

Police response to three 111 calls in Omapere

INTRODUCTION

1. At 6.05am on Monday 26 October 2015, Ms Z called the 111 emergency line from her home in Omapere, Northland. She informed Police that her 29-year-old son, Mr Y, was behaving erratically and had pushed her. A Mental Health Crisis Team was due to visit Mr Y at 10am that day because of concerns about his current mental state. Police decided to wait for the Crisis Team's assessment to take place and did not attend Ms Z's home in response to her call.
2. Ms Z called 111 again at about 10.43am, to advise that the Crisis Team would not take Mr Y because they did not consider him to be sick enough. Ms Z said she was concerned for her safety and did not want her son to stay at the house. Police told Ms Z they would attend when a unit became available.
3. At 11.15am, Ms Z's daughter called 111 to report that Mr Y had stabbed Ms Z in the back with a knife. Police and an ambulance were immediately dispatched to the address and Ms Z was subsequently taken to hospital by helicopter. Ms Z received treatment for the stab wound and survived.
4. The Police notified the Independent Police Conduct Authority of the incident, and the Authority conducted an independent investigation. This report sets out the results of that investigation and the Authority's findings.
5. The Authority concluded its investigation in September 2016, but delayed the release of its public report due to ongoing court proceedings.

BACKGROUND

Mr Y

6. Mr Y suffers from paranoid schizophrenia, and Police had been called many times in the past to deal with his behaviour.
7. On Friday 23 October 2015 Mr Y arrived unexpectedly at Omapere in Northland to stay with his mother (Ms Z) and two sisters.
8. Ms Z said Mr Y was “*up and down*”, and his behaviour worsened on Sunday 25 October 2015. That evening she called the Mental Health Crisis Team for help, and arranged for them to visit Mr Y at the house at 10am the next day.

First 111 call to Police

9. At about 6.05am on Monday 26 October 2015, Ms Z called 111 and requested Police. Communicator 1 answered the call and asked “*Where is your emergency?*”
10. Ms Z explained that her son was in the Mental Health system and that the Crisis Team was due to visit at 10am. She went on to say: “*... but I’ve just woken up and he’s really erratic at the moment.*” Communicator 1 enquired about what exactly her son was doing, and Ms Z said he was pacing up and down the hallway and going outside and swearing. She then said: “*I went outside to have a look and he started pushing me around.*”
11. Communicator 1 requested Ms Z’s address, and she provided it. The communicator then asked whether Mr Y was still outside, and Ms Z said he was inside the house pacing up and down the hallway. When Communicator 1 asked whether Mr Y had anything on him that could be used as a weapon, Ms Z replied: “*He’s ... not at the moment, no. I just came back in the room. I didn’t want to make it any worse.*”
12. Ms Z told Communicator 1 that her son was 29 years old and provided his name and date of birth. Meanwhile Communicator 1 created an event in the Police’s Computer Aided Dispatch (CAD) system, with the headline: “*INFT [Informant] WAS PUSHING HER EARLIER – INFT ADVISES 1M – NIL WEAPONS*”.
13. Communicator 1 later told the Authority that the headline was supposed to say “*MALE WAS PUSHING HER EARLIER*”. He did not realise he had made a typing error but, even if he had noticed it at the time, the CAD system does not allow anyone to change or edit event headlines. He believed it was clear from the content of the rest of the information entered into the event (the Event Chronology) that Mr Y had pushed Ms Z, rather than the other way around.

14. The event was assigned Priority 2 and coded as *"1M – Mental Health"*.¹ Communicator 1 believed this was the correct coding, rather than the coding for a domestic assault, because he identified from the call that Ms Z's main concern related to Mr Y's mental health.
15. Communicator 1 checked the Police database and added Mr Y's details to the Event Chronology, including his name, date of birth, physical description, and alerts for *"Mental illness/Mentally disaffected person"*.
16. Dispatcher 1, based at the Police Northern Communications Centre (NorthComms), noted in the Event Chronology that she had read the event. She was the dispatcher for the Northland radio channel.
17. Communicator 1 continued speaking with Ms Z and said: *"So there was a bit of pushing, was he trying to hurt you, or trying to move you away from him?"* Ms Z advised that after Mr Y had pushed her, she went to move past him to get away, but he blocked her and pushed her away again. Communicator 1 asked if Mr Y said anything to her, and she said he had told her to *"fuck off"*.
18. When interviewed by the Authority, Communicator 1 said he did not record this further information about the pushing and swearing in the Event Chronology because the pushing was mentioned in the headline of the event and he did not consider it necessary to add any extra details about it.
19. Communicator 1 asked Ms Z if there was anyone else in the house, and she replied: *"yeah there's heaps of us"*. She said the others were asleep, including her two daughters aged 18 and 20, and several young children. Communicator 1 noted this in the Event Chronology.
20. Dispatcher 1 was confused by the headline of the event, and typed into the Event Chronology *"SO INFMNT WAS PUSHING THE MALE?"* However Communicator 1 did not answer this question. He told the Authority he was busy recording other information from the call, and did not see the question. He also stated that the dispatcher should have been able to identify that Mr Y had pushed Ms Z from reading the rest of the Event Chronology, and could have taken further steps to clarify that aspect of the incident if she remained confused (see paragraph 37).
21. Meanwhile Communicator 1 asked Ms Z: *"In terms of his mental health state, is he in a state where he could harm himself or others?"* Ms Z said yes, and confirmed that he had been in that state before. Communicator 1 enquired about what Mr Y's behaviour had been like in the past, and Ms Z said he started smashing things.
22. Communicator 1 confirmed that the Crisis Team were coming to see Mr Y at 10am, and asked whether he had made any threats to hurt himself or others recently. Ms Z said Mr Y had threatened to hurt himself the previous day: *"I think he said he hoped he had a gun and yeah ... that's why we rang the Crisis Team ... and it's escalated, he's gotten worse now."*

¹ Police must endeavour to attend Priority 2 events within 30 minutes.

23. Ms Z explained that Mr Y was having trouble sleeping, and that lack of sleep usually led to his mental condition deteriorating. She stated that she did not think Mr Y had slept at all overnight and *“even the night before he was off and on.”*
24. While Communicator 1 added this information to the Event Chronology, Dispatcher 1 asked *“HAS INFMT CONTACTED MENTAL HEALTH CRISIS TEAM?”* Communicator 1 affirmed this, and then added further information he had gathered from Ms Z, including that Mr Y was up to date with his medication and had not taken drugs or alcohol. He added that Mr Y was still pacing while Ms Z was on the phone.
25. Dispatcher 1 asked Communicator 1 through the Event Chronology whether the Crisis Team were coming to see Mr Y, and he replied that they were not coming before 10am. When Dispatcher 1 asked Communicator 1 to confirm there was no current threat, Communicator 1 wrote that Ms Z wanted someone to see Mr Y before 10am because she was *“EXPECTING HIS BEHAVIOUR TO ESCALATE GIVEN THE WAY HE IS ACTING CURRENTLY”*. He also noted that Mr Y had implied he wanted to kill himself the previous day, by saying that he wished he had a gun. Dispatcher 1 wrote *“EXPECT DELAYS”*.
26. Communicator 1 asked Ms Z for her name and confirmed that he had the correct phone number for her. He attempted to give her a reference number for the event, but she did not have a pen and paper to record it, so he advised her to quote her address if she had to call back (which would enable Police to locate the Event Chronology for her original call).
27. Communicator 1 then told Ms Z:

“We’ll try and get someone to give you a hand here. If anything starts to escalate a bit, if he gets a bit more violent again and starts breaking things, do call us back and keep us updated on that.

I’ve put in that he was due to be seen by Crisis Team at 10am this morning, but that the way he’s been acting, it’s quite likely he’ll need to be seen earlier because, you’re Mum, you’ve got the experience and you know that, this is where it’s going to, given how he’s acting at the moment ... so hopefully they’ll have someone free in the area to come and give you a hand soon.”
28. Ms Z thanked Communicator 1 and he advised her to call back if she had any other concerns. The call had lasted eight minutes and ended at about 6.13am.
29. Communicator 1’s final action in relation to this call was to flag the event for ‘Family Violence’ in the Event Chronology.

Dispatcher 1 consults field supervisor

30. After discussing the matter with her team leader at NorthComms, Dispatcher 1 phoned the field supervisor at about 6.20am. The field supervisor on duty was Officer A, a sergeant based in Whangarei.

31. Dispatcher 1 and Officer A initially discussed an ongoing problem the dispatchers were having, regarding their private conversations accidentally being broadcast over the radio due to a software glitch. This conversation continued for about one and a half minutes.
32. Dispatcher 1 then advised Officer A that she wanted to run something past him regarding an incident in the far north. She told Officer A that:
- A mental health patient (Mr Y) had an appointment with the Crisis Team set for 10am, and they could not see him any earlier.
 - He was up to date with his medication and there were no alcohol or drugs involved: *"...all he's doing is pacing, he hasn't been to bed."*
 - Mr Y's appointment with the Crisis Team was arranged because he had threatened to harm himself the previous day, and said he wished he had a gun and wanted to kill himself.
 - Dispatcher 1 did not think Ms Z knew what she wanted Police to do:

"So I don't actually know what she wants, and I asked the question, they said informant would like someone to see him prior, because she's expecting his behaviour to escalate but"
33. Officer A said: *"Well, we can't make Mental Health do anything."* Dispatcher 1 agreed, and explained that the incident was near Rawene, an area that was being covered by the officer on call in Kaikohe (a 54-kilometre drive from Omapere). She said: *"I'm not gonna call them out to go all the way out there when he's got an appointment in four hours' time."* Officer A responded: *"No, exactly."*
34. Officer A advised Dispatcher 1 to tell Ms Z that Police would *"happily"* attend the house if something happened and the situation changed, but *"... at this very moment he seems to be doing nothing except walking around – get him through to 10 o'clock."* Dispatcher 1 thanked Officer A and ended the call.
35. When interviewed by the Authority, Dispatcher 1 said if there had been any local officers on duty at the time she would have dispatched someone to attend. However she was unwilling to dispatch the on-call officer to Omapere when the early shift officers at Kaikohe would soon be commencing duty.
36. During the call Dispatcher 1 did not pass on other risk-related information from the Event Chronology, including that:²
- family violence (pushing) had occurred;
 - Ms Z had reported that Mr Y was a risk to others (not just himself);

² The Event Chronology for Ms Z's call was available on Officer A's mobility device if he had chosen to read it. A mobility device is either an iPad or an iPhone that Police officers carry in their vehicles and can use to access Police databases.

- c) Mr Y was sensitive when lacking sleep; and
 - d) other family members were at the address, including young children.
37. Dispatcher 1 told the Authority that she had not realised she did not mention the pushing to Officer A. She commented:

“... it was confusing, the headline was confusing that at the time, so I did ask for clarification which wasn’t clarified in the job.

... the information that I was working on with that one headline, that the informant was pushing her earlier, indicated that the informant had pushed her son, not the other way around.”

38. Officer A said that even if he had known this additional information, he would not have recommended immediately dispatching the on-call officer. However he would have asked that the Kaikohe early shift officers be dispatched to attend the incident as soon as they came on duty, rather than waiting for the Crisis Team assessment. He believed the early shift officers would have started at 7am, but when advised that they actually started at 8am, he said:

“In that case, I’d be saying, ‘Let’s give someone a ring’ and get them out there. ... I would normally expect an early shift to be starting at seven and so that’s the latest I’d have been happy to leave it.”

39. At 6.28am Dispatcher 1 updated the Event Chronology to say that she had discussed the matter with her team leader and Officer A, and they had decided to hold the event until Mr Y’s appointment with the Crisis Team took place at 10am. She also recorded that the Kaikohe officers should be advised of the situation with Mr Y once they were available.

40. Dispatcher 1 then wrote in the Event Chronology that she was ringing Ms Z to advise her to call 111 again if Mr Y’s behaviour changed or escalated. About one minute later she noted that Ms Z had not answered her call.

41. There is no record in the Event Chronology of Police successfully contacting Ms Z, or leaving her a message to inform her they would not be attending.

Dispatcher 2 and Kaikohe officers commence duty

42. Dispatcher 2 took over the dispatching duties on the Northland radio channel at about 7am. Dispatcher 1 gave him a handover briefing and advised him about the decision to wait for the Crisis Team to assess Mr Y, and to inform the Kaikohe officers of the event when their shift began.

43. When the Authority asked what he was told about the pushing that had occurred, Dispatcher 2 said:

“The feeling that I got was there was confusion about that, not clarity, whether the informant had pushed him or he had pushed the informant, it

wasn't clear on handover and there was confusion about that so I think that was possibly downplayed."

44. Dispatcher 2 commented that he was not sure whether "1M – Mental Health" was the most appropriate code for the initial event, and suggested that if it had been coded as a minor assault or a trespass job then Police may have responded differently.
45. Dispatcher 2 also said he knew Ms Z had not answered a previous call from Police that morning, and he thought she may have gone back to bed. He did not want to harass her by calling again so he left the job waiting, with the intention of advising the Kaikohe officers when their shift began.
46. At 8am, Officer B (an acting sergeant) and Officer C started the early shift at Kaikohe. About this time, Officer B called Dispatcher 2 and asked if he needed to be made aware of any events that had occurred overnight. However Dispatcher 2 did not mention the call from Ms Z. He later said that he would have overlooked Ms Z's call because it was filed in the CAD system under the Rawene area rather than the Kaikohe area.
47. When interviewed by the Authority, Officer B said he had checked the list of recently recorded events when he started the shift, and noticed the event relating to Ms Z's call. He recalled that he discussed the event with Dispatcher 2 at around 8.05am, and was told that the Whangarei field supervisor had been consulted and the agreed approach was to wait for the Crisis Team. The Authority has not found any record of this discussion at that time, and it is possible that Officer B was remembering a conversation that occurred later in the day, after Ms Z called Police for a second time (see paragraph 62).³
48. Shortly after Officers B and C began their shift, they travelled to Omapere to conduct enquiries regarding an attempted abduction the previous day. Officer B told the Authority he intended to get an update on the situation with Ms Z and Mr Y once they had completed those enquiries:

"... from memory it was always my intention to go past [Ms Z's] address prior to leaving Omapere ... knowing that that job was in the system, I was going to go there anyway at the conclusion, or wait to hear what happened with the [visit from the Crisis Team]."
49. At 8.33am Dispatcher 2 made a note in the Event Chronology for Ms Z's call that the job was being held in the CAD system until 10am, in case she called again to request Police assistance.
50. About one hour and ten minutes later, Dispatcher 2 updated the Event Chronology by changing the priority level from 2 to 4. He then tasked a communicator at NorthComms (Communicator 2) with closing the event as Police had not received any further calls.
51. At 10.10am, Communicator 2 unsuccessfully tried to call Ms Z, then cancelled the event.

³ Officer B remains certain that his recollection of the conversation at around 8.05am is correct, but Dispatcher 2 has advised the Authority that he did not mention the incident to Officer B at that time (which is supported by his later comment that he was supposed to contact Officer B earlier – see paragraph 62).

Second 111 call to Police

52. At about 10.43am Ms Z called Police for the second time. Communicator 3 answered the call and asked for the location of the emergency. Ms Z told her it was in Omapere, Hokianga.
53. Communicator 3 asked what had happened, and Ms Z provided her address, saying that she had called earlier that morning and it *“should be on file”*. Communicator 3 requested Ms Z’s name, and then asked *“Was it about someone pushing you?”* Ms Z replied:
- “Yeah, it’s my son, he’s in the Mental Health, he won’t leave the house, I don’t want him here. Also, the Crisis Team just turned up, they can’t help us. So in other words they’re trying to find him somewhere to stay but, um, pretty much if he doesn’t find anywhere he’s gonna, you know, he’s gonna think he can stay here. So yeah, I was hoping they will help but they can’t. They won’t, he’s not sick enough.”*
54. Communicator 3 said: *“Oh but you don’t want him staying with you”*, and Ms Z responded: *“No, and I’ve told him to leave and he won’t, and I know he’s just gonna smash up everything, unless he’s found somebody to take him in.”*
55. Ms Z advised that the Crisis Team nurses were still at the house. Communicator 3 obtained confirmation from Ms Z that the nurses had said Mr Y was not sick enough for them to help, and then asked if there was any family Mr Y could go and stay with. Ms Z said no, because *“he’s pretty much exhausted everybody”*.
56. Communicator 3 asked Ms Z to stay on line while she created a new event in the CAD system, with the headline: *“MENTAL HEALTH REFUSING TO HELP INF [informant’s] SON AS MALE NOT SICK ENOUGH”*. The event was assigned Priority 2 and coded as *“1M – Mental Health”*. Dispatcher 2 immediately noted that he had seen the event.
57. Communicator 3 recorded Mr Y’s name and date of birth, then wrote *“POLICE ATTENDED THIS MORNING”*, although Ms Z had not said that Police attended (and in fact they had not). When interviewed by the Authority, Communicator 3 said she would have obtained this information from her interpretation of the Event Chronology for the first 111 call.
58. While Ms Z was waiting on the line, she told someone at the house with her *“I’m ringing the cops, I’ve just had enough.”* Communicator 3 asked Ms Z where Mr Y was at the moment, and she said he was still at the house and the Crisis Team nurses were leaving.
59. The communicator wrote in the Event Chronology that Ms Z was concerned for her safety and did not want her son staying at her address. She also noted: *“MALE IS AT HOUSE IS CALM”*. She later told the Authority that, although Ms Z had not said Mr Y was calm, she assumed he was because the Crisis Team were leaving. If Mr Y had been aggressive, Communicator 3 would have expected the Crisis Team to be calling Police for assistance.
60. After adding to the Event Chronology that there was no other family available to take Mr Y in, Communicator 3 checked Ms Z’s phone number and advised her she would get the Police to call when they were free. Ms Z thanked her and ended the call.

61. Dispatcher 2 wrote in the Event Chronology: *“WHAT DOES INFMT WANT POLICE TO DO?”* but no answer was recorded. Communicator 3 later said it is likely that she was answering another call by that time.
62. The dispatcher then called Officer B, and commented that he was supposed to have called Officer B about three hours earlier. He enquired about whether Officers B and C were still at Omapere, and Officer B confirmed that they were and would be for another 15-20 minutes. When Dispatcher 2 asked if they also had a *“1M”* (mental health) job out there, Officer B said he had seen it in the system and asked whether it had been closed.
63. Dispatcher 2 said the Crisis Team had now assessed Mr Y, but Ms Z had called Police again as they were refusing to help. He told Officer B *“apparently Police attended this morning”*, but he was unsure who had done this (Officer B said it was not him). He went on to say:
- “... but now she’s concerned for her safety, doesn’t want him staying there so ... I mean Mental Health has said ‘Well he’s not sick enough to go, to be sectioned’ obviously, so, I mean is it just a trespass job now or is it just, I don’t really know”*
64. Officer B advised the dispatcher that he and Officer C would *“tidy up”* the enquiries they were currently doing, and then he would get the dispatcher to call back with further details of the job so he could go to the address and speak to Ms Z.
65. At about 10.48am, Dispatcher 2 assigned Officers B and C to attend the incident in the CAD system. Meanwhile they completed their enquiries in Omapere.
66. At about 11.08am, Dispatcher 2 called Officer B again and he requested the details of the event. Dispatcher 2 told him:
- a) a *“1M”* (mental health) job had come in overnight;
 - b) *“someone was pushing [Ms Z] around earlier”*;
 - c) Mr Y was up-to-date with his medication but was pacing and would not go to sleep;
 - d) Mr Y had made suicidal threats or suggestions, resulting in his appointment with the Crisis Team, but these were not recent enough to require Police attendance;
 - e) the Crisis Team *“was refusing to help the son as he wasn’t sick enough”*, and *“they’re not that concerned about him”*; and
 - f) Ms Z was concerned for her safety and did not want Mr Y staying at the address, but Mr Y was calm and no other family was available to take him.
67. Dispatcher 2 and Officer B discussed the limitations around what Police could do in this situation, since the Crisis Team had refused to admit Mr Y and he was on private property (see paragraphs 80-83 for policy).

68. Dispatcher 2 told Officer B he had no idea what Ms Z wanted Police to do, and suggested that Officer B call Ms Z to find out what she wanted to happen. Officer B agreed to call Ms Z.

Third 111 call to Police

69. At about 11.15am, one of Ms Z's daughters called 111 to report that Mr Y had stabbed their mother in the back. Communicator 4 answered the call and immediately created a Priority 1 event that was coded as "Grievous Assault".⁴ The headline of the event was: "INFMTS [Informant's] BROTHER STABBED INFMTS MUM".
70. Dispatcher 2 immediately acknowledged the event, notified an ambulance, and called Officer B to inform him of the stabbing. Officer B was fetching Officer C from a different part of Omapere at the time, and the officers immediately drove to Ms Z's address.
71. Meanwhile Communicator 4 obtained further information from the daughter, including that the stabbing had happened five minutes ago and there were children in the house. About three and a half minutes into the call, Officers B and C arrived at the scene. Communicator 4 confirmed the daughter's phone number before ending the call.
72. Officer B arrested Mr Y, who was located standing on the lawn outside the house. Mr Y did not resist arrest. Officer C found that Ms Z was already receiving first aid, and assisted with this while the ambulance travelled to the scene. Meanwhile Dispatcher 2 arranged a helicopter to transport Ms Z to hospital.
73. Ms Z survived the stabbing injury, and Mr Y was charged with 'wounding with intent to cause grievous bodily harm'.
74. On 31 March 2017, a District Court Judge found that Mr Y was legally insane at the time of the stabbing and therefore he was acquitted of the charge. However the Judge ordered that Mr Y be detained in a hospital as a special patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

LAWS AND POLICIES

Communications Centres

75. Calls to Police Communications Centres are answered by communicators, who gather initial information and determine whether a Police response is required. If a response is required, a dispatcher allocates Police units to attend and also gathers and passes on any further relevant information to the field units. The communicators and dispatchers are overseen by a team leader.

⁴ Police must endeavour to attend Priority 1 events immediately (within 10 minutes).

Mentally Disordered Persons

76. The Communications Centres' standard operating procedures for 'Mentally Disordered Persons' instruct communicators to find out whether the person is a committed patient, and whether they are considered a risk to themselves or others.
77. The communicator should then gather key information about the "*mentally disturbed*" person, including:
- actions or behaviour causing concern;
 - details of any weapons;
 - reason why the caller believes the person is mentally disturbed;
 - current location (public place or private property);
 - whether intoxication by drugs and/or alcohol be discounted;
 - whether the person is placing him or herself in danger/likely to commit an offence/suicidal/jeopardising public safety; and
 - whether the person is alone.
78. Communicators are instructed to immediately enter the event as Priority 1 or Priority 2, as appropriate.
79. For incidents involving mentally disordered persons:
- a Police unit should be dispatched to attend the incident "*where warranted by behaviour to take person to his or her residence ([or] to care of a responsible person)*";
 - if requested, the dispatcher should call out a Duly Authorised Officer;⁵
 - two officers are to attend the incident and, for safety reasons, the dispatcher should maintain communication with the responding officers;
 - a "QP" (Police database check) is to be "*done as a matter of course and history is to be passed to the attending personnel*"; and
 - if Police are not required to attend, the dispatcher should "*inform and dispatch in accord with District Mobilisation Procedures*" (which, in Northland, require the Mental Health Crisis Team to be called).

People with mental impairments policy

80. The 'People with mental impairments' chapter of the Police manual states:

⁵ A Duly Authorised Officer is a mental health professional, defined by section 2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 as: "*a person who, under section 93, is authorised by the Director of Area Mental Health Services to perform the functions and exercise the powers conferred on duly authorised officers by or under this Act*".

*“Police have **no** power under the Mental Health (CAT) 1992 Act to enter private property or to detain a person with a mental disorder on private property, unless asked to do so by a DAO or medical practitioner [emphasis in original].”*

81. The policy advises officers dealing with a mentally disordered person on private property to carry out a TENR (Threat, Exposure, Necessity and Response) assessment. TENR is a framework provided by Police policy which officers use to assess, reassess, manage and respond to situations, ensuring that the response is necessary and proportionate given the level of threat and risk to themselves and the public.
82. The policy sets out the Police’s powers to enter private property under sections 7, 8, 14, and 18 of the Search and Surveillance Act 2012 (when a crime, or a risk to life or safety, is suspected or a person is unlawfully at large), and refers to other potentially relevant legislation, such as section 41 of the Crimes Act 1961 (prevention of suicide) and the Trespass Act 1980. It also explains the Police’s powers to return a mental health patient who is absent without leave from hospital.
83. The policy states: *“If none of the above apply and you must take action, call a medical practitioner or DAO [Duly Authorised Officer] to the scene.”*

THE AUTHORITY’S FINDINGS

Issue 1: Did Police handle the first 111 call in accordance with Police policy, standard operating procedures and good practice?

84. Police first became aware of Ms Z’s concerns about her son, Mr Y, when she called 111 at 6.05am on 26 October 2015 and spoke to Communicator 1. Communicator 1 sought information from Ms Z and recorded it in the CAD system in accordance with Police policy and good practice.
85. While other codes could have been used for this event (such as ‘domestic assault’), the Authority considers that it was reasonable for Communicator 1 to use the ‘mental health’ code in light of the information obtained from Ms Z during the call. Notwithstanding the ‘mental health’ code, Police were required to attend the incident due to the pushing that had occurred, Ms Z’s concerns for her and her family’s safety, and her fear that Mr Y’s behaviour would escalate. The assigned level of ‘Priority 2’ was appropriate in the circumstances, as it required Police attendance within a short time.
86. Communicator 1 mistyped part of the headline of the event, which suggested that the informant (Ms Z) had been pushing someone earlier when actually Mr Y had been pushing her. Even if Communicator 1 had noticed the error at the time, he could not have amended the headline to reflect the true situation. He did not respond to Dispatcher 1’s question about the headline because he did not see it, but later said the answer would have been clear from the rest of the Event Chronology.

87. The headline appears to have caused some initial confusion for Dispatchers 1 and 2, and Dispatcher 2 suggested that this may have led them to downplay the assault aspect of the incident when consulting officers in the field. The pushing was only mentioned in the headline of the event and, although Communicator 1 had gathered further information about the pushing from Ms Z, he chose not to add it to the Event Chronology. He did, however, add a 'Family violence' flag to the event.
88. Dispatcher 1 promptly read the event created by Communicator 1, and sought advice from her team leader. The dispatcher then called the field supervisor on duty, Officer A, to obtain his direction on whether it was necessary to dispatch the on-call officer to attend this event.
89. Dispatcher 1 did not convey all the relevant facts about Ms Z's call to Officer A, particularly that pushing had taken place and there were children in the house. This hindered Officer A's ability to make an informed decision on whether Police attendance was necessary. Officer A later said that if he had known the full story, he would have directed that Police should be dispatched by 7am to attend the incident. Instead he instructed Dispatcher 1 to put the event on hold until the Crisis Team had visited at 10am.
90. If Police had attended and established contact with Ms Z early that morning, they would have been in a better position to assess the situation and take appropriate action. Depending on the circumstances, such action could have included: calling on the Crisis Team for earlier assistance, ensuring Ms Z and her family were safe while they waited for the Crisis Team to arrive at 10am, persuading Mr Y to leave the house, trespassing him from the property, or arresting him for assault. In the Authority's view, the stabbing of Ms Z may have been avoided if Police had visited the address earlier.
91. Dispatcher 1 correctly updated the event in the CAD system following her discussion with Officer A, and noted that the Kaikohe officers on the early shift should be advised when they came on duty (at about 8am). However Dispatcher 2 forgot to notify the officers about the event. Officer B was already aware of the incident, but was not given any further details until later.
92. At about 10.10am, after no further calls from Ms Z, Communicator 2 closed the event. Police had unsuccessfully tried to contact Ms Z before taking this action, but did not leave a message when she did not answer her phone. The Authority considers that Police should not have closed the event without informing Ms Z of their decision to wait for the Crisis Team, particularly as there had been an assault, she was concerned for her safety and Communicator 1 had earlier told her Police would try to attend.

FINDINGS

Police should have attended this event earlier, and should not have decided to put it on hold until the Crisis Team's visit took place.

Dispatcher 1 should have advised Officer A of all the relevant information.

Dispatcher 2 should have alerted the Kaikohe officers to this event when they started their shift.

The event should not have been closed without first advising Ms Z of the Police's decision.

Issue 2: Did Police handle the second 111 call in accordance with Police policy, standard operating procedures and good practice?

93. Ms Z called Police again at 10.43am to report that the Crisis Team were refusing to help Mr Y because, in their view, he was not sick enough. Communicator 3 answered this call, and created a new event in the CAD system.
94. Communicator 3 generally handled this call in a manner consistent with Police policy and good practice and, in the Authority's view, gave the event the appropriate coding and priority level. She correctly recorded most of the information provided by Ms Z, but mistakenly added that Police had attended an earlier incident (this was her interpretation of the Event Chronology for the first 111 call). Ms Z's concerns for her safety were mentioned in the Event Chronology for this second event but were again left out of the headline.
95. Communicator 3 wrote that Mr Y was "*calm*" although Ms Z had actually told her "*I know he's just gonna smash up everything*". This may have had the effect of downplaying Ms Z's concerns, as had happened with the first call. However the Authority finds it was reasonable for Communicator 3 to conclude that Mr Y was calm at that point, on the basis that the Crisis Team nurses were leaving Mr Y at the house and she did not believe they would do so if he was aggressive.
96. Upon seeing this second call from Ms Z, Dispatcher 2 contacted the Kaikohe officers who were already in Omapere on an unrelated matter. Officer B told the dispatcher he was aware of the earlier event, and Dispatcher 2 did not fully relay all the information from both of Ms Z's calls (including that Ms Z had been pushed) to Officer B at this stage. Officer B decided that he and Officer C would complete their other enquiries before getting further details about Ms Z's second call.
97. At 11.08am Dispatcher 2 called Officer B and advised him of most of the information obtained from Ms Z's calls. Officer B decided to phone Ms Z to discuss what she wanted from Police. Before that happened, Ms Z's daughter called Police to report that Mr Y had stabbed their mother.
98. The Authority considers that Police should have treated Ms Z's second call with more urgency given that an assault had occurred, Ms Z feared that Mr Y's behaviour would escalate, and she was concerned enough to call Police for a second time. Officers B and C were nearby when the second call came in, and if they had visited Ms Z's address immediately instead of completing their other enquiries, the stabbing may not have occurred. However the Authority acknowledges that Dispatcher 2's and Officer B's sense of the urgency would have been influenced by the Crisis Team's decision not to remove Mr Y from the house.

FINDING

Police generally handled the second 111 call in accordance with Police policy, standard operating procedures and good practice. However Police should have treated the call with more urgency given Ms Z's ongoing concerns.

Issue 3: Did Police handle the third 111 call in accordance with Police policy, standard operating procedures and good practice?

99. At 11.15am, Ms Z's daughter called 111 and stated that her brother had stabbed Ms Z. Communicator 4 immediately created a Priority 1 event, and Dispatcher 2 notified Officer B and an ambulance.
100. Officers B and C arrived at the scene within about three and a half minutes and arrested Mr Y. Ms Z received first aid and Dispatcher 2 arranged for her to be transported to hospital by helicopter.
101. The Authority finds that Police responded promptly and appropriately to this third 111 call.

FINDING

Police handled the third 111 call in accordance with Police policy, standard operating procedures and good practice.

SUBSEQUENT POLICE ACTION

102. Police undertook a review of the Communications Centres' handling of this incident, in particular the actions of Dispatchers 1 and 2.
103. The Police review noted that Police are currently considering whether to change the coding system used for events in the CAD system.
104. Police have also advised the Authority that they have introduced a new online training course on mental health, which is currently being rolled out.

Ongoing work regarding mental health

105. The Authority notes that ongoing work is being undertaken by Police and Mental Health Services throughout the country to ensure that there is a more co-ordinated inter-agency response to calls for service relating to those experiencing a mental health crisis. This work is being undertaken within the framework of a Memorandum of Understanding that was signed by the Commissioner of Police and the Director-General of Health in 2015, backed up by Service Level Agreements in most Police Districts.

106. The intent of this work is to ensure that Police only respond to such calls on their own when there is an emergency. Otherwise there should be effective co-ordination between the two agencies before action is taken, and Mental Health Services should be the primary decision-makers.
107. If effective arrangements of this sort had been in place in the local area at the time of this event, there would have been communication between Police and Mental Health Services to determine the nature of the response that was required before the Crisis Team appointment at 10am. At the least that would have enabled Police decision-makers to take into account the information on Mr Y that was already held by Mental Health Services. It would also have enabled the latter to determine whether the visit from the Crisis Team needed to be brought forward.
108. The Authority understands that further work is now being undertaken by the Northland Police District and the Northland District Health Board to develop strategies to ensure effective co-ordination in the initial response to all non-emergency calls.

CONCLUSIONS

109. Ms Z twice sought assistance from Police before she was seriously injured by her son on 26 October 2015.
110. The Authority has determined that Police should have attended Ms Z's address following her first 111 call, and should not have closed the event without advising her of their decision not to attend. Police underestimated Ms Z's concerns and did not respond to the first and second 111 calls with enough urgency.
111. Police responded promptly to the third 111 call reporting that Mr Y had stabbed Ms Z, and handled that event appropriately.



Judge Sir David Carruthers

Chair
Independent Police Conduct Authority

11 May 2017

IPCA: 15-0849

ABOUT THE AUTHORITY

Who is the Independent Police Conduct Authority?

The Independent Police Conduct Authority is an independent body set up by Parliament to provide civilian oversight of Police conduct.

It is not part of the Police – the law requires it to be fully independent. The Authority is overseen by a Board, which is chaired by Judge Sir David J. Carruthers.

Being independent means that the Authority makes its own findings based on the facts and the law. It does not answer to the Police, the Government or anyone else over those findings. In this way, its independence is similar to that of a Court.

The Authority employs highly experienced staff who have worked in a range of law enforcement and related roles in New Zealand and overseas.

WHAT ARE THE AUTHORITY'S FUNCTIONS?

Under the Independent Police Conduct Authority Act 1988, the Authority:

- receives complaints alleging misconduct or neglect of duty by Police, or complaints about Police practices, policies and procedures affecting the complainant in a personal capacity;
- investigates, where there are reasonable grounds in the public interest, incidents in which Police actions have caused or appear to have caused death or serious bodily harm.

On completion of an investigation, the Authority must form an opinion about the Police conduct, policy, practice or procedure which was the subject of the complaint. The Authority may make recommendations to the Commissioner.



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