REPORT ON A REVIEW OF THE INITIAL POLICE INVESTIGATION INTO THE DEATH OF JOSEPHINE SUSAN MARNER ON 1 JANUARY 1997 AT TRENTHAM

NATURE OF COMPLAINT

On 3 June 1997 the Authority received notification from the Commissioner of Police of concerns expressed by Mr David Marner at a meeting on 1 May 1997 regarding the scope and competency of the initial Police inquiry into the death of his daughter Josephine Susan Marner ("the deceased"). The Police decided to submit this as a formal complaint to the Authority.

On 5 June 1997 the Authority received a formal complaint from Caroline Anne Marner, a sister of the deceased, also complaining about the initial investigation. That complaint raised a number of questions and allegations about the scope and competence of the investigation.

On receipt of these complaints the Authority decided, pursuant to s.17(1)(b) of the Police Complaints Authority Act 1988 ("the Act") to direct a Police investigation of the complaints, which would subsequently be reviewed by the Authority.

Detective Superintendent J. Millar of Christchurch was assigned to investigate the complaints. His inquiries were completed and his findings outlined in a report dated 19 November 1997. However, as the inquest into the death conducted by the Wellington Coroner was not completed until 14 July 1998 the Commissioner's report pursuant to s.20(1) of the Act on the inquiry into the complaints was not received by the Authority for review until early September 1998.

ADEQUACY OF THE POLICE INVESTIGATION OF THE COMPLAINTS

I have considered the extensive Police file generated by the investigation of the Marner family's complaints and I am satisfied that the concerns expressed in the complaints have been thoroughly and competently investigated. I now report with my findings. After obtaining

the consent of the deceased's family and in view of the considerable public interest in the matter I have decided to publish this report pursuant to s.34 of the Act.

BACKGROUND TO INCIDENT

On New Year's Eve 1996 a party was held in the Long Bar at the Wellington Racing Club's premises at Trentham to celebrate the New Year and the birthday of Mr Lyn Biddle. Among the guests were the deceased and her partner Mr Murray Cohen. Most of the guests had left by about 1.30am on 1 January 1997. A small number, including the deceased and Mr Cohen, remained. At approximately 2am the deceased and Mr Cohen were alone in the Long Bar. Four other guests were outside on a concrete patio.

Shortly after 2am Mr Cohen came through the Long Bar holding the deceased, who was bleeding from a neck wound, and calling out for an Ambulance to be summoned on 111. The deceased was placed on the floor by the doorway where she was lying when Police arrived. The Ambulance was called at 2.09am and arrived at 2.14am.

A witness, Mr S D Edhouse, told Police that he was sitting at a table outside the Long Bar when he heard shouting from the deceased in the Bar causing him to turn and look through the door. He thought the deceased and Mr Cohen were having an argument. He saw her fall backwards and then get pulled up. Shortly after Mr Edhouse heard Mr Cohen screaming out for someone to call 111 and when he turned to find out what was going on he saw Mr Cohen near the doorway with the deceased in his arms having carried her there several metres from where she had fallen. The deceased was bleeding from a serious wound to her neck.

The Ambulance officers on arrival found no signs of life. After unsuccessful attempts were made to revive her, the Police were called at 2.19am.

Mr Cohen made several statements to the Police about how the deceased came to fall to the floor and suffer the wound to her neck from which she died at the scene. He also gave evidence on oath at the inquest.

INQUEST FINDING

In a detailed 23 page finding released on 14 July 1998 the Wellington Coroner, Mr G L Evans, analysed the sworn evidence given to the Court and recorded an open verdict in that the evidence did not enable him to find "*exactly how Miss Marner came to suffer the wound to her neck as a result of which she died*". He found that the deceased "*died on 1 January 1997 in the building known as the Long Bar at the Wellington Racing Club's Racecourse,*

Racecourse Road, Trentham, of the effects of a sharply incised wound of the neck, which had transected the trachea (there being evidence of blood loss as well as aspiration of blood and stomach contents) but as to the manner in which such injuries were sustained, the evidence adduced does not enable me to say."

NATURE AND SCOPE OF AUTHORITY'S INVESTIGATION

The Authority's jurisdiction in the present case is limited to the investigation of the complaints alleging misconduct or neglect of duty by any member of the Police involved in the initial inquiry into the deceased's death. In particular, where as here the Commissioner reports to the Authority on a Police investigation of a complaint the Authority's task is to form an opinion on the issues raised in the complaint, and indicate to the Commissioner whether or not it agrees with the Commissioner's decision in respect of the complaint. The Authority is also required to inform the parties concerned of the result of the investigation.

The initial Police investigation into the death was concluded within two days. Late on 2 January 1997 the officer in charge of the investigation ("O/C Investigation") reached a conclusion that the death was the result of an accident, the deceased having fallen onto glass which caused the neck wound. That conclusion was reported to the family and the media.

It is the conduct and manner of that initial investigation that is the sole focus of this report. A few days later, as a result partly of concerns then expressed by members of the deceased's family, the Police investigation was reopened under the supervision and direction of a different officer.

No complaint has been made about the adequacy or any other aspect of that investigation. It is accepted that it was carried out in a professional manner. At the conclusion of that investigation the file was submitted to the Crown Solicitor who advised there was not sufficient evidence to justify homicide charges.

I record also that it is not the task of this Authority to revisit the cause of death. That was the task of the Coroner.

THE INQUIRY BY DETECTIVE SUPERINTENDENT MILLAR

Detective Superintendent J. Millar conducted the investigation into the complaints. He identified the complaints from both the written complaint made in June 1997 and matters raised during the course of his investigations. In a detailed report completed in November

1997 Superintendent Millar found that some of the complaints should be upheld, describing the deficiencies as errors of judgement.

ASSISTANT COMMISSIONER WILSON'S REVIEW

The findings of Superintendent Millar were considered by Assistant Commissioner C W Wilson following the inquest. In his report of 4 August 1998 he reached a similar conclusion that some of the complaints should be upheld. Assistant Commissioner Wilson concluded that there were some errors of judgement in the handling of the initial homicide inquiry and some management and communication deficiencies.

The Assistant Commissioner gave O/C Investigation the opportunity to comment on those findings and the findings of Superintendent Millar. The O/C Investigation took issue with some of Superintendent Millar's findings but acknowledged that there were some things he would do differently now, and with the benefit of hindsight could have done at the time. Further details of the response of O/C Investigation will be recorded later.

FINAL REVIEW BY POLICE NATIONAL HEADQUARTERS, INTERNAL AFFAIRS SECTION

The Internal Affairs Section at Police National Headquarters conducted a further review before submitting a report dated 1 September 1998 to the Authority. That report draws attention to two factors arising from the internal investigation. First, while most deficiencies exposed in the investigation are adequately covered in current training manuals and instructions, the Best Practice Manual Volume 3 for investigations is still in draft form. The practice issues noted by Superintendent Millar in his report had been referred by the Assistant Commissioner to the Training Development Section for inclusion in the Manual.

The second factor concerned issues of mitigation and recorded that O/C Investigation had not had the opportunity to attend an advanced training course in managing serious crime investigations, but he will be given that opportunity.

All the senior Police officers who had reviewed the internal investigation are satisfied there was no intent on the part of O/C Investigation to mislead or contrive an inappropriate result in this case.

The action to be taken in respect of the investigation is the prerogative of the Commissioner after the Authority completes this review. The Authority is advised that the Commissioner

proposes to counsel O/C Investigation regarding the deficiencies identified in this present investigation.

CONCLUSIONS OF POLICE COMPLAINTS AUTHORITY

The deficiencies or inadequacies that have been revealed in the complaint investigation and which this Authority now endorses are recorded below.

They are not listed in the order that they were made in the complaint and later identified in the investigation process, but rather in an order that is considered to be more appropriate for ease of reading and understanding.

1. Lack of background inquiries into parties involved

There was evidence from one witness (recorded earlier) that the deceased and Mr Cohen were arguing immediately before the fatal injury was sustained, although there was other evidence to suggest that at other stages of the evening the relationship between the two was happy. There was evidence that a chain worn by Mr Cohen was broken and was later in his pocket – which chain was never taken for forensic tests. O/C Investigation was aware on the first day of the inquiry that the relationship between Mr Cohen and the deceased had at times been turbulent. These factors should have persuaded O/C Investigation to undertake further background enquiries into the relationship. Family members were spoken to during the inquiry but there should have been a greater effort to establish a more in depth family history.

2. Manner of dealing with and interviewing Mr Cohen

Various concerns were expressed by the complainants about the manner in which Mr Cohen was dealt with and interviewed. The perception of the complainants was that Mr Cohen was treated as a witness rather than a suspect in a homicide inquiry; that he was released too early; that he was not arrested for a possible minor offence; that he was not blood tested sufficiently early; that he was allowed to change his clothes unsupervised; and that he was not interviewed by the use of video facilities.

The investigation revealed that uniform staff first attending the scene treated Mr Cohen as a potential suspect and that is further evidenced through the nature of successive interviews. In particular, the last interview on 2 January, during which O/C Investigation was present for at least part of the time, Mr Cohen appeared to be clearly questioned as a suspect.

Nevertheless having regard to the explanations that were being given by Mr Cohen when interviewed he should have been interviewed using video facilities. It is understandable that in the early stages, while endeavouring to clarify what had occurred before any formal

interviews were commenced, that video facilities were not used. But later they should have been if the Police were regarding Mr Cohen as a suspect in a homicide. Video facilities were available.

The Integrated Training Module (INV 142) issued after this incident suggested that a suspect in respect of an indictable offence should, if equipment was available, be interviewed by video. The Best Practice Manual issued subsequently makes such a practice mandatory. In fairness to O/C Investigation it is emphasised that both these documents were issued later in 1997.

As to Mr Cohen's release, the suggestion that he should have been arrested for a minor offence cannot be upheld as there was insufficient evidence that he had committed any such offence and his arrest would have been inappropriate. His release did lead to a chance meeting between him and members of the deceased's family at the flat of the deceased later in the day. That was a meeting that family members found embarrassing but Police cannot be criticised for the fact that Mr Cohen had by then been released.

He had not been allowed to change his clothes unsupervised. Following his initial interview at the Police Station he was taken home and his clothes were changed under the supervision of a Detective. A medical examination of Mr Cohen was arranged for 5.32am, during which blood tests were taken. This is a little over three hours after the Police became involved.

3. <u>The interview of immediate scene witnesses</u>

The witnesses who were still at the party at the time of the incident were interviewed immediately after the incident by general duties staff. It would have been preferable for such initial interviews to be followed up by qualified investigators. Furthermore, only those remaining at the scene at the time of the incident were seen. Again it would have been preferable for a wider range of those who had attended the function earlier, friends and work colleagues to be spoken to by experienced investigators.

O/C Investigation expressed his view that the interviews were conducted competently and were sufficient for the investigation purposes. To extend the interviews to all those who attended the function and even wider was not considered necessary. He pointed out that the second inquiry team discovered nothing further in this respect.

4. <u>Forensic testing</u>

The return of the deceased's clothing to her family within nine days led to a perception by the complainants that inadequate forensic examinations and blood testing was carried out during

the original inquiry. Significant forensic examinations were conducted but the results were unknown on 2 January 1997 when O/C Investigation decided that the matter was an accident and advised the deceased's family and the media accordingly.

It would have been more prudent to await the result of forensic examinations, the blood/alcohol tests, fracture tests on the glass, and blood grouping before a final decision was made as to whether this was an accident or a homicide.

5. Conference Reports

O/C Investigation did not record or keep notes of conferences attended by members of the investigation team. It is accepted practice that conference notes for any serious crime investigation be kept. They provide a permanent record, if only as personal notes compiled by the officer in charge of an investigation. They are a crucial record of matters discussed, submissions of individual investigative team members, a record of instructions given/tasks allocated, and the identity of those attending each conference. Although O/C Investigation was of the view that this was not a complicated inquiry with extended inquiries being required, submissions and concerns such as those advanced by one officer at the conferences should have been recorded. The lack of conference notes makes it difficult to clearly establish what happened and what was discussed at these conferences. The fact that conference notes were not kept was a deficiency.

6. Conclusion of investigation

O/C Investigation reached a conclusion as to accidental death very quickly. He published that conclusion late on the day after the incident, namely 2 January 1997. He was due to go on holiday on 3 January and did so. It is perhaps not surprising that the family of the deceased expressed concerns about what, on the face of it, was a hasty conclusion to the investigation.

Once O/C Investigation decided that the deceased had incurred her injuries as a result of an accident, he instructed a Detective Constable verbally to prepare the matter for a Coroner's hearing. He briefed the District Commander verbally and commenced annual leave. He had discussed some issues with the Acting District Commander during 2 January 1997. Nevertheless, he was responsible for the overall investigation, had the best knowledge of the facts and it was his responsibility to recommend the most appropriate course of action to the District Commander.

In view of all the information available to O/C Investigation, including the possibility of disharmony in the past between Cohen and the deceased, the evidence of one witness that

suggested an argument between the pair just before the incident, and the broken neck chain, O/C Investigation should have:

(a) prepared a written analysis of the file with a summary of his conclusions in support of his decision and submitted this to the District Commander;

(b) prepared written instructions for the Detective Constable concerning the Coroner's aspect, including follow-up action, which would include collection and collation of ESR results and written reports from the pathologist;

(c) Alternatively prepared written advice to his second in command to ensure these aspects were attended to.

Furthermore, the conclusion was reached before any forensic test results were known and without other interviews referred to earlier in this report being conducted.

In all the circumstances the early conclusion of accidental death was probably premature and clearly risky.

In fairness it must be acknowledged that the thorough second investigation was not able to reach a different conclusion. Throughout the first investigation Mr Cohen had never acknowledged responsibility for the death of the deceased.

Although O/C Investigation did commence leave on 3 January he told Superintendent Millar that if it had been required he would have stayed at work and cancelled all or part of his leave, an explanation that was accepted by Superintendent Millar.

7. Liaison with members of deceased's family

Concerns were expressed about the fragmented nature of the liaison with the deceased's family during the short initial investigation. The role appears to have been shared by the Detectives respectively appointed Officer in Charge of Body and Officer in Charge of Suspect. Liaison with the family of a deceased is vital in any homicide inquiry, not only for the purposes of obtaining an in-depth knowledge and understanding of the deceased in order to support and supplement overall investigative outcomes, but also to provide the appropriate victim support in such situations.

The impression of the original investigation team, held by the family of the deceased, is not good. It is likely that this arose partly through the failure to commit one member to the task of maintaining an effective liaison with the family.

O/C Investigation believes the O/C Body should have been aware of his allocated responsibility which included family liaison but O/C Investigation must accept responsibility for deficiencies that did occur.

Closer liaison may, for example, have avoided concern expressed by the complainants about an inaccurate media report that the deceased had died of a heart attack.

It is also unfortunate that when, on 2 January 1997, O/C Investigation came to report the accidental death conclusion to the family he did so by telephone rather than in person. Having reached his conclusion, O/C Investigation says he rang the deceased's father and indicated he wished to see him in person. Mr Marner, however insisted on being told immediately and he was so told. The deceased's sister complained of a comment made by O/C Investigation when he later advised her by telephone of the accidental death finding, a comment which O/C Investigation says he did not make. It is quite apparent however that the manner in which he advised the deceased's sister of the finding left her feeling aggrieved.

In all the circumstances it would have been more appropriate for O/C Investigation to have seen the family personally, not only because of the seriousness, significance and sensitivity of the matter, but to ensure that misunderstandings did not occur.

Other aspects of complaint investigation

There were other complaints or concerns that were addressed in the present investigation that have not been upheld.

They include the following:

1. It was suggested that the first Police on the scene did not control or guard the scene adequately and that this resulted in:

    (a) remaining witnesses being able to speak and mingle with Mr Cohen and perhaps after being influenced, alter initial statements of what they had seen; and

    (b) Mr Cohen being able to re-enter the scene and destroy the scene by upturning a table and smashing a glass and trampling through blood left at the scene.

Enquiries have established that uniform staff arrived at the scene within minutes of having been notified by Ambulance Control. Ambulance staff arrived at the scene at 2.14am and advised Police Control at 2.19am that the incident was serious. An acting Sergeant and a Police recruit are recorded as having arrived at the scene at 2.20am. While this is a mistake arising probably through the lack of synchronisation of individual Police watches, these two Police personnel did respond immediately from Upper Hutt and probably arrived approximately five minutes after being advised. Another Constable arrived moments earlier, having responded from mobile patrol at Trentham. It has been established that witnesses were moved from the immediate scene area and kept separate as far as possible as soon as Police arrived. Mr Cohen was treated as a suspect and was kept separate from other persons present. Precise instructions were issued by the acting Sergeant as to how Mr Cohen and the witnesses were to be treated.

The Authority is satisfied that the first Police attending the scene did an excellent job of control and supervision of the scene and those present.

It appears that Mr Cohen had upturned the table and disturbed the scene while Ambulance officers were endeavouring to resuscitate the deceased prior to Police arrival. Mr Cohen, however, did not re-enter the scene after the Police arrived. One Police officer did enter the scene to verify the circumstances and endeavour to locate the glass concerned but on seeing the complexity of the scene he immediately withdrew.

The Authority is satisfied that the Police did not allow Mr Cohen to re-enter the scene.

2. A female officer assigned to stay in the company of Mr Cohen at the Police Station after the incident occasionally comforted him by giving him a hug. A complaint was made about this apparent lack of professionalism and the possibility of contamination of subsequent forensic examinations. The officer did not know Mr Cohen. While her actions were unwise it was not found to be a significant issue. That officer has since left the Police service.

3. There was also a complaint that no Police Sergeant attended the incident sufficiently early. The inquiry revealed that an Acting Sergeant arrived at the scene within minutes of being advised of the incident. She was supported at the scene by another

Sergeant who arrived at 3.13am. The scene was also attended at an early stage by a supervising commissioned officer.

4. Although Police were aware about 3am that the deceased's sister was a serving Police member she was not advised of the death until about three hours later.

This inquiry disclosed that the current address of the deceased's sister was not held on Police records although her home phone number was known. Two Inspectors felt it inappropriate to advise her of the death by telephone and endeavoured unsuccessfully through Telecom to ascertain her home address. It was later ascertained that the deceased's sister was or had been attending a party and an Inspector travelled to the location of that party. He ascertained that the deceased's sister had left but was also able to ascertain her home address and he returned to Wellington and advised her at 6.05am.

Given the amount of activity that was occurring at the scene, the process of calling out an investigative team, transporting witnesses and arranging interviews, the time of day, the fact that it was early hours of New Year's Day together with the difficulties experienced in ascertaining the home address of the deceased's sister, the delay was most unfortunate but understandable.

5. The complainants expressed concern that Mr Marner received the phone call in which O/C Investigation advised him of the accidental death finding on 2 January before the conduct of the final interview of Mr Cohen.

Earlier in the afternoon the officer who conducted the investigation had received a telephone call from Mr Cohen indicating that it was possible that glass had been in the deceased's neck as she fell and he had not seen it until he lifted her.

The final interview for which O/C Investigation had been present for part of the time was commenced at 5.27pm. The Detective conducting the interview believes that the interview lasted 40-50 minutes (concluding therefore about 6.10 – 6.20pm) but his job sheet suggests the conclusion at 6.45pm. The deceased's father was of the view that he received the call from O/C Investigation between 4pm and 4.30pm. O/C Investigation and the Detective conducting the final interview are firmly of the view that the call to Mr Marner was after the last interview of Mr Cohen.

A search of Telecom records has revealed that the call to Mr Marner was made at 6.32pm and lasted 2 minutes 34 seconds. Shortly thereafter at 6.41pm the deceased's sister called O/C Investigation and spoke to him about the conclusion that had been reached.

CONCLUSION

As mentioned earlier in this report, I am satisfied that the complaints about the scope and competence of the initial homicide inquiry by Police have been adequately investigated. I accept that the decision made on 2 January 1997 to treat the case as one of accidental death was probably premature in the circumstances, and undoubtedly risky, but following the full re-investigation of the case the result of the initial inquiry was not altered. Nothing emerged in the evidence adduced before the Coroner at the inquest, or in the Coroner's findings, to establish a case of culpable homicide.

It is also recognised that much of the initial work at the scene and the obtaining of advice from the pathologist was promptly and competently carried out given that the incident occurred in the early hours of New Year's Day 1997. I find that the deficiencies in the initial handling of the homicide inquiry disclosed in this complaint investigation were remedied by the full re-investigation of the homicide which Police conducted. There it was concluded that there was insufficient evidence to charge any person with any criminal offence. That conclusion was reinforced by independent legal advice obtained from a Crown Solicitor.

With the benefit of hindsight it can often be possible to suggest ways in which the conduct and management of initial inquiries into a homicide can be improved. It is recognised that the investigation of potential homicides is stressful for the officers involved, particularly when required at times when Police resources and available staff are limited.

Nevertheless the most substantial stress is of course endured by family members and close associates of the deceased.

The aim of the Police must always be to conduct an investigation and liaise with the deceased's family in a thorough, careful and sensitive way that, as far as possible, ensures that the stress being suffered by the family and those closely associated with the deceased is not exacerbated.

Judge N C Jaine
POLICE COMPLAINTS AUTHORITY
13 November 1998