IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

Death of Jaye Taueli while in Police custody

1. On 30 August 2021, Mr Jaye Taueli lost consciousness while in a restraint chair at the Counties Manukau Custody Unit. He was taken to hospital. He never regained consciousness, and died the following afternoon. Police notified us of his death and we conducted an independent investigation.

2. Mr Taueli was arrested for breaching bail conditions. Officers were told he had consumed methamphetamine prior to his arrest.

3. Shortly after being placed in a cell, Mr Taueli began banging his head on the cell door and wall, then attempted to strangle himself.

4. At about 4.15pm, six officers placed Mr Taueli in the restraint chair.[1] During the struggle involved in doing so, one of the officers deliberately struck Mr Taueli on his face.

5. While in the chair, Mr Taueli forcefully thrashed his head back and forth over 160 times. After about 20 minutes in the chair, Mr Taueli began to lose consciousness.

6. At 5.10pm, a doctor assessed Mr Taueli and instructed Police to call for an ambulance immediately.

The Authority's Findings

Issue 1: Did custody staff accurately assess Mr Taueli and make appropriate decisions for his initial care?

Custody staff appropriately assessed Mr Taueli when he arrived at the custody unit. It was appropriate for them to place him in a cell and frequently monitor him.

[1] The restraint chair is approved Police equipment consisting of an inclined, padded chair on wheels that uses leg, wrist, waist and chest mechanical restraints to immobilise a person.

Issue 2: **Was it appropriate to place Mr Taueli in the restraint chair?**

While authorising the use of the restraint chair was justifiable, Officer C was too quick to do so, and did not act in accordance with policy. Less forceful and less intrusive options should have been used first.

Issue 3: **Were officers justified in using force on Mr Taueli while placing him in the restraint chair?**

Officer C had overall responsibility for ensuring the process of placing Mr Taueli in the restraint chair was executed correctly, in accordance with policy. Officers breached policy by not having one trained leader, a plan in place, and roles assigned to officers. The lack of organisation contributed to the officers taking an unnecessarily long time to place Mr Taueli in the chair, and using more force than might otherwise have been necessary.

Custody Officer D was justified in acting to prevent Mr Taueli from biting another officer. However, he used excessive force to do so.

Issue 4: **Did officers appropriately care for Mr Taueli while he was in the restraint chair?**

Officers failed to consider the risks posed to Mr Taueli, and that he might have been suffering a medical event. By assuming he was asleep, they failed to recognise he was losing consciousness. This led to a delay in calling an ambulance.

As custody sergeant, Officer C had overall responsibility for Mr Taueli's care. He failed to ensure:

- Officer B was adequately prepared and supported when monitoring Mr Taueli;
- he kept up to date with all relevant information concerning Mr Taueli;
- officers attempted to wake Mr Taueli, in accordance with policy; and
- that Mr Taueli was taken to hospital as soon as he became only partially responsive.

Analysis of the Issues

What occurred before Mr Taueli was taken to the custody unit?

7. On 16 August 2021, Mr Taueli was released from prison on electronically monitored bail. On 29 August, Mr Taueli cut off his bracelet and absconded from the address he was bailed to. On 30 August, Mr Taueli went to a family member's house. Police were informed and four officers arrived to take Mr Taueli back into custody.[2]

8. Mr Taueli resisted officers and was taken to ground to be handcuffed. He was not injured during the struggle.

9. Officers noticed Mr Taueli was behaving in an unusual way, mumbling and trying to pull his own pants down.

[2] Police had the power to arrest Mr Taueli under section 35(1) of the Bail Act 2000.

10. Family members told the officers they believed Mr Taueli was under the influence of methamphetamine.

11. Officer A and Officer B walked Mr Taueli to their patrol car and searched him. Mr Taueli initially complied with their instructions, however, while waiting for the transport van, his behaviour began to deteriorate. He tried to get out of the car and leaned forcefully onto Officer A, repeatedly saying: *"Just take me back to Puhinui."*

12. Given Mr Taueli's escalating behaviour, Officers A and B decided to take Mr Taueli to the custody unit themselves. They travelled the 7km under lights and sirens so they could get there quickly, as Mr Taueli was becoming more difficult to manage and was starting to use more force against Officer A.

13. During the journey, Mr Taueli behaved erratically. Officer A had to restrain him as he pushed himself onto Officer A with increasing force, attempted to climb across the backseat to where he was, and twice tried to bite him. He also attempted to put his hand down the back of Officer A's pants. Officer A says Mr Taueli's "*aggression appeared to come in waves as he built up more energy*".

14. Officer A tried to talk with Mr Taueli, who did not seem to be able to maintain a train of thought and did not always reply to his questions.

15. Mr Taueli apologised to Officer A as they pulled into the custody unit.

16. By this time, Officer A had become concerned that Mr Taueli might be mentally unwell. He planned to discuss this with custody staff and potentially organise for Mr Taueli to receive a mental health assessment while in custody. It was usual practice for officers to arrange mental health assessments at the custody unit rather than take violent detainees to a hospital emergency department.

17. Officers are regularly dealing with offenders who are under the influence of illegal drugs, such as methamphetamine, and who are acting in a bizarre manner. As Mr Taueli did not need emergency or immediate medical care, officers took him to the custody unit, where staff could assess him and arrange for a doctor to see him if they deemed it necessary.

ISSUE 1: DID CUSTODY STAFF ACCURATELY ASSESS MR TAUELI AND MAKE APPROPRIATE DECISIONS FOR HIS INITIAL CARE?

18. Officer C was the sergeant responsible for managing the custody unit. He had been in the role for five months at the time of the incident. Custody Officers D, E and F were the three on-duty custody officers.[3] The custody unit was working with restricted numbers due to Covid-19 protocols.

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

19. The control desk area is in the centre of the custody unit. From there, staff can see through windows into most cells and have television screens with CCTV live feeds, showing detainees in the cells.

20. Officer C was positioned in the control desk area. Custody Officer F was at the desk next to him, monitoring the CCTV screens, controlling the cell doors, and entering interactions with detainees into the database. Custody Officers D and E were 'on the floor', dealing with the detainees, and were sometimes by the control desk area. There were no more than three other detainees in the custody unit at any one time while Mr Taueli was there.

21. Officer C says the custody staff knew Mr Taueli was coming to the unit "*under lights*" because he was "*playing up*" in the patrol car. As they arrived, Custody Officer D saw Officer A was holding down Mr Taueli's upper body, restraining him in the backseat of the patrol car. He noticed Mr Taueli was sweating profusely.

22. Custody Officers D and E took Mr Taueli out of the patrol car. They stood on each side of Mr Taueli and took him by the arms, walking him to the wall, so he could be searched. Mr Taueli began to be uncooperative, refusing to walk or respond to directions. He swore and attempted to squat and pull away from the officers, and kept trying to pull his own trousers down from behind. Custody Officer D says it was obvious to him that Mr Taueli was under the influence of drugs.

23. Mr Taueli cooperated to some degree during the pat-down search, removing his shoes when told to. Custody Officer D says: "*He was responding, but still a bit unpredictable*". Custody Officer E recalls Mr Taueli would calm down and comply with instructions, then "*get all jumpy again".*

24. Meanwhile, Officer A told Officer C the details of the arrest and that Mr Taueli's family said he had taken methamphetamine. He also told Officer C that Mr Taueli had tried to bite him twice while in the car.

What was the custody staff's assessment of Mr Taueli?

25. Upon arrival in custody, staff are required to conduct a full risk evaluation of a detainee's physical and mental health. The information helps to identify any immediate health or welfare needs and to determine how often the detainee will be monitored.

26. Custody Officer D was responsible for assessing Mr Taueli. He says Mr Taueli was: "*… talking, he was making weird noises but he was sort of responding… to our questions."* He was: "*… sweating profusely, eyes are wide open, unable to concentrate on questions fully".*

27. Mr Taueli told Custody Officer D:

- he had taken drugs within the past 24 hours, though was unsure how much he had taken;
- he had none of the physical health conditions or symptoms Custody Officer D listed (such as diabetes and asthma); and

- he had previously attempted or had thoughts of suicide.

28. When asked if he was currently having suicidal thoughts, Mr Taueli mumbled and put his head down. Custody Officer D told him if he was having suicidal thoughts, staff would place him in a gown for his own safety.[4] He then asked Mr Taueli again if he intended to, or was having thoughts about, self-harming. Mr Taueli looked up and shook his head and mumbled "*no*". Custody Officer D asked Mr Taueli if he was going to be okay and he nodded his head to indicate, "*yes*".

29. Custody Officer D says he is unsure what Mr Taueli's understanding was, but did not ask him to elaborate. He had already appropriately determined Mr Taueli to be a 'high risk' detainee who would need to be frequently monitored due to his responses regarding self-harming.

30. Custody Officers D and E decided to place Mr Taueli into an observation cell, as it had a camera and Mr Taueli could be easily observed. [5] He would be on 'frequent monitoring', with officers conducting checks on him at least five times an hour, at irregular intervals.

31. Custody Officer D did not believe Mr Taueli needed a doctor at this point as he "*wasn't really showing any physical concern, not even mental health concerns.*"

32. Custody Officer D says Mr Taueli was still aggravated but calmer than he had initially been. He would not walk to the observation cell without assistance, so Custody Officers D and E each took an arm and guided him, with Mr Taueli in a bent over position. Custody Officer D says they are trained that if a person will not walk without any assistance, they should use this type of hold to guide the detainee towards the cell. He also says this enabled them to maintain control in case Mr Taueli "*acted up*" again. Once in the cell, Mr Taueli's handcuffs were removed.

33. Officer C agreed with the custody officers' decision to place Mr Taueli in the observation cell and that 'frequent monitoring' was appropriate based on what he saw of Mr Taueli's behaviour. He believed Mr Taueli was showing signs of having consumed methamphetamine: "*He came across as being unpredictable… irate and non-compliant."* He says it is usual for detainees believed to be under the influence of alcohol or drugs to be placed in observations cells to be monitored in case they deteriorate. Mr Taueli's behaviour was similar to what Officer C sees from other detainees and he did not consider Mr Taueli to be in need of immediate mental health or medical attention at this time.

34. We accept Mr Taueli did not need medical treatment at this time. We agree that it was appropriate for officers to place Mr Taueli in a cell where he could be easily and frequently observed.

FINDINGS ON ISSUE 1

Custody staff appropriately assessed Mr Taueli when he arrived at the custody unit.

[4] The gowns are used when staff remove a detainee's own clothing to prevent the clothes being used to self-harm, typically as a ligature. The gowns are made from tear resistant material and are designed to reduce a detainee's ability to self-harm.
[5] Detainees are placed there when they are considered at risk of harming themselves. There is a direct line of sight between the cell and the main office known as the custody desk, across a narrow corridor. The cell had a large window and the door had a window in the lower and upper half.

It was appropriate for them to place Mr Taueli in a cell and frequently monitor him.

ISSUE 2: WAS IT APPROPRIATE TO PLACE MR TAUELI IN THE RESTRAINT CHAIR?

35. Mr Taueli was placed into the cell at about 3.55pm. He removed his trousers and sweatshirt so he was only wearing his shorts and a t-shirt. He banged on the window to ask for a drink, then made his bed and sat on it.

36. About four minutes after entering the cell, Mr Taueli began deliberately hitting his head on the walls, windows and door. He banged his head six times in total, over about 30 seconds.

37. Officer C and other officers watched Mr Taueli banging his head, via a screen at the custody desk. Officer C described the banging as moderately hard - not very hard, but hard enough that Mr Taueli would have felt it. We agree with this assessment. CCTV footage shows Mr Taueli placed both hands on the surfaces, near the side of his head, each time he banged his head. His movements were neither forceful nor aggressive.

38. Officer A and Custody Officer E say they were not alarmed by Mr Taueli banging his head as they had seen other detainees do it to get attention and believed this was what Mr Taueli was doing.

39. Officer C told Custody Officer D to tell Mr Taueli to stop hitting his head, or he would be placed in a restraint chair. He also said to place the chair in view of the cell. Officer C explained to us that it is their general practice to do this, to show a detainee what will happen if they don't stop attempting to self-harm. We accept that, for some detainees, this would be a deterrent, causing them to stop the behaviour. However, staff need to be aware that for other detainees, this may unnecessarily increase their anxiety.

40. Custody Officer D placed the restraint chair outside the cell. Mr Taueli was sitting on his bed and *"appeared anxious looking at the cell wall"*. Custody Officer D entered the cell and warned Mr Taueli to stop banging his head and said if he continued he would be placed into the restraint chair for his own safety. Mr Taueli immediately agreed to stop banging his head. Custody Officer D took the removed clothing out of the cell, then left.[6]

41. At about 4.05pm, Mr Taueli lay down on the mattress, with a blanket over the upper half of his body, and his arms underneath the blanket. Over the next two minutes, he covered his face with the blanket three times, firstly for 42 seconds, then 30 seconds, then 20 seconds. Each time he removed the blanket, he was visibly breathing heavily.

42. Upon seeing this on the screen, Custody Officer F asked Custody Officer E to check on Mr Taueli to ensure he was not attempting to self-harm with his t-shirt.

43. At 4.08pm, Custody Officer E went to the cell, and saw Mr Taueli was still wearing his t-shirt. He told Mr Taueli not to put the blanket over his head. Mr Taueli initially removed the blanket,

[6] It is normal procedure to remove loose clothing from cells, to prevent them being used to self-harm.

however, put it back over his face when Custody Officer E went to leave the cell. Custody Officers D and E went into the cell and removed the blanket.

44. Within three seconds of them leaving the cell, Mr Taueli crossed his arms and put his hands around his neck, with his elbows pointing in the air. Custody Officer D was watching Mr Taueli through the cell window. He recalls hearing Mr Taueli making a wheezing noise as though struggling to breathe, and realised he was attempting to choke himself. As Custody Officers D and E entered the cell, Mr Taueli took his hands away from his neck.

45. Custody Officer D says:

- Mr Taueli was gasping for air after attempting to suffocate himself;
- he believed he had to intervene straight away to stop Mr Taueli from self-harming;
- Mr Taueli's aggressive behaviour towards Officer A when arriving at the custody unit, and display of intention to harm himself, indicated that Mr Taueli felt he had nothing to lose and just wanted to end his life; and
- Mr Taueli had received multiple warnings.

46. Custody Officer D radioed Officer C, who told the custody officers to place Mr Taueli in the restraint chair.

47. Officer C says he did not have a view about why Mr Taueli was attempting to self-harm but assumed it had something to do with having consumed methamphetamine. He intended to organise for a mental health professional to assess Mr Taueli before he was released from custody.[7] However, his immediate priority was to ensure Mr Taueli's safety. He also did not believe the mental health professional would assess Mr Taueli *"in the state that he was in*" at the time.

48. We are satisfied Officer C intended to have a mental health assessment conducted while Mr Taueli was in custody, as was appropriate.

Was Officer C justified in authorising officers to place Mr Taueli in the restraint chair?

49. Policy states that restraint chairs are "*one of the most intrusive of approved mechanical restraints.*" They must never be used as a punishment.

50. Policy says restraint chairs may be used to control a detainee who is:

- *"violent and intent on harming themselves and/or others; and*
- *where serious injury or death is a likely result; and*

[7] A designated and authorised health professional who has appropriate competence in dealing with persons who are mentally disordered in accordance with the Mental Health (Compulsory Assessment and Treatment) Act 1992.

- *where other available mechanical restraints would be ineffective."*

51. Policy provides an example of such behaviour, where a detainee is striking doors and walls with their head. It says: "*In such circumstances the use of handcuffs and other mechanical restraints would be ineffective or unable to secure the person in a manner where they cannot harm themselves or others."*

52. Officer C says:

> *"I believe that if it was delayed in authorising the use of the restraint chair or given [Mr] Taueli another chance to calm down, he would have continued to hit his head on the wall or strangle himself, or by harming himself in other means and could create serious injury to himself."*

53. Mr Taueli had shown he was intent on harming himself by hitting his head against the door and walls and attempting to strangle himself. These actions had the potential to cause him serious harm or death. As in the example provided in policy, other available mechanical restraints, such as handcuffs, would have been ineffective.

54. Officer C believed the restraint chair was the safest option as it is specifically for the purpose of stopping someone from harming themselves. However, in reality, the use of the chair caused Mr Taueli to become distressed and his behaviour escalated.

55. In addition to the criteria in paragraph 50, policy stipulates that restraint chairs *"must only* be *used as a last resort to control a detainee*".

56. Placing the chair outside the cell suggests the officers may have discounted other available options.

57. Based on the CCTV footage and what the custody officers told us, it is apparent they did not make a genuine effort to engage with Mr Taueli. We note that leading up to the use of the chair, Mr Taueli stopped self-harming whenever officers who were outside his cell, entered it. Their attention and presence appeared to calm him down. Therefore, an appropriate option was for an officer with him to constantly monitor Mr Taueli from outside the cell (with or without the door open), while engaging to try to de-escalate his behaviour.

58. Officer C was too quick to authorise the use of the restraint chair, given there was another option available that could have been tried before the use of the restraint chair.

59. If officers had used a less-intrusive option before resorting to the restraint chair, they may have avoided subjecting Mr Taueli to the force used while placing him in the chair, and he may have calmed down rather than then thrashing repeatedly while in the chair.

FINDING ON ISSUE 2

While authorising the use of the restraint chair was justifiable, Officer C was too quick to do so, and did not act in accordance with policy. Less forceful and less intrusive options should have been used first.

ISSUE 3: WERE OFFICERS JUSTIFIED IN USING FORCE ON MR TAUELI WHILE PLACING HIM IN THE RESTRAINT CHAIR?

60. Custody Officers D and E took hold of Mr Taueli's arms and moved him into a standing position. Custody Officer D says Mr Taueli "*became uncooperative, physically aggressive and refused to move any further".* They placed him in wristlocks to gain more control of him,[8] then escorted him to the restraint chair in the corridor. Custody Officer E says Mr Taueli did not appear to be feeling any pain from the wristlock, and his behaviour "*became erratic as he tried to break free from both our restraint holds*".

61. Custody Officers D and E began placing Mr Taueli in the restraint chair. During the first minute of attempting to do this, Officers A, C, G, and Custody Officer F, arrived to assist.

62. Officer G is a frontline officer who was constantly monitoring another detainee at the time. He says he came to assist because he noticed Custody Officers D and E were struggling to place Mr Taueli in the chair and he could see other custody staff were still putting on their Personal Protective Equipment (PPE).[9]

63. Custody Officer F says she also decided to come and assist after seeing officers struggling.

64. Mr Taueli continued to resist, kicking out, waving his arms around, trying to push himself up and out of the chair, stiffening his body and becoming increasingly aggressive. Officers say he was "*grunting and shouting*" and "*mumbling*" words that were mostly incomprehensible. He kept trying to grab the chair straps, preventing officers from being able to place his hands through them.

65. Officer C instructed some of the officers to swap positions, so the custody officers, who were more experienced in using the restraint chairs, could manage securing Mr Taueli into the straps.

66. Custody Officer F, who is trained in using a restraint chair, says there is a sequence for placing a detainee in the chair, and this was not followed. She recalls she was initially helping to secure Mr Taueli's hands. She then stood up and realised the belly belt and shoulder restraints had not yet been put on Mr Taueli, as they should have been.

67. Custody Officer D was trying to put Mr Taueli's arm into a strap when he saw Mr Taueli open his mouth and lean towards Officer A's arm, attempting to bite him. Custody Officer D used his right hand to strike Mr Taueli on the right-hand side of his mouth. (This is discussed further below.)

68. Officer C saw Mr Taueli's attempt to bite, so moved to stand behind Mr Taueli's head, placing his hands on both sides of Mr Taueli's face. This ensured Mr Taueli was facing forward, and stopped him from biting the officers.

[8] A wristlock is a technique where someone takes hold of another person's hand and twists or bends it in a non-natural direction. It allows pressure to be applied in a way that causes pain to the person if they resist.
[9] We acknowledge staff had the additional hinderance of having to wear PPE, which took time for officers to put on and generally made it more challenging when having to restrain detainees.

69. The officers used significant force on Mr Taueli for about five minutes, taking hold of his limbs and pushing him down into the chair, while attempting to secure the straps around his wrists, ankles, waist, and shoulders.[10] Custody Officer E says he also used his knee to push down on Mr Taueli's thigh.

70. Law allows officers to use "*such force as may be reasonably necessary in order to prevent the commission of suicide".*[11] Policy on using restraint chairs says:[12]

> *"Considerable force by a number of employees may be required to secure the person, so planning and a clear understanding of each employee's role in applying the restraint is paramount."*

This minimises the likelihood of any injuries or harm to the person and staff.

71. The officers did not have a plan in place before beginning the process, as they should have done. Custody Officer D says: "… *we were short staffed and I had to sort of react straight away."*

72. None of the officers were assigned specific roles, as they should have been. Policy recommends a team of four officers assist; however, the process began with only Custody Officers D and E present.

73. Officer C says: "… *obviously at that stage they've gone to grab him and put him in the chair… so that's essentially the planning."* He was confident the custody officers knew how to execute the process correctly. We do not consider this to be sufficient.

74. Custody Officer F says some of the difficulty arose because they were having to use people untrained in using the chair, to assist.

75. Officers should not have begun putting Mr Taueli in the chair until a proper plan had been developed, officers had been asked to assist and had time to put on their PPE, and roles had been assigned. Mr Taueli was not being aggressive prior to being placed in the chair and could have been monitored while a plan was put in place.

76. We acknowledge Covid-19 was placing limitations and staff resourcing. There was a lack of custody staff who were more familiar with the restraint chair process, with frontline officers having to assist. However, this was more reason to ensure assisting staff were briefed and that placing Mr Taueli in the chair was well co-ordinated.

77. Policy also says: "*One Police employee who is trained and currently certified in the use of the restraint chair must take charge",* providing advice, assistance and direction to the other employees. However, there was no clear chain of command or proper direction by one trained officer.

[10] The strap material is similar to the type used for car seat belts.
[11] Section 41 of the Crimes Act 1961.
[12] See paragraphs 198 to 200 for relevant policy on using restraint chairs.

78. Custody Officer D, who is trained, initially took the lead role, beginning the process of placing Mr Taueli in the chair. When Officer C arrived, he began issuing instructions, despite being untrained. Custody Officer F, who was trained, also provided some direction.

79. According to policy, only the trained officer in charge of the restraint process must take control of the person's head. While we accept Officer C took hold of the head to prevent Mr Taueli from biting officers, it would have been more appropriate, and safer, for one of the trained custody officers to do this.

80. The process of placing Mr Taueli in the restraint chair was poorly executed. It contributed to Mr Taueli being subjected to considerable force, over a longer period of time than is usually necessary when placing a struggling detainee in a restraint chair. It also placed the officers at risk of being injured.

Was the strike by Custody Officer D lawful and justified?

81. Section 48 of the Crimes Act 1961 states:[13]

> *"Everyone is justified in using, in the defence of himself or herself or another, such force as, in the circumstances as he or she believes them to be, it is reasonable to use."*

What did Custody Officer D believe the circumstances to be?

82. Custody Officer D believed Mr Taueli was about to bite Officer A on the arm. He believed he had to make *"a quick and decisive decision"* to intervene, to distract Mr Taueli and stop him latching on to Officer A's arm.

Was Custody Officer D's use of force for the purpose of defending Officer A?

83. Officer A did not see Custody Officer D strike Mr Taueli; however, he recalls hearing him saying: "*Watch, he's going to bite you*".

84. Officer C saw Mr Taueli's teeth on Officer A's arm and saw Custody Officer D's strike. He believes the strike was to stop Mr Taueli from biting Officer A.

85. No other officers saw the strike and we cannot see it on CCTV footage due to officers inadvertently obstructing the view.

86. Given Officers A and C's accounts, we accept Custody Officer D was acting to stop Mr Taueli from biting Officer A.

[13] See paragraphs 192 to 197 for relevant policy relating to the use of force.

Was Custody Officer D's use of force against Mr Taueli reasonable in the circumstances as he believed them to be?

87. Officer C recalls Custody Officer D striking Mr Taueli on the mouth with a closed fist. He says the strike "*wasn't a hard extreme sort of punch.*"

88. Custody Officer D's own account was that the strike was a forceful, closed-fist boxing move, "*basically… a cross hook*" punch.[14] He said custody officers are trained to use an open fist when using distraction strikes, however, he closed his fist as Mr Taueli's mouth was wide open and he did not want to get his fingers bitten.

89. When we asked Custody Officer D what level of force he used to hit Mr Taueli, he said that on a scale with one being weak and ten being the strongest use of force, "*probably six or seven*". Custody Officer D recalls, when he later saw blood on the wall: *"I was assuming it was from my cross hook that I'd done when restraining him.*"

90. At the time Custody Officer D struck Mr Taueli, Mr Taueli was being held down by four other officers, yet he still managed to get his mouth close to Officer A's arm. Officer D could not be sure Officer A would see Mr Taueli was attempting to bite him, and would move his arm away in time to prevent being bitten. Officers are aware of the risks of potentially being exposed to a transmissible disease if they are bitten.

91. It would have been reasonable for Custody Officer D to push Mr Taueli's face away using an open palm or push. However, using a cross hook boxing move to punch him was inappropriate and excessive.

FINDINGS ON ISSUE 3

Officer C had overall responsibility for ensuring the process of placing Mr Taueli in the chair was executed correctly, in accordance with policy. Officers breached policy by not having one trained leader, a plan in place, and roles assigned to officers. The lack of organisation contributed to the officers taking an unnecessarily long time to place Mr Taueli in the chair, and using more force than might otherwise have been necessary.

Custody Officer D was justified in acting to prevent Mr Taueli from biting another officer. However, he used excessive force to do so.

ISSUE 4: DID OFFICERS APPROPRIATELY CARE FOR MR TAUELI WHILE HE WAS IN THE RESTRAINT CHAIR?

92. Police have a specific legal duty of care towards detainees, who are considered to be vulnerable adults while in Police custody. Section 151 of the Crimes Act 1961 obligates Police to maintain the health and safety of detainees, providing them with 'necessaries' such as medical treatment.[15]

[14] The dominant hand is pulled backwards, before pushing forward, across the body, in a semi-circular motion.
[15] See paragraphs 184 to 187 for relevant law.

93. Once in the restraint chair, Mr Taueli was constantly monitored, as required by policy.

94. At 4.15pm, Custody Officer D wheeled Mr Taueli into a bare cell and placed him facing the back corner, beneath the camera. He and Custody Officer E stood outside, observing Mr Taueli through the window.

95. Mr Taueli leaned his head forward, then threw it backwards towards the chair headrest 11 times, seemingly with as much force as he could (we will refer to this as 'thrashing'). Each time he threw his head back, the chair rolled backwards a short distance.

96. Custody Officer D entered the cell and returned Mr Taueli to the back corner. He placed his foot against one of the wheels to stop the chair from rolling backwards and held the handles at the back of the chair. Mr Taueli thrashed another 9 times. Custody Officer D attempted to calm him through conversation. However, Mr Taueli thrashed 6 more times. Mr Taueli was breathing quite quickly, so Custody Officer D told him to take deep breaths and slow his breathing down.

97. Custody Officer D says he considered the head thrashing to be fairly normal behaviour as, in his experience: *"… this happens to mostly everyone that's been placed into a restraint chair."* He went on to explain*:* "… *they're basically [trying to] get out of the arm straps or they're basically [trying to] … hit themselves in the back of the head.*"

98. Generally, custody staff tell us detainees usually calm down once placed in a restraint chair. Therefore, we do not believe head thrashing, as Mr Taueli was doing, to be 'normal'.

99. Custody Officer D was comfortable the straps were tight enough that Mr Taueli would not be able to cause himself any harm. He incorrectly believed Mr Taueli's head was not coming into contact with the chair as his understanding was that the shoulder straps prevented people from being able to hit their head directly onto the back of the chairs.

100. Officer C watched Mr Taueli's thrashing on the screen. He believed the thrashing was an attempt to get out of the chair. He says he had confidence in the chair itself and he believed the design ensured Mr Taueli's airways would remain open due to its reclining position. He had confidence that the straps and padding were preventing Mr Taueli from coming to any harm when forcefully thrashing his head backwards and forwards. All of the other officers also believed the restraint chair was designed to keep people safe.

101. This was a reasonable assumption, given a restraint chair is an approved tactical option Police provide in custody units.

Did Officer C ensure Officer B was appropriately prepared to monitor Mr Taueli?

102. Mr Taueli required a high level of care. He had consumed methamphetamine, banged his head while in the cell, been placed under considerable force while being placed in the restraint chair, and been punched in the head.

103. When officers are trained in using a restraint chair, they are taught to look for signs of restrained people suffering from positional asphyxia (being in a position that blocks their airway) or excited

delirium (a state of mental or physical arousal). Mr Taueli displayed many of the signs taught to the trained officers, while he was in the chair. These included:

- changes in his behaviour;
- exceptional or unexpected strength;
- an abnormal tolerance of pain;
- agitation;
- sweating profusely;
- being hostile;
- exhibiting bizarre behaviour;
- vomiting;
- becoming limp and unresponsive; and
- losing, or having reduced levels of consciousness.

104. Officer C decided to use a frontline officer rather than a custody officer to continue constantly monitoring Mr Taueli as he needed the custody staff to remain free to deal with other detainees. It was common practice at the custody unit to use frontline officers to assist with constantly monitoring detainees.

105. Officer C says he told Officer A what he expected the monitoring officer to do:

- keep observing the detainee at all times;
- do not use a mobile phone – instead, use the custody unit's radio channel to communicate; and
- keep the control desk staff updated with any changes in the detainee.

106. Officer A said he would continue working on the documentation for Mr Taueli's arrest and would get Officer B to do the monitoring instead. Officer C did not know whether Officer B had monitored anyone constantly before but had no concerns with him doing it. Officer C left it up to Officer A to relay the requirements to Officer B.

107. Officer B had never monitored anyone in a custody unit, had no training in using a restraint chair, and in fact, had never seen a person in a restraint chair before. He did not know any of the relevant policies or procedures. He had not seen what had taken place since Mr Taueli arrived at the unit as he had been upstairs completing paperwork. Officer A told him Mr Taueli had been put in the restraint chair as he had hit his head against the wall a couple of times and had tried to choke himself.

108. Officer A did not pass on the information to use the custody unit's radio channel at this time. Subsequently, Officer B was not immediately able to communicate directly with the custody staff over the radio.

109. Officer B was insufficiently prepared to monitor Mr Taueli, who was high risk, vulnerable, and reliant on the care of Police for his wellbeing.

110. As the supervisor, Officer C has a responsibility to ensure all officers who assist in caring for detainees in the custody environment know exactly what is required of them, and how to access support. In this case, he assumed Officer B was aware, when he was not. Officer C did not ensure Officer B was properly supported and supervised.

Did custody staff appropriately care for Mr Taueli while Officer B was monitoring him?

111. Custody Officer D had no concerns for Mr Taueli's wellbeing. He considered Mr Taueli's sweating and quick breathing was related to struggling with the officers while being restrained in the chair: *"I gathered his adrenaline rush was still very fresh."* He recalls asking Mr Taueli how he was feeling and that he "*responded positively."*

112. Officer B entered the cell at 4.19pm. Mr Taueli thrashed again 16 times. When Officer B asked what to do, Custody Officer D told him to stop Mr Taueli from falling by holding the chair steady. He said to keep Mr Taueli seated in front of the camera and to place his foot on the wheel to prevent the chair from moving.

113. Almost immediately after Custody Officer D left the cell, Mr Taueli thrashed his head another 13 times, then a further 10 times. Officer B wondered why he was thrashing and how he could stop him from doing it. He considered Googling "*meth come downs*" as Officer A had told him Mr Taueli may be going through "*come downs*" and he was unsure what the term meant.[16]

114. Officer B tried to talk with Mr Taueli. Mr Taueli would stop thrashing, rest and get his breath back. Officer B would tell him to stop shaking his head, saying: "*Bro, calm down they'll take you outta the restraint chair, if you do that they're not gonna take you out."* Mr Taueli would indicate that he was going to stop thrashing, but continued doing it.

115. Officer B was finding it difficult to stop the chair from rolling backwards and could not work out how to stop Mr Taueli from thrashing. He thought the chair may fall over if he was not holding its handles. He was conscious that the sergeant and other custody staff would be watching through the CCTV: "*I was thinking I am not that strong … he's gonna fall and everyone's gonna laugh at me that this guy can't even hold the chair."*

116. Mr Taueli's head was making contact with the chair's padded headrest at times, but Officer B was comfortable it was not hitting any metal part of the chair. He considered holding Mr Taueli's head but thought it may make him become more agitated and aggressive. He was aware Mr Taueli was very strong and "*couldn't find any possible way of … trying to restrain his head movements without damaging him more".*

117. Officer B noticed Mr Taueli was sweating, however, was not concerned by this as he was also very hot himself in his PPE.

[16] English is not Officer B's first language.

118. At about 4.21pm, Mr Taueli became calmer for about 50 seconds. He spoke with Officer B, saying he was generally feeling depressed, then said: "*Get me out of here"* and thrashed another 44 times, over four episodes.

119. At 4.24pm, Mr Taueli's head began to loll from side to side. He spat a dark liquid, presumably blood, onto the floor and walls of the cell, thrashed another 13 times, then vomited.

120. Officer B says:

> *"[Mr Taueli] started spitting what looked like blood along with saliva. I could see a blood on his lips which looked like it was coming from a cut. He also threw [up] what looked like undigested food. I then said to him "Bro you all good?" to which he said 'Yes'. "*

121. At 4.26pm, Officer C told Custody Officer F to call the doctor. He decided to do this as Mr Taueli had been thrashing his head around for ten minutes and did not appear to be calming down. He thought the doctor may give Mr Taueli some medication to calm him down. Officer C did not know that Mr Taueli had vomited and spat blood and was unaware of it until about half an hour later.

122. Custody Officer F told the doctor Mr Taueli may have taken methamphetamine, had banged his head, put something around his neck, resisted Police, and had been placed in a restraint chair. She neglected to tell the doctor Mr Taueli was violently thrashing his head back and forth in the restraint chair.

123. Custody Officer F says she was told Mr Taueli had spat out a dark liquid shortly after it happened, however she cannot recall who told her and was unsure if she was told before or after calling the doctor. She did not recall telling the doctor Mr Taueli had vomited. However, the doctor recalls Custody Officer F told her Mr Taueli had vomited with streaks of blood in it.

124. The doctor immediately prepared to come to the custody unit, a journey of about 30 minutes.

What happened after the doctor was called?

125. Officer B says he did not notice any change in Mr Taueli after he vomited and spat blood:

> *"To be honest I wasn't much concerned about him because he is talking to me, I was just concerned to see how far the doctor is 'cos [Officer A] told me that we can't go until the doctor arrives".*

126. Officer B rang Officer A, telling him Mr Taueli would not stop "*shaking his head*". Officer A told him the custody officers were calling the doctor. Officer B hoped the doctor would be able to medicate Mr Taueli to calm him down so he would stop shaking his head, making him more controllable.

127. Officer A also texted Officer B, saying that Officer C had asked him to "*switch to [custody radio channel] in case you need help."* We are unsure exactly what time Officer B found the correct radio channel and began using it to communicate with custody staff, though believe it may have been at about 4.30pm. It is clear from CCTV footage that Officer B was using his mobile phone

rather than the radio. Officer C says he expected Officer B to communicate with him more, however made no effort to establish why there was a lack of communication from him.

128. Between 4.26pm and 4.33pm, Mr Taueli thrashed another 44 times over five episodes. He also spoke with Officer B about rugby and family.

129. Officer B sent Officer A texts and called him. He believed he needed Officer A to come and assist in controlling Mr Taueli, with some urgency. However, Officer A does not recall Officer B specifically asking him to come down to help and says he was unaware Officer B needed assistance.

130. Officer C says he believed Mr Taueli was repeatedly thrashing his head back and forth because he was "*just a bit annoyed*" that he was still in the chair. He did not consider going to the cell to check on Mr Taueli himself as his actions (as seen on the screen) showed he was breathing and Officer C had "*every confidence in the team"* to deal with him.

131. At 4.33pm, Mr Taueli thrashed his head 8 more times. He did not thrash anymore after this.

How did officers respond when Mr Taueli began to lose consciousness?

132. At about 4.35pm, Mr Taueli told Officer B: "*I'm tired now*". He slumped his head forward and closed his eyes. Officer B believed he had fallen asleep. Officer C thought the same.

133. Based on what the CCTV footage shows, we believe this was the point where Mr Taueli's level of consciousness began to visibly decline.

134. Officer B says:

> *"At this point I was a little bit relaxed that he's just calmed down now and he's snoring and sleeping… I just tried to shake him to see if he's all good but he was just snoring. I just did a normal touch like not too hard or anything."*

135. Officer B says he did not try to wake Mr Taueli at any point as he believed he was sleeping and probably needed to rest.

136. Around 4.40pm, Mr Taueli's body began pressing upwards and backwards into the restraint chair before slumping forward again. His eyes remained closed throughout. A few minutes later, his left leg began to move. It continued to do so periodically from this time onwards, moving side to side at times, and 'twitching' in smaller, faster movements at other times.

137. Officer B checked to see if Mr Taueli was feeling pain by pinching his left shoulder. Mr Taueli sometimes groaned or made grunting noises when he pinched and tapped him. CCTV footage shows Officer B pinched Mr Taueli's shoulder three times between 4.40pm and 4.49pm.

138. Officer B says:

> *"I was thinking if he is not responding he could be high on meth, but most of the times he did respond to me by stretching his body or something, and he was snoring the whole time which was the major relief for me…."*

139. Officer B thought the fact Mr Taueli stretched his body when touched indicated he could feel what Officer B was doing. He began regularly pressing down on Mr Taueli's shoulder, believing this relaxed Mr Taueli.

140. Officer B says Mr Taueli's snoring sounded exactly like his parents' snoring and his stretching reminded him of his father, who would "*stretch while sleeping and ease up*". This supported his belief Mr Taueli was simply sleeping.

141. At around 4.45pm, Mr Taueli began "*snoring harder".* Officer B did not consider that he may be losing, or have lost, consciousness and continued to believe he was just sleeping. He still did not try to wake Mr Taueli.

142. CCTV shows Officer B repeatedly glanced towards the cell door and pressed a call button by the cell door. Officer B says these were unsuccessful attempts to get assistance in case Mr Taueli woke up. He also tried to request help on the radio but was unsure if he was being heard or not. Other officers were unaware Officer B was seeking assistance.

143. Officer B was then able to contact Custody Officer F on the radio, telling her Mr Taueli was "*stretching his body and he's sleeping now, he's snoring hard out".*

144. Custody Officer F asked Custody Officer E to go to the cell and conduct a check to see if Officer B had any concerns as he had mentioned Mr Taueli's breathing sounds to her.

145. At about 4.51pm, Custody Officer E went into the cell. He recalls Officer B told him Mr Taueli's breathing was "*a bit funny*", having become quite loud and raspy. Custody Officer E says Officer B did not appear worried. Officer B showed Custody Officer E how Mr Taueli stretched then appeared to calm down when he put his hand on Mr Taueli's shoulder.

146. Custody Officer E tapped and pinched Mr Taueli's shoulder and shook him. He believed Mr Taueli was conscious and just sleeping and did not believe anything was wrong with him. He did not try to wake Mr Taueli before leaving the cell.

147. Custody Officer E says Officer B told him Mr Taueli was not responding to pain. However, we do not believe his recollection of this is correct. CCTV shows Mr Taueli stretching and Officer B with his hand on his shoulder, which is in line with Officer B's account. Custody Officer E says he returned to the custody desk, and told Officer C and Custody Officer F that Officer B had told him Mr Taueli was not responding to pain. However, Officer C does not recall Custody Officer E's check at all and Custody Officer F recalls he reported that Mr Taueli was breathing. There was no action taken following this discussion by any of the officers as you might expect if they understood the monitoring officer believed he was not responding to pain. In fact, Officer B continued to believe he was responding, by relaxing when he touched his shoulder.

148. At about 5.02pm, Mr Taueli's right leg began twitching, along with the left leg which had continued to move side to side, or twitch on and off, since 4.40pm.

149. Officer C recalls Officer B saying Mr Taueli was making "*gargling sounds*" over the radio. He says he thought the sounds were most likely due to tiring himself out when resisting officers and thrashing his head. At 5.04pm, he went to the cell to check on Mr Taueli himself. Officer C says:

> *"I saw his chest raising and falling which, to me, appeared as though he was breathing so I approached him and tried to speak with him. There was no response from him so I then tried to rouse him by rubbing along his collar bone. Again there was no response from him."*

150. Overall, Officer C determined Mr Taueli was breathing, making gurgling noises, moving his leg and "*moving around a little bit*", but "*he's not been too responsive*". Officer C went to speak with the doctor, who had just arrived.

What state did the doctor find Mr Taueli to be in?

151. The doctor went to Mr Taueli's cell at 5.11pm. She noticed clear fluid with streaks of fresh and 'coffee-ground' type blood on the floor.

152. Mr Taueli responded to the doctor's pain tests, however, his response was weak. The doctor noted:

- Mr Taueli was unresponsive to her voice;
- he made a "*slight response"* to pain, slightly flexing his finger when she applied sternal pressure and pinched his ear lobe';
- he had significantly unequal pupils which were unresponsive to light;
- he was moving his left leg and foot up and down, in a rhythmical manner;
- had a very elevated heart rate, blood pressure, and respiratory rate;
- noisy breathing (suggesting disrupted airflow) which lessened when she moved his tilted head to a neutral position;
- he had fresh blood around the right side of his mouth;
- there were superficial marks around his forehead, however the skin was intact and there was no swelling; and
- there were no marks noted around his neck, forearms, chest or abdomen.

153. The doctor told officers to call an ambulance urgently. The ambulance arrived at about 5.25pm. Paramedics found Mr Taueli had a very elevated temperature. Mr Taueli was moved from the restraint chair to the stretcher at the ambulance. He had been in the restraint chair for about 70 minutes in total.

154. After the restraints were removed, it became obvious that Mr Taueli was experiencing seizures. The ambulance staff requested the specialist paramedic to administer sedatives.

155. Mr Taueli arrived at the hospital at about 5.55pm, about 1 hour and 21 minutes from when he first started showing signs of losing consciousness. Hospital records indicate there were red marks and bruises around Mr Taueli's body, where the restraint chair straps had been. There were also red marks and blood on Mr Taueli's face and forehead, likely caused when Mr Taueli hit his head on the walls and windows of his cell, and when struck by Custody Officer D.

What was the cause of Mr Taueli's death?

156. The pathologist determined Mr Taueli's cause of death to be a subdural haematoma – a bleed on the brain. The pathologist says this was most likely caused by a rupture of long-standing "*vascular malformation"* (abnormal development of blood vessels). In his view, Mr Taueli's use of methamphetamine was most likely a significant contributor to his death as it increases blood pressure and is associated with subdural haemorrhages from vascular malformations.

157. Regarding the role of the head banging in Mr Taueli's death, the pathologist said this was unclear as "*head banging does not typically induce enough force to cause subdural haematomas".* He says there was no bruising or injury to the skin at the back of Mr Taueli's head, as is usually seen when people hit their head with significant force. In his view, this pointed to "*relatively low force impacts*". The pathologist believes the padding on the headrest slowed down the impact, lessening the force of the head banging: *"It's kept him from injuring his head. He just happened to have a major vulnerability."* He says the head banging *"would not be expected to contribute to a subdural haematoma"* if Mr Taueli had not already had the rare vascular lesions prior.

158. A neuropathologist who provided a second opinion also believes it was most likely the subdural haematoma was the direct consequence of Mr Taueli's methamphetamine use. He said:

> *"Whilst I cannot absolutely exclude [the head thrashing] as a potential cause of the subdural bleed I think that it is an unlikely cause [due] to the very limited force involved in such an action…. In my opinion the repeated head banging prior to collapse is unlikely to have precipitated bleeding from this lesion, although I cannot entirely exclude that possibility."*

159. There is no definitive evidence that Mr Taueli's thrashing his head against the restraint chair headrest led to his death.

160. Officers could not have known Mr Taueli had a pre-existing condition that placed him at higher risk of a subdural haematoma, heightened by him taking methamphetamine.

161. Officers did fail, however, to recognise Mr Taueli was becoming unconscious due to the bleed on the brain. Instead, they assumed he was asleep. Consequently, an ambulance was not called for 40 minutes after he first slumped forward, drooping his head, showing signs of a deteriorating level of consciousness.

162. While we do not know if calling an ambulance sooner would have increased Mr Taueli's chance of survival, medical help should always be sought as soon as someone shows signs of losing consciousness and is only partially responsive. Officers failed to do this.

Was it reasonable for officers to assume Mr Taueli was asleep?

163. The 'People in Police custody' policy states that officers must always consider the detainee's level of consciousness. Police employees are not trained medical professionals; however, they are dealing with vulnerable people daily, who may be intoxicated, mentally unwell, or medically unwell. It is vital that they are able to determine levels of consciousness in order to seek medical assistance as soon as someone becomes partially or totally unresponsive.

164. Policy instructs employees to be aware of the risks posed by the mixture of alcohol, drugs and current or pre-existing medical issues. It also says officers must be aware that the level of consciousness may change over time due to intoxication or medical complications.

165. Policy provides information about levels of responsiveness specifically relating to detainees who may be affected by drugs, alcohol, or medical complications. A person is deemed to be:

- *"alert"* if they are able to engage in a coherent conversation*;*
- *"drowsy or confused*" if they respond to voice and are able to reply. The person may need some assistance to walk;
- *"partially responsive"* if they respond to pain only, such as nail-bed pressure; and
- *"unresponsive"* if they do not respond to any stimuli.

166. Policy instructs officers that if someone is:

- *"Partially responsive... THEN - Treat this as a medical emergency and arrange for the person to be taken to hospital; and*
- *Unresponsive... THEN - 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."*

167. All the officers had received first aid training regarding how to check a person's level of responsiveness, however, some told us they were unclear how to do this. Officer B said he has no experience in assessing levels of consciousness or responsiveness: "*All I would say is that if someone is breathing… he's all good".* Other officers also told us they could see Mr Taueli was breathing, so assumed he was okay.

168. None of the officers questioned Mr Taueli's loud snoring and were unaware that policy clearly states: "*Note: Loud snoring is a sign the person is deeply unconscious"*.

169. Likewise, none of the officers considered Mr Taueli's leg movements and 'stretches' could be involuntary, and/or seizures, rather than responses to touch or pain checks.

170. According to policy, detainees should be physically roused if their risk assessment "*indicates they need specific care, are intoxicated, or exhibit any risk identifiers".* Given this, Officer B and Custody Officer E (during the 4.51pm check) should have tried to wake Mr Taueli.

171. Officer B, and Custody Officers E and F, who all saw Mr Taueli and believed him to be asleep, failed to recognise he was becoming unresponsive. They should have requested urgent medical attention sooner.

172. Detainees are reliant on officers to provide them with care while they are in custody. They are often in a high-risk, vulnerable position and Police staff are the only people available to assist them. Therefore, Police need to ensure custody and frontline staff are adequately trained to recognise levels of consciousness. We know staff learn about levels of responsiveness in their first aid training. However, the fact that none of the officers caring for Mr Taueli recognised he was losing consciousness, shows more work is needed by Police to ensure level of responsiveness training is adequate and ongoing.

173. Officer C failed in his duty of care as the officer in charge. In our view, he did not appreciate the risks posed to Mr Taueli. He did not take an active role in ensuring officers were performing their roles adequately and that policy was adhered to. Under Officer C's care, officers failed to recognise that Mr Taueli's level of consciousness had declined, and therefore Mr Taueli was not taken to hospital as soon as he became only partially responsive.

FINDINGS ON ISSUE 4

Officers failed to consider the risks posed to Mr Taueli, and that he might have been suffering a medical event. By assuming he was asleep, they failed to recognise he was losing consciousness. This led to a delay in calling an ambulance.

As custody sergeant, Officer C had overall responsibility for Mr Taueli's care. He failed to ensure:

- Officer B was adequately prepared and supported when monitoring Mr Taueli;
- he kept up to date with all relevant information concerning Mr Taueli;
- officers attempted to wake Mr Taueli, in accordance with policy; and
- that Mr Taueli was taken to hospital as soon as he became only partially responsive.

Subsequent Police Action

174. Police set up a National Custody Team (NCT) at Police Headquarters in October 2021. This permanent team replaced the previous Custody Enhancement Programme (CEP). The purpose of the NCT is to enable and enhance custodial operating capability. The core services and functions the NCT are responsible for are:

- providing assurance to the Police Executive of district compliance with national custody operating practices and policies through an evidence-based framework;
- providing support and guidance to districts, as well as monitoring and reporting on performance, health, safety and risk, nationally within the custody environment; and
- managing internal and external stakeholders to continuously improve custodial operating capabilities.

175. In February 2022 the NCT introduced updated online custody training modules (Custody Risk Assessment and Custody monitoring). These e-modules are compulsory training for all frontline staff. They include scenarios to help staff to assess a detainee's level of consciousness and provide guidance and instructions on how to respond. Police have also piloted a four-day custody supervisor's course.

176. Following the death of Mr Taueli, Counties Manukau Police District has implemented new local processes. These include:

- training all the district custody sergeants in the use of the restraint chair. Future custody sergeants will receive the training as part of their induction;
- now using a checklist which specifies the requirements for placing a detainee in a restraint chair, and the checks required once in the chair. The custody sergeant enters the information on the checklist into the Police database; and
- custody sergeants are now required to read a briefing to any officer undertaking constant monitoring of a detainee.

177. As the National Preventive Mechanism for Police custody, we are committed to working collaboratively with Police to improve custodial management policy and practices. Whilst we acknowledge that significant progress has been made since Mr Taueli's death, this investigation is another example of frontline staff lacking the knowledge to recognise when a detainee is seriously ill and in need of urgent medical help. We identified similar issues in our investigation into the death of Mr Allen Ball in Hawera in May 2019.

178. We are concerned that short online modules will not be sufficient to address these issues and that more face-to-face training is required. We recognise that custody sergeants have an important leadership role in safeguarding vulnerable detainees and dedicated training is required to equip them to manage the often complex and competing risks involved in managing people in Police custody.

Recommendations

179. We recommend that Police:

1) Provide all custody supervisors and custody officers with ongoing and regular education and face-to-face training to support them in identifying and managing risks in the custody environment. The training should enable custody staff to conduct effective monitoring checks, including how to assess levels of consciousness.

2) Require all custody sergeants to be trained in the use of restraint chairs and ensure restraint chair policy and training provides clearer, specific guidance about how to manage the risks involved in placing detainees in restraint chairs.

3) Provide more guidance in the 'People in Police custody' policy, to assist evaluating officers and custody sergeants in determining whether 'frequent monitoring' is sufficient for suicidal detainees, or whether 'constant monitoring' is more appropriate.

Judge Kenneth Johnston KC

Chair
Independent Police Conduct Authority

27 June 2023

IPCA: 21-8798

Appendix

LAW

Health and Safety Act 2015

180. Under section 36 of the Health and Safety at Work Act 2015, a person conducting a business or undertaking (PCBU) must ensure "s*o far as is reasonably practicable, that the health and safety of other persons is not put at risk from work carried out as part of the conduct of the business or undertaking."*

181. A PCBU must ensure staff receive "*information, training, instruction, or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking."*

182. Section 45 instructs workers to take reasonable care that their actions or omissions do not have an adverse effect on the health and safety of other people. They must adhere to the policies, procedures and instructions of the PCBU.

183. Under section 47, a person commits an offence if they are "*reckless as to the risk to an individual of death or serious injury or serious illness.*"

Crimes Act 1961

184. 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.

185. 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.

186. 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.

187. 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.

'People in Police custody' policy

188. Officers must consider detainees to be 'at risk' until an evaluation takes place, with those with signs of suicide risk being constantly monitored. Those without signs of suicide risk must be frequently 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."*

189. Detainees should be monitored, with checks being in accordance with their risk evaluation:

- If they require no specific care, they must be checked at least every two hours.
- If they require frequent monitoring, they must be checked at least 5 times per hour, at irregular intervals.
- If they require constant monitoring, they must be directly observed without interruption.

190. The level of monitoring can be increased at any time but can only be reduced on the advice of a health professional.

191. Constant or frequent monitoring is mandatory for detainees:

- in certain types of mechanical restraints; and
- at risk of suicide.

'Use of force' policy

192. The Police 'Use of Force' policy provides guidance to Police officers about the use of force. 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 and empty hand techniques (such as physical restraint holds and arm strikes).

193. 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.

194. 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).

195. Wherever possible and appropriate, officers should use tactical communication throughout an incident, alone or with any other tactical options. Tactical communication is crucial to safely de-escalating an incident with uncooperative subjects. Tactical communication should be attempted in every incident where Police action is necessary in response to uncooperative subjects, including those that may require force to be used.

196. 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.

197. 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.

'Mechanical restraints' policy

198. As a restraint chair is an intrusive mechanical restraint, "*a supervisor's authority must be obtained before using the restraint chair unless a supervisor is not available and immediate action is required to prevent the person harming themselves and/or others and where serious injury or death is a likely result.*" If an officer had to act immediately and a supervisor has not authorised the use of a restraint chair, they must be advised as soon as practicable.

199. Restraint chairs must be used in accordance with approved training and a person who is in a restraint chair must be constantly monitored to ensure their safety. The use of the chair must be assessed regularly during monitoring. Officers must record the time a person is placed in a restraint chair and the time they are removed. A restraint chair must not be used for more than two hours unless the person has been assessed by a Police Medical Officer before the two hours is up.

200. In order to minimise the likelihood of the person or a staff member being injured or harmed, it is recommended that a 4-person team takes control of a person who is being placed into, or removed from, a restraint chair.

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.

We are not part of the Police – the law requires us to be fully independent. The Authority is overseen by a Board, which is chaired by Judge Kenneth Johnston KC.

Being independent means that the Authority makes its own findings based on the facts and the law. We do not answer to the Police, the Government or anyone else over those findings. In this way, our 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 and may choose to investigate:

- complaints alleging misconduct or neglect of duty by Police;
- complaints about Police practices, policies and procedures affecting the complainant in a personal capacity;
- notifications of incidents in which Police actions have caused or appear to have caused death or serious bodily harm; and
- referrals by Police under a Memorandum of Understanding between the Authority and Police, which covers instances of potential reputational risk to Police (including serious offending by a Police officer or Police actions that may have an element of corruption).

The Authority's investigation may include visiting the scene of the incident, interviewing the officers involved and any witnesses, and reviewing evidence from the Police's investigation.

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. 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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