# Tillamook County Safety and Accountability Audit
# Executive Summary

## Background

In October of 2003, the Tillamook County Continuity of Intervention Project (TCCIP) received funding through a US Department of Justice Federal Violence Against Women Rural Enforcement and Child Victimization Grant. One of the activities of the grant, and the subject of this report, was a Domestic Violence Safety and Accountability Audit (Safety Audit) utilizing the process developed in Duluth, Minnesota, by Ellen Pence, Ph.D.

Safety Audits look at the context of agency intervention, such as information sharing mechanisms between agencies, the education of and training available to agency staff, and the resources available to staff. By doing this, the Safety Audit reveals work processes behind the problems and trends.

The strength of the Safety Audit lies in the emphasis on how, where and if agency **policies and practices** ensure the safety of victims and accountability of offenders. The Safety Audit **does not** look at the work of individual practitioners to determine their competence or compliance with these policies and practices.

The TCCIP partners chose to examine the 911, law enforcement and jail responses to domestic violence cases. The audit looked specifically at the Tillamook County Emergency Communications District (911), the Sheriff's Department Patrol Unit, and the Tillamook County Jail. These three agencies were chosen because of their work in the areas of focus as well as their exceptional openness to the process.

## Methodology

The Safety Audit was performed by a team of local practitioners from the agencies being examined and local victim and offender services providers led by a local Safety Audit Coordinator. Consultants from PRAXIS International and the Battered Women's Justice Project assisted in the planning, implementation and completion of the process and this report.

The audit team began by mapping all of the steps or "points of institutional action" involving the response and processing of a domestic violence case within each of the three areas. These maps allowed the team to follow the movement of a hypothetical domestic violence case through the system from the initial call for help to the booking of a suspect into the jail. From there the audit collected information in four main ways: focus groups, interviews, observations and text analysis.

In order to gain valuable information from individuals involved in the system, focus groups, interviews and observations were used. Focus groups provide a mechanism for bringing victims' voices into the audit process. Interviews and observations were done by all members of the audit team with both front-line and supervisory staff in all of the agencies being examined. The team identified important texts, both electronic and paper, from the maps and used these to form the basis for the text analysis portion of the audit.

The Audit Team began meeting in November of 2004 with a two-day audit training, and completed the audit with a two-day wrap-up process in November of 2005. The team was made up of John Schneidecker Tillamook County Sheriff's Office Patrol Unit; Kathleen Marvin and Eleanor Watkins, Tillamook County Women's Crisis Center; Jeanette Austin Tillamook 911; Cherry Reaksecker Tillamook County Jail; and Tam Hulburt, Solutions Domestic Violence Intervention Program. The team was led by local coordinator Erin Skaar with the support of Rhonda Martinson, Battered Women's Justice Project and Casey McGee and many others at PRAXIS.

**Audit Findings**

The focus of the two-day audit wrap-up was to bring together all of the data that had been collected into one place and find the most salient concerns. While there were many areas where we found strengths in the system as well as more areas of concern than the six detailed below, these were the areas that the team felt were of the greatest importance to address.

**Finding #1: There is a lack of recognition of the medical seriousness of strangulation.**

Several callers to 911 in this audit can be heard saying they'd been choked. In some of these calls voice changes such as hoarseness or coughing are evident, but there was no inquiry by practitioners into being strangled or choked and no inquiry into the need for

medical assistance related to being strangled or choked. Although dispatchers generally relayed what the caller said about being choked or strangled to responding officers, in only one instance was the suspect charged with strangulation.

**Finding #2: Violations of restraining orders are addressed inconsistently.**

Restraining orders are a critical piece of the system both to provide for victim safety and offender accountability. Every time a restraining order is enforced a message is sent to both the victim and the offender saying that violence against another person is not only unacceptable, it is illegal. In both focus groups with victims and interviews with practitioners information collected showed that the enforcement of restraining orders was inconsistent.

**Finding #3: Self defense and predominant aggressor criteria are applied inconsistently during arrest decisions.**

Safety is definitely the first priority of all deputies in their responses to domestic violence. However, assuring safety is difficult without an understanding of the dynamics of battering. Further, is can be difficult to determine who is a victim and who is a perpetrator when focusing only on the incident at hand.

Those interviewed understood law enforcement officers' role as interveners in domestic violence and referred generally to safety of victims, children, officers and suspects. Those interviewed also expressed frustrations, difficulties and lack of training, skill or experience regarding whether there are times:

- where no arrest is appropriate
- whether dual arrests are appropriate
- whether a party has legally exercised his/her right to self-defense
- if or how to determine the predominant aggressor
- at what point responsibility for these decisions should lie with police, prosecutors or judges.

**Finding #4: Underutilization of the dispatcher's role in assessing risk, heightening victim and officer safety, aiding probable cause decisions and providing evidence for prosecution.**

Interviews with practitioners painted a consistent picture of the dispatch role as emergency responders. Dispatchers are trained to ask the "6 W's:" who, what, when, where, why and weapons. One interviewee said these are guidelines as to what is important to note in the computer-aided dispatch system, so other dispatchers who may open this record can immediately understand the nature of the call. Although this seems straightforward, observations, interviews and text analysis revealed differing practices in information-gathering and missed opportunities for dispatchers to heighten victim and officer safety, aid in probable cause decisions and provide evidence for prosecution.

**Finding #5: Jail staff lacks technological resources, policy and training to collect and update victim contact and notification information, offender release and condition information, and incarcerated offender threat information.**

The jail has its own computer system, which is not connected with other systems such as dispatch (CAD reports) or law enforcement (police reports). Because the jail and law enforcement computer systems are not connected, corrections staff don't consistently have access to victim contact information. In addition, information about the victim's wishes regarding notification of the defendant's release is rarely available.

As for defendants who may issue threats during book-in or during incarceration, there is no way to write reports of this in the current jail computer system and there is no conduit to the prosecutor for information of this type. The same is true of defendants who appear to corrections staff to have also been victims (injuries discovered, facts revealed during book-in, etc.) – there is no way to write reports of this in the current jail computer system and no conduit to the prosecutor.

**Finding #6: County law enforcement and corrections agencies are unable to share vital data electronically thereby requiring practitioners to duplicate the collection and processing of data.**

In 2001 the Tillamook County Emergency Communications District (911) implemented a Computer Aided Dispatch (CAD) system with integrated Law Enforcement Records Management system (RMS). All information related to any police incident is entered into CAD by the 911 dispatcher. When the call is complete, the information is uploaded to the RMS server where the data resides until the officer ready to write his/her incident report utilizing the RMS report writing feature.

The corrections staff inputs all the data from the booking sheet into the jail's stand-alone computer system, which shares no data with the RMS system. When the officer returns to his/her office to complete the arrest report, the officer obtains the information already entered by the 911 Center and inputs all of the information that is contained on the handwritten booking sheet.

When the offender is released from jail, the corrections staff has no immediate access to the arrest report; no immediate access to the name(s) or address of the victim(s); and no immediate access to the status of the case. This lack of information could potentially result in an offender being released from custody with a Release Agreement that does not forbid the offender from having contact with the victim(s).

**Next Steps**

By working together across disciplines we feel we have all learned a great deal about what are systems are designed to do and what they are not. We look forward to continuing to work together to change these systems to further enhance victim safety and offender accountability.

# Tillamook County Safety and Accountability Audit
# Complete Report

## Background

In October of 2003, the Tillamook County Continuity of Intervention Project (TCCIP) received funding through a US Department of Justice Federal Violence Against Women Rural Enforcement and Child Victimization Grant. Partners in the project included law enforcement agencies, human service agencies, schools, churches, health care providers and local government.

One of the activities of the grant, and the subject of this report, was a Domestic Violence Safety and Accountability Audit (Safety Audit) utilizing the process developed in Duluth, Minnesota, by Ellen Pence, Ph.D. The Safety Audit is a systemic observation and analysis of work routines and documents used and produced between and among institutions as they process "cases" of domestic abuse. The team looks at a sequence of actions – for example, the route of an offender from a 911 call to the jail booking procedure – and determines if that sequence centralizes victim safety and offender accountability. The purpose of a Safety Audit is to see how, where, and if existing practices – those that are documented in forms or policies, and those that evolve within a work culture – ensure the safety of victims and the accountability of offenders.

Safety Audits look at the context of agency intervention, such as information sharing mechanisms between agencies, the education of and training available to agency staff, and the resources available to staff. By doing this, the Safety Audit reveals work processes behind the problems and trends. Specifically the audit collects information in four main ways: focus groups, interviews, observations and text analysis.

The strength of the Safety Audit lies in the emphasis on how, where and if agency **policies and practices** ensure the safety of victims and accountability of offenders. The Safety Audit **does not** look at the work of individual practitioners to determine their competence or compliance with these policies and practices.

The Tillamook TCCIP partners chose to examine the 911, law enforcement and jail responses to domestic violence cases. These areas were chosen for the focus of the Safety Audit for several reasons. First, a 911 call prompts a law enforcement response that for many victims of domestic violence may be the first time they have encountered

the criminal justice system. These contacts are a critical time to make a difference, both in terms of victim safety and offender accountability. Even when there is no arrest, a 911 or law enforcement response communicates a message to potential victims and offenders. For those offenders who are arrested, jail procedures and practices are also significant in contributing to victim safety and offender accountability. If improvements are made at the entry point to the criminal justice system, it is more likely that community members will view and use the criminal justice system as one tool for victim safety and offender accountability.

Secondly, this was the first attempt to use the audit process in Tillamook County and the partners felt that looking at as much of the system as was feasible in the time and with the resources provided would provide a strong base of knowledge for future work.

The audit looked specifically at the Tillamook County Emergency Communications District (911), the Sheriff's Department Patrol Unit, and the Tillamook County Jail. These three agencies were chosen because of their work in the areas of focus as well as their exceptional openness to the process.

## Methodology

The area of focus for the audit was chosen by the TCCIP partners and subsequently the audit team members were selected from those agencies that were being examined as well as victim and offender service agencies in the community. The audit was led by a local Safety Audit Coordinator with assistance from Consultants from PRAXIS International and the Battered Women's Justice Project.

The audit team began by mapping all of the steps or "points of institutional action" involving the response and processing of a domestic violence case within each of the three areas. These maps allowed the team to follow the movement of a hypothetical domestic violence case through the system from the initial call for help to the booking of a suspect into the jail (maps available upon request). In addition, important texts, both electronic and paper, were identified through he use of these maps and formed the basis for the text analysis portion of the audit.

The text analysis was done by the Battered Women's Justice Project consultant Rhonda Martinson. Rhonda listened to thirty 911 recordings, looked at thirty 911 transcripts, and looked at 15 Sheriff's Department Case Files including police reports and jail booking information (copies of recordings listened to and files reviewed available upon request). Of the texts that were examined, fifteen of the 911 calls were randomly selected by 911 dispatchers from domestic violence calls during the past year and fifteen cases were randomly selected by Lieutenant John Schneidecker of the Sheriff's Department based on there being an arrest made. Finally, 911 dispatchers located the corresponding calls for the fifteen cases selected by the Sheriff's Department to allow the team to follow actual domestic violence cases all of the way through the system.

In order to gain valuable information from individuals involved in the system, focus groups, interviews and observations were used. Focus groups provide a mechanism for bringing victims' voices into the audit process. One focus group was held with victim's of domestic violence who had contact with the criminal justice system. Focus group participants were recruited through the posting of flyers, newspaper articles, and word of mouth. Five women participated in the initial focus group.

Interviews and observations were done by all members of the audit team with both front-line and supervisory staff in all of the agencies being examined. Audit team members were assigned to interview and observe practitioners in agencies other than the ones in which they work.

Four observations and four interviews were done with 911 Dispatchers, one interview was done with the Emergency Communications Center Manager, and one interview was done with the Emergency Communications Center Director. Five interviews and five observations were done with Sheriff's Department "Road" Deputies, and one interview was done with a Sheriff's Department Detective. Two observations and two interviews were done with Corrections Deputies, one interview was done with the booking and transport Sheriff's Deputy, one interview was done with the Under Sheriff and two interviews were done with the Sheriff (one focusing on patrol and one focusing on the jail). All interviews and observations were done by audit team members.

The Audit Team began meeting in November of 2004 with a two-day audit training, and completed the audit with a two-day wrap-up process in November of 2005. During the course of the year the team met frequently, often every two weeks, to complete the

above detailed activities. The team worked very hard and very diligently to complete this process while still performing their regular full-time jobs.

The team was made up of John Schneidecker Tillamook County Sheriff's Office Patrol Unit; Kathleen Marvin and Eleanor Watkins, Tillamook County Women's Crisis Center; Jeanette Austin Tillamook 911; Cherry Reaksecker Tillamook County Jail; and Tam Hulburt, Solutions Domestic Violence Intervention Program. The team was led by local coordinator Erin Skaar with the support of Rhonda Martinson, Battered Women's Justice Project and Casey McGee and many others at PRAXIS.

During the course of the audit Sergeant Schneidecker was promoted to Lieutenant at the Tillamook County Jail and then tragically killed in an off-duty vehicle accident. Lieutenant Schneidecker brought a wealth of knowledge to the process from both his work as a "road" deputy and then his work as Jail Commander. He contributed immensely to the audit process prior to his death and his influence was felt throughout the entire audit process. Sheriff Todd Anderson attended the audit wrap-up meetings in Lieutenant Schneidecker's place.

**Audit Findings**

The focus of the two-day audit wrap-up was to bring together all of the data that had been collected into one place and find the most salient concerns. While there were many areas where we found strengths in the system as well as more areas of concern than the six detailed below, these were the areas that the team felt were of the greatest importance to address.

**Finding #1: There is a lack of recognition of the medical seriousness of strangulation.**

Several callers to 911 in this audit can be heard saying they'd been choked. See e.g., Call 1: "This is not the first time he has done this s**t. He's broken my stuff before. I've got to get my stuff out of there. He grabbed me by the throat a bunch of times." In some of these calls voice changes such as hoarseness or coughing are evident, but there was no inquiry by practitioners into being strangled or choked and no inquiry into the need for medical assistance related to being strangled or choked. Although dispatchers generally relayed what the caller said about being choked or strangled to responding officers, in only one instance was the suspect charged with strangulation.

This is a common issue nationwide, as strangulation has only recently been identified as one of the most lethal forms of domestic violence. Historically, "choking" was rarely prosecuted as a serious offense because victims minimize the level of violence and police and medical personnel fail to recognize it. Victims report symptoms ranging from difficulty in swallowing to lack of consciousness – see the checklist below which was adapted from a specialized form developed by the San Diego City Attorney's Office with Dr. George McClane and Dr. Dean Hawley and is currently being used at the San Diego Family Justice Center. Being strangled can result in internal swelling or tissue damage that can have serious consequences if left untreated. Trainings on strangulation developed by the San Diego City Attorney's Office and Drs. McClane and Hawley have presented case stories of strangulation victims who have later suffered voice impairment, brain damage, aneurysm and miscarriage.

**Symptoms and/or Internal Injury**

| **Breathing Changes** | **Voice Changes** | **Swallowing Changes** | **Behavioral Changes** | **Other** |
|---|---|---|---|---|
| ❒ Difficulty breathing<br>❒ Hyperventilation<br>❒ Unable to breathe | ❒ Raspy voice<br>❒ Hoarse voice<br>❒ Coughing<br>❒ Unable to speak | ❒ Trouble swallowing<br>❒ Painful to swallow<br>❒ Neck Pain<br>❒ Nausea<br>❒ Vomiting | ❒ Agitation<br>❒ Amnesia<br>❒ PTSD<br>❒ Hallucinations<br>❒Combativeness | ❒ Dizzy<br>❒ Headaches<br>❒ Fainted<br>❒ Urination<br>❒ Defecation |

Recent changes in Oregon law make strangulation a Class A misdemeanor and a much more easily prosecuted offense. When asked about strangulation in interviews, sheriff's patrol deputies and corrections personnel generally agreed that there was not any specialized training in the area of evaluation of injuries or specifically how to recognize the signs and seriousness of strangulation. Deputies who had more recently been to the academy received more training than those who had been to the academy more than 2 years ago.

Statements made by deputies during the interview process included the following:

Injury Evaluation

- "Had training at the academy on injury identification"
- "Listens to stories, looks at them – no specific training in injury evaluation"
- "Evaluates injuries based on statements taken – no training on injury evaluation"
- "Substantial injuries go to the hospital – not training on what is a substantial injury"
- "Have First Aid/Defibrillator training only – no medical evaluation"

Strangulation Training

- "Strangulation was touched on in training at the academy"
- "Only training on strangulation is in deputy medical examiner school – on dead people"
- "No strangulation training"

Awareness of Strangulation in Tillamook County

- "Haven't seen it here"
- "Strangulation is not seen often"
- "Have seen it twice in two years"
- "See strangulation often, but victims won't admit it"

Deputies were not asked specifically about their awareness of the change in the law regarding strangulation, but procedures for updating officers on statute changes such as this were explored with them as well as with the Sheriff and Under Sheriff.

The current practice for keeping officers up to date is based on information being provided to the Sheriff by the Attorney General's office and/or by the Sheriff's Association, and by information coming through DPSST. Information provided to the

Sheriff is passed on through the Patrol Sergeants at roll call and DPSST information comes as a training CD ROM that all officers are required to review and complete that is then returned to DPSST.

Patrol deputies interviewed generally agreed that they charged only the most obvious charges and left the rest to the district attorney's office. As a result there were very few charges of strangulation.

In interviews with 911 dispatchers we learned that medical assistance is only sent if the caller requests it or does not decline it when the dispatcher offers it. The same is true of medical assistance offered by deputies. Victims are asked if they would like medical attention. If they say no, none is called for. Taking the new information available about strangulation and how often the victim does not realize its seriousness into account, current ways of responding can create a problem for victim safety.

**Finding #2: Violations of restraining orders are addressed inconsistently.**

Restraining orders are a critical piece of the system both to provide for victim safety and offender accountability. Every time a restraining order is enforced a message is sent to both the victim and the offender saying that violence against another person is not only unacceptable, it is illegal. When a restraining order is not enforced, however, a very different message is sent. Victims are led to believe that violence against them is OK and offenders are reinforced in their use of violence.

During the focus group with battered women conducted for this audit, women shared that restraining orders were not a successful way to keep batterers away. They shared that orders against their batterers were not consistently enforced and therefore were not helpful in preventing violence.

While this is a critical issue, it is not a simple one. The data collected in the audit shows a variety of reasons why restraining orders are not consistently enforced. The following examples taken from the text of police reports elucidate some of the many reasons for the inconsistency.

- Victim or suspect statements that implied but didn't directly state repeated restraining order violations sometimes weren't "picked up" by practitioners,

which is indicative of lack of recognition of harassing or stalking behavior by practitioners and by citizens in general.

"I was approached in the [redacted] parking lot by my husband, who I have a restraining order on. He wouldn't get off my car. I was picking my daughter up from work. He's made third party contacts in the last couple days. He was crying and pleading with me to pray with him and be with him. I told him to get off the car door, that he wasn't supposed to be by me. He said he'd turn me in for this and turn me in for that . . . . The store owner came to see if I was all right. Everyone in town knows he is not supposed to be by me." (suspect's statement indicated he'd been following his wife earlier in the day as she ran errands….") (911 call, Case 5)

Practitioners interviewed had differing opinions as to whether a restraining order violation requires an arrest or not. Some believed there was discretion for the deputy and others felt it was always an arrest. It was also learned that there was not specific training offered on reading, serving or enforcing restraining orders.

- Issuance of the order, who it was issued for and against and when it was issued; and denials of orders, amendments to orders or dismissals of orders sometimes present a confusing picture to practitioners of who the violent party is and what they should do about it.

  "A week after arresting the female, deputy met her at the Women's Crisis Center. She said after the arrest, bruising developed from where her husband grabbed her arms after she slapped him. She had pictures taken of the bruising and obtained a restraining order against her husband." (law enforcement report, Case 9)

  [After dispatch received a call from a female complainant, the deputy arrived and saw the male] The deputy asked the male "if he was supposed to be on property. The male said the only ones trespassing were her and the cops. Deputy asked about the restraining order prohibiting the male from being on property. The male said he went to court yesterday and 'was found innocent of all charges.'" (law enforcement report, Case 10)

In addition to the examples from text above, interviews with practitioners also indicated frustrations: "Lots on interpretation in the deputies' role," and "Court exceptions to restraining orders make them difficult to enforce."

Tillamook County has four judges, all of whom hear domestic violence criminal cases and issue restraining orders. Thus, provisions of the orders and the language on them are not the same. The nature of exceptions and how they are written into orders can create difficult decisions for officers, e.g., if there is contact allowed for the transfer of children for example, officers are sometimes faced with the petitioner saying they were not transferring the children but the respondent saying that they were.

- Parties who have contact with each other or continue to live together after the issuance of a restraining order frustrate practitioners.

  "Deputy observed a traffic violation, and after stopping the vehicle, discovered restraining order between parties inside the vehicle." (911 call and law enforcement report, Case 13)

This frustration was a frequent area of comment for those interviewed. Some practitioners seemed to feel that in situations such as the one above, they or the system they worked in weren't being effective or successful. The following sample of quotes expresses a range of attitudes, approaches and concerns:

  - "It is a problematic process. The petitioner causes problems by contacting the perpetrator."
  - "Restraining orders are being abused by petitioner as a way to control others."
  - "Restraining order arrests depend on if victim is afraid and if suspect is on scene."
  - "Restraining orders are useless. Enforcement is not mandatory. There is lots of interpretation in deputies' role."
  - "Arrest for any restraining order violation. If in question call the DA."

- There is uncertainty in or lack of confidence about the full faith and credit to be afforded to restraining orders.

> The person who listened to the dispatch traffic associated with Case 13 described it as “Someone calls dispatch and says the prosecutor said a protection order is like restraining order and there is an interstate compact about these and we should arrest him. The dispatcher tries to call a prosecutor but can't reach him. The dispatcher calls someone (believed to be a jail staff member) and asks for information on the protection order. She gives the respondent's name and birth date. She gets confirmation that it is valid and asks for hard copy. The person at the other end (again, believed to be a jail staff member) offers to fax it. The dispatcher then calls a police supervisor and asks about arresting the subject. The supervisor says he talked to a prosecutor and that protection order is valid and we should arrest. The dispatcher advised the officer who was out with the subject. The dispatcher calls the jail and says an officer is on the way to jail with someone who has violated a protection order. She is faxing copy of confirmation.”

In addition to the example from text above, interviews with practitioners also exemplified this difficulty; e.g., “Not always possible to check the status of restraining orders easily – especially at night when there are no office staff at the jail,” and “Restraining orders are not served if out of jurisdiction.”

The current system for confirming the validity of orders requires staff at the jail to verify the restraining order paper copy prior to any arrest being made. During regular office hours this is done by the office staff at the jail. However, after office hours this requires a corrections deputy to physically leave the jail facility and go to the adjoining administrative offices of the jail to verify the paper copy of the restraining order. The jail is run with a very small staff, typically three to four officers at any time. This creates a burden for them to try to get over to the administrative office to check the orders and depending on the activities of the jail may take quite some time to complete.

**Finding #3: Self defense and predominant aggressor criteria are applied inconsistently during arrest decisions.**

Safety is definitely the first priority of all deputies in their responses to domestic violence. However, assuring safety is difficult without an understanding of the dynamics of battering. Further, is can be difficult to determine who is a victim and who is a perpetrator when focusing only on the incident at hand.

Those interviewed understood law enforcement officers' role as interveners in domestic violence. They referred generally to safety of victims, children, officers and suspects and specifically to safety-oriented actions such as separating the parties, removing the offender and advising victims of rights and resources.

Those interviewed expressed frustrations, difficulties and lack of training, skill or experience regarding whether there are times:

- where no arrest is appropriate
- whether dual arrests are appropriate
- whether a party has legally exercised his/her right to self-defense
- if or how to determine the predominant aggressor
- at what point responsibility for these decisions should lie with police, prosecutors or judges.

Although the text analysis of law enforcement reports revealed some knowledge of the importance of the history of the relationship and of the concept of risk assessment this sort of information wasn't inquired into or recorded consistently. Interviewees felt that on-site investigation is the basis for arrest determinations and that the history of the relationship did not play a large role in those determinations: "I take each call as if it is the first time;" "History has less influence than current stories;" and "History doesn't necessarily tell you - the female may strike out and commit the crime."

Practitioners also revealed a lack of knowledge about the negative impact of arresting both parties, arresting someone with a legitimate self defense claim, or arresting someone who even though was a user of illegal violence, was not the predominant aggressor.

In the 15 randomly selected cases examined in this study, this practice of looking only at the incident at hand resulted in the arrest of women in 40% of these cases. This number stands in stark contrast to the national average of 97% of all incidents of domestic violence being perpetrated by men.

See, for example, this dichotomy as expressed by Case 7. The police report indicates the female caller to 911 was arrested and taken into custody while the male was not. A transcript of the 911 recording:

**Caller:** I just got beat up by my boyfriend. (Caller's voice is shaky and out of breath) I got him out of the car on the road but I'm afraid he's going to come back. I'm at home. (Caller gives the dispatcher her name and address, and her boyfriend's name). He's on Highway 22 somewhere, walking. He beat me up in the car. He was calling me a bitch so I slapped him on his face and he beat me up.
**Dispatcher:** Do you need an ambulance?
**Caller:** No, it's just my face.
**Dispatcher:** Do you know your boyfriend's birth date?
**Caller:** I don't know.
**Dispatcher:** How old is he?
**Caller:** 44.
**Dispatcher:** Do you think he might make his way home?
**Caller:** Yes. And we have a gun here but I don't know how to use it and it's not on safety and I'm just really afraid.
**Dispatcher:** Does he have a key to the house?
**Caller:** No, but he wrecked door on my car. He'll break a window to get in. He was trying to bust my car door in, trying to break my car window in.
**Dispatcher:** Are the doors to house are locked?
**Caller:** Yes.
**Dispatcher:** I'll get help. Hold on. (Dispatcher gives all this information to officers. When she returns to call, caller has hung up. Dispatcher calls her back). Officers are on the way. Would you like me to stay on the line?
**Caller:** No, but if I have to call again, I will. I think what I am going to do, because he told me that the gun isn't on safety, I think I am going to sit on the couch, and if comes in, because I know he's going to be out to hurt me, I might have to hurt him.
**Dispatcher:** Why don't I keep you on the phone until officers arrive? And you can let me know if anything is going on and I'll be here. And if you need to go do anything, leave the phone open. I will be here, even if you don't hear me talking.
**Caller:** So if I need you, you'll be there?
**Dispatcher:** Yes. (There is a sound like someone setting phone down)
**Officer:** Enroute.
**Dispatcher:** (Returns to phone and says woman's name but no one responds. She says her name several more times but gets no answer.
**Caller:** (Banging noises in background. Woman comes back on line) He's here and he's knocking on the door!
**Dispatcher to officers:** The boyfriend is pounding on the door.
**Officer:** Is the caller is at the (redacted) or north of the (redacted)?

**Caller:** I'm at the (redacted).
**Officer:** We'll be there in a few minutes.
**Caller:** He's breaking the window down!
**Dispatcher:** Which one?
**Caller:** The outside one! He got inside! Hurry! Hurry!
**Dispatcher to officers:** The boyfriend broke the window.
**Officer:** We're almost there.
**Caller:** (More banging)
**Caller:** He's in the house! I'm going to have to –
**Dispatcher to officers;** The boyfriend is inside.
**Male in background:** (Loud unintelligible words)
**Caller:** Stay away from me! Stay away from me!
**Male in background:** Bullshit! (Loud unintelligible words from male, punctuated by him yelling "Fuck!") Yeah, shoot me, bitch! Shoot me! Shoot me right now! Shoot me in the fuckin' head!
**Caller:** Stay away from me!
**Male in background:** Fuck you! Fuck you! Pull the trigger! Pull the fuckin' trigger! Bitch!
**Caller:** No, I don't want to shoot you!
**Male in background:** Let go! It's my fuckin' gun now! (Roars loudly like an animal)
**Dispatcher to officers:** He's wrestling the gun from her. I believe every officer needs to respond.
**Male in background:** Let go of the gun, goddamn it! You want to fuck with me? You want to fuck with me, bitch? I'll put you through goddamn hell! Let go of the goddamn gun now! Fuckin' piece of shit! Fuck! (Clunking sounds like he has tossed the gun) You want to see how pissed off how I am?
**Caller:** Don't you hurt me!
**Male in background:** You fuckin' bitch! Leave me out there! Goddamn you!
**Caller:** Quit hitting me!
**Male in background:** Really? Fuckin' bitch! You're a fuckin' piece of shit!
**Caller:** No, I'm not.
**Male in background:** Yes, you are! Leave me out there like that. Look at my fuckin' head! Do you give a fuck that you ran over me? Do you?
**Caller:** Yes, I care.
**Male in background:** You lying sack of shit! Look at my fuckin' head! Does that make you happy? Fuckin' bitch!
**Caller:** Knock it off!

**Male in background:** I'll make you so happy! (Loud, unintelligible words from male) Ran right into my fuckin' head! Do you like that? Does that make you feel good?
**Caller:** No, it doesn't. (Voices trail off as officers arrive)

While the officer was not able to hear this recording from the 911 call prior to his arrival at the scene of the incident, his report does however detail her account of the violence and threats against her by the male and record the injuries to her. In spite of these things the file indicates that she was the only one arrested in this case and was in fact considered the predominant aggressor.

In Case 8 we also see the woman is the only one arrested while the police report indicates that the male also used violence and caused injury. See excerpts from police report below (names have been changed):

> Mary M. Jones was sitting in a chair at the kitchen table. She had a wrap around her arm and she was wiping blood off of her legs. I asked Jones what happened tonight. She told me that her husband was mad at her because they went shooting earlier today and she shot better than him. After they got home she wanted him to pick the kids up at the babysitter with her but he refused and walked off on foot (the babysitter lives across the street). Jones admits this created a lot of tension between them. She than tells me they got were in the kitchen trying to have a family meal and he pushed her down in the hall. I asked Jones how they got from the kitchen to the hall and she replied, "I don't know I wasn't taking notes". She said she went into the bedroom with their three children ages 7, 4 and 2 and was sitting on the bed. Jones didn't remember how her husband got into the bedroom but he was coming at her. Hones says she threw a lamp at him because he was coming toward her and she was afraid.

The officer then spoke to the son age 7. His statement from the police report said:

> He says the family was in the kitchen and there was a rug with lots of food on it and his mother was swinging it around. He says dad ran away and mom swung the rug around again and food went everywhere. He says when mom went in the hallway, dad pushed her down. He says mom came in the bedroom with him and his sisters and brothers and she was, "crying black tears". . . . He says after dad came into the bedroom he put mom on the ground "like the coppers do, except he did not use

handcuffs". He says when his mom got up she was very mad and she threw the lamp at his dad.

The officer photographed the injuries of both parties and took only the woman into custody. A memo in the file from the District Attorney instructed the jail to release the suspect immediately and the prosecutor would not be pressing charges.

Interviews with practitioners revealed disparity in the amount of knowledge and training that officers had in the area of responding to domestic violence. Some officers had no domestic violence training, some had had only the training provided at the academy, and others had extra or advanced training:

Training offered at the academy has changed and newer officers have more training in the area of domestic violence than officers trained two to three years ago. There is no required training on domestic violence beyond what is offered at the academy. Although there have been local trainings that officers have attended as possible, the training budget in the Sheriff's Department is not sufficient to have all officers attend all of the same trainings - there is no mechanism to cover officers' duties while they attend the training.

Additionally, deputies did not receive any specific training in the common statutes charged in cases of domestic violence nor did they receive any specific training in the collection of evidence for these charges. Comments made during the interviews included:

- "Can't arrest on threats, there is not a crime."
- "Aware of the menacing charge but have never used it successfully."
- "No training on the statutes."
- "No evidence collection policy."
- "Evidence collection is based on the situation."
- "I collect the evidence that is necessary for the charges."
- "Charge the obvious and let the D.A. add other charges."
- "Charges are up to the D.A. [Officers] collect evidence and statements and simply charge what is needed to arrest."

The analysis of law enforcement reports indicates that out of the 15 cases looked at, harassment was charged 12 times and the following charges were made once each: contempt, interfering with making a report, burglary, violation of a protection order and

unlawful entry to a vehicle (some cases resulted in more than one charge). The observations above about evidence collection were also borne out by the analysis of police reports, which indicated that generally, victims' injuries were photographed but the crime scene was not.

With so few officers and such large distances to cover there is sometimes simply not time to conduct as thorough an investigation as officers would like. Given the resource difficulties of covering distances and covering shifts, officers receive most training on the job from their peers.

**Finding #4: Underutilization of the dispatcher's role in assessing risk, heightening victim and officer safety, aiding probable cause decisions and providing evidence for prosecution.**

Interviews with practitioners painted a consistent picture of the dispatch role as emergency responders, as opposed to "sitting on the phone doing the investigation." The dispatch role was described as " . . . the 'in-between';" that is, to ". . . take . . . information and pass it on," "get information and make it available to the officer" and "provide for everyone's safety." And safety includes officer safety. The 911 recordings reviewed for this audit, which included radio traffic with officers, indicated radio checks with officers to check on safety and contacts with supervisors when officers couldn't be reached, which, given local radio "dead spots," was not an infrequent occurrence.

Dispatchers are trained to ask the "6 W's:" who, what, when, where, why and weapons. One interviewee said these are guidelines as to what is important to note in the computer-aided dispatch system, so other dispatchers who may open this record can immediately understand the nature of the call. Although this seems straightforward, observations, interviews and text analysis revealed differing practices in information-gathering and missed opportunities for dispatchers to heighten victim and officer safety, aid in probable cause decisions and provide evidence for prosecution.

When asked what information they asked for dispatchers all stated that they used the "6 W's" to guide them. This can however still lead to discrepancies in information gathered. For example, a caller who doesn't say much or indicates worry about making the call, may signal a dispatcher to avoid going into depth, as in Case 2:

**Caller:** There's a fight next door and the woman is bloody.
**Dispatch:** Where are they?
**Caller:** They're outside by the man's truck now.
**Dispatch:** Have they been drinking?
**Caller:** The woman hasn't. I know because she was with me earlier. There's another woman over there. (Caller lowers voice) You're not going to tell him I called, are you?

A caller who is "freaking out" may require more time from a dispatcher to focus the caller and pull out details. However, intoxicated callers are difficult to get details from. Someone calling from a noisy area (the call in Case 3, for example, is made from the fairgrounds) is hard to hear. Sometimes two parties try communicating with the dispatcher during the same call will make it difficult to gather the information, as in Case 15:

**Caller:** (hangs up).
**Dispatch:** (calls back)
**Caller:** (hangs up again)
**Dispatch**; (calls back again) 911 got a call from there. Was there an emergency?
**Caller:** No.
**Dispatch:** Who called?
**Caller:** (in clear voice) I did. My husband and I were having a dispute. It's fine now.
**Man in background:** (voice sounds slightly slurred) It's not fine.
**Dispatch:** Is he there now?
**Caller:** Yes.
**Man in background:** Send a sheriff over, please.
**Caller:** Our 10 month old is in his arms and that's not cool.
**Man in background:** Send a sheriff over, please.
**Caller:** (to dispatcher) It's fine. (to husband) You want a sheriff?
**Man in background:** Yes.
**Caller:** (to husband) You want a sheriff?
**Man in background:** Yes, I do.
**Caller:** Ok. (gives dispatcher her name). We were arguing over a divorce.
**Dispatch**er**:** Was it physical?
**Caller:** No.
**Dispatch**er**:** Has anyone been drinking?

**Caller:** A little. (to husband) You want a sheriff?
**Man in background:** Yes.
**Caller:** You're serious?
**Man in background;** I am serious.
**Caller:** (to dispatcher) There's a divorce pending.
**Dispatch**er**:** You both live there?
**Caller:** Yes.
**Dispatch**er**:** What is your birth date?
**Caller:** (gives birth date)
**Dispatch**er**:** What is your husband's birth date?
**Caller:** (gives birthdate)
**Dispatch**er**:** An officer is on the way.

A lone dispatcher is responsible for other phone lines and radio traffic in addition to 911 calls (in most of the 911 recordings, the dispatcher was interrupted by other phone calls or radio traffic). These things and more are factors in the time a dispatcher spends with a caller, which impacts the information transmitted to patrol deputies. Interview comments about this transmission of information to deputies ranged from transmitting only information that "is important" to "giving everything." There is nothing in writing instructing dispatchers what information to transmit over the radio to law enforcement officers; instead, this is guided by training. There was a general perception among everyone that no one would appreciate "long stories" or "unnecessary talking" over the radio.

As we saw in the 911 transcript of Case 7 in Finding 3, in some cases information gathered by dispatchers could assist officers in better assessing risks of the situation and better determining what has happened. In addition, the recording of the dispatch call may assist prosecution with their case if they are aware of what is in it.

There also is nothing in writing about whether or not to keep callers on the line while officers are enroute. Everyone understood that sometimes keeping the caller on the line may heighten safety (see, for example, the transcript of the 911 call from Case 7 on page ) but there isn't any policy guidance for dispatchers on assessing this. One dispatcher said he/she asked the caller if it is safe to be on the phone.

**Finding #5: Jail staff lacks technological resources, policy and training to collect and update victim contact and notification information, offender release and condition information, and incarcerated offender threat information.**

The jail has its own computer system, which is not connected with other systems such as dispatch (CAD reports) or law enforcement (police reports). In addition, the software is a shared package with 4 counties and is therefore not easily customizable to meet the local needs.

Because the jail and law enforcement computer systems are not connected, corrections staff don't consistently get victim contact information. There is no space on the booking sheet or in the computer system for victim information. The booking officer has to remember to get the information from the transporting officer, if they have it, or the suspect. In addition, information about the victim's wishes regarding notification of the defendant's release (none of the files examined for this audit had this information) is rarely available. When they do have victim information, staff doesn't proactively notify all victims of all offender releases; staff only does so when requested by an officer or a victim. In this situation, if an attempt to contact the victim is unsuccessful, corrections staff can't hold the offender until contact is made. Once bail is posted, the offender must be released.

Tillamook County Sheriff's Department utilizes the VINE (Victim Information and Notification Everyday) system, but there are no procedures for inputting or updating data, quality control, or usage. In order for a victim to be notified by the VINE system when an offender is released that victim must go into the system and register. Interviews with practitioners and battered women indicated the system is not widely known and is only used sporadically.

As for defendants who may issue threats during book-in or during incarceration, there is no way to write reports of this in the current jail computer system and there is no conduit to the prosecutor for information of this type. The same is true of defendants who appear to corrections staff to have also been victims (injuries discovered, facts revealed during book-in, etc.) – there is no way to write reports of this in the current jail computer system and no conduit to the prosecutor.

Interviews with jail deputies indicated that reports are occasionally written on other computers and put into the inmates file, but only if time permits.

**Finding #6: County law enforcement and corrections agencies are unable to share vital data electronically thereby requiring practitioners to duplicate the collection and processing of data.**

In 2001 the Tillamook County Emergency Communications District (911) implemented a Computer Aided Dispatch (CAD) system with integrated Law Enforcement Records Management system (RMS). A information related to any police incident is entered into CAT by the 911 dispatcher. When the call is complete, the information is uploaded to the RMS server where the data resides until the officer ready to write his/her incident report utilizing the RMS report writing feature.

When an offender is arrested, the 911 Center enters the offenders' name, date of birth, and other demographic data into the CAD system. The criminal charges are also entered. When the offender is lodged into the Tillamook County Jail, the officer completes a hand written booking sheet which contains the same data entered by the dispatcher, plus other demographic data such as place of birth, height, weight, etc.

The corrections staff inputs all the data from the booking sheet into the jail's stand-alone computer system, which shares no data with the RMS system (e.g., 911 recordings reviewed for this audit, the dispatcher phones the jail and verbally gives identifying information of parties being brought to jail, and then follows it up with a fax) to all the 911 calls obtained . When the officer returns to his/her office to complete the arrest report, the officer obtains the information already entered by the 911 Center and inputs all of the information that is contained on the handwritten booking sheet.
When the offender is released from jail, the corrections staff has no immediate access to the arrest report; no immediate access to the name(s) or address of the victim(s); and no immediate access to the status of the case. This lack of information could potentially result in an offender being released from custody with a Release Agreement that does not forbid the offender from having contact with the victim(s).

Under the current system, the Release Agreement is a part of the jail records and is not accessible to patrol officers and/or investigators. If a law enforcement officer wants to inquire about the release status of an offender, one of the corrections staff is required to complete a hand search of jail records to determine any restrictions.

The problems identified above are time consuming and redundant. More importantly they do nothing to ensure that the victims of domestic violence are given the greatest possible level of protection. They also cause grave concern about the ability to make, and keep, offenders accountable.

The aforementioned problems can be resolved by the integration of the jail computer system with the CAD and RMS system. CAD and RMS data is completely integrated and permits the sharing on information between 911, Tillamook County Sheriff's Office, Tillamook Police Department and Manzanita Department of Public Safety. The users can access their own data as well as the data of the other agencies.

The addition of a corrections module to CAD and RMS unites the entire law enforcement community and permits unlimited sharing of offender information. This solution both eliminates the redundancy of data collection and processing and helps to ensure the safety of victims' and the accountability of offenders by closing the cracks in the data sharing system.

**Next Steps**

By working together across disciplines we feel we have all learned a great deal about what are systems are designed to do and what they are not. We hope that the results of this audit will provide a place to continue our collaborative work to enhance victim safety and offender accountability.