

Independent Police Conduct Authority

**Thematic Report:  
Deaths in Custody-  
A Ten Year Review**



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# Deaths in Custody – A Ten Year Review

INDEPENDENT POLICE CONDUCT AUTHORITY

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## Glossary of terms

Abbreviation/term	Explanation
ACPO	Association of Chief Police Officers (England, Wales and Northern Ireland)
AOD	Alcohol and Other Drug
CAT	Community Assessment Team (OR Community Assessment and Treatment Team OR Crisis Assessment Treatment Team)
DAO	Duly Authorised Officer
GI	General Instructions, the highest level of police instructions issued by the Police Commissioner
HPRE	Health Professional Record of Examination, used from March 2005
HSMP	Health and Safety Management Plan for a Person in Custody, used from March 2005
IPCC	Independent Police Complaints Commission (England and Wales)
MRE	Medical Record of Examination, used prior to March 2005
NDICP	National Deaths in Custody Program (Australia)
NIA	National Intelligence Application, the New Zealand Police database
NPM	National Preventive Mechanism (under the OPCAT)
OPCAT	Optional Protocol to the Convention Against Torture
PMAF	Prisoner Management Assessment Form, used prior to March 2005
SPT	United Nations' Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

**Statistical note:** Some percentages may not add to 100% due to rounding.



# Executive Summary

INDEPENDENT POLICE CONDUCT AUTHORITY

1. In late 2010 the Independent Police Conduct Authority began a review of 27 deaths which occurred in the custody of the New Zealand Police during the preceding 10 years.
2. The main purpose of the review was to examine the circumstances of each death and identify any recurring issues or developing trends.

## SUMMARY OF FINDINGS

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3. Some of the key findings of the review were that:
  - All except one of the people who died while in police custody were male, and almost half were Maori.
  - The ages of the people who died ranged from 19 to 68 years. The average age was 38.5 and the median 37.
  - The most common cause of death was suicide by hanging, of which there were 10 cases (37%). However the number of suicides in custody has decreased in recent years.
  - Seven (25.9%) of the deaths followed the use of restraint by police during arrest, and seven (25.9%) were caused by the detainee's medical condition. Three (11.1%) of the deaths were due to drug-related causes.
  - Fourteen (51.9%) of the deaths involved people affected by mental health issues, including history of self-harm/suicide attempts, threats to commit suicide, depression, and schizophrenia.
  - Thirteen (48.1%) of the people who died in police custody were affected by alcohol at the time of their arrest, and nine (33.3%) were affected by drugs. Five of the 27 deaths (18.5%) involved people who were only in custody for the purposes of detoxification.

- Fifteen (55.6%) of the people who died in custody had been assessed as being at no risk, and eight (29.6%) had not undergone a formal risk evaluation.
  - Four of the 27 deaths involved serious neglect of duty or breaches of policy by police.
4. The recurring issues that emerged from the deaths in custody review include:
- the extent to which the detainees were affected by alcohol and drugs;
  - the mental health of the detainees;
  - police methods of restraint and the danger of restraint asphyxia;
  - problems with the searching, risk assessment and monitoring of detainees;
  - the provision of medical treatment to detainees;
  - handover procedures and the safety of police cells; and
  - the need for more extensive training of custody staff.

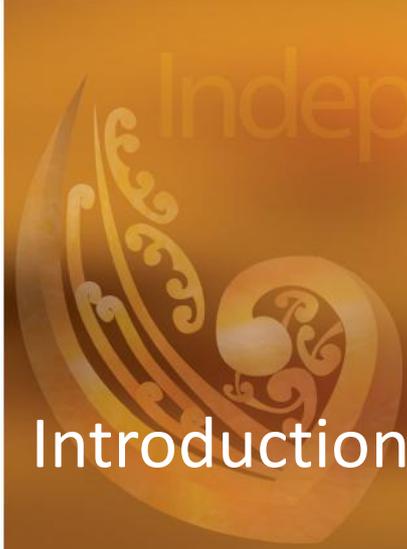
#### SUMMARY OF RECOMMENDATIONS

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5. The Authority has recommended that the New Zealand Police:
- 1) work with the Ministry of Health and other appropriate stakeholders towards the establishment of detoxification centres or temporary shelters in order to provide appropriate medical care for heavily intoxicated persons;
  - 2) ensure that the training provided to staff reinforces the dangers associated with restraining people in a prone position with their hands tied behind their back;
  - 3) ensure that the training provided to staff reinforces the risks of positional asphyxia and other restraint-related medical conditions, and the appropriate tactical options for dealing with people who may be affected by these conditions;
  - 4) amend the Custody/Charge Sheet to include a prompt to search the detainee and to record the outcome of the search;
  - 5) amend the *Managing Prisoners* chapter of the Police Manual to direct that custody staff are required to record and explain any decision not to contact a family member or other appropriate person when they are going to release a detainee that has been found to be in need of care (and frequent or constant monitoring) while in custody;
  - 6) provide custody staff with objective guidance (in the *Managing Prisoners* chapter of the Police Manual, the electronic custody module and the Custody/Charge

- Sheet) as to when a detainee should be assessed as being in need of care and frequent or constant monitoring;
- 7) amend the electronic custody module and the Custody/Charge Sheet to indicate that detainees who are unconscious or semi-conscious, unable to answer the risk assessment questions, and/or physically unable to look after themselves must be taken to hospital (as per the *Managing Prisoners* chapter of the Police Manual);
  - 8) amend the risk evaluation in the electronic custody module and the Custody/Charge Sheet so that the questions relating to the medical condition of the detainee are grouped together (including questions about injury, illness or pain) and separated from the suicide risk indicators;
  - 9) amend the risk evaluation in the electronic custody module and the Custody/Charge Sheet to include questions in respect of the level of consciousness of the detainee and the possible presence of a head injury;
  - 10) provide custody staff with clearer guidelines in relation to the checking and rousing of detainees (particularly those under the influence of alcohol or drugs);
  - 11) amend the *Managing Prisoners* chapter of the Police Manual to direct that custody staff are required to record and explain any decision not to contact a health professional for advice as to whether a detainee's medication should be administered by a health professional;
  - 12) amend the *Managing Prisoners* chapter of the Police Manual so that, in addition to being required to create NIA alerts when a detainee is known to have suicidal tendencies, custody staff are required to create a NIA alert when it is known that the detainee is a drug user or suffers from an ongoing medical condition;
  - 13) develop a formal shift handover process in respect the care of detainees for inclusion in the *Managing Prisoners* chapter of the Police Manual;
  - 14) continue to remove all potential hang points and CCTV blind spots, and to assess all police cells, including holding cells and day rooms, for suicide risks;
  - 15) amend the *Managing Prisoners* chapter of the Police Manual so it clearly states that detainees assessed to be in need of care and frequent or constant monitoring must be examined by a police medical officer, DAO or CAT member;
  - 16) amend the HSMP form so that it:
    - clearly states the requirement for custody staff to call a police medical officer, DAO or CAT member to examine a detainee because he or she has been found to be in need of care and frequent or constant monitoring; and

- includes a prompt for the custody officer to create a NIA alert when the detainee has been assessed to be in need of care while in custody;
- 17) work with the Ministry of Health towards extending the watchhouse nurse programme so that custody staff nationwide have better access to medical advice for the care of detainees;
- 18) continue developing a national training module to meet the requirements of employees assigned to duties in the watch house, with particular emphasis on responsibilities for the evaluation of risk and the care and protection of persons in custody (as recommended by the Authority in its report on the death of Francisco Javier de Larratea Soler, published on 1 July 2011);
- 19) resume working with the Authority towards the establishment of a framework for near miss reporting; and
- 20) engage with the Authority to develop an OPCAT awareness strategy and advance the agreed plan to develop an IPCA / Police OPCAT panel. The OPCAT awareness strategy and joint panel will provide a platform for raising staff awareness about custodial issues and enable effective implementation of custody-related recommendations.



# Introduction

INDEPENDENT POLICE CONDUCT AUTHORITY

6. In late 2010 the Independent Police Conduct Authority (the Authority) began a review of deaths in police custody which had taken place during the preceding 10 years. This review was prompted by several deaths in custody of heavily intoxicated detainees, and was conducted in light of the Authority's responsibilities as a National Preventive Mechanism under the Optional Protocol to the Convention against Torture (see paragraphs 18-23).
7. The purposes of this review were to profile the people who died in custody, identify trends, and determine recurring issues throughout the cases.
8. The review consisted of:
  - the analysis of 27 deaths in or following police custody which were referred to the Authority under section 13 of the Independent Police Conduct Authority Act 1988 (the Act) during the 10-year period from 1 January 2000 to 1 January 2010;<sup>1</sup>
  - an assessment of New Zealand Police policies and procedures for managing people in custody; and
  - consideration of international policies and research on deaths in police custody.
9. This paper discusses the findings of the review, in particular the recurring issues that have arisen in the 27 deaths.
10. As a result of the review, the Authority makes a number of recommendations in respect of the management of detainees. In making these recommendations, the Authority

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<sup>1</sup> The Authority notes that only two deaths in police custody have occurred since 1 January 2010 (see paragraphs 24-26 for a definition of the term 'death in custody'). In one case, an elderly woman suffered a heart attack while being transported to a mental health facility by police and later died. The Authority's investigation concluded that the force used by police was minimal and justified, and did not contribute to her death. The other death involved a man who died after police told him he was under arrest. The Authority's investigation into this death has not yet been completed, so it has not been included for discussion in this report.

acknowledges the efforts made by the Police in recent years to improve policies and procedures relating to the care of people in police custody.

11. While it is the Authority's role to express views and make recommendations, the responsibility for determining appropriate policy rests with the Commissioner of Police.



# Background

INDEPENDENT POLICE CONDUCT AUTHORITY

12. While it is rare in New Zealand for people to die while in police custody, such deaths can be controversial. There may be issues around the use of force by police during an arrest, or with the standard of care police provide to a detainee.
13. When a person dies while he or she is in custody, it has a serious impact on both the family of the deceased person and the police officers involved. Public confidence in the police may also be affected.
14. While not all deaths in custody are foreseeable or preventable, in some cases the actions or omissions of police staff may be a contributing factor.
15. In this paper the Authority examines the circumstances of 27 deaths in custody and considers whether improvements can be made to police policies and procedures in order to reduce the likelihood of deaths in custody in the future.

## INVESTIGATION OF DEATHS IN CUSTODY

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16. International case law states that, because people in custody are particularly vulnerable to abuse, an “effective” and “independent” investigation is required whenever a person has died while being detained.<sup>2</sup>
17. In New Zealand, the Commissioner of Police must notify the Authority whenever “a Police employee acting in the execution of his or her duty causes, or appears to have caused, death or serious bodily harm to any person”.<sup>3</sup> The Authority may then conduct its own

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<sup>2</sup> *Salman v Turkey* (2000) 34 EHRR 102, para 99; *Jordan v UK* (2001) 37 EHRR 52, para 106; Council of Europe, *Opinion of the Commissioner for Human Rights: Concerning Independent and Effective Determination of Complaints Against the Police* (CommDH 2009(4), 12 March 2009), para 48.

<sup>3</sup> Independent Police Conduct Authority Act 1988, section 13.

investigation into the incident, where it is satisfied that there are reasonable grounds to do so in the public interest.<sup>4</sup>

## OPCAT

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18. The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention) entered into force on 26 June 1987 and is designed to prevent torture and ill-treatment. The Optional Protocol to the Convention against Torture (OPCAT) entered into force on 22 June 2006 and is designed to provide an operational framework for State Parties to meet their obligations under the Convention. Following the enactment of amendments to the Crimes of Torture Act 1989, New Zealand ratified the OPCAT on 14 March 2007.
19. Ratification of OPCAT provides a significant opportunity to ensure that all places of detention in New Zealand are safe, humane environments that meet international human rights standards. OPCAT is an international instrument concerned with the *prevention* of violations and establishes a dual process of international and national monitoring and reporting.
20. In New Zealand, the Authority is one of four designated National Preventive Mechanisms (NPMs) co-ordinated by the Central NPM, the New Zealand Human Rights Commission. Pursuant to section 27 of the Crimes of Torture Act 1989, the Authority has statutory authority to:
  - Examine conditions of detention and the treatment of detainees (sections 27(a)(i) and (ii));
  - Make recommendations to those in charge of detention facilities with respect to the improvement of conditions of detention, the treatment of detainees, and the prevention of torture and other cruel, inhuman or degrading treatment or punishment in places of detention (sections 27(b)(i) to (iii)); and
  - Provide an annual report on its statutory functions and findings (sections 27(c) and (d)).
21. NPMs are entitled, pursuant to section 28 of the Crimes of Torture Act, to have unrestricted access to all information relating to the number, treatment of, and conditions applying to detainees. Section 34 provides that where a NPM has powers in

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<sup>4</sup> Independent Police Conduct Authority Act 1988, section 12(1)(b).

relation to the exercise of any functions under any other Act, the NPM has, in relation to the exercise of its OPCAT functions, the same powers.

22. The Authority is the designated NPM mandated to monitor the treatment of people held in police cells or who are otherwise in the custody of police. Each year, the Authority conducts fifteen or more site visits of places of detention; these visits may be announced or unannounced. It reports its findings to each site and engages with New Zealand Police at the district and national levels in monitoring the implementation of its recommendations. The Authority has, along with other NPMs, developed assessment criteria for site inspections by consulting applicable human rights law instruments. This means that Authority recommendations with respect to custody centres accord with New Zealand's obligations at the international level.
23. Site visits form part of a broader system of prevention under the OPCAT. In addition to site visits, NPMs engage in other strategic capacity building and prevention initiatives to fulfil their mandate. Such initiatives include, for example, engagement with civil society, awareness raising and capacity building projects, and preventive research and evaluation projects. The current review into deaths in police custody has relevance to the work of the Authority as a NPM under the Optional Protocol, as well as its police oversight function under the Independent Police Conduct Authority Act 1989.

#### DEFINITION OF 'DEATH IN CUSTODY'

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24. For the purposes of this paper, the term 'death in custody' refers to deaths which have occurred during arrest or detention by the police. This includes situations where a person has died after becoming ill or injured while in police custody, and situations where a person has died while being transported to a mental health facility by police.<sup>5</sup>
25. Police pursuits which result in death and shootings by police were not included in the review, although they may have taken place in the process of an arrest.
26. After reviewing and analysing the circumstances of the 27 deaths in custody for this paper, the Authority identified the following four categories:
  - i) deaths following the use of restraint by police;

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<sup>5</sup> Section 41 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 states that a duly authorised officer (DAO) may call upon the police for assistance in certain circumstances. Under this section a constable who is called upon to assist a DAO is empowered to enter the premises where the patient is and transport him or her back to hospital.

- ii) suicides;<sup>6</sup>
- iii) drug-related deaths;<sup>7</sup> and
- iv) deaths caused by the detainee's medical condition.

## METHODOLOGY

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27. The Authority compiled a list from its database of deaths in custody which occurred during the 10-year period between 1 January 2000 and 1 January 2010. Twenty-seven deaths were determined to be within the parameters of the review.
28. Data was then collected about each death from the Authority's investigation files.<sup>8</sup> These files generally contained the relevant custody documentation, a post mortem/toxicology report, the police investigation report, the Coroner's findings, and the Authority's investigation report or review of the case.
29. The following information was obtained from each file:
- date and time of arrest;
  - date, time and location of death;
  - gender, age and ethnicity of the deceased person;
  - cause of death;
  - whether the person had a pre-existing medical/psychiatric condition and whether it was known to the police;
  - whether the person was affected by drugs/alcohol at the time of the arrest;
  - whether the person was restrained by police, and if so, the method of restraint;
  - the circumstances of the death;
  - the reason for the person's arrest/detention;

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<sup>6</sup> Section 71 of the Coroners Act 2006 restricts publication of the details of self-inflicted deaths. However, under section 72 of the Coroners Act 2006, the Authority is permitted to publish reports which include the particulars of a suicide.

<sup>7</sup> In this paper the word 'drugs' refers to illegal (or illegally obtained) drugs rather than prescribed medication.

<sup>8</sup> The review was based on the official investigations into the deaths. Although some may question the official account of what happened in particular cases, it was not within the parameters of the Authority's review to re-investigate any of the deaths.

- the extent of the risk assessment undertaken by police;
  - police policy/procedure issues arising from the death;
  - other information (background information about the deceased, the police investigation findings, the Authority's findings, Coroner's findings); and
  - recommendations made by the New Zealand Police or the Authority as a result of the investigations into the death.
30. This information was collected in data sheets and file summaries were prepared for each case. The data was analysed to identify any trends or recurring issues in terms of the characteristics of the detainees and the circumstances of their deaths. Compliance with police policies, practices and procedures by police staff was also considered, as well as any recommendations or policy changes that were made in response to the deaths.

#### LIMITATIONS OF THE REVIEW

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31. This review considered 27 cases. As this is a small sample, the quantitative findings of the review may not be regarded as statistically significant. It is also difficult to identify meaningful trends from a small number of cases. It is however possible to detect recurring issues and thus to consider whether police policies, practices and procedures could be improved.
32. Deaths in custody are uncommon and do not necessarily reflect the quality of care generally provided by the police. While the investigations into some deaths identified procedural omissions or errors, the purpose of the review is not to attribute blame; rather, to learn useful lessons from these cases.





# Applicable Laws and Policies

INDEPENDENT POLICE CONDUCT AUTHORITY

33. Between 2000 and 2010, the care of detainees in police custody was governed at a national level by the New Zealand Police General Instructions (GIs) and Manual of Best Practice, and at a local level by district and watchhouse-specific instructions, including custodial suicide prevention policies.
34. In police stations which hold detainees, the watchhouse is the area where they are processed, and the officer responsible for receiving people into custody and looking after detainees in the cells is the watchhouse keeper. The watchhouse is also overseen by a watchhouse supervisor.
35. Police have recently reviewed their policies and procedures in relation to the management of people in custody. In July 2011, those policies were replaced by a new chapter in the Police Manual titled *Managing Prisoners*.<sup>9</sup>
36. The findings of the Authority's 10-year review of deaths in police custody are based on the policies and practices that were in place at the time of the review cases. Where relevant, the new *Managing Prisoners* policy and other policy developments are discussed throughout this report.

## RISK ASSESSMENT

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37. Police owe a duty of care to people who are detained in their custody.<sup>10</sup> This duty of care begins when the person is detained and continues until the person is released or transferred into the care of another agency. The police's duty of care is found in section

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<sup>9</sup> The terms 'watchhouse', 'watchhouse keeper' and 'watchhouse supervisor' have been removed from the new police policy for managing prisoners, which instead refers to 'custody staff'.

<sup>10</sup> Crimes Act 1961, section 151; *Kirkham v Chief Constable of the Greater Manchester* [1990] 3 All ER 246 (CA); *Commissioners of Police for the Metropolis v Reeves* [1999] 3 All ER 897 (HL). Also see New Zealand Bill of Rights Act 1990, section 8, International Covenant on Civil and Political Rights, article 6.

151 of the Crimes Act 1961 and in the common law, and is recognised in the police policies and instructions relating to the care of people in custody.

38. United Kingdom case law has defined the police duty of care as:<sup>11</sup>

*“ ... 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.”*

39. The duty has also been described as: *“a duty to any person in [Police] custody to take reasonable care for that person's health and safety.”*<sup>12</sup>

40. As part of this duty, police are required to assess people who are kept under their supervision for risks to their health and safety. People who are detained by police may be at risk to themselves or others for reasons such as their mental or physical health, or their level of intoxication. Following the assessment, police must determine the level of care the detainee requires and provide safeguards if the person is found to be at risk.

41. Police General Instruction (GI) P100(3) (Evaluation of Persons Detained in Police Custody and Prisoners), which was in force during the time period reviewed by the Authority, stated:

*“All people received into Police custody are to be evaluated and monitored in respect of:*

- *the state of their physical and mental health, the presence of any medical condition and any warning signs indicating suicidal tendencies; and*
- *the threat level that person may pose to Police staff; and*
- *any other risk that may arise from being held in Police custody (for example the nature of the charge against them, sexual orientation, affiliations or vulnerability to intimidation).”*

42. Until March 2005, police used the Loose Leaf Charge Sheet to carry out this evaluation. This form had a section called *“Watchhouse Keeper's Evaluation of Condition of Person in Custody”* which asked various questions about the detainee, such as whether he or she was:

- under the influence of drugs/alcohol/solvents;

<sup>11</sup> *Kirkham v Chief Constable of the Greater Manchester* [1990] 3 All ER 246, 253 (CA) per Farquharson LJ.

<sup>12</sup> *Orange v Chief Constable of West Yorkshire Police* [2002] QB 347, para 20 (CA).

- showing signs of being withdrawn/irrational/depressed/overly ashamed/agitated/anxious; or
  - showing signs of suicide/self-injury/injury/illness/pain.
43. The form also provided space for the arresting officer to note whether he or she was aware of any medical or psychological reasons which indicated that the person may require special care or be at risk while in custody.
44. After the evaluation the detainee would be categorised as no risk, low risk or high risk. If further assessment was considered necessary because the detainee was potentially at risk, a Prisoner Management Assessment Form (PMAF) was completed. If a doctor was called to see the detainee, a Medical Record of Examination (MRE) form would be completed.
45. In March 2005, the following forms were replaced with modified versions:

Prior to March 2005	From March 2005
Loose Leaf Charge Sheet	Custody/Charge Sheet
Prisoner Management Assessment Form (PMAF)	Health and Safety Management Plan for a Person in Custody (HSMP)
Medical Record of Examination (MRE)	Health Professional Record of Examination (HPRE)

46. The new Custody/Charge Sheet was introduced in order to provide a more in-depth evaluation of detainees. The “*Watchhouse Keeper’s Evaluation of Condition of Person in Custody*” section was expanded, and now includes questions relating to:
- health conditions such as diabetes/heart disease/epilepsy/depression;
  - mental health history;
  - medication; and
  - suicide risk factors such as whether the person:
    - has never previously been arrested or detained in a cell;
    - is a youth at risk;
    - is male;
    - has previously attempted to commit suicide; or
    - has been arrested because of a domestic incident or has a history of family violence.

47. In the course of completing this form, the arresting officer and/or watchhouse keeper or custody officer will check the police database (NIA) to see whether the detainee has any warning flags or ‘alerts’ which may be relevant to the risk assessment of the detainee.<sup>13</sup> Police are required to create a NIA alert in certain situations; for example, GI P209 (Suicidal Tendencies: Safety Alerts) provided:<sup>14</sup>

*“(1) Where a Police member becomes aware, through any reliable means, that a person:*

- is reasonably likely to attempt suicide; or*
- is known to have a history of suicide attempts anywhere, whether in Police custody or not;*

*Information is to be entered and stored in the National Intelligence Application (NIA) with the safety alert “Self Harm / Suicidal Tendency”.*

...

*(2) Members are to submit the notification of the suicidal tendency promptly and in any event before finishing duty on the shift the member is on when the member becomes aware of the suicidal tendency.”*

48. NIA alerts may also relate to other risk factors, such as the detainee’s history of drug use or violence.
49. Following the assessment, the detainee is monitored according to their assessed level of risk:

Risk Status		Level of monitoring required
Prior to March 2005	From March 2005	
No risk	Not in need of specific care	Must check every 2 hours
Low risk	In need of care	Frequent monitoring – observe at least five times an hour at irregular intervals
High risk	In need of care and constant monitoring	Constant monitoring – directly observe without interruption

<sup>13</sup> NIA (National Intelligence Application) became the main operational system for alerts and danger flags in 2005. Before that Police used the Wanganui (LES) system.

<sup>14</sup> This requirement is continued in the new *Managing Prisoners* chapter of the Police Manual (see paragraph 35).

50. If the person in custody is evaluated as being in need of care or in need of care and constant monitoring, a HSMP must be completed. This form was designed to be more directive and detailed than the earlier PMAF. The HSMP form:
- provides notice to the detainee that he or she has been found to be in need of care;
  - prompts police to ensure that mandatory procedures are completed before placing the person in a cell and offers options for managing the person;
  - lists a variety of contacts to assist with the provision of care to the person in custody; and
  - records relevant information such as medication and approved changes to the plan for managing the detainee.
51. The MRE was replaced by the HPRE, which provides space for medical professionals to record their observations and recommendations for police staff to follow.
52. In 2010, after successful trials in custody facilities in Rotorua and Manukau, New Zealand Police introduced the practice of recording the information that had previously been recorded on the Custody/Charge Sheets (including risk assessments) electronically in an 'electronic custody module'. Completing the records electronically makes it easier for custody staff to access NIA alerts and detailed risk information from previous risk evaluations of the detainee. The electronic custody module is now used to record custody information in all police custodial facilities. Smaller police stations that do not hold detainees also have access to the electronic custody module, so they can electronically transfer information about a detainee to a custodial site when necessary rather than completing a paper form.

### **Completion of risk assessment**

53. One difficulty with the risk assessment process is that it is dependent upon the information provided by the person in custody and upon the officer's ability to recognise relevant warning signs. Detainees may be uncooperative, or unwilling to answer personal questions relating to their health and mental state honestly. Similarly, assessments are sometimes undertaken in a busy custodial environment.
54. In none of the reviewed cases did the detainee refuse to answer the risk assessment questions, although it cannot be determined how truthful or accurate their responses were.
55. Sometimes an assessment cannot be properly completed because the detainee is too intoxicated to answer the risk evaluation questions. This happened in all five deaths in custody where the person had been arrested for detoxification (see paragraphs 61 - 65).

## SEARCHING OF PEOPLE IN CUSTODY

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56. When a person is taken into custody, the usual practice is for the arresting officer to search the person at the time of the arrest. The detainee is searched again at the police station when he or she is received and processed by the custody staff, and his or her property is collected and listed on the Custody/Charge Sheet or electronic custody module.
57. GI 205 (Searching) stated:
- “(2) If the person is assessed as in need of care or in need of constant monitoring, their shoelaces, belts, jewellery, and any article of clothing or footwear with cords must be removed and placed with other personal property. Staff should consider removing all the person’s clothing and replacing it with appropriate safe clothing such as a tear resistant gown.”*
58. It is important that people in custody are searched properly in order to locate and remove any items that they may use to harm themselves or others. The cell itself should also be checked for any items that may have been hidden by a previous occupant.
59. Failure to remove dangerous items from detainees was noted as an issue in four of the 10 suicides in custody that were reviewed by the Authority.

## MONITORING AND CHECKS OF DETAINEES

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60. GI P110 (Supervision of Prisoners) required 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.”* People in custody who are assessed to be in need of care or in need of care and constant monitoring must be checked more frequently:
- people in need of care require frequent monitoring, which means they must be checked at least five times per hour at irregular intervals;
  - people in need of care and constant monitoring must be directly observed without interruption; and
  - CCTV monitoring is not included as a method of frequent or constant monitoring.

## DETOXIFICATION

61. Police have the power to take people into custody when they are too intoxicated to take care of themselves. The person is then kept in the police cells until he or she is no longer intoxicated. Throughout this report this practice is referred to as taking people into custody for detoxification.

62. Until 2008, section 37A of the Alcoholism and Drug Addiction Act 1966 provided:

*“(2) Any constable who finds any person intoxicated in any public place –*

*(a) May take or cause that person to be taken to his usual place of residence ...; or*

*(b) If that place cannot reasonably be ascertained or it is not reasonably practicable to take that person to it or it may not be safe to leave him there, may take that person or cause him to be taken to any temporary shelter or detoxification centre; or*

*(c) If neither the course authorised by paragraph (a) nor that authorised by paragraph (b) of this subsection is reasonably practicable, detain or cause that person to be detained in a police station for any period not exceeding 12 hours.”*

63. Section 37A was repealed and replaced by section 36 of the Policing Act 2008, which provides:

*“(1) A constable who finds a person intoxicated in a public place, or intoxicated while trespassing on private property, may detain and take the person into custody if—*

*(a) the constable reasonably believes that the person is—*

*(i) incapable of protecting himself or herself from physical harm; or*

*(ii) likely to cause physical harm to another person; or*

*(iii) likely to cause significant damage to any property; and*

*(b) the constable is satisfied it is not reasonably practicable to provide for the person’s care and protection by—*

- (i) *taking the person to his or her place of residence; or*
- (ii) *taking the person to a temporary shelter.”*

64. A person detained in police custody under this provision must be released as soon as he or she ceases to be intoxicated, and cannot be detained for more than 12 hours unless recommended by a health practitioner.
65. For the purposes of section 36, ‘intoxicated’ means: “ ... *observably affected by alcohol, other drugs, or substances to such a degree that speech, balance, coordination, or behaviour is clearly impaired.*” A ‘temporary shelter’ is: “ ... *a place (other than a place operated by the Police) that is capable of providing for the care and protection of an intoxicated person.*”

#### MEDICAL TREATMENT/MENTAL HEALTH ASSESSMENT IN CUSTODY

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66. GI P100 (Evaluation of Persons Detained in Police Custody and Prisoners) provided that:

*“(7) All people, including children and young persons, who are considered as either in need of care or in need of care and constant monitoring because of their health, medical condition or presence of any suicidal warning signs, should be examined by a Police medical officer or Duly Authorised Officer or Community Assessment Team member as soon as practicable.”*

67. GI P111 (Medical Aid) stated:

*“(1) Prisoners’ wellbeing and health require regular monitoring and reassessment. This is especially necessary where any of the following apply:*

- *alcohol or drugs have been consumed;*
- *the prisoner has been injured;*
- *the prisoner has a known medical problem;*
- *a health professional has been called to attend the prisoner;*
- *there is a perceived suicide risk.*

*(2) If for any reason a member supervising a prisoner thinks it necessary, or should a prisoner request it, a health professional should be called.*

...

- (7) *Where medication is prescribed for a prisoner the medication shall be retained by the supervising staff and administered as specified.”*

#### TRAINING OF WATCHHOUSE / CUSTODY STAFF

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68. GI P202 (Mandatory Training) required police officers to be trained in first aid, and to complete custodial suicide awareness training every two years.
69. This training is intended to help them recognise custodial suicide risk factors. Officers are instructed to take anyone talking about suicide seriously, and to always err on the side of caution.
70. During the 10-year review period, there was no specific national training programme relating to the duties of staff who were assigned custody duties.

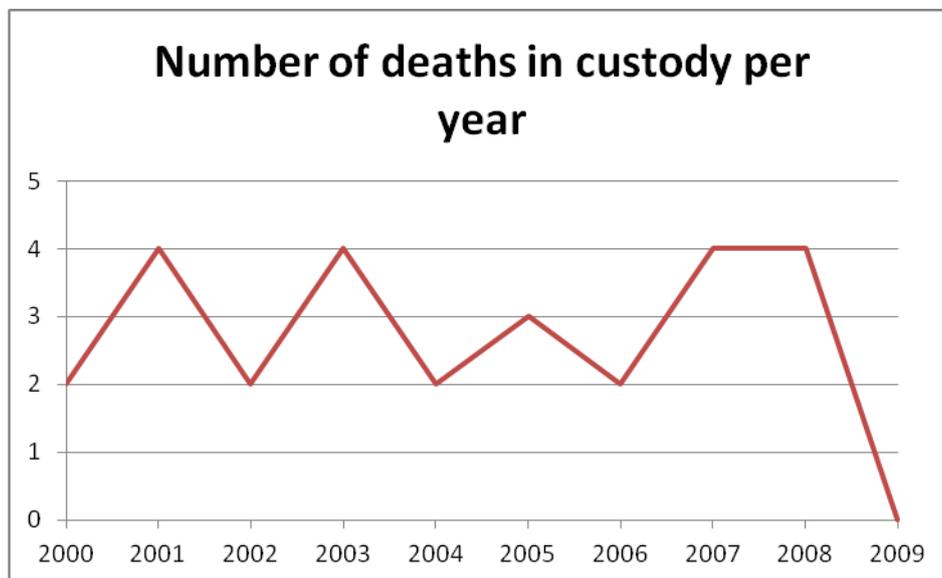


# Deaths in Police Custody: New Zealand Data

INDEPENDENT POLICE CONDUCT AUTHORITY

## NUMBER OF DEATHS IN POLICE CUSTODY

71. Section 13 of the Independent Police Conduct Authority Act 1988 requires the New Zealand Police to notify the Authority when a police employee acting in the execution of his or her duty causes, or appears to have caused, death or serious bodily harm to any person.
72. The Authority identified 27 deaths in police custody which occurred during the 10-year review period between 1 January 2000 and 1 January 2010. This is an average of 2.7 deaths in custody per year.



73. The death rate per 100,000 people in custody can be calculated using this formula:<sup>15</sup>  
$$(\text{number of deaths}) \div (\text{number of people held in police cells}) \times 100,000.$$

<sup>15</sup> Leigh A, Johnson G, and Ingram A, *Deaths in Police Custody: Learning the Lessons* (Police Research Series Paper 26, Home Office, London, 1998) 54.

74. According to the New Zealand Police Annual Reports, 1,367,476 people were held in police cells during the 10-year period from 1 July 1999 to 30 June 2009.<sup>16</sup> Using this number of detainees, the custodial death rate was 1.97 deaths per 100,000 people held in custody:

$$27 \div 1,367,476 \times 100,000 = 1.97 \text{ (2dp).}$$

75. This calculation does not take into account the fact that the recorded number of people held in custody (1,367,476) does not reflect the actual number of people who were detained by the police without being held in a police cell. This review included seven deaths which occurred during or shortly after arrest and therefore involved people who were not held in a police cell for any significant length of time. If those seven deaths are excluded, the custodial death rate was 1.46 deaths per 100,000 people held in custody:

$$20 \div 1,367,476 \times 100,000 = 1.46 \text{ (2dp).}$$

### International comparisons

76. It is difficult to make direct comparisons with overseas jurisdictions in respect of the number of deaths in police custody, due to differences in the way custody data is recorded and the different definitions used for 'death in custody'.<sup>17</sup> Nonetheless the Authority considered the following data as part of its review:

- A recent study conducted by the Independent Police Complaints Commission (IPCC) found that there had been a total of 333 deaths in or following police custody in England and Wales during the 11-year period between 1998/99 and 2008/09. This amounts to an average of just over 30 deaths per year.<sup>18</sup> However the rate of deaths fell over that time from 3.6 deaths per 100,000 notifiable arrests in 1998/99 to 1 death per 100,000 notifiable arrests in 2008/09.<sup>19</sup>
- In Australia, the National Deaths in Custody Program (NDICP) monitors deaths that occur in prison, police and juvenile custody. In relation to deaths in police custody,

<sup>16</sup> The time period covered by the Police Annual Reports is slightly different to the time period covered by the Authority's review - however the 27 deaths that were included in the review all took place within this time period.

<sup>17</sup> See, for example, Office of Police Integrity, *Review of the Investigation of Deaths Associated with Police Contact: Issues Paper* (OPI, Melbourne, 2010) 14-19.

<sup>18</sup> See Hannan M, Hearnden I, Grace K, and Bucke T, *Deaths in or Following Police Custody: an Examination of the Cases 1998/1999 – 2008/2009* (IPCC, London, 2010) 9-11. Also see Bucke T and Wadham J 'Deaths in Custody' in Wakefield A and Fleming J, *The Sage Dictionary of Policing* (Sage, London, 2009) 78 and Leigh A, Johnson G, and Ingram A, *Deaths in Police Custody: Learning the Lessons* (Police Research Series Paper 26, Home Office, London, 1998) 54.

<sup>19</sup> The actual rate of deaths in custody will be lower, because many more people are held in custody than just those arrested for notifiable offences. For example, being drunk and disorderly is not a notifiable offence – see Hannan M, Hearnden I, Grace K, and Bucke T, *Deaths in or Following Police Custody: an Examination of the Cases 1998/1999 – 2008/2009* (IPCC, London, 2010) 10.

the NDICP uses a wider definition than the Authority has used for its review. Deaths which occur in institutional settings such as police cells are recorded as 'Category 1a' deaths, and deaths resulting from police operations (i.e. deaths linked to police raids and shootings) are recorded as 'Category 1b deaths'. Category 1a deaths would come within the Authority's definition of death in custody, but Category 1b deaths would fall outside that definition. Ten Category 1 deaths were reported in 2008, but it is not specified in the NDICP's report how many of these were Category 1a. The report states that between 2000 and 2008 there were 83 Category 1 deaths at an average of 9.2 per year.<sup>20</sup>

### Deaths per district

77. Wellington had the greatest number of deaths in custody over the 10-year review period, with five deaths occurring within that district (18.5%). Canterbury and Waikato each had four deaths (14.8%).
78. Bay of Plenty has had two of the most recent deaths in custody (a drug-related death and a suicide in custody). These were also among the most serious cases considered in the Authority's review in terms of police failure to comply with custody policies.

District	N	%
Northland	1	3.7
Waitemata	1	3.7
Auckland City	1	3.7
Counties-Manukau	1	3.7
Waikato	4	14.8
Bay of Plenty	3	11.1
Eastern	3	11.1
Central	3	11.1
Wellington	5	18.5
Tasman	0	0
Canterbury	4	14.8
Southern	1	3.7
<b>Total</b>	<b>27</b>	<b>100</b>

<sup>20</sup> Lyneham M, Juodo Larsen J and Beacroft L, *Deaths in Custody in Australia: National Deaths in Custody Program 2008* (Australian Institute of Criminology, Monitoring Reports 10, Canberra, 2010) 34.

## CHARACTERISTICS OF THE DECEASED

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### Gender

79. The vast majority of the people who died in police custody during the 10-year review period were male (96.3%). Only one of the 27 deceased was female. This death was drug-related.

### Age

80. The ages of the people who died in custody ranged from 19 to 68 years, with most between the ages of 19 and 45. The average age was 38.5 years and the median age 37. The six youngest deaths were all suicides.

Age	N	%	Raw Data
15-24	7	25.9	19, 19, 22, 23, 23, 23, 24
25-34	3	11.1	32, 32, 33
35-44	10	37	35, 36, 36, 37, 41, 42, 42, 43, 43, 44
45-54	3	11.1	47, 47, 54
55-64	3	11.1	55, 56, 64
65-74	1	3.7	68
<b>Total</b>	<b>27</b>	<b>100</b>	

81. The average age of the Europeans who died in police custody (40 years) was slightly higher than the average age for Maori (39.3 years). The three oldest people who died were European.

### Ethnicity

82. Thirteen of the people who died in police custody were Maori (48.1%), 11 were European (40.7%) and two were Pacific peoples (7.4%).<sup>21</sup> One file did not contain enough information to confirm the ethnicity of the deceased person.
83. The percentage of Maori deaths may appear to be disproportionately high compared to the percentage of the New Zealand population who identify themselves as Maori (14.6% in the 2006 Census). However it is in line with the percentage of criminal apprehensions

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<sup>21</sup> 14.6 % of New Zealanders identified themselves as Maori in the 2006 Census. 6.9 % identified themselves as Pacific peoples and 67.6 % identified themselves as Europeans.

which involve a person identifying as Maori (42%) and the percentage of the prison population who are Maori (50%).<sup>22</sup>

84. The disproportionate number of Maori deaths in police custody reflects the over-representation of Maori in the criminal justice system generally. The causes of this over-representation were not within the scope of the review.<sup>23</sup>
85. None of the police or Authority investigations into the reviewed deaths in custody found failures by the police that were caused by racist attitudes or behaviour.

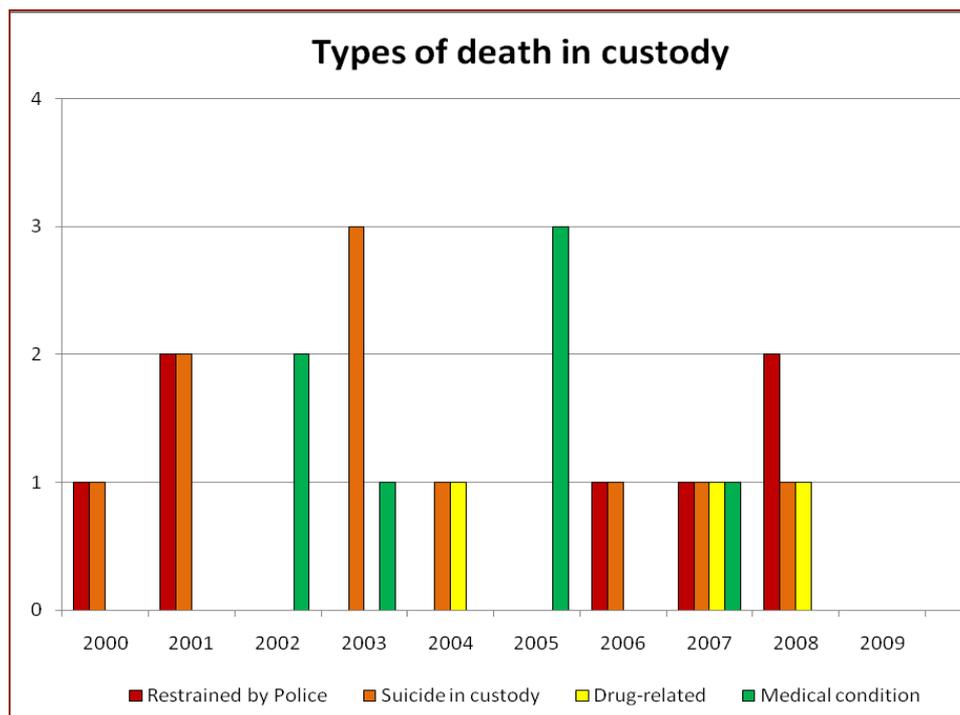
Ethnicity	European		Maori		Pacific		Not known		All	
	N	%	N	%	N	%	N	%	N	%
<b>Total</b>	11	40.7	13	48.1	2	7.4	1	3.7	<b>27</b>	<b>100</b>
<b>Gender</b>										
Male	10	90.9	13	100	2	100	1	100	26	96.3
Female	1	9.1	0	0	0	0	0	0	1	3.7
<b>Age</b>										
15 – 20	1	9.1	1	7.7	0	0	0	0	2	7.4
21 – 30	2	18.2	1	7.7	1	50	1	100	5	18.5
31 – 40	3	27.3	4	30.8	0	0	0	0	7	25.9
41 – 50	2	18.2	5	38.5	1	50	0	0	8	29.6
51 – 60	1	9.1	2	15.4	0	0	0	0	3	11.1
61 – 70	2	18.2	0	0	0	0	0	0	2	7.4
Average age	40		39.3		32.5		24		38.5	
<b>Type of death</b>										
Restrained by police	1	9.1	4	30.8	1	50	1	100	7	25.9
Suicide in custody	5	45.5	4	30.8	1	50	0	0	10	37
Drug-related	2	18.2	1	7.7	0	0	0	0	3	11.1
Medical condition	3	27.3	4	30.8	0	0	0	0	7	25.9

<sup>22</sup> Department of Corrections, *Over-Representation of Maori in the Criminal Justice System: An Explanatory Report* (Policy, Strategy and Research Group, 2007) 6.

<sup>23</sup> For further reading, see Department of Corrections, *Over-Representation of Maori in the Criminal Justice System: An Explanatory Report* (Policy, Strategy and Research Group, 2007).

## TYPES AND CAUSES OF DEATH

86. The most common type of death was suicide, accounting for 10 (37%) of the reviewed deaths in custody. The next biggest categories were deaths following the use of restraint by police and deaths due to the detainee's medical condition, at seven (25.9%) each. There were also three drug-related deaths (11.1%).
87. Five (45.5%) of the Europeans who died in custody committed suicide, compared to 10 (37%) for all ethnicities. Maori deaths were evenly spread over three of the categories: deaths following restraint, suicides in custody, and deaths caused by the detainee's medical condition, at four (30.8%) each. Only one Maori drug-related death was identified. Regarding the deaths of Pacific Islanders, there was one death following the use of restraint by police and one suicide in custody.
88. The graph below shows the distribution of the different types of death over the 10-year review period.



89. The cause of death for each detainee was determined from the Coroner's findings. The Authority found that 13 of the 27 deaths (48.1%) were caused by the detainee's own actions. These were the suicides and the drug-related deaths. The suicides were all by hanging and the drug-related deaths all involved methadone.
90. Seven deaths (25.9%) involved the use of force or restraint by police. Of these seven deaths, three people died from positional asphyxia (also known as restraint asphyxia) and three died due to heart problems. One person died from a cerebral infarction.

91. The other seven deaths were caused by the detainee's medical condition (25.9%). In two cases the detainees died from head injuries, and in another two cases the cause of death was epilepsy. One detainee died from a brain tumour, one from metabolic acidosis, and one from heart problems.

#### ALCOHOL/DRUGS

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92. Just under half (48.1%) of the people who died in or following custody were affected by alcohol and a third were affected by drugs at the time they came into contact with police. In two cases the detainee was affected by both drugs and alcohol (7.4%).
93. Of the 13 detainees affected by alcohol, five were European, seven were Maori and one was a Pacific Islander. All were male. The average age of these detainees was 42.6 years, which is 4.1 years older than the average age for all detainees.
94. Six of the detainees affected by drugs were European and three were Maori. One was female. The average age was 33.4 years, which is 5.1 years younger than the average age for all detainees.
95. Of the 20 people who were affected by alcohol, drugs, or both at the time they were detained by the police:
- three died after being restrained by police;
  - eight committed suicide in custody;
  - three died from drug-related causes; and
  - six died from a medical condition.
96. Five cases involved people who had been arrested solely for detoxification purposes. One of these people died from drug-related causes and four died from a medical condition.
97. An addiction to drugs was noted in five of the 27 death in custody cases, and alcoholism was also noted in six cases. However a greater number of people may have suffered from alcohol and drug addictions than was discovered during the investigations.
98. Four of the six known alcoholics died due to a medical condition, one committed suicide in custody and one died from drug-related causes. Of the people who suffered from an addiction to drugs; three committed suicide in custody, and two died from drug-related causes.

## MENTAL HEALTH

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99. Fourteen of the 27 reviewed deaths in custody involved people with mental health issues (51.9%). These issues included:
- history of self-harm or suicide attempts;
  - threats to commit suicide;
  - depression; and/or
  - schizophrenia.
100. Police were aware that the detainees had mental health concerns in seven of the 14 cases. None of these detainees were assessed by a mental health professional while they were in police custody, but in some cases there was no time for an assessment because the person collapsed or died during their arrest.
101. Thirteen of the 14 detainees with mental health issues were male and one was female. Six of the detainees were European, six were Maori, one was a Pacific Islander and one was of unknown ethnicity.
102. The average age of the detainees who suffered from problems with their mental health was 32.5 years, six years younger than the average age for all people who died in custody.
103. The main cause of death for those affected by mental health issues was suicide, which accounted for seven of the 14 deaths. Five deaths occurred following the use of restraint by the police, and in four of these cases the person who died suffered from schizophrenia. The remaining two deaths were drug-related.
104. One person died while being detained solely due to concerns over their mental health. This person was being transported by police to a mental health unit when he died following restraint.

## PHYSICAL HEALTH

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105. Thirteen of the 27 people who died in or following police custody are known to have had had significant health problems when they were detained by police (48.1%). These problems ranged from impaired cognitive function to heart disease.
106. Seven people with significant health problems died due to their medical condition, and five deaths occurred following the use of restraint by police. One death was a suicide.

107. All 13 cases involved males, and 53.8% were Maori (seven were Maori, five were European and one was a Pacific Islander). The average age of the people in custody who suffered from physical health issues was 46.6 years.
108. In only four of these 13 cases were the police aware that the person in custody had health problems prior to their death. These cases included one person who suffered from epilepsy, one who was physically disabled and two people who had head injuries (after falling down while intoxicated).

## OTHER FACTORS

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### Reason for arrest / detention

109. There was a wide range of reasons why the people who died in custody had been detained by police. Some noteworthy points are:
- Five of the seven people who died after being restrained by the police were being arrested for violent or aggressive offences, namely assault, wilful damage and threatening language. Another case involved a person who was arrested for interfering with a car, but had already been arrested for assault earlier on the same day.
  - In five of the 10 cases of suicide in custody the deceased person had been arrested because of their involvement in domestic violence.
  - In four of the seven cases of death from a medical condition, the only reason the deceased person was kept in custody was detoxification. These four cases all involved males aged 55 or over.
  - Only one person who died from drug-related causes was arrested for detoxification.

### Level of risk assigned

110. When a person is taken into police custody, he or she is assessed and assigned a risk level which determines the level of care that police are required to provide (see paragraphs 37-55).

Level of risk	N	%
No evaluation undertaken	8	29.6
Evaluation incomplete	1	3.7
No risk / not in need of specific care	15	55.6
Low risk / in need of care	2	7.4
High risk / in need of care and constant monitoring	1	3.7
<b>Total</b>	<b>27</b>	<b>100</b>

111. In fifteen (55.6%) of the reviewed deaths in custody the detainees had been assessed as being no risk/not in need of specific care before they died. Eight (29.6%) of the detainees did not undergo a formal risk evaluation.
112. A risk evaluation was not completed for the seven people who died following the use of restraint by the police, because there was no time for the assessment to take place. One person who committed suicide in custody should have been assessed for risk before he was put into a cell, but was not. In another case of suicide the risk evaluation was incomplete at the time of death.
113. Detainees were assessed to be at risk while in police custody in just three of the 27 deaths in custody (11.1%). Two detainees were assigned a risk level of low risk (including one drug-related death and one suicide in custody), and one person who committed suicide while in custody was assessed to be high risk (but his risk level had been downgraded to low risk five hours before he died).
114. Six of the 10 people who committed suicide while in custody had been assessed as no risk, as had two of the three people who died from drug-related causes and all seven of the people who died due to a medical condition (including five people who had been taken into custody for detoxification).

#### Location of death

115. Most of the people who died in or following police custody died in the cells (55.6%) or in hospital (33.3%).

Location of death	Restrained by police	Suicides in custody	Drug-related	Medical condition	N	%
Cell	0	7	3	5	15	55.6
Hospital	4	3	0	2	9	33.3
Private property	2	0	0	0	2	7.4
Public place	1	0	0	0	1	3.7
<b>Total</b>	<b>7</b>	<b>10</b>	<b>3</b>	<b>7</b>	<b>27</b>	<b>100</b>

#### Time spent in custody

116. Seven of the 27 deaths in or following police custody involved people who had not spent any time in cells (25.9%) – these were all people who died after being restrained by police during arrest.
117. Over half the people who committed suicide in custody had spent less than four hours in custody, and five of the seven people who died due to a medical condition had spent over 12 hours in custody.

Length of time spent in custody	Restrained by police	Suicides in custody	Drug-related	Medical condition	N	%
Not put in a cell	7	0	0	0	7	25.9
0 – 2 hours	0	2	0	0	2	7.4
2 – 4 hours	0	4	2	0	6	22.2
4 – 6 hours	0	0	0	1	1	3.7
6 – 8 hours	0	1	1	0	2	7.4
8 – 10 hours	0	0	0	1	1	3.7
10 – 12 hours	0	0	0	0	0	0
12 – 24 hours	0	2	0	4	6	22.2
Over 24 hours	0	1	0	1	2	7.4
<b>Total</b>	<b>7</b>	<b>10</b>	<b>3</b>	<b>7</b>	<b>27</b>	<b>100</b>

### Investigation outcomes

118. In 10 (37%) of the cases there were no noteworthy procedural failings by police. Most of these were deaths that occurred after the use of restraint by police. However in 52.6% of the cases the actions of the police fell short of the expected standards. These shortcomings ranged from minor policy breaches to serious failings by the police.
119. Four deaths in custody involved serious failings, including two of the most recent cases. Two of these cases involved drug-related deaths, one was a suicide in custody and one was a death caused by a medical condition.
120. In eight other cases the risk assessment, monitoring or search of detainees by police was found to be inadequate, and in a further five cases minor breaches of police policy or procedure were found.

Issues	N	%
Serious failings	4	14.8
Inadequate risk assessment	4	14.8
Inadequate monitoring	3	11.1
Inadequate search	1	3.7
Minor breaches of policy/ procedure	5	18.5
No notable issues	10	37
<b>Total</b>	<b>27</b>	<b>100</b>

121. Only two of the Authority's files relating to deaths in custody recorded disciplinary action being taken against the officers involved. The disciplinary action was in the form of an adverse report in one case, and written warnings in the other. In at least five other cases the officers involved were "counselled" for procedural failings.
122. No one was found to be criminally liable for any of the 27 deaths in or following police custody.

## CIRCUMSTANCES OF THE DEATHS

**Use of force / restraint by police**

Year	Gender	Age	Ethnicity	Cause of death
2000	M	24	Not known	Restraint asphyxia
2001	M	42	European	Cerebral infarction
2001	M	32	Maori	Restraint asphyxia
2006	M	47	Maori	Restraint asphyxia
2007	M	47	Maori	Heart problems
2008	M	54	Maori	Heart problems
2008	M	42	Pacific	Heart problems

123. All of the people who died following the use of restraint by police were male. The youngest was 24 years old and the oldest was 54 years old. The average age was 41.1 years, which is 2.6 years older than the average age for all types of death in or following custody.
124. Four of the seven people who died were Maori (57.1%), one was European (14.3%) and one was a Pacific Islander (14.3%). In one case there was not enough information in the Authority's file to confirm the person's ethnicity.
125. While there appears to be an over-representation of Maori deaths after being restrained, the total number of cases is too small for this over-representation to be accepted as statistically significant.
126. Five of the people who died had underlying medical conditions, ranging from heart disease to a lung tumour. In four of these cases the underlying health problems appear to have contributed to the person's death:
- Three people who suffered from heart disease all collapsed and died after physically struggling against the restraint that was applied to them. In one of these cases, the person who died had already been restrained by his family before the police arrived. However the police applied handcuffs to him before it was discovered that he had stopped breathing. In the other two cases the people being arrested had struggled with the police immediately before they collapsed. The physical exertion in combination with their already weakened hearts appears to have caused their deaths.
  - One case involved a police officer applying a neck hold to someone who was resisting arrest. Unknown to the officer, this person had weakened carotid arteries from surgery on his neck four years earlier, which made him susceptible to damage from the application of any kind of force to his neck. If the hold had been applied to a

person without that particular health problem, it most likely would not have caused death.

127. Four of the people who died after being restrained by police suffered from schizophrenia, including all three people who were found to have died from positional asphyxia and one person who died from heart problems. Three of these people were being arrested for violent behaviour at the time they collapsed, and one was being transported by police to a mental health unit after his mental condition had deteriorated.
128. OC spray was used in three of the seven cases (42.9%), but was not regarded as the cause of death in any of them. In five cases (71.4%) the detainees had been held down in a prone position immediately before they collapsed and died.

### Suicides

Year	Gender	Age	Ethnicity	Cause of death	Risk assessment
2000	M	19	European	Hanging	High risk (downgraded to low risk)
2001	M	23	Pacific	Hanging	No risk
2001	M	22	European	Hanging	No risk
2003	M	23	Maori	Hanging	No risk
2003	M	19	Maori	Hanging	Low risk
2003	M	23	European	Hanging	No risk
2004	M	41	Maori	Hanging	No risk
2006	M	35	European	Hanging	Assessment incomplete
2007	M	32	European	Hanging	Not in need of specific care
2008	M	33	Maori	Hanging	No assessment

129. Police have a common law obligation to prevent the suicide of people in custody, and under section 41 of the Crimes Act they are *“justified in using such force as may be reasonably necessary in order to prevent the commission of suicide”*.
130. Ten suicides were included in the Authority’s review. All of these involved males who hanged themselves while in custody.
131. The youngest person to commit suicide in custody was 19 and the oldest was 41. The average age was 27 years, which is 11.5 years younger than the average age for all types of death. Fifty percent of the people who committed suicide in custody were European, and 40% were Maori.

132. The rate of suicides in custody has reduced since 2004.<sup>24</sup> Of the suicides that were reviewed, seven cases occurred during the period between 2000 and 2004, and only three took place after 2004. However it also appears that the number of suicides following custody has increased – nine cases occurred within the 10-year review period and all took place from 2004 onwards.<sup>25</sup>
133. In March 2005, New Zealand Police introduced a revised Custody/Charge Sheet which expanded the risk evaluation of detainees, with a section devoted to considering the presence of any risk factors for suicide (see paragraph 46). The decrease in suicides in custody after this time indicates that the efforts of the police to identify and monitor people at risk of self-harm have been successful, and that it has become more difficult for people to commit suicide while they are in custody. Nonetheless the number of suicides following custody indicates that some people continue to be in danger from suicidal feelings after they have been released.<sup>26</sup>
134. The first six cases of suicide in custody during the reviewed period were all males aged 23 or younger, and the last four cases were males over the age of 30. This suggests that police became more aware of the suicide risk associated with younger males and have been monitoring them accordingly.
135. Five of the 10 people who committed suicide in custody had been arrested because of their involvement in domestic violence. In another case the detainee was on bail for a domestic violence offence, but his history of family violence was either not known or was not considered to be a risk factor for suicide by the officer who assessed him.
136. Six (60%) of the suicides occurred within about four hours of the detainee's arrest. The longest time spent in custody before death was 41 hours and the shortest time was one hour.
137. Nine of the suicides took place at police stations – four in individual cells, three in holding cells and two in dayrooms (both in the toilet area). One suicide took place in a holding cell at court. The trend since 2003 has been for suicides to occur when the person has been left alone in a holding cell or dayroom rather than their individual cell, although the most recent suicide did take place in a cell.

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<sup>24</sup> However it is important to note that the Authority's review has not examined the number of attempted suicides in custody.

<sup>25</sup> Another possibility is that police have started reporting post-custody suicides to the Authority more often in recent years.

<sup>26</sup> See for example: Webb R et al., 'National Study of Suicide in All People with a Criminal Justice History' (Archives of General Psychiatry, published online 7 February 2011).

138. In three of the first four suicides during the 10-year review period the people in custody used bedding as a ligature to hang themselves, including one case where the hemmed edge of a suicide-resistant blanket was used. Subsequently sheets and pillow cases have been withdrawn from service in police cells. Shoelaces were used as a ligature in three out of 10 cases, including the most recent suicide. 'Hang points' that were used included the bars of the cell, air vents, and grills used to cover windows and ventilation systems.
139. In respect of the risk assessment undertaken by police, six of the detainees were evaluated as not being at risk and two had not yet been assessed at the time they committed suicide. One detainee was evaluated as low risk, and one was initially assessed to be high risk but was then downgraded to low risk.
140. The Authority's review found failings (either minor or serious) by police in all but two of the suicides in custody. Many of these issues have been addressed in the wake of the deaths that occurred; however the most recent suicide also involved the most serious breaches of police policy of all the cases that were reviewed – the detainee was simply placed in a cell without being searched or processed.

#### Drug-related deaths

Year	Gender	Age	Ethnicity	Cause of death	Risk assessment
2004	M	37	Maori	Central nervous system depression	No risk
2007	F	36	European	Vomit inhalation	In need of care
2008	M	43	European	Methadone toxicity	Not in need of specific care

141. Three deaths in custody were caused by drug use, and all of these cases involved methadone.
142. Two of the people who died were male and one was female. The female death was suspected to be a suicide, but the Coroner did not make a finding to that effect.
143. The average age of the people who died from drug-related causes was 38.7, which is very close to the average age for all types of death. Two of the people who died were European and one was Maori.
144. One detainee spent over 3 hours in custody, another spent over 4 hours in custody and the other spent about 7.5 hours in custody before he died. Only one of the detainees was assessed to be intoxicated at the time of his arrest, and his intoxication was thought to be due to alcohol only.
145. In the earliest case within the 10-year review period, the Coroner found that death was caused by "the ingestion of prescribed as well as non-prescribed drugs" which resulted in "central nervous system depression". Police had given the detainee his prescribed

medication while he was in custody, without knowing that he had taken an overdose of methadone earlier in the day.

146. In the next case the Coroner found the cause of death to be *“inhalation of vomit due to or as a cause of an overdose of methadone”*. The detainee was on the methadone programme and had been given her morning dose of methadone by police about 2.5 hours before she died. The investigation into her death concluded that she must have ingested additional methadone and benzylpiperazine (BZP) before she was taken into custody that morning, although the officers who dealt with her at the time of her arrest did not consider her to be under the influence of drugs.
147. In the most recent case the cause of death was identified as *“methadone toxicity in association with alcohol and Zopiclone”*. Police had located a heavily intoxicated man lying on a footpath and taken him into custody for detoxification. They assumed that he was simply intoxicated and did not consider the possibility that he had also taken drugs. He was found dead in his cell after spending about 7.5 hours in custody.
148. If the influence of drugs had been identified in these cases, police may not have given the detainees their medication, or there may have been time for medical intervention. However it can be difficult to recognise when drugs are involved and their effect may be masked by alcohol, or confused with the symptoms of withdrawal.

### Medical conditions

Year	Gender	Age	Ethnicity	Cause of death	Risk assessment
2002	M	44	Maori	Epilepsy	No risk
2002	M	56	European	Head injuries	No risk
2003	M	36	Maori	Coronary artery thrombosis	No risk
2005	M	64	European	Metabolic acidosis	Not in need of specific care
2005	M	68	European	Head injury	Not in need of specific care
2005	M	43	Maori	Epilepsy	Not in need of specific care
2007	M	55	Maori	Brain tumour	Not in need of specific care

149. During the 10-year review period, seven detainees died in custody due to problems with their health (i.e. illness or accidental injury). Three were European (42.9%), and four were Maori (57.1%).
150. The average age of the detainees who died from a medical condition was 52.3, which is 13.8 years older than the average age for all types of death. All seven of the deaths involved males over the age of 35. The youngest was 36 and the oldest was 68. This

category includes four of the oldest people to die in custody during the review period, all four of whom had been arrested for detoxification.

151. Altogether six of the seven cases involved people who were affected by alcohol at the time of their arrest (85.7%). While alcohol abuse may have contributed to some of the deaths by worsening the health of the person in custody, it was not identified as a cause of death in itself.
152. None of the detainees who died due to a medical condition had been assessed to be at risk or in need of care. In all but one case, the person's medical condition existed prior to being in police custody. One detainee fell and sustained head injuries while in custody.
153. Two of the detainees were unaware of, or did not inform police about, their medical conditions, and in four cases police were unable to question the detainees about their health because they were too drunk. These were the detainees who had been arrested for detoxification. One detainee did inform police that he suffered from epilepsy and had stopped taking his medication, but the watchhouse keeper did not recognise the risk this posed to the detainee's health. None of the detainees had NIA alerts relating to their health.
154. Police sought medical attention for the detainees in three cases. In the other four cases police did not see any need for medical attention, and the detainees were found dead in their cells before medical assistance could be provided.
155. In the four cases where the detainees were heavily intoxicated and had been arrested for detoxification, the symptoms of their injuries or illnesses may have been masked by the alcohol they had consumed. In these cases:
  - One detainee was taken to hospital shortly after being brought into custody, but only after he had fallen and hit his head on two separate occasions while in the presence of police. After about eight hours the detainee was released from hospital but still seemed extremely intoxicated, incoherent and drowsy. Police took him back into custody for detoxification, where he stayed for another 30 hours without his condition improving. He was then taken back to hospital, where died from his head injuries four days later.
  - Another detainee was found lying unconscious on the pavement with a small cut on the back of his head. Police did not realise how serious the injury was, and thought the detainee's unresponsiveness was due to his intoxicated state. He was not seen by a doctor until over 12 hours after he had been taken into custody. He was then transferred to hospital and died three days later.
  - In another case, police found a severely intoxicated man lying in an alley. Before taking him into custody for detoxification they called an ambulance. Ambulance staff

considered that he did not need to be admitted to hospital. The detainee was found dead in his cell about 10 hours later – his death having been caused by a brain tumour.

- Another case involved a person who died in custody from “*metabolic acidosis complicating methanol ingestion with concurrent severe ischaemic heart disease*”. This detainee was known to drink methylated spirits and was regularly brought to the police cells for detoxification. After 12 hours in custody (at which time he appeared to have sobered up) the man was informed that he was free to leave, but police allowed him to stay longer because it was very early in the morning. A few hours later he was found dead in his cell.

156. The Authority considered whether any of the deaths were preventable, and reached the following conclusions:

- In two cases police could not have taken steps to prevent the deaths, because they were unaware of any reasons why the detainees’ health should be at risk, and the detainees did not display any clear warning signs.
- Three deaths may have been avoided if police had recognised the risks to the detainees’ health and sought medical attention in a timely manner. Two of these detainees had been brought to the cells for detoxification and one had stopped taking his epilepsy medication. However it is not known whether earlier medical treatment could have saved their lives.
- One case involved a man whose brain tumour may have been detected had he been examined by a doctor. Police had, quite reasonably, relied on the ambulance officers’ assessment that the man did not need to go to hospital. That assessment was complicated by the man’s heavily intoxicated condition.
- In one case, a detainee’s death may have been prevented if police had taken him directly to hospital after his first head injury, rather than leaving him unattended in a cell where he again fell down and sustained further head injuries. This person’s death was attributed to multiple head injuries.



# Issues Arising from the Cases Reviewed by the Authority

INDEPENDENT POLICE CONDUCT AUTHORITY

157. The Authority considered the following issues:

- 1) the detainees' use of alcohol and drugs;
- 2) the mental health of the detainees;
- 3) use of force and/or restraint by police;
- 4) searching of detainees;
- 5) risk assessment of detainees;
- 6) monitoring of detainees;
- 7) dispensing medication to detainees;
- 8) NIA alerts;
- 9) handover procedures in the watchhouse/custody facility;
- 10) the safety of police cells;
- 11) medical treatment and mental health assessment of detainees;
- 12) training of custody staff; and
- 13) near miss reporting.

## CIRCUMSTANTIAL ISSUES

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### **Issue 1: Alcohol / Drugs**

158. The extent to which a detainee is affected by alcohol or drugs is an important issue to consider at the time he or she is taken into custody.<sup>27</sup> As well as being a risk factor in itself, intoxication can mask the other warning signs that police look for during the evaluation process. Furthermore it is often the reason the person has come to the attention of police in the first place.

#### *Deaths following restraint*

159. In respect of deaths following the use of restraint by police, intoxicated people may be more likely to resist arrest and may be less susceptible to pain. Police may therefore have to apply greater force in order to restrain them. The use of alcohol or drugs is also a recognised risk factor for positional asphyxia (see paragraphs 200-207).

160. However none of the seven deaths following the use of restraint by police that were reviewed by the Authority involved people who were greatly affected by either alcohol or drugs. One person had traces of alcohol and two people had traces of cannabis in their system after they died.

#### *Suicides*

161. In half of the reviewed suicides in custody the detainee was affected by alcohol at the time of arrest, and in all of those cases the person went on to commit suicide within about four hours. In four cases the detainees were under the influence of drugs at some point during their detention – three people had used drugs just prior to arrest, and there was evidence that one person had been able to smoke cannabis while in custody.

162. Intoxication can make the risk assessment process in respect of suicide risk much more difficult, because the effects of the alcohol or drugs may mask the risk to the detainee. Mental health experts are reluctant to examine people who are affected by alcohol or drugs because of the consequent unreliability of their findings, yet police are regularly required to assess whether or not these people are at risk of harming themselves.

163. Police deal with a great number of intoxicated people, with the consequent danger that they may become desensitised to the risks that intoxication poses.

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<sup>27</sup> The Authority notes that the New Zealand Police have recently updated their guidance in respect of dealing with intoxicated or drug affected people (see paragraph 273).

164. Involvement with the police is an extremely stressful event for many people. Therefore any suggestion of suicidal thoughts must be taken seriously, and threats to commit suicide should not be discounted simply because the detainee is intoxicated.
165. Alcohol or drug withdrawal is another significant risk factor. One of the reviewed cases involved a detainee who was on a methadone programme and committed suicide after about two hours in custody, but it is not known whether drug withdrawal was a factor in the death. The officers who dealt with the detainee said that although he had missed his morning dose of methadone he did not appear to be suffering from withdrawal.

#### *Drug-related deaths*

166. Significantly, only one of the three detainees who died from drug-related causes while in custody was assessed to be at risk or in need of care, and none of the watchhouse staff in these three cases realised that the detainees had consumed drugs before being taken into custody. These cases illustrate how difficult it can be to recognise that a person is under the influence of drugs.
167. One of the detainees had been taken into custody for detoxification but was still found to be not in need of specific care. Police staff attributed his semi-conscious state to alcohol consumption alone and did not consider that he may also have taken drugs.

#### *Deaths due to a medical condition*

168. Six of the seven cases where detainees died due to their medical condition involved people who were affected by alcohol at the time of their arrest (85.7%). Four were so heavily intoxicated that they were being held in custody for detoxification, but none were significantly affected by drugs (although traces of cannabis were detected in one case). All of the detainees were assessed as no risk or not in need of specific care.
169. Alcohol appears to have masked the condition of the detainee in two cases involving head injuries. It may also have masked the condition of a detainee who died from a brain tumour – in that case the Coroner found that it was not unreasonable for the police and ambulance staff to conclude that the man was simply drunk and did not require hospitalisation.

#### *Detention period for detoxification*

170. In one of the reviewed cases, a man was held in custody for detoxification for about 30 hours, but his condition did not improve. Halfway through this period the police “released” the detainee then immediately took him back into custody again for detoxification.

171. The investigation into the detainee's death found this practice to be illegal, because section 37A of the Alcoholism and Drug Addiction Act 1966 only allowed for the police to detain a person for detoxification for a period not exceeding 12 hours. However it was determined that the police had acted in good faith, with the intention of looking after a detainee who was still incapable of looking after himself.
172. With hindsight, the officers should have been more concerned that the detainee's condition had not improved after 12 hours in custody, particularly when he had suffered head injuries the day before. The man's re-arrest for detoxification appears to have confused some watchhouse staff, who thought he had sobered up and then become intoxicated again, rather than apparently still being intoxicated from the first time he was in custody. Medical advice should have been sought when the first 12 hour period expired but the risk assessment was complicated by the fact that the detainee had already been treated for his injuries in hospital.
173. Section 36 of the Policing Act 2008 now states that police cannot detain a person for detoxification purposes for longer than 12 hours unless a health practitioner recommends it (see paragraph 64). The health practitioner must be satisfied that the person remains intoxicated and unable to protect themselves, and that the person does not have any health needs that may require medical attention.
174. The health practitioner can only extend the period of detention for a further 12 hours. Presumably, if the detainee has not recovered by then, police would transfer him or her to hospital, although the Policing Act does not specify what action should be taken.

#### *The need for detoxification centres/temporary shelters*

175. There have long been calls for New Zealand to establish detoxification centres or temporary shelters where extremely intoxicated people can be medically supervised while they sober up. The existence of such centres was contemplated by section 37A the Alcoholism and Drug Addiction Act 1966, which stated that when a police officer comes across an intoxicated person he or she reasonably believes is incapable of protecting themselves, the officer should take that person home if possible, and if not, he or she should take the person to a temporary shelter or detoxification centre. Section 37A has now been replaced by section 36 of the Policing Act 2008, which contains similar provisions (see paragraphs 61-65).

176. However the detoxification centres/temporary shelters have not been established as contemplated by the Acts.<sup>28</sup> Since shelters are not generally available, police have to take heavily intoxicated people who are incapable of looking after themselves into custody for detoxification as a last resort. This means that at times custody staff have to deal with a large number of intoxicated and vulnerable detainees who are only being detained due to their level of intoxication.
177. Temporary shelters would be a valuable resource for police. Deaths in custody may be prevented if heavily intoxicated people could be taken to facilities where the staff are capable of providing health care and are medically trained to detect whether alcohol may be masking a more serious medical condition. This would ease the burden on police staff and enable them to work more efficiently in managing and caring for the other detainees in the cells.
178. The establishment of temporary shelters requires careful consideration. Research may be needed in order to assess the demand, feasibility, and potential outcomes (both positive and negative) of such facilities. In addition, there would need to be cooperation between New Zealand Police and the Ministry of Health or other relevant stakeholders. The shelters would need to be able to provide care to a range of people of different ages, genders and ethnicities, and consideration would need to be given to the proper management of the health and safety concerns of the staff as well as the facility users. Guidelines would also be required in order to address the issue of violent individuals or those who attempt to leave the shelter while they are still dangerously intoxicated.

#### FINDINGS

Just under half of all the cases reviewed by the Authority involved detainees who were affected by alcohol and a third involved detainees affected by drugs.

As well as being a risk factor in itself, intoxication can mask other risk factors.

Half of the suicides in custody and 85.7% of the deaths due to a medical condition involved a person who was under the influence of alcohol.

None of the detainees who died from drug-related causes were assessed as being under the influence of drugs at the time they were received into custody.

<sup>28</sup> The Authority is aware of only one detoxification facility – a six-bed inpatient detoxification unit at Christchurch’s Hillmorton Hospital; see J Paulin and S Carswell, *Evaluation of the Mental Health/Alcohol and Other Drug Watch-house Nurse Pilot Initiative* (NZ Police, Wellington, 2010) 31. In any event detoxification centres are not widely available throughout the country as anticipated by the legislation.

Five deaths in custody involved people who had been taken into custody for detoxification but were assessed as being no risk or not in need of specific care.

Detoxification centres would be a valuable resource for police staff.

## Issue 2: Mental health

179. The mental health of detainees is another highly significant risk factor for police staff to consider, especially in relation to restraint deaths and suicides in custody. Just over half of the detainees who died during the 10-year review period were affected by mental health issues. None, however, were assessed by Duly Authorised Officers (DAOs)<sup>29</sup> or Community Assessment Team (CAT) members while in custody (see paragraph 66).

### *Deaths following restraint*

180. The mental health of people who are restrained by the police is particularly relevant because it may be the reason why the person is acting violently and needs to be restrained. People who are having a psychotic episode may exhibit unusual strength and appear not to feel pain, which makes it more difficult to restrain them.

181. Furthermore, people who suffer from a psychiatric condition appear to be more vulnerable to the impact of restraint, and more susceptible to positional asphyxia (see paragraphs 200-207).

182. In the cases reviewed by the Authority, four people who died after being restrained by the police suffered from schizophrenia, including all three people who died from positional asphyxia and one person who died from heart problems. Three of the people who suffered from schizophrenia were being arrested for violent behaviour at the time they collapsed, and one was being transported by police to a mental health unit after his mental condition had deteriorated.

### *Suicides*

183. At least seven of the people who committed suicide while in custody had experienced significant mental health issues before they were taken into custody (70%). These issues included prior suicide attempts, prior threats to commit suicide or self-harm, and depression.

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<sup>29</sup> A DAO is a mental health professional who may be called to assess a person in custody.

184. Police were aware of the mental health concerns in five of the suicides in custody; in three cases police knew that the detainees had previously threatened to commit suicide, in one case the detainee had a warning flag on NIA for suicidal tendencies, and in another case the detainee had a health alert flag on NIA because he had been prescribed anti-depressants.
185. In the other five suicides, no concerns about the detainees' mental health were noted on the Custody/Charge Sheet (in one of these cases police had failed to carry out a risk assessment at all).

#### *Drug-related deaths*

186. Two of the three people who died in custody from drug-related causes had a history of mental health problems. Both had attempted suicide by drug overdose in the past.
187. In one of these cases the detainee's "*psychiatric history*" was noted by police as a suicide risk, but the watchhouse keeper failed to check NIA and see that the detainee had an alert for suicidal tendencies.
188. In the other case the watchhouse keeper noted that the person in custody had "*psychological problems*". He later said he had written this on the charge sheet because the detainee appeared to be "*slow*". This person had an extensive psychiatric history of which the police were unaware, although he had been held in custody at least 65 times.<sup>30</sup> The investigation into his death found that he should have been flagged on NIA as a suicide risk two months before he died, because at that time he had been assessed to be at risk of suicide while in custody. However police had not created a NIA alert or called a DAO to assess him on that occasion (see paragraphs 47 and 66).

#### *Police review*

189. The New Zealand Police Organisational Assurance Group has recently undertaken a review of the police response to persons with mental impairment, which will examine the operational impacts on policing arising from contact with persons with mental impairment; seek to address gaps in knowledge and skill; and seek ways to improve service delivery with key stakeholders. The review is expected to be finalised by the middle of July 2012.

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<sup>30</sup> With the introduction of the electronic custody module, custody staff are now able to access a detainee's previous custodial risk assessments (if available), and to consider that information as part of the current risk assessment.

## FINDINGS

Over half of the cases reviewed by the Authority involved people affected by mental health concerns.

Mental health is a highly significant risk factor in respect of the management of detainees, particularly in relation to suicide and the use of force or restraint.

Four of the seven people who died after being restrained by police suffered from schizophrenia, and at least 70% of the suicides in custody involved people who had experienced significant mental health issues.

## PROCESS/PROCEDURAL ISSUES

**Issue 3: Use of force/methods of restraint**

190. Although deaths following the use of restraint by police have the most potential to be controversial, the investigations into the seven deaths that occurred during the 10-year review period found very few problems with the actions of police.
191. All seven had come to the attention of the police because of their strange or aggressive behaviour and had resisted the restraint that was applied to them. The primary issue to consider in these cases was whether the force used to restrain the person was reasonable and necessary in the circumstances.
192. Section 39 of the Crimes Act 1961 provides that officers may use “*such force as may be necessary*” to overcome any force used in resisting arrest unless the process can be carried out “*by reasonable means in a less violent manner*”. Section 62 of the Crimes Act makes officers criminally responsible for any excess use of force.
193. Furthermore section 48 of the Crimes Act states: “*Everyone is justified in using, in the defence of himself or another, such force as, in the circumstances as he believes them to be, it is reasonable to use.*”
194. In all seven cases in this review where restraint was used, police considered the restraint to be necessary because of the aggressive behaviour of the person with whom they were dealing.

Reason why restraint needed	Restraint used
struggled while being transported in a police car	<ul style="list-style-type: none"> <li>handcuffed behind his back</li> <li>held down in prone position</li> </ul>
resisted arrest	<ul style="list-style-type: none"> <li>neck hold applied</li> <li>handcuffed with arms in front</li> </ul>

tried to run away after causing wilful damage and resisted arrest	<ul style="list-style-type: none"> <li>• sprayed with OC spray</li> <li>• held down in a prone position</li> <li>• handcuffed behind his back</li> </ul>
attacked a police officer	<ul style="list-style-type: none"> <li>• OC spray applied to face</li> <li>• held down in a prone position</li> <li>• handcuffed behind his back</li> <li>• ankle restraints applied</li> </ul>
was smashing up the house he lived in	<ul style="list-style-type: none"> <li>• family members had pinned him to the floor in a prone position</li> <li>• handcuffed behind his back</li> </ul>
resisted arrest	<ul style="list-style-type: none"> <li>• handcuffed behind his back</li> <li>• held down in a prone position</li> </ul>
attacked a police officer	<ul style="list-style-type: none"> <li>• sprayed twice with OC spray</li> <li>• hit on the arm with a baton</li> <li>• placed in a headlock</li> <li>• handcuffed with arms in front</li> </ul>

195. All of the investigations into the deaths found the restraint or force used by police to be necessary and reasonable in the circumstances.
196. OC spray was used in three of the seven cases (42.9%), but was not found to be the cause of any of the deaths. All three people who were sprayed suffered from schizophrenia, although in at least one case the police were unaware that the person suffered from schizophrenia. It is questionable whether the use of OC spray on people who are known to be mentally ill is appropriate, since it is recognised to be less effective on people who are suffering from a mental disorder. It can also cause additional stress or trauma to an already vulnerable individual. In one case, the officer said that he had used OC spray because he believed it was the tactical option for restraining the person that involved the least amount of force.
197. In one case a person died after a neck hold was used on him. The officer did not apply a full 'carotid hold' (which would have involved him applying pressure to the person's neck to make him lose consciousness); he used the hold only to gain physical control over the person, who happened to be particularly vulnerable to the application of force to his neck due to an underlying medical condition (see paragraph 126).
198. The use of neck holds by police is a controversial issue worldwide, and several police departments in the United States have banned the carotid hold in order to avoid lawsuits for neck-restraint-related deaths. In New Zealand the carotid hold remains a tactical option for restraint, as long as the officer has been trained in its use.
199. In the three cases where the person died due to heart problems, there was a prolonged struggle before the person collapsed. One person was pinned to the ground by family members, and then handcuffed by police with his hands behind his back. Another was handcuffed and held down in a prone position. The third was sprayed twice with OC

spray, hit on the arm by a baton, and placed in a headlock before being handcuffed with his hands in front of him.

*Positional asphyxia, excited delirium and post-exercise peril*

200. Three of the restraint-related deaths were attributed to positional (or restraint) asphyxia, which is a condition that can result in sudden death.

201. Death is caused when the person's body is held in a position which restricts his or her ability to breathe. The condition occurs in circumstances where the person has an increased need for oxygen (for example, because he or she is resisting arrest) but is unable to meet that need. The most recent case occurred in 2006.

202. In all three cases where death was attributed to positional asphyxia, the person was handcuffed behind his back and held down while lying in a prone position. OC spray was used in two cases, and ankle restraints were applied in one case.

203. An important question to consider in the cases where people died from positional asphyxia is whether police have considered the risk factors. During the 10-year review period, New Zealand Police recognised the following risk factors in GI A267 (Positional Asphyxiation):

- the individual is highly stressed;
- wild, threatening, bizarre behaviour with possible mania or psychosis;
- violent behaviour and/or resistance;
- restraint of the individual, (especially in a prone, face down position);
- restraint of the individual, (especially in a prone position), whilst cuffed hand and foot;
- drug and alcohol use by the individual;
- male gender; and
- obesity.

Not all the risk factors need be present for the condition to occur.

204. In the earliest of the reviewed cases (which occurred in 2000) police had not recognised obesity as a risk factor. The Coroner recommended that police should be reminded that positional asphyxia is "*an ever present danger*", especially for obese people and people lying in prone positions. In response, New Zealand Police amended GI A267 to include

obesity as a risk factor. The Coroner also recommended that “*posterior handcuffing*” should be avoided wherever possible and not used for obese people.

205. The extent to which police took the risk factors of positional asphyxia into account was not always clear in the cases where restraint was used. Despite the risks, in five cases the restrained person was held down in a prone position and handcuffed behind his back. In all of these cases the person involved was highly stressed and displaying bizarre or violent behaviour. Furthermore, two of the three people who died from positional asphyxia were obese and one was tied with ankle restraints in addition to handcuffs.
206. On the other hand, police have to weigh the dangers of applying restraint against the need to restrain a person in order to ensure their own safety and the safety of the others. Backing off is a potential tactical option, but is sometimes not available or appropriate to the particular circumstances in which police officers find themselves. Although there are risks associated with some forms of restraint, such as holding a person down in the prone position, police cannot always avoid restraining people in this way – particularly when the person is large, powerful and violent.
207. In all three cases where people died from positional asphyxia, the restraint applied was found to be reasonable and necessary in the circumstances. Police had monitored the person’s breathing and quickly realised that something was wrong. Unfortunately by the time the person had collapsed it was too late to save them.
208. Two other medical conditions that are relevant to the issue of deaths following police restraint are ‘excited delirium’ and ‘post-exercise peril’.
209. Excited delirium is another condition that can be associated with sudden death. It was diagnosed (in combination with positional asphyxia) in one of the restraint deaths in the Authority’s review.
210. Someone in a state of excited delirium may seem impervious to pain and persist in struggling against restraint beyond the normal point of exhaustion. Symptoms of this condition include disorientation, overheating, agitation, unusual strength, fast heart rate and aggression. The condition is often associated with the use of cocaine or other illegal drugs such as methamphetamines and PCP. Its existence has recently been formally recognised by the American College of Emergency Physicians.<sup>31</sup>

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<sup>31</sup> Force Science Research Centre, ‘Emergency Doctors Confirm Excited Delirium Does Exist’ (Force Science News #136, 6 November 2009); Hoffman L, ‘ACEP Recognises Excited Delirium Syndrome’ (Emergency Medicine News, October 2009).

211. Post-exercise peril is a condition where a person who suddenly stops physically exerting himself or herself (or is made to stop because he or she is restrained) is at risk of death soon afterwards from cardiac problems.<sup>32</sup> This may explain the three deaths in the review that occurred in this manner.
212. It is widely accepted that more research is needed into the physiological causes of restraint-related deaths and the particular medical conditions that may be associated with positional asphyxia, excited delirium, and post-exercise peril.<sup>33</sup>
213. In July 2010, New Zealand Police published a chapter in the Police Manual titled *Positional Asphyxia*. This policy explains in detail the risk factors and warning signs for positional asphyxia, and includes diagrams of positions that may cause it. Police are advised to closely monitor and supervise any person considered to be at risk.
214. Also in July 2010, New Zealand Police published a chapter in the Police Manual titled *Mechanical Restraints*, which sets out guidelines for the use of approved mechanical restraints such as handcuffs, waist restraint belts, leg restraints, restraint boards and spitting hoods. The risk of positional asphyxia is mentioned several times throughout the policy, which prohibits transporting anyone in a vehicle who is restrained by a combination of linked wrist and leg restraints, due to the “*extreme risk of positional asphyxiation*”. The policy also states:

***“Caution***

*The use of mechanical restraints to provide a combination rear wrist and ankle restraint – linking the arms and legs of a subject – is a significant risk and is only to be used when no other way of calming or controlling that person is readily available. Positional asphyxiation is a clear and material risk and the prisoner must be continuously monitored and never allowed to lie face down.”*

***Training for use of force/restraint***

215. Lack of police training on the use of force or restraint was not noted as an issue in any of the cases reviewed by the Authority.
216. Police training should however continue to ensure that all officers are kept up to date with their training, so as to address:

<sup>32</sup> Dimsdale JE, Hartley LH, Guiney T, Ruskin J, and Greenblatt D, ‘Post-exercise Peril: Plasma Catecholamines and Exercise’ (1984) 251(5) Journal of the American Medical Association 630-632.

<sup>33</sup> See for example Independent Advisory Panel on Deaths in Custody, *Mid Term Progress Report on the Work of the IAP and Future Priorities for the Work of the Panel* (February 2011) 11.

- the need to consider the possibility of backing off rather than restraining a person;
- the need for the restraint to be proportionate to the risk posed by the person;
- the dangers associated with certain types of restraint (such as holding a person down in a prone position with their hands tied behind their back, and neck holds);
- the risk of positional asphyxia;
- awareness of the increased risks when drugs/alcohol/mental illness are involved;
- the need to closely monitor people who are restrained;
- the need for restraint to be as brief as possible;
- the tactical options for dealing with people who may be affected by excited delirium; and
- the possibility of post-exercise peril.

#### FINDINGS

The use of force and/or restraint by police was found to be reasonable and necessary in all of the cases reviewed by the Authority.

Five of the seven cases where people died after being restrained by police involved people who were held down in a prone position and handcuffed with their hands behind their back.

#### Issue 4: Searching of detainees

217. The Authority's review found a number of issues in respect of the searching of detainees by police, particularly in relation to suicides in custody and drug-related deaths.

##### *Suicides*

218. In two of the most recent suicides in custody, inadequate searching by police left the person in custody with the means to commit suicide. In one case, no search was conducted at all and the detainee's shoelaces were not taken from him before he was placed in a cell. In the other case, an officer conducted a general search but did not locate the cord in the waistband of the detainee's shorts. The officer said he thought police policy regarding general searches did not allow him to search the detainee's underwear.

219. Following that case the Authority found that there was ambiguity in the General Instructions and that they should be redrafted to enable police to search the upper part of a person's underwear as part of a general search. Police responded that they believed

the instructions were sufficiently clear; however they had taken steps to amend GI S106 (Justification for Strip and Full Body Searches) to allow a more liberal approach to the decision as to whether a strip search was warranted (see paragraphs 223-226 below for further discussion of strip searches).

220. In May 2010, New Zealand Police published a chapter in the Police Manual titled *Searching People*. This chapter explains the different types of search that may be carried out (general, strip and full body) and details the steps that must be followed by police when conducting each type of search. The policy states that:

- all searches must be justified by a “reasonable evaluation of risk”;
- following an arrest, a preliminary search for weapons and “easily disposed of” items must be made; and
- upon arrival in the custody area/police station, all prisoners must be fully searched by way of a general or strip search, unless in the circumstances it would be “unjustifiable” to do so.<sup>34</sup>

221. The new *Managing Prisoners* policy (see paragraph 35) provides that “All prisoners placed in a Police cell or in a court cell by themselves (apart from those awaiting bail bond signature) must have shoelaces, belts and any article of clothing or footwear with cords/laces removed.” The policy also instructs police to consider whether any of the prisoner’s jewellery requires removal because of its ability to cause injury to the prisoner or any other person.

222. When detainees are received into police custody using the new electronic custody module (see paragraph 52), it creates an alert in the system that a search of the detainee is required. This alert remains until a search is recorded as ‘completed’. However the paper version of the Custody/Charge Sheet, which is still in use when the electronic custody module is not available, does not include a prompt to search the detainee. Custody staff are required complete the “Accused Person’s Property” section of the Custody/Charge Sheet, which should remind them that the detainee must be searched, but as demonstrated by the latest reviewed suicide in custody this does not always happen.

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<sup>34</sup> The policy gives the following examples of circumstances where it would be “unjustifiable” to conduct a general or strip search: if it is a minor charge; if all evidence has been located; if the prisoner is not placed in a cell or left unsupervised and is being immediately bailed; or if the prisoner is not at risk of self harm.

*Drug-related deaths*

223. One of the reviewed cases involved a detainee who had been assessed to be in need of care but was not strip searched or dressed in a suicide-resistant gown. The Authority found that if these actions had been taken, police may have noticed recent needle marks which would have alerted them to the possibility that she had taken non-prescribed drugs prior to her arrest. Police would have had good reason to strip search her, because she had a lengthy history of drug abuse.
224. Following that case the Authority recommended that the GI P203(3) (Monitoring People in Police Custody and Prisoners) should be amended to require police to conduct a strip search whenever a person has been found to be in need of care. At the time the General Instruction only provided that: *“Persons in police custody identified as needing to be frequently monitored should be placed in a suicide resistant cell and issued with a tear resistant gown.”*
225. However GI S106 (Justification for Strip and Full Body Searches) clearly stated:
- “Every strip or full body 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.”*
226. The prohibition on blanket policies for strip searching is continued in the new *Searching People* chapter of the Police Manual (see paragraph 220). The policy states that strip or full body searches *“significantly disrupt a person’s dignity and privacy”* and should only be carried out when the risk assessment indicates that:
- there is the possibility of there being evidence on the person; or
  - the person may become violent, or commit self-harm/or inflict intentional damage to property; *and*
  - a general search may not sufficiently remove that risk.
227. There may be good reason not to strip search every person in custody who is found to be in need of care. Current policy provides that each case must be considered on its own merits.

## FINDINGS

Inadequate searching was an issue in two of the most recent suicides in custody and in one of the drug-related deaths.

Thoroughly searching detainees and removing any dangerous items such as cords from them before they are put into a cell is likely to reduce the risk of harm.

**Issue 5: Risk assessment of detainees**

228. The risk evaluation process is critically important because police need to recognise that particular people are at risk before they know to take extra measures to protect them, such as placing them in a suicide-resistant cell and monitoring them more closely.
229. It can be difficult for officers to judge whether a certain person is at risk, especially if he or she is intoxicated at the time of arrest, or there is a lack of information about his or her medical and/or psychological history.
230. Custody staff must endeavour to identify the risk factors associated with each person in custody and make a decision about the level of care required. These decisions will inevitably be influenced by the resources available to monitor and care for detainees.

*Deaths following restraint*

231. In the cases involving the use of restraint by police there was generally no proper risk evaluation because the people being taken into custody died or collapsed before they had been received and processed at a police station.
232. In one case the person who died while being arrested had already been in custody earlier in the day. On the first occasion he had been assessed as being in need of care and constant monitoring, but was released on bail without being seen by a DAO or CAT member as required by policy. If he had been assessed, police may have reconsidered their decision to release him on bail.
233. Another issue that arose in that case was the extent of the police's responsibility to care for people in custody. There was a question whether police should be required to contact a detainee's family, friends or a health professional when there have been concerns for that person's safety while in custody and the decision is made to release him or her. At the time GI P100(13) (Evaluation of Persons Detained in Police Custody and Prisoners) stated:

*"Prior to bail or other release of a person in need of care or constant monitoring, supervisors must consider whether it is necessary for family or friends of the person, or an appropriate health professional, to be*

*informed that the person has been evaluated and the level of care provided. This is particularly so in the case of people under the age of 25 [emphasis added].”*

234. This position is continued in the new *Managing Prisoners* policy, which states:

***“Releasing at risk people from custody***

*If a person is assessed by Police as needing care and constant monitoring, supervisors must consider whether family or friends or an appropriate health professional should be advised of this when the person is bailed or released.*

***Note:*** *This is particularly important in the case of people under the age of 25 due to their enhanced emotional vulnerability.”*

235. Following its investigation into the death the Authority suggested (but did not formally recommend) that New Zealand Police consider changing the policy so that custody staff are required to advise the next of kin or some other responsible person when a person who has been found to be in need of care and constant monitoring is going to be released – rather than just being required to consider whether such action is necessary. In any case, if the decision is made not to advise the next of kin (or other responsible person), the reasons for this decision should be recorded by the custody officer on the HSMP or electronic custody module.
236. In respect of the restraint cases involving people with mental health problems, it is unclear whether the police were aware of those problems and considered them in terms of the risks involved before they took action and restrained the person. It appears that in all of the reviewed cases police have had to react quickly to the situation unfolding in front of them, and have done what they believed necessary for the safety of the person involved, themselves and the public.

### *Suicides*

237. It can be extremely difficult to predict whether someone is going to attempt to commit suicide. Sometimes the person makes the decision spontaneously, and in many instances police cannot reasonably be criticised for believing the detainee not to be at risk. It is nevertheless worthwhile to examine these cases in order to determine whether police policies, practices or procedures could be improved in order to prevent suicides.
238. In six of the reviewed suicides in custody (60%), the detainee was assessed as no risk or not in need of specific care. Of the other four cases: one detainee was assessed as high risk then downgraded to low risk; one was assessed to be low risk; one had not yet completed the risk assessment process; and in one case (the most recent suicide) police neglected to undertake a risk assessment.

239. Of the six cases where the person in custody was assessed not to be at risk:
- in four cases the detainees showed no outward signs of risk – however all had been involved in domestic violence and three were also intoxicated at the time of arrest;
  - one detainee had a suicide warning flag (NIA alert);
  - one detainee had made a previous threat to kill himself which the police were aware of, and there were two prior self-harm incidents noted in NIA but not flagged.
240. Suicides in custody are statistically rare, but the warning signs are quite common in a custody environment. The risk indicators include:
- under the influence of alcohol/drugs/solvents or suffering from withdrawal;
  - showing signs of being withdrawn/irrational/depressed/overly ashamed/agitated/aggressive/angry etc;
  - history of mental illness;
  - evidence of prior self-harm;
  - not taking prescribed medication;
  - family problems / history of family violence (this risk factor was present in 60% of the reviewed cases); and
  - has suffered a recent adverse life event.
241. Each risk assessment is based on the answers given by the detainee to the questions in the *“Watchhouse Keeper’s Evaluation”* section of the Custody/Charge Sheet (or electronic custody module); the observations of the arresting officer and the custody officer; and any NIA alerts for the detainee.<sup>35</sup> This means that the person in custody generally has control over most of the information provided regarding their risk status, including their own behaviour.
242. When there are no outward warning signs, no known history of mental illness, and no other indicators, it is unreasonable to blame police for not anticipating that the detainee will commit suicide.

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<sup>35</sup> With the introduction of the electronic custody module, custody staff are now able to access a detainee’s previous custodial risk assessments (if available), and to consider that information as part of the current risk assessment.

243. However there is also a danger that custody staff may become accustomed to dealing with detainees who display the warning signs but do not go on to commit suicide. As a consequence, this may implicitly raise the threshold for categorising a detainee as in need of care. For example, while intoxication is a risk factor for suicide, police deal with so many intoxicated detainees that it may be impractical to assess them all as being in need of care.
244. Police must ensure that they take warning signs seriously, especially statements of suicidal intent and NIA alerts, and ensure that they make thorough assessments in every case. In four of the suicides in custody reviewed by the Authority, police were aware that the detainees had threatened to kill themselves or had attempted to commit suicide in the past. In only two of those cases were the detainees considered to be at risk – however in another case the detainee was assessed as no risk but still placed in suicide-resistant cell and made to wear a tear-resistant gown.
245. The charge sheet introduced in 2005 (the Custody/Charge Sheet) improved upon the earlier Loose Leaf Charge Sheet by providing a checklist of suicide risk factors. However some concerns about the new Custody/Charge Sheet were noted in the Coroner's findings in respect of one of the suicide cases. The Coroner obtained a psychiatrist's opinion which criticised the fact that the Custody/Charge Sheet's risk evaluation section provides no instructions as to how the risk factors are to be worked with in order to determine what level of risk should be assigned to the detainee. In other words, there is no direction as to how many risk factors need to be present before a detainee should be found in need of care, or whether certain risk factors are more significant than others.
246. It was suggested that, rather than leaving it to the subjective judgment of the officer conducting the evaluation to decide whether or not the person is at risk, some form of objective guidance, possibly an algorithm, was needed to improve the risk assessment process. This suggestion was echoed in the same Coroner's findings in relation to two other deaths in custody.
247. Another concern noted by the same Coroner was the potential lack of consideration of cultural factors in the risk evaluation. The Coroner recommended that GIs P200-P215 (Custodial Suicide Prevention) be redrawn so that these cultural factors must be taken into account during the *"Watchhouse Keeper's Evaluation"* and any subsequent risk assessment.
248. The Custody/Charge Sheet which was introduced in 2005 lists being Maori as a risk factor but does not detail the particular cultural factors which may predispose Maori to suicide. The *Managing Prisoners* policy introduced in 2011 does not specify that cultural factors should be considered as part of the risk assessment; however it does direct custody staff to refer to the Royal New Zealand Police College's 'Custodial Management: Suicide

Awareness' reference material for further information about suicidal warning signs and Maori suicide awareness.

### *Drug-related deaths*

249. As with the prevention of suicides in custody, the prevention of deaths due to drug overdose depends on first recognising the risk. Once the risk is identified, medical attention should be sought and more extensive monitoring put in place. In cases where drugs and/or alcohol are involved, there is a need to monitor the detainee's level of consciousness over time.<sup>36</sup>
250. In the cases reviewed by the Authority, only one detainee who went on to die from drug-related causes was considered by police to be intoxicated at the time he was arrested. Furthermore in that case police did not suspect the involvement of drugs, they simply thought the person was extremely drunk and needed to "sleep it off". The person in question was able to walk, but unsteady on his feet. Since police believed him to be unable to answer any of the risk evaluation questions, they did not ask him any. Nonetheless he was assessed to be not in need of specific care. The risk assessment focused primarily on whether the detainee was a suicide risk, and did not properly evaluate the risks to the man's health from his intoxicated state.
251. In the other two drug-related deaths, police reported that the detainees did not appear to be under the influence of drugs or alcohol, although they had both taken methadone before they were arrested.
252. One of these cases involved a detainee who appeared drowsy, but was coherent and able to walk unaided. Police were aware that he had been recently discharged from hospital but did not know he had been treated for a methadone overdose. When the risk evaluation was conducted the watchhouse keeper noted that the man complained of abdominal pain, but said he did not require medical attention for it. Otherwise there did not seem to be any warning signs, and police assessed him not to be at risk.
253. The drug the detainee had been given in hospital to counter the effects of the methadone (Narcan) appears have worn off while he was in custody, resulting in the methadone interacting dangerously with prescribed medication he was given by police after his arrest. During the investigation into the detainee's death, there was a question whether the police should have contacted the hospital to ascertain whether there were any

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<sup>36</sup> New Zealand Police have advised the Authority that they are investigating the use of the 'Coma scale' (as utilised by the Victoria Police) to assess a detainee's level of consciousness and whether there is a need for medical intervention.

reasons why the man may still be at risk. However there was no requirement to do so under police policy.

254. The other case involved a detainee who was a known drug addict and appeared “agitated” when she was evaluated. She was on the methadone programme and police knew that she had not picked up her morning dose from the pharmacy, so they attributed her behaviour to withdrawal from methadone. She was assessed to be in need of care and was frequently monitored.
255. However the watchhouse keeper had not checked the NIA database and was unaware that this detainee had alerts for past suicide attempts, violence and drug use. If these alerts had been noted she may have been assessed to be in need of care and constant monitoring.

#### *Deaths due to a medical condition*

256. None of the detainees who died due to a medical condition had been assessed to be at risk or in need of care.
257. Following a death in custody in 2002 (a case where the detainee died from epilepsy) the Coroner recommended that New Zealand Police should review their procedures for recording the medical conditions of people in custody.
258. The charge sheet was upgraded in 2005, and police are now required to ask detainees whether they are affected by a number of specific health conditions, namely: diabetes, heart disease, epilepsy, asthma, depression, schizophrenia, bipolar disorder and alcohol/drug addiction. However the questions relating to whether a person is ill, injured or showing signs of pain are now found in the “*key indicators for suicide*” section of the Custody/Charge Sheet, and there is no longer a dedicated space to describe the injury, illness or pain from which the detainee is suffering.
259. These changes to the Custody/Charge Sheet may lead officers conducting risk evaluations to only consider injury, illness or pain in terms of whether the detainee is likely to commit suicide, rather than as risks to the detainee’s health in their own right. Additionally, other important risk factors that are relevant to the detainee’s health are not mentioned on the Custody/Charge Sheet, such as whether the detainee:
- is unconscious, unresponsive or unable to be woken;
  - has a head injury; and/or
  - is incoherent or confused.

260. The Custody/Charge Sheet and the electronic custody module should be amended so that all the questions relating to a person's medical condition are grouped together, and so that a more comprehensive consideration of the detainee's health is required.
261. As discussed in paragraphs 245-246, in several cases of deaths in police custody the Coroner has recommended that watchhouse staff should be given more guidance on the Custody/Charge Sheet regarding when they should find a person in custody to be in need of care or in need of care and constant monitoring because of their health or mental state.
262. Although the Custody/Charge Sheet records particular medical conditions a person in custody may suffer from, it does not give any indication of the significance a custody officer should attach to the presence of any of these medical conditions. The assessment is left entirely to the subjective judgment of the officer conducting the risk evaluation (although if procedure is followed the assessment should also be reviewed by the custody supervisor). In his findings in relation to one death, Coroner Evans said:

*"It is desirable that there be a national standard as to what is required in processing prisoners. There is a need for consistent guidelines containing clear directions to Police officers as to how they should deal with persons taken into custody in particular ways. What is required is a clear algorithmic pathway. There is a need to get away, as far as possible, from the need for Police officers to make subjective judgments, the soundness of which, in objective terms, is dependent on the training, experience, maturity, knowledge and age of such officers."*

263. In response to this, it could be argued that it would be impossible to set out guidelines for every possible set of risk factors. Nonetheless, police should consider the possibility of implementing some form of direction on the Custody/Charge Sheet, the electronic custody module, and/or the HSMP as to when it will be necessary to find a detainee in need of care and seek medical attention or advice. Coroners have found that some of the specific health issues which should require the detainee to be assessed as being in need of care are extreme intoxication, head injuries and epilepsy.
264. Police need to be particularly careful to consider the risks associated with intoxication. The masking effect of alcohol appears to have played a part in at least three of the deaths from a medical condition and one death from drug-related causes, in that it has led custody staff (and in one case, ambulance officers) to incorrectly assume that the detainee's condition was solely due to the consumption of alcohol.
265. While many intoxicated people pass through custody without incident, police officers need to be alert to detainees who appear to be dangerously intoxicated and to the

warning signs that something more than alcohol may be involved. Some of the symptoms that may indicate there is an underlying medical problem or injury include:

- frequent vomiting;
- heavy snoring;
- the detainee is unconscious or semi-conscious or has to be carried to the cell; and/or
- the detainee is incoherent or unresponsive.

266. Police must also take any head wounds seriously and seek medical attention for the detainee, especially if they are uncertain as to how the injury occurred. In one case reviewed by the Authority, police saw that the man had a cut on his head but did not think it warranted medical attention.

267. Custody staff must be conscious of the need to reassess a detainee's condition over time. It is necessary to check that the person's health is not deteriorating, and, if the person is intoxicated, custody staff need to make sure that the person is sobering up. Two of the cases which illustrate this point involved detainees who had sustained head injuries and were being held for detoxification. In both cases the men showed no signs of recovery for very long periods before medical assistance was sought by police (30 hours and 12 hours).

268. In the United Kingdom, ACPO and the Home Office have produced "*Guidance on the Safer Detention and Handling of Persons in Police Custody*".<sup>37</sup> This document provides comprehensive guidelines for managing people in custody who are affected by alcohol, drugs, mental health issues and particular medical conditions such as diabetes, epilepsy, asthma and heart disease. Custody staff in New Zealand could benefit from a similar level of guidance.

### *Detoxification*

269. In all five cases where people died after being taken into custody for detoxification, police did not complete the "*Watchhouse Keepers Evaluation*" section of the Custody/Charge Sheet because they considered the detainee unable to answer the relevant questions. Four of these detainees died due to a medical condition and one died from drug-related causes.

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<sup>37</sup> Association of Chief Police Officers (ACPO), *Guidance on the Safer Detention and Handling of Persons in Police Custody* (Produced on behalf of ACPO and the Home Office by the National Centre for Policing Excellence, Centrex, Bedfordshire, 2006).

270. In these cases the detainees were invariably assessed not to be at risk, despite the fact that they were heavily intoxicated (all were either unconscious or semi-conscious) and the watchhouse keepers had been unable to obtain any information from the detainees about their medical or psychological history.
271. The detainees were being held for detoxification, which presupposes that they were at risk and incapable of looking after themselves. In such cases the detainees should be assessed as being at least in need of frequent monitoring, especially during their first few hours in custody when their condition is uncertain. This would enable police to ascertain whether or not the detainee's condition is deteriorating. Where the person is incapable of standing, walking or communicating he or she should be immediately taken to hospital for assessment.
272. Even when the detainee has received medical treatment, it does not guarantee that they are no longer at risk of their health deteriorating. Two of the detoxification cases involved situations where police had relied on the assessment of medical professionals when finding the detainee not to be risk. In one case ambulance staff had carried out a physical assessment of the man and deemed it unnecessary to take him to hospital, and in the other case the man had been taken to hospital by police and then taken back into police custody after being discharged. Police have assumed that because these detainees had received medical attention, they were not at risk. With hindsight however, both detainees still appeared to be extremely intoxicated at the time they were placed in a cell and should have been more closely monitored.
273. The new *Managing Prisoners* chapter of the Police Manual provides the following advice for dealing with intoxicated or drug affected people:

<i><b>If the person is . . .</b></i>	<i><b>then . . .</b></i>
<p><i>unconscious as a result of intoxication or a drug overdose or other unknown circumstance</i></p> <p><i>(Signs that the person is suffering from a drug overdose include:</i></p> <ul style="list-style-type: none"> <li><i>• no smell of alcohol on the person's breath or clothes</i></li> <li><i>• dilating of the pupils.)</i></li> </ul>	<p><i>it is critical that they are taken to hospital quickly.</i></p> <p><b>Caution:</b> <i>If you have any doubt, take the person directly to hospital. Calling an ambulance can involve further delay and should only be done if this is the best course of action.</i></p>

<i>semi-conscious, i.e.: unable to answer any questions during the initial assessment process or physically unable to look after themselves</i>	<i>arrange for an ambulance to take the person to hospital. If you expect a delay in the ambulance's arrival or the person's condition calls for immediate action, use a Police vehicle.</i>
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274. This means police are now required to take people who appear to be so intoxicated that they are unable to answer any risk evaluation questions to hospital to be medically assessed. The electronic custody module and Custody/Charge sheet should be amended to reflect the new policy.
275. This policy is consistent with practice in the United Kingdom. Hospitals may be reluctant to receive intoxicated detainees because they can be difficult to deal with, but medical staff are much more capable of providing care for dangerously intoxicated people than police officers.
276. Dr Hans Draminsky Petersen, a member of the United Nations' Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), has commented to the Authority that:<sup>38</sup>

*" ... it is a (too) high responsibility to give ordinary police officers to assess the health risk of a heavily intoxicated detainee and to monitor the state of health while in detention. Police officers do not have the appropriate background to do so. Ideally all detainees but in particular such persons should be seen by a doctor who should have the authority to refer the intoxicated or otherwise sick person to a health facility/hospital for further assessment, treatment and monitoring."*

#### *Completion of custody documentation*

277. In many of the reviewed cases, the custody documentation (that is, the Custody/Charge Sheet, HSMP form and the Inspection of Prisoners Book) was incomplete. It is important for custody staff to keep thorough and accurate records of the risk assessment process and their checks of detainees, because this is most likely to lead to better care and treatment of detainees. In addition, it enables police to demonstrate that they are meeting appropriate levels of accountability and have taken all reasonable steps to care for the person in custody.

<sup>38</sup> Dr Hans Draminsky Petersen is currently a consultant in medicine and gastroenterology in Denmark, and a consultant for the Rehabilitation and Research Centre for Torture Victims in Copenhagen (RCT). For more information about the SPT, visit its website: <http://www2.ohchr.org/english/bodies/cat/opcat/index.htm>.

278. Another issue which arose in relation to the risk assessment process was who should be responsible for conducting the *“Watchhouse Keeper’s Evaluation”*. In one case the evaluation had been completed by the arresting officer rather than the watchhouse keeper. This may lead to the situation where the watchhouse keeper or custody officer is not aware of the particular risks associated with the detainee for whom he or she has accepted responsibility.
279. The *Managing Prisoners* chapter of the Police Manual now states that it is the custody officer’s responsibility to complete the risk evaluation of the detainee (rather than the arresting officer). It is essential that custody officers conduct their own evaluation of each detainee, taking into account any relevant information the arresting officer may provide about the circumstances of the arrest and the behaviour of the detainee. The custody supervisor should then review the custody officer’s assessment and confirm his or her agreement with it.

#### FINDINGS

Effective risk assessment is crucial in order for custody officers to provide the appropriate level of care to each detainee.

None of the people who died in custody from a medical condition were assessed to be at risk or in need of care; nor were 80% of the people who committed suicide in custody.

The reviewed cases highlighted the risks associated with detainees who:

- have been involved in domestic violence;
- have a history of threatening to commit suicide;
- are heavily intoxicated or unconscious; or
- have a head injury.

#### Issue 6: Monitoring of detainees

280. Inadequate monitoring or checking of detainees was noted as an issue in about a third of all the deaths in custody reviewed by the Authority:
- In one case, temporary jailers did not understand the terminology of ‘frequent monitoring’ and ‘constant monitoring’, which resulted in the detainee being checked less often than he should have been.
  - One detainee required frequent monitoring (five checks per hour at irregular intervals) but was left alone in a holding cell for about 30 minutes.
  - One detainee in custody for detoxification was checked only three times in seven and a half hours. These checks were by way of observation only – no effort was made to rouse the detainee or assess his level of consciousness.

- Another detainee in custody for detoxification was observed during the night but not physically checked until over 12 hours after he was put into a cell.
- Four detainees assessed to be no risk or not in need of specific care were not checked once every two hours as required by policy.
- The constant monitoring of one detainee was provided by a guard who was looking after more than one detainee.

281. Another common issue was the failure to record checks or visits to detainees in the Inspection of Prisoners book (see paragraph 277).

282. In some cases there may be reluctance to assess detainees as requiring constant monitoring because it is resource-intensive and difficult to provide in a busy custody environment. Inadequate staffing levels were specifically noted in three cases reviewed by the Authority. Temporary staff may be called in to help care for detainees in police cells – however when police use temporary jailers or guards to do the monitoring they need to ensure that the jailers understand exactly what their duties are, as demonstrated by the first case discussed in paragraph 280.

283. Several cases in the review confirmed that CCTV monitoring does not eliminate the risk of deaths in custody. While CCTV can help police to detect detainees who have collapsed in their cells or are attempting to harm themselves, it does not remove the need to physically monitor or check detainees.

284. In the UK, poor checking and rousing procedures have been identified as a significant issue in police-related deaths. A report published in 2004 found that the checking of detainees in cells was opportunistic and dictated by the available resources, and that adequate records of the checks were kept in only one third of the cases.<sup>39</sup> In a 2008 study of near misses in police custody,<sup>40</sup> the IPCC found that the one of the common negative factors associated with near miss incidents was poor checking and rousing, and that the most common positive factor was good checking and rousing.<sup>41</sup> This study illustrates that deaths can be prevented when procedure is followed and checks are conducted properly.

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<sup>39</sup> Best D and Kefas A, *The Role of Alcohol in Police-Related Deaths: Analysis of Deaths in Custody (Category 3) Between 2000 and 2001* (PCA, London, 2004).

<sup>40</sup> A 'near miss' is any incident which resulted in, or could have resulted in, the serious illness or self-harm of a detainee.

<sup>41</sup> Bucke T, Teers R, Menin S, Payne-James J and Stark M, *Near Misses in Police Custody: A Collaborative Study with Forensic Medical Examiners in London* (IPCC, London, 2008) 13-14. Also see Hannan M, Hearnden I, Grace K, and Bucke T, *Deaths in or Following Police Custody: an Examination of the Cases 1998/1999 – 2008/2009* (IPCC, London, 2010) 39-42.

### *Suicides*

285. Police may be more reluctant to assess detainees as being at risk if they know they do not have the resources to monitor them as required by policy. One response to this is to place at risk detainees with other prisoners where possible. A person is less likely to commit suicide if he or she is not alone, and it is easier for custody staff if there are fewer cells to check.
286. However there are potential difficulties and risks with this approach – for example, some police cells are only designed to hold one person, and there may well be safety concerns around placing detainees in a cell together.

### *Drug-related deaths*

287. The number of checks carried out on drug-affected detainees depends on the level of risk that is assigned to them. If the detainee is identified as being under the influence of drugs, he or she should be assessed as at least in need of care until a police doctor has been called to assess their condition. Where there are concerns that the detainee may vomit and choke, constant monitoring is necessary.
288. It is not always easy to recognise when a person is dangerously affected by drugs, as demonstrated by all three of the drug-related deaths reviewed by the Authority. In particular it can be difficult to distinguish a drug overdose from intoxication.
289. In cases where detainees are heavily intoxicated, whether by drugs or alcohol or both, it is essential to monitor their level of consciousness and to assess whether they are sobering up or not. In all three of the drug-related deaths, the person in custody appeared to be sleeping before he or she succumbed to the fatal effect of the drugs in their system.
290. Custody staff may be reluctant to wake intoxicated detainees but it is crucial that they do so regularly in order to check that they are not slipping into a coma.

### *Deaths due to a medical condition*

291. None of the people who died in custody due to a medical condition were considered to be in need of care or in need of care and constant monitoring. This meant they were not placed under a regime of frequent or constant monitoring (see paragraph 49).
292. Police policy only requires custody staff to check detainees who are assessed to be not in need of specific care once every two hours.
293. In three of the deaths due to a medical condition there were some lapses in the monitoring of the detainees. In one of these cases there was a 3 hours and 19 minutes gap between checks, and in another case there was a gap of 2.5 hours before the person

was found dead in his cell. The third case involved a man who was not checked once every two hours. This lapse occurred after police told the man he was free to leave and the man had asked to be allowed to stay sleeping in his cell.

294. In the context of deaths in custody caused by a medical condition, an important issue to consider is the quality of the checks conducted by police.
295. The purpose of a check is to ascertain the well-being and safety of the person in custody. When the detainee is noticeably intoxicated, police should ensure that they regularly wake and obtain a response from the detainee in order to assess their state of health. This was not done in several of the reviewed cases.
296. In one case the detainee was incoherent, vomiting, and suffering from diarrhoea (police believed this to be a reaction from drinking alcohol while on medication for alcoholism); and in another the detainee was unresponsive, incontinent and snoring heavily. In both cases the required two-hourly checks were conducted by way of observation, but action was not taken quickly enough when the detainees' condition failed to improve. One of the detainees was eventually put under constant monitoring (after already being in custody for about 20 hours), but this was only because the guard was also being employed to constantly monitor a suicidal detainee in the opposite cell.
297. In the United Kingdom, police are required to visit all detainees at least once an hour, and to visit and rouse intoxicated detainees at least once every half hour.<sup>42</sup> However they are not required to wake a sleeping detainee when there are no concerns about their level of consciousness.
298. In 2006, the National Centre for Policing Excellence produced a document on behalf of the Association of Chief Police Officers and the Home Office, called "*Guidance on the Safer Detention and Handling of Persons in Police Custody*" (see paragraph 268). Among other things, this document provides guidelines for the observation and rousing of detainees. The New Zealand Police could benefit from similarly clear guidelines in relation to what a check of a detainee should consist of, and how often they should rouse a detainee in order to assess their well-being.
299. The new *Managing Prisoners* chapter of the Police Manual describes the different types of checks that may be carried out:

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<sup>42</sup> Police and Criminal Evidence Act 1984 Code C (Code of Practice for the Detention, Treatment and Questioning of Persons by Police Officers) (UK), para 9.3.

<b>Type of check</b>	<b>Action</b>
<i>Physical check</i>	<p><i>Enter the cell and physically wake the prisoner to establish well-being.</i></p> <p><b>Note:</b> <i>Prisoners should not be physically roused at every check unless their risk assessment indicates they need specific care, are intoxicated or exhibit any risk identifiers. Continual waking without due cause could be deemed as inhumane treatment and a breach of the Bill of Rights Act.</i></p>
<i>Verbal check</i>	<i>Enter the cell, and verbally rouse the prisoner to establish well being.</i>
<i>Observation check</i>	<ul style="list-style-type: none"> <li>• <i>Enter the cell and observe the prisoner's breathing and condition, or</i></li> <li>• <i>Observe through a cell view port to check the prisoner's well being.</i></li> </ul>
<b>All checks</b>	<i>Be vigilant for weapons, damage and items that could be used to cause injury or damage.</i>

300. However the policy does not clearly state when the different types of checks should be carried out. It provides that:

*“Police must carry out a check of a prisoner that is commensurate with the health and safety risk they are deemed to pose at the time. The frequency and type of check must balance the risks identified in the assessment and care of prisoners....*

*Alcohol and drugs affect people differently and the full effects may take many hours after last consumption. People under the influence of drink or drugs may become more intoxicated over time and this should be a considered factor in the nature of the check undertaken.”*

301. In the Authority’s view the policy should provide clearer guidance in respect of how often detainees should be roused when they are intoxicated (the UK policy of rousing intoxicated detainees every half hour seems reasonable), and should also describe the procedure for rousing a detainee. Where a person is being frequently or constantly monitored, a combination of the different types of checks should be used. When the person has been assessed to be not in need of specific care and is only being checked once every two hours, custody staff should carry out a verbal check at least, or a physical check if the detainee is asleep and does not respond to the verbal check.
302. Custody staff need to be alert to the possibility that the condition of a person in custody will change over time, and that warning signs which were not present at the time of the risk evaluation may appear after the detainee has been put into a cell. Officers should also be aware that heavy snoring can be a sign of respiratory problems, and that if a detainee gradually becomes difficult to rouse, he or she will require medical attention.

## FINDINGS

Inadequate monitoring was an issue in 33% of the deaths in custody reviewed by the Authority.

The reviewed cases highlighted the need for intoxicated detainees to be checked regularly to monitor their level of consciousness. To do this it is necessary to rouse the detainee from time to time – which means obtaining a verbal or physical response.

### Issue 7: Dispensing medication to detainees

303. There are risks associated with custody staff giving medication to detainees, which place police in a difficult position in respect of fulfilling their duty of care. Even when the medicine is properly labelled and provided in the correct dosage, the prescribed medication may combine with illicit drugs the person has already ingested, with lethal consequences. This occurred in two of the three drug-related deaths that were reviewed. However there are also dangers associated with depriving people of their prescribed medication, which may put their life at risk and could be considered a violation of their right to be treated humanely.

#### *Drug-related deaths*

304. During the period of time covered by the Authority's review (2000 – 2010), GI P111 (Medical Aid) stated: *"Where medication is prescribed for a detainee the medication shall be retained by the supervising staff and administered as specified"*.
305. One of the reviewed cases involved a detainee who asked for and was given his medication, which included anti-psychotics and antibiotics. Police correctly gave the detainee the prescribed amounts of each medicine along with some food. They did not give the detainee his sleeping medication because he already appeared to be drowsy, which showed that the officers had given some thought to the best way to give him the medicine. Unfortunately the prescribed medications, in combination with the illegal methadone he had already ingested, ultimately contributed to his death.
306. In another case the medicine administered was methadone. The dose given to the detainee by police was not fatal, but she had also consumed methadone before her arrest. The officers did not recognise that the detainee was already under the influence of drugs and did not call a doctor to assess her before giving her the medication.
307. In response to this death, the Authority recommended that a detainee requiring medication should be seen by a doctor, and that medication should be administered to detainees by a doctor or an appropriately qualified nurse.

308. However in both the cases where detainees died after police had given them their medication, there were no problems with the way in which the medication had been administered. The issue in both cases was that police were unaware that the detainees had already ingested methadone, because they did not appear to be intoxicated. It is not known whether, if the detainee had been seen by a doctor, the doctor would have made a different decision.
309. The new chapter on *Managing Prisoners* provides that when a detainee is on medication:
- Police should consider contacting a health professional to obtain advice as to whether the medication should be administered by a health professional.
  - Where police suspect the person has previously taken drugs or is under the influence of alcohol or other substances, they must seek medical advice and consider whether a doctor should assess the person.
  - When police do dispense medication, they must record all the details on the detainee's Custody/Charge Sheet and the Inspection of Prisoners book (or in the electronic custody module), and on the HSMP.
  - Police should err on the side of caution when considering whether to contact a health professional because of concerns about a detainee's health.
310. This policy seems to be a reasonable compromise between the old policy and the Authority's recommendation that medication should always be administered by a health professional. Police have to dispense prescribed medication to detainees on a daily basis, and it may be impractical to require custody staff to call in a doctor or nurse to administer the medication in every instance. As with most police work in relation to the care of people in custody, whether the policy works will depend on the risk assessment skills and the common sense of the custody officers. The wider availability of nurses in police custody facilities would also assist custody staff in making decisions about dispensing medication to detainees (see the discussion at paragraphs 349-356).

#### *Deaths due to a medical condition*

311. In one of the reviewed cases police were aware that the detainee suffered from epilepsy and had stopped taking his medication. The officer who assessed him did not consider that the detainee could be endangered by failing to take his medicine and did not seek medical advice because the detainee appeared unconcerned about his health.
312. This case highlights the need for custody staff to recognise that there may be serious risks associated with a detainee failing to take prescribed medication. It also demonstrates that police should not be influenced by a detainee's apparent lack of concern about their own health.

313. The Coroner found that the detainee should have been assessed to be in need of care and should have been examined by a doctor. He also found that since police are not medically trained, there should be a lower threshold for seeking medical advice when a specific medical issue has been identified (in this case, epilepsy). Although it was unlikely that the detainee's death could have been prevented, the correct medication may have helped.

#### FINDINGS

The reviewed cases demonstrate that it is essential for custody staff to:

- recognise the risk posed to detainees who require prescribed medication but have stopped taking it or do not have it with them; and
- carefully consider the possibility that a person in custody has already consumed drugs and/or alcohol before giving them prescribed medication.

#### Issue 8: NIA alerts

314. A detainee may have NIA alerts relating to various risk factors such as mental health concerns, previous suicide attempts, or alcohol and drug use (see paragraphs 47-48). Arresting officers and custody staff are required to check the NIA database in the course of completing a detainee's Custody/Charge Sheet or entry in the electronic custody module.

#### *Suicides*

315. Although most people with NIA alerts will not go on to commit suicide, it is important for police to check the database, follow the proper procedure and consider all the information available to them as part of the risk assessment process. It is also essential that police create these alerts whenever they become aware that a person is likely to attempt suicide, or has a history of suicide attempts.
316. Only two of the people who committed suicide in custody during the 10-year review period had alerts on NIA. One was flagged as a suicide risk, and the other had a health alert which warned police that he had been prescribed anti-depressants. In the first case the detainee was assessed not to be at risk in spite of the suicide risk alert, and in the second case the detainee committed suicide before the risk assessment process was complete.
317. In three other cases there were issues relating to the lack of suicide risk alerts on NIA. One detainee's family had advised police of the detainee's threats to commit suicide, but police did not consider that sufficient for him to be flagged as a suicide risk. Another person had attempted suicide about six months prior to his death and had received counselling from Mental Health Services, but the attempt was not reported to police. The other case involved a person who had been referred to Mental Health Services by police eight months before his death but police had failed to flag him as a suicide risk.

318. These cases illustrate the critical importance of meaningful and effective cooperation between the police and the local health services, so that police have access to as much relevant information as possible to base their risk assessments on.

#### *Drug-related deaths*

319. Two of the drug-related deaths reviewed by the Authority had issues relating to NIA alerts.
320. In one case the watchhouse keeper failed to check NIA, where the detainee had an alert for suicidal tendencies, and in the other case it was found that a NIA alert should have been created for the detainee two months earlier when he was assessed to be at risk of suicide while in custody.
321. Although the NIA alerts in these cases related to suicide risk rather than drug use, if the watchhouse keepers had noted these warnings they may have decided to assign the detainee a higher risk level, which would have resulted in the detainees being more closely monitored.

#### *Deaths due to a medical condition*

322. None of the detainees who died in custody due to a medical condition had NIA alerts relating to their health.
323. Police should ensure that NIA alerts are created for detainees when it is noted that they have an ongoing medical condition, especially when the detainee requires medication for it.

#### FINDINGS

NIA alerts are a valuable part of the risk assessment process.

Several of the deaths in custody reviewed by the Authority had issues relating to either:

- the lack of a NIA alert; or
- the existence of a NIA alert not resulting in the detainee being assessed to be in need of care.

#### **Issue 9: Handover procedures**

324. An issue which arose in several of the reviewed cases was the failure to adequately brief the officers responsible for looking after the detainee about the risks relating to that detainee.
325. In one case, court escort staff were not informed that the detainee had been flagged as a suicide risk and his PMAF form was not passed on to them. In two other cases the

detainee's charge sheet, including the "Watchhouse Keeper's Evaluation", was completed by the arresting officer rather than the watchhouse keeper, which meant that the watchhouse keeper was not aware that the detainee was at risk. In another case the watchhouse keeper did not hear the arresting officers' briefing about the circumstances of the detainee's offending, including the fact that he had made a threat to kill himself.

326. There is a need for custody officers and supervisors to perform their own assessments of the people in custody for whom they are responsible. In order to do this they must be made aware of any information that is relevant to the detainee's risk status. The same applies to the court escort staff who have to look after the detainee while he or she attends court.
327. Police must ensure that all risk-related information about detainees is passed on at shift handover and when detainees are handed over to the care of other agencies (such as court escort staff). A formal transfer of the custody duties should take place, including an inspection of each detainee in the cells by the oncoming and outgoing custody officers and supervisors. The custody staff should also sign on or off duty in the Inspection of Prisoners Book or electronic custody module, so that there is a clear record of who is responsible for the detainees.

#### FINDINGS

The cases reviewed by the Authority highlighted the need for all risk-related information to be passed on to staff who are taking over responsibility for the detainee (relieving custody officers or external agencies).

## FACILITIES/SERVICES/STRUCTURAL ISSUES

### Issue 10: Safety of cells

#### *Hang points*

328. All of the suicides that were reviewed by the Authority were by hanging. About 10% of hanging suicides occur in institutional settings such as prisons, hospitals or police cells.<sup>43</sup> In these cases people often use 'hang points' which are below head height. Those responsible for safety inspections of cells must be aware that hang points below head level are also a risk.

<sup>43</sup> D Gunnell, O Bennewith, K Hawton, S Simkin and N Kapur, 'The Epidemiology and Prevention of Suicide by Hanging: A Systematic Review' [2005] 34(2) *International Journal of Epidemiology* 433-442, 434.

329. People in custody are able to commit suicide by hanging when a combination of factors is present:
- absence of monitoring;
  - availability of a ligature; and
  - availability of a hang point.
330. As already discussed, the extent to which a detainee is monitored depends on whether he or she is considered to be at risk. During the time period reviewed by the Authority (2000-2010) the risk assessment may have also determined whether the person had access to a ligature, because police policy did not explicitly require that all detainees have shoelaces or cords taken from them (although some police stations would do this as a matter of practice).
331. GI P205 (Searching) only provided that detainees assessed to be in need of care or in need of care and constant monitoring must have *“their shoelaces, belts, jewellery and any article of clothing or footwear with cords”* removed. Watchhouse staff were also advised to consider replacing the person’s clothing with *“appropriate safe clothing such as a tear resistant gown.”*
332. However many people who commit suicide in custody have not been assessed to be at risk (this was the case in 70% of the reviewed cases). These people retain their clothing, which means they may have access to a ligature. Furthermore, checks on them are required only once every two hours, which means it is likely that there will be lengthy periods of time when they are not directly monitored. This makes the safety of the police cells extremely important, because the only remaining factor that may prevent the person from hanging themselves is the absence of a hang point.
333. As part of efforts to combat suicides in custody in recent years, police have endeavoured to remove potential hang points.<sup>44</sup> Larger police stations usually have suicide-resistant cells that are generally used for people who are assessed to be at risk of suicide or self harm.
334. Only one of the 10 people who committed suicide during the reviewed period was placed in a suicide-resistant cell. However, he was later placed alone in a holding cell at a District Court where he committed suicide. In another case there was no suicide-resistant cell available for the detainee because they were already occupied.

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<sup>44</sup> From 2004 to 2007 New Zealand Police spent \$3 million on removing hang points at high and medium risk sites. Police now engage with the IPCA as a key stakeholder in the construction of new custodial facilities.

335. Given that police will not always be able to identify the detainees who are at risk of suicide, they should continue to review the safety of all cells, not only those designated suicide-resistant. Police should also focus on the safety of holding cells and dayrooms (where six of the last eight suicides in custody took place). Furthermore, New Zealand Police should continue to eliminate hang points from any new police cells that are built.
336. Despite the best efforts of police, some people who are determined to commit suicide may still find ways to harm themselves in custody. For example, one of the reviewed cases involved a detainee who was able to thread his sock through an air vent in the ceiling. This cell had been recently inspected for suicide risks, but the holes in the air vent were so small that they had not been identified as a hazard.

#### *CCTV monitoring*

337. While CCTV monitoring is valuable for monitoring potentially suicidal detainees, it does not remove the risk of suicide. Detainees who are in need of care must be the subject of frequent or constant monitoring, which involves visiting or constantly monitoring the detainee in or nearby the cell.
338. Six people in custody committed suicide in holding cells or dayrooms. In two of these cases there was no CCTV monitoring of the area where the detainees hanged themselves.
339. The cells were CCTV monitored in the other four cases, but in only one was the camera view unobstructed. Of the other three cases, two detainees hanged themselves in the toilet area, and another used a blind spot in the CCTV coverage. Blind spots should be actively eliminated for the protection of vulnerable detainees.

#### *Numbers of watchhouse/custody staff*

340. A shortage of watchhouse staff was noted in three of the deaths in custody reviewed by the Authority. In one case the Authority's investigation determined that the watchhouse staff had been burdened with too many additional responsibilities which distracted them from their primary duty of processing and monitoring people in the cells.
341. A lack of custody staff compromises the ability to properly monitor and provide care to detainees and to thereby fulfil their statutory and common law duty of care (see paragraphs 37-40). Police need to ensure that there is adequate staffing for custodial facilities, particularly at times when there are more intoxicated detainees.

## FINDINGS

The Authority's review has determined that custody officers are (inevitably) unable to identify every detainee who is at risk of committing suicide.

The reviewed cases highlighted the need for police to:

- properly search and remove dangerous items from all people in custody;
- ensure that police cells (including holding cells and day rooms) are as 'suicide-resistant' as possible;
- ensure that there is adequate staffing for custodial facilities, to enable frequent or constant monitoring of detainees where necessary.

### Issue 11: Medical treatment / mental health assessment

342. During the 10-year review period, GI P100 (Evaluation of Persons detained in Police Custody and Prisoners) provided that:

*"All people, including children and young persons, who are considered as either in need of care or in need of care and constant monitoring because of their health, medical condition or presence of any suicidal warning signs, should be examined by a Police medical officer or Duly Authorised Officer or Community Assessment Team member as soon as practicable [emphasis added]."*

343. In one of the reviewed cases a detainee was assessed to be in need of care but the officers did not consider it necessary to call a police medical officer to examine her. The Authority's report on the death found that the officers had failed to adhere to the relevant General Instructions.
344. The new *Managing Prisoners* policy appears to continue the requirement for police to arrange for a detainee found to be in need of care to be examined by a medical officer, DAO or CAT member. It states:

***"Examination required if person needs care***

*All people identified as in need of care because of their health, medical condition or the presence of any suicidal warning signs may be examined as soon as practical by a:*

- *Police medical officer*
- *duly authorised officer, or*
- *(CAT) - Community Assessment Team member.*

*This examination will confirm or vary the custody staff's evaluation of the person's risk status.*

*The result of the assessment must be recorded in writing by the health professional.”*

345. There is an inconsistency within the policy, because although the heading states that the examination is “*required*”, the instruction below says that a person in need of care “*may be*” examined. In the Authority’s view, the wording of this instruction should be amended to state that the person in need of care “*must be examined*”.
346. In one of the reviewed cases, the Authority recommended that police should modify the PMAF form (the predecessor to the HSMP) so that it included prompts to:
- contact a medical officer, DAO or CAT member; and
  - create a warning flag (NIA alert) for a detainee (because the detainee has been assessed to be in need of care while in custody).
347. Although the current HSMP form provides spaces to record the details of the medical officer, DAO or CAT member contacted, it does not specify that it is mandatory for police to call one of these people when a person in custody has been found to be in need of care. Nor does it prompt the custody officer to create a NIA alert for the detainee. Improvements could be made to the HSMP form in order to remind officers of the procedure when a person is assessed to be in need of care.
348. The new electronic custody module does enable custody staff to view the details of any risk evaluations the detainee received when they were previously in custody (if relevant). However the electronic custody module is not always available, and creating a NIA alert may be a more effective way of providing important risk information to custody staff.

#### *Nurses in police custodial facilities*

349. A pilot programme in which nurses have been positioned in police stations has been conducted in South Auckland and Christchurch. The nurses have screened detainees with mental health or drug and alcohol issues and have referred them for further treatment when necessary.
350. Nurses are able to obtain valuable risk assessment information from detainees because detainees feel more comfortable talking to a health professional about their medical issues and mental health history. Importantly, the nurses also have electronic access to the District Health Boards’ mental health databases.

351. Early indications were that the pilot programme was working well:<sup>45</sup>

*“Inspector Dave Simpson, of Manukau police, said it has been a great success so far.*

*‘The alcohol and other drug (AOD) nurse project is probably less about dealing with a grossly intoxicated person and more about dealing with someone who’s sobered up, because it’s about engaging with that person to get them on the right track to get the help they need to manage a drink or drug problem ... The presence of a nurse in a police station does help police to manage people with disabilities and addictions, and identify what the effects of medications are and how to administer those correctly. Our staff are also getting valuable training advice and we have been able to create a much safer environment, both for the prisoner and for our staff.’...”*

352. An evaluation of the pilot nursing programme was published in August 2010.<sup>46</sup> As part of its explanation of the background to the pilot programme, the report stated that:

*“In December 2006, the Ministries of Health and Justice organised a Police focus group to discuss issues for Police when dealing with people with mental health and/or alcohol and other drug (AOD) problems. The Police considered the most serious situations occur when they are holding people with mental health and/or AOD problems in their watch-houses. The main issues they identified were:*

- *While Police officers are trained in first aid and custodial management, the level of care required of intoxicated people and those with mental health conditions often exceeds their expertise.*
- *No detoxification centres exist. Police are the only agency that presently provides a place for intoxicated people to be held.*
- *Arrested or detained people with mental health problems are often difficult and time consuming for the Police to manage.*

<sup>45</sup> NZPA, ‘Calls for Detox Clinics across NZ’ (Stuff.co.nz, 11 December 2008).

<sup>46</sup> Paulin J and Carswell S, *Evaluation of the Mental Health/Alcohol and Other Drug Watch-house Nurse Pilot Initiative* (NZ Police, Wellington, 2010).

- *The Police cell environment is likely to be detrimental to the wellbeing of people with mental health problems. It may result in an exacerbation of their problems.”*

353. The report found that the nurses had been meeting the following objectives of the programme:

- assessing and assisting in the clinical management of detainees experiencing drug, alcohol and mental health related problems;
- reducing the risk of harm to detainees and custody staff through the appropriate clinical management of intoxication, withdrawal and mental health disorders; and
- providing ongoing education to police in respect of the identification and management of mental health and addiction disorders.

354. According to the evaluation report, the nurses:<sup>47</sup>

*“... assess detainees’ risk of harm throughout their time in Police custody and are on hand to check on them and upgrade or downgrade their monitoring regimes in response to their changing risk levels. Police custody staff told the evaluators that they feel more supported and less at risk having immediate access to WHNs [watchhouse nurses] and their clinical knowledge, skills and judgement.”*

355. The report also referred to the Authority’s observations of the watchhouse nurse pilot initiative.<sup>48</sup>

*“The Authority endorses effective initiatives that enable custody centres to provide for the needs of detainees affected by mental illness, drugs, or alcohol-related issues. Such initiatives ensure that Police are able to foster confident, safe, and secure communities and that New Zealand fulfils its international obligations under OPCAT [The Optional Protocol to the United Nations Convention against Torture] and other international human rights law instruments. The fundamental principle of OPCAT, which is a principle that also underpins public health policy and healthcare in New Zealand, is prevention. Programmes such as the Pilot Initiative can, with appropriate planning and support, ensure that*

<sup>47</sup> Paulin J and Carswell S, *Evaluation of the Mental Health/Alcohol and Other Drug Watch-house Nurse Pilot Initiative* (NZ Police, Wellington, 2010) 98.

<sup>48</sup> Paulin J and Carswell S, *Evaluation of the Mental Health/Alcohol and Other Drug Watch-house Nurse Pilot Initiative* (NZ Police, Wellington, 2010) 100.

*vulnerable members of our community are understood, respected, and cared for when they need treatment the most: at the earliest possible opportunity, by qualified, committed Police and specialised health practitioners [emphasis in original].”*

356. Given the success of the programme, New Zealand Police should consider increasing the availability of nurses in police custodial facilities across the country.

#### FINDINGS

The Authority’s review has highlighted a need for clarity around the requirement for a police medical officer, DAO or CAT member to be called to assess detainees who have been assessed to be in need of care (and frequent or constant monitoring).

The pilot watchhouse nurse programme has helped custody staff to provide better care to detainees – particularly those with drug/alcohol issues.

#### Issue 12: Training of custody staff

357. Custody staff are currently required to undergo first aid and custodial suicide prevention training. There is, however, no national training programme which addresses all the demands of looking after people in custody, including:
- the risk evaluation process;
  - completing custody documentation;
  - searching and monitoring detainees;
  - creating NIA alerts; and
  - the communication of key information.
358. Policies and procedures that are designed to ensure the safety of people in custody will only be effective if custody staff are trained in, and follow them. Officers likely to be rotated into custody duties would benefit from a training programme to better prepare them for the responsibility of caring for people in custody.
359. In order to improve custody staff performance, New Zealand Police should develop a comprehensive national training programme designed specifically for custody duties.

Alternatively, custodial facilities should be operated by fully trained specialist custody staff.<sup>49</sup>

360. In that context, procedures are only effective if properly adhered to and staff receive appropriate supervision. In one of the reviewed suicides, inexperienced custody officers who had recently undergone training on watchhouse procedures were left unsupervised and put a detainee into a cell without a search or risk evaluation.

### *Suicides*

361. In several of the earlier cases within the reviewed time period, the police officers involved had not received custodial suicide awareness training or were not certified at the time. This meant that they were not as well-equipped as they should have been to assess whether the people in their custody were at risk of committing suicide.
362. Lack of training was an issue in four of the suicides – however it has not been found to be an issue in the more recent cases.
363. Current police policy is to have all officers who deal with people in custody trained in custodial suicide awareness and to require them to take a refresher course every two years. As discussed in paragraphs 132-134, this appears to have led to a decrease in the numbers of suicides in custody, particularly in relation to young males. However there may be a corresponding increase in the number of suicides which occur shortly after a person has been in police custody. This is an issue which requires further investigation.

### *Health risks*

364. Some deaths in custody cannot be predicted, and will occur no matter how well-trained or experienced officers are. Nonetheless, police must ensure that officers are as well equipped as they can be to identify risks, and to take appropriate actions in response to them.
365. The reviewed cases show that watchhouse staff did not always recognise or react appropriately to clear warning signs that a detainee's health was at risk, especially when the person was heavily intoxicated. It is possible that some of the deaths may have been prevented if medical attention had been sought at an earlier stage.
366. Since 2005 police have focused on the risk factors associated with custodial suicide during the risk evaluation process, possibly at the expense of risks relating to the medical

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<sup>49</sup> New Zealand Police have advised the Authority that, where possible, they have full time custody staff employed at major custodial sites rather than rotating staff into the role for a short period.

condition of the detainee. This supports the proposition that a wider training programme is needed, so that all the aspects of risk to a detainee are addressed during a risk assessment.

367. With regard to the medical condition of detainees, custody training should:

- prepare officers to recognise the danger signs relating to head injuries and other medical conditions, including (but not limited to) diabetes, asthma and epilepsy;
- instruct officers on when they should find a detainee to be in need of care or in need of care and constant monitoring because of their medical condition;
- emphasise the risks associated with alcohol and/or drug intoxication or withdrawal;
- educate officers about how to recognise when a detainee is dangerously intoxicated and how to respond;
- alert officers to the masking effect of alcohol and/or drugs, especially in combination with head injuries;
- provide clear guidelines for the checking and rousing of detainees; and
- emphasise the need for continual reassessment of the detainee's condition and well-being.

368. Since police officers are not medically trained, they should not be expected to diagnose or decide how to deal with a detainee's medical condition. Instead, the training should help them recognise warning signs and identify risks, so that they can take appropriate and prudent action in respect of the wellbeing of the detainee, such as seeking appropriate medical input.

#### FINDINGS

Although lack of custody staff training in suicide awareness was an issue in some of the earlier cases reviewed by the Authority, it has not been an issue in the more recent cases.

The Authority's review has established, however, that custody staff could benefit from further training through a national programme that comprehensively addresses the full range of custody duties, procedures and responsibilities.

### *Development of national training*

369. New Zealand Police have advised the Authority that they are developing a national training module for custody duties that will *“focus on the wider identification and management of all categories of risk: suicidal, medical and otherwise.”* An audit of the custodial management training that is currently available for police staff around the country was completed in late 2011, and the New Zealand Police Training Service Centre is undertaking a *“training needs analysis”* which is due to be completed by late 2012. It is anticipated that the National Manager Operations Group (Police National Headquarters) will provide business user requirements to develop national custodial management training utilising the information gained in the training needs analysis.

### **Issue 13: Near miss reporting**

370. In 2008, the Independent Police Complaints Commission (IPCC) published a study into near misses in police custody. Near misses are *“incidents which result in, or could have resulted in, the serious illness, injury or self-harm of a detainee.”*<sup>50</sup> The study estimated that in England and Wales there are approximately 1000 near miss incidents each year, compared to around 31 deaths in custody per year. Around 400 of those near misses per year would be incidents where death was considered to be very or fairly likely if action had not been taken to prevent it.<sup>51</sup>

371. Assuming that there is a similar ratio of near misses to deaths in custody in New Zealand, it would be useful for the New Zealand Police and the Authority to gather data on and review near misses in custody. By studying near misses in custody, we can find out more about what can go wrong while people are in custody, and we can also learn about what has gone right in order for death or serious injury to be avoided. This would help to identify the strengths and the weaknesses of the current police policies, procedures and training.

372. At present New Zealand Police are obliged to report to the Authority incidents *“where a police employee acting in the execution of his or her duty causes, or appears to have caused, death or serious bodily harm to any person”*.<sup>52</sup>

373. This means that incidents which *could have* resulted in death or serious bodily harm, but did not, are not reported. Since there are relatively few deaths in custody in New Zealand, if near misses were reviewed this would increase the available learning opportunities.

<sup>50</sup> Bucke T, Teers R, Menin S, Payne-James J and Stark M, *Near Misses in Police Custody: A Collaborative Study with Forensic Medical Examiners in London* (IPCC, London, 2008) 4.

<sup>51</sup> T Bucke, R Teers, S Menin, J Payne-James and M Stark, *Near Misses in Police Custody: A Collaborative Study with Forensic Medical Examiners in London* (IPCC, London, 2008) 2, 10.

<sup>52</sup> Independent Police Conduct Authority Act 1988, section 13.

The Authority and the New Zealand Police OPCAT portfolio holder have entered into dialogue with respect to reporting of near misses as part of the Authority's OPCAT function. This dialogue should resume with a view to establishing a suitable framework for near miss reporting.

374. Near miss incident reports could be recorded in a reporting form by one of the officers involved. This form could provide, for example:<sup>53</sup>

- the details of the person in custody (including age, gender and ethnicity);
- whether the detainee was affected by drugs, alcohol or solvents and whether the detainee was known to suffer from a mental illness;
- what type of incident it was (such as self-harm, drug overdose or medical condition);
- what the outcome was and why the incident occurred; and
- how such an incident could be prevented in the future.

#### FINDINGS

The collection and analysis of data in respect of near misses in police custody by New Zealand Police and the Authority would inform any future developments in practice and policy for the management of detainees.

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<sup>53</sup> An example of such a form is provided in the IPCC's study of near misses in police custody; see T Bucke, R Teers, S Menin, J Payne-James and M Stark, *Near Misses in Police Custody: A Collaborative Study with Forensic Medical Examiners in London* (IPCC, London, 2008) 52-53.



# Conclusions

INDEPENDENT POLICE CONDUCT AUTHORITY

375. The Authority's review examined deaths in or following police custody which occurred during the 10-year period between 1 January 2000 and 1 January 2010. Of the 27 deaths that occurred during this time:
- seven followed the use of restraint by police during an arrest;
  - 10 were suicides;
  - three were drug-related; and
  - seven were caused by the medical condition of the person in custody.
376. All except one of the people who died in or following custody were male and their average age was 38.5 years. The youngest was 19 and the oldest 68. Thirteen of the people who died were Maori (48.1%), 11 were European (40.7%) and two were Pacific Islanders (7.4%).
377. Just under half (48.1%) of the people who died in or following custody were under the influence of alcohol and a third (33.3%) were under the influence of drugs or solvents at the time they came into contact with the police. Fourteen people (51.9%) were affected by mental health issues ranging from depression to schizophrenia, and 13 people (48.1%) suffered from significant medical problems.
378. Although errors were made in some of the cases, it does not follow that the person's death would have been avoided if these errors had not been made.
379. Nonetheless there are lessons to be learned from studying these cases, particularly in relation to risk assessment and the provision of health care to people in custody. Some of the most important lessons learned from the review are:
- the need to evaluate, search and monitor detainees effectively;
  - the need to be aware of the dangers of extreme intoxication and the masking effect of alcohol; and

- the need to focus on all types of risk to detainees.

380. The Authority notes that New Zealand Police have recently reviewed their policies and procedures for the management of detainees, and have incorporated several new chapters into the Police Manual since 2010, including policies relating to:

- Managing prisoners;
- Searching people;
- Positional asphyxia; and
- Mechanical restraints.

381. Twenty recommendations follow.



# Recommendations

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382. A core function of NPMs is the formulation of effective recommendations with respect to the conditions applicable to and treatment of persons deprived of their liberty (see paragraphs 18-23 for a discussion of the Authority’s responsibilities as an NPM).
383. Article 19(b) of the OPCAT provides that NPMs shall be granted the power to “*make recommendations to the relevant authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty ... , taking into consideration the relevant norms of the United Nations*” and Article 19(c) provides that NPMs shall be granted the power to submit proposals and observations concerning existing or draft legislation. With respect to the implementation of NPM recommendations, Article 22 of the OPCAT provides that “*[t]he competent authorities of the State Party concerned shall examine the recommendations of the national preventive mechanism and enter into a dialogue with it on possible implementation measures.*”<sup>54</sup>
384. In New Zealand, the recommendatory powers of NPMs are provided in section 27(b)(i) to (iii) of the Crimes of Torture Act 1989. In addition, section 34 of this Act provides that an NPM has the same powers in exercising its functions as an NPM as it has under any other Act. This considerably strengthens the operational capability of the particular NPM.
385. It is clear, therefore, that the implementation of the OPCAT in New Zealand represents a significant step forward in the treatment and protection of persons deprived of their liberty. This review of deaths in custody, and the observations and recommendations it contains, advances the preventive impact of NPMs in New Zealand and lays a foundation for further preventive projects in the future.
386. In making its recommendations the Authority has taken into account that New Zealand Police have recently:

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<sup>54</sup> Further information on the basic principles applicable to NPMs, as well as their functions and powers, can be found in the SPT’s *Guidelines on National Preventive Mechanisms*, UN Doc CAT/OP/12/5 (2010) available online at <[www2.ohchr.org/english/bodies/cat/opcat/mechanisms.htm](http://www2.ohchr.org/english/bodies/cat/opcat/mechanisms.htm)>.

- undertaken a review of their response to persons with mental impairment; and
- introduced new chapters in the Police Manual which provide clearer guidelines for searching and dispensing medication to detainees.

387. The Authority recommends that the New Zealand Police:

- 1) work with the Ministry of Health and other appropriate stakeholders towards the establishment of detoxification centres or temporary shelters in order to provide appropriate medical care for heavily intoxicated persons;
- 2) ensure that the training provided to staff reinforces the dangers associated with restraining people in a prone position with their hands tied behind their back;
- 3) ensure that the training provided to staff reinforces the risks of positional asphyxia and other restraint-related medical conditions, and the appropriate tactical options for dealing with people who may be affected by these conditions;
- 4) amend the Custody/Charge Sheet to include a prompt to search the detainee and to record the outcome of the search;
- 5) amend the *Managing Prisoners* chapter of the Police Manual to direct that custody staff are required to record and explain any decision not to contact a family member or other appropriate person when they are going to release a detainee that has been found to be in need of care (and frequent or constant monitoring) while in custody;
- 6) provide custody staff with objective guidance (in the *Managing Prisoners* chapter of the Police Manual, the electronic custody module and the Custody/Charge Sheet) as to when a detainee should be assessed as being in need of care and frequent or constant monitoring;
- 7) amend the electronic custody module and the Custody/Charge Sheet to indicate that detainees who are unconscious or semi-conscious, unable to answer the risk assessment questions, and/or physically unable to look after themselves must be taken to hospital (as per the *Managing Prisoners* chapter of the Police Manual);
- 8) amend the risk evaluation in the electronic custody module and the Custody/Charge Sheet so that the questions relating to the medical condition of the detainee are grouped together (including questions about injury, illness or pain) and separated from the suicide risk indicators;
- 9) amend the risk evaluation in the electronic custody module and the Custody/Charge Sheet to include questions in respect of the level of consciousness of the detainee and the possible presence of a head injury;

- 10) provide custody staff with clearer guidelines in relation to the checking and rousing of detainees (particularly those under the influence of alcohol or drugs);
- 11) amend the *Managing Prisoners* chapter of the Police Manual to direct that custody staff are required to record and explain any decision not to contact a health professional for advice as to whether a detainee's medication should be administered by a health professional;
- 12) amend the *Managing Prisoners* chapter of the Police Manual so that, in addition to being required to create NIA alerts when a detainee is known to have suicidal tendencies, custody staff are required to create a NIA alert when it is known that the detainee is a drug user or suffers from an ongoing medical condition;
- 13) develop a formal shift handover process in respect the care of detainees for inclusion in the *Managing Prisoners* chapter of the Police Manual;
- 14) continue to remove all potential hang points and CCTV blind spots, and to assess all police cells, including holding cells and day rooms, for suicide risks;
- 15) amend the *Managing Prisoners* chapter of the Police Manual so it clearly states that detainees assessed to be in need of care and frequent or constant monitoring must be examined by a police medical officer, DAO or CAT member;
- 16) amend the HSMP form so that it:
  - clearly states the requirement for custody staff to call a police medical officer, DAO or CAT member to examine a detainee because he or she has been found to be in need of care and frequent or constant monitoring; and
  - includes a prompt for the custody officer to create a NIA alert when the detainee has been assessed to be in need of care while in custody;
- 17) work with the Ministry of Health towards extending the watchhouse nurse programme so that custody staff nationwide have better access to medical advice for the care of detainees;
- 18) continue developing a national training module to meet the requirements of employees assigned to duties in the watch house, with particular emphasis on responsibilities for the evaluation of risk and the care and protection of persons in custody (as recommended by the Authority in its report on the death of Francisco Javier de Larratea Soler, published on 1 July 2011);
- 19) resume working with the Authority towards the establishment of a framework for near miss reporting; and

- 20) engage with the Authority to develop an OPCAT awareness strategy and advance the agreed plan to develop an IPCA / Police OPCAT panel. The OPCAT awareness strategy and joint panel will provide a platform for raising staff awareness about custodial issues and enable effective implementation of custody-related recommendations.



JUDGE SIR DAVID CARRUTHERS

CHAIR

INDEPENDENT POLICE CONDUCT AUTHORITY

JUNE 2012



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# About the Authority

## WHAT IS THE INDEPENDENT POLICE CONDUCT AUTHORITY?

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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 District Court Judge and has three other members.

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?

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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.



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