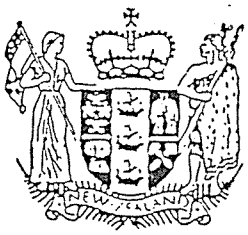

POLICE COMPLAINTS AUTHORITY

REPORT OF THE POLICE COMPLAINTS AUTHORITY
FOLLOWING NOTIFICATION OF THE DEATH OF
MATTHEW FRANCIS INNES AND THE
COMPLAINTS LODGED BY THE INNES FAMILY

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Police Complaints Authority

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REPORT OF THE POLICE COMPLAINTS AUTHORITY FOLLOWING NOTIFICATION OF THE DEATH OF MATTHEW FRANCIS INNES AND THE COMPLAINTS LODGED BY THE INNES FAMILY

Introduction

On 10 January 1994 at Middlemore Hospital in Auckland Matthew Francis Innes died aged 22 years, and the post mortem examination ascribed the cause of death to positional asphyxiation resulting from transportation to the Kingseat Mental Hospital in Auckland in the rear of a Police Falcon saloon motor vehicle on the evening of 3 January 1994 from the home of his brother, Craig Innes, with whom he had been staying on holiday from Australia. The Police had been summoned to Craig's residence at 1/8 Northpark Avenue, Howick, Auckland, to assist in the transportation of Matthew for a medical assessment at Kingseat. After a violent struggle he was placed in the rear of the vehicle by Police officers and others. He continued to struggle in the vehicle almost throughout the 35km journey but very close to the Hospital grounds he became quiescent and the Hospital staff on his arrival immediately recognised his physically parlous state and instituted emergency procedures which were unavailing. He was cyanosed, had lapsed into unconsciousness from which he never recovered and died a week later on 10 January 1994.

A death in circumstances described above required a full investigation in terms of statutory provisions set out hereafter, and because Matthew's father, on behalf of the family, laid a complaint to the Police Complaints Authority making allegations of misconduct and neglect of duty against Police officers and the Commissioner of Police.

Involvement of Police Complaints Authority

Where a member of the Police acting in the execution of a member's duty causes or appears to have caused, death or serious bodily harm to any person the Commissioner of Police shall as soon as practicable give to the Authority notice of the incident in which the death or serious harm was caused. On 4 January 1994 I received such advice on behalf of the Commissioner. On 6 January 1994 I travelled to Auckland to commence the overseeing of an enquiry by the Police and to brief myself as fully as possible at the earliest occasion of the circumstances surrounding the then grave medical condition of Matthew. My first receipt of notice indicated the possibility he would not recover, and this proved tragically correct.

On 14 January 1994 I received from the Innes family's solicitors a formal complaint in the following terms:

POLICE COMPLAINTS AUTHORITY - COMPLAINT

A. NAME OF COMPLAINANT:

Paul Reginald Innes on behalf of the family of the late Matthew Francis Innes.

B. CONTACT ADDRESS:

c/o Mr M P Tetley-Jones
Tetley-Jones Thom Sexton
Solicitors
PO Box 111
CPO Auckland 1
Telephone: (09)3797-840

C. POLICE OFFICERS AGAINST WHOM COMPLAINT IS MADE:

1. Sergeant A
   Constable B (the Police escort seated in the rear of the Police vehicle)
   Constable C (the Police vehicle driver)

2. The Commissioner of Police.

D. BASIS OF COMPLAINT:

Against the three Police officers specified in Paragraph C(1) above arising from:-

1. The unlawful arrest, detention and restraint of Matthew on the evening of Monday, 3 January 1994;

2. The unlawful and excessive use of force in restraining Matthew prior to and during Matthew's transportation in Police custody from 1/8 Northpark Avenue, Howick, Auckland to Kingseat Hospital during the evening of Monday, 3 January 1994;

3. Unlawfully causing the death from asphyxiation of Matthew during transportation in Police custody from 1/8 Northpark Avenue, Howick, Auckland to Kingseat Hospital during the evening of Monday, 3 January 1994 by;

   (a) The unlawful and/or excessive use of force to restrain Matthew and/or;

   (b) Neglect of duty to Matthew by failing to ensure that death from asphyxiation did not arise during the said transportation to Kingseat Hospital in Police custody.

And against the Commissioner of Police arising from:-

1. Neglect of duty in failing to ensure that adequate routine procedures were introduced to be adopted by Police officers during transportation of persons subject to the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992 such as would have prevented the death of Matthew from asphyxiation.

Note: Because of the decisions I make I have not named the officers involved, nor the Duly Authorised Officer.

My office therefore became involved in two ways: first as an incident as described above and, secondly, as a complaint about misconduct. I elected to oversee a Police investigation pursuant to s.17(1)(c) of the Police Complaints Authority Act 1988, which is a course open to me. When a complaint is received in my office I may investigate the complaint using my own staff; ask the Police to carry out an investigation and review the results, or oversee a Police investigation and then review the final decision. I elected the latter course because it seemed most appropriate in the circumstances. I regarded it as essential to achieve as speedy a result as possible and this investigation I recognised from the beginning would be far reaching and required, among other matters, the resources available from the Police. By overseeing the investigation personally I was able to keep close supervision of the investigation and direct avenues of enquiry, and, most importantly, concerning those allegations of unlawful and excessive use of force (D2) and unlawfully causing the death from asphyxiation during transportation in Police custody (D3). From the beginning a senior Police officer had acknowledged the incident as a "possible homicide" and therefore the conduct of the officers required scrutiny bearing in mind the possibility of criminal charges. As will be seen later in this report, this aspect of the enquiry was referred to Mr D S Morris, the Auckland Crown Solicitor, who is entirely independent of the Police service and widely experienced in criminal law and practice. The reference by the Police officer in charge of the investigation to Mr Morris was done with my approval as I required an impartial appraisal of the evidence on this vital aspect. His opinion is referred to hereafter.

Scope of the Investigation

Detective Inspector Kelvin McMinn of the Manukau Police District was placed in charge of the enquiry as it related to the incident (which first brought the PCA involvement) and the part of the complaint which was C1 and named three Police officers. This may conveniently be described as the Auckland segment. The complaint against the Commissioner (C2) was handled from the beginning by Deputy Commissioner Ian Bird after consultation

with me. This latter complaint was related to the Auckland segment but had a separate identity of its own. I will return to this issue later in this report but until then will concentrate on the Auckland segment which was the substance of the complaint, and main focus of the investigation.

On reviewing the results of the investigation I am satisfied all avenues were thoroughly investigated and most importantly all witnesses who could provide information or throw some light on the events, mainly of the afternoon and evening of 3 January 1994, were interviewed and written statements taken from them. Several important witnesses were re-interviewed and provided additional written statements. Needless to say the three subject Police officers made statements and were interviewed. The Innes family engaged their own lawyers, an Auckland firm. I travelled to Auckland on 20 January in the course of my supervision of the enquiry and met Mr and Mrs Paul Innes and their three sons and daughter-in-law (wife of Craig) for some two hours at their solicitors' office on 21 January. I was able to obtain much valuable information about Matthew's background and first-hand knowledge from Craig and his wife Natalie, with whom he had been staying since arriving in Auckland from New South Wales for a holiday on 23 December 1993.

Middlemore and Kingseat Hospitals both engaged their own lawyers. Middlemore Hospital became a separate complainant to me by way of a letter from the South Auckland CHE's Chairman dated 28 January 1994 but it was basically about Police conduct in the enquiry, and after the event. That is a separate complaint and will be dealt with accordingly.

Kingseat Hospital conducted its own internal enquiry into the incident as it was to that Hospital Matthew was first taken and found on arrival to be in a critical condition. That report was published through the Hospital's solicitors on 26 January and a copy forwarded to me. The report found no deficiencies in Kingseat's procedures or staff handling of Matthew's admission and transfer on to Middlemore Hospital for treatment.

I have been advised by the Innes family solicitors, after a request from me for information, that a separate complaint has been lodged with the District Mental Health Inspector, who is an Auckland barrister, concerning the Duly Authorised Officer. I further understand there may be a formal hearing of that complaint.

Narrative of Events

Before turning to a more detailed narrative of the events that led to Matthew's transportation in the Police vehicle on 3 January, I make some statements about the guidelines I have used in preparation of this report. My main aim is to cover all relevant issues but not in laborious detail which adds nothing significant to the result, and would possibly reduce its effectiveness. The central events as they unfolded were subject to broad agreement among witnesses. Many witnesses gave, as might be expected, differing versions, on substantially the same events, when they recorded their individual views of what had happened. As will become clear, many of the important events to this enquiry took place in exigent, tense and at times chaotic circumstances. Unquestionably considerable physical force was exerted to take and restrain Matthew and calm, collected appraisal is not helped by such situations. There, again not unexpectedly, were encountered material differences as to what was said and what witnesses observed, and where I have judged this relevant I have set out those differences. In the narrative to follow I have not identified by name many of the witnesses, and have only done so where it seemed called for.

The known antecedent medical history of Matthew from the Gosford District Hospital (Mandalla Clinic), New South Wales, will be referred to later as it is of significance. The account I now give is largely focussed on the relevant events as they unfolded from the time Matthew arrived in Auckland from Sydney on 23 December to spend the Christmas holidays with his brother and wife until his transportation to Kingseat Hospital on 3 January.

Matthew was living with his parents at 5 Banks Close, Kariong, Sydney, and operating successfully on his own account a

bricklaying business which he had done for some months in 1993 prior to leaving for the holiday. He had had two episodes of mental instability in 1991 and 1992, respectively, but at the point of departure in 1993 he had had a stable period and his parents had no concern for his proposed trip to New Zealand. The Innes's are a New Zealand family but Mr & Mrs Innes Snr had emigrated permanently to live in Australia some years earlier and Matthew had gone with them.

Matthew duly arrived on 23 December and was met by his brother Craig and his wife Natalie. On arrival he was described by Craig as cheerful, physically fit and pleased to see his brother. Christmas was spent at home and then a tour north followed with a male friend joining the Innes group. There was little that was remarkable for the few days they were away and they returned to Auckland on 1 January 1994 about 4.00pm. Craig did observe during the trip at times Matthew's speech and reactions had slowed down and holding conversations seemed difficult for him. In the early evening of 1 January Matthew began to exhibit early signs of disturbance in that he showed inappropriate indecision, agitation and the need to go outside for air. He did not retire at all that night. During the next day he was unable to relax, appeared restless and wandered around. Again he remained awake all night, eating very little. On the morning of 3 January he went to visit his grandfather and as it was Matthew's last day with Craig (he was to return next day to Australia) a barbecue was arranged for early evening, and a number of friends invited.

In the late afternoon (exact time difficult to establish but guests were arriving or had arrived) Matthew began to exhibit manifest mental disorder. It started with him climbing on the roof of a neighbour's property and raving, accompanied by throwing hands to the sky. At this point Craig, who was on the roof, thought he would be attacked if he went too close to Matthew and Craig thought his behaviour threatening. Craig's view of his behaviour on the roof was that he was not outwardly aggressive unless approached.

This and the following two paragraphs are taken largely from the narrative supplied by the family solicitors with the complaint. Initial attempts to persuade Matthew to come down were not successful but after about 30 minutes Natalie persuaded him to come down and it appeared the psychotic episode had passed. Matthew voluntarily came back into the home and appeared somewhat dazed and disorientated but was lucid and embarrassed at his behaviour. While Matthew was on the roof at approximately 6.30pm Craig had telephoned Kingseat Hospital for assistance and at approximately 7pm the psychiatric nurse (Duly Authorised Officer under 1992 Act) arrived at the residence. The DAO said the time of arrival was 8pm. The DAO spoke to Matthew for approximately 30 minutes to assess Matthew's mental condition. The DAO asked Matthew if he was prepared to leave the house to see a doctor but he refused and requested that the doctor be brought to the house. At approximately 7.30pm the DAO went to his car where he apparently made a telephone call and returned with the necessary papers for an application for assessment under s.8 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, (hereafter referred to as the 1992 Act) which was filled out by Craig without Matthew's knowledge at approximately 8.30pm. Craig said the DAO advised him that Matthew appeared to be a borderline case (presumably for s.8 proceedings) and that there was no cause to commit him.

Craig said the DAO further stated he could arrange to have Matthew taken away for assessment and that was what the form was for. Craig said he explained to Matthew that he would be taken away for assessment and Matthew replied "no way, bring the doctor here."

Since coming down from the roof and throughout these discussions, Matthew was calm and lucid. He appeared to be tired and under some strain and would undertake muscle stretching exercises on occasion which appeared to be intended to relieve tension. In all respects, Matthew appeared to be in control and did not exhibit any threatening behaviour, notwithstanding the repeated requests to go to the hospital which he consistently rejected. The DAO remained in contact

with Kingseat Hospital by telephone and from Craig's account, appeared to be unsure of what to do. The DAO claimed he was not unsure of what to do.

The decision to take Matthew to Kingseat for medical assessment was made after discussion betwen Craig and his father, Mr Paul Innes, in Australia. Also the DAO, had been in communication with Dr Marie Israel, a psychiatrist at Kingseat Hospital, who had herself been in telephone communication with Mandalla Clinic, Gosford, and had had faxed to her some records of the Hospital concerned with Matthew's two month period of treatment there beginning February 1992.

I pause here to record these facts. It appears the number at Craig's house in the early evening of 3 January including the guests was 11. Each of the guests and Craig and Natalie have been interviewed at least once. Two sisters who were guests had had experience with a brother similarly afflicted to Matthew. They spoke with Craig to assist him with advice. In addition to that group there were the DAO and ultimately at about 11pm the three Police officers, Sergeant A and Constables B and C arrived, whose assistance had been sought earlier by the DAO. Again statements have been taken from those four officials. I can say that overall there is a fair constancy of account as to what happened at Craig's house up until Matthew's quite violent apprehension yet to be described. I try to concentrate on the actions of the principal actors who I nominate as Matthew, Craig, the DAO, and the three Police officers.

The central features of the activities after the DAO's arrival have already been detailed. A further point the family stressed was that throughout Matthew had not directly threatened any person with violence and committed no violent act prior to his physical apprehension. I accept that as factual. From my reading of the statements and discussions with Craig and Natalie I think Matthew, as time passed in this highly charged atmosphere, was undergoing tension, agitation and awareness that he was going to be required to go where he did not wish.

By some time after 11pm it had become reasonably clear Matthew was obdurate and would not move voluntarily. In my view a halt should have been called at this stage and a complete reassessment made with a decision to follow another course; even to the extent of abandoning altogether a medical assessment that night. I return to this in more detail hereafter. After all, as Mr P. Innes has pointed out, at this point Matthew had displayed no violence or threat to another and was asking for a doctor to come to him. These observations are made in the hope that those in future who might face a similar situation will consciously remain flexible as to alternative courses.

It seems the point that triggered Matthew's violent outburst occurred outside the house when he was touched by one or more persons attempting gently to guide him to the Police vehicle. No useful purpose is served by dwelling upon the details of the physical confrontation whereby the three Police officers, the DAO, Craig and another male used very considerable force to subdue Matthew to the extent that he was handcuffed hands and feet before being placed in the rear of the Police Falcon motor vehicle with his head behind the passenger's seat and his legs behind the driver's seat. He was thrashing around and yelling and spitting as well. He was also attempting to bite people when the physical confrontation first began. This was commented on by an independent visitor to the house and by Sergeant A.

I pause here to mention two matters. First, as to the handcuffing of the hands. It was at first thought in the course of the investigation his hands were cuffed together behind at about the position of the small of the back. That is the firm view of Craig. A full assessment of all evidence, including medical witnesses on his arrival at Kingseat, has led Det. Inspector McMinn, who was the Police officer in charge of the investigation, to conclude that Matthew's right arm was bent above and over his right shoulder and met his left arm which was behind his lower back and raised upwards to the cuffing position. There was a strenuous and violent struggle to achieve this as Matthew was a lean and apparently very fit

young man. I believe this very awkward handcuffing position would have adversely affected Matthew's bodily position in the vehicle. I return to this shortly.

The second matter is the jacket Matthew was wearing when the physical confrontation occurred. It was a green and black jacket zipped in the front with an emblem on the left chest. That jacket as a result of repeated struggling and writhing in the confined space of the rear of the vehicle had ridden upwards and was at times partly covering his face. Again this would have adversely affected Matthew during the journey but on the evidence one could not say more.

Once Matthew was inside the vehicle Sergeant A gave instructions to have the two rear windows lowered because he feared Matthew might break them. This was done. Constable B took up a position in the rear entering first by the rear door behind the driver, and Constable C drove the vehicle. I have no doubt that to have a violent, and by this stage a severely mentally disturbed, strong young man in the rear of a relatively small vehicle with one man to restrain him to be transported a material distance of 35km to hospital was an error of judgment. Constable C had his attention fully occupied in driving the vehicle safely with a highly volatile environment within the vehicle and at night. The DAO followed in a separate vehicle, intending to be at Kingseat with the Police vehicle. I will need to return to this issue of the vehicle for transportation used. Sergeant A was later summoned to the Hospital when the physical condition of Matthew on arrival was held to be serious.

The vehicle in its journey to Kingseat took about 30 minutes. Matthew by this stage seems to have been in a near if not fully demented state. He was using obscenely abusive language and repeating phrases. He was spitting at Constable B, attempted to bite him and blood was present. Constable B conceded he had punched him to stop him biting. Constable C had little to do with controlling Matthew in the car but admitted he had struck his left knee with a baton to stop him kicking out. At one stage Matthew said "I'm going to die on you". This comment was

made at about three-quarters of the way through or nearer the end of the journey. It was heard by both Constables and apparently said in a quieter tone of voice which was contrasted with the repetitive and chanting voice for the obscenity phrases.

At the start of the journey Constable B was sitting on top of Matthew as a strategem to subdue him. Very close to the part of hospital where they were to be met (possibly as close as 100 metres) Matthew became quiescent. Constable B thought he may be "foxing" and would start up his yelling and struggling, and therefore did not relax his restraint. From that moment of quiescence Matthew never recovered consciousness he was observed to have lost when he was passed into the hands of Kingseat Hospital staff within a very short period of time.

Again it is appropriate here to address a point made with emphasis to me when I met the Innes family and later in correspondence. They requested I investigate their conclusion that the Police vehicle had stopped at a point on the journey to Kingseat Hospital and that the officers had made rearrangements possibly of Matthew's clothing and handcuffing. They had no direct evidence this had occurred but deduced its possibility by comparisons of timing with the vehicle driven by the DAO and perhaps by statements made to them by Kingseat staff who greeted the vehicle on arrival. Also it was Craig's view that Matthew had had his hands cuffed behind the small of the back when the vehicle left his home. I instructed Detective Inspector McMinn to examine carefully the possibility of a stoppage. He did so and has concluded the Police vehicle had not stopped and that the journey was continuous. Both Constables state firmly they never stopped and there is no other evidence circumstantial, or otherwise, that they had stopped the vehicle. Furthermore it seems most unlikely that two officers alone would have stopped along a roadway to rearrange handcuffing of a violent person when it had so recently taken six males to restrain him to the cuffing position. The DAO's statement was that Matthew was handcuffed in the manner described earlier when he left for the journey and he had assisted in that handcuffing position. I must agree

with the finding the vehicle had not stopped for rearrangement of handcuffing. I return later to the handcuffing as a separate issue.

When Matthew was first examined by hospital and medical staff on arrival he was immediately observed to be in a physically critical condition and unconscious. All staff members, including the medical staff, have been interviewed at least once and some more than once. I have read all those statements. It is not strictly part of my report to comment on the handling of Matthew by the Hospital staff but nothing I have read or had brought to my notice requires any critical comment by me. I am satisfied the Hospital staff there and at Middlemore, where he was taken, did everything in their power to save Matthew, but to no avail. I have read the report made on behalf of Kingseat Hospital and I have no dispute with its findings.

Post Mortem Examination Results

A post mortem examination was carried out on the body of the deceased Matthew Innes by Dr Jane C Vuletic on 11 January 1994 at the Auckland City Mortuary in the presence of Detective Inspector McMinn and a Police photographer. This is standard procedure for a post mortem in circumstances revealed by this case. Dr Vuletic is a duly qualified and registered medical practitioner practising as a pathologist at Auckland. I have examined the pathologist's report and all photographs taken of the body.

Of importance in this case is evidence on the body of recent injury. Full attention was paid to this in the report. The pathologist identified on the body several areas described as abrasions and green/yellow bruises of varying degrees of colour and healing. Green/yellow bruising was present circumferentially around the right and left ankles, which was consistent with the cuffing of the ankles. Somewhat similar abrasive patterns were found on the wrists, again consistent with handcuffing. Some of the abrasive injuries no doubt were attributable to the violent struggles that had taken place

eight days earlier but no other injuries were identified, absenting the condition of the brain. All body systems were found to be in the normal range excepting the central nervous system. Again excepting the brain, the body organs were normal. There were no injuries to the throat area.

The finding as to cause of death by the pathologist was as follows:

> *"COMMENT: The immediate cause of death is HYPOXIC ENCEPHALOPATHY (brain damage due to lack of oxygen to the brain). I have been made aware of the circumstances surrounding the transportation of the deceased to a psychiatric hospital for treatment and in my opinion the circumstances and the post mortem findings support a finding of POSITIONAL ASPHYXIA occurring during transportation as the event which lead to the development of HYPOXIC ENCEPHALOPATHY.*
>
> *POSITIONAL ASPHYXIA occurs when the position of the body interferes with respiration, resulting in asphyxia. Although this may involve a restricting or confining position, it may also involve simple flexion of the head onto the chest, a partial or complete external airway compression, or neck compression. When the deceased arrived at hospital he was noted by a number of witnesses to be in a prone position (face down) and his jacket was noted to have ridden up around his face to the extent that it had to be cut away before medical personnel could attend to his airway. It was also stated by the police officer travelling with the deceased in the back of the police car that it was necessary to sit on the stomach of the deceased in order to immobilise him. In my opinion these are all mechanisms by which POSITIONAL ASPHYXIA could have occurred.*
>
> *IN MY OPINION DEATH RESULTED FROM HYPOXIC ENCEPHALOPATHY DUE TO POSITIONAL ASPHYXIA."*

Positional Asphyxiation

Simply to remove any doubt, I should say that I accept without qualification the finding of Dr Vuletic that the operative cause of Matthew's death was positional asphyxia occurring during transportation as the event which led to the development of hypoxic encephalopathy. The evidence uncovered by the investigation reveals no reason to dispute that finding. Because of its relevance to the overall culpability of the officers at the scene, and the validity of the complaint against the Commissioner, I think I should say something of the emergent identification of this phenomenon.

Early in the investigation I had drawn to my attention the first article mentioned below and the others followed. The literature I have read on the subject is:

1. Positional Asphyxia During Law Enforcement Transport - Reay, Fligner et al.

2. The Perils of Investigating and Certifying Deaths in Police Custody - Luke and Reay

3. Positional Asphyxiation in Adults - Bell, Rao et al

4. Restraint Asphyxiation in Excited Delirium - O'Halloran and Lowman.

All authors are apparently practising pathologists in the United States and the case studies relate exclusively to United States' experience. The first three articles were published in The American Journal of Forensic Medicine and Pathology Vol.13 No.2 1992.

The fourth article was published in the same Journal in Vol.14 No.2 1993. All four articles were later supplied by Dr Vuletic to Det. Inspector McMinn with further published letters and literature review on the subject. I have read all the literature but eschew all comment except a general one, because I am not qualified. However one could not but be struck by the similarity with this case of Matthew Innes and the very many cases reported in the literature of positional asphyxiation whilst under Police transportation. I confine myself to quotation of one sentence in the 4th article referred to above under the heading Conclusions:

> *"Sudden death of people who are in a state of agitated delirium during prone restraint appears to be a not uncommon phenomenon that has been recognised for years but infrequently reported in the medical literature."*

I think that sentence from the 1993 article is of relevance to us in New Zealand. From the use of the double negative

construction it could be inferred even in the United States this phenomenon was not widely appreciated and this is reinforced by the final words that it has been infrequently reported in the literature. The articles referred to above directly on the subject were published first as recently as 1992 although there were references to earlier mention of the phenomenon mostly in the late 1980s. The problem, I understand, was generally unknown in Police circles in New Zealand until this tragic case.

Complaint by Innes Family

The complaint is drafted, particularly as far as C1 against the three attending Police officers in legal terms alleging in essence unlawful arrest, unlawful and excessive use of force and unlawfully causing the death from asphyxiation of Matthew during transportation in Police custody.

With the complaint which has been reproduced the solicitors acting for the Innes family made what they term General Submissions in support of the allegations contained in the Complaint. In those submissions it was argued that there were breaches of, or the actions were not authorised, under the Crimes Act 1961, the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Bill of Rights Act 1990. All those submissions were placed before the Crown Solicitor whose opinion is set out hereafter. On the General Submissions I make a further comment hereafter.

For reasons referred to in greater detail under 'Possible Criminal Prosecution' and elsewhere I do not regard it as my function to take a strict legal approach, which for possible criminal charges is fulfilled by the independent opinion obtained from the Auckland Crown Solicitor.

Having stated the foregoing, and notwithstanding the legal opinion about criminal charges set out hereafter, I do make several critical comments on procedure adopted by the Police and in particular the interaction between the functions of the DAO and the Police officers whom he called in to assist him.

The complaint against the Commissioner is dealt with under a separate heading.

I return to the General Submissions made by the Innes family lawyers that accompanied the formal complaint. Those Submissions are couched in the strict legal language of arguments presented to a Court. I do not make the final decision as to whether criminal charges in serious incidents (of which this is one) should be laid. Acting on behalf of the public I consider it my duty to ensure, in the New Zealand context, that decision is made independently of the Police as I state in greater detail hereafter. Likewise I do not make decisions on legal submissions of alleged illegality of Police actions such as are made by the family lawyers. That would be inappropriate as I do not, and should not, act as a court of law and give judgment. If the family wish for any reason to pursue those submissions there are other avenues open to them.

Possible Criminal Prosecution

Following the post mortem examination result Det. Inspector McMinn briefed the Auckland Coroner on the general circumstances surrounding the death and his enquiry in the first instance was of a "possible homicide" being the words used by a senior Police officer. It may help to mention that homicide is defined in section 158 of the Crimes Act 1961 as ".. the killing of a human being by another, directly or indirectly, by any means whatsoever." Homicide is not of itself an offence and only becomes so if it is "culpable" under section 160 of the Act. Under s.160(4) homicide that is not culpable is not an offence. The culpability issue was to the forefront of the Police investigation, and my oversight.

I pause here to clarify the position of the Police Complaints Authority. My function under my enabling Act is to investigate an incident and act on a complaint of misconduct or neglect of duty. As stated earlier, in this instance I had both an incident and a complaint. I elected to oversee a Police investigation. Overall I exercise an independent civilian oversight of Police conduct that comes into question. I act in

the public interest with emphasis on independence and for those investigations of high public interest I publish my findings so the public can judge for themselves the results and findings I make.

Generally speaking in New Zealand the Police service investigates suspected crime and itself decides whether to lay charges. This is to be contrasted with England and Wales which have the decision on the laying of charges in major crimes resting with the Crown Prosecution Services (formerly Director of Public Prosecutions) which is a body independent of the Police.

The Police Complaints Authority is in no way analogous to a Crown Prosecution Service and should not encroach into that arena. My function is, on this important aspect, to ensure that in the public interest an independent, disinterested scrutiny of relevant evidence is conducted and an opinion given whether prosecutions should take place. Because Police officers in the course of their duty caused, or may have caused, the death of a person then a final decision had to be made entirely outside of the Police service, even though that is in normal circumstances their function. Nothing less would be seen by the public as a proper course. For that reason Mr D S Morris, Crown Solicitor in private practice in the law, and widely experienced on these matters was consulted. I concurred in the proposal to seek his opinion.

I have examined the written material which was placed before Mr Morris and he was also fully briefed by Det. Inspector McMinn who had charge of the investigation. Mr Morris also had placed before him the full complaint of the Innes family which had been prepared by their lawyers. It has been reproduced earlier in this report and as can be observed, it is worded in a professional manner obviously prepared by a member of the legal profession.

Mr Morris' opinion was given in writing on 14 February 1994. He said the question to be determined was whether the death of Mr Innes was brought about by the unlawful act of any person,

or by the failure of some person to perform a duty which was imposed upon him by law and which he owed to Mr Innes. Mr Morris concluded his report in which he canvassed factual and legal issues as follows:

> *"In these circumstances and for the reasons that I have expressed in the foregoing paragraphs hereof, I am of the opinion that there is no evidence to justify a finding that any unlawful act by any person or any failure to perform any legal duty has resulted in the death of Mr Innes, and there is no basis for the laying of any criminal charges against any person."* (underlining in the original)

On the issue of criminal charges I accept the opinion of Mr Morris in respect of possible criminal charges and do not recommend that any further action in that regard be taken. That finding does not preclude me passing critical comments on some aspects of Police conduct which I do hereafter.

Police Investigation and Findings

As stated earlier in this report, the Police carried out an investigation into the death of Matthew Innes on behalf of the PCA. That investigation requires the Commissioner to report the results of the investigation to the Authority pursuant to s.20 of my enabling Act. The Commissioner after completion of the investigation of a complaint reports to the Authority whether the complaint has been upheld and, if so, what action has been taken or is proposed to be taken to rectify the matter. When reporting all relevant material must be supplied to the Authority to enable it to assess the adequacy of the Police investigation. The Authority shall, pursuant to s.28, form an opinion on the investigation by making an independent review. The Authority may disagree with the Commissioner's decision and make recommendations supported by reasons.

A very thorough investigation was done by the officers involved in the complaint which has been described as the Auckland segment. The complaint against the Commissioner is dealt with separately.

The Police investigation of the Auckland segment concluded with these central recommendations which the Commissioner advised me were adopted by him.

1. That no criminal proceedings be commenced against any Police officers/or other persons involved in the restraint of Matthew Innes.

2. That the complaints levelled against the three Police officers as detailed in para. 2.3 (the official complaint of the Innes family) be cleared 'Exonerated'.

As to Recommendation 1

For reasons set out under the heading "Possible Criminal Prosecution", and more particularly because of the opinion of Mr D S Morris, I accept that recommendation.

As to Recommendation 2

I disagree with this Recommendation. I propose to set out now in some detail, and in doing so attempt to draw together the main strands in the investigation, why I do not agree that the Police officers conduct should be cleared as 'Exonerated'. In this context exonerated is to declare free from blame, and in my view the facts do not allow that clearance. I make a recommendation and I am obliged under the Act to support it by reasons.

The tragic death of one young man in circumstances described in this report has opened huge potential areas for examination. I mention a few: the adequacy of Police procedures in dealing with mentally disturbed persons; the interaction of Police personnel with officials designated under the new 1992 Act; the general handling of persons with the combined problems of violence and mental disturbance; the need to act resolutely for the protection of such persons, and other members of the community from their acts; the balancing of the rights of disturbed and violent persons against the protection of others: judging in overwrought situations when force and restraint must be used; transportation of disturbed persons which is often

essential; and very many others.

I have set out a few of the foregoing issues but say immediately it is beyond the scope of the PCA to address all of them. The PCA is concerned with alleged Police misconduct within the boundaries of a particular fact situation, and it is on that which I must concentrate.

I will start by looking broadly at the few hours that commenced around 5-6pm on 3 January and ended around midnight with Matthew in a critical physical condition and deeply unconscious. I repeat here my function is to assess conduct of Police officers but because of the inseparable interaction between the officers and the DAO I cannot fail to pass critical comment on his part in the events because if I avoided doing so I would not be able to fulfil my function in assessing the Police officers.

Never again should a person in the mentally unbalanced state Matthew was in in the early evening of that day be dealt with as he was. Care must be taken not to overuse hindsight but on an objective appraisal of the facts, Matthew should not have been treated as he was. On the roof he might then have had the potential for violence to others (Craig had some apprehension on this point) but that is the highest it could be put. The severe symptoms of psychotic behaviour seemed to have subsided after he left the roof. He was not violent then and made no threats of violence. He was still very disturbed. I think several different persons, starting with Craig calling in the DAO for assistance, set in motion a series of events that seemed unable to be stopped. I think Craig's action in calling on the DAO was entirely understandable and done for Matthew's own sake. Craig knew of Matthew's history of mental disturbance and no doubt was anxious to get him medically treated.

However, the professional in this situation was the DAO and in my view he was the central person in the events that followed.

The Police were called because it seemed clear to the DAO that physical restraint was going to be required. Several sources

of information caused him to reach this conclusion. In a professional sense Matthew was of no "interest" at all to the Police. They were called there to assist because apparently the decision had been made to take him forcefully to the hospital.

I cannot avoid the finding that a collective mistake was made in the final decision to take Matthew by force. I do not think that was the correct procedure, and up to the point of eruption in violence once he was physically touched, there was nothing in his behaviour that called for his forceful apprehension against his will. He had on many occasions throughout the evening indicated he would not go voluntarily. The DAO had apparently told Craig Matthew was only a borderline case, one assumes for the strategy of a Section 8 assessment. I think the DAO had got Craig's signature on the papers and seemed from there on to act as if the proceedings could not be stopped or reassessed. In this pre-taking phase I think the main responsibility rested on the only professional present in the field of mental health and that was the DAO. At this point the technique of "talk down" could have been usefully employed and it is one with which the Police are not unfamiliar. I do not believe it is a harsh judgment to say that between the DAO and the Police, alternative strategies should have been considered once Matthew had made such an unequivocal statement regarding his position. I see it as part of the assessment on the ground, so to speak, that the stated wishes of the patient, and by this stage Matthew was a patient, should have been given careful consideration and failing quite forceful reasons to the contrary, then his wishes should have prevailed. I can find no forceful, or indeed any adequate reasons why his wishes could not have been followed.

I have already described his physical apprehension and how it began. I think it was wrong to handcuff him as described earlier, with the left arm drawn up behind his back to meet the right arm pulled down over his shoulder. That is a severe form of handcuffing and must never be used again.

There was faulty Police procedure in leaving one Constable alone in the back of a moderately sized sedan to control a, by

this stage, demented individual. I think there should have been another officer, or the DAO seated together in the back so as to assist in control and, most importantly, to keep the patient in an upright position. At the least, in my view, the DAO should have stayed throughout with the patient and not travelled in his own vehicle. I understand it is possible the Sergeant either suggested or instructed the DAO to follow in his own vehicle. Whatever generated that decision, I believe it was the obligation of the DAO to stay with the patient during transportation. Also, the Sergeant should have taken some control and himself travelled in the front passenger's seat, if not in the rear, to help the Constable in the way I have stated.

Having left one Constable alone in the back to control the patient, it was almost unavoidable that he would have to adopt the strategy of sitting on him. That must have been a significant factor in the positional asphyxiation that developed. I have already referred to the chaotic conditions inside the vehicle at night and without some control of the patient some danger to the public using the roadways was a distinct possibility.

The foregoing critical remarks are made bearing in mind the vehicle that was used. This is an observation made with the benefit of hindsight but a sedan is quite inappropriate to transport a patient in the condition of Matthew. It should have been in an ambulance which has the room and, I understand, facilities to restrain violent persons. A sedan is inappropriate and must not be used again. In absolutely emergency situations, if a Police vehicle is to be used it should be a van with sufficient persons to continue restraint.
It seems to stand to reason if it takes six males to restrain a person to the state of hand and feet cuffing (which brings about significant immobilisation but by no means complete), then numbers are still required to continue the restraint if it is to be done in a safe manner.

In summary, if Matthew was to be taken by force (which I have previously stated I do not believe on the evidence available he should have been) then the overall procedure was wrong in the

ways I have described and must never again be repeated. That point cannot be made too strongly. If anything that is helpful is to come out of this tragic death, it is that procedures must be put in place so that the subject event never occurs again.

In conclusion my finding is that there was fault on the part of the Police officers in their handling of Matthew even after making all proper allowances for the situation in which they unfortunately found themselves.

Having said the foreging then I stand back and look at the totality of the situation bearing in mind the Police were called in by a health professional, they were faced with a vexing and perplexing situation which might have tested the judgment and experience of those endowed with those characteristics beyond that of these relatively young Police officers. I do not believe any useful purpose is achieved by taking any further disciplinary action other than formal counselling. I have found fault in the ways I have described and I recommend to the Commissioner that the officers be formally counselled and have this report and my findings officially brought to their attention. It may be said that Constable C (the driver) was less involved than Constable B and Sergeant A, and there is some truth in that, but I do not make any distinction between them on fault other than this comment.

My final comment is this whole tragic episode underlines the extremely difficult situation in which Police officers are not infrequently placed.

Complaint Against Commissioner

This was a complaint against the Commissioner, which I accept, and for explanatory purposes I reproduce s.12(1)(a) of the Act:

> *"12. **Functions of Authority** - (1) The functions of the Authority shall be -*
> *(a) To receive complaints -*
> *(i) Alleging any misconduct or neglect of duty by any member of the Police; or*
> *(ii) Concerning any practice, policy, or procedure of the Police affecting the person or body of persons making the complaint in a personal capacity."*

Although the wording of the complaint is to allege neglect of duty against the Commissioner (s.12(1)(a)(i)), I regard the substance of the complaint as more properly coming under "practice, policy, or procedure of the Police".

In responding to the complaint against him I think it is proper to say that the Commissioner began by recording, on behalf of the New Zealand Police and himself, their sincerest regret over the death of Matthew Innes. He said the Police were dedicated to serving the community competently and compassionately and any suggestion that they may have failed in their duty concerned them deeply.

Under the previous heading "Police Investigation etc" I made reference to the "huge potential areas for examination" and the comments following have equal relevance here.

The Commissioner has had a full investigation made into this complaint against him and the results have been forwarded to me to be assessed in the normal way as set out under the previous heading.

The recommendation as a result of the investigation is that the complaint against the Commissioner be cleared as "Not Upheld" and with that decision I agree and now set out why.

Again I begin by saying the wording of the complaint is the language of lawyers and the allegation in substance is that the Commissioner was somehow negligent and it was that negligence that was causative of Matthew's death by asphyxiation. I propose to deal with this complaint without recourse particularly to legal language and principles but one or two observations must be made.

A legal cause of injury (in this case death) is a cause which is a substantial factor in bringing about the injury or death. For reasons set out hereafter I reject any allegation that the Commissioner caused the death of Matthew Innes. It is not entirely clear that the complaint alleges the Commissioner's negligence was causative but I have taken the more cautious approach to dispose of it.

I turn to negligence framed that there was a neglect of duty. Negligence is the doing of something which a reasonably prudent person would not do, or the failure to do something that a reasonably prudent person would do which most appropriately fits the facts of this allegation. Negligence is not judged by the standards of hindsight.

I turn now to deal with what appears to be the thrust of the complaint against the Commissioner and try to frame it in non-legal language. It seems that the complaint is that the Commissioner as the person responsible for the whole of the Police service in New Zealand has not ensured there were adequate routine procedures for Police officers faced with situations similar to that of the instant one on 3 January 1994.

The complaint on this aspect is broadly stated and seems to give no acknowledgement of the long history of the Police service's involvement with mentally disordered persons.

Prior to passing of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (hereafter referred to as the 1992 Act) the controlling legislation was the Mental Health Act 1969 which was replaced by the 1992 Act

As stated the Police service has long been involved in the handling of mentally disturbed persons under a great variety of circumstances. This service is expected of the Police and is accepted as ordinary frontline duties by the Police.

Before outlining the procedures in place by the Police prior to the incident concerning Matthew Innes the observations contained in this report about the phenomenon of positional asphyxiation have particular relevance here. It can be accepted after extensive enquiry conducted on behalf of the Commissioner that the danger of this phenomenon was not widely known in the ordinary medical profession and to all intents and purposes it was unknown within the Police service. The Commissioner in his response to this part of the complaint candidly acknowledges that none of the procedures put in place relating to the transport of people under the 1992 Act specifically addressed positional asphyxiation. I cannot find

that a failure by the Commissioner when it is realised that a country the size of the United States only began to positively identify the phenonenon in medical literature as recently as 1992/93. One would assume that Police forces in that country are now making appropriate responses.

The Commissioner advised me since this case he has taken urgent action to implement new procedures in the light of recent knowledge of positional asphyxia and he will ensure that the Police will remain responsive to any opportunity to improve on their procedures.

The primary document governing Police procedures is entitled "Mentally Disordered Persons". It was prepared in September 1992 and its central aim is to train Police personnel in the new procedures resulting from the 1992 Act. It is a 69 page document prepared by the Training Development Section, Police National Headquarters in Wellington. It is a study module and is designed specifically for training purposes in the NZ Police.

This document has been made available to me and overall it is wide ranging and naturally covers mentally disordered persons as offenders, and patient/victims as well as other conditions. There is a section on compulsory assessment and treatment of mentally disordered persons under the Act. Of more interest in the light of this case is the section headed "Police Powers in Dealing with Mentally Disordered Persons". The emphasis under this section is that Police are "to assist" duly authorised officers and medical practitioners. There are "Guidelines for Assisting Duly Authorised Officers". Without stating so specifically, it is a reasonable inference the DAO is the health professional in charge of the incidents and the Police are to aid and assist. It is true the Guidelines do not specificially state who precisely is in charge but that should now be addressed afresh following this case. There is a part dealing with transport of mentally disturbed persons which not surprisingly does not mention the phenomenon of positional asphyxiation. I have been informed by the Commissioner that the two Constables, B and C, had undergone the training programme prior to January 1994, but not the Sergeant.

In addition to the foregoing, Chief Inspector L F Beattie, Area Controller of Otahuhu, became interested and concerned about safe conduct of escorted mentally disturbed patients and a meeting was held with representatives of the Southern District Mental Health Services at Otara on 26 March 1993. As a result of that meeting Inspector Beattie issued a direction to the Senior Sergeants of the front line sections at Otahuhu on safe escort procedures. It had been agreed with those present at the meeting that where possible the DAO from the Mental Health Services would accompany the patient in the Police patrol car to Kingseat Hospital. It was further directed that the patient should sit in the back seat of a patrol car with a Police Officer and DAO seated either side of the patient. The direction did not contemplate the extreme situation which emerged in this instant case under review.

For the foregoing reasons I do not uphold the complaint against the Commissioner, but that does not preclude the revisiting of the whole problem in the light of this case as I suggest hereafter.

Conclusions

The PCA is concerned primarily with Police misconduct and the investigation of this case cannot, and should not, be likened to a kind of commission of inquiry into the handling of mentally disturbed persons. Having said that, it is hoped value will come out of the investigation and review by me. Some of the observations passed in the body of the Report are here assembled as a summary.

General

1. The 1992 Act is new and complicated legislation which materially changes the procedures previously existing under the 1969 Act in relation to the Police handling of mentally disturbed persons. The September 1992 Training Module did address these changes but this case has highlighted areas that need closer attention.

2. As a matter of urgency Police Headquarters will have to promulgate firm guidelines to frontline Police officers in the handling of mentally disturbed individuals in cases similar to this one. These must be followed by training.

3. The Police and mental health authorities will need to establish working protocols that more precisely delineate the areas of control when DAO's call in Police assistance in the handling of mentally disturbed persons with potential for violence. The final responsibility for taking a person by force must be clearly nominated.

   In most cases it should rest with a health professional rather than a serving Police officer but much would depend upon the circumstances.

4. There already has been dissemination of material on the dangers of positional asphyxiation and this must be constantly reviewed and updated.

Matthew Innes

5. It must be plainly understood never again should a mentally disturbed patient be dealt with as Matthew Innes was and in particular:

   (a) The wishes of the patient where clearly expressed are to be given the most careful consideration at all times.

   (b) The patient should only be taken by force after all other alternatives have been exhausted.

   (c) Any taking by force must only be in circumstances where it is likely the patient will be a danger to himself/herself, or to others, or to property.

(d) I leave it to Police and health professionals to finalise strategies for forceful taking of patients but restraint procedures and devices must be as clearly mandated as the circumstances allow. I appreciate the point made by the Commissioner that broad guidelines are better than specific directions on physical handling of persons but I still think it is possible to exclude certain procedures and still retain flexibility.

(e) Sedan or saloon motor vehicles are not to be used for transportation of such patients in the future. Only in emergencies should a Police van be used but otherwise patients should be transported by ambulances.

(f) A patient should wherever possible be transported in a sitting position with sufficient personnel to keep him/her upright. This may be qualified if an ambulance is used where proper and safe restraint devices are available.

(g) When a situation develops as occurred with Matthew, a medical doctor should be available to travel to the person, especially if there is a call for the presence of one by the patient. It is in a medical doctor that the public has most faith. Furthermore a qualified doctor is able to administer drug therapy on the spot should it be required.

Recommendations

1. That no criminal proceedings be commenced against any Police officers or other persons involved in the restraint of Matthew Innes.

2. That the complaint of excessive use of force by the three Police officers be upheld and that they receive formal counselling in respect thereof.

3. That the complaint against the Commissioner himself be not upheld.

Sir John Jeffries
POLICE COMPLAINTS AUTHORITY
15 April 1994