IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

Woman dies in Police custody at Gisborne

1. On the afternoon of Wednesday 22 November 2023, after a three-week trial at the Gisborne High Court, 63-year-old Lynne Martin was convicted of murder. At about 3.40pm, Ms Martin was taken to the Gisborne Police Station where she was to stay overnight, for later transportation to a Corrections facility.

2. Ms Martin was searched, assessed in terms of her physical health and mental wellbeing to determine the most appropriate monitoring regime while she was in custody, and placed in a cell by herself.

3. Ms Martin was scheduled to be checked every two hours. For various reasons, not all checks were completed.

4. At around 7.20am on 23 November, an officer went to speak to Ms Martin in her cell and found she had died.

5. Police notified the Authority of her death while in Police custody, and we investigated. The publication of this report was delayed until Police progressed their investigations.

6. We acknowledge the tragic circumstances of the overall event and the death of Ms Martin.

The Authority's Findings

Issue: **Did Police breach their duty of care under law and policy to Ms Martin while she was in their custody?**

Initially, the care of Ms Martin while she was in Police custody was appropriate and in line with Police's obligations considering the information available.

However, Officers A and B should have applied a wider consideration of Ms Martin's circumstances instead of only applying a computer-based assessment and observation plan. Ms Martin had just been convicted of murder and was in poor health.

We consider Officers C and D acted unprofessionally which presented a danger to the Police detainees by:

- failing to complete physical checks as outlined in Police policy; and

- submitting a false record of physical checks which were not completed.

Officer C displayed poor judgement when he left his duties during his shift.

Analysis of the Issues

POLICE DUTY OF CARE TO PEOPLE IN CUSTODY

7. For the duration of a person's time in Police custody, Police have a legal duty to take all reasonable steps to ensure their care, safety and wellbeing as codified in section 151 of the Crimes Act 1961.[1]

8. This duty of care is also recognised and given effect to in the Police Custody policy ('the policy') which states:

> *"Where a Police employee has care or charge of a person in detention... the Police employee is under a legal duty of care to provide that person with necessities and to take reasonable steps to protect that person from injury (including self-harm or harm from others)."*

9. Police responsibility for care, safety and security starts from the moment a person is detained and does not end until they are released or transferred into the care of another agency.

10. In this report we outline the evidence we gathered during our investigation and describe the events regarding the death of Ms Martin.

11. We consider if the staff responsible for Ms Martin's care and wellbeing while in custody adhered to their obligations at law and under Police policy. We also consider whether the safeguards themselves are fit for purpose.

12. In reporting the findings of our investigation, we have been careful to adhere to the rules on publicly reporting suspected suicides, specifically the prohibition on reporting the method of Ms Martin's suspected suicide.[2] This in turn limits some of the details about Police actions in our report.

ISSUE: DID POLICE BREACH THEIR DUTY OF CARE UNDER LAW AND POLICY TO MS MARTIN WHILE SHE WAS IN THEIR CUSTODY?

What were the circumstances leading up to Ms Martin's suspected suicide?

13. In November 2023, Lynne Martin was tried in the Gisborne High Court for the murder in 2013 of her 88-year-old father, Ronald 'Russell' Allison. During the trial, Ms Martin was not held in custody overnight. On Wednesday 22 November 2023, the jury returned a verdict of guilty, and the Judge remanded her into the custody of Corrections until sentencing. There is no Correctional facility in Gisborne, the options being Auckland or Wellington.

[1] This section is set out in the Appendix.
[2] https://coronialservices.justice.govt.nz/suicide/making-information-about-a-suicide-public/

14. At about 3.40pm, three Corrections officers took Ms Martin to the Gisborne Police Station where she was placed into the custody of Police, so that the next day she could be transported by Corrections to one of their facilities.

15. The handover from the Corrections officers to Police included custody documentation. No detail was provided to Police regarding any risks or concerns for Ms Martin's mental wellbeing.

Staff at the Gisborne Custody Suite

16. Officer A, a Police Authorised Officer, was working a late shift, 3.00 to 11.00pm. Ideally, two Authorised Officers work a shift in the Gisborne Custody Suite. However, due to staff shortages, Officer A was working alone.

17. The station sergeant, Officer B, who was working a day shift, tried to obtain a second officer to work the late shift. When unsuccessful, he followed the accepted practice and advised his supervisor and the late shift frontline supervisor of the staff shortfall in the custody suite, and that assistance may be required.

18. On this late shift, the usual uniform branch members were attending a training day, so the early, late and night shifts were being staffed by replacement staff from elsewhere in Police, such as Youth Services and the CIB. This meant that officers who were less familiar with frontline and custodial duties were working.

Police's evaluation of Ms Martin

19. Under the supervision of Officer B, Officer A received Ms Martin at the Gisborne Custody Suite and completed an assessment of her with the Electronic Custody Module (ECM).[3] This is a risk evaluation of a detainee's physical and mental health and helps to identify any immediate health or welfare needs and to determine how often the detainee will be monitored.

20. An ECM evaluation of a detainee is based around information gathered from questions, answers, and other sources regarding behavioural, mental and physical health indicators for the purpose of establishing the level of care and monitoring required while in Police custody.

21. Monitoring regimes that can be proposed from the ECM evaluation are:

    a) 'Not in need of specific care' - the detainee will have a recorded check every two hours.

    b) 'Care and frequent monitoring' - the detainee must have a recorded check at least five times per hour at irregular intervals.

    c) 'Care and constant monitoring' - the detainee must be directly observed without interruption.

22. The purpose of a check is to ensure the health, safety and wellbeing of people in Police care. Police policy, which is detailed in the Appendix at paragraphs 69-71, outlines that monitoring of

[3]The Electronic Custody Module (ECM) is a computer-based system where staff record risk information, any special care instructions, and everything that happens in relation to a detainee, from their processing to their release.

a detainee should include use of the CCTV displays, but recorded checks must be by one or more of three types, as follows:

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

23. Details can be individually entered in ECM for a detainee, or, when several detainees are checked at once, a group entry with the same text detail can be entered, for example: *"Check, all in bed with nil issues observed."*

24. Ms Martin's ECM evaluation revealed she had medical issues and was in pain, and she had a history of depression and a previous suicide attempt. When asked, Ms Martin did not reveal any thoughts of harming herself and said she was not depressed. Subsequently, the ECM evaluation algorithm determined that she was not in need of specific care; meaning she would have a recorded check every two hours.

25. When Officer A finished the ECM evaluation, he spoke with his supervisor, Officer B, who, satisfied the correct procedure had been undertaken, validated that no specific monitoring was required for Ms Martin.

26. Officers A and B did not consider Ms Martin's wider circumstances, such as her recent conviction for murder and her placement into custody.

27. Some property and medication were taken from Ms Martin and dealt with appropriately.

28. Ms Martin was searched using a standard pat-down technique with the assistance of the female Corrections Officer, and by Officer A using two metal detectors. Police told us they had no information that would have justified a more intrusive search.

29. Following that, Ms Martin was placed alone into one of the female cells, where she was provided with food and a drink. At around 5.00pm, she spoke to her husband, Mr Z, when he visited the Police Station. This took place in the non-contact visitor area through strengthened glass. After this visit, Ms Martin was returned to her cell at 5.17pm by Officer A.

The staffing of the custody suite across late and night shifts

30. Officer B finished work at about 6.00pm. This meant Officer A worked the rest of his shift (until 11pm) alone. Officer A did not request assistance from other late shift staff.

31. During the rest of his shift, Officer A completed checks of Ms Martin and eight other detainees who were in custody overnight. The last check he completed was at about 9.10pm.

32. When two Authorised Officers, Officers C and D, commenced night shift (10.00pm to 7.00am), arriving at about 10.00pm, they received a verbal handover from Officer A outlining who was in

custody and who may need specific attention. Ms Martin was mentioned but was not outlined to need any specific care or focus.

33. Officers C and D undertook a check of all detainees at about 10.00pm and this was entered into the ECM.

34. It transpires that Officer C was hoping to join Police as a constable, so had arranged to leave the custody suite to join up with a night shift uniform patrol so he could observe the duties of frontline officers. This is known within Police as a 'ride-along'.

35. Officer C advised the Authority that he believed the 'ride-along' was acceptable if his duties allowed it and the relevant shift supervisor provided approval. On this day, even though there were nine detainees in custody, including Ms Martin, Officer C believed there were no concerns in the custody suite, and he could be spared, and that the frontline supervisor had agreed. He said he raised this with Officer D, who told him that as it was quiet, he could go.

36. However, Officer D told us that Officer C did not raise this with him and while he heard Officer C discussing a 'ride-along' with a frontline officer, he only became aware he was working alone when he saw Officer C on a CCTV screen out on a Gisborne street.

The monitoring of Ms Martin (and other detainees)

37. After Ms Martin's death, Police reviewed the CCTV footage from inside the custody suite. They observed when officers physically visited the cell area to check the detainees.

38. A breakdown of ECM recorded entries and CCTV recorded cell visits regarding Ms Martin overnight on 6 and 7 November 2023 is set out below. Significant times and entries are shaded darker grey:

Time	ECM entry mode	CCTV detail
4.18pm	Officer A records *"Received"*	
4.20pm		Ms Martin taken to cell by Officer A
4.31pm	Officer A records "*In custody"*	
4.51pm		Officer A provides a meal and medication to Ms Martin
4.58pm		Ms Martin taken to visitor room by Officer A
5.17pm		Ms Martin returned to cell by Officer A
5.32pm	Officer B records summary for Ms Martin, and no concerns	
7.29pm	Officer A records *"check done all ok and asleep"*	
8.49pm		Officer A checks Ms Martin in cell
9.09pm		Officer A checks Ms Martin in cell

9.13pm	Officer A records *"check done all ok and asleep"*	
9.59pm		Officers C and D check Ms Martin in cell
10.13pm	Officer D records, *"Checked with* (Officer C) *all detainees are sleeping with breathing movements nil issues"*	
11.53pm	Officer C records, *"Checked all detainees"*	
1.33am	Officer D records *"Check, all in bed with nil issues observed…"*	
3.27am	Officer D records *"Check, all in bed with nil issues observed…"*	
4.29am		Officer D checks Ms Martin in cell
4.52am	Officer D records *"Check, all in bed asleep with breathing motions observed"*	
5.55am		Officer D checks Ms Martin in cell
6.12am	Officer D records *"Check, all in bed resting, nil issues observed"*	
6.24am		Officer D checks Ms Martin in cell
7.06am		Other officers go to speak to Ms Martin

39. CCTV footage indicates that Officers C and D did not always complete physical checks of the detainees despite recording they had done so in ECM:

    - Officer C did not physically check Ms Martin, or the other detainees, as he recorded in the 11.53pm ECM entry.
    - Officer D did not physically check Ms Martin, or the other detainees, as he recorded for the 1.33am and 3.27am ECM entries.

40. Officer C acknowledged this as an error on his part, saying his focus was on a pending 'ride-along' and this had distracted him from his key role.

41. Officer D acknowledged not doing the checks as per policy but claimed that, as he was alone in the custody suite without his agreement, he considered it better to observe the CCTV footage of the detainees instead for safety reasons.

42. Ms Martin was physically checked at 5.55am (with an ECM entry at 6.12am), and no issues were observed.

Locating Ms Martin deceased

43. At around 7.20am, a Gisborne Detective Sergeant and two early shift Authorised Officers went into Ms Martin's cell to speak to her. She was not breathing.

44. Officers summoned medical assistance, with an ambulance promptly arriving. Ambulance staff confirmed Ms Martin had died.

45. We consider it likely that Ms Martin died by suicide. However, the full circumstances of her death will no doubt be determined in the impending Coronial Inquiries.

What is our assessment of Police actions?

The staffing levels in the custody suite

46. Having only one Authorised Officer working a busy late shift responsible for nine detainees in custody, more especially alongside fill-in officers not used to frontline policing, was unsatisfactory.

47. We acknowledge staffing numbers can change at short notice, and that Officer B followed standard practice by highlighting the shortfall with his supervisor and the frontline supervisor, but this practice of merely highlighting a staff shortfall, rather than having recourse to a more proactive approach, appears inadequate for the circumstances of nine detainees in custody.

48. The Eastern District have a Command Centre based at Napier which was informed of the staff shortfall but was not able to provide personnel assistance. It was brought to our attention that low staff levels in the Gisborne Custody Suite is not unusual. We understand the District is endeavouring to address this.

The adequacy of the evaluation of Ms Martin

49. The ECM assessment of Ms Martin was followed in the usual way, and from that, Police had her on the monitoring regime prescribed for the provided information. However, we find that there were wider, highly relevant and concerning circumstances – a serious conviction that day, her poor health, plus her history of attempted suicide and depression – that the assessing staff should have considered when making their care decisions.

50. We note Officer A spoke to his supervisor, Officer B, regarding the ECM evaluation and we found no evidence that Officer B considered Ms Martin's risk of self-harm.

51. Both Officers A and B were experienced in their roles, and we found them to be competent and honest when speaking to us about what happened. We consider it likely that, on this shift, the workload, lack of staff and Ms Martin's calm presentation, and assertion she was not at risk, influenced their judgement and led to them making an inadequate care assessment.

52. We consider Ms Martin should have been on frequent monitoring, meaning she should have been checked at least five times an hour.[4]

[4] In Police's submissions on our draft report they accepted our finding, but noted that it was difficult to blame Officers A and B for their decision when they complied with the ECM's algorithmic recommendation. We remain of the view that the officers' experience and their knowledge of Ms Martin's circumstances should have led them to conclude that a more intensive monitoring regime was appropriate in the circumstances.

Officer C leaving the station for a 'ride-along'

53. We consider it was poor judgement by Officer C to partake in a 'ride-along' when there were nine detainees in the custody suite, and he would be leaving his colleague working alone.

54. Further, Officer C did not follow correct procedure as per the relevant policy, although this failure was compounded as the shift was being covered by relieving officers from other duties. It appears that the practice of 'ride-along' had fallen into a casual arrangement depending on who was working and supervising.

Officers C and D failing to complete physical checks as per policy

55. Both Officers C and D failed to undertake physical checks as required by Police policy, then falsely entered details into ECM indicating these had been completed correctly.

56. As we outlined in paragraph 39, Officer C did not check Ms Martin or the other detainees at 11.53pm. His ECM entry regarding this is a fabrication.

57. Given the medical evidence, it is unlikely Ms Martin was breathing when Officer D recorded at 4.52am: "*Check, all in bed asleep with breathing motions observed";* or when the same officer recorded at 6.12am: *"Check, all in bed resting, nil issues observed"*

58. We do not consider Officer D's explanation that he was alone is an acceptable reason for not doing checks in these circumstances. We accept this would be unwise if needing to open and enter a cell, although observation and verbal checks (as per paragraph 22) should still have been undertaken.

59. Officers C and D did not carry out their monitoring duties according to policy for Ms Martin or the eight other overnight detainees in the Gisborne Custody Suite.

FINDINGS

Initially, the care of Ms Martin while she was in Police custody was appropriate and in line with their obligations, considering the information available.

However, instead of applying a computer-based assessment and observation plan, Officers A and B should have applied a wider consideration of Ms Martin's circumstances (the fact she had just been convicted of murder and was in poor health) and the impact of this on her mental health and wellbeing.

We consider Officer C and D acted unprofessionally which presented a danger to the Police detainees by:

- failing to complete physical checks as outlined by their policy; and

- submitting a false record of physical checks which were not completed.

Officer C displayed poor judgement when he left his duties during his shift.

Subsequent Police Actions

60. Police undertook a critical incident investigation and reached a similar conclusion to our investigation. They also found:

- There were major departures from the standard of care required, although these did not reach the level required for a criminal charge.
- The failures and oversights identified would not have averted Ms Martin's intended actions, but they may have intervened, potentially saving her life.
- A District debrief should be undertaken with key Gisborne Police staff to ensure that all lessons learnt were understood and implemented.

61. Police also completed employment processes for Officers A, C and D based on their actions of not physically checking prisoners as required by policy, and for Officer C regarding leaving the custody suite.

62. A lesson-learnt conversation was undertaken with Officer B regarding the assessment of Ms Martin and her subsequent monitoring regime.

63. Police advise they are addressing the staff shortages within the Gisborne Custody Suite so that minimum strength is two officers per shift. They are considering bringing a supervisor onto shifts as required.

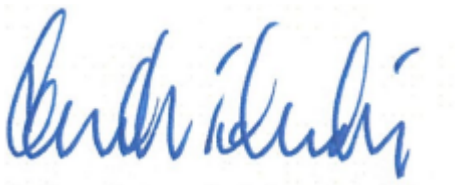
64. Gisborne Police have reassessed their 'Observer Management Policy' (for 'ride-alongs') and outlined the requirements of this to all staff.

65. Police are reinforcing across New Zealand that detainees are to be correctly checked, and not just by CCTV.

Recommendations

66. We recommended Police liaise with Corrections, and if necessary, the Ministry of Justice, pertaining to court cells, to define prisoner care and responsibility in situations where a person is remanded into Corrections care but is required to spend time detained in a Police Custody Suite (as per the Gisborne scenario). Police advise they are proposing a review of the MOU between them, Corrections and Justice.

67. We also recommended that Police re-evaluate the ECM evaluation process when considering this event and how a recent conviction for a serious offence should influence the subsequent monitoring schedule. Police advise they are assessing the ECM evaluation process and will ensure it captures this type of scenario.



Judge Kenneth Johnston KC

Chair
Independent Police Conduct Authority

25 March 2025

IPCA: 23-20479

Appendix – Laws and Policies

LAW

Crimes Act 1961

68. *Section 151 Duty to provide necessaries and protect from injury*

Everyone who has actual care or charge of a person who is a vulnerable adult and who is unable to provide himself or herself with necessaries is under a legal duty—
(a) to provide that person with necessaries; and
(b) to take reasonable steps to protect that person from injury.

POLICY

People in Police Custody Policy

Monitoring and recorded checks of a detainees

69. Checks of a detainee must be undertaken by one or more of the following and then entered into the ECM:

- Observation check - observe through a cell view port to check the detainee's wellbeing. If unable to confirm this, complete a verbal check.
- Verbal check - verbally rouse the detainee to establish wellbeing and if there is no response complete a physical check.
- Physical check - enter the cell and establish wellbeing.

70. CCTV is not an authorised means of carrying out a recorded check of a detainee. Where good quality CCTV systems are fitted, monitoring should include viewing the displays, but recorded checks, as prescribed, must be undertaken as per the monitoring requirement.

71. The purpose of a check is to ensure the health, safety and wellbeing of people in Police care. Police must carry out a check of a prisoner that is commensurate with the health and safety risk they are deemed to pose at the time. The frequency and type of check must balance any risks that are identified.

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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