IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

Use of force in Matamata not excessive

Summary of the Incident

1. On 13 December 2019, Officers A and B went to an address in Matamata to serve a court summons on one of the occupants. Upon their arrival officers found the two occupants, Mr Z and Ms Y, having a physical fight on the driveway of the address.

2. Shortly after being separated Mr Z started to have trouble breathing and became unconscious. The officers administered first aid including cardiopulmonary resuscitation (CPR)[1] until ambulance and fire staff arrived. Mr Z was unable to be revived and was pronounced dead a short time later.

3. On 19 December 2019, Ms Y wrote a letter to the Waikato Coroner stating that the officers at the scene had used excessive force on Mr Z. This letter was forwarded to Police. In September 2020, Ms Y wrote to the Authority with the same concerns.

Issues examined by the Authority

Issue 1: Did Officers A and B use excessive force on Mr Z?

Issue 2: Did Police thoroughly investigate Ms Y's complaint?

The Authority's Findings

4. The Authority found that Officers A and B did not use excessive force against Mr Z.

5. We also concluded that Police did not thoroughly investigate Ms Y's complaint in a timely manner and did not refer her complaint to the Authority, as required.

[1] CPR is an emergency procedure that combines chest compressions, often together with artificial ventilation, which helps maintain blood flow to the brain and heart of a person in cardiac arrest.

Analysis of the Issues

ISSUE 1: DID OFFICERS A AND B USE EXCESSIVE FORCE ON MR Z?

6. At about 6.00pm on 13 December 2019, Officers A and B were patrolling in Waharoa, Matamata. Both officers knew Ms Y but did not have any knowledge of Mr Z.

7. Officer B had a court witness summons to serve on Ms Y, so they drove to her address to see if she was at home. Upon nearing the house, they saw that the property's gate was open and there was a large sport utility vehicle (SUV) parked at the gate.

Ms Y's account

8. Ms Y told the Authority that Mr Z had accused her of drinking alcohol in his car and became angry at her. He hit her several times at the house before getting in his SUV and driving to the end of the driveway. Ms Y walked down the driveway to close the gate behind him. Mr Z stopped the SUV, got out and grabbed Ms Y, causing them both to fall to the ground.

9. Mr Z got on top of Ms Y and punched her several times. A short time later Police arrived. The two officers each grabbed one of Mr Z's arms and pulled him off her.

10. Ms Y says once she and Mr Z had been separated and he was being led towards his car, the taller of the officers put an arm around Mr Z's neck from behind. The officer pulled him backwards in a headlock, lifting his feet off the ground. She said the officer held him in this position for seven or eight seconds. She heard the officer say that Mr Z was having a seizure and saw her sit him in the back of his SUV.

11. Ms Y used her cell phone to call an ambulance. She said she advised the officers that Mr Z was diabetic and that he had medication in his car. She saw one of the officers get the medication while the other tried to find a pulse on Mr Z.

12. A short time later, the officers put Mr Z on the ground and started CPR on him. Once the ambulance staff arrived, they were able to revive Mr Z for a short time before he passed away in the ambulance.

13. Later that evening, Ms Y was interviewed by Officer A about the events leading up to Mr Z's death. There was no mention in that statement of the officers allegedly using excess force against Mr Z.

Officer A's account

14. Upon getting out of the patrol car, Officer A heard a female screaming '*Get off me*' and yelling for someone to call Police.

15. As Officer A got closer, she saw Ms Y lying on the gravel driveway with a male on top of her. They were positioned only a few metres behind the SUV. Officer A yelled at the male to get off

Ms Y. Ms Y yelled that he had been assaulting her. Officer A described Mr Z as being quite calm and Ms Y as being hysterical.

16. Officer A directed Officer B to tell the Northern Police Communications Centre (NorthComms) where they were and what they were dealing with.

17. The officers separated Mr Z and Ms Y. Officer A went with Ms Y down the driveway towards her house and spoke with her to find out what had happened.

18. About three minutes later, Officer B yelled out '*help I think I'm losing him.*' Officer A ran back to where the SUV was parked and saw Mr Z was slumped in the open boot area.

19. Both officers lifted him onto the ground and Officer A started CPR, while directing Officer B to call NorthComms for backup and an ambulance.

20. Officer A continued CPR on Mr Z until Officer C arrived and took over from her. Shortly after, Officer A heard a noise that she believed to be one of Mr Z's rib cracking. At the same time, Officer B tried to erect a makeshift wall to provide some privacy.

21. Fire and ambulance staff arrived a short time later and took over the medical care of Mr Z. The on-duty supervisor attended the scene as is required by Police policy. The District Command Centre (DCC)[2] and on-call Criminal Investigation Branch (CIB) staff were advised but decided that no specialist attendance was required at the scene.

22. After fire and ambulance staff had administered first aid for about 45 minutes, Mr Z was pronounced dead. Ms Y was given some time with Mr Z in the ambulance before he was taken away. When Ms Y got out of the ambulance, she yelled at Officer B: "*this is your fault".*

23. Officer A was identified as the taller of the two officers that attended. She stated that there was no need to put anyone in a headlock or use any type of force. She said that during her time in the Police she has never put anyone in a headlock and does not know how to do it.

Officer B's account

24. Officer B said that when they arrived at Ms Y's address, she noticed there was a green SUV type vehicle parked at the road end of the driveway with the driver's door open. The gate to the property was open and so she assumed Ms Y was at home.

25. On approaching the property, she heard a female screaming and saw a male (who she later identified as Mr Z) on top of Ms Y who was lying on the driveway, close to the rear of the SUV. Officer B noticed that Mr Z had some blood on his arm and said that Ms Y was very vocal.

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[2] The DCC has access to all communications information and maintains an overall view of policing within a Police District with a focus on crime prevention. The DCC may also act in an incident response capacity and is able to deploy a wide range of staff and resources, including staff that would not normally be deployed in response to an incident.

26. Officer B said that the officers helped Mr Z off Ms Y but when she was asked further about this, she said she could not remember if Mr Z got up by himself or if the officers had to assist him.

27. Mr Z walked unaided and sat in the open boot of the SUV breathing heavily. He asked Officer B to turn the vehicle off and explained that he suffered from diabetes. He also asked her to get his medication from the car. On her return to Mr Z, Officer B handed him the bag of medication and asked if he needed an ambulance.

28. Officer B said shortly after this Mr Z's body *"seized up and his eyes become glassy and rolled to the back of his head."* He slumped forward and Officer B caught and held him while calling out for help from Officer A.

29. Both officers lifted Mr Z out of the car and lay him on the ground. Officer B used her police radio to call for assistance while Officer A commenced CPR.

30. At some stage later she recalls Ms Y yelling at her that it was her fault that Mr Z was dead. Officer B said that she thought this was because she had been the last person with him before his death. In response, Officer B said she stood back so as not to upset Ms Y any further.

31. At no time leading up to his death, was Mr Z arrested or detained by Police.

What information was contained in the Police reports on the incident?

32. In accordance with Police policy, later that day, Officer B completed a family harm occurrence report and separate report covering the circumstances of Mr Z's sudden death.

Family harm occurrence

33. Officer B stated in this report that Police arrived at Ms Y's address to serve a summons on her. On arrival, Police observed a male on top of Ms Y, pinning her to the ground. She said;

> *'Police managed to get the male off the female and whilst talking to both parties the male has had a medical event and although Police have administered immediate CPR on the male he unfortunately passed away.'*

Sudden death report

34. Officer B stated in this report that Police were patrolling in and stopped at Ms Y's address. They saw a physical struggle occurring between Ms Y and Mr Z on the driveway. Police separated them and Mr Z sat in the rear of a vehicle parked nearby.

35. She further stated:

> *'Moments later [Mr Z] exhibited signs of breathing problems where his breathing appeared laboured, [Mr Z] stated he was diabetic, and seconds passed before his eyes rolled up into the top of their sockets and [Mr Z] passed out'.*

36. The report documented that a preliminary examination of Mr Z's body, was carried out by officers at the funeral home and it was found that Mr Z had no obvious injuries, despite a few small scrapes which were deemed to have occurred during CPR.

37. Officer B stated in the report that Mr Z had a large chest scar from previous open heart surgery, as well as another scar that ran from his groin area to near his left ankle.

Coronial autopsy report

38. The coronial autopsy report stated in summary that Mr Z's death was caused by ischaemic heart disease.[3] There was evidence of previous artery grafts and stent, narrowing of artery walls and an enlarged heart.

39. There were sternal and rib fractures, consistent with CPR being carried out.

40. There was no injury to Mr Z's larynx or trachea.

Our analysis

41. Although Ms Y genuinely believed events occurred as she described to the Authority, there is no evidence to support her allegation that Police used excessive force on Mr Z by placing him in a headlock. This was clearly a traumatic event for Ms Y, and it is possible the physical altercation with Mr Z, coupled shortly after with his sudden death, may have influenced her recollection of the events. We accept the evidence of the officers that once separated from Ms Y, Mr Z was totally compliant. There was no need for additional force to be used.

42. At the time the Authority's interviews were conducted with Officers A and B, they had no knowledge of Ms Y's complaint about excess use of force. Both officers were clearly taken aback at the allegation.

43. There was some confusion between Officers A and B about whether Mr Z lifted himself off Ms Y at the time of their arrival or if they assisted him off her. The wording of the family harm report is ambiguous in this regard. The Authority accepts that this confusion was genuine and due to the passage of time.

44. There were no injuries to Mr Z's trachea or larynx which may have presented if pressure was applied to the throat area in a headlock type manoeuvre, as was alleged by Ms Y.

45. The accounts provided by Officers A and B during their interviews with us were consistent with the reports written at the time and with the medical evidence obtained during the autopsy.

FINDING ON ISSUE 1

Officer's A and B did not use excessive force against Mr Z.

[3] Ischaemia is defined as inadequate blood supply (circulation) to the area due to blockage of blood vessels.

ISSUE 2: DID POLICE THOROUGHLY INVESTIGATE MS Y'S COMPLAINT?

46. On 9 January 2020, Ms Y wrote a letter to the Waikato coroner expressing concerns that Police had used excessive force on Mr Z during the incident on 13 December and would not listen to her about his diabetes.

47. That same day, the letter was forwarded by the coroner's office to the Waikato Police Coronial Services team. The letter was electronically attached to the sudden death file in the Police database, (known as National Intelligence Application (NIA)) by Officer D, the Police inquest officer. However, no investigative action was taken. On 27 February 2020, Officer D made an electronic entry on the file stating that it could be filed awaiting the coroner's findings.

48. On 8 September 2020, the new Waikato coroner directed Police to interview Ms Y in relation to the letter that she sent to their office in January.

49. On 7 October 2020, the coroner followed up on that direction. In response, Officer E, a sergeant based at Matamata, made attempts to speak with Ms Y.

50. When spoken to about Ms Y's letter of complaint received in January, Officer D acknowledged she had overlooked it and had not discussed it with her manager before attaching it to the file. She said in the normal course of events, the coroner would issue a direction for Police to make further enquiries, but there was no such direction in this case. Notwithstanding, Officer D accepted the absence of such direction did not preclude her from seeking advice from her supervisor or initiating her own enquiries.

51. The Authority accepts that Officer D mistakenly overlooked the letter of complaint from Ms Y. Once the Coroner raised concerns about the complaint with Police in September 2020, an investigation was commenced.

Did Police notify the Authority?

52. Pursuant to section 15 of the Independent Police Conduct Authority Act, 1988 (the Act), Police are required to notify the Authority of every complaint received by the Police. Officer D was not aware of this obligation.

53. We accept that this was not an intentional omission but rather a general lack of knowledge about the requirements of the Act.

FINDINGS ON ISSUE 2

Officer D mistakenly overlooked the letter of complaint from Ms Y which delayed the Police investigation. Although this was unfortunate, the Authority accepts it was unintentional.

Officer D was unaware of the obligation to notify the Authority of Ms Y's complaint. Again, the Authority accepts this was due to a lack of knowledge and was not intentional.

Judge Colin Doherty

Chair
Independent Police Conduct Authority

1 July 2021

IPCA: 20-4725

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 Colin Doherty.

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 of investigators and managers. 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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