IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

# Police response to Gisborne family harm episodes inadequate

## Summary of the Incident

1. Between 1 and 5 January 2020, Ms Z reported to Police three family harm episodes between herself and her long-term de facto partner, Mr X, that had occurred at her home in Gisborne.

2. During the last episode Mr X caused significant injuries to Ms Y, a friend of Ms Z, who was staying with her.

3. The incidents were all attended by the same group of frontline, uniformed officers.

## Issues examined by the Authority

**Issue 1:** Was the Police response to the family harm episode between Mr X and Ms Z, reported on 1 January 2020, reasonable?

**Issue 2:** Was the Police response to the family harm episode between Mr X and Ms Z, reported on 5 January 2020, reasonable?

## The Authority's Findings

4. The Authority found the Police Communications Centre Call taker 1 incorrectly coded and incorrectly prioritised the event that occurred on 1 January 2020.

5. We also concluded that:

    1) Call taker 2 failed to record critical information in the event chronology and pass it on to frontline staff. On receipt of the information, she also failed to change the code and the priority for the event;

2) On 5 January 2020, Officer E failed to understand the significance of what Ms Z was disclosing to him regarding the dynamic of family harm and level of risk Ms Z was subject to;

3) Officer E should have interviewed Ms Z about the abuse she initially alluded to. Had he done so, it is likely to have led to the disclosure of an offence or offences committed by Mr X. This would have given Police the opportunity to charge Mr X and hold him in custody to appear in Court; and

4) Police should have taken steps to ensure Ms Z's safety when Mr X made the threat towards her after he was released from custody. Failure to do so led to Ms Y sustaining serious injuries.

# Analysis of the Issues

## INTRODUCTION

### Police family harm process in Tairāwhiti

6. Tairāwhiti Police use the 'Whāngaia Ngā Pā Harakeke'[1] model to manage and reduce family harm in the area. In total, the group in Tairāwhiti is made up of 23 staff, of which one third is police, one third is local iwi and the remaining third is made up of kaiāwhina (social workers). The group is co-directed by a member of Police and an iwi representative.

7. The model ensures that tikanga Māori and whakapapa lead the practice, with a holistic view to focus on the whānau as a whole, to prevent offending for both victims and offenders. The staff work alongside the whānau to build trust and connect them with support agencies, with the goal of enabling and empowering them to develop the skills to prevent future episodes of family harm.

8. In 2017, Tairāwhiti area Police had the highest number of calls for service in New Zealand for family harm, on a per head of population basis. At that time, Police staff were attending 70 incidents per week. In 2020, the total number of calls for service increased to almost 75 per week.

9. Family harm episodes are attended by frontline staff, who provide the initial response. They complete a report on the episode and forward them to the Whāngaia group, who triage the episodes and plan any ongoing response.

10. The reports contain a dynamic risk assessment, which is a series of ten questions that are asked in all family harm investigations. The questions are asked of the person at risk about the person posing the risk. The questions are designed to gauge concerns for safety. On top of this, the report also includes a 'Static assessment for family violence recidivism' (SAFVR), which is a statistical model that calculates a person's likelihood of committing a crime against a person

[1] Whāngaia Ngā Pā Harakeke is a pilot Police sponsored initiative where Police and local iwi work in partnership to reduce family harm. Tairāwhiti is one of three pilot sites in New Zealand.

within the context of a familial relationship within the next two years. Based on the answers to the questions, the assessment returns a likelihood result of 'high', 'moderate' or 'low'. The dynamic questions and SAFVR combine in the report to produce a level for the 'total concern for safety'. This again produces a result of 'low', 'medium' or 'high' concern.

11. The triaging process in Tairāwhiti is based on numerous factors including but not limited to:

- what was documented to have occurred during the incident;
- the documented history of persons involved;
- the risk to the victim, both imminent and ongoing; and
- whānau engagement with support agencies.

12. Officer A, the co-director of Whāngaia Ngā Pā Harakeke, told us that nationally there was emphasis on using the dynamic risk assessment completed by the frontline staff to triage the episodes. However, she said that in her opinion the assessment does not take into account all the factors and importantly does not include what her staff know about the parties involved.

13. The frontline staff we spoke to have all received training on family harm while at Police college and had attended training days within the area about the Whāngaia response model.

## Police family harm policy

14. Police policy states that Police will provide an effective response to family harm, which involves:

- taking an 'eyes wide open' approach to all family harm investigations, recognising that early intervention helps to stop and prevent family harm;
- being culturally responsive;
- ensuring all parties are kept safe including victims, children, and Police;
- taking action with predominant aggressors/offenders through a prompt and comprehensive response;
- collecting specific risk information to enable effective assessment, planning, and risk management for and with victims and children, and to guide decisions around appropriate action with an offender;
- working collaboratively across Police; and
- working with partners as part of a multi-agency response.

## Background

15. Mr X and Ms Z were in a de facto relationship for approximately 20 years. They have one adult child together. Ms Z owns the house where the incidents took place. She told Police that she does not know where Mr X lives when he is not at her house.

16. Mr X has a recorded history of involvement in 20 family harm episodes and Ms Z has a total involvement in 21. The majority of these episodes were with each other.

## ISSUE 1: WAS THE POLICE RESPONSE TO THE FAMILY HARM EPISODE BETWEEN MR X AND MS Z, REPORTED ON 1 JANUARY 2020, REASONABLE?

17. At 4.25pm on 1 January 2020, Ms Z called 111 from her house stating that Mr X had weapons, was psychotic, and needed to be removed. She said Mr X was not a family member but lived at the address. She refused to give further detail to the call taker (Call taker 1) and repeatedly asked for Police to attend, before ending the call. Call taker 1 attempted to call Ms Z back several times but was unsuccessful. Call taker 1 entered the event as:

    - '1R' - the code for breach of the peace; and
    - 'Priority 2' - meaning Police should attend within 30 minutes.

18. At 4.27pm, the event was passed to a Communications Centre dispatcher. At 4.40pm, the dispatcher telephoned Officer B, the acting sergeant, to discuss the event. The dispatcher incorrectly informed Officer B that Ms Z was no longer at her home address.

19. It was agreed between them that if Ms Z was not present at the address and there were no offences committed, Ms Z would need to contact mental health services herself. Officer B said he would complete a welfare check on Mr X with the on-duty dog handler, Officer C. However, they were then diverted to a priority incident.

20. At 4.54pm, Ms Z called 111 again, this time providing her name. This call was answered by Call taker 2. Ms Z said she was at her home address and Mr X was still there. She told Call taker 2 that he was locked outside but he had a pickaxe with him and was trying to kick the doors in.

21. This information about Mr X was not recorded in the event chronology and not passed on to frontline staff.

22. The incident code was changed to '1M', the code assigned to calls for service relating to concerns about a person's mental health. The priority code was not changed.

23. At this point the dispatcher had enough information to carry out checks on the Police database and establish the event was family harm related.[2] The event code and priority should have been changed to reflect this.

[2] Police information database known as National Intelligence Application (NIA). This database holds information about all individuals that have come into contact with Police.

24. At 5.02pm, the first Police officers were logged as being enroute to the event. At 5.11pm, a third 111 call was made. This call was answered by Call taker 3. The call appears to have been made by a different informant, although it seems Ms Z was in the background. The caller repeated that they were locked inside the house and Mr X was wandering around outside. The informant was upset about the time it was taking for Police to arrive.

25. Officers B and C arrived at 5.17pm. Officer B spoke with Mr X outside the address and Officer C went into the house and tried to speak with Ms Z.

26. Officer B told us Mr X was compliant and agreed to be taken to another address in Gisborne. He said Ms Z refused to speak with Officer C, so no further information was gathered about what had happened.

27. After leaving the address, Officer B correctly requested the Communications Centre change the event to a family harm episode. He advised the Communications Centre that no offences were detected and no further action was necessary.

28. It took a total of eight minutes to conduct the investigation at the house and remove Mr X, and to recode and provide the result of the incident to the Communications Centre.

29. In accordance with Police policy, Officer B completed a family harm report about the incident. He recorded that Ms Z was being abusive towards Police about the time it took them to arrive at her home and she would not provide information about what had occurred.

30. Officer B completed the safety assessment on the report, which resulted in the situation being assessed as 'high risk' with moderate concerns for the victim's safety. Despite this, he noted on the bottom of the report: "*No further action required - for filing".*

31. The file was received and triaged by Whāngaia staff on 3 January. When we spoke with Officer A, she told us that on that day there were 56 files to triage by a skeleton staff of two, due to it being a public holiday.

32. It was noted on the file that Ms Z was already engaged with a counsellor in the area, but her level of engagement with the counsellor was unknown. Ms Z was referred to Women's Refuge, who had previously overseen the referral to the counsellor. No follow up was completed with either party between 3 and 5 January.

*Analysis*

33. Call taker 1 had sufficient information from Ms Z to correctly identify what type of incident was occurring, but wrongly coded it as a breach of the peace with the priority of attendance within 30 minutes. By prioritising the event this way, it affected the frontline staff's assessment of the urgency to attend.

34. Call taker 2 did not record the information about Mr X having a pickaxe and trying to kick in the doors in the event chronology. As soon as the parties involved were identified and checks were able to be made on them to confirm their relationship, the matter should have been coded as a family harm incident and the priority code changed to reflect the need for urgent attendance.

35. Frontline staff rely on accurate information gathered by the Communications Centre staff to assess the urgency of a situation and to inform them about what has occurred. The gathering of correct information is also imperative to enable staff to conduct risk assessments about their own safety when attending an incident.

36. In this case, the information provided by the Communications Centre staff led the officers to believe there was less urgency than what was actually required. This resulted in the officers attending 52 minutes after Ms Z first called for assistance.

37. Due to the delay in Police attendance, it was reasonable in our view for Ms Z to be upset with the officers when they arrived. Because she was upset, she was uncooperative and did not provide them with further information which likely would have led them to identify offences committed by Mr X. Given what they knew, we consider the officers' response in simply removing Mr X from the address, was entirely reasonable.

38. The family harm report did not accurately reflect the extent of Mr X's actions during the episode, as officers were unaware of them. Given the information in the report, including that Ms Z was already engaged with a support service (and mindful of the high workload the Whāngaia team triaged), it was reasonable that there was no urgent follow-up from Police with either party involved.

### FINDINGS ON ISSUE 1

Call taker 1 incorrectly coded and incorrectly prioritised the event.

Call taker 2 failed to record critical information in the event chronology and pass it on to frontline staff. On receipt of this information, she also failed to change the code and priority for the event. This led to frontline staff delaying their attendance and being unaware of the full circumstances of what had occurred.

## ISSUE 2: WAS THE POLICE RESPONSE TO THE FAMILY HARM EPISODE BETWEEN MR X AND MS Z, REPORTED ON 5 JANUARY 2020, REASONABLE?

39. At 12.29am on 5 January 2020, Ms Z called 111 from her home and asked for Police assistance. She told them that Mr X was inside her house *"ranting and raving".* She said she had not seen him, but she could hear him.

40. Ms Z explained that she had just been discharged from hospital and was sick and tired and had woken up to him being in her house. She was crying on and off and repeated to the call-taker that she was frightened. She asked Police to hurry, saying that the last time that she had called Police (on 1 January) they had taken an hour to arrive.

41. Ms Z told the call-taker that what was happening with Mr X was an "*all the time occurrence, every single day".*

42. Officers D and E arrived at Ms Z's home nine minutes after she called 111. The officers walked down the driveway and into the rear of the property.

43. Officer D said Mr X approached them and was immediately abusive towards them. Officer D told us that until they had further information about what had happened at the address, it was necessary to detain Mr X for the issuing of a Police Safety Order (PSO).[3]

44. Officer E went inside the house and spoke with Ms Z. Ms Z advised that Mr X was her de facto partner and he had been verbally abusive towards her.

45. Officer D advised Mr X of his rights under the New Zealand Bill of Rights Act 1990 and cautioned him. Mr X continued his aggression towards Police so Officer E postponed speaking with Ms Z and assisted Officer D with transporting Mr X to the Police station. The officers were concerned for their safety so activated the vehicle's emergency lights and siren and drove at speed back to the Police station. Mr X had to be physically restrained in the back of the Police car.

46. Officer E returned to Ms Z's home at 1.30am and completed the family harm report with her. The narrative of this report states:

> *"[Ms Z] is extremely scared of [Mr X]. She stated that she wants him and his belongings gone from her address. She wants nothing to do with him. She stated he is very controlling and abuses her both physically and verbally. [Mr X] doesn't let her talk to anyone. He is the reason why she cut her landline off. She would like to get in touch with Whāngaia ASAP as she would love any help she can get."*

47. Ms Z provided information about her relationship with Mr X and his propensity to abuse and control her. Both the dynamic risk assessment and the SAFVR gave a total concern for her safety as 'high'.

48. Ms Z told Officer E she would arrange for a friend to stay with her for the night as she did not want to leave her house. She called her friend, Ms Y, who arrived to stay with her. Officer E advised Ms Z to call 111 straight away if she needed Police.

49. When interviewed by the Authority, Officer E said he could remember Ms Z being scared for her safety and he had the impression there was more happening within the relationship than what she was telling him. Despite this, Officer E told us that he could not identify any offences in what Ms Z disclosed to him. When questioned further about this, he admitted that this was probably due to a lack of understanding about what she told him.

50. Officer B met with Officers D and E on their arrival back at the Police station with Mr X. He said that Mr X was highly agitated and aggressive, so he assisted with removing Mr X from the car and taking him into the custody area.

51. Officer G received Mr X into custody at 12.51am. Mr X told Officer G he had consumed alcohol but would not say how much. He said he did not use drugs. Officer G noted during the custody evaluation that Mr X was "*agitated*" and "*showing aggressive behaviour towards self or others*". Due to his demeanour, Mr X was left in the handcuffs and escorted to a monitored cell.

[3] A Police Safety Order is a short term order (up to 10 days) issued by Police attending a family harm episode where no family violence charge can be made but concerns remain for the safety of the people involved.

52. About 10 minutes later, Officer G spoke with Mr X, advising him that she would like to remove the handcuffs but he needed to stop his aggressive behaviour. Mr X asked how long he would be in custody for and was advised that he would not be held longer than two hours.[4]

53. Officer D explained the PSO to Mr X and the consequences of any breaches. At 2.21am, he released Mr X from custody and offered him a ride home to which Mr X replied: "*I'm not getting in another pig car again. I'd rather walk home*". Officer E asked where home was, and Mr X named the address where Officer B had dropped him off after the episode on 1 January.

54. Officer D asked Mr X if he understood the consequences of the order to which he replied: *"This ain't going to stop me".* He then walked from the station.

55. Officer D and E drove from the station towards the address that Mr X named, to ensure he was heading in that direction. They last saw him about 250m away from the Police station, walking towards his nominated address, the opposite direction to Ms Z's address.

56. Officer B also left the station to check on Mr X. He saw him about 450m away from the station, walking in a direction away from Ms Z's address.

57. Approximately one hour later, Ms Z and Ms Y heard a noise outside the house and believed that Mr X had returned to the property. They locked the door and Ms Y called 111.

58. Ms Z looked out her bedroom window and saw Mr X approaching the house from the road. He came to the window and asked her to let him in. She told him she was scared of him and that he needed to leave otherwise she would call Police.

59. Mr X broke into the house carrying what appeared to be a wool-handling bale hook. He attacked Ms Y with the hook while she was on the phone to the dispatcher.

60. Mr X then turned his attention to Ms Z who had retrieved the phone from Ms Y. Ms Z told us she believed Mr X was going to kill her. However, Mr X was momentarily distracted by Ms Y, which provided Ms Z the opportunity to lock herself inside a bedroom and continue the phone call.

61. On Police arrival, Mr X was outside the house. When he saw the officers, he attempted to sever his own arm and his leg with the hook. Police presented a Taser at him, and he was arrested. When Police entered the house, they found both Ms Z and Ms Y injured. The officers initially believed Ms Y was dead due to the severity of her injuries. Ambulance staff attended and Ms Y was transported to hospital with critical head injuries.

62. Mr X later pleaded guilty to serious violence offences and was imprisoned. Ms Y has been left unable to work, has difficulty with her memory, and has lost both her sense of smell and taste.

[4] Police policy states that Police can only detain a person for a duration of up to two hours for service of a PSO.

*Analysis*

63. When the officers first arrived at the address, it was clear to them that Mr X was aggressive and posed a risk to the safety of Ms Z and the officers themselves.

64. Due to Mr X's behaviour, Officer D made an immediate decision to detain him for the purpose of issuing him with a PSO.

65. Officer E spent time with Ms Z and, although he identified she was at risk of further harm from Mr X, he failed to understand the significance of what Ms Z was disclosing to him in relation to the dynamic of family harm and the level of risk to her. This was also despite the report he completed showing that the total concern for her safety was 'high'.

66. When Ms Z disclosed that Mr X abuses her both physically and verbally, Officer E should have interviewed her to gain further information. It is likely that, if explored, the abuse Ms Z initially alluded to would have led to the disclosure of an offence or offences. This would have given Police the opportunity to charge Mr X and hold him in custody to appear in Court.

67. The Police family harm and PSO policies both state that all enquiries should be *completed* to identify possible offences *before* considering issuing a PSO. This did not happen in this case, and even after information was provided by Ms Z, the decision was not revisited.

68. As an aside, the time duration of the order was also problematic. The PSO policy states that when it comes to the duration of the order, relevant considerations should be considered, including:

- weekends, public holidays, and an individual's ability to access the courts, if necessary; and
- how long it will take for the family to access appropriate support services and make ongoing arrangements for their safety.

69. The order was issued for a duration of 3 days (72 hours) from the early hours of Sunday morning. Therefore, in practical terms, this left only 48 hours for Ms Z and support agencies to work together to ensure her safety.

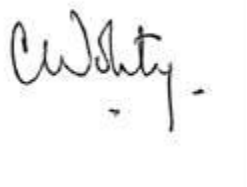
70. After Police released Mr X from custody, they briefly checked his direction of travel before continuing with other duties. Communications Centre records show that between Mr X leaving the Police station and Police being called back to Ms Z's address, they did not attend any other incidents. They did not check on Ms Z to ensure her safety, despite Mr X's threats when he left the station that the PSO *"would not stop him".*

## FINDINGS ON ISSUE 2

Officer E failed to understand the significance of what Ms Z was disclosing to him regarding the dynamic of family harm and the level of risk she was subject to.

Officer E should have interviewed Ms Z about the abuse she initially alluded to. If he had done so, it is likely to have led to the disclosure of an offence or offences committed by Mr X. This would have given Police the opportunity to charge Mr X and hold him in custody to appear in Court.

Police should have taken steps to ensure Ms Z's safety when Mr X made the threat towards her after he was released from custody. Failure to do so led to Ms Y sustaining serious injuries.



**Judge Colin Doherty**

Chair
Independent Police Conduct Authority

Thursday 7 April 2022

**IPCA: 20-1878**

# 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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