

FREEBORN COUNTY, MINNESOTA

**Domestic Violence Safety
&
Accountability Audit**

2004

TEAM MEMBERS

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Albert Lea Police Department
Freeborn County E911 Dispatch Center
Freeborn County Attorney's Office
Albert Lea City Attorney's Office
Freeborn County Crime Victim's Crisis Center
Freeborn County Court Services
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ADDITIONAL ACKNOWLEDGEMENTS

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INTRODUCTION AND OVERVIEW OF THE SAFETY AUDIT PROJECT

A Domestic Violence Safety and Accountability Audit is a systematic observation and analysis of the intra- and interagency routines and documents used and produced when institutions process “cases” of domestic abuse. A central activity is the assembling of an audit team, made up of practitioners from agencies that intervene in cases of domestic violence, to look at their collective response to these cases. 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 determine whether that sequence centralizes victim safety and offender accountability. 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 those staff command. In so doing, the audit reveals work processes behind the problems and trends. The strength of a safety and accountability audit lies in: (1) its emphasis, which is not on the competency or idiosyncrasies of individual practitioners, but rather on how, where, and if agency *practices* ensure the safety of victims and the accountability of offenders; (2) the participation of local practitioners as auditors of their own systems; and (3) the development of analytical skills with which practitioners can continue to evaluate other aspects of their system.

The audit in Freeborn County was conceived to examine the overall response to domestic violence by five elements of its criminal justice system: 911/dispatch, law enforcement, the jail, prosecution, and probation. However, the focus for the first phase of the audit is the dispatch and law enforcement response. A 9-member audit team, comprised of practitioners from those agencies as well as battered women’s advocates, has been meeting and planning since early 2002 to plan and organize this audit. They not only conceived and defined the audit’s scope, but also won cooperation from their respective agencies, shared and analyzed considerable amounts of institutional data, and dedicated hours of their time to the audit process itself. This same audit team will be central to the implementation of the audit’s findings and recommendations.

Phase 1 of the audit, conducted in 2003

The audit team mapped out every point of intervention within the law enforcement and dispatch systems and collected each agency’s relevant texts—forms, job descriptions, policies and procedures, statutes, and agency descriptions—into handbooks for points of reference during the audit. The team received training on the audit process and strategized how to organize its members into teams that would ensure maximum objectivity (e.g., practitioners were not the sole auditors of parts of the system in which they worked). The team analyzed not only the above handbooks, but also texts arising from actual cases involving domestic violence:

- Thirty-seven 911 and dispatch transcripts
- 50 reports of intimate partner violence produced by the Albert Lea Police department and 30 reports of intimate partner violence produced by the Freeborn County Sheriff’s Department between May 24, 2002 and February 10, 2003.

During the audit, team members conducted 19 interviews and observations of practitioners (both supervisors and line staff) in 911/dispatch, law enforcement, jail, records, court services, prosecution, and probation, including the observation of hearings at the court house.

Audit team members met five times to review and analyze findings from the text analyses as well as their interviews and observations. Team members assessed structural impediments to battered women's safety in the criminal justice system, and identified possible, safer alternatives.

Recommendations resulting from Phase 1 of the audit were compiled by the audit team and its consultants, the Battered Women's Justice Project. The recommendations were presented to the appropriate criminal justice agency supervisors. Pursuant to the recommendations, trainings were held in January and April 2004, and checklists for report writing and responding to strangulation were dispensed. Videotaped curriculums on law enforcement responses, and on responding to strangulation, were purchased.

Phase 2 of the audit, conducted in 2004

A second text analysis of both 911 transcripts and law enforcement incident reports was conducted as a conclusion to the formal safety audit. In June, 2004, the Battered Women's Justice Project conducted a second text analysis of emergency calls taken by the Freeborn County E911 Dispatch Center between February and April, 2004. This text analysis served as the follow-up to a similar analysis conducted in middle of 2003. The 2004 text analysis used the identical analytical tool as the 2003 analysis, which is attached to this document as Appendix A.

For the second text analysis of dispatch, Freeborn County provided BWJP with recordings of eighty (80) 911 calls, twice as many as provided for the 2003 analysis. Only a couple of the calls were inaudible, and the recording technology had clearly improved since 2003. A little over half of the 80 calls involved intimate partner violence or threatened intimate partner violence. The recordings did not include information exchanged between the dispatch center staff and the squads, so this could not be included in the analysis.

All law enforcement incident reports of intimate partner violence from February 1, 2004 to April 21, 2004 were collected with names and other identifiers redacted. This resulted in 31 Albert Lea police reports and 5 Freeborn County sheriff's reports, which were analyzed and compared to the Phase 1 text analysis. Findings and continued recommendations were compiled by the consultants, with input provided by participants at the trainings, and from final meetings with supervisors and team members.

As stated in the report following Phase 1, the audit team should continue to develop, refine, negotiate, add to, and implement in the coming months. The audit team must also begin strategizing an implementation plan. Importantly, the audit team's continued analysis, discussion, and identification of problematic practices will become woven into an ongoing process of change that will, over time, result in a widespread improvement of the community's response to cases involving domestic violence.

The Battered Women's Justice Project, in its role as facilitator of and consultant to the safety and accountability audit undertaken by practitioners in Freeborn County, is grateful for the openness shown by criminal justice practitioners to examine and change problematic practices. Hopefully, the audit process has helped to strengthen the channels of communication between segments of the criminal justice system and the community's objective examination of the system's response to domestic violence offenders and victims.

COMPARISON OF 2003 AND 2004 TEXT

Law Enforcement Patrol Response

Securing the Scene

Law enforcement continues to timely respond to domestic violence calls. In 2003 in Albert Lea, all cases documented response times, which ranged from less than a minute to 30 minutes, with most cases less than seven minutes. A third of the response times were a minute or less. In Freeborn County, all but one case documented response times which ranged from less than a minute to 32 minutes, with most cases between three and 12 minutes. In 2004 in Albert Lea, all cases documented response times, which ranged from less than a minute to 10 minutes, with all but six cases being responded to in three minutes or less. In Freeborn County, all cases documented response times, which ranged from 10 to 23 minutes.

Law enforcement reports still evidence inconsistency in checking for the presence of children and assessing/responding to needs of children who were present during violence. In 2003 in Albert Lea, one-third of the cases documented children as present. Officers talked to children in one of those cases. In Freeborn County, half the cases documented children as present. Officers assessed the children's well-being in three of those cases. In 2004 in Albert Lea, almost one-fourth (seven) of the cases documented children as present. Officers talked to, looked at or inquired about the children in five of these cases. In Freeborn County, in the one case out of five that documented children as present, those children were not talked to, although the officer must have observed the children because he did tell the suspect that the children were scared.

Recommendation. The inconsistency in checking for children was noted in Phase 1 of the audit, with recommendations that policy and/or investigative aids be updated and reinforced with training. The police and sheriff's department did dispense breast pocket cards for police as report writing checklists, and checklists for supervisors in supervising the writing of domestic violence police reports. Participants at trainings conducted during Phase 1 of this audit requested further training on how to address children on-scene. The training budget in the grant that funded this audit wasn't sufficient to add that training. CVCC applied for another grant to continue the work of this audit and the application was denied. The consultants have suggested: other grant programs to which CVCC might apply, using local resources and expertise for training and consulting about children, and maintaining a relationship with the consultants to provide additional expertise and training opportunities.

Victim Safety

There has been an improvement in inquiring of/addressing the victim's need for medical attention. In 2003 in Albert Lea, 20 of the 50 cases involved injuries. Six of these cases documented inquiring of/addressing the victim's need for medical attention. In Freeborn County, 11 of the 30 cases involved injuries. One of these cases documented inquiring

of/addressing the victim's need for medical attention. In 2004 in Albert Lea, 25 of the 31 cases involved injuries. 15 of these cases documented inquiring of/addressing the victim's need for medical attention. In Freeborn County, four of the five cases involved injuries. One of these cases documented inquiring of/addressing the victim's need for medical attention.

Law enforcement continues to give victim rights/referral information. In 2003 in Albert Lea, 41 of the 50 cases documented one or a combination of information-giving activities. In Freeborn County, 16 of the 30 cases documented one or combination of information-giving activities. In 2004 in Albert Lea, 15 of the 31 cases documented one or a combination of information-giving activities. In Freeborn County, three of the five cases documented one or a combination of information-giving activities.

Recommendation. These positive measures regarding victim safety were noted in Phase 1 of the audit and we would encourage their increase. The most recent training (June 2004) provided under this grant was about the proper response to strangulation, which included information on injuries often sustained in domestic violence incidents, the medical seriousness of such injuries, and appropriate responses. Continued monitoring of police reports, via the supervision and via collaboration with the local advocacy program, is also recommended to keep these measures on the increase.

Interviews

Victim and Witnesses. Law enforcement continues to understand the importance – both in safety and in the quality of evidence collection – of privately interviewing the victim. There was an improvement in documenting this. In Albert Lea in 2003, it was unclear in six out of the 50 reports whether parties were interviewed separately. In Freeborn County, it was unclear in 10 of the 30 cases whether parties were interviewed separately. In Albert Lea in 2004, all but two victims were interviewed privately and in all cases, it was clear from the report whether or not parties were interviewed separately. In Freeborn County, it was clear from the reports that victims were interviewed privately in all five cases.

Law enforcement continues to get preliminary information and relationship information from the victim in almost every case, as they did in 2003. There was an improvement in obtaining information about history. In Albert Lea in 2003, out of 50 cases, some information about history was documented in 15 cases. In Freeborn County, out of 30 cases, some information about history was documented in five cases. In Albert Lea in 2004, out of 31 cases, some information about history was documented in 21 cases. In Freeborn County, out of five cases, some information about history was documented in four cases.

Law enforcement reports continue to show a struggle with documenting excited utterances, which requires documenting both the speaker's demeanor and what the speaker said in direct quotes. In Albert Lea in 2003, out of the 50 reports, 14 documented victim demeanor and nine documented victims' direct quotes. No children's excited utterances were documented. In Freeborn County, out of the 30 reports, four documented victim demeanor and three documented victims' direct quotes. No children's excited utterances were documented. In both jurisdictions in 2004, most reports documented some victim demeanor. One Albert Lea report

documented victims' direct quotes. Three of the five Freeborn County reports documented victims' direct quotes. Four of seven Albert Lea cases where children were documented as present did document the child's demeanor but none of these documented any direct quotes from a child. In the one Freeborn County case that documented the presence of children, demeanor or quotes weren't documented.

There was a slight improvement in obtaining temporary contact information for victims. In both jurisdictions in 2003, no report documented getting temporary contact information for victims. In 2004, although the five Freeborn County reports didn't document temporary contact information, four of the Albert Lea reports did.

Suspect. Law enforcement continues to get preliminary information and statements, and document suspect injuries, as evidenced by the high incidence of this in reports by both jurisdictions in both years.

Recommendations. The improvement in history may have been aided by the trainings, the breast pocket cards, and the supervisor checklists for report-writing. The trainings included information on risk assessment and documenting. The breast pocket cards and supervisor checklists include risk assessment items, including history. Training participants have asked for additional training on risk assessment. We encourage the continued improvement in this area by using local resources and expertise for training and consulting about risk, and maintaining a relationship with the consultants to provide additional expertise and training opportunities. Continued monitoring of police reports, via the supervision and via collaboration with the local advocacy program, is also recommended to keep these measures on the increase.

Phase 1 of the audit noted the struggle with excited utterances, which has now been exacerbated by the Crawford case. During Phase 2 of the audit, one of the local prosecutors inquired as to the perceived national status/impact of this case to better determine the usability of excited utterances, or if the victim would now have to be available at trial. The consultants recently provided current resources on the impact of Crawford, including an announcement of an upcoming Minnesota Criminal Law Institute in August 2004 that has a presentation on Crawford scheduled. We recommend that local prosecutors be engaged to educate law enforcement about this area as it develops.

Regarding the slight improvement in obtaining temporary contact information for victims, we urge the continued improvement in this area. Again, continued monitoring of police reports, via the supervision and via collaboration with the local advocacy program, is also recommended to keep these measures on the increase.

Evidence Collection

Photographing the scene and suspects' injuries, and collecting physical evidence, has stayed low. Remembering that not all crimes have scenes remaining (e.g., crimes are sometimes reported later) and that not all suspects have injuries, in 2003 in Albert Lea, out of 50 reports, two documented photographing the scene, five documented collecting evidence, and two documented photographing suspects. In Freeborn County, out of 30 reports, one documented

photographing the scene, one documented collecting evidence, and no reports documented photographing the suspect's injuries. In 2004 in Albert Lea, of the 31 reports, two documented photographing the scene, five documented collecting evidence, and two documented photographing suspect injuries. In Freeborn County, out of the five cases, two documented photographing the scene, none documented collecting physical evidence, and none documented photographing suspect injuries.

However, there has been an improvement in photographing the victim's injuries. In Albert Lea in 2003, 10% of the reports documented photographing the victim's injuries. In Freeborn County, 16 % of the reports documented photographing the scene. In Albert Lea in 2004, 20% of the reports documented photographing the victim's injuries. In Freeborn County, one of the five police reports documented photographing the victim's injuries.

And the police department has implemented a new practice of downloading the 911 call for transcription. This was not being done during 2003, and was not documented in any 2004 Freeborn County reports, but was documented in three 2004 Albert Lea police reports. A meeting with supervisors revealed that now that this capability is known, it is being done more frequently. Although this was not documented in 2003 so that a comparison can now be stated, the consultant also observed that 2004 police reports often included what they were told by dispatch (e.g., "Dispatch advised screaming could be heard in the background"), which adds to the officer's probable cause determination as well as the officer's assessment of danger.

Recommendations. The issues regarding photography, collecting physical evidence, and utilizing the 911 call's evidentiary value were all noted in Phase 1 of the audit. This year's improvements in these areas may have been aided by the trainings, the breast pocket cards, and the supervisor checklists for report-writing. The trainings included information on evidence collection, report-writing, and documentation. The breast pocket cards and supervisor checklists include evidentiary items to remember. We encourage the continued improvement in this area with continued monitoring of police reports, via the supervision and via collaboration with the local advocacy program, is also recommended to keep these measures on the increase.

Arrest

Law enforcement continues to make good self defense and predominant aggressor decisions. In 2003, out of 50 cases, Albert Lea had three dual arrests and one predominant aggressor arrest. Out of 30 cases, Freeborn County had one dual arrest. None of these arrests appeared problematic, based on the facts of those cases. In 2004, out of 31 Albert Lea cases and five Freeborn County cases, there were no dual arrests and no predominant aggressor arrests.

An increase in arrests occurred. In 2003 in Albert Lea, out of 50 cases, there were 21 arrests, three forwards to prosecutors for consideration of charges, and four requests for warrants. In Freeborn County, out of 30 cases, there were five arrests, three forwards to prosecutors for consideration of charges, and two requests for warrants. In 2004 in Albert Lea, out of 31 cases, there were 21 arrests, three forwards to prosecutors for consideration of charges, and no requests for warrants. In Freeborn County, out of five cases, there were four arrests, no forwards to prosecutors for consideration of charges and no requests for warrants.

Although this wasn't documented last year so that no comparison can be made, this year the consultant observed that during the time period of Phase 2 of the audit, there were a large number of calls for service labeled "domestic violence" for which no report was written.

Recommendations. The number of calls for service for which no reports were written was discussed during the final meetings with supervisors and audit team members. There are several reasons why a report might not be written (e.g., mislabeling by the 911 caller, mislabeling by the dispatcher, etc). One of the consultants suggested that supervisors should monitor or supervise this function periodically to ensure the same quality of decision-making occurs at this point of the system as at the point of arrest. Some noted the upcoming computer system update, during which provisions could be made for documenting a "no report" situation better, such as providing for relabeling calls for service, etc.

Special Issues

Intoxication. One can see by scanning the text analysis of both departments that intoxication on the part of one or both parties continues, as it did last year, to play a frequent and frustrating role in domestic violence calls.

Mental Health. Although this wasn't documented in 2003 so that a comparison can now be made, the consultant observed several 2004 police reports documenting the existence of mental health concerns about domestic violence suspects.

Pregnancy. One of the 2003 reports documented that a victim was pregnant. This year, three police reports mention pregnancy in some fashion.

Coordination with Prosecution. The audit team, the dispatch center, the police department and the sheriff's department were supportive of the audit process and of continuing audit work in other parts of their criminal justice system. The city and county attorneys had agreed to participate in a next audit, if it could be funded. CVCC applied for such a grant and just found out that the application was denied. This denial has been a great disappointment to the team, and to the dispatch and law enforcement agencies. They had recognized that many findings and recommendations noted in the Phase 1 report and in this Phase 2 report cannot be fully addressed without the prosecutors, and had looked forward to another audit as a way of building that collaboration and "getting everyone on the same page" as far as appropriate evidence collection, documentation, and charging.

Stalking. Last year, two police reports of stalking were indicative of difficulty in recognizing stalking (no charges issued; complainants were told to get a harassment or restraining order). This year, two police reports again indicate the same difficulty. Law enforcement officers received training in January 2004 that included two hours on recognizing, investigating and documenting strangulation. However, during a final audit team meeting at the end of Phase 2 of this audit, a team member pointed out that while the training was good as far as telling participants what stalking is, the training didn't tell participants what to do.

Strangulation. Last year, one police report was indicative of difficulty in recognizing the medical urgency of strangulation. This year, one report indicates the same difficulty.

Recommendations. As a result of the observation about intoxication last year, the January 2004 training included vignettes of potential arrest situations where one or both parties had been drinking. There are no easy answers to this problem, which is experienced nationally, but what was discussed at the training was that documenting more in such situations helps clear some of the confusion that occurs when incoherent people try to give statements. The consultant was told by several participants at the January and June trainings, by several audit team members, and observed for herself that that overall, the 2004 police and sheriff's reports appeared to document more overall (e.g., downloading 911 calls, taking more photographs of victims and writing more comprehensive reports that include documentation of disarray at the scene, property damage, who appeared afraid, etc.). This may help account for why, even though intoxication is just as prevalent, that there was a higher percentage of arrests for both departments this year.

Law enforcement obviously recognizes the health and safety implications when parties involved in a violent or potentially violent incident are mentally ill or pregnant. We commend this and encourage continued and improved recognition and documenting of these circumstances, as well as referral to appropriate resources. As stated in other areas, this will be aided by using local resources and expertise for training and consulting about mental health and about pregnancy, maintaining a relationship with the consultants to provide additional expertise and training, and continued monitoring of police reports via the supervision and via collaboration with the local advocacy program.

As for coordination with prosecution, the consultants' have provided information about two upcoming local trainings for prosecutors, and have offered to network with and maintain a relationship with the prosecutors. The consultants will also work with CVCC in upcoming months to identify other grant programs for which the prosecution audit application might be successful.

The issues of appropriately addressing stalking and strangulation would be aided by the coordination with prosecution, as police must understand prosecutorial needs such as proving the difficult elements of stalking or of the substantial injury necessary to charge a felony for strangulation. In addition, the audit team member who said law enforcement needs instruction on what to do with a stalking case makes a good point. One of the consultants has offered to locate a recently-available national stalking protocol and provide it to CVCC and the audit team. As for strangulation, a one-day training in June 2004 was just held on this issue. CVCC purchased a strangulation curriculum that can be used to further educate, and purchased small laminated cards that can be used by advocates, police, dispatchers, or medical professionals to remind as to the immediate medical needs that need to be inquired into when encountering a strangulation victim.

Closing

An oft-forgotten way of encouraging improvement and positive change in the law enforcement response to domestic violence is the recognition of the good things, the unique things, the creative things, the “above-and-beyond” things that officers do. As with the last report, the consultant has reviewed this years’ reports for things we would like to commend, and to encourage other officers to emulate. Here they are. Please review for examples of:

- sending a message to offenders about preventing victims for calling for help
- going the extra mile in locating a “gone on arrival” offender
- corroborating the victim’s story
- giving extra information on resources where needed, requested or relevant
- ensuring the victim will be able to call for help
- recognizing the importance of documentation by making a report of an potentially unsafe situation even though no arrest was made
- sensitivity and providing of information of sexual assault information and resources even though the victim declined to report it
- standing by while victim left her residence to ensure her safety
- accepting weapons for safekeeping
- “quick thinking” on documenting an outwardly small detail that could later help corroborate victim’s version of events and prevent certain defenses by offenders
- inquiry into and documentation of medication taken by pregnant woman
- when suspect was gone on police arrival, checking the safety of not only the victim of that evening, but also a previous victim
- returning to a victim’s apartment with her to show her that it was safe and that the suspect was no longer there.

Freeborn County	
Case	Encourage the Following
1	Documenting the unplugged phone via victim and suspect statements and photographing the unplugged phone holds offender additionally accountable, sends message of unacceptability of preventing someone from calling for help, and gives prosecution more to work with.
2	Suspect was gone on police arrival. Two deputies checked the area, local bars, and residences of acquaintances looking for her.
3	Comprehensive photographing of the scene (empty beer cans, the stairway where suspect banged victim’s head, the doorway where suspect banged victim’s hand, the broken plate, the victim’s injuries) corroborates the victim’s story. Officer tried seven times to get suspect to make a statement.
4	
5	Officer informed victim of counseling options.

Albert Lea

Case	Encourage the Following
1	
2	
3	Victim told officer they had no home telephone, and suspect had the cell phone. She told officer she could be reached through the residence of another person. Officer went to jail and retrieved cell phone from suspect's property and attempted to bring it back to victim's residence. No one answered the door so he brought the phone back to the law enforcement center and placed it at the front window. He left a message on the answering machine of the residence named by the victim as to where the cell phone could be picked up.
4	Officer documented what happened and where victim could be reached even though no crime had been committed
5	
6	The officer speaking to the victim was aware that the suspect had told another officer that his girlfriend had been raped in the past and refuses to report it to anybody. The officer speaking the victim asked her about this statement. When she said she didn't want to report anything about the rape, the officer told her if she did not want to talk to police, she could talk to a female advocate at CVCC. He gave her an information card for CVCC and explained their services, location and 24 hour hotline. He told her if she had questions or wanted to talk to someone about this, to call police or CVCC. He asked if she was going to be OK.
7	Even though suspect said he wouldn't slit his wrists, officer brought him to the hospital for an evaluation.
8	Officers stood by while victim left residence.
9	
10	Victim gave officer two Asian weapons that suspect used to slash at her stuffed animals and asked that the officer keep them so that suspect didn't have access to them again. Officer took the weapons to the law enforcement center.
11	
12	
13	Officer documented where dish appeared to have struck a wall. This turned out to be helpful, as when a statement was later taken from suspect, he said he had accidentally brushed the dish off the counter and it simply fell to the floor.
14	
15	
16	Officer was dispatched to the hospital to take follow-up photographs of injuries/bruises on victim who had made a police report the previous day.
17	Suspect is four months pregnant. Complainant alleged that suspect took 8 or 9 Tylenol pills to hurt the baby. Officer asked why suspect would want to hurt the baby. Complainant said she did this to make him angry. Officer collected the Tylenol bottle and documented the strength of acetaminophen in the Tylenol. Suspect said she took 4 Tylenol because complainant gave her a headache. She denied taking pills to hurt the baby and said if she were trying to hurt herself she would slit her wrists. Officer took her to the hospital where she was admitted and seen by a physician. Officer advised suspect's mother where she was and what happened.
18	Prior to going home, the victim had tried to get away from suspect by jumping out of the car, but he prevented this by grabbing her sweater to the point of pulling or ripping it completely off. Officer looked for sweater where victim said this happened but could not find it. Officer then spoke to another person in the residence and documented that he saw victim enter the residence with no shirt on.

Albert Lea

Case	Encourage the Following
19	
20	
21	
22	
23	
24	Suspect punched the passenger side of the dashboard of victim's car. In addition to photographing the damage, officer documented a small nameplate that had been on the dashboard had been knocked loose and was lying on the passenger side of the floorboard.
25	One officer states that he searched the area for suspect, and checked an address where he had just taken a complaint of suspect making harassing phone calls to a different victim.
26	
27	
28	Officer went to victim's apartment with her to show her it was safe and that suspect was gone.
29	
30	
31	Underage intoxicated complainant was taken to detox.

E911 Dispatch Response

The purpose of the follow-up analysis for the 911 transcripts was to re-examine themes that surfaced during the first analysis. Below is a summary of the themes reported in the first analysis.

Seeing the Big Picture

- Identifying additional relevant information including: details of injuries, history of violence and threats between the parties, details of the incident, level of fear of the victim, details about weapons, whether there is an outstanding OFP and the parties' OFP history;
- Recognizing and evaluating the potential evidentiary value of excited utterances, admissions, emotionally-impacting content of a recorded call (to a jury); and
- Prioritizing calls more accurately by asking two or three questions that delve beyond the superficial appearance of a call to better understand the true danger involved in a situation.

Addressing Special Issues

- Becoming language accessible to all of Freeborn County;
- Inquiring into the involvement of children; and
- Exploring safety issues in the call (e.g. asking callers if it is safe to speak; if it is safe to remain on the line; conducting basic safety planning with caller)

Communication with Caller

- Explain that squad has been dispatched as soon as squad is en route;
- How soon the caller can expect a squad on the scene; and
- Explore medical needs more carefully.

These themes were provided, in part, to guide the data collection and analysis of the Safety Audit team. The themes were also provided to give the dispatch center a sense of goals for better institutionalizing victim safety into the practices, policies and work routines of their operations.

The Safety Audit Report resulting from all of the auditing suggested a couple steps the dispatch center could take to better institutionalize victim safety. One of those suggestions included drafting a more detailed policy on how staff should respond to domestics. A sample detailed policy was attached to the previous report and is attached to this document as Appendix B. The first report also included a proposed brief risk assessment that staff could use to help elucidate the actual danger a call involved, to both the alleged victim and the responding squads. A copy of the risk assessment is attached to this document as Appendix C.

Aside from the Safety Audit Report, with the sample tools and policy, dispatch staff also were offered training through the Safety Audit grant. The grant project funded a domestic

violence training in January, 2004, which was open and available to dispatch staff. The training emphasized understanding the dynamics of domestic violence and conducting risk assessments, among other topics. A second training was offered in June, 2004, specifically addressing strangulation.

Realizing the little time that has passed between the two text analyses, it is unreasonable to think that very much could have been changed or implemented since the first analysis. So, predictably, many of the themes that arose in the first analysis are also relevant to the second analysis.

The recordings provided for the 2004 analysis were overall shorter than those provided in the 2003 analysis, although operators often stayed on the line with callers until squads arrived on the scene. The amount of information collected by staff varied depending on the apparent nature of the call. Staff routinely sought information on: the identity of the parties; the address of the caller and where the incident took place; a brief explanation of what happened; and description of the suspect (and vehicle when relevant). When an assault was alleged, operators often asked if it was the first time something like this happened, and whether the alleged victim wanted an ambulance. Staff also regularly asked whether there were weapons in the house when physical violence was threatened or alleged.

Additional detailed information was not routinely sought by dispatch staff. Description of injuries, details about the history of violence or threats between the parties, explanation of alleged victim's fear, and parties' history of OFP's or separation attempts, was occasionally volunteered by callers but rarely sought by dispatch. In addition, many calls were placed by third party observers. These parties were actual eye-witnesses to the crimes. Very little information about what they witnessed was sought by dispatch staff. All of this could be attributed to the short length of the calls, or dispatchers' perception that the recordings are rarely listened to or used by others in the system.

Whether and to what extent the recordings are used for prosecution is still unclear after this analysis. The recordings did contain excited utterances, admissions and statements as to medical condition, which could possibly be used as evidence at trial. Dispatch staff should be prepared to enter into discussions with local prosecutors as to how these recordings might be used more routinely in the prosecution of offenders.

Dispatch staff are not routinely asking any risk assessment questions to better inform the prioritization of calls that come in. Sometimes dispatch receive calls that present as verbal domestics with no physical violence alleged. In some instances these calls involve more danger than what is immediately apparent. Asking the caller one or two risk questions helps clarify the true danger involved in the call. One explanation as to why dispatchers are not routinely asking these questions is that most domestic calls receive an immediate response from law enforcement, whether physical violence is alleged or not. However, it is important that dispatch be prepared to make more careful distinctions between calls, should they need to make priority designations at any given time.

Dispatch staff did not routinely inquire into the involvement or presence of children. Callers volunteered the presence of children in a few calls, which was sometimes followed-up by a query from dispatch, and some calls were unlikely to involve children; but generally, it was not explored by staff. Noting the presence of children might impact the dispatcher's safety planning with the caller, and might provide helpful pre-arrival information to squads.

Staff did demonstrate an awareness of callers' needs to strategize about their immediate safety concerns. Staff asked questions such as, "Does he know you are calling 911?" "Is he still in the house with you?" and "Are you someplace safe?" Strategizing with callers about their immediate safety concerns wasn't consistent throughout the calls. The dispatch center might benefit from a formal protocol or training that encourages greater consistency. Staff also routinely keep callers on the phone until squads arrive. Typically, this done for the sake of the squads who want as up-to-date information as possible about the scene. There are also victim safety dimensions to this procedure. Victims must be asked about whether staying on the phone with dispatch is making them any less safe. When officer safety considerations did not dictate that staff keep callers on the phone, there were a couple instances in which callers were asked whether they wanted to stay on the phone with 911 until a squad arrived.

Staff also greatly alleviated the anxiety of many callers by communicating to them that a squad had already been dispatched, was en route to the address, and would arrive in a set number of minutes. Especially in the more elevated cases, this is information keenly sought by callers, and often helps them make better safety assessments for themselves. While staff used good common sense in conveying this information to some callers, it was evident that this practice isn't currently standardized in the office. There wasn't substantial consistency in practice.

A practice noted in one call was the use of "yes/no" questions, when the caller's conversation with dispatch was clearly antagonizing her situation with the alleged perpetrator. The dispatch center staff began asking the caller only yes/no questions, which did ease the situation markedly.

While a controversial topic in many 911 agencies, it was clear from several recordings that the alleged victims of assault likely needed medical attention, although they responded negatively when prompted by dispatch staff. The role of dispatch in encouraging medical attention is one that should be explored by this department. While the responding squad would be able to make a determination on the scene, the time saved in getting an ambulance out earlier could be important in some cases. For example, when dispatchers have good reason to believe that an alleged victim might have been strangled, a couple minutes could make a significant difference.

Overall Recommendations

The Freeborn County E911 Dispatch Center is fortunate to have competent, thoughtful staff. The center manages calls responsibly and capably. As was suggested with the first text analysis, some of the good procedure of the center should be formalized so that the current response is maintained over time and staff revolutions. The center would do well to update and expand its current policy, and detail good procedure in a handbook or small card that is easy and

convenient for staff to use. Staff should be involved in the development of both. Continued training on responding to intimate partner violence is always a benefit to the public.

Appendix A

Answering the Call: v where you hear this information in the call	Notes What is the operator asking? Emphasizing? Asking first? Tone of voice? Safety concerns? What happens when suspect on the line? What happens when a child is on the line?	
Who is calling / on the line	<input type="checkbox"/> Victim <input type="checkbox"/> Suspect <input type="checkbox"/> Child <input type="checkbox"/> Neighbor	<input type="checkbox"/> Other _____ <input type="checkbox"/> On hold? #times; for how long? <input type="checkbox"/> How to reach 3 rd party caller
Nature of call	<input type="checkbox"/> Need for medical attention <input type="checkbox"/> What is or has just happened? <input type="checkbox"/> Present danger <input type="checkbox"/> Injuries to whom – describe <input type="checkbox"/> Civil protection order <input type="checkbox"/> Criminal no-contact order	
Immediate safety instructions	<input type="checkbox"/> Inform caller squad in progress <input type="checkbox"/> Medical instructions <input type="checkbox"/> Advise to go to safe place <input type="checkbox"/> Stay on phone – Is that safe? <input type="checkbox"/> Are children present? Secure safety of children	
Address and directions	<input type="checkbox"/> Double check address <input type="checkbox"/> Directions if needed <input type="checkbox"/> Entry to property <input type="checkbox"/> If suspect leaving, where, direction, vehicle, with whom	
Identity and location of parties at house/site	<input type="checkbox"/> Who is present/involved? <input type="checkbox"/> Description of suspect; identity & location <input type="checkbox"/> Children present; number & location <input type="checkbox"/> Others present; identify & location	
What has happened / is happening	<input type="checkbox"/> Details of the immediate threat <input type="checkbox"/> Details of what has occurred <input type="checkbox"/> Any physical contact – describe <input type="checkbox"/> Choking/strangulation <input type="checkbox"/> Any threats – describe <input type="checkbox"/> Criminal no-contact order? <input type="checkbox"/> Civil order for protection? <input type="checkbox"/> Spontaneous statements	
Who is still at risk	<input type="checkbox"/> Any weapons – what & where? <input type="checkbox"/> Have weapons been involved in this incident\past incidents? <input type="checkbox"/> Is he likely to use them—has he threatened to shoot or kill anyone including police officers? <input type="checkbox"/> Is he drinking / using drugs? <input type="checkbox"/> Does this make him aggressive?	

Past violence	<input type="checkbox"/> Records check – prior calls; crim\hist <input type="checkbox"/> Civil Protection Order; conditions <input type="checkbox"/> Criminal No-Contact Order; conditions <input type="checkbox"/> Probation; conditions <input type="checkbox"/> Caller provides information about prior violence; severity and frequency <input type="checkbox"/> Operator asks about prior violence; severity and frequency	
Other observations	<input type="checkbox"/> Language difference <input type="checkbox"/> Particularly distressing situation / caller	

(Continue on reverse if necessary)

Appendix B

Proposed

St. Tammany Parish Sheriff's Office Communication Center Policy

The St. Tammany Parish Sheriff's Office (hereafter Sheriff's Office) recognizes that domestic abuse related calls are highly volatile and potentially dangerous to all parties involved, including the responding deputies. 9-1-1 operators and dispatchers (both referred to as dispatchers in this document) are the first point of contact for domestic violence complainants, and the first point of response by the Sheriff's Office. It is therefore the responsibility of dispatchers to facilitate an appropriate and timely field unit response, to monitor field activity, and to provide and document information critical to the safety of citizens and Sheriff's Office staff. Toward that end, the Sheriff's Office adopts the following policy.

- 1) **General Training Requirements**—The Sheriff's Office has written *The Dispatch D.V. Training Guide*, a supplement to the emergency dispatch Standard Operating Procedure manual, specifically to address how to respond to domestic violence or domestic abuse related calls. This *Training Guide* is intended to educate and support dispatchers in effectively implementing the Sheriff's Office domestic violence policies. Dispatchers are required to read the *Training Guide* and receive an initial six hours of training on the implementation of the Sheriff's Office domestic violence policies and procedures. Dispatchers are required to receive an additional two hours of domestic violence training every year after their initial training.

- 2) **Taking the Call**—Dispatchers' duties and functions include: active listening, gathering information to determine the nature of callers' problems and needs for help, determining the appropriate level of response and coding accordingly, dispatching an accurate summary of the information to responding deputies, de-escalating the immediate situation whenever possible, providing preliminary safety instructions to callers, eliciting cooperation from the caller in verifying details and monitoring changes at the scene, updating the information available to responding deputies, and documenting the call for subsequent interventions. Dispatchers will adhere to the following guidelines when carrying out those duties in order to maximize victim and deputy safety:
 - A. Dispatchers will assign a response code to each domestic related call received:

- i) A Code 3 will be assigned to cases where there exists an elevated possibility of imminent harm, an assault is in progress, or someone is seriously injured.
 - ii) A Code 2 will be assigned to cases where there has been a recent assault, but cases in which the victim has minor or no injuries and there are no indications of escalating threats or violence.
 - iii) A Code 1 will be assigned to cases where there is no imminent threat to any party, nor has there been a recent assault.
- B. Upon receiving a Code 3 call, the dispatcher will immediately send deputies and any necessary medical units, and notify the caller that response units are on their way, before gathering additional information.
- C. Dispatchers will attempt to gather the following information on every domestic offense related call:
 - 1. If the caller can speak freely
 - 2. What is happening, or has just happened
 - 3. Any immediate medical needs of all involved parties and, if applicable, a description of injuries
 - 4. A description of immediate danger faced by any parties present
 - 5. The location of the problem (double-check address, directions, and points of entry to property)
 - 6. If the suspect has left the scene, a description of his/her person, clothing, vehicle, and possible destination
 - 7. The names and locations of all involved parties, including children
 - 8. If the suspect has possession of, has used, or has access to a weapon
 - 9. If the suspect is under the influence of drugs or alcohol and, if so, his/her demeanor (hostile, violent, uncontrollable, angry, etc.)
 - 10. How the suspect is likely to react to responding deputies.
 - 11. If previous emergency calls have involved that specific address or suspect, especially if they have involved domestic violence

12. If there exists a temporary restraining order against the suspect
 13. If applicable, the results of a records check, the suspect's probation status, or other existing court orders
 14. If the caller mentions any history of violence
- D. Dispatchers will not conduct investigative interviews, even if time allows.
- E. Dispatchers will take any safety measures appropriate to each call, including:
1. Determining if answering questions is safe for the caller, proceeding with the caller's safety in mind as described in the *Training Guide*.
 2. Monitoring the safety of parties present while squads are en route to the scene. This may include keeping the caller on the line or advising the caller to put the phone down and seek safety. In Code 1 and 2 calls, keeping an open line to the caller may not be necessary.
 3. Helping the caller to secure the safety of children and others present.
- F. Dispatchers will provide supporting information to responding deputies by cross-referencing names and addresses with available records to identify any previous incidents or reports, outstanding warrants, or current or past restraining orders have involved the same parties and/or address.
- G. Dispatchers will transmit a concise and accurate summary of the information gathered in (C) above to responding officers, as described in the *Training Guide*.
- H. Dispatchers will record in the CAD a summary of the information gathered and the disposition of all domestic cases as described in the *Dispatch D.V. Training Guide*. In addition, whenever possible, dispatchers will directly quote excited utterances into the CAD in order to help deputies to establish probable cause and prosecutors to identify tapes appropriate for use in court. This procedure applies to all cases originally coded as domestic related, even if it is re-coded by responding deputies.
- I. Dispatchers will consider the following circumstances of some domestic violence related calls, and respond accordingly.
1. Many callers cannot talk freely. Dispatchers will therefore not pressure callers to stay on the line if doing so puts the caller in danger. Dispatchers

will ask callers questions with yes or no answers when doing so will decrease the escalation of violence by the offender or in other ways reduce the risk to the caller.

2. Child callers (we need some advice here - this is only a suggestion) may be particularly traumatized and confused by the incident, but are still able to provide information that will assist an appropriate emergency response. Dispatchers will speak to the child's age level, use short sentences, and will reassure the child that help is on the way. Dispatchers will attempt to determine the presence and names of all parties and their injuries, the existence of weapons in the house, and a description of who was fighting. Dispatchers will advise deputies immediately if a child is the reporting party. As previously stated, children will not be kept talking on the line if doing so might place them in danger.
3. In some cases, callers will be intoxicated or heavily drugged. Dispatchers will be firm, yet not hostile, during such problematic calls so as to obtain as much accurate information as possible.
4. Dispatchers can sometimes de-escalate a situation by getting the suspect on the line and keeping him or her occupied while squads are en route to the scene. (See training guide for assistance.)
5. If a 9-1-1 call from a residence is hung up without any conversation, a deputy will be dispatched to that address to determine if all parties are safe and whether or not further response is needed.
6. It is not at the discretion of any caller to cancel the emergency response to a domestic call. Any calls attempting to cancel responding deputies will be disregarded.
7. If the dispatcher is unable to speak to a caller because of a language barrier the dispatcher should contact (put translating service numbers in here).
8. If a domestic complaint involves a deputy or other staff member of the Sheriff's Office, the dispatcher will notify the Communications Supervisor immediately after receiving the call. The Communications Supervisor will

notify and send a confidential copy of the CAD report to the deputy or staff member's supervisor.

III. Reports to D.V. Division and District Attorney—Twice weekly, the dispatch supervisor will provide one copy of all domestic violence related CAD reports to the Domestic Violence Division and the District Attorney's office. In addition, supervisors will provide the Domestic Violence Division with the CAD report on any calls re-coded by deputies responding to the scene.

IV. Supervisory Oversight

- A. If a dispatcher takes a particularly violent domestic violence call (involving suicide, severe violence, or homicide) the supervisor will immediately review the tape to determine if the dispatcher followed these policies and procedures. The supervisor will subsequently notify the Domestic Violence Division of any problems with the handling of the call, if any. In addition, the supervisor will help any dispatcher who takes such a call to “debrief” and take any measures necessary to reduce his/her trauma.
- B. The Communications Center supervisor will randomly select five D.V. related calls from each dispatcher twice a year to review for compliance with this policy.
- C. Twice per year, the Communications Center supervisor will submit the results of these reviews to the Sheriff. These written reports will include corrective action taken in cases where the dispatcher failed to follow the policy.
- D. Confidentiality
Under no circumstances will the dispatch center provide a copy of a 9-1-1 call to the suspect in a domestic case without a court subpoena. The Communications Center Supervisor will refer a victim's complaint about a dispatcher to the D.V. Division, who will immediately assign a deputy to review the tape and respond to the victim within 48 hours. If a complaining party is not satisfied with the resolution, the D.V. Division will forward a copy of the tape and the complaint to the Sheriff for review.

Appendix C

QUESTIONS FOR RISK ASSESSMENT AND CALL PRIORITIZATION

1. Do you think he will seriously injure or kill you or your children? Why?
2. How frequently and seriously does he intimidate, threaten or assault you?
3. Has he stalked you or acted obsessive toward you?
4. Have you tried to separate from him in the past?