

Independence

trustworthiness

accountability

**Inquiry into Police Conduct, Practices,
Policies and Procedures Relating to the
Investigation of Child Abuse: Part II**

vigilance
integrity

February 2011



IPCA

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



February 2011

IPCA
Level 8
342 Lambton Quay
PO Box 5025,
Wellington 6145
Aotearoa New Zealand

0800 503 728
P +64 4 499 2050
F +64 4 499 2053
www.ipca.govt.nz



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INDEPENDENT POLICE CONDUCT AUTHORITY

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Glossary

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INDEPENDENT POLICE CONDUCT AUTHORITY

Phrase or acronym	Explanation
Acute Child Abuse	Child abuse reported within 7 days of the abuse occurring
Adult	A person aged 17 years or older
AMCOS	Auckland Metro Crime and Operations Support
ASA	Adult Sexual Abuse
(The) Authority	Independent Police Conduct Authority
Case investigation plan	An investigation plan describes the investigation process. It translates the objectives from the Terms of Reference into a plan that sets out roles, responsibilities, timeframes, principal activities, critical decision points and objectives for any investigation
CAT	Child Abuse Team
Child	Unless specified, 'child' means any person under the age of 17 years at the time of the report, as defined in the Children, Young Persons, and their Families Act 1989
Child abuse	Child abuse is defined in the Children, Young Persons and their Families Act 1989 as the harming (whether physically, emotionally, or sexually), ill-treatment, abuse, neglect, or deprivation of any child or young person. Police guidance defines as follows: If the victim is a child and one or more of the following exist then the report of concern should be treated as child abuse: <ul style="list-style-type: none"> • physical abuse • sexual abuse • neglect • emotional abuse • psychological abuse • witness to serious crime • witness to family violence • presence in unsafe environments • cyber crime exploiting children • child trafficking

Child forensic interview	A video recorded forensic interview conducted by a trained child forensic interviewer that may be used as part of an investigation where a child has, or may have been, abused or witnessed a serious crime
Child protection portfolio holders	Trained investigators, often in remote or rural locations, who have the responsibility for investigating reports of concern about child safety. These investigators are not exclusively focused on child protection and may be called upon to investigate other serious crime
Child safety concerns	Child safety concerns include offences or suspected offences relating to physical, sexual, emotional abuse or neglect of a child. The categories overlap and a child in need of protection frequently suffers more than one type of abuse
CIB	Criminal Investigation Branch
COIPC	Commission of Inquiry into Police Conduct
Commissioner	The Commissioner of Police
CPP (Child Protection Protocol)	The Child Protection Protocol sets out the way that Child, Youth and Family and Police will work alongside each other in the situations of serious child abuse
CPP case	An agreed case between Police and CYF of serious child abuse being investigated in accordance with the CPP
CPT (Child Protection Team)	A Child Protection Team is exclusively focused on responding to reports of child safety concerns. A CPT is made up of trained investigators reporting to a supervisor
CRL	Crime Reporting Line
CSA	Child Sexual Abuse
CSV	Court Services for Victims
CYF	Child Youth and Family
CYFS	Child Youth and Family Services
Child, Youth and Family timeframes	The categories used by CYF: Critical - critical means the child or young person is in immediate risk of serious harm and the need for immediate protection may be necessary. Very urgent - the child or young person is at risk of harm but is not in any immediate danger. Urgent - the child or young person is at risk of harm but protected in the short term
CYRAS	Child Youth and Family Database
D-CAT	District Child Abuse Team
D-CPT	District Child Protection Team

Emotional abuse	The persistent emotional ill-treatment of a child, which causes severe and persistent effects on the child's emotional development
ESR	Institute of Environmental Science and Research Limited
EVI	Evidential Video Interview
FEO	Flexible Employment Option
Harm	Ill-treatment or the impairment of health or development, including impairment suffered from seeing or hearing the ill-treatment of another
Historic child abuse	Reports by an adult victim of child abuse that occurred against them when they were a child
HRX	High Risk Offender
Joint investigation plan	An agreed plan between Police and CYF so that employees involved know: <ul style="list-style-type: none"> • who is involved in the case • what they will do • when they will do it
LES	Law Enforcement System
LLA	Local Level Agreement
MOU	Memorandum of Understanding
MSD	Ministry of Social Development
Neglect	Neglect is the failure to provide a child's basic physical, emotional, or educational needs or to protect a child from harm or potential harm. Neglect can occur as an isolated incident, a series of incidents or it can be a continuous state
NIA	National Intelligence Application
Non acute child abuse	Child abuse reported 7 days or later from the abuse occurring
NZCASS	New Zealand Crime and Safety Survey
NZCYPS	New Zealand Children and Young Persons Services
OAG	Organisational Assurance Group
O/C	Officer in Charge
OFCANZ	Organized and Financial Crime Agency New Zealand
OoC	Office of the Commissioner
OPG	Organisational Performance Group
PEC	Police Executive Committee
PEM	Police Executive Meeting
PNHQ	Police National Headquarters
POL 1060	Victim Contact Record Document
POL 1065	Victim Notification Document
Psychological abuse	A person psychologically abuses a child if they: <ul style="list-style-type: none"> • cause or allow the child to see or hear the physical, sexual, or psychological abuse of a

	<p>person with whom the child has a domestic relationship (defined in s4 Domestic Violence Act 1995), or</p> <ul style="list-style-type: none"> • put the child, or allow the child to be put, at real risk of seeing or hearing that abuse occurring. (s3(3) Domestic Violence Act 1995) <p>The person who suffers the abuse is not regarded (for the purposes of s3(3)) as having:</p> <ul style="list-style-type: none"> • caused or allowed the child to see or hear the abuse, or • put the child, or allowed the child to be put, at risk of seeing or hearing the abuse
Puawaitahi	Auckland District Dedicated Multi Agency Child Abuse Team
QID	Police identification number
ROC	Report of Concern
RNZPC	Royal New Zealand Police College
SAT	Serious Abuse Team
Serious child abuse	<p>Serious child abuse includes but is not limited to:</p> <ul style="list-style-type: none"> • sexual abuse • serious physical abuse • serious wilful neglect • serious family violence where the child is a witness • all allegations against Child, Youth and Family approved caregivers that involve serious child abuse • all allegations against employees of Child, Youth and Family and Police that involve serious child abuse
Serious physical abuse	The actions of an offender that result in or could potentially result in physical harm or injury being inflicted on a child. The test for seriousness is determined by considering the action, the injury and the circumstances
Serious wilful neglect	When a person wilfully ill-treats or neglects a child or wilfully causes or permits the child to be ill-treated in a manner likely to cause the child actual bodily harm, injury to health or any mental disorder or disability. This includes failure to provide the necessities of life
Sexual abuse	An act involving circumstances of indecency with, or sexual violation of a child or using a child in the making of sexual imaging
SNEN	Single non-emergency number
SOR	Sexual Offender/Suspect Report
TMAPS	Tauranga-Moana Abuse Prevention Strategy

UNCROc	United Nations Convention on the Rights of the Child
Victim	A person against whom an offence is committed by another person. A victim may also include a parent or legal guardian of a child or young person
Witness to serious family violence	When a child witnesses violence resulting in, or having the potential to result in, a death or significant injury to a family or household member
6C Incident code	Any report of concern received by Police where a child is the victim

GLOSSARY OF OFFICERS

Ranks and duties as they applied at the time of reference in this report.

Name and rank	Role or duties
D/I Michael Arnerich	Crime Services Manager, WN District
D/S/S Paul Borrell	Acting Field Crime Manager, WN District
D/I Douglas Brew	Crime Services Manager, Central District
Commissioner Howard Broad	Commissioner NZ Police
Supt Michael Bush	D/Commander, Counties Manukau
D/I Shane Cotter	Field Crime Manager, WN District
Insp Bruce Dunstan	Area Commander, Lower Hutt
Det Manatua Faraimo	Det in Masterton and Featherston CIB
D/I Andrew James Gallagher	Officer in Charge, Operation River, PNHQ
D/S/S Neil Holden	National Coordinator: Audit and Child Sexual Abuse
Insp John Johnston	Area Commander, Wairarapa
Supt Mark Lammas	D/Cmdr, Central
D/S/S Ross Levy	Officer in Charge of CIB, Lower Hutt
Det Suzanne Mackle	Child Abuse Portfolio Holder, Masterton CIB
D/S/S Samasoni Malaulau	Officer in Charge of CIB, Lower Hutt
Acting Deputy Commissioner Peter Marshall	Assistant Commissioner: Operations
D/S Mark McHattie	Officer in Charge, Masterton/Wairarapa CIB
Supt Pieri Munro	D/Cmdr, WN District
Det Justine O'Connell	Detective in Masterton CIB
D/S Tusha Penny	Officer in Charge of CAT, Lower Hutt
Supt Robert Pope	District Commander, WN District then Deputy Commissioner (Operations) at PNHQ
D/I Harry Quinn	Crime Services Manager, WN District
Supt David Trappitt	Acting D/Cmdr, WN District
Det Supt Winston van der Velde	National Crime Manager
D/S William Van Woerkom	CIB Squad Supervisor, Masterton
D/S Glenn Williams	Officer in charge of CAT, WN Central
Greg O'Connor	New Zealand Police Association President
Steve Plowman	Editor of Police News, Police Association

KEY:

D/Cmdr	District Commander	Supt	Superintendent
D/I	Detective Inspector	Insp	Inspector
D/S/S	Detective Senior Sergeant	D/S	Detective Sergeant
Det	Detective	WN	Wellington



Foreword

INDEPENDENT POLICE CONDUCT AUTHORITY

This report completes the Authority's Inquiry into Police Conduct, Practices, Policies and Procedures Relating to the Investigation of Child Abuse in New Zealand.

The scale of the Inquiry has been unprecedented in the Authority's history. It has involved the Authority in reviewing more than 41,847 documents, amounting to more than 146,508 pages, and in conducting hearings involving 55 examinations on oath, supplemented by a further 33 interviews, culminating in two detailed reports.

Crimes against children often go unreported, as child victims may be unable to make a complaint against the offender. If a complaint is made to Police, child victims, unlike most adult victims, are typically poorly placed to raise concerns if the investigation of their complaint is not progressing. In addition to intense domestic concern on the subject, New Zealand has international obligations as a signatory to the United Nations Convention on the Rights of the Child 1989. In this context, failures in the investigation of child abuse by Police are of particular concern to the Authority.

Part I of the Authority's Report covered a wide range of systemic issues and made 34 recommendations designed to improve Police practices, policies and procedures in the investigation of child abuse.

Part II of the Report has focused on service failures which occurred in the Wairarapa and elsewhere. The Authority has concluded there were serious service failures which must never be repeated. However in the course of its Inquiry the Authority has heard from many dedicated and committed Police officers, including frontline child abuse investigators. The Authority is confident that those officers are representative of the majority of officers involved in child abuse investigations.

The Police response to this Inquiry, and to Part I of the Authority's Report in particular, has been positive and comprehensive. This is due in no small part to the longstanding personal commitment of Commissioner Howard Broad to the investigation of child abuse and to remedy the shortcomings identified by the Authority, to ensure that the investigation of child abuse is of a consistently high standard throughout the country.

Following the release of the Authority's Part I Report in May 2010, Commissioner Broad established a Child Protection Implementation Project Team to address the Authority's recommendations in that part of its Report. The Team is continuing to lead substantial changes to Police practices, policies and procedures, and this is detailed in the Appendices to this Report.

It is imperative that all child abuse cases must be reported to Police. The public can have every confidence that Police are committed to ensuring a consistently high standard of service in the investigation of child abuse.

It is also essential that the momentum for positive change resulting from this Inquiry is not lost. To that end the Authority is recommending, in addition to the recommendations in its Part I Report that the Child Protection Implementation Project Team be given an ongoing mandate for a further period of at least one year, to continue overseeing the implementation of changes arising out of the Team's work in responding to the Authority's Inquiry.



HON JUSTICE L P GODDARD
CHAIR
INDEPENDENT POLICE CONDUCT AUTHORITY
FEBRUARY 2011



Summary of Conclusions and Findings

INDEPENDENT POLICE CONDUCT AUTHORITY

Chapter 2 – Wairarapa Area prior to 2006

Resourcing in the Wairarapa Area was identified as an issue by Police staff prior to 2006. By 2005 Detective Mackle, based in the Masterton CIB Office, was holding 95 child abuse investigation files.

Detective Mackle's file holding was unmanageable and excessive. There was no realistic prospect of Detective Mackle investigating 95 child abuse files in a timely manner without significant assistance over an extended period of time. The fact that this number of files were able to accumulate demonstrates there was insufficient investigative resource to cope with demand.

It was **undesirable** that this level of file holdings was permitted to occur.

Chapter 3 – Wellington District: March 2006-July 2006

This backlog of files which had been permitted to accumulate represented a significant failure in supervision systems in the Wairarapa Area, and was **undesirable**.

In addition, there was no meaningful audit and assurance program which operated to identify the scale of the problems and remedy them at a district level, and again, this was **undesirable**.

By April 2006 Detective Mackle identified that her file holding had accumulated to a level where she held approximately 120 child abuse investigation files.

In response to an email sent by Detective Mackle on 28 April 2006 Detective Inspector Quinn requested an assessment of child abuse investigation files held in the Wairarapa Area by Detective Sergeant Penny. This action was appropriate.

Detective Sergeant Penny's report in response to Detective Inspector Quinn's request was a careful and considered piece of work that clearly identified a substantial backlog of child abuse investigation files in the Masterton office.

Direction was given from both Wellington District and Wairarapa Area management level to implement steps to address the backlog. As at July 2006, it appeared that action had finally begun in response to the backlog of child abuse investigation files in the Wairarapa Area.

Chapter 4 – Wellington District: August 2006-2008

On three separate occasions during August 2006 the Officer in Charge of Masterton CIB, Detective Sergeant McHattie, advised the Wairarapa Area Commander that the child abuse investigation files for the area amounted to a total of 76 files. This represented a significant reduction in file numbers relative to the conclusions of the Penny report and Detective Sergeant McHattie's own advice in June 2006 that Detective Mackle was by then holding 142 files.

On 31 August 2006, Detective Sergeant McHattie advised that the number of child abuse investigation files held in the Wairarapa had reduced to 57 files. On 4 September 2006 the Detective Sergeant further advised that the file holdings had reduced even further and that the total number was now 29 files.

An audit process carried out in 2008 by Detective Inspector Cotter as part of Operation Hope, known as the "10 Year Audit", identified that 46 files had been filed (closed) during the months of August and September 2006. The majority of those files had been filed during a two-day period, 31 August and 1 September 2006. Detective Inspector Cotter found that 33 of these files were "filed incorrectly" or "inappropriately resolved" during that two-day period.

The 10 Year Audit confirmed the information provided in the Penny Report. By that time there had been a further delay of over two years on the files which had been incorrectly filed during the months of August and September 2006. The lack of timely and professional service was **undesirable, unjustified and unfair** to the child victims. As the Commissioner has appropriately acknowledged, this was "a significant service failure".

Wairarapa Area and Wellington District management considered that the backlog of files in the Wairarapa Area had been resolved in September 2006 as a result of the assurances given by Detective Sergeant McHattie. Detective Inspector Cotter's findings in the 10 Year Audit demonstrate the backlog was not resolved.

The reduction of files reported by Detective Sergeant McHattie was dramatic when set against the information provided in the Penny Report and other available information.

An independent check involving the random sampling of files should have been carried out following Detective Sergeant McHattie's email of 4 September 2006. This should have been done as part of the supervision of the Masterton CIB and as part of District audit and assurance processes.

As set out in the introduction to this report, Police employment procedures arising from these events are ongoing. The focus of the Authority's Inquiry is on the underlying systemic issues: Police practices, policies and procedures generally.

The Authority finds that the supervision systems in the Wairarapa Area failed and that Wellington District did not have an audit and assurance program which included random sampling of files, either as part of routine audit and assurance processes or in response to high risk events. The absence of such systems was **undesirable** and **unjustified** and contributed to **unreasonable** delays on a number of child abuse investigation files later addressed by Operation Hope.

The backlog of files in the Wairarapa Area was not discussed at meetings of the Wellington District senior management team during the crucial months of June 2006 to September 2006. Had it been, a greater level of assurance may have been sought that the backlog had been properly resolved. The failure to ensure that a high risk situation of this kind was not on the agenda as a formal item at meetings of the Wellington District senior management team was **undesirable**.

Operation Hope assessed approximately 550 cases, which resulted in at least 41 prosecutions of child abusers and the conviction of a number of individuals, many of whom have received lengthy custodial sentences. These convictions underpin that many of the child abuse complaints reviewed by the Operation Hope team, despite being historic in nature were capable of successful prosecution and conviction.

The delays in the investigation by Police of complaints of child abuse were a significant service failure and were both **unjustified and unreasonable**.

Chapter 5 – Involvement of Police National Headquarters

Senior Police management at Police National Headquarters, up to Deputy Commissioner level, were aware of the backlog of files in the Wairarapa in 2006, and had been provided with Detective Mackle's email and Detective Sergeant Penny's report. The senior management advised the Authority that they expected the backlog to have been dealt with by Wellington District, subject to any request made for external assistance.

No request for external assistance was made by Wellington District, in contrast to steps being taken at about the same time by Counties Manukau District to deal with a backlog of child abuse investigation files which had accrued in that district. Rather than requesting assistance, the information provided by Wellington District to Police National Headquarters on 31 August 2006, was to the effect that the workload in the Wairarapa Area was under control. Similarly, the Wairarapa Area Commander was reported in the *Wairarapa Times-Age* on 7 September 2006 as stating that the area had only "25 to 30 live files".

This information was incorrect and as a result Wellington District failed to meet the minimum standards of service that Police National Headquarters rightly requires should be met. In order to meet its responsibilities, Headquarters must ensure minimum standards of service are met by districts, and that robust auditing processes involving random sampling of files is carried out, both as a matter of routine and as part of the response to identified risks such as the backlog of files in the Wairarapa.

Audit processes of this kind were not set as a mandatory requirement by Police National Headquarters in 2006 and that omission was **undesirable**.

In August 2006 Police National Headquarters was advised by the Police Association that it was preparing an article pointing to problems in the investigation of child abuse files in various parts of New Zealand. Headquarters responded to this information from the Police Association by, inter alia, conducting a national survey of child abuse investigations in all Police districts.

The information received from districts, while confirming the pressure of increasing workloads on front line staff and inconsistencies in file management practices, provided assurances that protocols were complied with and that there were no districts which were overburdened with unallocated files.

This Inquiry has highlighted the difficulty in relying solely on information provided by districts. Had audit and assurance processes involving random sampling of files been in place in 2006, Police would have had the opportunity to test the information reported by districts against objective data gathered as part of audit and assurance processes. The absence of random sampling of files as part of audit and assurance policy is **undesirable**.

Police National Headquarters established a CAT Managers Working Group following publication of the Police Association article in 2006, subsequent attendance of Police management at a CAT managers conference in 2006, and as a result of information received from districts in the national survey.

The Working Group identified, albeit in a preliminary way, a number of positive initiatives which the Authority considers would have improved the service provided by Police in the investigation of child abuse had they been developed and implemented.

Unfortunately, the Working Group met only once and was not reconvened. The failure to ensure the Working Group reconvened and continued its work in 2007 was **undesirable** and should not have been allowed to occur. The consequence is that initiatives which would have ensured greater consistency in the investigation of child abuse files nationally were not developed until after the Authority reported on Part I of its Inquiry.

Chapter 6 – Review of Police Districts “At Risk” Files

The Authority is satisfied Police have undertaken a thorough audit of child abuse files nationwide, using all tools reasonably available to them through the district reviews conducted as part of Operation Scope.

The results of the district reviews demonstrate that delays and other problems in the investigation of child abuse files were not confined to the Wairarapa, although nowhere else was the problem so acute.

The Authority has been advised that Police commenced a total of 18 Code of Conduct Investigations arising out of Operation Hope and Operation Scope. Five employees have been cleared of any misconduct and have been dealt with through informal processes.

Six more investigations have been completed, and Police are awaiting the completion of seven further.

At the completion of all investigations, decisions will be made by the National Disciplinary Committee.

Police have further advised the Authority that 67 employees are subject to Informal Intervention arising out of Operation Hope and Operation Scope.

Prompt action has been taken by all districts to remedy the shortcomings identified on all of the files identified through the district reviews.

The delays and other failures identified by Operation Scope demonstrate that victims of child abuse were not receiving a consistent standard of service from Police throughout the country.

However, if the changes to practices, policies and procedures proposed as part of the Police response are fully implemented, the Authority is confident this will minimise the risk of similar failures occurring in the future.

Chapter 7 – Review of Police Districts Practice, Policy, and Procedure

As a result of the Authority's Inquiry, significant changes and improvements are being undertaken in all Police districts to practices, policies and procedures at a district level in relation to the investigation of child abuse files.

These relate to both specific areas of investigation, such as victim contact and evidential interviewing, and to more general areas such as case management and district structures.

These general areas have a critical bearing on the quality of investigations and the ability of Police management to properly supervise and monitor the quality of investigations.

Training in the use of NIA as part of case management has been made available as a priority to child abuse investigators in all districts. In addition, each district will benefit from the appointment of a senior officer with responsibility for oversight for child abuse investigations throughout the district.

If the improvements referred to in this chapter and the following chapter are fully implemented by districts and Police National Headquarters, a consistently high standard of service is achievable for all victims of child abuse throughout the country.

Chapter 8 – Response of Police National Headquarters

As a result of the Authority's Inquiry, significant and comprehensive changes and improvements are being undertaken by Police National Headquarters to practices, policies and procedures in relation to the investigation of child abuse.

In particular, Police National Headquarters is proposing improvement to the management of child abuse investigations to promote public confidence in the integrity of the processes, by implementing all 34 of the Authority's recommendations in the Part I Report.

If the changes and improvements identified by Police in response to the Authority's Inquiry are fully implemented and embedded, both at a district and national level, a consistently high standard of service is achievable for all victims of child abuse throughout the country.

The Child Protection Implementation Project Team has played a lead role in the Police response to the Authority's Part I Report. The team contains a number of subject matter experts and was set up at Commissioner Broad's direction and enjoys his full support. The team has a role not just in setting the minimum standards identified in the Part I Report, but in implementing and embedding the practices, policies and procedures required to ensure minimum standards are met nationally and are sustainable.

The Authority considers it crucial to the success of the Child Protection Implementation Project Team that it, or at least a sub-group of it, has an ongoing mandate for at least one year while the policies, practices and procedures resulting from its work are fully implemented and embedded by the Police. In addition to the 34 recommendations made in the Part I Report, the Authority makes one further recommendation to the Commissioner of Police.

Recommendation:

The Child Protection Implementation Project Team, or a sub-group of that team, should be given an ongoing mandate for a further period of at least one year to oversee the implementation of changes to Police practices, policies and procedures arising out of its work, and to report back to the Police Executive Committee.



Chapter One: Introduction

INDEPENDENT POLICE CONDUCT AUTHORITY

1. The Independent Police Conduct Authority (the Authority) has completed Part II of an Inquiry into the conduct, practices, policies and procedures of the New Zealand Police in relation to child abuse investigation in New Zealand (the Inquiry).
2. The Inquiry has been significant in terms of its comprehensive scope and because it has addressed the important issue of the investigation of abuse of vulnerable children and young persons.
3. New Zealand has a sad history of child abuse. Crimes against children often go unreported as child victims may be unable to make a complaint against the offender. If a complaint is made to Police, child victims, unlike most adult victims, are typically poorly placed to raise concerns if the investigation of their complaint is not progressing. In addition to intense domestic concern on the subject, New Zealand has international obligations as a signatory to the United Nations Convention on the Rights of the Child 1989. In this context, failures in the investigation of child abuse by Police are of particular concern to the Authority.

Role and functions of the Authority

4. The Authority is mindful that some readers of this report will have no prior experience or involvement with the Authority. For that reason, and in order to assist readers to better understand the purpose of this Inquiry, it is helpful to begin with an overview of the role and functions of the Authority.
5. The Authority is an independent Crown entity that derives its functions and powers from the Independent Police Conduct Authority Act 1988. It is fully independent and is not part of the Police. There is no political involvement in the Authority's operations.
6. In general terms, the Authority is empowered to receive complaints and to conduct investigations and inquiries about matters involving the Police. Its functions include receiving and investigating complaints about misconduct or neglect of duty on the part of any member of Police, or about any practice, policy or procedure that affects a complainant. The Authority may investigate any apparent misconduct or neglect of

duty by a Police employee or any Police practice, policy or procedure which appears to the Authority to relate to a complaint, irrespective of whether the complaint refers to the misconduct, neglect, practice, policy or procedure. The Authority is also mandated to investigate incidents in which a member of Police causes, or appears to have caused, death or serious bodily harm, while acting in the execution of his or her duty.

7. The work done by the Authority has as its primary vision, the objective of promoting public trust and confidence in the Police. In this regard, the work undertaken by the Authority is designed to contribute to the goals of the Police as an organisation, with the ultimate goal being to achieve safer communities.
8. The Authority may carry out its own investigations, or refer a matter to the Police for investigation under the oversight of the Authority. The form of that oversight depends on the nature of the complaint, but can include directing or actively overseeing the Police investigation, or later reviewing the Police investigation once it is completed.
9. Once an investigation is concluded the Authority must determine whether any Police act (or failure to act) was **contrary to law, unreasonable, unjustified, unfair, or undesirable**. The Authority must inform the Police of its findings and has the jurisdiction to make recommendations. In addition, the Authority reports publicly on investigations of significant public interest. The Authority considers this Inquiry to be a matter of significant public interest.
10. The nature of any inquiry undertaken by the Authority is inquisitorial, not adversarial. The jurisdiction to inquire into all relevant matters in an independent and comprehensive manner is an important function of the Authority. The Authority has the same powers as a Commission of Inquiry to summon witnesses and gather evidence. The Police are required to provide all information and assistance needed for the Authority to carry out its functions.

Background

11. During 2008, the Wellington Police District (Wellington District) evaluated the possibility of establishing a centralised District Child Abuse Team and, as part of that evaluation, the Criminal Investigation Branch (CIB) offices within Wellington District were asked to provide a summary of child abuse file holdings as at September 2008. This process revealed a high number of child abuse file holdings in the Wairarapa. The backlog consisted of over 100 active files where there was little or no progress following the initial complaint made to Police.
12. Having discovered the files and the significant delays attached to them, the following month Police launched an operation named Hope. Operation Hope involved a team of approximately 20 staff assigned to assess, prioritise and investigate the relevant files.

Operation Hope was initially intended as a short term response to rectify the situation. However, staff working on Operation Hope continued to find additional child abuse files within the Wairarapa Area and it became apparent that there were major systemic failings in the management of child abuse investigations in that area.

13. The situation that arose in the Wairarapa was reported to the Authority by Police on 12 June 2009. The Authority assumed oversight of Operation Hope and on 15 July 2009 wrote to the Commissioner of Police (Commissioner) expressing the need for an urgent audit of child abuse investigations in all other districts, subsequently undertaken by Police as Operation Scope. On 5 August 2009 the Authority commenced its own independent inquiry into matters arising within Wellington District.
14. The Authority received information and complaints indicating failings in the investigation of child abuse within Wellington District and also other districts. In December 2009, the Authority announced it had widened the scope of its independent inquiry to cover the whole of New Zealand.

Inquiry

15. The fundamental purpose of the Inquiry was to ensure that any identified shortcomings were remedied by Police. This included both shortcomings on particular investigation files and any shortcomings in Police practices, policies and procedures generally.
16. Operation Scope was established by Police in response to the concern expressed by the Authority about the need for an urgent auditing of all Police districts and not just the Wairarapa Area. A key part of Operation Scope's function was to identify any shortcomings on particular investigation files and ensure they were remedied. While that file-specific work being undertaken by Operation Scope and Operation Hope was underway, the Authority focused in the first part of its Inquiry on Police practices, policies and procedures generally in relation to child abuse investigation.
17. The Authority's investigations in the first part of its Inquiry identified improvements which could be made to Police practices, policies and procedures. The Authority did not wish to defer publicly reporting on those matters, as it considered it important to do so without delay. Accordingly, the Authority issued a report on the completion of the first part of the Inquiry in May 2010 *Inquiry into Police Conduct, Practices, Policies and Procedures Relating to the Investigation of Child Abuse: Part I* (Part I Report).
18. The Authority's Part I Report covered a wide range of systemic issues in relation to the Police investigation of child abuse, and made 34 specific recommendations to the Commissioner.
19. Although the failures which occurred in the Wairarapa Area formed part of the overall discussion in the Part I Report, the immediate focus being given to the assessment,

prioritisation and investigation of all child abuse investigations by the Operation Hope team, meant that a more detailed examination of the failures in the Wairarapa Area and elsewhere could appropriately be addressed in the second part of the Authority's Inquiry.

20. The second part of the Authority's Inquiry is now complete. During the second part of the Inquiry the Authority continued to receive a large volume of material from the Police and from other agencies and individuals, and conducted a number of further examinations on oath and interviews. Overall, in the course of the Authority's Inquiry, a total of more than 41,847 documents amounting to more than 146,508 pages were examined by the Authority's Inquiry team. A total of 55 examinations on oath were conducted, supplemented by a further 33 interviews.

Scope of Part II Report

21. The scope of this report is different to the Authority's Part I Report.

22. This report is primarily focused on the nature of, and the reasons for, the service failures which occurred in relation to the investigation of child abuse files in the Wairarapa Area. It also addresses service failures in other Police districts, and discusses the positive steps that have been and are being taken by Police to address those service failures, both in terms of shortcomings on particular files and in relation to practices, policies and procedures, at both district and national levels.

23. The Terms of Reference for Part II of the Authority's Inquiry are included as **Appendix A** to this report. Essentially, Part II of the Authority's Inquiry focused on three broad areas and this report is structured accordingly:

- Wairarapa Area service failures
- Review of districts
- Response of Police National Headquarters (PNHQ)

24. The matters covered in this report are of critical importance to the investigation by Police of child abuse in New Zealand. The Authority expects the findings of the report will be carefully considered by Police and taken into account as part of the ongoing process by Police to improve its service delivery for victims of child abuse. However, because this report has a different scope to the Part I Report, only one recommendation is made. That recommendation is intended to ensure that the positive work underway by Police continues, namely, that the Child Protection Implementation Project Team established by the Commissioner continues in an ongoing role for at least a further year to ensure that the policy initiatives and improvements it has identified are fully implemented and embedded.

Wairarapa Area service failures

25. The service failures which occurred in the Wairarapa Area were the catalyst for this Inquiry and it has always been a key objective of the Inquiry to examine the nature of, and reasons for, those service failures.
26. This section examines both the events in the Wairarapa Area and Wellington District, and also the involvement of PNHQ in relation to the service failures in the Wairarapa Area in response to the resultant publicity.
27. There has already been significant publicity relating to these matters and some of the individuals involved, dating back to media reports in 2006. While it would be artificial not to refer to key individuals involved by name in this report, it is not the purpose of this report to attribute blame to individuals. Police employment processes remain ongoing in relation to some of the individuals involved and it is not necessary for there to be findings made in this report in relation to their culpability or otherwise. Rather, in examining the service failures in the Wairarapa, this report is focused on systemic issues: that is, on any failures identified in the practices, policies and procedures in the Wairarapa Area. Because of this focus, and to protect the privacy of individual victims, details of files examined by the Authority are not discussed in this report.

Review of Police districts

28. Operation Scope has conducted and completed a nationwide review of Police districts, both in relation to specific investigation files and also practices, policies and procedures generally. The Authority has considered the results of that review and a large volume of additional material from the districts. The Authority has also heard directly from district personnel, including evidence on oath from each of the 12 District Commanders.
29. File audits carried out by Operation Scope identified files where there had been failures in the investigation of child abuse by Police. The numbers of such files are detailed in this report and a brief description of the types of failures which occurred is also given. However, it is not appropriate to provide any further detail in a report of this kind, which is to be made publicly available. In particular, it is not appropriate for the Authority to provide further detail about individual files, which could potentially lead to the identification of victims of child abuse.
30. Of critical importance is the Police response to these identified failures. In all cases districts have been required by PNHQ to attend to such follow up inquiries and other steps, including prosecutions where appropriate, and are doing so as required. Areas of general practice, policy and procedure which can be improved are discussed and the significant steps being taken by districts to make improvements are also recorded in this section.

Response of Police National Headquarters

31. The final section of this report addresses the response of PNHQ to the findings and recommendations of the Authority's Part I Report. The Police response to the Part I Report has been prompt and comprehensive. The Authority considers it essential that the public is aware of the positive steps being taken by Police, primarily through the Child Protection Implementation Project Team, to improve the service provided by Police in the investigation of child abuse and to ensure consistency of approach throughout New Zealand. In this regard, the Authority has also heard directly from the Commissioner and other members of the Police Executive.

Acknowledgements

32. As with the Authority's Part I Report, the Authority wishes to formally record and acknowledge the commitment and dedication of child abuse investigators throughout the country and the work they perform in this very difficult and challenging area of policing.
33. The Authority also wishes to acknowledge the work undertaken by Detective Inspector Gallagher and his team in liaising with the Authority and managing the provision of the large volume of documentation required by the Authority from the Police for the purposes of this Inquiry.



Chapter Two: Wairarapa Area Prior to 2006

INDEPENDENT POLICE CONDUCT AUTHORITY

34. This chapter examines evidence obtained by the Authority in the course of its Inquiry about resourcing issues within the Wairarapa Area, and the Masterton CIB in particular, prior to 2006. The material is examined in order to highlight that the events of 2006, considered in subsequent chapters, did not occur in a vacuum.

35. This chapter records that resourcing had been identified as an issue in the Wairarapa Area for some time. The backlog of child abuse investigation files identified in 2006 represented a steady accumulation of files which staff in the Wairarapa were unable to cope with, rather than representing a flood of new complaints in 2006.

Average file holdings as at August 1994 and introduction of 1995 Policy

36. On 25 August 1994, a report was submitted to the Area Controller Masterton advising of detailed file holdings within various CIB offices. The average file holding per staff member in the Masterton CIB was 68.7 files; a figure significantly higher than the station with the next highest level of files, which was Upper Hutt CIB with 52 files per member. It also provided a contrast with Lower Hutt Central CIB, which had a total of 17.5 files per member of staff.¹

37. In 1995 Police introduced *Policy and guidelines for the investigation of child sexual abuse and serious physical abuse* (1995 Policy), which was discussed in the Part I Report.² At this time, child abuse investigations were covered as part of the work of the sexual assault team (SAT) within the Masterton CIB. One of the main impacts of the 1995 Policy was to encourage closer inter-agency working relationships, but there were practical issues relating to the geography of the Masterton Police station. Child, Youth

¹ Another issue raised in the report was the amount of time lost to Masterton CIB in relation to staff travelling to Wellington for court attendances.

² *Policy and Guidelines for the investigation of child sexual abuse and serious physical abuse (1995)* Part I Report, at pp 74-80.

and Family, Masterton, was managed from Palmerston North, which meant that staff had to travel to Palmerston North in order to conduct child evidential interviews.

2001

38. On 28 March 2001, the Wellington District Commander sent an email to all District Commanders requesting the secondment of four staff to the Wairarapa Area, following a Police Executive Committee (PEC) meeting at which resourcing for the Wairarapa Area had been discussed. The District Commander indicated that it would be a temporary measure until staff could be sourced from new Police college graduates in August of that year.

39. Later the same day, the Area Commander Wairarapa sent an email to the District Commander under the heading “Briefing for the Minister of Police, Wairarapa Resourcing issues”. The Area Commander expressed the view that he believed the Wairarapa Police were operating with a staffing shortfall of five officers and as a consequence:

“[All] sections of Wairarapa policing are regularly disrupted as we move staff from other areas such as Community or CIB to ensure that we maintain the minimum emergency response required (frontline capability).”

40. Later that year, on 26 June 2001, the Wellington District Commander sent an email to a large number of recipients outlining the goals agreed upon at the district management meeting. Resourcing for the Wairarapa Area was identified as an emerging priority:³

“I have authorised the Wairarapa’s recommendation to convert two [Uniform Branch] positions to CIB positions. Their sectional strength issue will be addressed separately scheduled for late July.”

41. On 3 July 2001, a detective working in the Masterton CIB submitted a report to the Wellington District Welfare Officer and Masterton Area Controller about what he considered to be inadequate staffing numbers to meet workload demands. At the time the report was written, the Masterton CIB office had only half its intended complement, with one Detective Sergeant and only three staff. The detective wrote:⁴

³ The following day on 27 June 2001 the Area Commander determined that the Area profile should be altered to include the addition of one constable, noting that there were staff shortages which had placed the Area under “considerable pressure”.

⁴ It was known that the (then) Area Controller had requested additional staff but that at the time of the relevant report those requests had not been met.

“Without increased staffing I believe it is very likely that the working environment will have an adverse effect on those staff left behind. It would seem likely that there will be further casualties in what is already a fragile CIB office.”

42. Approval was granted for the recruitment of a second Detective Sergeant to relieve the mounting workload in the Masterton CIB, although the exact date on which that occurred is unknown.

2002

43. Despite the recruitment of an additional Detective Sergeant, there were still remaining concerns about resourcing levels within the Wairarapa Area during 2002. The Wairarapa Area Commander sent an email on 24 September 2002 stating:

“Our crime rate is higher in almost every classification than every area in the district, our area is vast, back up an hour away at best, yet the status quo has remained.

I believe that a strong case exists for moving 5 constables into the Wairarapa from other parts of the Wellington District and that the District Commander must do so to alleviate the obvious risk.

It is not secret, I hope, that having suggested this and tried to generate some interest at the last two meetings, that I am primed to push this issue hard. It is time for some brave decisions to be made in high places.”

44. On 3 October 2002, the Area Commander Wairarapa sent a further email to the District Commander conveying staff concerns about being under resourced and the negative effect on staff morale. The Area Commander noted that staffing shortages were an ongoing concern in the Wairarapa and concluded:

“I have been ‘singing this song’ for five years now but no-one seems to want to listen. It is essential that change is made now before we lose more staff.”

45. During 2002 a “National Information Sheet” was created that contained a list of 36 Police stations where child abuse investigations were conducted. The National Information Sheet contained details for each station including: whether there was a child abuse team or a child abuse portfolio within the CIB; number of staff working on child abuse files; location of child evidential interviews and medical examinations; status of the relationship between Police and Child, Youth and Family; numbers of child abuse files investigated per year; and an indication of workloads expected of staff in addition to their core role as child abuse investigators.

46. In the National Information Sheet 2002 Masterton Police station is recorded as having a child abuse portfolio with a single detective assigned to managing that portfolio. It is of

note that medical examinations of child abuse victims from that area were listed as taking place in Wellington, while child evidential interviews were conducted at the Child, Youth and Family site in Palmerston North.

47. Masterton Police station was recorded as processing 40 child abuse files per year, which was commensurate with other stations operating child abuse as a portfolio staffed by a single detective. In Blenheim it was noted that Police processed 40 child abuse files per year; in Timaru this figure was slightly less at 30 files; and in Upper Hutt the figure was recorded as approximately 65 files per year.

2003-2004

48. The National Information Sheet 2003 provided no new information about the Masterton CIB, and child abuse investigations continued to be managed by a single detective holding the child abuse portfolio within the Masterton CIB.
49. A local service level agreement was signed between Child, Youth and Family and Wairarapa Police on 11 July 2003.⁵ This document showed a higher number of staff working on child abuse files in the Wairarapa Area than the staff numbers indicated in the National Information Sheet 2003. There were two Detective Sergeants listed together with two detectives, as the staff who made up the child abuse team.
50. The following year, the Wairarapa Area CIB Command Chart for 2004 showed that the level of resourcing for child abuse investigations had been reduced from two Detectives (as indicated in the local level agreement with Child, Youth and Family) to one full-time permanent detective. A second detective was listed as being assigned to work on child abuse investigations but for only a three month period.

2005

51. On 22 February 2005, the Officer in Charge of the Masterton CIB, Detective Sergeant McHattie, assessed the levels of staff resourcing for child abuse investigations:

“[We] currently have one staff member doing fulltime CAT Investigation work, but this is supplemented by a FEO Officer one day a week and a CIB Trainee on a ‘Three Month Rotation’.”

⁵ Local Service Level Agreement between Child Youth and Family and New Zealand Police. These “Local Level Agreements” are discussed elsewhere in this report.

52. On 22 April 2005, Detective Sergeant McHattie sent a report to the Wellington District Crime Manager advising that there was no longer a full-time dedicated child abuse investigator at Masterton CIB:

“Detective Mackle and O’Connell are both work [sic] in the Wairarapa Area CIB on the “Flexible Employment Option” with them both working on the Wairarapa Area CIB ‘Child Abuse Team’.”

53. Detective Sergeant McHattie stated that it was his intention for investigators to hold “about five” investigation files each. He went on to say that he had inherited a system where all files that entered the CIB were automatically assigned to investigators:

“This often meant that some Investigators were ‘holding’ thirty [30] to fifty [50] Files each and I am still attempting the (sic) manage this ‘legacy’ of those that preceded me.”

54. He also referred to the fact that the Detective assigned to South Wairarapa was currently holding 18 child abuse files, indicating that child abuse investigations were being conducted by at least one investigator who was not included as part of the Wairarapa child abuse team based in Masterton.

55. Detective Sergeant McHattie further reported that:

“Detective Mackle was / is holding ninety-five [95] ‘Child Abuse’ Files as she was/ is the Wairarapa Area CIB ‘Child Abuse Coordinator’ and part of her role was to collate all of these Files to ensure that the appropriate ‘Protocol’ was/ is being followed/ maintained with the majority of these Files requiring no or little Investigative involvement from the Police.”

56. Subsequently, on 2 May 2005, Detective Sergeant McHattie sent a six-monthly report to the Wairarapa Area Commander, titled “Wairarapa Area Child Abuse Team”. That report was intended as an update on the local interagency reporting protocol with Child, Youth and Family. Under the heading ‘CAT Staff’ he reported that there were three investigators (not including the Officer in Charge of the Masterton CIB working on child abuse investigations) two in Masterton and one in South Wairarapa. He said:

“It is important to note that Detective Mackle works only 24 hours per week on the Police ‘Flexible Employment Option’, Detective O’Connell works 21 hours per week on the same option and that Detective Faraimo is not solely working on ‘Child Abuse’ Investigation Files as he is the only Serious Crime Investigator in the South Wairarapa Sub-Area.”

57. Detective Sergeant McHattie recorded that at the material time there was a total of 107 child abuse investigation files in the Wairarapa Area. Child evidential interviews were

still taking place at the Palmerston North Child, Youth and Family site which was experiencing “extreme delays” in conducting interviews for the Wairarapa child abuse team due to local demands for interview slots. The Detective Sergeant acknowledged that the delays in conducting interviews was slowing the progress of investigations and could have a negative effect on future prosecutions.

58. On 2 October 2005, Detective Sergeant McHattie sent a further six-monthly report to the Wairarapa Area Commander. The composition of the child abuse team remained the same as when the May 2005 report was furnished but it was noted the working hours of those staff had increased. Detective Sergeant McHattie told the Inquiry that he raised his concerns about staffing levels with the Area Commander.
59. Detective Mackle had increased her hours from 24 hours per week, to working alternate weeks of 40 and 24 hours; and a second Detective O’Connell also increased her working hours from 21 hours to 28 hours. This was calculated to be the equivalent of having 1 ½ full-time equivalents over a two-week period investigating child abuse at Masterton CIB.

Conclusions and findings

60. Resourcing was identified as an issue by Police staff in the Wairarapa prior to 2006. During the period 2002 to 2004 the National Information Sheet showed that one detective was dedicated to child abuse investigations, which is consistent with evidence the Authority heard from Detective Mackle.
61. In 2005 the Officer in Charge of the Masterton CIB, Detective Sergeant McHattie, noted that there was no longer a full-time detective dedicated to child abuse investigations. Detective Sergeant McHattie advised he was still dealing with the legacy of individual investigators holding 30 to 50 files each. Detective Mackle was, in fact, holding 95 child abuse investigation files by 2005.
62. Detective Mackle’s file holding was unmanageable and excessive. There was no realistic prospect of Detective Mackle investigating this number of child abuse files in a timely manner without significant assistance over an extended period of time. Furthermore, the fact that this number of files was able to accumulate demonstrates there was insufficient investigative resource to cope with demand. The Authority finds that it was undesirable for this level of file holdings to have been permitted to occur.



Chapter Three:

Wellington District: March 2006 – July 2006

INDEPENDENT POLICE CONDUCT AUTHORITY

63. This chapter examines the events that took place during March to July 2006 within Wellington District. It records the fact that concerns were raised by Police staff about the backlog of child abuse investigations files held by Masterton CIB, and the proposal that emanated from other areas within Wellington District to assist with that backlog. The discussion then sets out the external review of child abuse file holdings at Masterton station, conducted in June 2006, and which resulted in a written report with short and long term recommendations.

64. By way of background, Wellington District has five areas: Wellington (Central); Wairarapa; Upper Hutt; Lower Hutt; and Porirua (also referred to as Kapiti-Mana). For the purposes of this chapter it is important to note that the Wairarapa Area encompasses Masterton and Featherston, both of which feature in the discussion below. Furthermore, although PNHQ is located in the Wellington central business district, it is separate from Wellington Police District.

Proposal to assist Wairarapa (March 2006)

65. On Friday 24 March 2006, a meeting of child abuse team (CAT) supervisors from different policing areas within the wider Wellington District was held in Wellington. During that meeting there was a discussion about difficulties within the Masterton CIB, specifically a backlog of child abuse investigation files held at the Masterton station.

66. Following the meeting, an offer was made by the Officers in Charge of the Lower Hutt CAT and the Wellington Central CAT, to the Officer in Charge of the Wairarapa CIB. The offer was for staff from Lower Hutt and Wellington Central to travel to Masterton, with each group of staff spending one week assisting with child abuse investigation files in

Masterton. The person with the child abuse portfolio in Masterton was Detective Mackle.⁶

67. The offer was conveyed by Detective Sergeant Penny, Officer in Charge of Lower Hutt CAT and sent by email to Detective Sergeant McHattie, Officer in Charge, Wairarapa CIB. The initiative was discussed on the basis of having staff working together more as a district team as opposed to working in individual areas, although it was acknowledged in the email that the operation would need to be approved at a higher management level. The purpose of the email was to ensure that Detective Sergeant McHattie supported the initiative and wanted such assistance, before further correspondence was generated.

68. Detective Sergeant McHattie responded positively to the proposed operation, and emailed his Area Commander, Inspector Johnston, advising that Masterton CIB should take advantage of the generous offer:⁷

“[To] ensure that this is a successful utilisation of a district resource to attempt to assist us with the significant backlog of CAT files that are accumulating in the Wairarapa... this will be of extreme assistance to enable us [the Wairarapa CIB Child Abuse Team] to get ahead before the problem becomes extreme.”

69. Detective Sergeant McHattie arranged for a register of child abuse files held in the Masterton CIB to be prepared in order to make an assessment of the resources needed. This responsibility was given to Detective Sergeant Van Woerkom, whose role was described as “Second in Charge” of the Masterton CIB.⁸ Detective Sergeant Van Woerkom requested Detective Mackle to complete the file register and report to Detective Sergeant McHattie. Although Detective Mackle was positive about the proposal of support from Lower Hutt Area and Wellington Central Area, she noted that it would take her weeks to prepare a register of child abuse investigation files and that the preparation of such a register would be over and above her other urgent work.

⁶ The Wairarapa Area child abuse work was based primarily in the Masterton Police station, with some files being dealt with in the Featherston Police station.

⁷ The email was also sent to Detective Sergeant Van Woerkom, Detective Mackle, and copied to the District Crime Services Manager, Wellington District, Inspector Quinn, as well as the two staff who had extended the offer, Detective Sergeant Penny and Detective Sergeant Williams.

⁸ The structure of the Wairarapa CIB at the time was shown to have two Detective Sergeants, one of whom was the Officer in Charge. When the designated Officer in Charge was on leave or secondment, the second Detective Sergeant was not designated the Acting Officer in Charge, but was instead referred to as the Second in Charge. Detective Sergeant McHattie has told the Inquiry that he was absent from the Wairarapa Area on leave or on other duties for significant periods in 2006, and that in his absence the Second in Charge performed the role of Officer in Charge.

70. Inspector Johnston, the Area Commander, obtained approval from Wellington District Headquarters for funding matters associated with the proposal. When advising the CAT supervisors involved with the proposal that financial approval had been obtained, Inspector Johnston noted that the proposal of support had the potential to address a number of issues including: inter area cooperation; reducing workload for the Wairarapa CIB; and reducing the potential likelihood of adverse public comment.

Wellington Central Area

71. Detective Sergeant Williams, Officer in Charge of CAT, Wellington Central, notified his supervisors about the proposal to provide support to Wairarapa staff by way of an internal memorandum headed "Support to Wairarapa CAT". In that document he noted the large workload of files held by Detective Mackle and commented:

"Detective Mackle was coming under increasing pressure with such a large workload. Such uninvestigated matters exposes the District to huge risk."

72. Detective Sergeant Williams confirmed in his email that the suggested solution which had been arrived at during the recent meeting of CAT supervisors was the proposal for assistance from both Lower Hutt and Wellington, as described above. Detective Sergeant Williams also attached an email exchange from Detective Sergeant McHattie at Masterton, who had broached the subject with Inspector Johnston, the Area Commander Wairarapa.

73. Detective Sergeant Williams concluded his memorandum by noting that it was anticipated that the assistance would be given the following month, and that it reflected "a District wide approach to crime".

Lower Hutt Area

74. Similarly, Detective Sergeant Penny, Officer in Charge of CAT, Lower Hutt, notified her supervisor about the proposal of providing support to the Wairarapa CIB. Detective Sergeant Penny forwarded copies of the relevant correspondence to her supervisor, Detective Senior Sergeant Malaulau, Officer in Charge of CIB, Lower Hutt.

75. In turn, Detective Senior Sergeant Malaulau forwarded the email chain to his supervisor, Inspector Dunstan, Area Commander Lower Hutt. When forwarding the information, Detective Senior Sergeant Malaulau expressed concerns that Lower Hutt CIB staff had been offered to assist in the Wairarapa Area without consultation with him and without obtaining his consent.

76. Inspector Dunstan, Area Commander, Lower Hutt, shared these concerns. In his email to Inspector Johnston, Inspector Dunstan reiterated the concerns noted by Detective

Senior Sergeant Malaulau and expressed his own view that Inspector Johnston should make a formal request for resources if his Wairarapa Area CAT team was under-staffed.⁹

77. Inspector Johnston notified Detective Sergeant McHattie that a formal request for resources needed to be made and sought a report from the Wairarapa CIB to support this request. In turn, Detective Sergeant McHattie emailed Detective Sergeant Van Woerkom and Detective Mackle to request the register of child abuse investigation files and report (that had been sought the previous day) noting that the documents would definitely be required.

78. Email records show that the proposal had also been notified to the Wellington District Crime Services Manager, Detective Inspector Quinn and the Wellington District Commander, Superintendent Pope.

Comment

79. It can be seen from the above that all three supervisors in the Wairarapa Area (Inspector Johnston, Detective Sergeant McHattie, and Detective Sergeant Van Woerkom) were aware of the backlog of child abuse files in their local CIB, and were involved in the proposal to receive support from the Lower Hutt Area and the Wellington Central Area. The response from the Wairarapa was a positive one and the email records show that the relevant supervisors and the Area Commander had taken initial steps in anticipation of staff from the Lower Hutt Area and Wellington Central Area arriving to assist with the backlog of files.

80. It appears however that the requested file register and report about child abuse file holdings in the Masterton office were not able to be completed. It is clear this would not have been a simple task because of the volume of files and Detective Mackle's heavy workload. Detective Mackle was in fact on leave in early April 2006 and did not return until the end of April. When she returned, she sent an email to a large number of recipients referring to her excessive caseload. This is referred to in more detail in paragraphs 91 and 107 to 114 below. The response to that email, including a detailed report on Detective Mackle's caseload prepared in June 2006 by Detective Sergeant Penny, effectively superseded the earlier proposal to assist the Wairarapa.

⁹ A short time after receiving a copy of this email Detective Sergeant Penny emailed her colleagues to refute suggestions that had arisen that she and Detective Sergeant Williams were attempting to work outside their lines of control and push something other than a co-ordinated approach to district CAT investigation.

Email sent by Detective Faraimo (April 2006)

81. In early April 2006, Detective Faraimo of the Featherston CIB sent a comprehensive email to Detective Sergeant McHattie relating to the state of child abuse investigations in the Wairarapa Area. His email was dated 5 April 2006 and was copied to Detective Sergeant Van Woerkom.
82. Detective Faraimo had previously worked in the Masterton CIB during 2001 to 2003 and referred to that period in his email, as well as describing his more general concerns about child abuse investigation in the Wairarapa Area.¹⁰
83. It is not proposed to set out Detective Faraimo's email message in full because a substantial excerpt is contained in the Part I Report.¹¹ However, it is worth noting that Detective Faraimo recalled that he had taken over the Sexual Abuse Team (SAT) portfolio in 2001 in Masterton CIB and that at the time he left in 2003, he and Detective Mackle shared that responsibility. Detective Faraimo noted that they each carried over 40 active files which he described as "not best practice". He commented that the sheer volume of work meant some of these files could not be properly investigated.
84. Detective Faraimo noted that the portfolio for child abuse investigations was now the responsibility of a single detective (Detective Mackle) who, although very experienced, was working only part-time. It was said to be common knowledge that Detective Mackle was carrying "over 100 active sexual abuse investigations" and continued to receive incoming files.
85. Detective Faraimo stated expressly that his email was not intended as a criticism of Detective Sergeant McHattie as the (then) supervisor, but was instead aimed at highlighting the difficulties. Detective Faraimo said:

"I do not believe we have the proper structure to meet the ongoing increasing demands of sexual abuse investigations in the Wairarapa let alone conduct any long term proactive work. As you are aware sexual abuse investigations take a considerable amount of time and resources, hence there are many separate SAT in existence throughout the region so we are not reinventing the wheel."

¹⁰ The email was sent to Detective Sergeant McHattie and copied to Detective Sergeant Van Woerkom. As noted above, Featherston CIB is also part of the Wairarapa Area.

¹¹ An excerpt of the email message is set out in the Part I Report at p 88, para 337.

Therefore, I strongly advise that the current structure change to include a separate Sexual Abuse Team comprising of a Detective Sergeant and three investigators, who report directly to the O/C CIB."

86. It is significant that at the time Detective Faraimo wrote this email in April 2006, he advised that he was still holding files from his time working in the Masterton CIB some two years earlier. In an interview with the Authority Detective Faraimo explained that he had left the Masterton CIB in September 2003 and had since been stationed in Featherston as the sole CIB Detective. In mid-2004 he had received a box containing all of the child abuse investigation files he had not been able to complete while in Masterton prior to September 2003. No work had been carried out on those files in the intervening period.

87. Detective Faraimo also recorded his concern over a recent article, published on 3 April 2006 in the *Wairarapa Times-Age*, reporting local crime statistics that showed the resolution rate of sex crimes had plunged over the preceding year. It was his reading of that which had motivated him to write the email. Towards the end of his email, Detective Faraimo stated:

"This community deserves a proper and professional service from those who are charged with investigating such crimes."

88. Detective Sergeant McHattie responded to Detective Faraimo's email two days later, on 7 April 2006, confirming that he was aware of the issues raised by Detective Faraimo and acknowledging twice in his response that the issues were longstanding:¹²

"[The] issues you have raised and highlighted in your email have been very much in my mind for the entire time that I have been in the Wairarapa."

And further:

"[There] is history within the Wairarapa for Child Abuse and this has been a pressure point for some time."

89. Detective Sergeant McHattie explained that the staffing situation had been brought about by staff leaving the office, being on leave, by inexperienced staff in the Wairarapa CIB, and by a long term vacancy. The situation had caused stress within the CIB environment and pressure on response to all crime.

¹² Detective Sergeant McHattie had been appointed as Officer in Charge of the Wairarapa CIB approximately two years previously, during 2004. An overview of the Wairarapa CIB during 1990-2005 is contained in the second chapter of this report.

90. Detective Sergeant McHattie further explained that the situation was short term and a “holding pattern” that was never foreseen as a long term solution. He said that he would discuss the issues with Detective Sergeant Van Woerkom and Inspector Johnston early the following week.

Email inquiry about Masterton file (April 2006)

91. Reference has been made above to Detective Mackle returning from leave at the end of April 2006 and sending an email about the heavy workload of child abuse investigation files that she held. Detective Mackle’s email was in response to an email chain that had started some weeks earlier, with an initial email inquiry to Police that had originated from Child, Youth and Family. The sequence of events in relation to that email chain is set out below.

92. On Monday 10 April 2006, a meeting was held in Palmerston North between Police and Child, Youth and Family, during which a Masterton child abuse investigation file was discussed. Following that meeting, a team leader from Child, Youth and Family sent an email to Detective Inspector Brew, Crime Services Manager for Central District, seeking his assistance with delays in the investigation of that Masterton child abuse case.

93. The email set out the background of the initial complaint of sexual assault that had been made to the Upper Hutt Police in July 2005. The file had been transferred to Masterton Police in early 2006, and it was known that the alleged offender had been interviewed during March 2006 but not arrested.

94. The email noted that the Police inquiry had not progressed very far and that the file was with Detective Mackle:

“Detective Sue Mackle, who has the file, has been unable to spend much time on the enquiry due to other duties (eg follow up to a rape and other matters). I want to stress that Sue has been very obliging when meeting with our staff and [Ministry of Education] and keeping us up to date with progress but unfortunately she works part-time and obviously has considerable other police priorities.”

95. Detective Inspector Brew immediately forwarded the email to Superintendent Lammas, District Commander Central. When forwarding the email from Child, Youth and Family, Detective Inspector Brew noted:

“[the current status of the investigation] has the potential to put the police at risk of embarrassment which should be and can be avoided by appropriate investigative action without further delay.”

96. In turn, Superintendent Lammas emailed the former District Commander Wellington, Superintendent Pope. The referral from one District Commander to another was

necessary because the two districts had an existing joint approach to the Wairarapa geographical area. The file was with the Masterton CIB within Wellington District and it was therefore necessary for Superintendent Lammas as District Commander Central to refer the inquiry to the District Commander Wellington.¹³

97. However, at the time of the inquiry from Child , Youth and Family in early April 2006, Superintendent Pope was no longer in the role of District Commander Wellington and had been appointed Deputy Commissioner at PNHQ. The position of District Commander Wellington was not at that time filled.¹⁴

98. Superintendent Lammas invited Deputy Commissioner Pope to contact Detective Inspector Brew, Crime Services Manager for Central District, to discuss the Masterton child abuse investigation file. Superintendent Lammas noted it was a significant child abuse investigation in Masterton which needed “some urgent review/resource”; that there had been delay; and that the matter required “some senior insight and resource/good decision making”.

99. Approximately one week later, on 17 April 2006, Deputy Commissioner Pope replied to Superintendent Lammas, confirming that he had spoken with Detective Inspector Brew and that it was agreed the matter could be “managed with appropriate oversight at district level”. Deputy Commissioner Pope noted there was a crossover of boundaries in relation to Child, Youth and Family services across Central District and Wellington District, and that the two Crime Services Managers for those districts would liaise with each other.

100. Deputy Commissioner Pope also directed that Detective Inspector Quinn, Crime Services Manager for Wellington District, provide a summary of the investigation plan and resource implications for the investigation. Deputy Commissioner Pope requested that if the child abuse file was likely to escalate on a public or political level, he was to be given early advice of that.¹⁵

101. Detective Inspector Quinn referred the matter back to Masterton and requested Detective Sergeant Van Woerkom to provide a summary of the investigation and the plan for the investigation to be concluded. He also requested Detective Sergeant Van

¹³ It was an established practice that Child Youth and Family staff had relevant meetings with the District Commander Central, rather than the District Commander Wellington. There was cross-border management between the two District Commanders for such issues.

¹⁴ Superintendent Pope left the role of District Commander on 2 April 2006 and began as Deputy Commissioner on 3 April 2006 at Police National Headquarters. The role of District Commander Wellington was subsequently taken up by Superintendent Trappitt for a 6 month period, April to September 2006.

¹⁵ The email reply from Deputy Commissioner Pope was copied to both Crime Services Managers.

Woerkom to set out any recommendations about resources needed, and the investigator's views on the inquiry, so that factual comment and analysis could be included.

102. The email was copied to Detective Mackle, the investigator who held the file, and to Inspector Johnston, Wairarapa Area Commander.¹⁶

Wairarapa response

103. At the end of that week, on Saturday 22 April 2006, Detective Sergeant Van Woerkom responded to Detective Inspector Quinn with a summary of the file and the investigative steps that had been taken to date. Detective Sergeant Van Woerkom also attached an investigation plan and noted that it had been intended that Detective Mackle would work on the file but her heavy file load and other operational duties (that included an intruder rape, a serious assault and arson which had arisen while she was on call) had occupied her and all Masterton CIB staff.

104. Detective Sergeant Van Woerkom advised that the aim was to have remaining inquiries completed within two to three weeks. He explained that he estimated that two staff members working on the file for several days could bring the file to a stage where it could be referred to the Crown for a legal opinion. Detective Sergeant Van Woerkom was hopeful that Detective Mackle would be able to resume inquiries; however, he reiterated that the rest of the office staff were busy with the operational matters he had already described. The email was copied to Detective Mackle.

105. On Thursday 27 April 2006, Detective Inspector Quinn replied to Detective Sergeant Van Woerkom and asked for a progress report in a fortnight. His email was copied to Detective Mackle. For the reasons examined below, it appears that the progress report sought was superseded by an email from Detective Mackle the following day, which is discussed in the following paragraphs. The child abuse investigation file which it concerns was one of the files that was reassessed and investigated by Operation Hope.

Email sent by Detective Mackle (April 2006)

106. On Friday 28 April 2006, Detective Mackle replied to the email chain set out in paragraphs 92 to 105 above, and which commenced with the email enquiry by Child, Youth and Family on 10 April 2006 about the Masterton child abuse file held by Detective Mackle. Detective Mackle's email had the distinctive subject heading "Child

¹⁶ Detective Sergeant Van Woerkom was emailed in the absence of Detective Sergeant McHattie who was not in the office for several weeks during April – August 2006.

Sex Abuse allegation". It was sent to Detective Inspector Quinn, Crime Services Manager, Wellington District, and copied to 20 other named recipients. The distribution list was extensive and included:¹⁷

- Her direct supervisors, Detective Sergeant McHattie and Detective Sergeant Van Woerkom
- Inspector Johnston, Wairarapa Area Commander
- Detective Inspector Quinn, Crime Services Manager, Wellington District
- Deputy Commissioner Pope
- Child, Youth and Family Services staff
- Greg O'Connor, New Zealand Police Association

107. As with the email sent by Detective Faraimo, discussed above, it is not proposed to set out the email from Detective Mackle in detail, as a substantial excerpt is already set out in the Part I Report.¹⁸ However, it is useful to here discuss some of the issues raised by Detective Mackle.

108. Detective Mackle explained to Detective Inspector Quinn that while the lack of progress on the particular file that had generated the initial enquiry from Child, Youth and Family was important the file was not her highest priority investigation at the time. She said:

"[The] lack of progress on this particular file is due to the same reason as the lack of progress on most of my other Child Abuse files – high workload, compounded by lack of resources. At present I think I have about 140 files, probably more. I work part time, about 66 hours per fortnight."

109. Detective Mackle confirmed that she too would like to see the file resolved as expeditiously as possible but that it would probably be some weeks at the earliest. Detective Mackle explained that while she had the assistance of one other staff member for a few days when the file first came in, she had since held the file herself.

110. She said her excessive file load was widely known at a local level and asserted that child abuse did not seem to be an area of importance for the Police, as opposed to other areas of policing, such as traffic. She said that on a number of occasions over the years

¹⁷ The email message shows that 17 recipients were within the Police; 3 recipients were within Child Youth and Family.

¹⁸ An excerpt of the email message is set out in the Part I Report at p 88, para 338.

she had voiced her dissatisfaction, suggested extra staff, and tried to get administrative support for the office in an effort to make a difference, but had been unsuccessful.

111. Detective Mackle noted that she had worked in the area of child abuse investigation for 13 ½ years, spending many years on teams in both Porirua and New Plymouth prior to starting work in Masterton in 2001. She explained that she was on the standby roster and “on-call” for one week of every four weeks. She stated that although she was happy to take her turn on the roster, they were invariably busy weeks and she would get very little, if any, child abuse investigation work done during those on-call weeks. She stated that, in effect, only three-quarters of her already part-time hours were spent on such work.

112. The offer of support from the Wellington and Lower Hutt CAT teams to visit the Wairarapa to assist Detective Mackle was described by her as efforts “to try to assist me in making some headway”. Detective Mackle noted that the offers of assistance had not progressed and that the staff involved in making the offers had been advised that the proposal was not proceeding. Detective Mackle stated that this reinforced to her that the Police did not see child abuse as particularly important.

113. Towards the conclusion of her email, Detective Mackle stated:

“While [this file] is an important enquiry, is it any more important than any other? Yes, maybe there would be somewhat of a stir if this lack of progress became public, and why is there not the same concern for every other victim and their family that we deal with. Most of my enquiry files have named offenders, some of whom are probably still abusing victims, but I am resigned to the fact that that’s just the way it is. To keep my head above water I remind myself of the old saying “Just do what you can do, and don’t worry about what you can’t do”.

114. In her evidence before the Authority, Detective Mackle referred to her frustration about her excessive file holding. Detective Mackle described being “at the end of her tether” and of typing her email of 28 April 2006 as a response to her frustration.

External review directed by District Crime Services Manager (June 2006)

115. On 6 June 2006, Detective Inspector Quinn sent an email to senior managers in the Wairarapa Area advising that a review would be undertaken of the workload held by Detective Mackle, and that a report would be provided to him with options as to how to reduce that workload. The review was to take place later that same week.

116. The person assigned to the task was Detective Sergeant Penny, Officer in Charge, CAT, Lower Hutt. Detective Inspector Quinn’s email was sent to Detective Sergeant Penny and copied to her supervisors as well as to the Officer in Charge of Wairarapa Station.

117. On 8 June 2006, Detective Sergeant Penny travelled to Masterton with another detective who had previously worked in Masterton CIB. Detective Sergeant Penny noted that her brief was to conduct an assessment of Detective Mackle's files and determine if appropriate file management systems were in place.

Written report with recommendations (Penny Report - June 2006)

118. Detective Sergeant Penny submitted a written report to her supervisor dated 16 June 2006 headed *Assessment of Masterton Child Abuse Process/File Holding*. This became known as "the Penny Report".

119. The Penny Report covered five topics: assessment source areas; summary of findings; limitations of the assessment; risk analysis; and recommendations (short and long term).

Penny Report - Assessment source areas

120. The phrase "assessment source areas" was used to describe the two sources of information relied upon during the assessment. The first source of information was an assessment of the physical files themselves. This was described as a "cursory" file inspection and involved categorising the total file holding in order to gain an overview of the work load and type of files held by Detective Mackle. The second source of information was a discussion with Detective Mackle and Detective Sergeant Van Woerkom of the Wairarapa CIB.

Penny Report - Summary of Findings and Observations

121. It was found that Detective Mackle was holding a total of 121 files and notifications (meaning notifications from Child, Youth and Family). This number of files for any individual investigator was described as "excessive and unmanageable".

122. Detective Sergeant Penny estimated that 61 files could be closed with minimal work, however, it was anticipated that completing that task alone would take an investigator at least four weeks. Of the remaining files, it appeared that five files could be considered high priority, although it was expressly acknowledged again that this observation was made after a cursory review only.

123. Detective Sergeant Penny provided a breakdown of assigned files as an attachment to her report headed "Assigned Files – Child Abuse Team (as at 08 June 2006)". It showed

the Child Abuse Team workload of 121 files assigned to Detective Mackle comprised the following file types:¹⁹

- 5 Prosecution
- 20 Child Sexual Violation
- 11 Indecent Assault
- 22 Child Physical Assault
- 0 Adult Sexual Violation
- 61 Filing

124. There was no file management system in place in relation to those child abuse files, although there was a file management system in place for other crime files. It was noted:²⁰

“As a result Detective Mackle was unable to advise me of the number or nature of her total files. In the absence of a current electronic file management system it would be extremely difficult to either prioritise or manage files, both on an individual or office perspective.”

125. It was also noted that the Masterton office utilised a CAT register book and allocated reference numbers to each notification or file in order for workload and accompanying statistics to be recorded. This was a process that enabled the capture of basic data only. The workload for Masterton was assessed as being significant for one investigator.

126. An important finding was headed “Initial Action on Referrals”, which noted that a number of files had not had preliminary work completed, such as evidential interviews, letters sent out, coordination with Child , Youth and Family, and a general priority assessment. The use of a checklist was recommended as a matter of process to ensure such steps were not overlooked in the future. In relation to evidential interviews, the particular observation was made that it was imperative that such interviews were

¹⁹ The file numbers total 119 files rather than the reported 121 total.

²⁰ The advice that 61 files could be closed was verbal advice given by Detective Mackle to Detective Sergeant Penny and was not the result of an assessment of those files.

completed as early as possible, irrespective of the length of time the case would take before it was fully investigated.²¹

127. The review noted that the Masterton Child Abuse Team effectively comprised one part-time detective (Detective Mackle) who was “not ring fenced and one week per month works duty shift as the on-call detective”. In recent months other investigators had provided limited assistance with the child abuse portfolio and had been allocated several files.

Penny Report - Limitations of Assessment

128. Detective Sergeant Penny was candid in her acknowledgement that she and her colleague were able to spend only six hours in Masterton and that such a short period of time did not allow for a thorough assessment of each file. She explained that much of the visit was devoted to categorising and sorting files. In her evidence before the Authority, Detective Sergeant Penny (now Detective Senior Sergeant Penny) advised that when she visited the Masterton office in June 2006, it was in a state of chaos with papers in various locations throughout the office. She recalled that she was shocked by what she found and the disorganised state of files resulted in the need for her to spend the majority of her time putting the papers into some sort of order before the files themselves could be assessed in a general way.

129. In her report, Detective Sergeant Penny also noted that the assessment was limited to a review of Detective Mackle’s files only, and did not extend to the entire case load of child abuse investigation files for the Wairarapa Area. For example, it was estimated that there were approximately 20 further child abuse files awaiting allocation, as well as other files held by Detective Faraimo at the Featherston Station, that were not included in Detective Sergeant Penny’s report.

Penny Report - Risk Analysis

130. During her review, Detective Sergeant Penny found that there were high risks associated with the Masterton office in relation to child abuse investigation files. This finding was contained in her report under the subheading “Serious Breach of Protocol”:

“[The] Masterton office undoubtedly presents as high risk with the sheer number of uninvestigated child abuse files and the timeframe they span. It is a significant breach of the protocol entitled “Interagency Protocol for the Reporting and

²¹ The importance of timely interviews was noted by the Operation Scope team during the course of its inquiries. The topic of such interviews is discussed later in this report.

Investigation of Child Sexual Abuse and Serious Physical Abuse (Revised, 2002)" agreed between the Chief Executive of the Department of Child Youth and Family Services and the New Zealand Police Commissioner."

Penny Report - Recommendations

131. Detective Sergeant Penny's report contained a total of eight recommendations: five short term; three long term. The recommendations were (paraphrased):

Short term

- File management system to be implemented
- Initial action checklist
- Detective Mackle's file load to be reduced
- Internal operation to address backlog (within Wairarapa Area)
- District operation (3-4 weeks) to address backlog

Long term

- Appointment of non-sworn CAT clerk for daily administration
- Review of CAT staff allocation; if current structure to remain, the alternative recommendation of Detective Mackle to come off the on-call duty shift roster
- Appointment of a Detective Senior Sergeant to maintain overview of district CAT files

132. The report was submitted to Detective Sergeant Penny's immediate supervisor, Detective Senior Sergeant Levy, Officer in Charge of CIB, Lower Hutt.

Penny Report provided to senior management (July 2006)

133. On 21 June 2006, the Penny Report was forwarded by Detective Senior Sergeant Levy to Detective Inspector Quinn, the District Crime Services Manager. Approximately two weeks later, on 3 July 2006, Detective Inspector Quinn forwarded the report with a covering email to Inspector Johnston, the Area Commander of Wairarapa.

Direction from District Crime Services Manager

134. The covering email sent by Detective Inspector Quinn to Inspector Johnston was comprehensive. It set out a summary of the circumstances giving rise to the inquiry from Child, Youth and Family three months earlier; the request for a briefing on the

investigation file from Masterton CIB; and the subsequent email sent out by Detective Mackle on 28 April 2006. Detective Inspector Quinn also summarised the proposed offer of assistance made in March 2006 by Lower Hutt and Wellington Area child abuse teams, and noted that the proposal did not proceed.

135. The covering email also set out the basis on which Detective Inspector Quinn had asked Detective Sergeant Penny to travel to Masterton; namely, to obtain information about the child abuse file investigation workload in order “to provide some factual information upon which the Area Command could work”. Detective Inspector Quinn noted that Detective Sergeant Penny had been asked to provide recommendations and suggestions.

136. Detective Inspector Quinn concluded his email to Inspector Johnston by encouraging discussion, as well as by making an offer to assist with both short and long term issues, and making it explicit that the issues needed to be addressed:

“I submit this report to you with recommendations that you discuss with your CIB command, the recommendations made in this report.

I am available to discuss as well should you wish. Obviously, if you are to seek outside support to manage this work load, that will need to be arranged with other Area Command or perhaps even Palmerston North Command.

I would also be keen to work with you on a strategy to address the longer term issues that seem to be apparent [...]

It is important to make some swift decisions and address the issues that are identified whilst planning some long term resolution of the problems.”

Direction that Penny Report be actioned (July 2006)

137. On 19 July 2006, Inspector Johnston, Area Commander Wairarapa, issued a memorandum requesting Detective Sergeant McHattie to immediately implement the short term recommendations from the Penny Report, including the possibility of a district level operation.

Conclusions and findings

138. The backlog of files which had been permitted to accumulate in the Wairarapa Area by July 2006 represented a significant failure in supervision systems, which the Authority finds was undesirable. As evidenced by Detective Faraimo, files were left for substantial periods of time without any action. Detective Mackle was unable to cope with her unmanageable file load, which steadily accumulated over time. The supervision systems in the Wairarapa Area did not operate to identify and remedy these problems. Instead, the problems were left to intensify.
139. In addition, there was no meaningful audit and assurance program which operated at a District level to identify the scale of the problems and remedy them, and again, this was undesirable.
140. As at April 2006, Detective Mackle identified that she had accumulated approximately 120 child abuse files. Her email of 28 April 2006 could be considered as a cry for help, and it certainly operated as a catalyst for action.
141. In response to the email Detective Inspector Quinn requested an assessment by Detective Sergeant Penny of all child abuse investigation files held in the Wairarapa Area. This action was appropriate. Although not directed to tender a written report, Detective Sergeant Penny elected to file a written report of her findings through her supervisor.
142. The Penny Report was a careful and considered piece of work that clearly identified a substantial backlog of child abuse investigation files in the Masterton office. The value of the report was recognised by Detective Inspector Quinn who commended the Penny Report to Inspector Johnston for both its short term and long term recommendations. Detective Inspector Quinn also extended the offer to discuss the issues raised in the Penny Report.
143. The scale of the backlog had been clearly identified in the Penny Report and upon receipt of the Penny Report there had been direction given at both district and area management level to implement steps to address the backlog of child abuse investigation files. As at July 2006, it appeared that action had finally begun in response to the backlog of child abuse investigation files in the Wairarapa Area.



Chapter Four: Wellington District: August 2006 - 2008

INDEPENDENT POLICE CONDUCT AUTHORITY

144. This chapter focuses on the events in Wellington District during August 2006 to 2008. As concluded in the previous chapter, as at July 2006 it appeared that action had been taken in response to the backlog of child abuse investigation files in the Wairarapa Area. August 2006 was the point at which a direction was given that the short term recommendations from the Penny Report were to be implemented. The discussion in this chapter examines the reasons why no significant action was taken to address the backlog of child abuse investigation files in the Wairarapa until Operation Hope began in late 2008.

Masterton CIB response to Penny Report (August 2006)

145. Inspector Johnston sent a memorandum dated 19 July 2006 requesting Detective Sergeant McHattie to implement the short term recommendations from the Penny Report. Detective Sergeant McHattie was away from the office and did not receive this memorandum until 2 August 2006.

146. On 8 August 2006, Detective Sergeant McHattie wrote to Detective Senior Sergeant Holden, National Manager: Adult and Child Sexual Abuse, advising that he had been tasked to commence a “thorough re-evaluation and audit of the process/procedures/practices used in the Masterton office and across the Area” in relation to child abuse investigations. He sought assistance with best practice in relation to file management and inquired whether there were standard forms and templates used on a national basis.

147. Detective Senior Sergeant Holden advised him there was no file management system operating on a national basis and proposed the subject as a useful topic to address at the upcoming National CAT Managers Conference, scheduled to run the following month during the week 4-8 September 2006. Detective Senior Sergeant Holden also extended an offer to help with issues that had arisen in the Wairarapa Area and made reference to the email sent in April 2006 by Detective Mackle. He stated that he would be “factoring that into some soon to be addressed common issues”. This was not explained further in the email.

148. On 11 August 2006, various emails were exchanged between the Officers in Charge of CIB across the Wellington District in relation to child abuse file holdings and the proposal for different staff to travel to the Wairarapa Area to assist with the backlog of child abuse investigation files. The Lower Hutt Area described the need for its staff to participate in the Duty Shift Roster due to the serious crime workload in the area. The additional comment was made that in order to stay on top of the area's child abuse file investigations, there were periodic internal operations within the Lower Hutt Area where CIB members from other squads would commit themselves to the Child Abuse Team for 2-3 weeks.
149. The systems and processes in place in Lower Hutt for child abuse investigations had been designed by Detective Sergeant Penny and it was noted that these systems enabled accurate records to be kept because the Lower Hutt Area viewed child abuse as its "biggest risk area". While Lower Hutt was supportive of the concept of assisting the Wairarapa it was made clear that the area viewed its own child abuse workload as a local priority that needed to be addressed first.
150. On 15 August 2006, Detective Senior Sergeant Levy, Officer in Charge, Lower Hutt CIB advised staff and supervisors within Lower Hutt that there would be a three-week operation to reduce the child abuse investigation backlog in the Lower Hutt Area. The following day, Inspector Dunstan, Area Commander Lower Hutt advised that Lower Hutt staff could not assist the Wairarapa Area with its child abuse investigations "when we have a similar problem of our own".²²
151. On 18 August 2006, Detective Sergeant McHattie provided a written report to Inspector Johnston that detailed the action he had taken in response to the Penny Report. It was headed *Wairarapa Area Police Child Abuse Team; Assessment of Masterton Child Abuse Processes and File Handling* and was a detailed response to the matters raised in the Penny Report.
152. Detective Sergeant McHattie's advice (paraphrased below) was set out against the five short term recommendations in the Penny Report as follows:
- *Immediate implementation of a file management system:* a CAT file management system that had been adapted from a system used by Counties Manukau District was implemented.

²² This email was sent to Detective Senior Sergeant Oxnam, Porirua CIB and copied to Superintendent Trappitt, Acting District Commander. His involvement is discussed later in this report.

- *Implementation of an initial action checklist for files:* an initial action checklist was stated to be already in place, but not being utilised by the Wairarapa Area CAT staff.
- *Detective Mackle's workload to be reduced:* Detective Mackle's workload had been reduced by distributing files to other Masterton CIB staff. Detective Sergeant McHattie was holding a large number of files in his office.
- *Area level operation to reduce backlog:* Detective Sergeant McHattie recommended that an area level operation should coincide with a district level operation.
- *District level operation to reduce backlog:* Detective Sergeant McHattie advised that, following discussions with other Officers in Charge of CIB within the Wellington District on 10 August 2006, it was proposed that a request be made for staff from other areas to attend and provide assistance in the Wairarapa for a four-week period starting at the end of August 2006. It was noted that three of the Wellington Areas confirmed that they were willing to send staff to the Wairarapa: Lower Hutt; Porirua; and Wellington Central.²³

153. Detective Sergeant McHattie further advised that he had completed an evaluation of the child abuse investigation files held in the Wairarapa Area and that there were 76 child abuse files requiring further investigation and that the figure of 76 comprised files held by Detective Mackle in Masterton, as well as files held by Detective Faraimo in Featherston, and other files received since Detective Sergeant Penny's report of 16 June 2006.²⁴

154. Detective Sergeant McHattie submitted his report to Inspector Johnston with a final paragraph advising that it was forwarded at the direction of Detective Inspector Quinn for consideration that a request be made to other areas for staff to be provided.

155. Detective Sergeant McHattie amended this report four days later on 22 August 2006, by adding some additional paragraphs to the end of the document. His amendments related to the need for prosecution files to remain in the Wairarapa Area rather than being taken by staff back to their own stations at the finish of the secondment. A

²³ At the time of sending his email of 15 August 2006, it appears that Detective Sergeant McHattie was unaware of the recent decision by Lower Hutt that it could not provide assistance at that time.

²⁴ Detective Sergeant McHattie also set out an estimate of 10-15 hours per file for preparation towards prosecution, calculating that in order to rectify the backlog there would be 760 -1140 hours of investigation time required.

proposal was made to utilise experienced former detectives to prepare such files for prosecutions.²⁵

156. On 24 August 2006, Detective Sergeant McHattie emailed Inspector Johnston about support offered by other area CIB offices within the Wellington District for the planned “reduction operation” (reduction of child abuse files). Confirmation had been provided that one staff member from the Kapiti-Mana Area would travel to the Wairarapa to work for three weeks, starting at the beginning of September 2006. In addition, it was planned that four staff members within the Wairarapa Area CIB would support the reduction strategy by having a primary focus on child abuse investigation files during the same period.

Formal request for assistance from Wairarapa Area (August 2006)

157. On Friday 25 August 2006, Inspector Johnston issued a memorandum headed *Masterton Child Abuse Processes and File Handling*. It was sent to the Area Commander Lower Hutt and to Detective Inspector Quinn and was a formal request for assistance for staff to be provided to the Wairarapa CIB.

158. Inspector Johnston referred in his memorandum to the findings of the Penny Report, noting that the report contained a number of conclusions and recommendations and advising that the majority of those had been put in place by Detective Sergeant McHattie. He also noted that a plan of action to use local staff had been implemented in order to reduce the file loading held by Detective Mackle, but that additional assistance would be required from outside the Wairarapa Area. Inspector Johnston concluded by referring to previous discussions about staff from other areas assisting and advised that the memorandum was a formal request for assistance. He referred to the report by Detective Sergeant McHattie, a copy of which was attached to the memorandum.

159. On 28 August 2006, Detective Sergeant McHattie confirmed that there were 76 active child abuse investigation files held in the Wairarapa Area. He advised that almost half, approximately 30, of those files were awaiting filing (closing).

160. On 31 August 2006, Detective Sergeant McHattie again advised that the total file holding for the Wairarapa Area was 76. He said approximately 20 of the 76 files were

²⁵ Detective Sergeant McHattie was tasked with implementing the short term recommendations only. For the sake of completeness the Authority notes that the first long term recommendation for administrative support did not appear to eventuate during 2006-2008; the second long term recommendation about child abuse investigators remaining on the duty roster, and the third long term recommendation about a senior role with district oversight of child abuse matters, are issues discussed elsewhere in this report.

“historic” and should not be included in the calculation of files requiring investigation. He concluded his email with the advice that the Wairarapa Area therefore held approximately 57 child abuse files that were under investigation at that time.²⁶

Detective Sergeant McHattie’s email (4 September 2006)

161. On 4 September 2006, Detective Sergeant McHattie sent an email with an update about the child abuse investigation files in the Wairarapa Area. The email was addressed to Detective Inspector Quinn and Inspector Johnston.

162. The email from Detective Sergeant McHattie stated:

“With my hand on my heart I can honestly say that the total number of CAT investigation files currently held for investigation [either under investigation or pending investigation] in the entire Wairarapa Area total twenty-nine [29] with currently five [5] not assigned.”

163. Detective Sergeant McHattie went on to state in this email that:

“There was a huge “issue” “non-filing” or “non-close off” of Files and with the holding by CAT of “historic” Sexual Abuse Files where the Victims had complained as adults of the offending committed upon them as children...this activity by CAT was never my policy, but was a legacy of previous systems still considered by some as being appropriate and this will not now endure or be in anyway entertained as those files [only less than 10] have now been provided to the Wairarapa Area “Adult Sexual Abuse Team.”

164. The lack of consistency in the interpretation by Police Districts as to what constituted “historic” and “unallocated” files is a subject that is discussed in the following chapter.

165. He also identified the absence of any system for recording the actual number of files held at Masterton, with the result that no one knew how many child abuse files existed or what stage of the investigation process had been reached in respect of each file. He said:²⁷

²⁶ This response was in reply to the request from Police National Headquarters to collate information from all districts.

²⁷ The Authority notes that the Wairarapa CIB chart structure shows that Detective Mackle was, in theory, reporting to Detective Sergeant Van Woerkom during the period January to September 2006. As noted elsewhere in this report, Detective Sergeant Van Woerkom was stated to be “2IC” of the Wairarapa CIB during the relevant time.

"I take responsibility for that "state of affairs" as I mistakenly [in hindsight] believed that the people that were tasked with that type of investigation were experienced and were conversant with the requisite processes required with dealing with Investigation Files of this type following their experience as well as training...I acknowledge that I should have audited those processes earlier and directly overseen the processes so that people involved with this type of work were provided with the necessary tools to ensure that the robust systems existed... I should not have expected/assumed that experienced people with specialist training in this area of investigation and considered by many to have significant capabilities in the arena to ensure that appropriate systems were in place...."

This has now been substantially resolved with the introduction and development of a specialist File Management System, CAT Investigation File Coversheets, Risk Assessment Sheets and File formatting that has been adopted/modified from colleagues in Auckland and Counties-Manukau as well as from my own experience...reporting lines have been instituted so that any 'concerns' are addressed immediately or, at the very least, at the weekly Wairarapa Area CAT office meeting.

The "dramatic" email of Detective MACKLE of early April 2006 has caused, albeit belatedly due to "it" awaiting my return to the Area at the end of July 2006, these issues to be addressed and rectified...this has been by the institution of the measures as describe[d]above and the provision of "ring-fenced" staff of Detective [A] [on FEO working 3 days per week] and Detective [B] "full-time" as part of an on-going "3 months trainee rotation"...with the current systems and staffing levels, I do not envisage that this situation will occur again.

Although staff have been requested from the other Areas, currently Kapiti-Mana CIB are supplying one staff member for the next three weeks only, no further staff are required."

Further update (5 September 2006)

166. The following day, on 5 September 2006, Detective Sergeant McHattie sent an email to Inspector Johnston, Area Commander, Wairarapa, to advise him of various measures that had been instituted resulting in changes to the staffing groups within the Masterton CIB office. In particular, he noted that Detective Mackle had been given the title "Officer in Charge of CAT" and now had two staff members working under her direction, one of whom was part-time and the other a trainee on 6 months rotation.

These officers were described as being “ring-fenced” to work “primarily on CAT investigation files”.²⁸

167. Detective Sergeant McHattie also advised that the file management system for serious crime files had been updated, that there would be ongoing assessment for all serious crime files held by all members of the Wairarapa CIB, and further development of the prioritisation of serious crime files using a grading system. Detective Sergeant McHattie said he would ensure the systems would continue even in his absence. His email was acknowledged by Inspector Johnston the following day.

Assistance from other staff (August – September 2006)

168. The planned operation to have assistance from outside the Wairarapa Area resulted in one detective from the Kapiti-Mana Area travelling to Masterton with the expectation that he would assist for a 3-week period. This officer worked for the week of 4-8 September 2006. However, after that week he was advised that neither he, nor any other staff, would be required to assist further in the Wairarapa Area. The detective said he was surprised by the advice that he or other extra staff members were not required for further work in Masterton.

Reports accepted by area and district management

169. It is clear from the evidence before the Authority that Detective Sergeant McHattie’s reports describing the position in the Wairarapa were accepted at face value by both area and district management. This included Detective Sergeant McHattie’s assessment of the number of child abuse files and advice that a district operation would not be necessary (beyond the assistance given by one detective from Kapiti-Mana for the week 4-8 September 2006).

170. In particular, it is clear that both Detective Sergeant McHattie’s supervisor, Inspector Johnston, and the District Crime Services Manager, Detective Inspector Quinn, accepted Detective Sergeant McHattie’s assessment of the position. It is also clear that, in reliance on Detective Sergeant McHattie’s assessment, Detective Inspector Quinn assured the (then) Acting District Commander Wellington, Superintendent Trappitt, that the backlog of child abuse files in the Wairarapa had been resolved when this was not in fact the case.

²⁸ It was noted by Police that purporting to give the title of “Officer in Charge” of a Child Abuse Team to a Detective, rather than a Detective Sergeant or Detective Senior Sergeant, was unusual. It was also noted that the designation of title would not have affected the capacity of the office to investigate child abuse.

171. In the course of its Inquiry the Authority heard considerable evidence about the Police approach to supervision and managing risk. This approach is based on an expectation that staff will always appropriately assess risks, and will escalate issues to their supervisors when necessary. By way of example, in his evidence, Deputy Commissioner Pope, referring to his management (as Wellington District Commander) of Area Commanders and the District Crime Services Manager, said it was their responsibility to advise him of any issues, meaning to escalate such issues, and it was his expectation they would do so. The reliance placed on Detective Sergeant McHattie to appropriately assess and identify risks in the Masterton CIB was consistent with this approach.
172. Wellington District had three different District Commanders during 2006. Superintendent Pope was District Commander from January 2004 until April 2006, before taking up his role as Deputy Commissioner at PNHQ. The position of District Commander Wellington was then held by Superintendent Trappitt who undertook the role in an acting capacity for a period of six months from April 2006 until September 2006. Superintendent Munro was then appointed District Commander in September 2006 and he remained in that role until April 2009.
173. The Penny Report of June 2006 was not provided to Superintendent Trappitt while acting as District Commander. At the time Detective Sergeant McHattie and Inspector Johnston were corresponding in mid-August 2006, about implementing the short term recommendations in the Penny Report, Superintendent Trappitt had not been briefed on the concerns expressed about the Wairarapa CIB and child abuse investigations.²⁹
174. This was confirmed by Superintendent Trappitt and is evidenced by an email he sent on Monday 14 August 2006 to Detective Inspector Quinn. In that email Superintendent Trappitt asked what information Detective Inspector Quinn had to quantify the current situation about sexual abuse inquiries in the Wellington District:

“We’ve carried a couple of conversations in [the] last few months about options for conducting sexual abuse enquiries within the district. I was just wondering what sort of information do you have that quantifies the current situation and how is the district currently placed when compared to historical perspectives.

In short do we have a problem and if so how big is that problem. Part of the information you have might include details on the timeliness of progressing of complaints i.e. how many do we have backlogged, what’s our normal ‘through-put’

²⁹ Superintendent Trappitt confirmed that during the period he was the Acting District Commander Wellington he had no direct contact with Detective Sergeant McHattie.

[are] we keeping up with the level of complaints coming in or are we steadily getting further behind? Are all our Areas in similar situations."

And further:

"Big question, would the situation you might describe in answering some of the above questions be improved by central co-ordination? If so, I'm wondering just how hard it might be to actually try something sooner rather than later? Like could there be an interim situation where we start an iterative approach. To explain further in the first instance we might do centralised co-ordination with local control and then that gets reviewed with a potential moving to central control...But back at the start point we should quantify the problem and qualify how the approach might resolve it."

175. As already recorded in paragraph 150, on 15 August 2006, the Lower Hutt Area sent advice that its staff were not in a position to assist the Wairarapa Area because Lower Hutt needed to reduce its own backlog of child abuse investigation files. That advice from the Lower Hutt Area Commander was copied to Superintendent Trappitt as Acting District Commander. On receiving this advice, Superintendent Trappitt followed up with inquiries of Detective Inspector Quinn by email on 17 August 2006, seeking further answers in relation to the overall state of child abuse investigations within the Wellington District. It is apparent from the first paragraph of his email that Superintendent Trappitt remained unaware of the circumstances within the Wairarapa Area that had generated the email correspondence of the previous few months and unaware of the site visit to Masterton and the resultant Penny Report.
176. Superintendent Trappitt set out various matters, including inquiring whether any other districts had attempted to categorise matters such as unassigned files and what he termed the "investigation queue". He concluded with a general observation about the Wellington District, noting that one of the benefits of having accurate numbers of unassigned files would be a "greater understanding of the issue and enable co-ordination between respective CIB offices for levelling the peaks. For example 10 unassigned in the Wairarapa might be more significant than 49 unassigned in the Hutt".
177. In his evidence before the Authority, Superintendent Trappitt recalled a discussion he had had with Detective Inspector Quinn about the situation in the Wairarapa. While Superintendent Trappitt could not remember the detail of the discussion, he had a clear memory of Detective Inspector Quinn advising him that a "hand on heart" assurance had been given by the Officer in Charge of the Masterton CIB. It is reasonable to infer that this was a reference by Detective Inspector Quinn to the 4 September 2006 email from Detective Sergeant McHattie.

178. Superintendent Munro succeeded Superintendent Trappitt as Wellington District Commander on 18 September 2006. Neither Superintendent Trappitt nor Detective Inspector Quinn briefed Superintendent Munro on the situation which had arisen in the Wairarapa, notwithstanding the media coverage on the issue, which is addressed in detail in the following chapter. The matter was regarded as having been resolved.

Wellington District – D-CAT Project Scoping

179. It was not until active research began for the establishment of a district-wide child abuse investigation team in Wellington in late 2008 that serious ongoing problems in the Wairarapa Area in relation to child abuse investigation files were once again revealed.³⁰

180. During September 2008, all CIB offices within the Wellington District were canvassed to ascertain file workloads in order to effectively plan for resources for the proposed new model of a centralised child abuse investigation team. The combined results were collated during October 2008 and various inquiries made during the course of November 2008.

181. During this research and inquiry process a backlog of multiple high risk files were identified within the Wairarapa Area.³¹ The backlog was found within the Wairarapa CIB at Masterton and consisted of over 100 active files where there was little, or no, progress in relation to the initial complaint that had been received by Police staff.³²

Operation Hope

182. Having discovered the files and the significant delays attaching to those files, Police launched an Operation named “Hope” the following month. Operation Hope, which involved a team of approximately 20 staff assigned to assess, prioritise and investigate the relevant files, commenced on 8 December 2008, with the primary focus of reducing the substantial backlog of files within Wellington District and specifically the number of investigation files held in the Masterton office.

³⁰ The initial request for a District Child Protection Team was made in November 2007 to the District Commander Wellington and approval to begin scoping planning was given in December 2007. The team has since been renamed the District Child Protection Team (D-CPT).

³¹ Part I Report, p 127, paragraphs 496-498; *Operation Hope, Closure Report, Wellington District*, November 2009, Detective Senior Sergeant Penny.

³² On 10 November 2008 Detective Sergeant Penny sent an email to Detective Sergeant Van Woerkom at Masterton to advise that there would be a District response required to assist with risk reduction around critical and urgent files. Detective Inspector Cotter was responsible for coordinating resources for the operation.

183. Operation Hope was initially intended as a short term remedial operation to rectify the situation. However, staff working on Operation Hope continued to discover additional child abuse investigation files within the Wairarapa Area and it became apparent that there were systemic failings or deficiencies of a major kind in the management of child abuse investigation files. This has been acknowledged by the Commissioner as “a significant service failure”.³³
184. Operation Hope concluded in November 2009 with the production of a comprehensive closure report, which was subject to independent review.³⁴ The prosecution of alleged offenders identified as a result of the inquiries undertaken by Operation Hope remains ongoing.
185. Operation Hope assessed approximately 550 cases, which resulted in at least 41 prosecutions. These prosecutions have resulted in the conviction of a number of individuals and many of those have received lengthy custodial sentences. It is not appropriate for the Authority to identify specific cases in this report, but these convictions demonstrate that many of the child abuse complaints reviewed by the Operation Hope team, despite being historic in nature were amenable to successful prosecution and conviction.
186. The Authority is aware that there are a number of prosecutions pending which have arisen from the Operation Hope review and assessment.
187. As acknowledged by the Commissioner of Police, the delays in the investigation by Police of complaints of child abuse were a significant service failure. These delays in the investigations were both unjustified and unreasonable.

District Child Protection Team

188. On 1 March 2010, the Wellington District Child Protection Team (CPT) commenced operations.³⁵ Detective Sergeant Penny was promoted to the rank of Detective Senior Sergeant and is now the Officer in Charge of the CPT. CPT staff in the Wairarapa are supervised by a Detective Sergeant who is based in the Wairarapa for part of each

³³ Part I Report p 17, paras 51-52. As noted the Part I Report at footnote 1, Commissioner Broad made this acknowledgment to the Authority. Operation Hope identified outstanding investigations for 108 Wairarapa child abuse files. This number later increased and, by the time Operation Hope concluded nearly a year later in November 2009, Police staff had undertaken a review of approximately 550 files, *Operation Hope: Review Report, A Review of Wellington Police District's Response to Operation Hope*, Assistant Commissioner (ret) G Jones, 27 November 2009, p 2.

³⁴ A detailed summary of Operation Hope is contained in the final chapter of the Authority's Part I Report.

³⁵ The shift in terminology from “Child Abuse Team” or “CAT”, to “Child Protection Team” or “CPT”, is addressed in Chapter 8 of this report.

week, who in turn reports to Detective Senior Sergeant Penny. She reports to the District Crime Services Manager, Detective Inspector Arnerich.

189. CPT staff in the Wairarapa are exclusively focused on child abuse investigation files, as are all CPT staff throughout Wellington District. Most importantly, the establishment of the CPT means that a district-wide response to child abuse is now being taken, so as to avoid a situation recurring where child abuse investigators in the Wairarapa should again face a substantial backlog of files without support.

Conclusions and findings

Sharp decline in file numbers (March – September 2006)

190. The evidence establishes that during March and April 2006 Detective Mackle’s workload exceeded 100 files. Detective Mackle herself estimated that she had responsibility for approximately 140 files. The Authority notes that the total number of child abuse investigation files held by Detective Mackle had been consistently high for some time. During the previous year the file analysis reports of child abuse file holdings in the Wairarapa for April 2005 showed Detective Mackle as holding 95 files.³⁶
191. The volume of files held by Detective Mackle, in particular the estimate of a holding of more than 100 files has been described as “excessive” for any investigator, even were that person employed full-time. The volume could therefore be regarded as even more excessive for an investigator whose role was part-time. Detective Mackle’s workload was aptly described as “unacceptable”.
192. In June 2006, Detective Mackle’s workload was confirmed to be 142 files. This total was recorded in a CIB Workload Survey completed by Detective Sergeant McHattie and returned to Detective Inspector Quinn, Crime Services Manager, on 8 June 2006.
193. Her total file holding comprised: 71 child abuse files; 13 rape files; 2 assault files; 47 files held for completion; and 9 files noted to be “at court”. This was in sharp contrast to the child abuse investigation workload of three other staff in the Wairarapa (who worked both part-time and full-time), who each held between 1 and 5 files in total.
194. The Penny Report was completed one week later on 16 June 2006, and the file holding of Detective Mackle at that time was estimated to be 121 files and notifications.³⁷ This estimated workload, as recorded in the Penny Report was therefore similar to the information provided earlier the same month by Detective Sergeant McHattie as Detective Mackle’s supervisor. The information in the Penny Report was also consistent with the estimates provided by Detective Mackle herself, and her colleague, Detective Faraimo.
195. The available evidence establishes that on three separate occasions during August 2006 Detective Sergeant McHattie advised that the child abuse investigation files for the Wairarapa Area amounted to a total of 76 files. On two of those occasions the advice

³⁶ Detective Mackle’s file holding was described by Detective Faraimo as “over 100” and by Detective Mackle herself as “about 140 files, probably more”.

³⁷ *Assessment of Masterton Child Abuse Process/File Holdings*, 16 June 2006, at p 2, Detective Sergeant Penny. As noted elsewhere, the file numbers in the Penny Report add up to 119 files.

was by emails sent to Inspector Johnston, Area Commander, and on the third occasion was by an email sent on Monday 28 August 2006, in response to information sought from PNHQ.

196. However, later that same week on 31 August 2006, Detective Sergeant McHattie advised that the number of child abuse investigation files held in the Wairarapa had reduced to 57 files. At the start of the following week, on Monday 4 September 2006, Detective Sergeant McHattie advised that the file holdings had now reduced even further and that the total number was 29 files.

197. Accordingly, the number of child abuse investigation files for the Wairarapa which had been counted at 121 files and notifications at the time of Detective Sergeant Penny's visit in June 2006, had subsequently reduced over an 11-week period to a total of 29 files, a reduction of 92 files. In one week, 28 August 2006 to 4 September 2006, the number of child abuse files reported by Detective Sergeant McHattie reduced from 76 files to 29 files.

Findings of The 10 Year Audit

198. During the early part of Operation Hope, an initial assessment of the preceding 10-year period was undertaken by Detective Inspector Cotter, Field Crime Manager, Wellington District, in relation to all child abuse files held in the Wairarapa Area. On completing his initial assessment Detective Inspector Cotter submitted a written report to Detective Inspector Arnerich, Crime Services Manager, Wellington District, entitled *Initial Assessment: 10 Year File Audit of Child Abuse Files from the Wairarapa* (10 Year Audit Report).

199. The audit process carried out by Detective Inspector Cotter identified all child abuse files that had been reported and investigated in the Wairarapa Area over the previous decade, which amounted to approximately 400 files. At the time the 10 Year Audit Report was submitted, 250 files had been located and provided to Detective Inspector Cotter for review.³⁸

200. The review process entailed an initial assessment of each file to determine if the file had been filed correctly, incorrectly, or had been inappropriately resolved.³⁹ The file was then reviewed by Detective Inspector Cotter, or by an experienced child abuse

³⁸ The remaining files were spread across staff in the Wairarapa CIB, other stations, archived, or not yet located at the time of the initial assessment being undertaken.

³⁹ Filed "correctly" meant the file had been investigated to an acceptable standard; "incorrectly" meant there were outstanding inquiries of a significant nature e.g. no summary report, offender not interviewed; "inappropriately resolved" meant that how the file was resolved was unacceptable.

investigator of the rank of Detective Sergeant, or Detective Senior Sergeant. Files that were found to have been incorrectly filed or inappropriately resolved were subject to a second assessment by a team of investigators and were assigned a risk rating of “low”, “medium” or “high”.⁴⁰

201. The summary of findings showed that 250 files had been assessed and of these 159 had been filed correctly. Of the 91 files remaining, these were assessed as being either “filed incorrectly” or “inappropriately resolved”. These files underwent a second assessment for the purpose of having a risk level assigned to each file:

42 files were rated “low” risk

28 files were rated “medium” risk

21 files were rated “high” risk

202. Detective Inspector Cotter determined that 46 of these 91 files had been filed during August and September 2006. Specifically, it was established that the majority of those files had been filed during a two-day period, 31 August and 1 September 2006.

203. The files that had been filed over this two-day period were examined by Detective Inspector Cotter. It was found that only two of the files had been correctly filed. Thirty-three of the files were found to have been filed incorrectly or inappropriately resolved. Of these 33 files, 14 were found to be low risk, 10 medium risk, and 9 were high risk files. The filings occurred three days before Detective Sergeant McHattie’s email of 4 September 2006 to the District Crime Services Manager, advising that the workload of active child abuse files in the Wairarapa Area had reduced to 29 files.

204. The 10 Year Audit conducted by Detective Inspector Cotter as part of Operation Hope confirmed the information provided in the Penny Report. By that time there had been a period of further delay of over two years on the files identified in the 10 Year Audit Report as incorrectly filed during the months of August and September 2006. The lack of timely and professional service was undesirable, unjustified and unfair to the child victims. As the Commissioner has appropriately acknowledged, this was “a significant service failure”.

⁴⁰ Files were risk assessed as: “low” when incomplete in terms of administrative tasks or below a level that required further investigation; “medium” for matters such as lack of consideration of additional victims, joint agency processes, or lack of offender profile; “high” when children remained at risk, the offender had history of offending against children, and for matters such as no suspect interview.

205. As set out in the introduction to this report, the purpose of this inquiry is not to make findings attributing blame to individuals, particularly as Police employment procedures remain ongoing. Rather, the focus of the Inquiry is on systemic issues and in particular Police practices, policies and procedures relating to child abuse investigations.
206. Accordingly the Authority makes no specific findings regarding decisions taken by individuals in relation to files which were incorrectly filed. The Authority simply records that the 10 Year Audit Report concluded that a significant number of files had been incorrectly filed and required further work, including a substantial number of files in August and September 2006.

Area and district failures

207. The backlog of child abuse investigation files in the Wairarapa was regarded by Wellington Area and District management as resolved in September 2006. As a result of the review of files conducted by Operation Hope, including the 10 Year Audit carried out by Detective Inspector Cotter, it is clear the backlog was not resolved.
208. The view reached in 2006 by the area and district management that the backlog had been resolved resulted from assurances given in Detective Sergeant McHattie's email of 4 September 2006. Prior to these assurances, as at 25 August 2006, Inspector Johnston had issued a memorandum to the Area Commander of Lower Hutt and to Detective Inspector Quinn, formally requesting that assistance in the form of extra staff be provided to the Wairarapa CIB. However, on 4 September 2006, Detective Sergeant McHattie advised there were now only 29 current child abuse investigation files in the Wairarapa Area, with only five unassigned to investigative staff.
209. The role played by particular individuals in the filing of child abuse files in August and September 2006 is disputed, but it is clear that the assurances in Detective Sergeant McHattie's 4 September 2006 email were taken at face value by area and district management. A number of witnesses before the Authority commented on Detective Sergeant McHattie's reputation for taking meticulous care in his work and as noted in paragraph 171 above and reported on in the Authority's Part I Report, the Police approach to risk management relied heavily on "escalation of risk" by staff. That is, it is for staff to escalate risks through the chain of command where they are unable to deal with those risks without assistance.
210. The substance of Detective Sergeant McHattie's advice on 4 September 2006 was that there was no longer a risk in the form of a backlog of files which the Masterton CIB could not deal with itself. Inspector Johnston and Detective Inspector Quinn accepted his advice and relied on it. No further checks or inquiries were made.

211. In its Part I Report, the Authority emphasised the importance of proactive supervision and of random sampling of physical files as part of routine audit processes. The events in the Wairarapa demonstrate the importance of both these matters and, additionally, the importance of independent checks as part of the response to particular events where a high level of risk to victims is identified. The identification of a backlog of files in the Wairarapa in 2006 was plainly such an event, given the volume of files and the high level of risk to victims and the community associated with a failure to investigate child abuse.
212. On any view of the matter, the reduction of files as reported by Detective Sergeant McHattie can only have been regarded as 'dramatic' when set against the information provided in the Penny Report and the other available information. An independent check involving the random sampling of files should have been carried out following Detective Sergeant McHattie's email of 4 September 2006. This should have been done as part of the supervision of the Masterton CIB and as part of District audit and assurance processes.
213. It is clear from all the evidence received by the Authority that the supervision systems in the Wairarapa Area failed and that Wellington District did not have an audit and assurance program which included random sampling of files either as part of routine audit processes or in response to high risk events. The absence of such systems was undesirable and unjustified and contributed to unreasonable delays on a number of child abuse investigation files later addressed by Operation Hope.
214. The Authority is also concerned that the backlog of files was not addressed in a more formal manner by Wellington District management. This was a high risk situation with significant adverse implications for child victims, and was the subject of considerable media coverage at the time (referred to in detail in the following chapter). Yet it is clear that Superintendent Trappitt was not formally briefed on, and nor did he receive, the Penny report. On the evidence the Authority has heard, Superintendent Trappitt received only informal, oral briefings from Detective Inspector Quinn and only at the end of the process when Detective Inspector Quinn advised Superintendent Trappitt that the situation had been resolved.
215. On the evidence the Authority has received it appears the backlog of files in the Wairarapa Area was not discussed at meetings of the Wellington District senior management team during the crucial months of June 2006 to September 2006. The new District Commander, Superintendent Munro, was not briefed on the matter when he took up office in September 2006.
216. The backlog of files identified in the Wairarapa Area in 2006 should have been a standing item on the agenda for meetings of the Wellington District senior management team until the matter was properly concluded. Had it been, a greater level of assurance

may have been sought that the backlog had been properly resolved. The failure to ensure that a high risk situation of this kind was not on the agenda as a formal item at meetings of the Wellington District senior management team was undesirable.

217. Operation Hope assessed approximately 550 cases, which resulted in at least 41 prosecutions of child abusers and the conviction of a number of individuals, many of whom received lengthy custodial sentences. These convictions underpin that many of the child abuse complaints reviewed by the Operation Hope team, despite being historic in nature were capable of successful prosecution and conviction.

218. The delays in the investigation by Police of complaints of child abuse were a significant service failure and were both unjustified and unreasonable.



Chapter Five: Involvement of Police National Headquarters

INDEPENDENT POLICE CONDUCT AUTHORITY

219. This chapter examines the role of PNHQ in relation to the backlog of child abuse investigation files in the Wairarapa in 2006. The chapter begins by examining the awareness of PNHQ of the particular situation in the Wairarapa Area during 2006. Following this, an examination of a wider body of information which came to the attention of PNHQ in August and September 2006 about child abuse investigations in the Wairarapa and elsewhere in New Zealand is examined, and whether there were any failures by PNHQ to act in relation to information that had been received.

Awareness of the Wairarapa backlog

220. Deputy Commissioner Pope was the Wellington District Commander until 2 April 2006 when he left that role to take up the position of Deputy Commissioner (Operations) at PNHQ. Deputy Commissioner Pope was one of the large number of recipients copied into Detective Mackle's subsequent email dated 28 April 2006 referred to in Chapter 3 above.

221. In his evidence before the Authority, Deputy Commissioner Pope advised that in the first instance he expected the matters raised in Detective Mackle's email to be dealt with by Wellington District, but if Wellington District required external assistance to deal with the resourcing issues identified by Detective Mackle then an appropriate request should be made to PNHQ and would be considered accordingly. No such request was made by Wellington District to PNHQ.

222. Deputy Commissioner Pope was overseas during August/September 2006. Peter Marshall acted in the role of Deputy Commissioner (Operations) in Deputy Commissioner Pope's absence in August/September 2006. Acting Deputy Commissioner Peter Marshall was subsequently appointed Commissioner of Police for the Solomon Islands in November 2006.

223. On 31 August 2006, Detective Sergeant Penny forwarded a copy of Detective Mackle's 28 April 2006 email and a copy of her report (the Penny Report) to Acting Deputy Commissioner Marshall, following a discussion she had with him about the situation in the Wairarapa.

224. In his evidence before the Authority, Commissioner Marshall (Solomon Islands) advised that he spoke with Detective Sergeant Penny to gain a better understanding of the situation in the Wairarapa following notification by the New Zealand Police Association (Police Association) to PNHQ of the Association's intention to publish an article about delays in the investigation of child abuse in the Wairarapa and elsewhere. The Police Association article and other media interest are matters discussed later in this chapter.
225. Commissioner Marshall (Solomon Islands) advised the Authority that resourcing issues within the Wellington District were for Wellington District to address, but if external assistance was required an appropriate request could and should have been made to PNHQ. Commissioner Marshall (Solomon Islands) advised that it was not uncommon for requests to be made for additional staff and that there were various opportunities for such requests to be raised, for example, during district visits or the twice yearly District Crime Services Managers conferences.
226. No request for external assistance to address the backlog of files in the Wairarapa was made by Wellington District to PNHQ. This can be contrasted, for example, with a request for external assistance made by Counties Manukau District to PNHQ in June 2006.
227. In June 2006, a backlog of child abuse investigation files had accrued in Counties Manukau District due to a number of factors, including three highly resource intensive child homicide inquiries in early 2006. The Acting Crime Manager, Detective Inspector Gallagher, supported by the Counties Manukau District Commander, put together a business case to PNHQ for assistance from outside the district to clear the backlog of child abuse investigation files.
228. This request by Counties Manukau was approved by PNHQ. In his evidence Commissioner Marshall (Solomon Islands) advised that, had a similar request been made by Wellington District in 2006, he saw no reason why it would not have been approved.
229. It is clear the Wellington District management regarded the backlog of child abuse investigation files in the Wairarapa as being able to be resolved by operations within the district without the need to request external assistance from PNHQ. As discussed in the previous chapter, as events transpired not even the proposed District Operation went ahead, with the only accepted assistance being the secondment of one detective from Kapiti-Mana for one week.

PNHQ request for information from districts

230. On 16 August 2006, the Police Association approached the Office of the Commissioner for comment about the subject of child abuse investigations. The Police Association

indicated that it was investigating high case loads of child abuse investigation files and the ability of Police to respond to such investigations.

Information sought from District Commanders

231. On 28 August 2006, Detective Superintendent van der Velde, National Crime Manager, acting on behalf of Deputy Commissioner Pope, emailed District Commanders seeking a response about the case loads of child abuse teams for all 12 Police districts.

232. In addition, District Commanders were asked to provide a detailed breakdown of case loads to assess six factors:

- Timeframes between notification and response in so far as removal and/or safety action;
- Timeframes between assignment of the file and commencement of investigation;
- The number of unallocated files;
- Management systems or processes in place to manage CAT files;
- Any abnormal increase in the number of referred child abuse files;
- Prioritisation processes that are being used to manage case load.

233. District Commanders were asked to provide information about multi-agency initiatives and, further, to advise whether there were pressures and whether such pressures were being managed appropriately within departmental guidelines.⁴¹

234. A written response was drafted by the Police Executive, in consultation with the Crime Group at PNHQ and the National Coordinator: Adult and Child Sexual Abuse, and provided to the Police Association in late August 2006.

Information sought from CAT supervisors

235. The email sent to District Commanders was also provided separately to staff members who were due to participate in the National CAT Managers Conference the following week. The email was forwarded by Detective Senior Sergeant Holden, National Coordinator: Adult and Child Sexual Abuse. He anticipated that District Commanders

⁴¹ The message was copied to others including Detective Senior Sergeant Holden and Acting Deputy Commissioner Peter Marshall. The information was required within a two-day period. The phrase “within departmental guidelines” was not explained.

would probably seek the information required from those staff members working in the area of child abuse investigations and also noted that it would be the subject of further discussion at the upcoming conference.

236. A response from the Wairarapa Area was provided by Detective Sergeant McHattie the same day, on 28 August 2006. He expressed various frustrations to Detective Senior Sergeant Holden. Detective Sergeant McHattie's initial frustration was that he considered the Wairarapa file numbers, which had been included in questionnaire results provided to PNHQ as part of national figures, were inaccurate.

237. Detective Sergeant McHattie advised that there were currently 76 active child abuse investigation files:⁴²

"[T]here are currently 76 active CAT Investigation Files throughout the Wairarapa with almost half of those files being allocated and some of the remaining files requiring only cursory enquiries before they will be "filed" without further action...there are approximately 30 files awaiting "filing action" with that to be completed with the assistance of a non-sworn clerk."

Detective McHattie went on to express his discontent:

"I am frustrated that you deemed it appropriate to provide inaccurate information as being a reflection of the current position of the Wairarapa."

238. The point of contention may have been that the initial *CAT Managers Questionnaire Results 2006* document, attached to Detective Superintendent van der Velde's email of 28 August 2006, represented the Wairarapa Area as having approximately 100 files, all of which were categorised as "unallocated".

239. On 31 August 2006, Detective Sergeant McHattie sent an email to Detective Senior Sergeant Borrell, who had been assigned the task of collating the Wellington District response. The email contained his formal reply to the request for information in Detective Superintendent van der Velde's email of 28 August 2006, and was described as a "preliminary 'thumbnail' of the current situation in the Wairarapa".⁴³

⁴² Detective Sergeant McHattie's email on 28 August 2006 repeated the same advice that he had recently provided to Inspector Johnston, Area Commander Wairarapa. As discussed above, in his report dated 18 August 2006 sent to Inspector Johnston, Detective Sergeant McHattie stated that there were 76 active child abuse investigation files.

⁴³ The further information was being collated as a Wellington District response. The email was copied to Inspector Johnston, Area Commander Wairarapa.

240. Detective Sergeant McHattie's response repeated the same total file holding of 76 files for the Wairarapa Area. However, he had subtracted nearly one quarter of the number of files, advising that those files should not be included in the files requiring investigation. He advised that of those 76 files, at least 20 of the files were "historic", meaning that the victim was over the age of 16 years at time of making complaint to the Police. It was concluded: ⁴⁴

"[with] those "historic" files not to be included...means that the Wairarapa currently "holds" approximately 57 Child Abuse Files that are being investigated."

241. Further, it was stated that the Wairarapa had approximately 32 "unallocated" files, with that number being reduced through the reduction operation.

242. In its request for information, PNHQ had sought responses about other areas of information, such as management systems and methods of prioritisation of child abuse investigation files. Detective Sergeant McHattie's responses provided in relation to those areas were amalgamated in one paragraph. It was stated that prior to 1 August 2006 there was no system to enable the capture of the information being sought by PNHQ, but that a "CAT File Management System" had been adopted and modified from the system utilised by Counties Manukau District in Auckland.

243. In relation to the request for information about pressures relating to the area of child abuse investigation work, Detective Sergeant McHattie expressed his view:

"The concerns about the Wairarapa's ability to conform with the departmental guidelines have manifested around a lack of supervision of the primary investigators with the mistaken belief on my part that they were extremely experienced and fully conversant with the requirements of their roles – this is now rectified while I am present in the Area and will be continued in my absence.

A complete Report on the information sought will be prepared and forwarded by the 6th September 2006.

I can comment that the Wairarapa's response to CAT Investigation has already significantly improved since the email of Detective MACKLE from early April 2006 and that her email did not accurately and/or fully reflect the situation in the Wairarapa at that time. Regrettably [there] were a number of other "issues" that caused that inaccurate [in my opinion] account in Detective MACKLE's email."

⁴⁴ Detective Sergeant McHattie stated that the historic files were to be placed with the Wairarapa Area Adult Sexual Abuse Team.

District responses to PNHQ request for information

244. On 2 September 2006, Detective Superintendent van der Velde emailed all District Commanders thanking them for providing responses at such short notice.
245. The district responses had been collated into a document titled *District Child Abuse Management Snapshot August 2006*. This set out, by column for each district: name of the district; CAT Teams (including CIB offices responsible for CAT work) within each district; number of files held; number of unallocated files; the average files per member; whether the CAT protocol was being followed; the file management system being used; and any new initiatives.
246. Supporting this data were the survey results of the questionnaire sent to all CAT managers. It was stated to have “word-for-word responses from all CAT managers” across the 12 Police districts.
247. Varying interpretations of what constituted “historic complaints” in terms of complaints, as well as what constituted “unallocated” in relation to an investigation file, were evident from the information provided and were acknowledged by Detective Superintendent van der Velde in his email to District Commanders.⁴⁵
248. A review of the data in the *District Child Abuse Management Snapshot August 2006* revealed 225 unallocated files nationwide. While the data certainly suggested there were areas which had to cope with high demand, contrary to media reports which followed, none of the districts reported having hundreds of unallocated files. This topic is discussed further below.
249. In relation to the Wairarapa, the data provided by Detective Sergeant McHattie did not suggest that file numbers or unallocated files in that area were inordinately high.
250. The information provided by districts highlighted a lack of consistency of approach to file management and case load monitoring. Detective Superintendent van der Velde noted in his email to District Commanders that this was an area where some simple solutions could assist to improve the position.
251. Detective Superintendent van der Velde noted that he would be spending time at the upcoming National CAT Managers Conference seeking feedback and recommendations on the development of national best practice and implementation of national process.

⁴⁵ The email was copied to Acting Deputy Commissioner Marshall, Deputy Commissioner Pope, Detective Senior Sergeant Holden and others at Police National Headquarters.

National CAT Managers Conference (September 2006)

252. The 2006 National CAT Managers Conference was held at the Royal New Zealand Police College in Porirua from 4 to 8 September 2006.

253. On 6 September 2006, as advised to PNHQ in advance by the Police Association, the *Police News* magazine published articles questioning the approach of Police to the investigation of child abuse. These articles are discussed below. Following the publication of the articles, and other media coverage, both Acting Deputy Commissioner Marshall and Detective Superintendent van der Velde attended part of the conference to obtain feedback, as signalled in Detective Superintendent van der Velde's 2 September 2006 email.

254. The feedback received was reflected in an email sent by Acting Deputy Commissioner Marshall to District Commanders on 8 September 2006, which is considered below. An important initiative coming out of the conference was the establishment of a CAT Managers Working Group to address file management issues in the context of child abuse investigations. This initiative is also considered below.

Police News – New Zealand Police Association Articles

255. The two articles about child abuse that were published in the September 2006 edition of *Police News*, were featured under the banner headline *New Zealand's "Dark Secret"*.⁴⁶

256. The first article had the title "*Suffer the Little Children*" and began with photographs and names of six of New Zealand's highest profile child homicides. The article set out domestic and international statistics with the comment that such statistics were increasing for established child abuse cases, as well as those cases notified as suspected child abuse. Various other factors were described such as the known links to poverty and the absence of one or more biological parents in a household. The article noted that Police, and Child, Youth and Family, were inundated with notifications about child abuse matters.

257. The inter-relationship with domestic violence was discussed, together with the role of Police in relation to a family violence document that was introduced in 2006, the *New Zealand Standard Screening Risk Assessment and Intervention for Family Violence including Child Abuse and Neglect*. The Standard was discussed by the Authority in its

⁴⁶ New Zealand Police Association, *Police News*, September 2006, pp 207-211. Both articles were written by Steve Plowman, Editor, *Police News*.

Part I Report.⁴⁷ It is aimed at providing a standard for screening, risk assessment and intervention for agencies working with both the victims, and perpetrators, of family violence.

258. The second article in the *Police News* was headed “*Child Abuse Teams Feeling the Pressure*”. Its focus was the specialist nature of child abuse teams working within each of the 12 Police districts. It noted that such teams were drawn from CIB staff and worked closely with Child, Youth and Family services as well as Serious Abuse Teams. The article stated that staff were finding it increasingly difficult to keep pace with the volume of complaints received, with “about half” of the complaints being historical in nature.

259. The article devoted several paragraphs to the Wairarapa Area and the work of Detective Mackle in Masterton, and Detective Faraimo in Featherston. It recorded Detective Mackle’s advice that she had in excess of 100 files in her caseload. The article also recorded Detective Mackle’s opinion that because of the overall nature of child abuse investigations those files languish in terms of Police priorities. Another, unidentified, detective was quoted as stating that volume crime was the priority for Police, with child abuse being “shuffled back down the list of priorities”.

260. The article referred to several high profile child abuse cases that had resulted in the deaths of those children. The observation was made that all of those cases were killings where the victims had come to the attention of Child, Youth Family and other agencies, and were deaths that had occurred in the Wairarapa Area. Detective Sergeant Penny, supervisor of the Child Abuse Team in the Lower Hutt Area, was quoted:⁴⁸

“We put all our resources into the murder inquiries for these children when they get murdered but when they’re alive and we know they’re at risk often we don’t have the resources to allocate to it...”

“These children don’t have a voice. When people are burgled and the Police are really busy and we don’t turn up at their house for 10 hours the adults in the house ring up and want to know why we haven’t come around, but when little children are sexually abused they can’t ring us up and say why haven’t you done anything about it for a year?”

⁴⁷ Part I Report at page 48, para 171. *New Zealand Standard Screening Risk Assessment and Intervention for Family Violence including Child Abuse and Neglect* NZS8006:2006.

⁴⁸ *Child Abuse Teams feeling the pressure*, New Zealand Police Association, *Police News*, September 2006, at p 210.

Unallocated files

261. There were two statements in the article that centred on the issue of “unallocated” child abuse files. The first was that “in some districts there may be as many as 200 unallocated child abuse files”. However, later in the article it was stated:⁴⁹

“Police News inquiries suggest there may be several hundred unallocated child abuse files nationwide. Because districts handle files in different ways, some files are not ‘officially’ unallocated but neither are they actually being worked on. They seem to fall in a No Man’s Land between being allocated and being active and that typically goes back to resourcing.

Child Abuse Teams echo the recently released Police Association CIB survey when they say that they get very good support from their internal CIB management... but that they generally feel as if there is little understanding or support from top level Police management about the extent of the problem.”

262. As discussed above, the national survey of all 12 Police districts that was undertaken by PNHQ towards the end of August 2006 and collated by Detective Superintendent van der Velde, found approximately 225 files nationwide had been categorised as “unallocated”. This data contradicted the first statement suggesting that some districts may have had as many as 200 unallocated files, although it is important to note that it was an explicit finding of the national survey that there was variation across districts as to what constituted an “unallocated” file.

263. The *Police News* went on to state that the existence of unallocated files created a high risk area. Detective Sergeant Penny noted that systems and processes must be in place to ensure file prioritisation, and that such prioritisation was regularly reviewed. However, Detective Sergeant Penny stated that even with “the most sturdy of processes in place” there is still a risk of error.

264. The existence of protocols within the Police as well as inter-agency agreements was recognised, however, it was noted that breaches sometimes occurred because child abuse files could not be handled in what such protocols referred to as a “timely manner”.

265. The article explained that some child abuse team staff were “ring fenced” while others were not, and highlighted the concern about staff being seconded to work on other CIB

⁴⁹ *Child Abuse Teams feeling the pressure*, New Zealand Police Association, *Police News*, September 2006, at p 210. During 2006, the Police Association had conducted a survey across the Auckland region that examined the environment of CIB work generally, rather than child abuse.

investigations such as homicides and aggravated robberies which diverted them from child abuse inquiries.

266. The pressures surrounding child abuse investigations was an issue known to both District Commanders and staff at PNHQ. Some of the pressure was regarded as being due to an increase in reporting and was viewed as an outcome of an improved joint agency approach. However, the overall pressure of the circumstances faced by Police staff working on child abuse investigation files was acknowledged by Deputy Commissioner Pope:

“He readily admits that for Police National HQ and districts it is a “challenge” to ensure that CAT investigators are supported in the face of what he terms “competing priorities”.

Pope says that he is aware that many staff are working “under difficult circumstances in the area of child abuse”. He gave an assurance to the Association that there will be “ongoing discussions with District Commanders in terms of an appropriate response to the concerns of staff”.

267. The article concluded with an explanation about the recent appointment of a National Coordinator of child abuse, a role based at PNHQ in Wellington. The role was described as one that required close liaison with the National Crime Manager who, in turn, liaised with District Commanders and the Crime Services Managers within their respective districts.

Police Executive Statement

268. On the same day the *Police News* articles were published, 6 September 2006, and following the receipt of the information provided by the 12 Police districts, a statement was published on the Police website headed “Child Abuse Top Priority for Police”. The media release began with an opening statement by Acting Deputy Commissioner Marshall:⁵⁰

“Child abuse is a top priority for the New Zealand Police says Acting Deputy Commissioner Operations, Peter Marshall.

Police have systems in place to prioritise and manage incidents of suspected child abuse and in all districts these systems are being managed appropriately.

⁵⁰ *Child Abuse Top Priority for Police*, 6 September 2006, 08:57, New Zealand Police website, www.nzpolice.govt.nz

This means that all reported complaints of child abuse are looked at and prioritised in accordance with Police protocols.

"We have capacity to deal with child abuse cases and every district does so in an ongoing, informed way in collaboration with appropriate Government agencies." Mr Marshall says."

269. The media release expressly recognised the pressures on front line staff and that some districts had an issue with the case load of detectives and where this was occurring a response was being made at the district level to alleviate the pressure. Acting Deputy Commissioner Marshall concluded the media release by stating:

"Property crime does not take higher priority than child abuse cases. Police prioritise their work according to threat to safety. Any threat to the safety of a child would take top priority in any police station in the country."

Other media articles

New Zealand Herald; Dominion Post

270. *The New Zealand Herald* published an article on 6 September 2006 headed "Police Defend Handling of Child Abuse Cases" and contained excerpts from the article contained in the *Police News* that discussed the pressures described by child abuse investigation staff as well as excerpts taken from the Police website.

271. Similarly, the *Dominion Post* ran an article the same day that also drew on the same sources and was published under the banner headline "Child Abuse Swamps Police" with the subheading "Fears of another high profile tragedy as caseloads pile up".⁵¹

Wairarapa Times-Age

272. The following day, 7 September 2006, the *Wairarapa Times-Age* published an article headed "Extra staff needed as police battle abuse backlog".

273. Inspector Johnston, Area Commander Wairarapa was quoted in relation to the workload held by Detective Mackle at Masterton. He disputed the accuracy of the

⁵¹ *New Zealand Herald*, "Police Defend Handling of Child Abuse Cases" 6 September 2006; *Dominion Post* "Child Abuse Swamps Police", 6 September 2006. The assertion that some districts held 200 unallocated files, and the fact this was refuted by Police National Headquarters, was repeated in both articles.

reports that Detective Mackle was swamped with unresolved cases and had “an overwhelming caseload of 100 files”. Inspector Johnston stated:⁵²

“There are now 25 to 30 live files with us, not 100. That is inaccurate.”

274. It is apparent that in making this statement Inspector Johnston relied on the advice provided to him from Detective Sergeant McHattie, including the file numbers contained in Detective Sergeant McHattie’s email dated 4 September 2006.

Email to District Commanders (8 September 2006)

275. On 8 September 2006, Acting Deputy Commissioner Marshall emailed District Commanders about feedback he had received during that week at the National CAT Managers Conference. Acting Deputy Commissioner Marshall had met with conference participants on two occasions during the week and noted that a number of recommendations had arisen from the conference. He recorded the consensus reached at the conference that current issues would not be solved by additional staff and summarised the recommendations as focussing on two main areas: file management; and enhanced inter-agency cooperation.

276. The remainder of the email message centred on the specific topic of child abuse investigators and their obligations in terms of “duty roster” requirements within the CIB. The requirements varied across the 12 Police districts with some requiring the duty to be completed over a weekend or undertaken over a full week.

277. Acting Deputy Commissioner Marshall noted that there was general agreement that child abuse staff members should contribute to the duty roster and, further, that they themselves welcomed the continuation of that obligation.

“They recognise it as a very healthy “circuit breaker” from their normal duties and an opportunity for them to interact with other investigative and generalist personnel..... Having said that, there was mutual disquiet about the philosophy and practice in some districts of having CAT personnel return from their “duty roster” and being required to retain investigation files...that required commitment over and above the specialised nature and workload of their current child abuse obligations... they also emphasised that any child abuse files, arising during any particular duty week, naturally went back to the CAT office without being diverted.”

⁵² “Extra staff needed as police battle abuse backlog”, *Wairarapa Times-Age*, 7 September 2006. This matter was also noted in the Part I Report at page 91, para 343.

278. Acting Deputy Commissioner Marshall advised that he had undertaken to communicate with each District Commander to see whether there might be any latitude in terms of this particular issue. In particular, the query was whether there could be a firm arrangement whereby child abuse investigators were relieved of investigation files immediately after their “duty roster” obligations were complete. The significant increase in the number of child abuse investigation files was highlighted: there were 1,600 child abuse files in 2004/2005, compared with over 3,000 files for the period 2005/2006.

279. Acting Deputy Commissioner Marshall advised that he sought to give the relevant managers within each district a specific answer, channelled through the National Manager: Crime, and the National Coordinator: Adult Sexual Assault & Child Abuse. He sought a response within seven days.

Responses

280. Six of the 12 Police districts provided a response to PNHQ: Waitemata; Counties Manukau; Waikato; Bay of Plenty; Eastern; and Central.⁵³

281. Counties Manukau District was the only district where staff working on child abuse investigations were not called out or placed on a duty roster, due to there being 24-hour Crime Car coverage within the district. The responses provided by the remaining districts were variable, with some districts advising that child abuse staff were placed on the duty roster, some districts advising that this occurred in only some areas within the district, and one district (Bay of Plenty) providing no specific answer but instead stating that the district was attending to the issue.

Wellington District response

282. It appears that no formal response was returned from Wellington District direct to PNHQ. Instead, there was email correspondence about the issue within Wellington District.

283. On 8 September 2006, Superintendent Trappitt, Acting District Commander Wellington, emailed Detective Inspector Quinn, District Crime Services Manager, with a copy of the email from Acting Deputy Commissioner Marshall.

⁵³ Six districts provided a response; three districts conducted discussions within their district (Auckland City; Wellington; Southern); and three districts have no information available on this topic (Northland; Tasman; Canterbury).

284. Detective Inspector Quinn responded one week later and advised Superintendent Trappitt that the issues raised “go right to the heart” of the query as to whether a child abuse team should be within an area CIB or not. He noted that there was no immediate or short term solution and that “you can’t have it both ways – they are either part of Area CIB Response or they are not”. He recommended that the situation in Wellington District be established first.
285. Superintendent Trappitt responded in agreement, suggesting that a project be established to allow the district to review systems in an orderly manner.

CAT Managers Working Group (25 October 2006)

286. On 14 September 2006, Steve Plowman, editor of *Police News* emailed Detective Senior Sergeant Holden, National Coordinator: Adult and Child Sexual Abuse, to ask how the National CAT Managers Conference had proceeded and whether some positive initiatives had come out of the conference, such as more staff, funding, or resources.
287. On 15 September 2006, Detective Senior Sergeant Holden emailed staff who had attended the National CAT Managers Conference seeking feedback on a draft letter to the Police Association. The draft letter expressed the support of the conference attendees of those who had spoken to the Police Association and advised that the conference sought to progress file management processes and systems and that a working group was being created to this end.
288. The draft letter was not sent. However, a CAT Managers Working Group (“Working Group”) was established by PNHQ and Detective Senior Sergeant Holden undertook to advise the editor of *Police News* of the positives which emerged from the National CAT Managers Conference.
289. The Working Group met to discuss matters of national policy and process, particularly around file management systems, on 25 October 2006 at PNHQ.⁵⁴
290. The Working Group identified the need to develop a file management system as a priority and discussed the various record keeping systems employed by different districts. It was known that districts used three different methods to record information: manual records; computer spreadsheets; and National Intelligence Application (NIA). The decision was made that the best available tool was NIA which had the potential to deliver file management requirements as it was then. There was a

⁵⁴ The Working Group was comprised of six attendees, four CAT staff from different districts, an information and technology representative from the Royal New Zealand Police College, and the National Manager: Adult & Child Sexual Abuse.

new programme within NIA scheduled for June 2007 which would deliver additional requirements and would assist with file management. The Working Group reached the decision to wait until that occurred.⁵⁵

291. There was also discussion about the type of data required from NIA for the purpose of file management. Furthermore, the different definitions utilised in Auckland for prioritising the status of files was noted, and there was also discussion about the use of a standard referral form for Child, Youth and Family notifications. The possibility of an email referral form was discussed, which was regarded as a form that would enable easy entry into both the Police and Child, Youth and Family data systems.⁵⁶

292. As discussed above, one of the important issues that arose during the canvassing of all 12 Police districts for information about file holdings in order to compile a “snapshot” of child abuse files, was the definition of whether a file was “active” or “unallocated”. The Working Group also discussed the lack of a clear definition of what was meant by the phrase “unallocated” and the possibility of the term “assigned” being used instead. The proposal was discussed that there might be sub-categories of assigned files, for example, those held pending investigation, of those under action which were being investigated, or prosecuted, or awaiting filing.

293. The Working Group identified some short term actions that could be undertaken, including an assessment in relation to the NIA training requirements for child abuse staff, and the need to reassess some district orders, such as an existing Wellington District order whereby sworn staff could not enter data into NIA. The need for an induction training booklet or computer training file was also identified, together with the need to review and update the specialist training course at the Royal New Zealand Police College.

294. The Working Group noted the clear distinction between the phrases “file management” and “case management”:

File Management – a system required by supervisors where file loads, types, dates and brief details can be recorded, assessed and utilised for stats and auditing purposes.

⁵⁵ The proposal to establish a working group had been advised prior to the conference by the National Manager: Adult & Child Sexual Abuse by email.

⁵⁶ The Authority notes that this discussion foreshadowed the current practice that has been adopted for notifications to Child Youth and Family, and Police, as discussed later in this report.

Case Management – a system required by investigators, supervisors, and managers where case details are recorded, the process and case requirements outlined and monitored. These would cater for investigative, operational, prosecution and other requirements but could also collate statistics, audit or research information.

295. Consideration was given to holding another Working Group meeting in January 2007. This did not occur due to the various work and annual leave commitments of members of the Working Group. In the event, the Working Group did not reconvene at all after its meeting in October 2006.
296. On 19 February 2007 a smaller meeting took place between the National Coordinator: Adult and Child Sexual Abuse, and staff from the Information and Technology section (Police I & T) in relation to the roll out of the file management tool being developed within the NIA based programmes. At this meeting it was outlined by Police I & T that, with the scheduled implementation of NIA case management due to occur later in 2007, a proposal by the Working Group to pilot the file management tool in some CAT teams (which had been a proposal put forward at the previous meeting in October 2006) was not required.
297. The 2007 CAT Managers Conference was hosted in Wellington in September 2007 and the agenda items included an update by the National Coordinator: Adult and Child Sexual Abuse on the topic of file management and NIA. Despite the work underway by Police I & T, the use of computer based spreadsheets (Excel spreadsheets) by some CAT teams was discussed at the conference and promoted as an interim measure until the case management system within NIA was available. As the Authority found in its Part 1 Report, Excel spreadsheets were still commonly used by CAT teams at the time of this Inquiry.

Conclusions and findings

Police National Headquarters role in the Wairarapa

298. Senior Police management at PNHQ, up to Deputy Commissioner level, were aware of the backlog of files in the Wairarapa in 2006, and had been provided with Detective Mackle's email and Detective Sergeant Penny's report. The senior management advised the Authority that they expected the backlog would be dealt with by Wellington District, subject to any request made for external assistance.
299. No such request was made by Wellington District. This is in contrast to steps taken at about the same time by Counties Manukau District to deal with a backlog of child abuse investigation files which had accrued in that district. Rather than requesting assistance, the information provided by Wellington District to PNHQ on 31 August 2006 was to the effect that the workload in the Wairarapa Area was under control. Similarly, the Wairarapa Area Commander was reported in the *Wairarapa Times-Age* on 7 September 2006 as saying the area had only "25 to 30 live files".
300. However, the importance of robust audit processes is again highlighted. In 2006 Wellington District failed to meet the minimum standards of service that PNHQ rightly requires should be met. In order to meet its responsibilities, PNHQ must ensure minimum standards of service are met by districts, and that robust auditing processes involving random sampling of files is carried out, both as a matter of routine and as part of the response to identified risks such as the backlog of files in the Wairarapa. This did not occur in respect of the backlog of files in the Wairarapa in 2006.
301. It does not follow from this conclusion that it is PNHQ staff who must be required to carry out auditing involving random sampling of files. At a minimum, however, PNHQ audits must ensure that districts have done so.
302. The backlog of files in the Wairarapa in 2006 presented a significant risk to Police and the child victims, was known to PNHQ, and had a considerable public profile at that time. Yet, there were no audit processes through which PNHQ sought to ascertain from Wellington District whether any checks had been made by someone independent of the Masterton CIB to confirm that the backlog had been resolved or was otherwise being satisfactorily dealt with. The failure by PNHQ to establish such processes as a mandatory requirement for districts was undesirable.

National issues

303. In August 2006, PNHQ was advised by the Police Association that it was preparing an article pointing to problems in the investigation of child abuse files in various parts of New Zealand.

304. PNHQ responded by: conducting a national survey; reporting to districts on the results of that survey and on feedback from CAT Managers at a 2006 conference; and establishing a working group to address file management issues which were seen as critical to ensure that child abuse files were appropriately investigated.
305. The information received from districts, while confirming the pressure of increasing workloads on front line staff, provided assurances that protocols were complied with and that there were no districts which were overburdened with unallocated files. The Police response to media coverage in September 2006 reflected those assurances.
306. This Inquiry has shown the difficulty in relying solely on information provided by districts in 2006:
- Inconsistency in file management processes meant that information about file numbers could not be safely relied on in all cases. File management issues were addressed in the Authority's Part I Report, Chapter 4.
 - Self-reported information could not be safely relied on in all cases, as events in the Wairarapa have shown.
307. The Authority concluded in its Part I Report that Police did not require random sampling of files as part of an audit and assurance process, and recommended that such processes be established. Had these processes been in place in 2006 Police would have had the opportunity to test the information received from districts against objective data gathered as part of audit and assurance processes. This Inquiry has demonstrated that the absence of random sampling of files as part of audit and assurance policy is undesirable. This is a matter Police are addressing as part of the response to the Authority's Part I Report, as set out in the following chapters.
308. Even without data gathered through file sampling, PNHQ had information available to it which demonstrated the inconsistency between approaches to file management. This issue was referred to in Detective Superintendent van der Velde's email of 2 September 2006 to District Commanders, although PNHQ was clearly unaware of the scale or severity of the problems. Addressing this inconsistency was a key objective of the Working Group established following Acting Deputy Commissioner Marshall and Detective Superintendent van der Velde's attendance at the National CAT Managers Conference in 2006.
309. Unfortunately, the CAT Managers Working Group met only once and did not reconvene. As noted above, consideration was given to holding a second meeting in January 2007 but that did not occur and a different meeting was instead held in February 2007, which confirmed the anticipated roll out within NIA in 2007. In addition, a new fully supported case management programme, which was discussed in detail in the Authority's Part I

report, was being developed around this time. It appears that the convergence of these events subsumed the work it was anticipated the CAT Managers Working Group would carry out, or have involvement with, during 2007.

310. The failure to ensure the Working Group reconvened and continued its work in 2007 was undesirable and should not have been allowed to occur. The Working Group consisted of highly experienced child abuse investigators who are experts in their field. The following chapter in this report addresses child abuse investigation files identified nationally through district reviews, where minimum standards were not met. The Working Group identified, albeit in a preliminary way, a number of positive initiatives which, if they had been developed and implemented, would have improved the service provided by Police in the investigation of many of the files identified in the district reviews.

311. Although a number of the issues being examined by the Working Group would be addressed by NIA Case Management, full implementation of NIA Case Management was always going to be a lengthy process, justifying interim measures being examined and overseen by the Working Group in the interim. Furthermore, the Working Group was addressing issues which were beyond the scope of work being undertaken by Police I&T, such as the way in which referrals from CYF were received and processed, training for child abuse staff in the use of NIA, and standardising key definitions. Finally, the ongoing input of the Working Group in the development of NIA case management would likely have facilitated enhancements of the kind which have arisen out of this Inquiry, such as ensuring all files involving child victims are noted as such and that offender risk forms a key part of the prioritisation matrix in case management.

312. By failing to ensure the Working Group reconvened, the momentum which had been generated during late 2006 was lost. As a result, initiatives which would have ensured greater consistency in the investigation of child abuse files nationally were not developed until after the Authority reported on Part I of its Inquiry.

313. PNHQ is now in the process of implementing a substantial number of changes designed to achieve a uniformly high standard of service throughout New Zealand, following the Part I Report. These changes will be discussed in the final chapters of this report.



Chapter Six: Review of Police Districts “At Risk” Files

INDEPENDENT POLICE CONDUCT AUTHORITY

Operation Scope

314. After the Authority received notification in June 2009 of the situation in the Wairarapa, the Authority’s immediate concern was to ensure that there was no ongoing risk to victims. The Authority wrote to the Commissioner expressing the need for a review of all Police Districts and Operation Scope was commenced to undertake that national review.
315. This chapter provides an overview of the files audited by Operation Scope during its review of all 12 Police districts, and discusses additional files that were identified during a second, more comprehensive computer based search that was initiated by Operation River during the course of 2010. The discussion focuses on two specific groups of files: a group of files audited during Operation Scope that had identifiable investigative shortcomings requiring further action; and a group of files audited by Operation River that did not necessarily have similar shortcomings but which, nevertheless, were not satisfactorily accounted for and needed confirmation about their status.
316. The discussion begins with a summary of Operation Scope, and sets out the terms of reference. The information discussed in this chapter demonstrates that failures in investigation of child abuse were not limited to the Wairarapa Area but occurred in a number of districts through the country. Police Districts have acted promptly to remedy these shortcomings on the files identified through the district reviews carried out by Operation Scope.

Timeline of Operation Scope

317. The Authority was notified in June 2009 about the backlog of files in the Wairarapa which resulted in Operation Hope. The Authority wrote to the Commissioner of Police the following month, July 2009, expressing the need for an urgent audit of child abuse investigations in all other districts. This was subsequently undertaken by Police as Operation Scope.

318. Operation Scope began in August 2009. It was established as a national operation to conduct an audit of child abuse files held in all 12 Police districts.⁵⁷ Four districts underwent a comprehensive review of matters pertaining to child abuse allegations, including interviews with child abuse investigation staff from groups within Police, relationships within the district between Police and partner agencies such as Child, Youth Family and the district health board. The remaining eight districts were subject to the same review except that interviews were not conducted with focus groups and partner agencies.⁵⁸

319. Operation Scope had three phases of district reviews which spanned August 2009 - February 2010 (excluding preparation of reports).

Phase 1 (August 2009)

320. The first phase was executed by means of a survey which required districts to audit child abuse file workloads and the quality of those investigations. The request was aimed at providing an assurance to the Police Executive that child abuse investigations were being appropriately assessed for risk, prioritised, and progressed. The Police Executive decided that the survey would be followed by a physical audit of files which would be undertaken on a national basis.⁵⁹

Phase 2 (September 2009 – February 2010)

321. The second phase included the in-depth assessment of four districts, Northland, Eastern, Auckland City and Canterbury. The districts were selected on the basis that they represented a range of populations: two districts being representative of metropolitan populations (Auckland City and Canterbury); and two districts representative of smaller suburban and rural populations (Northland and Eastern).

322. The approach adopted for district assessments included an examination of sample child abuse investigation files, some of which were active and some of which had been filed. The purpose of such “dip sampling” was to assess the quality and effectiveness of investigations from the start of the investigation, through to the closure of the file.

⁵⁷ Operation River was launched to examine the “whole of Police response to child abuse investigations”. One of the directives from the Police Executive was to conduct a national audit and it was Operation Scope that was launched as a work stream under Operation River for the purpose of conducting the audit.

⁵⁸ The four districts that underwent comprehensive reviews were: Northland District; Eastern District; Canterbury District; and Auckland City District. The account of two districts, Northland District and Eastern District, was set out in some detail in the Part I Report at p 93, paras 356 -366 and p 95, paras 367-390.

⁵⁹ *Operation Scope: Summary of Key Findings and Remedial Actions Taken*, G Jones, 1 September 2010, p 15, at paras 16-18.

323. Each file review involved the use of a file checklist based on two existing documents: the *Policy and guidelines for the investigation of child sexual abuse and serious physical abuse (1995/12)*; and the protocol between Police and Child, Youth and Family known as the *CAT/SAT Protocol*.⁶⁰

324. The Operation Scope team also conducted interviews with key Police staff working on child abuse investigations, and meetings were held with Police staff from operational work groups in order to gain a broader understanding of practical issues and challenges relating to child abuse investigations. Additional interviews were also conducted with representatives from partner agencies, such as Child, Youth and Family, and District Health Boards. In some districts the Operation Scope team also consulted the Office of the Crown Solicitor.

Phase 3 (February 2010)

325. The remaining eight districts were visited by teams over a two-week period during February 2010. The composition of these teams varied. In most cases, the district assessment teams included a number of specialists including at least one member who was experienced in child abuse investigations, an advisor from the Police Organisational Assurance Group (OAG) and a performance analyst.⁶¹ However during the visits to Waitemata and Southern Districts, the teams did not include an advisor from OAG or a performance analyst. The review process for these remaining eight districts had two notable differences from the process that had been undertaken for Northland, Eastern, Auckland City and Canterbury Districts.

326. The eight districts were reviewed on a condensed basis. The review of files, both active and filed, was conducted in exactly the same way as for the comprehensive reviews. Interviews with key Police staff involved in child abuse investigation were also conducted, including: District Commander, District Crime Manager, O/C Child Abuse Team(s) or the CIB Squad Supervisor(s). However, focus groups and interviews with partner agency representatives were not undertaken. Consequently, the review in February 2010 was less comprehensive overall, but did involve the essential process of a physical file audit in each district.⁶² The second difference was the improvement of file

⁶⁰ Both documents were referred to in the Part I Report.

⁶¹ *Operation Scope: Summary of Key Findings and Remedial Actions Taken*, G Jones, 1 September 2010, p 16, para 23. It was noted that there were constraints such as limited planning time, the absence of specific file information and no clearly defined outcome measures, which initially impacted Operation Scope. Further, it was noted at p 17, paragraph 28 that these matters were improved during the course of Operation Scope and although different approaches existed between phases two and three which meant there was limited value in making comparisons between districts, the information was regarded as useful in terms of a national picture.

⁶² Part I Report at p 133, paragraph 530.

information available to the Operation Scope team through the use of a refined search process.⁶³

Terms of Reference for Operation Scope:

327. The terms of reference for Operation Scope were finalised in November 2009.⁶⁴

- a) To examine and assess the current national policy in relation to the reporting, investigation and prosecution of child abuse files to determine whether or not the policy meets with international best practices and adequately addresses child protection issues.
- b) To consider whether the District response matched the risk to victims and whether decisions were made in a timely manner in order to mitigate risk.
- c) To provide assurance that all Districts are fulfilling their obligations under the following key response areas: Victims, Management, Structure, Resource (both human and equipment), Partnerships, File management.
- d) To provide recommendations, for the measurement and monitoring process that will allow ongoing national oversight and assurance, at the completion of district audits.
- e) To identify any breaches of policy, including the delivery of ongoing psychological assessment and support for personnel exposed to child abuse investigations.
- f) To identify strategic opportunities in relation to command and control, risk assessment and assurance as it relates to child abuse investigations and the oversight of CAT units.
- g) Not to conduct any employment investigations under the Code of Conduct provisions.
- h) To document and report on findings, including clear conclusions and recommendations regarding any identified deficiencies or potential improvements in practice, policy or procedure.

⁶³ *Operation Scope: Summary of Key Findings and Remedial Actions Taken*, G Jones, 1 September 2010, p 16, paras 24, 25. A Business Objects search was undertaken on 22 January 2010 and from this date forward, it was the Business Objects file information that became the basis for the file reconciliation process during Operation Scope.

⁶⁴ The terms of reference were issued in August 2009 and revised in November 2009. The final terms of reference are those set out above.

Operation Scope reports received for all 12 districts

328. At the time of issuing its Part I Report the Authority had received written reports from Operation Scope in relation to some districts only, with the remaining reports drafted but not yet finalised. The Authority has since received final reports for all 12 Police districts.⁶⁵

Operation Scope “186 files”

329. The Police receive and investigate approximately 5,000 cases of serious child abuse each year, which is a preliminary point that provides some context for the files that are the central focus of this chapter.⁶⁶ During the course of its national operation, Operation Scope reviewed and assessed 2,752 child abuse files. The discussion below is focused on a specific number of files, 186 files, within that total.

330. The 186 files were found to be sub-standard and were referred back to districts for remedial action. It is this group of 186 files that has been described during this Inquiry variously as the “at risk” files, or “the 186” files.

331. The primary reasons for the referral back to districts included:

- Undue investigative delay
- All avenues of enquiry not explored or completed
- Improper filing (including failure to address administrative requirements)
- File unable to be located/assessed
- Administrative shortcomings which included files having inadequate documentation

332. The majority of the group of 186 files involved sexual offending against children. The Operation Scope Summary Report noted:

Of the 186 files, 130 were sexual offending, 153 where the victim was a child at the time of the offence and in 128 cases the identified perpetrator was a member of the victim’s immediate and wider family.

⁶⁵ Part I Report at pp 93-95.

⁶⁶ New Zealand Police, *Annual Report 2009/10*, p 2. The figure is reported at a slightly lower level of 4,000-4,500 in *Operation Scope: Summary of Key Findings and Remedial Actions Taken*, G Jones, 1 September 2010, p 41.

333. In the discussion below, each district is examined individually. A short description is provided of the number and type of files which required further attention, and a summary of the updated position provided to the Authority about the status of those files.
334. During the course of conducting district reviews, Operation Scope teams held “Categorisation Meetings” at the end of each district audit. These were meetings to discuss the level of risk associated with files identified as having investigative shortcomings. Files where such failures were evident were then categorised as needing followup with the staff member responsible for the file, by way of either a “Code of Conduct” or “Informal Intervention” process.
335. In broad terms, serious investigative failures fell within the category of Code of Conduct and involved an internal Police employment investigation into the conduct of the relevant staff member. By contrast, files that were not at such a serious level of concern fell within the category of Informal Intervention and were not disciplinary in nature, but were instead addressed informally, for example, by way of further training.
336. It is not the purpose of this Inquiry to examine the employment processes adopted by Police. The information is provided by way of background to assist the reader in understanding the information provided by Operation Scope which is referred to in this report.

Additional Audit “346 files”

337. The discussion also includes a reference to a group of “346 files” being a separate audit undertaken by Operation Scope. This second audit employed broader search processes in order to capture all investigation files involving children, and identified a total of 4,530 files. The search was undertaken on 22 January 2010 and covered a 25 year period up until that date. It provided a more comprehensive means of searching for all files that involved children as victims.
338. Operation Scope identified a total of 7,282 files, and 2,752 of these files were physically reviewed. This comprised 2,197 active files, and 555 files that had been filed. The remaining 4,530 files were reviewed electronically, via NIA.
339. Of the 4,530 files reviewed electronically, Operation Scope identified 346 files that did not have sufficient information in NIA to provide assurance that the care and protection

issues had been addressed and an appropriate investigation had occurred. Districts were therefore requested to provide further information about those files.⁶⁷

340. Districts were asked to undertake inquiries to provide sufficient information to give confidence that the files had been satisfactorily addressed and accounted for by staff.⁶⁸

The second audit was an initiative driven by the Operation River team in order to achieve this level of confidence. It is important to emphasise that this request of districts did not mean that files had not been investigated adequately, but rather that the information available through NIA and the reconciliation process had not provided a sufficient level of detail to give assurance.

341. The Authority has included a commentary in relation to the status of the 346 files for each of the 12 Police districts in the discussion set out below.

342. The Authority has been advised that Police commenced a total of 18 Code of Conduct Investigations arising out of Operation Hope and Operation Scope. Five employees have been cleared of any misconduct and have been dealt with through informal processes. Six more investigations have been completed, and Police are awaiting the completion of a further seven. At the completion of all investigations decisions will then be made by the National Disciplinary Committee.

343. Police have further advised the Authority that 67 employees are subject to Informal Intervention arising out of Operation Hope and Operation Scope.

NORTHLAND DISTRICT

Operation Scope Files (186 Files)

344. Operation Scope began by conducting a visit and review of Northland District child abuse investigations. The Operation Scope team visited during 28 September to 2 October 2009. A written report was rendered the following month in November 2009, *Operation Scope Child Abuse Investigation Review, Northland District*.⁶⁹

⁶⁷ Districts were requested to provide the information to the Child Protection Implementation Project Team. *Operation Scope: Summary of Key Findings and Remedial Actions Taken*, G Jones, 1 September 2010, at p 21. It was noted at p 32, that as at 23 August 2010, 133 of the 186 cases had been resolved, and 193 of the 346 cases had been resolved.

⁶⁸ *Operation Scope Summary of Key Findings and Remedial Actions Taken*, G Jones, 1 September 2010, at p 4. The District Status Reports provided by all 12 Police districts showed the groups as "186 files" and "346 files". The Authority notes that some documents show the larger group as "346 files".

⁶⁹ *Operation Scope Child Abuse Investigation Review Northland District*, November 2009.

345. The report noted that the Northland District comprises two areas: Whangarei and the Far North. There is one dedicated Child Abuse Team in the Whangarei Station, with other child abuse files being held in four satellite stations: Dargaville, Kaitaia, Kerikeri and Kaikohe.

346. The actual number of child abuse files reviewed by the Operation Scope team was not recorded in the report. When the Operation Scope team began district visits towards the end of 2009 the team did not have available to it, information provided by means of a Business Objects search. Instead, file data was collated from various sources including NIA and the physical files produced at the time of inspection during the Operation Scope visit.⁷⁰

347. A later review of information about the Northland District visit confirmed that a total of 127 files had been reviewed, with four files being described as files where some delays were evident. Two child abuse investigation files were referred for “Informal Intervention”.

348. The two files were both sexual abuse files that involved historic complaints. One file involved a false complaint made by a young person who has since stated that she merely wanted to avoid living in a certain household. The second file had insufficient evidence to proceed. The Authority was advised that the files were able to be filed following some directed inquiries and improved reporting requirements.

Additional audit (346 Files)

349. Northland District had 64 files in this category; the Authority was advised on 28 January 2011 that 63 of these files had been resolved and the remaining 1 required final resolution.

AUCKLAND CITY DISTRICT

Operation Scope Files (186 Files)

350. Operation Scope conducted its review of Auckland City District during February 2010 and a written report was rendered in April 2010, *Operation Scope Child Abuse Investigation Review, Auckland City District*.⁷¹

⁷⁰ The first three district visits of Northland, Eastern, and Auckland City did not utilise the Business Objects search method which was introduced to Operation Scope for the remaining district visits.

⁷¹ *Operation Scope Child Abuse Investigation Review Auckland City District*, April 2010.

351. The report noted that Auckland City District has three areas: Central; East; and West. Auckland City District is regarded as a “model” district and has a centralised unit known as “Puawaitahi” that is well resourced and is described as the “flagship” inter-agency centre for New Zealand.

352. The Operation Scope team undertook an audit of 144 files and found no files that required any action. No files were put forward for the Categorisation Meeting (meeting held to discuss the level of risk and problems associated with such files) and a consequence no Informal Interventions or Code of Conduct matters arose for Auckland City District.

Additional audit (346 Files)

353. Auckland City District had two files in this category; the Authority was advised on 28 January 2011 that both of these files had been resolved.

WAITEMATA DISTRICT

Operation Scope Files (186 Files)

354. Operation Scope conducted its review of Waitemata District during February 2010 and a written report was rendered in March 2010, *Operation Scope Child Abuse Investigation Review, Waitemata District*.⁷²

355. The report noted that Waitemata District has three areas: Rodney; North Shore; and Waitakere. Two of the areas, North Shore and Waitakere have Child Abuse Teams, while Rodney has no dedicated team.

356. The Operation Scope team undertook an audit of 316 files and eight files were put forward for the Categorisation Meeting: Four files were referred for Informal Intervention; four files were referred as Code of Conduct matters.

357. The Informal Intervention files involved sexual assault complaints, with one recent case and three historic files. Two of the historic files dated from 2005, with one file having multiple victims in various cities. The other file was unable to be located although it was established that there had been an evidential interview conducted, there were no other investigative steps recorded.

358. The Code of Conduct matters were comprised of one historic physical assault file dating from 2008 and three sexual assault files dating from 2007. All files were of concern

⁷² *Operation Scope Child Abuse Investigation Review Waitemata District*, March 2010.

because of time delays and Police inaction; however, all four files have since been resolved, with one case resulting in criminal charges.

Additional audit (346 Files)

359. Waitemata District had 62 files in this category; the Authority was advised on 28 January 2011 that 49 of these files had been resolved and the remaining 13 required final resolution.

COUNTIES MANUKAU DISTRICT

Operation Scope Files (186 Files)

360. Operation Scope conducted its review of Counties Manukau District during February 2010 and a written report was rendered in April 2010, *Operation Scope Child Abuse Investigation Review, Counties Manukau District*.⁷³

361. The report noted that Counties Manukau District, like Auckland City District, is regarded as a “model” district. At the time of the Operation Scope visit there were centralised Child Abuse Teams, however, a new multi-agency centre “Te Pou Herenga Waka” opened on 17 May 2010.

362. The Operation Scope team undertook an audit of 144 files and found no files that required any action. No files were put forward for the Categorisation Meeting, referred for Informal Intervention, or referred as Code of Conduct matters.

Additional audit (346 Files)

363. Counties Manukau District had six files in this category; the Authority was advised on 28 January 2011 that all of these files had been resolved.

WAIKATO DISTRICT

Operation Scope Files (186 Files)

364. Operation Scope conducted its review of Waikato District during February 2010 and a written report was rendered in June 2010, *Operation Scope Child Abuse Investigation Review, Waikato District*.⁷⁴

⁷³ *Operation Scope Child Abuse Investigation Review Counties Manukau District*, April 2010.

⁷⁴ *Operation Scope Child Abuse Investigation Review Waikato District*, June 2010.

365. The report noted that Waikato District has three areas: Hamilton; Waikato East; and Waikato West, with only Hamilton having a dedicated Child Abuse Team.
366. The Operation Scope team undertook an audit of 233 files and 57 files were put forward for the Categorisation Meeting: 27 files were referred for Informal Intervention; 30 files were referred as Code of Conduct matters.⁷⁵
367. In relation to the 27 files referred for Informal Intervention, the investigation files involved both historic and recent complaints and were comprised of five physical assault matters and 22 sexual assault files. The files dated from 2006 and are too numerous to summarise easily, however, most concerns related to time delays and Police inaction. One file was noted to have been resolved inappropriately through the “Differential Response Model”.⁷⁶ The remaining concerns were inadequate documentation, and administrative shortcomings.
368. In relation to the 30 Code of Conduct matters, the files involved both historic and recent complaints and were comprised of ten physical assault matters and 20 sexual assault files. One file dated from 2004, two files dated from 2006 and the remainder spanned 2007-2010. As with the files referred for Informal Intervention, many of the Code of Conduct files had time delays and incomplete investigations. However, several of the Code of Conduct files had been filed without any investigation undertaken.

Waikato District internal audit

369. In relation to the concern about files having been filed inappropriately, or without any inquiries, it is worth noting that Waikato District undertook its own additional audit to address this issue. Of the 186 files referred back to districts for follow up, 146 were active files and 40 were filed cases. Waikato District had 21 of the 40 filed cases, which represented 70% of that group of cases. Consequently, Waikato District instigated a 3-year audit of all filed cases.⁷⁷
370. The Authority was advised that all 57 files identified in Waikato District had either been resolved, or were under active investigation and oversight. Of the 57 files, 49 of those

⁷⁵ The Operation Scope report recorded that 61 files were put forward for the Categorisation Meeting, however, that figure was later corrected to 57 files.

⁷⁶ The “Differential Response Model” is a process utilised by Child Youth and Family to assess prioritisation of files. It was adopted by Waikato District for the overall purpose of coping with file workload and volume. Some child abuse investigation files that were designated as lower level offending were dealt with outside of investigative teams and, in some instances, assigned to a Community Constable. Operation Scope, and inquiries made by the Authority, elicited concerns about the Differential Response Model and it was found that Waikato District was the only district utilising such an approach, which has since been abandoned.

⁷⁷ *Operation Scope Summary of Key Findings and Remedial Actions Taken*, G Jones, 1 September 2010, at p 21.

had been completed by 28 January 2011, and the remaining eight required final resolution.

Additional audit (346 Files)

371. Waikato District had 39 files in this category; the Authority was advised on 28 January 2011 that 32 of these files had been resolved and the remaining seven files were in the process of resolution.

BAY OF PLENTY DISTRICT

Operation Scope Files (186 Files)

372. Operation Scope conducted its review of Bay of Plenty District during February 2010 and a written report was rendered in May 2010, *Operation Scope Child Abuse Investigation Review, Bay of Plenty District*.⁷⁸

373. The report noted that Bay of Plenty District has four areas: Eastern; Rotorua; Taupo and Western; and a new multi agency centre has recently opened in Tauranga.

374. The Operation Scope team undertook an audit of 374 files and 42 files were put forward for the Categorisation Meeting: 23 files were referred for Informal Intervention; 19 files were referred as Code of Conduct matters.⁷⁹

375. In relation to the 23 files referred for Informal Intervention, the matters involved both historic and recent complaints, eight of which were physical assault files and 15 of which were sexual assault files.

376. One sexual assault file dated from 1999 and the state of investigation could not be ascertained as the file was eventually recorded as lost in 2007. One file dated from 2004 and was discovered within the documentation of another, unrelated, file dating from 2009. The remaining files dated from 2006-2010.

377. Most files were of concern for time delays and Police inaction, including a file where an offender had disclosed sexual offending against a family member, but which remained without any investigation for 11 months. The remaining files were of concern for administrative shortcomings.

⁷⁸ *Operation Scope Child Abuse Investigation Review Bay of Plenty District, May 2010.*

⁷⁹ The Operation Scope report recorded that 39 files were put forward for the Categorisation Meeting, although that figure was later corrected upwards to 42 files. However, the Bay of Plenty District itself reported in its District Status Report provided to the Authority that it had 45 files identified during Operation Scope.

378. The 19 files referred as Code of Conduct matters involved both historic and recent complaints, eight of which were physical assault files and 11 of which were sexual assault files.

379. Again, most concerns related to delays and little investigative work, or no record of such investigative action. One sexual assault file dated from 2002 and showed no work from 2003 to 2008, with the victim being contacted in 2009 at which time she stated she did not wish to pursue the matter. The alleged offender was never spoken to by investigators.

380. The Authority was advised that 42 files identified in Bay of Plenty District had either been resolved, or were under active investigation and oversight. Of the 42 files, 38 had been completed by 28 January 2011, and the remaining four required final resolution.

Additional audit (346 Files)

381. Bay of Plenty District had 18 files in this category; the Authority was advised on 28 January 2011 that 14 of these files had been resolved and the remaining four were the subject of ongoing reporting and monitoring at both area and district level.

CENTRAL DISTRICT

Operation Scope Files (186 Files)

382. Operation Scope conducted its review of Central District during February 2010 and a written report was rendered in June 2010, *Operation Scope Child Abuse Investigation Review, Central District*.⁸⁰

383. The report noted that Central District has six areas: Palmerston North (City); Palmerston North (Rural); Wanganui; Ruapehu; Taranaki; and New Plymouth.

384. The Operation Scope team undertook an audit of 302 files and put 26 files forward for the Categorisation Meeting: 19 files were referred for Informal Intervention; seven files were referred as Code of Conduct matters.

385. The 19 Informal Intervention matters involved both historic and recent complaints and were comprised of ten physical assault files and nine sexual assault files. Among these files was a sexual assault file involving multiple victims that dated from 1996. There was nothing to assist Operation Scope investigators to explain the delay.

⁸⁰ *Operation Scope Child Abuse Investigation Review Central District*, June 2010.

386. There was also a sexual assault file dating from 2002 where there had been an eight year delay, but nevertheless resulted in an offender being charged. A file dating from 2003 had been inactivated in 2005, was reactivated in 2009 prior to Operation Scope, and was ultimately resolved without prosecution.

387. The seven Code of Conduct matters also involved both historic and recent complaints and were comprised of five physical assault files and four sexual assault files, all of which dated from 2009 and 2010. Some of the files were identified as being of concern because the records on file did not show whether the child was safe, or the investigative steps that were presumed to have occurred.

388. The Authority was advised all 26 files had been resolved by 28 January 2011.

Additional audit (346 Files)

389. Central District had 9 files in this category; the Authority was advised on 28 January 2011 that all of these files had been resolved.

EASTERN DISTRICT

Operation Scope Files (186 Files)

390. Operation Scope conducted its review of Eastern District during November 2009 and a written report was rendered in February 2010, *Operation Scope Child Abuse Investigation Review, Eastern District*.⁸¹

391. The report noted that Eastern District has three areas: Hastings; Napier; and Gisborne. Each of the three areas has its own dedicated Child Abuse Team.

392. The Operation Scope team undertook an audit of physical files, both active investigation files and also files that had been filed. A total of 150 files were reviewed: 28 physical abuse; 118 sexual abuse; and four other types. The review team put forward 11 files for the Categorisation Meeting: one file was referred for Informal Intervention; ten files were referred as Code of Conduct matters.

393. The file referred for Informal Intervention was a sexual assault file that was a historic complaint. The complaint had been made in August 2005 and although the victim was interviewed at the time, the alleged offender had not been interviewed. Subsequently, the file had been inappropriately filed three years later in February 2008. The file had been coded as a lost file, "LF9999" which was a practice of concern in Eastern District

⁸¹ *Operation Scope Child Abuse Investigation Review Eastern District*, February 2010.

that was identified by the Operation Scope team, and was discussed by the Authority in its Part I Report.

394. The ten files referred as Code of Conduct matters involved one physical abuse complaint and nine sexual abuse complaints, dating from 2005 -2008. The concerns arising from these files related to delays and lack of recording of investigative steps taken. Significantly, all ten files had been filed to “LF9999”. The practice of utilising such a generic coding method is now prohibited and was a prohibition instigated on an urgent basis by the Commissioner.⁸²

395. The Authority was advised that steps have been taken to remedy the shortcomings on the files and, at 28 January 2011, ten of the 11 files had been resolved, with the remaining file being progressed.

Additional audit (346 Files)

396. Eastern District had 16 files in this category; the Authority was advised on 28 January 2011 that 10 of these files had been resolved with the remaining six files being actioned and monitored.

WELLINGTON DISTRICT

Operation Scope Files (186 Files)

397. Operation Scope conducted its review of Wellington District during February 2010 and a written report was rendered in July 2010, *Operation Scope Child Abuse Investigation Review, Wellington District*.⁸³

398. The report noted that Wellington District has five areas: Wellington; Wairarapa; Upper Hutt; Lower Hutt; and Porirua.

399. The Operation Scope team undertook an audit of 283 files and put forward 26 files for the Categorisation Meeting: 23 files were referred for Informal Intervention; the remaining 3 files were Code of Conduct matters that were already being addressed as part of other internal investigations.

400. The 23 Informal Intervention matters involved both historic and recent complaints and were comprised of seven physical assault files and 16 sexual assault files. Two sexual assault files dated from 2004 and 2005 respectively, with the remainder spanning 2006-

⁸² Commissioner’s Action Plan, Commissioner Broad, May 2010.

⁸³ *Operation Scope Child Abuse Investigation Review Wellington District*, July 2010.

2010. The primary concern for most files was undue delay, with only a few files having administrative shortcomings.

Additional audit (346 Files)

401. Wellington District had 39 files in this category; the Authority was advised on 28 January 2011 that 37 of these files had been resolved and the remaining two required final resolution.

TASMAN DISTRICT

Operation Scope Files (186 Files)

402. Operation Scope conducted its review of Tasman District during February 2010 and a written report was rendered in May 2010, *Operation Scope Child Abuse Investigation Review, Tasman District*.⁸⁴

403. The report noted that Tasman District has three areas: Marlborough; Nelson; and West Coast. There are no dedicated Child Abuse Teams and Tasman District deals with child abuse complaints through general CIB squads.

404. The Operation Scope team undertook an audit of 199 files and put forward eight files for the Categorisation Meeting, and all eight files were referred for Informal Intervention. The files involved historic and recent complaints and were comprised of seven sexual assault matters and one physical assault file.

405. Four files dated from 2003: three had poor investigation; one had no Police investigation at all. The remaining four files dated from 2006-2009 and had poor record keeping, for example, no evidence of referrals to Child, Youth and Family.

406. The Authority was advised in September 2010 that no child or young person remained at risk and that all files had been accounted for: two files were active; two files were with Crown Law; two files were with Operation Scope; one file was scheduled for trial in late September 2010; and one file was being assessed for prosecution. The Authority was further advised on 28 January 2011 that all eight had been resolved.

Additional audit (346 Files)

407. Tasman District had seven files in this category; the Authority was advised on 28 January 2011 that all of these files had been resolved.

⁸⁴ *Operation Scope Child Abuse Investigation Review Tasman District*, May 2010.

CANTERBURY DISTRICT

Operation Scope Files (186 Files)

408. Operation Scope conducted its review of Canterbury District during February 2010 and a written report was rendered in April 2010, *Operation Scope Child Abuse Investigation Review, Canterbury District*.⁸⁵
409. The report noted that Canterbury District has four areas: Christchurch; Timaru; Ashburton; and Rangiora. There is one dedicated Child Abuse Team based in Christchurch.
410. The Operation Scope team undertook an audit of physical files, both active investigation files and also files that had been filed. A total of 283 files were reviewed and six files were put forward for the Categorisation Meeting, all of which were referred for Informal Intervention. The matters involved both historic and recent complaints and were all sexual assault files.
411. One file dated from 2004 and related to historic offending, with the last action shown on the file as June 2008. The remaining files dated from 2006-2009 and all suffered from inaction and inadequate investigation. The Authority was advised on 28 January 2011 that five had been resolved and the remaining one file was being progressed.

Additional audit (346 Files)

412. Canterbury District had 67 files in this category; the Authority was advised on 28 January 2011 that 61 of these files had been resolved, and the remaining six required final resolution.

SOUTHERN DISTRICT

Operation Scope Files (186 Files)

413. Operation Scope conducted its review of Southern District during February 2010 and a written report was rendered in April 2010, *Operation Scope Child Abuse Investigation Review, Southern District*.⁸⁶
414. The report noted that Southern District has three areas: Dunedin; Invercargill; and Alexandra. Dunedin and Invercargill have dedicated Child Abuse Teams.

⁸⁵ *Operation Scope Child Abuse Investigation Review Canterbury District*, April 2010.

⁸⁶ *Operation Scope Child Abuse Investigation Review Southern District*, April 2010.

415. The Operation Scope team undertook an audit of 197 files and put three files forward for the Categorisation Meeting, all of which were referred for Informal Intervention. All three files involved sexual abuse, two of which were historic complaints. The files dated from 2008 and 2009 and were described as “over held files”, equating to a lack of action and delay in terms of the investigation. As a consequence, the files were managed by Southern District and their status reported to the Operation Scope team. The Authority was advised on 28 January 2011 that all three files had been resolved.

Additional audit (346 Files)

416. Southern District had 17 files in this category; the Authority was advised on 28 January 2011 that all of these files had been resolved.

Conclusions and findings

417. Operation Scope involved district visits and file audits by experienced officers with particular expertise in child abuse investigations. When it was appreciated that additional searches could provide a second more comprehensive auditing of files, Police ensured these searches were carried out. The Authority is satisfied Police have undertaken a thorough audit of child abuse files nationwide using all tools reasonably available to them.
418. The results of the district reviews demonstrate that delays and other problems in the investigation of child abuse files were not isolated to the Wairarapa, although nowhere else was the problem so acute.
419. The Authority has been advised that Police commenced a total of 18 Code of Conduct Investigations arising out of Operation Hope and Operation Scope. Five employees have been cleared of any misconduct and have been dealt with through informal processes. Six more investigations have been completed, and Police are awaiting the completion of a further seven. At the completion of all investigations decisions will then be made by the National Disciplinary Committee. Police have further advised the Authority that 67 employees are subject to Informal Intervention arising out of Operation Hope and Operation Scope.
420. The Authority's immediate concern upon being notified of the backlog of files in the Wairarapa was to ensure that children were not at risk as a result of Police inaction. By June 2009, when the Authority was notified, Operation Hope was already underway in relation to the Wairarapa backlog. Operation Scope was then established after the Authority wrote to the Commissioner expressing the need for a review of all other districts. Prompt action has been taken by all districts to remedy the shortcomings identified on all the files identified through the district reviews.
421. The delays and other failures identified by Operation Scope demonstrate that victims of child abuse were not receiving a consistent standard of service from Police throughout the country. This is acknowledged by Police through the comprehensive response to Operation Scope and the Authority's Part I Report, which is discussed in the following two chapters. If the changes to practices, policies and procedures proposed as part of the Police response are fully implemented, the Authority is confident this will minimise the risk of similar failures occurring in the future.



Chapter Seven: Review of Police Districts Practice, Policy and Procedure

INDEPENDENT POLICE CONDUCT AUTHORITY

District responses to Operation Scope and the Authority's Part I Report

422. This chapter examines the manner in which districts have addressed issues of practice, policy and procedure relating to child abuse investigations, as identified in the relevant Operation Scope reports and also the Authority's Part I Report.

423. As explained in the previous chapter, the Authority does not propose to traverse the detail of all Operation Scope reports or the extent of all remedial steps taken in all 12 Police districts in response to the findings contained in the Operation Scope reports and the Authority's Part I report.⁸⁷ The Authority has received an extensive volume of documentation about progress in response to those findings.

424. The Authority has also had the benefit of hearing evidence on oath from each of the 12 District Commanders about the steps their districts are taking in response to the district reviews carried out by Operation Scope and the Authority's Part I report. The Authority wishes to record and acknowledge the priority being afforded to these matters by each of the District Commanders.

425. Furthermore, a separate review of Operation Scope was undertaken at the request of Police for the express purpose of providing advice about progress implementing the key findings from Operation Scope, and identifying any residual issues that need to be addressed prior to Operation Scope being closed. A written report, *Operation Scope Summary of Key Findings and Remedial Actions Taken*, was completed on 1 September 2010 (Operation Scope Summary Report).⁸⁸

⁸⁷ The Authority notes that Northland District provided a written response to the Operation Scope report for its district, by means of an internal report from the District Crime Services Manager to the District Commander dated 25 March 2010.

⁸⁸ *Operation Scope Summary of Key Findings and Remedial Actions Taken*, G Jones, 1 September 2010. It was noted at p 4 that the information was current as of 23 August 2010.

426. Against that background, in reporting on the district reviews in this chapter, the Authority will focus on the following key topics:

- Victim contact and follow up
- Forensic (Evidential) Interviews
- Inter-agency relationships
- Case Management
- District Structures
- Audit and Assurance

427. Of necessity, the discussion in this chapter examines key themes for improvement in areas which were not always done well during child abuse investigations across the 12 Police districts. Some districts failed to consistently meet the standards expected in relation to child abuse investigations, which are achievable and have been demonstrated to a high standard in districts such as Auckland, Counties Manukau and Canterbury Districts.

428. This should not detract from the fact that for every district, including those where some deficiencies were identified, the review teams identified a great many positive features. Although a repetition of the positive findings from each district review undertaken by Operation Scope is not the purpose of this chapter, attention should be drawn to the positive commentary within the Operation Scope Summary Report which sets out two pages of examples of:

“highly motivated and professional staff who day in and day out are delivering outstanding services to victims of child abuse many of which are not well reflected in the district reports”.

Victim contact and follow up

429. Shortcomings identified in relation to child abuse investigations have a direct impact on the victims of abuse. The service offered to children, young persons and their families and caregivers is directly affected by such shortcomings, whether it is a general delay in investigation, a failure to investigate at all, or the failure to comply with mandatory documents such as the “POL1060” (Victim Contact Record Document) and “POL1065” (Victim Notification Document) forms. Such forms ensure there is a documented record

of victim liaison and ensure that victims have been given the opportunity to complete various request forms.⁸⁹

430. Inadequate victim follow up was a widespread issue pertaining to child abuse investigation files in several districts. The need for improvement in this area was a recurring theme identified during the district reviews undertaken by Operation Scope.

431. It is worth restating that the various procedural responsibilities that rest with Police are founded in legislation. The Victims' Rights Act 2002 places specific obligations on Police to ensure that victim liaison is maintained through an investigation. It is a national policy that every complaint file must have attached to it a POL1060 form to provide evidence of the following requirements:⁹⁰

- Provide victims with information about programmes, remedies, or services
- Provide victims with a Complaint Acknowledgement form
- Provide victims with information about the progress of the investigations (within 21 days of reporting the offence to Police)
- Complete a Court Services for Victims referral (CSVI)
- Complete prosecution related information including victims' views on bail and details about registration on the Victim Notification Register

432. Pursuant to the Victims' Rights Act 2002, certain files referred for prosecution must have the additional POL1065 form to provide evidence that the following actions have been taken:

- Victim personal details including details of a nominated person
- Accused offender details
- Referral to Victim Notification

433. The district reviews showed that immediate care and protection issues were generally found to have been dealt with effectively, but subsequent contact with victims was variable or, in some instances, unsatisfactory.

⁸⁹ Part I Report, p 100. The need for a nationally consistent usage of these forms was recommended in the review of Operation Hope, *Operation Hope Review Report, A Review of Wellington Police District's Response to Operation Hope*, 27 November 2009, G Jones, pp 3, 19.

⁹⁰ Part I Report, p 100.

434. The inadequacies in relation to recording contact with victims were remedied as part of the national Case Management Project initiative, discussed below. Updates to NIA in November 2010 enabled all (victim) contact information to be embedded within NIA case management functionality, so that the need to complete a separate POL1060 form was eliminated, thus minimising problems with victim follow up.⁹¹

Evidential Forensic Interviews

435. The quality of evidential interviews (EVI) was noted as a concern during the district reviews undertaken by Operation Scope and the Authority reported on this in its Part I Report. The Authority heard evidence that such concerns were not limited to any single district and were more widespread, with there being an obvious need to address the number of Police staff trained and available as specialist interviewers within all 12 Police districts.

436. The importance of national consistency for EVI had become even more apparent by the time Operation Scope had completed all its district reviews. The Operation Scope Summary Report summarises the national position well:

“The approach taken by districts to forensic interviews varied greatly, highlighting a lack of national consistency. Key issues identified included:

Three models operate across the country for forensic interviews. They include Police only, CYF only, or a mixed model. The lack of a nationally consistent approach impacts on the quality and quantity of interviews conducted per district/area, and also the time lapse between notification and the interview. There clearly needs to be a National NZP/CYF strategy put in place to address this.

Forensic interviewers in a number of districts undertook this role on a portfolio basis which created difficulties in having them released in a timely manner.

There is a need for districts to identify their current and future forensic interviewing requirements to ensure that succession plans are developed to recruit and train interviewers to meet future demand.

In areas where CYF provide staff to conduct forensic interviews, Police need to ensure that an investigator is available to monitor the interview. Where Police do monitor an interview they ought to provide the CYF interviewer with feedback on their interviewing style (both positive and negative) to ensure continuous

⁹¹ Operation Scope Summary of Key Findings and Remedial Actions Taken, G Jones, 1 September 2010, at p 32.

improvement. This should also occur when Police conduct the interview and CYF monitor.

In 31% of child abuse files reviewed by Operation Scope where a forensic interview was conducted, the delay between reporting to Police and the forensic interview was greater than two weeks.

In some rural districts child abuse victims have to travel between two and four hours each way to reach a forensic interviewing suite.

Southern District is seeking to address this issue through establishment of a mobile evidential interview suite. This initiative has the potential to mitigate the need for child abuse victims to travel long distances to forensic interviewing facilities. If the initiative is successful there may be merit in adopting this concept nationwide.

Some districts do not routinely conduct forensic interviews with all under 17 year old victims [for example Waikato and Tasman Districts] (as required by policy). Alternative methods of recording statement evidence from victims aged between 14 and 16 included (1) interviews by Police staff trained or qualified in investigative interviewing [aimed at adult victims] rather than child forensic interviewing, and (2) written statements taken from victims.”

437. The lack of standardisation and consistency in terms of quality and approach to forensic interviews is a topic that has been acknowledged at a national level.⁹² Child, Youth and Family and Police have conducted a number of workshops and policy reviews to improve forensic interviewing techniques. One of the workshops was specifically focused on updating training programmes and the introduction of a formalised accreditation process for forensic interviewers.

438. Forensic interviews are an integral part of the Police investigation process for child abuse inquiries. Their importance has long been recognised and in the context of this report the Authority refers to the identification of the critical nature of this investigative step in the Penny Report from the Wairarapa June 2006.

439. A joint Police and Child, Youth and Family working group has been established to assess whether the current number of joint forensic interviewers (15 full-time Police; 20 Child, Youth and Family) is sufficient. At a district level, all District Commanders acknowledged the importance of forensic interviews to the investigation process, and

⁹² Operation Scope Summary of Key Findings and Remedial Actions Taken, G Jones, 1 September 2010, at p 32.

advised the steps they are taking to have greater numbers of trained interviewers available in their districts.

Inter Agency Relationships - Child, Youth and Family

440. As part of its Inquiry, the Authority has heard evidence and received submissions from the Ministry of Social Development (Child, Youth and Family) and the Office of the Children’s Commissioner.

441. Child, Youth and Family has provided the Authority with a status report on a number of key collaborative projects with Police that will improve the service provision to “at risk children”. In particular there are three key areas where there have been important improvements to the relationship between Police and Child, Youth and Family.

These are:

- Enhanced coordination at a strategic and leadership level
- Renewed and revitalised joint policy documents
- Greater scope for joint training opportunities

Strategic Leadership and Governance

442. Regular meetings are convened between Child, Youth and Family and the Police in order to provide joint strategic oversight of a variety of collaborative work streams.

443. A Child, Youth and Family and Police working group was established to review and update jointly-held policy documents, which included the CAT/SAT protocol and the Memorandum of Understanding.⁹³ The outcome of these policy reviews will be discussed in more detail below.

444. At a local level, with the introduction of the Child Protection Protocol, with the exception of two sites, there are now monthly meetings occurring between Police and Child, Youth and Family social workers at all Child, Youth and Family sites nationwide.

445. Further evidence of enhanced coordination is seen in a recent agreement between Police and Child, Youth and Family to develop a national strategic plan for the future development of multi-agency centres around the country.

⁹³ Part I Report, p 83. These documents are also discussed in the final chapter of this report.

Police and Child, Youth and Family Policy Review

446. Police and Child, Youth and Family conducted a review of the CAT/SAT protocol and culminated in the creation of the new policy, the Child Protection Protocol which came into effect on 10 May 2010. The Child Protection Protocol replaced the existing protocol and any existing Local Level Agreements. The Child Protection Protocol is included as **Appendix B** to this report.

447. Child, Youth and Family has outlined the key elements of the Child Protection Protocol:

- *National consistency with the same requirements for all staff to follow.*
- *Monitoring through our system of reports.*
- *Clearer definition of serious child abuse cases that should be managed under the Child Protection Policy. A new test for seriousness has been developed for physical abuse as a guide to practitioners.*

448. A clear three-step process is to be followed by Child , Youth and Family and Police for any case coming under the Child Protection Protocol:

1. *Refer the case – as from 2 November 2010 this has involved Child Youth and Family National Contact Centre simultaneously referring all cases that meet the Child Protection Protocol criteria to the Police Crime Reporting Line which also “went live” as of that date, and to the relevant Child Youth and Family site.*
2. *Child Youth and Family and Police Personnel Consult about the case- share information and determine course of action.*
3. *Agree a Plan –who will do what and by when.*

449. The two agreed timeframes for completion of the three-step process for the Child Protection Protocol are:

- ***Immediate*** for cases requiring critical or very urgent action.
- ***2 working days*** for all urgent cases.

450. There is a requirement that each agency advise the other of outcomes at the close of their respective work.

451. Police and Child, Youth and Family have also revisited a number of other joint and interagency agreements. On 4 August 2010 a new Memorandum of Understanding (MOU) was signed between Police and Child, Youth and Family which replaced the 2001

MOU and the 2006 regional MOU. The Child Protection Protocol is a schedule to the newly agreed MOU.⁹⁴

452. As part of the Child Protection Protocol, Child, Youth and Family have introduced a new audit and assurance process to ensure compliance with the protocol. The Child, Youth and Family Deputy Chief Executive commented on compliance:

“In summary, the results varied across the country, however most areas were consistently meeting the requirements of the CPP. The response was overwhelmingly positive regarding the relationship with Police and how the process has fostered increased communication and collaboration.”

Police and Child, Youth and Family Joint Training Opportunities

453. A joint Child, Youth and Family and Police training programme took place with every Child, Youth and Family site following the introduction of the Child Protection Protocol. The training was focused on ensuring that staff understood the Child Protection Protocol referral criteria with the intent of establishing a consistent application of the Child Protection Protocol to individual cases. There were also joint monitoring initiatives around the introduction of changes to Child, Youth and Family National Contact Centre and the new Police Crime Reporting Line in October 2010.

454. Another key area of collaborative work and training is forensic interviewing of child victims. Police and Child, Youth and Family have conducted a number of workshops and policy reviews to improve forensic interviewing techniques. Police advised the Authority on 28 January 2011 that in order to further progress work in this area, a dedicated position would need to be established.

Case Management

455. The reviews undertaken for all 12 Police districts identified varying levels of understanding, and use, of the functions of NIA case management. This was evidenced by the utilisation of spreadsheets as a means of file recording for child abuse investigations. As noted in the Part I Report, it was common practice for Child Abuse Teams to create and maintain spreadsheets that operated outside of NIA, sometimes

⁹⁴ Other policy documents under review are the MOU on the Safety of Children in Hospital with Suspected or Confirmed Non Accidental Injury and the Operational Level Agreement between Police and Child, Youth and Family on Electronic Monitoring of Bail; both reviews are due for completion by the end of 2010.

being maintained in addition to standard NIA records, and sometimes being the only record.⁹⁵

456. The use of stand-alone spreadsheets in preference to NIA contributed to various problems, for example:

- Poor usage of case assignment or re-assignment functions
- Limited or no case categorisation and prioritisation
- Limited workload management and structured case allocation
- General lack of case monitoring or reviews
- In some districts inappropriate filing practices
- An overall lack of visibility at district and area management levels of child abuse cases resulting in an inability to either escalate or mitigate workload problems

457. As noted in the Part I Report, this Inquiry identified significant failures in the use of NIA, as it had not been operating as an accurate database for file holdings and information as to the status of files held.⁹⁶

458. The Case Management Programme is an important initiative in remedying many of these deficiencies and, at the time of the Authority issuing its Part I Report in May 2010, there had already been considerable improvements noted by staff from those districts where the Case Management Programme was being piloted.⁹⁷

459. Case Management is described as a:

New Zealand Police business initiative designed to enable case progress to be tracked and monitored end to end from case acceptance through to case closure in a structured and disciplined manner.

The model is characterised by the ability to identify key decision points at each stage of a case lifecycle to determine whether or not to close, suspend or refer a case for investigation.

⁹⁵ Part I Report, p 61. *Operation Scope Summary of Key Findings and Remedial Actions Taken*, G Jones, 1 September 2010, p 25.

⁹⁶ Part I Report, p 61.

⁹⁷ Part I Report, p 61.

The model is also aimed at lifting investigation timeliness and standards through the provision and use of improved NIA (case management) functionality.

460. Between February and October 2009, Auckland City District and Counties Manukau District piloted the Case Management model, with the support of a project team. Counties Manukau District was chosen for the pilot scheme on the basis of various factors including its history of significant case backlogs, high levels of reported crime, and the interest of the Police Executive to test Case Management in a complex district with a view to a national rollout, anticipating that if the pilot programme worked in Counties Manukau District it would be likely to succeed in other less challenging districts.

461. The importance of the Case Management pilot has been a recurring theme in the evidence put before the Authority and in the published reports and strategic documents issued by the Police. The Authority is pleased to note that there will be a national roll out of Case Management, a matter declared in the *Annual Report 2009/10*.⁹⁸

A pilot of new case management processes was completed in the Auckland City and Counties Manukau Districts in September 2009. Case Management has now been incorporated into Policing Excellence for national rollout. In 2009/10 Case Management delivered:

- *a system to categorise crime by levels of seriousness*
- *a process for prioritising workloads*
- *an initial file assessment and early case closure tool and methodology*
- *NIA system enhancements*
- *a reporting framework to benchmark and measure performance*
- *a benefits realisation methodology*

As a result of an Independent Police Conduct Authority inquiry, specialist child and adult sexual abuse teams are committed to using case management.

⁹⁸ New Zealand Police, *Annual Report 2009/10*, at p 19.

NIA Case Management functionality

462. Training for all child protection investigators and relevant supervisors has already been undertaken across all districts, with the aim of having a standardised approach to recording, managing, and monitoring child protection cases.

463. The case management functionality within NIA has been improved. All referrals (Reports of Concern) from Child, Youth and Family are required to be received via the Crime Reporting Line which serves to streamline processes (the Crime Reporting Line is discussed in further detail in the following chapter). In addition, a Child Protection Investigation Plan is now in NIA, which is a template that lists key investigative steps as a guide for “best practice”.

464. The enhancements to NIA have also provided improved reporting and monitoring functions which enable supervisors to view workloads, view cases by both category and priority, and assess other information such as how long a file has been open, which staff member has the file, and where the file is located. This enhanced functionality has been demonstrated to the Authority from the perspective of child abuse investigation supervisors.

465. The Authority also had the benefit of hearing from the District Commander Counties Manukau District, Superintendent Bush, where the case management programme has been piloted. Superintendent Bush provided examples of management reports he and his senior managers are now routinely provided with as a result of the implementation of case management and enhancements to NIA.

466. These management reports show, among other things:

- Total number of current child protection files in the district, broken down by numbers of files
- Where the investigation is in progress
- Where a prosecution is in progress
- Awaiting members assignment
- Awaiting forensic interview
- Awaiting a file review
- Which have been completed and await filing
- Total number of current child protection files by area within the district

- Total number of current child protection files per individual child protection investigator
- Number of current child protection files per crime type, with descriptions of the nature of abuse/injuries suffered by the child

467. It hardly needs to be said that this quality of information is a vast improvement on the quality of information previously available to district managers. The lack of clarity around child abuse file holdings in the Wairarapa in 2006 (at least prior to the Penny report) provides a stark example of this.

District structures

468. There is considerable variation across the 12 Police districts in terms of the structure and oversight of child abuse teams, and the resources available within those teams to conduct child abuse investigations in an effective and timely manner. The district reviews demonstrated that there were important factors that contributed to the variation:⁹⁹

The structure of child abuse teams and resources varied from district to district. This was primarily due to the geography and population differences between the 12 districts. The approach used in a metropolitan district such as Auckland City cannot be replicated in a geographically large district with remote communities.

469. Operation Scope recorded four structure types identified at the time of the reviews:¹⁰⁰

Structure	Districts
<p>District based team</p> <p>District based child abuse/protection team responsible for sexual and serious physical child abuse</p> <p>Child abuse investigators have limited involvement in other, non-child abuse duties</p>	<p>Auckland City</p> <p>Counties Manukau</p> <p>Wellington</p>
<p>District based team and general CIB</p> <p>District based child abuse unit servicing metropolitan areas</p> <p>General CIB staff investigating referrals and reports of child abuse in rural areas</p>	<p>Canterbury</p>

⁹⁹ Operation Scope Summary of Key Findings and Remedial Actions Taken, G Jones, 1 September 2010, at p 30.

¹⁰⁰ Operation Scope Summary of Key Findings and Remedial Actions Taken, G Jones, 1 September 2010, at p 30.

<p style="text-align: center;">Area based teams and general CIB</p> <p>Some area based child abuse teams have been established</p> <p>The defined responsibilities of child abuse teams vary between locations</p> <p>General CIB respond to referrals and reports in locations without child abuse teams</p>	<p>Northland</p> <p>Waitemata</p> <p>Waikato</p> <p>Bay of Plenty</p> <p>Eastern</p> <p>Central</p> <p>Southern</p>
<p style="text-align: center;">General CIB</p> <p>General CIB respond to all child abuse referrals and reports</p> <p>No child abuse teams have been established</p>	<p>Tasman</p>

470. The information derived from Operation Scope and from the Authority's own inquiries has demonstrated that the districts which have district based teams, for example, Auckland City and Counties Manukau (and more recently Wellington), have effective child abuse investigation teams and practices.

471. The value of a district based team is evidenced by the high quality and standard of child abuse investigation files found by the Operation Scope review team, and also evidenced by the fact that no files were presented to the Categorisation Meeting for remedial action, matters which have been discussed in the previous chapter.

472. The Authority heard evidence that not all districts consider a district based team the most suitable structure, particularly if the district is of wide geography. The preference for those districts is to have area based teams to address child abuse investigations on a more localised basis. The obvious disadvantages with separate, or localised, child abuse investigation teams are difficulties with consistency of practice, supervision and oversight and, as discussed elsewhere in this report, greater time and distance involved in accessing specialist services such as EVI.

473. However, it does not follow that therefore the absence of a district based team results in a poor service for child abuse investigations. In its Part I Report, the Authority acknowledged that the important point was that districts give consideration to key aspects of a centralised model, in particular, a means of central oversight and responsibility.¹⁰¹

474. The role of District Crime Services Managers in all 12 Police districts has been to provide oversight. However, the Authority heard evidence that not all District Crime Services Managers have the same level of line responsibility. A distinction is drawn between

¹⁰¹ Part I Report, p 112.

“line” control and “functional” control of investigative staff, the former broadly meaning direct control, the latter meaning oversight and input but not direct control (which remains with Area Commanders).

475. It is a matter for Police how each of the Police districts operates in terms of structure and oversight of child protection matters. However, it is of note that Counties Manukau District has adopted the view that a district based team, with line control through to the District Crime Services Manager, is its preferred model. This has worked very well for Counties Manukau notwithstanding the considerable geographical spread of that district and its diverse communities (highly concentrated urban areas and rural areas). The Authority considers that this model should be carefully considered by all districts.

Introduction of Detective Senior Sergeant (‘Gatekeeper’) role with oversight

476. Since issuing its Part I Report the Authority has received information from Police about changes in relation to child protection team structures and resources. Examples include the allocation by PNHQ of a further 16 positions to districts for policing child abuse investigations, and a national review of child protection structures and resource requirements.¹⁰²

477. All 12 Police districts have established a senior management role that is referred to by Police as a “gatekeeper” role. At the time of issuing this report, the position within Districts has been set at the level of Detective Senior Sergeant who has oversight of child abuse investigations for the whole district; however, it may be that there is future variation in the designation and rank of the person undertaking the role. The line of reporting from the Detective Senior Sergeant is, in most districts, a direct line to the District Crime Services Manager, although some districts have the direct line of reporting to the Area Commander, with District Crime Service Managers having “functional” control.

478. The Authority considers this newly created position will play a pivotal role in ensuring consistency of service and approach in each district. The position is particularly important in districts which do not have centralised child protection teams. Although Wellington District has now reformed its structures to ensure improved performance, had the Detective Senior Sergeant role existed in Wellington District in 2006 it would have been that officer’s clear responsibility to ensure that no lesser quality of service was provided in the Wairarapa than was provided, for example, in Wellington City.

¹⁰² *Operation Scope Summary of Key Findings and Remedial Actions Taken*, G Jones, 1 September 2010, at pp 34, 35.

Audit and assurance

479. All District Commanders appeared before the Authority and confirmed the importance of regular audits being undertaken within their respective districts, as a key practice in its own right, but also in conjunction with any nationally directed audit processes emanating from PNHQ.¹⁰³ The importance of a robust quality assurance programme within districts was universally acknowledged.

480. Districts need to have structures in place that permit this to occur. Some districts advised that consideration was being given to introducing a process whereby staff from neighbouring districts would undertake audits which would be reciprocated. Ultimately, districts will need to structure their processes to meet any audit requirements issued from PNHQ. This topic is therefore addressed in detail in the following chapter concerning the response from PNHQ.

¹⁰³ The discussion in this report is limited to audit and assurance processes relating to files, however, the Authority acknowledges the important changes introduced in relation to checking staff welfare for Police employees working within higher risk groups, which includes child protection teams. The new policy is the “Wellcheck Support Policy”.

Conclusions and findings

481. The Authority's Part I Report and Operation Scope identified shortcomings in practice in various districts around the country. The previous chapter referred to steps taken by districts to remedy shortcomings on particular investigation files. This chapter has identified, by reference to key topics, steps taken by districts to remedy shortcomings in practice, policy and procedure.
482. It is not suggested that this chapter is comprehensive of all the improvements being made by districts. From the summary provided, however, it can be seen that as a result of the Authority's Inquiry significant changes and improvements are being made by all Police districts to practices, policies and procedures in the investigation of child abuse files. These relate to both specific areas of investigation, such as victim contact and evidential interviewing, and to more general areas such as case management and district structures. These general areas have a critical bearing on the quality of investigations and the ability of Police management to properly supervise and monitor the quality of investigations.
483. Many of the improvements referred to are already very well advanced in districts such as Counties Manukau, Auckland City and Canterbury. Training in the use of NIA as part of case management has been made available as a priority to child abuse investigators in all districts. In addition, each district will benefit from the appointment of a senior person with responsibility for oversight for child abuse investigations throughout the district.
484. If the improvements referred to in this chapter and the following chapter are fully implemented by districts and PNHQ, a consistently high standard of service is achievable for all victims of child abuse throughout the country.



Chapter Eight: Response of Police National Headquarters

INDEPENDENT POLICE CONDUCT AUTHORITY

485. This chapter addresses the response of PNHQ to the Authority's Part I Report.

Child Protection Implementation Project

486. A Child Protection Implementation Project Team has been set up within Police to implement the Police response to the Authority's recommendations from its Part I Report, and the Commissioner's Action Plan relating to child protection issues.¹⁰⁴ A summary of the responsibilities of the Child Protection Implementation Project Team is set out below and the Commissioner's Action Plan is then discussed.

487. The Child Protection Implementation Project Team is sponsored by the Commissioner and provides fortnightly updates on progress. The team was mandated to substantially finalise the Police response to the Authority's recommendations and Commissioner's Action Plan by the end of October 2010.

488. The Child Protection Implementation Project Team has responsibility to address the following:¹⁰⁵

- Review and refresh child abuse (protection) policy and practice
- Accelerate the rollout of NIA Case Management functionality to all child protection investigators
- Implement the Crime Reporting Line to support the referral process between Police and Child, Youth and Family
- Ensure districts and PNHQ have the structures and resources to provide effective and timely service to victims
- Develop an audit and assurance framework to ensure the changes being made deliver the desired effects

¹⁰⁴ *Commissioner's Action Plan*, Commissioner Broad, May 2010. New Zealand Police, *Ten One*, Issue 337, 10 September 2010.

¹⁰⁵ New Zealand Police, *Ten One*, Issue 337, 10 September 2010.

489. The implementation is delivered through six workstreams:

- Policy
- Process and Systems
- Structures
- Practice and Procedure
- Audit and Assurance
- Project Support

Commissioner's Action Plan

490. In May 2010, Commissioner Broad identified a total of seven action points relating to child abuse matters which have been collated under a "Commissioner's Action Plan":¹⁰⁶

1. *Implement the Crime Reporting Line channel to support the referral process between Police and CYF ensuring seamless recognition and response to cases.*
2. *Restructure the national Crime Services Group (Violence Team) in order to:*
 - (a) *maintain currency of investigative best practice;*
 - (b) *insert a higher level of visibility of child abuse investigation including:*
 - (i) *the maintenance of national multi-agency protocols and*
 - (ii) *confirm and then ensure compliance with national investigation standards*
 - (c) *ensure that RNZPC (School of Investigation) and district training standards and methods align with the national investigation standard;*
 - (d) *[provide] resources for monitoring of reporting, caseloads, milestone achievement, issues and problems resolution, and external reporting;*
 - (e) *[support] assurance/risk management reviews (OAG).*

¹⁰⁶ *Commissioner's Action Plan*, Commissioner Broad, May 2010. For the purposes of some internal Police documents the Commissioner's Action Plan is described as having six action points. The plan contains six specific action points and has a broad seventh point to "progress other recommendations in the Interim report" (the Authority's Part I Report).

3. *Implement (prioritise the national rollout) of NIA case management for all abuse cases involving children. This will ensure that:*
 - (a) *there is a national approach to recording complaints;*
 - (b) *there is a national approach to creating and implementing statistics;*
 - (c) *there is a national approach to documentation;*
 - (d) *case management (managing criminal investigations) standards reach consistently high levels;*
 - (e) *assurance [that] technical case management standards are achieved.*
4. *Review the classification of all cases involving children (that is, bring together not only the “classic” abuse cases but also the investigation of cyber-crimes against children, abuse cases derived from family violence investigations (referred or indirect abuse) and related abuse cases (child trafficking) i.e. a new definition/scope of child abuse – to avoid defining child abuse cases “out” of compliance with national child abuse policies).*
5. *Define and implement a standard intelligence tasking around child abuse offenders in order to monitor risk of known or suspected offenders.*
6. *Implement a national structures policy:*
 - (a) *structure all district child abuse investigation teams consistently under a senior investigating officer reporting to the crime manager;*
 - (b) *estimate demand for investigation for all cases of abuse of children (new definition) and recommend/implement resource requirements to meet demand by location;*
 - (c) *ensure these cases under dedicated child abuse investigations teams, including an assessment of the potential for multi-agency centres in each district/area;*
 - (d) *co-manage all staff involved in dedicated child abuse investigation to ensure that all are trained to the national standard (i.e. mitigate the risk of transient/impermanent investigator base until sufficient assurance exists to hand these investigations back to district management).*
7. *Progress other recommendations in the Interim [Part I] Report.*

Commissioner's email to District Commanders (15 July 2010)

491. In addition to the above steps, on 15 July 2010 the Commissioner issued an email to all 12 District Commanders seeking assurances that the following matters are being addressed at a district level (paraphrased):¹⁰⁷

- **Coding:** All reports of child safety concerns are correctly recorded and coded in the NIA case management system;
- **NIA Case Management functionality:** All child protection cases must be managed and monitored using NIA case management functionality and no files are to be assigned or filed to generic codes such as LF9999. Files must be assigned to a person's QID;
- **District Business Plans:** Child protection is a priority in the National Business Plan for 2010/11 and is to be reflected as such within district level plans;
- **NIA Case Management training:** Staff are to attend case management training scheduled to commence 10 September 2010;
- **Local interagency agreements:** Any local level agreements are to address only matters particular to the district service delivery, or matters otherwise not covered by the Child Protection Protocol. Local agreements do not override the national Child Protection Protocol;
- **Police obligation to investigate not obviated by CYF actions:** Even if Child, Youth and Family have completed an investigation into a matter notified to Police, the onus remains with Police to make an independent assessment and undertake enquiries.
- **Child Protection investigator deployment:** Where demand dictates Child Protection Investigators are to be exclusively focused on child abuse investigations. It is acknowledged that it may not always be possible to ring fence such staff but where there are Child Protection Protocol cases pending or requiring immediate investigation, they will take precedence over less urgent matters.

¹⁰⁷ New Zealand Police, *Ten One*, Issue 337, 10 September 2010; *Update on Progress and Outcomes of Work Undertaken by Police in Response to IPCA Report Part I and the Commissioner's Action Plan*. The Commissioner's email also cross-referenced the relevant recommendations made by the Authority in its Part I Report.

Detailed response to recommendations in Part I Report

492. The Police response to the Authority's Inquiry and the 34 recommendations made by the Authority in its Part I Report issued in May 2010 has been prompt and comprehensive. The Authority wishes to acknowledge the expertise of, and time and effort invested by, the Child Protection Implementation Team, and the personal commitment of Commissioner Broad to ensuring a consistently high quality of service in the investigation of child abuse by Police throughout New Zealand.

493. The Authority has included as **Appendix C**, a detailed outline of the Police response to the Authority's 34 recommendations made in Part I of the Inquiry. The Commissioner's Action Plan and the actions taken in response by the Child Protection Implementation Team are included as **Appendix D**.

494. In light of the comprehensive response of Police, set out in Appendices D and E, the Authority will not repeat that material by going through all the changes underway as a result of the Police response to the Inquiry. However, there are specific matters the Authority wishes to address in further detail, which are as follows:

- Rebranding from Child Abuse to Child Protection
- Child Protection Protocol
- Crime Reporting Line
- Child Abuse Policy and Investigation Guidelines
- Audit and Assurance
- Annual Report 2009/2010
- National Business Plan 2010/2011-2012/2013
- National Consistency

Rebranding from 'Child Abuse' to 'Child Protection'

495. One of the changes in the intervening time between the Authority issuing its Part I Report and the second phase of the Inquiry, has been the change in terminology within Police for matters relating to child abuse investigations. The Police have undertaken a rebranding exercise which has resulted in revised language. The terminology now used is "child protection" rather than "child abuse", with consequent changes to labels such

as “Child Protection Teams” and “Child Protection Protocol”, as well as to position descriptions for staff working within this area of policing.¹⁰⁸ The Authority notes the positive change in terminology, and considers it is a reflection that Police have a key role to play in the protection of children.

496. However, the description of “child abuse” cannot be replaced in a wholesale manner because, unlike the term “protection” the term “abuse” is a description of criminal offending. Within the processes utilised to capture information about such offending, there are several situations where the general description of “child abuse” is retained. For example, the definition of “child abuse” used within the Child Protection Protocol is consistent with the statutory definition contained in the Children Young Persons and Their Families Act 1989.

497. The Child Protection Protocol applies to serious child abuse including:

- Sexual abuse
- Serious physical abuse (as per test for seriousness, considering: the action of the abuse; the injury inflicted; and the circumstances)
- Serious willful neglect
- Serious family violence where the child is a witness
- All allegations against Child, Youth and Family approved caregivers that involve serious child abuse
- All allegations against employees of Child, Youth and Family and Police that involve serious child abuse

498. The capture of data relating to offending against children in the Police computer system NIA is categorised and prioritised under the general description of “child abuse” and given a new separate incident code to identify all reports involving a child as a victim, before the information is then categorised under specific offence codes.¹⁰⁹

¹⁰⁸ The term “child protection” is used by Police in the United Kingdom, *Guidance on Investigation of Child Abuse and Safeguarding Children*, report by the National Policing Improvement Agency, 2nd edition, 2009.

¹⁰⁹ Children Young Persons and Their Families Act 1989, section 2. The new incident code of “6C” has been implemented by Police within NIA to identify all reports of concern involving a child.

Child Protection Protocol

499. As discussed by the Authority in its Part I Report, the national Memorandum of Understanding between Police and the Ministry of Social Development, through its service of Child, Youth and Family, was designed to enable Police and Child, Youth and Family to work co-operatively in the investigation of child abuse notifications. The national document allowed for the creation of individual protocols with the result that all District Commanders and, in turn, Area Commanders, within the 12 Police districts had been permitted to enter into their own arrangements with local Child, Youth and Family services. These documents were known as “Local Level Agreements”. At the time the Authority began its Inquiry, one of the essential documents for Police was an agreed policy document between Police and Child, Youth and Family: *Interagency protocol for the reporting and investigation of child sexual abuse and serious physical abuse*.¹¹⁰
500. At the time of issuing the Part I Report, the Police and Child, Youth and Family had revised their existing interagency arrangements and the Authority was provided with a draft copy of the new document entitled *Child Protection Protocol*. The Authority noted that implementation had already commenced through joint training of staff to familiarise them with the new requirements.¹¹¹
501. The Child Protection Protocol was issued in its final form on 15 April 2010. The Protocol is designed to establish and clarify roles and responsibilities for each organisation and contain improved processes which will ensure a prompt and effective joint investigative response to serious child abuse.¹¹²
502. This is a priority document, and as stipulated by the Commissioner in his email to all District Commanders, Local Level Agreements do not offset or override the obligations of Police.
503. The Protocol is considered by Police to have multiple benefits, including: improved capturing of all referrals, which will be recorded directly into the case management

¹¹⁰ This was referred to in the Part I Report at p 82, paragraphs 313-316. The evidence had shown that the existence of these different tiers of documentation had resulted in inconsistent practices across the districts. Police officers referred to the protocol itself as the “CAT/SAT protocol” (CAT meaning Child Abuse Team within the Police; SAT meaning Serious Abuse Team within Child Youth and Family).

¹¹¹ Part I Report at p 82, paragraphs 313-316. The Authority was provided with a draft version of the Child Protection Protocol in March 2010. Immediately after publication of the Protocol all district-based child protection investigators and Child Youth Family managers attended joint training sessions on the practical implications of the new document.

¹¹² *Operation Scope: Summary of Key Findings and Remedial Actions Taken*, G Jones, 1 September 2010, p 19, paragraphs 40-43. This topic has also been discussed above in chapter 7.

process; improved accountability for investigations; enhanced ability to track progress; and all cases being recorded on a joint Protocol case list which will ensure child abuse cases are regularly reviewed and monitored.¹¹³

504. An important corresponding initiative that enables the improved referral process to operate effectively is the Crime Reporting Line. This initiative is described and discussed below.

Crime Reporting Line

505. The Police introduced a Crime Reporting Line during 2006 for the purpose of taking non-emergency calls. The Crime Reporting Line commenced as a demonstration (pilot programme) in Auckland City District and Bay of Plenty District during November 2006. This followed an external review in 2005 of the New Zealand Police Communications Service Centre after high profile service failures had attracted media scrutiny during 2004. The external review panel was comprised of senior police communications experts from Australia, Wales and Canada and resulted in a written report (the external review).¹¹⁴

506. The external review identified that non-urgent calls received through the “111” queue into the Police Communications Centres were compromising the ability of Police to answer and respond to emergency calls in a timely way. The recommendation was made for the development of a national non-urgent number that was known as a Single Non-Emergency Number (SNEN) and which resulted in the concept of the Crime Reporting Line.

507. The Crime Reporting Line is designed as an accessible and efficient channel for the public to contact the Police for the reporting of non-emergency crime. These types of crime are ones that do not require immediate Police attendance which includes historic matters such as theft, lost property, unlawful taking of vehicles, burglaries, and other minor complaints.

¹¹³ Part I Report at p 82, paragraph 322, footnote 104.

¹¹⁴ *New Zealand Police Communications Service Centre Independent External Review “Titiro Whanui”: Final Report*, Corboy et al, May 2005. *Role of Crime Reporting Line*, Internal Memorandum, New Zealand Police, 22 September 2010. One of the most well known examples of a high profile service failure involved the disappearance of a young woman at Piha in West Auckland during 2004. The external review was instigated by Commissioner Robinson in October 2004.

508. The initial trial of the Crime Reporting Line in Auckland City District and Bay of Plenty District was expanded to include Counties Manukau District in January 2009.¹¹⁵ The five main objectives of the Crime Reporting Line are:

- Provide a nationwide tailored reporting channel for the public that is accessible, always available, professional and victim centric;
- Improve the efficiency of capturing non-emergency crime information into NIA;
- Provide a nationwide non-emergency call handling service which ensures that non-emergency call handling does not impact on the emergency response capability;
- Enhance the timeliness and quality of data recorded in NIA to improve the assignment of appropriate response or investigative resource; and
- Improve the data recorded in NIA to enable districts to better conduct case reviews, links to associated cases, and an initial file review through the Case Management process.

509. The Crime Reporting line model has been evaluated and shown to improve the efficient management of both emergency and non-emergency calls. The success of the Crime Reporting Line has recently resulted in the Crime Reporting Line supporting a range of additional national services such as Crimestoppers, Police Safety Orders and Parole Recall Warrants.¹¹⁶

Role of Crime Reporting Line re Child Protection Protocol

510. Using the Parole Recall Warrants as a means of illustration, the Crime Reporting Line process has created a centralised point of contact for the Parole Board to advise Police of the existence of a Parole Recall Warrant and for data entry to be undertaken so that a risk analysis can be conducted into the urgency of any situation. The process also enables Police to track the progress of an investigation. It is the process relating to

¹¹⁵ With the introduction of the Crime Reporting Line in Counties Manukau District there was a simultaneous implementation of the File Management Centre operating on a 24 hours/7days per week basis. The effect of the Crime Reporting Line and operation through the File Management Centre is to create a full electronic file in NIA. As noted above, the Crime Reporting Line uses standard electronic templates to ensure that all the necessary data is captured.

¹¹⁶ New powers came into effect on 1 July 2010 that give Police the ability to issue a [Police Safety Order](#) in situations of family violence. Such an order requires any person who represents a threat to leave the premises for up to five days. It also protects the person at risk by putting in place standard conditions that mirror those in Protection Orders, for the duration of the Police Safety Order. *Ten One Magazine*, New Zealand Police, Issue 336, 10 July 2010.

Parole Recall Warrants that has formed the basis of the management of notifications from Child, Youth and Family into the Police system.

511. The notifications between Police and Child, Youth and Family now take place through the Crime Reporting Line to enable early data entry in NIA. The Crime Reporting Line process for such notifications was launched in full on 2 November 2010. The process is streamlined with a single point of contact so that consistent standards are applied, and the referral is captured into the Police system at the first contact point in order to minimise any delays.

512. The Crime Reporting Line interface between Child, Youth and Family, and Police, is included as **Appendix E**.

Child Abuse Policy and Investigation Guidelines

The 1995 Policy: Investigation of child sexual abuse and serious physical abuse

513. The previous guidelines relating to the investigation of child abuse allegations were contained in one policy document entitled *Policy and guidelines for the investigation of child sexual abuse and serious physical abuse (1995 Policy)*. It was referred to throughout the Part I Report as “the 1995 Policy”.¹¹⁷

514. It was noted by the Authority in its Part I Report that, notwithstanding the fact that the original document dated from 1995, the 1995 Policy contained valuable content that provided an important foundation for District Commanders as well as inquiry staff working in the area of child abuse investigation.¹¹⁸

515. The 1995 Policy has since been revised and rewritten and is now labelled as *Child Abuse Policy and Investigation Guidelines (2010 Policy)*.¹¹⁹

Nature and scope

516. The 2010 Policy is more comprehensive than the 1995 Policy, extending to over 40 pages. It begins with an overview of the purpose of the policy and investigation guidelines and the type of situations that the policy and investigations cover in practice. Other associated or relevant documents are cross referenced, for example, the Child

¹¹⁷ The policy was numbered (1995/12) and was held within the Police Instructions site on the New Zealand Police intranet.

¹¹⁸ Part I Report, p 71 at paragraphs 272, 273.

¹¹⁹ *Child Abuse Policy and Investigation Guidelines* 2010.

Protection Protocol, and the internal Police policies relating to family violence, adult sexual assault, and staff welfare.¹²⁰

517. The 2010 Policy sets out relevant definitions and the factors requiring assessment for the purpose of determining the seriousness of physical abuse. The document has two key parts: Policy and Principles: and Investigation Guidelines.

Policy and principles

518. The document sets out the policy and principles that govern Police investigations of child abuse, with an initial statement of the Police commitment to victims, as well as a discussion about the core principles that guide Police: safety of children; accountability of offenders; working collaboratively; and service delivery.

Investigation Guidelines

519. The document then sets out the key investigative steps in terms of a child abuse investigation. These steps include practical considerations such as the working links within the Case Management function of NIA. The remainder of the document is set out under specific topic headings that include:

- Responsibilities for victims
- Initial actions and safety assessment
- Consultation and joint investigation and planning with Child , Youth Family
- Interviewing victims, witnesses, and suspects
- Medical Forensic Examinations
- Evidence gathering and assessment
- Mass allegations
- Online offences and investigations
- Charging offenders and considering bail

¹²⁰ *Family Violence Prosecution Policy; Family Violence Policy and Procedures*. The other related information is noted to be: *Wellcheck Support Policy; Adult sexual assault investigation guidelines; Prevention and Reduction of Family Violence – An Australasian Policy Strategy*; United Nations Convention on the Rights of the Child. *Child abuse Policy and Investigation Guidelines 2010*, initial chapter headed “Overview”.

- Prosecution and other case resolutions
- Final actions and case closure

520. It can be seen from the above that there are issues such as online offences that have been incorporated in the 2010 Policy which brings the guidance up to date with current issues of offending faced by investigation staff.

521. The 2010 Policy has been the subject of assessment and feedback. At the time of issuing this Part II Report, the Authority notes that the 2010 Policy is currently before the Police Executive for approval.

Audit and assurance

522. Following the release of the Authority's Part I Report, the Organisational Assurance Group was directed to establish a framework of audit and assurance for child abuse investigations. The project team identified two options for implementing an assurance framework:

Option One: implement compliance based file audits

523. The first option was a proposal for national audits on a 6-monthly basis, auditing a random sample of files from each of the 12 Police districts. The responsibility for co-ordinating the audits would rest with the National Criminal Investigations Group at PNHQ and files would be reviewed against a set of agreed minimum standards.

524. The strength of this option is its relatively quick and simple methodology, however, a reported limitation is that it is retrospective and would not provide a comprehensive approach or identify potential issues in advance. This option was not recommended.

Option Two: an integrated quality assurance and improvement framework

525. The second option is a framework that is stated to allow Police to have greater confidence in the quality of child abuse investigation services being delivered to child victims and their families and achieve positive outcomes:

"A framework that integrates quality assurance and improvement activities, effective monitoring and reporting, underpinned by sound HR and management practices (induction, performance management etc"

526. The systems and processes are depicted in diagrams within the proposal document and it is clear that this is the preferred option for Police.

527. The following diagram in particular sets out the key processes for the proposed Quality Assurance and Improvement Framework, this is attached as **Appendix F**.

528. The new assurance process is a mandatory tiered process. There will be a monthly review of investigator child abuse file holdings conducted by supervisors, who will review at least one file for every investigator on a random sample basis. This will be followed by a similar review conducted at four-monthly intervals on a district basis. There will also be similar reviews conducted at six-monthly intervals on a national basis of randomly selected files from all 12 Police districts.
529. The Crime Services Group which is now known as the National Criminal Investigations Group based at PNHQ will be responsible for the national review. A summary of findings from the national review will be provided to the Police Executive and District Commanders.
530. While it is a matter for the Police how to manage quality assurance, the Authority notes it is proposed that sampling of files will form a required part of reviews by supervisors and in district, and national levels. The Authority considers that random sampling of files is an essential part of the quality assurance programme.
531. The Authority notes the point made by Police about compliance based audits. In particular, that they are narrow in scope and backwards looking. Even with those limitations, the Authority considers there is merit in such audits, at least at district level, in particular circumstances where significant risks have been identified, such as occurred in the Wairarapa in 2006.

Annual Report 2009/2010

532. The *Annual Report 2009/10* notes in the introductory section headed "Commissioner's Overview" that Police are particularly concerned by levels of violence against the community's most vulnerable citizens, children:¹²¹

"Police receive more than 5,000 reports of child abuse a year. Most cases are handled extremely well with the safety of children the paramount concern.

An interim report by the Independent Police Conduct Authority [which] was released in May 2010, on Police handling of child abuse investigations made several recommendations. Several of these had already been identified and are being implemented by Police. Police welcomed the Authority's further recommendations and we are committed to taking whatever action is necessary to do our absolute best for children at risk."

¹²¹ New Zealand Police, *Annual Report 2009/10*, at p 2.

533. The Commissioner went on to note that the approach by Police to all family violence, including child abuse, is strengthened by the new Police policy, Family Violence Policy and made mention of the new multi-agency facility in Counties Manukau District:

“[The Family Violence Policy] emphasises the importance of Police working in partnership with other agencies and the community to address root causes with appropriate interventions. For example, Te Pou Herenga Waka is a multi-agency facility that opened in Counties Manukau in June 2010. Staff from Police, Child Youth and Family, and Counties Manukau District Health Board work under one roof to help child and adult victims of sexual and physical abuse.”

534. The Commissioner also noted the importance of Police Safety Orders as an important additional measure in order to reduce family violence. Since 1 July 2010 Police have had the ability to issue a Police Safety Order where there is insufficient evidence to charge a person with an offence, and where there is a reasonable belief that a person is subject to ongoing risk of family violence. The Police Safety Order requires the offending person to leave the address for up to five days.¹²²

535. The *Annual Report 2009/10* also contains additional comment about child abuse and the Authority's Inquiry:¹²³

“Better outcomes for children

Child abuse can take many forms, and child abuse offences are recorded in various offence categories, as appropriate. For the purpose of case prioritisation and screening, Police classify[y] a variety of offence codes from different offence categories as “child abuse”. The number of such recorded child abuse offences has risen gradually but steadily over the last few years.

In May 2010 the Independent Police Conduct Authority completed phase one of a comprehensive review into the investigation of child abuse. The Authority recommended a variety of initiatives and actions to improve the police response to these most vulnerable victims. Work will continue through 2010/11 to implement the recommendations, a number of which were already underway.

¹²² The Domestic Violence Act 1995 was amended from 1 July 2010. A Police Safety Order requires the person subject to the order to surrender any weapons and firearms to Police and to leave the address where the incident is occurring, for up to five days. New Zealand Police, *Annual Report 2009/10*, at p 9.

¹²³ New Zealand Police, *Annual Report 2009/10*, at p 14. The report also discusses the Online Child Exploitation across New Zealand (OCEANZ) team, working against online child exploitation.

A new child protection protocol has been agreed between Child, Youth and Family and Police. The protocol sets out a dual-agency response for children who are victims of serious child abuse. It explains how the parties will work alongside each other, the roles and responsibilities of each organisation, and the processes to be followed to ensure integrated, prompt and effective responses to serious child abuse.”

National Business Plan 2010/2011

536. The Authority notes that child abuse is included as a specific “change priority” in the *National Business Plan 2010/2011 – 2012/2013*. It is stated that child abuse will remain as a specific change priority until such time as the audit and assurance framework indicates that the changes are embedded and have the desired effect.

537. The *National Business Plan 2010/2011 -2012/2013* states:¹²⁴

“Vulnerable people are protected and safe

As well as its commitment to delivering high-quality services to all New Zealanders, the Police will take particular steps to ensure vulnerable people are protected and safe from harm. In particular, the Police will focus on children, older people, and people with disabilities who cannot look after themselves. These steps will include working with partner organisations to share critical information that will enable effective responses to protect people and prevent further victimisation.

Priority initiatives include the following:

- *Improve effective and proportionate responses for calls for service through a nationally available Crime Reporting Line. (As part of the Child Protection Protocol between Child, Youth and Family and the Police, Child, Youth and Family, referrals will be lodged through the Crime Reporting Line and recorded in the National Intelligence Application.)*
- *Ensure better prioritisation of cases and that sufficient resources are allocated to cases where vulnerable people remain at risk through improved case management. (Following its regular review of the management of cases reported to the Police, the Police, in 2009, started an investigation into how it handles child abuse cases. In August 2009, the Independent Police Conduct*

¹²⁴ *National Business Plan 2010/2011-2012/2013*, at p 16. The New Zealand Police *Statement of Intent 2010/11-2012/13*, at p 11, includes reference to the Ministry of Social Development and its inter-agency relationship with Police in relation to children in at-risk families. It also outlines, at p 15, some initiatives that are related to child protection matters e.g. Crime Reporting Line, Case Management initiative.

Authority initiated its own inquiry. Initiatives throughout the term of this Statement of Intent will reflect recommendations from the internal investigation and the inquiry.)

- *Develop multi-agency responses to ensure the safety of vulnerable children and reduce child victimisation. (Child, Youth and Family, the Ministry of Health and the Police have protocols that are being updated in 2010. Initiatives flowing from these protocols include a joint agency response to incidents where children appear at hospital with a non-accidental injury. This initiative is being piloted in 2010. Other initiatives are expected as part of the Government's 'Addressing the Drivers of Crime' programme.)"*

538. It is a matter for Police as an organisation as to how it chooses to express its priorities in its own strategic documents. The Authority is pleased to note that child abuse is now mentioned explicitly in the *National Business Plan 2010/2011 – 2012/2013*.

National consistency

539. A key theme which emerged from the Authority's Part I Report is the need for national consistency in the investigation of child abuse by Police. As noted in the previous chapters, Operation Scope found that some districts were performing to a consistently high standard (notably Counties Manukau, Auckland City and Canterbury), while practice in other districts was more variable. Although ease of access to particular services may vary depending on location, victims of child abuse are entitled to expect the same minimum standards of service from Police wherever they may live in the country.

540. The Police operate a district based model. However, a key role of PNHQ must be to ensure that minimum standards are met by all districts. It is self evident that this involves PNHQ setting minimum standards, monitoring compliance with those standards, and holding districts to account if they are not met.

541. Implementation of the Quality Assurance and Improvement Framework will be essential to the successful monitoring by PNHQ of district performance. In the context of child abuse investigations, the National Coordinator: Adult and Child Sexual Abuse, also has an important role.

542. There are proposed changes to this role which are currently under consideration by PNHQ. A recommendation has been made to the Commissioner that the revised structure for the Violence Reduction Unit should include the creation of a new position of Manager: Child Protection and Adult Sexual Assault. This position would have an appointee of the rank of Inspector and would report to the Manager Violence

Reduction. The reporting line upwards would be to the Assistant Commissioner Special Operations.

543. The revised structure would also separate the current role of National Coordinator: Adult and Child Sexual Abuse into two discrete positions: National Coordinator: Child Protection with exclusive focus on child protection; and National Coordinator: Adult Sexual Assault with exclusive focus on adult sexual assault. Both roles would have appointees of the rank of Detective Senior Sergeant and would report to the Manager: Child Protection and Adult Sexual Assault, whose reporting line is described above.

544. The National Coordinator: Child Protection role, which is of particular interest to the Authority in terms of this Inquiry, would collate critical information and focus on:

- Caseload analysis and monitoring (nation-wide)
- Milestone achievement against CPP and revised policy and practice guidelines
- Issue and problem resolution
- Supporting District Child Protection Coordinators
- Supporting the new and revised assurance and monitoring framework
- Internal and external reporting and engagement

545. The National Coordinator would be responsible for analysing and reporting to the Police Executive, the national results from regular six monthly file audits. These six monthly audit reports are intended to provide evidence that the changes made are having the desired effect.

546. The Authority views the implementation of these proposals as a critical step towards the Police achieving national consistency in this area of policing.

Conclusions and findings

547. It can be seen from the above that as a result of the Authority's Inquiry, significant and comprehensive changes and improvements are being made by PNHQ to practices, policies and procedures in relation to the investigation of child abuse.
548. In particular, PNHQ is proposing to improve the management of child abuse investigations to promote public confidence in the integrity of the processes, by implementing all 34 of the Authority's recommendations in the Part I Report.
549. If the changes and improvements identified by Police in response to the Authority's Inquiry are fully implemented and embedded, a consistently high standard of service is achievable for all victims of child abuse throughout the country.
550. The Child Protection Implementation Project Team has played a lead role in the Police response to the Authority's Part I Report. The team contains a number of subject matter experts and was set up at Commissioner Broad's direction and has his full support. The team has a role not just in setting the minimum standards identified in the Part I Report, but in implementing and embedding the practices, policies and procedures required to ensure minimum standards are met nationally and are sustainable.
551. The Authority considers it is crucial to the success of the Child Protection Implementation Project Team that it, or at least a sub-group of it, has an ongoing mandate for at least one year while the policies, practices and procedures resulting from its work are fully implemented and embedded by the Police. In addition to the 34 recommendations made in the Part I Report, the Authority makes one further recommendation to the Commissioner of Police.

RECOMMENDATION:

The Child Protection Implementation Project Team, or a sub-group of that team, should be given an ongoing mandate for a further period of at least one year to oversee the implementation of changes to Police practices, policies and procedures arising out of its work, and to report back to the Police Executive Committee.



Appendices

INDEPENDENT POLICE CONDUCT AUTHORITY

Appendix A – Terms of Reference, Child Abuse Inquiry: Part II

Appendix B – Child Protection Protocol

Appendix C – Summary of Recommendations, Child Abuse Inquiry: Part I, And Police Response

Appendix D – Commissioner’s Action Plan

Appendix E – Crime Reporting Line Interface

Appendix F – Quality Assurance and Improvement Framework

Appendix G – New Zealand legislation and international law

Appendix H – Bibliography

Appendix A

Terms of Reference, Child Abuse Inquiry: Part II

The Independent Police Conduct Authority (“the Authority”) is conducting an inquiry into practices, policies and procedures of the New Zealand Police (“Police”) in relation to child abuse investigations in New Zealand.

The Authority’s inquiry is in two parts. The first part of the Authority’s inquiry, reported on in May 2010, addressed systemic issues relevant to Police investigations of child abuse generally. The second part of the Authority’s inquiry will address:

- (a) The delays in the investigation of child abuse files in the Wairarapa which resulted in the Police operation known as Operation Hope.
- (b) The reasons why no significant action was taken to address the backlog of child abuse investigation files in the Wairarapa until Operation Hope began in late 2008, given the identification of a backlog of such files by some staff in 2006.
- (c) The response of Police National Headquarters (“PNHQ”) to information and publicity in 2006 about delays in the investigation of child abuse files as a result of the backlog identified in the Wairarapa.
- (d) The performance of each Police District in relation to child abuse investigations.
- (e) Any significant service failures in relation to child abuse investigations identified within particular Police Districts and the response by those Districts to ensure such service failures are not repeated in the future.
- (f) The response of each Police District to the Authority’s recommendations in Part I of its inquiry and any other relevant changes in each Police District to practices, policies and procedures relating to child abuse investigations.
- (g) The response of PNHQ to the Authority’s recommendations in Part I of its inquiry and any other relevant changes in PNHQ to practices, policies and procedures relating to child abuse investigations.

Appendix B

Child Protection Protocol

The full text of the Protocol can be found at: www.practicecentre.cyf.govt.nz/

A summary of its purpose, principles, and scope is provided below.

Child Protection Protocol Between New Zealand Police and Child, Youth and Family

15 April 2010

.....

3. Purpose

The purpose of this protocol is to clearly define the roles of each organisation, and set out the process for working together when responding to situations of serious child abuse.

It ensures timely, coordinated and effective action by Child, Youth and Family and New Zealand Police so that:

- children are kept safe
- perpetrators are held to account wherever possible, and
- child victimisation is reduced.

It sets out the process for working collaboratively at the local level, and as a formally agreed, national level document, it will be followed by all Child, Youth and Family and Police staff.

4. Principles

As part of both organisations' commitment to working in a way that keeps children at the centre of their work, Child, Youth and Family and Police are guided by the following principles:

- the welfare and the best interests of the child is the first and paramount consideration including identifying and seeking support from family members or others who can help
- work will be conducted collaboratively with other agencies
- staff undertaking the functions of the CPP will be suitably skilled and trained
- investigations will be concluded in a child centred timeframe
- perpetrators will be held to account wherever possible.

5. Scope of the protocol

This protocol applies to serious child abuse including:

- sexual abuse
- serious physical abuse (assistance with determining “seriousness” is attached in the test for seriousness for physical abuse)
- serious willful neglect
- serious family violence where the child is a witness
- all allegations against Child, Youth and Family approved caregivers that involve serious child abuse
- all allegations against employees of Child, Youth and Family and the Police that involve serious child abuse.

This protocol does not apply to:

- any report of force on a child which is of a minor, trivial or inconsequential nature and where there is no evidence of serious abuse or neglect.

Appendix C

Summary of Recommendations, Child Abuse Inquiry: Part I, and Police Response

1. Police review its policy documents to ensure that a consistent definition of child abuse applies nationwide.

Police Response: Completed. A new Child Protection Policy and Investigation Guidelines have been developed and published. The policy, defines the word ‘Child’ and the term ‘Child Abuse’ with reference to the Children, Young Persons, and Their Families Act 1989.

Existing policies have been reviewed and amended (subject to legislative constraints) to ensure that a consistent definition of child abuse applies nationally.

2. Districts to ensure there is certainty about the work types their Child Abuse Teams are responsible for, consistent with the new Child Protection Protocol agreed between Police and Child, Youth and Family.

Police Response: Completed. The Child Protection Protocol (CPP) has been adopted nationally.

CPP training delivered nationally to Child Protection Investigators and Supervisors.

The ‘Child Protection Policy and Investigation Guidelines’ (Child Protection Policy) clarifies, with specific reference to the CPP, work types and investigation responsibilities. The new Policy states (amongst other things):

(i) “Investigators on child abuse teams should be exclusively focused on child abuse investigations”; and

(ii) “Where circumstances require it, investigators on child abuse teams must only work on non-child abuse matters for the shortest duration possible.”

The Commissioner reinforced the importance of the CPP by clarifying:

(i) Local Area Interagency Agreements do not override the national CPP; and

(ii) Where demand dictates Child Protection Investigators are to be exclusively focused on Child Abuse investigations and that Child Protection Protocol cases (pending or requiring immediate investigation) were to take precedence over less urgent matters.

New CPP process maps, depicting the key steps of the referral process, were developed.

3. Consideration be given to the inclusion of the investigation of child abuse as a priority in the Police's National Business Plan.

Police Response: Completed. Implementing recommendations from Operation River and the IPCA inquiry into child abuse were included in the 2010/11 National Business Plan as a specific change priority.

Child Abuse initiatives will remain a specific change priority until such time as the audit and assurance framework indicates that the changes are embedded and having the desired effect.

4. District Commanders give consideration to including the investigation of child abuse as an independent topic in their Business Plans.

Police Response: Completed. All 12 districts have included implementing the recommendations from Operation River and the IPCA Inquiry into child abuse as a local priority in their Business Plans for 2010/11.

The improvements made to Child Abuse investigation and management will remain a specific change priority until such time as the audit and assurance framework indicates that the changes are embedded and having the desired effect.

5. Police continue to review ways in which the timely and appropriate investigation of child abuse allegations form part of measurable performance objectives within all Police districts.

Police Response: Completed. Implementing the recommendations from Operation River and the IPCA Inquiry into child abuse are included as a specific change priority within the National and District Business Plans (2010-2011).

The investigation of child abuse and District responsibility has been included as specific performance criteria in all District Commander's performance evaluation.

A new mandatory tiered audit process was developed. Supervisors will review investigator child abuse file holdings monthly by selecting a random sample of files. This will be followed by a four monthly district review of a random sample of district files and a six monthly national review of randomly selected files from all 12 Police districts. The National Criminal Investigations Group, based at PNHQ, will be responsible for the national review. A summary of findings from the national review will be provided to the Police Executive and districts.

In addition, the Performance Group has designed specific case management reports to improve visibility of child protection investigations.

NIA Case Management functionality provides end to end file management. Its oversight capability allows identification of issues inclusive of files falling short of investigative 'best practice'.

Case Management Reports in Business Objects are being developed to provide a summary of workgroup file holdings (inclusive of individual case file summaries, detailing actions taken from file conception to the date of the Case Management Report).

6. A directive to staff be issued re-stating that all child abuse files must be entered and updated on NIA.

Police Response: Completed. On 22 July 2010, the Commissioner issued a Bulletin Board notice to all staff, directing that all child abuse cases must be entered and updated in NIA irrespective of investigation or outcome.

The Commissioner's requirement to enter and update all child abuse cases was further emphasised in the Ten One article "Implementation team to deliver on IPCA recommendations" which stated (amongst other things):

"All reports of child safety concerns, regardless of how they are resolved, are to be correctly recorded and coded in the NIA case management system."

The new Child Protection Policy makes it clear that all child safety concerns must be entered into NIA using the new '6C' incident code (regardless of any other offence or response code used) and managed using the NIA Case Management functionality.

The 'National Recording Standard' (NRS) policy sets out a national standard for recording of offences, incidents and tasks in Police systems. With respect to reports, the NRS states: all reports must be entered into NIA and further, that the timely recording of updates is necessary.

7. A file to be created in NIA in respect of a notification of alleged child abuse even where the decision taken is that no action is required.

Police Response: Completed. See recommendation 6 above.

In addition, the implementation of the Crime Reporting Line (CRL) will ensure that all CPP referrals from Child, Youth and Family are entered into NIA in accordance with the Protocol.

8. Consideration be given to shifting as much file recording responsibility from child abuse investigators to dedicated file recording staff as possible.

Police Response: Completed. Police considered how it could shift or alleviate administrative recording responsibilities noting: that the new Crime Reporting Line (CRL) will partially address this issue, as all CPP referrals are entered by the CRL and not by investigators.

It was also noted, that the use of the case management functionality in NIA is a critical file activity, requiring considered file management input at key steps of a case lifecycle rather than being purely 'administrative'. The requirement is particularly important under the new framework where supervisors and relevant District and National staff, having oversight and audit functions, require a file 'status' to be justified.

9. Training be given to child abuse investigators and supervisors on the use of NIA in respect of file recording and file management tasks that must remain the responsibility of investigators and supervisors.

Police Response: Completed. To date, 390 investigators and supervisors (including the majority of staff working in Child Protection) have been trained in NIA Case Management functionality.

10. Consideration be given to ensuring all child abuse files are specifically identified in NIA as "child abuse files".

Police Response: Completed. A new incident code, '6C' has been implemented to assign and identify all reports involving a child victim.

New functionality included in NIA to identify all agreed CPP cases.

The combination of the new incident code 6C, CPP case management and specific offence codes will enable cases to be identified as child abuse.

11. A standard form coversheet for all physical investigation files be adopted as a checklist for key steps in the investigative process for child abuse files.

Police Response: Completed. A Child Protection Investigation Plan, (to be embedded in NIA Case Management functionality in early 2011) has been developed to provide a template for child protection investigators. The template lists key investigative steps that should be considered on a 'best practice' platform without unduly restricting the range of possible steps that may be necessary in the particular case.

12. The 1995 Policy and Guidelines for the Investigation of Child Sexual Abuse and Serious Physical Abuse be reviewed and updated.

Police Response: Completed. The 1995 policy was reviewed resulting in a complete overhaul of policy directives, content and investigative processes. The new policy: 'Child Protection Policy and Investigation Guidelines' replaces the 1995 policy.

The new policy was published on the Police Instructions Intranet site on 7 December 2010.

13. The review to ensure there is consistency of all definitions and terminology incorporated in updated or newly created documents.

Police Response: Completed. The drafting of the new Child Protection Policy has (subject to legislative restraints), ensured consistency of definitions with other directly related policies.

14. As part of the review, consideration be given to creating two separate policy documents addressing the following areas: (a) Overarching policies and principles for the investigation of child abuse in New Zealand; and (b) Practical guidance for investigators of child abuse cases.

Police Response: Completed. The Child Protection Policy and Investigation Guidelines were initially drafted as two separate documents. However, following consultation and for reasons of certainty and ease of reference, it was decided to include the policy and guidelines (as separate subject matters) in the same document.

15. Police National Headquarters to monitor the implementation of the new Child Protection Protocol (CPP) by Districts.

Police Response: Completed. A joint Police and Child, Youth and Family working group has been established to monitor the compliance with the CPP.

The Evaluation Services Team in the Organizational Assurance Group will review CPP intervention and practice, during 2011.

A joint Police and Child, Youth and Family audit is intended to be completed during 2011.

16. Local level interagency agreements only to address matters particular to the district or area that are not otherwise covered by the Child Protection Protocol.

Police Response: Completed. The new Child Protection Policy makes it clear that local area interagency agreements do not offset or override obligations set out in the national CPP.

This key message was additionally emphasised by the Commissioner in an email to all District Commanders on 15 July 2010.

17. Police policy on the investigation of child abuse to make clear that Child Youth and Family attendances do not negate the need for Police to conduct its own investigation of alleged child abuse.

Police Response: Completed. The new Child Protection Policy confirms that the police obligation to investigate an allegation of child abuse is not obviated by Child, Youth and Family involvement.

This message was additionally emphasised by the Commissioner on 15 July 2010 (in an email to all District Commanders), 22 July 2010 (Bulletin Board message to all staff) and on 10 September 2010 (Ten One article).

18. A directive to staff to be issued re-stating that the filing of child abuse files to code “LF9999” or other generic codes is unacceptable.

Police Response: Completed. The ability to assign and or file files using a generic identifier such as LF9999, was removed on 12 September 2010.

Files can now only be assigned to a station and workgroup (within the station), or, station, workgroup and a specific person using their unique station or workgroup identifiers and individual person (QID) and subsequently filed, using unique station and workgroup identifiers.

The Commissioner reinforced this requirement: 15 July 2010 (in an email to all District Commanders), 22 July 2010 (Bulletin Board message to all staff) and on 10 September 2010 (Ten One article).

19. A review be carried out of the ways in which files are able to be closed in NIA, aimed at ensuring child abuse and other serious crime files are not able to be filed to lost file codes or otherwise inappropriately filed.

Police Response: Completed. See IPCA recommendation 18, above.

In addition, the new Child Protection Policy states that child abuse files can only be filed following a review by a Child Protection Team Supervisor.

The audit and assurance framework will also assess compliance with the requirement for supervisors to review files prior to filing.

Note: Agreed CPP cases (irrespective of whether the file has been filed) remain on the joint CYF and Police case list until such time as the parties agree that all matters have been finalised.

20. Consideration be given to ways in which supervision of child abuse investigators can be improved, including training for supervisors and review and restatement of relevant policy.

Police Response: Completed. CPP and NIA Case Management functionality training delivered nationally. The training included the requirement for supervisors to regularly review staff child abuse file holdings in NIA.

The audit and assurance framework is designed, amongst other benefits to improve supervisory standards by clarifying those areas that supervisors are expected to complete. Regular file samples will assess compliance with these requirements.

Planning commenced for a new national child protection and supervisors course. Development and implementation will be the responsibility of 'The Royal New Zealand Police College' (School of Investigations and Intelligence).

See Recommendation 25.

21. Consideration be given to the setting of a national standard on the number of child abuse investigation files to be held by an investigator at any one time.

Police Response: Completed. Consideration of setting a national standard on the number of child abuse investigation files that can be held by an investigator was completed.

The assessment found there was no reliable statistical platform to set a national standard on the number of child abuse files that could be held and investigated according to best practice, as the factors that influenced this turned on a wide range of factors, inclusive of case complexity, risk and investigator experience.

The national structure review estimated service demand at 7,000 new child abuse cases annually and concluded that the current level of 174 full time investigators was sufficient to manage the workload. This was based on an assessed benchmark of each investigator having the capacity to complete 40 child abuse referrals annually.

22. Investigators on child abuse teams to be exclusively focused on child abuse investigations. Where exigent circumstances require it, investigators on child abuse teams to be required to work on non-child matters for the shortest duration possible.

Police Response: Completed. The new Child Protection Policy makes it clear that investigators on Child Protection Teams:

(i) should be exclusively focused on their core business (unless circumstances require otherwise); and

(ii) if circumstances require otherwise, investigators must only work on non-child abuse matters for the shortest duration possible.

The Commissioner reinforced this position in an email to all District Commanders acknowledging that while it may not be always possible to ring fence Child Protection Investigators, CPP cases were to take precedence over less urgent matters.

23. A review be carried out of the way in which staff are selected for child abuse teams to ensure that only staff with willingness and aptitude to investigate child abuse files are selected.

Police Response: Completed. A review of child protection investigator selection criteria was completed. The review concluded that the existing processes were adequate to screen and assess any identified willingness and aptitude concerns.

24. A review be carried out of the number of Police staff in all 12 Districts who are trained and available as specialist evidential interviewers, with particular attention to availability within areas of each district.

Police Response: Completed. The national structure review considered Child Forensic Interviews, demand, resources (inclusive of training) and structure.

The review found: there were 34 forensic interview facilities operating nationally, under different models (Police or CYF only, or a mixed model) and that accessibility was problematic in rural areas and this was compounded by some rural districts/areas having difficulty maintaining sufficiently trained interviewers.

The review noted that the Southern District had overcome this by establishing a mobile interview unit and that this approach appeared to be both effective and efficient.

In terms of increasing accessibility to a forensic interviewing facility the review recommends:

(i) Mobile interview units should be considered by rural districts/areas (where geography and interview capability are a problem).

In terms of training specialist evidential interviewers, the review recommends:

(ii) That a new position be established within the National Investigative Interviewing Unit (Coordinator: Child Forensic Interviewing), with sole responsibility for the provision of ongoing training, monitoring and accreditation of the child forensic interviewing programme;

Additionally, a joint Police and Child, Youth and Family working group has been established to assess whether the current number of joint forensic interviewers (15 full time Police and 20 CYF interviewers) is sufficient.

25. Consideration be given to means by which training can be made more readily available to child abuse investigators, including in-district training.

Police Response: Completed. Police have considered how training can be made more readily available to child abuse investigators. An additional specialist child protection course (for 20 investigators – 19 attended) occurred in early November 2010. A further specialist child protection course (for 20 investigators) is planned for February/March 2011.

Child Protection investigation training has been incorporated into the CIB Selection and Induction course. This is designed to provide all investigators with fundamental child protection investigative skills.

An advanced specialist course for Child Protection Investigators is planned for release in mid 2011. This is intended to build on the skills and competencies learned in the CIB Selection and Induction course.

In addition, advanced training (inclusive of international good practice) is being developed for the Child Protection Investigations Leaders annual conference.

An e-learning package on the Child Protection Protocol has been developed and is being released on line for all staff and supervisors.

From the start of 2011, NIA Case Management training will be included in the CIB Selection and Induction course and current Child Protection Investigators course.

26. Each district to review its structures for the investigation of child abuse.

Police Response: As part of Operation Scope, all 12 Police districts reviewed their ownership and oversight functions for child abuse investigation and management. As a result, the districts strengthened monitoring and oversight functions.

A national structure review has also been undertaken. The review found that all districts (except Tasman district) operated at least one dedicated Child Protection Team (either at district or area level) and that the makeup of each team, varied according to demand and district. The review noted that the 12 districts accordingly operated different structural models and recommended:

- (i) All districts establish and maintain at least one dedicated Child Protection Team.
- (ii) All districts appoint a Child Protection Co-ordinator who has district oversight and responsibility for monitoring all district child protection cases.
- (iii) The Child Protection Co-ordinator reports to the District Crime Services Manager.
- (iv) Child Protection Teams report to the District Crime Services Manager.
- (v) Police continue to operate the mixed structural model where demand dictates.
- (vi) Area Commanders have responsibility for area child protection portfolio holders.

Recommendations 26 to 31 relate to district structures for the management of child abuse investigations. Whilst the national structure review has been completed, its recommendations are still under consideration by the Police Executive.

27. As part of such a review, each district to assess the feasibility of: (a) a central child abuse team for the whole district; or (b) a child abuse team in each area of the district.

Police Response: Completed. The national structure review found:

- (i) All districts (except Tasman District) operated at least one dedicated Child Protection Team (either at district or area level) and that the makeup of each team, varied according to demand and district;
- (ii) There was insufficient demand to justify the establishment of separate child abuse teams in all District Areas; and
- (iii) That the current Child Protection staffing levels (at September 2010) were otherwise largely sufficient to meet service demands.

The review noted that the 12 Police districts operated different structural models (due to service demand and geographical spread) and recommended:

- (i) All districts establish and maintain at least one dedicated Child Protection Team.
- (ii) Police continue to operate the mixed structural model where demand dictates.
- (iii) District Crime Services Managers have responsibility for the overall performance of District Child Protection Teams and Area Commanders have responsibility for the overall performance of Area child protection portfolio holders.

28. If, following its review, a district will continue to have an area not served by a child abuse team, consideration is to be given to a child abuse team in another area in the district: (a) operating as a central point of intake for all child abuse notifications; (b) ensuring that file recording of NIA is appropriate on all child abuse files; (c) fulfilling an oversight role in respect of all child abuse files.

Police Response: Completed. See IPCA recommendations 6, 18, 20, 26 and 27 above.

In summary, the national structure review noted the 12 districts operated different structural models due to different service demands, CIB resource availability and geographical spread and recommended, amongst other things:

- (i) All districts appoint a Child Protection Co-ordinator who has district oversight and responsibility for monitoring all district child protection cases.

The new Child Protection Policy makes it clear that all child abuse cases must be entered and updated in NIA irrespective of investigation or outcome and that child abuse files can only be filed following a review by a Child Protection Team Supervisor.

The audit and assurance framework will assess compliance with the new Child Protection Policy.

29. Irrespective of the particular structure adopted, consideration be given to each district having a central point of command for all child abuse files in the district e.g. the Crime Services Manager.

Police Response: Completed. See IPCA recommendations 26 to 28. In summary, the national structure review recommends (amongst other things):

- (i) All districts appoint a Child Protection Co-ordinator who has district oversight and responsibility for monitoring all district child protection cases.
- (ii) The District Child Protection Co-ordinator and District Child Protection Team(s) report through to the District Crime Services Manager.

The national structure review also noted that some districts managed child abuse files, (due to limited service demand and wide geographical areas), through area CIB portfolio holders and recommended that the Area Commander have responsibility for the overall performance of Area child protection portfolio holders.

30. Consideration be given to the National Coordinator for Adult Sexual Assault and Child Abuse being given resources and responsibility to ensure a nationally consistent approach to the investigation of child abuse, through engagement with child abuse teams, CIB and district audit teams.

Police Response: Completed. The national structure review found a need to separate adult sexual assault and child protection functions to enable increased singular focus on each area. The review accordingly recommends that the current National Co-ordinator: Adult and Child Sexual Assault position should be separated into two discrete roles: National Co-ordinator: Adult Sexual Assault and National Co-ordinator: Child Sexual Assault.

In addition, the review recommends that a new position of Manager: Child Protection, Adult Sexual Assault with national responsibility should be established (in addition to the approved GNI national child abuse coordinator position) to amongst other things, ensure national consistency of child abuse investigations.

31. Consideration be given to the National Coordinator for Adult Sexual Assault and Child Abuse reporting to a member of the Police Executive on the compliance of districts with Police policy, standards and guidelines designed to ensure a nationally consistent approach to the investigation of child abuse.

Police Response: Completed. The national structure review recommends that the proposed position of Manager: Child Protection, Adult Sexual Assault should report through to the National Manager: National Criminal Investigation Group, who reports directly to a member of the Police Executive.

The National Criminal Investigation Group will report to the Executive on the national audit and specifically whether its framework delivers anticipated assurance.

This Closure Report recommends a transition team is tasked with having continued national oversight of the effects of the child protection implementation change phase until such time as the Police Executive has confidence that the changes are embedded and having the desired effect.

32. A process be established for the audit of child abuse investigations, which includes random sampling of investigation files.

Police Response: Completed. A new mandatory tiered audit process was developed. Supervisors will review investigator child abuse file holdings monthly by selecting a random sample of files. This will be followed by a four monthly district review of a random sample of district files and a six monthly national review of randomly selected files from all 12 Police Districts. The 'National Criminal Investigations Group', based at PNHQ, will be responsible for the national review. The audit process includes both compliance and quality measures.

A summary of findings from the national review will be provided to the Police Executive and Districts.

33. Police policy documents to clearly express and define the audit functions carried out by business units based at Police National Headquarters.

Police Response: Completed. The new Child Protection Policy describes the minimum requirements for monitoring and oversight.

34. A business unit within Police National Headquarters to have the responsibility, clearly expressed in Police policy documents, for ensuring districts are carrying out audits of child abuse investigations appropriately.

Police Response: Completed. The National Criminal Investigations Group at Police National Headquarters has responsibility for ensuring districts are carrying out audits of child abuse investigations appropriately.

Appendix D

Commissioner's Action Plan

1. Implement the Crime Reporting Line channel to support the referral process between Police and CYF – ensuring seamless recognition and response to cases.

Completed: The National Crime Reporting Line supporting the CPP process commenced on 2 November 2010.

2. Re-structure the National Crime Services Group (Violence Team) in order to:

(a) maintain currency of investigative best practice.

(b) insert a higher level of visibility of child abuse investigation including

i. the maintenance of national multi-agency protocols; and

ii. confirm and then ensure compliance with national investigation standards.

(c) ensure that RNZPC (school of investigation) and district training standards and methods align with the national investigation standard.

(d) providing resources for monitoring of reporting, caseloads, milestone achievement, issues and problems resolution, and external reporting.

(e) supporting assurance/risk management reviewed (OAG).

Action points 2(a) and (b) A national structure review of the National Crime Services Group – Violence Team (now known as the 'National Criminal Investigation Group') was completed. The review recommends that a new position of Manager: Child Protection, Adult Sexual Assault, with national responsibilities be created.

The review also recommends that the current National Coordinator: Adult and Child Sexual Assault position is separated into two discrete roles: National Coordinator: Adult Sexual Assault and National Coordinator: Child Sexual Assault, to enable a higher level of focus and visibility on each area.

The new Child Protection Investigation Guidelines inform 'best practise'

The Child Protection Protocol adopted nationally.

Action point 2(c) Completed: Child Protection investigation training has been incorporated into the CIB Selection and Induction course. This course reflects the new 'Child Protection Policy and Investigation Guidelines'.

An advanced specialist course for Child Protection Investigators is planned for release in mid 2011.

In addition, advanced training (inclusive of International good practice) is being developed for the Child Protection Investigation Leaders annual conference.

An e-learning package on the Child Protection Protocol has been developed and is being released on line for all staff and supervisors.

Action points 2(d) and (e) Completed: From the start of 2011, NIA Case Management training will be included in the CIB Selection and Induction Course and current Child Protection Investigators course.

A new incident code, '6C' has been implemented to assign and identify all reports involving a child victim.

New functionality included in NIA to identify all agreed CPP cases.

The combination of the new incident code 6C, CPP case management and NIA Case Management functionality will enable monitoring and oversight of 'child abuse' file holdings as well as milestone achievement and issue and problem resolution.

A new mandatory tiered audit process developed. Supervisors will review investigator child abuse file holdings monthly by selecting a random sample of files. This will be followed by a four monthly district random sample review of district files and a six monthly national random sample review of selected files from all 12 Police districts.

The audit process includes both compliance and quality measures.

A summary of findings from the national review will be provided to the Police Executive and districts.

The new Child Protection Policy informs and directs the audit process.

3. Implement (prioritise the national rollout) NIA Case Management for all abuse cases involving children. This will ensure that:

- (a) there is a national approach to recording complaints,**
- (b) there is a national approach to creating and interpreting statistics,**
- (c) there is a national approach to documentation,**
- (d) case management (managing criminal investigations) standards reach consistently high levels,**
- (e) assurance over technical case management standards are achieved.**

Action point 3(a) Completed: NIA Case Management reporting framework improved. This will enable District Commanders, Area Commanders and supervisors to monitor investigative workloads, the volume of active cases, the types of cases (by category and priority), time in the system, who the file is assigned to (by QID) and by location of the investigating member.

The implementation of the Crime Reporting Line on 2 November 2010 provides a central point to manage Child Protection Protocol referrals from Child, Youth and Family. Child abuse cases are coded '6C' and entered into NIA to allow identification and end to end case management.

Action point 3(b) Completed: A new incident code, '6C' has been implemented to assign and identify all reports involving a child victim.

New functionality included in NIA to identify all agreed CPP cases.

The combination of the new incident code '6C', CPP case management and NIA Case Management functionality will enable monitoring and oversight of child abuse file holdings as well as statistical reference.

Action point 3(c) Completed: The new Child Protection Policy sets out best practise guidelines and emphasises:

- (i) the mandatory recording of all reports of child safety concerns using the new incident code '6C' (regardless of any other offence or response code used); and
- (ii) the requirement for all child abuse cases to be managed using the NIA Case Management subsystem. This is consistent with the National Recording Standard (which is due to be updated to emphasise the new Child Protection Code '6C').

The ability to assign and or file a matter to generic QID such as LF9999 was removed on 12 September 2010. Files can now only be assigned to a station and workgroup (within the station), or, station, workgroup, and a specific person using their unique station or workgroup identifiers and individual person (QID) and subsequently filed, using unique station and workgroup identifiers.

Action point 3(d) A training booklet focusing on NIA Case Management functionality and Child Protection was developed.

NIA Case Management training was delivered nationally. As at 1 November 2010, 390 investigators and supervisors (including the majority of staff working in Child Protection) have been trained.

From the start of 2011, NIA Case Management training will be included in the CIB Selection and Induction course and current Child Protection Investigators course. 'Child Protection' has been included in the CIB Induction and Selection course.

Action point 3(e) The new mandatory assurance framework will review files for compliance with key NIA data entry, management and filing requirements. (See also action point 2 above).

4. Review the classification of all cases involving children (that is, bring together not only the "classic" abuse cases but also the investigation of cyber-crimes against children, abuse cases derived from family violence investigations (referred or indirect abuse) and related abuse cases (child trafficking)) – i.e. a new definition/scope of child abuse – to avoid defining child abuses cases "out" of compliance with national CA policies.

Completed: The new Child Protection Policy defines the word 'child' in a manner consistent with the Children, Young Persons, and Their Families Act 1989.

The new definition of the term 'child abuse' says: "If the victim is a child and one or more of the following exist then the report of concern should be treated as child abuse". The topics listed are: physical abuse; sexual abuse; neglect; emotional abuse; psychological abuse; witness to serious crime; presence in unsafe environments (e.g. locations for drug manufacturing or supply); cyber crime; child trafficking.

5. Define and implement a standard intelligence tasking around child abuse offenders in order to monitor risk of known or suspected offenders.

Completed: The National Intelligence Centre has established a process to identify and manage serious and repeat offenders through a National Offender Prioritisation Matrix and profiling. This allows escalation of identified risks at national, district or area levels.

A sharepoint system, utilising traffic and coordination processes, is being rolled out nationally to enable offenders to be tracked across the country.

6. Implement a national structures policy

(a) structure all district child abuse investigation teams consistently under a senior investigating officer reporting to the crime manager.

(b) estimate demand for investigation for all cases of abuse of children (new definition) and recommend/implement resource requirements to meet demand by location.

(c) ensure these cases under dedicated child abuse investigation teams; including an assessment of the potential for multi-agency centres in each district/area.

(d) co-manage all staff involved in dedicated child abuse investigation to ensure that all are trained to the national standard (i.e. mitigate the risk of transient/impermanent investigator base – until sufficient assurance exists to hand these investigators back to district management).

Action point 6(a) Completed: A national structure review of Child Protection Team structures and resource requirements was completed. The review recommends (amongst other things):

- (i) All districts establish and maintain at least one dedicated Child Protection Team.
- (ii) All districts appoint a Child Protection Co-ordinator who has district oversight and responsibility for monitoring all district child protection cases.
- (iii) The District Child Protection Co-ordinator and District Child Protection Team(s) report through to the District Crime Services Manager.

Action point 6(b) Completed: The review estimates service demand at 7,000 new child abuse cases annually and concludes that the current level of 174 full time investigators is sufficient.

Action point 6(c) Completed: The national structure review found that all districts (except the Tasman District) had a dedicated district and/or area Child Protection Team and recommended (as outlined in Action point 6) that all districts establish and maintain at least one dedicated Child Protection Team.

The review also found that while the current multi-agency centres were world class facilities, it would not be viable to replicate the models in every district. The review recommended as an alternative, co-location/co-sharing arrangements.

Action point 6(d) Completed: Child Protection investigation training has been incorporated into the CIB Selection and Induction course. This is designed to provide all investigators with fundamental child protection investigative skills.

An advanced specialist course for Child Protection Investigators is planned for release in mid 2011. This is intended to build on the skills and competencies learned in the CIB Selection and Induction course.

In addition, advanced training (inclusive of International good practice) is being developed for the Child Protection Investigation Leaders annual conference.

An e-learning package on the Child Protection Protocol has been developed and is being released online for all staff and supervisors.

From the start of 2011, NIA Case Management training will be included in the CIB Selection and Induction course and current Child Protection Investigators course.

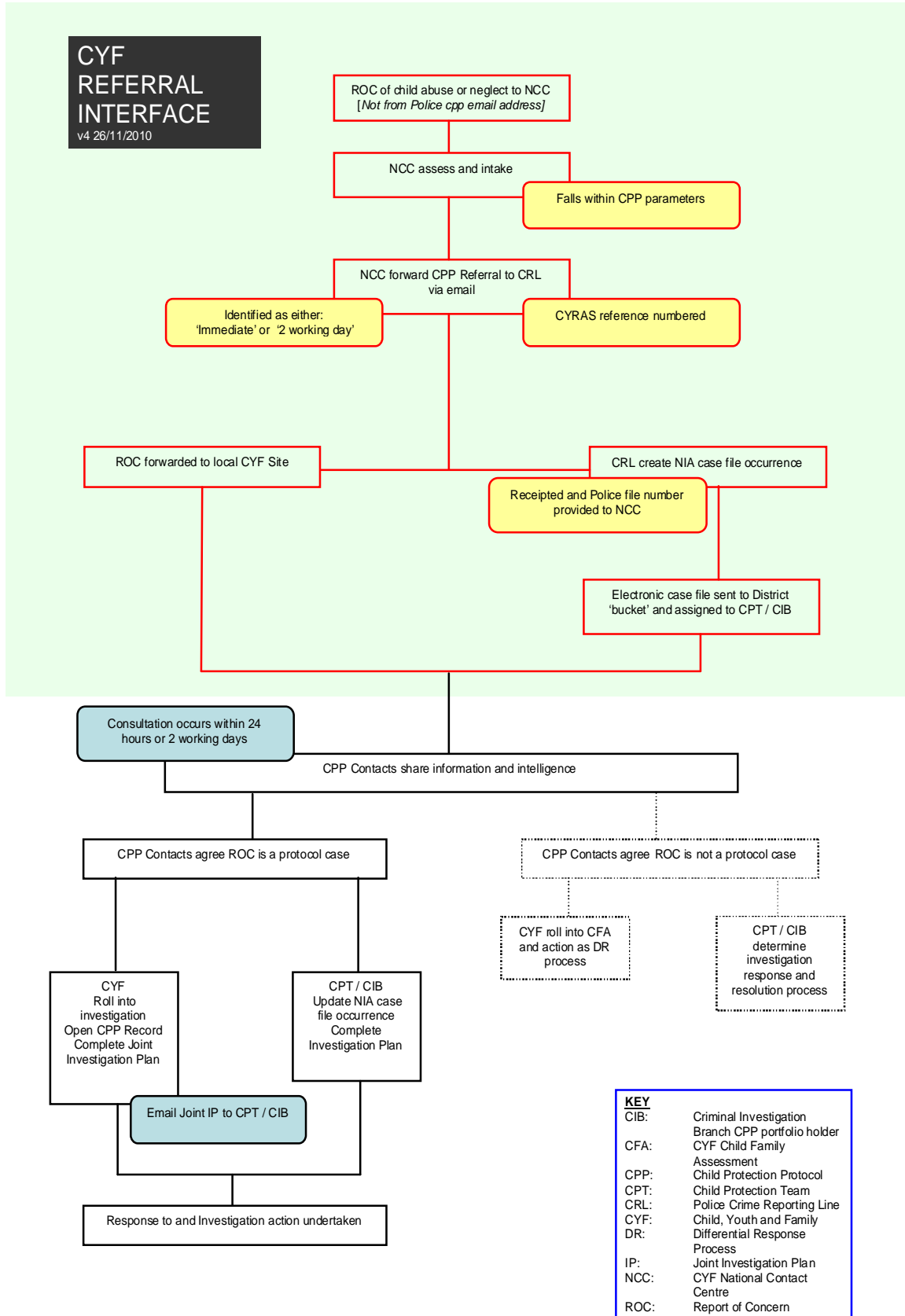
Additionally, a specialist child protection course (for 20 investigators – 19 attended) occurred in early November 2010. A further specialist child protection course (for 20 investigators) is planned for February/March 2011.

7. Progress other recommendations in the Interim report.

Completed: All 34 IPCA recommendations were either completed or substantially completed by 30 October 2010.

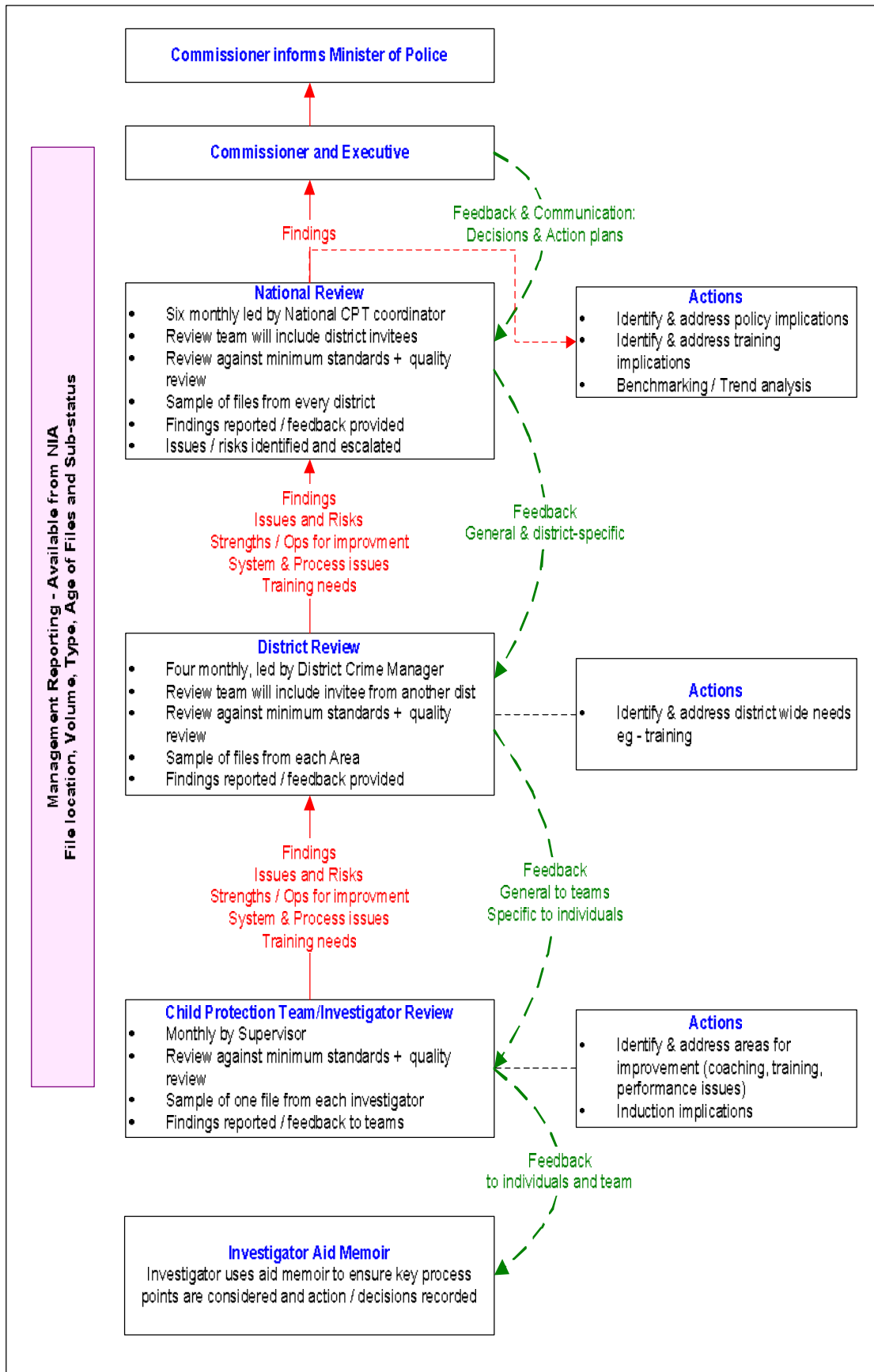
Appendix E

Crime Reporting Line Interface



Appendix F

Quality Assurance and Improvement Framework



Appendix G

New Zealand legislation and international law

Children Young Persons and Their Families Act 1989

Domestic Violence Act 1995

Victim's Rights Act 2002

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Appendix H

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PO Box 5025, Wellington 6145

Freephone 0800 503 728

www.ipca.govt.nz





IPCA
Level 8
342 Lambton Quay
PO Box 5025,
Wellington 6145
Aotearoa New Zealand

0800 503 728
P +64 4 499 2050
F +64 4 499 2053
www.ipca.govt.nz