgue; and,
- arranged for collection of blood, vitreous, and other evidence before release of the decedent to other authorities.

Additionally, in 96 percent of instances, agents searched the decedent for trace evidence, as well as reported the presence, or absence of perimortem[17] or postmortem[18] artifacts on the body; for example, petechial hemorrhages,[19]

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15 Alternate light sources are "bands of various light wavelengths used to detect human bruising and serological evidence in forensic cases. Routine use of ultraviolet light in medicolegal examinations to evaluate stains and skin trauma." Medical Science Law April 1995, 35(2):165-8.

16 An electrostatic dust lifter is "an instrument that utilizes electrostatic charges as a means of transferring dry origin impressions from a surface to a film." Scientific Working Group for Treadwear. Guide for Lifting Footwear and Tire Impression Evidence. http://www.swgtread.org/

17 The term perimortem refers to "the time between the fatal action being initiated and the time of death. Distinguishing between perimortem and postmortem fractures." Smithsonian Institute

18 The term postmortem refers to "the time after death." The American Heritage Medical Dictionary, 2007, Houghton Mifflin Company.

19 Petechial hemorrhages are "small, pinpoint size bleeding under the skin in minute spots." American Heritage® Medical Dictionary Copyright © 2007, 2004 by Houghton Mifflin Company.

abrasions,[20] contusions,[21] and other identifiable injuries or artifacts in the investigative report.

Documenting Signs and Indicators of Death

We analyzed whether agents focused on forensically available indicators used to determine time and position at death, where available and applicable. Investigators and Medical Examiners (MEs) often note livor mortis, rigor mortis, and algor mortis to assist in determining the position of the victim immediately following death, if the decedent was moved, and in calculating the estimated time of death. Livor mortis is a discoloration of the skin due to the settling of blood in the most dependent tissues; with time, the discoloration becomes fixed.[22] Rigor mortis is the rigid stiffening of skeletal and cardiac muscle shortly after death.[23] Algor mortis is the cooling of a body after death.[24]

When the time of death or position of decedent were in question and decomposition indicators of death would have been useful to obtain, agents did not note the presence of livor mortis in 6 examinations; the stage of rigor mortis in 7 examinations; or algor mortis in 4 examinations. Although these observations are to be noted by responding agents when they first examine the decedent, this information is also annotated by a medical examiner and documented in most autopsy reports. Documenting decomposition indicators early in the investigation equips investigators conducting witness or subject interviews with additional case facts to assist the investigator in the corroboration of statements. The practice also explains changes to the decedent's remains between removal from the death scene and autopsy.

Collection of Antemortem and Postmortem Records

The MCIOs obtained antemortem and postmortem medical records as required. In all cases evaluated, agents documented the circumstances leading up to the death, and collected corroborating documents such as decedent antemortem medical records. When the decedent's mental health was in question, and deemed to have contributed to the death, such as in a suicide, MCIO agents obtained available mental health records and questioned the child's psychologist in all but 1 investigation. Additionally, when the decedent's Internet or cell phone activity was relevant to the investigation, MCIO agents obtained and conducted

[20] Abrasions are also known as "a scrape. The rubbing away of the skin surface by friction against another rough surface." Gale Encyclopedia of Medicine. 2008, The Gale Group, Inc.

[21] A contusion is "an injury in which the skin is not broken, often characterized by ruptured blood vessels and discolorations; a bruise." The American Heritage Medical Dictionary, 2007, Houghton Mifflin Company.

[22] McGraw-Hill Concise Dictionary of Modern Medicine. 2002, McGraw-Hill Companies, Inc.

[23] American Heritage® Dictionary, Fourth Edition. 2000. Houghton Mifflin Company. Updated in 2009.

[24] McGraw-Hill Concise Dictionary of Modern Medicine. 2002, McGraw-Hill Companies, Inc.

forensic analysis of digital media in 81 of 82 investigations, or 99 percent. In 77 of 82 (94 percent) of investigations, MCIOs obtained emergency medical service (EMS) records.

Review of Decedent and Other Medical Records

We examined whether the MCIOs obtained a medical doctor's or medical examiner's review of medical records. We found the decedent's medical records were reviewed by qualified medical personnel 95 percent of the time. When the mother's medical records were necessary, such as in cases of Sudden Infant Death Syndrome (SIDS),[25] the MCIOs collected the mother's medical records 93 percent of the time, and, of those records collected, medical personnel reviewed the records 95 percent of the time. The mother's medical records are collected in these instances to document any pre-existing medical condition of the mother, any concerns in prenatal care, and obtain doctor's notes of the pregnancy. These apply to SIDS cases where the infant's death is before the age of 1 year old.

Autopsy Protocols

An autopsy of the decedent was conducted by a local medical examiner, coroner, a state-level medical examiner, or by a medical examiner of the Office of the Armed Forces Medical Examiner (OAFME)[26] in all cases. Autopsy protocol includes photography, fingerprinting and radiographs (X-rays) of the decedent, as well as obtaining autopsy reports and death certificates.

Photographs, Fingerprints, Footprints and Radiographs at Autopsy

Photographs at the time of autopsy are used to provide visual aids for investigators, medical examiners and those adjudicating the investigation. Photographs are also used for identification, to corroborate witness or suspect statements, to detail injuries or lack thereof, to memorialize fragile evidence, and to chronicle the autopsy. Our evaluation identified that 93 percent of investigations had autopsy photographs appended to the investigative file or documentation photographs were taken and retained by medical staff.

MCIO policies require the collection of post-mortem fingerprints or footprints. Decedent prints were collected in 89 percent of investigations.

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[25] Sudden Infant Death Syndrome (SIDS) Sudden infant death syndrome (SIDS) is the unexplained death, usually during sleep, of a seemingly healthy baby less than a year old. SIDS is sometimes known as crib death because the infants often die in their cribs. Diseases and Conditions SIDS www.mayoclinic.org

[26] The OAFME is the center of medical-legal investigations for the Armed Forces Medical Examiner System and works closely with investigative arms of the branches of the military. Forensic investigation of death scenes are conducted upon request.

Radiographs in child deaths allow medical and criminal investigators to identify signs of recent abuse or healing injuries that were not otherwise explained. Although MCIOs are not required to obtain radiographs, these records are beneficial in investigating equivocal deaths. In those autopsies where radiographs were taken, MCIOs collected them in 96 percent of cases.

Autopsy Reports and Death Certificates

The medical examiner or coroner publishes an autopsy report after completion of the autopsy, and usually after toxicology[27] reports are received. MCIOs obtained autopsy reports in 100 percent child death cases.

After an autopsy report is published, a government (State or Federal) prepares a death certificate for vital statistical records that incorporate the cause and manner of death as determined by the medical examiner or coroner. MCIOs obtained death certificates in 84 percent of investigations.

Multidisciplinary Approach

Although not always a requirement to coordinate with outside entities, we analyzed the MCIOs' efforts to collaborate with other military, local, State, and Federal agencies during the conduct of child death investigations, when appropriate. Representatives often include the medical examiner, Child Protective Services (CPS), Family Advocacy Programs (FAP), Social Work Services (SWS), Sexual Assault Nurse Examiners, local and State agencies, psychologists, and forensic laboratory assets. When investigators coordinate with these agencies, histories or patterns of abuse or neglect are often discovered. Working with agencies in a multidisciplinary approach often enhances the MCIO's knowledge of the family dynamics and paints a clearer picture of the child's environment prior to death.

MCIOs coordinated with State agencies, such as CPS,[28] in 89 percent of investigations, and with military-based organizations, such as FAP[29] and SWS,[30] in 89 percent of investigations.

MCIOs collected local police and ambulance call logs, as well as 911 emergency call recordings, in 95 percent of cases. They also checked military and civilian police records for past law enforcement complaints in 93 percent of investigations. When

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27 Toxicology is the science that deals with poisons and their effect (as clinical, industrial, or legal). http://www.merriam-webster.com/dictionary/toxicology

28 CPS responds to reports of child abuse and neglect by conducting family assessments and investigations.

29 FAP works to promote public awareness within the military and civilian communities and coordinate professional intervention at all levels, including law enforcement, social services, health services, and legal services. FAP is designed to break the cycle of abuse by identifying abuse as early as possible and providing treatment to the affected family member.

30 SWS provide counseling services for individuals, families, marital, children, adolescent, groups, and adults.

another law enforcement agency conducted the death scene examination, due to the death occurring in a jurisdiction outside of military control, MCIOs obtained a copy of the investigating agency's scene report in all cases evaluated.

Legal Coordination

The MCIOs conducted both initial and final case coordination, as well as obtained probable cause determinations, with staff judge advocates, assistant United States attorneys, or local district attorneys, when required, in all cases. A probable cause determination provides documentation of a reasonable belief based on the evidence obtained that a certain person committed a certain crime and could be prosecuted for that crime.

Subject Interviews

We examined the MCIOs ability to effectively interview and conduct post-interview protocols, such as taking DNA samples of subjects. Of the 19 child death investigations where subjects were identified, subjects were advised of their rights against self-incrimination and interviewed. The thoroughness of the interview was determined by the MCIO agent's ability to capture specific details, establish the elements of the crime, or ask additional logical questions. Of the 19 subject interviews, 16 (84 percent) were thorough. The MCIOs followed up on logical leads developed from the subject interviews in 17 of the 19 (89 percent) of the cases.

Suspects were offered polygraph examinations when the MCIOs determined it to be relevant. DNA samples were collected using Combined DNA Index System (CODIS)[31] collection kits, and the serial number of the kit was noted in the case file and was forwarded to the Defense Forensic Science Center (DFSC)[32] for entry into CODIS as required. Military suspects were released to a representative of the service member's chain of command in all cases. MCIOs documented the collection of subject fingerprints and subject mug shots (identification photographs) in 89 percent of the cases where subjects were identified. Subjects and suspects underwent law enforcement background checks which were appended to the files. The background checks included queries of the National Crime Information Center (NCIC),[33] Defense Central Index of Investigations (DCII),[34] and various other military, local civilian and national databases.

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[31] CODIS is the term used to describe the Federal Bureau of Investigation (FBI) program of support for criminal justice DNA databases as well as the software used to run these databases.

[32] The Defense Forensic Science Center in Forest Park, Georgia, provides forensic laboratory services to DoD investigative agencies and other Federal law enforcement agencies.

[33] NCIC is a computerized index of criminal justice information (that is, criminal record history information, fugitives, stolen properties, and missing persons).

[34] DCII is the single, automated central repository that identifies investigations conducted by DoD investigative agencies and personnel security determinations made by DoD adjudicative authorities. http://www.dodig.mil/Audit/reports/fy01/01136sum.htm.

Supervisory Reviews

Field unit leadership reviewed and approved investigative plans in 98 percent of the cases evaluated.

A field-level supervisor reviewed the investigative file at various stages of the investigation in 99 percent of the cases evaluated. Higher headquarters elements above the field level, or their staff (below the MCIO headquarters), reviewed the investigative file before closure in 96 percent of the cases evaluated.

The MCIOs require a MCIO headquarters-level operational review of completed investigations prior to or upon closure. CID policy requires headquarters "G-3" to conduct quality assurance reviews of all final reports for all death investigations. NCIS policy requires a headquarter-level death investigation board review and approval before closing an investigation. AFOSI policy requires a headquarters review of death investigations, and approval is required before closure. In 97 percent of the cases evaluated, NCIS and AFOSI completed headquarters-level investigations reviews as required. A total of 4 of 43 (9 percent) CID cases contained the required documentation of headquarters quality assurance reviews of final reports. A CID representative, when questioned regarding the headquarters quality assurance reviews, stated the reviews were completed; however, they were not documented as required in the case file.

Conclusion

Nearly all MCIO investigations met investigative standards or had only minor deficiencies.

76 of 82, or 93 percent of investigations met investigative standards or had only minor deficiencies. Of those, a total of 18 cases (22 percent) had no investigative deficiencies. The remaining 58 cases (71 percent) had minor deficiencies.

The MCIOs conducted subject and witness interviews; obtained evidence needed to gather case facts; and used various forensic assets in almost all investigations. Suspect, subject, and witness interviews were well documented, appropriately structured and contained adequate detail to support manner of death determinations in almost all investigations. The most common minor deficiencies were inconsistencies in the use of techniques such as evidence triangulation and descriptive narratives of the decedent's stages of decomposition. We also noted a total of 4 of 43 or 9 percent of CID cases contained the required documentation of headquarters "G-3" quality assurance reviews of final reports.

A total of 6 of 82 cases (7 percent) investigations had significant deficiencies. We requested the concerned MCIOs consider our significant deficiency findings and take corrective actions if practicable. A total of two investigations were reopened as a result. The deficiencies included: key evidence that was not collected from the death scene, the decedent, or the subject; death scene examinations were not conducted, not conducted thoroughly, or not conducted before the loss of crucial evidence; witness interviews were not conducted or not thorough; and/or subject interviews or re-interviews were not thorough.

Recommendations, Management Comments, and Our Response

Recommendation 1. Adequacy of Investigations

We recommend the Director and Commanders of the Military Criminal Investigative Organizations:

a. Continue to emphasize thorough completion of all child death investigations.

b. Consistent with policy guidance, emphasize thorough death scene evidence documentation, including evidence measurements, and postmortem decomposition stages, as well as through supervisory reviews, inspections, and recurring refresher training to improve child death investigations.

Commander, United States Army Criminal Investigation Command

The Commander, United States Army Criminal Investigation Command concurred with our recommendations.

Director, Naval Criminal Investigative Service

The Director, Naval Criminal Investigative Service concurred with our recommendations.

Commander, Air Force Office of Special Investigations

The Commander, Air Force Office of Special Investigations concurred with our recommendations.

Our Response

The comments are responsive.

Recommendation 2. Quality Assurance Reviews

We recommend the Commander, U.S. Army Criminal Investigation Command implement appropriate measures to ensure documentation of headquarters-level quality assurance reviews of final reports.

Commander, United States Army Criminal Investigation Command

The Commander, United States Army Criminal Investigation Command concurred with our recommendation stating they would ensure documentation of headquarters-level quality assurance reviews of final reports.

Our Response

The comment from the Commander, United States Army Criminal Investigation Command is responsive.

Appendix A

Scope and Methodology

We evaluated investigations of child deaths closed (completed and adjudicated) in FY 2012 and FY 2013, to assess their compliance with DoD, Military Service, and MCIO policy requirements in effect during the course of the investigation. We noted observations and deficiencies during the evaluation. For the purpose of this evaluation, a "child"[35] is defined as a person under the age of 18 and the person was not emancipated or a member of the Armed Forces.

We conducted this evaluation in accordance with the Council of the Inspectors General for Integrity and Efficiency, "Quality Standards for Inspection and Evaluation." We used professional judgment in making observations and recommendations.

At the onset of the evaluation, we requested each MCIO provide a listing of child death investigations closed in FY 2012 and 2013, including the case numbers, dates the cases were opened and closed, the number of subjects and victims in each case, the criminal offense investigated, and the MCIO office where the investigation was conducted.

We evaluated the MCIOs' child death investigative policy and procedures to assess the extent to which it comports with DoD and Military Service level policy and addressed investigative activity expected to be conducted in response to child death complaints. We familiarized ourselves with tasks expected in any child death investigation.

We developed a child death investigation case review protocol for each MCIO based on DoD, Military Service, and each MCIO's investigative policies and procedures. The protocol addressed, in detail, investigative steps utilized by the MCIO's identified as essential to complete a thorough child death investigation ensuring compliance with applicable DoD, Military Service, and MCIO policies in effect during the life of the investigation. We provided each case review protocol to the respective MCIO for verification of investigative tasks and validation of cited references prior to commencing fieldwork. Using the protocols for each MCIO as a foundation, a relational database was created encompassing areas of the protocols.

[35] For the purpose of this evaluation, a "child" is defined as a person under the age of 18 and the person was not emancipated or a member of the Armed Forces.

The evaluation team collectively evaluated the first three to five cases as work began at each MCIO, to facilitate a "norming" process. This norming process was designed to test the individual MCIO evaluation protocols as well as form a baseline for the evaluation team, and assist in developing a standard and consistent thought process amongst the evaluators for each MCIO. As the investigations were evaluated, the case evaluators entered information into the database for each investigation.

We noted both minor and significant deficiencies. A "minor deficiency" is a task or investigative step the MCIO did not perform, or performed not in conformity with DoD, Service, and MCIO policies and procedures. A minor deficiency is not likely to affect the outcome or have a negative impact on the investigation. A "significant deficiency" is one or more deficiencies which resulted from a failure(s) to conform to DoD, Service, and MCIO policies and procedures associated with proving the elements of a crime or in determining a cause and manner of death. A significant deficiency indicates a breakdown in practices, programs, and/or policy having an actual notable adverse impact on, or likelihood to materially affect the integrity of the investigation and/or adversely affect, or a high probability to adversely affect, the outcome of an investigation.

Observations are aspects of an investigation the case reviewer concluded warranted added attention and documentation. Observations included: administrative errors in a report, which deviated from MCIO policy; specific information the MCIOs requested we look for during our case reviews; or items outside the scope of the project but deemed noteworthy by the inspector and relevant to the investigation. We used professional judgment in making observations during the course of the evaluation.

The procedure for documenting cases with significant deficiencies involved providing a case summary, detailed description of the identified deficiency and policy requirement. Investigations with significant deficiencies would not necessarily warrant a case reopening to correct the deficiencies. Notwithstanding, cases found to have significant deficiencies were documented and returned to respective MCIOs for review, feedback, and corrective action if practicable.

An example of an investigation warranting reopening is one failing to fully identify and interview potential victims. In this example, identifying and interviewing additional victims could have led to the identification of a suspect and subsequent prosecution. The reopening of an investigation would not be expected or beneficial when the MCIO failed to conduct time-critical investigative steps or failed to conduct them according to established policy.

Quality Assurance

To ensure consistent application of evaluation methodology, the project manager and/or team leader performed quality assurance reviews on a random number of the evaluation sample cases.

Data Analysis and Deficiencies Analysis

At the conclusion of the case review phase the data collected and stored in the database was extrapolated into numerous queries designed to identify specific investigative tasks. Statistical percentages of the data identified investigative tasks successfully completed or problematic. The queries indicated what tasks or steps were involved with each deficiency and the number of instances of each.

Return of Cases with Significant Deficiencies and Documenting Minor Deficiencies for Review by MCIOs

Cases identified containing significant deficiencies were documented in detailed deficiency memorandums recording deficiencies and observations as identified by the evaluator. A peer review was completed wherein a second team member evaluated the investigation and documented concurrence or nonoccurrence with the identified deficiencies. The Project Manager then evaluated the identified deficiencies and applicable guidance identified, and documented the assessment. Upon completion of the evaluator assessment, peer review, and project manager analysis the deficiency memorandum was assessed by the Project Director for resolution.

If the case contained significant deficiencies, the deficiency memorandum was returned to the MCIO for review and resolution. Upon completion of the deficiency memorandums, a "Predraft Results Memo" was prepared for each MCIO outlining the tentative results of the evaluation. The Predraft Results Memo identified the number of cases evaluated, number of cases identified with minor deficiencies, and those identified with significant deficiencies. The memorandum and approved deficiency memorandums were transmitted via email to each MCIO with a request to evaluate our assessment of the significantly deficient investigations and provide comment. If an MCIO determined it relevant to conduct additional investigative work we will evaluate their subsequent efforts upon closure of the investigation. If the case was determined to contain minor deficiencies and/or observations, the protocol database was updated to reflect the final outcome of the work paper results.

At the conclusion of the case review process, we provided the MCIOs a spreadsheet listing of minor and significant deficiencies. Deficiency and observation entries in the database contained sufficient data to allow the MCIOs to pinpoint details of identified deficiencies. This allowed them to review the minor deficiency findings and provide mitigating or extenuating information.

Appendix B

Tables

Table B-1 Case Manner of Death Determination

Manner of Death	CID	NCIS	OSI
Homicide	2	6	2
Suicide	1	1	1
Accidental	10	3	7
Natural	14	6	10
Undetermined	16	3	0
Total	**43**	**19**	**20**

Table B-2 Child Death Investigations Closed in FY 2012 and 2013

Child Death Cases	Total	CID	NCIS	AFOSI
Case Population Evaluated	**82**	43	19	20

Table B-3 Cases with No Deficiencies or Minor Deficiencies

Case Deficiency	Total	CID	NCIS	AFOSI
None	**18**	4	10	4
Minor Deficiencies	**58**	35*	9	14

* Included failure to properly document MCIO Headquarters G-3 quality assurance reviews of final reports.

Table B-4 Cases with Significant Deficiencies

Cases	Total	CID	NCIS	AFOSI
Returned	**6**	4	0	2
Reopened	**2**	1	N/A	1

Cases Returned to CID

We returned four cases to CID for consideration of significant deficiency findings. CID agreed to reopen one of the four cases to conduct additional activity. CID declined to pursue additional investigative activity for the three remaining cases because they believed it would not alter the outcome of the case or too much time had elapsed, causing the corrective investigative activity to be impracticable. We agreed with CID's assessment.

Cases Returned to NCIS

We did not identify any NCIS cases with significant deficiencies.

Cases Returned to AFOSI

We returned two cases to AFOSI for consideration of significant deficiency findings. AFOSI agreed to reopen one of the two cases to conduct additional activity. AFOSI declined to pursue additional investigative activity for the remaining case because they believed it would not alter the outcome of the case or too much time had elapsed, causing the recommended investigative activity to be impracticable. We agreed with AFOSI's assessment.

Management Comments

Commander, United States Army Criminal Investigation Command

DEPARTMENT OF THE ARMY
U. S. ARMY CRIMINAL INVESTIGATION COMMAND
27130 TELEGRAPH ROAD
QUANTICO, VA 22134

REPLY TO
ATTENTION OF

CIOP-CO

1 December 2014

MEMORANDUM FOR Department of Defense Inspector General, Violent Crime Division (SA Scott Russell), 4800 Mark Center Drive, Alexandria, VA 22350-1500

SUBJECT: Report of the Evaluation of the Military Criminal Investigative Organizations' Child Death Investigations (Project No. 2013C016)

1. Reference you 24 October 2014 referral of the draft subject report.

2. We concur with the findings. CID is an organization dedicated to providing high quality death investigations to ensure justice for the victims. In doing so, we will continue to emphasize the thorough completion of all child death investigations. We have emphasized proper investigative efforts in regards to death scene evidence documentation, as well as through supervisory reviews, inspections, and recurring refresher training to improve child death investigations. In addition, we will ensure documentation of headquarters-level quality assurance reviews of final reports.

3. The point of contact for this action is [redacted] (571) 305-43022 or DSN 312-240-4302.

[redacted]
LTC, MP
G3

Director, Naval Criminal Investigative Service

DEPARTMENT OF THE NAVY
HEADQUARTERS
NAVAL CRIMINAL INVESTIGATIVE SERVICE
27130 TELEGRAPH ROAD
QUANTICO VA 22134-2253

December 9, 2014

MEMORANDUM FOR DEPUTY INSPECTOR GENERAL, POLICY AND OVERSIGHT, DEPARTMENT OF DEFENSE OFFICE OF INSPECTOR GENERAL

SUBJECT: Naval Criminal Investigative Service Response to the Evaluation of Military Criminal Investigative Organizations' Child Death Investigations (Project No. 2013C016)

The Naval Criminal Investigative Service (NCIS) has reviewed the report, findings and recommendations on the Review of the Military Criminal Investigative Organizations' Child Death Investigations and appreciates the opportunity to provide comment on the DODIG report.

The report does not have any recommendations for NCIS specifically; however, the report does include two (2) recommendations for all Military Criminal Investigative Organizations (MCIO):

- The Director and Commanders of the MCIOs continue to ensure thorough child death investigations.
- The Director and Commanders of the MCIOs ensure thorough death scene documentation as well as evidence identification and collection, and forensic identification and documentation of post-mortem decomposition in all child death scene processing, through increased supervisory reviews, and internal oversight.

NCIS concurs with both recommendations. If you have any comments and/or questions please contact Deputy Assistant Director [redacted] at 571-305-9010.

[redacted]
Executive Assistant Director
Criminal Investigations Directorate

Commander, Air Force Office of Special Investigations

DEPARTMENT OF THE AIR FORCE
AIR FORCE OFFICE OF SPECIAL INVESTIGATIONS
Quantico Virginia

30 October 2014

MEMORANDUM FOR IG, DoD, ATTN: Director, Violent Crime Division

FROM: HQ AFOSI/XRG
27130 Telegraph Road
Quantico, VA 22134

SUBJECT: AFOSI Response to DoDIG Project No. 2013C016, "Evaluation of Military Criminal Investigative Organization Child Death Investigations"

1. This memorandum is the Air Force Office of Special Investigations response to DoDIG Project No. 2013C016, pertaining to the *Evaluation of Military Criminal Investigative Organization Child Death Investigations,* dated October 24, 2014.

2. AFOSI reviewed and concurred with your recommendations. AFOSI continues to emphasize through policy and leadership guidance units thoroughly conduct and complete child death investigations in an accurate and timely manner. Investigations will continue to be documented IAW AFOSI policies and evidence collected in compliance with AFOSI training and based on recommendations from AFOSI Forensic Consultants.

3. AFOSI appreciates the opportunity to provide comments on this report. AFOSI continues to be committed to providing high quality investigations to the Air Force. Please contact SA [redacted] Chief, Criminal Investigations Program, at [redacted] or 571-305-8813, if you have any questions about this memorandum.

[redacted]
Director, Strategic Programs & Requirements

[redacted]

Acronyms and Abbreviations

AFI	Air Force Instruction
AFME	Office of the Armed Forces Medical Examiner
AFOSI	Air Force Office of Special Investigations
AFOSIH	Air Force Office of Special Investigations Handbook
AFOSIMAN	Air Force Office of Special Investigations Manual
AR	Army Regulation
CID	U.S. Army Criminal Investigations Command
CIGIE	Council of the Inspectors General on Integrity and Efficiency
CODIS	Combined DNA Index System
CPS	Child Protective Services
DCII	Defense Central Index of Investigations
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DNA	Deoxyribonucleic Acid
FAP	Family Advocacy Program
FBI	Federal Bureau of Investigation
FSC	Forensic Science Consultant
FSO	Forensic Science Officer
IG	Inspector General
MCIO	Military Criminal Investigative Organization
MCRT	Major Case Response Team
ME	Medical Examiner
NCIC	National Crime Information Center
NCIS	Naval Criminal Investigative Service
SECNAVINST	Secretary of the Navy Instruction
SIDS	Sudden Infant Death Syndrome
SUIDI	Sudden Unexpected Infant Death
SWS	Social Work Services
UCMJ	Uniform Code of Military Justice
USACIL	US Army Criminal Investigation Laboratory


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