



**IPCA**

Independent Police  
Conduct Authority

Whaia te pono, kia puawai ko te tika

# **Report on Police's handling of the alleged offending by 'Roastbusters'**

*March 2015*

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## Introduction

1. In early November 2013, the news media began reporting stories about the sexual activities of a group of young men<sup>1</sup> in Auckland who referred to themselves as ‘Roastbusters’<sup>2</sup>. The media approached Police for comment about their knowledge of this group and details of any Police investigation.
2. The Authority was immediately asked to conduct an inquiry into Police actions by then Minister of Police, Anne Tolley, and then Labour Spokesperson for Police, Jacinda Ardern. Complaints were received by the Authority from the spokesperson of a lobby group and two other members of the public. Concerns were also expressed to the Authority by the Children’s Commissioner, Dr Russell Wills.
3. The Authority subsequently decided to independently investigate two aspects of Police actions:
  - 3.1 the adequacy of the Police investigation and handling of any complaints or reports received by Police between 2011 and October 2013; and
  - 3.2 the information provided by Police to media concerning their involvement in these matters.
4. In November 2013, Police and New Zealand’s statutory care and protection agency, Child, Youth & Family (CYF), commenced a joint investigation into the activities of the ‘Roastbusters’. The investigation was named ‘*Operation Clover*’.
5. In December 2013, the Authority was notified by Police of a complaint made by a young woman regarding Police’s handling of a sexual assault complaint she made to them in November 2011, which involved members of the ‘Roastbusters’ group. The Authority was already aware of this incident and it was being considered as part of the Authority’s investigation (referred to in this report as Case 3).
6. On 22 May 2014, the Authority released a public report about its investigation into the information provided by Police to media<sup>3</sup>. The Authority was unable to report publicly on the other aspect of Police actions until Police had completed Operation Clover<sup>4</sup>. This was to ensure that the criminal investigation into potential offending by the young men was not prejudiced in any way.

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<sup>1</sup> As defined by the Children, Young Persons and Their Families Act 1989 (CYPFA), a ‘*child*’ means a boy or girl under the age of 14 years and a ‘*young person*’ means a boy or girl of or over the age of 14 years but under 17 years. For the purposes of the Authority’s report, the children and young people involved are referred to, generically, as young people/men/women.

<sup>2</sup> A name reportedly derived from the term ‘Spit Roast’, a euphemism for sexual activity involving two active males and a passive female (or male), and a play on the title of the film ‘Ghostbusters’.

<sup>3</sup> The Authority’s report, ‘*Police response to media enquiries about ‘Roastbusters’’*, can be found at: <http://www.ipca.govt.nz/Site/publications/Default.aspx>

<sup>4</sup> Under section 17(1)(ca) of the Independent Police Conduct Authority Act 1988, the Authority may defer action until receipt of a report from the Commissioner of Police following a criminal investigation initiated and undertaken by Police.

7. In late October 2014, Police concluded Operation Clover. Therefore, the Authority is now in a position to report on its investigation and its findings regarding Police handling of complaints or reports received about the 'Roastbusters' between 2011 and October 2013.

## Glossary of terms

Abbreviation/term	Explanation
CIB	Criminal Investigation Branch – responsible for investigating all serious crime.
CPP	Child Protection Protocol - sets out the way Police and Child, Youth & Family will work alongside each other in cases of serious child abuse.
CPT	Child Protection Team – a team of Police officers exclusively focused on investigating reports of serious child abuse.
CYF	Child, Youth & Family – New Zealand’s statutory care and protection agency.
CYPFA	Children, Young Persons and Their Families Act 1989
EVI	Evidential Video Interview
FGC	Family Group Conference – a formal meeting of extended family and professionals to discuss concerns for and develop a plan to support their child or young person.
GDB	General Duties Branch – uniformed Police staff responding to all reports of crime.
MAI	Mass Allegation Investigation – investigation of serious abuse of four or more children by the same offender or connected group of offenders.
NIA	National Intelligence Application – Police’s national computer database.
Serious child abuse	Serious child abuse includes but is not limited to sexual abuse, serious physical abuse, serious wilful neglect, and serious family violence where the child is a witness.
Sexual abuse	An act involving circumstances of indecency with, or sexual violation of, a child or using a child in the making of sexual imaging.

## Index of officers

	Roles of Officers
Officer A	Detective – Auckland City CPT
Officer B	Detective Sergeant – Supervisor, Auckland City CPT
Officer C	Detective Sergeant – Supervisor, Waitakere CPT (pre-July 2012); Waitemata CPT (post-July 2012)
Officer D	Detective Constable – Waitakere CPT (pre-July 2012); Waitemata CPT (post-July 2012)
Officer E	Detective Constable - Waitemata CPT
Officer F	Detective Senior Sergeant – Manager, Waitemata CPT & ASA
Officer G	Detective – Waitemata CPT
Officer H	Detective – Waitemata CPT
Officer I	Detective – Acting Supervisor, Auckland CPT

## Background

8. At the start of the Authority's investigation in November 2013, it was informed by Police that they had received reports of concern about four separate incidents involving the 'Roastbusters' group between late 2011 and early 2013. In each of these incidents the young men had allegedly engaged in sexual conduct with young women in circumstances that might have involved criminality. These reports were from the young women themselves or family members.
9. During its investigation into the adequacy of the Police handling of complaints or reports received about the 'Roastbusters', the Authority identified that Police also responded to three other reports of concern involving young women and this group of young men.
10. As at the date of this report, none of the Police investigations has resulted in criminal charges being laid by Police against members of the group.

## SUMMARY OF EVENTS

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11. The Authority would typically provide a relatively comprehensive summary of each incident or report of concern, and the subsequent Police investigation. In this case, however, given the sensitive nature of these matters, and the age and vulnerability of the young people involved, the Authority is particularly mindful to ensure that their welfare, interests, and rights are preserved, and their anonymity and privacy respected. Accordingly, the Authority has taken a very careful approach in the drafting of this report, and does not consider that it is appropriate to report on each incident in detail.
12. The Authority acknowledges the public interest in this matter, and also the requirement to provide sufficient evidence to support the Authority's findings in respect of Police actions. With that in mind, a brief overview of each of the seven cases identified by the Authority has been provided, and the common issues or themes that have emerged with regard to policing practices, policies, and procedures in these cases have been assessed and are discussed in depth in the findings section.
13. Case 4 involved a number of alleged incidents. However, as Police enquiries did not progress to a point where the incidents were investigated separately, the Authority has treated the matter, and refers to it throughout this report, as one case.

### Case 1

14. In February 2011, a young woman (then aged 14) spoke to Police following an incident involving two members of the 'Roastbusters' group during a party. After the initial response by General Duties Branch (GDB) or 'uniform' staff, the young woman provided a brief statement to Criminal Investigation Branch (CIB) staff. The matter was then referred to the Police Child Protection Team (CPT) at Auckland City for investigation, at which point the young woman expressed her wish not to take further part in the investigation process. On 18 March 2011, the officer

assigned to the investigation, Officer A, recommended that no further action be taken by Police, a decision that was later supported by the officer in charge of Auckland City CPT, Officer B.

## Case 2

15. In October 2011, a family member of a young woman (then aged 13) contacted Waitakere Police following an incident involving three members of the 'Roastbusters' group during a party. The matter was brought to the attention of Officer C, the detective sergeant in charge of the Waitakere CPT (which came under the auspices of the Waitemata Police District CPT<sup>5</sup>), and was immediately assigned by Officer C to a CPT member to make further enquiries. Although a preliminary statement was taken from the young woman, she did not wish to further participate in the investigation process. On 4 November 2011, the file was inactivated by Officer C.

## Case 3

16. In November 2011, a young woman (then aged 13) made a preliminary statement to a detective at Waitakere Police following an incident at a party a week earlier, which involved three members of the 'Roastbusters' group. The matter was forwarded to Officer C, at the Waitakere CPT, for investigation. The investigation, undertaken by Officer D, did not commence until January 2012. However, during the intervening period, the young woman participated in a formal 'evidential interview' (EVI) in which she made numerous allegations of sexual assault against the three young men.
17. Officer D conducted a number of enquiries and, in April 2012, two of the young men participated in formal Police interviews, the third having declined to do so. In July 2012, Officer D, in consultation with Officer C, determined that there was insufficient evidence for Police to lay charges against the young men, and the file was inactivated in August 2012.

## Case 4

18. In December 2012, Child, Youth & Family (CYF), notified Police (specifically Officer B, who was the supervisor of Auckland City CPT) of a possible 'Mass Allegation Investigation' (MAI) involving a group referring to themselves as the "*Spit Roasting Club*", who were reportedly "*plying young girls with alcohol and drugs at parties and having sex with them.*" This information and the details of four young men and six young women had been provided to CYF by staff from one of the local secondary schools after a student had expressed serious concerns about the young women and their involvement with the 'Roastbusters' group.
19. Officers B, C and F were subsequently invited to attend a meeting convened by CYF staff. Officer C thought that there was nothing new in the allegation, and he and Officer F declined the invitation. However, Officer B did attend. He advised that the concerns had previously been investigated by Police and that there was no new information/complaint/incident. When he

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<sup>5</sup> Waitemata Police District covers the area west and north of Auckland City from New Lynn up to Mangawhai in the north. It is split into three areas - North Shore, Waitakere and Rodney.

gave this advice, he was relying upon information given to him by Officer C before the meeting, and was unaware that it was incorrect.

20. At the conclusion of the meeting, it was agreed that CYF staff would arrange to speak directly with the student who had reported concerns to the secondary school, in order to determine whether there were issues requiring further attention, after which they were to reconvene the meeting. There is no record in Police or CYF files of any follow-up in this regard. However, information provided to the Authority by the secondary school reveals that the student was contacted in January 2013 by a CYF social worker (who the student mistakenly thought was a Police officer [see paragraphs 110.6 and 110.7]). The conversation was discontinued when the student became concerned that the social worker had no knowledge of the secondary school staff member who was meant to be acting as the student's liaison and support person. No further meeting between CYF and Police was convened.
21. At the end of January 2013, Officer A was directed by Officer B to meet with secondary school staff, when she was provided with brief details about some of the incidents in which the students were reportedly involved. The school staff expressed specific concerns about the age gap between the male and female students; the use of alcohol and drugs; the apparent escalation of the young men's behaviour; and the failure of anyone to intervene and address possible criminality. Officer A subsequently briefed Officer B and, given most of the young people identified came under the auspices of Waitemata's CPT<sup>6</sup>, prepared a report in February 2013 for Officer C and their supervisor, Officer F<sup>7</sup>. The report also included the details of the young women involved in Cases 1, 2, and 3. Given his involvement in two of the earlier cases, Officer C was tasked by Officer F to review the file.
22. Officer C then contacted CYF staff. He was provided with a list of names (see paragraphs 110.9 and 110.10) of most of the young women involved in Cases 2, 3, and 4, and was incorrectly told that all of the cases in which they were involved had already been investigated. He then determined that no further action by Police was necessary and informed Officer B of that in a meeting between them. He did not undertake the review requested by Officer F until June 2013, after he was again asked to do so following the release of videos on Facebook (see paragraph 31).

## Case 5

23. In January 2013, a young woman (then aged 13) made a complaint to Waitakere Police following an incident (unrelated to the 'Roastbusters' group) in December 2012. The matter was subsequently forwarded to Auckland City CPT and assigned to Officer A for investigation. This young woman had earlier been identified by the secondary school as one of those involved in Case 4. Although she was referred to during Officer A's meeting with school staff at the end of

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<sup>6</sup> In July 2012, Waitemata District centralised the way in which child protection work was undertaken. The CPTs from Waitakere and North Shore as well as staff from Rodney were all brought together at North Shore Policing Centre.

<sup>7</sup> In July 2012, Officer F, the Child Protection and Family Violence Co-ordinator (who had not previously had any direct line management of the CPTs within Waitemata District or any direct supervision of the CPT's specific cases), was appointed as the officer in charge of the District CPT and, from that point, had direct line management of all staff and files in the CPT.

January 2013, and in Officer A's February 2013 report, Officer A is unsure at what point she became aware of the connection between the two cases.

24. Police records also identify that Officer C and his staff at Waitemata CPT were involved with the young woman and her family in relation to other matters at this time, but were unaware that Auckland City CPT were investigating a criminal complaint made by the young woman. It is unclear whether Officer C made a connection between the young woman and Case 4.
25. In any event, the young woman was not spoken to by Police about her reported involvement with the 'Roastbusters' group.

#### Case 6

26. At the end of January 2013, Police were contacted by a member of the public after a young woman (then aged 14) was found in a distressed state following an incident (unrelated to the 'Roastbusters' group) a short distance from her home. Following initial Police enquiries into this matter it was also established that an incident had occurred a few days earlier involving the young woman and three members of the 'Roastbusters' group. The file was forwarded to Officer C at Waitemata CPT, and the case was assigned to Officer E for investigation.
27. There is limited information contained on the Police file evidencing what enquiries were made or what investigation tasks were undertaken by Officer E in respect of either incident involving the young woman. Officer E's investigation report was considered by Officer C in March 2013, and forwarded to Officer F for review and to seek funding approval for several exhibits (relating to the initial incident) to be forensically examined. The matter was filed in June 2013 after this was completed.
28. This young woman had also earlier been identified by the secondary school as one of those involved in Case 4. It is unclear whether Officer C made a connection between the young woman and Case 4.

#### Case 7

29. In April 2013, Police were called to an incident involving a young woman (then aged 17) and three members of the 'Roastbusters' group, at the home of one of the group members. Upon arrival, the attending GDB officers were told by the young woman that there was no need for them to be concerned about her safety and wellbeing. While both officers were uncomfortable about the situation they had encountered, they did not believe they had cause to take the matter further by requesting that CIB detectives attend. The officers dropped the young woman and her companion at an associate's address.
30. Approximately one hour later, Police were called to this address after the associate of the two young women reportedly received threatening text messages from a member of the 'Roastbusters' group. Upon arrival, GDB officers (different from those who attended the earlier incident) located the three young men in a vehicle near the address. While the responding officers were aware that Police had attended an earlier incident involving the young people,

they determined that there was no cause to hold the occupants of the vehicle, who were instructed to go home and warned not to return.

### Police actions post-June 2013

31. In June and July 2013, new information, in the form of videos posted to Facebook (in which a member of the 'Roastbusters' group talked about their activities and named several of the young women), was brought to the attention of Police by the family of one of the young women. Only one of these videos was reviewed by Police; the other was removed from the website before it could be accessed by them. Officer F subsequently tasked Officer C to follow up and he, in turn, assigned Officers G and H to make further enquiries.
32. Two of the young women were spoken to again by Police in August 2013. However, no further progress was made on the investigation prior to the matter coming to the attention of media in November 2013.

## The Authority's Investigation

### THE AUTHORITY'S ROLE

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33. Under the Independent Police Conduct Authority Act 1988, the Authority's functions are to:
- receive complaints alleging misconduct or neglect of duty by any Police employee, or concerning any practice, policy or procedure of the Police affecting the person or body of persons making the complaint; and to
  - investigate, where it is satisfied there are reasonable grounds for doing so in the public interest, any incident in which a Police employee acting in the course of his or her duty has caused or appears to have caused death or serious bodily harm.

### THE AUTHORITY'S INVESTIGATION

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34. As required under section 16 of the Independent Police Conduct Authority Act 1988, Police were notified by the Authority of the complaints, and of the Authority's intention to undertake an investigation pursuant to section 17(1)(a) of the Act.
35. The Authority's investigation has taken four forms.
36. First, the Authority has reviewed the Police files and any additional documents obtained during its investigation relating to each of the above cases. The Authority has also reviewed, where relevant, a number of documents resulting from Police's subsequent criminal investigation, Operation Clover. However, assessing the adequacy of the Operation Clover investigation was not part of the complaints received or within the scope of this investigation. The Authority's investigation was limited to determining whether there was any Police misconduct or any failure of Police practice, policy or procedure in their handling of the seven matters reported to them between 2011 and October 2013.
37. Secondly, the Authority has had the benefit of access to records held by CYF. The Authority has reviewed CYF file material and interviewed CYF staff in relation to those cases that CYF were aware of. The Authority has also interviewed staff from the secondary school involved in Case 4, and spoken with staff from another of the local secondary schools, about their interaction with Police in relation to several of the cases.
38. Thirdly, the Authority has interviewed eight Police officers involved in the investigation and/or oversight of each matter.
39. Finally, the Authority has assessed the actions of Police involved against Police policy and practice standards, applicable at the time of each case.

## ISSUES CONSIDERED

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40. Having completed its independent investigation and considered all of the relevant material, the following issues fall to be determined by the Authority:
  - 40.1 Was the initial response to the incidents by GDB and CIB staff adequate and appropriate?
  - 40.2 Were the investigations into the cases undertaken by Child Protection Team (CPT) staff robust and thorough and, in particular:
    - 40.2.1. Were adequate follow-up enquiries conducted and positive lines of enquiry pursued?
    - 40.2.2. Was information accurately recorded and evidence adequately assessed?
    - 40.2.3. Was supervisory oversight adequate and appropriate?
    - 40.2.4. Did the fact that the father of one of the young men was a Police officer have any influence on how the investigations were handled by Police?
  - 40.3 Was prosecution in relation to all available offences properly evaluated, specifically in relation to:
    - 40.3.1. issues of consent and alcohol consumption;
    - 40.3.2. sexual conduct with a young person under 16?
  - 40.4 Was alternative action, with regards to care and protection issues and potential offending behaviour, properly considered and dealt with?
  - 40.5 Were CPT staff's consultation and communication with each other and with stakeholders adequate and effective?

## The Authority's Findings

### ISSUE 1: WAS THE INITIAL RESPONSE TO THE INCIDENTS BY GDB AND CIB STAFF ADEQUATE AND APPROPRIATE?

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41. Police child protection policy and investigation guidelines (see paragraphs 123—129) set out the policy and principles that guide Police in responding to child abuse, and applies to all cases where the victim is under the age of 17 at the time the complaint is made.
42. Four of the seven cases were initially dealt with by GDB and/or CIB staff before being referred to the applicable Police CPT (see paragraph 43). The Authority is satisfied that in each of these cases, attending Police staff responded to the report of concern appropriately, by making initial enquiries and gathering evidence from the scene and witnesses, before forwarding the matter to the applicable CPT for investigation. In Cases 1, 5 and 6, responding CIB members completed substantive reports, which outlined pertinent issues for CPT follow-up.

#### FINDING

The initial response to the incidents by GDB and CIB staff was adequate and proper.

### ISSUE 2: WERE THE INVESTIGATIONS INTO THE CASES UNDERTAKEN BY CPT STAFF ROBUST AND THOROUGH?

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43. With the exception of Case 7, which was dealt with by GDB officers, all of the cases were investigated by a CPT<sup>8</sup>. These teams are specialised units that focus almost exclusively on responding to, and investigating, reports of child abuse and neglect. They are made up of qualified detectives who have completed extensive and intensive CIB training in investigation practices/approaches/methodology and the law, along with specialist training in the investigation of child abuse (and, typically, adult sexual assault).
44. The officers assigned to investigate, oversee and/or review the six 'Roastbusters' cases were qualified and experienced detectives. All of the officers had completed the child abuse investigators' course, and most had worked in their respective CPTs for some time.
45. In recent years there have been a number of developments and improvements in the Police response to complaints of sexual offending, and Police have specific procedural and legal obligations to adult and child victims of sexual assault, under both Police policy and the Victims' Rights Act 2002. The Authority has found that all of the Police officers involved in these matters treated the young women and their families with courtesy and compassion, and ensured that they were afforded both dignity and privacy. Officers were clearly victim-focused and motivated

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<sup>8</sup> This includes the investigation of Case 4, where concerns were expressed to Police about several alleged incidents involving a number of young women (see paragraph 13).

to act in accordance with the victims' wishes, and in their best interests. The Authority does not question the appropriateness and importance of this focus, and recognises the substantial improvements in policing practice that have been effected in the last decade. However, it is concerned that in several of the cases, because officers concluded that there was insufficient evidence to proceed without the cooperation of the young women, they decided that no further action was required. They therefore overlooked the importance of holding the young men accountable for their behaviour and preventing its recurrence.

46. The Authority is also conscious of the fact that Police must prioritise cases. It accepts that investigative resources must be directed to those cases that are serious or likely to be brought to a successful conclusion; the actions of the officers in this case, particularly where the young women did not wish to further participate in the investigation process, need to be set against that context. That said, the Authority's investigation into Police handling of these cases identified a number of deficiencies in investigative practices that could not be attributed to workload demands or the need to prioritise other cases. They are outlined in detail below.

#### Were adequate follow-up enquiries conducted and positive lines of enquiry pursued?

47. In three of the six cases assigned to CPT staff for further enquiries to be conducted, the young women did not wish to further participate in the investigation process after providing preliminary statements to Police. It is accepted that, without the cooperation of the young women, the ability of Police to proceed was hampered. However, the Authority considers that it remained incumbent upon the assigned CPT investigators to make the necessary follow-up enquiries. Indeed, Police policy states that *"all reports of child abuse must be thoroughly investigated"* even if the child or young person recants or parents/caregivers are reluctant to continue.
48. The Authority has determined that the failure to undertake basic investigative tasks resulted in a lack of sound and evidence-based decision-making in each case. In Case 2, for example, there is no evidence on the Police file, or from any other material collected during the Authority's investigation, to indicate that enquiries were made to determine if any of the young men had a history with Police. Had this task been undertaken, Police would have identified that one of the young men had also been involved in Case 1, and should have then recognised the existence of a possible pattern of behaviour, supporting the need for a more rigorous and extensive Police response.
49. The same could be said for Case 3, where there was no evidence that the files relating to the previous two cases were reviewed. There was highly relevant material contained in these files, which would have assisted Police during this investigation and, in particular, during the suspect interviews. Further, a review of these earlier files may well have led to a recommendation for these cases to be reopened so that additional enquiries could be conducted.
50. More generally, in all those investigations that were conducted subsequent to Case 1, the failure of Police investigators to recognise, or consider the significance of, the involvement of these young men in the earlier cases was a common theme. This was the most significant failing identified in the Authority's investigation.

51. Other examples of deficiencies in investigative practices involved the failure to:
  - 51.1 obtain statements from witnesses, particularly those to whom the young women first disclosed the incident (known as 'a recent complaint witness');
  - 51.2 attempt to speak to or take statements from all of the young men involved in the incident;
  - 51.3 make any enquiries that might have corroborated or refuted any inconsistencies between accounts;
  - 51.4 adequately consider the evidence in relation to consent issues (discussed in detail in paragraphs 80–86);
  - 51.5 secure all available evidence, such as CCTV footage, cellular telephone data, and photographic and video images.
52. The investigation undertaken by Officer D, in Case 3, was the most thorough of the cases reviewed by the Authority. This was the only case that proceeded to the '*suspect interview*' stage. Although Officer C had completed his substantive enquiries by January 2012, the young men were not interviewed by Police until April 2012. Officer D (the file holder and person with the most detailed knowledge of the case) advised the Authority that he was required to prioritise a number of matters scheduled for prosecution during this period before going on leave for the month of April. Critically, the interviews were conducted by other officers while Officer D was on leave. No satisfactory explanation has been provided as to why this was necessary, given the already lengthy delay and the fact that Officer D returned to work the week after the interviews took place.
53. The Authority has reviewed the transcripts of these interviews, and considers that the preparation for, and the standard of, the interviews with the young men were unsatisfactory. It is evident that the officers conducting the interviews did not have the requisite knowledge to challenge certain details provided by the young men or to discuss some of the highly relevant evidence that was obtained during Officer D's investigation. As this was the first occasion that any of the young men had been subject to a formal interview, this process was critical to the assessment phase of the investigation.
54. Of the six cases, the Authority considers that the investigation of Case 6, undertaken by Officer E, was the most inadequate and unsatisfactory. There is, in fact, no evidence on the Police file, or from any other material collected during the Authority's investigation, that any investigation was undertaken into the initial incident responded to by Police or the incident involving the members of the 'Roastbusters' group. Information recorded by Officer E reveals that he had a poor understanding of the details and facts of case, and that his management of the file fell well short of the standard expected of a qualified and experienced detective (see also paragraph 63).

## FINDING

CPT staff did not adequately follow up and pursue positive lines of enquiry.

### Was information accurately recorded and evidence adequately assessed?

#### *Young people's details*

55. The Authority's review of Police and CYF files has identified that in almost all of the cases there are deficiencies in the recording of information by Police about the young people involved. While this included errors, such as the incorrect recording of birth dates or ages of the young people, the most significant issues related to the failure to accurately record the identity or role of the young people in CYF referrals and in the Police database, the National Intelligence Application (NIA), at the conclusion of the investigation.
56. In Case 2, one of the young men involved in the incident was not recorded in NIA, so that none of the later Police checks completed on him revealed an association with the incident. In addition, only one of the three young men involved in the incident was recorded in the CYF referral as an alleged perpetrator.
57. In Case 6, the names of the young men were never checked or confirmed during the investigation, and were misspelled and/or incomplete in Officer E's investigation report. Therefore, at the conclusion of the investigation, there was no accurate record made in NIA of their involvement in the incident.
58. Had the details of the young men, and their involvement in the earlier cases, been adequately recorded by CPT staff in NIA, Police Communications Centre staff may have been able to provide GDB staff, who attended Case 7, with information that supported their existing concerns and encouraged them to escalate matters to CIB staff.

#### *Investigation reports*

59. The Authority's review of the Police files has also identified deficiencies in the final reports completed by CPT staff at the conclusion of five of the six cases that were investigated by them. (It does not appear that a final report was submitted in Case 2.)
60. The most significant deficiency involved the failure of the Police investigators, subsequent to the investigation of Case 1, to record in their final reports the involvement of these young men in previous incidents (see also paragraphs 48—50). Officer D accurately reported in Case 3 that the young men had no previous charges or convictions. However, he failed to provide details of their involvement in Cases 1 and 2.
61. While Officer A attempted to do so in Case 4, this report provided an inaccurate and incomplete summary of those cases already investigated by Police (Cases 1, 2 and 3). While the Authority acknowledges that it was not a final investigation report but merely intended as a synopsis for Waitemata CPT to enable them to determine what further enquiries should be made, it was

nevertheless misleading. In particular, it made no reference to the fact that the young woman in Case 3 had completed an EVI, and it stated that these young women were reluctant to progress their complaint because the sexual activity was consensual and their decision-making was affected by alcohol. It also mistakenly stated that all of the young women identified as being involved in Case 4 had been spoken to by CYF and none were willing to make a criminal complaint.

62. The Authority's review of these files has also identified issues with the overall quality of the assessment of the material and conclusions made by the investigating officers in each case. The failure to conduct thorough and robust investigations (see the previous section) had an impact in this regard, but several investigating officers also failed to make reference in their reports to relevant information obtained during their investigations. In Case 1, for example, Officer A did not refer to relevant information provided by a medical professional who examined one of the young women or the fact that no contact was made by Officer A with one of the young men involved subsequent to the incident.
63. A significant proportion of the investigation report completed by Officer E in Case 6 was taken directly from the CIB detective's report completed the day after the incident occurred (see paragraph 42). Officer E's report highlights a lack of basic knowledge of the details of, and relevant issues in, the case, and a failure to conduct any meaningful or robust enquiries. A number of statements and conclusions were made in this report without any supporting material on the Police file.
64. While the Authority accepts that Case 3 was the most thoroughly investigated of the files reviewed, the investigation report completed by Officer D contains a number of significant inaccuracies and assumptions. It is unbalanced in its assessment of, and reference to, the evidence gathered (such as interview material and text data). For example, Officer D's analysis of the young woman's immediate response to the offending was tenuous and made unfounded assumptions regarding her "*mindset*" and motivations by placing significant weight on the text messages that were sent by others. In fact, cell phone data from the young woman, herself, was never sought by Officer D during his investigation. Officer D submitted that he had no legal grounds to seek her text data, as the meeting with the young men had been coordinated using the phone belonging to the young woman's friend. However, Officer D could have sought the young woman's consent to the release of her text data, and did not do so.
65. Critically, Officer D failed to appreciate that one particular aspect of the account given by the young woman, alleging criminal behaviour by one of the young men, was supported by the accounts given by three witnesses, two of whom were members of the 'Roastbusters' group. In this instance, the young man continued his behaviour despite being told by the young woman to stop. When he failed to cease what he was doing after again being told to stop, this time by one of the other young men, the two other young men physically intervened to stop the behaviour. The failure of Police to properly consider the evidence with prosecution in mind is discussed at paragraph 83.

## FINDING

CPT staff should have more accurately recorded and more adequately assessed information obtained during their respective investigations.

### Was supervisory oversight adequate and appropriate?

66. It was the responsibility of the respective CPT supervisors, namely Officers B and C, to oversee these investigations by directing and guiding staff in the course of their duties, reviewing the work of their staff, and ensuring that this work was meeting required standards.

#### *Officer B*

67. Officer B was responsible for supervising Officer A's investigations into Cases 1 and 5, and had a significant role in the early stages of Case 4, subsequently tasking Officer A to liaise with the secondary school before the matter was then referred to Waitemata CPT for follow-up.
68. The Authority's review of the Police files in respect of Cases 1 and 5 identified that some basic investigative tasks were not undertaken. In particular, in Case 1, one of the young men involved and his family were never contacted during Officer A's investigation. However, the deficiencies were not necessarily evident from reading Officer A's investigation reports and it was reasonable for Officer B to have acted on the basis that Officer A had completed full and proper enquiries. No criticism can therefore be levelled at Officer B in this regard.
69. In Case 4, as outlined in paragraphs 18—22, Officer B was notified by CYF of the possible MAI. He then contacted Officer C at the Waitakere CPT and subsequently attended a meeting in December 2012 in which he provided inaccurate information about the cases previously investigated by Police (including Case 1, which Officer B had overseen) and the extent to which Police had followed up with the young men involved. The Authority accepts that, when he provided this information, Officer B was relying on what he had been told by other Police staff, and it was reasonable for him to do so.
70. At the time of the meeting between Officer B and CYF, a number of the young women identified in the allegation had not at that stage been spoken to (and it was not even known whether some of them resided in Waitemata or Auckland City). CYF staff unanimously reported to the Authority that it was therefore decided at the conclusion of the meeting that, in the first instance, CYF would approach the student who had provided the information to the secondary school to establish if her allegation related to recent incidents or only to the 'historical' matters already investigated by Police. It would then be determined whether any follow-up enquiries should be made. This is supported by brief notes recorded at the time by one of the CYF staff present. Officer B has a different recollection of the outcome. He has told the Authority that it was agreed that CYF staff would contact each young woman mentioned in the MAI to gather further information and to determine whether they wanted the matter taken further, and would let Police know the outcome.

71. The Authority has considered all of the evidence, and is satisfied that Officer B's recollection of events is inaccurate, and that the outcome of the meeting is as reported by CYF staff. While CYF staff subsequently contacted the student, as noted in paragraph 20, they failed to get her to divulge any additional information, and took no further action. Although it had been agreed that the meeting between CYF and Police would be reconvened after the student had been spoken to, this never occurred.
72. The Authority considers that it would have been desirable for Officer B, as the Police representative at the meeting, to ensure that the allegation was adequately followed up and that CYF reconvened the meeting as agreed. However, he did subsequently assign Officer A to contact the secondary school, and she subsequently prepared a synopsis of all of the cases for Waitemata CPT in February 2013. It appears that he was then wrongly told by Officer C at a subsequent meeting that all of the young women had been spoken to; that none wished to make a formal complaint; and that the young men and their parents had also been spoken to. Given this, the Authority does not think that his supervision of the case can be described as inadequate or inappropriate.

### *Officer C*

73. Officer C oversaw the investigation of Case 2 and was responsible for supervising Officer D's and Officer E's respective investigations into Cases 3 and 6. He was working with the young woman involved in Case 5 (see paragraph 24), in relation to other matters, at the time that case was being investigated by Officer A. Officer C was also tasked by Officer F to review the report resulting from Officer A's work on Case 4 (see paragraph 21) and, several months later, to follow-up on the social media posts that were brought to the attention of Police (see paragraph 31).
74. Officer C was involved, either directly or indirectly, with five of the six cases investigated by CPT staff. The Authority considers that Officer C failed to properly oversee the investigations he was responsible for or adequately scrutinise the investigation reports and files submitted before closure.
75. As discussed in paragraphs 48—51, the Authority's review of the Police files identified that the investigating officers failed to undertake some basic investigative tasks. The Authority considers that Officer C should have had sufficient knowledge of the files to recognise, for example, that Case 6 was not undertaken in accordance with policy and to the required standard of criminal investigations, and that the assessments made by his staff were not necessarily an accurate reflection of the work undertaken and the circumstances of the case. Indeed, a number of the deficiencies in the investigations should have been evident from reading the assigned officers' reports (see paragraphs 59—64), without having to undertake a thorough review of the files.
76. As the officer who was seemingly in possession of the most knowledge about the cases, Officer C's failure to recognise (and act upon) the systemic nature of these incidents is of particular concern to the Authority. Cases 5 and 6 initially came to the attention of Police as a result of unrelated matters, and it is unclear when, or if, Officer C became aware that Case 6 also involved an incident with the young woman and the 'Roastbusters' group, and that concerns

had earlier been expressed about both young women as part of Case 4. However, by February 2013, and certainly following the receipt of Officer A's report into Case 4, Officer C should have been fully aware that the young men had now reportedly been involved in six cases.

77. The Authority considers that it is at this point, at the latest, that Officer C's attention to these matters (irrespective of his, or his team's, workload) should have been made a priority, and he should have ensured that Officer F was adequately and correctly briefed about the cases, the behaviour of these young men and the risks they continued to pose. However, there is no evidence on the Police files or obtained during the Authority investigation that Officer C completed the review task assigned to him by Officer F in February (see paragraph 22). Nor is there evidence that Officer F was briefed about Cases 1—4 until she again tasked Officer C to undertake a review following the posting of videos on Facebook in June and July 2013. Officer F remained unaware that the young woman involved in Case 3 had participated in an EVI and that Officers D and C had determined that there was insufficient evidence to prosecute. It was not until August 2013 that Officer C developed a plan to re-visit the investigations and assigned Officers G and H to make further enquiries. The plan included the intention to speak with the young men and their parents and issue a verbal and written warning about their behaviour. At Authority interview, Officer C stated that this did not happen as he got "*side-tracked*".
78. The Authority considers that Officer C is ultimately responsible for the poor investigative practices demonstrated, and the lack of robust and critical analysis of the evidence obtained, by his staff. It is evident, for example, that Officer C did not ensure that all relevant investigation tasks had been undertaken (such as contacting the parents of the young men (see paragraphs 93—94 and 105—106)); that opportunities or interventions to prevent re-victimisation were considered; that the files contained all the correct and relevant documents; that all alleged offences were considered against relevant legislation (see paragraphs 80—86); and that all appropriate information was recorded in NIA before deactivating the files.

## FINDINGS

Officer B's supervision and oversight of the cases for which he was responsible was adequate and appropriate.

Officer C did not adequately supervise and oversee the cases for which he was responsible.

### **Did the fact that the father of one of the young men was a Police officer have any influence on how the investigations were handled by Police?**

79. The Authority's investigation identified that Police did not establish that the father of one of the young men was a Police officer until the interviews of the young men were conducted during the investigation of Case 3. The Authority has found no evidence to indicate that this had any bearing on the way in which Case 3, or any of the subsequent investigations, was handled by Police.

## FINDING

The fact that the father of one of the young men was a Police officer had no influence on Police's handling of the investigations.

### ISSUE 3: WAS PROSECUTION IN RELATION TO ALL AVAILABLE OFFENCES PROPERLY EVALUATED?

#### Issues of consent and alcohol consumption

80. The young men involved in these cases are alleged to have committed such offences as sexual violation by rape and unlawful sexual connection, attempted rape, and assault with intent to commit sexual violation. Section 128 of the Crimes Act 1961 states that the offence of sexual violation is committed if it can be proven that the alleged victim does not consent to the connection, and that the alleged perpetrator does not have a reasonably held belief that he or she is consenting (see paragraph 130).
81. There is no statutory definition of consent. The courts have held that genuine consent must be “full, voluntary, free and informed”<sup>9</sup> and that a person “must understand her situation and (be) capable of making up her mind when she agreed to the sexual acts”<sup>10</sup>. In addition, section 128A sets out a non-exhaustive list of the circumstances in which consent will not exist (see paragraph 131). These include that:

*“(1) A person does not consent to sexual activity just because he or she does not protest or offer physical resistance to the activity.*

*(3) A person does not consent to sexual activity if the activity occurs while he or she is asleep or unconscious.*

*(4) A person does not consent to sexual activity if the activity occurs while he or she is so affected by alcohol or some other drug that he or she cannot consent or refuse to consent to the activity.”*

82. In four of the cases, alcohol was known by investigating officers to have had an influence on the behaviour of the young women involved. In one case, the young woman passed out and awoke to find one of the young men on top of her. In another case, the young woman had no recollection of the incident, and was told a few hours later by one of the young men that “*you were roasted and then passed out.*” Material on these Police files reveals that the reported level of intoxication and the state of consciousness of the young women due to their alcohol consumption, and how this impacted on their capacity to consent, was an issue that was never adequately followed up by the officers. In some instances, it is apparent from the Authority's interviews with the officers and from the files that it was not even considered.

<sup>9</sup> *R v Isherwood* CA182/04, 14 March 2005

<sup>10</sup> *R v Adams* CA70/05, 5 September 2005

83. Case 3 was the only matter that was investigated by Police to the point where prosecution was a realistic consideration. The Authority is of the view that the Police assessment of the material gathered during the investigation was flawed. Officer D and Officer C did not properly assess the available evidence (including that outlined in paragraph 64). If they had done so, it should have led them to refer the matter for a legal opinion. However, prosecution is not currently an option, as the young woman is now unwilling to be involved in such a process.

### Sexual conduct with a young person under 16

84. Under section 134 of the Crimes Act 1961, everyone<sup>11</sup> who has a sexual connection with, or does an indecent act on, a young person (under the age of 16 years) has committed an offence and is liable to a term of imprisonment (see paragraph 132). There is no question that these young men were aware that the young women involved in the six cases investigated by CPT staff were under 16 years. As a result of their interaction with Police officers, it is also evident that several of the young men (certainly by the time the investigation into Case 1 had concluded) were aware that they were committing an offence, irrespective of their own ages.

85. Critically, the offence of ‘sexual conduct with a young person under 16’ did not require Police to determine whether there was consent. They merely had to prove that sexual connection had occurred and that the complainant was under 16 at the time. Clearly, therefore, the evidential threshold for prosecution was met. The only question for the Police was whether it was in the public interest to prosecute.

86. The Authority recognises that it is uncommon for Police to prosecute a young person under section 134 for sexual connection with a person of the same or a similar age<sup>12</sup>. This is because often such cases involve two young people, close together in age, who are engaging in mutually consenting sexual activity, and it is determined by Police that the public interest is not served by prosecution.

87. It is clear that this general thinking underpinned the approach taken by the officers in these cases. Indeed, Officer D told the Authority that he and Officer C determined that prosecutions under section 134 were “*inappropriate*” because two of the three young men were under 16 at the time of the offending. He added that section 134 is intended for “*consenting parties*” and that, if it had been used to bring a prosecution in Case 3, it would have implied that the Police did not believe the victim’s initial account that she was not consenting.

88. The Authority does not accept the validity of this reasoning, as there were a number of aggravating features in these cases that should have prompted consideration of such a prosecution. In four of these cases the young women were between two and three years younger than the young men involved. They were vulnerable (due to factors such as their level of intoxication); the extent to which they were willing parties was at best equivocal; and they

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<sup>11</sup> Section 127 of the Act states, “*There is no presumption of law that a person is incapable of sexual connection because of his or her age.*”

<sup>12</sup> The young men involved in these cases were aged between 14 and 17 years at the time of the incidents.

were subject to sexual acts by more than one young man. The behaviour of the young men was demonstrably unacceptable and required a response.

89. In our view, the fact that the parties are close together in age, while a relevant factor, is not determinative. Moreover, it is perverse to conclude that a prosecution for sexual violation cannot be brought because there is insufficient evidence to prove lack of consent beyond reasonable doubt, but then to reject a prosecution under section 134 on the basis that it would imply the existence of consent. The reality is that a prosecution under section 134 says nothing about the presence or absence of consent, because it is simply irrelevant to the facts that need to be proved.
90. At the least, officers should have discussed this option with victims and explained the implications to them. They were remiss in failing to do so.

## FINDING

CPT staff did not properly evaluate all available offences when determining the outcome of their respective investigations.

## ISSUE 4: WAS ALTERNATIVE ACTION, WITH REGARDS TO CARE AND PROTECTION ISSUES AND POTENTIAL OFFENDING BEHAVIOUR, PROPERLY CONSIDERED AND DEALT WITH?

91. In five of the six cases that were referred for CPT investigation, referrals of the young women were made to CYF by Police in line with Police policy (and the joint Child Protection Protocol – see paragraph 107)<sup>13</sup>. At this point, CYF had a statutory responsibility to follow up with the young women and their families with regards to their immediate and ongoing safety and wellbeing following the respective incidents. In a number of instances, Police referrals also rightly highlighted other care and protection concerns requiring CYF follow-up, such as at-risk sexual behaviour, alcohol abuse, and parental supervision<sup>14</sup>.
92. Police records reveal that all of the investigating officers noted, in some form, the presence of care and protection issues in respect of the young men involved in these cases. Given the ages of the young men at the time that most of these incidents occurred, and the concerns about their behaviour, enquiries into whether care and protection issues existed for them would have also been appropriate. However, only one of the young men was ever the subject of a referral to CYF, which was made by a CIB officer who initially responded to Case 1. Records show that CYF intended to contact the young man's parents to establish if they were aware of the incident. However, before this was undertaken, CYF were contacted by a detective at Auckland City CPT and advised that there was no need for CYF involvement or contact with the family due to the

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<sup>13</sup> CYF notified Police of Case 4.

<sup>14</sup> The assessment of the quality of CYF's care and protection investigations was not within the Authority's jurisdiction. However, the Authority has liaised with the Service during its investigation.

ongoing Police inquiry. No contact was ever made with the young man or his parents by Police during or at the conclusion of Officer A's investigation into this incident.

93. The fact that CPT staff failed to ensure adequate engagement with the young men and their parents, by either themselves or CYF, at the conclusion of the investigations was a significant oversight. In four of the cases, parents of the young women (having been advised by Police that there was insufficient evidence to proceed) and the secondary school involved in Case 4 made reasonable requests to, or were given an undertaking by, Police to speak to the young men and their parents about the incidents and the behaviour of the young men. Police, specifically Officers C, D, and E, failed to do so. This demonstrated a lack of appreciation of the seriousness of the allegations, the previous incidents, and the likelihood that the behaviour would continue.
94. In Case 2, neither the young men nor their parents were contacted during or at the conclusion of the investigation. Police records identify that Police expected CYF to assume the responsibility for following up and speaking with them. However, there was no discussion with CYF staff about this and CYF take the view that it is not within their jurisdiction to do so in the absence of a notification.
95. As outlined in paragraph 17, two of the three young men involved in Case 3 participated in suspect interviews. Following this, no further contact was made with them or their parents until they were sent letters over two months later advising them that Police would be taking no further action.
96. Officer D subsequently took steps to refer the other young man, with the support of his mother, to the SAFE Programme (a specialist treatment service working with young people who have harmful sexual behaviour). Officer D was the only officer assigned to investigate these cases who considered this course of action. However, the young man failed to attend a meeting with Officer D to sign the necessary paperwork. Despite the recorded concerns about the likelihood that the young man's behaviour would continue, Officer D made no subsequent effort to contact the young man or his family. During his investigation, Officer D determined that this young man was the "main offender". However, Officer D provided no sound basis for, or evidence to support, the decision that only this young man required professional intervention, and why the other two young men were perceived as less of a risk.
97. Although investigators determined that there was insufficient evidence for charges to be laid, there were provisions under the Children, Young Persons and their Families Act 1989 (CYPFA), which would have allowed both Police and CYF to intervene meaningfully and formally with these young men in an effort to address their behaviours and reduce the risk of harm to potential victims. For example, a referral for a Family Group Conference (FGC) could have been made under the care and protection (as opposed to youth justice) provisions of the CYPFA on the grounds that "*the child or young person has behaved, or is behaving, in a manner that is, or is likely to be, harmful to the physical or mental or emotional well-being of the child or young person or to others*" (section 14(1)(d)(i)).
98. As specialists in the area of child protection, it was reasonable to expect CPT staff to have some knowledge of other relevant courses of action. Despite the emergence of a pattern of incidents

involving similar behaviours, no proactive response was ever undertaken by Police (with the exception of Officer D's action with respect to the SAFE Programme) and no warnings, formal or otherwise, were ever issued to the young men. None of the investigating officers consulted their Youth Aid colleagues, or attempted to develop a meaningful plan of action with CYF or the schools attended by the young people.

## FINDING

CPT staff failed to properly consider alternative action to address the potential offending behaviour of the young men involved and their potential care and protection issues.

## ISSUE 5: WERE CPT STAFF'S CONSULTATION AND COMMUNICATION WITH EACH OTHER AND WITH STAKEHOLDERS ADEQUATE AND EFFECTIVE?

99. A theme that emerged during the Authority's investigation of these matters was the quality of CPT staff consultation and communication, both internally and externally, and the impact this had on the outcome of some of the investigations.

### *Young women and their families*

100. The Authority has determined that, overall, the communication of investigating officers with the young women and their families was good. In most cases, bearing in mind that several of the young women did not wish to participate in the investigation process subsequent to the incident, the attempts made by Police to explain the process, engage with the young women, and explain the outcome was more than adequate.

101. The one notable exception is Case 3. Immediately after the suspect interviews took place, one young man, who had declined to be interviewed, approached the young woman at school and attempted to bully her into withdrawing her complaint.

102. The young man was subsequently spoken to on his own at school by Officers C and D, where he was given a verbal warning for attempting to pervert the course of justice and instructed not to have any further contact with the young woman. No attempt was made by Police to contact the young man's parents following the incident, or to engage with the school (except to arrange the meeting) about the situation. The Authority considers that this was an inadequate response by Police to the seriousness of the entire incident.

103. At the conclusion of the investigation in Case 3, Officer D informed the young woman and her mother at a meeting that he had determined that there was insufficient evidence to meet the threshold required to lay charges against the young men involved. The young woman was recorded by Officer D as then stating that it was never her intention for the young men to be charged and that her primary concern was for them to get some assistance, without which, she believed, they would continue to treat other young women in a similar manner.

104. It is evident that the young woman's view was expressed after having been informed that a decision had been made that there was insufficient evidence to proceed. However, this was

later represented, in a formal letter advising the young woman of the outcome of the investigation, as the young woman having expressed “*specific wishes for the offenders not to be prosecuted*”, and that Police had taken this into account, along with the available evidence, in determining whether the young men would be the subject of a criminal prosecution. The Authority considers that this is not an accurate account of the sequence of events.

### *Young men and their families*

105. Contrary to their engagement with the young women and their families, the investigating officers’ contact and interaction with the young men and their families was, in all six of the cases investigated by CPT staff, inadequate or non-existent (see paragraphs 93–96)<sup>15</sup>. The failure of Police to make contact meant that the young men were never held accountable for their behaviour and, without any appreciation for the consequences or repercussions, there was no motivation for them to discontinue their behaviour. Furthermore, given that the parents of the young men were never made aware of several of the incidents and the details of their sons’ involvement, they were unable to intervene or act to address the behaviour.

106. Even in Case 3, where matters progressed to suspect interviews, Police did not meet with the three young men and their families at the conclusion of the investigation. Instead, letters were sent to them. These letters failed to outline the concerns or reference the previous incidents, made no reference to the SAFE programme, and did not warn the young men about what to expect if Police received further complaints about incidents involving them. In fact, the letters simply stated:

*“Having taken into account the victim’s wishes, along with the available evidence it has been decided that this case will not be followed through to a criminal prosecution. There will be no further Police action.”*

### *External stakeholders*

107. Police and CYF are parties to a Memorandum of Understanding (MOU) that sets out their commitment to a positive effective working relationship to ensure that the safety and wellbeing of the children and young people they come into contact with are a priority. The MOU is supported by a formal set of operating procedures for Police and CYF staff known as the ‘*Child Protection Protocol*’ (CPP), which applies to serious child abuse, including sexual abuse. Both documents promote effective communication and engagement through good intelligence and information sharing between Police and CYF, and with other organisations working to ensure the best interests of children and young people are being met.

108. The Authority’s review of Police and CYF files identified, for the most part, timely and regular communication and consultation by Police with CYF. However, the extent and quality of

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<sup>15</sup> Even in Case 7, the responding GDB officers did not attempt to speak with the parents of the young man hosting the gathering, despite their concerns and their awareness that the parents were home at the time.

collaborative efforts varied and, while files were discussed by supervisors at mandated CPP meetings, there was no evidence of joint investigative work by frontline staff.

109. While the Authority found no unwillingness on the part of Police to share information in an open, honest and timely manner, there were several instances where inaccurate information and miscommunication had a significant effect on the progress of an investigation. Case 4 provides a valuable example of how a lack of adequate care in the reporting and follow-up of information inadvertently derailed the investigation.

110. In summary, the following sequence of events led to no further action being taken by Police in Case 4:

110.1 CYF notified Officer B of a possible Mass Allegation Investigation (MAI). The details of the young people involved, obtained from the secondary school, were then forwarded by CYF to Officer I (who was Auckland City CPT's acting supervisor in the absence of Officer B).

110.2 In response, Officer I emailed CYF a brief and inaccurate summary of the three investigations (Case 1, 2, and 3) that had previously been undertaken by Police in respect of the young men involved.

110.3 As the young people involved resided in suburbs overseen by two CYF offices, which came under the auspices of both the Auckland and Waitemata CPTs, CYF staff invited Officers B and C (the supervisors of the respective CPTs), and Officer F (the officer in charge of Waitemata CPT) to attend a meeting to discuss the case and the way forward.

110.4 Officer C advised that he and Officer F would not be attending the meeting. It appears that Officer C misinterpreted Officer I's email (and failed to read the earlier conversation exchange), determining that the matters to be discussed related only to Case 3, which he considered had already been satisfactorily concluded by his team. He told Officer B that he would not be attending because all the allegations had previously been investigated by Police.

110.5 No one from the secondary school was invited to attend.

110.6 At the meeting, Officer B, who was relying upon what he had been told by Officer C, provided inaccurate information to CYF about the extent to which the cases had previously been investigated by Police. It appears that the repeated misinformation, and the absence of secondary school or CPT staff with accurate and detailed knowledge of each case, culminated in the loss of any appreciation of the fact that the young women involved in Case 4 were not all the subject of the investigations into Cases 1, 2 and 3. It was determined that, as the concerns had previously been investigated and there was no new information/complaint/incident, the matter did not constitute a MAI. However, it was agreed that arrangements would be made for CYF to speak directly to the student who reported the concerns to the school in order to determine whether further follow-up enquiries were needed.

- 110.7 The student refused to speak with the CYF staff member (see paragraph 19), but it does not appear that this was reported to anyone.<sup>16</sup>
- 110.8 Officer A subsequently advised the secondary school staff that the matter would be followed up by Waitemata CPT and, incorrectly, informed them that no complaints had been forthcoming and that the young men had been spoken to at some point during the Police investigations.
- 110.9 Officer C contacted CYF to confirm that the tasks resulting from the meeting, specific to the young women residing in the Waitemata CPT area, had been completed (no such tasks had, in fact, been set at the meeting). The misinformation that had been provided to CYF by Officer B at the meeting was simply repeated to Officer C. That is, Officer C was advised that all of the young women had previously been spoken to by CYF and Waitemata CPT between October 2011 and January 2012 (this, of course, only accounted for the young women involved in Cases 1, 2 and 3), so that there were no tasks to be completed.
- 110.10 Officer C was provided with the names of eight young women, which comprised most of those involved in Cases 2, 3, and 4<sup>17</sup>. The details of the young women identified as being involved in Case 4 were recorded together in an electronic document referred to by CYF as a 'Contact Record', but they were never subsequently documented by CYF as individual records. As a result, Officer C was also incorrectly informed that, with the exception of those young women involved in Cases 2 and 3, no report of concern was ever made to CYF in respect of the alleged offending by members of the 'Roastbusters' group.
- 110.11 Therefore, when Officers B and C subsequently met to discuss these matters, Officer C confirmed that all of the young women had been spoken to and none wished to make a formal complaint, and that the young men and their parents had also been spoken to.
- 110.12 No further action was taken by Police, and no further contact was ever made by Police or by CYF with secondary school staff to advise them of the outcome of the matter.

### *Internal communication*

111. The Authority considers that there are several examples, including those in Case 4, that highlighted inadequate and ineffective communication and consultation between the two CPTs and, specifically, between Officers B and C. Material on Police and CYF files, along with information obtained during the Authority's interviews, identified that a more adequate understanding of the cases, better teamwork and an ability to communicate and collaborate

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<sup>16</sup> During a subsequent discussion with the school staff member, the student provided information about the current membership of 'Roastbusters' and about their involvement a few days earlier in Case 6. School records identify that this information was forwarded to Officer B but there is no evidence that it was forwarded to Officer E, or even connected with Case 6.

<sup>17</sup> As outlined in paragraphs 23 and 28, this actually also included those young women involved in Cases 5 and 6.

directly, openly, and transparently, would have generated opportunities for a more robust and expansive organisational response, which would have led to better and more timely outcomes for the young people involved.

## FINDINGS

Overall, CPT staff's communication with the young women and their families was good. In contrast, their communication and engagement with the young men and their families was unsatisfactory.

CPT staff did not adequately consult and communicate with external stakeholders.

CPT staff, particularly at supervisory level, did not adequately communicate with each other.

## Subsequent Police Action

### POLICE

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112. As a result of the matter being brought to the attention of the public by the media in November 2013, Police launched Operation Clover to fully investigate the activities of the young men involved in 'Roastbusters'. The operation was concluded and findings publicly reported in October 2014. As a result of the Police investigation and a subsequent case review by the Auckland Crown Solicitor, Police determined that no charges would be laid.<sup>18</sup> It was not part of the Authority's remit to assess the adequacy of Operation Clover (the reasons for which are discussed in paragraph 36).
113. Police have informed the Authority that they have conducted a review of existing child protection investigation practices in the Waitemata District and have taken a number of actions to address identified shortcomings. This includes the appointment of a detective inspector to directly oversee child protection and adult sexual assault investigations, changes to case review practices (which often involves two detective inspectors), and the improvement of processes and communication with local and regional CYF offices.

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<sup>18</sup> Detailed information about Operation Clover is contained in the overview report authored by the officer in charge of the investigation, which was released to the public by Police on 29 October 2014. Go to: <http://www.police.govt.nz/about-us/publication/operation-clover-investigation-overview>.

## Summary of Findings

114. The Authority has made the following findings:

- 114.1 The initial response to the incidents by GDB and CIB staff was adequate and proper.
- 114.2 CPT staff did not adequately follow up and pursue positive lines of enquiry.
- 114.3 CPT staff should have more accurately recorded and more adequately assessed information obtained during their respective investigations.
- 114.4 Officer B's supervision and oversight of the cases for which he was responsible was adequate and appropriate.
- 114.5 Officer C did not adequately supervise and oversee the cases for which he was responsible.
- 114.6 The fact that the father of one of the young men was a Police officer had no influence on Police's handling of the investigations.
- 114.7 CPT staff did not properly evaluate all available offences when determining the outcome of their respective investigations.
- 114.8 CPT staff failed to properly consider alternative action to address the potential offending behaviour of the young men involved and their care and protection issues.
- 114.9 CPT staff did not adequately communicate and engage with the young men and their families.
- 114.10 CPT staff did not adequately consult and communicate with external stakeholders.
- 114.11 CPT staff, particularly at supervisory level, did not adequately communicate with each other.

## Conclusions and Recommendations

115. The Authority appreciates that the incidents involving the ‘Roastbusters’ presented Police with a complex set of challenges. The reprehensible and unacceptable behaviour demonstrated by this group of young men was further complicated by other issues. These included the vulnerability and fragility of the young women, the impact of peer, familial and social pressures in adolescence, attitudes towards sexual behaviour and the use of alcohol and other drugs, and the influence of youth culture and social media.
116. Indeed, the issues were such that it is unlikely they could have ever been dealt with meaningfully and effectively solely by Police. Regrettably, Police had numerous opportunities to ‘connect the dots’ earlier, to generate a more organised, expansive and cohesive response, and to work in collaboration with CYF, the schools, and the parents of these young men to prevent their behaviour from continuing.
117. While it is evident that the Police investigators were motivated to act in accordance with the wishes of the young women, and in their best interests, they focused on the victim’s wishes about prosecution in each individual case and failed to give adequate weight to the potential risk of harm to other young women. Critically, too, the Police investigations into these cases failed in several significant areas to meet the requirements of a good criminal investigation. Deficiencies in investigation practices, poor knowledge or understanding of legislation, and inadequate supervisory oversight were some of the primary factors that led to assessments that lacked critical analysis and sound, evidence-based, decision-making.
118. In the Authority’s view, most of the deficiencies identified in the Police investigations are a result of poor individual practices and cannot be said to be representative of Police child abuse investigations nationwide. The Authority considers that it was the failure of CPT officers to conduct their investigations to the required level, sufficiently meeting the standards of current policy and guidelines, that has had serious consequences in this instance. However, while existing Police child protection policy and investigation guidelines are sound, the lack of emphasis on prevention may be indicative of a more general problem with policy and practice requiring further attention. Police, themselves, have acknowledged that this is an area requiring further policy development to guide Police practice.
119. In 2007, following the 2004 Commission of Inquiry into Police Conduct, Dame Margaret Bazley reported that she was satisfied that child abuse policy (applicable at that time) was being applied consistently by Police and was “*working well in practice*”<sup>19</sup>. However, a special investigation, the ‘*Inquiry into Police Conduct, Practices, Policies and Procedures Relating to the Investigation of Child Abuse*’, commenced by the Authority in December 2009, found that this was not, in fact, the case in a number of policing districts around the country. In May 2010, at

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<sup>19</sup> A full copy of that report can be found at: <http://www.parliament.nz/resource/0000055162>

the conclusion of the inquiry, the Authority made 34 recommendations to Police to rectify the shortcomings identified<sup>20</sup>.

120. It is disturbing that several themes identified as a result of the Authority's child abuse inquiry (such as deficiencies in investigative practices, file recording, collaboration with CYF, and case supervision) have, again, been highlighted in the Authority's current investigation. This is notwithstanding the fact that the related recommendations made in 2010 to address the deficiencies were accepted and embedded by Police.
121. The Authority's focus in its investigation has been to identify what went wrong in this case so that similar failings can be avoided in the future. It has not considered what action, if any, should be taken in respect of the individual officers responsible for the performance shortcomings set out in this report. That is a matter for the Police.

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<sup>20</sup> Full copies of Parts I & II of the Authority's report can be found at: <http://ipca.govt.nz/Site/media/2010/2010-May-18-Child-Abuse.aspx> and <http://ipca.govt.nz/Site/media/2011/2011-Feb-17-Child-Abuse-Inquiry-Part-II.aspx>

122. In light of the above conclusions, the Authority recommends, pursuant to section 27(2) of the Act, that New Zealand Police:

- i) initiate an audit by the National Manager, Adult Sexual Assault/Child Protection Team into current cases being investigated by Waitemata CPT to determine whether any individual shortcomings still exist;
- ii) determine whether any other practice or policy issues need to be addressed, either nationally or in Waitemata, and in particular whether more emphasis is required on prevention;
- iii) ensure that the core training modules for CPT investigators provide adequate instruction on, and guidance about, the application of sections 128 and 134 of the Crimes Act 1961; and
- iv) advise the Authority of the outcome and any intended action by Police.



**Judge Sir David Carruthers**

Chair  
Independent Police Conduct Authority

19 March 2015



## Appendix 1: Applicable Laws and Policies

### POLICY

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#### Child protection policy and investigation guidelines

123. Police child protection policy and guidelines sets out the policy and principles that guide Police in responding to child safety concerns (including offences or suspected offences relating to the physical, sexual, and/or emotional abuse or neglect of a child), and applies to all cases where the victim is under the age of 17 at the time the complaint is made.

124. The policy sets out Police's commitment to victims as:

- Police will assess all reports of child safety concerns received;
- Police will take immediate steps to secure the safety and wellbeing of the child;
- Police will intervene to ensure the child's rights and interests are safeguarded;
- Police will investigate all reports of child abuse in a child centred timeframe, using a multi-agency approach;
- Police will take effective action against offenders so they can be held accountable;
- Police will strive to better understand the needs of victims;
- Police will keep victims and/or their families fully informed with timely and accurate information during the course of the investigation as required by section 12 of the Victims' Rights Act 2002.

125. The policy also sets out Police practice relating to reports of child safety concerns and the investigations of child abuse:

- all reports of child safety concerns and child abuse must be thoroughly investigated in accordance with the policy and guidelines, even if the child recants or parents or caregivers of the child are reluctant to continue;
- Police must take immediate steps to ensure the safety of any child who is the subject of a report of concern or is present in unsafe environments;
- all referrals made under the Child Protection Protocol must comply with the protocol;
- CYF inquiries do not negate the need for Police to conduct its own investigations into alleged child abuse;

- where a child is required to be interviewed, it must be conducted in accordance with the Evidential interviewers guidelines, by a trained child forensic interviewer and comply with the Evidence Regulations 2007.

126. The policy sets out ten process steps that Police should follow when responding to and investigating child abuse, which may vary depending on the individual circumstances of the case.

- Step 1: Record incident, event or occurrence** - details are recorded into the Police computer system, the National Intelligence Application (NIA) and a case is created, with the '6C' incident code and appropriate offence code.
- Step 2: Initial attendance** - Police respond to the report, enquiries commence, evidence is gathered or other action taken as necessary. Decisions and actions are taken to ensure the immediate safety of the child, and CYF are contacted and consulted as appropriate.
- Step 3: Gather and process forensics** - detailed scientific scene examination is conducted, forensic evidence is gathered and analysed (including medical examination), and the relevance of the forensic evidence is recorded and assessed.
- Step 4: Assess and link case** - initial assessment and review of all available information, identification of other cases which are related or relevant. Cases are either closed (filed, or inactivated) or forwarded to the appropriate work groups for further investigation.
- Step 5: Prioritise case** - cases identified for further investigation are assigned a case priority rating score based on crime type and the presence of a range of factors affecting the need for urgent investigation. All child abuse cases are recorded as 'Category 2' (Critical) under NIA Case Management. After an initial assessment of the case, serious cases are referred to CYF for consultation and to agree future actions and priority.
- Step 6: Investigate case** - initial investigation is conducted to bring the case up to a point where a suspect can be identified and all preliminary enquiries necessary prior to interview are complete. This includes gathering evidence (such as interviewing victims, witnesses, and suspects) and assessing it.
- Step 7: Resolution decision/action** - deciding on formal or informal sanction, prosecution or other action, confirming the appropriateness of charges and offender handling and custody suite actions.
- Step 8: Prepare case** - court files are prepared and pre-hearing actions such as disclosure completed.

**Step 9: Court process** – pre-trial and defended hearings take place in the courts.

**Step 10: Case disposal and /or filing** - occurs when a case will be subject to no further action. This occurs because either all reasonable lines of enquiry have been exhausted without result or the matter has proceeded to a resolution in the court system or by alternative action.

127. The policy reinforces the obligations of Police under the Children, Young Person's and Their Families Act 1989, to investigate any report they receive alleging child abuse, and that these investigations must be undertaken in a way that evidence gathered is admissible in court proceedings.

128. The policy discusses the importance of the initial Police approach to suspects and offenders, and that *"the best approach comes from good planning."* Police policy also includes a *'Investigative interviewing suspect guide'* that outlines the procedures for interviewing suspects in child abuse cases.

129. The policy also outlines a planning guide for the investigation of 'mass allegations', which are defined as *"an investigation of serious abuse of four or more children by the same offender or connected group of offenders."*

## LEGISLATION

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### Crimes Act 1961

130. Section 128 of the Crimes Act 1961 states:

*"(1) Sexual violation is the act of a person who—*

- (a) rapes another person; or*
- (b) has unlawful sexual connection with another person.*

*(2) Person A rapes person B if person A has sexual connection with person B, effected by the penetration of person B's genitalia by person A's penis,—*

- (a) without person B's consent to the connection; and*
- (b) without believing on reasonable grounds that person B consents to the connection.*

*(3) Person A has unlawful sexual connection with person B if person A has sexual connection with person B—*

- (a) without person B's consent to the connection; and*
- (b) without believing on reasonable grounds that person B consents to the connection.*

*(4) One person may be convicted of the sexual violation of another person at a time when they were married to each other."*

131. Section 128A of the Act outlines circumstances for which allowing sexual activity does not amount to consent:

*“(1) A person does not consent to sexual activity just because he or she does not protest or offer physical resistance to the activity.*

*(2) A person does not consent to sexual activity if he or she allows the activity because of—*

- (a) force applied to him or her or some other person; or*
- (b) the threat (express or implied) of the application of force to him or her or some other person; or*
- (c) the fear of the application of force to him or her or some other person.*

*(3) A person does not consent to sexual activity if the activity occurs while he or she is asleep or unconscious.*

*(4) A person does not consent to sexual activity if the activity occurs while he or she is so affected by alcohol or some other drug that he or she cannot consent or refuse to consent to the activity.*

*(5) A person does not consent to sexual activity if the activity occurs while he or she is affected by an intellectual, mental, or physical condition or impairment of such a nature and degree that he or she cannot consent or refuse to consent to the activity.*

*(6) One person does not consent to sexual activity with another person if he or she allows the sexual activity because he or she is mistaken about who the other person is.*

*(7) A person does not consent to an act of sexual activity if he or she allows the act because he or she is mistaken about its nature and quality.*

*(8) This section does not limit the circumstances in which a person does not consent to sexual activity.*

*(9) For the purposes of this section, —*

***allows** includes acquiesces in, submits to, participates in, and undertakes **sexual activity**, in relation to a person, means—*

- (a) sexual connection with the person; or*
- (b) the doing on the person of an indecent act that, without the person's consent, would be an indecent assault of the person.”*

**132.** Section 134 of the Act outlines the penalties for those who have sexual conduct with a young person under 16 years as:

*“(1) Every one who has sexual connection with a young person is liable to imprisonment for a term not exceeding 10 years.*

*(2) Every one who attempts to have sexual connection with a young person is liable to imprisonment for a term not exceeding 10 years.*

*(3) Every one who does an indecent act on a young person is liable to imprisonment for a term not exceeding 7 years.*

*(4) No person can be convicted of a charge under this section if he or she was married to the young person concerned at the time of the sexual connection or indecent act concerned.*

*(5) The young person in respect of whom an offence against this section was committed cannot be charged as a party to the offence if the person who committed the offence was of or over the age of 16 years when the offence was committed.*

*(6) In this section,—*

- (a) young person means a person under the age of 16 years; and*
- (b) doing an indecent act on a young person includes indecently assaulting the young person.*







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