

SPEECH NOTES

IPCA Chair, Judge Sir David Carruthers



Friday 27 March 2015

Release of report on death in Police custody and report on review of Police handling of prisoners in cells

Good morning

Today the Independent Police Conduct Authority is releasing two related reports. The first covers the findings of the Authority's investigation into the death in Police custody of Sentry Taitoko on 23 February 2014. The second is a report on issues with the way in which Police deal with prisoners in their custody, arising from a review of 31 complaints and incidents that have been referred to the Authority over the last three years.

I turn first to outline the findings into the death in custody of Mr Taitoko.

The Authority has found that there were a number of things that the Police should have done, but failed to do, to provide assistance to Mr Taitoko. Police breached the duty of care that they owed to him while he was in their custody.

In the early hours of 23 February 2014 Sentry Taitoko was taken into Police custody after he was arrested for a breach of the peace and detoxification. He was heavily intoxicated, had taken drugs and was acting in a violent and unpredictable way that posed a risk to himself. The officers involved in his arrest believed the only viable option available to them was to take him to the Counties Manukau District Custody Unit where he could be monitored.

After arriving at the Counties Manukau District Custody Unit at about 1.45am, Police put Mr Taitoko in a cell and officers periodically monitored him. They did not undertake a formal assessment of risk to his wellbeing in custody until over an hour later.

During the night officers witnessed Mr Taitoko rolling on the ground and thrashing his arms and legs about. Over a period of half an hour from 1.47am to 2.16 am, the CCTV footage shows him falling and hitting his head on the concrete walls or floor of the cell 83 times. Over the next hour, he hit his head around another 31 times. Over time the walls of the cell became smeared with blood from Mr Taitoko's nose and from grazes on his body.

At around 3.15 am, Mr Taitoko was observed by a mental health nurse who advised the custody sergeant that he needed medical attention. Shortly after, a Police doctor arrived at the cell block to examine another prisoner and was asked to look at Mr Taitoko. He did not enter the cell, but observed him through the window and told the custody sergeant that it was not necessary for Mr Taitoko to go to hospital and that he would return to examine him at 10.30am. The custody sergeant relied on that advice and sought no further medical treatment for Mr Taitoko.

From around 4:00am onwards Mr Taitoko stopped any violent movements and started lying on his right-side and his stomach. Although he had been made subject to frequent monitoring after his formal risk assessment (which requires checks by visits to the cell at least 5 times per hour), he was not checked at all for about 50 minutes after 4.26am, except by way of CCTV observation. However, CCTV is not in itself a valid form of monitoring.

At 5:15am one of the custody officers noticed blood on Mr Taitoko and called for another officer to come and look at him. At this time the officers opened the cell door and found Mr Taitoko's breathing to be short and gargled and his eyes rolling back in his head. An ambulance was called and officers began monitoring his breathing. However, attempts by paramedics to resuscitate Mr Taitoko were unsuccessful. Mr Taitoko was pronounced dead at 6:10am.

The Authority's report has found Police breached their legal duty of care in a number of ways:

- The officers who first detained Mr Taitoko should have called for urgent medical assistance given Mr Taitoko's confused and aggressive state and his inability to answer questions. They did not recognise that Mr Taitoko's behaviour was caused by an extreme and dangerous drug reaction and therefore never called for an ambulance or arranged for him to be taken to hospital.
- He should have been taken to hospital or an ambulance called when he arrived at the District Custody Unit and had to be carried to a cell and was unable to answer any questions.
- Given his condition Mr Taitoko should have been subject to a formal risk assessment when he first arrived in the cell block.
- He should have been subject to constant monitoring (that would have involved a person observing him continuously) rather than the periodic monitoring that did take place.
- He should not have been left for nearly 50 minutes after 4.26am without being checked.

Although the Authority has found that the Police breached their duty of care in all of these respects, we have determined that there is no criminal liability, because there are no actions of any individual officer that reach the gross negligence standard required by law.

The Authority has also found that it was reasonable for the custody sergeant to rely upon the advice of the Police doctor after that advice was given. The Authority makes no findings about the actions of the Police doctor, because our jurisdiction does not extend beyond Police employees.

The tragic death of Mr Taitoko demonstrates many of the problems that Police confront in dealing with the range of people that come into their custody. Detainees are often aggressive, uncooperative and intoxicated. Some of them are mentally impaired. Police sometimes fail to fulfil their duty of care simply because they do not have the necessary expertise and training to deal with some of the challenges presented by people being held in Police cells. And they are often required to manage people who, like Mr Taitoko, should not be in Police custody at all but are there due to a lack, or a perceived lack, of other more appropriate alternatives.

These issues are spelt out in more detail in the second report, to which I now turn.

That report identifies the wide range of problems that exist in the way in which Police handle people in their custody. These problems are particularly pronounced in relation to those who are mentally impaired. The Authority has found that people with mental health problems are often detained by officers and taken to a Police cell, not because they have committed an offence, but because they require a mental health assessment and there is no mental health worker immediately available to undertake that assessment at the person's home or another location, such as the hospital emergency department.

In some of the cases the Authority examined, the person's initial detention by the Police was unlawful. In other cases the person's initial detention was lawful, but they were subsequently detained for longer than the six hour period permitted by law.

This situation is largely not of the Police's own making. Mental health workers are often unavailable or unwilling to assess mentally distressed people at their home. Emergency departments may be reluctant to hold such people until a mental health assessment can be arranged because of the fear that they will be disruptive or violent.

As a result, the default response of a Police officer in most Police Districts is to take the person into custody and transport them to the Police cells until they are assessed.

This prevailing practice is entirely understandable. When Police are called as a 24-hour emergency service to deal with a mentally impaired person, family and friends of that person generally expect that the attending officers will do something to assist. In addition, the officers themselves commonly feel obliged to take effective action to resolve the situation as quickly as practicable and, in the absence of an appropriate alternative, take the mentally impaired person into custody.

This is confirmed by recent research in Wellington Police District, which found that out of 283 mental health crisis assessments requested by Police over a 3 month period, only one was done in someone's home, 30% were done in an Emergency Department and 70% were done at the Police station. Prior to this, in September 2014, Police took a national week-long sample of mental health-related calls which were not related to an offence, and found that 59% of the mental health assessments requested by Police during that week were conducted in Police stations.

However understandable this practice may be, the Authority considers that Police cells are entirely unsuitable for people in mental distress. They are a harsh, noisy and uninviting environment. The problems arising from custody officers' lack of skills and training in dealing with at-risk prisoners are accentuated when they are dealing with people who are in custody because they are mentally distressed. While officers try to deal with them patiently and professionally, the detainee's mental distress is often made worse and they sometimes suffer long term harm.

In the Authority's view, unless a person experiencing a mental health crisis is violent or poses an obvious and immediate threat to the safety of others, all practicable steps should be taken to avoid having them in Police cells.

It is unacceptable that, in many Police districts, the standard default inter-agency response to a public call for Police assistance to deal with a person who is experiencing a mental health crisis or is heavily intoxicated is to detain them in a Police cell. Police should not be left in the position of dealing with vulnerable and distressed people in this way. The fact that they do reflects an inter-agency and community failure to deal appropriately with mentally impaired and intoxicated people.

I acknowledge that the Police fully recognise this. Following Mr Taitoko's death the Counties Manukau District Custody Unit made fundamental changes to a number of its working practices. More generally many Police Districts have been working with District Health Boards to improve the way in which they work together. It is encouraging that this work is being undertaken. However, a much more comprehensive and consistent response to the problem must be developed.

The Authority has therefore recommended that Police work with the Ministry of Health and other agencies to look at ways of minimising the number of mentally impaired people who are taken into Police custody for a mental health assessment, and to explore ways to improve the current methods of dealing with intoxicated people.

I'm pleased to be able to present you with both of these reports today.

A copy of my speech notes is available from my Communications Manager on your way out.

Thank you.

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