Public report on Police response to the shooting of Navtej Singh

May 2010

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

May 2010

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Executive Summary

1. On 1 September 2008 a complaint was made to the Independent Police Conduct Authority concerning the delay in getting emergency medical treatment to Navtej Singh after he was shot during an armed robbery at the Riverton Liquor Store in Manurewa on the evening of Saturday 7 June 2008.

2. Following notification of the complaint to the New Zealand Police, the Independent Police Conduct Authority commenced an independent investigation.

3. The Authority's investigation focused on the Police response to the 111 calls made from the scene and the time delay in Navtej Singh receiving medical attention. The investigation also considered whether or not any decision, act, omission, conduct, policy, practice, or procedure, which was the subject matter of the investigation was contrary to law, unreasonable, unjustified, unfair or undesirable, as required by section 27(1) of the Independent Police Conduct Authority Act 1988, and if so, whether any recommendations should accordingly follow.

4. Though the Authority's investigation was completed in 2009, the Authority elected to not report publicly until completion of the trial of the men accused of Mr Singh's murder. That trial was completed in March 2010 and resulted in Anitilea Chan Kee being found guilty of murder.

5. An inquest into the death of Navtej Singh has been opened and adjourned pending the outcome of the criminal trial.

SUMMARY OF FINDINGS

6. The delay in Police attending the Riverton Liquor Store, and as a consequence the delay in Navtej Singh receiving emergency medical treatment, could not be justified and was undesirable. The delay was not caused by any single failing but rather by a series of procedural, and command and control failures.

7. Of these, the most significant were the failures to properly record, analyse and communicate all relevant information from the scene, which meant that the responding officers lacked clear information about Mr Singh's condition or the location of the offenders. It also affected coordination between Police and St John Ambulance, specifically in relation to the location of the Safe Forward Point. Other factors included: a shortage of local Manurewa Police units available to respond; unnecessary diversion of, and incorrect directions to, units that were responding; a lack of active oversight by NorthComms after command and control was handed to an officer in the field; a lack of flexibility in using units that were available to respond; and the time taken by officers to change into ballistic body armour.

8. The Police have a basic duty to protect life. Whilst Navtej Singh's injuries may not have been survivable, what is known is that he suffered significant pain and distress, both of which were inevitably heightened by the delays in getting him emergency medical treatment. By the time he arrived at Middlemore Hospital 60 minutes after he had been shot, Navtej Singh felt he was going to die.

9. The overall effect of the catalogue of events which together conspired to create a delay in the Police response and a consequential delay in getting emergency medical attention to Navtej Singh was arguably a breach of the Police duty of care to preserve life.

10. The Authority recognises too the distress caused to family and friends who made repeated calls to the emergency services requesting assistance. Despite reassurances that the Police and the ambulance were "*on the way*" they failed to attend the scene until approximately 31 minutes after the first telephone call to Police.

SUMMARY OF RECOMMENDATIONS

11. The Authority has recommended that Police:

    1) address communications centre training to:

        - ensure that staff understand the importance of managing critical information and ensuring it is passed to the incident controller in the field;

- ensure that staff understand requirements for formal handover of command and control, including appropriate timing for handover;
- ensure that shift commanders understand the need to maintain active oversight of critical incidents after incident control has passed to field units;

2) ensure that all staff are trained on the National Protocol for Interaction between communication centre and field staff;

3) treat all situations in which Police are told that someone has been shot as potentially life-threatening until medical assistance has been provided, rather than making assumptions based on the size of the wound or the presence of bleeding alone;

4) review training for all staff on command and control, and management of critical incidents in which people may have been injured;

5) fit the Police helicopter Eagle with video recording equipment so that critical events can be recorded at all times, and consider the feasibility of Eagle providing a 'live feed' of images to the communications centre;

6) review management of critical firearms incidents in which people have been or are suspected of being injured;

7) review Police inter-operability with St John Ambulance and other emergency services, particularly in relation to management, transfer of critical information and post incident debriefings;

8) ensure that Police and Ambulance use the same SFP unless there are sound operational reasons for not doing so, and ensure that other emergency services are clearly informed of the location of any SFP;

9) ensure that inter-agency debriefing takes place when more than one agency has been involved in a critical incident to enhance inter-operability between the agencies;

10) review firearms training to ensure that staff are competent and confident in responding to critical incidents;

11) provide a national policy on 'ride-along' and SCOPE passengers in Police vehicles;

12) prioritise the rollout of HAP vests to all districts, and ensure that, until HAP vests are available, firearms training includes familiarisation with ballistic body armour;

13) ensure that there are appropriate mechanisms for reporting mapping inaccuracies, and consider establishing a memorandum with local authorities to ensure that relevant information (such as road changes) is passed on to Police;

14) consider alternatives for when Language Line is not available, and ensure that communications centre staff who are experiencing difficulty with a caller's language ask if there is anyone else at the scene who speaks English;

15) ensure that when vehicles are permitted by District policy to carry firearms that ballistic body armour is also available in each vehicle;

16) clarify the recording requirements for the issue of firearms expressed in the Police Manual in the context of the practical need to get firearms to a scene urgently.

Introduction

12. On 1 September 2008, a complaint was made to the Independent Police Conduct Authority about a delay in getting emergency medical treatment to Navtej Singh after he was shot during a robbery at the Riverton Liquor Store in Manurewa in June of that year.

13. After notifying New Zealand Police of the complaint, the Authority began an independent investigation. This investigation focused on the Police response to 111 calls made from the scene, and the elapsed time between those calls and the arrival of emergency services at the scene and the administration of medical attention to Mr Singh.

14. The investigation also considered whether or not any decision, act, omission, conduct, policy, practice, or procedure, which was the subject matter of the investigation was contrary to law, unreasonable, unjustified, unfair or undesirable.

15. Though the Authority's investigation was completed in 2009, the Authority elected to not report publicly until completion of the trial of the men accused of Mr Singh's murder. That trial was completed in March 2010 and resulted in Anitilea Chan Kee being found guilty of murder.

16. This report explains the events of 7 June 2008 and subsequent Police actions, and sets out the Authority's findings and recommendations.

Glossary of terms

Abbreviation/ term	Explanation
AOS	Armed Offender Squad
ASN	District Shift Supervisor
Call taker	Based at the Communications Centre and is responsible for answering calls
CIMS	Coordinated Incident Management System A model which outlines the functions required and recommended structure to systematically manage incidents and operations
Command	The internal direction of members and resources of an agency in the performance of that agency's role and tasks Command relates to single agencies and operates vertically within an agency
Control	The overall direction of response activities in an emergency situation Authority for control is based in legislation or by agreement and carries with it the responsibility for tasking and coordinating other agencies Control relates to either the single-agency level or horizontally across agencies
Coordination	The bringing together of agencies and resources to ensure a consistent and effective response to an incident
Cordon	A cordon is the means to maintain an area and is used to restrict movement into and out of an area
Dispatch	To task and/or move a resource
Dispatcher	Works at the Communications Centre Receives a job that has been entered into a computer aided dispatch system by a call taker and allocates the job to a patrol or patrols in that area according to availability and priority
HAP vests	Hard armour protection vest
Eagle	NZ Police helicopter
Heritage language	Primary language that an individual identifies with
Incident Control	The overall management of the response to the incident
Incident Controller	The person responsible and accountable for the overall management of the response to an incident
Inner Cordon	A cordon established immediately around an event
IPCA	Independent Police Conduct Authority
Language Line	A telephone service that is funded by the Government and managed by the Office of Ethnic Affairs which offers a telephone translating service
MoU	Memorandum of Understanding
Multi Agency Response	An incident which requires a response from two or more agencies
Near miss	An unplanned event that did not result in injury, illness, or damage - but had the potential to do so
NorthComms	Police Northern Communications Centre
Outer Cordon	A cordon established further from an event than the inner cordon to enable access to the area of operations to be controlled
Post Incident Debrief	An opportunity for all staff to share views on the management of the incident so that good and poor practice can be identified and lessons learned can be included in future training, planning and risk assessment
Ride-along	A civilian passenger or Police officer accompanying a Police officer in order to gain an insight into policing or to gain specific experience
SCOPE	Surroundings, Conditions, Organisation, People, Prospects, Effects, Education
Section Manager	Ensures a coordinated approach is provided to major and serious events by; • managing day to day administrative functions • providing leadership and guidance to team leaders and other staff
SERT Paramedic	Specialist Emergency Response Officer
SFP	Safe Forward Point- A safe location near an incident from where the forward operations can be supported

Shift Commander	Manages team leaders, dispatchers and call takers to ensure a coordinated approach to major and serious incidents
Single-agency Response	An incident requiring a response from only one agency
SRBA	Stab Resistant Body Armour
Tactical Commander	An adviser with specialist skills which are needed to support incident operations
Team Leader	Direct manager of the call takers and / or dispatchers Functions include ensuring reports of events, incidents and offences are recorded, evaluated and resourced to meet approved operating procedures

Glossary of key Police and Ambulance officers

Police Communications Centre staff	Role	Involvement and key activities
Call taker 1	Call Taker Non sworn	Answered the first call from the Riverton Liquor Store to Police (at 9:04:33hrs) from the co-owner of the store Line was disconnected and she attempted to call back but the line was engaged Entered the job as Priority 1 which advised the dispatcher of the incident
Call taker 2	Call Taker Non sworn	Answered the call (at 9:07:53hrs) made by the Ambulance communication centre advising of the incident Entered the job as Priority 1 which advised the dispatcher of the incident
Call taker 3	Call Taker Non sworn	Answered the second call from the Riverton Liquor Store (at 9:10:28hrs) to Police from Navtej Singh's friend Entered the job as Priority 4 which did not advise the dispatcher of the incident
Call taker 4	Call Taker Non sworn	Telephoned Ambulance communications (at 9:29:42) to advise the location of the SFP: Shifnal Drive and Secretariat Place
Section manager	Section Manager Non sworn	Reviewed the radio transmissions and telephone calls
Dispatcher 1	Dispatcher Non sworn	Dispatched and managed the incident
Dispatcher 2	Dispatcher Non Sworn	Spoke with Navtej Singh's business partner and a friend on the telephone having been passed the call by the NorthComms team leader Kept the telephone line open until the Police arrived at the scene
NorthComms Team leader	Team Leader Non Sworn	Monitored the dispatch of the incident
Shift Commander	Inspector Shift Commander	Overall responsibility for the management of the incident Telephoned the AOS Tactical Commander (at 9:14:10hrs)regarding the robbery Advised AOS that the offenders had left the scene

Police Field Staff	Role	Involvement and key activities
Officer A	Senior Sergeant (District Shift Supervisor)	Incident Controller Near miss vehicle incident at Rainbows End whilst en route Second unit to arrive at the 1st SFP Moved to the 2nd SFP almost immediately Entered the scene once this had been cleared
Officer B	Detective Constable	In vehicle driven by Officer A with a prisoner from another incident Dropped off at the Manukau Police Station in Wiri Station Road Manukau
Officer C	Constable **Dog Unit**	Had a 'ride-along' with him in his vehicle Self issued with firearm Assisted other personnel with firearms and ballistic body armour when arrived at the SFP Deployed from the SFP to the Riverton Liquor Store to secure the scene with officers from the Howick team

Officer C (cont'd)		Called for the ambulance to attend the scene once this had been secured
Officer D	Constable **Dog Unit**	First unit to arrive at the 1st SFP, self issued with firearm No body armour available in vehicle When joined by Officer A at 1st SFP moved to 2nd SFP and assisted other personnel with firearms and body armour Deployed from SFP to the Riverton Liquor Store to secure the scene with officers from the Howick team
Ride-along	Constable	Was in vehicle driven by Officer D as a ride-along When joined by Officer A at 1st SFP moved to 2nd SFP Deployed from SFP to the Riverton Liquor Store to secure the scene with officers from the Howick team
Officer E	Acting Sergeant **Manurewa Unit**	At Manurewa Station when the incident happened Self issued firearms and body armour and issued firearms to Officer F En route to the SFP was re-directed by Eagle to intercept a motor vehicle seen to have left the scene
Officer F	Constable **Manurewa Unit**	At Manurewa Station when the incident happened Issued firearms and ballistic body armour by Officer E En route to the SFP was re-directed by Eagle to intercept a motor vehicle seen to have left the scene
Officer G	Acting Sergeant **Howick Unit**	Attended from the Howick area Had a 'ride-along' member of the public with him in his vehicle On arrival at the SFP asked by Officer A to distribute the firearms and body armour from his vehicle but unknowingly did not have key to the gun safe on his vehicle key ring Assisted other personnel with firearms, body armour and Fire Orders Once scene was clear he went there with Officer A
Officer H	Acting Sergeant **Howick Team**	In charge of a team from Howick The team entered the scene from the SFP with the Dog Unit
Officer I	Constable **Howick Team**	Part of Howick team
Officer J	Constable **Howick Team**	Part of Howick team
Officer K	Acting Sergeant **Papakura Unit**	Attended from the Papakura area On arrival self issued firearm but no body armour available in vehicle Originally directed by NorthComms to stop traffic on Portchester Road then re-directed by Eagle to intercept a motor vehicle seen to have left the scene Re-directed again by Officer A to attend SFP Upon arrival at the SFP issued body armour from another unit He went to the scene once this was clear
Officer L	Constable **Papakura Unit**	Part of Papakura Unit Re-directed again by Officer A to attend SFP Assigned to cordon control Shifnal Drive and Magic Way
Eagle	Senior Constable & Constable	Air support from deployment to attendance of Police and ambulance at scene.

St John personnel	Role	Involvement and key activities
St John call taker 1	111 St John Ambulance call taker	Answered the 1st call from the Riverton Liquor Store (at 9:06:52hrs) to Ambulance from Navtej Singh's business partner Call was disconnected She called back the scene (at 9:11:10hrs) and spoke with the business partner Received call from Police Communications Centre (at 9:29:42hrs) advising of a change in the SFP
St John call taker 2	111 St John Ambulance call taker	Telephoned the Police Communications Centre (at 9:07:47hrs) to advise them of the call received from the Riverton Liquor Store (call having been answered by St John call taker 1) Took the 3rd call from the Riverton Liquor Store (at 9:39:28) from Navtej Singh's friend requesting the ambulance to attend the scene
St John call taker 3	111 St John Ambulance call taker	Answered the 2nd telephone call from the Riverton Liquor Store (at 9:20:22hrs) from Navtej Singh's friend requesting the Ambulance/Police attendance
St John dispatcher	111 St John Ambulance Dispatcher	Dispatched and managed the incident, set up the initial Ambulance SFP
St John team leader	St John Team Leader	Managed the incident within the St John Northern Communications Centre Directed units to the SFP and spoke with the Field Operations Manager and the Duty Operations Manager
St John team manager	St John Operations Team Manager	Attended the 1st SFP and then directed by the St John Northern Communications Centre to 2nd SFP before being directed to the scene

CRITICAL TIME CHRONOLOGY[1]

Time (pm)	Service	Comment/Event
7 June		
9:03:08	CCTV at SCENE	Gunman and two other men enter the Riverton Liquor Store
9:03:44	CCTV at SCENE	Navtej Singh shot He immediately collapses to the floor behind the counter
9:04:13	CCTV at SCENE	All offenders leave the Riverton Liquor Store
9:04:33		Telephone call from Mr Singh's business partner to Police (111) Recorded as a Priority 1 event
9:05:41	CCTV at SCENE	Approximate time that Mr Singh's business partner calls Mr Singh's wife
9:06:08		First police unit (Officers E and F) dispatched to scene Officer A acknowledges information and advises will travel towards the scene
9:06:49	CCTV at SCENE	First customer arrives in store
9:06:52		Telephone call from Mr Singh's business partner to Ambulance Recorded as a Priority 1 event
9:07:19		Officer A requested Eagle to be deployed over scene
9:07:27	CCTV at SCENE	More customers arrive in store
9:07:47 (Police NorthComms times the call at 9:07:53)		Telephone call from Ambulance to Police
9:07:59	CCTV at SCENE	Mr Singh's wife arrives in store
9:08:30		Dispatch advises the St John Team Manager of incoming shooting details

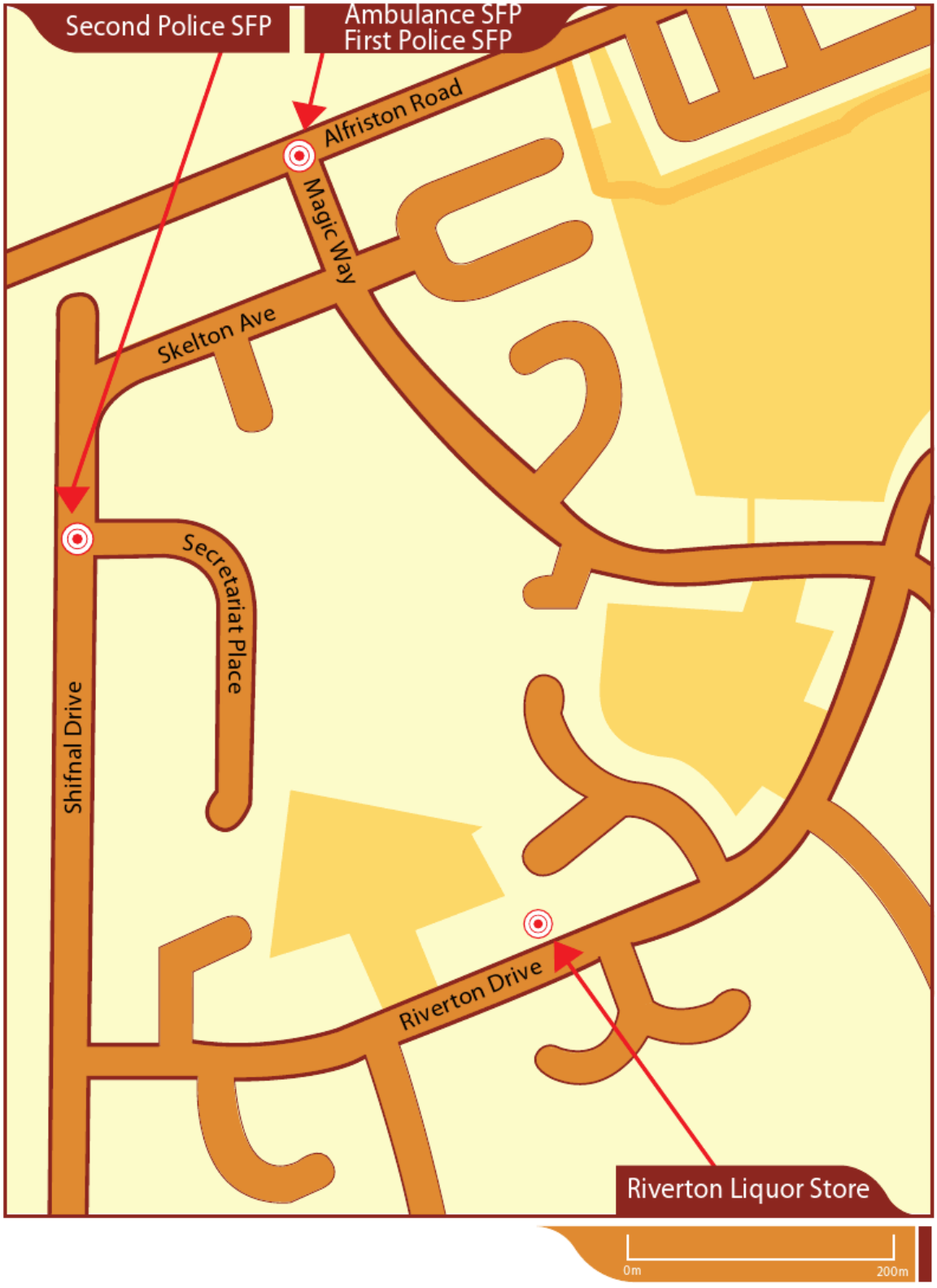
[1] Note that three main sources of time are used in this report; NorthComms, Ambulance and CCTV at the store. Some slight variations in time may occur as a result.

9:08:33		NorthComms provide update to Eagle and units on radio Advises location of incident, possibly three offenders time delay of 5-10 minutes NorthComms attempt to re-contact the store
9:09:15		NorthComms provide update to units on radio saying; • Ambulance is the informant • a 28 year old male shot during a robbery and is not breathing • believe offenders may have left on foot
9:09:47		NorthComms establish an SFP at the intersection of Alfriston Road and Magic Way, Manurewa
9:10:25	CCTV at SCENE	Mr Singh's friend arrives in store and telephones 111
9:10:28		First ambulance dispatched to scene
9:10:28		Telephone call from the store (Mr Singh's friend) to NorthComms (call taker 3) Call not brought to the attention of the NorthComms dispatcher or team leader recorded only as an 'advised event' Priority 4
9:11:10		Telephone call from Ambulance to store
9:12:15		Officer A requests that the AOS Commander be informed of incident
9:12:39		Eagle arrives over area
9:13:10		First Police unit (Officer D) arrives at SFP
9:13:45		Eagle provides update regarding number of vehicles and persons outside the store
9:14:08		Officer A requests SFP to be relocated
9:14:10		Telephone call from NorthComms shift commander to Duty AOS Tactical Commander

9:14:49		Officer A arrives in the area and requests Eagle to nominate a new SFP
9:15:36		Telephone call from NorthComms to store Call remains open until Police arrive at the store
9:18:21		First ambulance arrives at the SFP
9:19:58		NorthComms advises Officer A; • confirmation someone has been shot unsure if alive or dead • description of offenders given as three Maoris
9:20:22		Telephone call from store (Mr Singh's friend) to Ambulance
9:20:27		Officer A confirms change in SFP: now the intersection of Shifnal Drive and Secretariat Place
9:22:50		NorthComms advises over radio that someone has been shot
9:20:58	CCTV at SCENE	Navtej Singh is assisted from behind the counter to rear of the store by his business partner, his wife and a friend
9:21:05	CCTV at SCENE	Navtej Singh enters the toilet cubicle in the rear of the store.
9:23:04		NorthComms advises on radio male has been shot has no puncture wound and is not bleeding
9:23:14	CCTV at SCENE	Navtej Singh exits the toilet cubicle and immediately collapses to the floor in the rear of the store
9:23:18		Officer G is directed incorrectly by NorthComms using mapping system which is outdated
9:23:48		Clarification from Manurewa station that access cannot be gained from Alfriston Road into Shifnal Drive
9:26:54		NorthComms advise that they remain on the telephone to the store and that they have been advised that the male has vomited blood or something similar
9:29:42		Police advise Ambulance of changed SFP

9:31:11		NorthComms advises Officer A that he is Incident Controller
9:33:33		Officer A advises NorthComms of his tactical plan to enter the store
9:34:31		Officer A asks if the team from Howick (Officers H, I and J) is ready to go to scene
9:35:09	CCTV at SCENE	First Police units enter scene
9:35:10		The team from Howick, plus Officers C and D enter and clear scene Dog unit requests Ambulance to attend scene
9:35:57		NorthComms request an officer attend Portchester Road to locate Ambulance and inform them clear to enter the scene
9:36:48		Dog unit (Officer C) provides update to NorthComms saying: • Mr Singh is lying at the back of the store • it appears he has a bullet wound on the left side of his chest • he is conscious • ambulance requested ASAP
9:38:24		Ambulance is cleared to enter the scene by verbal instruction from Police
9:39:28		Telephone call from store to Ambulance
9:41:45		Ambulance arrives at store
9:44:35		Navtej Singh is carried from rear of store to front and placed on a stretcher/trolley
9:44:51		Navtej Singh departs store with ambulance staff
9:52:24		Ambulance advises Navtej Singh travelling Priority 1 to Middlemore Hospital
10:04		Ambulance arrives at Middlemore Hospital
10:05	HOSPITAL	First medical assessment at Middlemore Hospital
8th June		
11:45pm	HOSPITAL	Navtej Singh pronounced dead

Map of the scene



EVENTS OF 7 JUNE 2008

17. Shortly after 9pm on Saturday, 7 June 2008, Mr Chan Kee, armed with a semi-automatic rifle, and accompanied by two other men, entered the Riverton Liquor Store on Riverton Drive in Manurewa. He shot the store's owner, 28-year-old Navtej Singh, in the abdomen and the offenders left the store with alcohol and the cash till.

18. Navtej Singh's business partner was on the premises at the time but did not see the shooting. He found Navtej Singh lying on the floor behind the counter. Navtej Singh said he had been shot and asked his business partner to call for an ambulance.

19. At 9.04:31pm, the Police Northern Communications Centre (NorthComms) received a 111 call from the business partner. During this brief call, the business partner provided the name of the store and said *"somebody robbed me"*. He then said that three people had committed the robbery and *"they had a gun"*. In response to further questions, he said: *"My friend is hurt."* and *"My friend is lying on the floor"*. The call taker (call taker 1) asked if the offenders had left the scene in a car, and appeared to mis-hear the response. The exchange is recorded as:

> *"NorthComms: Have they gone in a car?*
>
> *Caller: Yeah, a... I don't know.*
>
> *NorthComms: A bike..."*

20. Call taker 1 sought further clarification about how many offenders there had been, then asked "*How did they leave?*" The business partner said *"Hurry, please"* and hung up before calling Mr Singh's wife.

21. Call taker 1 recorded the incident as 'priority one' – meaning that within 10 minutes Police should be either at the scene or at a Safe Forward Point (SFP), a safe location near an incident from where the forward operations can be supported.

22. A NorthComms dispatcher (dispatcher 1) immediately received the information.

23. At 9.06:08pm, dispatcher 1 assigned an acting sergeant (Officer E) and a constable (Officer F) from the Manurewa Police Station to attend. They issued themselves with firearms and ballistic body armour and left in a Police vehicle. A Senior Sergeant (Officer A) who was at that time on another job also acknowledged the dispatch and advised that he would attend.

24. At 9.05:53pm call taker 1 attempted to call back the Riverton Liquor Store but the line was engaged.

25. At 9.06:52pm, Mr Singh's business partner made another 111 call in which he spoke with an Ambulance call taker (St John call taker 1). During this call, he gave the location, said that a robbery had occurred, a man had been shot, and the offenders had left on foot. He received advice about first aid for Mr Singh. During this call, St John call taker 1 asked: *"...now where is the person who was shot?"* Mr Singh's business partner, appearing to misunderstand the question, responded: *"...he's Navtej Singh."* St John call taker 1 in turn misheard this response as: *"He's not breathing."*

26. At 9.07:19pm, Officer A requested that the Police Eagle helicopter be deployed over the scene.

27. Around this time, store CCTV cameras recorded several customers coming and going from the store, and Mr Singh's wife arriving.

28. At 9.07:47pm, another St John call taker (St John call taker 2) contacted NorthComms, providing the location of the store, stating that an armed robbery had occurred, that a 28-year-old man had been shot in the chest and was not breathing, and that the offenders had left on foot. St John call taker 2 said an ambulance would be sent to a SFP and asked whether Ambulance should nominate one or whether Police would. The Police call taker (call taker 2) responded: *"Yeah, yeah, I mean you guys can just go and sort of wait where you're going to wait. I mean we're well on the way, we've had a few calls so we will just sort of see you there."* St John call taker 2 then commented: *"It sounds like we need to get in there pretty quick... will you, can you please call us back a.s.a.p. when we can enter?"*

29. At 9.08:33pm, dispatcher 1 provided updates to Eagle and the Police units, giving the address of the liquor store and stating that an armed robbery had occurred with possibly three offenders. At 9.09:15pm, dispatcher 1 provided a further update that "*it looks as though we've had a shooting at this robbery, ambulance are our informants reporting 28 year old male has been shot and not breathing... I believe offenders may have left on foot".*

30. Officer A, who was at that time returning to the Manukau Police Station with Officer B and a prisoner, acknowledged this information, instructed the Manurewa unit (Officers E

and F) to *"tool up"* (arm themselves), and asked dispatcher 1 to establish a SFP. At this time NorthComms believed that 'incident control' (control of the Police response) had been handed to Officer A, and the NorthComms Shift Commander thereafter monitored the Police response, along with other incidents occurring that evening, without seeking to actively control or oversee it.

31. Officer A, as he was returning to the station, drove at speeds exceeding 100kph – the fastest recorded was 156kph. At one point he ran a red light at an intersection near Rainbows End in Manukau and had to swerve to avoid a truck.

32. At 9.09:47pm, dispatcher 1 established a SFP at the corner of Alfriston Road and Magic Way, just over 1.2km from the scene.

33. At about 9.10pm, a friend of Mr Singh's arrived at the store. At 9.10:25pm, he phoned 111, and spoke to Police call taker 3, stating the location, that a robbery had occurred and a gun presented, and that someone was injured and was *"in really deep trouble"*. Dispatcher 1 was not told about this call, which was recorded as a priority 4 (not requiring follow-up). Call taker 3 later explained to the Authority investigators that he felt that dispatcher 1 already had all of the relevant information, and believed that Police and an ambulance were already on their way to the scene.

34. Also at 9.10:28pm, the first St John ambulance vehicle was dispatched, carrying a St John manager who was also an advanced paramedic. At 9.13:29, another ambulance was dispatched, carrying an ambulance officer and a paramedic.

35. At 9.10:46pm Officer A – who believed that the offenders were still at or near the scene – asked for a team from Howick (Officers H, I and J) to be armed and to go to the SFP. Officer A had formed a plan to send this team, along with dog units, into the store. He later explained to the Authority's investigators that in his view this team was properly equipped, was used to working and training together, and was proficient to respond to the armed situation he believed he was facing. At the time the Howick team was requested, Officers H, I and J were on another job in Otara.

36. At 9.11pm, St John call taker 1 phoned the liquor store and spoke with Mr Singh's business partner, obtaining further information including that Mr Singh was bleeding and had a pain in his chest, and that there were 10-15 people in the store.

37. At 9.12pm, Officer A – believing that the offenders were still in the area – asked NorthComms to advise the Armed Offender Squad (AOS). The NorthComms Shift Commander soon afterwards phoned the AOS duty tactical commander and told him that a robbery had occurred in Manurewa, a shopkeeper had been shot, three offenders had left on foot, and that Police had no idea of the direction of travel, no location for the offenders and no details of the weapon used. The Shift Commander also advised that

officers were *"tooling up"* before going to the scene in case the offenders were still nearby. On the basis that the offenders had left the scene, with no known location or direction of travel, the AOS was not called out.

38. Between 9.10pm and 9.12pm, two more Police units advised that they were heading to the scene.

39. At 9.12:39pm, the Eagle helicopter arrived over the scene and reported that people were coming and going from the store.

40. At about this time the first Police unit, Officer D, (who had a Glock but no ballistic body armour) arrived at the SFP.

41. At about 9.14pm, Officer A arrived at the SFP and asked that a new one be established closer to the scene. Eagle advised that it *"should be safe"* at the corner of Shifnal and Riverton Drives, a few hundred metres from the scene. However Officer A accompanied by Officer D instead established a new SFP at the corner of Shifnal Drive and Secretariat Place, about 800m from the scene. Officer D issued himself with a Glock and put on ballistic body armour from Officer A's vehicle.

42. At 9.15:36pm, a NorthComms team leader called the liquor store on a cordless phone (not the standard headset used by Northcomms staff), and spoke with Mr Singh's business partner, who confirmed that Mr Singh had been shot and that the offenders had left. This information was not passed on to field units. The NorthComms team leader gave an assurance that Police and an ambulance were on their way, before seeking further information about the offenders. The call was handed to a NorthComms dispatcher (dispatcher 2). Dispatcher 2 was not briefed by the team leader before taking over the call, but was advised to keep the line open and to keep the caller calm. As she was not using the conventional headset she instead cradled the phone in the crook of her neck. She was therefore unable to enter the information she was given into the event chronology record. Dispatcher 2 continued to talk with the business partner until Police arrived some twenty minutes later.

43. During the first six minutes of his conversation with dispatcher 2, the business partner said that his friend was dying and made repeated requests for the ambulance to hurry. He also repeated several times that Mr Singh had been shot and said he was in pain but was not bleeding, and that there was a *"red shape"* or a *"red mark"* on his chest. The following exchange was recorded:

> *"NorthComms: Is he lying on his back or on his stomach?*
>
> *Caller: No, he's just pain no bleeding no bleeding just red shape on his chest.*
>
> *NorthComms: Is he bleeding from his chest?*

Caller: No, no.

NorthComms: He hasn't been shot?

Caller: Yeah, he's shot, he's got a red shape on the chest on the right-hand side.

NorthComms: Okay, so like, he has been shot… what's he been shot with, like, with a gun?

Caller: Yeah.

NorthComms: Okay, is there blood coming out?

Caller: No, no, no, not blood.

NorthComms: Oh, he's shaken up, so he's not injured?

Caller: Yeah.

NorthComms: Okay, you just stay on the phone."

44. Shortly afterwards, a NorthComms staff member was recorded telling another staff member: *"I don't think he's been shot."* Dispatcher 2 subsequently suggested to Mr Singh's business partner that Mr Singh may have been shot with a BB gun.

45. At 9.17pm, NorthComms directed a Papakura unit (Officer K), equipped with a Glock but no ballistic body armour and who was heading to the new SFP, to stop and check a vehicle seen leaving Riverton Drive. Very soon afterwards, Officer A asked if the Manurewa unit (Officers E and F) was far away, saying *"I need units here."* Officer A also asked Eagle to direct all units to the SFP.

46. At 9.18pm, the first ambulance unit (a Jeep carrying a St John manager who was also an advanced paramedic) arrived at the SFP at the corner of Alfriston Drive and Magic Way. Another St John manager, also an advanced paramedic, arrived shortly afterwards. [In responding to an armed incident, Ambulance units may not go directly to the scene but must wait at the SFP until Police inform them that the scene is safe to enter].

47. At 9.19:02pm and 9.19:39pm, Eagle directed the Papakura and Manurewa units (Officer K, and Officers E and F respectively) to stop and check vehicles seen leaving the scene. The Manurewa unit subsequently stopped and checked a number of vehicles. The female occupants of one vehicle said they had been in the liquor store, that a robbery had occurred and as a result the store was now closed and they were having to go elsewhere to buy alcohol. Neither Officer E nor F communicated this information to NorthComms or any other Police staff.

48. At 9.19.58pm, NorthComms advised units that they had spoken to someone at the scene and confirmed that someone had been shot, and NorthComms was unsure if the person was dead.

49. At 9.20pm, a Police unit from Howick (Officer G) sought directions to the SFP but received incorrect information from NorthComms due to an outdated map which had been provided to NorthComms by the company Terralink, that in turn gets it information from local authorities. This error also caused delays for two other units, a dog handler (Officer C) and the team from Howick (Officers H, I and J) – which, under Officer A's tactical response plan, were to go to the scene.

50. At 9.20pm, Mr Singh's friend made another emergency call to the Ambulance communications centre, once again confirming that the offenders had left the scene and that Mr Singh was in deep shock and was not responding. The Ambulance call taker (St John call taker 3) provided an assurance that the ambulance was not far away.

51. At 9.22:50pm, NorthComms provided an update to Police units stating that someone had been shot. About a minute later, a further update stated that someone had been shot but was not bleeding.

52. At about 9.23pm, an ambulance, which was driven by an ambulance officer and carried a paramedic, arrived at the SFP on Alfriston Drive.

53. At 9.23:04pm, NorthComms advised: *"Someone at the scene's saying a male has been shot has no puncture wound and is not bleeding."*

54. At 9.24:13pm, Officer K arrived in the area and NorthComms dispatcher 1 directed him to stop and check a car that had been seen leaving the area. Officer A interrupted and said he needed the unit at the SFP.

55. At about this time, Mr Singh's business partner – who had remained on the phone to dispatcher 2 from NorthComms – stated that Mr Singh had started to vomit blood. The phone was subsequently handed to a friend of Mr Singh's, who confirmed once again that he had been shot and that he was now vomiting blood. The friend offered to take Mr Singh to hospital but was told to wait for Police.

56. At some point (the exact time is not known) another dog unit, Officer C, arrived at the SFP. Officer G also arrived. Officer A briefed Officer C, who issued himself with a Glock and put on body armour. Officer A also instructed Officer G to distribute firearms and ballistic body armour from his vehicle, but Officer G couldn't because he didn't have the key to his gun safe as it had become separated from the main key ring without his knowledge.

57. The team from Howick (Officers H, I and J) arrived at about 9.25pm. Prior to their arrival, Officer A did not feel he had sufficient, properly equipped staff to secure the liquor store. The team from Howick armed themselves, and Officer A briefed them, saying that a man had been shot and that there were two or three gunmen whose location was unknown.

The team from Howick all had some difficulty changing from stab resistant body armour to ballistic body armour, a process that took several minutes.

58. At 9.25pm the shift inspector contacted NorthComms asking if the incident was a possible homicide or if the victim was okay. NorthComms responded: *"...unknown if we're dealing with a homicide. As said the male who has been shot has no puncture wound and is not bleeding, but not confirmed."*

59. At 9:26:54pm NorthComms advised: *"Just to advise we are still on the phone to the scene. The male is now vomiting blood or similar. He's got some sort of wound."* At this time Officer A said he should be ready to enter in about three minutes.

60. At 9.29pm, another call taker from NorthComms (call taker 5) advised the Ambulance communications centre (St John call taker 1) of the new SFP at the corner of Shifnal Drive and Secretariat Place, and the ambulance and two St John managers in separate vehicles subsequently drove to the new SFP. The Ambulance personnel did not arrive at the new SFP until after the Police had entered the store.

61. At approximately 9.30pm Mr Singh's friend asked NorthComms how far away the ambulance was and offered to take Mr Singh to hospital himself. NorthComms advised him to stay where he was.

62. At 9.31pm, NorthComms advised Officer A that he was the incident controller. Officer A – who still believed that the offenders may be nearby – then confirmed that three armed units – the team from Howick and the two dog units (Officer C and Officer D) – were going in to the store.

63. At 9.35pm those units arrived and cleared the scene.

64. At 9.38pm, Police cleared Ambulance to enter the scene. At 9.39pm, Mr Singh's friend phoned Ambulance communications, speaking with St John call taker 2, saying that the Police had arrived but the ambulance had not.

65. The ambulance arrived at the liquor store at 9.41pm.

66. Mr Singh was taken to Middlemore Hospital, where he arrived at 10.04pm. He received emergency surgery but died the following day.

67. Altogether, 31 minutes passed from the initial 111 call until Police entered the store, and a further six minutes passed before the ambulance arrived. During the period before the Police arrived, the store CCTV camera recorded some 75 movements of family, friends and customers into and out of the store. Throughout this incident, those at the scene stated repeatedly to Police and Ambulance communications centres that the offenders had left.

NAVTEJ SINGH

68. Navtej Singh was born in India on 1 January 1978. He was a Sikh whose heritage language was Punjabi. He married in 2001 and he and his wife moved to New Zealand. They had three young children.

69. Mr Singh, together with his business partner, bought the Riverton Liquor Store in Manurewa in early 2008.

PUBLIC CONCERN OVER THE POLICE RESPONSE

70. The shooting of Navtej Singh and the delay in the Police response attracted a significant level of media interest and criticism of the Police. The focus of public concern was the failure of Police to attend in a timely way the scene of a crime where someone had been shot and was in need of emergency medical attention.

THE HOMICIDE INVESTIGATION AND TRIAL

71. Following the shooting, the Police launched a homicide investigation. Six days after the shooting, on 13 June, seven men appeared in the Manukau District Court facing charges arising from the robbery and homicide.

72. The trial of the seven men involved was completed in March 2010 and resulted in Anitilea Chan Kee being found guilty of murder; five other men were found not guilty of the murder and manslaughter of Mr Singh; all six were either found guilty or had earlier pleaded guilty to aggravated robbery. A seventh man was found not guilty of being an accessory after the killing. Mr Chan Kee was sentenced on 7 May 2010 to life imprisonment with a minimum non-parole period of 17 years.

CAUSE OF MR SINGH'S DEATH

73. A post-mortem examination was carried out by a forensic pathologist on 9 June 2009. The pathologist concluded that Mr Singh died as a result of a single gunshot injury to his abdomen. The pathologist stated that the wound had damaged numerous blood vessels and injured the region in front of the aorta, leading to a lack of blood to the large bowel which was surgically removed. Impaired blood clotting – a recognised complication of trauma and massive blood transfusions – had led to extensive bleeding within the body, in particular the chest, and there had been an ongoing lack of blood to the remainder of the small bowel. *"All of this has culminated in this man's death,"* the pathologist stated, explaining:

"While the complications have arisen as a direct result of the injury, a further factor has been the delay in resuscitation. It is difficult to quantify the impact that this has had upon this man's chances of survival. However, there is no doubt that earlier medical intervention would have been preferable."

POLICE REVIEWS OF THE EMERGENCY RESPONSE

Initial review by the Acting Area Commander

74. An Inspector, then the acting Area Commander for Counties Manukau South, conducted a preliminary review of the Police response dated 10 June 2008, in which he identified several issues of concern, including: command and control of the Police response (see paragraphs 114 to 161 for the Authority's findings command and control); the role of Eagle (paragraphs 128 to 137): the location of and access to the SFPs (paragraphs 167 to 169, and 188 to 193); availability of firearms (paragraphs 201 to 1); body armour and ballistic body armour (paragraphs 183 to 187); communication of clear information to Officer A (paragraphs 102 to 111, paragraphs 162 to 173, and paragraphs 194 to 200); and viability of a forward SFP.

75. The Inspector concluded: *"In this case there was no single major failing but rather a series of more minor issues that together resulted in an unacceptable delay."*

Review by a Superintendent of the Police management of the incident

76. A Superintendent conducted a review of the Police management of the incident and prepared a 15-page review document. The purposes of the review were to assess the initial emergency response with particular attention to the time it took for the Police to get to the scene; and to ascertain whether there had been any departure from practice or policy and to document any lessons that could be learnt.

77. The Superintendent concluded that Officer A had followed basic Police principles for dealing with armed offenders (these are briefly summarised in paragraph 108), and that this approach was sound. He also stated that NorthComms, Eagle, and ground staff were *"working in an extraordinarily busy district"* and had *"handled a very difficult situation as well as they could have in the circumstances"*.

78. The Superintendent nonetheless made a number of recommendations. These included: development of protocols for communication between Eagle and ground staff during *"incidents such as this"* (see paragraph 216 for the Authority's recommendations); consideration of when handover of incident control from NorthComms to staff in the field should occur (paragraphs 120-125); availability of body armour in the Counties Manukau district (paragraphs 183-187); determining whether problems with inaccurate maps are widespread (paragraphs 188-193); researching the 'average' aggravated robbery to

provide staff with information about how to respond; and ensuring that gun safe keys are stored with car ignition keys to prevent a repeat of the situation referred to in paragraph 202.

79. The Superintendent recommended that no changes be made to the basic principles for responding to armed offender incidents.

80. The Superintendent's review, whilst addressing some important issues, did not address others such as the inter-operability between Police and Ambulance, command and control or post incident debriefing. This risked missing the opportunity for Police to learn, as an organisation, from this incident with a view to developing policy around the response to an incident of a similar nature.

Review by a Superintendent in NorthComms of NorthComms management of the incident

81. A NorthComms Superintendent, initiated and conducted a review of NorthComms response, and prepared an eight-page review document dated 20 June 2008. This review was solely concerned with the actions and responses of NorthComms staff, and did not form any part of the incident review conducted by the Police superintendent (paragraphs 76-80.)

82. The NorthComms Superintendent's review considered: the process of appointing an incident controller (see paragraphs 114 to 127 for the Authority's findings on this issue); the timing of the handover of control to the incident controller (paragraphs 120-122); issues relating to the use of Eagle (paragraphs 129-136); and the support provided by the NorthComms shift commander to the incident controller (paragraphs 122-125 and 127).

83. The NorthComms Superintendent recommended:

- that NorthComms staff be provided with reminder notices and refresher training regarding procedures for formal handover of command and control of an incident to field units;
- that dispatchers, team leaders and shift commanders be provided with refresher training about the timing of handover of incident control, with consideration given to retaining control at the communications centre until the incident controller is at a SFP, is fully briefed, and has had time to formulate his or her tactical plan;
- that an operational policy be developed for the deployment, command and control of Helicopter Support (at present, the only policy relates to management of pursuits);
- that shift commanders receive training in relation to the need to maintain active oversight of critical incidents – including peer support and mentoring – after incident control has been handed to field units.

84. The Authority commends the quality, timeliness and usefulness of the NorthComms Superintendent's review.

ST JOHN AMBULANCE REVIEW OF THE EMERGENCY RESPONSE

85. The Northern Region Operations Manager for St John conducted a review of the St John management of the incident and prepared a three-page review document dated 19 June 2009. In that document, he acknowledged that family and friends of Mr Singh had been critical of the Ambulance response time, but concluded that St John responded to the incident according to policy.

86. The Northern Region Operations Manager suggested that St John should have assigned its Specialist Emergency Response Team (see paragraph 170) to the incident, but that this did not contribute to the delay in getting into the store.

87. He said that St John was justified in taking a *"cautious and sensible approach"* to armed incidents, and also that: *"The benefit of hindsight would suggest that it was safe for us to enter at an earlier time, but what is quite clear today was not so obvious in the dark at 9pm on the Saturday night in question."*

The Authority's Investigation

THE AUTHORITY'S ROLE

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

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

89. The Authority's role on completion of an investigation is to determine whether Police actions were contrary to law, unreasonable, unjustified, unfair, or undesirable, and to make such recommendations as it thinks fit.

THE COMPLAINT

90. On 1 September 2008, the Authority received a complaint from Mr Singh's father, Nahar Singh, concerning the delay in getting emergency medical treatment to his son. Mr Singh had travelled to New Zealand from New Delhi after his son's death.

91. The same day, the Authority notified Police that it had received Nahar Singh's complaint, as it is required to do under the Independent Police Conduct Authority Act 1988.

92. The Authority also informed Police that it intended to carry out an independent investigation, and on 23 September Police confirmed that they would not investigate the complaint, leaving the Authority as the sole investigating body.

THE AUTHORITY'S INVESTIGATION

93. The Authority began its independent investigation in September 2008. An investigator was assigned to the investigation. A second investigator subsequently joined the investigation.

Issues considered

94. In the course of its investigation the Authority considered all issues relevant to the complaint, including:

- compliance by Police staff with communication policies, and whether all relevant information was obtained by NorthComms and passed on to field staff;
- whether the handover of incident control from NorthComms to field staff was handled appropriately, and whether NorthComms provided appropriate support after incident control was handed over;
- the role of Eagle;
- the Police duty of care to Navtej Singh;
- whether there were issues with inter-operability between Police and Ambulance;
- the resources available to Police in responding to the incident;
- whether the donning of the ballistic body armour caused any unnecessary delay in getting officers to the scene;
- whether the inaccuracies in the mapping system used by NorthComms caused any unnecessary delay in the time it took Police to respond;

- whether the Police response was hampered by the heritage language accent of the 111 callers and whether this resulted in any unnecessary delay in sending officers to the scene; and

- whether the policy of carrying firearms only in supervisory vehicles caused any unnecessary delays in sending officers to the scene.

Liaison with Mr Singh's family

95. On 18 September 2008, the Authority Chair, Investigations Manager, and the assigned investigator met with Nahar Singh and a number of the leaders in the Sikh community to explain the Authority's role and the investigation process. The following month, the Authority's investigators interviewed Nahar Singh with the assistance of an interpreter.

96. From that time, the Authority's investigator maintained regular contact with Nahar Singh, informing him of the progress of the Authority's investigation.

97. A further meeting involving the Authority Chair, the Authority's investigator, and Nahar Singh took place in Auckland in February 2009, to inform Nahar Singh of progress with the investigation.

Timing of release of this report

98. In October 2009, the Authority informed Mr Singh's family that it had completed its investigation and would publicly report after the conclusion of the trial of the men accused of Mr Singh's murder. The Authority also made a media statement to this effect.

Conduct of the Authority's investigation

99. In conducting its investigation, the Authority interviewed 48 people including NZ Police staff (including operational staff, communications centre staff and policy/technical staff), St John Ambulance Service staff (paramedic/ambulance staff, communications centre staff and policy/operations management staff), medical experts, and family and friends of Mr Singh.

100. The Authority's investigators also reviewed Police and Ambulance event chronologies, recordings of 111 calls, recordings of radio transmissions, data from Police vehicles, closed circuit television footage from the liquor store, and Police and Ambulance internal review documents.

101. The Police response was considered against all relevant legislation and policies including communication protocols, standard operating procedures for armed offender events, the Police Manual of Best Practice (entries for armed offender events, robberies, firearms, body armour, radio protocols, responses to serious crimes, multi-agency responses to incidents, and perimeter control), and the New Zealand Coordinated Incident Management System (CIMS).

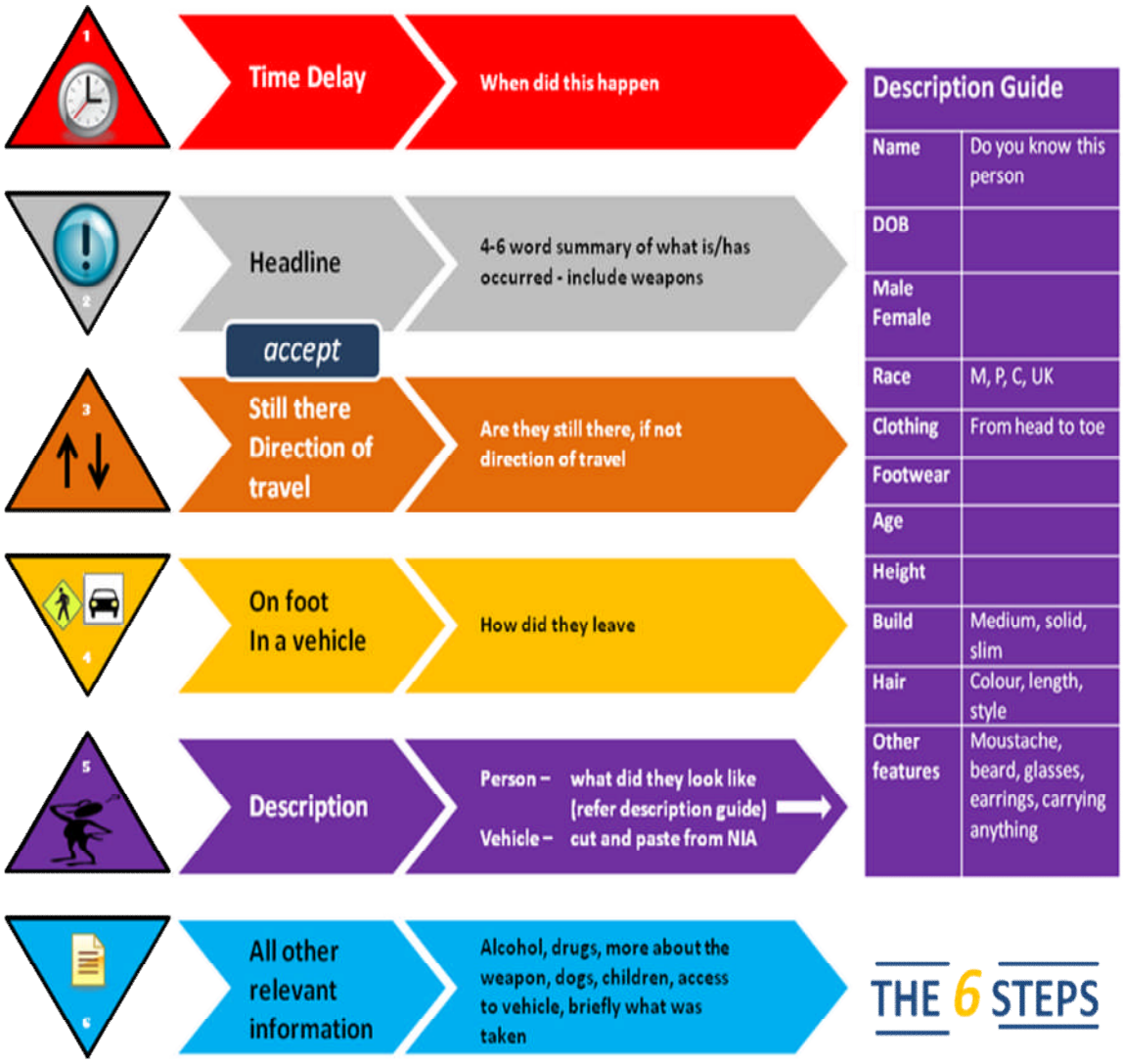
1. COMMUNICATION

Did the Police, in receiving the 111 calls and dispatching staff in response, comply with all relevant communication policies and procedures? Was all relevant information obtained by NorthComms and passed on to field staff?

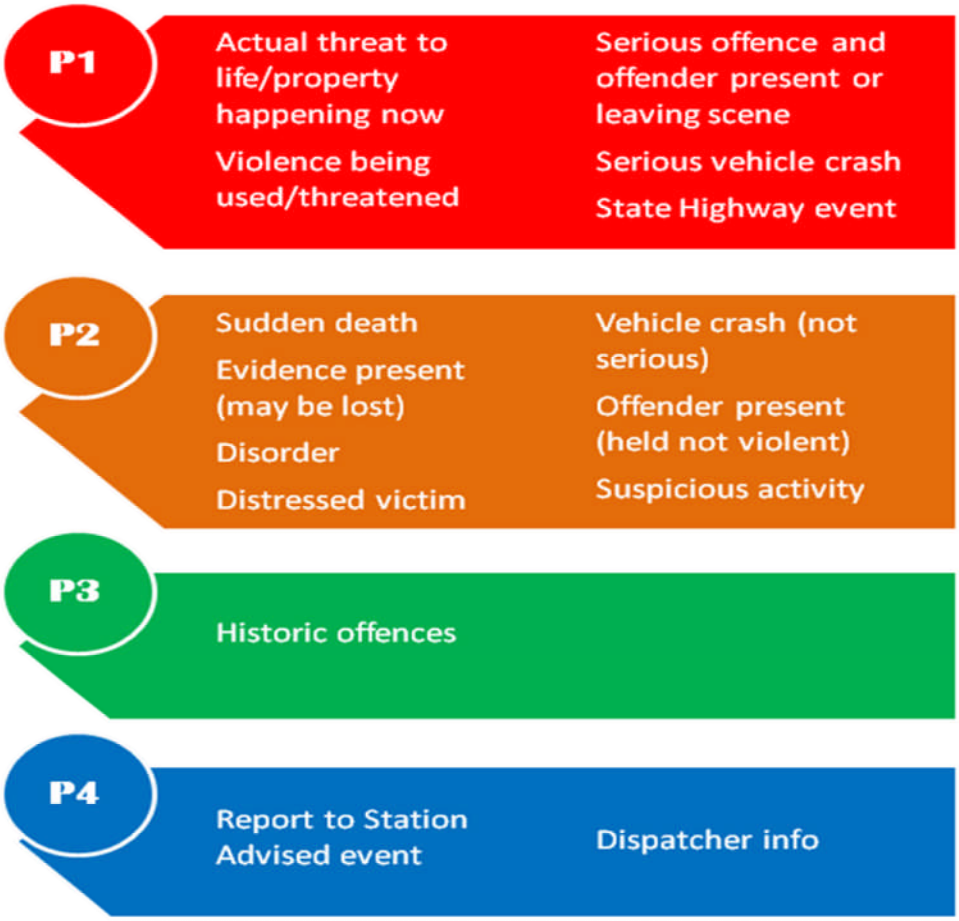
Applicable policies

102. The National Protocol for Interaction between Communication Centre and Field Staff, implemented in July 2007, sets out roles and responsibilities for communications centre staff, and procedures for working with field staff to respond to incidents. This includes the information to be gathered during a 111 call to Police; processes for assigning field units to respond; and co-ordinating and controlling the response; and the information to be communicated to field units.

103. Under the protocol, when a 111 call is made to Police, communications centre call takers follow a six-step process to gather information. In summary, the six steps are: when the incident occurred; what happened (including whether weapons were involved); whether the offenders are still at the scene; how the offenders left; a description of the offenders; and any other relevant information (such as involvement of alcohol or drugs, presence of children or dogs, any further details about weapons, access to vehicles, and whether anything was taken). Call takers have the following chart to assist them in obtaining this information:



104. The call taker then assigns a priority to the call, ranging from priority one – for serious incidents including those where there is a threat to life or property, or violence being threatened or used – to priority four for events that do not require a Police response.



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

106. Where a response is required, the dispatcher determines the required response and directs Police units until an officer is in a position to effectively manage the response, direct resources and formulate a tactical plan. The dispatcher also (among other things) provides relevant information – such as the location of the incident, the key people at the scene, and the presence of hazards – and maintains a continuous electronic record of events and the status of Police units. The dispatcher is overseen by a team leader and a section manager. For major and serious incidents, the shift commander directly manages the team leaders, dispatchers and call takers to ensure a coordinated approach.

107. Field units assigned to an incident are required to (among other things) keep the dispatcher fully informed of their activity, location and status; respond to incidents without delay as directed by the dispatcher; and (in consultation with field supervisors) formally assume command and responsibility for incidents on arrival at the scene.

108. NorthComms has a Standard Operating Procedure for an *Armed Offender Event,* which identifies the key roles and responsibilities of the call taker, dispatcher and team leader. This sets out information to be gathered during a 111 call about an armed offender incident (including whether anyone is injured). It also requires that any armed offender event be immediately classified as priority one (requiring a response within 10 minutes).

Analysis

109. NorthComms was informed in the initial 111 call at 9.04pm that the offenders had left the scene, that a firearm had been presented, and that someone was hurt. They were further informed by St John Ambulance staff at 9.07pm that Mr Singh had been shot and the offenders had left. This was known to the NorthComms shift supervisor when he spoke with the AOS duty tactical commander at 9.14pm, and was subsequently confirmed in the call back from NorthComms to the liquor store after 9.15pm. Though the initial call was brief and did not provide clear information, and there were some misunderstandings arising from difficulties with language (see paragraphs 194 to 200), in all subsequent calls those at the scene told Police and Ambulance communications that the offenders had left and sought urgent medical help.

110. This information was not clearly conveyed to Officer A or to other units attending. Rather, the information provided about the location of the offenders and the seriousness of Mr Singh's condition was conflicting or unclear. Specific failings included:

i) Though both NorthComms and Ambulance were told that the offenders had left the scene, this was not directly conveyed to field units. Rather, at 9.08pm, NorthComms dispatcher 1 said the offenders *"may have left"*.

ii) Call taker 3 who received the second 111 call to Police (at 9.10pm) did not follow the 'six step' process for gathering and recording information from the caller, did not record the call as 'priority one', did not keep the caller on the line, and did not inform dispatcher 1 or his team leader of important information including Mr Singh's condition and the location of the offenders. (see para 33.)

iii) Police communications staff, having lost contact with the scene after the initial 111 call at 9.04pm and trying to call back without success at 9.05pm, did not subsequently call back until shortly after 9.15pm. This meant that there was a lost opportunity, of about 10 minutes, during which information could have been gathered.

iv) The call back at 9.15pm was initially handled by a NorthComms team leader, who was told that one person had been shot and that the offenders had left. This information was not passed on to field units.

v) The team leader subsequently passed the phone to dispatcher 2, who was not briefed and therefore did not know what was already known and what further information was needed. Dispatcher 2 struggled to analyse the disparate information coming from the scene. This information variously included that Mr Singh was "*dying*", *"there's a hole"* in his chest*, "the guy is vomiting blood", "he's on the floor", "he's shot"* and also that there was *"no bleeding no bleeding just red shape on his chest"*. This resulted in confusing information being passed on to field units about the seriousness of his injuries, including a radio communication at 9.23:04pm to the effect that there was no puncture wound. It was only when dispatcher 2 was told that Mr Singh was vomiting blood that she realised the injuries were serious. Units were informed at 9.26pm that Mr Singh was vomiting blood. Dispatcher 2 later told the Authority's investigators that she had no experience of firearms injuries and, from the information she received from the scene, initially formed the view that the absence of an obvious wound and pool of blood led her to believe that he had not in fact been shot.

vi) Officers E and F did not inform NorthComms that they had stopped a car at about 9.20pm and spoken with two women who had had been inside the store and who had told them that a robbery had occurred and the store was closed (paragraph 47).

vii) Throughout the incident, NorthComms staff including the shift commander and team leader believed that Officer A was aware of all relevant information, including the seriousness of Mr Singh's condition (as described by callers from the scene – see paragraphs 29-30) and the fact that the offenders had left. As time went on, those staff did not take opportunities to query Officer A's approach, nor to confirm that he was aware of all relevant information, even when he asked that the AOS be informed. Officer A, for his part, assumed that NorthComms would pass on all relevant information and did not actively seek information about Mr Singh's condition or the whereabouts of the offenders. Indeed, no field officer sought information at any stage about the condition of the victim.

viii) During a serious incident, the protocol requires officers who are not assigned to an incident to keep radio channels clear. During this incident, radio discipline was poor and the volume of traffic was high, making it difficult for units to communicate and leading to some information needing to be repeated such as the location of the SFP.

111. As a result of these shortcomings, the information provided to field units – both about Mr Singh's condition and about the location of the offenders – was inconsistent and unclear. Officer A told the Authority's investigators that when he arrived at the second SFP he remained *"90% certain"* that the offenders were still in the area, and was also not certain that Mr Singh had in fact been shot. On that basis, he planned a cautious and measured response by armed officers.

112. Such a response would have been justified – in order to reduce the risk of further casualties – if there was good reason to believe that the offenders were in fact still at the scene or in the close vicinity. However, as the Police had been informed that the offenders had left, there was no requirement for the level of caution shown. Rather, the immediate need was to ensure that Mr Singh received medical attention. Officer A told the Authority's investigators that, had he been fully aware of the facts, he would have taken a different approach and entered the store sooner.

FINDINGS

Police staff did not comply with all relevant policies and protocols in responding to the 111 calls and dispatching staff to respond. In particular, the failure to properly record and prioritise the 9.10pm call to Police was a significant breach of policy.

NorthComms furthermore did not effectively communicate all relevant information to field units.

Together, these failings significantly contributed to the delay in getting medical attention to Mr Singh.

The Authority notes that Police have since completed a Performance Improvement Plan in respect of NorthComms call taker 3 who received and did not properly prioritise the 9.10pm emergency call. As the Authority has found, the failure to deal with the call was a significant failure that contributed materially to delays in the Police responding. Recommendations follow at the conclusion of the report.

Subsequent action

113. In January 2009, Police amended the National Protocol for Interaction between Communication Centre and Field Staff, partly in response to a review of this incident. The changes are explained in paragraph 127.

2. COMMAND AND CONTROL

Was incident control handed over at an appropriate time and in compliance with relevant policies; in light of the circumstances; the information available; and the applicable policies?

Applicable policies

114. Under the National Protocol for Interaction between Communication Centre and Field Staff[2], the communications centre is responsible for the initial Police response to an incident. While this responsibility formally lies with the shift commander, in practice the team leader or dispatcher is delegated to and usually acts as incident controller and coordinates the response.

115. The communications centre retains responsibility for incident control until a field unit is able and willing to assume the role of incident controller.

116. The dispatcher should explicitly inform that officer that he or she is the incident controller, the officer should acknowledge that, and the dispatcher should record it in the event chronology.

117. Police and military command and control is widely described and variously defined by specialists in the field. The New Zealand Coordinated Incident Management System (CIMS) is built around four major components: control; planning/intelligence; operations; and logistics. It describes 'command' as the internal direction of members and resources of an agency in the performance of that agency's role and tasks, and 'control' as the overall direction of responses in an emergency situation.

118. A commander's role is to make decisions, give clear directions and ensure that those directions are carried out. The absence of effective command undermines the efficacy of an operation.

119. The command structure should provide for an effective tactical response to an incident, and in particular should ensure the efficient flow of information, which is necessary for decisions to be communicated quickly and accurately. This is particularly important where there is a multi agency response to a situation, when confusion and uncertainty can result in ineffective responses.

[2] The Authority notes that Police are currently revising their policy on command and control

Analysis

120. Officer A was appointed incident controller at about 9.31pm, more than 22 minutes after the initial 111 call. At that time, he was at the second SFP and had formed a tactical response plan, on the basis that the offenders may still be at the scene.

121. While there had been no formal handover of command prior to this, NorthComms dispatcher 1 and the shift commander both believed that command responsibility had been handed to Officer A at about 9.08pm, when he acknowledged the NorthComms radio transmission and began to direct other units. The delay in formally appointing him incident controller was an oversight.

122. At the time of the initial handover of incident control, Officer A was engaged on another job and was driving Officer B and a prisoner to the Manukau Police Station. He was some distance from the scene. Realistically, this must have affected his ability to accurately assess the initial information, particularly the nature and seriousness of the incident and the location of the offenders. He did not know, for example, that St John Ambulance had provided information that a man had been shot, although NorthComms had broadcast this information on the police radio. The manner of his driving (see paragraph 31) contributes to the view that he could not reasonably be expected to form a response plan at that stage.

123. The NorthComms shift commander believed, from when he first became aware of the incident a few minutes after the initial 111 call, that incident control was already in the hands of Officer A. He regarded Officer A as an experienced and competent officer who was giving *"measured and clear"* instructions indicating that he had formed a plan for responding. On that basis, the shift commander monitored the response (along with other events) from his workstation. The incident was one of 12 Priority One and 21 Priority Two calls in the Counties Manukau District alone between 8.00pm and 10.00pm that night. The shift commander was not aware that Police and ambulance were at separate SFPs, nor that a mapping error had affected the directions given by NorthComms to field units.

124. The shift commander, during a Police debrief in June 2008, said that after about 17 minutes from the initial 111 call he started to become concerned about the length of time it was taking to get into the scene. He considered phoning Officer A to ensure that all relevant information had been passed on and acknowledged, but did not do so as he believed that would further delay the response. He told the Authority's investigators that he sought an assurance from the NorthComms section manager that Officer A knew the offenders had left the scene, however, there is no record of this, and the section manager does not recall being asked to provide such an assurance.

125. The shift commander told the Authority's investigators that, with hindsight, the best opportunity to speak to Officer A would have been when Officer A asked NorthComms to notify the AOS tactical commander. This would have provided the opportunity to discuss Officer A's response plan and ensure that Officer A knew that the offenders had left the scene.

FINDINGS

Officer A assumed command and control of the incident at a time when he was not in a position to effectively manage the response, direct resources, or formulate a tactical plan. His action in this regard was undesirable. Command and control should have remained with the shift commander until Officer A had arrived at the SFP, was fully briefed, and had formulated his tactical plan.

The shift commander should have maintained an active oversight of this incident throughout. He should have ensured that full and accurate information was passed to the AOS duty tactical commander, and was also passed to Officer A, and should also have contacted Officer A to query the time taken in getting to the victim. His failure to retain command and control as specified above and maintain active oversight of the incident was undesirable. The failure to record the handover of incident control until 9.31pm did not have any direct effect on the management of this incident as command and control had been transferred. That transfer should, however, have been handed over in accordance with the National Protocol.

A recommendation follows at the conclusion of the report.

Subsequent action

126. Several officers interviewed by the Authority commented on the lack of formal policy or training on command and control. The Police are reviewing command and control training and are planning to issue national guidelines and develop a formal training package in the near future.

127. Also, in May 2009, partly as a result of this incident, the National Protocol for Interaction Between Communications and Field Staff was amended (now called Radio Protocols). The amendments included, among other things (**bold** emphasis is that of Police):

1	*"The shift commander must give careful consideration as to when Incident Control is to be passed to the field unit. In the early stages of an incident, regardless of the rank of the responding unit, the Communication Centre is most often better placed to perform this function for an ongoing period of time.*
2	*The dispatcher is to seek guidance from the Shift Commander as to which field unit will be appointed as the **incident controller designate**.*

3	*The dispatcher (under instruction from the shift commander) must notify the nominated field unit that they are appointed as the* ***incident controller designate*** *but that incident control will remain with Comms until they have:* ▪ *arrived at the scene, safe forward point (SFP) or other place, and* ▪ *been fully briefed, and* ▪ *formulated their tactical response plan* *The field unit must then contact the Comms Centre and advise that they are ready to assume incident control, at which time the formal handover of command as outlined in the Radio Protocols will occur.*
4	*Overall responsibility and accountability for managing critical events and fulfilling the role of incident controller (while under the Communications Centre Command) remains with the shift commander. Accordingly, the shift commander is expected to actively manage, direct and supervise those staff responding to the incident, including determining initial tactics to be utilised.*
5	*When incident control has been passed to a field unit, the shift commander is required to maintain an active oversight of the Police response. That oversight could include such things as:* ▪ *engagement with the incident controller over tactics and timing* ▪ *peer support and mentoring* ▪ *advice around legislative powers*
6	*Shift commanders need to appreciate that there will be occasions when the field unit appointed as the incident controller ceases to be the best person to continue to control an incident as it unfolds. It remains the shift commanders prerogative (with delegated power from the district commanders) to take back incident control in situations. Where an offender is mobile (as distinct from a pursuit), or where there are multiple scenes are two such instances where it may develop to a point where the incident controller on the ground can no longer perform the role effectively and the shift commander should consider taking back incident control."*

3. WAS THE ROLE OF THE AERIAL SUPPORT UNIT ('EAGLE') CLEARLY DEFINED AND WAS IT EFFECTIVELY AND APPROPRIATELY USED?

Applicable policies

128. At the time of this incident, the only policy applying specifically to Eagle was the Police Pursuit Policy.

Analysis

129. In this incident Eagle was requested at 9.07:19pm and was overhead at 9.12:15pm. It was able to provide information about the movements of vehicles and persons to and from the scene.

130. At 9.17:24pm, Officer A stated *"I need units here"* (at the SFP), and at 9.18:12pm specifically asked Eagle to send units to the SFP. Despite this, at 9.19:02pm and 9.19:39pm Eagle directed two units to stop vehicles in the vicinity. This was contrary to the direction of Officer A, who had command and control of the incident (see paragraph 47).

131. At 9.24:13pm NorthComms advised Officer K to stop a vehicle. However this was overruled by Officer A who repeated his earlier request to send units to the SFP.

132. This redeployment caused a delay in getting units to the SFP. In particular, it delayed Officers E and F, a Manurewa unit, who were the first assigned to the incident and who had issued themselves with firearms and ballistic body armour. It also delayed Officer K who came from Papakura.

133. Officer A told the Authority's investigators that he did not initially overrule the directions from Eagle as he trusted the judgement of Eagle staff and believed they would have *"a very important reason"* for directing that vehicles be stopped. He did however subsequently overrule Eagle and ask for units to be sent directly to the SFP.

134. It is clear that vehicles leaving the vicinity of the store may have been in some way connected to the incident, as was so in the case of two women who were stopped by Officers E and F after they had gone into the store to try to buy alcohol (see paragraph 47). However, based on the information that someone had been shot and that the offenders had left on foot, it would have been prudent to have used the available units to attend the scene rather than focus on locating offenders.

135. Furthermore, even if stopping and checking vehicles was a worthwhile line of enquiry, there were potential risks to the officers in the event that they did stop a vehicle carrying armed offenders. Before directing these units, NorthComms did not seek assurances that the officers had firearms or were wearing ballistic body armour.

136. At this time there was no video recording equipment fitted to Eagle, although it did have the Forward Looking Infra Red ('FLIR') which was of significant assistance. The ability of Eagle to have a 'live feed' and to actively record from its visual platform would prove an invaluable tool. In real time it would allow the shift commander in the communications centre to view the scene in order to assist with the strategic management of the incident. Further, in terms of a post incident review or independent investigation it would provide an indisputable record of the event.

FINDINGS

The directions given by Eagle to field staff to stop and check the vehicles leaving the area of the Riverton Liquor Store reduced the number of units at the SFP. Had this not occurred, Officer A would have had those units available earlier at the SFP and would have had the option of sending them to the scene.

A recommendation follows at the conclusion of the report.

Subsequent action

137. As a result of this and other incidents, Police identified a need to clarify Eagle's role. Particular issues were the fact that Eagle relayed information through NorthComms even though an incident controller had been appointed, and Eagle is seen by some staff as a 'de facto' incident controller during pursuits, resulting in some staff interpreting commentary from Eagle staff as instructions. A policy on deployment of Eagle was implemented in February 2009. The Authority notes that within Police and amongst Police stakeholders, there are several valid and competing arguments regarding the role Eagle should play in critical incidents. The debate on this issue is something that the Authority has suggested needs be pursued further.

138. The Authority has been advised that Eagle is trialling a down-linking system for real-time transmission of images to NorthComms. The Authority supports the continuation of such a trial.

4. DUTY OF CARE

Did Police exercise an appropriate duty of care for Navtej Singh considering the timeliness of the response, the information available and the duty to protect and preserve life.

Applicable policies

Police policies on the response to serious crimes, armed offender emergencies, and robberies

139. The Police Manual of Best Practice has several chapters relevant to Police responses to serious crimes, armed offender emergencies, and robberies.

140. When responding to armed incidents, the manual advocates cordoning the area and taking a *'wait and appeal'* approach in which the offender is contained while Police negotiate. The manual also states that any force used should be the minimum necessary, that it is better to take a matter too seriously than too lightly, and that every effort must be made to prevent casualties.

141. The Manual's chapter on initial response to serious crime states:

> *"Preservation of life is paramount, Police's first responsibility is with the victim and actions must be quick decisive and professional."*

Communications centre policies

142. Communications centres have standard operating procedures for armed incidents. According to these procedures, the Police response to an armed incident will reflect what is known about the incident, including whether weapons have been presented, whether

shots have been fired, whether anyone is injured and the nature of those injuries, the location of the offenders, and who and where the informant is.

143. For robberies, the Manual states that when the offenders have left the scene, the nearest unit should be appointed interim officer in charge and should attend the scene, confirm details provided by the informant, and provide a situation report to the communications centre. This is an integral part of the command and control process.

Analysis

144. In this case, NorthComms had been given information that the offenders had left the scene and about the nature of Navtej Singh's injuries and his status throughout the incident. Officer A says that he was not aware of this information which in turn led him to assume that the offenders were still at the scene. This assumption set the scene for the Police response to this incident and the delay in getting into the scene and as a consequence the delay in getting emergency medical assistance to Navtej Singh.

Actions of Officer A

145. Officer A was driving to the Manukau Police station with Officer B and a prisoner when he responded to this incident. While driving at high speed in order to respond, NorthComms gave him information about the offenders. In the circumstances it is likely Officer A was not able to process this information when it was given to him. Neither he nor NorthComms at any later time clarified the known location of the offenders or the identity of the informant.

146. Officer A's initial response plan was for Police units to gather at a SFP and arm themselves before going to the scene. He formed this plan based on a belief that the offenders were most likely still present, and that sending officers to the scene without firearms and ballistic body armour would create further risk to life. He did not seek confirmation from NorthComms that the offenders were still present, but rather relied on them to pass on any relevant information. This was in fact NorthComms responsibility.

147. In forming his plan, Officer A specifically intended the Howick team to go to the scene with a dog handler. He explained to the Authority's investigators that he wanted the Howick team because they were used to working together and were *"a very good unit"*. The Howick team were in Otara on another job when the first 111 call came in at 9.04pm and that, combined with a mapping error (paragraph 190), meant that they did not get to the SFP until about 9.25pm.

148. By that time, two dog handlers had arrived (Officers C and D), armed themselves, put on ballistic body armour, and were willing to go to the scene. There were other units at the SFP, and additional units in the area included the Manurewa unit (Officers E and F), who

would have been first at the SFP had they not been diverted by Eagle, and the Papakura unit (Officers K and L), both carrying acting sergeants.

149. Despite these units being present or nearby, Officer A told the Authority's investigators that until the Howick team arrived he did not feel he had sufficient staff to go to the scene. He said he would have changed his plan if he had two units available that were fully equipped with firearms and ballistic body armour. Contrary to this view, it is arguable that the staff who were available or nearby and could have been directed to go straight to the SFP had as much or more experience as those in the Howick team.

150. Officer A told the Authority's investigators that, in hindsight, he should have taken into account the fact that he had other staff at the SFP *"and been a little bit more flexible in sending forward those other staff members".* He also said that, had he been clearly informed that the offenders had left and had he been certain that someone had been shot and was seriously injured, he would have gone to the scene himself.

> *"If someone had come to me directly saying he's dying and we need to get in there I would have gone in without a doubt, and yes they [the offenders] had left but we didn't know that."*

151. The Authority does not advocate immediate Police attendance at all firearms scenes, and nor does it question the 'cordon and contain' approach to armed incidents as outlined in the Manual of Best Practice. However, in this incident, even given Officer A's belief that the offenders may still be present, more flexible use of the available staff would have allowed a quicker response.

Response of the NorthComms shift commander

152. The NorthComms shift commander, despite being concerned about the delay in getting to the scene, did not make contact with Officer A. Had he done so and conveyed the same information to him as he did to the AOS commander, then Police response may have been different, and he may have had the opportunity to guide, direct and support Officer A in his decision making process. A key aspect of his role as shift commander was to provide an active oversight of the Police response in all aspects but particularly with regard to tactics and timing.

153. As already noted, the NorthComms shift commander did not intervene and query the tactical response plan, either when he was asked to contact the AOS duty tactical commander or when he noticed that there was a delay in responding.

FINDINGS

Officer A formed his tactical response plan assuming that the offenders were still at or near the scene, without seeking to confirm this assumption and despite having received information to the contrary. On the basis of this assumption, Officer A's plan was

cautious, was based on the need for an armed response. Having formed this plan, he did not demonstrate flexibility as events unfolded.

It was not reasonable for Officer A to assume that the situation at the scene would remain the same. Given the timeframe involved, events at the scene would certainly be changing. Officer A did not act proactively in asking for an update on either the victim or the location of the offenders. In this regard the actions of Officer A were unreasonable.

The NorthComms shift commander should have actively overseen the response and should have queried the tactical response plan with Officer A, especially given the lengthy timeframe involved (over 30 minutes), and Officer A's request that he call the AOS tactical commander. The failure of the shift commander to actively oversee this matter was unreasonable.

The overall effect of the catalogue of events which together conspired to create a delay in the Police response and a consequential delay in getting emergency medical attention to Navtej Singh was arguably a breach of the Police duty of care to preserve life.

5: INTER-OPERABILITY

Were there issues with inter-operability between Police and Ambulance, and did these issues contribute to delays in getting medical attention to Navtej Singh?

Applicable policies

154. The New Zealand Coordinated Incident Management System (CIMS): *"Safer communities through integrated emergency management"* was introduced in 1998.

155. The CIMS model is a structure designed to systematically manage emergency incidents and was developed to deal with problems in emergency management. Police and Ambulance are two of the emergency service providers which have adopted the CIMS model.

156. The principles of the CIMS model are:

- common technology
- a modular organisation
- integrated communications
- consolidated incident action plans
- manageable span of control
- designated incident facilities
- comprehensive resource management.

157. 'Incident management' includes establishing command and control, ensuring responder safety, assessing incident priorities, determining operational objectives, managing incident resources, and coordinating overall emergency activities.

158. Incident management involves 'control' across organisations and 'command' within the home organisation. While the model accepts that each agency has its own line of command, the requirement for the establishment of effective liaison between agencies becomes paramount. The incident controller has the primary responsibility for managing the incident.

159. The model recognises that liaison enables supporting organisations to have clear directions on their allocated role and how they fit into the incident action plan. Potential areas of conflict should be recognised and addressed. The CIMS model also requires that relevant authorities are well informed and consulted as appropriate.

160. A SFP is defined within the CIMS model as a safe location near the incident from which forward operations can be supported and coordinated. It is the location where agencies and resources are brought together to ensure a consistent and effective response to an incident.

161. As the lead agency Police give the clearance for their staff and those of other agencies to enter the scene.

Communication centres

162. During the 37-minutes from the shooting of Navtej Singh to the arrival of the ambulance, two calls were made from the scene to Police (at 9.04:33pm and at 9.10:25pm) and three calls were made to Ambulance (at 9.06:52pm, 9:20:23pm and 9:39:28pm). Both Police and Ambulance called back the scene, Ambulance getting through at 9.11:03pm and Police getting through at 9:15:36, keeping the line open until officers arrived at the scene almost 20 minutes later.

163. Over the same period, only two calls were made between the Police and Ambulance communications centres – one at 9:07:47pm from the Ambulance communication centre advising Police of the incident, and one from NorthComms at 9:29:42pm advising of the new SFP. An Ambulance call taker interviewed by the Authority said that she had phoned NorthComms with more information after receiving the 9.11pm call from the scene, but there is no record of this call having been made.

164. The lack of contact meant that potentially significant information was not shared, and that new information provided to Ambulance communications staff about the location of offenders and the condition of Mr Singh could not be passed to Officer A.

165. One St John staff member interviewed by the Authority commented: *"We were basically just sitting in the dark, we knew the ambulances were sitting at the SFP [Safe Forward Point]. We just didn't get any information from the Police."*

166. Another commented that difficulties with communication between Police and Ambulance were commonplace and arose from them being separate agencies on separate computer systems, with all communication done by phone.

Safe Forward Point

167. Ambulance staff responding to this incident went to a SFP at Alfriston Drive and Magic Way, and awaited Police clearance to go into the scene. This was consistent with St John policy for responding to armed offender incidents.

168. There had been no discussion between the Police and Ambulance communication centres about where the SFP should be located, and nor was there clear communication once decisions were made. It was not until 9.29pm – more than 10 minutes after the SFP was moved – that NorthComms advised Ambulance of that fact. The Ambulance units subsequently went to the new SFP and soon afterwards continued on to the scene.

169. Having separate SFPs meant that Ambulance staff were not able to share what they knew with Officer A, for example about Mr Singh's condition and the need to get to the store urgently.

Assignment of SERT officer

170. At the time of this incident Ambulance had a Specialist Emergency Response Team (SERT) officer available. SERT officers are trained to respond to armed incidents, and have ballistic body armour and Police radios. Ambulance did not assign the SERT officer to attend this incident as he was already assigned to (but had not yet arrived at) another, lower priority one. Had the officer been reassigned, he would have been able to monitor Police radio, which would have meant that Ambulance staff were aware of the location of the Police SFP, and also may have resulted in better information-sharing between the two agencies.

Post incident debrief

171. A post incident debrief provides an opportunity for all staff to share views on the management of the incident so that good and poor practice can be identified and lessons learned can be included in future training, planning and risk assessment. Inter-agency debriefing should take place when more than one agency has been involved in a critical incident to enhance inter-operability between the agencies

172. Following this incident there was no effective operational post incident debrief between Police and St John Ambulance. In the view of the Authority, the failure to hold such a debrief was a missed opportunity for inter-agency learning.

FINDINGS

There were failings in respect of inter-operability between Police and Ambulance. Police and Ambulance did not use the same SFP, Ambulance was not made aware in a timely manner of the change in the Police SFP and Police and Ambulance communications centres did not share potentially significant information which may have influenced Officer A to enter the scene earlier. In such a critical situation it was highly undesirable to have such a failure in communication.

Recommendations follow at the conclusion of the report.

Subsequent action

173. Since 2006, a whole-of-government work programme has been under way to improve management of emergency calls and to improve radio communications between agencies responding to emergencies and disasters. As a result of this project, since June 2009 the InterCAD system has allowed emergency service communications centres to electronically transfer incident information between the Police/Fire and Ambulance dispatch systems. The introduction of this system does not, however, mitigate the need for communications centres to ensure that all relevant information is shared.

6: STAFF

Were there sufficient staff available to respond to this incident?

Availability of staff

174. In the Counties Manukau District on the evening of Saturday 7 June 2008 there were 19 rostered units on duty, comprising 32 staff. At the time of the incident there were five District units that were uncommitted and able to respond. The only local Manurewa unit available (Officers E and F) was the first assigned to respond.

175. Other units from across the District subsequently became available and made their way to the SFP. Officers responded from across the District including Papakura, Howick, Manurewa, Eagle and two dog units (which cover the greater Auckland area). In every area within Counties Manukau, the supervisors were acting sergeants.

176. Between 8pm and 10pm that evening, Counties Manukau had 12 Priority One calls and 21 Priority Two calls. NorthComms staff indicated that this was a typical Saturday night workload.

177. Both sworn and non-sworn staff interviewed by the Authority's investigators raised concerns about staffing and resourcing in the District. Officer A told the Authority's investigators that, other than poor information, the main factor contributing to the delay in responding was the number of staff available. If sufficient staff had been available from Manurewa to respond *"I would have sent them in definitely"*. Likewise, if the team from Howick had been available earlier, *"they would have been sent in"*.

FINDINGS

The lack of availability of field staff, especially local staff from the Manurewa area, played a part in the delay in getting officers to the SFP and consequently to the scene. Officers had to come from some distance away, and rely on directions from NorthComms to get to the SFP.

The level of staff available in NorthComms was sufficient to be able to manage the incident from a communications perspective.

Subsequent action

178. Counties Manukau has recently undergone a review of staffing numbers and, with further government funding, is likely to be able to increase its frontline staff numbers.

Were there ride-along passengers in units that responded?

179. One of the dog units that responded and subsequently went to the scene was carrying a constable as a ride-along passenger. This passenger accompanied the dog handler (Officer D) to the scene, despite the fact that he was not wearing ballistic body armour or carrying a firearm.

180. Another officer who responded (Officer G) was accompanied by a friend – a civilian who hopes to join Police.

181. NorthComms was not aware of these ride-along passengers, and Officer A was not aware that the unarmed constable was accompanying the dog handler to the scene. Under these circumstances, the presence of these ride-alongs raised safety issues.

182. There is no national policy regarding ride-alongs, though there is a long-standing practice which allows civilians to gain an insight into policing and officers to gain experience. Civilian ride-alongs are generally participants in the SCOPE programme through which

Police applicants are assessed; SCOPE participants sign agreements dealing with issues such as confidentiality, safety and conduct, and providing a disclaimer.

FINDINGS

The lack of national policy and clear guidance around the use of ride-along officers and SCOPE applicants poses a risk to both the individual and the Police organisation. In this case, a ride-along officer went to the scene without ballistic body armour or a firearm and without NorthComms or Officer A knowing he was there, and a civilian ride-along was present at the SFP during an armed incident.

A recommendation follows at the conclusion of the report.

7: BALLISTIC BODY ARMOUR

Did the ballistic body armour issued to officers for use in conjunction with stab resistant body armour cause any unnecessary delay in the time it took officers to respond to the incident?

183. Stab resistant body armour has been used since 2006. It is issued on a personal basis to sworn and non-sworn members of Police and provides protection against slashing, stabbing and low velocity handguns. Staff routinely wear stab resistant body armour, and also wear utility belts containing batons, sprays and personal protection kits.

184. Under General instruction F069 (Issue of Police Firearms, Body Armour and Ammunition), staff attending armed incidents must wear ballistic body armour. To put on ballistic body armour, an officer has to first remove his or her stab resistant body armour and utility belt, then put on the ballistic body armour and the utility belt. This process can take some minutes, especially when conditions such as lighting and surface are not ideal. Ballistic body armour is heavy, restricts movement, and is uncomfortable for the wearer.

185. According to the NorthComms event chronology, the Howick team arrived at the SFP at 9.25:46pm. The liquor store's CCTV camera showed the officers arriving at 9.35:09pm. During the intervening nine-minute period, the officers were briefed, armed themselves, received Fire Orders (orders advising when firearms may be used), changed into their ballistic body armour and travelled about 800m to the scene. It is likely that the change into the ballistic body armour accounted for most of this time.

186. In interviews with the Authority's investigators, all officers who attended the incident said the requirement to change into ballistic body armour caused delays, not only because the armour is cumbersome to put on, but also because the officers lacked sufficient experience at using it. All of the officers from the Howick team had difficulties getting into

the armour. One had never before worn it, another was seen with the armour on backwards, and the third described the process of changing as a *"nightmare"*.

FINDINGS

The time taken to change into ballistic body armour clearly contributed to the delay in officers getting to the scene.

A recommendation follows at the conclusion of the report.

Subsequent action

187. The Authority is advised that Counties Manukau, and other districts, have started to introduce a new ballistic vest, known as the Hard Armour Protection (HAP) vest, a lightweight vest that can be pulled over the stab resistant body armour without the need to remove the utility belt. HAP vests provide the same ballistic protection as the ballistic body armour, covering the upper torso and vital organs.

8: MAPPING SYSTEM

Did inaccuracies in the mapping system used by NorthComms cause any unnecessary delay in the time it took Police to respond to the incident?

188. Police communications centres use a computer-based mapping programme provided by Terralink. Maps are updated regularly as Terralink receives new information from local authorities about changes to roading networks.

189. In this case, the map showed an intersection between Shifnal Drive and Alfriston Road, and NorthComms directed staff to take this intersection as they headed to the second SFP. The intersection had in fact been closed since 2005, as the local authority regarded it as an accident hot spot, but this was not shown on Terralink's map.

190. The incorrect directions caused at least three units – Officer C, Officer G and the Howick team – some delay in getting to the SFP, though it is not possible to quantify this delay. One officer from the Howick team told the Authority's investigators that her unit followed Officer G up and down Alfriston Road and they were all getting frustrated until a staff member from the Manurewa Police Station advised by radio *"Can't get from Shifnal into Alfriston"*, and gave accurate directions.

191. Officer A told the Authority's investigators that this was *"the second or third time"* he was aware of that units had been directed to take the closed intersection, and he had believed the problem had been dealt with.

192. Police have advised the Authority that it is likely that the mapping system contains a significant number of errors as a result of road changes that have been made by local authorities but not advised to Terralink or Police.

FINDINGS

The inaccuracy in the mapping system delayed staff from arriving at the SFP, though it is not possible to quantify the delay. Police had been aware of the inaccuracy for some time, and should have raised it with Terralink when it first became obvious.

Local road changes that have not been notified to Terralink or Police have the potential to significantly affect the Police response to future emergencies.

A recommendation follows at the conclusion of the report.

Subsequent action

193. Police advised Terralink of the error in the map on 12 June. Terralink supplied updated maps on 30 June which were then tested before going live in the communications centre in August.

9. LANGUAGE

Was the Police response hampered by the heritage language of the callers to emergency services, and did this result in any unnecessary delay in deploying officers to the scene?

194. NorthComms employs a number of staff who are bilingual. All staff have access to a list of bilingual staff and are encouraged to use them when they have difficulties understanding a caller. The languages spoken included Maori, Samoan, Tongan, Niuean, Cantonese, Mandarin, Japanese, Malaysian, Indonesian, Hindi, Afrikaans, German, French, Italian and Dutch.

195. Police communications centres also have access to Language Line, a telephone interpreting service which offers translation in 39 languages. However, this service is available only on Monday to Friday from 9am to 6pm.

196. The heritage language of both the business partner and the friend of Navtej Singh who called NorthComms and Ambulance from the liquor store is Punjabi.

197. Navtej Singh's business partner speaks English fluently but with a heavy accent. In his calls to NorthComms and Ambulance he was also clearly distressed, and it is apparent that call takers had difficulty understanding him, as shown by call taker 1 appearing to hear that the offenders had left on a bike (paragraph 19). The initial call to NorthComms was, in addition, very brief. St John call taker 1 more effectively managed the business partner's

anxiety and gathered information, including the details that Navtej Singh had been shot and that the offenders had left the scene, though as previously noted the call taker also misheard *"he's Navtej Singh"* as *"he's not breathing"*.

198. The other caller speaks excellent English with a soft accent. During his calls, though he spoke with a sense of urgency, he could be easily understood. In his call to NorthComms at 9.10pm he provided detailed information to call taker 3. However, as already stated, call taker 3 ended this call and did not pass on this information. The second caller subsequently spoke to Ambulance twice, and to NorthComms for several minutes during the call back. Each of these calls provided significant opportunities for the communications centres to clarify details.

199. On no occasion during the telephone calls with NorthComms was any question asked about language, nor whether there was someone available at the scene who may speak English more fluently.

200. Police staff interviewed by the Authority's investigators spoke of difficulties understanding the first caller, and of conflicting information coming from the scene. While language appears to have been a factor in the initial 111 call to NorthComms, information was subsequently provided from the scene to both St John Ambulance and NorthComms, that the offenders had left and that Navtej Singh had been shot and needed urgent medical attention. By 9.14pm, the NorthComms shift commander was able to clearly convey this to the AOS duty tactical commander. As already stated, there were issues with the way this information was interpreted, managed, shared between the communications centres, and passed on to field units.

FINDINGS

Whilst a difficulty with understanding the callers – in particular the first caller – was a factor in the Police response, it was not the dominant factor. Rather, any initial confusion was aggravated by miscommunication and misinterpretation of the information that was provided, and a failure to take opportunities to clarify information.

There was no opportunity to use the services of Language Line, and there did not appear to be any staff member in NorthComms who spoke Punjabi. However, it is unclear if NorthComms staff even considered whether these options were available.

A recommendation follows at the conclusion of the report.

10. ACCESS TO FIREARMS

Did the policy of the carrying of firearms only in supervisory vehicles cause any unnecessary delay in the arming and deployment of Police to the scene?

201. At the time of the incident Counties Manukau had a district policy for security of and access to firearms, which acknowledges that NZ Police is generally an unarmed service but aims to ensure that firearms are available quickly, easily and safely when they are needed. The policy requires that supervisory vehicles (including the one driven by Officer A on 7 June 2008) *must* carry firearms for use in emergency situations, and specifies which other vehicles *may* carry firearms. In practice, firearms are routinely carried in gun safes in supervisory vehicles and in the other vehicles authorised under the policy.

202. In this incident, Officer G, an Acting Sergeant, arrived at the SFP in a vehicle carrying firearms, but was unable to get them out because he did not have the key to his vehicle's gun safe as it had, without his knowledge, become detached. This reduced the range of weapons available to Officer A, meaning he could not send all of the officers in to the scene with rifles as he would have preferred, but rather issued some with rifles while some went to the scene with Glocks. However, this did not cause a delay in getting to the store.

203. Another sergeant (Officer K) arrived in a 'spare' vehicle that did not have a gun safe (the regular sergeant's vehicle was off the road with a mechanical fault). This 'spare' vehicle was assigned to a cordon.

204. One of the dog handlers (Officer D) routinely carried a Glock in his vehicle, but did not carry ballistic body armour. This was a breach of General Instruction F059, which required officers carrying firearms in their vehicles to also carry ballistic body armour.

205. General Instruction F059[3] also required officers, when they are issued or returning firearms, to sign a firearms register. The officers from the Howick team did not sign the register before going to the scene.

206. Having examined the firearms records from this incident, the Authority notes the tension that arises between the recording requirements expressed in both GI FO59 and its replacement, the Police Manual: Police firearms 'Firearms registers', and the practical need to get firearms to a scene urgently.

[3] This General Instruction was on 21 October 2009 replaced by the Police Manual: Police Firearms. However on 7 June 2008 General Instruction FO59 was Police policy.

207. The Manual appears to give the option of completing the firearms register either when the firearm is issued or returned:

> *"The firearms register must be completed:*
>
> - *Whenever a firearm, ammunition, holster or body armour is issued and/or returned"*

208. However, the supervisor's responsibility when issuing firearms states:

> *"Any person supervising the issuing or returning of Police firearms must ensure as part of a Police station's internal control:*
>
> - *The Firearms register (POL 369) is completed at the time of issue and return"*

FINDINGS

Officer A had sufficient firearms in his vehicle to respond to this incident. The policy did not contribute to any delays in responding to this incident, and neither did issues with access to firearms from other vehicles.

Some officers did not comply fully with GI FO59 (by not signing the firearms register and by carrying a firearm without ballistic body armour) but these breaches did not contribute to any delay in getting to the scene.

Recommendations follow at the conclusion of the report.

Subsequent action

209. Counties Manukau in August 2008 reviewed storage and security of small tactical equipment (including firearms, OC spray, stab resistant body armour and portable radios) and found that staff were complying with relevant policies.

210. The Police are conducting a review of the carriage of firearms in Police vehicles, which is considering whether to establish permanently armed units as part of a Differential Response Model, and is also considering the focus of Police firearms training.

Conclusion

211. The delay in Police attending the Riverton Liquor Store, and as a consequence the delay in Navtej Singh receiving emergency medical treatment, could not be justified and was undesirable. The delay was not caused by any single failing but rather by a series of procedural, and command and control failures.

212. Of these, the most significant were the failures to properly record, analyse and communicate all relevant information from the scene, which meant that the responding officers lacked clear information about Mr Singh's condition or the location of the offenders. It also affected coordination between Police and St John, specifically in relation to the SFP. Other factors included: a shortage of local Manurewa Police units available to respond; unnecessary diversion of, and incorrect directions to, units that were responding; a lack of active oversight by NorthComms after command and control was handed to an officer in the field; a lack of flexibility in using units that were available to respond; and the time taken by officers to change into ballistic body armour.

213. The Police have a basic duty to protect life. Whilst it cannot be said with any certainty that Navtej Singh's injuries were survivable, it is known that he suffered significant pain and distress, both of which were inevitably heightened by the delays in getting him emergency medical treatment. By the time he arrived at Middlemore Hospital 60 minutes after he had been shot, Navtej Singh felt he was going to die.

214. The overall effect of the catalogue of events which together conspired to create a delay in the Police response and a consequential delay in getting emergency medical attention to Navtej Singh was arguably a breach of the Police duty of care to preserve life.

215. The Authority recognises too the distress caused to family and friends who made repeated calls to the emergency services requesting assistance. Despite reassurances that the Police and the ambulance were "*on the way*" they failed to attend the scene until approximately 31 minutes after the first telephone call to Police.

Recommendations

216. The Authority has recommended that Police:

1. address communications centre training to:

   - ensure that staff understand the importance of managing critical information and ensuring it is passed to the incident controller in the field;
   - ensure that staff understand requirements for formal handover of command and control, including appropriate timing for handover;
   - ensure that shift commanders understand the need to maintain active oversight of critical incidents after incident control has passed to field units;

2. ensure that all staff are trained on the National Protocol for Interaction between communication centre and field staff;

3. treat all situations in which Police are told that someone has been shot as potentially life-threatening until medical assistance has been provided, rather than making assumptions based on the size of the wound or the presence of bleeding alone;

4. review training for all staff on command and control, and management of critical incidents in which people may have been injured;

5. fit Eagle with video recording equipment so that critical events can be recorded at all times, and consider the feasibility of Eagle providing a 'live feed' of images to the communications centre;

6. review management of critical firearms incidents in which people have been or are suspected of being injured;

7. review Police inter-operability with St John Ambulance and other emergency services, particularly in relation to management, transfer of critical information and post incident de briefings;

8. ensure that Police and Ambulance use the same SFP unless there are sound operational reasons for not doing so, and ensure that other emergency services are clearly informed of the location of any SFP;

9. ensure that inter-agency debriefing takes place when more than one agency has been involved in a critical incident to enhance inter-operability between the agencies;

10. review firearms training to ensure that staff are competent and confident in responding to critical incidents;

11. provide a national policy on 'ride-along' and SCOPE passengers in Police vehicles;

12. prioritise the rollout of HAP vests to all districts, and ensure that, until HAP vests are available, firearms training includes familiarisation with ballistic body armour;

13. ensure that there are appropriate mechanisms for reporting mapping inaccuracies, and consider establishing a memorandum with local authorities to ensure that relevant information (such as road changes) is passed on to Police;

14. consider alternatives for when Language Line is not available, and ensure that communications centre staff who are experiencing difficulty with a caller's language ask if there is anyone else at the scene who speaks English;

15. ensure that when vehicles are permitted by District policy to carry firearms that ballistic body armour is also available in each vehicle;

16. clarify the recording requirements for the issue of firearms expressed in the Police Manual in the context of the practical need to get firearms to a scene urgently.

HON JUSTICE L P GODDARD

CHAIR

INDEPENDENT POLICE CONDUCT AUTHORITY

May 2010

About the Authority

WHO IS THE INDEPENDENT POLICE CONDUCT AUTHORITY?

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

It is not part of the Police – the law requires it to be fully independent. The Authority is chaired by a High Court Judge and has two other members.

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

The Authority has two investigating teams, made up of highly experienced investigators who have worked in a range of law enforcement roles in New Zealand and overseas.

WHAT ARE THE AUTHORITY'S FUNCTIONS?

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

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

On completion of an investigation, the Authority can make findings and recommendations about Police conduct.

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