

Death of Alo Ngata following his arrest in Auckland

Outline of Events

1. On 1 July 2018, Police were called to a residential street in central Auckland, where Alo Ngata was violently assaulting a stranger, Mr Y. The Police helicopter (Eagle) was overhead within a minute and recorded the assault and part of the subsequent arrest of Mr Ngata.
2. Mr Ngata was tasered three times and pepper sprayed without any apparent effect.¹ He was tasered a fourth time, causing him to drop to the ground. Both officers attempted to handcuff Mr Ngata, who was fighting them off, despite being face down on the ground.
3. Other officers who had arrived at the scene came forward to help hold Mr Ngata down. During the struggle to handcuff Mr Ngata, he was pepper sprayed again.
4. Eventually the officers managed to cuff Mr Ngata's hands behind his back and restrain his legs with plastic ties. He was spitting, with blood present, so a spit hood was put over his head. Mr Ngata was put into the back of a Police transport van and driven to the Auckland District Custody Unit (the custody unit). An officer kept watch on Mr Ngata throughout the short drive, although the spit hood remained over his face. He was talking unintelligibly throughout.
5. The van arrived at the custody unit at about 3.49pm. Six Police staff removed Mr Ngata from the van and carried him to a cell. Officers said he was still violently resisting and shouting 'gibberish' while they carried him, however, CCTV footage suggests he was in a reduced state of consciousness. His entire face was covered by the spit hood.
6. In the cell, five officers held Mr Ngata down while a sixth searched him and removed the Taser probes. His handcuffs and leg restraints were removed, but the custody supervisor told officers to leave the spit hood over his face. This took about nine minutes. When officers left the cell, Mr Ngata was placed on constant monitoring. CCTV footage shows moving staff outside the cell, but no officer was constantly observing him. Mr Ngata remained lying face down, with his hands

¹ 'Pepper spray' means Police-issued oleoresin capsicum spray, also known as OC spray.

behind his back as if still handcuffed. He can be seen taking several deep breaths, but these stopped soon after he was left alone.

7. At 4.04pm, Police re-entered the cell and discovered Mr Ngata had no pulse. Police staff gave CPR to Mr Ngata until Fire and Emergency New Zealand, then Ambulance staff, arrived and took over. Ambulance staff continued working on Mr Ngata until he could be safely taken to hospital.
8. Mr Ngata arrived at hospital alive but unconscious. He did not regain consciousness and was declared brain dead two days later. He was kept on life support until his family arrived from overseas on 4 July 2018. He died after his life support was switched off. A post-mortem report concluded that Mr Ngata died as a result of brain damage caused by a suddenly abnormal heart rhythm, which itself arose from *“the combined physiological effects of being restrained, methamphetamine, cardiac hypertrophy (enlarged heart) and possible suffocation due to the spit hood.”*

The Authority’s Investigation

9. Police notified the Authority of this incident and the Authority undertook an independent investigation into Police actions. As part of its investigation, the Authority:
 - interviewed 19 Police officers involved in the arrest and at the custody unit;
 - interviewed Mr Ngata’s partner and her family, who were present at the arrest;
 - interviewed Mr Ngata’s wider whanau and last employer;
 - reviewed the Police investigation files, including Eagle, Taser camera, and custody unit CCTV footage;
 - interviewed the pathologist who conducted the post-mortem; and
 - spoke with Police tactical options trainers about use of the Taser, pepper spray and spit hood in this case.
10. During the initial response to this incident, it was discovered that Police had dealt with Mr Ngata the day before, in response to 111 calls about a possible family harm incident. The Authority spoke with officers who had attended this incident and is satisfied they responded appropriately. There was nothing Police were made aware of which might have indicated a future deterioration in Mr Ngata’s mental state.
11. The Authority identified and considered the following issues:
 - 1) Were Police justified in using force to arrest Mr Ngata?
 - 2) Did Police transport Mr Ngata to the custody unit appropriately?
 - 3) Was Mr Ngata received appropriately at the custody unit?

- 4) Was Mr Ngata monitored appropriately when left in the cell?
- 5) Was Mr Ngata given appropriate medical assistance at the custody unit?

The Authority's Findings

ISSUE 1: WERE POLICE JUSTIFIED IN USING FORCE TO ARREST MR NGATA?

12. At about 3.25pm on Sunday, 1 July 2018, Police received a 111 call reporting a violent assault in Auckland Central. A man, Alo Ngata, had violently assaulted a stranger, Mr Y, on the street. Mr Y was said to be lying unconscious and bleeding from his head. Mr Ngata was aged 29 years, about 185cm tall and of solid build. Mr Y was in his mid-70s and much smaller than Mr Ngata.
13. At about 3.26pm the Police Eagle helicopter was overhead and filming the incident. Eagle footage shows Mr Ngata kicking Mr Y in the head intermittently over a period of about two and a half minutes, then dragging him down the street. Mr Ngata is seen shouting and waving his hands at the helicopter, then taking something out of a car and smashing it against his own forehead. He turns his attention down the street, where Officers A and B enter the frame of the footage.

Officer A's uses of Taser and pepper spray

14. At 3.29pm, Officer A armed his Taser, ready to fire, which activated the Taser camera. Officer A's Taser footage shows the Taser pointed at Mr Ngata, and Officer A can be heard repeatedly shouting at Mr Ngata to "Get on the ground!" Mr Ngata pauses for a moment and leans forward, with his hands on his thighs. He stands upright and walks towards Officer A, fists clenched, shouting "I'm ready" and "Come and get me." He told Officer A, "I've been tasered before, Tasers don't affect me."
15. Officer A fired his first Taser cartridge, which had no effect. The second cartridge was fired about 4 seconds later, also with no effect. Officer A then fired pepper spray at Mr Ngata:

"[The] spray initially hit his chest area and I tried to bring it up into his face, so my aim was low.... I'm not sure if any got into his face and into areas that affected him such as his eyes because his behaviour didn't change at all."
16. Mr Ngata was significantly larger than Officer A and had shown himself to be extremely violent. He demonstrated that he was not going to submit to arrest by his words and the threatening way he was advancing on Officer A.
17. Police are justified in using force against a person during an arrest if the force is necessary to overcome force being used to resist the arrest, and the arrest cannot be made in a less violent manner.
18. The Authority is satisfied that Officer A's use of both the Taser and pepper spray were necessary and proportionate given Mr Ngata's violent aggression, strength, attitude and persistence. At this stage, Police had only batons, pepper spray and Taser available to them.

19. Police policy requires officers to give a specific warning before using Tasers or pepper spray, to give the person a chance to comply and to warn others nearby. The Authority is satisfied that, although Officer A did not give the prescribed warnings before discharging his Taser or pepper spray, the ongoing calls to get on the ground and the surrounding circumstances were adequate warning.

Officer B's uses of Taser

20. Officer B said, when she arrived, she saw Mr Ngata dragging Mr Y along the road, then kicking him in the head. She said:

"I thought he [Mr Y] was dead. I thought we'd come across – like, I thought he'd murdered him. I thought we'd come across a dead body. [Officer A] already had his Taser out and we ran towards the offender."

21. Officer B saw Officer A confront Mr Ngata and instruct him to get on the ground. She heard Mr Ngata shouting at Officer A and saw Officer A taser Mr Ngata twice and use pepper spray, with no effect.
22. Officer B armed and presented her Taser. Footage from her Taser camera shows Mr Ngata continuing to move towards the officers, still shouting. Officer B shouted at Mr Ngata to *"Get on the ground! Get on the ground now!"* Mr Ngata continued to come towards the officers. Officer B pulled the trigger on her Taser and held it down. This caused the Taser to fire both cartridges, one after the other. The second discharge incapacitated Mr Ngata and caused him to fall forwards onto the ground.
23. At the time Officer B discharged her Taser, Mr Ngata was still displaying violent aggression, strength, attitude, and persistence. Lesser force would have allowed Mr Ngata to continue his violent behaviour and put both officers and members of the public at risk.
24. The Authority is satisfied that Officer B was justified in firing her Taser to arrest Mr Ngata. This was proportionate to Mr Ngata's resistance to his arrest. Although Officer B did not give the warning prescribed by Police policy, her words were adequate warning.

Restraining Mr Ngata on the ground

25. Once Mr Ngata was on the ground, Officer A moved forward to complete the arrest by handcuffing Mr Ngata. Eagle footage shows Officer A putting his knee on Mr Ngata's lower back to hold him down, while handcuffing his left arm. Officer B approached Mr Ngata from the other side to help restrain him.
26. It was raining lightly and both officers said Mr Ngata was *"slippery"*, with bare arms and legs in the wet. Mr Ngata quickly regained movement, and the officers were unable to restrain and control his right arm sufficiently to complete handcuffing him. Both Officers A and B said Mr Ngata was able to lift his torso up off the ground, even with the partial weight of two officers on his back.

27. Officer B re-energised her Taser, sending a further charge to Mr Ngata for about five seconds. Taser footage shows Mr Ngata was swearing and still moving, apparently unaffected by the electrical charge.
28. Officer B punched Mr Ngata three times in the kidney area, intending the pain to subdue him but with no effect.² Officer A deployed his pepper spray a second time. He said he held the spray at arm's length, about 30 centimetres from Mr Ngata's face. Officer A said:

"I did a lot of short bursts towards his face, however, because of the angle that I had my can in a dynamic situation, most of it went onto the ground and I remember a small little pool of OC spray forming just in front of his face, so I believe some may have splashed up into his eyes, not sure how much."
29. Police training material states that pepper spray is effective from a range of about 3.5 metres and should not be used at a range of less than one metre to avoid eye damage from the pressurised canister.
30. The Authority notes, in the circumstances of this arrest, manual restraint and pain compliance techniques were not effective, and tasers were no longer available. The only alternative option for Police was the use of batons, which may not have been effective, and could have become 'weapons of opportunity' for Mr Ngata. In the circumstances of this arrest, the use of pepper spray at close range was justified and reasonable.
31. Mr Ngata continued to struggle and kick, so Officer B punched Mr Ngata in the kidney area again. Officers C and D arrived about this time. They had heard over the radio that Mr Ngata had been tasered. On arrival, Officer C could see Mr Ngata's eyes were "non-stop tearing" so he knew pepper spray had been used, and Officer D said she could smell it in the air.
32. They joined Officers A and B in restraining Mr Ngata, and with their help the second handcuff was applied to Mr Ngata's right wrist. Officer A then left to check on Mr Y, and Officer B followed shortly after. Officer B said she told "probably everybody" that Mr Ngata had been tasered and pepper sprayed.
33. The Authority is satisfied that each of these uses of force was justified. Mr Ngata clearly presented a serious and credible threat and had already shown a high degree of violence in his actions towards Mr Y. Police had an urgent need to attend to Mr Y, and could not do so until Mr Ngata was restrained. The uses of force by Police were necessary and proportionate to overcome the force used by Mr Ngata in his highly aggressive resistance of Police. Police had no less violent means with which to arrest Mr Ngata.

FINDINGS ON ISSUE 1

Officer A was justified in firing his Taser and using pepper spray to arrest Mr Ngata.

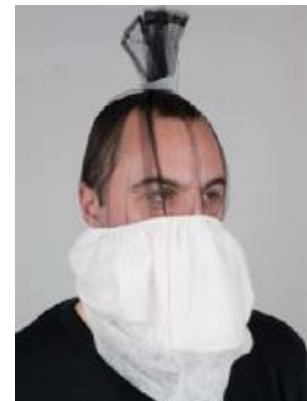
Officer B was justified in firing her Taser to arrest Mr Ngata.

The use of pepper spray at close range was justified in the circumstances of this arrest.

² This is a technique taught to Police officers to help control a person resisting arrest.

ISSUE 2: DID POLICE TRANSPORT MR NGATA TO THE CUSTODY UNIT SAFELY?

34. Another four officers arrived on the scene during the struggle. Mr Ngata was kicking out after being handcuffed, so plastic cuffs were put around his legs. The cuffs were loose enough that he could walk.
35. Once Mr Ngata was restrained, officers stood him up. Officer E carried out a quick pat down search and removed Mr Ngata's passport and other personal effects. Police tried to move Mr Ngata to the Police car, but he was not cooperative, dragging his feet, and it took several officers to move him a few metres. After moving, Mr Ngata would not remain standing, so was placed back on the ground, lying on his side. Officers decided to call for a Police transport van, instead of trying to get Mr Ngata into the back of a Police car.
36. Although Mr Ngata had been handcuffed and leg restraints were in place, he was still struggling hard and trying to lie on his stomach. Officers were mindful that Mr Ngata had been on his stomach for a period of time during his arrest, with the weight of several officers on him. This increased his risk of positional asphyxia, which can occur when the position of a person's body stops them from breathing enough oxygen. To prevent this, Mr Ngata was held on his side, which required the effort of two or three officers at all times.
37. Officer F tried to offer decontamination assistance to Mr Ngata, but he refused this, telling Officer F to "fuck off". At this point, Mr Ngata was speaking intelligibly, there were many officers around him who could have observed any change in his condition, and it was only a short drive to the custody unit, where Mr Ngata could be given assistance for the pepper spray and tasers. On this basis, Officer F decided to wait before providing Mr Ngata with assistance. The Authority is satisfied that this was an appropriate decision in the circumstances.
38. While waiting for the Police van to arrive, Officers D and E saw Mr Ngata spitting. Officer D saw blood on her arm and Officer E said he saw saliva on his boot. Officer C said he heard someone say that Mr Ngata should be put into a spit hood, to stop blood getting on the officers. He handed Officer D a spit hood he kept in his vest.
39. A spit hood is a covering for the head, with the top third made of mesh and the rest made of plasticised paper to prevent fluids escaping. The bottom third of the hood is shirred with elastic, to secure the hood around a person's neck without constraining it. Police policy requires that when a spit hood is applied to a person, they should be monitored constantly until the spit hood is removed.³



Example of a spit hood correctly applied. Photo supplied by NZ Police and used with permission.

³ See paragraphs 136 to 138 for more detail.

40. Officer D attempted to apply the spit hood, but Mr Ngata was struggling, and the spit hood tore. Officer D was handed a second spit hood, which she applied successfully. This spit hood remained on until Mr Ngata was at the custody unit.
41. Police policy on the use of pepper spray states that a person who has been pepper sprayed 'should' not have their face covered, because pepper spray will cause a person to produce more saliva and fluid, and they may reasonably need to expel fluid build-up. The word 'should' implies a limited discretion for officers to apply a spit hood, even if it means covering the face of a person who has been pepper sprayed.
42. Although Officers C and D knew pepper spray had been used, a balance needed to be found between the risk of infection from blood and saliva, and the need to be near to Mr Ngata to keep him on his side. The ongoing efforts to keep Mr Ngata on his side demonstrated an awareness of the safety risks for Mr Ngata while he was being restrained. In these specific circumstances, the Authority accepts the application of the spit hood was appropriate.
43. If Police decide to cover the face of a person who has been pepper sprayed, it is even more important that the person is constantly monitored. However, the Authority could not find evidence that any officer was specifically assigned to monitor Mr Ngata until he was in the Police van.
44. At about 3.35pm, the Police transport van arrived. It was driven by Officer G, who was accompanied by Officers H, I, and J. The Police van has two rows of seats in the front, and in the back is a cell for transporting detainees. This van has a single cell, with bench seats down each side. There is a small window between the back row of seats and the cell, allowing officers to see detainees while driving.
45. Officer I recalled seeing Mr Ngata handcuffed on the ground when they arrived, with officers holding him down using their hands. She said Mr Ngata was *"still just going off and trying to get away."* Officer I was handed Mr Ngata's belt which she placed into a plastic bag. She remembered being told that Mr Ngata had been tasered and pepper sprayed. She saw that Mr Ngata was wearing a spit-hood and said:

"I saw blood on the spit hood around the mouth area. The blood was in blotches. There were a couple of blotches which were about the size of a 10 cent coin."

46. Officer I told the Authority she thought the spit hood was applied correctly, with the mesh covering Mr Ngata's eyes and the material covering his mouth. Because Mr Ngata was moving violently and shouting, it was assumed he was breathing. However, Police policy on use of force includes a section on positional asphyxia, which contains the following reminder:⁴

*"**Note:** There is a common misconception that if a person can talk then they are able to breathe, this is not the case. **Remember:** Never assume you know better - if an offender is complaining of difficulty breathing or feeling sick, seek medical attention immediately!"*

⁴ Refer to paragraphs 139 to 141 for more information. Emphasis as per the original.

47. Because Mr Ngata was still struggling, and had restraints on his legs, officers considered the easiest way to get him into the van was to lift him in. Officers A, C, E and F carried Mr Ngata to the van and lifted him inside. Officer G climbed in and tried to position Mr Ngata on his side. Mr Ngata kept struggling and rolling onto his stomach. Officer G decided to leave him and got out of the van. He said:

"[Mr Ngata] was still moving and when someone's yelling and screaming at you, they're not having any problems breathing, so I made the decision that, well, 'I could either be here all night fighting with him, ... trying to position him correctly, or I could get him back to somewhere safe where we could help him properly.'"

48. The positional asphyxia policy states that when transporting a person at risk of positional asphyxia, "under no circumstances, allow such a person to lie prone, face down, in a vehicle." The policy also states that if a person is cuffed, by their hands or feet or both, officers must ensure that their breathing is not impeded.

49. The decision to leave Mr Ngata on his stomach in the back of the van was a pragmatic one and reasonable for the short drive to the custody unit. It would have been more dangerous to have officers in the van cell during the drive to hold Mr Ngata on his side.

50. Officer G told Officer I to monitor Mr Ngata constantly in the van. Officer I had graduated from Police College about 6 months previously. She was sitting in the back row of seats watching Mr Ngata through the viewing window. She said:

"I spoke to the male through the window and I tapped on the window to get his attention... I could hear the male although I could not make out what he was saying. When I tapped on the window, he would respond by making more noise. ... I did not have any concerns about his ability to breathe because of the amount of noise he was making."

51. Officer I said throughout the journey she constantly relayed her observations to her colleagues in the van.

52. Officer I was not able to see Mr Ngata's face because of the spit hood. The incoherent noise she heard was her only indicator of Mr Ngata's wellbeing. As noted above at paragraph 46, making noise is not a reliable indicator someone is breathing.

53. The policy on positional asphyxia lists a number of risk factors which may increase risk, including:

- Physical exhaustion (or any factors that increase the body's oxygen requirements, for example anxiety in a highly stressed or struggling individual).
- Restriction of the airway (including covering the face).
- Alcohol or drug effects reducing the subject's ability to breathe sufficiently even if they are not obviously drugged (because sedative drugs and alcohol act to depress breathing so reducing oxygen taken into the body).

- Position of the body interfering with breathing. This position may be the result of a mechanical (handcuffs) or physical restraint (being held), especially in a prone, face-down position.
 - Wild, threatening, or bizarre behaviour with possible mental disturbances.
 - Violent behaviour and/or resistance.
 - Being male.
54. Mr Ngata was known to have a high risk of positional asphyxia and needed careful and constant monitoring. He had been tasered and pepper sprayed, his hands and feet were cuffed, he was wearing a spit hood, and he was lying face down on the floor of the van.
55. The Authority accepts that the initial use of the spit hood was a pragmatic decision in the circumstances of a very difficult arrest, as was the decision to leave Mr Ngata lying on the floor of the Police van. However, Police needed to consider and mitigate whatever risk factors for positional asphyxia they could before leaving Mr Ngata alone in the van for transport. At a minimum, the Authority considers there should have been a reassessment of the need to retain the spit hood on the journey to the custody unit.
56. This would have allowed Officer I to see Mr Ngata’s facial expressions, a better indicator of comfort or distress than his incoherent speech.

FINDINGS ON ISSUE 2

It was appropriate to delay pepper spray decontamination at the scene of the arrest.

The application of the spit hood was appropriate while Mr Ngata was being restrained.

It was a pragmatic decision to leave Mr Ngata prone in the van during the drive to the custody unit. However, the need for the continued use of the spit hood should have been reassessed.

ISSUE 3: WAS MR NGATA RECEIVED APPROPRIATELY AT THE CUSTODY UNIT?

Arrival, staff briefing and welfare assessment

57. Policy on ‘People in Police detention’ sets out rules for safely managing people’s time in Police custody, especially in custody units and Police cells. When a person is first brought into custody they should be searched, their health and wellbeing assessed, and any information relevant to their time in custody entered in an electronic database (the electronic custody module or ECM).⁵ At any time, if custody staff think a person needs medical attention, they must call a health professional or take the person to hospital.

⁵ For more detail, see paragraphs 142 to 149 below.

58. During Mr Ngata's arrest, Officer K, the sergeant supervising the custody staff, recalled hearing radio transmissions which indicated "*something major*" was going on. Custody Officer L heard that Mr Ngata had been tasered and was still struggling with officers at the scene.⁶
59. Before the Police van arrived, Custody Officers L and M decided to take Mr Ngata directly into a cell on arrival. This meant his welfare needs would not be formally evaluated until he had been in the cell for a time. Policy allows for this and requires officers to treat a person as in need of specific care and constant monitoring until the assessment is completed.
60. Officer K was not part of this decision. She told Police she could hear "*... the guys talking about how we were going to receive him...*" and that if she had thought they needed to do something differently she would have told them.
61. CCTV footage from the custody unit shows the van arriving in the secure entrance to the custody unit at about 3.49pm. Officers G, H, I, and J got out of the Police van and gathered near the rear doors. Custody Officers L and M joined them, as did Officers N and O. Officers N and O were at the custody unit on another matter and had realised that the custody officers might need help.
62. Before Mr Ngata was taken out of the van, Officer G briefed the other officers about the uses of force during the arrest, including the tasing, pepper spray and restraints. Officer K did not attend this briefing. As supervisor, she was ultimately responsible for ensuring all aspects of Mr Ngata's health and wellbeing were attended to, so it was important for her to be aware of this information.
63. Before Mr Ngata was taken out of the van, custody staff had their first opportunity to evaluate Mr Ngata's wellbeing for themselves.
64. Custody Officer L said, when the van's cell door was opened, Mr Ngata was "*... making noise but not really listening to instructions. At that point I observed that he was well restrained and there would be no threat to myself.*" He got into the van, and with Custody Officer M's help, slid Mr Ngata out of the van, legs first.
65. CCTV footage shows that the plasticised part of the spit hood, intended to cover a person's mouth, was pulled up and covered Mr Ngata's entire face. Only the top of his head was visible through the mesh section.
66. Mr Ngata had been observed during the drive to the custody unit, but it is not clear if the spit hood was over his eyes during the drive. If it was, the ability to monitor him was severely compromised. Mr Ngata was speaking incoherently, so assurances of wellbeing could not be taken from that. Custody Officer M, when he looked into the Police van, was appropriately concerned with his own safety, but did not look for indicators of Mr Ngata's wellbeing.
67. Five officers carried Mr Ngata, face up and in a semi-sitting position, through the custody unit receiving area. All the officers said Mr Ngata was struggling and resisting while being carried.

⁶ Custody officers (or 'authorised officers') are non-sworn Police employees who have responsibility for managing the health, safety and secure custody of detainees.

Custody Officer L was holding Mr Ngata's left arm. He said Mr Ngata *"was thrashing, moving around quite violently...."* Custody Officer M said, *"... he was struggling the whole time, the whole time. He, he was, well I use the term 'talking' he was, in another language."* Other officers described Mr Ngata as speaking 'gibberish'.

68. However, the CCTV footage does not show Mr Ngata struggling. Instead, he appears to be unresponsive in the officers' arms. His head is, for the most part, bent forward over his torso, as if sleeping. When the officers turn a corner, Mr Ngata's head slumps to one side. He makes no effort to lift it. His arms and legs are not visibly moving. He is not twisting or pulling away from the officers. The officers appear to struggle to share Mr Ngata's weight, as it shifts unevenly as they walk through the custody unit. This may have created a perception for some officers that Mr Ngata was deliberately moving and therefore resisting.
69. Because CCTV at the custody unit does not record audio, the Authority cannot tell if Mr Ngata was speaking at all, let alone in a language other than English, or had become incoherent. Incoherent speech could have indicated medical distress.⁷ Instead, officers interpreted his vocalisation as verbal resistance to their efforts.
70. CCTV footage shows that, as officers carried Mr Ngata through the cell door, he was dropped and landed heavily, face down, on the cell floor. Officer O, holding Mr Ngata's right arm, said Mr Ngata *"twisted violently"* and *"half-fell, half-dropped"*, face first onto the floor. Other officers said they lost their hold on Mr Ngata due to his weight and the strength of his struggles.
71. CCTV footage shows that, as when walking through the custody unit, Mr Ngata is not visibly moving as officers enter the cell. He does not make any visible attempt to brace himself against the impact of the fall, nor does he react in any way to hitting the floor. The Authority considers his lack of reaction to be consistent with reduced consciousness.⁸
72. Officers used the restraints on his legs and the shoulder of his shirt to drag Mr Ngata into the cell and around to lie parallel to the cell door. CCTV shows that Mr Ngata does not move other than as manoeuvred by the officers, and the spit hood remains over Mr Ngata's entire face. The Authority is concerned that none of the officers checked Mr Ngata's responsiveness once inside the cell, instead continuing a physical and risky receiving process.
73. None of the officers noticed that the spit hood was incorrectly positioned. This implies that none of the officers attempted to look at Mr Ngata's eyes or face, a most basic method of establishing wellbeing when a person is not speaking. Nor were the officers aware that Police policy included a reminder that a person may be able to vocalise without being able to breathe.⁹

Search and Taser probe removal

74. Policy on 'People in Police Detention' requires that a person be searched before they are put into a cell, and that anything which might be used to harm themselves or someone else be

⁷ Refer to paragraph 46 above.

⁸ See also the pathologist's view on Mr Z's consciousness, in paragraphs 106 and 107 below.

⁹ Refer to paragraph 46 above.

removed. Taser probes are to be removed by a Taser trained officer as soon as possible, with the person's consent. The person can ask for a medical professional to remove the probes, which must be arranged as soon as possible.

75. Mr Ngata was not asked if he consented to having the Taser probes removed by Police. Officer K told Custody Officer M to remove the probes for Mr Ngata's safety before searching him. This was appropriate in the circumstances, but also represents another missed opportunity to properly engage with Mr Ngata and determine his level of responsiveness.
76. The Taser probe removal and search process took approximately eight minutes and throughout there were at least four officers restraining Mr Ngata at all times, in addition to Custody Officer M, who conducted the search. The officers tried to keep Mr Ngata on his side as much as possible during the search, but said this was difficult, because Mr Ngata was fighting against them the whole time.
77. The CCTV footage belies this. Because of the number of officers in the cell, it is difficult to see Mr Ngata clearly but for much of this period Mr Ngata appears limp and unresponsive. At one point, Officer O tried to lift Mr Ngata's lower legs and fold them up, so his feet were near his buttocks. Mr Ngata's legs fell back to a flat lying position.¹⁰ This was interpreted as resistance and two officers repeated the manoeuvre, this time applying their upper body weight to Mr Ngata's legs to hold them up. There are, however, three times where Mr Ngata appears to put up a short struggle to the extent that the restraining officers move to counteract his efforts.
78. Custody Officer M said he explained to Mr Ngata what was happening:

"Throughout the search and removal of the cuffs I was constantly talking to him so he knew exactly what I was doing, and what we were doing, ah this didn't seem to make any difference at all as he kept talking what seemed like another language..."

79. The officers said Mr Ngata was making noise through the search, and Custody Officer M was deliberately checking that Mr Ngata's chest was moving to show his breathing. Most of the officers said that Mr Ngata was making noises rather than speaking or was speaking gibberish. Officer M was positive Mr Ngata was talking in *"what sounded like another language"*; he did not identify which language. None of the officers heard Mr Ngata say distinct words about his breathing or anything else. Because the spit hood was still covering Mr Ngata's eyes, nose, and mouth, officers had no other indicators of any distress. None considered incoherent speech could be a sign Mr Ngata was not fully conscious, continuing to interpret his lack of cooperation as active resistance.
80. Although the officers searching Mr Ngata had been told about pepper spray used in the arrest, none of them provided the necessary assistance to Mr Ngata. This is unsurprising, given the difficulty of the search. Mr Ngata's entire face was covered by the spit hood, so officers did not have visual reminders that assistance was needed, such as seeing reddened or teary eyes.

¹⁰ The pathologist considered this could have been a focal seizure. See paragraphs 105 to 109 for more detail.

81. When the search was completed, officers dragged Mr Ngata around, so his feet were pointing towards the cell door. He was lying face down on the cell floor. The plastic cuffs were removed from his legs, then the handcuffs were removed. Officers left the cell one at a time. Mr Ngata did not move while this was happening.
82. The last to leave was Custody Officer M. He asked Officer K if he should take the spit hood off before leaving the cell. She told him to leave it on. Officer K told Police she thought leaving the spit hood on Mr Ngata was a good idea, because it *“would give them time to get out of the cell if the guy jumped up, he would have to remove the spit hood himself.”*
83. The ‘Mechanical restraints’ policy provides that all mechanical restraints must be removed from a person as soon as it is believed that the need for using them ceases. The spit hood should not have been left on Mr Ngata. Officer K’s rationale was poor and failed to consider all the relevant factors. Leaving the spit hood on:
- prevented Mr Ngata from clearing his mouth and nose as he recovered from the pepper spray;
 - prevented custody staff from being able to monitor Mr Ngata effectively while his face was covered;
 - created a risk that Mr Ngata would be able to remove it, and use it as a ligature to self-harm or against custody staff; and
 - created a situation whereby, if Mr Ngata had been able to remove it, custody staff would have had to re-enter the cell to remove the spit hood from his possession, allowing for another high-risk physical interaction.
84. The Authority considers it was unacceptable to leave the spit hood on Mr Ngata when leaving him alone in the cell.
85. The Authority accepts that the officers involved in the search genuinely believed Mr Ngata was actively resisting them, because of his lack of response to their verbal commands and attempts to move him. This belief was reinforced by Mr Ngata’s ongoing vocalisations, as none of the officers knew a person could speak while not being able to breathe. However, this belief was based on assumptions formed while listening to radio transmissions describing the violent arrest, reinforced by the briefing given by Officer G. Mr Ngata’s failure to cooperate with instructions further confirmed the officers’ presumptions.
86. Throughout the search, officers apparently relied on the strength of their own numbers, assuming that ‘someone’ would notice if something was wrong with Mr Ngata, rather than any officer taking responsibility for satisfying themselves that Mr Ngata was alert and coherent and well. This is where effective supervision makes a critical difference. Because the spit hood remained over Mr Ngata’s eyes and mouth during the entire process, it would have been impossible to establish Mr Ngata’s wellbeing with any certainty.

87. At no point in the receiving process did any officer attempt to independently assess Mr Ngata's level of wellbeing or responsiveness. Rather, they assumed what they considered to be talking and active resistance to mean there were no problems.

Supervision in the custody unit

88. Officer K, as custody supervisor, was ultimately responsible for everything that happened in relation to Mr Ngata while he was in the custody unit. She told the Authority she was fairly new to the custody supervisor's role and relied on her staff:

"... to me these guys are the experts, they've, I've only been there since March and lot of this is really new to me as well, but they've done a lot of work around oh the training around cell extraction and stuff like that and I've seen them operating before and watched, observed what they do and they know what they're doing."

89. Although Officer K was new to the custody supervisor's role, starting early in March 2018, she told the Authority she qualified as a sergeant in 2005. While the custody officers were proficient and more experienced in the custody unit, they had not been trained for a leadership role. A supervisor should provide oversight and advice and instruct staff on safer and better ways to manage tasks. However, Officer K's supervision fell short of the standard required. During this incident, the Authority noted:

- Officer K relied too heavily on the experience of the custody officers, failing to recognise their need for more than cursory supervision.
- Officer K did not take part in the planning for receiving a potentially dangerous person into custody and did not attend the briefing Officer G gave before Mr Ngata was taken out of the van. This meant she was not aware Mr Ngata had been pepper sprayed, tasered, and subject to significant force during his arrest.
- Officer K ought to have ensured a transporting officer was with a custody officer, entering Mr Ngata's details into the custody system, and evaluating Mr Ngata's health and wellbeing. While several officers were needed to restrain Mr Ngata, one of the officers outside the cell could have done this, freeing up Officer G.
- During Mr Ngata's search, he was kept on his front for several minutes, and had the weight of several officers on his back and legs. While each officer was mindful of the risk of positional asphyxia from their own efforts, there was no oversight in respect of the combined effects of all their weight and the time spent struggling on the ground during the arrest. This should have come from Officer K, along with plans to manage Mr Ngata more safely.
- Officer K did not recognise Mr Ngata had the spit hood incorrectly positioned, nor did she consider the difficulty staff would have monitoring Mr Ngata if they could not see his face.
- Officer K expressly instructed Custody Officer M to leave the spit hood on Mr Ngata when leaving him in the cell.

- Officer K, having ultimate responsibility for Mr Ngata’s welfare, did not properly assess the need for the spit hood, or whether it was positioned correctly.
 - Officer K did not arrange for Mr Ngata to be constantly monitored, and this was left to operational staff to arrange (see Issue 4 below).
90. These shortcomings, which the Authority considers a failure of leadership, led to inadequate care of Mr Ngata. While custody officers paid attention to immediate concerns around safety for themselves and Mr Ngata, Officer K did not provide the proper oversight of the incident as a whole. At key times when critical decisions were being made, Officer K was passive or absent.
91. Police accepts some responsibility for inadequacies in the training of supervisors such as Officer K in this area at the time of this event. That is regrettable given Police’s recognition of the educative needs in this area (see paragraphs 119-120). However, while the lack of training of Officer K may well have contributed to her actions and inactions, the ultimate supervisory responsibility was hers.

FINDINGS ON ISSUE 3

Officers failed to assess Mr Ngata’s level of wellbeing or responsiveness during the receiving and search processes.

Officers continuously interpreted Mr Ngata’s lack of cooperation as resistance, although in retrospect it was more likely to be reduced consciousness.

None of the officers considered whether Mr Ngata’s ongoing vocalisations were a sign of distress, nor that they did not mean he could breathe.

None of the officers were aware that Mr Ngata’s spit hood was incorrectly positioned.

It was appropriate for Police to remove the Taser probes during the search.

It was unacceptable to leave the spit hood on Mr Ngata when leaving him alone in the cell.

Officer K’s supervision during the receiving and search fell short of the standard required.

ISSUE 4: WAS MR NGATA MONITORED APPROPRIATELY WHEN LEFT IN THE CELL?

92. Police policies provide that a person must be constantly monitored when they:
- have been tasered, until seen by a doctor;
 - have been pepper sprayed, for at least 45 minutes;
 - are wearing a spit hood; or
 - are brought into custody, have not been evaluated and are considered to be at risk.
93. Constant monitoring requires an officer to watch the person continuously from a cell door or window. Monitoring a person using CCTV does not meet the requirement for constant monitoring.

94. Custody Officer L recalled the cell door being closed and:

"I then made a general comment out loud to all staff in the immediate area that constant monitoring would be required due to and I remember exactly saying 'due to the fact he'd been tasered a number of times.'"

95. Custody Officer L said a female officer (later identified as Officer I) volunteered to monitor Mr Ngata. CCTV footage from inside the cell shows officers were moving around outside the cell, but none were watching Mr Ngata. Officer K had returned to the receiving desk to follow up on other detainees. She told Police:

"I was satisfied that he was being watched and he was being monitored so then I could go and see my guys as well, so I've got a lot of welfare things going on in there as well."

96. Officer I does not recall either volunteering or being directed to do this. Given her newness to the job and lack of experience, she thinks she would remember if this had happened.

97. Mr Ngata was lying face down on the floor. His hands remained on his lower back, in the position they rested when the handcuffs were taken off. The spit hood was still covering his entire face.

98. The Authority considers that, even within the three minutes when Mr Ngata was alone in the cell, the requirements for constant monitoring were not met. CCTV footage shows Officer I was not watching Mr Ngata through the cell window. Even if Mr Ngata had been watched constantly, it was not possible to properly monitor Mr Ngata's wellbeing with his entire face covered by the spit hood.

99. Custody Officer P, an authorised officer watching the CCTV monitors at the main desk of the custody unit, noticed that Mr Ngata's arms were not moving. She thought his hands were starting to change colour. Custody Officer P alerted other officers, including Officer K and Custody Officer M.

100. CCTV shows officers moving around outside the cell, then Custody Officer M opening the meal tray slot in the door and looking into the cell. Mr Ngata did not respond to the tray slot being opened or Custody Officer M calling out.

FINDINGS ON ISSUE 4

Mr Ngata was not constantly monitored after being left in the cell.

Even if he had been, constant monitoring could not have been effectively undertaken from outside the cell while the spit hood was in place.

ISSUE 5: WAS MR NGATA GIVEN APPROPRIATE MEDICAL ASSISTANCE AT THE CUSTODY UNIT?

101. Almost four minutes after Police left the cell, the door was reopened. Custody Officers L and M, and Officer K, all recalled instances where a detainee had feigned unconsciousness but had lashed out at them when a cell door was opened. Custody Officer M used his boot to shift Mr Ngata's foot three times, to check whether Mr Ngata was responsive. Mr Ngata did not move.

102. Once inside the cell, Custody Officers L and M tried to put Mr Ngata onto his side. Custody Officer M realised Mr Ngata had urinated, a sign of something being wrong. Custody Officer L removed the spit hood from Mr Ngata's head and saw blood on the hood and on the ground where Mr Ngata's mouth had been resting. Custody Officer L called for the portable defibrillator and first aid kit and began resuscitation. Custody Officer P called an ambulance.
103. Fire and Emergency New Zealand (FENZ) arrived at 4.16pm, and an ambulance arrived around the same time. FENZ and ambulance personnel were taken straight to the cell and took over CPR from the Police officers. A second ambulance arrived at 4.21pm. Mr Ngata was taken to hospital by ambulance at 4.53pm.
104. Once concern for Mr Ngata's welfare was raised by Custody Officer P, officers were overly cautious when re-entering the cell. On the basis of the CCTV footage, it appears that they did not re-enter until between one and two minutes after the alert was raised. Their actions do not display any sense of urgency or awareness of the possibility of a critical incident. On their own subsequent account they were focused solely on their own safety rather than the immediate wellbeing of Mr Ngata. There were a number of officers nearby who could have assisted if Mr Ngata had been pretending to be unconscious. None of the officers considered Custody Officer P's advice that Mr Ngata's hands were changing colour when assessing the risk associated with re-entering the cell. This ought to have alerted them to the fact that something was seriously wrong. The Authority considers the delay in discovering Mr Ngata was in medical distress and starting first aid was unacceptable.

FINDING ON ISSUE 5

Once inside the cell, medical attention was appropriate. However, there was an unacceptable delay in starting treatment due to a reluctance to enter the cell.

Pathologist's findings

105. The post-mortem report for Mr Ngata recorded the cause of death as being a lack of oxygen to the brain causing brain cells to die (hypoxic ischemic encephalopathy). This occurred because of an abnormal heart rhythm, which itself was brought on by a combination of positional asphyxia, methamphetamine intake, an enlarged heart and possible suffocation by the spit hood. The pathologist ruled out the effects of the Taser and pepper spray as contributing factors.
106. The pathologist saw the footage of the assault, the arrest, and CCTV footage from the custody unit. His opinion was that Mr Ngata appeared to have reduced consciousness when taken out of the van and while being carried to the cell:

"However, the lack of any degree of aggressive movement, or signs of attempting to resist the Police from the time he was removed from the Police van, raise the possibility that he was already unconscious prior to entering the cells. This is further supported by the fact when he is taken into the cells there is no response from him when he comes into contact with the floor."

107. In respect of the strong leg movement Mr Ngata made during the search, the report said:

“... it was not clear if this was purposeful movement and an attempt to resist the Police officers. The possibility of focal seizure is not excluded. If it is a seizure, then by implication he was likely unconscious at this stage.”

108. The report also stated that the spit hood could have contributed to obstruction of Mr Ngata’s breathing:

“If there had been any excessive salivation, or fluid or blood from the airways, then the fluid between the hood and face would have led to the formation of relatively impermeable membrane and thus potentially restricted his breathing.”

109. The report noted that removal of the spit hood might not have changed the outcome in terms of breathing, but that it would have “obscured recognition” of a change in Mr Ngata’s vital signs or loss of consciousness.

110. The cause of Mr Ngata’s death will be the subject of a Coroner’s inquest.

Subsequent Police Action

111. Police undertook their own investigation of the circumstances surrounding Mr Ngata’s death. Police found that there were minor deficiencies in the management of this incident, but that existing policies addressed these adequately. Police noted lessons learnt around:

- the treatment of highly agitated detainees who may be vulnerable to medical events, particularly after use of force (described as suffering from ‘excited delirium’);
- using spitting hoods after pepper spray has been applied, and the elevated risk of positional asphyxia; and
- the need to avoid complacency where a detainee may be in genuine distress.

112. A bulletin was sent to all staff regarding the use of spit hoods on a person who has been pepper sprayed:

“When utilising OC spray, staff need to recognise the anticipated response will see the subject expelling increased saliva and nasal cavity discharge. This is not the time to introduce the spit hood; policy clearly states among other things that the face should not be covered.”

Conclusions

113. Mr Ngata's arrest was difficult and highly physical. The Authority found that all uses of Taser and pepper spray were justified in arresting Mr Ngata, including one use of pepper spray at close range. Additional uses of force were necessary and proportionate to the resistance Mr Ngata used to avoid arrest.
114. However, once Mr Ngata was taken to the custody unit, Police failed to assess Mr Ngata's wellbeing or responsiveness. His ongoing lack of response to officers, and incoherent vocalisations, were taken to be resistance, and therefore signs that Mr Ngata was breathing. The Authority concluded that these were more likely to be signs of reduced consciousness. Monitoring and assessment of Mr Ngata's wellbeing was hampered at all times after the arrest by the continued presence of the spit hood covering Mr Ngata's entire face.
115. Officer K's supervision of custody staff fell short of the standard required. She was overly reliant on the experience of her staff, not recognising their need for oversight and advice. She made a number of poor decisions, contributing to failures in Mr Ngata's assessment and care, and when key decisions were required, Officer K was passive or absent.
116. There was an unacceptable delay in entering Mr Ngata's cell to provide medical assistance, due to a failure in constant monitoring and the ongoing presence of the spit hood. However, when assistance was provided, it was appropriate.
117. The Authority also found that, in the specific circumstances of this case:
- 1) It was appropriate to delay pepper spray decontamination at the scene of the arrest;
 - 2) It was appropriate to apply a spit hood while Police were manually restraining Mr Ngata;
 - 3) It was a pragmatic decision to leave Mr Ngata on the floor of the van during transport to the custody unit;
 - 4) It was appropriate for Police to remove Taser probes during the search; and
 - 5) None of the officers realised Mr Ngata's spit hood was incorrectly positioned.
118. On 27 March 2015, the Authority recommended:
- 1) the Police introduce more systematic and nationally consistent training for both sworn staff and authorised officers working in custodial facilities, particularly in relation to:
 - a) the risk assessment and treatment of intoxicated and mentally impaired persons; and
 - b) how to recognise the signs that a prisoner requires urgent medical attention (such as the symptoms of drug overdose/head injury).

119. Police accepted the recommendation on 29 July 2015, and produced relevant training materials some time ago, but regrettably at the time of this incident had not yet implemented a nationally consistent training programme. Such training would have been a benefit to the officers involved in this incident.
120. Very recently, Police have undertaken a new programme of work (“National Police Custodial Review Programme”) designed to cover the care of detainees from the point of detention through to release or transfer from Police custody.

A handwritten signature in black ink, appearing to read 'C. Doherty'.

Judge Colin Doherty

Chair
Independent Police Conduct Authority

27 August 2020

IPCA: 18-0016

Appendix – Laws and Policies

USE OF FORCE

Law on use of force

121. Section 39 of the Crimes Act 1961 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.”*
122. Under section 62 of the Act, anyone who is authorised by law to use force is criminally responsible for any excessive use of force.

Police policy on use of force

123. 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. These include communication, mechanical restraints, empty hand techniques (such as physical restraint holds and arm strikes), OC spray, batons, Police dogs, Tasers, and firearms.
124. 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.
125. Police officers must also constantly assess an incident based on information they know about the situation and the behaviour of the people involved; and the potential for de-escalation or escalation. The officer must choose the most reasonable option (use of force), given all the circumstances known to them at the time. This may include information on the incident type, location, and time; the officer and subject’s abilities; emotional state, the influence of drugs and alcohol, and the presence or proximity of weapons; similar previous experiences; and environmental conditions. Police refer to this assessment as an officer’s Perceived Cumulative Assessment (PCA).
126. 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.

127. 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.

Use of a Taser

128. Police policy states that a Taser may only be used to arrest an offender if the officer believes the offender poses a risk of physical injury and the arrest cannot be effected less forcefully. A Taser must only be used on a person who is assaultive (defined as *“actively hostile behaviour accompanied by physical actions or intent, expressed either verbally and/or through body language, to cause physical harm”*) and cannot be used on a person who uses passive resistance in relation to Police.

129. To encourage de-escalation and to warn others nearby, officers must give a verbal warning in conjunction with the deployment of a Taser unless it is impractical or unsafe to do so. The warning relevant to the presentation of a Taser is *“Taser 50,000 volts”*. The warning relevant to a discharge or contact stun is *“Taser, Taser, Taser”*.

130. A ‘discharge’ is an *“application by firing two probes over a distance from an air cartridge attached to the Taser, or subsequent applications of electrical current via the probes, which are in contact with the subject after firing, in conjunction with a verbal warning”*. A ‘contact stun’ is *“activating the Taser with or without the air cartridge attached while the device is applied to the body of the subject, in conjunction with a verbal warning”*.

131. Police policy also states that subsequent applications and extended cycles of the Taser should be avoided, but where they are unavoidable must be reasonable, necessary, and proportionate in the circumstances.

132. The officer who deploys the Taser is responsible for ensuring:

- The person who was Tasered is constantly monitored until seen by a doctor or qualified ambulance officer;
- If the person is detained in custody, ensuring their custody records show that the person requires constant monitoring until seen by a doctor or qualified ambulance officer, and then monitored in accordance with medical advice;
- With the person’s consent, that Taser probes are removed at the earliest opportunity. A person who has been Tasered may refuse to give consent for Police to remove Taser probes, and have a medical professional remove the probes.

Use of oleoresin capsicum (pepper) spray

133. Police use pepper spray to subdue people; it causes a stinging sensation and generally makes people very compliant so as to avoid further aggressive behaviour.

134. Police policy states that pepper spray may only be used on someone who is actively resisting and then only when less forceful means cannot resolve the situation. Active resistance includes physical actions such as pulling, pushing, or running away – that is, *“more than verbal defiance”*.
135. Policy states that a person’s face should not be covered after the application of OC spray, and the person must be monitored for at least 45 minutes or until the effects of pepper spray are no longer apparent.

Spitting hoods

136. Police policy on mechanical restraints provides that spitting hoods may be used with other restraints to restrain people *“who are prone to spitting or have threatened to spit.”* A supervisor’s authority is required before applying a spit hood unless immediate action is required to prevent the person spitting and a supervisor is not available. In this case, a supervisor must be notified as soon as practicable.
137. All mechanical restraints must be removed from a person as soon as it is believed that the need for using them ceases, and a spitting hood cannot be left on a person for more than two hours without medical assessment.
138. Officers must apply the TENR model to determine if a mechanical restraint is necessary and proportionate to the threat faced, given all the circumstances known at the time. The overriding question officers must use when deciding whether to use mechanical restraints is *“In the particular circumstances, what possible risks are posed by the person?”* Officers must assess and frequently re-assess any risk during and after the restraint has been applied.

Positional asphyxia

139. The Police ‘Use of force’ manual includes a section on positional asphyxia. 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.
140. Police policy provides that nobody should be restrained face down for longer than is absolutely necessary to gain control. There must be continuous observation of a person in the prone position until such time as the person is no longer lying face down.
141. A person whose legs and wrists are restrained has an increased risk of asphyxiation. The policy contains the following note:

*“Note: There is a common misconception that if a person can talk then they are able to breathe, this is not the case. **Remember:** Never assume you know better - if an offender is complaining of difficulty breathing or feeling sick, seek medical attention immediately!”*

PEOPLE IN POLICE DETENTION

142. 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.
143. 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."* The ECM (electronic custody module) is a Police database used in custody units.
144. 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."

145. 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"*.
146. There are three types of checks, with an observation check being the minimum standard for checking detainees:

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

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

147. 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."*
148. 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.

149. 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.”

About the Authority

WHO IS THE INDEPENDENT POLICE CONDUCT AUTHORITY?

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

It is not part of the Police – the law requires it to be fully independent. The Authority is 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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