La Crosse County
Domestic Violence Safety and Accountability Audit
Findings and Recommendations

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Introduction

How is safety for victims of domestic violence in La Crosse County built in to law enforcement response and other community intervention initiated by a call to 911?

La Crosse County has a twenty-year legacy of changing community response to domestic violence. It has been in the forefront of developing the idea of coordinated community response in Wisconsin. The Domestic Violence Intervention Project[1] and its many partners have worked across multiple agencies to strengthen the fabric of safety for victims of battering. Since 1999, the Domestic Abuse Reduction Team has worked to identify and reach out to victims of ongoing and severe abuse, and intervene with perpetrators. In this spirit and tradition of "challenge and change," the DVIP initiated a Safety and Accountability Audit, as part of its Grant to Encourage Arrest Polices and Enforcement of Protection Orders.[2] Just as it was a pioneer in exploring coordinated community response, La Crosse County is the first community in Wisconsin to initiate a Safety Audit.

It is a brave act for systems and communities to examine their own work and then share the results with others. We all want to believe that our good intentions and commitment make all victims safer and all offenders more accountable. Peoples' lives are complex, however, as are the elements of risk and safety for any victim of battering. Emergency dispatching and law enforcement, along with most of the institutions that intervene in domestic violence, were not designed with the unique characteristics of battering in mind. The legal system reform work that has been underway since the 1970s seeks a better fit between what people need to stay safe and what institutions provide. The Safety Audit process complements this inter-agency reform work. The process of analyzing what is happening within different aspects of institutional response frequently points to the solutions for gaps in safety. The La Crosse Safety Audit is an avenue for refreshing the mission, purpose, and function of the coordinated community response and its components, beginning with 911, patrol response, and DART.

Methodology

The Domestic Violence Safety and Accountability Audit, developed by Praxis International, Inc., uses a local team to look at how work routines and ways of doing business strengthen or impede safety for victims of battering.[3] By asking ***how*** something comes about, rather than looking at the individual in the job, we discover systemic problems and produce recommendations for

[1] Acronyms used throughout this report: CCR (coordinated community response); DVIP (Domestic Violence Intervention Project); DART (Domestic Abuse Reduction Team); CVP (Crime Victims Project).
[2] Funded by the Office on Violence Against Women, U.S. Department of Justice, the La Crosse grant supported DART; increased services to underserved populations, specialized training for judges, prosecutors, law enforcement officers, and victim advocates; and the Safety Audit.
[3] Praxis International, Inc., (218) 525-0487; www.praxisinternational.org. Over forty communities nationwide have used the Safety and Accountability Audit to explore criminal and civil legal system response to domestic violence, the intersection of domestic violence and child abuse, and the role of supervised visitation and exchange in post-separation violence.

longer-lasting change. The Safety Audit is designed to leave communities with new skills and perspectives that can be applied in an ongoing review of its coordinated community response.

The Safety Audit is built on a foundation of understanding 1) institutional case processing, or how a victim of battering becomes "a case" of domestic violence; 2) how response to that case is organized and coordinated within and across interveners; and, 3) the complexity of risk and safety for each victim of battering. To learn about victims' experiences and institutional responses, the audit team conducts interviews, including victim/survivor focus groups; observes interveners in their real-time-and-place work settings; and, reads and analyzes forms, reports, case files, and other documents that organize case processing. Over a series of debriefing sessions, the team makes sense of what it has learned in order to articulate problem statements, support them with evidence, and frame the kinds of changes that need to occur.

Since the Safety Audit focuses on institutional processes rather than individual workers, there are no systematic sampling procedures. Instead, interviews, observations, and text analysis sample the work process at different points to ensure a sufficient range of experiences. Interviews and observations are conducted with practitioners who are skilled and well-versed in their jobs. They are co-investigators with the audit team. Their knowledge of the institutional response in everyday practice and their first-hand experience with the people whose cases are being processed supply many of the critical observations and insights of the audit.

Safety Audit data collection and analysis pay attention to eight primary methods that institutions use in standardizing actions across disciplines, agencies, levels of government, and job function. These "audit trails" help point the way to problems and solutions.

1. Rules and Regulations: any directive that practitioners are required to follow, such as policies, laws, memorandum of understanding, and insurance regulations.

2. Administrative Practices: any case management procedure, protocols, forms, documentary practices, intake processes, screening tools.

3. Resources: practitioner case load, technology, staffing levels, availability of support services, and resources available to those whose cases are being processed.

4. Concepts and Theories: language, categories, theories, assumptions, philosophical frameworks.

5. Linkages: links to previous, subsequent, and parallel interveners.

6. Mission, Purpose, and Function: mission of the *overall process*, such as criminal law, or child protection; purpose of a *specific process*, such as setting bail or establishing service plans; and, function of a worker in a *specific context*, such as the judge or a prosecutor in a bail hearing.

7. Accountability: each of the ways that processes and practitioners are organized to a) hold abusers accountable for their abuse; b) be accountable to victims; and, c) be accountable

to other intervening practitioners.

8. Education and Training: professional, academic, in-service, informal and formal.

In a Safety Audit, our constant focal point is the *gap* between what people experience and need and what institutions provide. At the center of our interviews, observations, and case file analysis is the effort to see the gap from a victim's position and to see how it is produced by case management practices. In locating how a problem is produced by institutional practices, we simultaneously discover how to solve it. Recommendations then link directly to the creation of new standardizing practices, such as new rules, policies, procedures, forms, and training.

Audit question, scope, and data collection

The La Crosse County Safety Audit explored this question:

> How is safety for victims of domestic violence in La Crosse County built in to law enforcement response and other community intervention initiated by a call to 911?

This question was developed from audit team discussions at its initial training, taking into account information from focus groups, a previous survey[4] of victims who had received DART services, and the expertise of the audit team. Focus group participants spoke to the confusion of multiple interveners. Survey respondents spoke to the support and help they received from DART officers and advocates, and also suggested further exploration in three areas: safety and risk for victims who cannot be located or reached after initial contact, the reluctance of some victims who experience continued violence to report it to the team or law enforcement, and a gap between available resources and victims' access and use.

We did not try to examine every aspect of every point of intervention in domestic violence cases in La Crosse County. Because the audit was a component of the arrest grant, our attention was primarily on 911, patrol, and DART response, and how other interveners, such as community advocates and hospitals are linked to that response.

We launched the Safety Audit with a community forum presentation on September 2, 2004. The audit team completed a two-day training on October 14-15, 2004. Between then and August 2005, team members conducted interviews and observations, analyzed 911 calls and incident reports, and met for periodic debriefing sessions. Our findings are based on information gathered during the following activities.

- ✓ 3 Community focus groups with a total of 37 participants; two groups with women who had experienced battering and abuse and one group with Hmong women.
- ✓ 82 Individual interviews, including law enforcement officers and supervisors, community advocates, hospital social workers, 911 operators and dispatchers, DART

[4] Carmen R. Wilson VanVoorhis, *Summary of D.A.R,T. Evaluation Survey Data*, University of Wisconsin-La Crosse, July 2002.

officers and advocates, and probation officers.

- ✓ 41 Observations, including patrol officers, 911 center, Crime Victims Project, and court appearances.

- ✓ Text analysis of 25 emergency calls and 56 law enforcement incident reports from 6 jurisdictions; 911 and law enforcement domestic violence policies and protocols; CVP summaries; DART case processing forms and victim and offender information packets; and, victim information distributed by New Horizons, CVP, DVIP, Gundersen Lutheran Hospital, and Franciscan Skemp Hospital. A detailed analysis was completed for 20 of the patrol reports and 13 of the 911 calls.

Findings and Recommendations

Each team member had several opportunities to participate in framing our findings and to review and comment on this report. We have rewritten, clarified, added, and set aside problem statements as a result of this collective effort. We wanted to produce an account of gaps and changes that we could all agree on, while making note of questions that required further inquiry or fell outside of the immediate scope of our question.

Design and purpose

This report provides a summing up of the audit team's work and identifies gaps to address in the ongoing intervention in domestic violence in La Crosse County. We have used quotes and excerpts from focus groups, individual interviews, 911 calls, incident reports, policies, and audit team observations to support our findings. Each gap is presented in a way that an ad hoc work group or committee could initiate the discussion and craft solutions for closing the gap.

- Statement of the gap
- How is it a problem? For which victims of battering?
- What contributes to the gap?
- How do we close the gap?
- Who should be involved?

We have made suggestions for how to close each gap, highlighting the type of changes that may need to occur. We have also identified who might be involved in that process, with an emphasis on contributions by victims of battering and the practitioners most directly responsible for safety and intervention.

Recognizing a strong foundation

Throughout the Safety Audit we saw evidence of the strong foundation of coordinated community response that has been built in La Crosse County. Nine different agencies contributed personnel and staff time to a twelve-month process. Agencies throughout the county

cooperated in setting up interviews, providing time for observations, and sharing tapes, reports, and case files.

There is broad participation in the DVIP and in DART. An effort is made to look at every one of the roughly 1800 domestic abuse-related incidents reported to law enforcement each year and determine what level of intervention would best promote safety. Written policies are in place across law enforcement agencies, acknowledging domestic violence as a crime and providing direction to officers. Patrol officers routinely contact New Horizons in an effort to make a timely link between a victim and advocacy services. Practitioners routinely call on one another to strategize about how best to respond to concerns about safety and accountability in specific cases.

Throughout the Safety Audit we encountered frequent examples of practitioners' actions that made a difference for individual victims. Early on, in the pre-audit planning work, some of us heard a 911 call where quick thinking helped guard the caller's safety when the assailant got on the phone. Officers in another case took time to consult with a prosecutor about arrest charges that might provide additional breathing room for a woman who was *scared for her life*, and they acknowledged to her and her son that *we knew it was a tough night for them*[5]**.** Focus group participants spoke of the importance of DART support in providing ongoing contact and a cell phone, attending court hearings, and keeping them informed of probation revocation actions: *[the DART advocate] let me know when and where he was.* For another woman, *before DART, there was really nothing that was so supportive*.

Discovering gaps

We also discovered gaps in the fabric of safety that La Crosse County has tried to weave. Our findings center on eight aspects of safety that need additional attention in order to provide the most flexible safety-driven and victim-oriented response possible.

1. Many victims of battering receive multiple contacts and packets of information from multiple interveners, without a clear understanding of interveners' various roles or the accuracy of the information.

2. Some victims receive incomplete information about operating emergency cell phones.

3. Response to domestic violence incidents does not thoroughly account for the complexity of risk and safety for victims of battering from different social positions.

4. Understanding and methods of determining "primary physical aggressor" vary among law enforcement officers in La Crosse County.

[5] Throughout this report quotations from focus group participants, 911 calls, incident reports, and interviews appears in *italics*.

5. Key aspects of safety and danger assessment are inconsistently applied or have not been well-developed in the 911 and initial law enforcement response.

6. Information about the presence and well-being of children and teens is inconsistent in 911 calls and patrol reports.

7. It is unclear that DART intervention consistently reaches victims of battering who are most at risk of ongoing violence, intimidation, and coercion.

8. Intervening agencies do not consistently produce statistical information that contributes to an accurate understanding of reported domestic violence incidents.

IMPORTANT: At points throughout this report we use excerpts from "redacted" 911 call transcripts and law enforcement reports to illustrate findings. That means that individual names and addresses have been changed or removed. Where a name has been changed, any resemblance to a resident of La Crosse County is coincidental.

Asking questions from the standpoint of a victim of battering is a key principle in the Safety Audit design. We are constantly asking how our interventions take into account her[6] whole experience. With that in mind, we begin with brief descriptions of some of the cases that raised questions about safety, risk, and danger, and the ways in which those who responded were organized and prepared to act.

Case 2:
The suspect's whereabouts were unknown at the time of the call. The victim fled her apartment with her child, but the call-taker did not keep her on the line or establish a safety plan pending the officers' arrival. There were no questions related to use of violence or injury, weapons, or restraining orders. The victim told officers that her husband *grabbed her and pushed her around …knocked the television over along with a floor lamp and potted plant …he did not care about any restraining orders that [she] might get and threatened to kill her if she went to the police…put his hand around her throat and took a kitchen knife from the "knife block" where he held it to her throat and said, "Do you want to die, are your scared?"…grabbed her by her feet and pulled her out of bed onto the floor…told [her] "I'll kill you."* She had recently disclosed her plans for divorce to her husband. She had been abused by him in the past and had recent physical evidence of that abuse.

Case 3:
The victim had bruising and swelling to her neck, abrasions to her breast and thigh, bruises on her chest, a curling iron burn to her wrist, and a cigarette burn to her forehead, all injuries inflicted by her husband. He told her, *I'm going to cut off your windpipe.* She expressed fear of her husband, fear that he will not honor a no-contact condition, and fear that he will take their daughter. She had made plans to obtain a restraining order. She told officers that he had *choked* her in the past. Advocates apparently had difficulty placing her and her children in a safe place. The perception of the practitioner who called 911 to arrange for an officer to pick her up was that *they won't bend the rules; won't let her kids stay with her.*

Case 10:
The victim's statements to 911 were tearful and she was begging for help*: My boyfriend's hitting on me. (Crying) …Get him out of here, before it gets any more escalated…[I don't need medical] not yet anyway, but if you don't hurry.* The caller confirms that there are guns in the house and that her boyfriend had been abusive to her in the past, but *he's never been known to hit me like that or throw me around…he's getting really out of hand.* The responding officer's report notes: *he grabbed her by the throat and threw her to the floor…pushed her down, put his knee in her abdomen, and hit her.* She told police: *she drove home and locked all the doors* and *he gets mean when he drinks.* She mentioned numerous incidents of prior abuse, with recent bruising noted by officers. *He pinches and squeezes me very hard, leaving bruises and finger marks, but always in areas that do not show.* She tells law enforcement that her boyfriend's behavior has been escalating over the past two months.

[6] Both men and women use violence in intimate relationships, although how that occurs and the consequences differ greatly. Information from police reports, emergency room visits, counseling centers, divorce courts, and community social service agencies points to a significant gender disparity in who initiates violence, who is more physically harmed, and who seeks safety. Women are far more likely to be victims of battering and men more likely to be the perpetrators. Some of the language in this report reflects that reality.

Case 11:
The victim told 911: *My husband is threatening to kill me.* She wanted to leave her apartment with her son while her husband had fled, but the call-taker wanted to keep her on the line. The caller is coughing, breathing heavily, and tells 911: *He grabbed me by the throat and threw me down.* The suspect returned to the apartment while the victim was on the phone with 911. The victim's teen-age son was locked in the bathroom, *scared to death.* She referenced prior violence by her husband and asks for protection: *he said he was going to come back and kill her.* She describes three acts of strangulation-type assault by her husband. The report noted that the parties were going through a divorce. Her husband told law enforcement that *he didn't care if he goes to prison or not, but he will take care of them.* He told the officer he was going to kill both Jill and Tom (a mutual friend).

Gap #1: Many victims of battering receive multiple contacts and packets of information from multiple interveners, without a clear understanding of interveners' various roles or the accuracy of the information.

How is it a problem? For which victims of battering?

Multiple interveners can provide support that best fits the circumstances of the widest number of victims of battering, particularly those who do not want to use the criminal legal system, or those who seek help that accounts for distinct aspects of their culture or community. At the same time, when a battered woman receives three, four, or five contacts from different agencies, or several information packets from several sources, arriving when she is hurt, frightened, or preoccupied with everything going on in her life, it may not be useful to her. As one focus group participant described it, *I had at least three agencies and thirteen calls in a week; it was overwhelming*. Where the information is inaccurate, such as a wrong phone number or out-dated procedure, it complicates her efforts to build safety.

What contributes to the gap?

In our focus groups with battered women, we learned that as many as seven agencies could be involved in talking with her or contacting her as a result of a 911 call (see Figure 1). Within three to ten days following patrol response, a victim might receive as many as three or more packets of information related to the case and community services.

Practitioners within these agencies described the information they handed out or mailed and their telephone or other contacts with victims. We analyzed these materials, trying to read and see the information as if we were a victim of battering receiving it.

We found:

- Wrong numbers
- Phone numbers where victims would most likely reach an answering machine and not a person
- Materials accessible only to those who speak English
- Multiple copies of material, such as the Power and Control Wheel
- Material such as the Power and Control Wheel presented without context or explanation
- Material that presents battering as a problem of feeling angry
- Similar letters or information repeated in the same packet
- Confusion about which agency was sending the packet
- Confusion about what each agency or point of contact could do to help build safety for victims
- Little information about confidentiality (with the exception of material from New Horizons)
- No information about links to on-line resources and how to use them safely

Gap #1: Many victims of battering receive multiple contacts and packets of information from multiple interveners, without a clear understanding of interveners' various roles or the accuracy of the information.

We did not find any regular process of review that would ensure that victim information is coordinated across intervening agencies and kept up to date.

Patrol officers, Crime victims project staff, New Horizons advocates, DART, DVIP, and hospital social workers all have distribution of victim information within their job functions. Each has a specific format, content, and delivery (in person, by phone, and/or mail). They are not well linked, however, in coordinating their efforts to provide the most useful and accurate information to victims of battering. They do not actively involve victims and survivors in the design and review of these materials.

How do we close the gap?

1. Coordinate material across intervening systems to provide the most useful and accurate information to victims of battering.

2. Redesign administrative practices related to organization and distribution of victim information materials.

3. Produce new or revamped victim information materials. Involve victims of battering from diverse communities in the design of these materials.

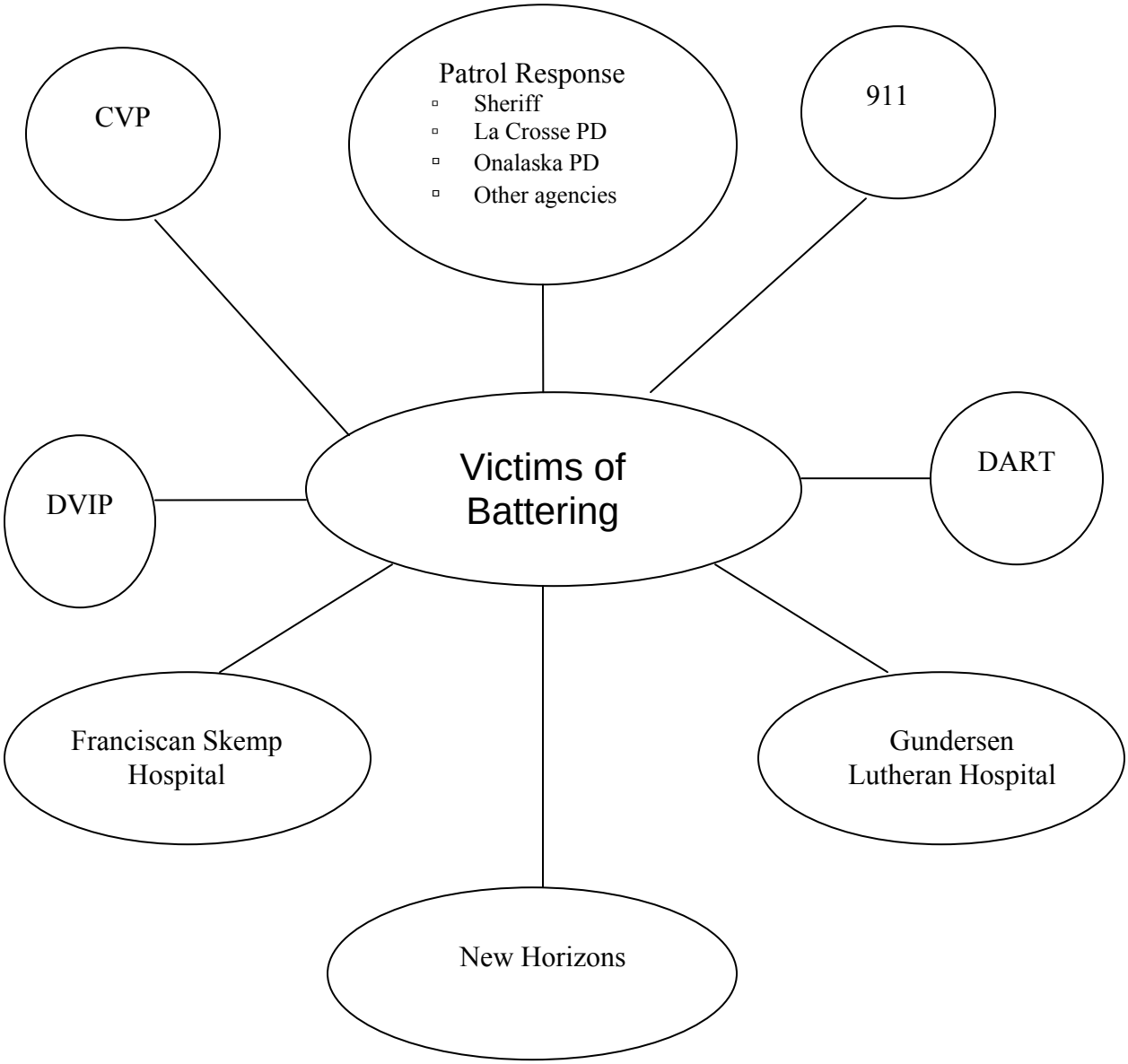
4. Account for immediate and ongoing needs for help, confidentiality, agency roles and services, language and literacy, and minimal duplication.

Requires changes in:
- Administrative practices
- Linkages

Who should be involved?

- ✓ Victims and survivors of battering
- ✓ DVIP
- ✓ DART
- ✓ New Horizons
- ✓ Hospitals
- ✓ 911

Figure 1


CVP
Patrol Response
Sheriff
La Crosse PD
Onalaska PD
Other agencies
911
DVIP
Victims of Battering
DART
Franciscan Skemp Hospital
Gundersen Lutheran Hospital
New Horizons

Gap #2: Some victims receive incomplete information about operating emergency cell phones.

How is it a problem? For which victims of battering?

Victims who receive cell phones that only dial 911 need complete instructions on the use of the phones to avoid delay in response to their call. Lack of understanding about how 911 receives the phone calls, and the information that the call-taker and dispatcher need about the code name and location, can create a false sense of security. The expected emergency response could be delayed or impossible.

What contributes to the gap?

Some victims and service providers issuing phones are unaware that when 911 is called from a cell phone, in contrast to what happens with a standard landline telephone, no information shows on the dispatcher's screen. There is nothing about the number of the calling phone, the name of the person the phone is registered to, and the street address and city where the phone is located. Donated cell phones are "unsubscribed phones" which have no phone number attached to them, and hence no subscriber information. An additional problem occurs if the cell phone tower does not route the call to the La Crosse 911 center.

Victims choose code names by which to identify themselves. If the code name has not been cleared with the 911 center prior to issuing the phone, it could cause confusion due to the similarity of locations and businesses located in La Crosse County. For example, the code name "Alaska" was rejected by 911 because it could be confused with "Onalaska." Another code name rejected was "Cheerios". Many calls are received from the bar "Cheers" which is very similar to "Cheerios".

The agencies handing out cell phones do not all use a standard form. Copies are kept at the 911 Dispatch Center for reference, but information is not always located in the same place on the forms if a dispatcher needs to find it quickly. The form does not indicate the importance of using a "current" address for the victim. Often the address is the shelter or a post office box, but officers cannot be dispatched to a post office box. When the victim moves to a different residence, the move is not always forwarded to the 911 Dispatch Center, which could result in sending officers to the wrong address. It is important that victims understand that if they need to make an emergency call on a donated cell phone that they provide their current location, particularly if they are away from their registered address.

Incidents have occurred when the victim has called 911 using a code name prior to the information reaching the Dispatch Center. Although this problem has only occurred a few times, the failure to notify dispatch creates a false sense of security for the emergency phone recipient.

How do we close the gap?

1. Provide precise instructions to victims receiving emergency 911 phones.
    a. Revise the existing instruction sheet to include: the process for address changes;

Gap #2: Some victims receive incomplete information about operating emergency cell phones.

the importance of knowing and reporting the victim's location if she calls; and, notice that the call will be answered by the county where the receiving cell phone tower is located. to create an instruction sheet for all applicants.

b. Develop a basic step-by-step instruction sticker that can be attached to cell phones.

2. Review, revise, and provide up-to-date instructions on emergency cell phone procedures to advocates and others who distribute phones.
    a. This should include DART officers, who may issue a phone that a victim needs to use before the DART office gets notice that it was issued.

3. Consult with the Dispatch Supervisor when assigning code names.

4. Standardize the forms given out so all the information is in the same order and quickly accessible. Street addresses should be used instead of Post Office Boxes and be updated if the victim changes residence. If she was staying at a shelter and that is the address on the form sent to the Dispatch Center, when the victim leaves the shelter for another residence the information needs to be updated with the Dispatch Center.

5. Establish a process to track who has the phones and when they should be updated and/or deactivated.

Requires changes in:

- Administrative practices
- Linkages
- Training

Who should be involved?

- ✓ DVIP
- ✓ DART
- ✓ New Horizons
- ✓ Hospitals
- ✓ 911

Gap #3: ***Response to domestic violence incidents does not thoroughly account for the complexity of risk and safety for victims of battering from different social positions.***

How is it a problem? For which victims of battering?

Peoples' lives are complex and the factors that reinforce or diminish safety and risk are complex. Coping skills, survival strategies, and help-seeking differ for each victim of battering, both individually and in the context of cultural identities and immediate life circumstances. For example, mental illness, poverty, drug use, rural isolation, sexual identity, and limited English proficiency can increase vulnerability. Aspects of culture, such as family structures, religion, and community practices around children, can be a source of strength, but can also be used by a batterer to isolate and control.

Our institutions are not structured in ways that account for different social positions of people in the community. Legal, judicial, advocacy, health care, and other interventions cut off avenues of potential safety and support when they are not well organized to account for this diversity of life experience and identity. Women of color, for example, "are between a rock and a hard place: perhaps at greater risk for domestic violence than white women because of poverty (of self and of partners); unable to trust the police for themselves or their partners; less able to rely on internal community resources because of low awareness of domestic violence; and confronted with reluctance . . . to further criminalize men of color."[7] The La Crosse Safety Audit raised questions about safety and support for Hmong and African-American victims of battering, in particular.

What contributes to the gap?

Across the United States, legal system reforms around domestic violence, along with community-based resources and advocacy, have been built largely on concepts of maximizing criminal sanctions and presenting victims of battering with individual-focused options, with an emphasis on leaving a relationship and seeking shelter. These changes have contributed greatly to the safety and well-being of many victims of battering. For others, particularly those from non-dominant and new-American communities or marginalized social positions, such as people who are mentally ill or alcoholic, the changes are more problematic. For example, women of color have realistic fears that intervention by police and social service agencies is more likely to lead to their children being taken away.[8]

Shelters developed in the 1970s to help women in violent relationships get out. Much of the advocacy response and most of the resources have been organized to provide practical support to battered women who leave: e.g., shelter, protection orders, legal advocacy, and transitional housing. Women who continue to live with a violent partner may not see these traditional

[7] Rinku Sen, "Between a Rock and a Hard Place: Domestic Violence in Communities of Color," *ColorLines*, 2:1, Spring 1999.

[8] See Nicholson v. Williams concerning New York City child welfare practices in domestic violence cases. And, *Activist Dialogues: How Domestic Violence and Child Welfare Systems Impact Women of Color and Their Communities*, Chic Dabby and Angela Autry, Family Violence Prevention Fund, April 2005.

Gap #3: ***Response to domestic violence incidents does not thoroughly account for the complexity of risk and safety for victims of battering from different social positions.***

services as offering much to help them cope and stay safe. For some of the Safety Audit focus groups participants, for example, there was a sense that *the systems want a certain response; they want you to leave, get divorced*.

Information gathered during the Safety Audit suggests that the shelter has a negative image in the Hmong community, sometimes described as *the whorehouse or runaway house*. The tradition of advocacy in battered women's programs, with its individual emphasis and focus, runs contrary to expectations in the Hmong community that the advocate will also talk with men and with mothers-in-law.

Privacy and confidentiality are big concerns for Hmong women, who might prefer to seek help outside of their community, but may be blocked by language differences. A primary service available to the Hmong community – shelter-based advocacy – is one designed thirty years ago for a different group of people. The accommodation that has been made, in La Crosse as well as in other agencies across the country, is to provide an advocate who can translate or explain that service. There has not been a mechanism for going into the community and asking: "If you were going to design something to help women who were beaten or abused by their husbands, what would it look like?"

In our first focus group, when asked what we should ask about and listen for in the audit, one participant replied: *race should be your number one priority*. She described overhearing this slur: *He's a mud face.* Around the circle followed these comments: *they* [police] *don't take her information seriously . . . they're more likely to go after Black men . . . you should talk to the Hmong; they'll do anything to avoid police contact.*

It is important to consider this information with a recognition that when someone experiences something from a particular standpoint of identity – e.g., as a Black woman or Latino or Deaf man or Lesbian – it does not necessarily happen to every one who shares that identity. However, in communities where people are few in number, have a fear of dominant institutions, or are less able to speak freely about their lives, events or comments like those reported by the focus group participants can become central to the relationship between that community and the institutions that intervene in their lives. The actions of one worker can become magnified to represent the official response. The agency or institution involved is then charged with discovering whether that experience is widespread or isolated, and whether and how people have a ready way of bringing problems forward.

In talking with Hmong women, we heard that when a woman does call the police she may be *at her wits end* and may want him to stay in jail. She will not expect him to be released on bond within a few hours. We also heard that Hmong women may be particularly reluctant to identify themselves as needing to go to New Horizons for safety. In a public forum they were more likely to make light of scenarios describing abuse and violence: *Can I come to New Horizons for a vacation?*

Gap #3: ***Response to domestic violence incidents does not thoroughly account for the complexity of risk and safety for victims of battering from different social positions.***

In our interviews with practitioners we learned more about the barriers to safety for Hmong women, in particular. One team member described seeing *a courtroom full of support for the perpetrator, with the victim sitting alone.* We learned that there are no certified legal interpreters readily available in domestic abuse cases, in any language. Civilian interpreters spoke about the complexity involved in interpreting in a community where they live and may know the family, and may also have some extended family connections to victims and/or offenders. In the focus group, Hmong women raised concerns about their children being used as interpreters. On-scene, officers may not have the time or be prepared to communicate with someone who has limited traditional English proficiency. They may not have ready access to an interpreter. La Crosse County agencies across many systems – from shelters to police to hospitals – are not alone in grappling with the question of how to best provide flexible, reliable interpreter services across a range of languages.

We saw that Hmong victims of battering have some access to culturally-grounded advocacy via DART and New Horizons. Community growth, in part because of several hundred new Hmong refugees from Thailand, is likely to present new demands for culturally-specific advocacy. African-American victims may have contact with each agency's multi-cultural advocate, but it is not with someone who shares their identity and experience. Information compiled by the DVIP suggests that the number of African-American victims in domestic abuse related arrests has tripled since 2002 (from 18 to 59).

Our case file review raised the importance of further inquiry to learn more about whether and why African-American and Hmong women might refuse DART intervention. Of the twenty cases analyzed in detail, we saw three where women from these communities experienced severe violence, reported strangulation, or had multiple reports of domestic abuse and declined DART intervention.

How do we close the gap?

1. Convene cross-community forums and work groups to develop a framework for intervention in domestic violence cases that maximizes safety for multiple communities in La Crosse County, and accounts for differences in social standing.

2. Identify the range of supports and services that could be available to victims of battering from diverse communities and social standing. Look beyond traditional domestic violence service agencies and interventions.

3. Form and maintain advocacy partnerships: involve communities in crafting and defining policies and practices, not just commenting on them. Never ask a single individual, a single voice, to represent all of any community.

4. Strengthen 911 operators' skills in and resources for communicating with callers who have limited spoken English proficiency.

Gap #3: ***Response to domestic violence incidents does not thoroughly account for the complexity of risk and safety for victims of battering from different social positions.***

5. Identify and develop certified interpreters to intervene in domestic violence cases; establish protocols for calling interpreters to the scene.

6. Develop protocols for how children can provide limited interpretation in ways that minimize harm. The reality is that children do and will likely continue to act as interpreters in domestic violence incidents and related intervention.

7. Translate the Victim's Rights Form and other materials provided to victims and offenders into Hmong and Spanish. Ensure that if a publication written in either language lists a phone number to call that someone will answer in that language, or make it clear when and how someone will be available.

8. In addition to translating existing material, present information in a more familiar format and context for different communities.

9. Ensure that TTY numbers listed on any victim information materials are accurate and that the location listed knows how to use the equipment.

10. Initiate and sustain <u>ongoing</u> discussion about culturally-respectful intervention around domestic assault. No single training or single addition to an agency staff will address the breadth and complexity of building safety for victims of battering from diverse communities. It is ongoing work, undertaken both within intervening agencies and within the community at large. It may also be helpful to involve those who are engaged in this discussion on a statewide and national level.

11. Develop and strengthen ongoing relationships with organizations that have a presence in and connection with diverse communities in La Crosse County. For example: Hmong Mutual Assistance Association, YWCA Social Justice Program, Women United for Friendship, Family and Children's Center, African American Mutual Assistance Network, Catholic Charities, NAACP, and La Crosse County Health Department.

12. Identify and build relationships with informal community leaders: individuals who are known to be helpful, to be someone victims are likely to talk with, and who "get the word out."

Requires changes in:

- Rules and regulations
- Administrative practices
- Resources
- Concepts and theories
- Linkages

Gap #3: ***Response to domestic violence incidents does not thoroughly account for the complexity of risk and safety for victims of battering from different social positions.***

- Mission, purpose, and function
- Accountability
- Education and training

Who should be involved?

- ✓ Victims and survivors of battering from diverse communities and social positions
- ✓ DVIP
- ✓ DART officers and advocates
- ✓ Coordinated community response task force
- ✓ Multi-cultural advocates
- ✓ Community-based advocates
- ✓ 911 call-takers and supervisors
- ✓ Patrol officers responding to domestic calls and their supervisors
- ✓ Administrators and others responsible for policy oversight
- ✓ Organizations that have a presence in an connection with diverse communities in La Crosse County
- ✓ Practitioners, researchers, and advocates engaged in the national dialogue on response to battering in diverse communities.

Gap #4: Understanding and methods of determining "primary physical aggressor" vary among law enforcement officers in La Crosse County.

How is it a problem? For which victims of battering?

Many victims of battering use force at some point to defend themselves or in reaction to the threats and abuse they experience. Misapplication of the concept of primary physical aggressor, however, can lead to the arrest of the ***least*** dangerous person, with significant consequences for ongoing safety and well-being. These include: restricting access to safety resources; reinforcing batterer power and coercion; increasing the risk of ongoing violence and intimidation; increasing the possibility of a victim losing her children in a child protective services or custody action; reducing future reporting, outreach, and intervention; increasing the possibility of eviction, particularly for victims living in income-based housing; further isolating victims of different cultural and language traditions; and, magnifying the vulnerability of those who are alcoholic, addicted, or already under criminal legal system sanctions.

What contributes to the gap?

Focus group participants reported being arrested under circumstances that suggest that responding officers do not always establish the context of the violence or primary physical aggressor in making their arrest decisions. Officers sometimes "discount our fear, such as when I say 'I'm afraid he's going to kill me.' " Another participant reported being arrested in spite of her children telling officers that it was their father who was the violent one.

The kind of dilemma that a battered woman who has been arrested faces is illustrated by this exchange, observed by an audit team member during an initial court appearance post-arrest: *a woman with noticeable injuries pointed out that her husband did not have any noticeable injuries; no one took pictures of her injuries, which became visible over the weekend; he had a history of beating her, yet she had the no-contact order issued against her, had nowhere to go, no one was there for her, and no one made any referrals.*

Interviews with officers and advocates and review of incident reports suggest that interpretation of primary physical aggressor varies and sometimes leads to the arrest of victims who are experiencing ongoing battering. It appears that some officers understand "primary" as the person who called 911 first or who hit, pushed, or shoved first, not the person who poses the greatest threat. The language of the mandatory arrest law contributes to this, with its emphasis on primary <u>physical</u> aggressor. In evaluating conflicting information about a domestic abuse call, it leads officers to focus on 'who hit first' rather than who poses the most danger to the other. It also makes no reference to self-defense considerations. It leads to reactive violence being treated in the same fashion as coercive violence.

Interviews with officers also suggest other concepts and factors that influence some primary aggressor decisions: "provocation," i.e., who started the argument that preceded the violence, or said or did the most hurtful thing; and, alcohol use and intoxication.

Gap #4: Understanding and methods of determining "primary physical aggressor" vary among law enforcement officers in La Crosse County.

Under 968.075(3)(a)1b, the mandatory arrest law lists three factors that officers should consider in determining who is the primary physical aggressor: 1) the intent of the law to protect victims of domestic violence, 2) the relative degree of injury or fear inflicted, and 3) any history of domestic abuse. Review of patrol reports showed that officers do not consistently apply these factors in making arrest decisions.

Officers either did not document or did not consistently ask follow up questions that would lead to a more thorough investigation of self-defense considerations and the context of ongoing violence, fear, and intimidation. For example, what does it mean that she *did not want to get her boyfriend in trouble* or *she drove home and locked all of the doors* or *broke up on bad terms?* What does *hit* or *push* mean? In response to what action?

Our case review found references to wounds that may have been inflicted by an arrested woman on her male partner as she attempted to keep him away or break his hold: *small scratches on his face . . .several scratches on his neck . . .numerous scratches to the back of his neck . . .the inner earlobe of [his] ear had been burned . . .a very deep scratch and also numerous superficial scratches [on the back of his neck]*. In these cases, the women arrested reported that their partners: *pushed her and then held her down . . .was pushing her, put her in a headlock and knocked her head against the wall . . .she wanted to get out, at which time [he] asked her where she was going and accelerated the car down the driveway.* There was no visible attention in the reports to relative size and strength differences that may have helped evaluate the parties' actions.

Our review of patrol reports showed that officers were sporadic in considering past history of domestic abuse. Information that was included seemed to be largely volunteered by one of the parties involved rather than developed via the officer's inquiry. This was evident across the cases and in those involving a female arrest. Of the twenty reports analyzed in the most detail, ten contained no information about prior domestic abuse, including five that resulted in a female arrest. Going to records kept by the Crime Victims Project, however, we saw that all but one of these ten involved prior La Crosse County domestic abuse calls (resulting in both arrest and non-arrest). The history of abuse seemed to be there – some with four, five, or six incidents and multiple arrests – but was not referenced in the reports.

Policies guiding officer actions in domestic abuse calls largely reflect the language of the mandatory arrest law. They do not provide direction on establishing who poses the most significant ongoing threat. Reading the reports where women had been arrested left us curious about whether some arrests would have been made had the officers been guided by policy and training to ask questions in ways that would establish:

a. Do you think he or she will seriously injure or kill you or your children? What makes you think so? What makes you think not?
b. How frequently and seriously does he or she intimidate, threaten, or assault you?
c. Describe the most frightening event/worst incidence of violence involving

Gap #4: Understanding and methods of determining "primary physical aggressor" vary among law enforcement officers in La Crosse County.

him/her.[9]

Training on domestic violence issues and investigations across La Crosse law enforcement agencies has been sporadic. There is no regular, required refresher training. Officers do not have many opportunities to examine enforcement of the mandatory arrest law or the context of battering and domestic abuse crimes, or address problematic practices via training. We saw how officers can make use of such opportunities in the extent to which strangulation behavior was noted in reports. This has been the most recent training topic for some agencies, although it is not mandatory and not every officer in the county has received it. Many officers noted victims' descriptions of strangulation behaviors in their reports, although they did not always follow up with a more thorough investigation.

How do we close the gap?

1. Strengthen understanding of the context of battering and the consequences of arresting and prosecuting victims of battering. This might begin, for example, with presentations by and discussions with those who have been addressing these issues in research and community work around the country. It would involve examining and discussing concepts and theories about domestic violence, women's use of illegal force in response to battering, and the mission, purpose, and function of intervention.

2. Review and revise departmental policies to strengthen investigation and report writing that better accounts for the context of battering, including: severity of injuries and fear, use of force and intimidation, prior domestic abuse, likelihood of future injury, and each person's fear of being injured by the other.

3. Explore the design and implementation of a uniform county-wide domestic violence policy for law enforcement response that incorporates the features listed above.

4. Design and implement scenario-based county-wide training to patrol officers and supervisors, beginning with comprehensive updates on domestic violence issues and response and carrying through to new policies and procedures.

5. Contribute to current statewide legislative efforts to address problematic features of the mandatory arrest law, such as the concept of primary physical aggressor and lack of consideration of self-defense.[10]

[9] These questions come from the St. Louise County (MN) Sheriff's Office. They are included on a pocket card and discussed in more detail, along with interview strategies, in the Domestic Violence Handbook and Training Guide for Patrol Deputies.

[10] Assembly Bill 436 has been introduced in the Wisconsin Legislature to repeal the primary physical aggressor language, replace it with *predominant aggressor*, provide guidance to officers on how to determine the predominant aggressor, and discourage (but not prohibit) the arrest of more than one party.

Gap #4: Understanding and methods of determining "primary physical aggressor" vary among law enforcement officers in La Crosse County.

Requires changes in:

- Rules and regulations
- Administrative practices
- Concepts and theories
- Mission, purpose, and function
- Accountability
- Education and training

Who should be involved?

- ✓ Victims and survivors of battering who have been arrested
- ✓ Community-based advocates
- ✓ Patrol officers responding to domestic calls
- ✓ Shift commanders or other supervisors approving arrests
- ✓ Administrators and others responsible for policy oversight
- ✓ District Attorney
- ✓ Coordinated Community Response Task Force
- ✓ Practitioners, researchers, and advocates engaged in the national dialogue on the impact of mandatory arrest laws and the concept of predominant aggressor

Gap #5: Key aspects of safety and danger assessment are inconsistently applied or have not been well-developed in the 911 and initial law enforcement response.

How is it a problem? For which victims of battering?

A call to 911 activates a complex institutional apparatus responsible for public safety, beginning with 911 operators, dispatchers, and patrol officers. If practitioners are organized, trained, and prepared to attend to safety and risk, there are multiple opportunities at each step to enhance safety. Conversely, there are multiple opportunities to diminish safety if their work is not fully organized to help determine who is in danger. Their recognition of and actions around the risk that one party poses to another influence the immediate safety of everyone at the scene, as well as ongoing safety and the actions of subsequent interveners. Their initial assessment of risk is a building block for the many other agencies in a coordinated community response that intervene in the case.

What contributes to the gap?

A. An emphasis on keeping a domestic violence victim on the line in a 911 call, but without determining whether it is safe to do so.

Initiating a call to 911 can put a victim of battering in a precarious situation, particularly if the threat to her immediate safety is high and she cannot speak freely. She might need to call without the batterer being aware of the call, or while he is temporarily in another room. It might be safest for her to leave when she is being directed to stay on the line. At the same time, the call-taker and dispatcher want to maintain contact with the caller in order to relay information that assists the responding officer in arriving safely and with as much information as possible. This priority, however, might be more dangerous for the caller. The challenge is to develop procedures and skills that will support call-takers to balance these needs and maximize safety for all involved.

In listening to 911 calls and reading transcripts of calls, where the caller was an apparent victim, we saw an emphasis on keeping her on the line until an officer reached the location: *I'd like to keep you on the phone . . . I'm going to keep you on the phone until they make contact . . .Well, you stay on the line with me . . .They should be there shortly. Why don't you just stay on the phone with me? . . .You stay on the phone and we'll get someone going that way . . .Stay on the line.*

In one call, the woman wants to leave with her son when her husband goes to take a shower. The call-taker wants her to stay on the phone and asks several questions, without waiting for the caller's response.

> Caller: . . . He's back here now. Me and my son are leaving.
> 911: So he's back in the house?
> Caller: (Interrupts) Me and my son are leaving. I'm not staying here, not a minute longer.
> 911: Okay. A. Okay, you're leaving with your son?
> Caller: Yes.

Gap #5: Key aspects of safety and danger assessment are inconsistently applied or have not been well-developed in the 911 and initial law enforcement response.

> 911: Where are you . . . We have officers en route.
> Caller: (interrupts) I'll probably go to my mother's.
> 911: Okay. We have officers en route. Is it okay to wait for them to get there? They should be there shortly. Why don't you just stay on the phone with me? Make sure you're okay. And then you can speak to the officers before you go. How old is your son?

As the patrol report for this call established, it was a highly volatile situation where the caller's husband had made repeated threats to kill her.

Prior to establishing whether it is safe for the caller to talk, 911 call-takers ask questions that require the caller to provide details, rather than a yes or no response: *What happened? . . . What's going on there? . . .What's going on?. . .What's the problem?* This asks the caller to provide information that may be overheard, instead of determining first: Are you at this address? Is it safe to talk?

Across the 911 calls we could see where the primary emergency dispatch function was to get an officer to a location as quickly as possible, not to determine whether it was safe for the caller to remain at that location. In interviews and observations with 911 personnel, we learned that they saw their role as keeping the caller on the line, which they understood as keeping the caller safe. Their guide sheet emphasizes information that they are to collect and does not include any specific directions for how to establish whether it is safe to keep the caller on the line and whether she can speak freely.

B. Underutilizing third-party calls to establish safety for all involved and identify potential witnesses.

Neighbors and bystanders who call 911 – "third parties" – can have important information about the immediate situation, presence of weapons, a suspect's level of aggressiveness, and other factors that influence the safety of responding officers, victims, and everyone involved. A 911 call-taker is in a unique position to draw out information from these callers. Information from third-party callers can help officers make appropriate self-defense and primary aggressor determinations. As witnesses they can support prosecution, particularly when a victim is fearful and reluctant to contradict a battering partner's statement, information.

In listening to calls and reading transcripts, we saw that third-party calls varied considerably in length, often under sixty seconds, with callers not kept on the phone once the address has been verified. The following examples illustrate how relatively little information was developed during the call, particularly in the shorter calls. The caller's description of events and operator's questions are separated out to more clearly see the response and kinds of questions asked.

Gap #5: Key aspects of safety and danger assessment are inconsistently applied or have not been well-developed in the 911 and initial law enforcement response.

Case	Length	Caller description of events	Operator questions
9A	0:59	*…there's like two guys fighting in the hallway now* *… and a girl screaming.* *But she's screaming Help me! Help me! Help me!* *Either that [in response to 911] or she's fighting with him or she's fighting with the other male but they're breaking shit like crazy.*	*What's your address? 45 … what?* *But it sounds like the two men, the two … males are fighting and she's screaming at them?*
16	1:57	*I would like to report a domestic abuse going on at my neighbors' house . . . I tried knocking on the door and there is no answer and they have been fighting all week and it sounds like things are getting thrown around . . .this has happened since I moved in here like four months ago and I am just really sick of it.* *It sounds like it's getting physical . . .* *Yeah definitely [hear yelling]. They yell almost nightly for the last week . . . I just wanted to call it in, 'cause –*	*OK, where is it at?* *OK, in Namples?* *Is this a guy and a girl, or-?* *OK. You hear them yelling or something?* *OK. Can I get your name?* *OK. And your last name?* *And your phone number?* *And you live in the apartment building there?* *Do you know who they are at all?* *OK. And it's 763 Vernon Boulevard, Number 5, right?*
17	0:58	*. . . I was just wondering if someone could check on the welfare of someone. I just walked past an apartment and I could hear a girl in there screaming . . . I heard her yelling, yeah, and it sounds like someone is crying in there and when I walked by closer to the apartment I heard someone shut the door and lock it.*	*What's the address?* *Tyler Street?* *You hear a female screaming from that apartment?* *All right, did you want to speak to an officer or just have him check on it?*

C. Inconsistent attention to the presence and use of weapons.

The Domestic Disturbance guide sheet for 911 operators directs operators to ask: "Are there any weapons, type and where are they." Our review of 911 recordings found that call takers did not consistently ask about weapons. They asked about weapons in six of the thirteen calls we analyzed in greatest detail. In seven of the calls, the operator did not ask about weapons.

In Case 2, the caller was not asked about weapons. Responding officers found that the perpetrator had threatened to kill the victim and held a knife to her throat stating, *do you want to die…are you scared?*

In Com 25, it was later determined in the course of interviewing witnesses, that the

suspect had brandished a knife to the intervening third party. The suspect was not found until thirteen hours later. The call-taker had not asked about weapons.

We found calls where information about weapons came at the very end of the call, before the connection ended or was lost. Operators tended to ask for a yes/no verification – *Does he have any weapons* – without follow-up questions or detail about the type of weapon, availability to the parties involved, and whether the apparent aggressor has previously used or threatened to use weapons against the caller, another party, or officers. For example:

Case 20
(Late in the call, almost at the end before connection is lost)
911: O.K. Do they have any weapons at all?
Caller: I don't know.

Case 10
911: Do you know if there are any weapons in the house?
Caller: Oh, yeah, we're fully loaded.
911: O.K., is he anywhere near where you keep them?
Caller: No. He's just mad and angry. I would say a lot of drugs.

Case 05
911: Are there any weapons in the house?
Caller: Um, yeah there are.
911: Guns?
Caller: Yes.
911: Are they loaded?
Caller: I don't know. I have no idea.
911: Where are they?
Caller: Um, I think they're in his bedroom.
911: Where is he sleeping?
Caller: (in pain) Ow! Ow! Um, in the, yeah, in, in …I don't think he'd do that. He wouldn't do that.
911: Alright.

In Case 10 and Case 05, the corresponding law enforcement reports did not document any questions about the presence of or threats with weapons. In Case 10 the victim's written statement reads: *[he] grabbed me by the neck and put me to the floor, hit me, told me I will never mess with him again.* In Case 05 the victim reported being *hit in the sternum* and her wrist was broken. In assessing a victim's ongoing risk, it is important to question the victim about and document previous incidents of violence where a weapon was used. We did not find this information in the law enforcement reports.

Law enforcement policies direct officers to assess for "weapons, occupants, tension level" and to "de-escalate and neutralize the situation (remove potential weapons)." Policies also reflect an officer's responsibility to "document by an incident report" or "prepare a thorough offense report with a taped narrative." Policies guide officer to evaluate and document the elements of a crime to establish probable cause. The policies reviewed during the safety audit do not, however, guide officers to ask about and document prior history of the threat and/or use of weapons.

Gap #5: Key aspects of safety and danger assessment are inconsistently applied or have not been well-developed in the 911 and initial law enforcement response.

D. Inconsistent follow-up and medical attention to indicators or reports of possible strangulation.

Research indicates that strangulation in a domestic incident is a lethality indicator and "red flag" for further danger assessment.[11] Consistent 911 and patrol follow-up on signs or reports of strangulation links victims to medical care and advocacy, can help DART flag cases for risk and closer intervention, and may contribute to prosecution and ongoing criminal legal intervention. It could also save the life of a victim who may be unaware that she has experienced a significant medical emergency. The need for medical care and good documentation can also be useful for subsequent prosecution.

In our review of 911 calls, 3 of the 13 calls analyzed in the most detail included statements from the victim referencing strangulation.

Case 11:	*He grabbed me by the throat and threw me down…couple times.*
Case 12:	*You strangled me! I've got bruises all over me…cuts on my face…*
Case 20:	*He choked me, ah, uh, his cousin choked me and threw me to the ground …he threw me to the ground and he choked me.*

Two of the victims did not receive medical attention. The outcome of medical attention for the third was unknown. Victims who receive emergency medical attention at either hospital receive the benefit of a social worker to assess and refer; others do not.

Callers demonstrated symptoms that suggest possible strangulation, such as voice loss or hoarseness, coughing, shortness of breath, heavy breathing, or panting. Call-takers did not acknowledge these symptoms or question the caller about her need for medical attention. In Cases 2 and 9 there was no reference to strangulation in the call, but it was documented in the law enforcement report.

Of the twenty patrol reports that we analyzed, nine involved victim references to strangulation in that current incident. Of these nine cases, three were treated at the hospital for their injuries. In a fourth case the intoxicated female party (.18 PBT reported by the emergency room) went to the hospital for a wrist injury, with no apparent report of strangulation (Case 14). She was subsequently jailed and the jailer contacted one of the responding officers, indicating: *fingerprint impressions were noted on victim's neck area.* The officer added: *At no time did Ross mention any problems with neck to officers or medical person.*

[11] For example, as addressed in the work of Dr. Jacquelyn Campbell, fatality reviews, and the National Institute of Justice-funded Chicago Women's Health Risk Study.

Gap #5: Key aspects of safety and danger assessment are inconsistently applied or have not been well-developed in the 911 and initial law enforcement response.

In three cases, the patrol report did not indicate whether or not the victim was offered medical attention. Two reports documented victims who declined medical treatment: *she indicated that she did not require medical attention* and *when asked if she wanted medical attention she refused.* It could not be determined from the report whether or not the officer explained the risk in not being medically evaluated in cases of strangulation. The description of the injuries and/or incidents of those victims who were not medically treated are as follows:

> Case 2:
> *Matthew put his hand around her throat and took a kitchen knife from the "knife block" where he held it to her throat and said, "Do you want to die, are you scared?"*
>
> Case 10:
> *… grabbed her by the throat and threw her to the floor.*
>
> Case 11:
> *… got very angry, grabbed her around the neck, pushed her up against the microwave.*
>
> Case 12:
> *…tried to strangle her by putting both hands around her throat, cutting off her air supply.*
>
> Case 16:
> [week earlier] *… finger size bruises on her neck…he started squeezing my neck, pinning me to the floor… pinned me once again to the bed, this time holding his arm against my throat, crushing my neck …I couldn't breathe once again...* [this incident] *pinned me down to the bed wrapping his hand around my neck.*

Our review of patrol reports suggests that there is rarely questioning and/or documentation of prior strangulation experiences. In two reports the victim offered information pertaining to prior incidents *has choked her before but this was the hardest he has ever choked her* (Case 3) and [previous week] *he started squeezing my neck, pinning me to the floor … holding his arm against my throat crushing my neck* (Case 16). There is little indication in the reports that the officer followed up on the victims' statements regarding being strangled or choked.

911 intervention is organized around its function of assessing a problem and sending assistance quickly and accurately. Patrol officers also assess a problem and intervene to protect victims and the community. However, in the Safety Audit we saw that the initial 911 and patrol response to domestics does not always factor in the importance of assessing *ongoing* protection for victims by establishing the degree of risk in a battering situation, with strangulation being a significant factor. The initial assessment is a building block for the many other agencies in our coordinated community response that intervene in domestic violence subsequent to a 911 call.

The 1016 (Domestic Disturbance) guide sheet available to 911 personnel directs

Gap #5: Key aspects of safety and danger assessment are inconsistently applied or have not been well-developed in the 911 and initial law enforcement response.

dispatchers: "If anyone is injured, dispatch ambulance and first responders." From our review of 911 calls we saw that follow-up questions about strangulation are not being asked and conveyed to officers. The guide does not cue an operator to follow-up when a caller's behavior suggests possible strangulation (i.e., breathless, hoarse, coughing, difficulty speaking), or the importance of conveying information regarding injuries and/or possible strangulation to the responding officer. Additionally, it does not guide a call-taker in responding if a victim denies the need for medical attention.

The policies of law enforcement jurisdictions generally direct an officer to "Determine if medical assistance is needed or desired by either party." And, "upon arrival, officers should check for injuries and provide or summon first aid when appropriate." The policies do not specify what situations would be considered "needed" or "appropriate." There are no guidelines for strangulation incidents, nor are there guidelines for officer action when a victim refuses treatment, even if an officer determines that it is "needed."

Information collected and documented by initial responders, particularly related to significant risk factors such as strangulation, could be improved to aid in the overall intervention and safety for victims.

Officers should be able to knowledgeably communicate to victims the risks of not obtaining medical attention subsequent to strangulation. Victims may deny initial offers of medical evaluation because of cost, poor or no health insurance, or other reasons. They need to be clearly informed about assistance that might be available through Crime Victim Compensation. There is presently no systematic follow-up occurring to address incidents where a victim refuses medical attention and an officer may have had concern about significant injury. There is follow-up by the hospitals if a victim accepts a referral to their domestic abuse programs.

The La Crosse community has been a forerunner in offering training to patrol officers on strangulation and domestic violence. A local nurse and community-based advocate have presented to agencies in the county and throughout Wisconsin. Local awareness has been raised and competencies increased, as evident in the numerous references to strangulation in the reports. This is not required law enforcement training, however. Not all law enforcement officers or jurisdictions within La Crosse County have participated in the training. Nor have 911 call-takers, local first responders, and paramedics have been trained about how to recognize the signs and symptoms of strangulation and how to ask follow-up questions when strangulation is suspected or reported.

Local hospitals provide strangulation assessment by specially trained nurses who are certified Sexual Assault Nurse Examiners, although patrol officers are not uniformly aware of this support.

Gap #5: Key aspects of safety and danger assessment are inconsistently applied or have not been well-developed in the 911 and initial law enforcement response.

E. Irregular recognition, communication, and documentation of risk factors within and between agencies.

Throughout the course of this audit, in patrol ride-alongs and interviews with officers, there seemed to be a lack of familiarity with the range of factors related to assessing danger level/risk/lethality for victims of battering. Officers generally could verbalize what constitutes a "dangerous" domestic. However, many were unable to identify when a victim might be at high, ongoing risk of significant abuse, injury, or death. Officers were unfamiliar with the range and interconnection of established risk indicators, such as:

1. Threats of homicide and/or suicide.
2. Expressed fantasies about homicide and/or suicide, such as "I dreamed I killed you."
3. Harm to family pets.
4. Obsession with his current or former partner and the partner's children, family, and friends, including their whereabouts and interactions with his partner.
5. Stalking behavior. This can include use of phone, e-mail, notes left on a door or windshield, cards and flowers sent to a home or office, third party messages, and appearing at someone's house, place of employment, and other locations.
6. Depression.
7. Possession of and threats with weapons.
8. Violent and constantly jealous: "If I can't have you no one can."
9. Knowledge of the location and access to the victim and her family.
10. Drunk or use of drugs every day or almost every day.
11. Strangulation behavior.
12. Increase in frequency of physical violence.
13. Forced sex.
14. Control over most or all of daily life activities, such as friends, money, and when, where, and with whom she can use the car or go shopping.
15. Beaten while pregnant.

Much of the information gathered in the calls and reports appears to have been offered by the victim, with little exploration or follow-up questions by practitioners, such as: Why are you afraid? What makes you think your husband will try to kill you? What happens when he or she drinks? Is this the first time you've been "choked"? How does this compare to other times you've been hit? Have you recently separated from your boyfriend?

The La Crosse County Crime Victim Project, reports that in 2003 there were 60 victims involved in 3 domestic violence calls, 29 victims with 4 calls, 16 with 5 calls, and 7 victims with more than 5 calls for domestic violence. In 2004, 61 victims were involved in 3 domestic violence calls, 24 victims with 4 calls, 15 with 5 calls, and 12 victims with more than 5 calls for domestic violence. Approximately 15% of all domestic calls in the last two years involved repeat victims. A systemic assessment of the ongoing violence,

Gap #5: Key aspects of safety and danger assessment are inconsistently applied or have not been well-developed in the 911 and initial law enforcement response.

intimidation, and danger is imperative: Who is doing what, to whom, and with what impact on individual and public safety?

Victims in the audit focus groups expressed concern that their fears and experience can be discounted by officers who may not understand the dynamics of domestic violence or recognize the elements of danger and violence. When participants said *I'm afraid he's going to kill me* or *he threatened to kill me*, others expressed concern that their fear may not be taken seriously or misinterpreted by an officer. *They're more apt to remove him if he says he's going to kill himself,* was one observation, rather than if he said he was going to kill her. Multiple participants verbalized the experience that if they don't want to leave the perpetrator, police and other interveners may not understand the dynamics involved and respond differently than if she expressed intent to leave the relationship.

In looking at agency policies, administrative practices, and training, we found that specific attention to risk, and how to establish it and relay that information to subsequent interveners, was not always clear or well-developed.

The 1016 (Domestic Disturbance) guide sheet available to 911 personnel does not direct call-takers to be aware of risk factors for victims of battering, such as threats of homicide or suicide, incidents of strangulation, prior history of violence, and recent attempts to leave or obtain a restraining order. In interviews with call-takers we learned that they check for history between parties if time allows, although the guide sheet does not provide that instruction or indicate what information should be communicated to responding officers.

Law enforcement policies guide officers to consider the history of domestic abuse involving the parties in their investigation – "previous calls involving the same parties"…"previous threats/offenses against the victim by the suspect"…"ask about prior incidents and how they were resolved" – as an aspect of establishing probable cause in the immediate incident. Policies do not guide officers to specifically interview victims and witnesses about or document information related to the danger level of the relationship, with specific attention to risk factors such as strangulation, increase in abuse and/or severity, recent attempts to leave, and threats of homicide/suicide.

Intervention in domestic calls by initial responders is geared towards assessing a problem quickly and accurately, as well as resolving the situation with protection of the victim and general public in mind. However, the initial response in our community does not thoroughly account for the importance of assessing the overall risk/danger level to a victim of battering. This initial assessment is vital to the many other agencies in our coordinated community response that may provide services and intervention at a later date.

For example, some La Crosse County law enforcement jurisdictions direct their officers

Gap #5: Key aspects of safety and danger assessment are inconsistently applied or have not been well-developed in the 911 and initial law enforcement response.

to document domestic abuse related calls that do not result in arrest, or "verbals," as these incidents are typically called. This response is inconsistent across the county, however.

When officers respond to a domestic abuse call, regardless of whether an arrest is made, it can be an opportunity for victims of battering and their children to be connected to support and services. Law enforcement documentation of a non-arrest incident also provides information for subsequent interveners as they assess risk and safety. It provides officers who respond to a later call involving the same parties with more information from which to consider the history and ongoing risk and danger level, which in turn might contribute to determining primary physical aggressor. It can further establish a documented pattern of abuse that can help DART, advocates, prosecutors, and the court reinforce victim safety and offender accountability. A documented pattern of calls for service can reflect an increase in frequency and/or severity of abuse, or a victim's efforts to leave or obtain restraining orders.

We learned via our interviews that training on domestic violence issues and investigation has been sporadic across law enforcement and emergency communications. There is no formally established regular training on domestic violence. There is no current training for initial responders related to assessment of risk, danger level or lethality indicators for victims of battering. The types of questions asked by 911 call-takers and follow-up interviewing techniques of patrol officers can enhance the safety of victims, accountability of offenders, and aid in the ongoing assessment and intervention of victims by later intervening agencies. Documentation related to this assessment can be useful to advocates, prosecutors, judges, and probation officers.

How do we close the gap?

1. Develop a framework of safety-oriented dispatching for 911response. This would include attention to the caller's immediate safety in staying on the phone and providing information to the call-taker; closer attention to developing information from third-party callers about the circumstances of the situation and the immediate safety of all parties; and recognition and follow-up to indications of strangulation and attention to risk factors and other indicators of dangerousness, including type, presence, and past and current use or threats with weapons; threats to kill.

2. Train 911 personnel in the new framework and procedures.

3. Design and implement county-wide training to patrol officers, EMS personnel, 911 call-takers, and supervisors on strangulation in domestic violence cases.

3. Design and implement county-wide training to patrol officers and supervisors on interviewing techniques and documentation that more fully account for attention to danger and safety. Develop a guide sheet for officers to utilize in the field.

Gap #5: Key aspects of safety and danger assessment are inconsistently applied or have not been well-developed in the 911 and initial law enforcement response.

4. Explore the creation of free or reduced cost medical evaluations for victims of strangulation and serious injury resulting from domestic violence.

5. Establish a protocol for follow-up to victims of possible strangulation who do not seek medical attention in order to decrease their risk of significant medial problems and lethality.

6. Create an information sheet that officers can provide to victims of possible strangulation that outlines symptoms and medical conditions that can develop and who victims can contact for further evaluation.

7. Inform 911 personnel and law enforcement about the availability of strangulation assessment in local hospitals by Sexual Assault Nurse Examiners.

8. Revise department policies to strengthen investigation and report writing in ways that improve the overall understanding of the context of battering and risk/danger assessment, including the type and use of weapons (past and present), tactics of intimidation, prior domestic abuse and violence, likelihood of future injury, and fear. Provide guidance to officers on what action to take in situations where they have particular concern for the victim's safety.

9. Strengthen understanding of the context of battering and approaches to gauging risk and safety assessment that can be utilized by all interveners.

10. Strengthen accountability by developing a process for reviewing calls and patrol reports for consistency in attention to safety-oriented dispatching and report writing.

11. Explore the design of a county wide domestic violence policy that would provide a consistent framework for 911 and law enforcement response, including documentation of non-arrest domestic abuse related calls.

Requires changes in:

- Rules and regulations
- Administrative practices
- Resources
- Concepts and theories
- Linkages
- Mission, purpose, and function
- Accountability
- Education and training

Gap #5: Key aspects of safety and danger assessment are inconsistently applied or have not been well-developed in the 911 and initial law enforcement response.

Who should be involved?

- ✓ Victims and survivors of battering
- ✓ Community-based advocates
- ✓ 911 operators, dispatchers, and supervisors
- ✓ Patrol officers and supervisors
- ✓ DART officers and advocates
- ✓ Administrators and others responsible for policy oversight
- ✓ DVIP
- ✓ Coordinated Community Response task force
- ✓ District Attorney's Office
- ✓ Practitioners, advocates, and researchers engaged in the national dialogue on safety and danger assessment

Gap #6: Information about the presence and well-being of children and teens is inconsistent in 911 calls and patrol reports.

How is it a problem? For which victims of battering?

The tactics of battering – intimidation, control, entitlement, manipulation, physical violence – that a batterer uses against an adult partner are also used against and have ramifications for children. Batterers create role models for violence; undermine a mother's authority, care, and comfort for children; retaliate against her for efforts to protect the children; feed family divisions and tensions; and, use children as weapons, emotionally and sometimes physically, to control and punish a mother.[12]

Battered mothers face particular difficulties in negotiating safety for themselves and their children. They are constantly responding to the multiple ways in which batterers use children. Leaving a relationship becomes even more complicated and custody decisions may increase a battering father's access to his children. In a series of fifteen focus groups conducted across Wisconsin in 2002, "participants articulated an ever-present fear that their children would be taken away, either by the batterer or by CPS."[13]

Children who live with a battering parent can face increased risks in behavioral, social, cognitive, and emotional development, and learn an increased tolerance for or use of violence in their adult relationships. The youngest children, in another room, and out of sight during an incident, can still be affected by the chaos.[14] Children's immediate safety can be at stake during an incident that leads to a 911 call and patrol response. Children may also provide information about the events that keeps their mother from being arrested. Acknowledging children and checking on their welfare can also be an opportunity to provide reassurance and a link to ongoing support and advocacy.

What contributes to the gap?

According to data collected by the Crime Victims Project, since 2003 approximately 30% of domestic abuse incidents reported to police in La Crosse County involve children. The Safety Audit showed that we know little about their presence, welfare, and experiences with on-scene response, such as being interviewed or being used as interpreters between their parents and responding officers.

Mothers in the focus groups expressed numerous concerns about their children and the actions of

[12] For a more detailed discussion of battering and parenting, see the work of Lundy Bancroft, including *The Batterer As a Parent*, Synergy, Newsletter of the National Council of Juvenile and Family Court Judges, Winter 2002. Available at www.lundybancroft.com, Articles.

[13] Jane Sadusky and Jennifer Obinna, *Violence Against Women: Focus Groups with Culturally Distinct and Underserved Communities*, Rainbow Research, Inc., December 2002, p.19.

[14] Additional sources of information about children and domestic violence include: *The Brain Game*, La Crosse Kids Committee, et al., 2000, 2004; and, *Children and Domestic Violence: A Bulletin for Professionals*, National Clearinghouse on Child Abuse and Neglect Information, 2003.

Gap #6: Information about the presence and well-being of children and teens is inconsistent in 911 calls and patrol reports.

police and other interveners, including: lack of attention to and referrals for their children by victim-centered agencies; concerns about officers speaking in front of the children, interviewing them, using them as interpreters, and arresting the suspect in front of children, and its implications for children's mistrust of police.

In nine of the thirteen 911 calls that we analyzed in detail, it was unknown whether or not children were present or nearby. The call-taker did not specifically ask about children, nor did the caller make any reference to children. The following cases illustrate the kind of references to children that we found in the 911 calls.

> Case 2: Caller says that she's *with my son.* Operator does not ask about the son's age. Asks: *Is your son at the apartment yet, or …?*
>
> Case 9: Operator does not ask specifically about children; asks *Is there anybody else with you*
>
> Case 10: Caller says: *And I want his daughter out of here, too.* Operator asks for the daughter's name, but does not ask about age, whether child or adult.
>
> Case 11: 16-year old son has locked himself in the bathroom during the assault. Operator asks how old her son is; no other questions about him. The caller wants to leave with her son; 911 keeps her on the phone.
>
> Case 20: Caller makes reference to *my baby* but there is no additional information about whether or not the baby is with her.

Of the twenty patrol reports we analyzed in detail, in thirteen it was unknown whether or not children were present or nearby. While officers may have verified that there were no children on the premises or bystanders to the incident, it was not indicated in the report.

Of the reports making any specific reference to children, there was little consistency within or across agencies in the officer's actions with respect to children. Some officers spoke with the children, as these examples illustrate.

> Case 2:
> OFFICER #2 REPORT: *Contact with Doug - I briefly made contact with Pam's son Doug* [8 years old] *reference the incident. Doug said he was sleeping in bed with his mother when Mathew came into the room. Stated that Mathew and his mom argued. Stated that Mathew took his mothers left hand and began to hit himself (Mathew) in the head with her hand. Doug said that Mathew was hitting the right side of his own head with his mother's hand. Doug stated that Mathew did not hit or push him in any manner. Stated he last saw Mathew leaving the bedroom.*
>
> Case 15:
> *I observed a small child standing in the doorway . . .I went and talked to the child. I asked what the child's name was. He told me his name was Peter. I asked him how old he was and he said, "three." He said Sara*

Gap #6: Information about the presence and well-being of children and teens is inconsistent in 911 calls and patrol reports.

> *was his mom. I asked him if he knew what happened tonight. He said that his mom and Brian were yelling. He said that he is not scared of Brian* [unclear in handwritten report] *his mom. I then asked if he saw anybody push or hit anybody. He said that his mom had pushed Brian first and Brian pushed her back. I then asked Peter to stay inside the house. Peter seemed very intelligent for a 3-year-old and he did not seem scared or shaken up by the incident . . .Sgt. ABC made arrangements for Peter to go to his grandmother's. Sgt. ABC transported Peter to Sara's mother's house with Sara's wishes.*

More common, however, was a reference to children, without any information about their involvement or presence during the incident. In Case 12, for example, three children between ages four and twelve are named in the report, which concerned multiple assaults against their mother over a two-day period. The report makes no reference to whether the children were present, what they saw or heard, or their welfare. The report tells us only that: *Cornwall got her children ready for school . . .does not think Smith will stay away from her or her children . . .afraid that Smith will take their daughter, Jean, and use her to get to Cornwall*.

We learned in our interviews that DVIP has specific services for children, free of charge to victims via a children's counselor working out of the DART office, although patrol officers did not seem to be widely aware of it.

How do we close the gap?

1. Develop a briefing bulletin for officers and/or revise the CVP victim "green sheet," to include information about how to obtain help for children. This might include, for example, how a battered parent can contact the New Horizon's Children's Advocate, the children's counselor available via DVIP/DART, and similar services.

2. Convene discussions with victims of battering, DVIP partners, and others in the community to examine current practices around 911 response to children, intervention with children on-scene, and the process of referrals to Child Protective Services. This discussion is necessary in order to inform guidelines for 911 and patrol response. One resource is the published report of Vermont's experience: *A Balanced Collaboration*: How Vermont Built a Protocol for Law Enforcement Response to Children and Domestic Violence, available at www.bwjp.org.

3. Develop guidelines for 911 personnel and law enforcement officers on response to children. Such guidelines would address communication with the non-battering parent, developmentally-appropriate interview methods, making arrests in ways that minimize stress to children, and strategies for minimizing the use of children as interpreters.

4. Provide training on these guidelines to 911 and law enforcement on response to children.

Requires changes in:
- Rules and regulations
- Administrative practices

Gap #6: Information about the presence and well-being of children and teens is inconsistent in 911 calls and patrol reports.

- Concepts and theories
- Linkages
- Mission, purpose, and function
- Accountability
- Education and training

Who should be involved?

- ✓ Victims and survivors of battering
- ✓ Community-based advocates
- ✓ 911 operators, dispatchers, and supervisors
- ✓ Patrol officers responding to domestic calls and their supervisors
- ✓ Shift commanders and others responsible for policy oversight
- ✓ DART officers and advocates
- ✓ DVIP
- ✓ Coordinated community response task force
- ✓ Child Advocacy Center
- ✓ Child Protective Services
- ✓ Practitioners, researchers, and advocates engaged in the national dialogue on the impact of battering on children and intervention strategies

Gap #7: It is unclear that DART intervention consistently reaches victims of battering who are most at risk of ongoing violence, intimidation, and coercion.

How is it a problem? For which victims of battering?

DART offers an important resource to many victims of ongoing battering, by linking them with police, community advocates, and community resources. It helps victims craft and carry out safety plans. It gives offenders the message that they have an opportunity to change, and that the community is keeping watch over their abusive conduct. Calls from neighbors or bystanders can lead to DART intervention with victims who are particularly isolated and fearful of initiating a call to police, and who may also be unaware of the help available in La Crosse County. If cases of ongoing battering are not coming to the team's attention, however, or if the DART approach is not helpful to certain victims, that avenue of potential protection is closed. Information from the Safety Audit suggests that women from non-majority communities may be particularly disconnected from DART intervention.

Victims should be free to reject or accept services from DART. Understanding why and under what circumstances victims decline DART involvement, however, is critical to the fabric of safety that La Crosse is trying to create. It will help identify practices that should be changed in order to reinforce its mission and ensure that victims who are most at risk of harm can connect with safety planning that best fits their circumstances.

What contributes to the gap?

The focus groups suggested that for many battered women, DART is *the best program this town has*, as one participant described her experience, with praise for the DART advocate's ongoing efforts to stay in contact, provide information and a cell phone, and monitor her ex-partner's probation revocation status: *[Name] knew everything!* Another participant had much praise for the DART officer's attention to her safety and for recognizing the patterns of abuse and danger that her former husband posed to her and her children, in contrast to her experience in her home county in Minnesota.

Other focus group members suggested that some victims who may benefit from DART services and intervention may not be aware of or connected with it: *What is DART?* And, *I found out about DART by pure chance when I was paying a parking ticket.* They suggested that aspects of DART's design and procedures may discourage battered women from connecting with or participating in the offered services. One felt almost pressured into participating. Another emphasized that *contact in the courthouse and mailing need to be more discrete.* For another, DART *didn't come through with their promise to contact the male partner, my husband*, which is why she agreed to the intervention. Another expressed doubts about whether the DART team who became involved was *experienced enough* about domestic violence.

Respondents to a 2002 telephone evaluation survey of victims using DART services spoke to the support and help they received from DART officers and advocates. They also suggested possible gaps in safety and protection for victims who cannot be located or reached after initial contact,

Gap #7: It is unclear that DART intervention consistently reaches victims of battering who are most at risk of ongoing violence, intimidation, and coercion.

for victims who experience continued violence but do not report it to the team or law enforcement, and victims who for some reason do not access and use available resources.

DART has three criteria for assigning cases: 1) three or more calls for police service within a one year period; or, 2) a significant level of violence; or, 3) referrals from officers, partner agencies, or concerned citizens. While it is difficult to get a precise year-by-year comparison between multiple cases reported to law enforcement and DART case activity, the available information suggests a gap between the number of repeat domestics and the number receiving DART intervention. According to data compiled by the La Crosse Police Department Crime victims project, in 2004 there were 117 cases with three or more domestic calls. At mid-year, June 30, DART had opened 23 new cases and carried a total of 31 open cases. This is similar to figures for 2003: 112 cases with three or more domestic calls; at mid-year DART had opened 12 new cases and carried 23.

In of the twenty law enforcement reports analyzed in detail, we found eight examples where DART intervention was refused, including six that each involved from three to six domestic calls in 2004. The DART refusals also included cases with some of the more severe violence we saw described in the text, along with reports of strangulation.

> Case 20:
> *. . .[she] appeared to be unconscious . . .her head hurt and she felt dizzy . . .I observed a large bump on the back of [her] head . . .speech was very muffled and hard to understand . . . [she stated] George grabbed her by the neck and "choked" her. He then threw her to the ground as he had hold of her by her neck.* [This incident resulted in a dual arrest.]
>
> Case 3:
> *Two bruises on both the right and left side of her neck . . .swelling to the neck . . .sore throat, cough and lightheadedness . . .red mark on the side of the back of her neck . . .two bruises on the upper right side of her chest . . [She reported that he] . . .grabbed her by the throat with both of his hands and started choking her . . .told her that "I'm going to cut off your windpipe" . . . then let her go and she took him to work . . .has choked her before but this was the hardest he has ever choked her . . .grabbed her by the neck and started choking her . . .grabbed her by the neck again and pinned her down . . .grabbed her by the neck and pushed her up against the door.*

Out of twenty incident reports included in the text analysis, four involved at least one party who was identified as other than White. In the three cases where the woman and man shared the same racial identity, they refused DART intervention. All involved multiple prior incidents and two included the reports of injuries and strangulation noted above.

In the course of our data collection we learned about several other aspects of DART response and links with other interveners that could be strengthened. While these aspects of organization and coordination do not directly address the concern about those who decline DART intervention, they contribute to the overall communication between various practitioners who respond to domestic violence.

Gap #7: It is unclear that DART intervention consistently reaches victims of battering who are most at risk of ongoing violence, intimidation, and coercion.

- In ride-alongs and interviews with patrol officers we learned that officers do not have a good understanding of DART's procedures and roles, or who in their patrol area may be receiving those services.

- References to DART are largely absent from law enforcement policies. Of the three largest agencies in the county, only one includes any direction to officers about DART: "If the officer believes that it is a more serious situation or continual problem, or if serious injury has occurred, the officer should consider forwarding a copy of the report to DART."

- Law enforcement reports outside of the City of La Crosse do not come to the DVIP in a timely fashion, leaving a victim of battering unconnected with DART and other advocacy services for up to a week or more.

Our review of the material that DART delivers to offenders raised a question about the accuracy and suitability of some of the information. A DART officer gives the packet to the offender when they meet, after the victim agrees to services and agrees that DART can make the contact. It includes a description of the DART program and Justice Sanctions (batterer intervention), plus versions of the Equality Wheel and Power and Control Wheel (developed by the Domestic Abuse Intervention Project), and two handouts: How to Stop the Violence Now! and Self-Talk.

Language in the handouts raises questions about whether this material should be distributed to likely batterers, and whether the emphasis on time-outs and anger management could inadvertently reinforce batterer tactics of minimization, denial, and deflecting responsibility for violence to the victim of that violence. The DAIP curriculum, *Creating a Process of Change for Men Who Batter,* has this caveat about time-outs: "Our experience with time-outs is that some men who batter have used this technique in a way that confuses and controls their partner."[15] These materials reach batterers without the context of a facilitated dialogue, such as should occur in a batterer intervention program. They do not come with any requirement for discussion, questioning, and challenge to the many varieties of coercion and control that victims of battering experience. In addition, the two wheels are not the most current versions. While the Equality wheel is similar content-wise, the Power and Control Wheel does not reflect changes made as the DAIP Men's Program has revised its curriculum and the wheel in the past seven years.

How do we close the gap?

1. Conduct a case review of all DART "refusals" within the past twelve months. Pay attention to history, type, and severity of violence; cultural and community identity; pattern of dual arrests; relationship status; and, use of restraining orders. Be alert to factors that may discourage a victim from agreeing to DART intervention, such as the

[15] Add credit & page #

Gap #7: It is unclear that DART intervention consistently reaches victims of battering who are most at risk of ongoing violence, intimidation, and coercion.

timeliness of the initial contact, probation status, domestic abuse arrests, alcohol or drug use, or mental illness. Attempt to determine whether victims received support from other places in the community.

2. Conduct focus groups and/or interviews with victims who have declined DART services. This requires accounting for safety considerations and should not be conducted by or associated with DART or DVIP.

3. Strengthen patrol officers' understanding of and links with DART. This might include roll-call presentations, pairing patrol officers with DART officers and advocates for ride-alongs, and adding policy language to guided patrol consultation with DART.

4. Review processes for identifying and contacting parties involved in high-risk battering cases.

5. Review and revise DART offender materials.

6. Convene a "think tank" of DART officers, advocates, and others to refresh its mission, purpose, and function. Such a process might benefit from a facilitator who is not directly involved in current intervention efforts, but who is well-grounded in the dynamics of battering and complexity of risk and safety.

Requires changes in:

- Rules and regulations
- Administrative practices
- Concepts and theories
- Linkages
- Mission, purpose, and function
- Accountability
- Education and training

Who should be involved?

- ✓ Victims and survivors of battering
- ✓ DART officers and advocates
- ✓ Community-based advocates
- ✓ Patrol officers responding to domestic calls
- ✓ DVIP

Gap #8: Intervening agencies cannot consistently produce statistical information that contributes to an accurate understanding of reported domestic violence incidents.

How is it a problem? For which victims of battering?

Reliable figures for reported violence are a key element in identifying community needs, gaps, trends, and efficacy of domestic violence intervention. When numbers are missing or inconsistent across calls for service, arrest decisions, charges, types of cases, and repeat offenders, for example, we can develop an inaccurate picture of the scope of the problem and the impact of our response.

What contributes to the gap?

One of the challenges of our Safety Audit was attempting to gather domestic violence statistics for La Crosse County. We found that numbers varied significantly between agencies. For example, in 2004, DVIP reports 1827 domestic calls for service, with 911 Communications reporting 1643. The La Crosse County arrest total reported by DVIP for 2004 was 785, yet 294 domestic arrests were reported to the DOJ by La Crosse County in 2004. (Appendix A)

Additionally, we found that agencies are unable to consistently provide statistics that could impact the types of services needed in our community or help identify trends in calls for service. For example, figures for verbal domestic incidents, dual arrests, non-arrests and children present were unavailable in some local agencies. We were also unable to readily or accurately verify how many incidents of bond or restraining order violations occurred in a given year, or how many led to an arrest.

In attempting to identify repeat victims of domestic violence, DVIP was able to provide the numbers from their database, but individual agencies were not. DART was also unable to provide statistics on interventions offered to victims of significant or repeat violence and those who refused services. The ability to analyze such figures in order to gauge who is at on-going risk and what interventions are utilized can be paramount in identifying gaps and trends.

It would be advantageous for La Crosse County to explore available technology that might improve the overall consistency of domestic violence related statistics.

How do we close the gap?

1. Survey all intervening agencies to assess current data collection practices and capacity for tracking domestic abuse cases and the response at that point of case processing.

2. Explore available technology that might improve the overall consistency of domestic violence related statistical information and case tracking. For example, DAIN (Domestic Abuse Information Network) is a database designed to assemble the information necessary to track and monitor domestic assault related cases in a coordinated community response.

Gap #8: Intervening agencies cannot consistently produce statistical information that contributes to an accurate understanding of reported domestic violence incidents.

Requires changes in:

- Rules and regulations
- Administrative practices
- Resources
- Linkages

Who should be involved?

- ✓ Law enforcement agencies
- ✓ 911 Communications
- ✓ DVIP
- ✓ DART
- ✓ New Horizons
- ✓ Hospitals

Additional observations

As we worked through our analysis of the information we gathered, we began to see a "need more information" list take shape. The items include aspects of safety in La Crosse County that we were less certain about, still wondering about, or needed to know more about. We have included them in our findings in order to not lose track of them and to suggest paths for further inquiry.

- Restraining orders
  Focus group participants communicated that they do not feel that they can count on enforcement of restraining and no contact orders. The 911 guide sheet instructs workers to "Check for paperwork…check restraining orders and no contacts." None of the thirteen calls that we analyzed in detail showed the operator asking the caller about the existence of restraining orders, in addition to checking the paper record. Asking a caller about restraining orders can provide important information about the context of the violence, and options for responding officers. For example, a caller may indicate that she has had an order in place for several years, but it just expired; or, obtained an order that morning, but she does not know if it has been served; or, recently moved here from another state and has the order with her.
  In the course of patrol ride-alongs, some officers indicated that they rarely arrest at the time of an alleged restraining order violation. In most cases, they refer to investigations for follow-up.
  There are no statistics available that reliably track restraining order violations. Information reported to the Wisconsin Department of Justice shows little charging on restraining order and no contact/bail violations: only four charges of "knowingly violate a domestic abuse order" in 2004. In 2004, La Crosse County received 96 petitions for domestic abuse injunctions; 84 for harassment injunctions. La Crosse County processes approximately 1800 domestic violence cases each year. The contrast suggests that victims of domestic violence may be reluctant to seek restraining orders.
  The limited attention to civil restraining orders across these multiple points of intervention suggests a closer examination of what victims of battering experience in requesting a civil order of protection and subsequent enforcement of violations.

- Bail procedures and prosecution
  In the focus groups participants expressed uncertainty about knowing when a suspect is released from jail or when he's been apprehended if he had left the scene before police arrived. In some cases they did not understand why he could be released at all, or so quickly, or were surprised at the low bond amount.
  In our interviews, officers said they make arrests but then do not hear when or why the case was declined. Some focus group participants felt they were being persuaded to agree to the plea negotiated with the offender. The case file review left many questions about what happens next, once the case leaves the officer's hands.

- Children
  Beyond the gaps noted above in 911 and patrol response, our process raised questions

about the broader response to children. The Crime Victim Project sends a copy of the law enforcement report to CPS if children are mentioned and there is a dedicated social worker whose job it is to determine if an investigation is warranted. Battered mothers have many fears for their children, including losing them to CPS. *Nicholson v. Williams* raised many cautions about child welfare actions in domestic violence cases.

- Coordinated Community Response Task Force
  The Task Force and practitioners who have day-to-day responsibility for domestic abuse calls seem to be poorly linked. At one debriefing session we realized that several members of the team had little or no awareness of what the CCR did, how it was organized, who participated, and how it related or might related to their work.

Next steps

We launched the Safety Audit with this question in mind: *How is safety for victims of domestic violence in La Crosse County built in to law enforcement response and other community intervention initiated by a call to 911?* We began this report with brief accounts of the experiences of a handful of victims of battering in our community, including "Case 3."

> The victim had bruising and swelling to her neck, abrasions to her breast and thigh, bruises on her chest, a curling iron burn to her wrist, and a cigarette burn to her forehead, all injuries inflicted by her husband. He told her, *I'm going to cut off your windpipe.* She expressed fear of her husband, fear that he will not honor a no-contact condition, and fear that he will take their daughter. She had made plans to obtain a restraining order. She told officers that he had *choked* her in the past. Advocates apparently had difficulty placing her and her children in a safe place. The perception of the practitioner who called 911 to arrange for an officer to pick her up was that *they won't bend the rules; won't let her kids stay with her.*

There is no one response that will support this mother and her children. Rather, it is the act of weaving an understanding of safety within and through the community response that might make a difference. Safety is a state of being – of being free, from danger, risk, and injury. It is being free from your partner's coercion, threats, and assault if you come home later than you said you would or didn't have supper ready on time – or if you came home drunk or had an affair with the neighbor. Safety is not dependent upon someone's judgment of worthiness, or deservingness. It means acknowledging the right to be free from danger, risk, and injury, regardless of character or compliance with expectations of how a "good victim" should act.

What intervention, what coordinated community response offers is the promise of safety, of action that will prevent someone from experiencing further harm at the hands of an intimate partner. It requires understanding the nature and context of violence, of repeatedly asking: Who is doing what, to whom, and with what impact and to what degree? What are the likely implications of our intervention actions? How does our action in individual cases affect the overall use of violence in our community?

La Crosse has produced a strong fabric of safety for many victims of battering. For others it is a less certain protection. The Safety Audit has revealed some of those gaps, and suggested ways to close them. The next step is to launch the broad discussions and problem-solving that will refresh the mission, purpose, and function of each system, agency, and worker that is a part of our community response to battering and abuse.

Domestic Violence in La Crosse County – 2004

Category	911	DVIP	LPD	LCSO	Onalaska	As reported by CVP: Bangor	Campbell	Holmen	Shelby	West Salem
Calls for service	1643	1827	1390 (1344)	109 (100)	64 (95)	(7)	(35)	(42)		(20)
Arrests		785	665	102	71	0	20	31	6	2
Verbals		725	740	Unk	Unk					
Non-Arrests		152	220*	5	Unk	0	1	5	0	1
Dual Arrests		47	Unk	3	7					
Female Arrests		204	195	20	14					
Children Present		523	115	8*	Unk					

( ) = number of calls tallied by 911; LCSO number includes Shelby
* = approximate

Non-arrest refers to incidents where the suspect or part of interest is gone when officers arrive at the scene.

The following numbers are reported for La Crosse County by the WI Department of Justice

	2002	**2003**	**2004**
Arrest	432	438	292
No Arrest	99	70	72
Dual Arrest	86	66	30
	617	574	394

La Crosse County Domestic Violence Safety & Accountability Audit

Victim Focus Groups: Themes & Questions

The following themes and questions were raised by 14 participants in two focus groups conducted in October 2004 and one forum with 23 participants from a Hmong women's community group in April 2005. Caveat: Not every woman had the same experience and these are presented as paths for the audit team to explore, not conclusions.

- Discounting battered women's fear and experience: what it means when she says, "I'm afraid he's going to kill me." It's a problem when an officer interprets events for her.

- Police officers are more apt to remove him if he says he's going to kill himself. Police officers' assessment misses fear, does not always take a woman's fear seriously.

- Police may not separate victim and suspect sufficiently to keep suspect from hearing her conversations with officer.

- Race "should be your number one priority." Questions about different impacts on different communities. One example was given of a suspect who was Black being arrested quicker than White; another example, a racial slur, "mud face", when searching for suspect. [Information reported to WI-DOJ suggests a significant jump in African-American victims of reported domestic abuse since 2002; African-American victims and offenders are represented in reported domestic abuse in higher numbers than their proportion of the county population.]

- Systems really want a certain response – i.e., "want you to leave, get divorced" – and if a victim doesn't provide that response there is less support for her.

- In a public setting, such as a community forum, Hmong women may make light of abuse: "Can I come to New Horizons for a vacation?" They do not necessarily want to identify themselves as needing New Horizons for safety.

- Police and others do not understand the dynamics of domestic violence; do not understand why she would stay in the relationship.

- There is uncertainty about knowing when a suspect is released from jail, or when he has been apprehended if he had left the scene before police arrived. Women sometimes are not notified when he is eventually picked up.

  Other jail-related issues include: untimely notification of release, suspect being released on bond after a Domestic with a .174 Intoxilyzer reading; jail allowing suspect to use victim's credit card to bond out.

- Victims expressed numerous concerns about the impact on children, including: lack of adequate attention to and referrals for their children by victim-centered agencies; concerns about officers speaking in front of the children, interviewing them, using them as interpreters, and arresting the suspect in front of children (and how this might generate a child's mistrust of police).

- DART is helpful, and for some victims an important source of support in building safety. Others felt more talked into participating in something that they didn't entirely understand or necessarily want.

- DART was more helpful/involved when he actually re-offended.

- DART follow-up contacts with a victim's partner may not always occur as promised.

- Victims who may benefit from DART services and intervention may not be aware of or connected with it.

- There are multiple people from multiple agencies who intervene on the front end of a criminal case, but drop or disappear when victims might want more ongoing contact.

- These interveners also seem to know more about what's going on than the victim, i.e., when it comes to offender release or apprehension.

- The level of continued system response to continued harassment. How do DART and other interveners respond to no-contacts, bond conditions, probation conditions?

- It makes a big difference when officers recognize patterns of violence, danger, and context. Police should listen with compassion, not attitude that 'someone's going to get arrested.'

- Victims cannot count on enforcement of restraining orders and no-contact orders. [Information reported to WI-DOJ shows little charging on restraining order and no-contact/bail violations.] Participants had many comments about calling police when he is violating no contact or RO, and then nothing happens. Also, comment about DA and New Horizons giving victims different messages about RO's.

- Some women with cognitive disabilities and/or weak communication skills may need time to tell a much larger story – the 'whole picture' – before they can relate a certain experience with domestic violence or a particular incident.

- Probation: many comments about lack of follow-through from probation officers to enforce the no-contact condition of probation, taking probationer's "side", not being helpful to victim.

- DA: victims feeling like they are being "persuaded" to take a plea, and not recommending what they verbalize suspect needs…ie. Counseling, chemical dependency issues, etc.

- Victims report surprise at the low bond amounts, especially for felonies, and the fact that offenders can be released so quickly after a domestic, jeopardizing her safety and her children's safety. Some women in the Hmong group suggested that they only call the police when they are "at their wits end" and want him to go to jail; they had many questions about why he then gets out so quickly.

- Impressions of how mandatory arrest law works suggests a lack of knowledge or conflicting interpretations by interveners.

- Comment from victim that a family court commissioner told her "he's going to have to do a lot worse than hit you in order to get supervised visitation."

- Advocate at the Scene: It would be helpful to have a female advocate at the scene who has an understanding of the system and dynamics of domestic violence.