IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

Death following attempted suicide in Tauranga District Court cell

INTRODUCTION

1. Police arrested Mr X for a breach of bail on Saturday 7 October 2017 and took him to Tauranga Central Police Station where he was held in custody for four days. On Wednesday 11 October 2017 Mr X attempted suicide in a cell at the Tauranga District Court. He died in hospital three days later.

2. The Police notified the Independent Police Conduct Authority of the incident, and the Authority conducted an independent investigation. This report sets out the results of that investigation and the Authority's findings.

BACKGROUND

3. This section of the report provides a summary of the incident and the evidence considered by the Authority. When quoting or describing the accounts of any officer, complainant or witness, the Authority does not intend to suggest that it has accepted that particular account.

4. Analysis of the evidence and explanations of where the Authority has accepted, rejected or preferred that evidence is reserved for the 'Authority's Findings' section.

Summary of events

Friday 6 October 2017

5. At approximately 3pm on Friday 6 October 2017, Officer A went to the address of Mr X's mother (Ms W) to speak to Mr X's partner (Ms V) about an upcoming Court case against Mr X. When Officer A arrived, he saw Mr X in the sleepout with Ms V and knew that Mr X was breaching bail conditions that had been imposed on him some months earlier.

6. As there was a large dog on the property, Officer A did not immediately approach Mr X but called out over the fence to him that he was under arrest for a breach of his bail conditions. Officer A

attempted to negotiate his way past the dog. As he did so, Mr X jumped out of the sleepout's back window and ran away.

7. Officer A searched for Mr X nearby but could not find him, so he advised Ms V that Mr X would not be charged for escaping Police custody if he contacted Officer A. Mr X did not do so.

Saturday 7 October 2017

8. The following day, Officer A returned to the property at about 1.45pm with Officer B. Once again, he saw Mr X, who disappeared from the sleepout, so he ran around to the back of the property and found Mr X standing in a shallow stream.

9. Officer A stood on the bank above Mr X. He turned his Taser on and presented it at Mr X. He "*considered [Mr X to be] actively resistant … with significant potential to become assaultive."*

10. Officer A told Mr X to walk towards him as he was under arrest for breaching his bail conditions. The Taser camera footage shows Mr X looking up at Officer A and saying *"What have I done wrong? Can you talk to me?"*

11. Mr X said he wanted to speak to his lawyer. Officer A told him he could do so at the station but if he did not hurry up and get out of the water, he would be tasered. As he thought Mr X was about to pull himself up the bank rather than surrender, Officer A sprayed his oleoresin capsicum (pepper) spray at him from several metres away. Mr X ran up the bank on the other side of the stream and Officer A followed him through the water and into the bush behind the property.

12. Officer A chased Mr X up a steep hillside through thick bush with Mr X's dog following behind. When he caught up with Mr X, who had fallen over, he realised he still had his Taser in his hand, so he holstered it. Officer A jumped on top of Mr X and attempted to handcuff him, but Mr X resisted.

13. According to Officer A, Mr X *"started trying to set his dog on me… he was shouting 'Sic 'em boy. Get him boy'."* Officer A told the Authority the dog started biting at his boots, so he determined that Mr X was 'assaultive'.[1] He said:

> *"In order to stop him setting his dog on me I punched him once with my left hand in the mouth … he appeared to go unconscious and then I sprayed his dog a number of times with [pepper] spray."*

14. Officer B, who had remained near the property, told the Authority he heard Mr X yelling *"get him boy"* and he heard Officer A tell Mr X to keep the dog away from him, and then there was silence. Officer A then called Officer B to assist him in getting Mr X out of the bush and back to the Police car.

[1] 'Assaultive' behaviour includes someone who displays intent to cause harm, through body language/physical action.

Arrival at the Police station

15. At about 2.45pm, Officers A and B and Mr X arrived at Tauranga Central Police Station. Officer A searched Mr X and found $1825 in cash, three bags of methamphetamine (weighing a total of 8.4 grams), a set of digital scales, and a 'tick list' in his wallet.[2]

16. Mr X was arrested for breaching a bail condition (being at his mother's address on 6 and 7 October 2017) and was subsequently charged with escaping from Police (on 6 and 7 October 2017), assault with a weapon (the dog) and possession of methamphetamine for supply.

17. Officer A advised the custody sergeant (Officer C) and the custody constable (Officer D) that he had punched Mr X in the face and that Mr X may have lost consciousness at some stage. Officer D completed an evaluation of Mr X and received him into Police custody.

18. Mr X was strip searched (as it was believed he may have drugs secreted on him) and allowed to have a shower. He was then given clean, dry clothing. Mr X was placed on 'frequent monitoring' (custody staff are required to check a person five times an hour at irregular intervals) and placed in an observation cell with a camera.[3]

19. At 3.45pm Officer C called a doctor to assess Mr X. The doctor advised Officer C that Mr X had concussion and was to be checked every hour on the hour until 9pm that night. She instructed the officers to ask Mr X basic questions during each check to ensure he could answer coherently.

20. The incoming custody sergeant, Officer E, arrived for his shift while the doctor was still examining Mr X and received the briefing from the doctor at the same time as Officer C. Officer E said he was not made aware of any alerts for Mr X in the Police database.[4] Officer D said he told Officer F, the custody constable working with Officer E, that Mr X was being frequently monitored. As with Officer E, Officer F arrived for her shift while Mr X was still being seen by the doctor and was aware that Mr X needed to be woken up every hour until 9pm and asked questions due to his concussion.

21. Officer E told the Authority that when he handed over to Officer G, the night shift custody sergeant, he informed him that Mr X was in an observation cell, that he had earlier been seen by a doctor, that he was on frequent monitoring and he had been on hourly checks at the direction of the doctor up until 9pm as a precaution because of a head injury. Officer G told the Authority that he was told Mr X was in an observation cell largely because he was quite agitated when he arrived at the station and was likely to be under the influence of methamphetamine. He understood Mr X was being frequently monitored because of his erratic behaviour. He said he was unaware that Mr X had been seen by a doctor, had a concussion or that he had a suicidal tendency alert in the Police database.

22. Officer F said she advised Officer H, the incoming night shift custody constable, the same information that Officer E said he had passed onto Officer G. Officer H said he and Officer G were told that Mr X was possibly under the influence of a drug and possibly alcohol. He was also

[2] A 'tick list' is a list of drug debts owed to a person who sells drugs.
[3] See paragraph 149 for relevant policy.
[4] Alerts on an individual's record in the Police database indicate specific risks to, or by, that person.

advised that Mr X was being frequently monitored because he had been exhibiting "*irregular behaviour*" due to possibly having taken drugs and that he had been aggressive. Officer H said he was made aware of Mr X's alerts for attempting to self-harm and knew he had been seen by a doctor when he arrived at the station. However, he was not aware Mr X had a concussion.

23. Officers G and H decided to move Mr X into a cell without a camera at 11.07pm because it was a Saturday night shift and the observation cells are often required for people who are intoxicated. Officer G said Mr X slept through the night without any issues.

Sunday 8 October 2017

24. Officers I and J were the custody sergeant and custody constable respectively on the early shift on 8 October. At handover, Officer G said he advised Officers I and J that Mr X was on frequent monitoring due to having taken methamphetamine. He said he did not advise them of a self-harm alert or that Mr X might have a concussion as that information had not been conveyed to him by the previous shift. Officer I told the Authority that Officer G told him Mr X had been aggressive and had a history of suicidal behaviour which were the reasons he was being frequently monitored. Officer I was unaware of Mr X's possible head injury at the time. Officer J said he was advised that Mr X was being frequently monitored due to displaying "*irregular behaviour*". He was told that Mr X had previously been aggressive. He also found alerts in the Police database that Mr X had previously attempted to self-harm.

25. Officer A, who was also working an early shift, attempted to speak to Mr X about the items found during the search. He said Mr X was verbally abusive towards him and wanted to speak to his lawyer. Officer A contacted Mr X's lawyer, as requested.

26. Ms W visited Mr X at 10.30am for about 10 minutes. She said *"[Mr X's] face was red, swollen, and grazed … he told me he didn't feel safe … [he said] 'please help me, please help me'."* However, Ms W said she did not pass this information on to Police when she left as she felt too distressed to speak to them.

27. Officers C and D returned for their next shift at 3pm. Officer I told the Authority that, because Officer C was the custody sergeant when Mr X arrived at the station, he knew he was aware of relevant issues so he would have just told Officer C what happened with Mr X during his shift. Officer C said Officer I told him there were no issues with Mr X. Officer D said that Officer J also told him there had been no issues with Mr X during their shift.

28. Officer C said he checked the Electronic Custody Module[5] and it appeared *"[Mr X] had been taken off frequent monitoring at that stage as he was only required to be checked regular 'once an hour'."* Officer D also believed Mr X had been taken off frequent monitoring so that he only needed to be checked once an hour.

29. Officer K was the night shift custody sergeant. He recalled getting a handover from Officer D because Officer C was busy. Officer D told him that Mr X had received a knock to the head during his arrest, had been seen by a doctor and was on frequent monitoring. He could not recall

[5] The Electronic Custody Module is an electronic Police system used to record details relating to a person in custody.

whether he was aware of any alerts for self-harm. Officer F was the custody constable and said that Officer D provided her with a general handover about the prisoners and told her that Mr X was still on frequent monitoring. She said she spoke with Mr X several times throughout the night and *"his demeanour was good, he gave me no cause for any concerns."*

Monday 9 October 2017

30. Officers I and J returned to work the early shift on 9 October. Officer K did a handover to Officer I in which he "*ran through the prisoners in a general way*". This included a discussion of the prisoners who were on frequent monitoring and the reason for this. Officer I said he received a handover from Officer K and that there were no issues identified.

31. Officer L, who was responsible for transferring prisoners from the Police Station to the District Court and was also based at the Court, was at the station at about 7.15am. He spoke to Mr X who told him he wanted to get off methamphetamine and needed help to do so. Following this conversation, Officer L said Mr X slept in the Court cell for most of the day in between his appearances and that *"he was a bit emotional when he was awake. He never expressed to me why he was a bit emotional."* Officer M, who was also a Court-based Police officer, noticed that Mr X was withdrawn.

32. Mr X's parents, Ms W and Mr Z, attended the Court hearing. Mr Z said in his Police statement, *"[Mr X] looked like he was in a bad state. Just his whole demeanour, it looked like he was in a bad space."*

33. Mr X was remanded in custody for two days, until 11 October 2017, and was transported back to the Police Station cells at approximately 4.30pm. At this time, Officers C and D were the late shift custody staff.

34. Mr Z visited Mr X at the Police station at 5.12pm. He said in his Police statement:

> *"[Mr X] was very distraught. He looked 'tortured' and emotional. He was abusive to me but also desperately begging me for help. I knew it was partly because he was where he didn't want to be but also that it was his mental health as well. He told me that he wanted to just smash his head against the wall and split his head open … he was dreading going to prison …."*

35. As he left, Mr Z took the opportunity to tell the officer at the front counter he was worried about Mr X and asked Police to keep an eye on him.

36. Meanwhile, Mr X was returned to his cell. Shortly after, Ms W arrived to see him but he declined to see her. Officer C, who was the custody sergeant at the time, recalled Mr X say words to the effect of: *"Please tell Mum I love her, but I don't want to see her while I'm in here."*

37. Officers K and F returned for the night shift at about 10pm. Officer K said that he spoke with Officers C and D and they told him Mr X had been in Court that day and had been remanded in custody. Officers K and F were both aware that Mr X was still being frequently monitored.

Tuesday 10 October 2017

38. On the morning of 10 October 2017, Officers N and O were the duty custody sergeant and custody constable respectively. Officer K said he did a "*full handover*" to Officer O and then ran through the prisoners who were being monitored, required medications or who had been causing any issues during the shift with Officer N. Officer N said Officer K advised him Mr X was remanded in custody to appear in Court the following day. Officer N was also aware that Mr X was on frequent monitoring but did not recall any conversation about Mr X having a head injury. Officer O said that Officer F told him Mr X was on frequent monitoring because he had fallen over during his arrest and that he was in Police custody until his next appearance in Court on 11 October.

39. At 8.15am, Officer O spoke to Mr X, who said he was not feeling well and started crying. Officer O asked Mr X if he wanted to see a doctor, but he said he did not need to. Mr X was again moved to an observation cell.

40. Officer O said: "*After being put in the observation cell [Mr X] cried on and off for a few minutes but his mood quickly improved and he appeared to be feeling a lot better.*"

41. At about 12.45pm Mr X asked to be moved to another cell so he could sleep. Officer O said he agreed to this request as he did not have any concerns about Mr X at this time. Mr X was placed in a cell with no camera at 12.51pm.

42. At about 2.45pm Officer O heard Mr X vomiting in his cell. Officers N and O agreed he needed to see a doctor. Mr X vomited a second time and the incoming custody sergeant (Officer P) and custody constable (Officer J) moved him to an observation cell just after 3pm. Officers N and P checked Mr X's evaluation form and saw that he had received a head injury. Officer P said he was not aware of a previous alert for self-harm at the time.

43. At about 3.20pm, two officers took Mr X to the local medical centre so that his condition could be assessed. For some unknown reason, the sleeves of Mr X's long-sleeved t-shirt were cut by medical staff at the medical centre; one sleeve was cut vertically from the cuff right up to the shoulder and the other was cut horizontally to the length of a short sleeve. Mr X wore the t-shirt in that condition from that time onwards. Mr X was then taken to Tauranga Hospital for further assessment. Hospital staff thought Mr X could be withdrawing from drugs but that he could be returned to Tauranga Central Police Station.

44. When he returned to the station at 7.40pm, Mr X was initially placed in a holding cell and started banging on the door. He again asked if he could be moved to a quieter cell so that he could get some sleep. He was moved to a cell without a camera but remained on frequent monitoring.

45. Officers C and D were the custody sergeant and custody constable respectively on the night shift. They were advised that Mr X had been in hospital earlier that day and had been vomiting but was well enough to be in the Police cells. They said that during the shift they did not have any issues with Mr X, who slept most of the night.

Wednesday 11 October 2017

46. Officers N and O were working the early shift on 11 October when Mr X was due to appear in Court again. Officer N said he checked the Police database to see what had happened with Mr X and saw that he had been seen by a doctor and returned to Police custody. Officer O said he had a handover with Officer D and they discussed the status of each prisoner including Mr X. Officer D told Officer O that Mr X had been seen by a doctor and no medical issues had been identified.

47. Prior to Mr X being transferred to the District Court cells, Officer O said he advised Officer L that Mr X had been crying and vomiting the day before. Officer L transferred Mr X along with other prisoners to the Court at 8.50am and he was placed in a cell with two other prisoners. Mr X remained on frequent monitoring during that time.

48. From 11am to 11.20am, Mr X saw his appointed lawyer, Mr Y, in one of the interview rooms. Mr Y described Mr X as in "*emotional distress*" and crying. Mr X indicated to Mr Y that he had thought about self-harm but, after discussing this with Mr Y, Mr X said he no longer felt this way and would not do "*anything silly*".

49. As he had concerns about Mr X's wellbeing, Mr Y spoke to Officer M about Mr X before his Court appearance. Mr Y said he told Officer M that Mr X had *"clearly been upset and agitated … [Mr X] reported to me that he (Mr X) had been 'spinning out' (Mr X's words) and was scared …."* Mr Y said he would normally advise the Forensic Mental Health officer at the Court but there was nobody from that service present that day.

50. Officer M said:

> *"[Mr Y] expressed to me that he had concerns for [Mr X] and to keep an eye on him as his family expressed that they had concerns for him."*

51. Mr X appeared before the Court at 11.56am for approximately three minutes. He was remanded without plea in custody for three weeks. Following the hearing, Mr Y spoke to Mr X's parents and shared his concerns with them about Mr X's mental health.

52. Meanwhile, Mr X returned to the Court cells, initially with two other prisoners. One of the other prisoners said Mr X had asked him about how he could get off methamphetamine. He also said:

> *"[Mr X's] behaviour was unusual. When he was relaxed he was shaking, he went to sleep on the ground in the middle of the cell. His eyes would roll back into his head … He was just sad and depressed the whole time."*

53. The two prisoners were removed one by one, leaving Mr X alone at 12.07pm.

54. CCTV footage shows Officer L looked in the cell door window as he walked past at 12.12pm. He told the Authority he saw Mr X standing at the back of the cell with his back against the wall.

55. Mr X subsequently tied a piece of material torn from a cut sleeve of his t-shirt around his neck and unscrewed part of the basin plug fitting which he used as a ligature point. Mr X slid down to the ground next to the toilet and attempted to asphyxiate himself.

56. Corrections Officer Q, a Senior Corrections officer, who had been loading prisoners into the prisoner van and had come to collect Mr X, opened the door to the cell at 12.35pm and found Mr X slumped on the ground. He approached Mr X and shouted for help. Officers L and M ran to the cell to assist.

57. Officers L and M and Corrections Officer Q lifted Mr X up off the basin plug fitting and removed the ligature from around his neck. They moved him into the middle of the cell floor. Officer L said he could not hear Mr X breathing, nor could he feel a pulse.

58. Officer M began chest compressions, and Officer R, who was walking through the custody area at the time, called for an ambulance while Corrections Officer Q went to get a defibrillator.

59. The fire service arrived within seven minutes and provided initial emergency care until the ambulance arrived five minutes later. Mr X was taken to hospital and placed on life support for three days.

60. With the agreement of his family, Mr X was taken off life support and died on 14 October 2017. The autopsy confirmed the cause of death was complications arising from the asphyxiation.

Police investigation

61. The Police investigation found that not all relevant information relating to Mr X's care was included in his initial assessment. An earlier alert for 'suicidal tendency' was not included as part of the evaluation.

62. The doctor's examination of Mr X was not recorded in the Electronic Custody Module, including that he had consumed methamphetamine that day. A paper copy of the doctor's report was filed in a ring binder. The Police investigation determined that the system in place for recording relevant information about detainees should be available at a single source.

63. Mr X was not checked five times an hour at irregular intervals as he should have been in accordance with Police policy. However, Police are of the view that none of the above contributed to Mr X's death.

THE AUTHORITY'S INVESTIGATION

64. As part of its investigation the Authority interviewed Officers A, B, C, D, E, G, I, K, L, M, N and P. Officers F, H, J and O only provided statements to Police. The Authority also interviewed Mr X's parents (Ms W and Mr Z), Corrections Officer Q and the two lawyers who represented Mr X on 9 October and 11 October 2017. The Authority also monitored the Police investigation throughout and reviewed documentation and CCTV footage provided by Police.

THE AUTHORITY'S FINDINGS

65. The Authority identified and considered the following issues:

1) Was the force used by Officer A on Mr X during his arrest on 7 October 2017 justified and proportionate?

2) Was Mr X provided with timely and appropriate medical assistance for his head injury?

3) Was Mr X evaluated and monitored appropriately while in custody at Tauranga Central Police Station from 7 October to 11 October 2017?

4) Was Mr X monitored appropriately while in Police custody at Tauranga District Court cells on 9 October and 11 October 2017?

5) Was Mr X provided with timely and appropriate medical assistance after his suicide attempt was discovered?

Issue 1: Was the force used by Officer A on Mr X during his arrest on 7 October 2017 justified and proportionate?

66. On 7 October 2017 Officer A returned to Ms W's address to arrest Mr X for escaping from Police custody the day before. Officer A observed Mr X attempt to escape for the second time but found him standing in a stream behind the house. He believed his arrival caught Mr X by surprise. Officer A said that when Mr X saw him, he moved to the opposite side of the stream, which led Officer A to believe he was again trying to avoid being arrested.

Pepper spray

67. As Mr X refused to get out of the stream and it appeared as if he was going to pull himself up the bank rather than surrender, Officer A deployed his pepper spray, without warning, for one second. The deployment can be seen on the TaserCam footage. However, this was ineffective, and Mr X pulled himself up the bank on the other side of the stream and ran away. Officer A then jumped into the stream and followed Mr X. In doing so, he ran through the cloud of pepper spray.

68. Officer A said he pepper sprayed Mr X in an attempt to prevent his escape. He said he did not give a warning as there was not enough time to do so. However, Officer A had been conversing with Mr X, who was standing still at the time, indicating there was sufficient time to give a warning.

69. Officer A said that he perceived Mr X as 'actively resistant' which is defined in Police policy as pulling, pushing or running away.[6] The TaserCam footage shows Mr X standing still until the pepper spray is deployed. Standing still is not actively resisting, however, it is clear from the footage that Mr X's intention at the time was to attempt to escape. While Officer A technically

[6] See paragraph 140 for relevant policy.

did not comply with Police when he deployed his pepper spray, the Authority finds the deployment was reasonable in the circumstances.

Punch to the face

70. Mr X ran through the grass and bush on the other side of the stream. Officer A eventually caught up to him and, because Mr X had fallen over, jumped on top of him. Officer A told the Authority that Mr X was instructing his dog to bite him. He pepper sprayed the dog in an attempt to stop him but this was ineffective. He subsequently punched Mr X once in the face to stop him continuing to instruct his dog. He said he did so in self-defence. Section 48 of the Crimes Act 1961 states: *"Everyone is justified in using, in the defence of himself or herself or another, such force as, in the circumstances as he or she believes them to be, it is reasonable to use."*[7]

71. The Authority has considered the reasonableness of the force used by Officer A, and whether section 48 can be relied upon in these circumstances. In order to determine this, Officer A's actions must be assessed on the basis of the following three questions:

    1) What did Officer A believe the circumstances to be at the time he punched Mr X?

    2) In light of that belief, did Officer A use force for the purpose of defending himself?

    3) Was the punch to Mr X's face a reasonable degree of force for Officer A to use in the circumstances as he believed them to be?

What did Officer A believe the circumstances to be at the time he punched Mr X?

72. Officer A chased after Mr X as he ran into thick bush up a steep hillside. When Officer A caught up to Mr X, he jumped on top of him to manually restrain him and handcuff him behind his back. Officer A successfully handcuffed one arm, but Mr X would not present the other. He was struggling and resisting arrest.

73. Mr X instructed his dog (who had followed them) to attack Officer A. In response, Officer A kicked out at the dog. He considered Mr X's behaviour to be 'assaultive' as the dog began to attack his boots as Mr X incited it. He was concerned that the dog would bite him as he was restraining Mr X and that he had no means to prevent this occurring.

74. Officer A could not physically control the dog and Mr X at the same time. He said he believed the best course of action to stop the dog attacking him was to punch Mr X in the face so he could not continue to instruct the dog.

75. Officer A was alone with Mr X and the dog, attempting to arrest him in thick bush on a steep slope with little room to manoeuvre. Furthermore, Officer B was not in the immediate vicinity to assist. The Authority accepts that Officer A was being attacked by the dog.

In light of that belief, did Officer A use force for the purpose of defending himself?

[7] See paragraph 130.

76. Officer A reasonably believed that he was at risk of being bitten. He needed to act to prevent the dog from attacking him. Mr X was inciting the dog to attack. Officer A was therefore acting in self-defence by punching Mr X in the face to prevent the dog attacking him.

Was the punch to Mr X's face a reasonable degree of force for Officer A to use in the circumstances as he believed them to be?

77. Police 'Use of Force' policy states that officers have a range of tactical options available to them to restrain a person or effect an arrest, including empty hand techniques such as grabbing hold of, pushing, or punching a person.[8] The Authority accepts that Mr X's behaviour was 'assaultive', attempts to pepper spray the dog had been unsuccessful, and a single punch to Mr X's face was a reasonable use of force to overcome the threat he posed by continuing to command his dog to attack Officer A.

FINDINGS ON ISSUE 1

Although Officer A's deployment of pepper spray was technically contrary to Police policy, it was reasonable in the circumstances.

It was reasonable for Officer A to apply a single punch to Mr X in self-defence.

Issue 2: Was Mr X provided with timely and appropriate medical assistance for his head injury?

78. Following Mr X's arrest, Officer B arrived to assist Officer A in taking Mr X out of the bush and back to the Police car. Mr X was wet and muddy and quiet on the way to Tauranga Central Police Station, a 10 to 15 minute drive away.

79. After arriving at the station, Officer A informed Officers C and D that Mr X had received a head injury and possibly been knocked unconscious.[9] Mr X was arrested just before 2pm and received into Police custody at 2.52pm. A doctor was called to assess him at 3.45pm, nearly an hour after he was received.

80. Mr X was strip searched, had a shower, and then was placed in an observation cell (with a camera). The doctor conducted an examination of Mr X at 4.40pm. She outlined a care plan for Mr X which included hourly waking for the following four hours until 9pm. The plan was to be urgently reviewed if Mr X was "*hard to rouse/confused/vomiting more than once.*"

81. Officer F conducted the checks, including asking Mr X basic questions as per the doctor's instructions, and provided Mr X with painkillers when requested.

82. The Authority finds it unacceptable that it took almost an hour for custody staff to call the doctor when they were aware as soon as he came into custody that Mr X had been hit by Officer A and possibly been knocked unconscious. Custody staff should have immediately recognised that, notwithstanding the absence of symptoms, the possibility of Mr X having a head injury or concussion was real and should have prioritised arranging for a doctor to attend at the earliest possible opportunity. The doctor should have been called immediately and prior to asking the

[8] 'Empty hand' refers to a weaponless use of force. See paragraph 132 for relevant Police policy.
[9] See paragraph 147 for relevant Police policy.

evaluation questions. The Authority also finds it unacceptable that it took almost three hours for Mr X to be seen by a doctor from the time he was injured, although it acknowledges that a third of the delay involved the doctor getting to the station. However, the Authority is satisfied that, once Mr X was seen by a doctor, he was provided with appropriate medical assistance for his head injury.

FINDINGS ON ISSUE 2

It was unacceptable for it to have taken almost an hour for custody staff to call the doctor when Mr X had received a head injury and for it to have taken almost three hours from the time he was injured for him to be seen by a doctor.

Once he was seen by a doctor, Mr X was provided with appropriate medical assistance.

Issue 3: Was Mr X evaluated and monitored appropriately while in custody at Tauranga Central Police Station from 7 October to 11 October 2017?

Evaluation

83. The 'People in Police detention' policy requires an arresting or detaining officer to complete a check of the Police database at the earliest opportunity and advise the employee receiving the detainee of any alerts relevant to the detainee's safe custody. Officer A arrested Mr X so technically should have completed a database check prior to arriving at the station, or at the station, and advised Officer C accordingly. However, Officer A's arrest of Mr X was not straightforward and involved him having to follow Mr X through water and bush before engaging in a physical struggle with him and his dog. In such circumstances, and given the relatively short drive to the station, the Authority is of the view that it would be unfair to be critical of Officer A for not completing a database check. The receiving officer was in a better position to do so.

84. When detainees are received into Police custody, receiving officers are required to ask them a series of questions to evaluate their health and wellbeing and help identify any risks that might arise while they are in custody. Responses are chosen from drop-down boxes and a computer-generated recommendation for a detainee's level of care is created.

85. Both Officers C and D told the Authority that they completed the initial evaluation of Mr X. However, the Police database shows that the first access of Mr X's records on 7 October 2017 was by Officer D at 2.53pm. There is no record that Officer C accessed Mr X's records on that date.

86. On Mr X's evaluation, the question: 'Are you aware of any medical or psychological reasons that indicate the person in custody may require special care or may be at risk while in custody?' was answered 'no' even though Mr X's head injury (which happened during his arrest) was detailed.

87. The next section on the evaluation form, which asked whether Mr X was 'under the influence' of any substances, was answered 'none'. However, given the fact Mr X was found in possession of methamphetamine, the evaluation should have included that it was possible he was under the influence of drugs.

88. Mr X also had a 'suicidal tendency' alert on his profile for threatening to kill himself during an incident on 11 May 2017. The evaluation did not refer to the 'suicidal tendency' alert under the 'Mental Health risks' section. As mentioned above, it is primarily the responsibility of the arresting officer to check the Police database for relevant alerts, however a link to a person's alerts automatically displays when a receiving officer conducts an evaluation so there is a second opportunity to capture any relevant alerts. The 'suicidal tendency' alert should have been identified by Officer D.

89. The initial evaluation of Mr X was inadequate in a number of respects. Officer D should have ensured it was completed accurately and particularly that it included Mr X's 'suicidal tendency' alert relating to 11 May 2017.

Monitoring

90. Police policy requires a person who is deemed 'not in need of specific care' to be checked once every two hours; a person who is deemed in need of 'frequent monitoring' must be checked five times an hour at irregular intervals; and a person requiring constant monitoring is subject to direct continuous monitoring. Custody staff can increase the level of monitoring but cannot decrease it unless on the advice of a health professional.[10]

91. Most custody staff were aware that Mr X was on frequent monitoring for the duration of his detention in Police custody. Officers C and D were the only officers who believed Mr X's monitoring frequency had been decreased to 'not in need of specific care' but it is not clear why they were of this view.[11]

92. Officer C said:

> *"During the times that I dealt with Mr X while he was in Police custody, he did not say or do anything that raised any concerns that he might self-harm or attempt to commit suicide. We only put him on frequent monitoring when he first arrived in Police custody because of the head injury he had possibly sustained prior to his arrival. He also had a history of mental health but did not display any behaviour of concern while I saw him in custody."*

93. Officers D, H and J all stated that frequent monitoring checks mean a regular check (every 10 or 15 minutes) but sometimes it is not possible to complete the checks when required due to workload. Frequent monitoring checks should be at irregular, not regular, intervals and are mandatory under Police policy. It was not appropriate for custody staff not to comply with policy because of a busy workload and deciding there are other priorities because the principal reason for the policy is prisoner safety.

94. Mr X should have been frequently monitored for the duration of his time in Police custody due to the range of factors affecting, or potentially affecting, him (a head injury, drug withdrawal, a suicidal tendency alert and a previous self-harm incident). Of the approximately 415 checks that

[10] See paragraphs 149-153 for relevant Police policy.
[11] See paragraph 153 for relevant Police policy.

should have been conducted, only 188 were recorded.[12] Based on the recorded checks, frequent monitoring was not achieved on any of the shifts Mr X was in Police custody at Tauranga Central Police Station. However, the Authority notes that the shifts worked by Officers E and F substantially met policy requirements.

Reassessment of monitoring level

95. The initial evaluation of Mr X resulted in a monitoring level of 'frequent monitoring'. This monitoring level did not change while Mr X was in Police custody.

96. Police policy requires custody staff to reassess a detainee's monitoring level if there has been a "*change in their circumstances*" which includes a detainee being remanded in custody, under the influence of drugs or when transferred from Court to Police cells.

97. Mr X's evaluation would have been completed by the time he was received into Police custody on 7 October 2017 at 2.52pm. The doctor's examination of Mr X at 4.40pm that day stated that he had smoked methamphetamine that morning. Arguably, Mr X could still have been under the influence of drugs at this time and this should have prompted a reassessment of his monitoring level.

98. Mr X was transferred to the Tauranga District Court cells on the morning of 9 October 2017 ahead of his Court appearance that day. When he was returned to the Police cells that afternoon at 2.38pm, a reassessment of his monitoring level was completed at 3.32pm by custody staff at the station.

99. Mr X was taken first to a medical centre and then to the hospital on 10 October 2017. The hospital medical records mention he was experiencing 'drug withdrawal syndrome'. Again, a reassessment of Mr X's monitoring level should have occurred at this time to reflect the outcome of his hospital visit.

100. In addition, Mr X's records showed he had deliberately hit his head against a cell wall after being arrested on 20 May 2017 and was put in a restraint chair as a result.[13] However, custody staff did not create a 'self-harm' alert in the Police database at that time as they should have done. Instead, they documented this under the 'Incidents' section of the Electronic Custody Module. This record does not appear to have been seen by custody staff either at the time of Mr X's evaluation or during the period he was in custody. That information, had it been recorded appropriately, is likely to have been considered by staff at some point during Mr X's time in custody and is likely to have resulted in a subsequent reassessment of Mr X's monitoring level.

101. Despite changes in Mr X's circumstances on 7 and 10 October 2017, there was no reassessment of his monitoring level at any time.

[12] From when he arrived into Police custody on 7 October 2017 to when he was taken to the Tauranga District Court cells on 11 October 2017.

Handovers

102. As detailed in the 'Summary of events', there was a lack of consistency in the handovers provided by outgoing custody staff to incoming custody staff. During his time in custody, staff believed Mr X was on frequent monitoring for a variety of different reasons (listed below) largely without having a full appreciation of those reasons:

a) Mr X had received a head injury and regular checks were advised by the doctor;

b) Mr X had taken drugs and was likely withdrawing;

c) Mr X had mental health alerts on the Police database;

d) Mr X had demonstrated aggressive or unusual behaviour;

e) Mr X had fallen over while trying to run away from the arresting officer;

f) Mr X had previously demonstrated suicidal behaviour;

g) Mr X was unwell and had been to hospital.

103. The Authority notes that at the time Mr X was in custody in 2017, the Electronic Custody Module listed detainees at Tauranga Central Police Station. It included a column to provide an indication of the level of 'monitoring' of a detainee. However, there was no ability to include any comments showing why the person was on frequent monitoring. A change has since been made to the Electronic Custody Module to allow for comments to be included which alleviates reliance at stations on verbal handovers and also allows additional information to be added or removed when a detainee's circumstances change during the person's time in custody.

Mr X left wearing cut t-shirt

104. As detailed at paragraph 43, the sleeves of Mr X's long-sleeved t-shirt were cut when he was at the medical centre on 10 October. He returned to Police custody at the station at about 7.40pm that evening when late shift staff were working. Night shift staff started their shift at 11pm. Early shift staff started their shift at 7am the next morning.

105. CCTV footage of Mr X being placed into Cell 1 at Tauranga District Court at 8.50am on 11 October shows him still wearing the cut t-shirt. The 'People in Police detention' policy requires Police to remove any items that a detainee could use to harm themselves. The cut sleeves of the t-shirt clearly had the potential to be used by Mr X to harm himself. After Mr X returned to Police custody on 10 October, staff from the three subsequent Police shifts should have ensured he was either not wearing the cut t-shirt or removed the cut sleeves. By leaving Mr X in the cut t-shirt, Police have failed to meet their duty of care to Mr X.

FINDINGS ON ISSUE 3

Officer D should have ensured that Mr X's initial evaluation was accurate and included his 'suicidal tendency' alert.

Mr X was not frequently monitored in accordance with Police policy by custody staff at the station and his monitoring level was not reassessed when there were changes in his circumstances.

The handovers from outgoing staff to incoming staff were inconsistent.

Custody staff at the station should have ensured Mr X was not wearing a cut t-shirt while in custody.

Issue 4: Was Mr X monitored appropriately while in Police custody at Tauranga District Court cells on 9 October and 11 October 2017?

106. On 9 October 2017 Mr X arrived at the Tauranga District Court cells at 8.24am. He returned to the station at 2.38pm. Officers L and M were aware Mr X was being frequently monitored. There were nine documented checks of Mr X at the Court on this date. In accordance with Police policy, approximately 30 checks should have been completed during this time. However, Mr X would have been in Court or with his lawyer for some of this time.

107. On 11 October 2017 Mr X arrived at the Tauranga District Court cells at 9.03am. His suicide attempt was discovered at 12.35pm. Again, both Officers L and M were aware Mr X was on frequent monitoring. Officer L said in his Police statement that he had been advised *"[Mr X] had been to hospital that night for vomiting. He was still on frequent but I'm not sure what it was for either for his vomiting or his emotional state."*

108. There were only seven documented checks of Mr X on 11 October 2017, instead of the approximately 15 checks which should have been completed in accordance with Police policy. The last documented check was at 12.02pm. Again, it is accepted that Mr X would have been in Court or with his lawyer for some of this time.

109. Officer M told the Authority: "*The normal course of practice is to look in every time you walk past but they're not all recorded.*" However, it is evident from the CCTV footage from 11 October 2017 that there were multiple times when Officer L and Corrections Officer Q walked past the cell that Mr X had been placed in without looking in.

110. The CCTV footage also shows Officer L walk past Mr X's cell at about 12.13pm and give a momentary glance into the cell without stopping. Although Officer L walks past the cell at about 12.18pm and again at 12.22pm, he does not look toward the cell on either occasion. Officer L said that he last saw Mr X standing at the back of the cell by the toilet. The last possible time Officer L could have observed Mr X was at 12.13pm and therefore he remained unchecked for at least 22 minutes until he was found at 12.35pm.

111. Officer L acknowledged that the documented checks of Mr X did not meet policy requirements but said that they were short staffed as an officer was on leave and no replacement had been provided.

112. Police policy was not adhered to in relation to completing and/or documenting checks at Tauranga District Court on 9 or 11 October 2017. However, the Authority accepts that the Court cell environment is different from the Police station, as detainees are frequently moved in and out of cells for reasons such as Court appearances or to meet with their lawyer. The Authority also acknowledges that Police officers on duty at Court were under-resourced on 11 October 2017, thereby reducing their capacity to complete the necessary checks on detainees.

Consideration of placement in monitored cell

113. Officer L said he considered placing Mr X in a monitored cell on 11 October 2017 but felt he was not displaying the type of behaviour that warranted doing so. Mr X was, however, placed in a cell with other prisoners. The 'People in Police detention' policy does not require prisoners who are being frequently monitored to be placed in a monitored cell.

114. Following this incident, the Ministry of Justice also completed an investigation. It was identified that Police had not considered a CCTV camera needed to be placed in the cell Mr X was in because it was not intended that high-risk prisoners would be placed in that cell.

Mr X left wearing cut t-shirt

115. As detailed at paragraphs 104 and 105, Mr X was placed into Cell 1 at Tauranga District Court on the morning of 11 October still wearing a cut t-shirt.

116. Police officers on duty at Court should have ensured Mr X was not wearing the cut t-shirt while in custody. They did not comply with policy and failed to meet their duty of care to Mr X.

FINDINGS ON ISSUE 4

The documented checks of Mr X on 9 and 11 October 2017 by Police officers on duty at the Court did not meet policy requirements. However, the Authority accepts that the Court cell environment is different from the Police station as detainees are frequently moved and Police officers at Court were under-resourced on 11 October 2017.

The Police officers on duty at the Court should have ensured Mr X was not wearing a cut t-shirt while in custody.

Issue 5: Was Mr X provided with timely and appropriate medical assistance after his suicide attempt was discovered?

117. The details of Mr X's suicide attempt are set out in paragraphs 55-60. Corrections Officer Q found Mr X at 12.35pm and called for assistance. Officer M arrived shortly afterwards. Officer L placed a prisoner (who he was escorting down the corridor) into an adjacent cell and ran to Mr X's cell.

118. The three officers lifted Mr X to release the pressure from his neck and to remove the ligature. They moved him into the middle of the cell to create enough space to provide medical assistance. Officers L and M attempted to elicit a response from Mr X but Officer L was unable to find a pulse, so Officer M began chest compressions.

119. Corrections Officer Q, who was in the cell area at the time, called for an ambulance at 12.37pm.

120. Corrections Officer Q left the cell to open the rear loading bay doors for fire and ambulance staff. He also retrieved the defibrillator and returned to the cell to begin cardiopulmonary resuscitation (CPR).

121. Corrections Officer Q turned on the defibrillator and the machine provided a tempo to assist Officer M in continuing chest compressions. Officer L placed a mouthpiece over Mr X's mouth and blew through the mouthpiece to provide oxygen.

122. The CCTV footage shows that fire service staff arrived at 12.42pm and took over CPR. Ambulance staff arrived in the cell area at 12.47pm. Mr X was subsequently carried out to the ambulance on a stretcher and taken to hospital.

123. The Authority is satisfied that Mr X was provided with timely and appropriate medical assistance after his suicide attempt was discovered.

FINDING ON ISSUE 5

Mr X was provided with timely and appropriate medical assistance after his suicide attempt was discovered.

SUBSEQUENT ACTION

124. A Ministry of Justice report states the Tauranga District Court cells were included in the first phase of national cell remediation work. Upgrade work was done between August 2016 and January 2017. However, this did not include replacing or rectifying the toilet and basin unit or the modesty screen in Cell 1. The Authority attempted to establish the reason for this but the Ministry did not respond.

125. Following the incident on 11 October 2017, nationwide Police and the Ministry of Justice were notified of the ligature point and this plug type was removed from cells.

CONCLUSIONS

126. The Authority has determined that Police did not comply with policy and failed to meet their duty of care to Mr X during his time in Police custody, in particular by leaving Mr X wearing a cut t-shirt.

127. The Authority also concluded that:

1) Although Officer A's deployment of pepper spray was technically contrary to Police policy, it was reasonable in the circumstances.

2) It was reasonable for Officer A to apply a single punch to Mr X in self-defence.

3) It was unacceptable for it to have taken almost an hour for custody staff to call the doctor when Mr X had received a head injury and for it to have taken almost three hours from the

time he was injured for him to be seen by a doctor. Once he was seen by a doctor, Mr X was provided with appropriate medical assistance.

4) Officer D should have ensured that Mr X's initial evaluation was accurate and included his 'suicidal tendency' alert.

5) Mr X was not frequently monitored in accordance with Police policy by custody staff at the station and his monitoring level was not reassessed when there were changes in his circumstances.

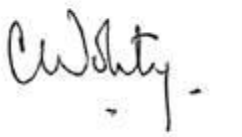
6) The handovers from outgoing staff to incoming staff were inconsistent.

7) Custody staff at the station should have ensured Mr X was not wearing a cut t-shirt while in custody.

8) The documented checks of Mr X on 9 and 11 October 2017 by Police officers on duty at Court did not meet policy requirements. However, the Authority accepts that the Court cell environment is different from the Police station as detainees are frequently moved and Police officers at Court were under-resourced on 11 October.

9) The Police officers on duty at the Court should have ensured Mr X was not wearing a cut t-shirt while in custody.

10) Mr X was provided with timely and appropriate medical assistance after his suicide attempt was discovered.



Judge Colin Doherty

Chair
Independent Police Conduct Authority

30 June 2020

IPCA: 17-0802

APPENDIX – LAWS AND POLICIES

Legislation

128. Section 39 of the Crimes Act 1961 provides for law enforcement officers to use reasonable force in the execution of their duties such as arrests and enforcement of warrants. Specifically, it provides that officers may use *"such force as may be necessary"* to overcome any force used in resisting the law enforcement process unless the process *"can be carried out by reasonable means in a less violent manner."*

129. Section 40(1) of the Crimes Act 1961 provides for Police officers to use reasonable force to *"prevent the escape of that other person if he takes flight in order to avoid arrest".*

130. Section 48 of the Crimes Act states: *"Everyone is justified in using, in the defence of himself or herself or another, such force as, in the circumstances as he or she believes them to be, it is reasonable to use."*

131. Under section 62 of the Act, anyone who is authorised by law to use force is criminally responsible for any excessive use of force.

Police policy on use of force

132. The Police Use of Force policy provides guidance to Police officers about the use of force. The policy sets out the options available to Police officers when responding to a situation. Police officers have a range of tactical options available to them to help de-escalate a situation, restrain a person, effect an arrest or otherwise carry out lawful duties. These include communication, mechanical restraints, empty hand techniques (such as physical restraint holds and arm strikes), OC spray, batons, Police dogs, Tasers and firearms.

133. Police policy provides a framework for officers to assess, reassess, manage and respond to use of force situations, ensuring the response (use of force) is necessary and proportionate given the level of threat and risk to themselves and the public. Police refer to this as the TENR (Threat, Exposure, Necessity and Response) assessment.

134. Police officers must also constantly assess an incident based on information they know about the situation and the behaviour of the people involved; and the potential for de-escalation or escalation. The officer must choose the most reasonable option (use of force), given all the circumstances known to them at the time. This may include information on: the incident type, location and time; the officer and subject's abilities; emotional state, the influence of drugs and alcohol, and the presence or proximity of weapons; similar previous experiences; and environmental conditions. Police refer to this assessment as an officer's Perceived Cumulative Assessment (PCA)).

135. A key part of an officer's decision to decide when, how, and at what level to use force depends on the actions of, or potential actions of, the people involved, and depends on whether they are: cooperative; passively resisting (refuses verbally or with physical inactivity); actively resisting (pulls, pushes or runs away); assaultive (showing an intent to cause harm, expressed

verbally or through body language or physical action); or presenting a threat of grievous bodily harm or death to any person. Ultimately, the legal authority to use force is derived from the law and not from Police policy.

136. The policy states that any force must be considered, timely, proportionate and appropriate given the circumstances known at the time. Victim, public and Police safety always take precedence, and every effort must be taken to minimise harm and maximise safety.

Use of Taser

137. Police policy states that a Taser may only be used to arrest an offender if the officer believes the offender poses a risk of physical injury and the arrest cannot be affected less forcefully. A Taser must only be used on a person who is assaultive (defined as *"actively hostile behaviour accompanied by physical actions or intent, expressed either verbally and/or through body language, to cause physical harm"*) and cannot be used on a person who uses passive resistance in relation to Police.

138. Officers must take special care when using a Taser on subjects who are in or near a body of water. Officers must not use a Taser in circumstances or a situation where there is a risk of the subject drowning.

Use of oleoresin capsicum (pepper) spray

139. Pepper spray is used by Police to subdue people; it causes a stinging sensation and generally makes people very compliant so as to avoid further aggressive behaviour.

140. Police policy states that pepper spray may only be used on someone who is actively resisting and then only when the situation cannot be resolved by less forceful means. Active resistance includes physical actions such as pulling, pushing or running away – that is, *"more than verbal defiance".*

'Arrest and detention' policy

141. Police policy states that when an officer arrests or detains a person, they have a responsibility to protect that person and keep them safe from self-harm and/or suicide while they are in Police custody.

142. The arresting officer's responsibility starts from the moment they arrest or detain the person at the incident scene or elsewhere, continues while transporting the detainee to a Police station and during processing. The arresting officer has responsibility for the detainee until they are transferred to someone else's custody (e.g. a custody officer) or the person is released.

143. When arresting a person, officers must be alert to information and make enquiries from the person, their friends and family, to ascertain if there are any factors suggesting the person might need special care, or could harm themselves or commit suicide while in Police custody.

144. Officers must ensure that any information gathered about the person that might be relevant to their care and safety is recorded and passed on to any other employees taking over responsibility for the person's custody.

145. Anyone arrested or detained in Police custody must be continually assessed and monitored to determine their physical and mental health, particularly whether they have any medical conditions or warning signs indicating suicidal tendencies or risks of self-harm.

'People in Police detention' policy

146. The responsibility of the arresting officer remains until the detainee is formally processed and evaluated in the Electronic Custody Module (ECM), unless responsibility is transferred to another officer, agency or person.

147. The arresting officer should "*ensure a NIA check is done at the earliest opportunity. Be vigilant for any flags relevant to the detainee's safe custody or risk and advise the employee receiving the detainee of these".*

148. Officers should search the detainee under section 11 of the Search and Surveillance Act 2012, preferably in the presence of custody staff. Items that a detainee could use to harm themselves must be removed and any risk information or any special care instructions must be recorded in the ECM.

149. All detainees must be considered to be 'at risk' until an evaluation is completed. Monitoring frequencies are as follows:

- No specific care – check at least every two hours;
- Frequent monitoring – check at least five times an hour at irregular intervals;
- Constant monitoring – directly observe the detainee without interruption.

150. Police policy specifies that checks may be completed via:

- Observation through the cell view port;
- Verbal checks to establish a response; and
- Physical checks which require officers to enter the cell and establish the well-being of detainees.

151. CCTV is not an authorised means of monitoring or carrying out checks of detainees.

152. After a detainee's monitoring level has been determined, custody staff must re-assess the detainee if there is a change in their circumstances, for example, they are:

- remanded in custody;

- under the influence of alcohol or drugs as the effects can worsen over time and can cause death;
- advised of more serious additional charges; or
- transferred from Court or prison to a Police jail.

153. A detainee's monitoring level is not to be reduced without the authority of a health professional. Any reasons for decreasing the monitoring level must be explained.

154. Police must take all practical and reasonable steps to prevent the suicide of detainees. Section 41 of the Crimes Act 1961 provides that everyone is justified in using necessary reasonable force to prevent the commission of suicide.

155. When a suicide attempt is discovered, Police staff must ask another employee to obtain medical assistance while they intervene to stop the attempt. Police must carry out first aid as necessary.

Custodial suicide prevention (Bay of Plenty)

156. Employees receiving and escorting prisoners are responsible for the prisoner's safe and secure custody.

157. All Police employees who in the course of their duties detain persons 'in custody' must hold a current first aid certificate and have completed the bi-annual Custodial Management Suicide Awareness training.

158. Persons who are assessed as being 'in need of care' or 'in need of care and constant monitoring' because of their health, medical condition or presence of any suicidal/self-harm warning signs, must be examined by a Health Professional.

159. Persons who are evaluated as being 'in need of care' or 'in need of care and constant monitoring' must be detained in a cell specifically designated for this purpose and if considered necessary provided with a tear resistant gown.

160. A person's health and safety is not a static state. A further evaluation must be carried out whenever the status of the person changes: e.g. if they are remanded in custody, or when additional charges of a more serious nature are advised to the person or when transferred from Court to a police facility.

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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 Colin Doherty.

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.

This report

This report is the result of the work of a multi-disciplinary team of investigators, report writers and managers. At significant points in the investigation itself and in the preparation of the report, the Authority conducted audits of both process and content

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