IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

Inadequate Police investigation of fatal car crash

1. On 2 April 2018, a car crash occurred in the southbound lane of State Highway 10 near Puketona junction, 10 kilometres south of Kerikeri. The crash involved a red Subaru wagon travelling south and a silver Toyota van travelling north.

2. The driver of the Subaru, Mr Z, and the front passenger, Mr Y, died at the scene. The two passengers in the back of the Subaru, Mr X and Mr W, were seriously injured.

3. An American tourist, Mr V, was the driver of the Toyota. He and his passenger, Ms U, survived the crash. Mr V sustained a bloody nose and Ms U a broken wrist.

4. Police charged Mr V with five counts of 'Aggravated Careless Driving Causing Injury or Death'.

5. Mr V applied for his charges to be dismissed, arguing that there was insufficient evidence to proceed to trial. Four working days before the Dismissal of Charge hearing, Mr V's lawyers (the defence) submitted new statements from the Subaru passengers which stated that it was their friend, Mr Z, who caused the crash. The defence's theory was that Mr Z was suicidal and deliberately drove into the Toyota.

6. Given the new statements of Mr X and Mr W, at the hearing on 28 May 2019, the Judge found that there was insufficient evidence for the case to go to trial. The five charges against Mr V were dismissed.

7. Mr V's lawyer applied for full indemnity costs. An award of $30,000 was made.

8. There was news coverage in October 2021 about how Mr V had his charges dismissed due to Police having inadequate evidence that he caused the crash, which killed two men and seriously injured two others. Police then referred this matter to the Authority in November 2021. We conducted an independent investigation into the Police investigation of the crash, and prosecution decisions.

The Authority's Findings

Issue 1: Were the actions of officers who initially attended the crash in line with best practice?

The officers correctly prioritised providing first aid.

The officers in charge (Officer A then Officer C) did not have sufficient command and control of the scene and should have requested experienced staff attend, including Criminal Investigation Branch staff.

Officer A did not record in his notebook any of the comments made by Mr V.

The Serious Crash Unit Analyst's initial scene investigation was not sufficiently robust given the seriousness of the crash and the likely criminal charges.

Officer C did not ensure the integrity of the vehicles was maintained for evidential purposes.

The initial decision to charge Mr V was appropriate.

Issue 2: Was the ongoing investigation in line with best practice?

The Serious Crash Unit Analyst's investigation was not sufficiently thorough.

Officer A failed to ensure that all key witnesses were interviewed by appropriate staff.

Officer A failed to ensure that all witness statements were sufficiently detailed and fact checked.

Officer A failed to record in the Police database, in his notebook, or in job sheets, the actions and contacts he made throughout the investigation.

Officer A failed to update the whānau of the deceased adequately as to the Police investigation.

Officer A did not respond to communication or requests from the prosecutor in a timely fashion.

Officer C's supervision of Officer A was insufficient. He should have ensured Officer A had the support required to perform his role adequately.

Issue 3: Were the prosecution decisions in line with best practice?

Officer C was justified in laying charges in the hours following the crash.

Prosecutor A was not justified in escalating the charges two days following the crash.

The Northland Manager of the Police Prosecution Service should have immediately re-assigned the file after Prosecutor A went on leave.

The prosecution should have ensured disclosures were provided to the defence in a timely manner.

The prosecution was justified in continuing their case against Mr V, despite the views of the defence.

Analysis of the Issues

ISSUE 1: WERE THE ACTIONS OF OFFICERS WHO INITIALLY ATTENDED THE CRASH IN LINE WITH BEST PRACTICE?

Did Police prioritise saving lives?

9. At about 11.20pm on 2 April 2018, Officer A was driving from Kawakawa Police Station to the Kerikeri Police Station. He came across the crash between the Subaru and Toyota on State Highway 10. Officer A noted both vehicles were in the southbound lane, with the Subaru facing south and the Toyota facing north.

10. Officer A advised the Emergency Communications Centre (Comms) of the crash and requested Fire and Ambulance assistance.

11. Officer A initially checked on one of the passengers in the rear of the Subaru, Mr X, and then the driver, Mr Z, who was pinned up against the steering wheel. Mr Z appeared unconscious but breathing. Officer A tried to release the driver's seat to aid in his breathing but could not do so given the condition of the car.

12. Mr W was in the rear of the Subaru. He was alert and complaining about his pain.

13. Officer A then moved to the front passenger of the Subaru, Mr Y, and found him unresponsive and not breathing. Officer A removed him from the car, placed him on the ground and started cardiopulmonary resuscitation (CPR). He did this for some time before a member of the public took over compressions.

14. Officer B arrived while Officer A was performing CPR on Mr Y. She checked on Mr X, who was alert and being comforted by the Toyota's driver and passenger, Mr V and Ms U.

15. At 11.40pm, ambulance staff arrived and took over care of the injured. A short time later, Officer A was told Mr Y had died and that Mr Z was likely to die once he was released from the car.

16. We are satisfied that Officers A and B quickly assessed the scene to determine who needed medical attention, and prioritised saving lives.

Did Officers A and C appropriately oversee the crash scene?

17. Police 'Serious crash' policy requires a substantive supervisor to be designated the Officer in Charge of the scene, who must ensure:

    - suitably qualified employees are assigned;
    - an inquiry appropriate to the circumstances be carried out with urgency;
    - the integrity of the vehicles is maintained; and
    - that an Iwi Liaison Officer is contacted to facilitate the blessing of the scene.

18. Officer A was initially the Officer in Charge. This was the first time he had attended a fatal crash involving a possible offender and victims, where the possible offender was still alive. In hindsight, he says he should have asked for more staff to assist which would have enabled him to divide up tasks and ensure everything was completed.

19. Shortly before midnight, a sergeant, Officer C, arrived. He replaced Officer A as the officer in charge of the scene. Officer C had attended three fatal crashes before this one.

20. Officer C set up cordons at each end of the crash scene. In accordance with Police policy, he ensured that a Serious Crash Unit (SCU) Analyst and a tow truck operator were on their way, and that the District Commander was notified.

21. Officer C also arranged for the Iwi Liaison Officer to attend to ensure the appropriate cultural aspects were adhered to, such as the whakawātea blessing. The Iwi Liaison Officer arrived just before 12.30am and remained until 4am.

22. It was not standard practice for the Criminal Investigation Branch (CIB) to attend fatal crashes at the time. However, on reflection, Officer C said: "*if this happened today, they would be the first people I call.*"

23. As the Officers in Charge, Officers A and C did not have sufficient command and control of the scene. Officer A described the scene to us as *"chaos"*, given the number of people involved in the crash, the number of serious injuries that needed attention, and the need to deal with Fire and Ambulance staff, witnesses, and evidence. More staff were needed to divide the jobs and complete them thoroughly. Officers A and C should have requested more experienced staff attend the scene, including the CIB who were available to be called out.

Did Officers A and B adequately examine the scene and collect evidence?

24. Police policy requires that:

    - The scene is examined on the presumption that a crime has been committed.
    - An early assessment will be made as to the criminal liability of any party.

- All reasonable, practicable efforts must be made to facilitate the forensic evidence collection process.

25. Officers A and B carried out an examination of the crash scene after the emergency services arrived. Officer B took photographs, as is required.

26. Officer B also spoke to potential witnesses who had come across the crash. However, none had seen the crash. She took Mr X and Mr W's details, noting they appeared grossly intoxicated.

27. When helping the passengers, Officer B had looked inside the Subaru and seen:

    - beer bottles and bourbon cola cans;
    - a cannabis bong; and
    - a large bag of cannabis plant material.

28. Section 20 of the Search and Surveillance Act 2012 allows officers to search a vehicle without a warrant if they have reasonable grounds to be believe it contains a controlled drug. Given this, Officer B legally searched the car, seizing the cannabis and bong.

29. Officer B retrieved passports, a wallet, and vehicle documents from the Toyota for Ms U and Mr V. However, the Toyota was not searched as there was no lawful reason to do so.

30. As Mr V's car was in the wrong lane, an early assessment indicated that he had caused the crash. Officer A spoke to Mr V and advised him of his rights, pursuant to the Bill of Rights Act 1990. Mr V told him he was in the "*right lane*". Officer A did not record Mr V's comment, or any of their conversation, in his notebook or in a job sheet.[1] Officer A should have clarified what Mr V meant by the comment at the time and recorded it as evidence in case later required. Mr V later told us that by "*right lane*" he meant he was in the correct, northbound lane before the crash, as opposed to the right hand southbound lane.

31. Mr V underwent a breath screening test which returned a negative result for alcohol.

32. Police may also carry out a compulsory impairment test on drivers they suspect of driving under the influence of drugs. Mr V was not tested as Officer A did not believe there were grounds to do so.

33. With the exception of Officer A failing to make a record of his conversation with Mr V, Officer A and B adequately undertook initial examination of the scene.

[1] A Police notebook is a diary of times, dates, places, people and events. It records duties, who was spoken to, observations, sketch plans, action taken, decisions made and initial interview notes. It is used to review and compare notes to aid an investigation and refresh the employee's memory when giving evidence in Court. A job sheet is an electronic form where Police chronologically record action taken, information gathered, and people spoken to.

Did the Serious Crash Unit Analyst conduct a thorough investigation of the scene immediately after the crash?

34. The SCU Analyst travelled to the crash scene from Whangārei, about 75 kilometres away. He recorded in his notebook that he arrived at the scene at 12.36am. Fire and Emergency services had removed the roof and driver's side door of the Subaru to extract Mr Z, before the SCU Analyst arrived.

35. The SCU Analyst noted:

- the two vehicles had collided on the Toyota's passenger-side front corner and the Subaru's driver's-side front corner;
- frontal impact damage on both vehicles with damage to the Subaru's at a slight angle and the Toyota's damage being straight-on;
- red marks from the red paint of the Subaru across the front of the Toyota; and
- the pattern of debris and position of window glass on the road.

36. The SCU Analyst concluded on the night that there was an off-set head on crash, with the vehicles partially disengaging after the crash. Given the impact angles, the debris pattern and the lack of evidence of the vehicles swerving, the SCU Analyst told us it was clear the Toyota was on the wrong side of the road leading into the crash.

37. The SCU Analyst took photographs and marked the scene. However, the scene mapping equipment had been sent away for calibration and so he was unable to complete this at the time. He did not find any tyre marks or gouge marks at that time, despite both being clearly visible in photographs taken that night.

38. According to the SCU Analyst's notebook, he was at the scene for less than an hour. He says the cause of the crash was obvious to him and he had completed all he could, so did not need to stay any longer. We find the SCU Analyst's initial scene investigation was not sufficiently robust given the seriousness of the crash and the likely criminal charges.

Was the integrity of the vehicles maintained?

39. Police policy specifies that the integrity of the vehicles must be retained for vehicle inspection and forensic examination by securely storing the vehicles to avoid contamination of evidence.

40. There are conflicting accounts about whether the SCU Analyst was present when the vehicles were being removed, to ensure their integrity was maintained:

- the SCU Analyst believes he stayed at the scene until the tow truck operator separated the two vehicles. His notebook indicates he arrived at the scene at 12.36am and was back at the Police station at 1.30am;

- Comms records show the tow truck operator first arrived at the scene at 2.03am. The Iwi Liaison Officer's account and the Fire Service's incident report corroborate this; and
- the tow truck operator initially said he saw the SCU Analyst at the scene, but later said he had not.

41. We note it was the Iwi Liaison Officer who ensured the cars were transported separately to maintain the integrity of the evidence. The first vehicle was loaded onto a standard tow truck, but the Iwi Liaison Officer said a Hiab truck would be needed to winch the second vehicle onto the truck by crane. The Iwi Liaison Officer recalls ringing the SCU Analyst, who was on his way back to Police station at the time, to confirm this decision.

42. Given these facts, it is a reasonable to conclude that the SCU Analyst did not witness or direct the separation and removal of the involved vehicles.

43. Officer C should have overseen this process and directed the tow truck operator how to store the vehicles to maintain their integrity for the ongoing investigation.

Was it appropriate for Officer C to charge Mr V?

44. Officer A says Officer C and the SCU Analyst discussed the crash with him. They collectively considered it highly likely Mr V caused the crash by crossing the centre line.

45. The SCU Analyst told us the normal procedure before charging someone in relation to a crash was for the Serious Crash Unit to collect all the information and put a report together. A panel would then decide if any charges would be laid.

46. Police policy at the time encouraged staff to defer the decision for immediate prosecution until after they had an opportunity to discuss the matter with their supervisor, unless circumstances demanded immediate action, such as overseas-tourist involvement.[2]

47. Mr V spoke with his lawyer and elected not to make a statement to Police.

48. Just over three hours after the crash, Officer C charged Mr V with two counts of Careless Driving Causing Injury or Death.

49. Officer C says he decided to charge Mr V because he did not provide an explanation as to why the vehicles were positioned as they were and why his vehicle crossed the centre line. Officer C also was mindful that, because Mr V was a tourist, he could leave New Zealand if he was not charged and placed on bail conditions.

50. Given the evidence available at the time, we accept that charging Mr V soon after the crash was appropriate. There were no other powers available to Police at the time to ensure that Mr V remained in the country while they completed their investigation.

[2] The updated Serious Crash Investigation policy for Northland now requires, in all traffic crashes involving death, no final decision on prosecution until the Road Policing Manager has first reviewed the file. This is to be done in consultation with the Detective Sergeant Serious Crash Investigation, Police Prosecution Service and Local Crash Analyst.

FINDINGS ON ISSUE 1

The officers correctly prioritised providing first aid.

The officers in charge (Officer A then Officer C) did not have sufficient command and control of the scene and should have requested experienced staff attended, including Criminal Investigation Branch staff.

Officer A did not record in his notebook any of the comments made by Mr V.

The SCU Analyst's initial scene investigation was not sufficiently robust given the seriousness of the crash and the likely criminal charges.

Officer C did not ensure the integrity of the vehicles was maintained for evidential purposes.

The initial decision to charge Mr V was appropriate.

ISSUE 2: WAS THE ONGOING INVESTIGATION IN LINE WITH BEST PRACTICE?

51. On 3 April 2018, a Vehicle Inspector for Vehicle Testing New Zealand (VTNZ) conducted mechanical inspections of the Subaru and the Toyota, on behalf of Police. The defects the inspector found were limited to:

    - tyre faults on the Subaru, which may have caused a level of handling and directional instability under braking and cornering; and
    - that the left rear tyre on the Toyota was mismatched in size and not up to warrant of fitness standard, which may have affected the braking balance on the rear axle, causing the vehicle to have an instability under braking.

52. On 4 April 2018, Officer C completed the initial Traffic Crash Report which said the cause of the crash appeared to be Mr V coming around a sweeping bend too wide, crossing the centre line, and colliding with the oncoming Subaru driven by Mr Z. The speed of the vehicles was unknown.

53. The Traffic Crash Report said it was suspected Mr Z may have been under the influence of drugs and there was a blood test pending. It said Mr V was not suspected of being under the influence of drugs.

Was the Serious Crash Unit Analyst's investigation sufficiently thorough?

54. The SCU Analyst did not return to the scene the day after the crash as he was on stand-down for working too many hours. He returned to the scene on Wednesday, 4 April, to map and take photographs of the road.

55. As stated above, the SCU Analyst had not located any tyre or gauge marks initially at the crash scene. Upon his return to the scene, the SCU Analyst saw a tyre mark on the road. However, he says he was not comfortable including it on his map of the scene as he could not prove whether it was made during the crash or the following days. The SCU Analyst should have included the marks in his report and caveated it with the fact that he could not be sure it was from the crash, so that this information was not lost.

56. The SCU Analyst's failure to thoroughly investigate the tyre and gouge marks when initially at the scene, possibly led to the loss or deterioration of vital evidence and an inability to then determine whether the tyre and gouge mark was related to the crash.

57. His initial action at the scene did not follow basic training given to staff that covers photographing, gathering scene evidence, scene sketches and gathering evidence from damage to the vehicles.

Were the vehicles thoroughly examined before being released back to their owners?

58. After mapping the scene, the SCU Analyst took photographs and further examined the vehicles at the tow yard.

59. That same day, the SCU Analyst informed Officer A he was finished with his examination of the vehicles, and they could be released back to their owners.

60. As the vehicles had been released from Police custody, the tow truck operator moved the cars from the forensic examination bay and stacked them on top of other cars in the yard, meaning Police could no longer ensure the integrity of the evidence.

61. The SCU Analyst returned to have another look at the vehicles on 18 April 2018. He said that this was for the purpose of checking the tyre sizes. Although it is agreed that these are unlikely to have changed, in alignment with best investigative practice, the SCU Analyst should have completed a comprehensive examination before releasing the vehicles back to the owners.

Should a crush analysis and reconstruction of the crash have been completed?

62. The SCU Analyst told us he did not perform a crush analysis,[3] because he had not done one before and he saw the crash as being *"clear cut"* where speed was not an issue. The senior Police crash expert (who later reviewed the SCU Analyst's report) told us that such analysis was not standard practice, and only about half a dozen Police officers in the country had the training to do crush calculations.

63. The SCU Analyst also did not conduct a reconstruction of the crash to determine the place and nature of impact of the vehicles. Nor did he take any photographs from above as he told us the cause was clear and he saw no need for reconstructing the impact.

64. We accept that crush analysis was not usual practice at the time. However, to support his theory, the SCU Analyst should have carried out a reconstruction of the respective vehicles' trajectories and taken photographs from all angles, in line with best investigative practice.

Should airbag data have been downloaded from the Toyota?

65. The SCU Analyst told us airbag data would have only identified the speed of impact and he did not consider speed to be a factor in this crash. It was not standard practice at this time to obtain

[3] Ccomplex calculations to accurately figure out the speed at impact, the principal direction of force, the cars relative positioning at first contact and whether the cars rotated at impact.

airbag data in the event of a crash. Therefore, we accept it was reasonable for the SCU Analyst not to collect the data.[4]

What was the SCU Analyst's view of the toxicology report?

66. On 30 April 2018, the Crown toxicology report was issued. Mr Z's blood alcohol level was recorded as more than five times the legal limit and methamphetamine was also found in his blood. The report stated that:

> *"Epidemiological evidence suggests that methamphetamine adversely affects the skills necessary for safe driving. It may be dangerous to drive after using psychostimulants due to overconfidence in driving skills that is not supported by an actual improvement in driving ability, taking unnecessary risks, aggressive and dangerous driving, impaired ability to react appropriately, and the driver can suddenly fall asleep as the stimulant effects wear off."*

67. The SCU Analyst's view was that although Mr Z was drunk and under the influence of drugs, he was on his side of the road, and the Toyota was on the wrong side of the road – in Mr Z's lane. While the presence of alcohol and drugs may have impacted his ability to respond to the Toyota being in his lane, he was in the correct lane at the moment of impact and therefore did not cause the crash.

68. When considering whether Mr Z could have been in the wrong lane prior to impact, causing both the Subaru and Toyota to swerve, the SCU Analyst believed the cars would not have ended up as they did – with a front-on impact.

Were the SCU Analyst's conclusions based on a thorough investigation?

69. The SCU Analyst's report concluded Mr V entered the southbound lane and Mr Z had been unable to avoid a collision with the Toyota. Its appears that the SCU analyst decided early on at the scene that Mr V was at fault and reached his conclusion as to the cause prior to the investigation being completed.

70. Our view is that the SCU Analyst's assumption in thinking the American tourist must be at fault, coupled with the fact that the two vehicles were found in the southbound lane, resulted in him not completing an objective and thorough investigation.

71. Regardless of how "*clear cut*" a case appears to be, a thorough investigation should always be conducted, and judgement withheld until that investigation is concluded. The SCU Analyst's analysis was not sufficiently thorough. He did not appear to take into account the witness statements, scene evidence and toxicology evidence in his analysis.

[4] The Senior Crash Expert told the Authority that they do download airbag data if the car manufacturer uses Bosch equipment, however, a lot of the earlier 2000s cars are not supported by the programme that Police use (the Subaru is from 1993 and the Toyota is from 2000).

Were Officer A's enquiries adequate?

72. On 3 April 2019 Officer A became the Officer in Charge of the prosecution case and the ongoing investigation into the crash.

Did Officer A ensure potential evidence from the vehicles was collected and handled appropriately?

73. At about 9am on Wednesday 4 April, after Officer A had released the vehicles, Officer E went to the tow yard with Mr V and Ms U to retrieve their belongings from the Toyota.

74. Later that afternoon, Officer F met Mr Z's mother and sister at the tow yard and assisted them to retrieve items from the Subaru. While they were there, the tow truck operator mentioned to Officer F that he had found cannabis in the Toyota.

75. Officer F subsequently mentioned the cannabis to her sergeant, Officer D.

Was evidence in the Toyota handled appropriately?

76. The tow truck operator says he had found a small plastic sandwich bag of cannabis, a cannabis pipe, a grinder, a lighter and Zig Zag papers in the Toyota.

77. The tow truck operator says he rang Officer D the day *before* the vehicles were released to tell him about the drugs. However, according to Officer D, he only learned about it *after* the vehicles had been released, when Officer F told him about the cannabis, and he rang the tow truck operator. Officer D's account is supported by his jobsheet, dated 6 April 2018, which details his phone call to the tow truck operator, who told him about drugs in both vehicles (see paragraph 79 about drugs found in the Subaru).

78. After hearing that cannabis was found in the Toyota, Officer A should have sought to interview Mr V and Ms U to establish whether Mr V was under the influence of any drugs at the time of the crash. Ms U told us that the cannabis items were hers, but that neither herself or Mr V had smoked any cannabis that day.

79. When the tow truck operator told Officer D about the cannabis in the Toyota, he also said he had found a container with point bags, a 'P' pipe,[5] and some crystals of methamphetamine in the Subaru. The tow truck operator believes that Mr Z's mother and sister took these items when they retrieved other possessions from the vehicle.

80. Officer F says she did not see the methamphetamine paraphernalia described by the tow truck operator, and if she had, she would have secured them. She recorded the items taken by Mr Z's whānau and took photographs. Officer F told us she assumes she uploaded the photos of the items taken from the Subaru to the file or gave them to Officer D, but it is unclear what happened to them as there is no record of her notes or photographs on the investigation file.

[5] A pipe used for smoke methamphetamine.

81. As the officer in charge of the investigation, Officer A should have ensured a thorough check of the Subaru was completed after initially finding the cannabis in it at the scene. However, this did not occur. Subsequently, Police had not found the methamphetamine and other items.

82. Officer A also should have ensured the photos were loaded into the investigation file. This would have avoided doubt that a methamphetamine pipe and point bags were seen in the Subaru and returned to Mr Z's mother.

Did Officer A ensure all witness accounts were taken appropriately?

83. Officer A arranged for another officer to take Mr W's statement while he was in the hospital on 5 April 2018. Mr X initially would not give a statement, but eventually did so on 12 April 2018. Officer A also took statements from Mr Z's former partner and the tow truck operator.

84. Mr V chose not to make a statement to Police. Officer A did not make any record of the conversations he had with Mr V at the crash scene, or back at the Police station. Officer A also did not interview Ms U, which is concerning given she was a key witness to the crash. Instead, he relied on her recollection of events which she provided to Mr V's lawyer which was provided to Police.

85. The statements Officer A took all lacked detail. There were inconsistencies that should have been investigated further to withstand legal scrutiny. For example, Mr W and Mr X gave conflicting accounts on where they were driving to before the crash. While Officer A reviewed some CCTV footage to confirm Mr X's account, he could not locate the Subaru on the roads indicated by Mr X. He did not make further inquiries to establish exactly where the Subaru had been.

86. Officer A did not seek statements from the attending fire service staff. He says he interviewed the ambulance officer in charge over the phone, but there is no record of this on file and she cannot recall speaking to Police.

87. As the officer in charge of the investigation, Officer A should have ensured all witnesses were interviewed, and statements were taken. Officer A says in hindsight, he should have had the Criminal Investigation Branch staff conduct the interviews of the key witnesses.

88. We find that Officer A failed to:

a) identify all witnesses that should have been interviewed;

b) ensure all witnesses were interviewed by officers with the requisite interviewing skills;

c) ensure all statements were sufficiently detailed; and

d) ensure all statements were fact-checked to ensure accuracy, and where any inaccuracies were identified, witnesses were re-interviewed, and further inquiries made.

What were the original accounts of those involved in the crash?

89. In Mr X's initial statement, he said Mr Z did not seem intoxicated, and had one sip from a can of bourbon before putting it in a cup holder. He said the drugs in the car were Mr Z's, but he did not see him smoke any. Mr Z and Mr Y began having a friendly argument, with Mr Y "*just having a laugh really*". Mr X then noticed a car on their side of the road, heading towards them from the distance of a football field away. Mr X told Mr Z to go around it, but Mr Z said: "*nah, they should get back on their side of the road.*" Mr X said: *"nah bro it's not moving."* Within about three seconds, the lights were about half a second away, and Mr X was staring right at its bumper in front of them. Mr Z let go of the wheel and said: *"Sorry cuzzies sorry"* just prior to them crashing.

90. Mr W did not remember the actual impact but did not think Mr Z had much to drink and believed he had been on the correct side of the road. He recalled Mr Y and Mr Z were involved in a friendly argument.

91. In her affidavit for Mr V's lawyers, Ms U said they were being very cautious to ensure Mr V remained on the correct side of the road , as it was his first day driving in New Zealand. She was certain Mr V was driving on the left-hand side of the road just prior to the crash and that she would have noticed if Mr V veered into the wrong lane. As they came around the corner, she saw the Subaru's very bright lights directly in front of them and started yelling. After seeing the bright lights, Ms U said she felt their car move or swerve.

Did Police properly consider the defence crash expert arguments about what happened during the crash?

What were the findings of the crash expert engaged by the defence?

92. On 18 April 2018, Mr V's lawyer engaged a crash expert to provide an opinion on the crash.

93. In his report dated March 2019, the expert concluded that the impact occurred in the southbound lane and the vehicles entered the impact at an angle to each other but was inconclusive as to the cause. He found Mr X's account of events was not supported by the timeline of events analysis. He found Mr V's account remained consistent and there was no independent forensic basis to rebut the evidence of Mr V and Ms U. He believed Mr Z's level of intoxication could not eliminate the possibility he may have had difficulty staying in the correct lane. He could also not eliminate the possibility that headlight glare experienced by Mr V contributed to the crash.

94. Mr V's crash expert also identified information and analysis that he believed was missing from the SCU Analyst's report, such as crush profiling and airbag data, to accurately determine the speed of the vehicles and precise angle of impact.

95. A senior Police crash expert reviewed Mr V's crash expert's report, and the SCU Analyst's report. The senior crash expert did not find that Mr V's expert's report changed the Police case. The case would still proceed to court, where they would both present their evidence.

Were the deceased's whānau kept informed of the progress of the investigation?

96. About a week after the crash, the Iwi Liaison Officer took Mr Y's whanau to the scene of the crash and walked through what Police believed happened.

97. Officer A told us he did not make a plan for managing the victims' families, including Mr Z's parents. He says he did not have a contact number for Mr Z's mother, so did not keep her updated with the investigation. We have not seen any record of contact with Mr Z's father either. Officer A says he visited Mr Z's former partner often, to let her know what was going on. Again, we have not seen any record of this contact either.

98. Mr Y's father was initially the whānau spokesperson, and Mr Y's sister later took over this role. Officer A says he spoke with Mr Y's father sporadically and had contact with Mr Y's sister a couple of times. While Mr Y's father was satisfied with the amount of contact he received from Police, Mr Y's sister was not. She found it difficult to get any answers from Police.

99. We find that Officer A should have kept the whānau better informed as to the progress of the Police investigation and prosecution, as required by Section 12 of the Victims' Rights Act 2002.

Did Officer A adequately perform his role as Officer in Charge of the investigation?

100. Officer A was working by himself out of Kawakawa Police Station at the time. He told us he did not have the capacity to spend the necessary time on the investigation as he had at least 15 other investigation files. He also candidly told us he probably did not have the experience and knowledge to be responsible for a file of this nature.

101. We recognise that Officer A was working in a rural station with a limited number of staff, and he would therefore be expected to handle anything that came his way, including files where he may have limited training and experience, and where there is limited supervision or support.[6] In our *"Policing in Small Communities"* report we highlighted the risks to both Police and the community when appropriate experience and supervisory support are not available to officers in sole-charge stations like Kawakawa. Having said that, despite the inherent constraints of working in a rural station, the onus was on Officer A to seek assistance when he recognised the job was beyond his capabilities.

102. Officer A failed to keep records of his enquiries and contact with whānau members as required. He did not complete notebook entries, jobsheets or entries in the Police database. Such records are vital when a case proceeds to court.

103. We reviewed Officer A's emails and found he did not respond to the prosecutor's requests for information in a timely manner. Responses were often one word answers and did not show the level of care expected of an officer, particularly of an Officer in Charge of a crash investigation into a double fatality.

[6] These failings are symptomatic of what our thematic review of 'Policing in Small Communities' found (our 'Policing Small Communities' report can be found here).

Did Officer C adequately perform his role as Officer A's supervisor?

104. Officer C was in a different station from Officer A. They discussed the case on occasion.

105. In hindsight, Officer C says he gave Officer A too much to deal with and he should have supported him more, organising the specialist support the case needed.

106. Officer C failed to provide sufficient supervision and support to Officer A. He did not meet his responsibilities to:

a) ensure that Officer A had the capacity to complete taskings in a timely fashion;

b) ensure the prosecution file was prepared to the standards required; and

a) check all files submitted by Officer A before forwarding to prosecution to ensure accuracy and completeness.

FINDINGS ON ISSUE 2

The SCU Analyst's investigation was not sufficiently thorough.

Officer A failed to ensure that all key witnesses were interviewed by appropriate staff.

Officer A failed to ensure that all witness statements were sufficiently detailed and fact checked.

Officer A failed to record in the Police database, in his notebook, or in job sheets, the actions and contacts he made throughout the investigation.

Officer A failed to sufficiently update the whānau of the deceased on the Police investigation.

Officer A did not respond to communication or requests from the prosecutor in a timely fashion.

Officer C's supervision of Officer A was inadequate. He should have ensured Officer A had the support required to perform his role adequately.

ISSUE 3: WERE THE PROSECUTION DECISIONS IN LINE WITH BEST PRACTICE?

107. On 3 April 2018, the morning following the crash, the Traffic Crash Panel reviewed the file. They supported the charges against Mr V, of two counts of 'Careless Driving Causing Injury or Death', determining there was a case to answer. Prosecutor A was assigned the file.

Was it appropriate for Police to escalate the charges on 5 April 2018?

108. On 5 April 2018 (two days after the crash), Prosecutor A reviewed the *"very brief"* file. She escalated the charges to five counts of 'Aggravated Careless Driving Causing Injury or Death' on the basis that Mr V was probably overtaking using the wrong lane.

109. We do not accept there was any evidential basis to escalate the charges against Mr V, given there was no further evidence or Police findings known to the Prosecutor at the time.

110. On 6 April 2018, Mr V pleaded not guilty to the charges.

What was the view of Mr Y and Z's whānau regarding prosecuting Mr V?

111. Mr V was invited to attend a hui at Mr Y's whānau's marae on 19 May 2018, to start a healing process under the tikanga custom of Ngati Kura, called Hou Hou Te Rongo. Mr Z's and Mr Y's whānau and friends (including Mr W but not Mr X) attended, along with Mr V, Ms U, Mr V's father and lawyer, and the Iwi Liaison Officer.

112. Mr Y's father saw the hui as a chance for whānau and friends to mourn, vent their hurt and anger, and move forward in forgiveness. Mr Y's father says after expressing themselves to Mr V, the whānau and friends decided that the crash was just an accident:

> *"…that it was something that happened but what was the point in ruining a young fellow's life with a conviction for a moment... so they decided to ask the Court to not press any charges."*

113. Mr Y's sisters had a different understanding of the purpose and outcome of the hui – they believed the hui was an opportunity to come kanohi ki te kanohi (face to face) with Mr V and Ms U, and that Mr V would take accountability for the crash. They had the same belief at the conclusion of the hui, too – that Mr V was going to be taking accountability for what had happened and plead guilty.

114. Mr V told us that at the hui it felt like the whānau thought the crash was his fault: *"[it] was basically three hours of them yelling at me."*

115. Following the hui, Mr Y's father filed a Restorative Justice report, on behalf of the whānau and friends, in the hope the charges against Mr V would be dropped. However, Mr Y's sisters were unaware their father sought to have Mr V's charges dropped. They believed the Restorative Justice report was to be submitted to the court for consideration when it came to sentencing Mr V, on the understanding he was going to plead guilty.

116. The Iwi Liaison Officer completed a jobsheet following the hui, in which he said there was "*forgiveness from a minority*" towards Mr V. He noted that when Mr Y's father spoke in closing, he directed his kōrero at Mr V's lawyer, saying: "*There are no winners here. We, the whānau, are seeking a discharge without conviction."* The Iwi Liaison Officer thought some whānau and friends appeared to accept this, but there was not full support.

Did Police Prosecution Services ensure the matter was appropriately managed?

117. On 15 May, Prosecutor A injured herself and in June, went on extended leave. Rather than assigning the case to another prosecutor, the Police Prosecution Service (PPS) Northland Manager returned it to Officer A to progress the investigation. However, given the seriousness of the file and charges laid, the case should have been immediately assigned to another prosecutor.

118. Prosecutor B completed necessary administrative tasks but was not assigned as the prosecutor for the case.

119. In April, a five-day Judge-alone trial was confirmed for June 2019, Prosecutor B ensured that the relevant documents were filed with the Court. He understood the inquiries and disclosures were up to date and under control but had not reviewed the full file or evidence himself.

120. In light of his further investigation, Mr V's lawyer was dissatisfied with the fact that the case was being pursued and did not feel they were given a sufficient reason why.

Was the prosecution file appropriately reviewed by Police?

121. In December 2018, Prosecutor C was asked to review the file after Mr V's lawyer voiced concerns about the sufficiency of the evidence.

122. Prosecutor C determined that Mr X's account, that the Toyota was on their side of the road, and Ms U's account, that she was certain that they were on the correct side of the road, essentially cancelled each other out. By implication, Ms U was likely saying that they swerved right, into the southbound lane, to avoid the Subaru coming towards them. The Subaru must have swerved left, also into the southbound lane where the collision occurred. It was therefore up to the forensic evidence to determine who was in the right.

123. The frontal crush damage to the Toyota was evenly spread across its whole width, which indicated it was square on to the Subaru in the southbound lane at the time of impact, meaning it did not swerve suddenly into that lane immediately before the crash. Prosecutor C concluded that the Toyota had been driving in the wrong lane and did not suddenly swerve into the wrong lane. Prosecutor C consulted with the senior crash expert who agreed with this finding.

124. Prosecutor C's view was that there was enough evidence to proceed to trial. However, he did not believe the aggravated form of careless driving charges was warranted, as he suspected that Mr V likely drifted across the centreline after falling asleep, which is involuntary, not deliberate.

125. We find it was appropriate for Prosecutor C to review the file and draw the conclusions he did.

126. Following the review, Prosecutor C requested specific documents be added to the prosecution file, and the case was assigned to Prosecutor B.

Did Police ensure information was disclosed to Mr Y's lawyer in a timely manner?

127. There were a number of instances where Police did not disclose documents to Mr Y's lawyer in a timely manner as they were required to do, and a hearing was set to address that issue.

What happened next?

128. On 9 April 2019, Prosecutor B and Mr V's lawyer met with the Judge. Prosecutor B said the charges against Mr V would be amended down from 'aggravated' to 'careless'. The defence argued that in light of their crash expert's report, the charges against Mr V should be withdrawn. The Judge decided he would consider this at a hearing in May 2019.

129. On 26 April 2019, Prosecutor B received and reviewed the full file for the first time and was happy with the state of it.

130. Around this same time, Mr Y's sister told Prosecutor B she had heard a private investigator, working for Mr V, was asking questions about whether the crash was caused by Mr Z's deliberate act to die by suicide.

Where did the suicide theory come from?

131. When we spoke with Mr Y's father, he told us that Mr V's lawyer invited him to his office to read the Police file. He read in Mr X's statement that Mr Y was still alive and complaining about his legs, which made him doubt the Police case as the Police had told him he died instantly. Mr Y's father then spoke with Mr X and Mr W, who he said told him what really happened was that Mr Z was having a hard time with methamphetamine and was *"losing it"* and driving erratically that night. From what Mr Y's father remembers, they said: *"[Mr Z] just laid back and said: 'Sorry', and aimed straight for the [Toyota]".* Mr Y's father said he did his own investigation and found that Mr Z had been suicidal for several months, and that he may have been committing suicide in the accident. Mr Y's father told us he did not tell Police about what was said that he took this theory to Mr V's lawyer, and thinks that the lawyer spoke to Police about it. Mr V's lawyer told us that Mr Y's father told Police about this, and after Police inaction, he brought the theory to him.

132. Due to insufficient Police records, we cannot reconcile these accounts or determine what Police learned and when, and what they decided to do with that information. However, upon hearing of this theory, or learning of doubt as to the cause of the crash, Officer A should have re-interviewed Mr X and Mr W.

133. Of note, Mr Y's sisters told us when Mr Y was laid at the marae, Mr Y's father asked Mr W what happened. Mr W told them all he had no memory of the crash. The sisters say Mr W maintained this with everybody until the private investigator was involved.

What did the defence do with the suicide theory?

134. Mr V's lawyer hired a private investigator to explore the possibility Mr Z had caused the crash due to being suicidal.

What evidence did the private investigator find?

135. Over two weeks the private investigator spoke to several people and got six signed statements about Mr Z's state of mind in the lead up to the crash, what they had heard about the crash, and Mr W's and Mr X's new account of the cause of the crash.

136. Mr W had told Police he could not remember the crash, but now said he was lying in the back of the car when he noticed they were going 80-90 kph. He asked Mr Z if he was "*all goods?"* Mr W thinks Mr Y (the front passenger) may have taken offence to the comment as he shunted the wheel to push the car onto the righthand side of the road, in the wrong lane. Mr Z appeared to be shocked and frozen. Mr X dove through the seats to grab the wheel to pull it back, and then they hit the Toyota. Mr W said: *"at that last second our car had gone onto the other side of the road, onto their side"* (see paragraph 900 for his original statement).

137. Mr X's statement starkly contrasted with what he told Police – that the Toyota was on their side of the road, heading towards them. In his new statement, he said Mr Y and Mr Z were "*really*

going at each other". Mr Z was cutting corners and crossing the centreline and speeding up to 140 kph into the straight. Mr Y was taunting Mr Z and his driving. Mr Y then jerked the wheel, and the car went onto the gravel on the lefthand side of the road. Mr Z said: "*eh, you wanna die*?" Mr X grabbed Mr Y's arm to free it from the wheel so that Mr Z could regain control. A few seconds later they saw full-beam lights ahead of them, about 20-30 metres away. Mr Z headed straight at the car and took his hands off the wheel, leaned back and said: "*sorry cuzzies*". Mr X said: *"by this stage, just at the end I saw the other car on the centre line. It was like we were going to crash."* Mr X grabbed the wheel and pulled it to try to avoid hitting the car directly, and that was when they hit the Toyota (see paragraph 89 for his original statement).

138. Mr X's partner and Mr Z's former partner's statements spoke about Mr Z's methamphetamine use and alleged depression in the lead up to the crash.

139. Mr X's partner showed the private investigator some of Mr Z's Facebook posts which she thought indicated a cry for help or that he wanted to self-harm.

What was Mr Y's sisters' response to the suicide theory and changed statements?

140. Mr Y's sisters told us Mr Z was like a brother to them and that he was absolutely not suicidal. They said he would not have harmed his brother, cousin, and friend by deliberately crashing the car.

141. One of Mr Y's sisters met with the private investigator. She thought he was trying to find evidence to support the suicide theory and says he only spoke about Mr Z's alleged mental health issues with her, rather than the crash. He also started writing her a "*statement*" when she spoke with him. He did this without her agreement, and she did not sign it.

What was the Police response to the evidence in support of the suicide theory?

142. Four working days before the Judge was to consider whether the charges should be dismissed, Prosecutor B received an email with the new defence statements taken by the private investigator. The change of accounts came as a surprise to Prosecutor B.

143. Officer A tried to get in contact with Mr X, but found he had shifted to another district. He did not follow this up as he should have done.

144. Officer A believes he spoke to Mr Z's former partner about this, and she said he had not been suicidal. There is no record of this conversation on the file.

145. Prosecutor B considered the key witness, Mr X, to now be so unreliable that even if he gave evidence at the trial that was consistent with his initial Police statement, he would be cross-examined by Mr V's lawyer on his new inconsistent statement and undermine it to such a degree that his evidence could not be accepted. The other witnesses, such as Mr W and the tow truck driver, would further undermine the Police case. Given this, Police conceded that they did not have sufficient evidence to proceed to trial. The Judge agreed and dismissed the charges.

What was the Judge's view?

146. Mr V's lawyer sought full indemnity costs of $149,673, for his fees as well as his expert and a private investigator. In the end, Mr V was awarded $30,000. In his judgment the Judge said that there was no bad faith on the part of the Police. He clearly concluded that further investigation should have been conducted once more information came to light but recognised further inquiries were contingent on Police resourcing.

147. The Judge's view concluded that there was a case for Mr V to answer.

148. We have also reached the view that on the evidence gathered, Police were justified in pursuing the case against Mr V.

FINDINGS ON ISSUE 3

Officer C was justified in laying charges in the hours following the crash.

Prosecutor A was not justified in escalating the charges two days after the crash.

The Northland Manager of the Police Prosecution Service should have immediately re-assigned the file after Prosecutor A went on leave.

The prosecution should have ensured disclosures were provided to the defence in a timely manner.

The prosecution was justified in continuing their case against Mr V, despite the views of the defence.

Subsequent Police Action

149. Police held a debrief to discuss lessons learnt on 5 November 2021, three-and-a-half years after the crash.

150. Northland District have made changes since the crash in 2018. These included:

- establishing a Detective Sergeant and CIB investigator role within the Road Policing Group.
- assigning sergeants to crash files who are responsible for overall management of the files;
- having a permanent Serious Crash Analyst mentor any relieving analysts to share knowledge and experience and promote best practice;
- tasking the Detective Sergeant with:
    i. carrying out initial action reviews to identify issues or gaps;
    ii. liaising with sergeants and staff involved with crash files; and
    iii. providing guidance, support and supervision of the analysts; and
    iv. identifying and promoting lessons identified;

- developing a guide for staff undertaking interviews of persons involved in crashes;
- giving a Checklist for fatal crashes to all Non-Commissioned Officers;
- providing Serious Crash training;
- improving connections to Emergency Services (FENZ and Ambulance);
- increasing the number of staff recruited into the area and improving rostering. and
- developing a clear victim/families management role and plan.

151. During 2021, sessions on what to do at serious crashes were delivered at Far North Public Safety Team (PST) Training Days and PST staff attended the Basic Crash Investigation Courses.

152. The Serious Crash Investigation policy for Northland was updated in July 2022. The policy now requires Criminal Investigation Branch (CIB) involvement in any fatal crash, until a decision is made by the relevant Area Commander as to the appropriate level of the investigation. CIB must attend and take ownership of the investigation where it appears that serious criminal charges may result. The policy also requires that vehicles involved in the crash are not released to any party until the forensic examinations and the driver/witness interviews are completed.

Judge Kenneth Johnston KC

Chair
Independent Police Conduct Authority

28 September 2023

IPCA: 21-9635

Appendix – Laws and Policies

LAW

Land Transport Act 1998

153. Section 38 provides that a person commits an office if they operate a vehicle on a road carelessly or without reasonable consideration for other persons using the road, causing injury to or the death of another person.

154. The aggravated form of this offence is covered by Section 39, which provides that a person commits an offence if they cause bodily injury to or the death of a person by carelessly using a motor vehicle while –

a) driving the motor vehicle at a speed exceeding the applicable speed limit; or

b) driving the motor vehicle in such a manner as to commit an offence against the regulations or the rules concerning the manner in which a driver may overtake another vehicle or concerning the part of the road on which a driver may drive his or her motor vehicle.

About the Authority

WHO IS THE INDEPENDENT POLICE CONDUCT AUTHORITY?

The Independent Police Conduct Authority is an independent body set up by Parliament to provide civilian oversight of Police conduct.

We are not part of the Police – the law requires us to be fully independent. k is overseen by a Board, which is chaired by Judge Kenneth Johnston KC.

Being independent means that the Authority makes its own findings based on the facts and the law. We do not answer to the Police, the Government or anyone else over those findings. In this way, our independence is similar to that of a Court.

The Authority employs highly experienced staff who have worked in a range of law enforcement and related roles in New Zealand and overseas.

WHAT ARE THE AUTHORITY'S FUNCTIONS?

Under the Independent Police Conduct Authority Act 1988, the Authority receives and may choose to investigate:

- complaints alleging misconduct or neglect of duty by Police;
- complaints about Police practices, policies and procedures affecting the complainant in a personal capacity;
- notifications of incidents in which Police actions have caused or appear to have caused death or serious bodily harm; and
- referrals by Police under a Memorandum of Understanding between the Authority and Police, which covers instances of potential reputational risk to Police (including serious offending by a Police officer or Police actions that may have an element of corruption).

The Authority's investigation may include visiting the scene of the incident, interviewing the officers involved and any witnesses, and reviewing evidence from the Police's investigation.

On completion of an investigation, the Authority must form an opinion about the Police conduct, policy, practice or procedure which was the subject of the complaint. The Authority may make recommendations to the Commissioner.

THIS REPORT

This report is the result of the work of a multi-disciplinary team. At significant points in the investigation itself and in the preparation of the report, the Authority conducted audits of both process and content.

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