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Independent Police Auditor Report

Complaint Regarding DPD's Response to a Suicidal Subject

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IPA received a copy of a complaint signed by four individuals who lived across the street from a home in Davis in which a suicide occurred last year. Having known the decedent and having observed the actions of Davis Police Department ("DPD") personnel during their response to the incident, they wished to provide the Chief with what they characterized as "constructive critiques" of DPD's performance.

Factual Background

One weekday afternoon, DPD received a 911 call from a relative of a 72-year-old man who had called another family member to express discouragement over his health and other circumstances and to say he intended to end his own life. DPD learned that the man lived by himself in a single-family home and that he had access to firearms. It was his sister whom he had called, and she in turn notified her adult son and daughter-in-law; all three were eventually in contact with DPD that afternoon in an effort to help resolve the crisis.

Several DPD officers – including members of the Department's Hostage Negotiations Team – responded to the man's house and attempted to contact him. These efforts included several phone calls and voicemail messages that were not answered, and the deployment of a PA system for making announcements that they hoped the man would acknowledge. He did not.

Some two hours after the original 911 call, DPD decided to utilize a robot from the Yolo County Explosive Ordnance Detail in order to approach the house safely and ascertain more information about the man's status. This was a painstaking process, but after more than an hour of effort the robot was able to "breach" the garage door and locate the man, who was in fact already dead from a self-inflicted gunshot wound. (A gun was found by the body.) DPD officers made entry to ensure that no one else was present and/or in danger and found nothing of additional significance. It is believed that the suicide occurred well before the active process of trying to gain entry actually began.

An extended period of investigation followed from there, including the arrival of a paramedic and then a representative of the Coroner's Office, and forensic work by DPD personnel. The Coroner then took official control of the matter per standard protocol.

The Complaint to DPD

The complaint was signed by four individuals who, as mentioned above, lived across the street and who witnessed the unfolding events outside the man's home. While the tone of the letter was thoughtful and restrained, they asserted that, in their view, DPD's

handling of the crisis had been "upsetting, discouraging, and disrespectful." They offered several points in support of this notion, including the following:

- The lack of communication with neighbors during the pendency of the response left them uncertain and agitated as to what was occurring – and kept them from providing DPD with potentially useful information about the man's circumstances.
- The DPD personnel did not appear to be well-trained to address the needs of a man whom they described as both physically infirm and emotionally vulnerable against the backdrop of the pandemic.
- The DPD efforts to communicate – particularly in the form of the repeated loud-speaker announcement – were ineffective and not well-tailored to the situation.
- DPD should have recognized after a period of time that its approach was not working, and should have transitioned to a more action-oriented approach to intervention.
- DPD officers showed a lack of focus and sensitivity during the hours in which they were staged outside the man's house, and were described as chatting and laughing when they could have been providing neighbors with useful updates.

The letter concluded by describing the tragic outcome as a "disheartening" experience, and by urging DPD to re-assess its training and strategies for suicide intervention in the future.

DPD Response

The Department's response to this outreach was mixed. On the positive side, the command staff member who handled the complaint (who had been at the scene of the incident and was quite familiar with its particulars) seems to have considered its various points thoughtfully and with a genuine interest in treating them as a learning opportunity. He also responded directly to the primary complainant in the form of a gracious and relatively prompt letter. It extended sympathy, pledged to use the letter's "very good points" as a basis for agency improvement, and – importantly – included an offer to discuss the matter further if the complainants were so inclined.

These steps were constructive (though they did not lead to further communication with the complaints' four signatories). Moreover, the specifics of the complaint were apparently a jumping off point for some useful introspection. And it is also true that the complaint was styled as feedback and operational critique – as opposed to an allegation of specific misconduct or violations of policy. Lastly, as we discuss in more detail below, our sense was that there were valid explanations for the Department's actions in many

of the challenged areas, and that its overall performance had been solid in a challenging context.

Nonetheless, we were left with the impression that a more *formalized* review process would have been appropriate. The Department declined to style the feedback as a formal "complaint" that would have implicated a certain level of documentation and investigation, and whatever insights that did emerge were not memorialized or turned into concrete action items. While we are not under the impression that necessary or appropriate *accountability* failed to occur (in terms of flawed officer performance), there is more to a robust and meaningful review process than disciplinary consequences. Indeed, the best approaches welcome critical incidents as a learning opportunity with benefits for future effectiveness – even it entails nothing more than reinforcing things that have gone well. Here, there were certainly opportunities to revisit specific aspects of the operation and consider adjustments going forward.

IPA Review

DPD provided us with a large amount of material (including body-worn camera recordings from several officers at the scene) that was useful in assessing what had occurred. As noted above, we found the Department's overall performance to be sound in response to a suicidal individual who, seemingly and unfortunately, was not open to assistance.[1] At the same time, we were surprised to learn that DPD did not characterize this as a "critical" or "major" incident that – apart from whether it generated a complaint – was unusual and significant enough to warrant the agency's formal scrutiny. Nor does the Department seemingly have an established mechanism for providing these types of events with a holistic evaluation as to individual performance and possibly systemic improvements in areas such as training, supervision, equipment, communication, or tactics.

We are proponents of such a process, and think it would have beneficial in the aftermath of this matter. Standardizing the review ensures that all aspects of the Department's response get thoughtful consideration, and that identified action items are recorded and then addressed for the future good of the agency.

[1] We note also that DPD went further in its efforts at intervention than many contemporary agencies would have. Primarily because of risk management concerns, law enforcement agencies throughout California are now "standing down" and leaving the scene when initial efforts to engage a reportedly suicidal individual are not effective (provided that no one else is being collaterally endangered).

RECOMMENDATION ONE: DPD should consider designing a major incident review process that would enable it to address significant matters in a formalized and comprehensive way, so as to identify potential improvements in individual or agency-wide performance.

As for the particular issues identified by the complainant, we note again the advantages that follow from opening a formal case, addressing allegations methodically and with documentation, and addressing concerns pro-actively. Here, for example, the complainants' reference to officers' insensitively laughing and chatting at the scene struck us as a perfect opportunity. While lapsing into unrelated pleasant conversation or other diversions seems entirely understandable in the context of a long, uneventful wait at an investigation scene, and while there is no reason to believe the conduct was egregious or malicious in any way, the complainants' perception offers an important reminder. The same events that constitute "another call for service" for the police are unusual or even traumatic for involved members of the public. It is easy to lose sight of this fact, and the incident could have been a forum for a useful briefing item or other form of a "teachable moment."

Similarly, the other itemized concerns raised by the complainants offered a perspective worth considering. It is true that some aspects of the critique are offset by elements of the DPD response that the complainants would not have reason to know about. For example, the Department had a trained negotiator on scene whose approach seemed quite suitable to the known circumstances. That person's outreach in the form of attempted telephone calls (which we could observe on the recordings) struck us as careful, sensitive, and strategic.[2]

Moreover, the aforementioned family members who first notified the police that day were in regular communication with Department representatives throughout the incident and provided background about his condition and recent history. This presumably lessened the need to solicit additional information from neighbors – a dynamic that carries its own complexities with regard to privacy rights and other variables.

As for others of the complainants' observations – including the questionable technique of repeating the same loudspeaker announcement past of the point of likely efficacy, and the lack of informational updates for anxious neighbors – it is *possible* that DPD representatives reflected on them. Perhaps they even found merit in them that could inform its approach to a comparable future incident. But no documentation of such an

[2] Again, the timing of the subject's self-inflicted injuries probably preceded the Department's efforts to contact him.

effort was captured in the materials we saw. This has both substantive and procedural implications: we can't be sure of the merits of any analysis that did take place, and have less reason to be confident that any lessons learned won't slip through the cracks in spite of good intentions.

Though we reiterate that the Department's handling of the call was sound in our view, we do think more generally that its own operations would be better served by a more structured and rigorous process of responding.

> RECOMMENDATION TWO: DPD should formalize its treatment of all complaints from the public, even when traditional allegations of officer misconduct are not clearly implicated, and should adopt both a more rigorous documentation of its responsive actions and a more inclusive approach to learning from public feedback.

The IPA Office did reach out to the complainants who submitted the initial correspondence to the Department. We introduced ourselves and our role, and explained the City's Restorative Justice process as an option that the complainants might wish to consider. However, IPA did not receive any reply to our offer of further assistance.