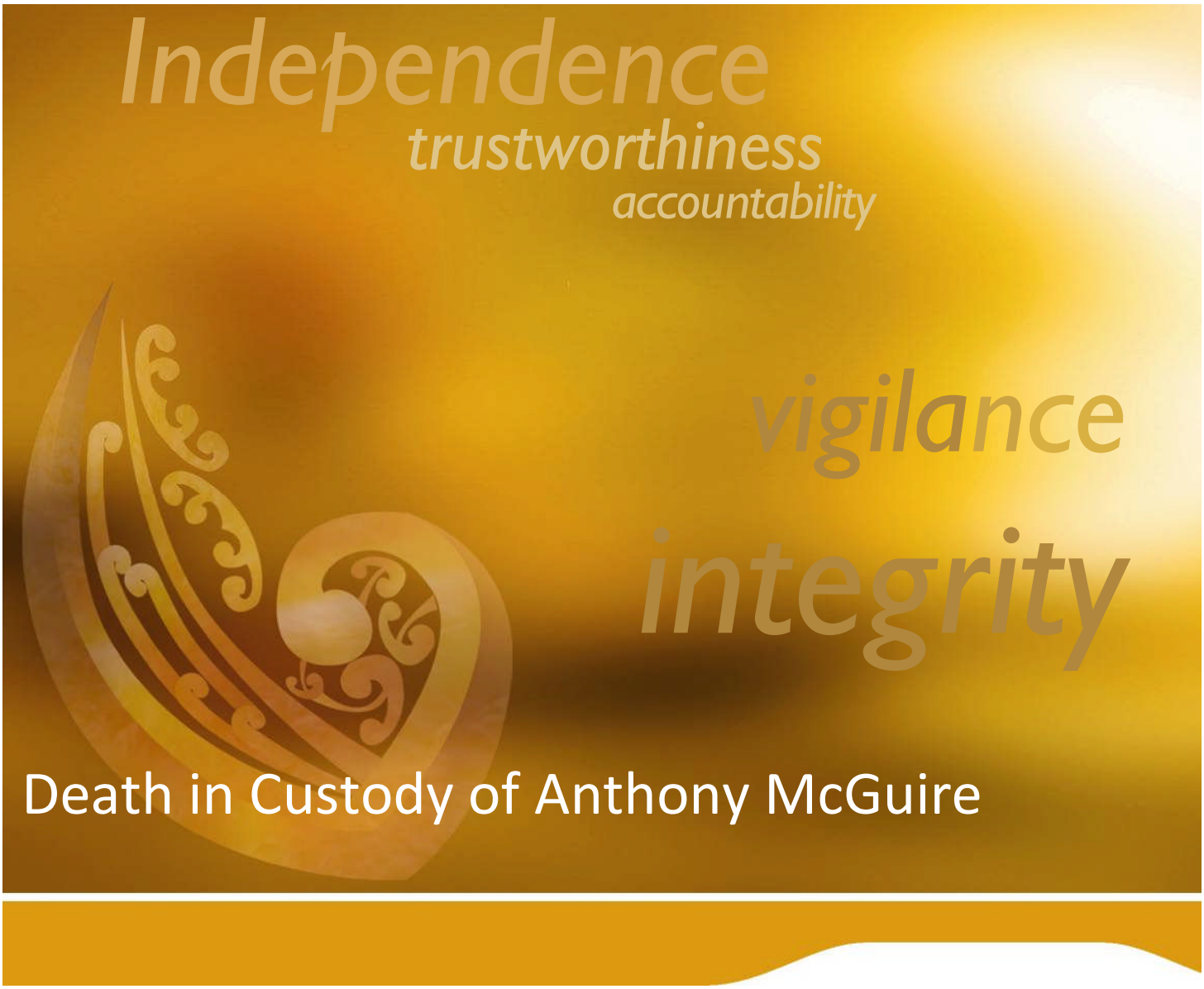

Death in Custody of Anthony McGuire

November 2010

IPCA
Independent Police Conduct Authority
Whaia te pono, kia puawai ko te tika

November 2010

IPCA
Level 8
342 Lambton Quay
PO Box 5025
Wellington 6145
Aotearoa New Zealand
0800 503 728
P +64 4 499 2050
F +64 4 499 2053
www.ipca.govt.nz

Contents

Introduction and Background

INTRODUCTION

1. Anthony McGuire, aged 33, was found dead in a cell at the Rotorua Police Station at 8.56pm on 26 May 2008. Mr McGuire had been arrested following a domestic incident and placed in the cell at 5.28pm that evening.

2. As required under section 13 of the Independent Police Conduct Authority Act 1988 (the Act), the Police notified the Authority of the death, and the Authority conducted an independent investigation. This report sets out the results of that investigation and the Authority's findings and conclusions.

Glossary of Officers

Officers	Roles	Comment
Officer A	constable	Arrested Mr McGuire.
Custody Officer B	temporary sworn officer[1]	Received Mr McGuire in the charge room. Six weeks experience
Custody Officer C	temporary sworn officer	Placed Mr McGuire in a cell. Six weeks experience
Officer D	constable	Supervisor of Custody Officers B and C
Officer E	acting sergeant	Trained for supervisory duties as an acting section sergeant on the afternoon Mr McGuire was brought to the cells.

[1] A 'temporary sworn' officer is not a fully qualified constable, but is authorised to perform a defined range of duties involving the exercise of sworn powers – in this case the duties relating to the care and management of prisoners in Police custody.

BACKGROUND

Summary of events

3. On the afternoon of 26 May 2008, Officer A and a partner officer were called to a domestic incident at Rotorua involving Mr McGuire and Ms X. Ms X told the officers that Mr McGuire had driven to her home, pushed her while she was holding their baby, and tried to strangle her.

4. At approximately 4.10pm, Officer A arrested Mr McGuire for assault upon Ms X. Officer A did not carry out any search of Mr McGuire.

5. Officer A and his partner then took Mr McGuire to the Rotorua Police Station, where he was tested for excess breath alcohol and returned a positive result.

6. Officer A took Mr McGuire to a holding area in the charge room, where he was charged with 'assault with intent to injure' and 'driving with excess breath alcohol'.

7. When Mr McGuire was brought to the Rotorua cells, Custody Officers B and C were on duty as the late shift custody officers, temporary sworn roles with responsibility for receiving and processing people to be held in custody. Their duties included searching, fingerprinting and photographing prisoners and carrying out risk assessments.

8. Officer D was responsible for supervising Custody Officers B and C. Acting section sergeant, Officer E, was also on duty. He was responsible for overseeing staff and prisoners in the watchhouse as well as officers on patrol.

9. Mr McGuire had been advised of his Bill of Rights by Officer A and expressed his wish to speak to a lawyer. Officer A showed him the list of duty solicitors that was kept in the charge room.

10. Officer A and Custody Officer B tried to contact four lawyers for Mr McGuire but could only reach answering machines. Officer A told Mr McGuire that he would not be granted Police bail and would therefore stay in custody overnight. Police do not usually grant bail to people accused of domestic violence because of concerns for the safety of the alleged victim.

11. Officer A completed some sections of Mr McGuire's custody/charge sheet with details he was aware of from carrying out the arrest. He did not however answer a question in the arresting officer's section of the custody/charge sheet relating to whether he was aware of any reason why Mr McGuire may be at risk while in custody.

12. Custody Officer B did not complete the 'Watchhouse Keeper's Evaluation of Condition of Person in Custody' section of the custody/charge sheet, which was one of his duties.

13. Mr McGuire was not searched, fingerprinted, or photographed by either Custody Officer B or C before being placed in a cell at 5.28pm by Custody Officer C.

14. At the time, Mr McGuire was still in possession of shoes with laces, a necklace, bracelet, and hooded sweatshirt and shorts with drawstrings. He also had cigarettes and a lighter.

15. The day after Mr McGuire's death, Custody Officers B and C both made statements.

Custody Officer B said:

"I did not assist in filling out any part of the charge sheet for the prisoner McGuire. I cannot recall if I was asked to or not.... I cannot recall how McGuire got from the charge room down to the cells."

This officer recalled seeing Mr McGuire in a cell when taking another prisoner to a cell at about 7.15pm. Mr McGuire was lying on the bed facing the wall and appeared to be asleep.

Custody Officer C said:

"I can't remember [Mr McGuire] arriving, coming into the charge room or even going into the cells. I don't recall even seeing him in the cells, him asking for anything at all."

The CCTV footage shows that it was Custody Officer C who took Mr McGuire to his cell.

16. No checks of Mr McGuire were recorded in the Inspection of Prisoners book. CCTV footage shows that Custody Officers B and C visited the cell area in the course of their duties on the evening of 26 May 2008. They walked past Mr McGuire's cell at least 14 times between 5.28pm and 8.45pm, however the footage does not show either officer entering the cell to check on him.

17. The last confirmed sighting of Mr McGuire alive was at 7.30pm, when another prisoner saw him lying on the bed in his cell. Sometime between then and 8.56pm, Mr McGuire removed the laces from his shoes, used them to make a ligature and hanged himself from the wire mesh of the cell door.

18. At 8.56pm, a prisoner who was being escorted to a cell by Custody Officer C noticed that Mr McGuire was hanging from his cell door and alerted the officer.

19. Despite immediate medical attention by officers and paramedics Mr McGuire could not be revived.

Police officers involved

20. Officer A had been a constable for over 2 years at the time of Mr McGuire's death. He was certified in custodial suicide awareness and first aid.

21. Custody Officers B and C each had about six weeks of experience as custody officers. They had been trained for staffing in a new custodial facility in Rotorua, but were working in the 'old' Police cells because of a delay in the opening of the new facility. Their training included custodial suicide awareness and first aid.

22. Officer D had nine years experience as a constable and was assigned responsibility for supervising the custody officers on the night of Mr McGuire's death. He had current custodial suicide awareness and first aid certifications. He had recently been assigned to the Rotorua Watchhouse on a Performance Improvement Plan (PIP) because of his poor performance as a court escort officer.

23. Officer E had eight and a half years of experience as a constable. He received training on his duties as an acting section sergeant earlier in the day Mr McGuire died. This training briefly addressed his responsibilities in relation to supervision of the watchhouse. In his statement after Mr McGuire's death, he said that he had not been told specifically what his role was in relation to the custody officers.

Situation at the Rotorua watchhouse

24. At the time Mr McGuire was found dead there were 14 other prisoners in the cells, however there appears to have been up to 22 prisoners present earlier in the evening. There were only two custody officers on duty to receive, process and monitor them in the cells.

25. Custody Officer C was diverted from his routine watchhouse duties when prisoners were brought back to the cells from court without their custody documentation, which meant he had to go to the court, before it closed at 5pm, to attempt to locate the documents.

26. No sergeant was appointed to supervise the Rotorua watchhouse during the late shift. Officer E as the acting section sergeant was expected to look after the watchhouse in addition to managing and supervising the officers on patrol.

27. Officer D, who had the responsibility of supervising the custody officers, was on a PIP and had been identified by Rotorua Police management as someone requiring *"an increased level of supervision when managing prisoners"*.

Post mortem and toxicology

28. A post mortem examination established that Mr McGuire's death was due to neck compression secondary to hanging.

29. Toxicology results established that Mr. McGuire's blood contained 130 milligrams of alcohol per 100 millilitres. There was no evidence of other substances in his blood.

Coroner's findings

30. The Coroner found that the cause of death was *"Neck compression secondary to hanging."*

31. He made two recommendations under section 57(3) of the Coroners Act 2006 in relation to the Police:

> *"I recommend that the New Zealand and Rotorua Police review their communication processes in respect of not granting bail to people arrested for alleged domestic violence offences.*
>
> *I recommend that the New Zealand Police must continually audit and review their procedures surrounding the retaining of people in custody overnight. There must be a proper audit trail to ensure that the policies and protocols are working and, in my view, there should be a zero tolerance policy. The lapses in this case were extraordinary and followed very recent training. The Police were very frank and open and honest in acknowledging the lapses and senior policemen in evidence could not understand how it had occurred. However, it had, and clearly there was no audit trail to ensure they were working. That relates to proper supervision at the time and these procedures must be regularly audited and followed through with each prisoner periodically."*

Police response to Coroner's recommendations

32. In response to the first recommendation from the Coroner, in relation to the Police's communication processes, Rotorua Police have advised the Authority that people who are denied Police bail are informed that they will be brought before the court at the next opportunity. At that time they can speak to a duty solicitor and make an application for bail. This is in accordance with the law and should be the invariable practice.

33. With regard to the second recommendation, shortly after Mr McGuire's death the new Police custody facility was opened and the old Police cells were decommissioned. The level of supervision at that facility has been improved by the appointment of sergeants to supervise the custody staff during every shift. The custody documentation is now completed electronically, requiring staff to enter information in certain mandatory fields before the custody record can be finalised. Custody supervisors are required to complete an 'end of shift report' which notes any problems that arose during the shift. There is a clear record of the activity in the cell block and an improved ability for Police to audit that activity and the custody documentation.

POLICE POLICIES, PRACTICES AND PROCEDURES

Duty of care

34. Police owe a legal 'duty of care' to all people arrested, detained or placed in their custody. This duty begins from the moment the person is detained and applies until the person is released from custody or transferred into the care of another agency.

35. The Police duty of care is found in section 151 of the Crimes Act 1961 and in the common law, and is recognised in Police policies and instructions relating to the care of people in custody.

36. The common law duty of care, which requires Police to take reasonable care for persons whom they take into their custody, has been considered in numerous cases and is identified in the *Police Custodial Management: Suicide Awareness Manual* ('the Manual'). The Manual's 'Duty of Care' chapter, citing cases and commentary on this area of law, provides: "*…there is a duty on the person having custody of another to take all reasonable steps to avoid acts or omissions which he could reasonably foresee would be likely to harm the person for whom he is responsible*."

37. In May 2008, the care of prisoners was governed at national level by Police General Instructions (GIs), and locally by the Rotorua Standard Operating Procedures for Custodial Management (Rotorua Police SOPs).

Searching of prisoners

38. GI S101 (Reasons for Search) provides that Police may search a person in order to remove any article or substance which the person may use to harm themself, other prisoners, Police or members of the public. They may also search a prisoner if he or she is considered to be at risk of attempting suicide.

39. GI S106 (Justification for Strip and Full Body Searches), states that every strip search must be:

> *"...justifiable on its merits, on a case-by-case basis, and there must be a good reason or reasons for such a search.... Police districts, areas, stations or units are not to have any standing orders, instructions, mandated procedures or customary practices which require, as a matter of routine, all prisoners, or suspects for certain offences, to be subjected to a strip or full body search."*

40. Rotorua Police SOPs required that: "*All offenders are to be **searched** at the time of arrest and prior to being placed in the patrol vehicle or any holding cell within the custodial facility."* [Emphasis in original.] They further required the arresting officer to take from

the person in custody *"All property and items ... that could be used to inflict harm on police staff or other persons in custody or harm to the offender*."

41. The Rotorua SOPs also stated that: *"Where a prisoner is not being bailed and will be held in custody, he/she is to be **strip searched."*** [Emphasis in original.]

Receiving and assessment of prisoners

42. GI F013 (Persons to be Fingerprinted and Palmprinted) and P043 (Persons to be Photographed) and the Rotorua Police SOPs state that a person in custody who is charged with an offence must be fingerprinted, palmprinted and photographed.

43. As part of the Police duty of care towards people being held in their custody, all people who are detained or arrested must be evaluated for risks to their health and safety. GI P100 (Evaluation of Persons Detained in Police Custody and Prisoners) requires that an evaluation of a person received into custody *"…must be undertaken using the Watchhouse Keeper's Evaluation of Condition of Person in Custody section of the Custody/Charge Sheet"*.

44. In order to conduct the Watchhouse Keeper's Evaluation, the officer must ask the person in custody specific questions relating to his or her medical history and mental state. On the basis of the answers to these questions as well as the observations of the officer and any other relevant information, the person in custody is classified into one of three categories depending on the risk they pose to themselves and/or others.

45. The categories are:

- not in need of specific care;
- in need of care; or
- in need of care and constant monitoring.

46. If the person in custody is assessed to be in need of care or in need of care and constant monitoring, the watchhouse keeper (or custody officer) must complete a Health and Safety Management Plan for Person in Custody. The assessment must then be approved by the watchhouse supervisor.

47. Extra measures are taken for people judged to be in need of care or in need of care and constant monitoring. For example they are placed in a suicide-resistant cell if possible.

Monitoring of prisoners

48. GI P110 (Supervision of Prisoners) requires that: "*All prisoners in police custody are to be checked (visited) at the beginning and at the end of each shift, and at least every two hours during the shift."*

49. The Rotorua Police SOPs state that the watchhouse supervisor is responsible for ensuring that these checks are carried out.

50. The Rotorua Police SOPs also required that: *"All checks (visits) of prisoners by police members, the movements of prisoners to and from cells, meals, showers, visitors, etc are to be recorded in the Inspection of Prisoners book."*

Right to a lawyer

51. Police must give a person being held in their custody access to a lawyer if the person requests it. Section 23(1)(b) of the New Zealand Bill of Rights Act 1990 provides that: *"Everyone who is arrested or who is detained under any enactment shall have the right to consult and instruct a lawyer without delay...."*

THE AUTHORITY'S FINDINGS

Searching of prisoners

52. The Rotorua Police SOPs required Mr McGuire to be searched both at the time of arrest and prior to being placed in a holding cell (see paragraph 40).

53. The arresting officer, Officer A, did not search Mr McGuire at the time of his arrest. Custody Officer B did not search Mr McGuire when he arrived in the charge room at the station, and Custody Officer C did not search him before placing him in a cell.

54. The SOPs also required the arresting officer to take from Mr McGuire any items that could be used to inflict harm on himself or others.

55. Officer A did not take any items from Mr McGuire; nor did Custody Officers B and C. He was placed in a cell in possession of several items with which he could harm himself or others, including jewellery, a lighter, cords from his clothing and shoelaces.

56. The officers who failed to search and remove items from Mr McGuire did not follow the Rotorua Police SOPs and provided the opportunity for Mr McGuire to hang himself.

FINDING
Police failed to comply with policy and standard operating procedures in respect of searching people in custody.

Additional matters

57. In May 2008, Rotorua Police policy required officers to strip search all prisoners who were not bailed. This was contrary to GI S106, which prohibited Police from conducting routine strip searches. The Rotorua Police SOPs have since been amended to comply with the General Instructions. They now provide that: *"Where a prisoner is not being bailed and is to remain in custody, he/she should not be strip searched unless there are good reasons*

for doing so." The irony is that had the District's strip search policy of the day been followed, Mr McGuire would not have had possession of anything with which to hang himself.

Receiving and assessment process

58. GIs FO13 and PO43 state that a person in custody who is charged with an offence must be fingerprinted, palmprinted and photographed (see paragraph 42). GI P100 addresses the evaluation requirements of a person detained in Police custody (see paragraphs 43-45).

59. Mr McGuire was not fingerprinted, palmprinted or photographed and his custody documentation was incomplete, specifically:

- Officer A did not indicate on the custody/charge sheet whether, as the arresting officer, he was aware of any medical or psychological reasons why Mr McGuire may be at risk while in custody.
- The Accused Person's Property section of the custody/charge sheet was not filled in. This was the responsibility of the custody officers (Custody Officer B or C).
- The Watchhouse Keeper's Evaluation section of the custody/charge sheet was left blank. This should have been completed by Custody Officer B or C.
- The custody/charge sheet was not signed by a custody officer (either Custody Officer B or C) or by the watchhouse supervisor (Officer D or E). Officer E explained that he had not had time to sign the custody/charge sheet before Mr McGuire was found dead in his cell.

60. None of the officers responsible for Mr McGuire's care asked him any questions about his health or state of mind. It was the custody officers' duty to conduct a risk assessment of Mr McGuire and if either Custody Officer B or C had done so he may have been found to be 'in need of care' or 'in need of care and constant monitoring' (see paragraphs 45-47). This would have resulted in Mr McGuire being placed in a suicide-resistant cell, issued with a tear-resistant gown and monitored appropriately.

61. It was established, following Mr McGuire's death, that he suffered from depression, had an alcohol problem and was experiencing a relationship break up. Had Mr McGuire been asked the questions in the Watchhouse Keeper's Evaluation, these factors may have been discovered and would have indicated that Mr McGuire was at risk of self harm.

62. Mr McGuire may not have been forthcoming with such information; however there were some common external signs, recorded in the custody/charge sheet, that he:

- was intoxicated;
- had been arrested because of a domestic violence incident; and

- was being detained in custody overnight (Officer A noticed that he *"went quiet"* after being told he would not get bail and Custody Officer B noticed that he appeared *"angry and pissed off")*.

63. The officers involved in Mr McGuire's care did not properly conduct any of the assessments required by Police policy.

64. The prime fault was a lack of communication between the officers who dealt with Mr McGuire while he was in custody, namely:

- Officer A assumed that Custody Officer B had taken responsibility for processing Mr McGuire;
- Custody Officer C put Mr McGuire in a cell without consulting Custody Officer B or checking that he had completed the receiving process; and
- Custody Officer B did not follow up with the other officers regarding whether Mr McGuire had been processed.

65. None of the officers have been able to explain why correct procedures were not followed. In a statement the day after Mr McGuire died, Custody Officer C said he could not remember dealing with Mr McGuire at all, even though he took Mr McGuire to a cell (see paragraph 15).

FINDING

Mr McGuire was not managed correctly by the Police following his arrest and detention. There were significant breaches of Police policy by the officers involved.

Adequacy of checks while in custody

66. GI P110 required that Mr McGuire be visited at the beginning and end of each shift, and at least every two hours during the shift. The watchhouse supervisor is responsible for ensuring that these checks have taken place and the checks are recorded in the Inspection of Prisoners Book (see paragraphs 48-50).

67. As discussed in paragraph 16, there is no CCTV footage of either Custody Officer B or Custody Officer C entering Mr McGuire's cell to check on him. Custody Officer B recalled seeing Mr McGuire in his cell once, but did not speak to him or record this as a check on Mr McGuire. The Inspection of Prisoners book has no record of Mr McGuire receiving the required two-hourly inspection.

68. Officer D, who had been given responsibility for supervising Custody Officers B and C, did not visit the cell area at all. He did not ensure that two-hourly inspections of the

prisoners in the cells were being carried out and recorded in the Inspection of Prisoners Book.

69. Officer E has said that he was not aware that one of his duties as an acting section sergeant was to ensure that the two-hourly inspections took place. He understood Officer D to be responsible for this.

FINDING
Police did not comply with policy in relation to the mandatory inspection requirements.

Supervision of police staff

Actions of Officer D

70. Officer D was assigned the duty of supervising Custody Officers B and C.

71. Custody Officers B and C were inexperienced, having only six weeks experience as custody officers. Officer D left them to receive, process and care for prisoners without any oversight.

72. In a statement the day after Mr McGuire's death, Officer D said that when prisoners started to arrive he "*left it up to [Custody Officers B and C] to process those prisoners*" as they were *"both very capable".*

73. Officer D did not conduct any checks of the prisoners or inspect the custody/charge sheets and the Inspection of Prisoners book. He failed to fulfil his responsibilities as a supervisor.

Actions of Officer E

74. Officer E was the acting section sergeant. He was tasked with overseeing the watchhouse as well as managing the officers on patrol.

75. One of his duties was to check that the custody/charge sheets were completed fully and correctly. He had not done this by the time Mr McGuire was found dead, which was more than three hours after he had been put into a cell.

76. Officer E had been given training on his responsibilities as an acting section sergeant on the day Mr McGuire died. Nonetheless he has said that he had not been informed of his role in relation to the supervision of the custody officers (see paragraph 23).

77. If the custody officers had been properly supervised by Officers D and E, their failure to search, evaluate and monitor Mr McGuire would have been discovered and rectified.

FINDING

Officers D's and E's supervision of the custody officers was inadequate.

Station Management

78. Rotorua Police, at station management level, should have been alert to the lack of appropriate supervision at the Rotorua watchhouse at the time of Mr McGuire's death.

79. In particular, Officer D had a supervisory role, although he was on a PIP that required him to have extra supervision when managing prisoners.

80. The failure to ensure that custody staff had satisfactory supervision put prisoners and staff at risk. It was undesirable for the inexperienced custody officers to be left to deal with numerous prisoners without adequate oversight.

FINDING

The Rotorua watchhouse and custody areas were not appropriately staffed and supervised.

Right to a lawyer

81. The New Zealand Bill of Rights Act specifies that everyone who is arrested shall have the right to consult a lawyer without delay.

82. Officer A and Custody Officer B attempted to contact four different lawyers for Mr McGuire. None were available. Ultimately Mr McGuire was unable to speak to a lawyer that evening.

FINDING

Police made a reasonable attempt to contact a lawyer for Mr McGuire.

Subsequent actions

83. The Coroner recommended that the Legal Services Agency:

> *"...give urgency to the establishment of a national on-call legal service for prisoners in custody. That service should be properly resourced and be available to all prisoners at any time of the day or night."*

Medical assistance

84. Mr McGuire was found hanging from his cell door at 8.56pm. Custody Officer C immediately cut the ligature from Mr McGuire and together with Officer D commenced CPR. Both officers had current first aid certifications.

85. Paramedics received a call to attend at the Rotorua Police Station at 8.59pm and attended at 9.02pm. Upon arrival they asked the officers to continue the CPR while they prepared their equipment. They then took over the CPR. At 9.14pm a senior paramedic terminated CPR. Mr McGuire was not responding and had died.

FINDING

The medical assistance provided by the officers was immediate and appropriate, albeit too late.

DISCIPLINARY AND REMEDIAL ACTION

86. The Police considered whether, arising from the Police duty of care, there was any criminal liability for Mr McGuire's death on the part of the officers involved in his detention and decided there was not. The Authority notes that the Police obtained a Crown Solicitor's opinion before reaching this conclusion.

87. However, the conduct of the officers involved was found to breach the Police Code of Conduct. Custody Officers B and C and Officer D were disciplined through the issue of written warnings as a result of their failings in the care of Mr McGuire.

88. Significant changes have been made to practices in the (new) Rotorua custody facility since Mr McGuire's death, including:

- every prisoner's footwear is removed and placed with the prisoner's property;
- the custody/charge sheet and the former Inspection of Prisoners book are recorded electronically;
- the custody facility has dedicated supervisors; and
- custody documentation is audited regularly.

Conclusions and Recommendations

CONCLUSIONS

89. The Police had a duty of care in respect of Mr McGuire which was not fulfilled.

90. Had Mr McGuire been searched, assessed for risk, and monitored in accordance with policy, he would not have had the opportunity to commit suicide in the manner that he did.

91. In terms of section 27(1) of the Act, the omissions by several officers to perform their duties in accordance with Police policies, practices and procedures were unjustified and undesirable.

92. The environment in which officers were working at the time of Mr McGuire's death, in particular the lack of adequate supervision of Custody Officers B and C, contributed to a situation in which Mr McGuire was able to commit suicide.

RECOMMENDATIONS

93. The Authority makes no recommendations to the Commissioner of Police, pursuant to section 27(2) of the Act, on the basis that:

- it has noted the recommendations of the Coroner and the Police's response (see paragraphs 30-33);
- it recognises that the Police at Rotorua have moved into a new custodial facility and have significantly improved their processes with regard to the management of persons in custody;
- policies, practices and procedures in place at the time of Mr McGuire's death were sufficient, had they been followed, to have prevented Mr McGuire's suicide at the time and in the manner it occurred; and

- the Police considered criminal proceedings against the officers involved and have taken disciplinary action.

HON JUSTICE L P GODDARD

CHAIR

INDEPENDENT POLICE CONDUCT AUTHORITY

3 NOVEMBER 2010

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.

It is not part of the Police – the law requires it to be fully independent. The Authority is chaired by a High Court Judge.

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 has highly experienced investigators who have worked in a range of law enforcement 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;
- 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 determine whether any Police actions were contrary to law, unreasonable, unjustified, unfair, or undesirable. The Authority can make recommendations to the Commissioner.

PO Box 5025, Wellington 6145
Freephone 0800 503 728
www.ipca.govt.nz

IPCA
Level 8
342 Lambton Quay
PO Box 5025
Wellington 6145
Aotearoa New Zealand
0800 503 728
P +64 4 499 2050
F +64 4 499 2053
www.ipca.govt.nz