IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

Self-harm in Police custody

INTRODUCTION

1. On 24 October 2017 and 18 November 2017, Police arrested Ms X and brought her into Counties Manukau Police Station. On both occasions Ms X attempted to asphyxiate herself with an item of clothing and was taken to hospital by ambulance.

2. The Police notified the Independent Police Conduct Authority of the incidents, and the Authority conducted an independent investigation. This report sets out the results of that investigation and the Authority's findings.

BACKGROUND

3. This section of the report provides a summary of the incidents and the evidence considered by the Authority. When quoting or describing the accounts of any officer, complainant or witness, the Authority does not intend to suggest that it has accepted that particular account.

4. Analysis of the evidence and explanations of where the Authority has accepted, rejected or preferred that evidence are reserved for the 'Authority's Investigation and Findings' section.

Summary of events

24 October 2017

5. At approximately 1.20am on 24 October 2017, Officers A and B were on patrol in Manurewa when they saw Ms X walking along a suburban street. They stopped to speak to her about an earlier incident. While Ms X provided a false name, the officers were able to establish her true identity and that she was on bail and not complying with her hours of curfew. Officer A arrested Ms X for breaching her bail conditions. The officers then transported her to the Counties Manukau Police District Custody Unit (DCU).

6. Officer B later stated that, on the way to the station, Ms X was upset, *"crying and hyperventilating"* in the back of the patrol car. He reported that Ms X told the officers that she had previously been warned about the consequences of breaching her bail conditions, and that she was scared of going to prison.

7. Officer A stated that upon arriving at the DCU (at 1.50am), Ms X was "*crying and upset*". Officer A proceeded to search Ms X, who removed her shoes, jewellery, and hair tie as requested. However, Ms X refused to remove her pounamu necklace.

8. Officer A eventually managed to persuade Ms X to remove her necklace after explaining that it was necessary to ensure her safety. At 1.54am Officer A placed her in one of the holding cells, which have glass doors and windows and are located immediately in front of the custody counter.[1] Officer B left the custody suite to move the patrol car.

9. At the time Ms X was placed in the cell, acting custody sergeant, Officer C, was sitting at his desk speaking to Officer D. At 1.56am Officer A walked behind the custody counter and began to make notes in her notebook. She approached Officer C at 1.57am, gave him Ms X's first name and advised him that she had been arrested for breaching bail. Officer A also told Officer C that she had had difficulties accessing her mobility device to complete the paperwork in respect of Ms X's arrest and that she would need to go upstairs to use a Police computer to do so.[2] Officer A remained with Officers C and D for over five minutes discussing other matters.

10. Custody officers, Officers E and F, were also working behind the custody counter. CCTV footage shows Officer E standing facing Ms X's cell but working at a computer and not looking at her, while Officer F was sitting at a computer with Ms X out of his line of sight.

11. CCTV footage (which has no audio) shows Ms X pacing around the cell, while Officer E remained focused on the computer. At 1.57am Ms X sat down, removed her sock and wrapped it around her neck, apparently pulling it in an attempt to asphyxiate herself. Meanwhile, Officer A continued talking to Officers C and D.

12. After a minute, Ms X walked over to the cell door, standing directly in front of it, looking towards the custody counter. At 1.58, Ms X fell to the ground, landing on her back with her feet facing the door. None of the staff noticed this occur.

13. At 1.59am, Officer B returned to the custody suite and immediately noticed Ms X lying on the floor of the cell. Officer B did not bring this to the attention of the custody staff, and simply walked behind the custody counter and engaged in conversation with Officer F. Officer B later stated that he was not concerned about Ms X as he thought she was resting or asleep.

14. The custody officer who was responsible for processing smart arrests (which Ms X was),[3] Officer G, had been dealing with another detainee. When he returned to the custody desk at 2.02am, he noticed that Ms X was lying on the ground and brought this to the attention of Officer E. Although both intermittently looked into the cell from the custody counter, they continued their conversation. At this time, Officer A was still engaged in her conversation with Officers C and D at the sergeant's desk.

[1] The times on the three Police custody CCTV cameras were inconsistent. The Authority has determined the sequence of events and relayed the background information in accordance with one of the time stamps for the purpose of consistency.
[2] A 'mobility device' is either an iPad or an iPhone that Police officers carry with them and can use to access the Police computer system.
[3] Smart arrests enable officers to complete the necessary arrest paperwork on their mobility devices prior to arriving at the custody suite.

15. CCTV footage shows Officer A leaving the custody suite at 2.04am. At this point, five and a half minutes after Ms X fell to the floor, Officer E approached and entered the cell. She tapped Ms X's foot with her own but Ms X did not respond. Officer B joined Officer E at the cell door. He saw that Ms X was unresponsive but later stated that he believed "*she was just being difficult*."

16. Officer E noticed that "*her eyes were opening and closing and [there was] no sign of her lips being blue*". Officer D subsequently approached the cell and Officer G followed. Officer G entered the cell to conduct a nail bed test,[4] which Ms X responded to by "*making a noise and moving her hand slightly*".

17. Officer G later stated that, consequently, he believed Ms X was likely pretending to be unconscious. However, he and Officer E decided to put Ms X into the recovery position as a precaution. None of the staff checked Ms X's airway or informed Officer C that there might be an issue.

18. Officer E subsequently asked Officer B if he had had any concerns about Ms X. Officer B advised that he thought Ms X might have been drinking, and that she had also been upset in the back of the car on the way to the station.

19. The officers exited the cell as they were satisfied that Ms X was breathing. CCTV footage then shows the officers standing around the custody counter talking. They remained there for over a minute and a half before Officers B and E followed Officer G into an office to view the CCTV footage to establish how Ms X came to be on the ground. Officer G said:

> "*We observed on the footage her fall back down on to her hands and on to her back. As the female had dropped on the floor we decided to go and physically assess her again to make sure there were no injuries to the back of her head*."

20. The officers did not view the footage leading up to Ms X's fall. When Officers B, E and G returned to the cell, three and a half minutes later, they noticed that Ms X had rolled from her side onto her back. Officer E checked that the hood on Ms X's sweatshirt was not restricting her breathing and, in doing so, found the sock around Ms X's neck. Officers E and G were able to remove the sock without any difficulty.

21. At 2.10am, Officer G exited the cell and advised Officer C of the situation and that an ambulance was required. Officer B contacted Officer A to advise her of what had happened, and she returned to the custody suite. Staff remained with Ms X, monitoring her breathing, until paramedics arrived 10 minutes later. Officer A accompanied Ms X, who was unconscious, to the hospital. Upon arrival, Ms X was sedated and placed in intensive care. The toxicology results show that Ms X had drugs in her system but the degree to which this effected the outcome of the incident is unknown. The available medical records show that she was treated for self-harm and strangulation. Ms X was discharged from hospital two days later.

[4] This involves putting pressure on the fingernail bed to see if there is a physiological response from the patient. It is often used to check for signs of shock, however a person may respond to pain even while unconscious.

22. Police documents identify that no custody record was created for Ms X's period of detention in the DCU and that no charge was laid in respect of Ms X's arrest. However, an alert was recorded on Ms X's record in the Police computer system, stating:

> *"[Ms X] attempted to [commit suicide] by tying a sock around her throat in the Manukau Custody Unit. Upon being located by Police she was unresponsive and required transportation to hospital."*

9 November 2017

23. On 9 November 2017, Ms X was arrested after the stolen car (in which she was a passenger) crashed following a Police pursuit. Ms X was transported to the Counties Manukau DCU. Despite the alert (see paragraph 22), the arresting officer recorded that they were not aware of any reason why Ms X might require special care or might be at risk while in custody.

24. When a detainee is received into Police custody, it is the responsibility of the receiving officer to complete an evaluation form to determine the level of care a person requires. In order to progress through the electronic evaluation form, officers must select, from drop-down boxes, pre-set responses to questions about intoxication, behaviour, history, mental health and level of consciousness. The response to these drop-down boxes creates a computer-generated recommendation for a detainee's level of care. A person who is deemed 'not in need of specific care' requires a check once every two hours; a person who is deemed in need of 'frequent monitoring' must be checked five times an hour at irregular intervals; and a person requiring constant monitoring is subject to direct continuous monitoring.[5]

25. The custody officer who received Ms X at the DCU at 3.14pm, Officer H, detailed her previous offending, family circumstances, her behaviour, and the incident on 24 October 2017, as part of his risk evaluation. The officer correctly entered the information into the electronic risk evaluation form, including appropriate responses for Ms X's behaviour, mental health and suicide risk. This created a computer-generated recommendation of "not in need of specific care". However, the officer manually changed the recommended monitoring to 'frequent', based on his knowledge of her recent history and actions. Police records show that custody staff monitored Ms X in the Police cells in line with Police policy.

26. Ms X was escorted from the DCU to Manukau District Court (through a tunnel connecting the two buildings) at about 8.45am on 10 November 2017 in preparation for her appearance in court. The transfer over to the court automatically generated a copy of the evaluation form completed by Officer H who received Ms X at the DCU the previous day. The court custody officer recorded as receiving Ms X, Officer I, was then required to check the evaluation and make any applicable amendments.[6]

27. There is no evidence that Ms X's evaluation (completed 17 hours before by Officer H) was considered or updated, except for the fact that Officer I recorded confirmation that Ms X's active alerts had been reviewed. Notwithstanding the information about Ms X's recent history

[5] See paragraph 118 for relevant Police policy.
[6] Manukau District Court custody officers are Police employees.

and risk, Officer I reduced the monitoring frequency to 'not in need of specific care' without any reason being recorded, as is required by Police policy.[7] Based on the information set out in the original evaluation detailing Ms X's risk, it is evident that Ms X should have remained on frequent monitoring.

28. Ms X was released on bail from the court at 7.10pm. During her time in custody at the court, records identify that custody staff did not check Ms X every two hours (as required by policy for detainees deemed 'not in need of specific care'), and that some of the checks were made using the CCTV monitors, which is also a breach of Police policy.[8]

18 November 2017

29. On 18 November 2017, Police found Ms X intoxicated on the street and arrested her for breaching her bail conditions. Police took Ms X to the Counties Manukau DCU, where she was received into custody at 3.30am. The arresting officer correctly identified on Ms X's custody evaluation form that she might be a risk due to the incident at the DCU on 24 October 2017.

30. It is evident from his recorded comments that the custody officer who received Ms X, Officer J, spoke with her about the alcohol and other drugs that she had consumed that evening as well as the previous attempt to harm herself while in Police custody. While Officer J determined that Ms X was not under the influence of any substance and did not hold any immediate concerns for her safety (he based his assessment on her presentation at the time), he changed the recommended monitoring frequency from 'not in need of specific care' to frequent monitoring based on her disclosed alcohol and drug use and the recent incident of self-harm. Officer J told the Authority that he recorded the details in the comments sections of the evaluation form in an attempt to deter other staff from downgrading Ms X's monitoring level while she was in Police custody. Police records show that Ms X was checked in line with policy.[9]

31. Ms X was escorted over to the Manukau District Court at 9.20am that morning. The transfer automatically generated a copy of the evaluation form completed by Officer J. Records show that court custody officer, Officer K, received Ms X. Despite the information recorded by Officer J in the evaluation, and the fact that Officer K recorded that he reviewed Ms X's active alerts, Ms X's monitoring frequency was changed to 'not in need of specific care'. No explanation for this change is recorded. Records show that court custody staff checked Ms X at two hourly intervals (in line with policy for a detainee deemed 'not in need of specific care').

32. Following her court appearance, Ms X was remanded in custody. Due to a delay in the arrival of Corrections staff, Ms X and other remand prisoners were taken to the cells at the DCU to await transport to prison.

33. Ms X was received back at the DCU at about 1.30pm. She is recorded as being received and evaluated by Officer F (who was present during the incident on 24 October 2017). Once again, the transfer automatically generated a copy of the evaluation form completed by Officer J but

[7] See paragraph 123 for relevant Police policy.
[8] See paragraphs 121-122 for relevant Police policy.
[9] See paragraph 118 for relevant Police policy.

with the amendment made by court staff that Ms X was not in need of specific care. There is no evidence that the evaluation form was reviewed by Officer F, other than the fact that he recorded having reviewed Ms X's active alerts.

34. Officer E (also present during the incident on 24 October 2017) and another custody officer, Officer L dealt with Ms X and Ms Y (coincidentally an old school friend of Ms X, who she had become reacquainted with while in the court cells) at the custody counter in the DCU. The officers spent some time chatting with the two women. Officer E later stated, "*Both female remands were chatting and laughing with each other, myself and [Officer L]. We asked them how they were feeling, both were in good spirits and just said they were still hungry*." Officer L later stated that Ms X "*was chatting away, showed no signs of wanting to hurt herself. Happy and compliant.*"

35. In her Police statement following the incident, Ms Y outlined her conversation with Ms X in the court cells. She said:

> *"After a while she started crying and talking really negatively saying she was done with life. I was trying to say positive things to her like it's going to be okay and to just get through the Court stuff. She was saying she was done with life over and over. I tried heaps of times trying to tell her positive stuff but she wasn't taking it very well. She was just thinking about prison and she told me her lawyer said to her she is looking at four years in prison. While I was trying to tell her to keep positive she said something along the lines of "no matter what you say I'm not going to listen…She seemed a bit loopy like she was bipolar. She was crying one minute and then okay and laughing about things the next minute."*

36. Despite her presence and knowledge of the earlier incident, Officer E did not inform Officer L or the duty supervisor, Officer M, of the incident on 24 October 2017 or the known risk Ms X posed to herself.

37. Given the pair were getting on well, Officer E decided to put them in a cell together to await prison transport. The cell had no CCTV coverage. Ms Y later informed Police that Ms X appeared to be in better spirits upon return to the DCU and did not further discuss "*ending it all or hurting herself*".

38. Officer L brought them lunch at 1.35pm. Ms X then lay down on a bed in the cell and pulled a blanket up around her, facing away from Ms Y.

39. In her statement to Police, Ms Y said that she had been reading a book for 20-30 minutes, before she noticed that Ms X did not appear to be breathing. Ms Y said that she immediately tried to alert staff by pushing the cell intercom button (which she believed to be an emergency bell) and banging on the door. She said that she also told a detainee in another cell to push their cell intercom button. Ms Y estimated that it took custody staff about five minutes before responding to the bell.

40. Cell call activation data shows that Ms Y pressed the intercom button in her cell 58 times within a seven minute period. Activating the cell call button produces a flag for staff on one of

the computers at the security desk situated behind the custody counter. There is no audio alert to the presence of the flag but it remains on the screen until it is acknowledged and physically removed by staff using the computer. CCTV footage shows that, during the period that Ms Y was pressing the button, Officers E, L and N were sitting in the processing area directly behind Officer F, who was sitting at the security desk. Officer M was standing behind Officer F. For the most part, all of the officers appeared to be looking at the CCTV monitors and engaged in conversation about what they were watching.

41. At about 2.28pm, it is evident that Officer F noticed the flag and responded to Ms Y, who reportedly advised "*there's a chick in here not breathing*". When asked who it was, Ms Y said that it was Ms X. CCTV footage shows that staff responded immediately.

42. Custody staff entered the cell and found that Ms X had her sweatshirt and a blanket pulled up around her neck so that only her head was exposed. Once the blanket was removed and Ms X's sweatshirt was pulled down, it was established that her bra was wrapped around her neck. The bra was cut from Ms X and an ambulance was called.

43. The ambulance arrived five minutes later and Ms X was transported to hospital (accompanied by Officer E). After being examined by medical staff and assessed by a psychiatric nurse, Ms X was discharged from hospital at 7pm into the care of Corrections staff.

44. Following this incident, a further alert was recorded on Ms X's record in the Police computer system, stating:

> *"[Ms X] has several suicide attempts while in custody. All have required medical attention; one suicide attempt required her to be transported to hospital by Ambulance with DCU staff. She must be placed in a Suicide Cell, refer custodial suicide training and consider TENR.[10] A proper assessment as to her monitoring frequency needs to be completed by the DCU Sergeant."*

4 December 2017

45. On 4 December 2017, Ms X was received (as a Corrections prisoner) and evaluated by custody staff at 9.40am, prior to her scheduled appearance at Manukau District Court. Police records identify that, although the evaluation form was not completed correctly as the custody officer selected 'None' in response to the drop-down boxes, (resulting in a computer-generated recommendation that Ms X was 'not in need of specific care'), it is evident that the receiving custody officer clearly appreciated Ms X's self-harm risk based on her history. The officer changed the recommendation to ensure that Ms X was frequently monitored.

46. Ms X was placed in a cell with other female remand prisoners. Police records show that Ms X was checked, on average, once every one to one and a half hours instead of the required five

[10] The Police threat assessment methodology 'TENR' (Threat Exposure Necessity Response) is a decision making process that supports the timely and accurate assessment of information directly relevant to the safety of Police and others. The response to any given situation must be considered, timely, proportionate and appropriate. The overriding principle when applying TENR is that of 'safety is success'.

times an hour at irregular intervals. Ms X was released, without incident, back into the care of Corrections staff at 7.15pm.

14 December 2017

47. On 14 December 2017, Ms X was received (as a Corrections prisoner) by custody staff at 1.29pm, prior to her scheduled appearance at Papakura District Court. The evaluation form contained no information (other than the fact Ms X was able to engage in coherent conversation) and no appreciation of Ms X's history. No amendment was made to the computer-generated recommendation that Ms X did not require any specific care.

48. Police records show that Ms X was checked once (at 2.55pm) prior to her release at 5.23pm.

THE AUTHORITY'S INVESTIGATION AND FINDINGS

49. As part of its investigation the Authority interviewed all of the Police staff involved in the incidents on 24 October and 18 November 2017. The Authority also visited the DCU, reviewed CCTV footage and cell alarm data, and reviewed all material obtained during the Police investigation into these incidents.

50. The Authority identified a number of issues during its investigation into Ms X's detention in Police custody and considered the following:

    1) Did Police fulfil their duty of care to Ms X while she was in custody on 24 October 2017?

    2) Did Police staff properly undertake the risk evaluation process on each occasion when she was received into the DCU?

    3) Did Police staff adhere to the monitoring frequency required by Police policy?

    4) Did Police properly manage Ms X during her time in custody on 18 November 2017?

Issue 1: Did Police fulfil their duty of care to Ms X while she was in custody on 24 October 2017?

51. Police policy states that the arresting officer's duty of care starts when they arrest or detain a person, and continues while the detainee is being transported to a Police station and during the receiving process. The arresting officer maintains responsibility for the detainee until they are transferred to someone else's custody (e.g. a custody officer or custody sergeant) or the person is released.[11]

52. During the arrest process, officers are required to ascertain any factors which suggest that the person might need special care, or could harm themselves or commit suicide while in Police custody. They should then notify the custody staff of these concerns.[12]

53. On the way to the Police station Ms X displayed a number of concerning behaviours. She was crying and hyperventilating in the back of the patrol car and was visibly upset, during which time she expressed concerns to Officers A and B about going to prison.

54. On arriving into Police custody, she removed her jewellery and clothes as asked. However, she was distressed about removing her pounamu and it took some persuasion to get her to do so. Officer A later told the Authority that she did not consider Ms X's behaviour to be unusual. However she also said:

> *"I do remember her being worked up and upset because otherwise I wouldn't have written in my notebook, like if people just had a few tears that would not be something I'd usually note down but she was upset and she was from what I recall angry at me for not letting her off."*

[11] See paragraphs 103 -104 for relevant policy.
[12] See paragraphs 105-106 for relevant Police policy.

55. As Ms X's behaviour was noteworthy, the Authority does not accept Officer A's position that her behaviour was ordinary. Ms X had been upset on the way to the station and about removing her pounamu. Officer A placed Ms X into a holding cell but did not advise the acting custody sergeant, Officer C, of Ms X's behaviour. As per Police policy (see paragraph 52), these concerns needed to be relayed to custody staff so they were aware of her presence in the cells and of possible risk factors.[13] Officer G was responsible for receiving smart arrests into custody on 24 October 2017. However, he was processing another detainee at the time Ms X was brought into custody and he was not advised of her arrival.

56. Officer A left Ms X unsupervised in the holding cell while she spoke to Officers C and D behind the custody desk for seven minutes. While she was engaged in conversation with them, Ms X (who was in the cell opposite the custody desk) tied a sock around her neck and fell to the floor. Despite being in close proximity, Officer A was unaware of the incident unfolding behind her.

57. Due to technological issues, Officer A then left the custody suite without checking on Ms X, to complete the arrest paperwork. Officer A told the Authority that:

> *"From my understanding when I arrest somebody it's my responsibility and they're in my custody and then with this police station [Counties Manukau DCU] we put them in the holding cell and when I've let the custody sergeant know that I've arrested somebody then that's when the responsibility goes to custody."*

58. The Authority accepts that it was reasonable for Officer A to find a computer in order to complete the arrest paperwork. However, she should have asked a staff member to carry out regular checks on Ms X in her absence, while she was in the holding cell and until she had been received into Police custody.

59. In her submissions to the Authority, Officer A reiterated her understanding of Police policy (as outlined in paragraph 57), stating that the introduction of 'Smart Arrests' had changed the process. Officer A's understanding is manifestly wrong. In accordance with Police policy (paragraph 51), Ms X remained Officer A's responsibility, as she had not yet been received into Police custody. Officer A failed to perform her duty of care by appropriately monitoring Ms X and passing relevant information on to Officer C.

60. Officer A said that everyone she had spoken to following this incident was also of the view that once a detainee has been placed in the holding cell and the custody supervisor has been advised, the detainee becomes the responsibility of DCU staff. If this is the case, it is particularly concerning as it gives rise to the possibility that no one takes responsibility for managing detainees prior to being received, which is exactly what occurred in Ms X's case.

61. Officer C did not inform any of his custody staff that Officer A was leaving the DCU to complete the necessary paperwork and that they needed to monitor her until this was completed and that they could proceed with processing Ms X. While the Authority accepts that it was only Officer C's second shift as a custody sergeant and that he was unfamiliar with the

[13] See paragraph 106 for relevant Police policy.

requirements of the role, he had overall responsibility for the custody unit and failed to ensure that proper process was followed. As Ms X had not been assessed and was not being monitored at the time, she had the opportunity to tie the sock around her neck.

62. Police staff also failed to act appropriately and ensure Ms X's wellbeing when she was seen lying on the floor. CCTV footage shows that Police did not assist Ms X for five and a half minutes after she fell down in the holding cell. When Police staff made an initial assessment of her, Officer E put her in the recovery position but did not look for an obstruction to her airway. Ms X was left unattended while Officers B, G, and E went to check the CCTV footage to establish what happened, and only established that something was obstructing Ms X's breathing when they returned three and a half minutes later.

63. Officers B, E and G viewed the CCTV footage and decided that it looked like Ms X may have staged the fall, as she put her hand out behind her to break her fall. Officer G said: *"It was no sudden fall, it was very controlled, she fell back down onto her hands. I think if anyone was to drop they'd go forward, fall, and just fall down."*

64. On the basis of this observation, they concluded that Ms X was feigning. However, they had only reviewed the CCTV footage from the moment she fell. They did not sufficiently investigate the cause of her fall because, had they rewound the footage further, they would have seen her tie the sock around her neck.

65. The officers were unaware of Ms X's history as she had not been evaluated and received into Police custody. However, Police policy requires that all detainees be considered 'at risk' until an evaluation has been completed.[14] The officers' collective approach to Ms X was casual and did not reflect any concern that she might be at risk. They did not act appropriately or quickly enough when they noticed she was unresponsive, and failed to fulfil their duty of care to her.

FINDINGS

Officer A should have advised Officer C about Ms X's concerning behaviour on the way to the Police station.

Officer A was responsible for monitoring Ms X on arriving into Police custody but did not fulfil that responsibility in accordance with Police policy. As a result, Ms X was left unassessed and unsupervised, giving her the opportunity to tie the sock around her neck.

Officers B, E, and G failed to act appropriately or quickly enough to ensure Ms X's wellbeing when she was seen lying on the floor.

Although Officer C was inexperienced and unfamiliar with the responsibilities of the role, it was his responsibility to make sure his staff managed Ms X's care. He failed to do so.

[14] See paragraph 118 for relevant Police policy.

Issue 2: Did Police staff properly undertake the risk evaluation process on each occasion when she was received into the DCU?

66. When Police custody staff complete a risk evaluation for a person who shows signs of mental health and/or suicide risk, this must be recorded so that the detainee is appropriately monitored while in Police custody.[15]

24 October 2017

67. On 24 October 2017 Ms X was taken to hospital after she was discovered unconscious in the holding cell with the sock around her neck. Ms X was never subject to an evaluation, nor was a custody record created after the fact to reflect her time at the DCU. It was not sufficient to create a noting of the incident and enter the suicide alert. Police should have created a custody record even though she had not been formally received into Police custody prior to being transported to hospital.

9 and 10 November 2017

68. On 9 November 2017, Officer H completed a thorough evaluation of Ms X, taking into consideration her previous self-harm attempt and other risk factors. He selected appropriate responses to the drop-down boxes on the evaluation form but recognised that the computer-generated recommendation of 'not in need of specific care' was insufficient. He correctly determined that Ms X should be placed on frequent monitoring and changed the monitoring requirements manually.[16]

69. When Ms X was transferred to court on 10 November 2017, Officer I did not update Ms X's evaluation. Instead, she reduced Ms X's recommended monitoring frequency with no explanation for the change in monitoring or apparent consideration of the history (which was clearly detailed on the evaluation).

70. Officer I recorded that she had reviewed Ms X's active alerts (which noted the self-harm attempt). However, Ms X's risk factors had not been reassessed despite the reduction in monitoring frequency. In accordance with Police policy, a detainee's monitoring level should not be reduced without the authority of a health professional. Any reasons for decreasing the monitoring level must be explained.[17] This unauthorised and unexplained reduction in monitoring frequency increased the time and opportunity for Ms X to self-harm, as she had done just 17 days earlier.

18 November 2017

71. Ms X was received into custody at 3.30am. The evaluation detailed her alcohol and drug consumption that evening, and the earlier self-harm incident. However, Officer J selected 'None' for the drop down box options relating to Ms X's current behaviour and the extent to which she was under the influence of substances. The system generated a monitoring

[15] See paragraph 110 for relevant Police policy.
[16] See paragraph 25 for evaluation summary.
[17] See paragraph 123 for relevant Police policy.

frequency recommendation of 'not in need of specific care'. Officer J recognised that this was insufficient given his knowledge of the risk Ms X posed to herself, and manually changed it to 'in need of care and frequent monitoring'. Ms X was checked five times an hour as per Police policy.[18]

72. When Ms X was transferred to court on 18 November 2017, Officer K amended the monitoring frequency to 'not in need of specific care'. Despite the clearly recorded concerns about Ms X's previous self-harm, no reason was entered for this amendment.[19]

73. On her return from court at 1.30pm, Police staff did not re-evaluate Ms X but did put her in a cell with another person, providing an additional safety measure. Police staff should have checked and updated the evaluation, especially since she had been intoxicated on her initial reception, and 10 hours had elapsed since the initial evaluation.[20]

4 and 14 December 2017

74. On 4 December 2017 the evaluating officer inputted minimal detail and failed to appropriately utilise the drop-down boxes. He did however note that she had a history of self-harm and suicidal tendencies so changed the monitoring frequency to 'in need of frequent monitoring'.[21]

75. On 14 December 2017 the evaluation lacked sufficient detail to determine the suitable monitoring requirements. The ECM recommended 'not in need of specific care', which was accepted by the custody officer.[22]

Concluding comments

76. It is evident that the custody staff from the DCU and Court did not complete the various evaluations of Ms X properly or in accordance with policy. Records were not completed fully and accurately, resulting in questionable computer-generated monitoring recommendations.

77. Police staff did not provide correct answers in the drop-down boxes on the evaluation forms, even though in some instances there was substantial detail in the comment boxes relating to each question. The computer generated recommendation as to the level of monitoring is based on the responses in the drop-down boxes, irrespective of the information inputted into the comment boxes. The detail in the comment boxes was therefore not reflected in the recommended monitoring frequency. In all but one of these instances, the custody staff did make a manual adjustment to the monitoring frequency. But the incorrect answers in the drop-down boxes accompanied Ms X when she went to court, thus increasing the risk of subsequent errors in her treatment.

78. In fact, the Authority notes that on each occasion when Ms X went to court, the officers in charge of the court cells reduced the monitoring frequency, without recording reasons for doing so. In a larger Court cell block, such as Manukau, there is generally more than one

[18] See paragraph 118 for relevant Police policy.
[19] See paragraph 104 for relevant Police policy.
[20] See paragraphs 30-31 for evaluation summary.
[21] See paragraph 45 for evaluation summary.
[22] See paragraph 47 for evaluation summary.

person in each cell, resulting in a number of informal, unrecorded checks on cell occupants and a reduced opportunity for self-harm. Nonetheless, this is not a justification for custody staff to reduce the monitoring frequency for an individual without authorisation and without recording the reasons for doing so.

FINDINGS

Officer C should have ensured that a custody record was created in respect of Ms X on 24 October 2017.

Evaluations were not properly completed on each occasion when Ms X was received into the DCU, resulting in potentially inaccurate monitoring recommendations. In all but one instance, this was manually corrected.

Court custody staff, Officers I and K, reduced the monitoring frequency for Ms X without authorisation and without recording the reasons for doing so.

Issue 3: Did Police staff adhere to the monitoring frequency required by Police policy?

79. Ms X was monitored by Police and court custody staff on seven occasions between 9 November and 14 December 2017.

80. On 9 November 2017 Ms X was received into Police custody and monitored in line with frequent monitoring (five times an hour at irregular intervals). The following morning, 10 November 2017, she was received by court custody staff at Manukau District Court. During this time Ms X's monitoring frequency was reduced to 'not in need of specific care' (check at least once every two hours) without explanation. However, Ms X was not checked even as regularly as every two hours. She was not monitored in line with Police policy, nor was she monitored at the appropriate frequency given the known risk she posed to herself.

81. Police policy also specifies that checks should be done via observation through the cell window, communication or physical checks. CCTV is not an authorised means of monitoring or carrying out checks on detainees.[23]

82. When Ms X was in court on 10 November 2017, Officer I recorded *"Physical check on all prisoners due to the cameras faulty/frozen/delays."* This indicates that it may have been common practice for checks to be conducted via CCTV instead of physical observation as required by Police policy.

83. When Ms X was initially received into Police custody on 18 November 2017 she was frequently monitored in accordance with Police policy. Once again, when she was received at court later that same morning, the monitoring frequency was reduced without explanation. She was monitored in accordance with policy for those 'not in need of specific care' but this was not sufficient given her recent self-harm. When Ms X was returned to the DCU later that day, the

[23] See paragraph 122 for relevant Police policy.

monitoring frequency remained unchanged, with staff complying with policy (for an individual 'not in need of specific care') prior to the incident in the cell occurring.

84. On two occasions when Ms X was in court (4 December and 14 December 2017), records show that staff did not complete the checks in accordance with the allocated monitoring frequency. On 4 December 2017 Ms X was on frequent monitoring (five checks an hour at irregular intervals) but was checked once every one to one and a half hours. On 14 December 2017, records show that Ms X was 'not in need of specific care' (check at least once every two hours) but was checked only at the times she was received and released, nearly four hours apart.

85. During her interview with the Authority, Officer I acknowledged that, while checks on prisoners may include looking through the door to see if they are talking, moving, or asleep, some checks are carried out via CCTV.

86. Officer I also told the Authority that while court staff can frequently monitor detainees, if they have specific concerns about a detainee's welfare, that person is sent back to the Police cells, as court staff do not have sufficient cells with cameras, or resources, to monitor high risk individuals. This may help to explain why, despite the recorded self-harm risks, Ms X's monitoring status was changed by court custody officers on 10 and 18 November 2017 and that, even then, Ms X was not monitored as required by Police policy.

87. But more fundamentally, it became clear to the Authority following all of the interviews with Police staff that they did not have the requisite knowledge about monitoring frequency requirements as outlined in Police policy.

FINDINGS

Ms X was not consistently monitored in accordance with frequent monitoring requirements.

None of the Police staff spoken to by the Authority correctly understood monitoring frequency requirements as outlined in Police policy.

Issue 4: Did Police properly manage Ms X during her time in custody on 18 November 2017?

88. On 18 November 2017, Ms X was advised that she was going to be remanded in prison. Detainees who are to be remanded in prison present a higher risk for attempted suicide.[24]

89. Police custody staff would have been aware that Ms X had been remanded in custody, since she was returning to them from court until prison staff could collect her. They should therefore have been aware that Ms X was a higher risk, given her history and remand status. However, court staff had reduced her monitoring frequency to 'not in need of specific care' and this information was transferred with her on her return to the DCU.

[24] Fazel et al, 2008; Hayes, 2012. Source: http://www.corrections.govt.nz/resources/research_and_statistics/journal/volume_5_issue_2_november_2017/suicide_in_new_zealand_prisons_-_1_july_2010_to_30_june_2016.html

90. Both Officers E and F had been present at the incident on 24 October 2017. It is evident that on 18 November 2017, Officer F reviewed Ms X's evaluation record when she returned from court but that it was Officer E who was responsible for updating the record with any new relevant information. Records identify that Officer F confirmed he reviewed Ms X's active alerts (which highlight the previous self-harm incident). Based on the information in the alerts and the evaluation, and his prior knowledge of the 24 October incident, Officer F should have recognised that 'not in need of specific care' was an insufficient monitoring level and that it should have been increased to frequent monitoring once again.

91. Both officers also failed to advise their colleagues, particularly Officer M, about Ms X's previous self-harm in the Police cells. Had other staff been made aware, they could have been particularly vigilant in assessing and monitoring Ms X.

92. Officer E did, however, decide to place Ms X in a cell with another female detainee, as the two women knew each other and seemed happy to be in each other's company. While Officer E said she did not do this due to concerns about the previous incident, this decision potentially saved Ms X's life.

93. Ms Y said that she attempted to contact Police staff via the cell intercom system once she realised Ms X was not breathing but it took more than five minutes for them to respond. Officer F, whose duty it was to answer the intercom on this particular shift, said that he answered the call in *"less than two seconds."*

94. Each cell has an intercom button which detainees can press to gain staff attention. The intercom system is monitored by a staff member at the custody desk and notifies staff of an incoming call via a pop up on the computer screen. There is no sound, only a visible cue. Staff can then answer the call either via receiver or speaker phone.

95. Records from the cell intercom system show that, between 2.28pm and 2.35pm, the button was pressed 58 times which corroborates Ms X's account that she waited about five minutes for help. However, the CCTV footage shows Officer F answer the phone at 2.28pm and turn to speak to his colleagues. The timings from the cell intercom data do not reconcile with the CCTV camera times. While it is evident that Ms Y waited for about seven minutes for Police to respond, the Authority is satisfied that once Police staff became aware of the incident they reacted immediately and ran to Ms X and Ms Y's cell.

96. In both incidents on 24 October (see Issue 1) and 18 November 2017, communication between Police and custody staff was poor. Police staff failed to pass on essential information to their respective colleagues, resulting in key risk factors being missed. Nonetheless, once Police staff recognised that Ms X had attempted to harm herself, they took appropriate steps to provide first aid and call for an ambulance to assist.

FINDINGS

Officer F did not adequately check that the details on Ms X's evaluation form were correct when she returned to the DCU.

Officers E and F failed to advise their colleagues of Ms X's self-harm incident on 24 October 2017.

SUBSEQUENT POLICE ACTION

97. Police conducted an investigation into the two incidents and determined that no further action needed to be taken in respect of any of the staff involved.

98. However, the Police investigator made a number of recommendations to improve practices at the Counties Manukau DCU, including that:

- Police should work with Corrections so that remand prisoners returning to the DCU following court appearances can be avoided and that, in any exceptional circumstances, a detained person must be formally re-evaluated and re-entered into the ECM.
- Risk assessments for persons known to have a recent self-harm history (six months or less) must be frequently monitored as a minimum.
- CCTV should be placed in all cells for better monitoring and to increase safety for detainees and staff alike.
- The intercom system should be upgraded to enable better communication between staff and detainees.

99. The Counties Manukau Police District have advised the Authority that they are in the process of completing a review of the incidents and have a plan in place to use this matter as a training exercise to effect behaviour change for all DCU and court custody unit staff and supervisors. A random auditing process has been reinstituted which reviews the custody modules and CCTV footage to ensure staff are held accountable for monitoring prisoners and handovers of such.

100. The Authority intends to review the district's progress in implementing its plan as part of its next inspection of the Counties Manukau DCU.

CONCLUSIONS

101. The Authority has determined that Police did not sufficiently fulfil their duty of care for Ms X during her time in Police custody, primarily by failing to appropriately evaluate her and monitor her accordingly.

102. The Authority also found that:

1) Officer A should have advised Officer C about Ms X's concerning behaviour on the way to the Police station;

2) Officer A was responsible for monitoring Ms X on arriving into Police custody but did not fulfil that responsibility in accordance with Police policy. As a result, Ms X was left unassessed and unsupervised, giving her the opportunity to tie the sock around her neck;

3) Officers B, E, and G failed to act appropriately or quickly enough to ensure Ms X's wellbeing when she was seen lying on the floor;

4) Although Officer C was inexperienced and unfamiliar with the responsibilities of the role, it was his responsibility to make sure his staff managed Ms X's care. He failed to do so;

5) Officer C should have ensured that a custody record was created in respect of Ms X on 24 October 2017;

6) Evaluations were not properly completed on each occasion when Ms X was received into the DCU, resulting in potentially inaccurate monitoring recommendations. In all but one instance, this was manually corrected;

7) Court custody staff, Officers I and K, reduced the monitoring frequency for Ms X without authorisation and without recording the reasons for doing so;

8) Ms X was not consistently monitored in accordance with frequent monitoring requirements;

9) None of the Police staff spoken to by the Authority correctly understood monitoring frequency requirements as outlined in Police policy;

10) Officer F did not adequately check that the details on Ms X's evaluation form were correct when she returned to the DCU; and

11) Officers E and F failed to advise their colleagues of Ms X's self-harm incident on 24 October 2017.

Judge Colin Doherty

Chair
Independent Police Conduct Authority

27 November 2018

IPCA 17-0866

APPENDIX – LAWS AND POLICIES

Arrest and detention policy

103. Police policy states that when an officer arrests or detains a person, they have a responsibility to protect that person and keep them safe from self-harm and/or suicide while they are in Police custody.

104. The arresting officer's responsibility starts from the moment they arrest or detain the person at the incident, scene or elsewhere, continues while transporting the detainee to a Police station and during processing. The arresting officer has responsibility for the detainee until they are transferred to someone else's custody (e.g. a custody officer) or the person is released.

105. When arresting a person, officers must be alert to information and make enquiries from the person, their friends and family, to ascertain if there are any factors suggesting the person might need special care, or could harm themselves or commit suicide while in Police custody.

106. Officers must ensure that any information gathered about the person that might be relevant to their care and safety is recorded and passed on to any other employees taking over responsibility for the person's custody.

107. Anyone arrested or detained in Police custody must be continually assessed and monitored to determine their physical and mental health, particularly whether they have any medical conditions or warning signs indicating suicidal tendencies or risks of self-harm.

National Recording Standards: Custody Record Requirements

108. NIA custody records must be completed for everyone person detained in police custody.[25]

109. Additional records should be created to handle transfers of people between custody facilities.

110. Where Police custodial staff do a risk assessment as they process a person into Police custody, and the person has mental health and/or suicidal factors, this must be recorded to give higher visibility to the risks in the custody suite.

Summary of Police procedure for receiving detainees into custody

111. When an arresting officer brings a detainee into custody, they search them and place them in a holding cell until the custody sergeant or a custody officer is able to 'receive' them. The receiving officer will complete an evaluation of the detainee, establishing basic personal information, the reason(s) why they have been arrested, whether they are intoxicated, whether they have any physical or mental health conditions, and/or are presenting suicidal behaviour.

[25] The National Intelligence Application (NIA) is a Police database which holds information about individuals who have come into contact with Police.

112. A detainee may have NIA alerts relating to various risk factors such as mental health concerns, previous suicide attempts, or alcohol and drug use. Arresting officers and custody staff are required to check the NIA database in the course of inputting a detainee's details into the electronic custody module.

113. The Electronic Custody Module will then automate a recommended level of care for the detainee. They may require constant monitoring, frequent monitoring (five checks an hour completed at irregular intervals), or they may not be in need of specific care (which requires one check at least every two hours).[26]

114. Police can increase the level of care if they see fit but reducing the level of care requires a health care professional's assessment of the individual. On completion of the evaluation, the detainee should then be placed in an appropriate cell and monitored accordingly.

115. Custody staff must be conscious of the need to reassess a detainee's condition over time. It is necessary to check that the person's health is not deteriorating, and, if the person is intoxicated, custody staff need to make sure that the person is sobering up.

116. It is important for custody staff to keep thorough and accurate records of the risk assessment process and their checks of detainees, because this is most likely to lead to better care and treatment of detainees. In addition, it enables police to demonstrate that they are meeting appropriate levels of accountability and have taken all reasonable steps to care for the person in custody.

People in Police detention

117. The responsibility of the arresting officer remains until the detainee is formally processed and evaluated in the Electronic Custody Module, unless responsibility is transferred to another officer, agency or person.

118. All detainees must be considered to be 'at risk' until an evaluation is completed. Monitoring frequencies are as follows:

- No specific care – check at least every two hours;
- Frequent monitoring – check at least five times an hour at irregular intervals;
- Constant monitoring – directly observe the detainee without interruption.

119. A Police database check must be done at the earliest opportunity. Police should be vigilant for any alerts relevant to the detainee's safe custody or risk and advise the employee receiving the detainee of these.

120. Officers should search the detainee under section 11 of the Search and Surveillance Act 2012, preferably in the presence of custody staff. Items that a detainee could use to harm

[26] See paragraph 118 for relevant Police policy.

themselves must be removed and any risk information or any special care instructions must be recorded in the ECM.

121. Police policy specifies that checks may be completed via:

- Observation through the cell view port;
- Verbal checks to establish a response; and
- Physical checks which require officers to enter the cell and establish the well-being of detainees.

122. CCTV is not an authorised means of monitoring or carrying out checks of detainees.

123. A detainee's monitoring level is not to be reduced without the authority of a health professional. Any reasons for decreasing the monitoring level must be explained.

124. Police must take all practical and reasonable steps to prevent the suicide of detainees. Section 41 of the Crimes Act 1961 provides that everyone is justified in using necessary reasonable force to prevent the commission of suicide.

125. When a suicide attempt is discovered, Police staff must ask another employee to obtain medical assistance while they intervene to stop the attempt. Police must carry out first aid as necessary.

Who is the Independent Police Conduct Authority?

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

It is not part of the Police – the law requires it to be fully independent. The Authority is overseen by a Board, which is chaired by Judge Colin Doherty.

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

The Authority employs highly experienced staff who have worked in a range of law enforcement and related roles in New Zealand and overseas.

What are the Authority's functions?

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

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

On completion of an investigation, the Authority must form an opinion about the Police conduct, policy, practice or procedure which was the subject of the complaint. The Authority may make recommendations to the Commissioner.

This report

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

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