## Conclusions

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

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

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

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

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

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

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

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

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

## Recommendations

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

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

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

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

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

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

**Judge Sir David Carruthers**

Chair

Independent Police Conduct Authority

25 May 2016

**IPCA: 14-2044**