DESCHUTES COUNTY BEST PRACTICE ASSESSMENT: 911 & POLICE PATROL

INTRODUCTION

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In addition to implementation of the Lethality Assessment Program and an Intensive Supervision Parole & Probation Program, select MOU partners of the Arrest Grant agreed to embark on a Best Practice Assessment of 911, Police Patrol, Police Follow-Up Investigations and Prosecution Charging Decisions. This report reflects findings and recommendations from the 911 and Police Patrol responses. The Assessment occurred over a period of several months in 2013 and was completed Sept. 2013.

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METHODOLOGY

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Deschutes County 911 randomly selected 30 domestic violence cases which occurred between May and August of 2012. Both arrest and non-arrest cases were selected. Of the 30 cases, 20 closed cases were selected for review which would provide an even balance of cases among the three participating law enforcement agencies and which focused on intimate partner violence specifically.

LIMITATIONS

This assessment reflects 20 domestic violence incidents reported to police. While it is possible findings would be different if a larger sample size were utilized, it is also important to note some findings were consistent and therefore bear consideration.

Assessments were conducted by reviewing 911 recordings of the call taker and dispatcher's dialogue and police reports. The 911 assessments contained more transparency in the sense that all information was recorded and CAD notes were available. The police response assessments were generally clear based upon information provided in the report; however, ability to assess was limited on cases settled by contact which did not include any reporting.

OVERVIEW OF CASES

Of the 20 cases reviewed, 11 resulted in arrest, one resulted in a citation, seven were settled by contact (SBC), and one was sent for review by the DA's Office. Of the 11 cases resulting in arrest, nine involved male suspects and two involved female suspects (one of which was a female who offended against another female). The case which resulted in citation involved a female suspect. Of the seven cases that were SBC, four involved male suspects, one involved a female suspect, one involved both male and female calling to report a crime, and one involved a third party caller alleging mutual aggression between a male and female. In one of the SBC cases, a gun was removed from the house for safekeeping at Bend Police Dept.

There were a variety of individuals who made the 911 call, including an 11-year old girl, neighbors, relatives, and the victims themselves.

Eight of the cases involved Deschutes County Sheriff's Office response, seven of the cases involved Bend Police Dept. and five of the cases involved Redmond Police Dept. A number of shifting circumstances were found at the scene, most notably suspects who were gone on arrival and mention of weapons on the call which needed to be assessed immediately upon arrival.

FINDINGS

There were findings which reflected an exemplary response from 911 and Police Patrol, such as excellent teamwork between call taker, dispatcher and responding officers, ensuring safety of the caller, and consistent and thorough reporting among the three law enforcement agencies. The intent of the assessment, however, is to identify where gaps may have occurred and propose recommendations to mitigate the gaps. Following are findings of the gaps.

911: Receiving Calls

Pages 37-40 of the assessment (Appendix A) contain the information analyzed with regards to receiving 911 calls. A brief overview of aspects analyzed include: eliciting information safely; reflecting cultural or social factors in communication; determining the nature of injuries and need for medical attention; establishing whether children are safe or unsafe; using appropriate type codes; eliciting information about immediate present danger; eliciting information about history of aggression; determining risk to those at scene, including officers; and accessing and relaying records such as protection orders or premise history.

- When callers indicate a physical incident has taken place, the protocol is to code the incident as "Domestic 2." When callers indicate the nature of the altercation is verbal only, the protocol is to code the call as "Domestic 3." Consensus was that four of the calls coded as Domestic 3 should have been coded as Domestic 2.
- When physical injury was reported by the caller, the call taker did not always ask about the need for medical attention. This was found in five cases. In another case, a caller requested medical attention, but the call taker did not include it in the CAD notes.
- Questions to help assess for risk, such as presence/use of weapons or intoxication were not always asked. In two cases each, weapons or intoxication were not asked about. In one case, the (third party) caller believed suspect and victim were intoxicated, but it was not included in the CAD notes. Another risk-related question, suspect's "history of aggression" is included as a best practice to inquire about. History of aggression was not always asked about. Conducting a premise check, running driver's licenses, checking for protection orders or outstanding warrants were common practice, but asking the victim about the suspect's history of aggression/violence was not as common in practice.
- In three cases, it was not clearly determined whether children were on the scene, whether or what they witnessed, and safety related to the children present.
- Other findings that were not as common related to the call taker's not having clarified what had happened, what the caller should do for their safety while waiting, or suggestions to the caller to find a safe spot to talk.

911: Dispatching Calls

Pages 40-42 of the assessment (Appendix A) contain the information analyzed with regards to dispatching calls. A brief overview of aspects analyzed include: relaying immediate threat of harm to officers, the victim and others; nature of injuries and need for medical attention; identities and descriptions of who is involved; checking officer status and safety; updating changes on scene, suspect location or caller location; details of violence or threats; and records checks and court orders.

- Four cases involved suspects with criminal background or premises where past domestics had occurred which were not conveyed to the officers. In one of the four cases, two law enforcement agencies responded, and only one of the agencies was apprised of a protective order that was in place.
- On two calls, mental health issues which were conveyed by caller were not verbally conveyed to officers, such as PTSD and alleged diagnosed, untreated mental illness.

- On one of the above mental health-related calls, it is presumed the dispatcher did not verbally convey info about PTSD because the officer acknowledged the dispatch call by saying, "copy." Consensus among the workgroup was that it is important that dispatch verbally relays concerns that relate to safety/risk and that officers not rely on CAD notes solely to gather safety-related information.

Police Patrol Response

Pages 56-58 of the assessment (Appendix A) contain the information analyzed with regards to police patrol response. A brief overview of aspects analyzed include: complete description of the scene; attending to indicators of strangulation; summary of actions taken by the officer/s; account of evidence collected; witnesses' account of events; officers' observation related to accounts of events; injuries; emotional state/demeanor; performing a risk assessment; and details regarding children at the scene.

- In four of the seven cases in which no arrest was made, there was no reporting. This made the assessment difficult to judge. In one of the cases with no arrest and no report, the workgroup concluded that the call should have been coded a domestic 2 (physical) rather than domestic 3 (verbal); the other three no-report cases were coded domestic 3.
- In three of the 11 cases resulting in arrest, it was found that more details would enhance the report, such as: details related to condition house/property were in; detail/photos of injuries (or lack thereof); and better description of the order of events.
- In four of the cases, there were issues with the Lethality Assessment Program (LAP). In two of these cases, no LAP appeared to have been performed (or at least was not attached to the report). In one case, the officer indicated s/he would conduct the LAP on their next shift (but we found no documentation in the report indicating whether it was done or not.) In one case, the officer indicated the victim refused to do the LAP screen, but there was no accompanying form indicating as much. (The LAP protocol states the form is also part of the report when the victim refuses – officer writes victim name on the sheet, and writes in that the victim refused to do the screen.)
- The workgroup concluded three cases could have included more follow-up questions to elicit information indicating whether additional charges were appropriate.
- In three of the cases where children were involved or present, it was noted there could be better documentation about the children's involvement. One particular case appeared as though it could have been felony assault (11-year old child witnessing), although there was not enough documentation to support this.

RECOMMENDATIONS

After the workgroup reviewed the case processing map, whether policies are in place related to domestic violence response, and the assessment of 911 and police patrol, the following recommendations are suggested:

- Ensure each agency has a domestic violence-specific response policy/protocol. Ensure staff are aware of, and follow, domestic violence protocols. There are a number of

sample protocols available online. The International Association of Chiefs of Police has a sample policy in Word format online which can be adapted to fit agency needs.

- Ensure appropriate documentation occurs (according to department policies and procedures) when officers respond to an incident of domestic violence. This includes: 1) if crimes are alleged but no evidence is found, or 2) if evidence is found but crime is alleged not to have occurred when officer arrives on scene.

- Review the Lethality Assessment Protocol with officers. Ensure LAP screens are being conducted in domestic violence arrests; ensure victim refusals to complete screens are documented as well; ensure patrol officers call the LAP hotline with every high danger screen to talk about a safety plan regardless whether victim consents to speak with an Advocate.

- Accompanying 911 protocol that details domestic violence protocol, ensure call takers and dispatchers consistently attend to questions related to safety/risk, including: detail regarding physical acts of violence; weapons; intoxication; premise history and background checks; and presence (or not) of children and children's involvement.

- Suspect's history of aggression (or violence) is noted in both the 911 and police patrol assessments as an important tool in determining the nature of a crime. The workgroup noted that 911's primary role in obtaining history is through records search. History that is proffered by the caller is entered into CAD notes, which can assist with officer and victim safety. Patrol officers have more latitude to ask questions related to history of violence. Officers should be cognizant of the significance of prior history. It is one factor that can help determine the offender and should be considered. Officers should be careful not to weigh history disproportionately more than other factors. Although it is important not to lead victims, witnesses or suspects, they should attempt to elicit some history. When there is a question regarding who to arrest, refer to ORS 133.055.

- Attention to allegations and evidence of Strangulation are recommended. As part of the Arrest grant, a law enforcement trainer was in Bend in Sept. 2012, and presented on strangulation. Regarding a strangulation study of 300 victims in the San Diego area, 50% of victims had no visibly injury. He stressed the importance of asking follow-up questions when strangulation is indicated, stating, "Focusing on symptoms, police reports showed police often neglected to clearly document what, if any, symptoms victims experienced." While strangulation can be challenging to prove when physical evidence is not present, its lethality requires that we vigorously investigate when such allegations occur.

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