

Police investigation into the death of Rachel Molloy

1. In October 2024, the mother of Rachel Molloy, Ms Z, complained to the Authority regarding the Police investigation into the 2022 death of her daughter and how Police had treated Ms Molloy in a complaint from 2020.
2. At her passing, Ms Molloy was a 30-year-old professional woman living by herself in a 2-bedroom flat in Mount Eden, Auckland. The Authority acknowledges Ms Z's bereavement, and we extend our deepest sympathy to her and her family.

The Authority's findings

Issue: Did the Police respond appropriately to Rachel Molloy, both in June 2020, and on 4 May 2022, and did they conduct an adequate review of their actions?

We are satisfied that Police robustly reviewed their 2020 and 2022 actions.

We accept their later findings in relation to the events of 4 May 2022 that:

- The initial officers (Officers A and B) acted appropriately.
- The subsequent crime scene examination was inadequate, and conclusions were reached without full evidential consideration. At the least, the scene should have been secured for a potential re-assessment as well as consideration applied as to how it was returned to the next of kin.
- The communication with Ms Molloy's family was inadequate and Police failed to appreciate and address their concerns.

We are satisfied that Police eventually completed sufficient enquiries that enabled a finding, on balance of the information available, as to how Ms Molloy suffered her fatal injury.

In relation to Ms Molloy's 2020 complaint, we accept that overall Police responded appropriately with charges brought against all offenders. However, Police failures occurred regarding:

- an initial administration error and poor communication when Ms Molloy was incorrectly advised her report had been filed, and
- victim impact statements should have been prepared and presented at the sentencing of those convicted.

Analysis of the Issues

Background events with Rachel Molloy in 2020

3. On 6 June 2020, Ms Molloy was living in an apartment in central Auckland and was the victim of a crime where a large amount of her property was stolen. CCTV footage from outside her apartment later established that five people, four women and a man, had entered her home and taken the property. Police later understood that Ms Molloy had been given a drug by one of the offenders, without her knowledge, which had rendered her unconscious. Police also believed Ms Molloy had been sexually assaulted.
4. On 7 June, Ms Molloy made a complaint to Police. Due to Ms Molloy having limited memory of what occurred, when recording the crime in their database, Police coded it as theft from a dwelling.
5. On 21 June, Ms Molloy complained to the Authority as it appeared her complaint had been closed. It transpired that an administration error, arising from the initial theft code, led to a filing letter being posted to her. Police were, in fact, still proceeding with an investigation as they then understood the incident was more serious.
6. Police apologised to Ms Molloy for the error and the Authority closed our 2020 case.
7. From the ongoing Police investigation, the five perpetrators were located and charged with varying offences. Three women pleaded guilty to theft and were dealt with. The fourth woman, the person Police believed was the principal offender and had drugged Ms Molloy, and the man, pleaded not guilty and were due to defend charges at an Auckland District Court trial on 1 June 2022.
8. The Crown Prosecutor ultimately withdrew the charges against the fourth woman. In the end, the male pleaded guilty to burglary, along with other unconnected crimes, and was sentenced to imprisonment.

ISSUE: DID THE POLICE RESPOND APPROPRIATELY TO RACHEL MOLLOY, BOTH IN JUNE 2020, AND ON 4 MAY 2022, AND DID THEY CONDUCT AN ADEQUATE REVIEW OF THEIR ACTIONS?

What was the situation with Rachel Molloy in May 2022?

9. After the incident in June 2020, Ms Molloy shifted away from Auckland. In February 2022, she returned, moving into the Mount Eden flat which was in a complex of twelve similar units.
10. On 3 May 2022, Ms Molloy went to a doctor where she was declared unfit to work for a week due to anxiety. We accept this was from stress arising from the 2020 crime and the pending court trial. The doctor prescribed Ms Molloy medication, which was advised to be not taken with alcohol.

What action did the Police take on 4 May 2022?

11. At about 11.39pm on Wednesday 4 May 2022, a person (Ms Y), who lived in a nearby flat, rang Police on 111 to report a woman was lying on the ground outside. She said: *"I think my next-door neighbour like, must have fell down the stairs or something."*
12. Ms Y told Police she did not know her neighbour's name, also saying: *"Yeah, and she hit the bottom of the stairs by the rubbish bin."*
13. The first officers, Officers A and B, arrived at 11.52pm and found an unknown woman (Ms Molloy) lying on her back at the base of the outside stairs. The woman was positioned with her head below her legs, with her legs draped up the stairs. She was wearing a dressing gown over under garments with socks on her feet, without footwear. There was no identification, keys or phone with her.
14. Officers established the woman was breathing but unconscious. One of the officers moved a plastic wheelie bin to provide better access, but they did not move her for fear of causing further harm. An ambulance was immediately requested but did not arrive until 12.10am (now 5 May 2022), followed by a second ambulance at 12.22am.
15. Ms Molloy, whose name was still not known, arrived at Auckland hospital at 12.53am where she underwent assessment. Within a short time, it was established that she was not going to survive.
16. Officers at the Mount Eden flat found both external doors were locked with the lights on and music playing inside. No windows were ajar. Crime Squad investigators arrived at the scene at 1.04am and began assessing the outside area and requested a locksmith to gain entry to the flat.

What investigation was commenced by Police?

17. At 2.46am a locksmith opened the door for the investigators. Information was then obtained that established Ms Molloy's identity.

18. A Crime Squad Detective [Officer C] and a colleague completed a cursory scene examination. We accept that at that stage officers were not dealing with a death, although they knew a serious injury had occurred. We also acknowledge that at the time of attending, officers did not know about Ms Molloy's victimisation in 2020.
19. At 3.04am, the investigators left the flat, locking the door. No forensic examination was undertaken; some items were taken as exhibits (empty medication packet, cigarettes and butts, a lighter along with keys). Notebook entries were recorded, and a series of photographs were taken. Blood on the concrete path was left in place.
20. Based on Officer C's observations and from information available, he and his colleagues decided there was nothing to suggest suspicious circumstances or involvement of a third-party. They determined that Ms Molloy was drinking alcohol at home alone, had gone outside to have a cigarette, then had fallen down the stairs. At some stage, the front door closed and locked.
21. Officers did not test the door, which opened inward, to see if it was able to self-close. They did not conduct fingerprinting or lift swabs. Importantly, the scene was not forensically secured to allow later examination if deemed necessary.
22. At 2.50am, another Detective attended Auckland Hospital and was advised Ms Molloy had non-survivable injuries. This officer provided Ms Molloy's details to medical staff.

How was Rachel Molloy's family advised?

23. At 4.45am Police at Levin advised Ms Molloy's mother, Ms Z, of the incident and that Ms Molloy had suffered a non-survivable injury due to falling down her stairs. Ms Z and her partner then travelled to Auckland and onto the hospital. When they arrived, the outcome for Ms Molloy was confirmed.
24. Later in the day, another Detective (Officer D), was tasked to speak to Ms Z at the hospital and he did this at 12.45pm. There is a conflict of accounts as to what was communicated at that meeting, although it is known Ms Z raised concerns around the pending trial and that she was worried about the potential involvement of those individuals in Ms Molloy's fall. Ms Z repeated this, including her recollection of the 12.45pm conversation, in a formal statement to Police three days later.
25. At about 8.51pm, hospital staff recorded that Ms Molloy had passed away.

What did Rachel Molloy's postmortem establish?

26. A forensic pathologist found that Ms Molloy sustained a fatal blunt force head injury. This most likely was a consequence of falling backwards down the stairs. There was an absence of evidence (eyewitness or CCTV footage) regarding the exact 'mechanics of the fall'.

27. Ms Molloy's blood alcohol was extremely high. Anti-anxiety drugs were also in her system which can exacerbate the effects of alcohol to include dizziness, drowsiness and confusion. The pathologist considered the toxicology results, *"made a [accidental] fall more likely due to the effect of being unsteady on feet or dizziness."*

What did Police determine happened to Ms Molloy?

28. From the outset, Police treated the death as an accident, believing Ms Molloy had sustained the injury from falling down her stairs while alone. In contrast, Ms Z said she had received mixed messages as to what Police were doing investigatively and she brought forward strong concerns as to the involvement of several people, including those from the 2020 crime.
29. The file was eventually overseen by a Senior Constable attached to the Police Coronial Investigation Team (Officer E). Officer E arranged and conducted further enquiries which included assessment of social media and phone activity, an area canvas, previous acquaintances and contacts of Ms Molloy as well as updates to the family.
30. Officer E also assessed the potential involvement of those individuals who were due to appear in court from the 2020 crime, but only doing this by way of checking electronic monitoring data. Officer E submitted the file to the Coroner.
31. In frustration with what she believed Police had failed to do, Ms Z went to the media. That resulted in a story being released to the public which raised questions as to what happened to Ms Molloy. As outlined above, in October 2024 Ms Z also complained to the Authority.

What happened because of Ms Z complaining to the Authority?

32. After notification by the Authority, in March 2025 a Detective Inspector (Officer F) completed a review of the investigation into Ms Molloy's death and the other concerns. Officer F found that:
- The initial attendance by officers (uniform and CIB members) was appropriate.
 - However, the scene examination lacked objectivity with initial conclusions reached without robust evidential foundation. That likely contributed to a delayed transition from the Crime Squad to Area Investigations for further enquiries.
 - Police should have proactively engaged with Ms Molloy's family when they arrived at the hospital. That communication became fragmented and only improved due to efforts by the family. Police staff have since acknowledged that contact with the family could have been better.
 - The available evidence supports the premise that Ms Molloy's injuries were accidental.
 - In the main, Police acted appropriately in relation to the 2020 crime, aside from identified issues with the administration error and poor communication. Also, Police should have had victim impact statements from Ms Molloy prepared and presented at the sentencing of those convicted.

33. The Authority assessed Officer F's review, and we agree with those findings, plus the proposals to move forward with an update and apology to the family. Before that, to lessen uncertainty for the Molloy family, we recommended Police complete further enquiries to eliminate those persons involved in the 2020 crime. We also interviewed several officers and evaluated the Police information.
34. Police then conducted enquiries which removed any known suspect from involvement. Other enquiries were also completed along with re-consideration of the scene. No sinister aspect was uncovered.

Conclusion

35. We acknowledge that Police are often required to respond to matters with limited information. We find that on the night of 4 May 2022, Officers A and B operated with professionalism and empathy.
36. However, the crime scene examination was inadequate, and conclusions were reached without full evidential consideration. At the least, the scene should have been secured for a potential re-assessment as well as consideration applied as to how it was returned to the next of kin.
37. We are satisfied that Police robustly reviewed their actions, and we accept their later findings. Nevertheless, there is a lesson here regarding the victims of crime. Due to Ms Molloy's victimisation in 2020, which severely impacted her life and wellbeing, Police failed to understand that her family might be similarly affected, no doubt compounded by the grief in dealing with her death. Within three days, Police knew the concerns held by Ms Z and were fully aware of the 2020 crime. We find that supervisors involved with the file in the early stages (some of whom were high ranking), failed to understand the importance of addressing the family's concerns. Having those aspects canvassed months later by way of a coronial investigator, notwithstanding the wider work he did, was inadequate and not timely.

FINDINGS:

We are satisfied that Police robustly reviewed their 2020 and 2022 actions in relation to Ms Molloy.

We accept their later findings in relation to the events of 4 May 2022 that:

- The initial attending officers acted appropriately.
- The subsequent crime scene examination was inadequate, and conclusions were reached without full evidential consideration. At the least, the scene should have been secured for a potential re-assessment as well as consideration applied as to how it was returned to the next of kin.
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Subsequent Police Action

38. On 9 September 2026, a senior officer provided an apology to Ms Z regarding Police failures. A key aspect of the apology was an undertaking that Police will include this case in delivering training to officers on the lessons learnt.



Judge Kenneth Johnston KC

Chair
Independent Police Conduct Authority

20 October 2026

IPCA: 24-24855

Appendix – Law and Policy

LAW - VICTIMS' RIGHTS ACT 2002

39. Section 4 – victim means

- (i) a person against whom an offence is committed by another person; and ...
- (iv) a member of the immediate family of a person who, as a result of an offence committed by another person, dies ...

40. Section 4 - immediate family, in relation to a victim means

- a member of the victim's family, whanau, or other culturally recognised family group, who is in a close relationship with the victim at the time of the offence; and
- to avoid doubt, includes a person who is ... a parent or step-parent of the victim.

POLICY – VICTIMS (POLICE SERVICE TO VICTIMS)

41. *"Policy statement and principles - Victim Focus is recognised as a key aspect of how our people will deliver 'Our Business'. Police are bound by the Victims' Rights Act 2002 to treat victims of offences in a particular way and provides them with information about their rights and services available to them."*
42. *"Victims should be given the opportunity to make a written statement about the impact the crime has had on them, through a victim impact statement [VIS] (ss17AA-27). The statement is required, if possible, at first appearance and must be on file for second appearance. Prosecution guidelines require the VIS to be completed ASAP and at the latest by second appearance. This enables the court to accept and process a guilty plea at the earliest opportunity while ensuring the victim's views are considered. Failure to place a VIS on file may lead to unnecessary adjournments or the victim not being heard. The VIS should be updated before key stages and must be updated, signed and provided to the prosecutor in time for sentencing."*

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. The Authority 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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