
Attempted suicide at Auckland Custody Unit

INTRODUCTION

1. At about 6.36am on 24 December 2017, Mr X was arrested for trespass in Auckland and taken to the Auckland Custodial Unit (the ACU). After being placed in a cell, Mr X tore a strip of fabric from his clothing and used it to restrict his breathing. Mr X was taken to hospital and returned to Police custody later that day.
2. Police notified the Independent Police Conduct Authority (the Authority) of the incident, and the Authority conducted an independent investigation. This report sets out the results of that investigation and the Authority's findings.

BACKGROUND

3. This section of the report provides a summary of the incident and the evidence considered by the Authority. When quoting or describing the accounts of any officer, complainant or witness, the Authority does not intend to suggest that it has accepted that particular account.
4. Analysis of the evidence and explanations of where the Authority has accepted, rejected or preferred that evidence is reserved for the 'Authority's Findings' section.

Summary of events

5. At about 6.36am on Sunday, 24 December 2017, Mr X was arrested for trespass outside Sky City Casino in Auckland. Additionally, a warrant for Mr X's arrest had been issued in respect to outstanding domestic violence and theft charges.
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6. Police took Mr X to the ACU. CCTV footage shows Mr X being searched in the sally port of the ACU.¹ Mr X appeared cooperative; voluntarily taking off his shoes and emptying his pockets. While the arresting officer removed the shoelace from one of Mr X's shoes, Mr X removed the shoelace from the other. Mr X held his t-shirt out of the way while the arresting officer carried out a pat-down search, so the officer had unobstructed access to search Mr X's waistband and pockets.
7. The arresting officer placed Mr X into a holding cell and went to speak with Officer A, the supervising sergeant, about the arrest. Because of the nature of the charges Mr X was facing and Mr X's offending history, Officer A decided to retain Mr X in custody until the next court sitting date, on Tuesday, 26 December 2017.² Officer A's rationale for this decision was recorded in the electronic custody module (ECM).³
8. Custody Officer B began processing Mr X into custody at 7.47am.⁴ Mr X was evaluated to assess his health and wellbeing and the level of monitoring required while in custody. Custody Officer B saw that Mr X's historical custody records included references to self-harm in custody. An alert had been placed on Mr X's file in 2008, stating that he had suicidal tendencies. This existing alert had been modified in 2009, 2010 and 2013 to note further incidents relating to Mr X's mental health and self-harm attempts, but separate new alerts had not been added to the custody records on these occasions.
9. Custody Officer B asked Mr X about his current mental health, and noted this in the ECM: *"Previous attempts or threats to commit suicide, psychiatric history. States historic self-harm issues (says not an issue). Diagnosed with anxiety (says not medicated)."* On that basis, Mr X was evaluated as being 'not in need of specific care'.⁵
10. Mr X was calm throughout this process, although he became argumentative when he realised he would be in the ACU over Christmas. Mr X asked to speak to a lawyer, and at 8.14am he called a duty lawyer. Not satisfied with the advice that lawyer gave him, Mr X asked to speak to another lawyer. This request was refused.
11. CCTV footage shows that after speaking to the lawyer, Mr X appeared argumentative.⁶ Custody Officer B decided not to take Mr X's photographs or fingerprints until Mr X had calmed down.
12. At 8.33am, Mr X was placed alone in a cell. The cell contained a toilet with sink and drinking fountain, two built-in concrete bed bases, and two mattresses, and a CCTV camera. Mr X said that he does not remember anything after being placed in the cell.

¹ A sally port is a secure, controlled entryway to a Police station where officers bring detainees in to be searched and received into Police custody.

² There was no Court on Monday due to the Christmas Day holiday.

³ The ECM is an electronic Police system used to record information relating to a person in custody.

⁴ Custody officers (or 'authorised officers') are non-sworn Police employees who have responsibility for managing the health, safety and secure custody of detainees.

⁵ Detainees with this evaluation are required to be checked by custody staff at least once every two hours.

⁶ There is no sound recording for CCTV footage at the ACU.

13. CCTV footage shows Mr X entering the cell, carrying a blanket and his hoodie. When the cell door closed, he angrily punched out towards the cell door. He looked up at the CCTV camera and raised his middle finger. He spent some time using the toilet and arranging a mattress and his blanket. He appeared to have calmed down.
14. At 8.37am, CCTV footage shows that Mr X sat on the mattress, cross legged, underneath the CCTV camera, with his back to it. He pulls at his hoodie as if to tear it. Mr X put the hoodie on and pulled the hood up over his head. CCTV footage shows his hands were moving at the front of his body. Because of his position relative to the CCTV camera, it is not possible to see what he is doing.
15. At 8.38am, Mr X reached underneath his hood, moving his hands behind and around his neck. He pulled his arms into the body of his hoodie. At 8.40am, he moved to sit on the edge of the bed with his feet on the cell floor. At 8.42am, Mr X fell forward onto the cell floor, landing head first. He lay still on his front, with his back facing the cell door.
16. At about 9am, Custody Officer C noticed on CCTV monitors that Mr X was lying on his side, on the floor. Although it is not uncommon for detainees to lie on the floor, Custody Officer C decided to go and make an observation check on Mr X.⁷ Custody Officer C said to the Authority that:

“When I went down at that time and saw him breathing, it was just nice, relaxed, just on the side of his hip, and so that didn’t ring any alarm bells for me...”
17. Custody Officer C didn’t record this observation in the ECM (or anywhere else) because he was not making a scheduled check.
18. At 9.20am, Custody Officer B carried out an observation check on Mr X. He saw Mr X lying on the floor with his back away from the cell door. Custody Officer B opened the tray slot in the cell door so he could hear whether Mr X was breathing.⁸
19. Custody Officer B said: *“I could hear him snoring and I could see his chest going up and down quite slowly. So from that I determined that he was just sleeping on the floor...”* Hearing Mr X’s breathing satisfied Custody Officer B that Mr X was safe. Custody Officer B recorded the check in the ECM, but did not make any note as to Mr X’s position on the floor or breathing.⁹
20. CCTV footage shows that by this time there was a small pool of blood on the floor near Mr X’s mouth. Custody Officer B couldn’t see it as it was obscured by Mr X’s head when checking through the cell door or window.

⁷ An observation check involves watching a detainee through the cell window to establish their wellbeing. Other checks are described in paragraph 69 below.

⁸ CCTV cameras in the ACU do not record sound.

⁹ The word “check” was entered as a comment against this record.

21. CCTV footage shows that Mr X continued to lie in the same position. At about 9.58am, he stirred and lifted his head a few times, as if waking from sleep, then placed his head back on the floor. He remained in the same position, with his back to the cell door, until his next check.
22. At 11.05am, Custody Officer D came to the cell window to carry out an observation check. She opened the tray hatch in the door and called Mr X's last name. He did not respond, and Custody Officer D thought that something didn't seem right. She could see Mr X moving: "he was doing this weird shudder and I wasn't sure if he was having a seizure". Custody Officer D could hear Mr X making snoring type noises and recognised that this could be a sign of distressed breathing.
23. Custody Officer D called Custody Officer C over to check Mr X. Both officers looked through the cell window and could see the pool of blood by Mr X's mouth, which had spread further by this time. Custody Officer C radioed to have the cell unlocked. The cell door was unlocked and Custody Officer C went in.
24. Custody Officer C took the shoulder of Mr X's hoodie and tugged at it to get Mr X's attention. Mr X lay still. Custody Officer D was at the cell door, and radioed a request for an ambulance. Officer A came in briefly, checked what was happening and left again to call an ambulance. Mr X continued to lie still.
25. Custody Officer C held Mr X's head off the floor. He checked that Mr X's mouth was clear from obstruction. Mr X began jerking his legs sporadically. Custody Officer D moved Mr X's legs into the recovery position, and placed a blanket under Mr X's head.
26. CCTV footage shows that Mr X's hips and legs, and occasionally his right arm, were jerking from time to time, when the custody officers were with him. Custody Officer C said that:

"It kind of looked like a mini seizure, from what I've seen in the past in custody, but we put him in the recovery position and then we like, we checked his body just in case, so like checked his mouth and then as we were going down we checked his neck and then we realised there was something wrapped around it."
27. While checking Mr X's airways were clear, Custody Officer C discovered a strip of material from Mr X's hoodie around his neck. Custody Officer C said:

"Firstly when I went to remove it, it came off quite easily, it wasn't very tight, didn't require cutting or anything, just – I just put two fingers under it and it just like almost lifted it off, didn't really tear it."
28. Custody Officers C and D stayed with Mr X until ambulance officers arrived. Mr X did not react to the custody officers, and his arms and legs were sporadically jerking.
29. Ambulance staff entered Mr X's cell at 11.19am. They checked Mr X and assessed his injuries not to be life threatening. By 11.26am, Mr X was able to stand with assistance, and walked to a stretcher in the corridor.

30. Mr X was taken to Auckland Hospital. He was medically cleared, and was returned to the custody unit at 1.59pm. Because Mr X had used his clothing to self-harm, at 2.12pm his clothes were taken from him and he was given a tear-resistant gown, which he initially refused to wear. Officer A stayed with Mr X, who put the gown on after a period of negotiation.
31. Mr X was put onto a constant monitoring regime.¹⁰ At about 5pm, a duly authorised officer (DAO) met with Mr X and assessed his mental well-being.¹¹ At 6.09pm, following this assessment, Mr X's monitoring frequency was downgraded to frequent monitoring.¹² He remained in an observation cell, with a CCTV camera and full length windows facing into the receiving area.
32. At about 11.56am on Monday, 25 December 2017, a DAO returned to reassess Mr X. No new concerns were raised, and Mr X remained on frequent monitoring. At 2.47pm, Mr X was taken to make a phone call to his family, returning to his cell at about 3pm.
33. After returning from hospital, Mr X remained in custody for a total of 38 hours. Based on ECM custody records, frequent monitoring requirements were fully complied with by custody staff for five of the 38 hours. Only one check was recorded in the ECM for nine of the 38 hours. The average number of checks was fewer than three per hour.
34. When a check is completed, custody staff have the option to add a note in the ECM detailing their interaction with a detainee. Those checks that were recorded for Mr X during this period of frequent monitoring were generally accompanied by detailed notes, such as "*check, nodded his head*" and "*sleeping / body moved / good skin colour*".

THE AUTHORITY'S INVESTIGATION

35. Police referred this incident to the Authority on 3 January 2018. The Authority conducted an independent investigation. This included reviewing Police records, viewing CCTV footage of the incident, visiting the custody unit and interviewing Mr X and relevant Police staff.
36. When the Authority contacted Mr X, he raised a concern that he was kept naked for an extended period of time on his return to the ACU. The Authority considered this as part of its investigation.

THE AUTHORITY'S FINDINGS

37. The Authority identified and considered the following issues:
 - 1) Whether Mr X was searched appropriately when he was brought into the ACU;
 - 2) Whether Mr X was evaluated appropriately when he was received into custody;

¹⁰ Constant monitoring means that a person is watched continuously without interruption.

¹¹ Duly Authorised Officers are health professionals with powers to act under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

¹² Frequent monitoring requires a detainee to be checked 5 times every hour, at irregular intervals.

- 3) Whether Mr X was monitored in accordance with Police policy prior to his self-harm attempt being discovered;
- 4) Whether Mr X was provided with appropriate medical care after his attempt at self-harm;
- 5) Whether Mr X was kept naked on his return to the ACU; and
- 6) Whether Mr X was monitored appropriately and in accordance with Police policy after he returned to the ACU.

Issue 1: Was Mr X searched appropriately when he was brought into ACU?

38. Police are entitled to search a person when they are brought into custody, under section 11 of the Search and Surveillance Act 2012. One purpose of the search is to ensure that a person does not have anything with them that they could use to harm themselves or another person while in custody. In addition, any money or property that the person has with them is collected and held in safekeeping while the person is being detained.
39. The Authority has viewed CCTV footage of Mr X being searched when he was brought into custody.¹³ The search was completed adequately, and any items that Mr X might have used to harm himself were removed. The Authority is satisfied that, at that time, there were no risk factors indicating that Mr X's hoodie or other clothing needed to be removed.

FINDING

Mr X was searched appropriately when he was first brought into custody and there were no risk factors indicating that Mr X's clothing needed to be removed.

Issue 2: Was Mr X evaluated appropriately when he was received into custody?

40. The 'People in Police detention' policy requires custody staff to ask detainees a series of questions to establish their health and wellbeing, and to identify any risk factors that should be considered while they are in custody. The outcome of this evaluation determines how often a detainee must be checked (monitored) while in custody.¹⁴
41. Custody Officer B asked Mr X a series of questions to evaluate his health and wellbeing. Mr X was compliant and cooperative throughout this process. Mr X was asked specifically about his self-harm history. He told Custody Officer B that this was no longer an issue for him, and Custody Officer B recorded this appropriately in the ECM.¹⁵ As a result Mr X was assessed as being 'not in need of specific care'. This meant that custody staff were required to check on him at least once every two hours.

¹³ Discussed in paragraph 6 above.

¹⁴ Set out in more detail at paragraphs 68 and 69 below.

¹⁵ Discussed in paragraph 8 above.

42. The Authority considers that the initial assessment of Mr X as being 'not in need of specific care' when he was received into custody was appropriate. Custody Officer B asked appropriate questions about Mr X's mental state, and made clear notes reflecting this.
43. The Authority is concerned that, in past interactions with Mr X, the existing 2008 alert for suicidal tendency was simply amended on each subsequent occasion that self-harm incidents arose.¹⁶ This meant that when Police were dealing with Mr X on this occasion, a quick check of his alert history suggested that there had been only one incidence of self-harm in his interactions with Police and that had been nearly 10 years earlier. A separate alert should have been entered for each incident, allowing staff dealing with Mr X in the future to quickly recognise that this was more than a one-time occurrence.

FINDINGS

Mr X was evaluated appropriately when he was received into custody.

Separate alerts should have been created on Mr X's file by Police on each occasion that Mr X presented with suicidal issues.

Issue 3: Was Mr X monitored in accordance with Police policy prior to his self-harm attempt being discovered?

44. Having evaluated Mr X as being 'not in need of specific care', custody staff were required to check on him at least once every two hours to comply with the 'People in Police detention' policy. Everything that happened in relation to Mr X's time in custody should be recorded in the ECM.¹⁷
45. Custody staff complied with the number of checks required. When Custody Officer C saw Mr X lying on the cell floor, he was concerned enough for Mr X's welfare to make a visual check. This was not recorded in the ECM, but ought to have been.
46. The Authority notes the length of time which elapsed between Mr X's self-harm attempt and its discovery. However, the Authority considers that custody staff made appropriate checks. Following Custody Officer C's initial check at about 9am, Custody Officer B made a visual check at 9.20am. He observed Mr X's regular breathing, heard his snoring, and assumed he was asleep. When Custody Officer D made the third visual check of Mr X at 11.05am, she observed Mr X shuddering, saw mucus on the floor near his mouth, and considered that Mr X's snoring was a potential sign of troubled breathing.¹⁸ Accordingly, Officer D made a physical check.
47. On balance, the Authority is satisfied that custody staff made appropriate checks that were consistent with Police policy.

¹⁶ Set out in paragraph 8 above.

¹⁷ For more detail, refer to paragraph 67 below.

¹⁸ See paragraph 22 above.

FINDING

Prior to Mr X being taken to hospital, monitoring checks complied with Police policy, but Custody Officer C should have entered the initial check into the ECM.

Issue 4: Was Mr X provided with appropriate medical care after his attempt at self-harm?

48. After Mr X was discovered to have attempted to self-harm, Custody Officers C and D provided Mr X with appropriate first aid, and an ambulance was called promptly. He was taken to hospital and medically cleared before returning to the ACU.
49. DAOs assessed Mr X's mental health after he returned to the ACU, and again the following morning.

FINDING

Mr X was provided with appropriate medical and mental health care after his attempt to self-harm.

Issue 5: Was Mr X kept naked on his return to the ACU?

50. Mr X raised a concern with the Authority that, on his return to the ACU, his clothes were taken from him and he was kept naked for a period of time. Officer A was constantly monitoring Mr X when he returned from the ACU, and confirmed that Mr X was naked for some time.
51. Officer A said that Mr X's clothes were taken from him due to his earlier use of his hoodie as a ligature. He was provided with a tear-resistant gown to wear, but refused to put it on. Officer A could not confirm how long Mr X was naked, but thought that Mr X's estimate of about 30 minutes was probably correct. By the time the Authority became aware of this ground of complaint, CCTV footage showing this had been destroyed.¹⁹
52. The Authority is satisfied that custody staff were right to remove Mr X's clothing, and to ask him to wear a tear-resistant gown. It is generally appropriate, in such cases, to ask a person to put the gown on themselves, rather than using force to put the gown on an individual. The Authority accepts that Mr X was most likely naked for a period of time, but this was not a deliberate act by Police designed to embarrass or degrade him.

FINDINGS

It was appropriate to remove Mr X's clothing and ask him to wear a tear-resistant gown.

¹⁹ CCTV footage is routinely retained for three months, and then destroyed.

The Authority accepts that Mr X was naked for a period of time. However this was not a deliberate act by Police to embarrass or degrade him.

Issue 6: Was Mr X monitored appropriately and in accordance with Police policy after he returned to the ACU?

53. When Mr X was brought back to the ACU from hospital, he was placed on a constant monitoring regime. ECM records show who was monitoring Mr X and when the officer carrying out the monitoring changed.
54. Mr X was assessed by a DAO before his monitoring status was changed to frequent monitoring. This is in accordance with the 'People in Police detention' policy.²⁰
55. Once Mr X was downgraded to frequent monitoring, the number of checks recorded in the ECM fell well short of that required by policy. However, the amount of detail recorded in notes corresponding to each check indicate that custody staff had a particular awareness of the need to observe Mr X carefully.²¹
56. The Authority notes that Mr X was in an observation cell which can be easily viewed from the charge desk, and so on balance, accepts that Mr X was most likely observed more often than ECM records reflect. However, observations of a detainee, particularly those made in passing, do not meet the standard required by Police policy. A person on a frequent monitoring regime must be checked five times an hour, at irregular intervals, and those checks must be recorded in the ECM.

FINDINGS

Mr X was monitored appropriately when on constant monitoring, and this regime was not downgraded until a DAO had assessed Mr X.

After Mr X was placed on frequent monitoring, the number of checks recorded in the ECM fell well short of requirements.

SUBSEQUENT POLICE ACTION

57. Following the Authority's investigation, Police advised that they have taken steps to improve monitoring in the ACU. These included:
 - Prioritising keeping detainees safe as a performance measure for ACU staff
 - Completing weekly audits of ECM records for detainees on frequent monitoring

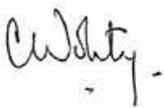
²⁰ Set out in paragraph 68 below.

²¹ See paragraph 34 above.

- Developing strategies to ensure that checks are completed, particularly during periods of high demand; and
- Sharing good practice and learnings across the ACU team and wider organisation through regular team feedback.

CONCLUSIONS

58. The Authority found that Police searched, assessed and monitored Mr X appropriately when he was brought into custody on Sunday 24 December 2017. When his self-harm attempt was discovered, custody staff took appropriate steps to ensure Mr X had medical treatment and mental health assessment.
59. The Authority also found that:
- 1) On each occasion that self-harm was an issue for Mr X, a new alert should have been created;
 - 2) All checks should be entered into the ECM;
 - 3) It was appropriate to remove Mr X's clothing and to ask him to wear a tear-resistant gown;
 - 4) The Authority accepts that Mr X was naked for a period of time. However this was not a deliberate act by Police to embarrass or degrade him;
 - 5) Mr X was monitored appropriately on his return to the ACU under a constant monitoring regime; and
 - 6) After Mr X was placed on frequent monitoring, the number of checks recorded in the ECM fell well short of requirements.



Judge Colin Doherty

Chair
Independent Police Conduct Authority

14 March 2019

IPCA: 17-1398

Searching detainees

Law

60. The Search and Surveillance Act 2012 sets out the rights and obligations in relation to searching people in Police custody.
61. When a person has been taken into custody, a full search of a person can be carried out under section 11 of the Search and Surveillance Act 2012. This allows officers to check the person more thoroughly before they are locked up. Once a search is carried out under section 11, the person can only be searched again if, since being searched:
- the person has been in close proximity to a person who is not in Police custody, or
 - the person has been in close proximity to a person who has not been searched by officers, or
 - there are reasonable grounds to believe that the person has anything that could be used to harm themselves or another person.

Police policy

62. The 'People in Police detention' policy requires that officers who arrest or detain a person carry out a rub-down search of a person before transporting him or her.
63. The policy expressly tells officers to leave a section 11 search until they reach the station. It clearly states that a section 11 search cannot be conducted again unless one of the circumstances in section 11(3) arises.
64. The policy also instructs custody staff to verify the arresting officer's search under section 11 of the Search and Surveillance Act 2012. They are referred to the instructions to arresting officers, but not expressly reminded that there can only be one section 11 search unless one of the circumstances in section 11(3) applies.

Care of people in custody

65. The 'People in Police detention' policy provides that:

"All Police employees are responsible for the care, safety and security of everyone detained including at scenes, during transport, within Police stations and cells at courts.

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

Alongside the use of force, the detention of people is the strongest legislative power that can be executed by Police. To ensure every detainee is treated humanely we will:

- *comply with all legislation related to detained people*
- *ensure all staff working in custody areas understand and apply the contents of this chapter*
- *ensure sufficient staff are allocated to work in custody areas.”*

66. The policy contains procedures for receiving, assessing, monitoring and managing people in custody, and provides instructions for what to do when a person has consumed alcohol or drugs, is injured, has a known medical issue, or there is a risk of self-harm or suicide. It also sets out the responsibilities and duties of staff involved in custodial management to maximise health, safety and security.
67. Custody staff are instructed to *“Record risk information, any special care instructions, and everything that happens in relation to a detainee, from processing to release, in the ECM.”*
68. The ‘Procedures for custody area staff’ states that custody staff must evaluate and classify detainees as either not in need of specific care, in need of care and frequent monitoring, or in need of care and constant monitoring. A person who is not in need of specific care must be checked at least once every two hours. Frequent monitoring requires a detainee to be checked at least five times an hour at irregular intervals. Constant monitoring requires a detainee to be *“directly observed without interruption”*. A detainee’s monitoring frequency cannot be downgraded except on advice of a health professional.
69. There are three types of checks, with an observation check being the minimum standard for checking detainees:

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

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

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

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

Who is the Independent Police Conduct Authority?

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

It is not part of the Police – the law requires it to be fully independent. The Authority is overseen by a Board, which is chaired by Judge Colin Doherty.

Being independent means that the Authority makes its own findings based on the facts and the law. It does not answer to the Police, the Government or anyone else over those findings. In this way, its independence is similar to that of a Court.

The Authority employs highly experienced staff who have worked in a range of law enforcement and related roles in New Zealand and overseas.

What are the Authority's functions?

Under the Independent Police Conduct Authority Act 1988, the Authority:

- receives complaints alleging misconduct or neglect of duty by Police, or complaints about Police practices, policies and procedures affecting the complainant in a personal capacity;
- investigates, where there are reasonable grounds in the public interest, incidents in which Police actions have caused or appear to have caused death or serious bodily harm.

On completion of an investigation, the Authority must form an opinion about the Police conduct, policy, practice or procedure which was the subject of the complaint. The Authority may make recommendations to the Commissioner.

This report

This report is the result of the work of a multi-disciplinary team of investigators, report writers and managers. At significant points in the investigation itself and in the preparation of the report, the Authority conducted audits of both process and content.



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