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

Death in custody of Dwayne Walters

March 2016

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Introduction

1. At around 3.47pm on Monday 4 May 2015, Police found Dwayne Walters sitting on the floor of a Papakura District Court cell with an item of clothing around his neck. The garment was secured to a tap within the cell and appeared to be supporting Mr Walters' weight. Mr Walters was unresponsive when discovered and first aid was administered prior to the arrival of ambulance staff. Despite attempts to resuscitate him, Mr Walters was pronounced dead at 4.05pm.

2. The Police notified the Independent Police Conduct Authority of the death, and the Authority conducted an independent investigation into Police actions both before and during the period Mr Walters was detained. This report sets out the results of that investigation and the Authority's findings and recommendations.

Index of civilian witnesses

Civilian Witnesses	Roles/Comment
Ms Y	Mr Walters' mother Reported her concerns regarding Mr Walters' welfare to Police
Ms Z	A friend of Ms Y Assisted Ms Y during her first 111 call to Police

Index of officers

Police Staff	Roles/Comment
Officer A	Attended Mr Walters' mother's address a number of times on 3 May 2015 after concerns regarding Mr Walters' welfare were expressed
Officer B	Working with Officer A
Officer C	Acting Sergeant Undertook search of Mr Walters' mother's address on 3 May 2015 Arrested Mr Walters for a breach of bail Briefed Officer E following Mr Walters' arrival at Manukau Police Station
Officer D	Working with Officer C Assisted Officer C with the search of Mr Walters' mother's address Escorted Mr Walters to Manukau Police Station
Officer E	Custody Sergeant when Mr Walters received at Manukau Police Station on 3 May 2015
Officer F	Authorised Officer Conducted health and safety assessment of Mr Walters
Officer G	Custody Sergeant who received handover from Officer E on 4 May 2015
Officer H	Court Custodial Officer with responsibility for Papakura District Court cells Collected Mr Walters from Manukau Police Station on 4 May 2015 Administered first aid to Mr Walters after finding him unresponsive in his cell

Background

EVENTS PRECEDING CONCERNS FOR MR WALTERS' WELFARE BEING EXPRESSED BY MS Y

3. Mr Walters was a 36-year-old male from Papakura. He lived with his mother (referred to in this report as Ms Y) in the Papakura area and was unemployed.

4. On 5 February 2015 Mr Walters was released after serving a 5-year term of imprisonment for injuring with intent to injure.

5. At the time of his death Mr Walters was on bail in respect of two common assault charges following an incident in November 2014. A condition of his bail was to reside at Ms Y's address in Papakura.

6. On 4 April 2015, Mr Walters married his partner of 5 months. Mr Walters breached his bail by residing with her in Rotorua.

7. It is reported that, despite previously enjoying a good relationship, Mr Walters became violent and overbearing towards his partner following their marriage. Mr Walters allegedly "*threatened to kill himself*" following an argument with his partner on Sunday 26 April 2015.

8. On Saturday 2 May 2015 matters between Mr Walters and his partner escalated and culminated in Mr Walters allegedly kidnapping her and driving her around Rotorua.

9. Mr Walters' partner was able to escape and notified Rotorua Police who commenced an investigation and sought to locate and arrest Mr Walters.

10. Mr Walters was contacted by phone and spoken to by the investigating officer a short time after his partner approached Police. Mr Walters was told what charges he would be facing and asked to cooperate with the Police investigation.

11. At about 3.00pm on Saturday 2 May 2015, Mr Walters contacted Ms Y and asked her to collect him from Rotorua.

12. At about 5.20pm on the same day Papakura Police were tasked by Rotorua Police to visit Ms Y's address to locate and arrest Mr Walters for breaching his bail. Information provided by Rotorua Police was limited to basic details about Mr Walters and the vehicle from which his partner had escaped. Police intended to lay further charges against him following his arrest.

13. Other than a brief reply to a text message, Mr Walters ignored further requests from Rotorua Police to hand himself in.

14. At about 11.50pm on Saturday 2 May 2015 a Papakura Police officer (subsequently referred to in this report as Officer C) visited Ms Y's address to locate and arrest Mr Walters on behalf of Rotorua Police. According to this officer, Ms Y told him that Mr Walters was living in the Rotorua area, having recently got married. Having no reason to doubt Ms Y, the officer left the

address and recorded a breach of bail in respect of Mr Walters. The officer then closed the task on the Police computer system, noting that no further Police action in respect of Ms Y's address was required.

MS Y'S FIRST 111 CALL TO POLICE

15. At approximately 11am on Sunday 3 May 2015 Ms Y contacted Police to report that Mr Walters had taken her car and left her address earlier that morning with a quantity of pills. Ms Y initially stated that Mr Walters had not expressed any intention to harm himself but was concerned by his general demeanour, which she described as being "*too calm*". She did disclose that Mr Walters was "*talking about suicide last…night*" but when asked whether Mr Walters had said he was going to harm himself Ms Y said "*No*". However, she was fearful that he might do something. Ms Y also stated that Mr Walters had recently separated from his wife and was being sought by Police in Rotorua. According to Ms Y, Mr Walters had said he would not return to prison.

16. While speaking to Police, Ms Y handed the phone to a family friend (referred to in this report as Ms Z) who advised Police that Mr Walters had removed half the contents of a "*two-and-a-half inch bottle*" of 30mg codeine phosphate tablets from Ms Y's address along with 14 10mg rizatriptan benzoate tablets and 30 ibuprofen tablets. Ms Z also disclosed that Mr Walters had visited his brother's grave the previous evening and had "*told his mother he was going to top himself.*"

17. About ten minutes after Ms Y's call commenced, the following text was added to the Police Event Chronology[1] generated as a result of her call:

> "*UPGRADED AS IT WAS LATER ESTABLISHED MALE DID SAY TO* [informant] *HE WANTS TO TOP HIMSELF*".

18. The Event Chronology records both the medication reported as missing from her address (although the quantity of codeine phosphate pills is inaccurately recorded as "*1/2 A 30MG BOTTLE OF CODEINE*") and Ms Z's comments that Mr Walters wanted to commit suicide. This information was brought to the attention of a Police supervisor at about 12.43pm on Sunday 3 May 2015 who acknowledged the incident but had no free staff to allocate at that time.

19. Notwithstanding the lack of available staff, Police conducted a number of enquiries regarding Mr Walters and the vehicle he had absconded in immediately following Ms Y's call. Telecommunications data in respect of Mr Walters' cell phone were obtained to complement information provided by Ms Y and identify locations he was likely to visit. A call was also made to Mr Walters' cell phone but went unanswered.

[1] The Event Chronology is a chronological record that details occurrences and developments in respect of the incident to which it relates.

MS Y'S SECOND 111 CALL TO POLICE

20. At about 1.27pm on Sunday 3 May 2015, Ms Y made a further call to Police. The following text was added to the Event Chronology that was created following her first call:

> "INFMT BACK ONLINE STATES SHE HAS SPOKEN TO [Mr Walters] ON THE PHONE...SHE HAS NO MORE CONCERNS FOR [Mr Walters]...SHE DOESN'T KNOW WHERE HE IS BUT HE STATED HE IS OKAY".

21. On 15 May 2015 Ms Y provided a statement to Police as part of their enquiries into the death of Mr Walters. In relation to her second call Ms Y states:

> "*I called police back and said that* [Mr Walters] *was ok. I said that he had made contact with us and that he was alright and I was not concerned with him anymore.*"

22. This statement also indicates that Ms Y's second call was made while Mr Walters was present at her address.

23. When the Authority asked Ms Y about her second call to Police, she confirmed that she told Police Mr Walters was okay, but only in the sense that he had not yet killed himself. Ms Y was of the view that Mr Walters "*still wasn't himself*" but did not convey this information to Police during the course of her second call.

POLICE ACTIONS FOLLOWING MS Y'S 111 CALLS

24. At about 2.30pm on Sunday 3 May 2015, Officers A and B attended Ms Y's address to conduct further enquiries in respect of Mr Walters after becoming aware of Ms Y's concerns for him. Both officers had previously dealt with Mr Walters in respect of the matters detailed in paragraph 5.

25. Nobody was at home at the time of Officers A and B's attendance but further enquiries to locate Mr Walters were completed. These were unsuccessful and at about 2.46pm the officers updated the Police Event Chronology with the enquiries they had completed and requested that further checks be conducted later on. Officer A was aware that Mr Walters had also breached a condition of his bail.

26. Officers A and B revisited Ms Y's address at about 8.02pm on Sunday 3 May 2015. Ms Y's car, which Mr Walters was reported to have taken earlier that day, was parked outside her address. According to Officer A, Ms Y said she had had a telephone conversation with Mr Walters and that he was okay. She stated she had notified Police of the outcome of this conversation with Mr Walters and appeared to have no further concerns regarding his wellbeing. Ms Y also disclosed that Mr Walters had left her car at a nearby location. She had collected it following her telephone conversation with him. Officer B said that he was standing back and did not engage with Ms Y while she spoke with Officer A. Officer B was therefore unable to elaborate upon what was discussed between Ms Y and Officer A. In a statement provided to Police as part of their investigation into Mr Walters' death, Ms Y gave a different

version of events, saying that Mr Walters did not return to the address with her car but that he recovered it sometime later from a nearby location which was not disclosed to her.

27. Officer A told the Authority that Ms Y gave the impression that Mr Walters was not present at the address at the time of their second visit. Ms Y invited the officers to search the premises but Officer A declined, as there was no reason to doubt Ms Y. Officer A was also of the view that Ms Y was not overly concerned regarding Mr Walters' wellbeing and no longer wanted Police to pursue the matter, a view shared by Officer B.

28. At the conclusion of their enquiries, Officer A updated the Police Event Chronology and requested that it be revisited by other units until such time as Mr Walters had been located. Officers A and B then returned to Papakura Police Station to complete paperwork.

EVENTS LEADING UP TO THE POLICE SEARCH OF MS Y'S ADDRESS

29. Shortly after his shift commenced at 10pm on Sunday 3 May 2015, Officer C examined the Police Event Chronology created following Ms Y's first 111 call to Police.

30. During their investigation into this matter, Officer C told Police that upon examining the Police Event Chronology he "*couldn't see any information saying that* [Mr Walters] *had actually made any threats to harm himself, it just seemed like* [Ms Y] *was just worried about him.*" Officer C maintained this position when speaking to the Authority and reiterated that he did not see comments that suggested Mr Walters intended to harm himself. Officer C was also unable to recall seeing details of the medication allegedly taken from Ms Y's address by Mr Walters (as detailed in paragraph 16).

31. As detailed in paragraph 14, Officer C had previously visited Ms Y's address on Saturday 2 May 2015 with a view to locating and arresting Mr Walters on behalf of Rotorua Police.

32. After becoming aware of Ms Y's call to Police, Officer C liaised with Officers A and B at Papakura Police Station and expressed concerns regarding Ms Y's credibility.

33. Officer C advised the Authority that he had concerns regarding the length of time between Mr Walters' alleged disappearance and Ms Y's first call to Police, a period of about seven hours. Officer C was also aware that, according to Ms Y, Mr Walters had left her address about four hours after Officer C's visit on Saturday 2 May 2015. Officer C therefore queried why Ms Y had not brought this to the attention of Police sooner when she knew Police wanted to speak to Mr Walters[2]. Officer C also told the Authority that, in his view, these inconsistencies "*downplayed*" the significance of Ms Y's concerns for Mr Walters' welfare.

34. Suspecting Mr Walters was in fact present at Ms Y's address, Officer C therefore revisited it at about 10.53pm on Sunday 3 May 2015. Officer D, a Pukekohe-based officer who was providing

[2] The Authority notes that Officer C told the Police: "*I told* [Ms Y] *that the…Police wanted to speak to* [Mr Walters] *about an incident, and asked her that if she spoke to him could she tell him to contact the Police.*" The onus therefore appeared to be on Mr Walters to contact Police.

cover for the Papakura area, accompanied Officer C to the address. Officer D did not examine the Police Event Chronology detailing Ms Y's call and was unaware of her concerns.

35. Upon arrival at Ms Y's address on Sunday 3 May 2015, Officer C went to the front door. Officer D went to the rear of the property where he saw a male leave via a side door while Officer C was talking to Ms Y. Officer D challenged the male who identified himself as Mr Walters before running off. Officers C and D pursued Mr Walters on foot for a short distance but were unable to apprehend him.

36. After becoming aware of preceding events, Officers A and B left Papakura Police Station and conducted an area search for Mr Walters. They then parked their patrol car outside Ms Y's address and in such a position as to prevent Mr Walters from using her vehicle to escape should he have returned to that location. Other officers maintained cordons with a view to preventing Mr Walters from leaving the immediate area.

37. According to Officer A, Ms Y approached both her and Officer B while they were outside her address. Officer A could not recall Ms Y expressing any concerns over Mr Walters' welfare at this time. Officer B recalled a brief conversation during which Ms Y asked: "*Have you found my son?*" Neither officer suspected that Mr Walters was present at the address following their interaction with Ms Y but remained in position for several minutes before returning to Papakura Police Station and going off duty.

THE POLICE SEARCH OF MS Y'S ADDRESS

38. After standing down the officers manning the cordons, Officer C returned to Ms Y's address with Officer D at about 12.05am on Monday 4 May 2015. Based on what was believed to be his last known direction of travel, Officer C was of the view that Mr Walters had returned to Ms Y's address.

39. According to Officer C, Ms Y appeared irritable when spoken to during the early hours of Monday 4 May 2015. He attributed this to the frequency of Police visits.

40. Conscious that Police had visited the address a number of times to locate Mr Walters, and aware that he had in fact been at the location prior to running off, Officer C asked Ms Y whether both he and Officer D could search the property. Permission was granted. Officer C told the Authority that, prior to giving permission, Ms Y told him she did not know where Mr Walters was.

41. Ms Y told the Authority that she was annoyed with Police for shining the lights of their patrol vehicle into her address during the early hours of the morning and went out to challenge them. Frustrated, she told them: "*Go through the house, he's not here.*" Ms Y then describes Police "*rushing*" through her house and opening cupboards before entering her bedroom. In her Police statement, Ms Y recalled saying "*something to the effect that I had had a guts full of them, and they should just come in and search the place.*"

42. Officer C found Mr Walters hiding in Ms Y's bedroom wardrobe a short time after the commencement of the search. He was arrested for breaching a condition of his bail and

handcuffed by Officer C at 12.07am on Monday 4 May 15 before being removed from the address.

43. Ms Y told the Authority that she recalled a male officer "*yelling and screaming at me, calling me a liar*" as Mr Walters was led from the address.

INFORMATION CONVEYED BY MS Y TO POLICE FOLLOWING MR WALTERS' ARREST

44. When leaving Ms Y's address, Officer D recalled her handing him a jacket for him to give to Mr Walters on his release.

45. When spoken to by the Authority, Ms Y confirmed that she handed a jacket to a female officer but was also adamant that she "*told the officer that had him in cuffs…he should be watched, he's taken pills…I told them I'd rung this morning to the police and put him on…suicide watch.*"

46. Ms Y told the Authority that the "*three of them*" heard her comments[3]. Neither Officer C nor Officer D recalled Ms Y expressing any ongoing concerns regarding Mr Walters as he was being escorted from the address. Officer D advised the Authority that comments like this would have come as a shock and been memorable as he was unaware of the details of Ms Y's earlier calls to Police. Officer C told the Police that Ms Y said something but he was not paying attention to her.

47. A search of Mr Walters was conducted by Officers C and D when they reached their Police vehicle. According to the officers, a small bottle of pills, as well as several loose pills, fell out of one of Mr Walters' trouser legs during the search. Mr Walters identified the pills as codeine but did not say what they were for. According to Officer D, Mr Walters also stated that he had hidden the pills in his crotch area but had forgotten about them. When asked, Mr Walters told the officers that he had not taken any.

48. A further search of Mr Walters was conducted following his arrival at Manukau Police Station. About 2-3 loose pills were found at this time. Officer C told the Authority that a total of 7-8 pills were recovered from Mr Walters.

INFORMATION CONVEYED TO CUSTODY STAFF FOLLOWING MR WALTERS' ARREST

49. Mr Walters was received at Manukau Police Station at 12.34am on Monday 4 May 2015. Officer E was the Custody Sergeant at this location at this time and received a verbal update from Officer C regarding the circumstances surrounding Mr Walters' arrest.

50. Officer E recalled Officer C telling him that Police had been "*looking for* [Mr Walters] *and that the family had been obstructive and were just basically lying to them about where he was*".

51. When spoken to by the Authority, Officer E confirmed that Officer C discussed Ms Y's concerns that Mr Walters may try to commit suicide. Both Officers C and D told the Police and the

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[3] The Authority's investigation suggests only two officers were present at this time.

Authority that Mr Walters appeared "*rational*", "*sober*", "*lucid*" and "*fine*" following his arrest. As far as Officer C was aware "*he hadn't actually made any threats or anything,* [Ms Y] *was just concerned because he'd taken the tablets with him.*" Officer C's understanding of the Police Event Chronology has already been discussed in paragraph 30.

52. Officer C told the Authority that he brought Ms Y's concerns regarding Mr Walters to the attention of Officer E. However, when spoken to by the Police following Mr Walters' death Officer C conceded: "*I wasn't sure how much weight to put on what* [Ms Y had] *said, because it appeared that she had been lying several times about not knowing where he was*". He also notified Officer E that pills had been found on Mr Walters following his arrest and told him that he thought a Prisoner Management Assessment Form (PMAF)[4] should be completed.

53. According to Officer C, Officer E told him that if he had any concerns regarding Mr Walters, consideration should be given to taking him to hospital for assessment. Based on emails that had previously been circulated in the workplace Officer C thought Officer E was referring to a mental health assessment, as opposed to determining whether Mr Walters had in fact taken any pills. Officer E told the Authority that detainees are regularly taken to hospital when it is suspected they have overdosed. Officer E was of the view that the meaning of his comments would have been known to Officer C.

54. Following conversations with Officer C, who gave him "*a definitive answer that* [Mr Walters] *definitely hadn't taken any of the tablets*", Officer E was satisfied that Mr Walters had already been thoroughly searched and had not taken anything that was likely to cause him harm while detained in Police custody. He therefore made the decision not to subject Mr Walters to a strip search or send him to hospital. He did however endorse the Electronic Custody Module (ECM) with the following comment prior to handing Mr Walters over to an Authorised Officer (referred to in this report as Officer F) who was performing the role of 'Evaluating Officer' at the time:

> "*FAMILY SUGGEST CONCERNS FOR* [SUICIDE] *AS LEFT WITH TABLETS THIS MORNING – FOUND WITH* [UNKNOWN] *MEDS ON HIM – THOROUGHLY SEARCHED BY* [ARRESTING OFFICER]

55. Officer F's role was to "*accurately assess any risk that a prisoner may represent whilst in custody. The evaluation process determines the level of care that is required for any prisoner*". Officer F was aware of Officer E's comments (detailed in paragraph 54) at the time of assessing Mr Walters.

56. Officer F asked Mr Walters a series of questions regarding his health and wellbeing and completed a visual assessment to gauge his demeanour. Officer F told the Authority that "*At the time I evaluated him I felt like he was unremarkable. He was normal.*" According to Officer

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[4] The PMAF, or Health and Safety Management Evaluation, is a form completed by custody staff and accompanies a prisoner if they are moved between locations, such as Police custody to Court. The PMAF is only used for prisoners who have been assessed as either in need of frequent or constant monitoring. See footnotes 5 and 7 for further information.

F Mr Walters also stated that "*he did not want to harm himself whilst he was in custody.*" Based on this and his responses to other welfare questions, Officer F considered that Mr Walters was not in need of specific care[5] while detained in Police custody. No PMAF was therefore completed.

57. Officer E told the Authority that he had oversight of Officer F's assessment and was satisfied with the outcome, having previously conducted checks and finding "*absolutely nothing in his past that would indicate any suicidal feelings at any stage in his custody records.*"

58. Following the completion of Officer F's assessment, Mr Walters was placed in a cell which had a camera. Officer E told the Authority that, if a cell with a camera had not been available, this would not have affected the overall risk assessment of Mr Walters. Officer E further stated that the decision to use the cell with a camera was not indicative of latent concerns about Mr Walters – "*if it's a facility you've got, why not use it?*"

59. No concerns regarding Mr Walters' wellbeing or demeanour were raised or recorded by any member of Police charged with his care prior to 6.45am on Monday 4 May 2015 when Officer G and his staff relieved Officer E and his team.

THE CUSTODY HANDOVERS

60. A Daily Shift Summary is maintained at Manukau District Custody Unit. Custody supervisors are expected to complete this prior to the conclusion of their shift and endorse it with handover notes pertaining to those in custody. The shift summary covers a 24-hour period commencing at 7am.

61. Officer E added the following notes about Mr Walters to the shift summary:

> "*Family believe he may try to* [commit suicide] *by tablets – Found with what appears prescription tablets but none taken, he denies any suicidal intent*".

62. Officer E told the Authority that he could not recall his entire handover to Officer G but that his usual practice is to print a copy of the shift summary, hand this to the next Custody Sergeant and discuss any issues surrounding prisoners with them. Officer E did recall mentioning that Mr Walters was to be spoken to about events that had taken place in Rotorua. When interviewed as part of the Police investigation, Officer E stated that he "*would have summarised what I knew about the concerns of the family that he might have taken some pills*".

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[5] There are three levels of care that can be applied to a detainee in Police custody: not in need of specific care; in need of care (frequent monitoring); and in need of care and constant monitoring. The Counties Manukau District Custody Unit's Custody Sergeants' Reference Desk File states a "[PMAF] *must not be completed for any prisoner who does not fall under one of the two monitoring regimes.*" The same document goes on to state that a PMAF "*is to be filled out any time that a person at risk is identified. This is even if the person is subsequently deemed to be 'no risk'.*"

63. Officer G told the Authority that as part of any handover he would expect to be made aware of any at-risk prisoners along with all information contained in their PMAF. Officer G also referred to the Daily Shift Summary as an additional source of information but could not recall being advised of Ms Y's concerns or the pills found in Mr Walters' possession. He did recall Officer E referring to other matters that Police wanted to discuss with Mr Walters.

64. Mr Walters remained in custody at Manukau Police Station until about 8.03am on Monday 4 May 2015 when he was collected by a Court Custodial Officer[6] (referred to in this report as Officer H) and transported to Papakura District Court.

65. Officer G told the Authority that he gave Officer H "*very little*" by way of briefing upon attending Manukau Police Station as he was unaware of any risks to Mr Walters. Officer G also stated that Officer H would only ever be given a list of detainees for Court and PMAFs for those who required special care. Officer H told the Authority "*there was never any information passed to us that there were concerns, health concerns, whether that be physical, mental or other*". Officer H went on to say that he did receive a list of property removed from Mr Walters following his arrival at Manukau Police Station.

MR WALTERS' DETENTION IN PAPAKURA DISTRICT COURT CELLS

66. Mr Walters arrived at Papakura District Court Cells at 9.05am on Monday 4 May 2015. As part of the Police investigation into Mr Walters' death, Officer H said there "*was nothing in his demeanour that caused me any concern.*"

67. In keeping with Officer H's understanding that there were no underlying or anticipated issues regarding Mr Walters, he was placed in the cell furthest from Officer H's office (cell 4) with three other male prisoners. Officer H described "*a bit of banter going on between the 4 male prisoners but it wasn't aggro.*"

68. In terms of his duty of care towards those under his supervision, Officer H stated that all prisoners are checked "*at least once an hour*", unless a PMAF has been provided or there are other concerns regarding a detainee. In these cases detainees are placed in a cell directly opposite his office where they can be observed and subjected to a more rigorous monitoring regime[7].

69. Officer H told the Authority that he routinely monitors and undertakes risk assessments of prisoners in his care. A PMAF is completed where necessary to advise others of any risks or issues of concern. This did not apply to Mr Walters in respect of whom Officer H had "[a]*bsolutely no concerns*".

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[6] The Court Custodial Officer's role is to take care of prisoners detained in Papakura District Court Cells. He is also responsible for collecting prisoners from Manukau Police Station at the start of his shift and transporting them to Pukekohe and Papakura District Courts.

[7] Five physical checks per hour at irregular intervals in the case of detainees subject to frequent monitoring or constant one-on-one monitoring where appropriate.

70. According to Officer H Mr Walters was removed from his cell shortly before 10.00am on Monday 4 May 2015 to speak with a solicitor. He was returned to his cell about ten minutes later before receiving lunch at 1.00pm. "[T]*here was nothing concerning about his behaviour*" at this time. According to records maintained by Officer H, one of the cell's occupants was bailed at 10.31am that morning, leaving three occupants including Mr Walters.

71. At about 2.20pm on Monday 4 May 2015 Mr Walters was called to see the Community Magistrate in Court 2. Officer H accompanied him and was present when Mr Walters was remanded in custody to appear in the Rotorua District Court on 11 May 2015. Mr Walters was returned to cell 4 at about 2.28pm. There was no discernible change in Mr Walters' demeanour following court proceedings.

72. In addition to the routine checks undertaken by him, Officer H told the Authority that he would have seen Mr Walters in passing when placing other detainees in the bail room opposite cell 4 at about 2.53pm and 3.03pm. These detainees had previously been removed from cell 4, leaving Mr Walters on his own. Officer H also recalled overhearing one of the detainees in the bail room speaking to Mr Walters at about 3.05pm. Officer H could not make out what was said due to his distance from the cell, but no concerns regarding Mr Walters' wellbeing were raised at this time.

73. At about 3.47pm on Monday 4 May 2015, Officer H attended cell 4 to remove Mr Walters and hand him to First Security for onward transport to Mt Eden Corrections Facility. At this time Officer H found Mr Walters sitting on the floor of the cell with an item of clothing around his neck. The garment was secured to a tap within the cell and appeared to be supporting Mr Walters' weight. Mr Walters was unresponsive and first aid was administered prior to the arrival of ambulance staff. Despite attempts to resuscitate him, Mr Walters was pronounced dead at 4.05pm.

THE POLICE INVESTIGATION

74. Police have completed a criminal investigation into Mr Walters' death, and a policy, practice and procedure review.

Toxicology

75. Mr Walters' blood and urine was tested by the Institute of Environmental Science and Research (ESR) for the presence of alcohol and drugs.

76. The ESR states that "indications" of rizatriptan and sumatriptan (medication used to treat the symptoms of migraine headaches) were found in Mr Walters' blood along with the presence of codeine.

77. Traces of paracetamol, codeine, rizatriptan, sumatriptan and ibuprofen were found in Mr Walters' urine.

78. The ESR reported that the quantities of drugs found in Mr Walters' blood and urine were not at a level that would cause issues.

Pathologist's findings

79. The cause of Mr Walters' death is ultimately for the Coroner to determine.

80. The pathologist concluded that Mr Walters' death was a direct cause of hanging, consistent with Officer H's account of how he discovered Mr Walters.

81. No other injuries that would have contributed to Mr Walters' death were noted.

The Authority's Investigation

THE AUTHORITY'S ROLE

82. Under the Independent Police Conduct Authority Act 1988, the Authority's functions are to:

- Receive complaints alleging misconduct or neglect of duty by any Police employee, or concerning any practice, policy or procedure of the Police affecting the person or body of persons making the complaint; and to

- Investigate, where it is satisfied there are reasonable grounds for doing so in the public interest, any incident in which a Police employee, acting in the course of his or her duty has caused or appears to have caused death or serious bodily harm.

83. The Authority's role on the completion of an investigation is to form an opinion about the Police conduct, policy, practice or procedure which was the subject of the complaint.

84. The Authority also monitors conditions of detention and the treatment of detainees in Police custody in accordance with its obligations under the Optional Protocol to the Convention against Torture (OPCAT). It is able to make any recommendations it considers appropriate for improving conditions of detention and the treatment of detainees, and for preventing torture or other cruel, inhuman or degrading treatment.

THE AUTHORITY'S INVESTIGATION

85. As required under section 13 of the Independent Police Conduct Authority Act 1988, Police notified the Authority on 4 May 2015 of Mr Walters' death.

86. In addition to reviewing information produced during the Police investigations into Mr Walters' death, the Authority visited Papakura District Court to view the cell where Mr Walters died and interviewed ten people including civilian witnesses, the officers involved in searching for and arresting Mr Walters, and officers working at Manukau Police Station and Papakura District Court.

87. The Authority has maintained regular contact with Mr Walters' family throughout the course of its investigation.

ISSUES CONSIDERED

88. The Authority's investigation considered the following issues:

1) When Bay of Plenty Police sought assistance from the Counties Manukau District Command Centre (DCC)[8] following events of 2 May 2015 (see paragraph 8), did they provide sufficient information about Mr Walters' state of mind?

2) Did Police take appropriate action following the 111 call during which concerns regarding Mr Walters' welfare were expressed?

3) Did the Police accurately record information conveyed by Ms Y when she telephoned them to tell them that Mr Walters had contacted her?

4) Was the Police search of Ms Y's address on 3 May 2015 lawful?

5) Did Ms Y express ongoing concerns regarding Mr Walters' wellbeing following his arrest?

6) Was appropriate action taken following Mr Walters' arrival at Manukau Police Station?

   a) Was information provided during Ms Y's first call to Police adequately conveyed to custody staff?

   b) Were Police justified in determining Mr Walters was not in need of specific care?

7) Should Officer H have been made aware of risk information concerning Mr Walters?

8) Did Officer H comply with Police policy in relation to the monitoring of prisoners?

9) Did the physical condition of the Papakura District Court Cells comply with minimum accepted standards at the time Mr Walters was detained?

10) Was appropriate action taken in respect of the pills found in Mr Walters' possession?

   a) Did Officer C take sufficient steps to determine whether Mr Walters had taken any pills prior to his arrest?

   b) Was Police policy regarding the handling and destruction of property adhered to after pills were found in Mr Walters' possession?

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[8] New Zealand Police is divided into 12 districts. Papakura Police Station is part of the Counties Manukau Police District. The Rotorua area forms part of the Bay of Plenty Police District. DCCs have oversight of and ensure that Police resources are deployed purposefully in order to achieve strategic goals identified by the New Zealand Police. See also paragraph 12.

The Authority's Findings

ISSUE 1: WHEN BAY OF PLENTY POLICE SOUGHT ASSISTANCE FROM THE COUNTIES MANUKAU DISTRICT COMMAND CENTRE AFTER MR WALTERS ALLEGEDLY KIDNAPPED HIS WIFE, DID THEY PROVIDE SUFFICIENT INFORMATION ABOUT HIS STATE OF MIND?

89. On 2 May 2015 and as part of the Rotorua Police investigation into her alleged kidnapping, Mr Walters' wife disclosed that Mr Walters had "*threatened to kill himself*" following an argument on Sunday 26 April 2015.

90. Mr Walters' threat was acknowledged by the investigating officer who, in a subsequent statement completed on 20 May 2015, stated "[t]*his is something that I have heard of on a number of occasions by manipulative offenders as they attempt to prevent the partner from leaving the relationship…I had no specific concerns about his threats to commit suicide at that time.*"

91. As Mr Walters' threat was interpreted as controlling behaviour in the context of his volatile relationship, no reference to it was made by Bay of Plenty Police. This information may have assisted Papakura Police to more accurately determine the level of risk to Mr Walters' wellbeing. It may also have helped substantiate information provided by Ms Z during Ms Y's first 111 call to Police, which should have been flagged against Mr Walters' Police Personal Record Number (PRN) by the Police Communications Centre at the time the call was made, thereby ensuring that information concerning Mr Walters' threat was visible via the Police National Intelligence Application (NIA). It would therefore have been desirable for Bay of Plenty Police to have alerted Counties Manukau DCC to the fact that Mr Walters had threatened to kill himself by flagging him as suicidal.

92. However, current Police policy leaves it to the judgement of individual officers to determine whether a threat is sufficiently real to justify the completion of a Suicidal Tendencies Notification (see paragraph 176 for further information). In the circumstances of this case, the investigating officer cannot be criticised for judging that it was unnecessary to complete a notification, based on the limited information known to him at the time of speaking to Mr Walters' partner.

FINDINGS

It would have been desirable for Bay of Plenty Police to have alerted Counties Manukau DCC and others to the fact that Mr Walters had threatened to kill himself by flagging him in NIA.

However, Police policy did not require the investigating officer to pass on that information, as it could not be substantiated and was not deemed to be credible.

ISSUE 2: DID POLICE TAKE APPROPRIATE ACTION FOLLOWING THE 111 CALL DURING WHICH CONCERNS REGARDING MR WALTERS' WELFARE WERE EXPRESSED?

93. As a result of Ms Y's call to Police at about 11.00am on Sunday 3 May 2015, an Event Chronology was created by the Police call-handler. An outline of information recorded by the call-handler is given in paragraphs 15-18. The Event Chronology also notes:

> "*MALE WAS BREACHED YESTERDAY AND HAS* [Warrants To Arrest]..."

94. Police conducted several enquiries regarding Mr Walters and the vehicle he was believed to have absconded in following Ms Y's call. Polling[9] and call data for Mr Walters' cell phone were obtained but provided limited information. Mr Walters' service provider notified Police that his cell phone last polled in the vicinity of The Whitehouse Tavern, Papakura at 3.27am that morning when a call was made from it to Ms Y's landline. As already noted, Police attempted to contact Mr Walters on his cell phone after Ms Y's call but there was no answer.

95. Issues arising from Ms Y's call were also brought to the attention of the Counties Manukau DCC and notified to a Papakura Police supervisor at about 12.43pm on Sunday 3 May 2015. There were no available units to help locate Mr Walters at this time.

96. The Authority notes that Ms Y contacted Police about seven hours after Mr Walters was said to have left her address. This delay impeded the ability of the Police to make timely enquiries.

97. Notwithstanding this, the fact that Mr Walters had breached a condition of his bail and was being actively sought by Police in relation to another matter meant that Police did take reasonable steps to locate him. Their attempts to do so were still ongoing at the time Ms Y made further contact at about 1.27pm on the same day.

FINDING

Police made reasonable enquiries to locate Mr Walters based on the information provided and available to them. The fact that Police were seeking Mr Walters in relation to other matters ensured that there were continued attempts to locate him.

ISSUE 3: DID THE POLICE ACCURATELY RECORD INFORMATION CONVEYED BY MS Y WHEN SHE TELEPHONED THEM TO TELL THEM THAT MR WALTERS HAD CONTACTED HER?

98. As previously stated, Ms Y contacted Police for a second time at 1.27pm on Sunday 3 May 2015 and the Event Chronology that was created following her initial call was endorsed with the following:

[9] In basic terms, the general location of a powered cell phone can be determined by identifying the cellular telephone antenna to which it is connected. The accuracy of this method is subject to a number of variables.

"*INFMT BACK ONLINE STATES SHE HAS SPOKEN TO* [Mr Walters] *ON THE PHONE…SHE HAS NO MORE CONCERNS FOR* [Mr Walters]*…SHE DOESN'T KNOW WHERE HE IS BUT HE STATED HE IS OKAY*".

99. As detailed in paragraph 21, Ms Y provided a statement to Police on 15 May 2015 and disclosed the following in relation to her second call:

"*I called police back and said that* [Mr Walters] *was ok. I said that he had made contact with us and that he was alright and I was not concerned with him anymore.*"

100. As a result of their second visit to Ms Y's address, neither Officer A nor Officer B was of the view that Ms Y had any concerns regarding Mr Walters' wellbeing. This view was shared by Officers C and D following their dealings with Ms Y later that day and accords with the update detailed in paragraph 98.

101. When interviewed by the Authority Ms Y was adamant that Police misinterpreted the tenor of comments made by her during the second call she made. She maintained that she told them that Mr Walters was okay at the time she spoke to him – to the extent that he had not harmed himself – but that she continued to harbour genuine concerns regarding his continued wellbeing and state of mind.

102. Audio of Ms Y's second call to Police is available. Her concerns are not conveyed during this call. The information recorded by Police and detailed in paragraph 98 accurately captures comments made by her.

103. Confronted with this information, officers reviewing and dealing with this matter were entitled to take the view that Ms Y had no further concerns regarding Mr Walters' safety and wellbeing.

104. The Authority has examined a Police review of their handling of Ms Y's calls. There is no information to suggest that her second call went beyond what is detailed in paragraphs 20 and 21 and there is no evidence that it was mishandled by the call-taker.

FINDING

Ms Y's comments during her second call to Police were accurately recorded. The information as conveyed does not suggest that Ms Y had continuing concerns for Mr Walters' safety and wellbeing.

ISSUE 4: WAS THE POLICE SEARCH OF MS Y'S ADDRESS ON 3 MAY 2015 LAWFUL?

105. Officer C stated that Ms Y gave Police permission to search her address for Mr Walters. According to Officer C, the search that both he and Officer D undertook was therefore consensual. Despite providing a different interpretation of the circumstances in which consent was given, Ms Y also confirmed that she invited Police into her address to check whether Mr Walters was present.

106. Officer C told the Authority that he did not "*believe we had any powers for searching.*" Despite breaching a condition of his bail, Mr Walters was not the subject of an arrest warrant and was therefore not unlawfully at large at the time the search of Ms Y's address was undertaken. Because of this, Officers C and D had no warrantless power of entry to search for and arrest Mr Walters[10]. The search undertaken by them was therefore subject to the relevant provisions of the Search and Surveillance Act 2012 that govern consent searches.

107. Section 92 of the Search and Surveillance Act 2012 details the purposes for which a consent search may be undertaken:

(a) to prevent the commission of an offence:

(b) to protect life or property, or to prevent injury or harm:

(c) to investigate whether an offence has been committed:

(d) any purpose in respect of which the enforcement officer could exercise a power of search conferred by an enactment, if he or she held a particular belief or suspicion specified in the enactment.

108. Although Officer C arrested Mr Walters for breaching a condition of his bail, he was aware that Mr Walters was being sought by Bay of Plenty Police for a suspected kidnapping. His search of the house for the purpose of apprehending Mr Walters therefore had the subsidiary purpose of investigating an offence, and therefore fell within the terms of section 92(c).

109. However, Officers C and D did not comply with the additional duties placed on them by section 93 of the Search and Surveillance Act 2012, which requires an officer conducting a consent search:

(a) to determine that the search is for a purpose authorised by section 92; and

(b) to advise the person from whom consent is sought of the reason for the proposed search; and

(c) to advise the person that he or she may either consent to the search or refuse to consent to the search.

110. When interviewed by the Authority, Officer C stated that he did not advise Ms Y of the reason for the proposed search, nor advise her that she could refuse to consent to the search.

FINDINGS

The search of Ms Y's address with her consent was lawful under section 92(c) of the Search and Surveillance Act 2012.

[10] Section 7 of the Search and Surveillance Act 2012.

Officers C and D did not comply with the provisions of section 93 of the Search and Surveillance Act 2012 prior to undertaking that search.

ISSUE 5: DID MS Y EXPRESS ONGOING CONCERNS REGARDING MR WALTERS' WELLBEING FOLLOWING HIS ARREST?

111. As noted in paragraph 46, Ms Y stated that her concerns regarding Mr Walters were communicated to the officers[11] present at her address when Mr Walters was arrested at her home on 4 May 2015.

112. Neither Officer C nor Officer D recalled any such concerns when spoken to by the Authority. Documentation prepared by them following their dealings with Mr Walters makes no reference to any comments to that effect by Ms Y.

FINDING

It is not possible to determine whether Ms Y brought her concerns to the attention of Officers C and D due to conflicting information.

ISSUE 6: WAS APPROPRIATE ACTION TAKEN FOLLOWING MR WALTERS' ARRIVAL AT MANUKAU POLICE STATION?

A: Was information provided during Ms Y's first call to Police adequately conveyed to custody staff?

113. Officer C's reservations regarding Ms Y's credibility are discussed in paragraphs 33 and 52. His understanding of Ms Y's initial call to Police is detailed in paragraph 30.

114. When referring to the briefing he received following the arrival of Officers C and D at Manukau Police Station, Officer E told the Authority "[t]*hey did say that the family had some concerns about his state of mind in that they were concerned that he might try and attempt suicide. What I got from them was that he had given no indication of that at all and they were pretty annoyed with the family and the way the family had been all day.*"

115. Following Officer C's briefing, Officer E added the comment detailed in paragraph 54 to the Electronic Custody Module. This comment reflected Officer C's understanding of Ms Y's initial call to Police. No reference was made to the comments made by Ms Z and recorded on the Event Chronology (refer to paragraph 16 for further information).

116. The Authority has formed the view that Officers C and D had a limited appreciation of the content of the 111 call made by Ms Y. Officer C did not adequately check the Event

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[11] As previously stated, Ms Y was of the view that three Police officers were present at her address when Mr Walters was arrested. The Authority is satisfied that this was not the case.

Chronology created following Ms Y's first call to Police and should have been aware that Mr Walters had threatened to harm himself. His interpretation of events caused important risk information concerning Mr Walters to be overlooked when Officer E was briefed.

117. Had it been known to Officer E that Mr Walters had actually threatened suicide it would have been incumbent on him to identify Mr Walters as 'at-risk' and implement an appropriate monitoring regime to ensure his ongoing safety and wellbeing. This would also have led to the completion of a PMAF, which would have ensured the systematic communication of information about Mr Walters to others who would assume responsibility for his care.

118. Even without information as to the threat of suicide, the Authority is of the view that it would have been desirable for a PMAF to be completed. Police policy[12] in that respect was ambiguous. On the one hand, it stated that no PMAF was necessary if a detainee did "*not fall under one of the two monitoring regimes.*" Since Mr Walters had not been found to be in need of either constant or frequent monitoring, he did not meet this criterion. On the other hand, the same policy also stated that a PMAF "*is to be filled out any time that a person at risk is identified. This is even if the person is subsequently deemed to be 'no risk'.*" The Authority believes that in the circumstances the discovery of pills in Mr Walters' possession, combined with the reported information about the family's concerns about his state of mind, was arguably sufficient to meet this criterion, and that the information needed to be properly recorded on a PMAF for the reason outlined in paragraph 117.

FINDINGS

Officer C should have been aware that Mr Walters had threatened to kill himself and should have passed this information on to custody staff at Manukau Police Station.

It would have been desirable if the fact that pills had been found in Mr Walters' possession had been recorded on a PMAF.

B: Were Police justified in determining Mr Walters was not in need of specific care?

119. After the ECM had been endorsed by Officer E (paragraph 54), Officer F was tasked with evaluating Mr Walters and completing a risk assessment in respect of him. At the time of completing the risk assessment, Officer F had completed about four months' service with New Zealand Police.

120. The Authority is satisfied that Officer F's work was appropriately peer-reviewed by Officer E and other colleagues as part of his ongoing professional development. Officer F's assessment of Mr Walters is summarised in paragraph 56.

121. When asked about the weight placed on in-custody risk assessments when determining a detainee's level of care, Officer E told the Authority that "[i]*t does depend on the*

[12] As articulated in a 'Custody Sergeants' Reference Desk File' for the Counties Manukau District Custody Unit.

circumstances but I think…it's equally important that we take the whole picture rather than part of the picture and then form an opinion on the whole weight of everything that we've got in front of us. I don't think really we could say one's more important than another. I think everything has to be put on the table and then draw that conclusion from what you've got in front of you." Officer F also shared this view and suggested that Mr Walters may have been placed in a cell with a camera as a result of the pills that were found on him, although he could not be sure.

FINDING

Officer E was entitled to form the opinion that Mr Walters was not in need of specific care based on information conveyed to him by Officer C and as a result of the health and safety assessment completed by Officer F.

ISSUE 7: SHOULD OFFICER H HAVE BEEN MADE AWARE OF RISK INFORMATION CONCERNING MR WALTERS?

122. As detailed in paragraph 63, Officer G told the Authority that he could not recall Officer E informing him about Ms Y's concerns or the pills found in Mr Walters' possession. Officer E said that he did summarise these issues as part of his handover.

123. The Authority is unable to reconcile these competing accounts and is therefore unable to determine whether Ms Y's concerns regarding Mr Walters and the fact that pills had been found on him were communicated to Officer G.

124. Officer G also told the Authority that "*there is an opportunity in* [the ECM] *to put a little note in the obvious spot on the front screen that there might be, I mean, it might not even be a risk or anything but there might be just a little note there for some reason…so we would quite often have a quick look through those just on that front screen.*" The Authority's enquiries suggest that notes detailing the issues referred to in paragraph 122 were added to the ECM but not necessarily examined by Officer G at the time of Officer E's handover.

125. Officer G further stated that he was not aware of Officer E's note on Mr Walters' in-custody risk assessment (detailed in paragraph 54), which it was "*unlikely I'd even look through…if they weren't considered to be a risk.*" Officer G added that in his opinion knowledge of it would not have affected Mr Walters' overall risk assessment.

126. In any event, during the relatively short period between Officer G commencing his shift and Officer H arriving at Manukau Police Station, there was no change in Mr Walters' circumstances that warranted a review of the risk assessment completed by Officer F.

127. The briefing given to Officer H following his arrival at Manukau Police Station is detailed in paragraph 65.

128. Officer H told the Authority that he "*would have expected at the very minimum a PMAF*" if concerns such as those expressed in relation to Mr Walters were known to custody staff. Officer H also stated that in his experience a PMAF would be completed where detainees were known to have "*behavioural issues or drug issues*", as well as health issues such as "*chronic asthmatic, or known hepatitis*".

129. As it was, Officer H was not made aware of the concerns that had been expressed about Mr Walters' and proceeded in the belief that there were no issues in respect of him.

FINDINGS

There was no change in Mr Walters' circumstances that necessitated a review of his risk assessment by Officer G.

No risk information concerning Mr Walters was conveyed by Officer G to Officer H. Any risk information known to Officer G should have been brought to the attention of Officer H as part of his handover, but it is not possible to determine whether he had any such information due to conflicting information.

ISSUE 8: DID OFFICER H COMPLY WITH POLICE POLICY IN RELATION TO THE MONITORING OF PRISONERS?

130. As previously discussed, no risk information concerning Mr Walters was conveyed to Officer H. Officer H's assessment of Mr Walters following his arrival at Papakura District Court cells is detailed in paragraph 66.

131. In keeping with Officer H's understanding that there were no underlying or anticipated issues in respect of Mr Walters, he was placed in the cell furthest from Officer H's office and almost directly opposite the bail room[13] where detainees await paperwork prior to being released.

132. Officer H told the Authority that Mr Walters "[s]*eemed to know the routine so…it indicated to me that he'd been through the system before.*" Officer H further stated that "*nothing I personally picked up on gave me any cause to think…he's voiced concerns about going back into custody…he's threatened to self-harm*". Officer H therefore had no reason to complete a PMAF, as would have been his usual practice had such concerns existed on his part.

133. As Mr Walters was considered to be not in need of specific care, it was incumbent on Officer H to check him at least every two hours at varying times. This requirement was stipulated in Police policy in force at the time Mr Walters was detained in custody.

[13] The Authority has examined the Papakura District Court cell that was occupied by Mr Walters on 4 May 2015. There is a reinforced glass window measuring approximately 46.5cm x 20cm near the top of the cell door. The cell door is not directly opposite the door to the bail room but is located a short distance along the corridor that runs between them (cell 4 being further from Officer H's office, which is located at the other end of the Papakura District Court cell complex). Detainees standing at either door have a direct line of sight to one another but it is not possible to see the full extent of cell 4 due to the dimensions and location of its window. There is an approximate diagonal distance of 173cm between doors.

134. Officer H told Police that all prisoners in his care who are not deemed to be at risk are checked "*on average…at least once an hour*". When spoken to by the Authority, Officer H stated that checks are probably conducted "*no later than every 30 minutes.*"

135. As a result of having no access to the ECM, Officer H told the Authority that he maintains an Inspection of Prisoners book as part of his custodial duties. With reference to the relevant entries contained in this book, it is apparent that Officer H placed a number of detainees in the bail room directly opposite Mr Walters' cell at irregular, less than two-hourly intervals up to the time Mr Walters was discovered at 3.47pm. It can be inferred that Officer H would have seen Mr Walters in passing at these times (see paragraph 72).

136. Police policy in force at the time Mr Walters was detained in custody stated: "*Everything that happens in relation to a prisoner, from processing to release, must be recorded in a custody module or the Inspection of Prisoners book including details of:*

- *reception and release*
- *prisoners checks*
- *searches*
- *showers*
- *medication or medical aid*
- *meals*
- *fingerprinting and photographing*
- *visitors, including interviews*
- *telephone calls*
- *numerical count of prisoners*
- *custody staff commencing and finishing duty.*"

137. However, the Inspection of Prisoners book is a standard A4-sized journal supplied by Police with columns to record details such as name of detainee, cell and courtroom allocation, time of Court attendance and release, outcome, general remarks, and whether a meal has been provided. No information concerning the regularity and outcome of checks is captured, nor is it possible to record these details due to the restrictive format of the book.

138. Of note, Officer H told Police that once Mr Walters "*had spoken to the lawyer he was taken back to Cell 4. This wasn't logged in the Prisoner Inspection Book. It's not normal that we would log during the day a prisoner being brought up to speak with his lawyer.*"

FINDINGS

The Authority is satisfied that Officer H conducted adequate physical checks of Mr Walters based on what he understood Mr Walters' level of risk to be.

However, Officer H did not comply with Police policy concerning the management of prisoners, as no written record of checks or other events was maintained.

ISSUE 9: DID THE PHYSICAL CONDITION OF THE PAPAKURA DISTRICT COURT CELLS COMPLY WITH MINIMUM ACCEPTED STANDARDS AT THE TIME MR WALTERS WAS DETAINED?

139. In accordance with its responsibilities under the OPCAT (as detailed in paragraph 84), the Authority, along with representatives of the Ministry of Justice and Police, visited Papakura District Court cells on 13 May 2015 and examined the cell where Mr Walters died.

140. At the time of the Authority's visit, cell 4 was in a state of disrepair[14] and below an acceptable standard. Both the tap above the basin and the pipe from the toilet were available ligature points[15]. Similar ligature points existed in all other Papakura District Court cells and a grill on the inside of the door to the bail room was also available for use as a ligature point.

141. Perspex light fittings throughout the Court holding cells were readily accessible and could be easily broken by detainees for the purposes of self-harm.

142. There was also no CCTV coverage of the cells or of the corridor outside the cells.

143. Officer H and other Court staff did not have access to any form of electronic custody module for recording checks on and monitoring the movements of prisoners.

144. During its investigation, the Authority discussed the condition of Papakura Court cells, and the condition of Court cells in general, with the Ministry of Justice, and ascertained that a substantial proportion of Court cells throughout the country were similarly substandard to varying degrees.

FINDING

Papakura Court cells did not comply with accepted minimum standards at the time Mr Walters was detained. Nor did a substantial proportion of other Court cells throughout the country.

ISSUE 10: WAS APPROPRIATE ACTION TAKEN IN RESPECT OF THE PILLS FOUND IN MR WALTERS' POSSESSION?

A: Did Officer C take sufficient steps to determine whether Mr Walters had taken any pills prior to his arrest?

145. As detailed in paragraph 30, Officer C was not aware of the quantities of pills allegedly removed by Mr Walters from Ms Y's address.

146. However, mindful that pills were found in Mr Walters' possession, Officer C told the Authority that he asked him a series of welfare questions to establish whether he had taken any, or had

[14] All cells were heavily graffitied and burn marks were visible on ceilings. The floor covering of cell 4 was ripped and lifting away from the underlying surface. An area of floor covering had been removed.

[15] A ligature point is any structure that could be used to support a noose or other strangulation device.

had any thoughts about self-harm or suicide. According to Officer C, Mr Walters told him that he had neither taken any pills nor been contemplating suicide.

147. Officer C also told the Authority that there was nothing in Mr Walters' demeanour that gave him cause to suspect that he had taken any pills. His assessment is supported by Officer D's observations, as detailed in paragraph 51.

148. Based on Mr Walters' responses to his questions and the fact that he was satisfied that he "*seemed a very normal sober guy without any issues*", Officer C told Officer E that Mr Walters had not taken any pills (see paragraph 54). Despite misunderstanding Officer E's comments regarding a hospital assessment, Officer C told the Authority that such an assessment would not have been necessary in his opinion.

FINDING

Officer C took sufficient steps to determine whether Mr Walters had taken any pills prior to his arrest.

B: Was Police policy regarding the handling and destruction of property adhered to after pills were found in Mr Walters' possession?

149. Officer C told the Authority that he discussed with Officer E what he should do with the pills that had been in Mr Walter's possession. Officer C indicated that a drug exhibit form was mentioned as part of this discussion but he decided to return the pills to Ms Y as he considered this to be a more straightforward course of action.

150. As part of the Police investigation into the circumstances surrounding the death of Mr Walters, Officer E stated that he told Officer C the pills would need to be disposed of. He assumed that Officer C was aware of the correct procedure that needed to be followed.

151. Policy concerning the handling and destruction of drugs states that Police should treat drugs or drug related items as exhibits and comply with a rigorous procedure for their destruction. See paragraph 190 for further information.

152. However, Officers C and D failed to comply with this policy.

153. Officer C told the Authority that, following his conversation with Officer E, he took the pills and put them in his patrol vehicle with the intention of returning them to Ms Y.

154. Officer D told Police that he was not aware of Officer C's conversation with Officer E but was handed the pills by a member of custody staff as both he and Officer C were leaving Manukau Police Station.

155. Officer D further stated that he put the pills in his and Officer C's patrol vehicle. They then discussed whether they should be returned to Ms Y or destroyed. Officer D told the Authority that "*we didn't come to a decision about that.*"

156. Officers C and D did not in fact revisit Ms Y's address.

157. Unable to return the pills due to other commitments that arose during the remainder of his shift, Officer C told Police that he placed the pills in his correspondence tray at Papakura Police Station. It was his intention to return them to Ms Y when he returned to work on Thursday 7 May 2015.

158. Officer C told the Authority that the pills were no longer where he thought he had left them when he returned to work.

159. Officer D told the Authority that he thought the pills were mistakenly left in the patrol vehicle at the end of his and Officer C's shift. He was unable to account for the whereabouts of the pills when spoken to.

160. Officer E advised the Authority that he had examined a property form[16] completed when Mr Walters was processed at Manukau Police Station. Officer E told Police that the form itemises a container containing multiple pills amongst other items of property taken from Mr Walters but it "*appears there has been some entry crossing that line off*".

161. Officer C told Police that the form examined by Officer E also shows that the container of pills was destroyed, an outcome he is unable to account for.

162. It is not possible to determine what has happened to the pills that were found in Mr Walters' possession at the time of his arrest.

FINDINGS

The Authority is of the view that the pills were released to either Officer C or D on the understanding that they would be disposed of.

Officers C and D did not comply with Police policy concerning the handling and destruction of drugs.

[16] This form is known as a POL48 and is used by Police to record property removed from a detainee following their arrival at a custody unit.

Subsequent Police Action

POLICE

163. Since this event, Police at Counties Manukau have made changes to processes in the District Custody Unit to prevent any reoccurrence. A PMAF (now termed a Health and Safety Management Evaluation or HSME) is now completed for people where suicide is mentioned or discussed, even if that person is assessed as not being in need of frequent or constant monitoring. The form will be provided to anyone having subsequent care of that person.

164. Exhibit handling procedures within the Counties Manukau Police District have also been revisited. All items are now entered onto and tracked via an electronic property system.

165. Police officers who were involved in the handling of pills found in Mr Walters' possession have been reminded of their obligations in respect of seized property.

166. A more general revision of exhibit handling policy is currently being undertaken by New Zealand Police. The Authority is also actively involved in this process.

Conclusions

167. The Authority is of the view that a primary contributing factor in Mr Walters' death was the poor condition of the Court cell in which he was detained. In particular, a number of ligature points were present in the cell and fixtures could be easily adapted to inflict injury. The cell should also have been maintained to an acceptable standard and not allowed to deteriorate to the level discussed in paragraphs 140 and 141.

168. During its investigation, the Authority drew its concerns about the condition of Papakura Court cells to the attention of the Ministry of Justice. It also ascertained that this was not an isolated state of affairs and that a substantial proportion of other Court cells suffered from similar defects and were in similar states of disrepair.

169. As a result, the Ministry has undertaken a systematic review of all Court cells and is developing a national programme of work to remedy all identified deficiencies and ensure that Court cells throughout the country are constructed and maintained to the required standard. In the meantime, significant renovations to the Court cells at Papakura District Court were completed during the second half of 2015 and encompassed the replacement of basins and toilets with units bearing no ligature points.

170. The Ministry is also undertaking a courthouse design standards review that includes Court cell construction. This review will take into account standards for Police cells and learnings from the Joint Custodial Working Group, an inter-agency forum established in mid-2015 to address custodial issues concerning Police, Corrections and Justice.

171. The Authority will continue to monitor the Ministry's development of a court cells design standard and the implementation of its remediation programme.

172. Turning to other events that preceded Mr Walters' death, the Authority is largely satisfied that Police acted appropriately in the circumstances. In particular, Police:

- Took appropriate action in respect of information conveyed by Ms Y during her 111 calls to Police;
- Took reasonable steps to locate Mr Walters after those calls; and
- Provided an appropriate level of care after Mr Walters' arrest, based on what his risk of self-harm was perceived to be.

173. However, there were some shortcomings by individual officers in the way in which they dealt with Mr Walters:

- While the search was lawful, Officers C and D did not comply with the obligations imposed on them under section 93 of the Search and Surveillance Act 2012 when they searched Ms Y's house with her consent, in that they did not fully explain the lawful grounds for the search;

- Officer C should have been aware that Mr Walters had threatened to kill himself and should have passed that information on to the custody staff at Manukau Police Station.

- Officer H should have recorded his checks of Mr Walters in the Court cells as required by Police policy.

- Officers C and D did not comply with Police policy concerning the handling and destruction of drugs.

- The non-completion of a PMAF despite the discovery of pills in Mr Walters' possession at the time of his arrest;

- The inadvertent omission of relevant risk information during custody handovers.

174. In addition, there were a number of missed opportunities in this case for officers to have recognised and communicated Mr Walters' risk of self-harm. Those missed opportunities point to some gaps in current police systems and processes.

175. First, it is apparent that Counties Manukau District policy concerning when a PMAF (or HSME) should be completed contains conflicting information that may discourage the capture of relevant risk information. The importance of completing a PMAF that details *any* matter of concern (as opposed to completing one only when a detainee is subject to frequent or constant monitoring) cannot be understated. It ensures that others, who do not have access to the ECM or other electronic systems, have all relevant information when they assume care of a detainee.

176. Secondly, the Authority notes that Police have the ability to electronically submit a Suicidal Tendencies Notification. This enables relevant concerns to be recorded on an individual's NIA record but is first subject to approval by Police Vetting Services at Police National Headquarters. A Suicidal Tendencies Notification in respect of Mr Walters was not completed at any stage despite his wife's disclosure that he had "*threatened to kill himself*" (see paragraph 89) nor as a result of Ms Y's first 111 call to Police (detailed in paragraphs 15 and 16). Given Police policy, that leaves it to the judgment of individual officers to determine whether a suicide threat warrants notification, the Police staff concerned cannot be criticised for choosing not to complete a notification in this case, based on the limited information known to them at the time of their dealings with either Mr Walters' partner or Ms Y. However, the Authority is of the view that Police policy should err on the side of caution and require a notification in all cases unless there are reasonable grounds in the individual case for believing that the threat lacks credibility.

177. The Authority recognises that if a Suicidal Tendencies Notification had been submitted it would not have been validated, and therefore visible, until after 9.00am on Monday 4 May 2015 due to the operating hours of Police Vetting Services. As detailed in paragraph 64, Mr Walters was collected from Manukau Police Station at about 8.03 am on 4 May 2015. Officer H had no reason to check Mr Walters' NIA record following his arrival at Papakura District Court (see

paragraphs 69 and 71) and would have therefore been oblivious to any alert had one been entered.

178. However, during the course of the Authority's investigation Police advised that an interim Suicidal Tendencies Notification can be uploaded to NIA by Police File Management Centres. This is valid for a 24-hour period pending review by Police Vetting Services. Police also advised the Authority that the capability of File Management Centres to fulfil this function is not widely known.

179. Further to paragraph 91, the Authority is also of the view that Mr Walters' threat to kill himself should have the subject of a Suicidal Tendencies Notification by the Police Communications Centre at the time of Ms Y's first 111 call. This is not routinely done at present.

Recommendations

180. The Authority recommends that the New Zealand Police:

1) Amends current policy to ensure that an HSME is completed whenever a person is in need of specific care; they otherwise require or have received medical attention; or any other matters of concern need to be communicated to any person who takes over the detainee's care or custody.

2) Amends current policy to ensure that a Suicidal Tendencies Notification is submitted as a matter of course and at the earliest opportunity where threats to self-harm or commit suicide are made by an individual or disclosed by a third party in respect of another person, unless the officer has reasonable grounds for concluding that the threat lacks credibility.

3) Ensures that the existence of the Suicidal Tendencies Notification is brought to the attention of all frontline staff, and is included in the suicide awareness training on Te Puna.

4) Ensures that all front-line staff are aware that, when they are making an 'out-of-hours' Notification, they should forward this to a File Management Centre with 24/7 capability, so that it can be recorded against an individual's PRN on an interim basis.

Judge Sir David Carruthers

Chair
Independent Police Conduct Authority

17 March 2016

IPCA: 14-2076

Applicable Laws and Policies

BREACH OF BAIL

Contravening or failing to comply with any condition of bail

181. Section 35(1) of the Bail Act 2000 provides that any constable may arrest without warrant a defendant who has been released on bail if the constable has reasonable grounds to believe that the defendant has contravened or failed to comply with any condition of bail.

182. Police policy regarding bail states: "*that police have no power of entry to premises under section 35, unless they are lawfully there, such as after having been invited in by an occupant.*"

CONSENT SEARCHES

183. Section 92 of the Search and Surveillance Act 2012 provides:

"*An enforcement officer may ask a person to consent to undergo a search or to consent to a search being made of a place, vehicle, or other thing apparently in the control of the person, if the enforcement officer wishes to conduct the search for 1 or more of the following purposes:*

(a) to prevent the commission of an offence:

(b) to protect life or property, or to prevent injury or harm:

(c) to investigate whether an offence has been committed:

(d) any purpose in respect of which the enforcement officer could exercise a power of search conferred by an enactment, if he or she held a particular belief or suspicion specified in the enactment."

184. Section 93 of the Search and Surveillance Act 2012 provides:

"*Before conducting a search by consent, the enforcement officer who proposes to conduct it must—*

(a) determine that the search is for a purpose authorised by section 92; and

(b) advise the person from whom consent is sought of the reason for the proposed search; and

(c) advise the person that he or she may either consent to the search or refuse to consent to the search."

Risk assessment

185. The *Managing Prisoners* policy provides that: *"Everyone in Police custody must be formally assessed on their receipt at Police stations using the custody module to determine requirements for their care and safety and any warning signs indicating suicidal tendencies."*

186. This assessment is intended to identify any risks relating to the prisoner's physical and mental health (including medical conditions and risks arising from alcohol or drug consumption), and warning signs indicating suicidal or self-harm tendencies.

187. Following the risk assessment the officer processing the prisoner will determine whether he or she is 'not in need of specific care', 'in need of care and frequent monitoring' or 'in need of care and constant monitoring'.

Monitoring prisoners

188. All checks on prisoners must be recorded in the electronic custody module (ECM) or the 'Inspections of Prisoners book. Prisoners who are assessed to be 'not in need of specific care' must be checked at least once every two hours, and following table defines the monitoring requirements for prisoners found to be 'in need of care':

If the prisoner requires …	***the prisoner must be…***
frequent monitoring	*observed at least 5 times per hour at irregular intervals*
constant monitoring	*watched or directly observed without interruption.* ***Note****: CCTV is not an authorised means of constant monitoring.*

189. Regular checks are meant to enable Police to continually re-assess the health and safety of prisoners in their custody. The *Managing Prisoners* policy states that:

"The purpose of a check is to ensure the health, safety and well being of people in the care of Police. 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."

190. Police policy concerning the handling and destruction of drugs details the following steps that should be observed:

1. *"Make an entry in the drug register including:*
    - *a description and the amount of the suspect items*
    - *the name of the employee who seized them*
    - *the date and time they were seized*
    - *the suspect's name*
    - *the file number.*
2. *Obtain the register exhibit number.*
3. *Obtain a standard drug envelope and, if your station has a drug seal, stamp it twice across the seams on the back.*
4. *Place the drugs in the envelope. Do not seal it, but deliver it together with a Drug Exhibit Form (POL 374) to the sergeant/senior sergeant, who will inspect and check them and countersign the drug register.*
5. *Seal the drug envelope and label it with the drug register number, file reference name, and locality of sender. If there are numerous exhibits for one register number, label the envelopes accordingly.*
6. *Have the sergeant/senior sergeant countersign the drug seal stamps or, if there is no drug seal, sign across the seams of the envelope.*
7. *Sellotape over the signatures and envelope seams, to ensure the integrity of the contents.*
8. *Place the envelope in the drug safe.*
9. *Place the top (white) and bottom (green) copy of the POL 374 in the drug folder, beside the drug register.*
10. *The middle (pink) copy of the POL 374 goes with the O/C of the Police file for attachment to the file.*
11. *The person responsible for property clears the drug safe and forwards specimens for analysis as required."*

About the Authority

WHO IS THE INDEPENDENT POLICE CONDUCT AUTHORITY?

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

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

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

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

WHAT ARE THE AUTHORITY'S FUNCTIONS?

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

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

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

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