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Report of Enquiry Established by Assistant Commissioner Brion Duncan, Region 1 Commander of the New Zealand Police, into the Janine Alison Law Homicide - 26 April 1988 - Conducted by Assistant Commissioner Ian N. Holyoake and Reviewed by the Police Complaints Authority

Introduction

On 26 April 1988 Janine Alison Law had not attended at her workplace, which alarmed her colleagues, who communicated with Police. Constable Ross Craig Leadley (left Police in February 1995) was directed to attend Janine's residence at 64 Crummer Road, Grey Lynn, Auckland. Several of the Police officers who played their parts have since left the Police service or retired. Throughout this report I will use the rank they possessed at the appropriate time. Constable Leadley arrived about 1015hrs and after speaking with Janine's concerned colleagues he broke into the house, as no one could be roused, and entered Janine's bedroom to find her spreadeagled on her bed and lifeless. More details of the events of that day are set out later in this report.

An investigation team was established under the control of Detective Inspector Noel Arthur Plumer of the Criminal Investigation Branch, Auckland, who retired from Police service in October 1989.

D/I Plumer and other Police officers commenced their investigation which continued in the following months. In his evidence at the first Coroner's Inquest conducted by the Auckland Coroner, Mr Stephen Osborne, on 16 November 1988 D/I Plumer said in his deposition:

> *"On a preliminary inspection of the scene and the body with other senior Police officers, and from initial enquiries it seemed likely that the deceased had died from an asthma attack."*

That view dominated the Police enquiry from discovery of the body on 26 April down to the date of the Inquest on 16 November 1988. D/I Plumer's deposition at the Inquest concluded as follows:

> *"Although from a Police perspective one must conclude that Police enquiries have failed to fully establish the full circumstances surrounding the deceased's death, a stage has been reached that unless fresh information is received, further active Police enquiries will not be continued."*

The Coroner, Mr Stephen Osborne, at the Inquest found:

> *"... that the deceased died at her home on or about 26 April 1988 from a probable attack of acute bronchial asthma."*

It is appropriate to state here that the parents of Janine and the family had formed a settled view within three to four days of the death that Janine had been raped and murdered. Their views, I am satisfied, were consistently conveyed to the Police investigation team throughout 1988 by themselves personally, and by their lawyer Ms Sandi Anderson in writing before and after the Inquest of November 1988. This will be further explored in this report.

The action of the investigation team under D/I Plumer, reinforced by the Coroner's finding, was confirmed by the then Region Commander, Assistant Commissioner Brian Davies (since retired from the Police), in a letter dated 27 January 1989. That letter was effectively a response to a very detailed four page letter dated 21 December 1988 written by Ms Anderson following the Inquest on the instructions of the Law family analysing the available evidence and disputing the Police case and Coroner's finding. Later events proved that letter of Ms Anderson in all material aspects to be a remarkably accurate assessment of the total circumstances, and must be a lesson to Police officers in future about the wisdom of keeping an open mind, and being positively willing to accept their preliminary view as to causation of death might be wrong, as it most certainly was in this instance.

In circumstances that will be outlined hereafter the present Region Commander, Assistant Commissioner Brion Duncan, in May 1994 ordered that the death of Janine be re-opened as a straight homicide enquiry and Detective Inspector S J Rutherford headed the second investigation team. The result was that on 26 September 1994 James Tamata was charged with Janine's murder, among other offences. Before his trial which commenced on 3 July 1995 he pleaded guilty to burglary, rape and sodomy, but not to murder. On the second day of trial on 4 July 1995 he changed his plea to the murder charge to guilty, and on 14 July 1995 he was sentenced to life imprisonment for murder and cumulative sentences of 14 years for rape, 10 years for sodomy, and 5 years for burglary, with the latter to be served concurrently with the 24 year sentence.

In the intervening years between the Coroner's finding of 16 November 1988 and the commencement in June 1994 of a further homicide investigation it is fair to say that dissatisfaction as to the official Police disposal of the case by concluding an innocent death, confirmed by the Coroner's finding, grumbled away within the Police service in Auckland in a very significant way, as will be outlined. It would be unfair to individual members of the Police service in Auckland to speak of the Police because within the service there was significant discontent about the first result, and it was the determined efforts of two Auckland officers, Constable Glen Dixon (serving member of Police) and Detective Senior Sergeant Brian Kemp (retired 1993) which effectively caused in the upper echelon of officers in Auckland the re-evaluation of the first investigation. Full details of the events leading to the re-evaluation are set out hereafter.

Steps in the Police Rethink of Original Investigation

A clear enough watershed for the official view of Police was reached by the reply of Assistant Commissioner Davies dated 27 January 1989 to Ms Anderson's letter of strong dissatisfaction of 21 December 1988 written on behalf of the Law family. As far as the Auckland Police were concerned they rested at that stage on the conclusion of D/I Plumer's investigation advanced and accepted by the Coroner at the Inquest on 16 November 1988.

However the undeniable fact is that several of the junior members of the CIB who were either in D/I Plumer's investigating team (eg. Constables Dixon and Ruth, Detectives Caldwell, O'Donovan and Steward) or had had a lesser involvement, such as Constable Leadley, were

not satisfied with the disposal of the case as a probable asthma death. In the course of this reappraisal of the total case there have been questions asked as to the strength of the disbelief and how and to whom it was made by these officers, and this aspect is referred to later in this report. My finding is that they (and perhaps others) did conscientiously hold a contrary view to the Police case presented at the Inquest. However there can be no doubt Constable Dixon took very positive steps to act upon his lack of conviction over the disposal, and it is to that I now turn.

The first material step towards a reconsideration of the Janine Law case was taken by Constable Dixon. Constable Dixon had a conviction in his own mind that the result encapsulated by the Coroner's verdict was wrong and that Janine had met her death by homicide in circumstances of violence. It is worth mentioning Constable Dixon was O/C Body and made notes during the post mortem which he attended. Inspector Manning in a report, later to be mentioned, commented on the quality of the job sheets submitted as exemplary. It does not exaggerate his personal feelings to say that throughout 1989 his reflections on the result caused him significant personal trouble and he settled on a method of voicing that concern by taking the professional route of preparing a presentation by way of case study to a trainee detectives' course at the Police College at Porirua which he was attending in June 1990. I think it properly conveys Constable Dixon's attitude at this point that he possessed this firm belief in homicide but being relatively junior in the service it was not at the level of dogmatic certainty. Constable Dixon made that case study presentation to a group of trainee detectives and for the sake of the record I am informed it was agreed on the basis of his presentation, and from the distance of the classroom, it was probably a homicide. I have examined a copy of the case study and it was a fair and impartial presentation of the facts of the case. Furthermore those who opposed this view, and then later the re-opening of the investigation, must concede that Constable Dixon's analysis in 1990 was a remarkably accurate one. Another point is that the analysis and presentation did not rely on the discovery of any material new evidence but used only that evidence that had been available at the time of the Coroner's finding.

If Constable Dixon can rightfully be given the credit for taking the first substantial step in the Police re-thinking with his presentation at the Police College in 1990, then he also deserves credit for taking his doubts and uncertainties to the right man in the Auckland Police,

Detective Senior Sergeant Kemp who retired from the Police service in 1993. Once D/S/S Kemp had convinced himself, in the way I will describe, an error had occurred in the first investigation, he showed determination, and not a little courage, in helping to overturn the decision and the recommencement of the search for Janine Law's murderer.

D/S/S Kemp joined the Police service in 1961 and was full-time employed for 32 years of which 27 were spent in the CIB. He had a particular interest in homicide enquiries and had considerable knowledge and experience in this field of criminal detection.

D/S/S Kemp had no involvement in the first investigation and his recollection is that his first direct contact with the Janine Law enquiry was when his opinion, during the initial stages of the investigation, was sought concerning the possibility of her dying of an asthma attack. He was not surprised he was approached because he was known among his colleagues as an asthmatic. His recollection at interview with me and confirmed by a later interview is that he was approached by D/I Plumer who presented him in writing with six scenarios and that every conclusion or proposition put to him about the effects of asthma in the Janine Law enquiry was wrong. When he reviewed the files later he was dismayed to find his written report was missing and I have been unable to obtain any explanation for this. D/I Plumer when interviewed for this enquiry denies he ever put in writing such questions to D/S/S Kemp or asked him for his opinion. There is a conflict between the two which I cannot resolve, and therefore take the matter no further.

It is convenient here to make a general observation. I am reviewing events that occurred over 7 1/2 years ago and which in 1988 and in the following years generated large Police files. Not infrequently it has been discovered some documents are now missing from the files. I have no evidence at all of any deliberate removal or destruction of these documents, but neither have I any explanation. Likewise the investigation and review of 1995 have thrown up some facts and events which are not capable of entirely satisfactory explanation. Some of these facts and events encompass conflicts between witnesses' accounts. It is my view that overall the missing documents, unexplained items and conflicts have not materially affected the conclusions I have reached. Furthermore I state explicitly that I have no reason at all to doubt the credibility of any Police officer, past or present, who has been questioned in regard

to this enquiry. All have, I am entirely satisfied, honestly assisted the enquiry to the best of their abilities.

D/S/S Kemp's next involvement was an approach from Constable Glen Dixon conveying to him his continued dissatisfaction with the first result, and a request that D/S/S Kemp read his presentation made at Porirua College and comment upon it. This was early 1991. D/S/S Kemp read the presentation, became interested and called for the full files on the Janine Law enquiry and several Eastlight folders were delivered to his office. At interview D/S/S Kemp emphasised to me that Superintendent Brian Rowe as head of Auckland CIB and Detective Chief Inspector Jenkinson (now retired) were his superiors and he found himself in sharp disagreement with their endorsement of the result of the first investigation which will be described.

Having his interest engaged in the manner I have described that remained until the end of his career in the Police in October 1993. No useful purpose is achieved in recounting all steps D/S/S Kemp took after his serious entry into the case in 1991 but some should be mentioned. Constable Dixon considered he had a suspect and sought D/S/S Kemp's help to obtain a DNA testing which at that time had to be done in England, at not inconsiderable cost. By this time apparently the activities of D/S/S Kemp on the Janine Law file were known to his superiors and he said they took an unfavourable view. The DNA test was done and excluded the suspect.

It seems that in the middle months of 1991 D/S/S Kemp was quite active in his pursuit of re-examination of the file. He took the trouble to reduce to writing a report dated 1 August 1991 addressed to Detective Chief Inspector Jenkinson of the Central District CIB. In effect he said the conclusions of the first investigation were wrong. I have examined a copy of this report. D/S/S Kemp is unable to claim he sent the draft report to DCI Jenkinson for him to read but he says it was attached to the file even though it was only in draft. He wanted there to be some record on the file of a contrary view to the asthma theory. D/S/S Kemp also approached Dr Glen Richards, Respiratory Physician, Department of Respiratory Medicine at Greenlane National Women's Hospital for an opinion. Dr Richards was against the conclusion reached by the first investigating team that Janine Law's death was caused by her asthma. His report was dated 27 August 1991.

In 1992 D/S/S Kemp's position changed by his deep involvement with the Kiwi Mussel case in Nelson. He was working in conjunction with Superintendent Les McCarthy. In that year he spent about 30 weeks in Nelson. However his association with Superintendent McCarthy did have a beneficial effect in this instant case. Because Superintendent McCarthy was by this time stationed in Wellington at National Headquarters D/S/S Kemp raised with him the Janine Law enquiry and the results of his re-examination. He showed him his report of 1 August 1991 and his memorandum of 8 November 1991 (yet to be mentioned). D/S/S Kemp said he received support for his viewpoint from Superintendent McCarthy and as will be observed from Assistant Commissioner Duncan's letter of instruction to Assistant Commissioner Holyoake to carry out an investigation reproduced hereafter, this influenced A/C Duncan.

Official Action in 1993/94 at Regional Headquarters in Auckland

The combined effect of the Dixon/Kemp actions through 1990/93, which might have had elements of informality, but were never improper in any way, began to achieve results. It must not be overlooked that throughout the Law family never lost faith in their own belief their daughter was raped and murdered, and continued to do what they could to re-activate the investigation.

Some boundaries in regard to size of this report must be imposed and I now mention only the essential steps. Also prolonged examination of the detail adds little because the result was successful and well publicised.

Assistant Commissioner Brion Duncan, Region Commander, sent a memorandum to the District Commander: Auckland City District, Superintendent N W Stanhope, dated 22 September 1993 of which the first two paragraphs contain the essence of the instruction and are reproduced:

"22 September 1993

The District Commander
AUCKLAND CITY DISTRICT

LAW SUSPICIOUS DEATH INVESTIGATION - 1988

1. *Please refer to the attached papers. They relate to the death in 1988 of a young Auckland woman who was found dead in her bed in unusual circumstances. I am advised that the matter was initially regarded as suspicious but it was finally resolved that she had died from asphyxia resulting from an asthma attack.*

2. *Detective Senior Sergeant Kemp has confided to Superintendent McCarthy that during the past few years he has been troubled over the way the case was handled and believes that the woman was murdered. He contends that the circumstances are not at all consistent with death due to an asthmatic condition and points out that the position of the body, a rag in the deceased's mouth, bruises on her body, blood on her hands and the bed linen indicate foul play rather than natural causes."*

On 4 October 1993 A/C Duncan instructed Superintendent Hartley of the Manukau District to review the action that was taken to determine if the case had been properly handled. He was further instructed to identify aspects that did not receive due attention, and to indicate how the Police might recover - even at that late stage - and to let A/C Duncan know if he believed any member had been remiss in his/her duty.

Preliminary investigations were undertaken by Detective Inspector Manning and D/S/S S R Upton of Manukau District who identified four areas capable of further exploration. On 16 December 1993 Superintendent Hartley sent to A/C Duncan a report recommending the investigations undertaken thus far indicated further investigation was required. In particular it was thought desirable further expert evidence be obtained on the asthma theory of death and a review of the pathological findings of the first investigation. The opinions of Dr Richard Beasley and Dr Ken Thomson, asthma and pathology experts respectively, were obtained and both were quite strongly opposed to the first investigation conclusions and the Coroner's verdict of 16 November 1988. An opinion was obtained from Dr Martin Sage, a forensic pathologist who also reached the same conclusions.

On 30 March 1994 Detective Inspector Manning sent a comprehensive report to his District Commander, Superintendent Hartley, summarising the re-investigation since September 1993 and recommended that Janine Law's death be further investigated. Superintendent Hartley in a memorandum dated 5 April 1994 addressed to the Region Commander asked it be accepted on the totality of the evidence Janine Law was murdered and that the investigation be reopened.

Result of Second Investigation Under Detective Inspector Rutherford

In June 1994 Detective Superintendent Peter L. Ward was Officer Commanding Auckland City District CIB. In a memorandum dated 2 June 1994 addressed to Detective Inspector Stephen J. Rutherford he was appointed to investigate the death of Janine Alison Law on the assumption that her death was homicide. D/I Rutherford was to have access to the members who previously investigated for their assistance.

D/I Rutherford assembled his team and went to work. A puzzling but unidentified fingerprint was quickly identified as that of a previous owner of the property which closed out that line of enquiry. As the enquiry now was exclusively focussed on homicide the person who had had sexual intercourse with Janine was the target of identification as the offender. It was on that aspect the re-investigation concentrated as any consensual aspect of the sexual relationship was excluded on the total analysis of the fact pattern. It is unnecessary to detail the steps taken by the team between June and September 1994 with the arrest of James Tamata on 26 September but a few remarks must be made. The team recommenced by going back to the basics of criminal detection and in the circumstances thrown up by those facts a painstaking series of searches began of which the area canvass and compilation of a suspect list were given priority. It was discovered that on the night of the murder Tamata had been living at a property very close to Janine's residence. It is fair to the original team to state that residents of this property were interviewed at the time in 1988 and did not disclose the occasional presence there of Tamata and that he was there on the night of 25/26 April 1988. He apparently had been sleeping intermittently there in an outbuilding on the property. Having established Tamata had been in the area that night, coupled with other material, attention turned to Tamata. Tamata gave a blood sample to a member of the enquiry team on 8 July 1994. The result of testing identified Tamata as the person who had had sexual intercourse with Janine on 25 April 1988. On Monday 26 September 1994 Tamata was interviewed by staff from the enquiry team and confessed to burglary, rape, sodomy and killing of Janine Law. He appeared on the above charges on 30 September 1994. Early in this report I recounted the final result.

I finish this section by stating that the Law family were advised at a very early stage of the re-investigation by Detective Superintendent Peter Ward and Detective Inspector Stephen Rutherford travelling to their home in Whakatane to tell them of this development. Mr &

Mrs Law expressed to me their satisfaction at the way they were treated in the second investigation from the beginning and their gratification with the result.

Actions of Auckland Region Commander following Arrest of James Tamata on a Charge of Murder

The death of Janine Law and the result of the second investigation bringing about an arrest and charge of murder in September 1994, more than six years after her death, was in the public arena and quite properly was a subject of debate as to how the first investigation reached its conclusion, coupled with the Coroner's verdict of 16 November 1988.

Following the arrest of James Tamata A/C Brion Duncan, of his own volition, in October 1994 had taken action to carry out a Police review of their conduct throughout. It must be remembered as at October 1994 Tamata had pleaded not guilty to all charges and A/C Duncan was careful not to make any public statement as to his response to the arrest so as not to jeopardise Tamata's trial. However he did take a positive step in advance to meet the public's desire for a complete investigation and that independence be seen by inclusion of the Police Complaints Authority.

The document that started the Police enquiry is dated 9 October 1994 and is reproduced. It was addressed to Assistant Commissioner Ian N. Holyoake, Region Commander of Region 6 in the lower part of the South Island.

"9 October 1994

JANINE ALISON LAW - SUSPICIOUS DEATH AT AUCKLAND ON 25/26 APRIL 1988 - CHARGE OF MURDER LAID IN 1994

1. *As discussed, herewith find papers relevant to the above case. The main file is held by Detective Inspector RUTHERFORD, Auckland City District CIB.*

2. *I should be grateful if you would examine the manner in which the original investigation was conducted and let me know if you believe there is a case for action against any member(s) or a need to revise any aspect of our investigative procedures.*

3. *The Police Complaints Authority has been notified of the general circumstances of the enquiries (through Superintendent McCARTHY) and may wish to be informed of how you intend to conduct your review. The Assistant Commissioner: Crime and Operations is also aware of your proposed involvement and likewise has an interest in the outcome.*

4. *Please keep me advised of progress and do not hesitate to contact me over any aspect in which I may be able to assist. If you should wish to personally speak with members in Auckland, their district commanders will be pleased to make them available at your convenience.*

B P DUNCAN
Assistant Commissioner of Police"

Before Tamata was sentenced on 14 July 1995 but after his plea of guilty to all charges A/C Duncan made a media release on Friday 7 July 1995 of the details of A/C Holyoake's brief to enquire, and my involvement with that enquiry. My direct entry in the enquiry began following A/C Duncan's media release of 7 July 1995. A/C Holyoake had begun his investigations and interviews following his appointment in October 1994. It is proper to state that the bulk of the investigation had been carried out by A/C Holyoake by the time of my involvement, although I interviewed myself the Law family, Ms Sandi Anderson their solicitor, and D/S/S Brian Kemp. I have received a written report from A/C Holyoake dated 24 July 1995 summarising his investigation to that date and since then have conferred frequently with A/C Holyoake on most aspects of the enquiry. A further series of interviews and re-interviews were carried out by A/C Holyoake in October 1995.

It is appropriate that I refer to my own position on the jurisdiction of the Authority. The main events of this enquiry occurred in 1988 before the establishment of the Police Complaints Authority and therefore on one analysis I have no jurisdiction. Furthermore Mr & Mrs Law wrote to the Authority on 6 June 1993 expressing dissatisfaction with the first investigation and sought the Authority's assistance to have the decision reviewed. To have written that letter five years after the death of their daughter confirms the conviction and determination of the family to have a wrong corrected. The then Deputy Police Complaints Authority received that letter and replied pointing out that the events of which they complained took place before establishment of the Authority therefore there was no jurisdiction. The present enquiry into Police conduct included public allegations by D/S/S Kemp (a retired officer) of suppression by other officers of the re-investigation and this aspect is in the time of the Authority. This is referred to hereafter under a separate heading. My present involvement has been at the invitation of A/C Duncan and I decided to accept a role in the enquiry and publication of a report by me. My normal jurisdiction is complaint or

incident and this enquiry does not strictly fall into either category. It is also appropriate to mention Mr George Hawkins, Member of Parliament for Manurewa, lodged a complaint with my office on 3 August 1995 about the first Janine Law investigation. He detailed several areas which he said required investigation and all have been taken into account in my review. On 11 August 1995 in a letter I assured Mr Hawkins his particular concerns would be addressed.

1995 Enquiry and Review of First Investigation

The adequacy of the first investigation, which in terms of time took place from the discovery of the body of Janine Law on 26 April 1988 through to the Coroner's verdict on 16 November 1988, was the area on which A/C Holyoake concentrated in his investigation and on which this review has been focussed. As far as the public is concerned this is the most important issue and I agree. Many other issues have emerged and it is intended to cover them as appropriate.

It may help the assessment of this report if it be stated explicitly that the approach of A/C Holyoake and me, in the respective areas of our involvement, has not been to use the indisputable fact that Janine met her death through murder as the starting point, but instead to examine objectively and fairly the established fact pattern as it presented on 26 April 1988 and developed in the following months, and from that decide whether there were inadequacies and deficiencies in the first investigation. In short we have actively sought to avoid hindsight analysis as being unfair to the participants. Instead we have used a test which we think helps to determine in an impartial way whether the original investigation was adequate and efficient not whether its conclusion was correct, for it is established beyond doubt that it was not. We ask and answer this question: if a team of Police investigators of ordinary prudence and training had been in the same situation, possessed of the same knowledge, would they have reached the conclusion of innocent death? That in our view is the essence of this whole enquiry and review. Applying that test our joint answer is that the first investigation was inadequate and deficient. The reasons are set out hereafter.

Having stated the central point of this report I want to add some other observations that flow from that. This report is an examination of professional standards of Police work in the first investigation and all the material points surrounding the crime are already established as true

facts. There was a fact pattern at first thought to disclose an innocent death by natural causes which on deeper investigation has been found to be murder. Given that base only the main points of substance in the first investigation will be highlighted so that the purpose of this report, which is avowedly remedial, can take prominence. This report is not an exercise in distributive blame, although some downright statements must be made in this area, but is to assist in achieving the goal that the mistakes are not repeated. The central lessons to be learned can be learned without minute combing of every single mistake or misjudgment, because everyone knows without even a fanciful doubt that the original investigation was wrong, as was the Coroner's verdict.

Tuesday Morning 26 April 1988 - 64 Crummer Road, Grey Lynn

I believe because of differing comments that have been made in the media, and because the trial of Tamata was aborted by his unexpected change of plea to the murder charge on the morning of the second day which stopped the trial, the exact sequence of events which led to the discovery of the body of Janine Law be detailed. Furthermore the precise acts of several Police officers who attended the scene on the Tuesday morning be established.

Experience teaches that criminal investigations, along with most other investigations, are very much controlled for the future by what is discovered and inferences made at the very beginning. It is my view that the discovery in the house of three asthma ventilators and some comments from work colleagues Janine suffered from asthma exercised a disproportionate and generally baleful influence over the entire first investigation. To put this important issue another way, the controlling inference that remained throughout the investigation right to the Coroner's finding was that the death was caused by the medical condition of asthma. An inference is a deduction of fact that may logically and reasonably be drawn from another fact or group of facts established by evidence gathered at the scene and later. It is my view that the inference of asthma as a cause of death was not logically and reasonably drawn from the scene and later enquiries. Furthermore it seems, although at this distance cannot be proved with absolute certainty, an asthma related death was being seriously entertained on the first or second day of the first investigation. That first perception did not fade in the face of further enquiries but grew and against strong contrary evidence.

As stated earlier, Constable Leadley was directed to Janine's residence at 64 Crummer Road to make enquiries after two of her colleagues became concerned at her failure to appear at work. The following accounts are from evidence at the second Coroner's Inquest conducted by Mr Mate Frankovich, Deputy Coroner at Auckland, on 9 and 10 August 1995. Constable Leadley was alone in his Police vehicle and at the address was met by the concerned colleagues. The time of arrival would have been about 10.15am. No occupant of the home could be aroused and Constable Leadley effected entry by breaking a lounge window and he climbed inside. He went straight to the bedroom. Although it was dim he there observed the body of a young woman later identified as Janine Law. He checked for a carotid pulse to the neck and was unable to find one. She was clearly dead. He called for Police assistance. Within a very short time because they were in the vicinity Detectives Patrick Brian O'Donovan and Peter John Steward arrived. Both were CIB officers. All three officers went back to the bedroom where the deceased was lying on her bed. The important observations of Constable Leadley were as follows The covers were lifted and her legs were spread wide apart and she was naked from the waist down. She was lying almost face down with both arms underneath her and her pyjama top was tightly wrapped around her upper torso, seemingly restricting her arms. The pyjama top came to about the middle of her back and below that she was naked. Constable Leadley observed there was seminal fluid around the rectum/vaginal area. Constable Leadley then went to the head of the deceased and pulled her up onto her right shoulder by lifting her left shoulder so that the detectives could get a better view of her face. Constable Leadley said *"I noticed blood from one of her nostrils and that her face appeared to be heavily cyanosed. By that I mean the purple blotchy look of her skin due to lack of oxygenated blood."* It was noticed she had a cloth in her mouth, which on closer view was identified as a teatowel. *"The cloth seemed to be jammed down her throat."* It is uncertain exactly why but several folds of the teatowel came out of her mouth. Constable Leadley said *"I remember thinking that it was stuffed in her mouth down to her throat and that no more could have been physically pushed into her mouth."* Constable Leadley said *"I distinctly remember the tea towel coming out of the deceased's mouth in tight folds as we turned her and thinking that the tea towel had been jammed in her mouth and throat."*

The statements at the Inquest of Detectives O'Donovan and Steward do not give the detail that Constable Leadley gives as set out above. It is appropriate to mention here that both Detectives O'Donovan and Steward said they submitted job sheets on this visit but now there

is nothing on the investigation file to this effect. Constable Leadley under cross-examination wavered on who had moved the body and this was not fully explored. I think it was Constable Leadley. His job sheet dated 26 April 1988 said he had moved the body. However both Detectives say the body was not moved by either of them, or in their presence. They both noticed the cloth in the mouth. I accept their statements as correct, and particularly that neither moved the body. At this distance the conflict between them and Constable Leadley as to who was present when the body was moved is irreconcilable but I do not think it requires further attention. I am of the view that the body was moved as described by Constable Leadley and the other two Detectives took no part in that act. Also Constable Leadley's job sheets in April 1988 were not as complete as his deposition for the Inquest but he had recorded the teatowel was forced down the deceased's mouth.

I do not say that the extent of the intrusion of the teatowel inside the mouth by exact measurement is not important, but nevertheless I have the impression it is attracting more attention at this re-evaluation of the first enquiry than it deserves. I find the teatowel was discovered clearly inside the mouth first by Constable Leadley and then observed by the other two Detectives (possibly by them after some portion had fallen out by gravitation or movement of the body by Constable Leadley as described) in circumstances that the most obvious explanation was that a third person had performed the act of placing, forcing, or jamming the teatowel into her mouth (it cannot now be decided which is the more appropriate word to describe the situation) and possibly to the back and into the throat. In his deposition Detective O'Donovan described the cloth as *"... jammed right in her mouth and her cheeks were bulging from the amount of material that was in her mouth .... the top of the throat was bulging as well."* I think this is demonstrated by the photographs taken of the head and mouth that day. The essential point of teatowel inside mouth was known or should have been known to the senior investigators from day one of investigation. I reach this conclusion <u>not</u> using the unanimous view of the medical asthma experts that it is unlikely that an asthmatic in the throes of a severe attack would obtain relief by seeking to introduce a cloth obstruction to the airway of the mouth, but by the evidence of the Police officers and the photographs. That is the evidence that was available to D/I Plumer and his team and to all reviews of the evidence as the investigation progressed to Coroner's Inquest and the review carried out in January 1989, which I will reach in due course.

In making the finding as outlined above I have not overlooked the confession of Tamata that he said he only applied the teatowel to *"her mouth ... to try and stop the blood"*. Whilst he did make a full confession I find on the evidence presented at the scene to the first three Police officers there his statement on this aspect cannot be accepted. These statements contained in his confession of September 1994 were unknown to Police at April 1988 and my finding, as stated above, is on the totality of the evidence revealed by the scene.

It is appropriate to mention here that whilst the injuries observed at the discovery of the body were not of extreme violence, in my view they were extremely significant. There were material facial injuries and presence of blood and bruising on the body and blood on the fingers. There was blood on the pillow and blood and urine on pyjama pants.

Adequacy of Police Investigation: April - November 1988

I turn now to face directly the adequacy of the Police investigation from April to November 1988. I hope it is accepted this report is to achieve identification of areas where improvements could be made for the future by learning from the mistakes of the past. It is not to scapegoat an individual, or a team of individuals. However responsibility for mistakes must be identified and stated.

It should be stated that the scene at 64 Crummer Road on 26 April 1988 did present some problematic features. This was a crime perpetrated by a skilful criminal in a way that left confusing signals. Unfortunately rape and murder scenes usually leave little doubt as to what has occurred. A scene examination did not immediately reveal a point of entry. Nothing was disturbed in an exceptionally tidy and ordered household. No signs of disturbance of items in bedroom outside bed area. There undoubtedly were injuries and blood but perhaps not consistent with a very violent assault. The bed upon which the deceased was lying was not excessively disturbed. Asthma inhalers were present. Nothing was identified as missing from the house.

The later pathologist's report produced by Dr Warwick Smeeton following the post mortem on 26 April 1988 did equivocate somewhat in key areas. It did not come down solidly on the side of homicide, but in my view it definitely favoured homicide over natural cause death, such as asthma. Dr Smeeton in his evidence at the second Inquest in August 1995 conceded

his first written report should have been firmer in expressing an opinion in favour of homicide. I think there was a material misreading of the pathologist's report by D/I Plumer and others who reviewed the original disposal. I say more on Dr Smeeton's post mortem report hereafter.

Whether an investigation was adequate or not cannot be established in any mechanical or automatic way. It is essentially a judgment decision by looking at the totality of the circumstances. The test of ordinary prudence and knowledge outlined earlier in the report is used. It is certainly not possible to scrutinise at this distance in time (if it ever could be in any event) the thinking of the investigation team as it progressed through the investigations beginning with the discovery of the body to the Inquest of November 1988.

An assessment must be made. Whilst conceding that there were some confusing signals at the point of discovery of the body, I think the overriding accumulation of evidence at the scene and later should have decided the investigating team under D/I Plumer to follow a dedicated and determined investigation that it was homicide, and nothing else. When supplying evidence for this enquiry both D/I Plumer and Superintendent Rowe have stated it was a homicide enquiry from the beginning but if it was it lacked any sort of conviction or belief in that, and it quickly faded in favour of a natural cause death by asthma. In a reported dated 1 September 1988 (also dated 7 September 1988) D/I Plumer prepared a 22 page report addressed to Detective Superintendent Rowe which began with this:

> *"2.* <u>*INITIAL ACTION*</u>
>
> *On a preliminary inspection of the scene and the body with Detective Senior Sergeants JONES and HIGGINSON and from initial enquiries it seemed likely that the deceased had died from an asthma attack...."*

The said report ended with this Recommendation:

> *"10.* <u>*RECOMMENDATIONS*</u>
>
> *To finally suspend enquiries into what must still be classed as an unexplained death, some minor enquiries have yet to be completed. These include awaiting the result of the latest DNA examination of [suspect cleared] blood to be*

forwarded to CELLMARK on 10/9/88 by way of Mr Steve CORDINER, D.S.I.R. , Wellington who is travelling to Oxfordshire with other samples.

At the completion of these enquiries and subject to any other information being forthcoming I recommend that I finally consult with the Coroner and prepare the file for Inquest."

The file was in fact prepared for the Inquest which took place on 16 November 1988 with D/I Plumer in his deposition at the Inquest advanced this conclusion:

"It is my conclusion that the deceased has had intercourse voluntarily with someone she knows elsewhere than in her house or at least elsewhere than on the bed, that she had had some sort of attack causing her to fall and injure her face and to strike same on the wooden bed headboard, (the house has been shut up with the polyurethane paint fumes present), has obtained the tea towel from the kitchen to dab her injuries, has gone to bed after placing her pyjama pants and panties on the floor under the bed and has at that time succumbed from an asthma attack which has subsequently led to her death."

That was the finding of the Coroner. I must say that I have been unable to discover any evidence at all that would lend support to D/I Plumer's conclusion Janine Law "has had intercourse voluntarily with someone she knows elsewhere than in her house or at least elsewhere than on the bed ...." The objective evidence points to the exact opposite of all those speculative propositions.

In this review the central conclusion of the first investigation was the determination very early in the investigation (perhaps even on first or second day) right through to Inquest that the most feasible cause of death was asthma was a fundamental error. All other deficiencies or shortcomings in the investigation are subordinate to that point but were affected by it.

I have already observed a review such as this cannot scrutinise thinking but must look at circumstances. In the conclusion that it was an asthma related death there were several strands that contributed to that result, and each one, in my opinion, was weak. Admittedly at the scene there were ventilators but not recently used. Her friends said she was an asthmatic,

but that is a background fact not a causative fact. It was never doubted she was asthmatic. Her body was discovered with a teatowel inside the mouth, but that does not point to an asthma attack but strongly suggests other possibilities of which violence is the most obvious. There had been recent fresh painting in the house but that hardly rates as a likely precipitating cause of fatal asthma.

The investigating team took these insubstantial indicators discovered at the beginning of the enquiry and it seems tested the asthma death proposition in three ways:

(a) Dr Smeeton's report following post mortem.

(b) Statement from Margaret Miriam Hight, Education Officer of the Asthma Society and several others

(c) Dr Peter Swinburn, an expert on asthma

I deal with each of these sources which ended with the Police conclusion of asthma death.

(a) I reproduce the summarising Comment from Dr Smeeton's report:

"Comment

The lung changes found at post mortem examination support the evidence documented elsewhere that the deceased suffered from bronchial asthma.

It is possible that the deceased died as a result of acute bronchial asthma or that asthma was a factor in her death.

However, there are other features that require explanation before this cause of death could be accepted. These include the florid petechial haemorrhages, the injuries about the face, the towel in the mouth, and the findings from the swabs and smears.

In my opinion, in view of these circumstances the cause of death remains uncertain."

It is to be regretted, as previously stated, that Dr Smeeton did not state his views more positively rather than negatively but read by an experienced investigator in a critical and analytical way that does not in my view support an asthma death. The third paragraph heavily qualifies the possibility of the second paragraph and combined with the last paragraph leaves cause of death absolutely at large, at the very least. I repeat here my earlier observation the report definitely favoured homicide over natural causes. It should also be stated that in his evidence given at the second Inquest Dr

Smeeton said he had discussed his misgivings that the death was innocent with senior Police officers at the time. Furthermore the results of the swabs and smears supported unprotected sexual intercourse which takes the death further from asthma related and positively points to a sexual attack, and coupled with the other evidence in the report, to violence. In the 1995 enquiry original senior officers have referred repeatedly to Dr Smeeton's report as supporting an asthma death but that is not my interpretation.

(b) Mrs Margaret Hight was interviewed on 28 April 1988 largely on a hypothetical basis by a Police officer. Mrs Hight was interviewed by A/C Holyoake in October 1995. She stated she was concerned that at the interview on 28 April 1988 she had created a wrong impression with the Police, but was unsure what to do about it until the 1995 trial publicity when of her own volition she telephoned A/C Holyoake. I have read her statement and without going into detail the interview conducted in April 1988 with Mrs Hight was unsatisfactory because the discovered factual findings of two days previously had not been put to Mrs Hight. Her statement was basically about the types of asthma condition and that sometimes during an attack persons put things in the mouth. The short point is Mrs Hight is a social welfare/education officer of the Asthma Society possessing no professional qualifications in medicine. She undoubtedly has experience in the asthma condition and her statements should simply be accorded importance commensurate with her status and experience. She could not be regarded as possessing expert knowledge in this field. Likewise with Mr R S O'Connell, a staff training officer for St John's Ambulance. It should also be mentioned that D/I Plumer said that work colleagues of Janine were seen by other officers about her asthma condition. D/I Plumer himself did not see Janine's doctors but they were seen. There was an enquiry conducted through Auckland Hospital but no record could be found that she had ever been admitted. It is a fair inference no relevant information emerged from these sources.

(c) I turn now to the only expert interviewed by the investigating team.

On 29 April 1988 D/I Plumer himself interviewed Dr Peter Swinburn at his surgery, 41 Symonds Street, Auckland. Dr Swinburn is a Doctor of Medicine, a member of the Royal College of Physicians and a Fellow of the Royal Australasian College of Physicians. At the time he was President of the Auckland Asthma Society. Since

1957 he had been involved in the Chest Diseases Ward at Greenlane Hospital and has been in private practice since 1964. He said two thirds of his practice time is spent dealing with asthma complaints, both in and out of hospital.

Dr Swinburn was informed of the circumstances surrounding the death of Janine Law and he viewed the series of photographs showing the deceased in the position she was found. D/I Plumer said he informed Dr Swinburn that there seemed to be indications that the deceased had suffered an asthma attack leading up to her death and he was asked to comment as to his opinion regarding the actions of a person suffering such an attack. This proposition advanced by D/I Plumer three days after the discovery of her body was firmly rejected by Dr Swinburn and I reproduce replies as recorded by D/I Plumer which adequately and sufficiently demonstrate his central position without reproducing all other replies that simply re-enforced his view:

"He stated: *"From the way she is lying I think it highly unlikely that she has died as a result of an asthma attack. I think it very uncharacteristic. I would expect her to be more in a sitting position. Normally a person suffering from an asthma attack would sit on the bed or on a chair leaning forward on to a table."*

He said: *"I think it very unlikely that a person would place something in their mouth such as a teatowel on this occasion, unless she felt sick and was going to vomit."*

To other questions put Dr Swinburn dismissed fresh paint as a material influence and that she would be unlikely to thrash about so as to injure themselves in the course of an asthma attack. *"They usually sit very still and their main preoccupation is to get their breath"* he said. Furthermore he added *"From my experience most persons suffering from an asthma attack wouldn't put something in their mouth"*. Dr Swinburn also said *"... from what you say it would appear that her condition was a mild one."* All that information is recorded by D/I Plumer on a Job Sheet dated 4 May 1988.

As far as this enquiry has been able to discover the foregoing represents the available hard information and evidence upon which D/I Plumer advanced his conclusion at the Inquest. At

the Inquest D/I Plumer read in full the statement of Mrs Hight, his recorded comments of Dr Swinburn and the full statement of Mr O'Connell, the St John's Ambulance staff training officer. I am aware there was other anecdotal evidence of past asthma attacks but they were not important. First, isolated out from all other indicators which I will mention hereafter, that assemblage of information simply does not justify a conclusion of asthma related death. The only true expert consulted in this period was very firmly against such a conclusion. His evidence at that time was at best attenuated and perhaps at worst put to one side. It is to be noted Dr Swinburn's clearly stated opinion has been supported by all other asthma experts subsequently consulted so there can be no question as to the validity of the opinion given at the material time. In a letter dated 10 July 1995 to Assistant Commissioner Holyoake Dr Swinburn confirmed his original opinion that *"asthma was a very unlikely cause of Janine Law's death."*

If the foregoing conclusion is then put in the context of all other evidence available such as unprotected sexual intercourse leaving spread seminal deposits, towel in mouth, discovery of body in bizarre circumstances and position, very significant personal injuries especially about the face and further revealed by post mortem examination, generally fastidious lifestyle of deceased, free of even vague suggestions of promiscuity with quite strong indicators of a very moral lifestyle, then a conclusion of consensual sex and asthma related death cannot, in my opinion, be sustained then, or now, on any basis.

In reaching this conclusion I have adopted the test I have postulated and used only information and evidence available to the investigating team in this critical period.

I now cannot avoid returning here to several points already referred to in this report. Known to D/I Plumer and presumably other members of the investigating team and his superior officers who had overall control of the CIB was the firm conviction of the family and their lawyer recorded in writing in a letter dated 21 July 1988 that the death was caused by violence and not by an asthma attack. The letter of 21 July 1988 was not simply an assertion of death by violence but was supported by argument. The view of the Law family is dealt with under the next heading, for it deserves special attention.

Also there were within that investigation team at least three detectives, and possibly more, who held very serious doubts that it was an innocent death, but most likely a criminal homicide. That is an established fact from this enquiry and details have been given earlier in this report. Constable Dixon's fundamental doubts are established beyond all question and he was in the original team.

Finally something must be said about communications within the first team arising out of what the three Police officers first at Crummer Road, namely, Constable Leadley and Detectives O'Donovan and Steward, conveyed of what they found late morning 26 April 1988 and thereafter in the course of the first investigation. This 1995 enquiry seems to suggest that there is some feeling among the 1988 team leaders that information was not conveyed accurately or at all to them by officers. Furthermore there is thought to be differences between what was available to the team leaders in 1988 from what was said to Inspector Manning in his review begun after September 1993 towards the re-opening of the case in June 1994. There have been statements that the junior officers' contrary views were not strongly enough asserted by them or they had not accurately conveyed what they found on that first morning. Involved in this is an exact account of the towel in mouth which I have dealt with elsewhere. It is near impossible to establish at this distance in time the hard facts but enough has been revealed for me to say this. Seniority of service together with leadership must bear the main responsibility to ensure that all available information has been teased out. Furthermore the team leaders have a duty to ensure junior members are given the opportunity to have their views fully explored and aired, including their doubts. Junior members have a correlative duty to state unambiguously their views but in the final analysis responsibility rests with the leaders.

I finish this segment of my report by saying explicitly this unambiguous criticism of the first investigation does not blame the team for not arresting Tamata at the time, although the chances would have been increased if the investigation had not settled so early and so firmly on an innocent death, because the most efficiently conducted investigation can still fail to identify the criminal. The criticism is of the adequacy and efficiency of the investigation.

This 1995 enquiry as conducted by A/C Holyoake since October 1994 has covered a very wide range of individual subjects and areas in an investigation such as this. As might be

imagined an enquiry such as this following a successful conclusion in 1994 has identified other deficiencies and shortcomings that perhaps do not require exhaustive examination in this report, but still some must be mentioned.

Whilst I accept that a lengthy scene examination was conducted over several days following 26 April it did fail to identify a point of entry which it should have. The scene examination was in the hands of Detective Sergeant Cummins and I have read his report addressed to D/I Plumer dated 5 May 1988. He was concerned that so many people had entered the house on 26 April 1988 and thought this needed an explanation. He said in the scene search considerable time was spent on all exterior doors and windows to the house. The report said *"No sign of forced entry could be found, in fact a recent scuff mark found on one particular rear window was later attributed to Constable Leadley as he initially tried to gain entry"*. Constable Leadley denies he caused it by attempting to enter at that point. He said he never attempted an entry on the house by climbing which failed. He surveyed the windows visually, made some efforts by prising windows, and then decided on a break-in through a lounge window at the side of the house. Constable Leadley has no recollection of being asked by D/S Cummins about the scuff mark and can give no reason why D/S Cummins should have attributed the scuff mark to him. As stated below, this was the window through which Tamata gained entry.

Mr David Alexander Muir at the time was a Fingerprint Officer with the rank of sergeant and he attended Crummer Road on 26 April 1988 to carry out an examination for fingerprints. He was interviewed on 6 October 1994 and said on 26 April 1988 he found a small line of soil consistent with the width of a shoe against the upper leading edge or along the windowsill of a rear window. The rear window is a 4 panel window, with panels of equal size and the two bottom panels fixed with a panel above each one. The upper panel is hinged at the top and opened by pulling out. Tamata on video on 27 September 1994 said the upper panel he entered was open. There is a sill beneath the windows and Tamata demonstrated his manner of entry by putting his left foot on the sill. After Tamata's confession it is accepted this was the rear window into the bathroom/laundry area through which Tamata effected entry to the house. Fingerprint Officer Muir stated when he found this shoe scrapping he brought it to the attention of D/S Cummins who was in charge of the scene. It was Fingerprint Officer Muir's theory that the scrapings may have been left by a shoe as a

possible point of entry. He said D/S Cummins did not seem particularly interested. It is difficult to make definite findings on the scuff mark, but it is of some importance. It is clear D/S Cummins knew of the scuff mark within days of 26 April (in view of Mr Muir's evidence he may have known of it on the day) and it seems he may have wrongly concluded it had been caused by Constable Leadley thereby in his mind excluding it as a point of entry of a possible offender. The preponderance of available information, admittedly now some 7 1/2 years later, appears to be that D/S Cummins misinterpreted or paid insufficient attention to this important clue. The scuff mark is described in his report using unfocussed language when such an issue should have been conclusively and unambiguously disposed with. If this approach had been adopted the point of entry would have probably been known right then and there, and possibly changed the course of the enquiry.

There is another puzzling aspect to this case and it concerns the window mentioned above. The window which has been described was the one through which Tamata gained entry to the house. He said so in his statement and in the video interview conducted at the scene. Tamata said he was able to enter the house by simply pulling the right-hand window hinged at its top outwards and he climbed through. No force other than just mentioned was required and particularly nothing needed to be broken. In the video interview on 27 September 1994 Tamata was specifically asked whether after getting through the window did he leave it open or did he shut it. His reply was "*Left it open*". The issue was not pursued beyond that reply. In the interview with a Police officer the day before when he made his written statement he was not questioned on the point. Tamata said he exited the house through the front door which had a lock able to be used on the inside. I think the evidence of officers who attended the scene on 26 April 1988 that the house was secured and indeed Constable Leadley had to break in with a hammer through glass suggests strongly the rear bathroom/laundry window was closed. The point is if Tamata's statement is both true and accurate then the window was closed by another. The only other person who could on the evidence have been responsible was Janine Law herself after Tamata left the house. In my view this is only fanciful speculation and must immediately be excluded. Based on the condition of Janine Law's body when found a few hours later, the semen observed by all three Police officers strongly suggests she never moved after it was deposited, together now with the graphic description of what Tamata admits he did to her and her physical state as observed by him as he departed, this thesis of her as the person who closed the window and returned to the bed to die

presumably of an asthma attack is utterly untenable. The most readily acceptable reconciliation is that Tamata himself closed the window after climbing through (or later) and he has forgotten a relatively commonplace physical act when questioned six years five months after the event, or else he has not told the truth. I have earlier in this report rejected his statements about the teatowel. Furthermore it is not at all uncommon for a criminal in a statement confessing fully to a crime to get some peripheral details wrong inadvertently, or deliberately. I do not believe this apparent inconsistency would have troubled a jury in any way because commonsense tells us not every single fact, or set of facts, are capable of complete explanation, especially so many years after the event. There is one other in a similar vein. Tamata denied he had been wearing gloves that night yet after a thorough examination by Fingerprint Officer Muir his fingerprints were not discovered anywhere in the house or outside. Finally assessing all the evidence in the case I think little turns on who closed the window in view of Tamata's confession to murder.

The area canvass also failed to reveal that Tamata was at an address that night on a property very close to 64 Crummer Road. I do not overlook that some misleading information was supplied from the address at the area canvass but the questioning at this address should have been more insistent as to casual residents there on the actual night of 25 April 1988 of which Tamata was one. An audit of the area canvassed reveals that similar omissions were made at a number of addresses, ie. persons never seen even when they were known about. Furthermore I think there were deficiencies in the questionnaires used in the area canvass and I simply mention this to bring it to the attention of Police senior officers who no doubt will examine this report.

The area canvass and suspect list are two independent aspects of an enquiry but have an inter-relationship. The suspect list phase is a most important part of the overall investigation and there is no better way of illustrating its importance than to refer to D/I Rutherford's 1994 investigation which virtually began with a suspect list that within a little over one month was focussing strongly on Tamata.

A suspect list was prepared that largely concentrated on nine persons known to have had an acquaintanceship with the deceased. All co-operated and by DNA, fingerprint and explanation were excluded. It appears from the files that there was no determined

compilation of a suspect list outside acquaintances and based on known offenders which should have been running parallel with the acquaintance list investigated. The 1993/94 Police review was critical of this part of the original investigation and is referred to in the recommendations of this report.

An obvious point that in view of the publicity this whole case has received might be raised is the extent to which the conferences of the team canvassed alternative views to an asthma related death such as a violent sexual attack. All senior Police officers in the CIB state there was a full flow of ideas and alternative scenarios. I have above given my views on the responsibilities of the seniors and leaders of the CIB. However I must also add that the alternative views from within the investigating team, and from the family and their lawyer, simply had little influence. The views might have been there and examined but they did not receive the value they deserved. Further than that I cannot take this issue.

My overall conclusion is that the first team's investigation under D/I Plumer was materially inadequate and deficient. I must also add, for it follows, the Police case to the Coroner on 16 November 1988 was similarly flawed.

The First Investigation from the Law Family Perspective

I personally travelled to Whakatane on 29 August 1995 and interviewed Mr & Mrs Law and members of their family in their home. On 22 August 1995 I had interviewed in Auckland their lawyer who acted throughout for them, Ms Sandi Anderson. The accounts of lawyer and clients are able to be interwoven as there is no discrepancy or noticeable difference between them. I will not dwell upon the devastation experienced by the family at hearing of the death of Janine and the circumstances of it. Also there is unanimity within the family as to what happened following her death, and most times I will refer to their views as that of the family. They regard themselves as a close knit family and that was my impression. This has exact significance with the first investigation because all members knew intimately the lifestyle and habits of the others and if asked could have supplied highly relevant information to Police investigators about Janine's asthma, her sleeping habits, and especially how she was known to dress for sleep and positions adopted in sleep; but most importantly her known interpersonal relationships with males. Some of this information in fact was supplied as set out hereafter. Janine may not have permanently resided with her parents for the previous 14

years but that is of little significance. There was, it seemed to me, a constant closeness among all members of the family and where Janine was actually living did not matter in the relationships.

The family said they were dissatisfied with the late notification on the first day and concede the events of that day may have got them off on the wrong foot with the Police officer in charge of the investigation. Understandable, and underlines the overriding importance of establishment of as cordial relationships as the circumstances allow at the very first exchange between Police investigators and a victim's family in these circumstances. From here on in the interests of brevity I will only refer to central points up to the date of the Coroner's Inquest on 16 November 1988.

Mr & Mrs Law and Janine's sister, Robyn Richardson, were interviewed by Constable I G Parke, a local constable at Whakatane, at 9.30am on Wednesday 27 April 1988, one day after the discovery of the deceased. Constable Parke had undertaken this interview at the request of D/S/S Marshall (2 I/C in investigation team) and it was to him he addressed his notes of interview on 29 April 1988. The notes indicate that the enquiries were being made by Police into "the suspicious death" of Janine in Auckland. The notes do not reveal explicitly the possibility of violence, but by a reply from Mrs Law it seems that asthma had been canvassed. She is recorded as saying "*I wonder if the paint fumes might have had an affect on the asthma attack, if that's what she had*". It would appear from Constable Parke's notes on the Job Sheet few hard facts of the scene discovered were available for comment by the Laws. However important background information even at that early stage was supplied. They all agreed they did not know of a boyfriend with whom she might have had sexual relations. They told the Constable if someone in that category existed he would have to be special and they knew of no-one. Her sister Robyn said "*I think I would have known if she had a boyfriend and if she was sleeping with him. If she slept with anyone it would have to have been someone special. She wouldn't just have a relationship sexually with someone casual.*" The Law parents said "*She has had an asthma problem since childhood but it has not been much of a problem to her.*" Although Janine had not lived at home since she was about 18 years all members claimed they knew her lifestyle well. Robyn said "*She was always a person full of life and she loved life.*" It was very early days in the enquiry but

nevertheless some telling points were made to a Police officer which were never disproved at any stage of the investigation.

There is no doubting that the Law family were aggrieved and dissatisfied with their overall treatment in the first investigation. Their dissatisfaction centred around these factors. They knew the investigation was headed by Detective Inspector Plumer and D/S/S Marshall. In the specified period they saw each of these investigators only once and then at the Laws' request, and in Auckland. They had a copy of the pathologist Dr Smeeton's report and they were not satisfied with its findings. The first meeting they think was in May or June 1988 with D/S/S Marshall. From Mr & Mrs Law's viewpoint this was an unsatisfactory meeting. They said they put Janine's asthma in perspective; that it did not trouble her much and that presence of ventilators in her house was for security purposes which indicates she was not a severe, or even moderately affected asthmatic. They also sought explanations for the injuries Janine had suffered. Mrs Law was particularly aggrieved that her account of Janine's asthma and also her moral habits (for want of a better way of describing them) were seemingly taken no notice of. They were first conveyed to the Police on 27 April 1988. The Laws think it was probably after this meeting with D/S/S Marshall they instructed Ms Anderson to write the letter of 21 July 1988 to the Auckland Police where it was set out in the plainest of language the adequacy of the Police investigation to that date was strongly challenged, and backed up with sensible and logical reasons all of which proved to be true. This letter received only a holding reply dated 23 August 1988 saying principally Police enquiries had not been completed.

The next important event in the probable sequence of events was the interview Ms Anderson had with Detective Inspector Plumer which according to Ms Anderson took place about 3-4 weeks before the Inquest of 16 November. It has been confirmed by D/I Plumer it took place on 12 October 1988. At that meeting Ms Anderson said she was shown in draft a report written by D/I Plumer which he said he was going to present to the Coroner. Ms Anderson at this meeting also viewed the booklet of photographs of the body when found. On reading that report Ms Anderson recalled at interview with me that she had a sense the Police had not taken notice of the clearly expressed views of the family which had been conveyed to the Police in writing in her letter of 21 July 1988. She did express to D/I Plumer that the family wanted an open verdict from the Coroner so that Police enquiries could continue into the

death of Janine, which they thought was the result of violence not an asthma attack. Ms Anderson is firm in her belief that she had received an assurance from D/I Plumer that the Police were prepared to co-operate with the family and seek the open verdict. Two separate items supported Ms Anderson's recollection of this important arrangement. She said D/I Plumer had communicated with her office to establish that she would not be cross-examining at the Inquest which course she had agreed to on the basis of the open verdict agreement. Secondly she said she had read Dr Peter Swinburn's brief which patently did not support an asthma death.

Attention returns to the Laws. Mr & Mrs Law said their only meeting with D/I Plumer took place after Ms Anderson had seen him and probably only a matter of one or two weeks before the Inquest. This has been confirmed by D/I Plumer as taking place on 20 October 1988. Again the Laws were dissatisfied with the meeting. They told me D/I Plumer laid emphasis on the fact there was no sign of break-in and there was nothing disturbed in the house. They said D/I Plumer's view at this meeting was that Janine had died of natural causes. The Laws said at this single meeting with D/I Plumer they quite clearly told him he was down the wrong track and that he was wrong in ascribing Janine's death to natural causes such as asthma. The matter of attendance at the Inquest was raised and D/I Plumer told them it was not for him to say, but he could not see any reason why they would want to go to the Inquest. This remark the Laws told me was made by D/I Plumer because it was on the basis that he had indicated to them the Police would ask for an open verdict so that the Police file could continue as an investigation. After receiving this assurance they went and saw Ms Anderson and she confirmed she had been told the same thing at a meeting earlier than that of the Laws. The Laws on that basis did not attend the Inquest.

The Laws repeated what hurt them most is that no-one sought their views on Janine's asthma and further that no-one who knew anything about her asthma was interviewed. Moreover in a close-knit family they would have known of any promiscuous behaviour on Janine's part and there was none. The Police investigation from the family's perspective was concentrated on seeking a consensual sexual partner for her that night, and an asthma caused death.

Attention turns back to Ms Anderson. She attended the Inquest on 16 November on the basis of an agreement with the Police that they would be requesting an open verdict, and that it

would eventuate. Ms Anderson said both she and the Law family felt assured there would be an open verdict. When D/I Plumer representing the Police furnished his evidence at the Inquest it became obvious that the request or case of the Police was for an asthma death finding. Ms Anderson to that point had not spoken but she stood to object to the Police case. She said her recollection is that she was advised that she was not entitled to make any submissions and did not. Nevertheless her recollection is that she said to the Coroner the family insisted there be an open verdict. The Coroner gave his verdict apparently immediately after the hearing concluded that Janine Law died at her home from a probable asthma attack of acute bronchial asthma.

Ms Anderson advised at interview with me that she confronted D/I Plumer outside the Court with his retreat from the understanding that an open verdict would be requested by the Police. She told me she had a strong sense that there had been a retreat by the Police from the agreement which she thought had been reached.

There is quite persuasive corroboration of the joint view of Ms Anderson and the Law family of the foregoing account of the arrangements leading to the Inquest which is contained in the opening two paragraphs of her long letter of dissent dated 21 December 1988 addressed to the District Commander of Police:

> *"RE: JANINE ALISON LAW - SUDDEN DEATH*
>
> *I have been instructed by the family of Janine Law and have already written to you to express some concerns that they had about the nature of the enquiry that was being carried out in early 1988 as the result of Jan Law's sudden death.*
>
> *It was as a result of that letter and as a result of continued enquiries by both the family and the Police that I attended at the office of Detective Inspector Plumer to view his Report and to consider in his presence what would be the likely view of the Police when questioned as to the cause of death. I left that Office confident that the cause of death that the Police would support would be that of unknown cause, although it was likely that something had precipitated an asthma attack. The members of Ms Law's family were also left with the same impression after visiting Detective Inspector Plumer."*

The letter then went on for four pages in a most detailed analysis of the evidence in the case which it is now unnecessary to reproduce for the simple and very telling reason it was astonishingly accurate as revealed by the final result. The issue must now be faced whether

or not there was an indication, or understanding, or agreement that the Police would request an open verdict. It is important to make this distinction. It is not alleged by either Ms Anderson or the Laws that D/I Plumer said the verdict would be an open one (that is the Coroner's prerogative and obviously not for D/I Plumer to state what it would be) but whether on a fair appraisal of the available evidence D/I Plumer had given the Laws and their lawyer some indication, understanding or agreement the Police would make that request for the Coroner's consideration. There is no doubt the request was not made and that the Police case was an asthma death. In my view the available evidence which has been referred to leads me to conclude D/I Plumer had conveyed to the Laws and Ms Anderson that was the request he would make and he did not. In reaching that conclusion in fairness to D/I Plumer I can see how a misunderstanding might have arisen but objectively assessed Ms Anderson and the Law family have made their point.

Reviews of the First Investigation within Police at Auckland

There have been three reviews of the first investigation with the first taking place within perhaps two weeks of discovering the body of Janine Law on 26 April 1988; the second in January 1989 after a family complaint following the first Inquest; and a third review commencing September 1993 through to May 1994. All reviews took place within the Police in Auckland and the third review reached an entirely different conclusion from the first two reviews. It is also relevant that each review used substantially the same set of discovered facts that unfolded after Constable Leadley broke into the dwelling at Crummer Road on 26 April.

I will deal with each review, but not in great detail as a review of reviews is unlikely to add greatly to the overall result, but there are lessons to be learned. The central lesson is that a case that does present confusing evidence is likely to benefit from an independent and detached examination as occurred here with the ultimate findings by D/I Manning with his report to his District Commander dated 30 March 1994.

While not enshrined in any policy, there is a not uncommon practice for Police to review major investigations when solution seems uncertain or evidence against the particular suspect needs assessing. The question of such a review in the Janine Law case in the first two

reviews is somewhat indistinct and does not show a necessary air of independence for the second review.

It is said that some two weeks into the enquiry the senior members of the investigating team took part in a "brain storming" session with the head of CIB, Detective Superintendent Rowe, and apparently three of his other commissioned officers (two of them are now unable to recall this happening - all of the other participants are sure that it did). D/I Plumer and D/S/S Marshall were present.

It is stated that at this meeting the evidence was reviewed and the conclusion reached that Janine Law was unlikely to have died as a result of foul play and that she had more likely succumbed to asthma.

It is not easy to evaluate this review. For myself I do not think it can really be elevated to a review. It took place only two weeks into the enquiry, and although one cannot at this distance say at exactly which point the investigation had reached in regard to the assembling of evidence, there could have been further evidence and enquiries to be made. That it did reach a conclusion that death was unlikely to have occurred as a result of foul play indicates the very early perception was taking a strong hold.

To my mind a review is a general survey or assessment of the total fact situation which can only be carried out with conviction when all relevant material is before the reviewers. An important ingredient of a review is that it is retrospective in nature in that it looks back to the past. It is a revision of all available material once it is considered unlikely further evidence will emerge. I concede there is some speculation in these views because it is not possible to state what hard facts were there and what were still to be obtained. In my conclusion this so-called "brainstorming" was most probably an exchange of ideas about the evidence that had been assembled to that point and little else. I offer no criticism that this was not an independent examination because one would not expect that because the investigation was incomplete. The early May 1988 meeting has little standing as a review as I have defined it.

I take a different view of the review of the case which was carried out January 1989 following an approach by the Law family's solicitor expressing complete dissatisfaction with

the Police enquiry and the conclusions reached in the Coroner's Court. This has been cited as a review by Superintendent Rowe and on a definitional basis as outlined above it fulfils those requirements. In a memorandum addressed to A/C Duncan dated 11 November 1994 Superintendent Rowe said *"A detailed report in response was submitted by then Detective Inspector Plumer and I read and reviewed the whole file."* It was a retrospective revision of a completed investigation when with the shutting down of active Police enquiry no further evidence or revelations could be reasonably expected. The dispositive letter addressed to Ms Anderson dated 27 January 1989 was signed out by the then Region 1 Commander, Assistant Commissioner B R Davies. The elements of that review must now be examined remembering that almost seven years have elapsed.

Ms Anderson's letter was addressed to the Commissioner of Police, Auckland, and was received by the Region 1 Commander. He treated the matter as urgent and issued a direction to the District Commander to have D/I Plumer respond to the matters raised. A holding reply was sent to Ms Anderson signed by A/C Davies.

I have examined the internal Police correspondence on this issue that took place in January and February 1989. The short point is that D/I Plumer prepared a report dated 13 January 1989 addressed to Detective Superintendent Rowe which was a detailed justification for the case which was in substance put to the Coroner. It seems Detective Superintendent Rowe then prepared the reply which was signed by the Region Commander and sent to Ms Anderson.

I dispose of this review as being simply a restatement of the settled official views of the CIB in Auckland. There was no new or fresh look at the totality of the evidence and lacked independence which I think was its principal failing. What was wrong with this review of the first investigation is adequately illustrated by the first full and independent review that took place from September 1993 to which I now turn.

The review which commenced in September 1993, in the manner I have outlined earlier in this report, resulted in the very full report of D/I Manning dated 30 March 1994. That report caused the present Region Commander, A/C Duncan to order a full re-opening of the

investigation as a homicide enquiry in May 1994. The work of the team under D/I Rutherford commenced in June 1994 and in September 1994 the murderer was arrested.

The central lesson of a completely independent team, still within the Police, reviewing a case needs no further elaboration by me. I make a recommendation to that effect in this report.

Allegations that some Police Officers in Auckland were Seeking to Prevent a Reopening of the Law Investigation

This is an aspect of the enquiry that has emerged in the media since the conviction of Tamata. It was not referred to in A/C Duncan's briefing letter to A/C Holyoake dated 9 October.

Since July 1995 D/S/S Kemp has been interviewed several times by the media and he has not hesitated to make allegations against Police officers, but principally Superintendent Rowe, that attempts had been made since his entry into the case in 1991 to prevent him pursuing his belief the first investigation was wrong. When I interviewed D/S/S Kemp on 22 August 1995 he largely repeated those allegations to me.

The foremost allegation that there was a concerted attempt by senior officers to stop his further enquiries and agitation for a re-opening must be addressed. Depending on the facts this could amount to misconduct which would be within my jurisdiction by exercising a discretion available to me to go back more than one year. I have undertaken to examine this aspect as possible misconduct so that the public can be informed as the allegation is in the public arena.

D/S/S Kemp in his statement to me said that from the time in 1991 when he put himself firmly on the side of Detective Dixon's conclusions previously mentioned and had called for the files of the first investigation he became aware of cumulative incidents which indicated to him he was being subjected to critical and unfavourable attention from several quarters which he attributed to his support of Detective Dixon's view and his other activities with the file. He had never wavered in his view that the first investigation's conclusion of asthma death was wrong. He said his confidence began to be affected and his reaction was to redouble his work efforts to meet the highest standards. This plainly suggests D/S/S Kemp thought

criticisms of his work in unrelated fields was motivated by his expressed opinion about the first investigation in the Law case.

This undercurrent, if it could be described as that, surfaced directly by D/I Hastings, whilst occupying temporarily Officer Commanding CIB, Auckland District, directing a written memorandum to D/S/S Kemp about his reactivation of the Janine Law enquiry and ordering him to stop further enquiries immediately. Detective Inspector Hastings (now retired) when interviewed in October 1995 confirms that D/S/S Kemp was ordered by him to stop his enquiries. His recollection is he carried out this direction on the instructions of Superintendent Rowe possibly passed to him by DCI Jenkinson. The written instructions to D/S/S Kemp of 1 November 1991 have been lost. Apparently D/I Hastings personally delivered the memo to D/S/S Kemp and a very heated exchange took place between them. D/S/S Kemp said it might be described as a stand up shouting match. That memo was replied to by D/S/S Kemp on 8 November 1991 and I have read that reply. It was over two pages and it could be described as very robust and if the original memo was designed to shut D/S/S Kemp down in any way it spectacularly failed. However it must be said that although the wording of D/S/S Kemp's reply is unclear, he did not seem then to favour a straight out reopening of another investigation. He may have thought that was not a decision for him.

Another allegation made by D/S/S Kemp to me and in the media was that he had reason to believe the actions by him were to result in a transfer back to uniform branch, a course considered by D/S/S Kemp to be punitive and demeaning. This has been investigated by me and I could find no support for it at all. The transfer certainly never happened and there is in existence no document I have discovered to support it. The original information given to D/S/S Kemp was hearsay in very unreliable circumstances, and later denied by the alleged conveyor of the information. Furthermore A/C Duncan, Superintendent Stanhope (District Commander) and Superintendent Rowe have all denied there was any such proposal. I accept that as true.

There are several official documents I have examined signed by Superintendent Rowe after the commencement of the serious review within the Police service from September 1993 onwards and previously referred to that quite firmly supported the first investigation finding and actively opposed a reopening. I believe that in advancing this viewpoint Superintendent

Rowe was doing so with conscientious intentions, even though events have proved him wrong. Freedom of speech is freedom to be right and wrong. In those circumstances I set my face against any form of censuring of what Police officers say if it is in absolute good faith. Free speech is all pervasive and must not be even surreptitiously eroded. I say more on this hereafter.

I have little doubt there existed for some time an underlying distinctly contrary feeling against those who questioned the original result and the re-examination commenced by the two detectives previously identified. What was begun by those detectives in 1990/1991 with elements of informality and personal challenges became with A/C Duncan's letter to Superintendent Stanhope in September 1993 a formal revisitation of the original investigation. That resulted in June 1994 with the establishment of D/I Rutherford's team charged to locate an offender in a straight out homicide enquiry. It is to be regretted that some persons probably indulged in critical, even sarcastic sniping, aimed at those who supported the view of the first investigation as inadequate and wrong, but that does not call for a witchhunt by this Authority on Police officers' speech. Those people who might have acted in that manner have the final successful result to reflect upon.

I want to go just a little further on this aspect of suppression by one group of another's activities. In the context of this case it began with allegations that some attempts were being made within the Police service to prevent a re-examination of an unsatisfactory first investigation. Since then, bolstered by a dramatically successful result by the second investigating team, there seems to have emerged a table turning exercise whereby the first alleged suppressors are now themselves to be the target.

To dispose of this I begin with the established fact notwithstanding there was undoubtedly opposition to the re-investigation it most certainly did not succeed and the Region Commander, A/C Duncan, was undeterred in his determination to re-examine an error and correct it. That was achieved. My impression of D/S/S Kemp was that opposition may have strengthened his belief and determination to continue. He most certainly never wilted in this case right to the end of his Police service and after. The matter should now rest at that. This Authority is not going to embark on any activity or make any pronouncements that will chill down, or might in the future be interpreted as an attempt to regulate free speech. Let Justice

Holmes "free trade in ideas" flourish in the Police service in New Zealand, even if some insensitive and bruising comments are exchanged in the process. Those who for a time might be taking a less than popular stand must absorb that and console themselves later with the successful accomplishment of their mission. In the field of criminal detection it is to be expected there will be differences, clashes in some cases, between officers who hold strongly to one viewpoint. That D/S/S Kemp was greeted by others who held different views from him with less than admiration or enthusiasm is simply the lot of those who go against the prevailing tide. In this case, as in many others, what started out as heresy ended up as orthodox doctrine, which for the original heretics should make the satisfaction that much more exquisite. A principle that must not suffer is the freedom to express views whether in the end they turn out to be right or wrong. The greatest chance of correcting error is afforded by ensuring that Police officers work in an environment where freedom of speech is encouraged and protected saving only that the views are honestly held and reasonably expressed. The qualifications "*honestly held and reasonably expressed*" place a special duty on an officer in a command structure such as the Police service to voice opinions responsibly and carefully. Absenting exceptional circumstances the obligation to obey lawful orders remains unaffected. On both sides of the equation with which this aspect of the enquiry is concerned those conditions in my view were fulfilled. For reasons given I find no misconduct.

Coroners' Inquests in Janine Law Case

There have been two Inquests with the first of 16 November 1988 and the second on 9/10 August 1995 before two different Coroners. In this report I have used the evidence presented at both Inquests by the Police. The second Inquest inevitably reached a different result from the first, and it was that the deceased died at her home on or about 25 April 1988 from asphyxiation secondary to suffocation inflicted by James Tamata who was as a result convicted of her murder on 4 July 1995.

I am not unaware of the controversy surrounding the Coroner's office in Auckland connected with this case, but I state explicitly it is no part of my jurisdiction to make any comment on the way the Coroners discharged their functions in this case. That explains why I have said nothing.

I confine my remarks in this area to the following because it might help the public to understand the general issue of coronial enquiries and those in authority who might wish to re-examine Coroners' jurisdiction. Coroners' work is difficult, and at times complex, and it might be of public interest to know that controversy over the office of Coroner has emerged in a significant way in the United States. The America Bar Association Journal's lead story in the June 1995 issue was entitled "Body of Evidence" and is an informative and interesting survey of the way decisions are made in that country where a death has occurred in circumstances where a judicial decision might be required.

Conclusions

1. The first investigation under the command of D/I Plumer and his 2 I/C D/S/S Marshall was inadequate and deficient in the ways I have detailed in this report. At the very least this was a suspicious death and the investigating team seemed to move to innocent death far too early.

2. There was a failure of communication within the investigating team itself both as to basic information gathered by officers, and exchange of contrary views. Despite claims to the contrary I am not satisfied the conferences, especially in the early days, were frequent enough and results properly recorded on the files.

3. Deficiencies were revealed in the scene examination and area canvass which must be addressed to ensure they are not repeated. Furthermore, the preparation and combing of lists of suspects did not seem to be properly addressed in the first investigation.

4. It follows that the case presented to the Coroner on 16 November 1988 was also inadequate and deficient.

5. No proper account was taken of the views of the Law family which they endeavoured to express personally and which they did in some detail through their solicitor.

6. The review of the first investigation ordered by Region 1 Region Commander Brian Davies and carried out by Superintendent Brian Rowe in January 1989 following the

solicitor's letter of dissatisfaction dated 21 December 1988 was inadequate and deficient..

7. The active dissatisfaction of Detective Glen Dixon and Detective Senior Sergeant Kemp starting in 1990 is to be commended. There might have been elements of informality in their activities, but they were not improper.

8. The review of the first investigation begun by the now Region 1 Commander, Assistant Commissioner Brion Duncan, in September 1993 and conducted by Inspector Manning and Detective Senior Sergeant Upton under Superintendent Hartley's supervision and which culminated in a re-opening of a second homicide investigation in June 1994 is to be commended

9. There was opposition to the review of September 1993 and the re-opening of a second investigation by some Police officers but it was in good faith.

10. The relatively early and successful conclusion of the second investigation of Detective Inspector Stephen Rutherford and his team with the arrest of the offender in September 1994 is to be specially commended. Over six years after the death this was a particularly fine effort and conducted in a very professional manner.

Recommendations

1. If a death appears suspicious and is designated as a homicide enquiry, that should not be displaced except by unchallengeable further evidence.

2. The most careful active consideration should be given to contrary views to the ones tentatively reached whether from family members, other Police officers, or lawyers on behalf of families. The files should record how these contrary views are dealt with.

3. A familiar managerial method of operating in Police work is by way of a team under command structure. As part of Police training procedures to develop communication skills within a team structure should be established as a separate discipline. The

teaching of communication skills within a working group is relatively commonplace in the commercial environment.

4. Steps should be taken to ensure that 2 and 3 above are covered in training and in the Manual of Best Practice and that the recommended procedures are in fact followed.

5. If there is to be a review, (ie. because of the complexities of a case, the nature of the evidence or the lack of resolution) it should be carried out by a fresh team to impart the required impartiality and independence.

6. Inspector Manning and Detective Senior Sergeant Upton should be commended for their work in the review commenced in September 1993.

7. That Detective Inspector S. Rutherford and Detective Senior Sergeant J. Gallagher should be commended for their work in the second investigation.

Many of the officers whose actions are commended and criticised have now left the Police service. Some are still in the service. I think the findings and recommendations of this report are sufficient to reinforce the requirement of maintenance of high professional standards without further action against any officer. There are procedural obstacles by time limitations which prevent internal disciplinary actions. As stated in the body of the report it is avowedly remedial and to satisfy the public on all material aspects of the case.

Whilst this document represents the PCA review this exercise has been a joint investigation and review by Assistant Commissioner Ian Holyoake and the PCA. A/C Holyoake has read and approved this report.

Sir John Jeffries
POLICE COMPLAINTS AUTHORITY
21 November 1995