IPCA
Independent Police Conduct Authority
Whaia te pono, kia puawai ko te tika

The Police investigation into Nathan Booker's death

INTRODUCTION

1. Nathan Booker, aged 15, was severely disabled and regularly stayed at a respite care facility in Palmerston North. On 10 January 2014, Nathan died after drowning in a bath at the respite care facility.

2. Nathan's mother, Angela Middlemiss, complained to the Authority on 30 June 2014 that Police had not properly investigated her son's death and had failed to lay criminal charges against the caregiver who left Nathan unattended in the bath.

3. The Authority conducted an independent investigation. This report sets out the results of that investigation and the Authority's findings.

4. The Authority concluded its investigation in July 2015, but delayed the release of its public report due to the ongoing court proceedings.

BACKGROUND

5. Nathan Booker suffered from cerebral palsy and epileptic seizures, and required a high level of care. His mother, Angela Middlemiss, told the Authority:

> *"… [Nathan] couldn't speak very well, he couldn't ask you to feed him. He wouldn't know how to ask so you had to guess if he was hungry, thirsty, you had to change his nappy 'cos he was still in nappies and he was in a wheelchair and quite flimsy so he had no support, only in his arms and his legs to a certain degree. One side was paralysed."*

6. Due to his very high needs, Nathan routinely spent two days a week in a respite care facility run by IDEA Family/Whanau Services at Woburn Place in Palmerston North.

7. On Friday 10 January 2014, Ms Middlemiss dropped Nathan off at the care facility at about 3.30pm. Six children, including Nathan, were staying overnight and two staff were on duty: Ms X and Mr Y. Ms X and Mr Y had worked part-time at the care facility for two years and five years respectively.

8. That evening Mr Y fed Nathan his dinner at about 7.00pm, and at about 7.30pm Ms X gave him his medication. Ms X then prepared a bath for Nathan and, using a sling and a hoist, placed him in the bath at about 8.30pm.

9. After washing Nathan, Ms X left him alone in the bathroom from about 8.45pm to 9.00pm while she attended to other children. She returned to check on Nathan several times during that period.

10. At about 9.00pm Mr Y opened the bathroom door to talk to Nathan and found him submerged under the bath water. He noticed vomit in the bath, and when he lifted Nathan's head out of the water he saw there was vomit in his mouth. He checked for a pulse but could not find one.

11. Mr Y called out to Ms X and she helped him lift Nathan out of the bath and onto the floor. Mr Y commenced CPR while Ms X called an ambulance, at 9.09pm.

12. Two ambulances arrived at 9.12pm and 9.14pm respectively. One of the paramedics later said that Mr Y told them Nathan had been underwater for three to five minutes. The paramedics took over performing CPR and at 9.34pm Nathan was transported to Palmerston North Hospital.

13. A supervisor from the respite care facility went to Ms Middlemiss's house and advised her that Nathan was in hospital after having an accident. When she arrived at the hospital a doctor explained that Nathan had drowned, and his heart had stopped. Although medical intervention had restarted his heart, he was not breathing on his own and it was uncertain whether he would make it through the night.

14. Later that evening Nathan was taken off life support. He was pronounced dead at 11.58pm.

Police investigation

15. Police were advised of Nathan's death and attended the hospital and the respite care facility that night. The water in the bath Nathan was using had already been drained and the area had been cleaned. Consequently the level of the bath water is not known for certain, however one of the paramedics later said the bath was *"at least a third full"* and two other paramedics said it was about half full.

16. The attending officers prepared a 'sudden death' report for the Police's Criminal Investigation Branch (CIB) which stated: *"It is clear that this death needs further investigation to establish culpability on the part of any person and whether any criminal liability is established."*

17. According to Police policy, the circumstances of Nathan's death required a 'category 2' homicide investigation and subsequently, as a minimum, a detective senior sergeant should have been appointed to lead the investigation.[1]

[1] 'Category 2' includes murder investigations (where the offender is known or is *"likely to be identified in a timely manner"*), manslaughter investigations, and serial rape investigations.

18. Officer A, a constable, was assigned to investigate Nathan's death. Officer A had been selected to become a detective but was inexperienced as an investigator and had not completed CIB training. Officer A was supervised by Officer B, an acting detective sergeant. Officer B later told the Authority that while Officer A (and another officer) completed the enquiries, she maintained overall command of the investigation and Officer A did nothing without her knowledge or direction.

19. A detective senior sergeant, Officer C, was briefed about the case but there is no record of his involvement apart from a review he completed at the end of the investigation.

20. Officer A prepared a basic investigation plan and:

    a) conducted a scene examination, including photographs;

    b) obtained statements from Ms X and Mr Y, Ms Middlemiss and Nathan's regular caregiver, and from other witnesses including the attending paramedics and other caregivers at the respite care facility;

    c) obtained communication records, Nathan's care plan, and the employment and training records for Ms X and Mr Y; and

    d) received pre-prepared statements from three managers of the respite care facility.

21. After reviewing the information obtained, Officers A and B were of the view that there was not sufficient evidence to prove that Ms X or Mr Y had been grossly negligent (as required for a manslaughter prosecution based on a breach of a legal duty).[2]

22. Officer C reviewed the investigation on 6 February 2014 and decided not to lay any criminal charges. He did not seek a legal opinion on the matter. Although Police policy states that investigations led by a detective senior sergeant should be overseen by a detective inspector, that did not occur in this case.

23. The respite care facility did not notify WorkSafe New Zealand (WorkSafe) about Nathan's death; however WorkSafe found out about it through an article in the media and subsequently commenced their own investigation.[3]

24. Police subsequently liaised with WorkSafe and disclosed the statements they had gathered but, as the Police investigation had been completed before the WorkSafe investigation commenced, did not take any steps to obtain information gathered by WorkSafe and assess whether it could support a criminal prosecution.

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[2] Section 150A of the Crimes Act 1961 states that the omission to perform the legal duty must be *"a major departure from the standard of care expected of a reasonable person in the circumstances."*

[3] WorkSafe NZ is New Zealand's workplace health and safety regulator, and may conduct investigations to determine the causes of harm in the workplace and take action to prevent the recurrence of harm. In this case WorkSafe prosecuted IDEA Services for failing to take all practicable steps to ensure people were not harmed by their employees (section 15 of the Health and Safety in Employment Act 1992). IDEA Services pleaded guilty to the charge, and was fined $63,500 and ordered to pay $90,000 in reparation to Nathan Booker's family in March 2015.

The Police's meeting with Ms Middlemiss

25. Officers A and B met with Ms Middlemiss in February 2014 to advise her Police would not be laying any criminal charges against staff at the respite care facility.

26. Ms Middlemiss later told the Authority that she did not accept the Police's explanation for why they were not laying charges. She said Officer A had a sarcastic attitude during the meeting and, when arguing that it was unrealistic to expect constant supervision of Nathan, told her: *"I could've done you for neglect by not sleeping in the same room as your son or [not] being in the lounge with him when he was in the lounge."*

27. Ms Middlemiss alerted the officers to a 2010 case which was very similar to Nathan's, where a caregiver in Auckland pleaded guilty to a charge of manslaughter after leaving a cerebral palsy patient in a bath and was sentenced to 400 hours of community service. She told the Authority that Officer A was *"pre-determined"* not to take the case seriously and:

> *"… was sympathetic but very sarcastic at the same time. Like telling me that I'm just overreacting and … [when] I gave him that case, … he turned around and said to me,* "You seriously want me to do this big, massive investigation for 40 hours a week?" *I said,* "Yes I do." *It's like he didn't want to do all that work just for 40 hours a week, 40 hours a week community service or whatever it is. Forty hours' community service. I wanted it for justice. I wanted [Ms X] to know that she did wrong."*

28. When the Authority interviewed Officer A, he strongly denied that he had said the comments alleged by Ms Middlemiss and said that he grew up with a family member with similar needs to Nathan and totally understood disability of this type. Officer B could not recall Officer A saying anything about "40 hours' *community service"* and did not believe Officer A was insensitive during the meeting. Officer B thought Ms Middlemiss may have taken what Police explained to her *"out of context"*.

Complaint from Ms Middlemiss

29. Ms Middlemiss complained to the Authority on 30 June 2014, saying:

> *"My son died tragically and I feel police did not take the investigation seriously because they didn't understand disability. I even showed the cops a similar case where the person was charged with negligence causing death, manslaughter, still police never charged* [Ms X] *for leaving my son unattended in a bath causing him to drown causing death."*

Police review of the original investigation

30. As required by law, the Authority notified Police of Ms Middlemiss's complaint. Police decided to review the case.

31. The Police investigator who conducted the review was a detective inspector. He interviewed Ms Middlemiss and Officers B and C, and obtained WorkSafe's investigation file.

32. The Police investigator concluded in his review that:

a) Officer A investigated the case under the strict supervision of Officer B, an acting detective sergeant. Officer C, a detective senior sergeant, had active oversight of the investigation and therefore the investigation complied with Police policy (which required the investigation to be led by a detective senior sergeant).

b) Officers B and C failed to adequately document their decision-making process regarding the decision not to lay any criminal charges.

c) In accordance with best practice, Officer C should have obtained a legal opinion in relation to criminal liability before deciding not to prosecute.

d) The three pre-prepared statements received from managers at the respite care facility lacked sufficient detail and were not taken in accordance with the principles of the Police's investigative guidelines.

33. The above matters have been addressed with Officers B and C.

34. Following the review Police sought a legal opinion on the case, and then assigned a detective senior sergeant to carry out further enquiries.

Manslaughter charge

35. On 7 May 2015 Police charged Ms X with manslaughter in relation to Nathan's death.

36. In November 2015 the Crown Solicitor decided to ask leave to withdraw the manslaughter charge against Ms X. The charge was withdrawn in the Palmerston North High Court on 7 December 2015.

THE AUTHORITY'S INVESTIGATION

37. The Authority interviewed Ms Middlemiss, Officers A, B and C and the WorkSafe investigator, and reviewed the Police files relating to Nathan's death.

38. When investigating this matter the Authority did not consider the issue of whether or not the Police should have prosecuted anyone in relation to Nathan's death following the initial Police investigation.

39. The Authority has considered the following issues:

1) Did Police carry out their initial investigation into Nathan Booker's death adequately, and did that investigation comply with Police policy?

2) Was Officer A insensitive during the meeting with Ms Middlemiss?

THE AUTHORITY'S FINDINGS

Issue 1: Did Police carry out their initial investigation into Nathan Booker's death adequately, and did that investigation comply with Police policy?

40. Police policy required that the investigation into Nathan's death be led by a detective senior sergeant. In this case Officer A was assigned the investigation and conducted the enquiries. He was a constable, had not completed CIB training, and did not have experience in investigating complex matters. However Officer A was closely supervised by Officer B, an acting detective sergeant.

41. It appears that Officer C (a detective senior sergeant) was briefed by Officer B at times during the investigation but there is no documented record of those briefings. Although Officer C reviewed the completed investigation and made the final decision not to lay criminal charges, in the Authority's view it cannot be said that he 'led' the investigation and therefore Police failed to comply with policy in this respect. Furthermore the investigation was not overseen by a detective inspector, as required by policy.

42. After reviewing the Police's investigation, the Authority considers that it was inadequate in the following areas:

a) The investigation plan prepared by Officer A did not clearly identify which legal offences may have been committed by Nathan's caregivers and what evidence would be required to prove gross negligence.

b) Ms X and Mr Y were treated as witnesses rather than people who were potentially guilty of an offence. They were not interviewed under a Bill of Rights caution and the statements obtained did not sufficiently address the issue of gross negligence and what they understood the risks to be if they left Nathan alone in the bath.

c) Similarly, the three statements from managers of the respite care facility were pre-prepared and did not sufficiently address the issue of gross negligence. The statements did not contain enough information regarding supervision and training of staff, care plans, medication, and what was expected of staff, particularly at bath time. The Authority acknowledges that Police sought to interview the respite care facility managers and, after they refused to participate, accepted the pre-prepared statements as a last resort. However the Authority considers that Police should have made more of an effort to obtain the information relating to the issue of gross negligence (as described above), by asking follow-up questions or further seeking interviews with the managers.

d) Police did not seek expert evidence on the effects of Nathan's medication (such as whether it could have made him more drowsy during the bath), or the risks his health conditions posed to him while bathing. They also did not complete a timeline of what occurred on the night of Nathan's death.

e) Police did not obtain a legal opinion once the investigation was completed. Cases of negligence causing death are typically complex and Police should have sought legal advice before deciding not to lay charges. As noted in the Police review, Officers B and C did not adequately document the reasons for their decision not to prosecute anyone.

FINDING

Police did not carry out their initial investigation of Nathan Booker's death adequately and did not comply with Police policy regarding 'category 2' homicide investigations.

Issue 2: Was Officer A insensitive during the meeting with Ms Middlemiss?

43. Officers A and B met with Ms Middlemiss in February 2014 to advise her they would not be laying any criminal charges in respect of her son's death.

44. Ms Middlemiss told the Authority that Officer A had a *"sarcastic attitude"* during the meeting, made insensitive comments and dismissed the fact that she had found a very similar case where a caregiver had been convicted of manslaughter.

45. When interviewed by the Authority, Officer A strongly denied that he had made the comments. Officer B also denied that Officer A had made insensitive comments and suggested that Ms Middlemiss may have misinterpreted what she and Officer A said to her.

46. Faced with this conflicting evidence, and without further independent evidence of what occurred during the meeting, the Authority is unable to determine whether Officer A was insensitive during the meeting with Ms Middlemiss.

FINDING

Due to conflicting evidence, the Authority is unable to make a finding on whether Officer A acted insensitively during their meeting with Ms Middlemiss.

CONCLUSIONS

47. The Authority has determined that the Police did not initially investigate Nathan Booker's death adequately, and did not comply with policy regarding 'category 2' homicide investigations. The Authority was unable to make a finding in respect of Ms Middlemiss's complaint that Officer A was insensitive when Police met with her in February 2014.

SUBSEQUENT POLICE ACTION

48. Police have advised the Authority that, as a result of this incident, they have taken the following actions:

    a) The Central District Commander has directed that greater emphasis and senior oversight is required for the decision making process regarding prosecution of suspicious deaths or death involving criminal culpability. Subsequently a review of all current death investigations was conducted, including fatal crashes and workplace deaths.

    b) Senior leadership for Central District CIB has changed and all detective senior sergeants and detective sergeants have been advised about the threshold of notification for suspicious deaths or deaths involving criminal culpability to the District Manager: Criminal Investigations (DM:CI), a detective inspector.

    c) In Central District:

        i) all suspicious deaths or deaths involving criminal culpability are immediately notified to DM:CI;

        ii) all detective senior sergeants are now required to document active homicide investigations in monthly written reports to the DM:CI; and

        iii) a decision not to prosecute must be approved by the DM:CI.

    d) Nationally, the National Manager: Criminal Investigations has taken steps to ensure that all crime managers remind their staff of the existing requirements of Police policy regarding the investigation of deaths.

49. Police are also working to update their existing Memorandum of Understanding with WorkSafe New Zealand to address the information-sharing issues identified in this case.

Judge Sir David Carruthers

Chair
Independent Police Conduct Authority

21 December 2015

IPCA: 13-2190

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 on whether any Police conduct, policy, practice or procedure (which was the subject of the complaint) was contrary to law, unreasonable, unjustified, unfair, or undesirable. The Authority may make recommendations to the Commissioner.

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