IPCA

Independent Police Conduct Authority

Mana Whanonga Pirihimana Motuhake

Man self-harms in Police custody

Summary of the Incident

1. On the night of Saturday 8 October 2022, Police arrested a man (Mr Z) for breach of bail and took him to the Waitematā District Custody Unit (DCU).

2. While at the DCU, Mr Z attempted to self-harm using his clothing as a make-shift ligature. DCU officers acted promptly, and Mr Z was transported to hospital. After being assessed, Mr Z was returned to the DCU and the following morning he was transferred to the Waitakere District Court cells.

3. At the court cells Mr Z made a further attempt at self-harm by drinking the contents of an unlabelled eye drop bottle that officers had given to him from his property. Mr Z was found by an officer to be unresponsive, and an ambulance was called. The contents of the bottle were later discovered to be a class A drug, Gamma-Butyrolactone (GBL).

4. Mr Z recovered in hospital in the custody of Corrections officers. While still in hospital, Mr Z tried a third time to harm himself, even though handcuffed to an officer.

5. Police notified the Authority of Mr Z's attempts to self-harm, and we investigated.

The Authority's Findings

Issue: Did Police breach their duty of care under law and Police policy in respect of Mr Z?

For the most part, Police care of Mr Z while he was in custody was appropriate and in line with their obligations. However:

- Police did not correctly follow policy in processing Mr Z's property. This lapse allowed dangerous items to be accessible in the custody area, breaching their duty of care to staff and detainees; and
- Officers A and B breached their duty of care in respect of Mr Z when they:
  - provided him with an eye drop bottle, which was unlabelled, and which contained an unidentified liquid,

- did not watch him self-administer the liquid from the eye drop bottle, and
- failed to remove the eye drop bottle from Mr Z and the cell.

The breaches by Officer A and B enabled Mr Z to self-harm, an action which could have resulted in his death.

Analysis of the Issues

6. In this section we outline the evidence we gathered during our investigation and describe the events leading up to Mr Z's attempts to self-harm. We assess whether Police reasonably managed Mr Z's wellbeing while in custody according to their obligations at law and under Police policy.

ISSUE: DID POLICE BREACH THEIR DUTY OF CARE UNDER LAW AND POLICE POLICY IN RESPECT OF MR Z?

What were the circumstances leading up to Mr Z attempts to self-harm?

7. On the night of Saturday 8 October 2022, officers were sent to arrest Mr Z for breach of bail relating to a family harm event. On the way to his house, officers spotted him travelling as a passenger in a passing car and attempted to stop it. Mr Z's associate (Mr Y), who was driving the car, stopped after a short time and pulled over. Mr Z jumped out of the car, and ran off, leaving behind his dog and two bags of property. Mr Y then drove off.

8. Two officers pursued Mr Z on foot while another Police unit followed Mr Y. Mr Z stopped running when the officers called out to him that he was under arrest.

9. Officers took Mr Z to the Henderson DCU and charged him with breach of bail in relation to earlier charges for kidnapping, contravening a protection order and burglary.

10. Officers assessed Mr Z at the DCU and entered information into the Electronic Custody Module (ECM).[1] The ECM evaluation raised no concerns for Mr Z's safety, so it was determined he would not require a specific monitoring regime.[2] Mr Z was placed into one of the cells to await his court appearance. The property he was carrying was processed, itemised and entered into the property system (PROP).

11. In the meantime, Police had stopped Mr Y's car. Mr Y was arrested, and his car impounded. Inside the car was a large dog which Mr Y said belonged to Mr Z. Local council staff were called to remove the dog so Police could search the car. Mr Y also identified two sports bags in the car as belonging to Mr Z.

[1] The Electronic Custody Module (ECM) is where staff record risk information, any special care instructions, and everything that happens in relation to a detainee, from their processing to their release.

[2] ECM evaluations record behavioural, mental and physical health indicators in the ECM for the purpose of establishing the level of care and monitoring required. Monitoring regimes are: no specific monitoring, frequent monitoring and constant monitoring. No specific monitoring means the detainee will be checked every 2 hours. Frequent monitoring means the detainee must be checked at least 5 times per hour at irregular intervals. Constant monitoring means the detainee must be directly observed without interruption.

12. A sergeant looked through the two sports bags as part of the search. He removed a glass methamphetamine pipe and a cell phone, which were later handed over to the officer who arrested Mr Y. Recording nothing else of interest, the sergeant passed the two sports bags to a constable and directed that officer to take the bags to the DCU for them to be put with Mr Z's other property.

13. The constable took the two sports bags to the DCU and passed them over to the officers there.

14. At the DCU, an officer removed a glass bottle of clear liquid and four cans of alcohol from one of the bags. He photographed those items together and took an external shot of the two sports bags. The photograph was then digitally entered into PROP and the property bundled together with Mr Z's other property and stored securely.

Mr Z's first attempt to self-harm

15. At approximately 11.00am on Sunday 9 October 2022, Mr Z was in a cell in the DCU when he attempted to self-harm by using his t-shirt as a ligature. Officers found Mr Z before he was able to harm himself and called the mental health team. Officers increased Mr Z's monitoring regime to constant monitoring until he was taken to hospital for assessment (see footnote 2). Once hospital staff had assessed and released Mr Z, he was returned to the DCU where he continued being constantly monitored.

16. At 7:30am on Monday 10 October 2022, the custody officers who work at the Waitakere Court cells arrived at the DCU to pick up the detainees who were due to appear in court that day. On that Monday, the Court cells had two staff absent, one of whom was the supervisor.

17. The custody officers were told of Mr Z's attempt to self-harm. They were told he would remain on constant monitoring at the DCU, although they were expecting medical notes from the hospital outlining future care requirements for Mr Z. If Mr Z remained on 'constant monitoring', he would not attend Court in person, but would participate from the DCU via Audio-Visual Link (AVL).[3]

Transfer to Waitakere Court cells

18. At around 9.30am, the Custody Sergeant at the DCU ('DCU Supervisor') contacted the officer acting as Controller at the Court cells ('the Controller') to inform him that Mr Z's medical notes had arrived and based on that information, Mr Z's monitoring level had been downgraded from 'constant' to 'frequent'. This meant that, in line with normal practice, Mr Z could be taken to Court to appear in person. The Controller agreed with this course of action.

19. At approximately 10:00am, Mr Z was transported to the Waitakere District Court cells. He was in a tear-resistant suicide prevention gown and officers placed him in a cell directly in front of the control room. This cell had windows on two sides and in the door to assist with 'frequent monitoring'.

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[3] Police practice is that people who are placed on constant monitoring do not attend Court in person and instead have their hearing via Audio-Visual Link.

20. Officers placed Mr Z's property in two tamper-proof plastic bags which were put on top of a low cabinet near the control room. In the usual course of events, property belonging to detainees is taken and secured next to the Bail Room.[4] However, due to Mr Z's late arrival and staff shortages, this was not done, meaning Mr Z's property remained within view of his cell.

21. The officers later told us that Mr Z was a *"needy"* detainee, continuously asking for things to be brought to him such as water, food and blankets. The officers outlined that they endeavoured promptly to provide requested items to Mr Z and then get on with other tasks. Officer A told us:

> *"We try and help them out as much as we can. It's because he (Mr Z) had tried to 1X (Police code for attempted suicide), we didn't want him to play up …."*

Mr Z's second attempt to self-harm

22. At about 10.30am, after several other requests, Mr Z told Officer A that his eyes were itchy and requested his eye drops which were in one of his bags. Because Mr Z's property was close at hand, Officer A searched through the bags and found an eye drop bottle. Mr Z could see this through the cell door window and confirmed that that was what he was seeking.

23. Officer A told us:

> *"… he (Mr Z) asked for his eye drops 'cos he did the whole, 'Oh my eyes are itchy,' and like, okay yeah. We (I) just went to his property, found the eye drop bottle and you know that moment where, oh that's dodge, but we had no supervisor to check and I asked my mate, 'This smells, does this smell like eye, as I say eye drops,' and he had no idea, but we gave it to him anyway."*

24. The eye drop bottle was unlabelled and not marked in any way. It was partially filled with a liquid. Officer A brought the eye drop bottle to the cell door, opened it and passed it under the nose of Officer B to smell.

25. Neither officer could identify the contents of the bottle but did not suspect it held anything other than eye drop liquid, so Officer A handed the bottle to Mr Z and left him to self-administer the liquid. Mr Z also received some water, and the cell door was closed.

26. According to CCTV footage, once he was alone in his cell, Mr Z initially feigned putting the drops in his eyes (presumably in case someone was watching) before drinking from the bottle several times. He also added the liquid from the eye drop bottle to his water and drank that.

27. We also spoke to Mr Z who told us he had pretended to have itchy eyes, saying:

> *"And I had a whole lot of drugs in my property, and it was in a Clear Eyes bottle and when I went to court, I seen my property and I asked the officer if I could have my Clear Eyes, my bottle, and, and I drunk all of it, about 20 mls …"*

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[4] The Bail Room is a room near the Court rooms where people granted bail are processed and released on bail. Their property is held in an area near the Bail Room for convenience.

28. It was later established, from remnants in the eye drop bottle, that the liquid was the class A drug, Gamma-Butyrolactone (GBL). The amount taken by Mr Z, who thought it was about 20 mls, is not confirmed, but it was sufficient to render him unconscious within fifteen minutes of ingestion. When viewed by officers through the cell windows, Mr Z was lying on the bed with his face in view and appeared to be sleeping.

29. Twenty-two minutes after Mr Z was given the eye drop bottle, Officer B went into the cell and found Mr Z unresponsive. After calling for assistance, Mr Z was placed into the recovery position and an ambulance was requested.

30. During the attendance by ambulance staff, Officers A and B realised the liquid in the eye drop bottle may be relevant and passed that information on.

Mr Z's transfer to Corrections and third attempt to self-harm

31. Mr Z spent several days in hospital while he recovered from his consumption of GBL. Mr Z's Court hearing went ahead in his absence, and he was remanded into Corrections custody.

32. Police provided a clear transfer of information and concerns about Mr Z to Corrections.

33. While in hospital, Mr Z was under the close watch of three Corrections officers when he again tried to harm himself, this time using a restraint chain. This was easily prevented, and further steps were then taken to lessen the opportunity for Mr Z to self-harm.

34. Police notified the Authority of Mr Z's three attempts to self-harm, and we investigated. The Authority does not have jurisdiction over Corrections employees, so we have only focused on the events which occurred while Mr Z was in Police custody.

Did police breach their duty of care under law and Police policy in respect of Mr Z?

35. For the duration of a person's time in Police custody, Police have a legal duty to take all reasonable steps to ensure their care, safety and wellbeing as codified in section 151 of the Crimes Act 1961.

36. That duty of care is also recognised and given effect to in Police policies relating to arrest, detention and the care of people in custody.

37. The Police Custody policy ('the policy') notes that Police employees are responsible for the safety of themselves and others. This includes being responsible for the care and security of people detained within Police stations and this may include cells at courts. Police responsibility for care, safety and security starts from the moment a person is arrested or detained and does not end until they are released or transferred into the care of another agency, individual or family member.

38. Our investigation covered the following matters related to Police's duty of care to Mr Z:

- Mr Z's assessment, including the ECM evaluation;
- The monitoring regimes applied to Mr Z;

- The processing of Mr Z's property at the DCU;
- The care following Mr Z's first self-harm attempt, including the later briefing of officers for Waitakere Court;
- The decision to send Mr Z to Court in person when he could have appeared via AVL;
- The handling of Mr Z's property at the Court cells;
- The provision of the eye drop bottle to Mr Z from his property; and
- The care provided following Mr Z's second self-harm attempt, including the briefing to Corrections when his care was transferred from Police.

Was Mr Z appropriately assessed and monitored in custody at the DCU?

39. When Mr Z arrived at the DCU he was assessed by an Authorised Officer and had information entered into the ECM.[5]

40. The ECM is a computer-based assessment tool which uses a set of questions to evaluate Mr Z's behavioural, mental and physical health indicators for the purpose of establishing the level of care and monitoring required. Part of that evaluation process includes checking previous records and "Evaluation History" and capturing any relevant risk.

41. The assessment process includes a wellness questionnaire which involved questions to Mr Z about mental health and suicidal ideation. Mr Z's replies did not raise concerns for the Authorised Officer. The arresting officer also noted that they had no concerns for Mr Z's welfare or safety and said Mr Z had made no comments about harming himself.

42. Based on the information recorded, the ECM evaluation raised no issues in relation to Mr Z's safety, and he was assessed as requiring no specific monitoring regime. This meant that, while in custody, Mr Z would receive the standard two-hourly checks.

43. In our assessment, Mr Z's evaluation was correct and that from the information they had, Mr Z was initially placed on the appropriate monitoring regime.

Was Mr Z's property processed at the DCU in accordance with Police policy?

44. Police policy notes that not all property needs to be itemised, but it must be photographed, and the photograph/s entered into Police's electronic property system (PROP). It also states that all bag contents should be removed, examined and photographed as this will capture more information than just listing it. Officers should take as many photos as required to best record the entirety of the property.

45. Mr Z was initially searched when he was arrested and further searched more formally on arrival at the DCU. The few items of property he arrived with were itemised, photographed and entered into PROP.

46. As outlined in paragraphs 11 to 13, two sports bags belonging to Mr Z were taken from Mr Y's car and brought to the DCU to be joined up with Mr Z's other property.

[5] Authorised Officers are uniformed, non-sworn NZ Police employees.

47. In this instance, the two sports bags were not properly processed before being recorded in PROP and physically placed together. From one of the bags, some cash, four cans of alcohol and one 750ml Jim Beam bottle containing clear liquid were removed. Those items and the outside of both bags were photographed, and the photographs then entered into PROP. These photographs did not capture the entirety of Mr Z's property as it was later revealed to include clothing, the eye drop bottle, two syringes, a small crowbar and hammer, zip ties, numerous ink markers, a lighter, and other assorted items.

48. On the morning of 10 October, a detective, Officer C, who was working on the kidnapping charge against Mr Z, went to the DCU and took two cell phones and the Jim Beam bottle from Mr Z's property. Officer C says that he suspected the Jim Beam bottle contained GBL, so secured it for testing.

49. Officer C recorded in his notebook that he had seized the cell phones and the Jim Beam bottle. However, no notes were added to PROP to reflect the officer's access to Mr Z's property, nor the removal of these items. The clear liquid in the bottle was found to be ethanol.

50. The processing of Mr Z's property on his arrival at the DCU was completed in accordance with Police policy and secured appropriately. However, the property in the two sports bags was not. The entire contents of the bags should have been fully processed and photographed or itemised, and this information recorded in PROP. Any item that could be dangerous within the Court custody area, such as those listed in paragraph 47, should have been separated out.

51. Later access to Mr Z's property and removal of any items should also have been noted in PROP to reflect the movement of that property and uphold the chain of custody.

Did Police adequately manage Mr Z's first self-harm attempt?

52. Mr Z's first attempt at self-harm using his t-shirt was spotted by officers completing a cell check. The officers quickly entered the cell and removed the t-shirt. They also notified a supervisor who requested an ambulance and placed Mr Z on constant monitoring.

53. A Detective Sergeant, who is also a trained intensive care paramedic, was at the DCU and assessed Mr Z within two minutes of the officers finding him. Mr Z had not lost consciousness and was able to communicate with staff.

54. Mr Z was transported by ambulance to Waitakere Hospital for both medical and mental health assessments.

55. Mr Z was there cleared of any injuries by medical staff and his mental health was assessed by the mental health team. Mr Z was returned to Police custody at the DCU under instructions that he could be downgraded to frequent monitoring.

56. Although the DCU Supervisor received verbal communications from a medical professional in relation to Mr Z's monitoring, he maintained Mr Z's constant monitoring regime until Mr Z's medical assessment notes arrived by email.

57. Police management of Mr Z's first attempt to self-harm was undertaken well and officers were quick to seek medical assistance. The prompt change of Mr Z's monitoring regime to constant

monitoring was also in line with their duty of care to take reasonable steps to protect detainees from injury (including self-harm). It was also appropriate that the later change in monitoring regime to frequent monitoring was only completed following the receipt of written record from a medical professional.

Was the decision to send Mr Z to Waitakere Court cells appropriate in the circumstances?

58. The usual Police practice is that a detainee who is subject to constant monitoring does not travel from the DCU to the Court cells but attends their court hearings via AVL. This is for their safety and the safety of others as reducing travel from secured areas helps to lower risk levels and opportunities for harm.

59. In this case, although the DCU Supervisor had placed Mr Z on constant monitoring following his attempt to self-harm, he had downgraded Mr Z's monitoring regime to frequent following the receipt of written medical advice. This meant that Mr Z then became eligible to attend his court hearing in person.

60. The DCU Supervisor told us he telephoned the Court cells and spoke to the Controller to advise him that Mr Z would now be coming to Court.

61. Although it was standard practice for Mr Z to attend in person, the DCU Supervisor said that if the Controller had been concerned about the staff's ability to undertake the frequent monitoring, they could have communicated that concern and the DCU Supervisor could have kept Mr Z at the DCU for his appearance via AVL.

62. Considering the circumstances known at time, our view is that it was a reasonable decision for the DCU Supervisor to send Mr Z to the Court cells to attend his hearing in person.

Was Mr Z's property at the Waitakere Court cells handled in accordance with Police policy?

63. On the morning of 10 October, Mr Z's property travelled with him to the Waitakere Court cells in two tamper-proof bags and was placed on a low cabinet in the custody area. At Court, the bags were not searched nor were they securely stored. Officers told us that they do not search property from the DCU as they assume it has been properly processed before being placed into tamper-proof bags.

64. Officers said they left the property on the cabinet in the custody area because they were understaffed and too busy to take the property to the secure storage area. This meant that, without the officers being aware, inadequately processed and potentially dangerous items remained unsecured in a custody area.

65. Under the policy, officers must take reasonable care that their acts or omissions do not adversely affect the health and safety of other persons (including detainees). Undertaking the process outlined in paragraph 44 above would have ensured that Mr Z's property was properly dealt with at the DCU and would have enabled separation of items that could be dangerous in a custody area.

66. Ensuring that Mr Z's property was placed in the secure storage area may also have avoided his second attempt to self-harm by making the bags more difficult to access. Because Mr Z's was close at hand, an officer was easily able to access the eye drop container for him.

67. Once Mr Z's property went with him to Court, care should have been taken to properly store it in the secure storage area and away from the custody area.

Was the provision of the eye drop bottle to Mr Z in accordance with Police policy?

68. Mr Z's property had been bundled together and sealed in two tamper-proof bags. Officer A had to open at least one of those bags to obtain the eye drops requested by Mr Z. Policy is that any time a sealed tamper-proof bag is opened, the reason must be recorded in the custody record. This was not done.

69. The policy addresses the provision and administration of medication to detainees. It specifies that:

   - medication provided to a detainee must be prescription medication;
   - that medication must be labelled in the name of the detainee; and
   - a visual examination of the medication must not raise concerns about its legitimacy.

70. The policy is also clear that where a prescription medication is provided to a detainee:

   - The medication must be administered or self-administered in accordance with the prescription information,
   - The medication must be removed from the detainee after it has been administered, and
   - The provision of medication, including the dosage and timing, must be recorded in the ECM.

71. The eye drop bottle had no label, such as the manufacturer, contents or Mr Z's name and we consider it could not be treated as prescription medication. Police only had Mr Z's say so that the bottle contained eye drops.

72. Officer A, in consultation with Officer B, provided the eye drop bottle to Mr Z. Officer A acknowledged the error, saying:

   "I've got nothing to hide, it's you know I take that I, you know, I did it. I take that on the chin. It's yeah, my mistake."

73. This initial error was then compounded by the officers:

   a) failing to remove the bottle from Mr Z following his feigned administration of the drops; and

   b) not recording in the ECM, the provision of the eyedrops to Mr Z.

74. Police inform us that an eye drop bottle is not an unusual item in detainee property, being commonly found with cannabis users.

75. It is possible that Officers A and B did not consider the eye drops to be 'medication' as such and therefore believed the policy did not apply in the circumstances. However, Officers A and B are both experienced officers and would be aware of their duty of care to detainees. Regardless of whether they considered eye drops to be medication, the bottle was unlabelled, and they could not be sure of the contents. From a safety perspective, and bearing in mind Mr Z's earlier attempt to self-harm, they should have erred on the side of caution and refused to provide the eye drop bottle to Mr Z.

76. Officer A and B's breaches of policy enabled Mr Z to self-harm, an action which could have resulted in his death.

Did Police adequately manage Mr Z's second self-harm attempt?

77. Having given Mr Z the eye drop bottle, Officers A and B continued with their other work. As part of Mr Z's frequent monitoring regime, Officer B checked on Mr Z and thought he had fallen asleep.

78. About six minutes later, Officer B entered the cell where Mr Z was lying on the bench. Officer B tried to rouse Mr Z, but he could not. Officer B called over Officer A and together they lowered Mr Z onto the floor and into the recovery position. Officer B tried to elicit a response from Mr Z, but Mr Z remained unresponsive, so an ambulance was called.

79. Ambulance staff arrived within minutes and began working on Mr Z. It was then that Officers A and B realised that their provision of the eye drop bottle might be relevant and passed that information on.

80. Officers carried out their monitoring of Mr Z correctly in accordance with the frequent monitoring regime. They also acted quickly when they discovered that Mr Z was not able to be roused, placing him on the floor in the recovery position and calling an ambulance. Officers also passed on the detail of the eye drop bottle promptly.

Were Corrections staff adequately briefed about Mr Z's attempts to self-harm?

81. As noted above in paragraph 31, Mr Z's Court appearance was conducted in his absence, and he was remanded in custody. This meant his care was transferred from Police to Corrections.

82. While in hospital Mr Z was initially in the custody of three Corrections officers and coupled to one of the Corrections officers by double handcuffs and a short chain.

83. We have not been able to ascertain who provided a handover briefing to Corrections, or the specific information provided. However, the fact Mr Z had three Corrections officers providing constant monitoring of him while recovering in hospital, would indicate that they were aware of the previous attempts to self-harm and the need to watch him closely. In addition, his third attempt to self-harm while coupled to a Corrections officer would have shown the officers that he would take any opportunity, even if it was clearly likely to be unsuccessful.

Overall assessment

84. The physical and ECM assessments of Mr Z were undertaken correctly, and Police had him on the correct monitoring regime at different times. Officers carried out all monitoring according to policy.

85. Mr Z's property was not properly processed at the DCU in accordance with Police policy and notes should have been added to PROP to reflect access to, and removal of items from, Mr Z's property. The two sports bags should have had their entire contents itemised (or at least photographed) and added to the PROP system at the time they were brought to the Waitematā DCU.

86. Items in that property that could be dangerous within a cell area, such as those later found in the Mr Z's bags (syringes, a small crowbar and hammer, zip ties, a lighter and other items), should not have travelled to the Court cells with Mr Z.

87. Officers A and B should not have given the eye drop bottle to Mr Z. Nor should it have been left with him in the cell due to it not being prescription medication, labelled or the contents identifiable.

88. Officer A or Officer B should have recorded the provision of the eye drop bottle in the ECM.

89. In those respects, our assessment is that Officers A and B breached their duty of care to Mr Z.

90. We consider that there was adequate briefing between Police and Corrections as Mr Z had three Corrections officers providing constant monitoring of him while in hospital.

FINDINGS ON ISSUE:

For the most part, Police care of Mr Z while he was in custody was appropriate and in line with their obligations. However:

Police did not correctly follow policy in processing Mr Z's property. This lapse allowed dangerous items to be accessible in the custody area, breaching their duty of care to staff and detainees; and

Officers A and B breached their duty of care in respect of Mr Z when they:

- provided him with an eye drop bottle, which was unlabelled, and which contained unidentified liquid;
- did not watch him administer the liquid from the eye drop bottle; and
- failed to remove the eye drop bottle from Mr Z and the cell.

The breaches by Officer A and B enabled Mr Z to self-harm, an action which could have resulted in his death.

Subsequent Police Action

91. Police undertook a critical incident investigation, but we are yet to receive the outcome of this.

92. Promptly after this incident, Police published an internal Lessons Learnt notice regarding eye drop bottles in custody suites, together with a copy of the policy relating to the provision of medication while in custody. We note that this notice provides an outline of what occurred in the incident but does not provide specific advice about whether officers should provide detainees with eye drops in similar circumstances, or in fact any substance that the officer cannot be confident is safe.

93. Waitematā District Police has Implemented a local order ensuring that as standard practice a substantive Sergeant is always present and has oversight and management of the Court Custody Units at both Waitakere and North Shore.

Judge Kenneth Johnston KC

Chair
Independent Police Conduct Authority

12 October 2023

IPCA: 22-15438

Appendix – Laws and Policies

LAW

Crimes Act 1961

Section 151 Duty to provide necessaries and protect from injury

Everyone who has actual care or charge of a person who is a vulnerable adult and who is unable to provide himself or herself with necessaries is under a legal duty—

(a) to provide that person with necessaries; and

(b) to take reasonable steps to protect that person from injury.

POLICY

People in Police Custody Policy

94. *Medication*

- Check if the detainee has any prescribed medication.
- All the detainee to take medication in accordance with the prescription information so long as the prescribed medication is in the name of the detainee and a visual examination of threw medicine does not raise concerns about its legitimacy. Note: injectable medications (e.g., insulin) for suicidal detainees must only be administered in the presence of, or by, a health professional.
- If the medication is not held with the detainee, it may need to be obtained from the detainee's home or through a new prescription.
- Record the details of the medication, including the dosage and timing, in the ECM.
- Call a health professional where you are concerned that the medication may not be legitimate.

95. *Monitoring levels and frequency of checks*

- A detainee's monitoring level can be increased at any time but cannot be reduced except on advice of a health professional.
- If the detainee requires…
  - no specific care, the detainee must be checked at least every two hours.
  - frequent monitoring, the detainee must be checked at least 5 times per hour at irregular intervals.
  - constant monitoring, the detainee must be directly observed without interruption.

96. *Receiving and recording detainees property*

- Photographing the detainee's property will capture more information than listing their property. Police issue cell phones are suitable to photograph property and should be used when a dedicated camera is not available.
- The requirement to list property only exists where photographic recording is not available, when property is retained as an exhibit, or when making a partial return.
- Follow these steps:

a. Minimise property that comes in with a detainee.

b. Separate any property for further investigation and retain it as an exhibit (s150-151 Search and Surveillance Act 2012) ensuring the exhibit property is entered in the Police Record of Property (PROP) system and a receipt produced from PROP is given to the detainee.

c. Check the time/date on the camera is correct. It should align with the time on the ECM.

d. Lay out the detainee's property in the presence of the detainee. If it is impractical for the detainee to be present e.g., they are violent, use another Police employee as a witness.

e. All cash must be laid out in a way it can be counted from the photograph(s) if required. Cash amounts exceeding $1000 must be secured in a safe or secure drop box, entered into the PROP system and approved by a Sergeant, Custody Team Supervisor or above. (See 'Holding cash at Police stations' in the 'Cash handling' chapter).

f. Photograph the detainee's property. Take as many photos as required to collect the entirety of the property.

g. Secure the property in a tamper proof bag and seal it. Note that:

   i. medication is held in a separate bag to allow it to be given to the detainee when scheduled.

   ii. cash of over $1000 must be stored in accordance with the cash handing policy.

   iii. small and valuable items should be stored in a small, sealed, clear plastic bag and stapled inside the main bag of property near the top.

   iv. if the detainee has to be put in a tear resistant gown, then a second property bag, containing the clothing that was removed from the detainee, must be attached to the main property bag.

h. Ensure the property is entered into the PROP system and the Property Seizure and Return Form is given to the detainee to sign. If the detainee refuses to sign, or is unable to, endorse the form accordingly and countersign.

i. Retain a copy of the signed Property Seizure and Return Form in accordance with current practices.

J. Place the bag(s) in the allocated storage location.

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.

We are not part of the Police – the law requires us to be fully independent. The Authority is overseen by a Board, which is chaired by Judge Kenneth Johnston KC.

Being independent means that the Authority makes its own findings based on the facts and the law. We do not answer to the Police, the Government or anyone else over those findings. In this way, our 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 and may choose to investigate:

- complaints alleging misconduct or neglect of duty by Police;
- complaints about Police practices, policies and procedures affecting the complainant in a personal capacity;
- notifications of incidents in which Police actions have caused or appear to have caused death or serious bodily harm; and
- referrals by Police under a Memorandum of Understanding between the Authority and Police, which covers instances of potential reputational risk to Police (including serious offending by a Police officer or Police actions that may have an element of corruption).

The Authority's investigation may include visiting the scene of the incident, interviewing the officers involved and any witnesses, and reviewing evidence from the Police's investigation.

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. 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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