IPCA

Independent Police Conduct Authority

Whaia te pono, kia puawai ko te tika

Police response to missing person report regarding Nicholas Stevens

May 2016

Contents

Introduction 3
Background 6
The Authority's Investigation 30
The Authority's Findings 31
Subsequent Police Action 39
Conclusions 41
Recommendations 42
Applicable Laws and Policies 43

Introduction

1. At 2.38pm on Monday 9 March 2015, the Henry Rongomau Bennett Centre in Hamilton notified Police that a committed patient, Nicholas Taiaroa Macpherson Stevens, aged 21, had gone missing. Police were aware that Nicholas Stevens was at risk of suicide.

2. Two days later, on the afternoon of 11 March 2015, Police commenced a Search and Rescue operation for Nicholas Stevens. A member of the public found Nicholas Stevens' body in the Waikato River the next morning.

3. Nicholas Stevens' family complained to the Authority on 22 May 2015 about:

   a) the *"slowness and half-heartedness"* of the Police's response to the missing person report;

   b) Police overlooking information provided to them that Nicholas Stevens was a serious suicide risk and had threatened to drown himself;

   c) the Police's handling of a media release related to Nicholas Stevens; and

   d) the failure of the Commissioner of Police's and the Waikato District Commander's offices to respond to an email from Nicholas Stevens' father, Dave Macpherson, on 10 March 2015. The email expressed his concerns regarding the lack of contact from Police about what was being done to locate his son.

4. The Authority conducted an independent investigation into the family's complaints. This report sets out the results of that investigation and the Authority's findings and recommendations.

5. The Authority has examined issues relating to the Police Northern Communication Centre's handling of the missing person report, the oversight of the incident by the Waikato District Command Centre, the Police's search for Nicholas Stevens, Police media releases, and whether Police liaised appropriately with Nicholas Stevens' family while he was missing.

6. The Authority notes that it has no jurisdiction to review or comment on the actions of any person other than Police involved in this case.

Index of key officers

Communications Centre Staff	Roles/Comment
Communicator 1	Answered the call from the HBC nurse reporting that Nicholas Stevens was missing at 2.38pm on 9 March 2015, and created a 'missing person' event.
Dispatcher 1	Read the missing person event created by Communicator 1 at 2.38pm on 9 March 2015 and decided to broadcast a message to all officers and alert the Hamilton City CCTV operators. Placed the event on hold for two hours.
Dispatcher 2	Read the missing person event at 4.55pm and arranged for a Whitianga unit to check an address for Nicholas Stevens.
Dispatcher 3	At 11.43pm on 9 March 2015, placed the missing person event on hold until 1pm the next day.
Hamilton public counter staff	
Ms Z	Spoke to Jane Stevens and Dave Macpherson at the Hamilton Police Station public counter on 9 March 2015.
Waikato DCC staff	
DCC supervisor	Senior sergeant on duty from 3pm on 9 March 2015. Read the missing person event relating to Nicholas Stevens.
Intel Support Officer	On duty from 2pm on 9 March 2015. Noted the missing person event for Nicholas Stevens.
Waikato District Police	
Officer A	Acting senior sergeant on duty until 4.30pm on 9 March 2015. Did not hear Dispatcher 1's broadcast and was not notified of missing person event relating to Nicholas Stevens.
Officer B	Acting sergeant on duty from 3pm on 9 and 10 March 2015. On 9 March, Dispatcher 1 mentioned that she had forgotten to notify the custody sergeant about Nicholas Stevens, and they discussed their expectation that the HBC would fax their missing person report to Police. On 10 March, he was assigned to contact Dave Macpherson but passed the job on to Officer F.
Officer C	Custody sergeant on duty from 3pm until 11pm on 9 March 2015. Not aware of missing person event relating to Nicholas Stevens, or that fax from HBC should have arrived.
Officer D	Custody sergeant on duty on 10 March 2015 from 6.45am to 3pm. Advised of missing person event at about 7.30am, located the fax from the HBC and gave report to the File Management Centre.
Officer E	Senior constable, officer in charge of missing persons. Assigned the file for Nicholas Stevens on 10 March 2015. Conducted bank enquiries and rang HBC to confirm Nicholas Stevens had not returned.
Officer F	Custody sergeant on duty from 3pm to 11pm on 10 March 2015. Assigned the task of contacting Dave Macpherson, and called him

	at about 11pm.
Officer G	Acting detective sergeant, Officer E's supervisor. Assumed responsibility for the missing person file relating to Nicholas Stevens on morning of 11 March 2015.
Officer H	Detective senior sergeant, Officer G's supervisor.
Officer I	Detective sergeant. Assumed responsibility for the missing person file, including oversight of SAR operation, from 2.45pm on 10 March 2015 (while Officer G off duty).
Officer J	Sergeant in charge of SAR. Conducted search for Nicholas Stevens on 11 and 12 March 2015.
Communications Manager	Drafted media release relating to Nicholas Stevens on 11 March 2015.
District Commander	Copied into an email from Dave Macpherson on 10 March 2015.

Background

ADMISSION TO HENRY RONGOMAU BENNETT CENTRE

7. Twenty-one year old Nicholas Stevens, who suffered from schizophrenia, was admitted to Waikato Hospital on 17 February 2015 following a serious suicide attempt. On 19 February 2015 he was transferred to the Henry Rongomau Bennett Centre (HBC) and his compulsory treatment order status was changed from community patient to inpatient.[1]

8. While he was being treated at the HBC, Nicholas Stevens' psychiatrist allowed him to have unescorted leave for periods of 15 minutes, usually so he could have a cigarette. Since Waikato Hospital has a no-smoking policy, patients are required to leave the grounds to smoke.

9. Nicholas Stevens' parents, Dave Macpherson and Jane Stevens, repeatedly expressed their concerns to the HBC about allowing Nicholas Stevens to have unescorted leave for extended periods of time. In Police statements, they said Nicholas Stevens told his mother and brother that he had gone to the Waikato River while on unescorted leave and tried to drown himself. Nicholas Stevens also told his parents he had gone drinking with friends during unescorted leave.

10. The unescorted leave was stopped for a short time until Nicholas Stevens was assigned a new psychiatrist, who subsequently approved unescorted leave for Nicholas Stevens for 15 minutes twice a day. Nicholas Stevens' parents continued to raise their concerns with the HBC, but the approval for unescorted leave remained in his treatment plan.

EVENTS ON 9 MARCH 2015

Nicholas Stevens leaves the HBC

11. CCTV footage from the HBC shows that Nicholas Stevens had four periods of unescorted leave from about 8am on the morning of Monday 9 March 2015.

12. At about 12.30pm, Nicholas Stevens left the HBC on a fifth unsupervised break. He re-entered the building twice, including visiting the toilets, before finally leaving through the western exit at 12.59pm. He walked around to the eastern side of the HBC building and was last captured on CCTV footage just after 1pm, walking down a gully heading towards the Waikato River.

13. At about 1.30pm a group of Nicholas Stevens' friends arrived at the HBC to visit him, but he could not be found. At 2pm, the HBC notified Jane Stevens that her son was missing. HBC staff searched the immediate area, and at 2.38pm a nurse called the general line (not 111) at the

---

[1] Under the Mental Health (Compulsory Assessment and Treatment) Act 1992, the court may make a compulsory treatment order relating to a person who, following assessment, is found to be *"mentally disordered"*. Compulsory treatment orders are either: (a) *"inpatient orders"* – where the person is required to be continually detained at a hospital for treatment; or (b) *"community treatment orders"* – where the person is given treatment as an outpatient.

Police Northern Communications Centre (NorthComms) to report that Nicholas Stevens was missing.

HBC notifies Police

14. Communicator 1 answered the call, and the nurse advised that he was calling from the HBC at Waikato Hospital. He said he wanted to report a missing person and had already faxed the details to Police.

15. The HBC nurse gave Communicator 1 Nicholas Stevens' name and date of birth. Communicator 1 then requested the HBC nurse's name and the contact number for the ward. He asked whether Nicholas Stevens was a patient and the HBC nurse confirmed that he was.

16. Communicator 1 enquired about when Nicholas Stevens had gone missing, and the HBC nurse explained that he had left on unescorted leave at 12.30pm but never returned to the ward. The HBC nurse said he had informed Nicholas Stevens' mother, and that *"… he came to the hospital because he cut his wrist, attempted suicide. … At the moment he's low risk but still potential to self-harm and stuff like that."*

17. In response to further questions from Communicator 1, the HBC nurse advised that Nicholas Stevens was New Zealand European, wearing a black hoodie and a dark green top underneath, with black trousers and bare feet. He confirmed Nicholas Stevens' age, and said he was of slim build.

18. Communicator 1 asked: *"Was he mentally okay today or was he feeling suicidal?"*, and the HBC nurse replied: *"He was not too bad, he was quite stable and was taking his regular medications but he's diagnosed with Psychotic Disorder and Schizophrenia."*

19. After a pause, Communicator 1 said: *"And in the past, has he tried to commit suicide or were they, was he just threatening it?"* The HBC nurse said: *"Uh no he, he had quite serious damage to wrist"* which required him to have surgery to get his tendon fixed, so it *"can be, you know, very serious"*.

20. Communicator 1 then asked whether Nicholas Stevens was physically okay when he left that day, and the HBC nurse said he was but he had a dressing and a cast on his left arm. He also mentioned that Nicholas Stevens' right arm had a dressing but that had been taken off. The HBC nurse confirmed that the dressings were needed because Nicholas Stevens had cut himself, and Communicator 1 asked when that had happened. The HBC nurse said Nicholas Stevens was admitted *"maybe about 10 days ago, something like that"*,[2] and had been found in the bathroom by his friends after the suicide attempt.

21. The HBC nurse stated a possible address for the attempted suicide, then commented *"or down by the river as per family."* Communicator 1 said: *"So his likely destination may be towards the river?"* and the HBC nurse said yes, because about a week ago he told his family he was going to drown himself, *"so that's where, another place the family's thinking."*

[2] The suicide attempt was actually 20 days earlier.

22. Communicator 1 continued gathering information from the HBC nurse, who advised that Nicholas Stevens did not have access to any transport and, as far as he knew, did not have any money with him. He said Nicholas Stevens would be due to have medication in the evening and would be *"quite familiar"* with the area. He also confirmed that he had already informed Nicholas Stevens' mother and had faxed a missing person report to Police.

23. Although the HBC nurse said he had faxed a missing person report to Police, the fax was not actually sent. Another HBC nurse discovered the report sitting in the fax machine tray about 10 hours later, and sent it through to the Hamilton Police Station watchhouse at 1.08am on 10 March 2015.

24. The HBC nurse told Communicator 1 that Nicholas Stevens would not go to his family because he did not want them involved, but provided the phone number and address for his mother, Jane Stevens.

25. Communicator 1 said: *"Okay we've made local Police aware that he's gone missing so they'll be able to look out for him, or anyone matching that description."* The HBC nurse said he would also inform the Crisis Team in case they were in contact with Nicholas Stevens, and promised that the HBC would let Police know as soon as they got any further information. Communicator 1 provided the HBC nurse with the Police event number and ended the call, which lasted just over 10 minutes.

26. Communicator 1 did not ask whether Nicholas Stevens had a cell phone, which may have been useful information because it could potentially be used to track his location. However Nicholas Stevens did not have a cell phone, so this had no effect on the outcome of the incident.

NorthComms' response

Communicator 1

27. Throughout the phone call with the HBC nurse, Communicator 1 entered the information he received into an 'Event Chronology' in the Police's Computer Aided Dispatch (CAD) system, with the headline *"MENTAL HEALTH PATIENT NOT RETURNED FROM LEAVE – LAST SEEN AT 1230 HOURS"*. The event was assigned Priority 2 and coded as *"2M – Missing Person"*.

28. Along with the other information about Nicholas Stevens' situation and physical description, Communicator 1 recorded that:

    - there were fears for Nicholas Stevens' safety due to his history of suicide attempts;
    - Nicholas Stevens was physically okay but had a dressing on his left arm from a suicide attempt 10 days ago;
    - Nicholas Stevens had schizophrenia; and
    - *"one possible destination is the river – family advised he has said in the past he will drown himself."*

29. Police standard operating procedures for 'Missing Persons' require communicators to advise their Shift Commander or Team Leader when there are concerns for a missing person's safety. That did not occur in this case.

30. When interviewed by the Authority, Communicator 1 could not remember this call from the HBC nurse but said he would have followed the 'six step guide' for gathering information and used the *"communicator checklist"* for missing person incidents (see paragraphs 240-255 for an explanation of the relevant policies).

31. Communicator 1 acknowledged that in this case there were genuine concerns for Nicholas Stevens' welfare, but said he would not have considered them to be *"immediate"*:

> *"The way I would have perceived it is that the way that the informant's ringing it through, given their time delay, that it's not like he has a knife with him, cutting himself right now, … that he's gone for a walk, so there is a concern for his safety because of his history but it's not something that's happening now.*
>
> *… For something like immediate [fears for safety] I would expect the informant to say something along the lines of 'He's running off to the river to kill himself now', or 'He's got a knife in his hand, he's cutting his arm now'."*

Dispatcher 1

32. The dispatcher for the Hamilton radio channel, Dispatcher 1, read the information as it was entered into the CAD system and noted in the Event Chronology that she had received it. At about 2.51pm she broadcast a message to all units saying:

> *"Comms on, 10/1 [broadcast to all units]. 10/1, 10/1 to all staff be on the lookout for the following 2M patient from the hospital. Gone AWOL, last seen at 12.30 this afternoon. The patient is Nicholas Stevens. Nicholas is 22, 23 years old, male Caucasian and today he's wearing a black hoodie, dark green top, black pants, no shoes. Previous 1X history [i.e. history of suicide attempts]. Has a dressing on his left arm. If any sightings, 10/1 out City cameras Comms."*

33. Dispatcher 1 did not mention in her 10/1 broadcast that Nicholas Stevens was a mental health patent, who may be headed to the river and had very recently tried to commit suicide. She did not alert her Team Leader or Shift Commander about the concerns for Nicholas Stevens' safety, nor did she advise the Waikato District Command Centre (DCC).

34. Police standard operating procedures for 'Missing Persons' state that dispatchers must conduct a risk assessment and, when dispatch is required due to concerns for safety, the dispatcher must dispatch a unit to the scene and alert a field supervisor.

35. The standard operating procedures also state that dispatchers must notify Search and Rescue (SAR), and consider the need for a media release. However Dispatcher 1 advised the Authority that in practice those actions are the responsibility of the supervisors, rather than the dispatchers.

36. Although the event was coded 'Priority 2', which requires Police to endeavour to be at the scene within 30 minutes, Dispatcher 1 did not consider that it was necessary to dispatch anyone to attend this incident. Nor did she think that she needed to alert a NorthComms or field supervisor, or the DCC. Instead she noted in the Event Chronology that the Hamilton City CCTV camera operators were aware of the situation and, at 2.54pm, put the event on hold for two hours.

37. When interviewed by the Authority, Dispatcher 1 said she followed the *"usual"* process for a missing person job by doing a 10/1 broadcast to all units and alerting the Hamilton City CCTV camera operators. She described the job as *"a normal 2M report that we would get on a regular basis"*. She could not recall whether she had a unit available for dispatch when the job came in (although Police have advised the Authority that there were free units at the time that could have been dispatched).

38. Dispatcher 1 commented that the two-hour time delay from when Nicholas Stevens went missing to when the HBC contacted Police, along with the coding of the incident, affected her response:

> *"If we had got the call at the time he went missing I believe I would have had a unit available to attend and do areas* [enquiries]. *But with a time delay like that, two hours, you've got, you can get quite a ways in two hours. If he's quite determined to get somewhere, and two hours is a lot of time to do it in.*
>
> *… If I felt there was more to go on, maybe if it was coded a 1X* [Suicide] *as opposed to a 2M* [Missing Person] *then maybe a different response would have been done ... but that's what I had at the time."*

39. Dispatcher 1 said that the river destination was *"possible"* but no one knew where Nicholas Stevens was going. She did not think she had enough information to justify sending any officers to the river or to the HBC, but recognised that if she had dispatched a unit to the HBC *"they probably would have found out information that we didn't get until later on."*

40. When asked whether there were fears for Nicholas Stevens' safety, Dispatcher 1 acknowledged that he had a *"previous suicide history"* but said this was not unusual with HBC patients. At the time of this incident she did not check the Police database for further information about Nicholas Stevens. Nor did she refer to the Police standard operating procedures for 'Missing Persons'.

41. Dispatcher 1 said that, in hindsight:

> *"… because of his history at the hospital or even his mental state, in a nutshell that would mean that I should have done more. … I guess, that's what I take with me.*
>
> *… I do feel for the family, I do wish things had been different. That's all I can say. I did what I thought was best with what I had at the time."*

42. Some frontline officers were due for a shift change at 3pm, and it is possible that the 10/1 broadcast from Dispatcher 1 was overlooked or not heard at the time. The acting senior sergeant on duty, Officer A, could not later recall being advised about a missing person by the name of Stevens.

43. Since no officers were dispatched to attend this incident, no search for Nicholas Stevens was commenced by Police that afternoon. Nicholas Stevens' family conducted their own search but did not find him.

44. At about 3.30pm Dispatcher 1 rang Officer B, an acting sergeant. She mentioned the missing person report for Nicholas Stevens while discussing a number of other matters with him, and said she had forgotten to pass the job on to the Hamilton Police Station watchhouse. Officer B said: *"Well they should've, the hospital will fax that through to our FMC* [File Management Centre] *anyway."* Dispatcher 1 replied: *"They're usually pretty onto it at the hospital, so that should be taken care of."*

45. Dispatcher 1 told the Authority that she asked the next Hamilton channel dispatcher who was coming on duty at 4pm, Dispatcher 2, to alert the watchhouse about the missing person report. However Dispatcher 2 had no recollection of that when interviewed by the Authority and the watchhouse was not alerted.

46. The custody sergeant at the watchhouse, Officer C, said that if he had known that a missing person report was supposed to be arriving from the HBC, he may have tried to find out what was happening with the report, taken steps to ensure a missing person file was created, and liaised with NorthComms and the DCC.

47. No missing person file was created that day, because the fax from the HBC did not arrive at the Hamilton Police Station watchhouse until 1.08am the next morning (see paragraph 20).

Jane Stevens and Dave Macpherson visit the Hamilton Police Station

48. At about 3.58pm (according to Police CCTV), Jane Stevens arrived at the Hamilton Police Station to find out what Police were doing to search for her son. She told the Authority she was extremely worried about the suicide risk to Nicholas Stevens, and conveyed that to a woman who was working at the public counter. According to the family's complaint:

> *"The receptionist was only able to confirm that a missing persons report had been logged, and that an APB alert had been placed 'in the system' but was unable to contact any serving officer to see if any action had been taken."*

49. The woman at the counter gave Jane Stevens an incident number, and Jane Stevens told her she had not seen any Police searching the Waikato riverbank (she had expected to see them there because the HBC had told her Police were out searching). Jane Stevens left the Police station at about 4.13pm.

50. At about 4.44pm Jane Stevens returned to the Police station with Dave Macpherson. They waited for about seven minutes until one of the two women working at the public counter, Ms Z, was free to help them.

51. When interviewed by the Authority, Ms Z did not remember Jane Stevens' first visit to the public counter. Jane Stevens could not recall *"100 percent",* but said she believed that she had dealt with a different woman during her first visit to the Police station.

52. According to the family's complaint:

    a) Dave Macpherson and Jane Stevens asked Ms Z whether Police had Nicholas Stevens' photograph and bank details, and she suggested that they load these onto a website for missing persons when they got home.

    b) When they asked whether any search had been commenced, she told them not to worry and that *"she had personally seen a message go out on the Police messaging service about Nicky."*

    c) They wanted to provide information about Nicholas Stevens' possible whereabouts, and Ms Z told them it would be quicker to ring an 0800 number, which she supplied, than for her to try to get onto the computer system and enter the information.

    d) *"Throughout these two visits to the counter, the parents were treated as over-anxious, and somewhat of a nuisance to a busy receptionist."*

53. Ms Z had quite a different recollection of the conversation. She told the Authority that Jane Stevens advised her they had been in contact with Police about their missing son and they wanted to give Police some information that he may be hitchhiking to Whitianga. Ms Z said she told Nicholas Stevens' parents that she would pass the information about Nicholas Stevens' possible location on to the custody sergeant, and:

    > *"… from what I can remember they were happy with that response, or you know satisfied with that. They didn't ask me any further questions or query me about anything and then they moved away from the front counter."*

54. When the Authority asked Ms Z about Dave Macpherson's and Jane Stevens' account of what happened at the counter, she denied providing them with an 0800 number or saying that they should call that number because it would be faster than her getting onto the computer. She also explained that she was a casual employee and had not seen any messages about Nicholas Stevens being missing, and could not have directed his parents to the missing person website because she was unaware that it existed. She did not recall any discussion about a photograph, or any reference to suicide or concerns for Nicholas Stevens' welfare but said: *"I felt that, you know he was from Henry Bennett* [and] *there must have been some concern for his welfare so that is why I escalated it anyway."*

55. After Jane Stevens and Dave Macpherson left the counter, Ms Z went to the custody area (the CCTV footage shows her leaving the reception area at this time). She advised the Authority: *"I believe I recorded* [the information] *on a piece of paper, on a post-it note, and then I provided*

that to the custody sergeant." Ms Z said the custody sergeant on duty (Officer C) took the information, and told her he was already aware of the missing person report for Nicholas Stevens and would take it from there.

56. Officer C told the Authority he was not aware of the missing person report that day and could not remember Ms Z handing him a post-it note or giving him any information about it. He said if he had received that information, he would have passed it on to the DCC because: *"the DCC have a better idea of staff and who's available and who's not available than the custody sergeant would."* In respect of the usual process when people bring in photographs for Police to use, Officer C said he would direct that the photographs be copied and attached to the file, and the originals returned.

57. CCTV footage shows that the conversation between Ms Z and Nicholas Stevens' parents lasted for about two and a half minutes. Dave Macpherson and Jane Stevens then stood in the lobby and made a phone call. According to their complaint, they called the 0800 number Ms Z gave them and were again advised to enter any new information onto the missing persons website.

NorthComms advised of potential location

Dispatcher 2

58. Meanwhile, at 4.55pm, the missing person event for Nicholas Stevens came off its two-hour hold at NorthComms and appeared in Dispatcher 2's 'pending jobs' queue. Dispatcher 2 read the Event Chronology and ran a check on the Police database to confirm Nicholas Stevens' identity. The Police database had a 'self-harm' alert for Nicholas Stevens from 2009, but did not yet have a 'missing person' alert. This was because the fax of the missing person report from the HBC had not arrived at the Hamilton Police Station and therefore no missing person file had been created.[3]

59. Dispatcher 2 and other NorthComms staff have advised the Authority that it is common for there to be a delay in the creation of missing person files, and sometimes they have to chase up the HBC to send in the missing person report form. The missing person event cannot be closed by NorthComms until the file has been created and an officer has been assigned.

60. When interviewed by the Authority, Dispatcher 2 said that from his reading of the Event Chronology relating to Nicholas Stevens:

> *"… there was a history of suicide attempts, but from reading the job there was no current intention that … we could discern that there was a current intention for him to commit suicide. Mental Health had not called us for two hours. They did not appear to show any urgency in notifying Police.*
>
> *… Mental Health who had been looking after him did not appear to share any concern that there was an immediate risk of him committing suicide.*

[3] Consequently, if any Police officers on the street had been in contact with Nicholas Stevens and checked the database, they would not have known that he was missing from the HBC. However the Authority has not found any evidence to suggest that any officers were in contact with Nicholas Stevens after he left the HBC on 9 March 2015.

> *… Mental Health felt that it was fine for him to be out for 15 minutes unsupervised 10 days after* [he attempted suicide]*."*

61. Dispatcher 2 believed they needed some indication of a current threat or intention to commit suicide (i.e. within the last three days) before they would dispatch units to search for Nicholas Stevens and gather further information from the HBC, or take any other action such as contacting SAR or arranging a media release. He also considered that there was a lack of information regarding where Nicholas Stevens might be, taking into account the time delay:

> *"We'd also need obviously an area to search, a location to go. In this case we had, it was rather vague, we had a possible destination is the river, and two hours, the average walking speed of a male is about five kilometres an hour. It's already at the stage where, apart from broadcasting to units to keep a general lookout, where would we search if I had to dispatch a unit? So it gets difficult due to the time delay.*
>
> *… We don't just dispatch units. We deal with a lot of people who go missing, a lot of people with histories of suicide attempts. We're more than happy to send units, but we need something that indicates that there's a current intention to commit suicide.*
>
> *… It is very sad. We do have all these resources available and I wished we'd just had a little bit more information."*

62. Dispatcher 2 acknowledged that there were fears for Nicholas Stevens' safety, but said Police had no lines of enquiry to pursue or actions to take at that stage, aside from the 10/1 broadcast done by Dispatcher 1 at 2.51pm. He also noted that the frontline officers could have accessed information about the missing person event on their mobility devices.[4]

63. At 5.01pm, Communicator 2 updated the Event Chronology to report that an 'informant' (this appears to have been Dave Macpherson calling from the lobby of the Hamilton Police Station) had received information from Nicholas Stevens' flatmate that he may be heading to a place called *"the Wilderlands"* in Whitianga, and that he may be hitchhiking. Communicator 2 noted that there was *"Nil other information"*.

64. Dispatcher 2 said this update indicated to him that Nicholas Stevens may have run away from the HBC because he did not like staying there, and that he had gone to be with his friends. He created an associated event and sent it to the Waikato Rural channel dispatcher in order to get a unit to go and check the address in Whitianga (he could not dispatch the unit himself as it was outside the area he controlled).

District Command Centre oversight

65. The role of the Waikato DCC is to oversee the tasking and coordination of events occurring within the District and ensure they are handled appropriately, taking into account the resources available. The DCC has access to NorthComms' records, and often consults with

[4] A mobility device is either an iPad or an iPhone that Police officers carry in their vehicles and can use to access Police databases.

NorthComms about how to manage certain events. The DCC also considers crime prevention opportunities and completes reports on trends, staffing levels, any incidents of note and organisational risks they encounter during each shift.

66. The senior sergeant on duty at the DCC (the DCC supervisor) first became aware of the missing person event relating to Nicholas Stevens when he heard a request being made for a unit to check the Whitianga address at about 5pm. He had not heard Dispatcher 1's 10/1 broadcast about Nicholas Stevens at 2.51pm, because his shift started at 3pm.

67. The DCC supervisor looked at the Event Chronology. By that time it was about four and a half hours since Nicholas Stevens had gone missing, which he considered to be a significant time delay. He later advised the Authority:

> *"I think if I had a prior knowledge of it, there would have been some courses of action I would have taken, around that time. I don't know whether it would have stopped him, stopped the end* [result] *or what actually occurred, but sending some units to, around the river certainly would have gone through my head at that time."*

68. The DCC did not take any action on the missing person report for Nicholas Stevens (such as ensuring that a unit was sent to the HBC or that the fax from the HBC was followed up).

69. The Intel Support Officer on duty in the DCC did make note of the report in her log, including information about the suicide risk, but could not recall discussing it with the DCC supervisor. She told the Authority that the DCC would normally monitor the Police response to such an event, but she recalled that the shift was *"really chaotic".*

70. The DCC supervisor said that, in hindsight, he could have contacted NorthComms when he became aware of the missing person report and asked whether any units were free to go to the river and try to locate Nicholas Stevens. He also commented that people are reported missing from the HBC all the time, and there would have been more urgency if the event was coded 1X (Suicide). He noted that his role is very busy and he has many competing demands for his attention. He was relieving as the DCC supervisor at the time and was not given any training before taking up this acting role, nor was he aware of any desk file regarding how to deal with missing person events.

71. Meanwhile at NorthComms, at 5.47pm, Communicator 3 updated the Event Chronology for Nicholas Stevens' missing person event to advise that Dave Macpherson had called in saying that he had a photograph he wanted to be attached to the missing person report. The communicator noted that Dave Macpherson would put the photo on the missing persons website, and recorded his and Jane Stevens' phone numbers.

72. At 6.52pm, Dispatcher 2 updated the Event Chronology to report that the Whitianga unit had checked the address provided and Nicholas Stevens was not there. At this time the DCC supervisor was busy dealing with a robbery involving a firearm which had been reported to NorthComms about nine minutes earlier. He did not give any further consideration to the Nicholas Stevens' missing person event during his shift.

73. Both the DCC supervisor and the Intel Support Officer told the Authority there was an unusually high number of missing person reports during their shift (14), with seven remaining unresolved when they went off duty at 10pm. Consequently the DCC Supervisor noted that the number of missing people was an *“organisational risk”* in his end of shift report. The DCC was not staffed overnight and reopened at 6.30am the next day.

Further updates

74. At 10.02pm on 9 March 2015, Communicator 4 updated the Event Chronology to record that the HBC had called, at the request of Nicholas Stevens’ parents, to report that two of Nicholas Stevens’ friends came to visit him that night. The friends did not know where Nicholas Stevens was and the HBC employee who rang did not know the friends’ names or contact details. Communicator 4 noted: *“Nil further info about where he might be.”*

75. At 10.08pm Dispatcher 3 noted that she had phoned the HBC, who confirmed that Nicholas Stevens had not returned.

76. At 11.11pm Communicator 5 recorded that Jane Stevens had sent in Nicholas Stevens’ bank account number through the Crime Reporting Line (CRL) *“web portal”,* and entered that number into the Event Chronology. About 10 minutes later Communicator 6 noted that Jane Stevens had sent a photo of Nicholas Stevens to be attached to the file once it was created.

Decision to hold the event overnight

77. At about 11.43pm a Hamilton sergeant phoned Dispatcher 3 to discuss several missing person events. For an event involving a child, the sergeant directed that a unit should be sent to an address to see if they could find her there. He then said:

> *“… the other two, I see one’s going to report to the station in the morning, and the one at the hospital, they normally send through their own 2M reports.”*

78. The sergeant advised Dispatcher 3 to hold those two missing person events until the morning. Dispatcher 3 noted this in the Event Chronology for the event relating to Nicholas Stevens and put the event on hold until 1pm the next day.

EVENTS ON 10 MARCH 2015

Fax sent to Hamilton Police Station

79. At 1.08am on Tuesday 10 March 2015, the HBC faxed the missing person report for Nicholas Stevens to Police, as described above (see paragraph 23).

80. The left edge of the missing person report form used by the HBC was cut off by the fax machine, which meant that the first two or three letters of some words on the left edge were not visible. For example, the heading ‘Location/Address’ read ‘cation/Address’ and the heading

'Clothing' read 'thing'. On page 2, the tick boxes on the left side of the section titled 'Fears for safety' were cut off. This included the box for 'Suicidal', which appears to have been ticked by the HBC nurse but is not clear. The box for 'Medical Condition – Mental' was not cut off and was also ticked.

81. The report provided a description of Nicholas Stevens, including that he was *"NZ European"*, was wearing a black hoodie top and bare feet, and had a dressing on his right hand (though the HBC nurse had told Communicator 1 he no longer had a dressing on that hand). The report did not mention that Nicholas Stevens had a cast on his left wrist.

82. Under the 'Health' section of the form the HBC nurse had noted that Nicholas Stevens had *"wound laceration on both wrist* [sic]*"* and was diagnosed with Psychotic Disorder and Schizophrenia. Under the heading 'Possible reasons why they are missing', the HBC nurse wrote: *"Mental illness, low mood, feeling of being* [unreadable word, possibly 'stuck'] *in ward."* Under 'Possible whereabouts', the HBC nurse put his home address, *"or around river as previously stated getting drowned."*

Missing person file created

83. Dispatcher 1 was on the early shift at NorthComms on 10 March 2015, and at about 7.10am she noticed that the missing person event for Nicholas Stevens was still on hold.

84. After noting in the Event Chronology that there was no 'Missing Person' alert, Dispatcher 1 called the Custody Suite at the Hamilton Police Station and spoke to the custody sergeant on duty, Officer D, to check whether the missing person report had arrived from the HBC.

85. Officer D found the faxed report on the watchhouse printer and, at 7.27am, advised Dispatcher 1 to assign the missing person event to him. He completed a three-page cover document for the missing person report and gave it to the File Management Centre (FMC).

86. At 7.55am the FMC created a missing person file for Nicholas Stevens. Some parts of the electronic file were automatically filled with information from a previous missing person event for Nicholas Stevens in 2010, including a description of him as being Maori and wearing a khaki jacket, black and white basketball style sneakers and black jeans.

87. The data entry person who created the file on 10 March 2015 was unaware that the computer system would carry forward the information about Nicholas Stevens' clothing from an earlier missing person file. The 'Clothing' section of the HBC's missing person report had been left blank (Nicholas Stevens' clothing was mentioned in a later section of the report), and when she skipped through that entry field of the electronic file, she did not notice that the computer system had *"self-populated"* the field from the last missing person report.

88. The clothing information therefore did not reflect the description of Nicholas Stevens given in the missing person report from the HBC. Nor was it mentioned in the file that Nicholas Stevens looked *"NZ European"*. However other information from the HBC report was transferred into

the file, including the information relating to Nicholas Stevens' health, state of mind and possible location (as described in paragraph 82).

89. The FMC assigned the file for Nicholas Stevens to Officer E, a senior constable responsible for missing persons. The missing person event at NorthComms was then closed by Dispatcher 1 at 9.23am.

Officer E's handling of the missing person file

90. At around 12.30pm Officer E checked the Police database and saw that he had been assigned the missing person file for Nicholas Stevens. He told the Authority that he had an influx of missing person reports that morning, which is why he had not checked the database earlier. He retrieved the file from his tray in the FMC, which included the faxed missing person report from the HBC.

91. Officer E ran a check on Nicholas Stevens on the Police database and looked at the alerts on his profile, including the one for self-harm in 2009. He decided to send a request to Nicholas Stevens' bank for details of any recent activity on his accounts.

92. At 1.50pm Officer E updated the missing person file with information the bank had provided relating to Nicholas Stevens' accounts. The latest transaction was at 10.23am on 9 March 2015, at a dairy near the HBC. Officer E noted that the bank would monitor the account and notify him of any further activity.

93. Officer E also phoned the HBC and was advised that they had not seen or heard from Nicholas Stevens. He recorded this in the missing person file at 1.53pm and noted: *"Will reassess the file in the morning."* He did not take any further action on Nicholas Stevens' file that day and his shift ended at 2pm.

94. When interviewed by the Authority, Officer E said he had not been given any specific training for his role as the Missing Persons co-ordinator for the Waikato District. He had not received any training on mental health issues and was not very familiar with the Police's policies on 'Missing persons' and 'People with mental impairments' (see paragraphs 257-263).

95. Officer E recalled that there were one or two photos of Nicholas Stevens in the missing person file. However he did not notice the discrepancies between the description of Nicholas Stevens that was in the file, and the description provided in the missing person report from the HBC.

96. Officer E did not attempt to gather any further information from the HBC when he called, such as:

- whether CCTV of Nicholas Stevens leaving the area, showing his direction of travel, was available (it was);
- what items Nicholas Stevens had left behind (for example, his wallet); or
- whether they had any further information about his state of mind and risks to his safety.

97. Officer E told the Authority that any concerns held by the HBC, or information about fears for safety, would normally already be recorded on the file. If the HBC were concerned for Nicholas Stevens' safety, he would have expected a more explicit statement about that on the file, and *"often when* [the HBC] *do have concerns they're on the phone to the police station constantly."*

98. When asked if he had seen the 'Event Chronology' recorded by NorthComms, and whether he had looked at what had been done so far to locate Nicholas Stevens, Officer E could not remember. He said he was focused on the bank enquiries to start with because they have been a very useful tool for him to find people. He commented that this case *"didn't ring any real alarm bells"* with him, and that Police often get missing person reports from the HBC where people return after a few hours or a day. He did not see any need to escalate this case to the DCC or to consult his supervisor.

99. Officer E also did not contact Nicholas Stevens' family. He advised the Authority:

> *"… every one's different but as a rule with Henry Bennett patients I don't, very rarely contact parents. Normally, and that'll be outlined, the HBC normally outlines that on their report, parents contacted, but that's normally if there's a, they're worried about the safety of the parents, something like that."*

Dave Macpherson contacts NorthComms for an update

100. At around 3pm, Dave Macpherson called NorthComms to get an update from Police about what was happening with the search for his son. According to the family's complaint, Dave Macpherson had initially tried to call the Hamilton Police Station six times from 2.40pm, but was cut off after three minutes each time. On the seventh attempt he got through to the switchboard who put him through to an *"operations room".*

101. At 3.03pm Communicator 7 created a new event and linked it to the original missing person event for Nicholas Stevens. The headline for the event was *"[INFORMANT] VERY UNHAPPY WITH POLICE AND HIS SONS 2M [MISSING PERSON] CASE"*, and the event was assigned 'Priority 2'.

102. The communicator noted that Dave Macpherson had said:

- his son was *"very high risk"* and missing from the hospital;
- he had not heard anything from Police since Nicholas Stevens was reported missing; and
- he was *"very concerned"* and requested that the sergeant call him as soon as possible (he also advised that he was in a meeting until about 4pm but would be available after that).

103. The communicator advised Dave Macpherson that she would get someone to call him back as soon as possible. The Event Chronology shows that, at 4.08pm, Officer B was assigned the task of contacting Dave Macpherson to provide him with an update.

104. However Officer B requested that Officer F, the custody sergeant on duty, contact Dave Macpherson instead. He told the Authority he passed the job on to Officer F because Officer B was only an acting sergeant and was also very busy with frontline work at the time.

105. Officer B remembered speaking to Officer F soon after he was assigned the job, but Officer F recalled that he only became aware of the job much later. The Event Chronology records that the job was re-assigned to Officer F at 6.27pm, however Officer F did not contact Dave Macpherson until about 11pm.

Dave Macpherson emails Commissioner of Police

106. At 10.41pm, after receiving no response to his 3pm phone call to NorthComms, Dave Macpherson sent an email to the Commissioner of Police and the Minister of Police about the Hamilton Police's failure to make any contact with him or Jane Stevens about the disappearance of his son. The email requested that Police take urgent steps to search for Nicholas Stevens and to contact the family. The Waikato District Commander and the MP for Hamilton West were copied into the email.

107. The email address Dave Macpherson used for the Commissioner was incorrect, but the next day Dave Macpherson received a response from the secretary for the Minister of Police, advising that politicians cannot instruct Police in operational matters. The secretary noted that he had also forwarded the email to the Commissioner's office. However Dave Macpherson never received any response from the Commissioner or the Waikato District Commander.

108. Police have advised the Authority that there is no record of the Commissioner or the Waikato District Commander receiving Dave Macpherson's email, or a copy of it, on 10 March 2015 or the next day.[5] It is not known why the email failed to reach Police.

Officer F calls Dave Macpherson

109. As noted above, Officer F only recalled Officer B giving him the task of contacting Dave Macpherson towards the end of his shift on Tuesday 10 March 2015, at about 11pm.

110. Officer F read the Event Chronology for Dave Macpherson's 3pm call, and looked at the Missing Person file for Nicholas Stevens in the Police database to see what had been done so far.

111. At 11.12pm (according to Officer F's job sheet) Officer F called Dave Macpherson to provide him with an update. Dave Macpherson thought Officer F may be calling because of the email he had just sent to the Commissioner of Police, but Officer F was unaware of the email.

112. Officer F told Dave Macpherson that the missing person file showed Police had checked Nicholas Stevens' bank accounts, and the latest transaction had been at 10.23am. Dave

[5] The Commissioner's office first received a copy of the email on 17 April 2015, after the secretary for the Minister of Police forwarded it to Police Ministerial Services following further emails from Dave Macpherson.

Macpherson knew that transaction related to Nicholas Stevens buying cigarettes from a dairy near the HBC, because Jane Stevens had spoken to the dairy manager on Monday afternoon.

113. Officer F advised Dave Macpherson that there may have been additional Police enquiries which were not recorded on the electronic file, so he would ask the officer holding the file (Officer E) to contact him in the morning and provide a further update.

114. After the call ended Officer F emailed Officer E to notify him that Dave Macpherson had called and was expecting an update the next morning. At 11.24pm Officer F updated the Event Chronology regarding Dave Macpherson's request for information, to report that he had spoken to Dave Macpherson and had asked Officer E to contact Dave Macpherson with further information. The event was closed by NorthComms at 11.30pm.

EVENTS ON 11 MARCH 2015

Officer G takes over the investigation

115. On the morning of Wednesday 11 March 2015, Officer E had to attend First Aid training. At 7.30am he told some constables in his office that he was leaving his cell phone behind and asked them to answer his calls and record any information relating to Nicholas Stevens. He then advised his supervisor, Officer G (an acting detective sergeant), about Nicholas Stevens' missing person file.

116. When interviewed by the Authority, Officer G said that Officer E had informed him of Nicholas Stevens' case at 7.50am because Officer E would not be able to advance Police enquiries that morning. Officer E told him the file was of concern because:

> *"… the HBC had made multiple calls about this and that was unusual for them to make multiple calls about a missing person, as in we receive approximately 10 to 12 files, missing person files from HBC a week and this stood out for their eagerness, or their attention, and so I then reviewed the file."*

117. Officer G recalled that the HBC's concerns related to Nicholas Stevens' suicide risk. He read the file and the Event Chronology for the missing person event, and conducted an assessment to determine what further information should be gathered and what needed to be done. He also decided to inform his supervisor (Officer H, a detective senior sergeant) about the case.

118. From reading the file, Officer G noticed there was a lack of information available and realised that Nicholas Stevens' family had not yet been spoken to by Police. He was also concerned by the delay in the HBC faxing the missing person report to Police, because *"no action had really been taken except for a 10/1* [broadcast] *and* [alerting] *City Cameras*."

119. At 8.55am Officer G rang the DCC to confirm that they were aware that Nicholas Stevens was missing, which they were. At 9.09am he emailed the Intel Support Officer at the DCC with the details of the file, so she could urgently prepare a Front Line Intelligence (FLINT) document that would be emailed to all Waikato officers on duty. He anticipated that the FLINT report

would later be updated with information he intended to get from speaking to Nicholas Stevens' family.

120. Officer G used the information recorded in the electronic missing person file to prepare his email to the Intel Support Officer, because it was easier to read than the faxed missing person report from the HBC and he had no reason to believe it was incorrect. This resulted in the incorrect description of Nicholas Stevens (i.e. that he looked Maori, and was wearing a khaki jacket, black and white basketball style sneakers and black jeans) being included in the FLINT report.

121. The email to the Intel Support Officer included the information that the HBC and Nicholas Stevens' family held serious concerns for his safety due to previous suicide attempts and his current state of mind, and that he had told his family he would drown himself in the Waikato River.

122. At 9.14am Officer G called Dave Macpherson to obtain further information about the circumstances of Nicholas Stevens' disappearance. He explained that he had first seen the file this morning and expressed his surprise that Police had not contacted the family sooner. Officer G commented that Dave Macpherson:

> *"… seemed quite approachable to speak to. He seemed appreciative that I'd rung and he gave me a lot of very good information that I could then work a plan of how to get things going to search for Mr Stevens."*

123. Officer G questioned Dave Macpherson about Nicholas Stevens' friends and associates, his interests, his Facebook account, the places he frequented, his previous suicide attempts, his behaviour and medication, and his current description and state of mind. He asked whether Nicholas Stevens had a cell phone and was told that he did not at the moment, and that he often lost them or gave them away. He also enquired about what sort of conversation topics might calm Nicholas Stevens down if he was found by Police in an agitated state.

124. During the call Officer G obtained Dave Macpherson's permission to use the photographs of Nicholas Stevens, which the family had already provided, for Police media releases. He also advised that Police had checked the Whitianga address suggested by the family on Monday evening.

125. After finishing the call Officer G texted and emailed Dave Macpherson his contact details and advised that he would be the family's point of contact for now. He also recorded the information provided by Dave Macpherson in the electronic missing person file.

126. At 9.45am the Intel Support Officer at the DCC acknowledged Officer G's email. She created a FLINT report for Nicholas Stevens based on the information Officer G had provided, and included a photo. The FLINT report was subsequently distributed to all officers on duty.

127. At 10.12am Officer G updated Officer H with the information he had received from Dave Macpherson. SAR was advised about Nicholas Stevens and started planning a search to commence that afternoon.

128. At 10.30am Dave Macpherson emailed Officer G to thank him for his call and to provide him with Nicholas Stevens' most recent bank statement, a recent photograph, and his old cell phone numbers. Officer G added this information to the file.

129. Officer G advised the shift senior sergeant on duty about Nicholas Stevens, because frontline officers were needed to conduct some enquiries. At 10.45am he discussed the file with the DCC senior sergeant on duty and arranged for officers to visit the addresses of two of Nicholas Stevens' friends (however they did not find him there).

130. Meanwhile, around midday, Nicholas Stevens' father and brother went to the HBC to conduct another search of the area between the HBC and the Waikato River. This search was also unsuccessful.

131. At 12.37pm Officer G received a call from an HBC charge nurse, who mentioned that comments had been made about Nicholas Stevens telling his family that he wanted to drown himself in the Waikato River, and that CCTV footage was available of Nicholas Stevens' movements just before he went missing.

132. Officer G then contacted the security office for Waikato Hospital to discuss the CCTV footage. The security office confirmed that the footage showed Nicholas Stevens was last seen walking towards a gully leading to the river. Officer G sent an officer to collect the footage.

Media release

133. At about 1pm, Officer G spoke to the Waikato District Communications Manager about issuing a media release regarding Nicholas Stevens being missing. Police subsequently released a media statement which said that Police had serious safety concerns for Nicholas Stevens and that he had not returned to the HBC from approved leave. The media statement noted that he was wearing a black cast on his left wrist.

134. Nicholas Stevens' family later complained to the Authority that the media statement contained inaccurate information, in particular the paragraph which said:

> *"When last seen he was wearing a khaki jacket, black jeans and black and white basketball shoes. Nicholas is described as a light skinned Maori male about 166cm tall of thin build with below the shoulder length light brown hair and a brown goatee beard."*

135. As explained above, the inaccurate description came from the electronic missing person file, which retained information from an earlier missing person report for Nicholas Stevens in 2010. No one had picked up on the discrepancy between that information and the description given by the HBC nurse during the initial call to NorthComms and recorded in the faxed missing person report.

136. The Authority interviewed the Communications Manager who drafted the media statement. He said he would have checked the Police database to confirm the information he was given

about Nicholas Stevens. In this case the Police database was the source of the inaccurate information, so that did not help him to identify the problem.

137. The Authority asked the Communications Manager whether media statements were ever provided to the family of the missing person so they could approve them before release. He advised that it would be done on a case by case basis, not by his office but by the family liaison officer.

138. Nicholas Stevens' family also complained that Police had released another media statement around the same time, which concerned an alleged indecent assault at Waikato Hospital. They argued that this suggested the two incidents may be related, when in fact the assault had taken place on a different day and in a different area of the hospital, and the alleged offender was riding a bicycle which Nicholas Stevens could not have done with both wrists bandaged. The family's complaint stated:

> *"The Communications Manager had no right to have raised the two issues in the same communication, and drew attention to them both as being somehow 'together' by doing so. A simple checking of facts would have shown that to anyone competently doing their job.*
>
> *… The Police Communications Manager did a very poor job in respect of his part in the Missing Person situation regarding Nicky."*

139. The Communications Manager advised the Authority that it was not the Police but the media who, of their volition, started linking the two unrelated matters. He subsequently sent an email to media clarifying that Police had nothing to indicate there was a connection between the two incidents but were *"keeping an open mind".* He told the Authority:

> *"There were separate incidents that were subject to separate releases at separate times and in fact the Police went so far as to send an email to all media at 1.57pm clearly stating the two matters weren't linked ….*
>
> *… that was prompted after the dozens of media calls into the DCC trying to link them which is why we took this step of using an auditable trail documenting us, clarifying with the media that they weren't linked…."*

Further information discovered by the family

140. At 1.15pm, Dave Macpherson called Officer G to report that he and his son had been out looking for Nicholas Stevens. He also advised that one of Nicholas Stevens' friends had told him that Nicholas Stevens asked another friend to kill him when they visited the HBC on Sunday afternoon, the day before he went missing.

141. At about 2.30pm Nicholas Stevens' brother went to the HBC and, after initially being denied access, searched Nicholas Stevens' belongings. He found that Nicholas Stevens had left his wallet and bank card behind (the HBC reported this information to Police two hours later).

Officer I assumes responsibility for the investigation

142. At 2.45pm Officer H briefed Officer I, a detective sergeant, about Nicholas Stevens' missing person file, so that he could take over and become the contact point for SAR and Nicholas Stevens' family when Officer G went off duty at 4pm. Officer I learned that Nicholas Stevens had gone missing two days earlier, that the missing person report from the HBC had arrived at 1.08am on 10 March 2015, and that Nicholas Stevens was flagged as 'suicidal' in the Police database.

143. Officer H also informed Officer I that SAR had been notified and were close to commencing a search of the area where Nicholas Stevens was last seen. Officer I later told the Authority that he was not briefed on why there was a delay of two days before the search was commenced.

144. At 3.01pm, Officer G emailed Dave Macpherson to advise him that Officer I would become the officer in charge of Nicholas Stevens' missing person file. He also provided a number for the DCC in case Dave Macpherson was unable to get hold of Officer I.

145. At 3.45pm Officer I met with the officer in charge of SAR, Officer J (a sergeant), to discuss the area that would be covered during the search for Nicholas Stevens. Officer J advised that the search was about to start and would continue until 8pm, and Officer I told Officer J that he was the point of contact if anything of interest was found.

146. Straight after his meeting with Officer J, Officer I called Dave Macpherson to introduce himself and provide an update. Officer I's job sheet for the call recorded:

> *"Introduce myself to MACPHERSON as the Late Shift Detective Sergeant who was overseeing the 2M* [Missing Person] *investigation.*
>
> *MACPHERSON began to question me on a number of elements of the investigation and search including:*
>
> - *Why the 2M report was not acted on earlier.*
> - *Had a Police dog unit been deployed to search for STEVENS.*
> - *Had a search team commenced a search around the river area?*
> - *Were the Police aware STEVENS was suicidal?*
>
> *I explain to MACPHERSON I had just received the file and I would be able to answer his questions during a face to face meeting later that evening, ensuring I was supplying him with the correct information."*

147. According to the complaint from Nicholas Stevens' family, when Dave Macpherson questioned Officer I about using Police dogs, he explained that it was only worth using them in the first few hours as smells and other traces a dog could pick up would fade over time. When Dave Macpherson asked why it had taken Police so long to commence a search, Officer I told Dave Macpherson that Police had to prioritise their missing person files, and claimed he was unaware of any suicide risk and could see nothing on the file about it. The complaint states that Officer I *"appeared to get annoyed or angry with Nicky's father and told him that keeping him 'on the phone' was holding up the search for Nicky, ending the call."*

148. At the time the family made its complaint to the Authority, Dave Macpherson did not remember Officer I arranging a face to face meeting with him.[6] However when asked about it later he accepted that it must have happened.

149. Officer I told the Authority that when he called Dave Macpherson to say he was taking over from Officer G, Dave Macpherson appeared to be concerned *"that maybe the buck had been passed"*. So Officer I had to explain that Officer G's shift was ending, and it was better for Officer I to take oversight of the investigation during the late shift and be a contact point for the family, than for the investigation to be put on hold until Officer G was back on duty the next morning.

150. He said that during the call, Dave Macpherson:

> *"… bombarded me with a set of questions, which are fair enough, but I had to reiterate to him that I was not across the file completely and I couldn't give him those answers.*
>
> *And I remember vividly saying to him, 'My job tonight is to do the best thing by your son, is to try and find him and all these questions and all that will be answered, but at this stage, you know, the focus is on trying to find Nicky.'*
>
> *He wasn't really accepting of that and was obviously generally upset with the Police response and again I said to him I was unable to give him some answers. But I said to him, 'Let's have a face to face meeting later on', because he was just getting upset on the phone. So I said, 'Let's meet face to face and discuss this and you'll give me a bit more time to read the file and read what else has been done, so I can give you a bit more information.'*
>
> *… he was happy to meet face to face and the phone call ended, yeah it was fine."*

151. Officer I advised the Authority that, while he was well aware that Nicholas Stevens was flagged as 'Suicidal' in the Police database, he would not have told Dave Macpherson that during the phone call due to privacy concerns. The officer also said that he was focused on doing what he could to find Nicholas Stevens at that point, rather than examining or criticising the Police response (or lack thereof) so far, which would be done at a later time.

152. The Authority asked Officer I whether he became annoyed or irritated with Dave Macpherson during the call. He said:

> *"No. He was probably getting upset because I was unable to answer his questions and, you know, that's fair. … he had very good questions, as I would as a father, and I couldn't answer them, and that's why I asked him to meet me face to face to give me an hour or two to read over the file and prepare my answers."*

153. At 6.50pm, Officer I spoke to the HBC charge nurse who had called earlier that day, to discuss what clothing Nicholas Stevens was wearing at the time he went missing. He later recalled that

[6] The complaint stated that the family's first face to face contact with Police was the next day, after Nicholas Stevens' body was found.

this was prompted by Dave Macpherson raising the issue when he spoke to him on the phone, particularly in relation to Nicholas Stevens' footwear. The HBC charge nurse confirmed that Nicholas Stevens was not wearing any shoes (contradicting the Police's media statement which said he was wearing black and white basketball shoes).

154. At 7.50pm Officer I met with Dave Macpherson at the Hamilton Police Station for about 20 minutes. He told him that Police were reviewing the CCTV footage from HBC and had spoken to some of Nicholas Stevens' associates. He showed Dave Macpherson some CCTV stills and asked him to identify some people seen with Nicholas Stevens, so that Police could conduct further enquiries later.

155. Officer I also briefed Dave Macpherson on the SAR operation that was underway, and showed him a map of the search area. He advised that the search would stop at around 8pm, as daylight hours were running out, but would restart the next morning.

156. Dave Macpherson again raised the issue of the lack of action by Police up until that morning. Officer I said he was unable to comment on that, as there was *"some discrepancy"* as to when Police received the missing person report. However he did explain his own view that the missing person report from the HBC had not clearly flagged Nicholas Stevens as suicidal, which would have affected the urgency of the Police response.[7] Officer I later advised the Authority he had not reviewed the 'Event Chronology' of the initial phone call to NorthComms by the HBC nurse, which set out further information about the suicide risk.

157. Officer I asked Dave Macpherson if there were any further lines of enquiry he could think of, and whether it was likely that Nicholas Stevens would go to the Wilderland commune in Whitianga. Dave Macpherson thought that was a high possibility and said he had already given Police all the information he knew. At the end of the meeting, Officer I gave Dave Macpherson his business card and assured him he would be kept updated.

158. Officer I told the Authority that Dave Macpherson was a lot calmer in person, and was happier once he had been given some information on what Police were doing to find his son. He said:

> *"Probably on the phone* [Dave Macpherson] *felt that I'd put up a wall where I wasn't telling him anything. It was more so I didn't want to give him misinformation which is worse."*

159. At 8.14pm Officer I received a phone call from a woman who worked at Waikato Hospital. She said she knew Nicholas Stevens and would keep an eye out for him on the streets.

160. Officer J called at 8.30pm to advise Officer I that the search had finished for the day, and nothing of interest had been located. Officer I rang Dave Macpherson to update him on the outcome of the search that day, and said Police would be in touch as soon as any further information came to light.

---

[7] On closer inspection of the faxed HBC missing person report, it does appear that the box for 'Suicidal' under the heading 'Fears for safety' was ticked. However, as explained above, the box is not clearly visible because the left side of the page is cut off.

161. At 9.42pm Officer I updated the electronic missing person file for Nicholas Stevens and noted two *"Tasks for tomorrow"*, which were to liaise with Officer J about a further search, and to get an officer to make enquiries at the Wilderland commune to ensure Nicholas Stevens had not turned up there.

EVENTS ON 12 MARCH 2015

Search recommenced

162. At about 8.20am on Thursday 12 March 2015, Officer G tasked Officer E with making enquiries about information received overnight that Nicholas Stevens may have been seen at a Countdown supermarket the previous day (Wednesday). Police later determined that the person sighted was not Nicholas Stevens.

163. The SAR operation resumed that morning, including a search of the Waikato River using a Police boat. There was no sign of Nicholas Stevens. Dave Macpherson also travelled to Hamilton to search areas where Nicholas Stevens might be found.

164. At 10.20am Officer G called Officer J to discuss the outcome of the search so far.

Nicholas Stevens' body discovered

165. At about 10.30am, a member of the public saw a body floating in the Waikato River near Memorial Park and dragged it to the river bank before alerting Police.

166. Officer G heard that a body had been found in the river, and informed the officer in charge of the Hamilton City CIB. He travelled to the scene and determined that the deceased person was likely to be Nicholas Stevens due to the similarity of appearance and the cast on his left arm.

167. Officer G initially arranged for Dave Macpherson to be notified in person by another officer, but that officer could not locate him. Officer G was concerned that Dave Macpherson may find out through the media, so he decided to call him instead.

168. Dave Macpherson and Jane Stevens met with Officer G that afternoon at the Hamilton Police Station, and he took them to the Waikato Hospital mortuary to identify Nicholas Stevens' body.

FAMILY TOLD OF POSSIBLE SIGHTING OF NICHOLAS STEVENS ON 10 MARCH

169. On 9 April 2015 two people provided Dave Macpherson with a written statement, saying that they saw a young man they believe to have been Nicholas Stevens on Tuesday 10 March 2015, sometime between 12.45pm and 1.30pm.[8] Dave Macpherson passed this information on to Police and asked them to investigate.

[8] The witnesses first contacted Dave Macpherson by text message two weeks earlier.

170. Police obtained statements from the two witnesses on 6 June 2015. The statements suggest that Nicholas Stevens was still alive on 10 March 2015, but it is not known whether or not this was actually the case. The witnesses say their bank records support the sighting occurring on 10 March 2015.

COMPLAINT TO THE AUTHORITY

171. The family's complaint to the Authority on 22 May 2015 states:

> *"Nicholas' family believe that, had Police acted even reasonably swiftly on the information they received in either the phoned or written Missing Person's report, there is a chance that Nicholas might have been found alive.*
>
> *In any event, the family believes that the slowness of the Police to treat Nicholas' absence as a matter of serious concern, and their failure to have early consultation with the family, demonstrate a Missing Persons system and protocol that may have, and will inevitably in the future, lead to unnecessary deaths and harm to vulnerable people."*

CORONER'S INQUEST

172. The Coronial post-mortem report was completed on 8 June 2015. The pathologist noted that:

> *"In my opinion postmortem findings indicate that death was consistent with drowning.*
>
> *… Given the time of the year and prevailing temperatures, the time of death is consistent with the deceased having passed away within the last 48-72 hours, prior to the deceased having been found."*

173. The Coronial inquest into Nicholas Stevens' death is yet to be heard.

The Authority’s Investigation

THE AUTHORITY’S ROLE

174. Under the Independent Police Conduct Authority Act 1988, the Authority's functions are to:

- receive complaints alleging misconduct or neglect of duty by any Police employee, or concerning any practice, policy or procedure of the Police affecting the person or body of persons making the complaint; and to
- investigate, where it is satisfied there are reasonable grounds for doing so in the public interest, any incident in which a Police employee, acting in the course of his or her duty has caused or appears to have caused death or serious bodily harm.

175. The Authority's role on the completion of an investigation is to form an opinion about the Police conduct, policy, practice or procedure which was the subject of the complaint.

THE AUTHORITY'S INVESTIGATION

176. Police notified the Authority on 29 April 2015 that they had initiated a review into their handling of the missing person report relating to Nicholas Stevens. The Authority decided to oversee the Police investigation.

177. After receiving a complaint from Nicholas Stevens’ family on 22 May 2015, which contained specific allegations, the Authority commenced an independent investigation.

178. In addition to reviewing material produced by the Police investigation, the Authority spoke to Dave Macpherson and Jane Stevens and interviewed 17 Police officers, DCC and Communications staff.

ISSUES CONSIDERED

179. The Authority's investigation considered the following issues:

1) Did NorthComms handle the initial missing person notification from the HBC in accordance with Police policy, standard operating procedures and best practice?
2) Did the Waikato DCC provide effective oversight of the missing person event?
3) Did Waikato Police take appropriate action to search for Nicholas Stevens?
4) Was the Police’s media release relating to Nicholas Stevens accurate and appropriate?
5) Did Police liaise appropriately with Nicholas Stevens’ family after the HBC reported him missing?

The Authority's Findings

ISSUE 1: DID NORTHCOMMS HANDLE THE INITIAL MISSING PERSON NOTIFICATION FROM THE HBC IN ACCORDANCE WITH POLICE POLICY, STANDARD OPERATING PROCEDURES AND GOOD PRACTICE?

180. Police policy and standard operating procedures set out the required response from Police in respect of incidents involving missing persons and people with mental health concerns (see paragraphs 240-263 for an explanation of the relevant policies).

181. In this case the first opportunity for Police to respond arose when the HBC called NorthComms to report that Nicholas Stevens was missing, at 2.38pm on 9 March 2015.

182. Communicator 1 gathered information from the HBC nurse and correctly noted the fears for Nicholas Stevens' safety in the Event Chronology. He coded the event as 'Priority 2' rather than 'Priority 1', and 'Missing Person' rather than 'Suicide'. The Authority considers that this was a reasonable decision based on the information given by the HBC nurse, especially in light of his comment that Nicholas Stevens was *"low risk but still potential to self-harm and stuff like that".* The call from the HBC nurse was on the general line, not a 111 emergency call, and there was a delay of two hours since Nicholas Stevens had gone missing.

183. Although some additional information could have been sought from the HBC nurse, such as whether Nicholas Stevens was carrying a cell phone, Communicator 1's recording of the event was largely in accordance with standard operating procedures. However he failed to alert his Team Leader or Shift Commander about the fears for Nicholas Stevens' safety, and as a result there was no oversight of the handling of this event by NorthComms supervisors.

184. Dispatcher 1 read the event and conducted a risk assessment to determine what Police action was required. She determined that the appropriate response was to broadcast a message to all officers on the Hamilton City channel, alert the Hamilton City CCTV operators, and await the arrival of the faxed missing person report from the HBC.

185. The timing of the broadcast was just before a shift change and it appears to have gone unnoticed. Dispatcher 1 did not repeat the broadcast before her shift ended at 4pm.

186. Dispatcher 1 did not:

    a) mention in her broadcast to all officers that Nicholas Stevens was a mental health patient, had recently attempted suicide and may be headed for the river;

    b) dispatch any officers to attend the HBC and search the area for Nicholas Stevens (although units were available);

    c) alert the NorthComms Shift Commander, Team Leader, or any field supervisor about the concerns for Nicholas Stevens safety; or

    d) advise the Waikato District Command Centre (DCC).

187. As no supervisors were advised about the concerns for Nicholas Stevens' safety, no consideration was given to calling on SAR to conduct a search, or to issuing a media release to alert the public to look out for Nicholas Stevens.

188. The Authority finds that the Dispatcher 1's risk assessment of the event, and subsequent response, were clearly inadequate in light of the obvious suicide risk factors identified and the circumstances of Nicholas Stevens' disappearance.

189. Dispatcher 1 did not refer to standard operating procedures, and did not check the Police database for further information about Nicholas Stevens. She put the event on a two-hour hold, even though it was a Priority 2 event which by definition required Police attendance at the scene within 30 minutes.

190. Dispatcher 1 and other NorthComms staff have suggested that the time delay of two hours was a significant factor, because Nicholas Stevens could have travelled quite a distance by foot and 'could be anywhere' by then. However the Authority's view is that it is common for there to be some delay between a person going missing and the Police being notified, and this does not negate the need for a Police response when there are fears for that person's safety.

191. In this case the obvious location where Police could have looked for Nicholas Stevens was the area surrounding the HBC, in particular the Waikato River which is nearby. A unit should also have been sent to the HBC itself, to commence an investigation by questioning the staff further about Nicholas Stevens' recent behaviour and possible whereabouts, and examining the CCTV footage to determine the direction Nicholas Stevens was headed when he left the HBC.

192. Another factor mentioned by NorthComms staff and some Police officers during the Authority's investigation was their perception that the HBC did not appear to think Nicholas Stevens was at immediate risk, given that they had allowed him out on unescorted leave and only notified Police two hours after he failed to return. While the Authority acknowledges this, it considers that the information provided by the HBC nurse about Nicholas Stevens' recent history should have been enough to prompt Police to dispatch a unit to attend the HBC to make further enquiries and commence a search that afternoon.

193. Dispatcher 1 forgot to alert the custody sergeant at the Hamilton Police Station that a faxed missing person report from the HBC should have arrived. Although she recalled that she asked Dispatcher 2 to follow it up, that never occurred and the fax was only found the next morning (after the HBC had sent it at 1.08am).

194. Dispatcher 2 said he first became aware of the missing person event at around 4.55pm on 9 March 2015, when it came off its two-hour hold. He read the Event Chronology, checked the Police database and noticed there was no 'Missing Person' alert, which suggested that no missing person file had been created. He did not take any further action to find out what was happening with the missing person report from the HBC.

195. Dispatcher 2 did not broadcast another message to all units about Nicholas Stevens, or advise any of his supervisors about the missing person event. He believed there were no real lines of

enquiry to pursue, other than the information that Nicholas Stevens may be in Whitianga which came in just after 5pm. He arranged for a unit to be dispatched to that address but did not dispatch any other units to search for Nicholas Stevens.

196. As explained above, the Authority does not agree that there were no lines of enquiry for Police to pursue at that stage. Dispatcher 2's risk assessment of the event was inadequate, and he should have taken further steps to initiate a Police search and ensure that his supervisors were aware of the fears for Nicholas Stevens' safety, which were clearly identified in the Event Chronology. However the Authority does accept that his understanding of the risks involved may have been influenced by Dispatcher 1's earlier lack of action.

197. Later that night Dispatcher 3 called the HBC to confirm Nicholas Stevens had not returned, and was advised by a field sergeant to put the event on hold overnight while Police awaited the report from the HBC.

198. NorthComms staff and officers have advised the Authority that it is common for there to be significant delays in the creation of missing person reports. The Police's National Recording Standards policy states that missing person reports must be entered into the Police database within four hours, but it appears that Police regularly breach that requirement. In this case the file for Nicholas Stevens was not created until 7.55am on 10 March 2015, over 17 hours after the HBC nurse reported him missing, and he was not flagged as 'Missing' on the Police database until then.

199. The Authority finds that the Police's arrangements for receiving missing person reports from the HBC were unsatisfactory, and should not have relied upon the arrival of a fax before a missing person file was created. Police have advised the Authority that they have changed that process, and the HBC now scans and emails the reports directly to the Police's File Management Centre so they can be entered into the database more quickly (see the 'Subsequent Police Action' section of the report at paragraph 231).

200. During its investigation into this case the Authority observed that the 'Missing persons' chapter of the Police Manual, and the standard operating procedures used by Communications staff, do not include guidance about the steps to take when a mental health patient is reported missing. Policy on this subject is set out in the 'People with mental impairments' chapter of the Police Manual (see paragraph 263), but most of the people interviewed by the Authority were unaware that policy existed.[9]

201. Overall, the response provided by NorthComms to the notification from the HBC that Nicholas Stevens was missing was not sufficient or timely, and did not comply with good practice. The event was not appropriately dealt with and prioritised in a way that was consistent with the known concerns for Nicholas Stevens' safety.

[9] The 'People with mental impairments' policy includes a requirement to consult a Duly Authorised Officer (DAO) about what actions to take and the level of Police assistance required.

FINDING

NorthComms' handling of the initial missing person notification from the HBC was inadequate and did not comply with Police policy, standard operating procedures and good practice.

ISSUE 2: DID THE WAIKATO DCC PROVIDE EFFECTIVE OVERSIGHT OF THE MISSING PERSON EVENT?

202. One of the core roles of the Waikato DCC is to oversee the tasking and coordination of events occurring within the district and ensure that they are managed appropriately by Police.

203. In this case the Intel Support Officer on duty noted the missing person event for Nicholas Stevens in her log when it came in, but did not discuss it with the DCC Supervisor or take any further action.

204. The DCC Supervisor only became aware of the event at about 5pm on 9 March 2015, because he overheard a request for a unit to be sent to Whitianga to check an address and see if Nicholas Stevens was there. He read the event but did not direct any further action to be taken by NorthComms or officers in the field. When interviewed by the Authority he acknowledged that he could have asked for officers to be dispatched to the river to look for Nicholas Stevens, despite the time delay.

205. Both the DCC Supervisor and the Intel Support Officer commented that they were very busy during that shift and there was a high number of missing person reports (14).

206. While acknowledging that there are many competing demands for the Waikato DCC's attention, the Authority considers that the DCC missed an opportunity here to ensure there was an appropriate and timely Police response to the missing person report regarding Nicholas Stevens. The DCC Supervisor should have recognised the risks associated with Nicholas Stevens' disappearance and asked further questions about what Police were doing to locate him.

FINDING

The Waikato DCC did not provide effective oversight of the missing person event.

ISSUE 3: DID WAIKATO POLICE TAKE APPROPRIATE ACTION TO SEARCH FOR NICHOLAS STEVENS?

207. After the missing person file for Nicholas Stevens was created at about 8am on the morning of 10 March 2015, it was assigned to Officer E, the officer in charge of missing persons for the Waikato District. Up until that point no officers had been assigned to investigate the report.

208. Officer E said he was very busy that morning with other missing person reports, and noticed that he had been assigned the report relating to Nicholas Stevens at 12.30pm. The only actions he took on the file that day were banking enquiries, and calling the HBC to confirm Nicholas Stevens had not returned. At 1.53pm he decided to reassess the file the next morning.

209. Officer E did not contact Nicholas Stevens' family or attempt to gather any further information from the HBC about the circumstances of Nicholas Stevens' disappearance. Nor did he note and correct the inaccurate description of Nicholas Stevens in the electronic missing person file on the Police database, which was inconsistent with the description provided in the faxed HBC report and the Event Chronology.

210. The Authority finds that Officer E failed to take appropriate steps to investigate Nicholas Stevens' disappearance and commence a search. He did not sufficiently consider the risk factors present in Nicholas Stevens' case and the reasons to be concerned for his safety. Aside from conducting the banking enquiries, Officer E's approach was to wait and see what happened, and what further information came in, rather than taking active steps to investigate as set out in the Police's 'Missing persons' policy (see paragraphs 257-262).

211. It is concerning that Officer E was not familiar with the 'Missing persons' policy, or with the Police's 'People with mental impairments' policy, given his role as the Missing Persons co-ordinator for the Waikato District.

212. Officer G took over responsibility for the file the next day, 11 March 2015, because Officer E had to attend training and was not available to conduct any further enquiries that morning.

213. Officer G immediately undertook an assessment of the further information required and the actions needed to get a search for Nicholas Stevens underway. He made the first contact with Nicholas Stevens' family, and gathered further information from Dave Macpherson and the HBC. He also obtained CCTV footage which confirmed Nicholas Stevens' direction of travel.

214. Officer G consulted his supervisor and the DCC, and arranged for a FLINT report on Nicholas Stevens to be distributed to officers and a media statement to be released to the public. SAR was notified and commenced a search that afternoon.

215. Officer I assumed oversight of the SAR operation at around 2.45pm, because Officer G's shift was ending. Both officers ensured that Dave Macpherson was kept up to date on the search.

216. Although Dave Macpherson later complained about his contact with Officer I during the initial phone call between them, the Authority considers that Officer I responded appropriately by meeting with him in person that evening to hear his concerns and explain what action Police were now taking to find his son. Officer I was aware of the suicide risk to Nicholas Stevens, but did not feel he could openly discuss it with Dave Macpherson due to privacy concerns. Nor did he feel that he could comment on why the Police's search for Nicholas Stevens had been delayed, without knowing the full background.

217. Both Officers G and I updated the missing person file with the actions they took while they had oversight of it. Officer G reassumed responsibility for the file on 12 March 2015, and notified Dave Macpherson after Nicholas Stevens' body was found.

218. The Authority finds that, although the Police response up until 11 March 2015 was wholly inadequate due to the delays involved and lack of action taken, Officers G and I took appropriate steps to search for Nicholas Stevens when they assumed responsibility for the missing person investigation.

FINDINGS

Officer E's response to the missing person report for Nicholas Stevens fell well short of the standard expected for the Missing Persons coordinator for the Waikato District, and did not comply with Police policy and good practice.

Once Officers G and I became aware of the file, they took appropriate steps to investigate and conduct a search for Nicholas Stevens.

ISSUE 4: WAS THE POLICE'S MEDIA RELEASE RELATING TO NICHOLAS STEVENS ACCURATE AND APPROPRIATE?

219. Nicholas Stevens' family complained about the Waikato District Communications Manager's handling of the media statement that was released on 11 March 2015 to alert the public that Nicholas Stevens was missing.

220. The first aspect of the complaint concerned the inaccurate description of Nicholas Stevens given in the media release. The Authority has determined that the source of the inaccurate information was the electronic missing person file in the Police database (see paragraphs 86-88). The inconsistency between the description of Nicholas Stevens in that file, and the description from the faxed HBC report and the Event Chronology, was not noticed by anyone dealing with the file.

221. In the Authority's view the Communications Manager cannot be blamed for relying on information from the Police database when he had no reason to doubt its accuracy. In this case Police did not consider it necessary to get the family's approval of the media release before it was published.

222. The second aspect of the family's complaint related to the release of the media statement about Nicholas Stevens occurring alongside another media release about an alleged indecent assault at the Waikato Hospital. Nicholas Stevens' family believed that the Communications Manager had incorrectly drawn a link between the two events, implying that Nicholas Stevens may have been involved in the attack.

223. The Communications Manager told the Authority that there were two separate media statements, released at different times, which both happened to involve the Waikato Hospital. After the media started drawing a link between the two incidents, he sent out an email to say

that Police had nothing to suggest the events were connected, but were *"keeping an open mind"*.

224. The Authority considers that, while the Communications Manager could have been clearer in his email that the two incidents should not be linked together, he took reasonable steps to correct the media's interpretation of the two Police media statements.

FINDINGS

The Police's media release relating to Nicholas Stevens was inaccurate in respect of his current description. This resulted from a systemic problem rather than the failing of any particular individual.

The Communications Manager did not draw a link between the indecent assault at the Waikato Hospital and Nicholas Stevens' disappearance.

ISSUE 5: DID POLICE LIAISE APPROPRIATELY WITH NICHOLAS STEVENS' FAMILY AFTER THE HBC REPORTED HIM MISSING?

225. On the afternoon of 9 March 2015, after the HBC had reported Nicholas Stevens missing, Jane Stevens and Dave Macpherson visited the public counter at the Hamilton Police Station (Jane Stevens visited twice). They sought information about what Police were doing to find their son, and tried to provide his photograph, bank details and information on his possible whereabouts. They said the public counter staff were not helpful and simply referred them to a website and a phone number where they could pass the information on.

226. One of the women working at the public counter, Ms Z, recalled advising Nicholas Stevens' parents that she would pass on the information about his possible whereabouts to the custody sergeant. However neither the custody sergeant, nor Jane Stevens and Dave Macpherson, remembered that happening.

227. The next day, on 10 March 2015, Officer E was assigned the file but made no contact with Nicholas Stevens' family. Concerned by the lack of communication from Police, Dave Macpherson called NorthComms at about 3pm, requesting an update. He only received a call back from Officer F, a custody sergeant, at 11pm.

228. In the meantime Dave Macpherson sent an email to the Commissioner and the Minister for Police, which was copied to the Waikato District Commander. He never received a response to that email from the Commissioner or the District Commander, which compounded his dissatisfaction with Police. Police have advised that there is no record of the Commissioner or the District Commander receiving the 10 March email in March 2015.

229. The first contact initiated by Police towards Nicholas Stevens' family was made by Officer G, after he assumed responsibility for Nicholas Stevens' missing person file on 11 March 2015. From then on Dave Macpherson was in regular contact with Officer G and Officer I.

230. The Authority finds that the Police's liaison with Nicholas Stevens' family on 9 and 10 March 2015 was wholly inadequate. Jane Stevens and Dave Macpherson were frustrated by the Police's lack of response to the concerns for their son's safety and Police, particularly Officer E, missed an opportunity to gather further information from them in respect of the risks posed to Nicholas Stevens. The Police's failure to contact Nicholas Stevens' family caused them much distress and anger at a very difficult time.

FINDING

Police failed in their obligation to liaise with Nicholas Stevens' family after the HBC reported him missing, up until 11 March 2015 when Officer G contacted Dave Macpherson.

Subsequent Police Action

231. Police conducted a review of this incident which recommended that:

a) The managers of NorthComms, the Waikato DCC, and Hamilton City Police should be informed of the shortfalls identified and liaise with all staff to ensure compliance with Police Policy, Practice and Procedure is maintained.

b) The Police Manual's chapter on missing persons should be updated to reflect the involvement of the District Command Centre.

c) The Waikato District Command Centre desk file should be updated on Police Practice, Policy and Procedure for dealing with missing persons.

d) A local document should be distributed for dealing with missing persons, with an emphasis placed on inpatients missing from the HBC, and that the service level agreement that has been put in place since this incident between the Waikato Police and the Waikato DHB should be maintained and incidents regularly de-briefed.

e) At the request of the Waikato District Commander, there will be a six monthly review of recommendations from any debriefs of missing mental health patients with the Waikato DHB Chief Executive.

232. These recommendations were accepted and are being implemented by Police.

233. Police have also advised the Authority that, following this incident:

a) the DCC Supervisor (on duty on 9 March 2015) and Officer E were subject to Code of Conduct investigations;

b) the HBC now emails scanned copies of their missing report forms to the Waikato File Management Centre, instead of faxing them to the Hamilton Police Station watchhouse;

c) a working group has been convened to consider the issues around people missing from Mental Health facilities;

d) Police are developing:

   i) a national training package for all Police staff to improve their understanding of people challenged by mental health problems; and

   ii) *"an investment proposal for the recording of missing persons from mental health providers on a national basis to ensure that alerts are in place at the earliest possible time"*;

e) Police Communications Centres have identified issues regarding their handling of calls for service relating to issues of mental health, and developed terms of reference to

improve and align their standard operating procedures, training, leadership, and culture (however Police need to identify a resource to carry out this work);

f) the 'Missing persons' policy is being reviewed and revised to reflect the involvement of District Command Centres, and implementation of the revised policy should be completed by 30 June 2016;

g) a new statistical reporting system "will allow a Missing Persons Dashboard to be implemented, enabling Districts easier access to Missing Persons information" (however Police cannot confirm a timeframe for this);

h) the Waikato District Command Centre is now operating 24/7, supported by a substantive senior sergeant, with the aim of ensuring that a quality service is provided and that policies and processes are being adhered to; and

i) a case risk assessment team (a sergeant and four staff) has been established at Hamilton Central Police Station, and files such as missing persons will go through a sergeant for assessment and direction as appropriate.

Conclusions

234. After examining various aspects of the Police's response to the missing person report regarding Nicholas Stevens, the Authority has found that policy and good practice was not followed in this case and that, up until the morning of 11 March 2015, no one took responsibility for ensuring that Police were doing all they reasonably could to locate Nicholas Stevens. In particular:

    a) NorthComms' handling of the initial missing person notification from the HBC was inadequate and did not comply with Police policy, standard operating procedures and good practice.

    b) The Waikato DCC did not provide effective oversight of the missing person event.

    c) Officer E's response to the missing person report for Nicholas Stevens fell well short of the standard expected for the Missing Persons coordinator for the Waikato District, and did not comply with Police policy and good practice.

    d) The Police's media release relating to Nicholas Stevens was inaccurate in respect of his current description. This resulted from a systemic problem rather than the failing of any particular individual.

    e) Police failed in their obligation to liaise with Nicholas Stevens' family after the HBC reported him missing, until 11 March 2015 when Officer G contacted Dave Macpherson.

235. There were a number of missed opportunities on 9 and 10 March 2015 for Police to reassess the risk posed to Nicholas Stevens and realise that further action was required. The lack of action and contact from Police caused Nicholas Stevens' family great distress at a very difficult time.

236. However the Authority also determined that, once Officers G and I became aware of the file on 11 March 2015, they took appropriate steps to investigate and conduct a search for Nicholas Stevens. Additionally, the Communications Manager did not draw a link between an indecent assault at the Waikato Hospital and Nicholas Stevens' disappearance, and took reasonable action to correct the media's incorrect interpretation of the two separate media releases.

237. The Authority has no jurisdiction to review or comment on the actions of any person other than Police involved in this case, such as the HBC. The Authority understands the HBC are conducting their own review of the handling of this incident.

Recommendations

238. The Authority supports the Police's efforts to:

   a) develop a national training package on mental health; and

   b) ensure that alerts for people missing from mental health providers are in place *"at the earliest possible time"* (see paragraph 233 (d)).

239. The Authority also recommends that the New Zealand Police:

   1) Update the Communications Centres' standard operating procedures for 'Missing Persons', and the 'Missing persons' chapter of the Police Manual, to include the steps to be taken *"when a mental health patient is reported missing"* as set out in the 'People with mental impairments' chapter of the Police Manual (see paragraph 263).

   2) Review the data entry process for the creation of missing person files to ensure that information is not mistakenly retained from earlier files.

Judge Sir David Carruthers

Chair
Independent Police Conduct Authority

25 May 2016

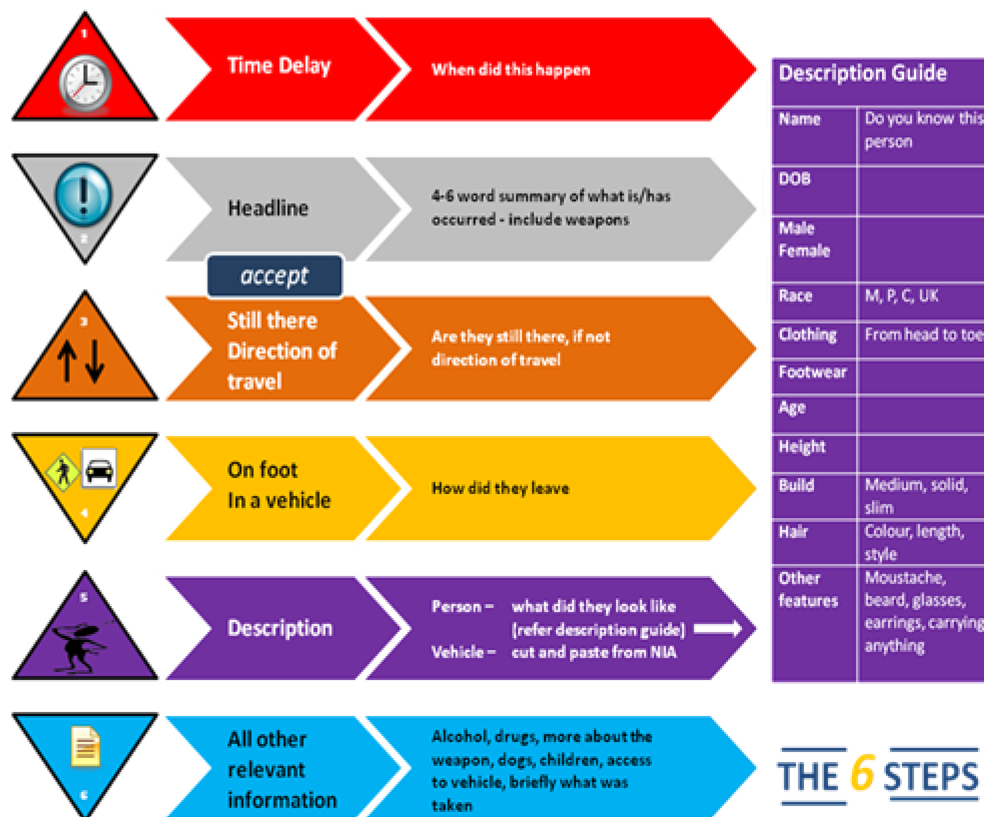
IPCA: 14-2044

Applicable Laws and Policies

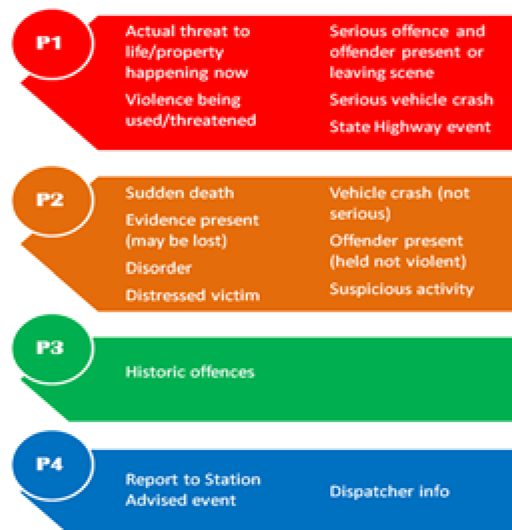
COMMUNICATIONS – STANDARD OPERATING PROCEDURES

240. 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.

241. When a call is made to Police, communications centre communicators follow a six-step process to gather information. In summary, the six steps are: when the incident occurred; what happened (including whether weapons were involved); whether the offenders are still at the scene; how the offenders left; a description of the offenders; and any other relevant information (such as involvement of alcohol or drugs, presence of children or dogs, any further details about weapons, access to vehicles, and whether anything was taken). Call takers have the following chart to assist them in obtaining this information:



242. The communicator then assigns a priority level to the call, ranging from Priority 1 – for serious incidents including those where there is a threat to life or property, or violence being threatened or used – to Priority 4 for events that do not require a Police response.



243. The information entered by the communicator is immediately received on the screen of the communications centre dispatcher responsible for the area in which the incident is occurring.

Missing Persons

244. The Police Communications Centres' standard operating procedures for 'Missing Persons' require communicators firstly to determine whether there are fears for safety. If the communicator finds that there are no immediate concerns for safety and Police attendance is not necessary, he or she must instruct the caller to go to the nearest Police station to complete a missing person report, with a photograph of the missing person if possible.

245. If there are fears for safety, the communicator must gather *"sufficient details to enable the job to be dispatched."* This includes information about:

- the missing person's age and description;
- clothing and what equipment carried;
- physical and mental condition;
- medication;
- next of kin;
- where they are missing from (also familiarity with the area, type of environment, weather conditions, where they were last seen, mode of transport, possible destinations);
- the caller's details
- *"any unusual circumstances i.e. suicidal thoughts"*; and
- the level of concern about the missing person and the reason for that concern.

246. Communicators are instructed to immediately enter the event as Priority 1 or Priority 2, as appropriate, and to advise their team leader or Shift Commander.

247. When the dispatcher receives the event, they must conduct a risk assessment. According to the standard operating procedures, if dispatch is required due to *"concerns for safety"*, the dispatcher must:

- exercise command and control;
- conduct an appreciation in accordance with dispatch appreciation model;
- dispatch a Police unit to the scene (urgency depending on whether the event is coded Priority 1 or Priority 2);
- broadcast a message about the missing person to all units in the search area (i.e. a 10/1 broadcast), and consider broadcasting the message in neighbouring areas;
- advise the field NCO (e.g. sergeant on duty);
- consider advising Shift Commanders / NCO in neighbouring Districts;
- notify SAR, and the Police Criminal Investigation Branch (CIB) if relevant; and
- consider a media release.

248. When Police attendance is required, missing person events must be assigned to an attending unit for further investigation – the event cannot be closed or left on hold for other units.

249. The standard operating procedures also require team leaders to ensure that all risk factors are considered and appropriate steps are taken by the dispatcher. They must consider whether further action is necessary.

Mentally Disordered Persons

250. The standard operating procedures for 'Mentally Disordered Persons' instruct communicators to find out whether the person is a committed patient, and if so, whether they are considered a risk to themselves or others. The communicator must also ask where the patient may be heading to or where they can be found, and request written notification of the patient's absence by fax.

251. 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.

252. Communicators are instructed to immediately enter the event as Priority 1 or Priority 2, as appropriate.

253. The standard operating procedures state that, when the person is a committed patient, the dispatcher must request that a Duly Authorised Officer (DAO) attend the scene with Police *"where it is believed the patient can be found, where the patient poses a risk"*. However Police may have to act regardless of whether a DAO is available.

254. 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;
- 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 Hamilton, require a DAO to be called).

Suicide

255. The Police standard operating procedures document for '1X – Suicide' has been left *"Deliberately blank"*.

NATIONAL RECORDING STANDARDS

256. The Police's National Recording Standards for missing person events require that a missing person report is entered into the Police database within four hours.

MISSING PERSONS POLICY

257. The 'Missing persons' chapter of the Police Manual states that missing person reports must be taken immediately and should be entered into NIA as soon as they are taken. The person taking the report must conduct a risk assessment and, if urgent action is required, must advise

their supervisor immediately as *"command and control of the situation is required, and relayed to the appropriate communications centre."* If only routine action is required, then the person should *"continue the process of entering the file and assigning as appropriate."*

258. While the policy includes mental health as a factor to be considered in any risk assessment relating to the missing person, it does not have any particular instructions on the actions to take when a mental health patient is missing because they have absconded from a health facility.

259. In respect of the investigation of missing person reports, the policy states six key principles that Police should consider in their response:

> *"1. The missing person's well-being.*
>
> *2. Respect for the right of an individual – to choose not to have contact with family or friends.*
>
> *3. Compassionate treatment of the missing person's relatives and friends.*
>
> *4. The possibility that the person has become a victim of serious crime.*
>
> *5. In suspicious cases,, preserving and managing evidence.*
>
> *6. Assessing the appropriate level of resources for each report."*

260. The aim of the initial investigation is to gather sufficient detailed information so Police can accurately assess the facts and circumstances, determine the focus and structure of the investigation, and identify the resources required.

261. This may include interviewing the 'informant' (i.e. the person who reported someone missing), conducting a thorough search of the area where the missing person was last seen, informing the missing person's next of kin, consulting with supervisors and considering the use of specialist units such as SAR or Police dogs. The investigator must ensure the missing person report has been completed in full and entered into the Police database, and that the next of kin have signed an 'Authority for Publicity' form.

262. The policy has a section that sets out the duties of the 'Case Officer':

"If you are assigned the missing person file, follow these steps:

Step	***Action***
1	*Assess all information by conducting a full appreciation and risk assessment.*
2	*Consider conducting a scene examination, if this has not already been done.* *Evaluate the scene and its appearance. If relevant advise your supervisor and the O/C CIB, and treat it as a crime scene to:* • *prevent contamination of the scene* • *identify items of evidential value.*
3	*Maintain regular contact with the informant and family.*

	Obtain further details that were not available at the initial interview.
4	*Liaise with relevant groups, such as: CYFs, Youth Services, Coronial services.*
5	*Conduct enquiries to locate the person, and:* • *manage the specific lines of enquiry, as circumstances dictate* • *interview the missing person's friends, employer and associates.*
6	*Attempt to track the person's movements, by:* • *obtaining bank records and reviewing them for recent transactions* • *obtaining passport and border movements* • *reviewing cell phone records to determine whether the phone has been used recently and where it is polling* • *contacting outside agencies, such as: WINZ and Land Transport.*
7	*Consider whether the enquiry would benefit from general media coverage.*
8	*Consider profiling the missing person on the NZ Police Missing Person Web page or Facebook page.*
9	*Collect forensic specimens for identification purposes (if applicable).*
10	*Record all enquiries made and attach to the missing person occurrence.*
11	*Complete file reviews and update the missing person occurrence narrative."*

PEOPLE WITH MENTAL IMPAIRMENTS POLICY

263. The 'People with mental impairments' chapter of the Police Manual has a section titled *"Returning a patient to hospital who is absent without leave"*, which sets out the steps to be taken when a mental health patient is reported missing:

> ***"If a patient is reported missing***
>
> *Follow these steps if a patient is reported as absent without leave.*

Step	***Action***
1	*Notification. It is expected that police will be initially notified by phone of the escape of a patient, to be promptly followed by a faxed notification.* *When receiving a call ascertain:* • *if the patient is considered a threat to themselves or others and the extent of any threat* • *whether the patient has any weapons* • *if it is known where the patient may be located or where they may be going and;* • *request a faxed notification.*
2	*Enter them as 'missing' in NIA as a Person Alert.*

	***Note**: Decisions on the level of further Police action are made in the same way as for other persons reported missing but with high priority (P1) for those considered to pose a threat.*
3	*Consult a DAO about:* • *the action to take* • *whether a press release is needed* • *the level of police assistance required* • *whether the patient is likely to suffer harm* • *whether the patient is likely to harm other people or damage property* • *the DAO attending the location when it is believed a patient considered to be a threat can be located.*
4	*Keep a written record of all consultations with health authorities, taking particular note of the assistance sought and the level of possible threat.”*

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.

PO Box 25221, Wellington 6146
Freephone 0800 503 728
www.ipca.govt.nz