



IPCA

Independent Police
Conduct Authority

Mana Whanonga Pirihiimana Motuhake

Excessive uses of force while in custody in Tauranga

Summary of the Incident

1. Ms X, a homeless woman who suffers from mental health issues, was arrested on 21 June 2019 for fighting with a man in the Tauranga CBD. Once placed in the patrol car Ms X struggled with officers and one of them punched her on the right cheek. She was placed in a spit hood and taken to Tauranga Police Station.¹
2. While in custody, Ms X attempted to strangle herself twice, once with a spit hood and once with a sweatshirt. She was physically restrained twice by a number of officers and was placed in a restraint chair².
3. Ms X was taken to a medical centre, where a laceration on her right cheek was treated. She was also found to have a broken wrist which was possibly the result of an officer using a “wrist lock” on her.³ Police notified the Authority of the incident and we independently investigated the matter.

Issues examined by the Authority

- Issue 1:** Were Police justified in using force to arrest Ms X?
- Issue 2:** Did Police adequately assess Ms X when she was taken into custody?
- Issue 3:** Were Police justified in using force on Ms X while she was in custody?
- Issue 4:** Did Police provide appropriate care for Ms X while she was in custody?

¹ A spit hood is a restraint device intended to prevent someone from spitting or biting. The spitting hood slips over a detainee’s head. The bottom half is cloth, designed to prevent spitting. The top half is dark mesh so that officers may view the top half of the detainee’s head.

² A restraint chair is an inclined chair that uses leg, wrist, waist and chest mechanical restraints to immobilise a person.

³ A wristlock is a technique where someone takes hold of another person’s hand and twists or bends it in a non-natural direction. If applied suddenly and/or forcefully, a wristlock can cause ligament tears or possibly even dislocation or bone fractures.

The Authority's Findings

4. The Authority found:
 - 1) officers were justified in placing a spit hood on Ms X in the patrol car;
 - 2) Officer A's punch to Ms X's cheek was an excessive use of force;
 - 3) officers failed in their duty of care to Ms X by not conducting an assessment and checking her alerts in the Police database earlier;
 - 4) Ms X and officers were placed at risk by being unaware of the alerts in the Police database;
 - 5) Police negligence in assessing Ms X and their lack of appropriate actions, led to officers needing to use force to prevent Ms X from self-harming. Therefore, the three uses of force were unjustified;
 - 6) the significant force used, and the number of officers involved in restraining Ms X, was excessive and unreasonable;
 - 7) we are unable to determine when Ms X's wrist fracture occurred;
 - 8) officers should have placed Ms X in a tear-resistant gown following her attempt to self-harm with the spit hood. This would have eliminated the need to use force again immediately afterwards; and
 - 9) officers should not have removed Ms X's trousers before restraining her in the chair.

Analysis of the Issues

ISSUE 1: WERE POLICE JUSTIFIED IN USING FORCE TO ARREST MS X?

5. At about 11.18am on 21 June 2019, Police were alerted to a fight between Ms X and a male in Willow Street, Tauranga. Officer A, the supervising sergeant of the Tauranga Police Custody Suite, responded as he happened to be near Willow Street at the time.
6. Officer A found Ms X sitting at a bus stop and tried to speak with her. She did not want to speak to him, other than saying she had been fighting in self-defence. (CCTV footage later showed she had started the fight.)
7. Officer A had dealt with Ms X before as she had been taken into custody on a number of occasions. He was aware she had mental health issues and that she *"doesn't have a way of coping with... situations such as this"*. He also described her as having *"a problem with authority"*.
8. Officer A made the decision to arrest Ms X for fighting in a public place, which was permissible under the Summary Offences Act 1981.

9. Officer A put on his black leather tactical gloves in case there was “*some kind of scuffle*”. Ms X became tense when she was handcuffed with her hands behind her back.
10. Ms X was placed behind the passenger seat in the patrol car without incident, however she then moved herself across to the other side, which was potentially a danger to the driver.⁴ She would not come back across to the passenger side when told to, so Officer A reached in through the back left-hand door to try to move her. Ms X leaned back against the right-hand passenger door and pulled her knees up close to her chest. Officer A considered her “*quite aggressive at that point*” and thought she would use both legs to kick him in the chest or face if he went any closer.
11. Officer A backed away and called Officer B and his partner Officer C for assistance. Officer A told us Ms X was “*quite large*” and strong and was becoming increasingly agitated. Officers B and C arrived a short time later. Officer B had dealt with Ms X before and knew her to be “*violent and unpredictable*”.
12. Officer B stood at the back left-hand door and pulled Ms X over to the passenger side while Officer A pushed her across from the back right-hand door. Officer C then came to the passenger side to assist and Officer B went to the driver’s seat.
13. As Officer A reached across Ms X to get the seatbelt, she tried to bite his left forearm. Officer A said:

“... she’s actually got close enough, she’s got her lips on my arm so I’ve managed to pull my hand away but at that point I have needed to keep her under control. I needed to keep her close and so that’s when I’ve punched her in the head just to keep her under control so that would allow me time to get the seatbelt and get it clipped in so I could at least have that part of her body secured in so she couldn’t move around in the seat.”
14. Officer A described the punch as “*a sharp jab to the head, just to sort of snap her out of that way of thinking*”. He said he thinks she “*got the message that I wasn’t mucking around*”.
15. Officer A then saw a trickle of blood coming from a “*tiny little cut*” on Ms X’ right cheek and believes it came from the punch which “*definitely stunned*” Ms X and gave him enough time to click her seatbelt in.
16. Officer C was positioning the front passenger seat to try to hold Ms X’s legs in the footwell of the car at the time. He did not see the punch but recalled hearing Officer A yell: “*Don’t you bite me*”. He looked up to see Officer A holding Ms X’s head against the window, trying to stop her from biting him.
17. It appears Officer B did not see or hear anything about the bite or punch as he was going around to the driver’s seat.
18. Ms X then made a “*hoiking*” noise and moved her face in a way that indicated she was going to spit at Officer A, who was beside her on the back seat. Officer A placed his gloved left hand over

⁴ General Police practice is to transport offenders on the passenger side of the car to prevent assaults or interference with the driver.

Ms X's mouth. He said Ms X was struggling violently and her legs were lashing out, so he pushed himself as close as possible to her, pinning her to the left side of the car.

19. Officer A told Officer C to get a spit hood out while he kept his gloved hand over Ms X's mouth. Officer C noticed the small cut to Ms X's cheek before removing her hat and placing the spit hood over her head.
20. We are satisfied the officers were justified in placing a spit hood on Ms X because she placed them at risk by spitting on them. Officers complied with spit hood policy.⁵
21. Officer B drove the two-minute journey to the Police Station. He recalled Ms X tried to kick him between the two front seats and he had to use his left forearm to fend her off.
22. CCTV footage shows the initial encounter on the street between Officer A and Ms X. It shows Officer A spoke to Ms X for nearly 5 minutes before placing her in the back of the patrol car. She sat inside the car for a little over 2 minutes while Officer A stood outside and then conferred with other officers before opening the car door and trying to communicate with her. It was nearly 2 minutes later that the spit hood was put on Ms X. The entire encounter, from when Officer A first approached Ms X until the spit hood was put on her, took about 9 minutes.
23. Officer A's account lines up with this footage. There is no footage showing what occurs inside the patrol car.
24. Officers B and C's overall accounts are similar to Officer A's. There were no known witnesses to the punch as neither officer saw it and no members of the public appear to have seen it.
25. Medical records from when she was later taken for medical treatment, show Ms X's right cheek was bruised and swollen and the laceration was less than 10mm long.

Was Officer A justified in punching Ms X?

26. Officer A believed he was justified in punching Ms X under section 48 of the Crimes Act 1961, which allows for officers to use reasonable force in self-defence or in defence of others.⁶
27. In order to rely on this defence, Officer A's actions must be assessed using the following three questions:
 - 1) What were the circumstances as he believed them to be?
 - 2) Did he use force for the purpose of defending himself?
 - 3) Was the force used reasonable in the circumstances?

⁵ See paragraphs 103 to 108 for policy about spit hoods.

⁶ See paragraphs 86 to 88 for relevant law and paragraphs 90 to 94 for relevant policy on the use of force.

What were the circumstances as Officer A believed them to be?

28. Officer A assessed Ms X as being ‘assaultive’ and believed the punch was necessary and proportionate at the time.⁷ He said he believed Ms X was definitely going to bite him and he was lucky he got his hand out of the way because otherwise he would have “*copped a full bite on the forearm*”. He said that even with handcuffs behind her back, Ms X was still being very aggressive.
29. Officer A also said he needed to calm Ms X down and give the officers time and distance so they could get the seatbelt on Ms X so she was not “*free in the back seat*”. According to Officer A, “*jabbing*” her enabled him to do this.
30. When asked if there were other tactical options he could have used, Officer A said there were no other reasonable options available to him. He said other options would have involved using a lot of force to restrain her. According to him, if they had held her in position it would have created a spectacle as they were in a place with a number of bystanders, and others may have tried to intervene. He did not want the situation to “*spark up*”. He said he could have backed away or pushed his hand into Ms X’s face to push her away but made a split-second decision to punch her.
31. Officer A said he was comfortable with his decision and that it did exactly what he wanted it to do. He thought the punch dealt with the situation quickly and effectively.
32. The Authority was unable to speak to Ms X to hear her version of events. Ms X indicated to Police she did not want to talk about the incident. As she is homeless, she was also difficult to locate or contact.

Did he use force for the purpose of defending himself?

33. Officer A said he used the punch as a tactical option to calm Ms X down and enable him to put on her seatbelt, which is not an act of self-defence. However, the punch occurred directly after the attempted bite, and Officer A assessed her as aggressive and assaultive. On balance, therefore, the evidence indicates that Officer A genuinely reacted to defend himself.

Was the force used reasonable in the circumstances?

34. Ms X was a vulnerable woman who was in handcuffs in the back of a Police car. Other options were available:
 - two other officers were present and could have been used to help restrain her;
 - Ms X’s face could have been held away from Officer A;
 - the seatbelt could have been passed across Ms X by one of the other officers;

⁷ ‘Assaultive’ in the Tactical Options Framework includes someone who displays intent to cause harm, through body language/physical action.

- the officers could have stepped back and formulated a plan to reduce the risk to themselves and to Ms X, which does not appear to have happened (see paragraph 22); and
 - officers could have asked for a prison wagon to be brought to the location to transport Ms X to the nearby station.
35. Officer A said Police officers get taught to use strikes. We sought clarification around what is currently taught to officers. Although punching was taught many years ago, it is not taught now. Some palm strikes are taught (as opposed to using fists), however these do not include striking in the face, head or throat. We do not consider it is an action which would have been likely to calm Ms X down. Indeed, it was more likely to have had the opposite effect.
36. Officer A also suggested the punch was justified under section 39 of the Crimes Act 1961, which allows for officers to use force if it is necessary to overcome the force someone uses to resist arrest. We do not agree that the use of force was justified under section 39 as we disagree with Officer A’s claim that there were no less forceful options available to him.
37. The Authority therefore concludes that the punch was not necessary or reasonable in the circumstances and was accordingly an excessive use of force. Officer A should have used other tactical options.

FINDING ON ISSUE 1

Officers were justified in placing a spit hood on Ms X in the patrol car.

Officer A’s punch to Ms X’s cheek was an excessive use of force.

ISSUE 2: DID POLICE ADEQUATELY ASSESS MS X WHEN SHE WAS TAKEN INTO CUSTODY?

38. When a person is taken into custody, the usual process is for them to be received at the custody counter. They are asked evaluation questions in order to assess the level of care they require, which are entered into the Police database (NIA).⁸ The property that is removed from them for safekeeping is also recorded.
39. Ms X’s aggressive behaviour led officers to decide to ask her the evaluation questions while she was secured in the cell. However, no evaluation questions were in fact asked of her, and no attempt was made to enter her details into the Police database for about an hour. We do not accept there was any valid reason for officers not to conduct an assessment. Ms X’s level of aggression and the fact some officers had dealt with Ms X before and had knowledge of her tendencies to self-harm and attempt suicide, should have prompted officers to ensure a sound assessment was conducted.
40. Police policy instructs officers to ensure they check the detainees on the Police database “*at the earliest opportunity*”, being vigilant in noticing alerts which are relevant to the safety of the

⁸ The National Intelligence Application (NIA) is a Police database which holds information about individuals who have come into contact with Police.

detainee.⁹ Previous alerts and evaluation history records should also be checked to identify any risks. This would usually be done when the detainee is received into custody, and the arresting officer may also have looked on their mobility device before bringing the offender into custody.

41. There were multiple important alerts about Ms X's suicidal tendencies and mental health in the database:
- Under 'Suicidal Tendency' there were two entries from 2015. One stated Ms X had made suicidal threats, bashed her head against a wall and tried to strangle herself. She had also deliberately fallen backwards and tried to hit her head on the floor. The other entry said she had made an attempt to strangle herself using items of clothing.
 - Under 'Mental Health' there were three entries from 2007 to 2015. They included that her moods were "*up and down*". She was also noted to have wanted to hang herself and die, and that she had behaved aggressively over a period of four weeks, which was believed to have been related to mental health issues.
 - Under 'Other – Mental Illness' entries said Ms X has tried to harm herself by hitting her head against walls and windows. She had allowed herself to fall backwards onto hard concrete floors in order to hit her head and had tried to strangle herself.
42. There were also alerts relating to searches. One stated: "*Be aware during searches. [Ms X] has a false upper plate in her mouth. She also hides items in her underwear. She becomes angry when hidden items are located.*" Two other alerts mentioned the need to search Ms X thoroughly. Officers dealing with Ms X were placed at risk by being unaware of this information when searching her.
43. The first time the database appears to have been accessed was at 12.27pm, when Officer A, as the arresting officer, completed Ms X's custody evaluation. This was after Ms X had already made three attempts to self-harm, once throwing herself on the ground, and twice attempting to strangle herself (discussed in Issue 3). These were all specific behaviours mentioned in the alerts.
44. Officer A said officers usually try to determine any alerts as soon as possible, however this was bypassed "*because of the way it played out*" and that "*time was against us*". It is unclear who exactly checked the alerts, and, based on the evidence available to us, it appears they may not have been checked at all.
45. Officer D also said there was not enough time to check for alerts due to Ms X's physical behaviour. He said: "*Anecdotally I know of her, of those things*", however he realised new staff did not. This is at odds with his statement to us that he only became aware Ms X might try to self-harm after her attempt to use the spit hood to do so.

⁹ A Police safety alert flags important information about the potential risks that an offender may pose to the Police officers he or she has contact with. See paragraphs 95 to 102 for relevant policy about people in Police detention.

46. Officer A said he knew about Ms X because of previous experiences with her but he did not consider the self-harm aspect until she attempted to self-harm with the spit hood.
47. We do not accept there was any valid reason for not checking the alerts earlier. Ms X was alone in a holding cell for about 30 minutes before being searched and a number of staff were present in the custody suite.
48. When we asked Officer D if things would have been done differently if officers knew of Ms X's alerts when she first came into custody, he said they probably would have deferred to the Mental Health Crisis Team immediately rather than waiting until after her suicide attempts. He also said the alerts could have helped them to determine Ms X's frame of mind sooner.
49. Officers should have read the alerts and conducted an assessment of Ms X at the start of her detention. The alerts provided crucial information about Ms X that directly related to her care. With this knowledge, officers should have developed an appropriate plan to manage Ms X's risks including putting her in a tear-resistant gown so she could not use her clothing to self-harm. If preventive measures had been taken, the use of force could have been avoided. By not checking the alerts earlier, officers failed in their duty of care to Ms X.

FINDINGS ON ISSUE 2

Officers failed in their duty of care to Ms X by not conducting an assessment and checking her alerts in the Police database earlier.

Ms X and the officers were placed at risk by being unaware of the alerts in the Police database.

ISSUE 3: WERE POLICE JUSTIFIED IN USING FORCE ON MS X WHILE SHE WAS IN CUSTODY?

What took place before the uses of force?

50. Officer A called ahead to the Police station to ask for the secure drive-in entrance area (sally-port) to be opened and to let them know assistance would be required once they arrived. Officer D was a senior sergeant who was relieving as supervisor of the custody suite while Officer A was away from the station.
51. The patrol car arrived at the station at about 11.30am. Ms X was monitored while Officer A briefed the three female officers who were going to assist, Officers E, F, and G. He made them aware of Ms X's behaviour and the risks she posed based on what had taken place during her arrest. A plan was developed to get Ms X straight into the holding cell, which was next to the patrol car. She would then be brought out to be searched in the sally-port and taken through to the observation cell. Ms X was removed from the car and put into a holding cell without incident.
52. CCTV footage showed Ms X sitting on the bench in the holding cell with the handcuffs and spit hood still on. She went to the door a couple of times. Blood could be seen on the spit hood, in the right cheek area.

53. Officer F said she tried to communicate with Ms X through the hatch to see if she could create a rapport with her, but Ms X did not want to communicate and appeared to be very angry.
54. Ms X was taken out of the cell at 11.59am. Officers E, F and G searched her and Officer A observed. Ms X's spit hood remained on during the process to stop her spitting at the officers.
55. Ms X was put against the wall. A pat-down search was conducted with an officer holding each arm. Officer E removed her scarf, checked her pockets, and cut cords from the two pairs of pants she was wearing. One handcuff was removed, and Ms X's puffer jacket was taken off her. Ms X remained wearing her leggings underneath trousers, and a long-sleeved top and sweatshirt. The other handcuff was then removed. Officer E said Ms X was "*quite tense*" and did not talk to them. The search took place without incident.
56. Ms X was escorted to the observation cell, with Officers E and F holding her arms up behind her back, and Officers G and A following behind. Officer F said Ms X tried to walk into the custody desk "*quite aggressively*" and then threw herself on the floor. Officers E and F fell to the ground with her. Ms X was told to get up but refused and kicked her legs out. The officers got control of her arms, lifted her to her feet, and walked her to the observation cell with the intention of constantly monitoring her.
57. CCTV footage shows Ms X being put in the observation cell at 12.06 pm with the handcuffs off and the spit hood still on. Officer A said he thought Ms X would "*just calm down*" and would be able to be evaluated.

Were the three uses of force justified and reasonable?

58. Section 41 of the Crimes Act 1961 allows for officers to use "*such force as may be reasonably necessary*" to prevent someone from committing suicide or causing themselves serious injury.
59. If officers had read the alerts and conducted an assessment of Ms X when she was first brought into custody, she would likely have been put in a tear-resistant gown. The only reason Ms X was able to use the spit hood and sweatshirt to attempt to commit suicide was because she had access to them. Ms X was a vulnerable person who was in need of mental health care, but instead she was subjected to three uses of force.
60. The three uses of force were:
 - 1) Immediately after being placed back in the cell after being searched, Ms X removed the spit hood and indicated she was going to use it to strangle herself. Officer D "*tackled*" Ms X onto the mattress and three other officers assisted him in restraining her while he took the spit hood off her.
 - 2) Ten seconds after the officers retreated, Ms X removed her sweatshirt and tied the sleeves around her neck as if to strangle herself. Officer D said Ms X kicked at him at least four times, so Officer A "*took her down*". Ms X fell backwards and a struggle took place, with five officers in total restraining her. Officer A used a wrist lock to restrict Ms X's

ability to move. Ms X's trousers were removed, her hands were placed in handcuffs, and her feet were secured with cable ties.

- 3) While the officers were restraining Ms X on the bed, they made the decision to place her in a restraint chair. She was carried into the custody area where she was strapped into the chair by eight officers and placed back in a spit hood. She was then wheeled into the cell where she remained in the restraint chair for 90 minutes.
61. If an appropriate plan had been put in place when Ms X first came into custody, officers would not have found themselves in a position where they had to act quickly to prevent Ms X from using the spit hood and clothing to self-harm. The three uses of force were unjustified because they would not have been necessary if the officers had acted appropriately earlier.
62. Four officers restrained Ms X on the bed the first time, and five restrained her the second time. Officers A and D said they used their full force to restrain Ms X both times. The significant force used, and the number of officers used to restrain her, was excessive and unreasonable.
63. It was unnecessary to use handcuffs and cable ties to secure Ms X before placing her in the restraint chair. The lack of forethought meant Ms X was subjected to more discomfort than was needed.
64. Officers complied with policy regarding the use of restraint chairs.¹⁰ They also complied with policy when using the spit hood, constantly monitoring her. However, there was minimal risk of Ms X being able to spit at staff as she was facing away from the cell door, and it was probably unnecessary for her to have it on for an hour while in the chair.
65. After being taken out of the restraint chair, Ms X was assessed by a Duly Authorised Officer (DAO) from the Mental Health Crisis Team who concluded that Ms X did not need constant monitoring, so her monitoring regime was lowered to "*frequent monitoring*".¹¹

How was Ms X's wrist injured?

66. At about 2.15pm Officer A directed Officers H and I to take Ms X to a medical centre for treatment. When we spoke to Officers H and I they recalled Officer A briefing them before they took Ms X. Officer H recalled Officer A saying Ms X had "*a bit of sore arm, quite a bit of pain in her arm*" and that it would possibly need to be x-rayed. Officer I also recalled being told Ms X was complaining that her wrist was sore. Officer A did not say how the injury may have occurred.
67. Officer A did not recall knowing Ms X had an injured wrist at this time. He said he thought she needed to have a medical check as there was a visible injury on her face and he had punched her once, had been dragged to the cell, and had been handled by several officers while being restrained. She had been "*subjected to significant force*" which would "*take a toll*".

¹⁰ See paragraphs 135 to 141 for policy about the use of restraint chairs.

¹¹ "Frequent monitoring" requires officers to check a detainee at least 5 times per hour, at irregular intervals; "constant monitoring" requires officers to directly observe a detainee without interruption.

68. None of the other officers recalled hearing Ms X mention having a sore wrist and there is no record of her complaining about it.
69. Officer H said during the trip to the medical centre, Ms X's demeanour changed. She was quiet and did not respond to their attempts to communicate with her. They had no issues with her behaviour.
70. Medical records list the initial issues when triaged as being a laceration to the cheek and a "sore R wrist". The records show Ms X's right wrist was fractured and state: "... talking to police officers present they said [they] thought it was sustained when 'wrist lock' was applied". Officer A could not remember if he had mentioned the wrist lock to them, but this implies he had, and that either Officer H or Officer I had mentioned it to medical staff.
71. Officer A told us he believed there were multiple opportunities for the injury to Ms X's wrist to have occurred, such as when she was seen fighting in town. He also said he would not be surprised if the fracture occurred while in the cells, though he would expect someone to scream if they broke a bone, whereas Ms X did nothing to indicate she was in pain. He suggested if the break did occur in the cell, it may indicate she has a resistance to pain.
72. It is impossible to determine exactly when Ms X's wrist was fractured due to her lack of acknowledgement of it. It could have occurred during the fight on the street, when she threw herself to the floor in the custody unit, when she was banging on the cell door, when she was being restrained, or when Officer A used the wrist lock on her.

FINDINGS ON ISSUE 3

If Police had properly assessed Ms X earlier this should have led to them taking action to prevent self-harm attempts and avoid the need for any force to be used. Therefore, the three uses of force were unjustified.

The significant force used, and the number of officers involved in restraining Ms X, was excessive and unreasonable.

We are unable to determine when Ms X's wrist fracture occurred.

ISSUE 4: DID POLICE PROVIDE APPROPRIATE CARE FOR MS X WHILE SHE WAS IN CUSTODY?

73. Although officers discussed the risks Ms X posed to the officers and how to best manage these, there does not appear to have been any discussion about her care leading up to the uses of force. As the officers were unaware of the alerts, nothing was put in place to prevent her from throwing herself on the floor or walls or strangling herself, until officers realised the risk of self-harm and restrained her in the chair. It is fortunate officers were diligent in monitoring Ms X constantly and could act quickly when needed.

Should Ms X have been left in a cell with the spit hood and items of clothing?

74. When asked why the decision was made to leave the spit hood on Ms X, Officer A said it was because she was spitting and had blood on her, so there were concerns about her contaminating

officers with her blood and saliva. He said in hindsight they should have taken the spit hood off her. However, he did not think it would be strong enough to allow her to self-harm as he had never seen it used for that purpose before.

75. Officer D said after the spit hood was removed, the officers got out of the cell immediately because Ms X was being 'assaultive' towards them. He said at this time he realised they needed to take action immediately because she was self-harming. Ms X's next attempt to strangle herself was made only 10 seconds after officers left the cell.
76. Officer D said officers took some learning away from the incidents with Ms X: "*One interaction would have been better*". He said there was an opportunity for them to do something different when they took the spit hood off Ms X before she used her clothing to attempt to self-harm. He assumed everything would go to plan, but Ms X became more combative with each interaction.
77. If officers had ensured Ms X was put in a tear-resistant gown as soon as she attempted to self-harm with the spit hood, it would have eliminated the need to restrain her a second time.
78. After Ms X used her sweatshirt to make another attempt to self-harm, it is unclear why officers felt it necessary to remove her trousers, but not her long-sleeved top. At this point she was about to be put in the restraint chair, so the trousers posed no greater risk than the long-sleeved top.

Did officers manage Ms X's dignity appropriately?

79. According to the New Zealand Bill of Rights Act 1990, the dignity of every detainee should be respected.¹²
80. During her time in custody, Ms X was restrained by several officers, both male and female. Officers were mindful of using female officers to search Ms X and to restrain her legs.
81. However, Ms X suffered a loss of dignity when handled by several officers and left in the chair in her underpants. Officer could have put her trousers or leggings back on her before restraining her in the chair. Alternatively, she could also have been placed in a gown.
82. Officer A said Ms X was not put in the tear-resistant gown when she was first taken into custody as she was "*very aggressive and difficult to control*". He also said a gown is only used if there are concerns the detainee may self-harm, and that Ms X showed no indication she was going to self-harm while being searched. Once again, this indicates officers would have been in a better position to care for Ms X if they had known about the alerts.
83. Officer A said officers discussed whether they should have put Ms X in a gown after the incidents. He believed it would not have been practical or safe for either officers or Ms X for them to attempt to put her in the gown while she would not comply with instructions. Officer A told us they are usually only used if a detainee is willing to put it on themselves, as otherwise they do

¹² See paragraph 89 for relevant law.

not keep it on. He said they have recently found the gowns can be picked apart and he had seen detainees tear strips off them.

84. A gown would have been more appropriate than Ms X remaining in her own clothing or in her underpants. There were enough officers to enable her to be put in one. If Ms X had been provided with a gown but then removed it herself, that would have been her choice.

FINDINGS ON ISSUE 4

Officers should have placed Ms X in a tear-resistant gown following her attempt to self-harm with the spit hood. This would have eliminated the need to use force again immediately afterwards.

Officers should not have removed Ms X's trousers before restraining her in the chair.



Judge Colin Doherty

Chair
Independent Police Conduct Authority

29 September 2020

IPCA: 18-2964

Appendix – Laws and Policies

LAW

Use of force

85. According to Section 41 of the Crimes Act 1961, *“everyone is justified in using necessary reasonable force”* to prevent someone from committing suicide or causing immediate serious injury to themselves.
86. Section 39 of the Crimes Act 1961 provides for law enforcement officers to use reasonable force in the execution of their duties such as arrests and enforcement of warrants. Specifically, it provides that officers may use *“such force as may be necessary”* to overcome any force used in resisting the law enforcement process unless the process *“can be carried out by reasonable means in a less violent manner.”*
87. Section 48 of the Crimes Act states: *“Everyone is justified in using, in the defence of himself or herself or another, such force as, in the circumstances as he or she believes them to be, it is reasonable to use.”*
88. Under section 62 of the Act, anyone who is authorised by law to use force is criminally responsible for any excessive use of force.

Human rights

89. Section 23 of the New Zealand Bill of Rights Act 1990 allows for every detainee to be treated *“with respect for the inherent dignity of the person”*.

POLICY

‘Use of force’ policy

90. The Police Use of Force policy provides guidance to Police officers about the use of force. The policy sets out the options available to Police officers when responding to a situation. Police officers have a range of tactical options available to them to help de-escalate a situation, restrain a person, effect an arrest or otherwise carry out lawful duties. These include communication, mechanical restraints, empty hand techniques (such as physical restraint holds and arm strikes), OC spray, batons, Police dogs, Tasers and firearms.
91. Police policy provides a framework for officers to assess, reassess, manage and respond to use of force situations, ensuring the response (use of force) is necessary and proportionate given the level of threat and risk to themselves and the public. Police refer to this as the TENR (Threat, Exposure, Necessity and Response) assessment.
92. Police officers must also constantly assess an incident based on information they know about the situation and the behaviour of the people involved; and the potential for de-escalation or

escalation. The officer must choose the most reasonable option (use of force), given all the circumstances known to them at the time. This may include information on: the incident type, location and time; the officer and subject's abilities; emotional state, the influence of drugs and alcohol, and the presence or proximity of weapons; similar previous experiences; and environmental conditions. Police refer to this assessment as an officer's Perceived Cumulative Assessment (PCA)).

93. A key part of an officer's decision to decide when, how, and at what level to use force depends on the actions of, or potential actions of, the people involved, and depends on whether they are: cooperative; passively resisting (refuses verbally or with physical inactivity); actively resisting (pulls, pushes or runs away); assaultive (showing an intent to cause harm, expressed verbally or through body language or physical action); or presenting a threat of grievous bodily harm or death to any person. Ultimately, the legal authority to use force is derived from the law and not from Police policy.
94. The policy states that any force must be considered, timely, proportionate and appropriate given the circumstances known at the time. Victim, public and Police safety always take precedence, and every effort must be taken to minimise harm and maximise safety.

'People in Police detention' policy

95. A detainee must be entered into the NIA Electronic Custody Module (ECM) as soon as is practicable.
96. A full risk assessment should also be carried out as soon as possible. *"Until an evaluation takes place, all detainees are considered to be 'at risk' requiring frequent (those without signs of suicide risk) or constant monitoring (those with signs of suicide risk)."*
97. Officers need to ensure a NIA check is done *"at the earliest opportunity"*. Officers must be vigilant in checking for flags which are relevant to the detainee's safety. Officer must check previous alerts and evaluation history records to identify any risks. The officer must pass this information on to any employee receiving the detainee.
98. *"Police must take all practical and reasonable steps to prevent the suicide of detainees."* When a detainee is identified as a suicide risk, officers should consider removing their clothing and replacing it with a tear-resistant gown.
99. A detainee requires care and constant monitoring if they are restrained by a spit hood, a restraint chair, or a combination of either a rear wrist and ankle restraint, or a waist restraint belt and ankle restraint, that are linked.
100. When an employee discovers a detainee has made an attempt to commit suicide, they must first ask another employee to obtain medical assistance, then intervene to stop the attempt and do first aid. The detainee must be constantly monitored and referred to a health professional for assessment. The incident must be reported to the custody supervisor who informs the District Commander. The District Health and Safety Advisor is also advised. An occurrence and new suicide alert must be created in NIA before the detainee is released or transferred.

101. Detainees should be monitored, with checks being in accordance with their risk evaluation:
- If they require no specific care, they must be checked at least every two hours.
 - If they require frequent monitoring, they must be checked at least 5 times per hour, at irregular intervals; and
 - If they require constant monitoring, they must be directly observed without interruption.
102. The level of monitoring can be increased at any time but can only be reduced on the advice of a health professional.

‘Mechanical restraints’ policy

Spitting hoods

103. A spit hood is approved Police equipment. It comes in one size and slips over a person’s head. The top half of the hood is dark mesh so a person can still be seen, and the material used in the lower part stops the person from being able to spit, reducing the risk to others.
104. Police approved spit hoods can be used in conjunction with other approved mechanical restraints if someone is prone to spitting or has threatened to spit. Officers are instructed to only use a spit hood if they have assessed the risks and identified a risk of spitting or a person has spat at Police.
105. As a spit hood is an intrusive mechanical restraint, *“a supervisor’s authority must be obtained before using the spitting hood unless a supervisor is not available and immediate action is required to prevent the person spitting.”* If an officer had to act immediately and a supervisor has not authorised the use of a hood, they must be advised as soon as practicable.
106. As considerable force may be required, officers must have a plan and a clear understanding of each officer’s role when putting a hood on someone.
107. Spit hoods must also be applied in accordance with training and a person who is wearing a spit hood must be constantly monitored. Officers must record the time a spit hood is put on and the time it is removed. A spit hood must not be worn for more than two hours unless they have been assessed by a Police Medical Officer before the two hours is up.
108. In order to manage the risks posed to officers and members of the public, officers must:
- *“be trained in the safe application of the Police-approved spitting hood*
 - *assess and reassess any risk frequently during and after the spitting hood has been applied*
 - *not use the spitting hood on anyone who is vomiting, having difficulty breathing or bleeding profusely from the mouth and nose area.”*

Restraint chairs

109. A restraint chair is approved Police equipment. It consists of an inclined chair that uses leg, wrists, waist and chest mechanical restraints to immobilise someone. It has wheels which allows for people to be moved in and around custodial areas safely.
110. Officers must only use a restraint chair as a last resort *“to control a detainee who is violent and intent on harming themselves and/or others and where serious injury or death is a likely result and where other available mechanical restraints would be ineffective.”* Examples of this include when a person is hitting doors or walls with their body or head. In cases like this, the use of mechanical restraints such as handcuffs would be ineffective as the person would still be able to harm themselves.
111. A restraint chairs is never allowed to be used as a form of punishment.
112. As a restraint chair is an intrusive mechanical restraint, *“a supervisor’s authority must be obtained before using the restraint chair unless a supervisor is not available and immediate action is required to prevent the person harming themselves and/or others and where serious injury or death is a likely result.”* If an officer had to act immediately and a supervisor has not authorised the use of a restraint chair, they must be advised as soon as practicable.
113. Restraint chairs must be used in accordance with approved training and a person who is in a restraint chair must be constantly monitored to ensure their safety. The use of the chair must be assessed regularly during monitoring. Officers must record the time a person is placed in a restraint chair and the time they are removed. A restraint chair must not be used for more than two hours unless the person has been assessed by a Police Medical Officer before the two hours is up.
114. In order to minimise the likelihood of the person or a staff member being injured or harmed, it is recommended that a 4-person team takes control of a person who is being placed into, or removed from, a restraint chair.
115. One Police employee must take charge each time a person is restrained in a restraint chair. They must be trained and currently certified in the use of restraint chairs. Before a person is placed in the chair, the Police employee in charge must fully brief each person assisting and ensure they understand their individual role. *“During the restraint process the employee in charge must take personal control of the person’s head and provide advice, assistance and direction to the other employees as required.”*

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 Colin Doherty.

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 our Memorandum of Understanding, which covers instances which may present reputational risk to the 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 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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