IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

Death of a man in custody at Hawkes Bay Area Custody Unit

INTRODUCTION

1. Mr X was arrested and taken into Police custody in the early morning of Sunday 12 November 2017. In the early morning of Monday 13 November, he suffered a medical event and died. Mr X's death was not discovered until about 9.50am, when Police tried to wake him to take him to a court hearing.

2. The Police notified the Independent Police Conduct Authority of Mr X's death, 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 incident 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 Findings' section.

Summary of events

Arrest

5. At 1.03am on Sunday 12 November 2017, Police received a 111 call about a domestic dispute. Officers A and B were dispatched to the address, where they located Mr X. By being at this address, Mr X was breaching a protection order. Additionally, a warrant to arrest Mr X had been issued by the District Court.

6. Mr X was placed under arrest, but he ran from Police. He was pursued by Officer A, brought down to the ground and handcuffed.

7. The officers drove Mr X to the Hawkes Bay Area Custody Unit (the custody unit) in Hastings. They said Mr X was *"irate"* during the journey, but had calmed down when they arrived at the custody unit at 1.23am.

8. Mr X was not eligible for Police bail. This meant he was to be held in the custody unit until Monday morning, when he would appear in court.

Search

9. At the custody unit, Mr X was brought into the charge room to be processed. Officer C began entering Mr X's arrest details into the Police computer system.

10. Mr X quickly became aggressive again. Officer C said Mr X *"…was pacing around the charge room and would not listen to any instructions given to him by any officers. He was thrashing his head around and would not stand still."* CCTV footage shows that Mr X was pulling away from officers and moving almost constantly.[1] Officer D (who was an acting sergeant and the custody supervisor) decided to cut short the processing, and get Mr X safely into a cell.

11. Officers A and B attempted to restrain Mr X so he could be searched. Mr X continued to struggle. Officer D took over from Officer B, and Mr X was held against the charge desk. Officer B said that Mr X's *"… demeanour was very up and down, when his demeanour was up, there was no calming him."*

12. Officers A and D held one of Mr X's arms each, and walked him to the centre of the charge room. CCTV footage shows Officer E carrying out a pat-down search of Mr X but, because of the position of the CCTV camera behind the charge desk, it only shows the search above Mr X's waist. Officer C cut a cord from the waistband of Mr X's trousers, to prevent him from using it to self-harm. Mr X continued struggling throughout the search.

13. At 1.39am, Mr X was placed into Cell 3, which is monitored with a CCTV camera, has large windows in the wall and door, and is almost directly opposite the charge desk. Officers working behind the charge desk have a clear line of sight into Cell 3, approximately five metres away. Despite the proximity, staff behind the charge desk are unable to accurately tell if a detainee in the cell is breathing.

Evaluation

14. Once Mr X was in the cell, Officer C continued to enter Mr X's details into the electronic custody module (ECM), an electronic Police system used to record details relating to a person in custody. Officer C was relieving in the custody unit and was unfamiliar with the ECM, so Officer D supervised her.

[1] The CCTV cameras in the Hawkes Bay Area Custody Unit do not record sound.

15. Custody staff are required to ask detainees a series of questions to evaluate their health and wellbeing, and to help identify any risks that might arise to the detainee while in custody. Because Mr X was already in a cell, Officer C could not ask Mr X these questions. She and Officer D completed the evaluation based on their observations of Mr X.

16. Questions relating to Mr X's physical and mental health were completed with a comment that Mr X had *"refused to answer questions"*. Two additional fields asking for details of any health conditions and any other risk factors were left blank.

Mr X's medical history

17. Mr X's entry on the Police database showed a number of alerts and historical custody records relating to his health. In 2015, it recorded Mr X had suffered a brain aneurysm and was medically unstable. Historical custody records contained more information about Mr X's brain injury and the care Police needed to provide while he was in Police custody. Additional notes made in 2015 stated Mr X had been prescribed medication for seizures and, at that time, he was not regularly taking it. Other alerts recorded that Mr X was known to use methamphetamine.

18. When entering a detainee's details into the ECM, the system alerts custody staff when a person has been in custody before. A button on the evaluation screen opens the person's previous custody history, including past evaluations, monitoring frequency applied, and officer comments. However, neither Officer C nor Officer D checked Mr X's historic custody records. Officer C checked the Police database *"…for name and address and stuff like that but I didn't look at his alerts at that point."* Officer D said that:

> *"I looked at Mr X's alerts when he was booked in and… that's when I saw the flag about having had an aneurysm... along with all the other violence flags …."*

Officer D did not consider the aneurysm as a factor in assessing Mr X's health and wellbeing.

Mr X's monitoring frequency

19. The number of checks Police need to make on a person in custody is based on their responses to the evaluation questions. The ECM weights the responses and recommends a monitoring frequency; however custody staff can override this (see paragraph 140 for more detail).

20. The ECM recommended that Mr X be assessed as at risk and 'in need of care and frequent monitoring' based on the responses entered by Officers C and D. Officer D said:

> *"This concurred with my own assessment that he needed a higher level of care. This was based on his highly agitated state and refusal to answer questions to help determine the appropriate level of care."*

21. Accordingly, Mr X was recorded as being in need of care and frequent monitoring. This required custody staff to check on Mr X at least five times each hour. Observation via CCTV does not constitute a 'check' in this respect.

First night shift

22. Officer D was supervising the night shift. He said Mr X remained aggressive after being put into the cell, and was *"… one of our more violent prisoners. He certainly – he was a concern not for his safety, but for ours."*

23. Officer C recalled checking on Mr X through the night, shining her torch through the cell window and seeing Mr X's chest rising and falling. Between 2am and 7am, checks were recorded in the ECM as follows:[2]

Timeframe	Number of checks recorded	Timing of checks recorded
12 November 2017 2am – 3am	5	2.01, 2.18, 2.30, 2.47, 2.59
3am – 4am	2	3.33, 3.54
4am – 5am	4	4.07, 4.24, 4.42, 4.58
5am – 6am	3	5.21, 5.36, 5.52
6am – 7am	5	6.09, 6.24, 6.39, 6.46 (meal), 6.57 (handover)

First early shift

24. At 6.57am, Officers F and G began the early shift. During handover they were told Mr X had been aggressive when received into custody.

25. At 9am, Officers F and G took Mr X from the cell, photographed him and took his fingerprints. This was recorded in the ECM. Officer G thought Mr X was *"cooperative and compliant"*, while Officer F said Mr X was acting erratically and appeared to be coming down from methamphetamine.

26. Officer G said *"during the shift I was constantly in and out of the charge room and conversing with Mr X."* At some point, Mr X *"…asked to speak to someone from [the Criminal Investigation Branch] and expressed concern for the safety of his family and also stated he had information about meth dealing."* Officer G passed this on to a detective in the Criminal Investigation Branch (CIB). This was not recorded in the ECM.

27. Officer G noted:

> *"About mid-morning Mr X became aware that [a relative] was in the cell next to him. He became a lot more relaxed and spent the reminder of the shift talking to his [relative] by lying on the floor and talking under the door."*

[2] For the purposes of counting checks, 'an hour' has been taken to start on the hour, and end at 59 minutes 59 seconds past the hour. There were no checks between Mr X being put into the cell at 1.39am and 2am.

28. From 7am to 2pm, checks were recorded in the ECM as follows:

Timeframe	Number of checks recorded	Timing of checks recorded
12 November 2017 7am – 8am	3	7.08, 7.30, 7.46
8am – 9am	5	8.18, 8.30, 8.47, 8.48, 9.00 (photographed, fingerprinted)
9am – 10am	4	9.02, 9.04, 9.25, 9.38
10am – 11am	4	10.00, 10.23, 10.42, 10.57
11am – 12 noon	5	11.01, 11.17, 11.35, 11.48, 11.59
Noon – 1pm	3	12.22 (meal), 12.35, 12.47
1pm – 2pm	2	1.25, 1.38

Late shift

29. At 2pm, Officers H and I began the late shift. Handover was recorded in the ECM at 2.09pm. During handover the officers were advised that Mr X had been aggressive and agitated when he was brought in, but had calmed down during the day.

30. Officer H described Mr X as being *"very active for the majority of the shift"*. Mr X was pacing around his cell, standing on the bed bench, and trying to attract attention. At about 6pm, Officer H spoke with Mr X:

> *"…I opened the door and spoke to him. He was whispering that he needed to talk to me. He appeared paranoid and restless. I asked him what about and he said 'My family is in danger'."*

31. Mr X repeated his earlier concerns regarding the safety of his family. Officer H contacted the CIB and confirmed that they planned to follow up with Mr X on Monday morning. Officer I also recalled Mr X telling him he was worried about his family. Neither officer recorded these interactions in the ECM.

32. Officer H told Mr X that Police would know if anything happened to his family, and offered him dinner, which he ate. Officer H said *"at no point did he mention that he was feeling unwell or needed medical attention and I did not observe anything that caused me to think he was unwell."*

33. Officer I said *"throughout my dealings with Mr X he was polite, not aggressive; softly spoken but appeared to be very dynamic, at no point did he disclose any discomfort or medical concerns."*

34. During the late shift, the custody officers observed Mr X by visual checks and on CCTV, and checks were recorded as follows:

Timeframe	Number of checks recorded	Timing of checks recorded
12 November 2017 2pm – 3pm	4	2.08 (handover), 2.09, 2.28, 2.53
3pm – 4pm	3	3.12, 3.28, 3.40
4pm – 5pm	4	4.00, 4.18, 4.37, 4.50
5pm – 6pm	3	5.09, 5.39, 5.57
6pm – 7pm	3	6.26 (meal), 6.41, 6.43
7pm – 8pm	3	7.03, 7.25, 7.52
8pm – 9pm	3	8.10, 8.33, 8.56
9pm – 10pm	2	9.14, 9.52
10pm – 11pm	4	10.11, 10.19, 10.31, 10.45

Second night shift

35. At 11pm on Sunday 12 November, Officer D and Officer J began the night shift. Handover was not recorded in the ECM.

36. Officer D observed that Mr X seemed to have calmed down, but was still agitated. He thought Mr X no longer needed to be on frequent monitoring. He said:

> *"He was on frequent 'cos that's where he got put when he first came in, 'cos we weren't able to really assess him, but for me my risk assessment of him was a two hourly check, just the system wouldn't let us at the time."*

37. Police policy requires authorisation from a medical professional to reduce a detainee's monitoring frequency. Officer D said:

> *"We'd have to call in the on-call doctor, which is quite expensive and if I was doing that all the time I would be – I don't think the organisation would be very pleased with me. So it seemed appropriate that for him some of those checks were done by CCTV and it negated the need to get a doctor in."*

38. Meanwhile, Officer J was unwell and in severe pain. He had been called in to cover another officer on the night shift, and later said: *"…in hindsight I should have gone home… but I did not want to let anyone down."* Officer J's employment arrangement meant that he was not entitled to sick leave, and would only be paid for hours he worked. Officer J did not tell Officer D that he felt unwell. Officer D told the Authority: *"I was completely unaware. He's told me since that he was unwell which I feel really stink about 'cos I honestly didn't realise."*

39. Officer J said he *"… was able to complete some physical checks within the cell block but only about 3 maximum…."* At times, Officer J was unable to stand because of the pain he was in. He spent most of the night shift in a large office down the corridor from the cells, using the CCTV monitor to observe the prisoners. The CCTV monitor shows footage from 16 CCTV cameras in a grid format. Each camera image is roughly postcard sized, so it is difficult to see much detail.

40. At about 1.57am on Monday, 13 November, Officer D *"spoke with [Mr X] who was making a lot of noise talking to [his relative]. Both seemed fine and I left them still talking to each other."* This interaction was not recorded on the ECM.

41. Between 11pm and 3am, 19 checks were recorded in the ECM. However, Officer J's admission that most of these checks were made by CCTV means that the actual number of checks completed in accordance with policy was three or less. The ECM records show:

Timeframe	Number of checks recorded	Timing of checks recorded
12 November 2017 11pm – midnight	5	11.05 (handover), 11.18, 11.31, 11.44, 11.57
13 November 2017 Midnight – 1am	4	12.09, 12.21, 12.34, 12.49
1am – 2am	5	1.01, 1.13, 1.26, 1.38, 1.52
2am – 3am	5	2.04, 2.17, 2.34, 2.46, 2.58

Medical event

42. At 3.11am, a check was recorded in the ECM. At about 3.21am, Officer D saw Mr X moving in his cell: "*Notice on CCTV [Mr X] get up and go to the toilet to get a drink. Laid back down afterwards. Moved normally and seemed fine."* These observations were not recorded on the ECM, as a check or otherwise, but on a jobsheet completed on 16 November 2017.

43. At 3.25am, CCTV footage shows Mr X's foot twitching. Over the next hour or so, this movement intensified. By 3.33am, Mr X's right hand and foot were visibly shaking. At 3.35am, a check was recorded in the ECM.

44. CCTV footage shows that Mr X continued to tremble and, by 3.44am, the shaking appears to be uncontrollable. At 3.48am, a check was recorded in the ECM. By 4am, Mr X's entire body appeared to be involved in seizures. At 4.01am, a check was recorded in the ECM.

45. At 4.14am, two checks were recorded in the ECM, and at 4.26am a further check was recorded. CCTV footage shows that during this time Mr X was having violent seizures.

46. At 4.32am, Mr X appeared to relax. CCTV footage shows only very small foot and shoulder movements from this point. At 4.34am, Mr X moved onto his stomach, with his head lying off the edge of the mattress. His arms were stretched upwards on either side of his head, pointing towards the cell door. He does not appear to move after this time.

47. At about 5.42am, Officer J slid a breakfast tray underneath the cell door. The fact that the meal remained untouched appears to have gone unnoticed. Checks throughout this period were recorded as follows:

Timeframe	Number of checks recorded	Timing of checks recorded
13 November 2017 3am – 4am	4	3.11, 3.23, 3.35, 3.48
4am – 5am	5	4.04, 4.14 (two entries), 4.26, 4.39, 4.52
5am – 6am	4	5.06, 5.18, 5.42 (meal), 5.57
6am – 7am	4	6.09, 6.22, 6.34, 6.49 (handover)

Second early shift

48. At 7am on Monday 13 November, Officers K and L began their early shift. At handover, Officer K was told Mr X had been very aggressive on arrival but *"had since calmed down and gone to sleep."* Officer L's first duty was to deal with an impounded car, and Officers K and L were busy preparing detainees for court. Officer K said that throughout the morning *"both myself and [Officer L] were in and out of the cell block and keeping an eye on the prisoners as we did so."*

49. Officer K recalled making at least one visual check on Mr X, and thought he saw Mr X's chest rise and fall. This was not recorded in the ECM. Officer K said *"[Mr X] appeared to be sleeping through this time, due to the fact he was 'very aggressive' I believed it was best to leave him to sleep rather than wake him."*

50. Between 7am and 9am, checks were recorded in the ECM as follows:

Timeframe	Number of checks recorded	Timing of checks recorded
13 November 2017 7am – 8am	3	7.01, 7.32, 7.46
8am – 9am	2	8.14, 8.52 (last recorded check).

Discovery of Mr X's death

51. At about 9.50am, the detainees were ready to be transferred to the courthouse. Mr X had still not been disturbed. Officer L decided to wake Mr X last, to avoid disruption to the other detainees if he became aggressive. He said:

> *"I tried to wake [Mr X] to go to Court. I banged at the door and called to him. I noted he was face down on his side with a clenched fist. He didn't wake or respond to my banging on the door and yelling at him. I let the rest go to Court."*

52. Officer L could see Mr X's hands were clenched in fists. He thought Mr X was pretending to be asleep, and was likely to attack anyone who opened the cell door. Officer L took his glasses off and placed them on the charge desk in case there was a physical altercation.

53. Officer L opened the cell door to wake Mr X. Once they entered the cell, both Officers L and K quickly realised that Mr X was deceased. Officer L called the Custody Manager. The CIB was notified and the cell was preserved for investigation. A Family Liaison Officer was asked to contact Mr X's whānau.

Police investigations

54. The CIB carried out a cell examination and took photographs of the scene. Mr X's body was released to Hawkes Bay Hospital.

55. On 14 November 2017, a post mortem examination was conducted in Palmerston North. The forensic pathologist concluded that the cause of Mr X's death was methamphetamine toxicity, based on the high level of methamphetamine in his blood. Blood tests also showed the presence of a low level of a drug used to treat seizures, which was *"below levels associated with a recent normal dose".*

Expert medical opinion

56. Police sought two expert opinions. One opinion only covered the effects of methamphetamine, while the second (provided by Dr Y) also addressed whether medical intervention may have prevented Mr X's death.

57. Dr Y works as a consultant specialist in Emergency Medicine. He is expert in the management and treatment of people presenting with drug and alcohol-related medical emergencies. He viewed the CCTV footage of Mr X in the cell, as well as reviewing relevant Police records and the post mortem and toxicology reports.

58. His view was that Mr X probably died from positional asphyxia resulting from *"prolonged seizure activity induced by methamphetamine use."* Positional asphyxia can occur when someone's position prevents them from being able to breathe fully. They do not get enough air and carbon dioxide builds up in their system. This has an anaesthetic effect, causing the person to go into a coma and stop breathing. It can cause death. Dr Y estimated Mr X had died at approximately 4.35am on Monday 13 November 2017 (described in paragraph 46 above).

59. Analysis of the level of methamphetamine in Mr X's blood, compared against descriptions and CCTV footage of Mr X's behaviour in his first hours in custody, suggested to Dr Y that Mr X ingested a large dose of methamphetamine sometime between 11.30pm on 12 November and 2.30am on 13 November 2017 (during the period when Mr X was in custody).

60. Dr Y acknowledged it was difficult for him, even as a medical professional, to clearly determine when Mr X moved from being merely agitated to having seizures. He stated that "*recognizing seizure activity and the patterns associated with obstructed breathing I believe is difficult for a non-medically trained personnel."*

61. Dr Y noted that the nature of Mr X's seizures seemed to alter at about 3.40am, and again at about 4am. Dr Y found:

> *"… it is probable that if his level of consciousness had been formally checked and physically reviewed when he initially exhibited signs of seizure activity, he could have received treatment that would have prevented further seizures and maintained his ability to breathe. While it is likely he would have required intensive medical care it is probable that he would not have died."*

THE AUTHORITY'S INVESTIGATION

62. The Authority independently investigated Police actions at the Hawkes Bay Area Custody Unit from the time Mr X was taken into custody until his death was discovered. As part of its investigation, the Authority:

- visited the Hawkes Bay Area Custody Unit;
- reviewed material obtained during the Police investigation.
- viewed CCTV of Mr X being received into the custody unit;
- viewed CCTV footage of Mr X in the cell, including footage of his medical event;
- interviewed custody staff, including officers who worked during Mr X's time in custody on 12 and 13 November 2017; and
- interviewed the Custody Manager.

63. In addition to investigating the circumstances immediately relating to Mr X's time in custody, the Authority examined matters relating to custody staff duties, support, and training.

THE AUTHORITY'S FINDINGS

64. The Authority identified and considered the following issues:

1) whether Mr X's arrest and detention was lawful;
2) whether Mr X was searched adequately at the Hawkes Bay Area Custody Unit;
3) whether Mr X's health and wellbeing were adequately evaluated;
4) whether Mr X was monitored adequately;
5) whether Police fulfilled their duty of care to Mr X; and
6) whether the Police's failure to perform their duty of care gave rise to potential criminal liability.

Issue 1: Were Mr X's arrest and detention lawful?

65. Police were called because Mr X was at an address, breaching a protection order and arguing with the female occupant. At that time, there was an unexecuted warrant to arrest Mr X in relation to an earlier breach of the protection order.

66. The Authority is satisfied that Police were justified in arresting Mr X under the warrant for arrest and for breaching a protection order.

67. When Mr X was arrested, Officer A used force to restrain Mr X as described in paragraph 6 above. Section 39 of the Crimes Act 1961 (the Crimes Act) allows Police to use reasonable force, if needed, when making an arrest (see paragraph 115 below). The Authority is satisfied that the force used by Officer A was legally justified and reasonable in the circumstances.

68. Because Mr X had an outstanding warrant to arrest on 12 November 2017, he was not eligible for Police bail. He was to be held in custody until the next sitting of the Hastings District Court on Monday morning. The Authority is satisfied that Mr X's ongoing detention was legally justified.

FINDINGS

Mr X's arrest and detention were legally justified.

The force used by Officer A in arresting Mr X was legally justified and reasonable in the circumstances.

Issue 2: Was Mr X searched adequately at the Hawkes Bay Area Custody Unit?

69. Section 11(2) of the Search and Surveillance Act 2012 (the SSA) allows Police to search a person who is in Police custody *"before that person is locked up"* (see paragraphs 121 to 123 for more detail). Searches are carried out to locate and preserve evidence, remove weapons or means of escape, remove and care for a prisoner's property, and locate and remove items or substances that could be used to self-harm or to harm another person.

70. Mr X was searched as described in paragraphs 11 and 12 above.

71. Toxicology reports and medical evidence suggest that Mr X ingested methamphetamine between 11.30pm on Sunday night and 2.30am on Monday morning. As Mr X was in a cell at this time it raises the question of how he was able to access drugs while in Police custody. One possibility is that Mr X brought the drugs into custody with him, either in his clothing or hidden in a body cavity. If the latter was the case, drugs would not have been found without a more invasive search, such as a strip search.

72. The search of Mr X was a 'pat-down' search. Under the SSA strip searches are only permitted in specific circumstances (see paragraphs 131 to 133 below). Police guidelines on strip searches require that all such searches are justifiable either by necessity (the person is

concealing evidence, or something that might harm the person or allow them to escape), or by risk assessment (the person may have weapons or be at risk of suicide, or has a history of concealing things from Police).

73. Although Mr X was a known drug user, there was nothing in his custody history or arising from his arrest that justified a strip search. The Authority is therefore satisfied that Police did not have justification to carry out a strip search, and that the 'pat-down' search that they undertook was the only lawful search method available to them.

74. Mr X was uncooperative and the search was a difficult one. CCTV footage shows the search only from one angle, and only above Mr X's waistline. The Authority has therefore been unable to determine the effectiveness of the search. In any event, due to the ease with which a small quantity of methamphetamine can be concealed, it may not have been detected even after a thoroughly carried out 'pat-down' search.

75. The Authority is unable to establish how Mr X obtained the methamphetamine he ingested while in custody.

FINDINGS

The Authority is unable to determine whether Mr X was searched thoroughly.

The Authority is unable to establish how Mr X obtained the methamphetamine he ingested while in custody.

Issue 3: Was Mr X's health and wellbeing adequately evaluated?

76. The Police 'People in Police detention' policy requires custody staff to ask new detainees a series of standard questions to evaluate their health and wellbeing. The outcome of this evaluation determines how often a detainee must be checked while in custody (see paragraphs 140 to 141 below). The policy states that a detainee is to be treated as in need of frequent monitoring until evaluated, and if a detainee *"is unable to be evaluated for any reason, then this monitoring regime remains until the evaluation is completed in its entirety."*

77. Custody staff are required to *"record risk information, any special care instructions, and everything that happens in relation to a detainee, from processing to release, in the ECM."*

78. Because Mr X was aggressive when received into custody, he was put into a cell before his evaluation could be completed. The evaluation record was then completed on the basis of his earlier behaviour observed by Officers C and D.

79. As part of the assessment of Mr X, Officer D did not ask Officer C to check Mr X's previous custody or evaluation history, nor did he check it himself.

80. Once Mr X had calmed down, there was no reconsideration of the evaluation. Changes in Mr X's behaviour were not noted in the ECM, leading all staff to treat him in accordance with the initial comments about his aggressive behaviour.

81. The Authority therefore finds that Mr X was not properly evaluated when received into Police custody. As a result, relevant and important information regarding his physical health was overlooked.

82. Custody staff should have waited until Mr X had calmed down enough to answer the evaluation questions, instead of completing them on Mr X's behalf. Subsequent observations about Mr X's behavioural changes should have been noted in the ECM, as required.

FINDINGS

Police did not evaluate Mr X properly when he was received into custody, and relevant and important information regarding his health was overlooked.

Mr X's evaluation should have been completed when he was calmer.

Subsequent observations about changes in Mr X's behaviour should have been noted in the ECM.

Issue 4: Was Mr X monitored adequately?

83. Mr X was assessed as being *"in need of care and frequent monitoring"* for the duration of his stay at Hawkes Bay Area Custody Unit. The 'People in Police detention' policy provides that frequent monitoring requires a detainee to be checked at least five times per hour at irregular intervals. Checks can be made visually, verbally, or physically, as required to confirm that the detainee is safe and well. As noted above, checks via CCTV are not adequate to meet the requirements of the monitoring regime (see paragraph 142 below).

84. While Mr X was in the custody unit on 12 and 13 November 2017, the requirement to carry out five checks per hour was not met in full by any shift. On the basis of the ECM record, the second night shift appears to have met the standard for several hours. However, this is misleading because the majority of checks were made by CCTV, contrary to policy. All other shifts completed only a small proportion of checks in the required manner.

Police submissions

Officers F and H submitted that they were making regular checks on Mr X as they worked behind the charge desk or walked through the receiving area. Mr X conversed with them and was standing and talking, so the officers knew he was well. They each submitted that they did not record these interactions in the ECM as checks or otherwise, because they were doing other tasks at the time. The Authority accepts the submissions of these officers, but notes that Police policy requires that all matters relating to a detainee be recorded in the ECM, which includes checks and other interactions.

85. Indeed, at the time of the Authority's investigation, shortcuts by custody staff such as reliance on CCTV or making peripheral observations or casual checks into monitored cells in passing were common. Checks were therefore cursory and inadequate and fell well short of the standard prescribed by policy.

86. Officer D told the Authority that some people who were required to be on frequent monitoring based on the ECM recommendation would *"seem fine"*, and that someone *"could be right down the bottom end of frequent, basically they're in the two hourly monitoring…."* He said *"…you'd still check them but it was more just keeping an eye on them and the CCTV seemed sufficient for that."*

87. Officer D thought Mr X fell into this category by the time of the second night shift (see paragraph 36). However, Officer D had not been told about Mr X's agitation and anxious behaviours during the day, nor was this information available to him in the ECM. Had this information been given to Officer D in handover, his assessment in this respect might have been different.

88. But Officer D's personal assessment does not in any way excuse the serious and repeated failures to comply with policy by multiple shifts. As noted above, shortcuts by custody staff such as reliance on CCTV or making casual glances into monitored cells in passing were common. These do not comply with policy, and do not address the risks that the monitoring regime is designed to mitigate. Nor does observation from the charge desk suffice, since it is too far away from the cells to determine the detainee's well-being. Moreover, Police policy requires that monitoring levels cannot be downgraded, except on advice of a medical professional. It is not acceptable for staff to make their own determination to effectively downgrade a person's care and monitoring frequency, either by skipping some checks, making them in passing, or making them via CCTV. The fact that staff in the custody unit had a general culture of ignoring the requirements of policy and developing their own operational practice does little, if anything, to mitigate the culpability of individual staff members involved in this incident.

89. The Authority is particularly concerned by the conduct of Officers D and J on the second night shift (see paragraphs 35 to 47 above). By Officer J's admission, he conducted almost all of his checks on Mr X by CCTV. These non-compliant checks were recorded in the ECM as completed. It is unclear which of the recorded checks were made in person. Officer J did have one confirmed opportunity to check Mr X in person at about 5.42am, when he slid a meal tray under the cell door, but he did not do so. Officer J did not advise his shift supervisor, Officer D, that he was unwell and could not complete checks in person. Correspondingly, Officer D did not notice that Officer J was not moving around regularly to conduct checks in person.

90. Officer J said he did not see the seizure activity, and the Authority has no reason to question this. Given the size of the image on the CCTV monitor screen, a CCTV check would have made it difficult to distinguish between a restless sleeper and a medical event. This is precisely the reason why Police policy is clear that checking a detainee's welfare by CCTV is not sufficient.

91. Dr Y commented that it would have been difficult for a non-medically trained person to recognise seizure activity. The Authority accepts this, but considers that if Mr X had been checked in person, custody staff would have recognised that something was wrong, whether or not they identified that as a seizure. Visual checks, if unclear, could have been supported by verbal and physical checks if needed. In addition to seeing Mr X moving erratically, staff would have heard any sounds Mr X was making. While custody staff would not have been able (nor

be expected) to make a diagnosis of seizure activity, they would have detected that Mr X was not well and in need of urgent medical attention.

92. The Authority is also deeply concerned by the actions of the morning shift on 13 November 2017. Officers L and K said they were busy that morning, with Officer L tied up with a non-custodial matter, and both officers trying to get ten other detainees ready for court. This again does not excuse their actions or lack of them. They recorded only five checks between 7am and 10am, of a required 15, and they did not detect that Mr X was dead in any of those checks. That speaks for itself.

FINDINGS

None of the officers working shifts during Mr X's time in custody met the monitoring standards required by Police policy.

Had Mr X been checked in person during the second night shift, as required by policy, custody staff would have recognised his distress and the need for urgent medical attention.

The length of time that passed before Mr X's death was discovered is inexcusable.

Issue 5: Did Police fulfil their duty of care to Mr X?

93. Detainees are considered 'vulnerable adults' as that term is defined in the Crimes Act 1961. A person is a vulnerable adult if they are unable to withdraw themselves from the care or charge of another person for a specified reason, one of which is the fact that they are in detention.

94. Because detainees are vulnerable adults, Police have a specific legal duty of care towards them. In particular, under section 151 of the Crimes Act they are required to provide detainees with *"necessaries"* such as food and medical treatment, and to take reasonable steps to protect them from injury. In other words, Police have a broad legal duty to maintain the health and safety of detainees. In addition, Police have duties owed to persons in a workplace under section 36 of the Health and Safety at Work Act 2015. Police policy is designed to ensure that these legal duties are fulfilled.

95. The Authority's findings set out above clearly demonstrate that there were a number of serious breaches of this policy. In summary:

a) Mr X's risk was not properly evaluated when he was received into custody.

b) The degree of risk he posed as a result of his health issues and drug use was not identified because of a failure to check his custody history or ask him questions when he had calmed down.

c) Many checks of his wellbeing required by policy were not undertaken at all, and many of those that were recorded as being undertaken were improperly done by way of CCTV observation or a casual glance in passing.

d) The fact that Mr X was in distress was observable, yet his need for medical attention went unnoticed.

e) Remarkably, Mr X's death went undetected for more than five hours, notwithstanding a change of shift half way through that period.

96. There is no doubt that these failures collectively constitute a failure by Police, and by the individual officers concerned, to fulfil their legal duty of care in respect of Mr X during his time in custody on 12 and 13 November 2017.

97. The Authority has inquired as to the cause of these failures. Custody officers who were interviewed reported several reasons that, in the opinion of the Authority, contribute to Police failings. Custody sergeants reported issues with rotation of staff, and staffing numbers, which often left custody officers acting as custody supervisor without the proper training and supervision needed to fulfil that role. All officers reported a lack of ongoing training and supervision. All permanent Police staff spoke of the pressure of being required to complete administrative work not related to custody duties, particularly file management tasks, and custody sergeants reported being expected to have responsibility for the public counter and answering the station telephone, and the tracking of exhibits and property during their shifts.

98. Police have submitted that there were difficulties during this shift caused by the demands of a heavy workload. At least one of the officers interviewed by the Authority had made submissions to Police that staff numbers in the custody unit were too low before this incident. Given that these submissions appear to have gone unheeded, the Area Commander and Custody Supervisor bear substantial responsibility for the poor culture that had developed within the custody unit. Nonetheless, staff on duty still had responsibility for ensuring they could fulfil their duties as required, and to seek assistance if that was not possible.

99. Overall, the Authority is satisfied that there was generally poor leadership, supervision, and support of custody staff, and that this contributed to a culture in the custody unit that tolerated a repeated and serious disregard of Police policy and good practice.

FINDINGS

Police as an organisation, and the individual officers concerned, failed to fulfil their legal duty of care to Mr X.

There was generally poor leadership, supervision, and support of custody staff, which contributed to a culture in the custody unit that tolerated a repeated and serious disregard of Police policy and good practice.

Issue 6: Did the Police's failure to perform their duty of care give rise to potential criminal liability?

100. The Authority has considered whether the failure by Police and by the individual officers to fulfil their legal duty of care in respect of Mr X's care gives rise to any potential criminal liability arising as a result. Section 150A of the Crimes Act provides that a person who fails to perform

or discharge a legal duty of care under section 151 (see paragraphs 93 and 94 above) may be held liable for a relevant criminal offence if the failure is a "*major departure from the standard of care expected of a reasonable person to whom that legal duty applies….*" The legal duty of care in section 151 of the Crimes Act applies to custody staff in charge of detainees, who are vulnerable adults (as set out in paragraph 93 above).

101. In relation to the conduct of individual officers, the Authority considers on the balance of probabilities that the actions of some individual officers, and in particular Officers D, J, K and L, do constitute a major departure from the standard of care expected of a reasonable person to whom the duty of care applies. Their omissions were repeated, serious and inexcusable.

102. Their omissions would constitute manslaughter if any of them could be proved to have caused the death. Otherwise, if the omissions were likely to cause suffering, injury, adverse effects to health, or any mental disorder or disability, they would constitute the offence of ill-treatment or neglect of a vulnerable adult under section 195 of the Crimes Act, carrying a maximum penalty of 10 years' imprisonment. This offence does not require a connection between the omissions and any actual suffering or injury; it requires only the likelihood that that such injury or suffering would arise.

103. In relation to Officers K and L, they could not be liable for either offence because Mr X was already deceased by the time they started their shift.

104. In relation to Officers D and J, the Authority has determined that there is insufficient evidence that Police actions contributed to Mr X's death and that a charge of manslaughter against them would not be open to the Police.

105. However, the Authority considers that on the balance of probabilities their omissions were likely to cause suffering and injury, thus potentially constituting the offence under section 195. Mr X had an increased risk of a medical event due to his medical history and drug use. Officers failed to identify his risk level appropriately, and despite prescribing him a regime of frequent monitoring, failed to monitor him according to the minimum standard prescribed by Police policy. The policy exists precisely to avert the sort of risk that materialised in this case, and in the circumstances the Authority considers that the officers' omissions were likely to cause injury or suffering.

106. Having said that, the Authority accepts that on the facts it would be difficult to prove this beyond reasonable doubt; there would therefore not be a reasonable prospect of conviction; and a prosecution could not be justified.

107. Finally, the Authority notes that the offences of manslaughter and neglect of a vulnerable adult under s 195 can presently be committed only by a natural person, and not a corporate body such as the Police. The Police as an organisation therefore cannot be held criminally liable for either of the offences identified. However, the Authority notes that under section 48 of the Health and Safety at Work Act 2015 an organisation such as Police could be held criminally liable for the actions of staff who fail to fulfil their obligations under that Act.

FINDINGS

The omissions to fulfil their duty of care by Officers D, J, K and L were repeated, serious, and inexcusable. These constituted a major departure from the standard of care expected of a reasonable person. On the balance of probabilities, Officers D and J's actions were likely to cause injury or suffering, thus potentially giving rise to an offence under s 195 of the Crimes Act. However, this would be unlikely to be able to be proved beyond reasonable doubt, so that a prosecution would not be justified.

SUBSEQUENT POLICE ACTION

108. Police have completed a Policy, Practice and Procedure Review which includes a focus on lessons learnt. All staff involved have individually received training on the responsibilities arising from their duty of care. Employment proceedings in relation to the incident are very close to being finalised. The Senior Sergeant in charge of the Hawkes Bay Area Custody Unit at the time has since retired from the Police.

109. Significant changes have been implemented in the Hawkes Bay Area Custody Unit including:

- the appointment of a new Officer in Charge of the custody unit;
- new staff induction procedures and training programmes;
- changes to the supervision and support of custody staff;
- adherence to policy audits and reporting of events which have resulted in significant improvements to the culture of the unit and the results within;
- a new and highly effective metal detecting machine/device has been approved for both Hawkes Bay and Tairawhiti Custody Units. This should significantly decrease the contraband being smuggled into custody units; and
- a Mental Health Nurse working Monday to Friday 0800-1600 hours in the custody unit.

110. A Custody Review Working Group has also been set up by the Eastern District Senior Management team. The Authority has met with the District Commander and Area Commanders and been provided with the Terms of Reference for this working group. The Authority notes that the working group has been given a broad mandate to consider ways to "*…identify and challenge the barriers to high performance, seek out opportunities for improvement and recommend innovative solutions… to ensure a safe custodial environment….*''

CONCLUSIONS

111. Officers in the Hawkes Bay Area Custody Unit did not properly evaluate Mr X when he was brought into custody, so relevant and important information regarding his health was missed. Staff failed to fully appreciate the vulnerability of Mr X while he was in their custody, and did not provide adequate care. Officers failed in their duty of care to Mr X by omitting to conduct checks and, at a crucial time, not recognising his need for medical attention. The Authority considers that, if Mr X had been properly monitored while in custody, custody staff would have recognised his distress and the need for urgent medical attention.

112. The Authority considers that generally poor leadership, supervision, and support of custody staff contributed to a culture in the custody unit that tolerated a repeated and serious disregard of Police policy and good practice.

113. The Authority also found that:

1) Mr X's arrest and ongoing detention were legally justified.

2) The force used by Officer A in arresting Mr X was legally justified and reasonable in the circumstances.

3) It could not determine whether Mr X was searched thoroughly.

4) It could not establish how Mr X obtained the methamphetamine that he ingested while in custody.

5) Mr X's evaluation should have been completed when he had calmed down.

6) Observations about changes in Mr X's behaviour should have been noted in the ECM.

7) None of the officers working shifts during Mr X's time in custody met the monitoring standards required by Police policy.

8) An unacceptable length of time passed before Mr X's death was discovered.

9) Police, and the individual officers concerned, failed to fulfil their legal duty of care to Mr X. The omissions to fulfil their duty of care by Officers D, J, K and L were repeated, serious, and inexcusable. These constituted a major departure from the standard of care expected of a reasonable person.

10) There is insufficient evidence to bring a criminal prosecution against any individual officer.

RECOMMENDATION

114. The Authority recommends that Police amend the 'People in Police detention' policy to include a requirement for custody staff to check a detainee's previous evaluation history as part of the receiving process.

Judge Colin Doherty

Chair
Independent Police Conduct Authority

30 May 2019

IPCA: 17-1012

APPENDIX – INDEX OF OFFICERS

Officer	Roles/Comment
Officer A	Arresting officer
Officer B	Arresting officer
Officer C	Constable, relieving as a custody officer
Officer D	Acting sergeant, custody supervisor
Officer E	Authorised Officer
Officer F	Constable
Officer G	Constable
Officer H	Sergeant, custody supervisor
Officer I	Constable
Officer J	Authorised Officer
Officer K	Constable
Officer L	Sergeant, custody supervisor
Family Liaison Officer	Family Liaison Officer
Custody Manager	Senior Sergeant, custody unit manager

Use of force

Crimes Act 1961

115. Section 39 of the Crimes Act provides for law enforcement officers to use reasonable force in the execution of their duties such as arrests and enforcement of warrants. Specifically, it provides that officers may use *"such force as may be necessary"* to overcome any force used in resisting the law enforcement process unless the process *"can be carried out by reasonable means in a less violent manner."*

116. Under section 62 of the Crimes Act, anyone who is authorised by law to use force is criminally responsible for any excessive use of force.

Police policy - 'Use of force'

117. The Police 'Use of force' policy provides guidance to Police officers about the use of force. The policy sets out the options available to Police officers when responding to a situation. Police officers have a range of tactical options available to them to help de-escalate a situation, restrain a person, effect an arrest or otherwise carry out lawful duties.

118. Police policy provides a framework for officers to assess, reassess, manage and respond to use of force situations, ensuring the response (use of force) is necessary and proportionate given the level of threat and risk to themselves and the public. Police refer to this as the TENR (Threat, Exposure, Necessity and Response) assessment.

119. A key part of an officer's decision to decide when, how, and at what level to use force depends on the actions of, or potential actions of, the people involved, and depends on whether they are: cooperative; passively resisting (refuses verbally or with physical inactivity); actively resisting (pulls, pushes or runs away); assaultive (showing an intent to cause harm, expressed verbally or through body language or physical action); or presenting a threat of grievous bodily harm or death to any person. Ultimately, the legal authority to use force is derived from the law and not from Police policy.

120. The policy states that any force must be considered, timely, proportionate and appropriate given the circumstances known at the time. Victim, public and Police safety always take precedence, and every effort must be taken to minimise harm and maximise safety.

Searches

Search and Surveillance Act 2012

121. The Search and Surveillance Act 2012 (the SSA) sets out the rights and obligations in relation to searching people in Police custody.

122. When a person has been taken into custody, an initial rub-down search is permitted under sections 85 to 87 of the SSA. The purpose of the search is to ensure the person is not carrying

anything that may be used to harm themselves or another person, or to facilitate their escape. Section 88 also permits a rub-down search without a warrant, if an officer has reasonable grounds to believe that there is any thing on or carried by the person that may be used to harm themselves or another person, facilitate their escape, or that is evidential material relating to the offence for which the person was arrested.

123. A full search of a person can be carried out under section 11 of the Search and Surveillance Act 2012 before the person is locked up. Once a search is carried out under section 11, the person can only be searched again if, since being searched:

- The person has been in close proximity to a person who is not in Police custody, or
- The person has been in close proximity to a person who has not been searched by officers, or
- There are reasonable grounds to believe that the person has anything that could be used to harm themselves or another person.

124. A strip search is defined in section 3 of the SSA to be a search in which the person being searched may be required to undress, or to *"remove, raise, lower or open any item or items of clothing so that the genitals, buttocks, or (in the case of a female) breasts…"* are bare, or are only covered by underwear.

125. Section 126 of the SSA requires Police (or any other agency authorised to search a person) to issue and make publically available, guidelines to Police employees setting out when a strip search may be carried out.

Police policy - 'Searching people'

126. The 'Searching people' policy states that searching people may be necessary to:

- *locate and preserve evidence*
- *remove weapons or means of escape*
- *remove and care for a prisoner's property*
- *locate and remove articles or substances that could impact on the safety of …[prisoners, the public or Police staff]*
- *ensure the safety of a prisoner considered to be at risk of suicide or self-harm.*

127. Three main types of personal searches are rub-down searches, strip searches and internal searches. The policy sets out the law relating to searching people, including the SSA and the New Zealand Bill of Rights Act 1990, and provides guidance to Police staff to assist with compliance with the law and to promote good practice.

Police policy - 'People in Police detention'

128. The 'People in Police detention' policy requires that officers who arrest or detain a person carry out a rub-down search of a person before transporting him or her.

129. The policy expressly tells officers to leave a section 11 search until they reach the station. This part of the policy is very clear that a section 11 search cannot be made again unless one of the circumstances in section 11(3) arises.

130. The 'People in Police detention' policy contains a section for custody area staff, specifically addressing receiving a detainee. Custody staff are instructed to verify the arresting officer's search under section 11 of the Search and Surveillance Act 2012.

Police guidelines for conducting strip searches

131. Police guidelines for conducting strip searches state that a strip search may be carried out when there is a search under the SSA, authorising a search for:

- *"arms*
- *offensive weapons*
- *drugs*
- *evidential material relating to offences punishable by imprisonment of 14 years or more*
- *evidential material in the course of an authorised search of a place or vehicle, when any person:*
- *is found at the place or in or on the vehicle, or*
- *who arrives at the place, or*
- *stops at, or enters, or tries to enter or get onto the vehicle*
- *thing(s) incidental to arrest or detention that may be used to harm any person, facilitate the person's escape or that is evidential material relating to the offence in respect of which the arrest is made or the person is detained*
- *money or other property after a person is locked up."*

132. Strip searches must be justified by necessity or by risk assessment. A search may be justified by necessity when there are reasonable grounds to believe that a person is concealing evidential material, a person has an object that may be used to harm any person or facilitate their escape, and a less intrusive search may not be sufficient to find the evidential material or object. A strip search may be justified by risk assessment when a TENR assessment gives rise to reasonable grounds to believe that a person may be concealing items such as weapons or anything that may be used to facilitate escape or harm any person.

133. The guidelines contain detailed instructions to Police as to how a strip search must be carried out. These address practicalities for conducting the search and steps to take to preserve the dignity of the person being searched.

Duty of care

Crimes Act 1961

134. Section 151 of the Crimes Act 1961 states that everyone with *"actual care or charge"* of a vulnerable adult, who is unable to provide himself or herself with *"necessaries"* is under a legal duty to provide that person with necessaries, and to take reasonable steps to protect that person from injury.

135. The Act defines a 'vulnerable person' as "a person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person." All detainees are, therefore, vulnerable people under the Act. The Act also defines 'necessaries' as the basic requirements of life, such as food, water and adequate warmth.

136. Failing to fulfil this duty may be sufficient for criminal liability where there is a resulting death or injury, or where there is a risk of harm, by way of criminal nuisance, manslaughter, injuring (where, if death had occurred, there would be liability for manslaughter), or ill-treatment of a vulnerable adult.

137. Under section 150A(2) of the Crimes Act, liability for any of these offences will only arise if the failure is *"a major departure from the standard of care expected of a reasonable person."* This is commonly referred to as a gross negligence standard. A person who simply fails to provide a reasonable standard of care, without more, cannot be convicted.

Police policy - 'People in Police detention'

138. The 'People in Police detention' policy contains procedures for receiving, assessing, monitoring and managing people in custody, and provides instructions for what to do when a person has consumed alcohol or drugs, is injured, has a known medical issue, or there is a risk of self-harm or suicide. It also sets out the responsibilities and duties of staff involved in custodial management to maximise health, safety and security.

139. Custody staff are instructed to *"Record risk information, any special care instructions, and everything that happens in relation to a detainee, from processing to release, in the ECM."*

140. The 'Procedures for custody area staff' states that custody staff must evaluate and classify detainees as either not in need of specific care, in need of care and frequent monitoring, or in need of care and constant monitoring. The policy states that:

> *"Until the evaluation takes place all detainees must be considered to be 'at risk' and frequently monitored, with the exception of detainees showing signs of suicide risk - they must be constantly monitored. If the detainee is unable to be*

evaluated for any reason, then this monitoring regime remains until the evaluation is completed in its entirety."

141. Frequent monitoring requires a detainee to be checked at least five times an hour at irregular intervals. Constant monitoring requires a detainee to be "*directly observed without interruption*".

142. There are three types of checks, with an observation check being the minimum standard for checking detainees:

• *"Observation check*	*Observe through a cell view port to check the detainee's wellbeing. If unable to confirm this, complete a verbal check.*
• *Verbal check*	*Verbally rouse the detainee to establish wellbeing and if there is no response complete a physical check.*
• *Physical check*	*Enter the cell and establish wellbeing.*

CCTV is not an authorised means of carrying out observation checks."

143. If a person is under the influence of drugs or alcohol, custody staff are to *"reassess the detainee if there is a change in their circumstances, eg… they are under the influence of alcohol or drugs as the effects can worsen over time and can cause death."*

144. The person in charge of a cell block is required to brief incoming staff to ensure that monitoring is maintained, and record the handover in the ECM.

145. Custody staff are required to call a health professional if they are supervising a detainee and think it necessary. Staff are required to *"always consider the level of consciousness and whether the person should be transferred to a health facility."* If a detainee is partially responsive, custody staff are instructed to treat this as a medical emergency and arrange for the person to be taken to hospital. If a detainee is unresponsive, staff are advised that:

"This is a medical emergency and immediate hospitalisation is required. If you expect a delay in the ambulance's arrival or the person's condition calls for immediate action, use a Police vehicle."

Death in custody

146. The 'People in Police detention' policy provides that when a death in custody is discovered, regardless of the cause, the scene must be immediately frozen and evidence preserved. This includes securing CCTV footage and custody documentation. A supervisor must be notified, and they will arrange for the death to be notified to the Criminal Investigation Branch, the District Commander, and Police National Headquarters. The Police 'Trauma' policy will be applied to all employees involved in the incident.

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.

Mana Whanonga Pirihimana Motuhake

PO Box 25221, Wellington 6146
Freephone 0800 503 728
www.ipca.govt.nz