IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

Police delay in responding to fatal hit and run

1. At about 3am on 24 January 2023 Mr Z was driving along State Highway 30 about one kilometre from the Benneydale township, when his car struck Mr W, who was walking along the road. Mr Z did not stop to ascertain injury but drove to his mother's address in Benneydale and advised her what had happened. Mr Z's mother (Ms Y) phoned 111 to report the incident, however Police decided to delay attendance until it was daylight. When they did attend, they found Mr W deceased in a grass verge on the side of the road. The factors considered by Police in deciding to delay attendance are discussed further in this report.

2. Mr Z was driving from Auckland to Benneydale with his partner and child to visit his mother. It was a dark rural road with no lighting other than the car headlights.

3. As Mr Z rounded a corner he struck Mr W who was walking on the road, smashing the windscreen, and causing frontal damage to his car. Mr Z continued to his mother's address in Benneydale.

4. Mr Z told his mother what had happened. He said he had hit something on the road, possibly a person, but he could not be sure. Ms Y and Mr Z's partner then drove along SH 30 in search of the scene but did not find anything.

5. Ms Y then called 111 and spoke to a call-taker (Ms X) based in the Southern Communications Centre. She reported that her son had hit something on the road, a person or an animal, but they were not sure. Ms X obtained details from Ms Y and entered a job in the Police computer system, coding it as a Priority 2 event (described below).

6. Details of the job were then assessed by a dispatcher based in the Northern Communications Centre in Auckland. The dispatcher did not send a patrol car to Benneydale but tasked the job to the night shift sergeant in western Waikato (Officer A) to consider the Police response.

7. Officer A discussed the job details with the night shift senior sergeant, Officer B. Before deciding whether to dispatch a patrol car to Benneydale, Officer B asked that Ms Y be contacted again to

obtain further information. After this was done, Officer B decided not to send a car to Benneydale until morning when it was daylight, a decision to which Officer A agreed.

8. Before the end of shift at 7am, the job details were passed onto the new day shift and an officer (Officer C) was tasked to travel to Benneydale to speak to Mr Z and Ms Y and make further enquiries into what had happened.

9. As Officer C drove into Benneydale on SH30 he slowed and made a cursory search of the roadsides but did not locate anything. He then drove to Ms Y's address, arriving at 8am, and spoke to her and Mr Z.

10. After speaking with them, Officer C asked Mr Z to accompany him in his patrol car to try and find the location of the incident. At 8.27am, after driving up and down a stretch of State Highway 30, searching each side of the road, they found Mr W deceased on the grass verge, beside a fence. From that point the scene was secured, and further Police were called to commence an investigation.

11. Mr W's family complained to the Authority about the Police decision to delay their response until the morning, angry that Mr W may have been laying injured. We acknowledge that as an entirely understandable concern. While of little consolation to Mr W's family, we note the pathologist's advice that Mr W would have died instantly, and any medical intervention would not have prevented his death.

12. Mr W's family also complained about aspects of Police actions after their initial attendance.

13. Mr Z was later charged with failing to stop after the crash. He pleaded guilty to the charge and on 22 April 2024 was sentenced to seven months and seven days home detention and disqualified from driving for one year.

14. As a result of this complaint, Police undertook a review into their response, and the Authority decided to conduct an independent investigation.

The Authority's Findings

Issue 1: Should Ms Y's emergency call have been coded as a Priority 1 event, rather than a Priority 2?

The event should have been coded as a Priority 1.

Issue 2: Should Police have attended at the time of Ms Y's call, rather than deciding to wait until morning?

Police should have attended the job at the time of Ms Y's call.

Analysis of the issues

ISSUE 1: SHOULD MS Y'S EMERGENCY CALL HAVE BEEN CODED AS A PRIORITY 1 EVENT RATHER THAN A PRIORITY 2?

15. In this section we describe what happened when Police received Ms Y's emergency call and how it was coded for dispatch. We will assess the coding of the call against Police instructions dealing with priority calls.

16. Ms Y called Police at 3.50am and spoke with Ms X. After obtaining Ms Y's details and the nature of the call, and an approximate time delay of 30 minutes, Ms X entered the job, coding it as a 'Vehicle Collision, Priority 2'. The duration of the call was 14 minutes, during which Ms Y told Ms X that:

    - her son had hit something and he didn't know if it was an animal or a human;
    - she had been in search of the scene, driving up and down the road for half an hour, but couldn't find anything;
    - she was worried someone could be lying in a ditch or crawled off somewhere;
    - Mr Z's car was 'a bit of a mess'
    - Mr Z had stopped after the crash but couldn't see anything because it was too dark.

17. Ms X then spent some time with Ms Y trying to narrow down the crash location. She also obtained the registration number of Mr Z's car and the damage caused to it.

18. As Ms X was speaking with Ms Y she recorded the details onto an event chronology. At 3:54am Ms X entered the headline *"Inft [Informant's] son hit something with his car - can't find anything on the road"*. At 4.02am Ms X recorded *"Inft is really worried that son hit a person and they are lying dead somewhere".*

19. We note that Mr Z's details were not given, or sought, during this call. We think they should have been so that the appropriate checks on him could be made, including his driving history and behaviour.

20. Before ending the call, Ms X told Ms Y that the information had been passed on to the local Police and invited her to call back if she had anything to update. The event remained coded as a Priority 2.

Standard Operating Procedures relating to Vehicle Collisions (1V)

21. The Police Emergency Centre Intranet provides that a vehicle collision (car crash, motor vehicle accident, or traffic incident) can be a dynamic event, requiring a thorough assessment for response to ensure that public safety is prioritised and that investigations can be completed where required.

Priority 1 events

22. Priority 1 events are described in Police instructions as an *"actual threat to life or property happening now, violence being used or threatened, serious incident in progress and offenders present or leaving the scene, and serious vehicle crashes (persons trapped/seriously injured)".*

23. In relation to instructions for traffic incidents specifically, there are several factors that meet this criteria, including traffic incidents where *serious injury or death is likely or confirmed.* If an incident is coded Priority 1, Police will endeavour to be at the scene within 10 minutes of receiving the call (subject to resource availability and travel time).

Priority 2 events

24. Priority 2 events include those where there is no immediate threat to life or property, or violence being threatened, and there is a lesser degree of urgency.

25. In relation to instructions for traffic incidents specifically, the criteria includes incidents where the parties are still present at the scene, or where there are non-life-threatening injuries, or where a party has recently decamped without providing details. If an incident is coded Priority 2, Police will endeavour to be at the scene within 30 minutes of the call (subject to resource availability and travel time).

What did Ms X say about coding the event P2?

26. Ms X was working as a call-taker at the Southern Communications Centre when she received Ms Y's call. She recalled Ms Y appeared panicked and was very concerned that her son had hit something but didn't know what it was. Ms X spent about four minutes with Ms Y trying to narrow down the location of the scene. Ms X also established from Ms Y that the time delay since the incident was approximately 30 minutes.

27. Ms Y told Ms X that her son got out of the car after the crash and looked around but couldn't see anything. Ms X also ascertained that Ms Y had herself gone out in search of the scene but couldn't find it. Ms X learnt that the vehicle had sustained frontal damage but there was no apparent blood on it. At 3.54am Ms X coded the job as a Priority 2 event.

28. In coding the event as Priority 2, Ms X told us that although there was evidence of damage to the car, and it was clear there had been a collision, there was no confirmation of what Mr X had hit. Ms X also considered that Ms Y had searched the area without finding anything, and the possibility that Mr Z may have hit a farm animal. Ms X says that if there had been more certainty around whether a person had been hit, she would have coded the event Priority 1.

29. After coding the event Priority 2, Ms X continued speaking with Ms Y for several minutes, entering further details onto the event chronology including that *"[Ms Y] is really worried that [her] son hit a person and they are lying dead somewhere".* The call ended at 4.04am, by which time a Communications Centre dispatcher, based in the Northern Communications Centre and responsible for dispatching cars in the Waikato rural area, had read and received the job for dispatch. Ms X had no further involvement.

Analysis

30. When Ms X received the emergency call she followed a standard six-step process to obtain relevant information from Ms Y. This included trying to establish the event location, the time delay, and details of the incident itself. After doing so Ms X ended the call, giving Ms Y an assurance that the job was now with local Police for response.

31. Ms X explained her thinking to us around coding the event Priority 2, including the criteria outlined in paragraphs 24 and 25. We accept there was no confirmation that a person had been hit and this was a primary consideration for Ms X. We also accept that many of the criteria for Priority 1 as outlined in paragraphs 22 and 23 were not met.

32. However, the Priority 1 criteria includes incidents involving serious vehicle crashes where people are seriously injured. Whilst accepting there was no confirmation that anyone had been serious injured, or even hit by Mr Z's car, we consider the uncertainty in this case should have prompted Ms X to prioritise or re-prioritise the event to a Priority 1, particularly given that Ms Y was worried that her son may have hit and killed someone.

33. We note, however, that coding the event as Priority 2 did not influence the decision to delay the Police response. That decision was made elsewhere and did not involve Ms X in any way.

FINDING ON ISSUE 1

The event should have been coded as a Priority 1.

The coding as Priority 2 did not influence the subsequent decision to delay Police attendance.

ISSUE 2: SHOULD POLICE HAVE ATTENDED AT THE TIME OF MS Y'S EMERGENCY CALL, RATHER THAN DECIDING TO WAIT UNTIL MORNING?

What happened after Ms Y's call?

34. In this section we describe what happened after Ms Y's call to Police and how the decision was made to delay Police attendance.

35. After the call ended, the job was in the hands of the dispatcher at the Northern Communications Centre. Having read details of the event, the dispatcher did not dispatch a car to the job, but instead called the night shift sergeant on duty in the western Waikato area (Officer A) and asked him to review the job and advise if a Police unit should attend. We think it was appropriate for the dispatcher to do this.

36. Officer A was at the Te Awamutu Police Station when he reviewed the job details, and after doing so he contacted the night shift senior sergeant (Officer B) at the Hamilton Police Station and sought advice on whether a unit should be dispatched to Benneydale. Before making a decision, Officer B tasked Officer A to make enquiries with Ms Y to obtain further details. Officer A tasked this to a constable who telephoned Ms Y.

37. Unfortunately, the tasking to the constable was quite general in terms and did not specify what information was required from Ms Y, for example, the name and details of her son. We think

this was a significant omission. As a consequence, when the constable reported back to Officer A, little additional information had been obtained beyond what had been disclosed in Ms Y's initial emergency call.

38. Officer A then reported back to Officer B. Officer A says the discussion centred largely on what would be achieved by sending a unit to Benneydale, given that Ms Y had already searched the area and not found anything. They considered the viability of calling out the Benneydale or Piopio officers, but they were either unavailable or not on-call. Although the Te Awamutu unit was available, Officer A was aware that it would take approximately one hour for it to get to Benneydale.

39. Based on the discussion and on the direction of Officer B, Officers A and B agreed not to send a unit to Benneydale. Instead, they decided Officer A would task the oncoming dayshift sergeant to arrange a unit to attend in the morning.

What did Officer B say?

40. Officer B was working in the District Command Centre based at the Hamilton Police Station. When he heard the Northern Communications dispatcher task Officer A to review the job, he also looked at the job details himself. About 15 minutes later he received a call from Officer A. They discussed what was known at that time and Officer B tasked Officer A to make further contact with Ms Y. After this was done they again discussed what was known and the Police response.

41. Officer B was aware that Ms Y had made a concerted effort to locate the collision site but was unsuccessful in doing so. Shortly after 5am, he and Officer A discussed the availability of staff to attend - those on duty and on-call. Consideration was given to dispatching the Te Awamutu patrol car, but knowing it would take over an hour to get to Benneydale it was considered more viable to wait for the Te Kuiti day shift to start at 7am. They saw the other benefit of this plan being that it would be daylight, which would allow a more thorough search. On that basis they considered little would be achieved by dispatching a unit immediately.

42. Officer B acknowledged that he wrongly drew an inference that it was likely an animal had been struck by Mr Z, basing this inference on the rural location, his belief it unlikely a pedestrian would be wandering at that time of night and it being common for goats or deer to be on the road. He said if he had thought otherwise he would have definitely arranged for a car to attend. He said that if the same set of circumstances were presented to him again, he would make a different decision.

43. Officer B also agreed that Police should have obtained details of the driver, that was an oversight and Mr Z should have been identified and spoken to earlier.

Analysis

44. We consider it appropriate that the Northern Communications dispatcher tasked the job to Officer A to review, and that Officer A consulted Officer B. We also consider it appropriate that Officer B directed further enquiry with Ms Y.

45. Officers A and B gave due consideration to the information they had before them and made a decision to delay deployment until morning. Although made in good faith, we think that decision was an error in judgement.

46. Had Police responded sooner to Ms Y's call, it was possible that Mr W might have been found on the roadside and attended to much earlier.

47. It is also highly likely that if Police had attended sooner to Ms Y's call, Mr Z would have been located, breath tested and interviewed.

FINDING ON ISSUE 2

Police should have attended the job at the time of Ms Y's call rather than delaying until morning.

ISSUES OF CONCERN RAISED BY MR W'S FAMILY

48. In this section we outline other concerns Mr W's family raised with us concerning Police actions in response to this incident.

What route did Officer C travel to Benneydale and did he search for Mr W along the way?

49. Officer C commenced his shift at 7am and was tasked to travel to Benneydale to speak with Ms Y and Mr Z to find out what had happened. He was also tasked to look for Mr W as he neared Benneydale. Officer C knew the crash had occurred on SH30 *"just out of Benneydale somewhere"*, but nothing more specific.

50. Officer C drove from Piopio to Benneydale. He told us that when he got to Mangapehi on SH30 (about seven kilometres out of Benneydale) he slowed his vehicle down to about 50-60kph and started scanning the verges until he reached the township. He said it was now daylight and the road quite busy with road users. When he did not find Mr W, he made his way to Ms Y's address.

51. It is evident that Mr W was not immediately visible to Officer C or other road users. This also proved to be the case when Officer C took Mr Z in search of Mr W and it was only after several sweeps of the highway that they found him.

52. We are satisfied that Officer C took reasonable steps to search for Mr W on his way to Benneydale.

The time it took to formally identify Mr W

53. Mr W was located on a grass verge at about 8.30am that morning. His body was facing away from the road and Officer C covered him with a blanket. Mr W was formally identified by a relative about six hours later at 2.40pm.

54. When Officer C discovered Mr W he sought assistance, and further staff were mobilised, including the Police Serious Crash Unit from Hamilton which took over an hour to reach the scene. Mr W's body was not moved until the unit had completed its scene examination in the afternoon. Mr W's pockets were searched and his wallet was located, but it did not contain any

identification. During this period two people arrived at the scene cordons and provided information indicating the deceased might be Mr W. Both were friends of Mr W, one arriving at the scene at about 11.30am and the other shortly after midday.

55. Based on the information they provided, Police made an enquiry at Mr W's father's address in Benneydale to obtain further identification details. They advised him they suspected Mr W may be his son. Later, at 2.40pm, a relative of Mr W attended at the scene and formally identified him before he was removed from the scene.

56. The options available to Police to formally identify Mr W sooner were limited. These were confined to (1) bringing one of Mr W's friends into the immediate scene to view his body in situ during the scene examination, (2) removing Mr W's body from the scene before the examination was completed, or (3) photographing Mr W's body for identification purposes, which would also have involved moving his body. Given the need to keep the scene secure during the examination, we do not think these options were viable. Further, although the scene may have been compromised by the delay in Police attendance, we note it is standard policing practice not to allow people into the scene.

57. Overall, given the remoteness of the scene location and the time required for staff to mobilise and complete the scene examination, we think the time it took to formally identify Mr W was reasonable in the circumstances.

The undue delay in breath and alcohol testing Mr Z

58. The first face to face contact Mr Z had with Police that day was with Officer C, at about 8am approximately five hours after the crash. Officer C says he did not detect any signs of intoxication on Mr Z. He said that after obtaining his details, he asked Mr Z to accompany him in search of the scene.

59. Officer C told us he was not specifically tasked to breath test Mr Z, and he did not request Mr Z to undertake one. He was aware of the time delay since the crash and he said Mr Z did not smell of alcohol or exhibit any signs of intoxication.

60. Section 68 of the Land Transport Act provides that a Police Officer may require a person to undergo a breath screening test at the time of a motor vehicle accident, or if the officer has good cause to suspect the driver has recently committed an offence that involves driving a motor vehicle.

61. In this instance, it was five hours after the crash before Police located Mr Z, and in our view it is arguable whether there was good cause to suspect Mr Z had committed an offence. We do, however, think Officer C should have requested Mr Z to undergo a breath screening test, despite the delay and his apparent sobriety. Whether alcohol may have been detected at that time can only be a matter of speculation.

62. Mr Z was not breath tested until 11.09am at the Benneydale Police Station, approximately eight hours after the crash, by an officer assigned to the investigation. The breath screening device produced a 'pass' result, indicating that no alcohol was detected. After a formal statement was

taken from Mr Z, arrangements were made for him to attend at Te Kuiti hospital where a blood sample was taken from him at 3.46pm. Subsequent analysis found the sample to contain tetrahydrocannabinol (THC), the active constituent of cannabis.

63. We find the delayed breath and blood testing of Mr Z was a consequence of the decision to delay Police attendance earlier in the morning. Had Police attended at that time, it is highly likely Mr Z would have been tested then.

Why was Mr Z not arrested?

64. The officers who dealt with Mr Z were tasked to test him for alcohol and interview him to obtain his account of what happened. There was no specific direction given on how to deal with Mr Z after those tasks had been completed.

65. We spoke to the officer in charge of the Police investigation, who told us that if an arrest was considered necessary, he could have made that decision himself, or elevated it for higher level consideration. He said in this case, because the circumstances were not immediately clear, it was more appropriate for the matter to be elevated for charging decisions to be made, without the need to arrest Mr Z.

66. We agree that in these circumstances it was not necessary to arrest Mr Z. His account, together with other evidence gathered, required careful consideration before charging decisions were made. In our view this was not a case where Mr Z needed to be arrested.

Inadequacy of charges

67. Contrary to Ms Y's initial belief that Mr Z had stopped after the crash (see para 27), Mr Z was charged with failing to stop and ascertain injury. This is an offence under the Land Transport Act 1998 and punishable upon conviction to 5 years imprisonment or a $20,000 fine.

68. This charge followed consideration of other potential charges including careless use of a motor vehicle causing death, and careless use of a motor vehicle while under the influence of drugs. Following legal advice in relation to these offences a decision was made to charge Mr Z with one charge of failing to stop and ascertain injury.

69. We are satisfied that Police took appropriate steps to consider the evidence before deciding to lay the one charge against Mr Z. We are unable to say whether more serious charges would have been laid if Police had attended the incident sooner, as that would be a matter of speculation.

Not returning all of Mr W's property

70. Typically when Police deal with sudden deaths, property and exhibits are seized for safekeeping, including personal items of the deceased.

71. On 27 January 2023 arrangements were made for the return of Mr W's personal property to a family member in Cambridge. These items comprised Mr W's clothing and property found inside his pockets. Not returned at the time were five rounds of ammunition and a firearm magazine that were found in Mr W's possession. Mr W's family queried why this was the case.

72. Police have advised that these items were not returned at the time but retained for safekeeping until they could lawfully be returned to the holder of a firearms licence. We think this was appropriate and note the property has since been returned.

Failure to arrange Victim Support

73. In the early stages of the Police investigation, Victim Support was arranged for Mr W's father and the relative who completed the formal identification. It was not arranged or offered to other members of Mr W's immediate family including his mother and siblings. It was only arranged some weeks later at the request of family. It is apparent that Police did not consider more widely the provision of victim support to family and we think this was an unfortunate oversight.

FINDINGS

Officer C took steps to search for Mr W on his way to Benneydale.

The time it took to identify Mr W was reasonable in the circumstances.

The delay in breath and alcohol testing Mr W was a consequence of the decision to delay Police attendance.

It was not necessary to arrest Mr Z after he had been interviewed and tested for alcohol.

The laying of one charge only was properly considered. Whether further charges could have been laid if Police had attended earlier, is a matter of speculation.

It was appropriate for Police to retain Mr W's magazine and cartridges.

Police should have considered more widely the provision of Victim Support to family.

Subsequent Police Action

74. As a result of the complaint to the Authority, Police conducted its own review into the response to Ms Y's emergency call. That review also found Ms Y's call should have been coded as a Priority 1 event, and Police should have been dispatched to attend at the time of the call.

Judge Kenneth Johnston KC

Chair
Independent Police Conduct Authority

11 June 2024

IPCA:

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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.

We are not part of the Police – the law requires us to be fully independent. The Authority is overseen by a Board, which is chaired by Judge Kenneth Johnston KC.

Being independent means that the Authority makes its own findings based on the facts and the law. We do not answer to the Police, the Government or anyone else over those findings. In this way, our 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 and may choose to investigate:

- complaints alleging misconduct or neglect of duty by Police;
- complaints about Police practices, policies and procedures affecting the complainant in a personal capacity;
- notifications of incidents in which Police actions have caused or appear to have caused death or serious bodily harm; and
- referrals by Police under a Memorandum of Understanding between the Authority and Police, which covers instances of potential reputational risk to Police (including serious offending by a Police officer or Police actions that may have an element of corruption).

The Authority's investigation may include visiting the scene of the incident, interviewing the officers involved and any witnesses, and reviewing evidence from the Police's investigation.

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.

THIS REPORT

This report is the result of the work of a multi-disciplinary team. At significant points in the investigation itself and in the preparation of the report, the Authority conducted audits of both process and content.

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