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

Detention of a person by Police for a mental health assessment

INTRODUCTION

1. At about 2am on Sunday, 9 October 2016, Police were called to Mr X's address in Lower Hutt, Wellington, by his partner, Ms Y. Ms Y was concerned for Mr X's wellbeing as he had been mentally unwell for several days and was trying to find objects with which to hang himself. Police took Mr X into custody so that a mental health assessment could be conducted.

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, it is not intended to suggest that the Authority 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

5. Ms Y told the Authority that when Mr X came home from work on Thursday, 6 October 2016, he was "*not himself*".[1] She did not think he had slept from that Thursday night until the Sunday morning when Police came to the address. During this time, Mr X also asked Ms Y if she could hear voices coming from the television. Ms Y said she did not call the Crisis Resolution Service (CRS)[2] at any point as she did not have their number.

[1] After Mr X was detained for a mental health assessment, Police found a suicide note that he had written on 6 October 2016 at his address.
[2] The CRS was formerly known as the Crisis Assessment and Treatment (CAT) team and is based at Kenepuru Hospital.

6. On the night of Saturday, 8 October and in the early hours of 9 October, Ms Y said that Mr X was trying to find the dog chains she had hidden from him. He also pulled a strap off her handbag and put it round his neck. Ms Y tried to wrestle the strap off Mr X, but he overpowered her and then tried to hang himself with the strap. While she called Police, Ms Y tried to talk Mr X out of hanging himself.

Police attendance at Mr X's address

7. At about 2am, the Police Central Communications Centre (CentComms) broadcast on the Police radio that a male was attempting to harm himself at his address in Lower Hutt. Police arrived at the block of flats shortly afterwards. From the street, Officer A saw Mr X trying to hang himself with a belt from a curtain railing in his flat on the first floor.

8. Officer B arrived at about the same time, and Officer A yelled out to him that he had seen Mr X trying to hang himself. Both officers ran to the main entrance of the block of flats. As the door was locked, Officer A used his Police baton to break a glass panel on the door to gain access. Officers A and B said they relied on the authority provided by section 14(1) of the Search and Surveillance Act 2012 to do this.[3]

9. Both officers ran up to the first floor. Ms Y called to them and they opened the unlocked door to the flat. Mr X was in a corner close to the window with the belt beside him. Officer A told the Authority that when they arrived Mr X was "*very aggressive and determined to harm himself*". He later clarified that Mr X was both verbally and physically aggressive. Officer B said that Mr X was uncommunicative and staring into space.

10. As he deemed Mr X's behaviour in the assaultive range and there were a number of potential weapons nearby,[4] Officer A took his Taser out of its holster and kept it at his side while Officer B spoke to Mr X.[5] He did not turn his Taser on. Officer B said that he tried to reassure Mr X that he was not in trouble and Police were there to help him.

11. Officers C and D then arrived at Mr X's address. Officer C said that Mr X was sitting in a chair, looking down at his feet and not responding to Officers A and B. Officer D said that Mr X was not listening to anything he was being told and thought he recalled Mr X being "*aggressive*".

12. Officer A directed Officer D to speak to Ms Y. He also decided that Mr X needed to be medically assessed. Officer A told the Authority that he considered calling the CRS to get them to come to the address, but due to Mr X's behaviour did not think the environment was safe enough. He also considered taking Mr X to hospital but again did not think that was a safe option. Officer A

[3] Where there is risk to the life or safety of any person requiring an emergency response, section 14(1) of the Search and Surveillance Act allows an officer to enter a property and take any action he or she has reasonable grounds to believe is necessary to avert an emergency.
[4] The officers saw knives, scissors and a baseball bat.
[5] A Taser can be used against a person if an officer assesses that the person's behaviour is assaultive or beyond. 'Assaultive ' is defined as "*intent to cause harm, expressed verbally, through body language/physical action*".

decided that Mr X needed to be taken into Police custody and directed Officer C to detain him under the Mental Health (Compulsory Assessment and Treatment) Act 1992.[6]

13. Although Mr X initially complied with Officer B's instructions, he became agitated and uncompliant as he was guided towards the door to be taken to the Police car. He said he would not go anywhere unless Ms Y came with him and that he was concerned for her safety. Officer B said that Mr X "*suddenly swung out in an attempt to resist*".

14. Officers B and C used an approved arm bar technique to restrain Mr X and took him to the ground. Mr X was then handcuffed and walked to the Police car.

Transport to the DCU

15. After another short struggle getting Mr X into the Police car, Officers C and D drove him to the District Custody Unit (DCU) at Wellington Central Police Station. During the trip, Mr X repeatedly said that Ms Y was in danger but would not provide any explanation. He became agitated when he was told that he would be assessed by the CRS.

16. Officer A told the Authority that he reiterated to Officers C and D that they needed to explain "*the issues and the risks surrounding [Mr X]*" to custody staff at the DCU. Officer A said that he was still acting under section 14 of the Search and Surveillance Act at this point.

17. At about 2.45am, while they were still on their way to the DCU, Officer C called the CRS. He said he was advised that they would "*get round to seeing [Mr X]*". It is not clear whether Officer C specifically told the CRS that Mr X had attempted suicide that night or, if he did, that the message was passed onto staff who subsequently attended at the DCU to assess Mr X.

18. While Mr X was being transported to the DCU, Officer A also called the custody supervisor at the DCU, Officer E, to tell her that Mr X was on his way. He told the Authority that he advised Officer E that Mr X was at serious risk of harming himself. Officer E told the Authority that Officer A advised her that Mr X had tried to commit suicide at his address, although she said that she was unaware of the number of times he had tried to do so. Officers A and E also had a discussion about taking Mr X to hospital for an assessment. However, they decided it was not safe for hospital staff or Police to do so because of Mr X's behaviour.

19. After speaking with Officer A, Officer E made arrangements for Mr X to be taken straight to a monitored cell and placed in a tear resistant gown as soon as he arrived at the DCU. Custody Officer F said that, prior to Mr X's arrival, he was told by Officer E that Mr X had been aggressive and non-compliant and was being brought to the DCU for a mental health assessment.

[6] However, as Mr X was not "*found wandering at large*" in a public place, he could not lawfully be detained by Police under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (see paragraphs 52 to 54).

At the DCU

20. After arriving at the DCU at about 2.53am, Mr X was taken straight to the only available monitored cell, cell F1, which was in the female area of the unit. Custody Officer F removed Mr X's handcuffs, and he and Custody Officer G instructed Mr X to remove his clothing and put on a tear resistant gown.[7] Mr X followed their instructions.

21. The 'Text of Charge' on Mr X's custody sheet is recorded as *"THREATENS/ATTEMPTS SUICIDE"*. Underneath this, Officer C, the arresting officer, has circled an 'X' (the other option is 'no') and handwritten "1X" in response to 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?"* Underneath this the form states *"If the answer is YES outline reasons and advise Watchhouse Keeper and Supervisor"*.

22. Officer C told the Authority that he spoke to custody staff about what had happened at Mr X's address, as he was instructed to do by Officer A.

23. Officer C also wrote on the 'Health and Safety Management Plan for Person in Custody' (HSMP) *"Talking about suicide for a number of days – Came home from work depressed – tied a strap round his neck & attempted to hang himself – Talked down by partner"*. Officer C recorded on the HSMP that he had called the CRS at 2.30am.

24. Police usually evaluate detainees by asking them risk assessment questions before they are placed in a cell. As Mr X had been taken straight to a cell, he had not been processed in the usual way. Custody Officer F said that Officer C told him that Mr X had attempted suicide that night as he began entering Mr X's details into the electronic custody module (ECM).

25. Custody Officer F then returned to cell F1 to go through the 'Evaluation' questions with Mr X. He typed the answers Mr X had given him into the ECM at about 3.05am.

26. Under the first 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?"*, Custody Officer F selected 'No'. Under the heading 'Mental Health risks', Custody Officer F selected *"Previous attempts or threats to commit suicide"* and *"Outpatient of a mental health service"* from the options available in the dropdown box.[8] 'Comments' that would have had to be either typed or copied into this area by Custody Officer F were *"Has attempted to 1X tonight"*, *"Very emotional"* and *"Concerns for his partners safety"*.

27. Mr X was evaluated initially by Custody Officer F as 'In need of care and frequent monitoring'. His evaluation was then supported by Officer E and confirmed by the automated ECM evaluation.

[7] Custody Officer F has documented a task in the ECM at 3.06am and noted in the comments "*gowned due to 1X tonight*". The Police code '1X' stands for 'threatens/attempts suicide'.
[8] There was a suicidal tendency alert in the Police database relating to an incident that occurred on 9 November 2015 and resulted in Police taking Mr X to Hutt Hospital for a mental health assessment.

28. A 'Notice to Person in Custody' form was completed by Custody Officer F but not signed by Mr X.[9]

29. Custody Officer F said that after speaking to Mr X "*I obviously managed to ascertain that he had [suicidal] thoughts*". However, after going through the questions, Mr X told him that he would not do "*anything silly*" and that he needed to talk to someone. Custody Officer F told him that the CRS had been called.

30. Custody Officer G said that Custody Officer F told him Mr X needed to be frequently monitored because he had attempted suicide. Not long after Mr X had been placed in cell F1, Custody Officer G spoke to him through the cell door. He said Mr X was calm and answered the questions he was asking. About five minutes later, Mr X banged on the cell door and asked Custody Officer G why he had been detained.

31. Custody Officer G said he did not record these two checks on Mr X in the ECM. He was busy processing other detainees and believed they would not affect the required frequent monitoring checks that would be done on Mr X.

32. Custody Officer F also said that Mr X yelled out and banged on his cell door for some time. While processing other detainees, Custody Officer F was aware that Mr X needed to be frequently monitored and checked appropriately. However, he said that the noise Mr X was making reassured him that he was okay.

33. At 3.19am Officer E entered a comment in the ECM regarding Mr X's mental health assessment which stated "*Assessment must be undertaken within 6 hours*".

34. At about 3.30am, two CRS staff members were directed to go to the DCU to assess Mr X. They arrived at Wellington Central Police Station at about 3.45am, however, one of them told the Authority that they could not initially be taken through to the DCU[10] as custody staff were busy processing a number of detainees at the time.[11] It is not clear whether the CRS staff were aware, or advised, that Mr X had earlier attempted suicide when they arrived at the DCU.

35. Once the CRS staff were taken through to the DCU, they tried to access Mr X's mental health records from the dedicated terminal but were unable to do so. At about 3.55am, without having seen Mr X, they left to go to the Emergency Department at Wellington Hospital to access Mr X's records. As there were no custody officers available to monitor an assessment of Mr X at this time, the decision was made by the CRS staff that both of them would go to the hospital, rather than one of them remaining at the DCU.[12] While at Wellington Hospital, the CRS staff found out

[9] As Mr X was not in Police custody but had been detained so that a mental health assessment could be completed, a 'Notice to Person Detained' should have been completed.
[10] In 2015 Police provided CRS staff with access cards so that they could let themselves into the DCU. It Is not clear why the CRS staff members were unable to access the DCU at the time of this incident in October 2016.
[11] The ECM shows that there were another 12 people in custody while Mr X was in custody.
[12] It was contrary to Capital & Coast District Health Board policy for CRS staff to enter the cells without a custody officer being present. They did not consider taking Mr X to hospital for an assessment because they had been told by Police that Mr X was too aggressive and were also of the view that it was likely Mr X would have tried to abscond if he was taken to hospital.

about Mr X's 2015 suicide attempt and called the psychiatric registrar at Hutt Hospital at about 4.10am. She advised she would go to the DCU.

Suicide attempts

36. Meanwhile, at about 4.04am, CCTV footage shows that Mr X grabbed the back of his gown and tried to pull it tight around his neck. He then tried to tear his mattress by biting it.

37. At about 4.17am, Mr X took off his tear resistant gown, placed it on the floor and rolled it up into a tube. He then wrapped the rolled-up gown around his neck momentarily, before putting it back on. This does not appear to have been seen on the CCTV monitor by custody staff.

38. Mr X then knelt on the floor and bent forward and subsequently lay down on the floor on his stomach.

39. Custody Officer F noticed alerts in the ECM regarding checks that needed to be conducted so he did a check of the whole cell block. The check of Mr X was documented at 4.24am with the comment "*Check – breathing visibly and regularly – nil general concerns*".

40. At about 4.23am, CCTV footage shows that Mr X looked out the window of the cell door. He then took off his tear resistant gown. He put his head through an arm hole and the head hole then twisted the rest of the gown and sat down. Mr X then knelt on the ground, twisted the gown again and bent forward. He subsequently fell onto his right side.

41. At about 4.32am, Mr X rolled onto his left side. He twisted the gown again, got back into a kneeling position and bent forward. Custody Officer F saw Mr X on the monitor a couple of minutes later and ran to his cell. He removed the gown and, as he anticipated that he would have to perform cardiopulmonary resuscitation (CPR), dragged Mr X into the corridor where there was more space. Mr X was unresponsive; he had no eye, voice or motor response.

42. Custody Officer F yelled for assistance. He managed to locate a strong carotid (neck) pulse and could see that Mr X was breathing. He also ensured Mr X's airway was clear and tilted his head back to maintain his airway. At this point, Custody Officer H arrived to assist. Both custody officers tried to contact CentComms so that an ambulance could be called but they could not get radio reception in the cell block. Custody Officer H had to use the base set radio in the processing room to call CentComms and request an ambulance.

43. As Custody Officer F was concerned about Mr X's shallow breathing, he asked Custody Officer H to bring him a manual resuscitator to assist his breathing. He then located a strong radial (wrist) pulse.

44. Officer E was at the District Command Centre[13] looking for the appropriate form to complete in relation to Mr X's detention[14] when she heard Custody Officer H request an ambulance for an attempted suicide on her radio. She ran to the cell area immediately to offer assistance.

[13] The main focus of the District Command Centre (DCC) is to plan, deploy, and monitor the prevention activities across the District. The DCC manages all District deployable resources under the direct command of the District Commander.

45. An ambulance arrived at 4.42am and Custody Officer F assisted ambulance staff.

46. The CRS staff returned to the DCU just after ambulance staff arrived and were told that paramedics were assisting Mr X. One of the CRS staff members told the Authority that he advised Police at this time of Mr X's attempt in November 2015, which was the attempt already noted in the Police database (see footnote 8). The psychiatric registrar arrived shortly afterwards.

47. Mr X was initially taken to Wellington Hospital, then transferred to Hutt Hospital. He remained in the care of mental health services for a month after this incident.

POLICE INVESTIGATION

48. Police carried out an investigation into the actions of DCU staff with regard to the custody management and attempted suicide in custody of Mr X on 9 October 2016. This investigation made a number of recommendations in relation to Police policy and practices within the DCU and staff training.

THE AUTHORITY'S INVESTIGATION

49. During its investigation, the Authority interviewed Officers A, B, C and D (who attended at Mr X's address) and Officer E and Custody Officers F and G (custody staff). Ms Y was also interviewed by phone.

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

    1) Was it appropriate for Police to detain Mr X?

    2) Was Mr X evaluated and monitored appropriately while at the DCU?

    3) Was Mr X provided with the appropriate medical assistance after his suicide attempt?

[14] The form that Officer E completed had the question "*If detained, please specify what legislation has been used for detention*". Officer E had either typed or selected "*Section 109 Mental Health Act 1992*". Officer E told the Authority that one of the CRS staff members advised her to complete the form in this manner in order to get a duly authorised officer (DAO) to attend.

THE AUTHORITY'S FINDINGS

Issue 1: Was it appropriate for Police to detain Mr X?

Did Police have the authority to detain Mr X?

51. Section 41 of the Crimes Act 1961 (see paragraph 93) provided Officer A with the justification to use reasonable force when breaking into Mr X's block of flats to prevent Mr X from committing suicide.[15]

52. If Mr X had been found in a public place, section 109 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 would have provided appropriate authority for Police to detain Mr X for no longer than six hours for the purposes of a medical examination.[16]

53. Officer E told the Authority that, during her phone conversation with Officer A, he acknowledged that Police did not have grounds to detain Mr X under section 109 of the Mental Health (Compulsory Assessment and Treatment) Act because Mr X was at his address and not in a public place. However, Officer A said Police had a duty of care to Mr X and needed to ensure he was safe.

54. Section 109 did not apply, and the Authority is of the view that it is unlikely that section 41 of the Crimes Act could be used to justify Mr X's ongoing detention by Police for any significant period of time. However, as Mr X had attempted suicide a number of times that evening and probably would have continued to do so if Police had left the address and not detained him, Police were justified in detaining him. Police had a duty of care to Mr X and detaining him was reasonable in the circumstances.

Would it have been more appropriate for Police to arrange for a CRS staff member to assess Mr X at his address?

55. Police policy (see paragraph 94) states that the preferred places to carry out mental health assessments are a person's home or a health facility, and that these options should be explored before a person is taken into Police custody.

56. The District Custody Hub (Wellington) local order (see paragraph 100) states that a "*violent or aggressive*" person who needs a mental health assessment should be taken to the DCU.

57. Officer A told the Authority that the CRS was not contacted to get them to come to Mr X's address. Although he considered doing so, he decided that "*due to [Mr X's] behaviour it wouldn't have been a safe environment for him to be assessed*".

58. The consensus of the accounts of the attending officers (see paragraphs 9 and 11) is that, although Mr X could be described as non-compliant when they arrived, he was not violent or

[15] Officers A and B said they relied on section 14(1) of the Search and Surveillance Act 2012, however, section 41 of the Crimes Act specifically allows for the use of force so was the more appropriate provision to rely on.

[16] Section 41 of the Mental Health (Compulsory Assessment and Treatment) Act also provides authority for Police, when called to assist a duly authorised officer (DAO), to detain a person for no longer than six hours so that a medical examination can be conducted.

aggressive towards them at this stage. It was not until Mr X was advised that he was being taken to the DCU, and as he walked toward the door, that he became aggressive and needed to be restrained by Officers B and C.

59. Officer C also told the Authority that Mr X's address was not an appropriate place for him to be assessed. It was cramped and there were a number of potential weapons nearby that Mr X could have used on himself or someone else. However, any visible weapons could have been secured by attending Police.

60. The Authority is of the view that, given Mr X's non-compliant behaviour and Police policy, it would have been preferable for attending Police to have contacted the CRS to see if it were possible for a DAO to come to the address within a reasonable timeframe to assess Mr X, or to see if an assessment could be conducted over the phone.[17]

Would it have been more appropriate for Police to take Mr X to hospital?

61. Officer A considered that it would have been unsafe to take Mr X to hospital due to his behaviour. Officers B and D did not recall any conversation around taking Mr X to hospital. Officer C told the Authority that Mr X was too unpredictable to be taken to hospital, and Officer E, who was not one of the attending officers so did not witness Mr X's behaviour, said:

> *"Because [Mr X] was violent at the time towards [Ms Y], as well as attending Police, it was decided that … it wasn't safe for our staff or for hospital staff for him to be assessed at the hospital and that he would need to be transported to the District Custody Hub so that we could ensure everyone's safety as well as that of the CAT team when they arrived."*

62. The Authority is of the view that it would have been preferable for attending Police to have discussed taking Mr X to hospital before telling him he was going to be taken to the DCU. Hospital was the more appropriate place for Mr X to get the care that he needed, although Police may have had to stay with him initially or while he was being assessed to ensure the safety of hospital staff.

FINDINGS

Police had a duty of care to Mr X and were justified in detaining him.

It would have been preferable if Police had tried to contact the CRS to find out if a DAO was available to come to Mr X's address to assess him or could conduct an assessment over the phone.

It would also have been preferable if Police had discussed taking Mr X to hospital before telling him he was going to be taken to the DCU.

[17] After this assessment, the DAO may then direct Police to take the person to another location for further assessment under the Mental Health (Compulsory Assessment and Treatment) Act.

Issue 2: Was Mr X evaluated and monitored appropriately at the DCU?

Evaluation

63. Mr X had attempted suicide immediately before being detained by Police and custody staff were made aware of this through conversations between Officers A and E, and Officer C and Custody Officer F. The paperwork completed by Officer C (custody sheet and HSMP) also made it clear that Mr X had attempted suicide before coming into Police custody.

64. Mr X was evaluated initially by Custody Officer F as 'In need of care and frequent monitoring'. His evaluation was then supported by Officer E and confirmed by the automated ECM evaluation.

65. Currently information that is typed or copied into the 'Comments' box under the 'Mental Health risks' section of the ECM evaluation (see paragraph 26) does not form part of the automated evaluation. In this case, it meant that relevant information Custody Officer F put into the 'Comments' box in Mr X's evaluation ("*Has attempted to 1X tonight*") did not form part of the automated evaluation. If the information about Mr X attempting suicide that night had formed part of the automated evaluation, it may have resulted in an automated evaluation of 'In need of care and constant monitoring', rather than 'In need of care and frequent monitoring'.

66. Despite the automated evaluation confirming Custody Officer F's assessment of 'In need of care and frequent monitoring', the Authority is of the view that Officer E should have overridden that evaluation. She should have recognised that, since Mr X had attempted suicide immediately before coming into Police custody, he needed to be evaluated as 'In need of care and constant monitoring' until CRS staff were able to assess him.

Monitoring

67. From the Authority's finding above, it follows that Mr X should have been constantly, rather than frequently, monitored. Police policy requires people under constant monitoring to be "*directly observed without interruption*".

68. Officer E told the Authority that she did not have any concerns that frequent monitoring might not be sufficient, and she gave no consideration to constant monitoring until CRS staff were able to attend.

69. In his Police statement, Custody Officer F stated:

> *"I did not evaluate him as needing constant monitoring as he was compliant, non-aggressive and conversing freely with me. He was calming down well and his agitation was significantly reduced.*
>
> *…*
>
> *I discussed [constant monitoring] with my supervisor and we both agreed that frequent monitoring was sufficient in the circumstances."*

70. When interviewed by the Authority, Custody Officer F said:

"… after having evaluated him for things that he presented to me, of things he'd said and obviously the things he'd told me and the circumstances in my opinion at that time, I didn't think necessary to put him on constant monitoring."

71. As Mr X was evaluated as 'In need of care and frequent monitoring', Police policy required that he be checked at least five times an hour.[18]

72. However, after being placed in a cell at 3.06am, the documented checks of Mr X show that he was checked only once at 4.24am, before his suicide attempt was discovered at about 4.35am. In relation to the lack of documented checks of Mr X, Officer E told the Authority:

"… we were busy and we had other people in cells as well … that were on frequent [monitoring] and we did the amount of checks that we could with the staff that we had."

73. As outlined at paragraphs 30 and 31, Custody Officer G said he conducted two checks of Mr X not long after he was placed in cell F1 but did not document these checks. Even allowing for these undocumented checks, Police policy was still not adhered to in relation to the frequent monitoring of Mr X.

FINDINGS

Mr X was inappropriately evaluated as 'In need of care and frequent monitoring'. Officer E should have recognised that he needed to be evaluated as 'In need of care and constant monitoring' until the CRS staff were able to assess him, and should have overridden Custody Officer F's evaluation and the automated evaluation.

Mr X should have been constantly monitored. However, as he was evaluated as 'In need of care and frequent monitoring', Officer E should have ensured that Mr X was at least frequently monitored.

Issue 3: Was Mr X provided with appropriate medical assistance after his suicide attempt?

74. CCTV footage shows Mr X removing his tear resistant gown at about 4.23am. He then put his head through one of the arm holes and the head hole started twisting the rest of the gown.

75. Custody Officer F saw Mr X's suicide attempt on the CCTV monitor at about 4.35am and immediately ran to his cell. Mr X appears unresponsive in the CCTV footage when he is found by Custody Officer F.

76. Custody Officer F removed the gown from around Mr X's neck and pulled him into the corridor, where there was more space, so that he could start providing medical assistance. He then yelled for assistance from his colleagues.

[18] The requirement for these checks to be at irregular intervals has been reintroduced in the current 'People in Police detention' policy.

77. Custody Officer F told the Authority that he anticipated that he would need to perform CPR. At the time, he was an operational frontline ambulance officer studying towards becoming an emergency medical technician. He treated and assessed Mr X in accordance with this training. He then located a strong carotid pulse on Mr X so performed a jaw thrust to ensure that there was nothing precluding his airway and tilted his head back to maintain his airway.

78. When Custody Officer G arrived at the cell, Custody Officer F asked him to request an ambulance. He tried himself to request one via his radio but had no reception. Custody Officer F also asked Custody Officer G to bring him a resuscitation kit as he was concerned about Mr X's shortness and shallowness of breath. He used a bag valve mask to assist Mr X's breathing.

79. An ambulance arrived at the DCU at about 4.42am. Custody Officer F continued to assist ambulance staff. Back-up paramedics and an intensive care paramedic also arrived.

80. As soon as Custody Officer F saw on the CCTV monitor that Mr X was attempting suicide, he immediately rushed to the cell and provided medical assistance. Given his background, Custody Officer F was able to provide a higher standard of care than a custody officer would normally be able to provide.

FINDING

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

CONCLUSIONS

81. The Authority finds that:

1) Police had a duty of care to Mr X and, given his state of mind and determination to harm himself, they were justified in detaining him. It would have been preferable if Police had tried to contact the CRS to find out if a DAO was available to come to Mr X's address to assess him or conduct an assessment over the phone. It would also have been preferable if they had discussed taking Mr X to hospital before telling him he was going to be taken to the DCU.

2) Mr X was inappropriately evaluated as 'In need of care and frequent monitoring'. Officer E should have recognised that he needed to be evaluated as 'In need of care and constant monitoring' until CRS staff were able to assess him, and should have overridden Custody Officer F's evaluation and the automated evaluation. Mr X should have been constantly monitored. However, Officer E should have ensured that Mr X was at least frequently monitored.

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

SUBSEQUENT ACTION

82. Officers A, C, D and E have received expectation setting conversations from Police in relation to the appropriate application of section 109 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

83. Officer E and Custody Officers F, G and H have received expectation setting conversations from Police in relation to Police policy around checks of detainees who are evaluated as 'In need of care and frequent monitoring'.

84. The Authority has been working with Police to ensure that frontline staff have a clear understanding of the appropriate application of section 14 of the Search and Surveillance Act 2012, section 41 of the Crimes Act 1961 and section 109 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. Police advise that a notice explaining the difference between these provisions will shortly be released to staff.

85. As outlined at paragraph 42, Custody Officers F and H were unable to contact CentComms after Mr X's suicide attempt was discovered because of poor radio reception. The inability to effectively communicate via Police radios, or cell phones, in custody areas, where there are large amounts of concrete, is not limited to Wellington DCU. A national solution is being sought. In the interim, custody staff have access to personal alarms on their uniforms in case of emergencies.

RECOMMENDATION

86. As outlined at paragraph 65, information that Custody Officer F put into the 'Comments' box in Mr X's evaluation about him attempting to commit suicide that night did not form part of the automated evaluation. If it had, it may have resulted in an automated evaluation of 'In need of care and constant monitoring', rather than 'In need of care and frequent monitoring'.

87. The Authority recommends that New Zealand Police review whether the 'Previous attempts or threats to commit suicide' option in the dropdown menu under the 'Mental Health risks' section of the ECM evaluation adequately reflects when someone has made a recent suicide attempt or a suicide attempt immediately prior to coming into Police custody.

Judge Colin Doherty

Chair

Independent Police Conduct Authority

12 July 2018

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'People with mental impairments' policy

88. Police have no power under the Mental Health (Compulsory Assessment and Treatment) Act 1992 to enter private property or to detain a person with a mental disorder on private property, unless asked to do so by a duly authorised officer (DAO) or medical practitioner.

89. When dealing with a person with a mental disorder on private property, Police should use the operational threat assessment tool, TENR, to assess the threat, exposure, the necessity to act now, later or not at all, and to develop an appropriate response. In appropriate circumstances, as required by the Police operating strategy, Prevention First, Police should consider the use of Police discretion and alternative resolutions.

90. If action is required, an appropriate response may involve seeking help from the DAO, the person's doctor, family, friends or associates or using other legislation to enter the premises.

91. Like members of the public, Police officers have an implied licence to enter a property. If requested to leave by a lawful occupier of the property, Police must do so if they do not have a lawful justification to remain on the property. Police can also enter a property if requested to do so by a lawful occupier of that property.

Relevant legislation

92. Section 14 of the Search and Surveillance Act 2012 allows Police officers to enter private property or a vehicle without a warrant if it is suspected there is a risk to life or safety that requires an emergency response. It also allows warrantless entry if officers have reasonable grounds to suspect that their entry will stop or prevent an offence being committed that might injure someone, damage or cause serious loss of property.

93. Under section 41 of the Crimes Act 1961, Police can use such force as may be reasonably necessary to prevent a suicide or the commission of any offence that would be likely to cause immediate and serious injury to anyone, or serious damage or property, or to prevent an act that they believe, on reasonable grounds, would amount to suicide if committed.

'People in Police detention' policy

94. This policy states:

> *"Mental health assessments should wherever practical be carried out in the least restrictive environment. The preferred option is the person's home or a health facility. The custody area should only be used after all other options have been explored."*

95. The 'Procedures for custody area staff' states that custody staff must:

> *"evaluate and classify the detainee into one of the following categories:*
>
> - *Not in need of specific care*
> - *Care and frequent monitoring*
> - *Care and constant monitoring."*

96. Frequent monitoring requires a detainee to be checked at least five times an hour. At the time of this incident, the policy did not state the checks were to be at irregular intervals. However, it did state this in earlier iterations of the policy and is also now in the current policy.

97. Constant monitoring requires a detainee to be "*directly observed without interruption*".

98. The policy includes a 'Procedure when suicide attempt discovered'. The first three steps of the procedure are:

    1) the staff member identifying the attempt asking another staff member to obtain medical assistance;

    2) intervening to stop the attempt; and

    3) carrying out any necessary first aid.

District Custody Hub (Wellington) local order

99. This Order starts that, in accordance with Police instructions, any person suffering mental distress who requires assessment should not be returned to a Police station *"unless they are violent or aggressive*".

100. The Order requires any person who is mentally unwell or has threatened or attempted suicide and is violent and aggressive to be brought into the DCU. When transporting such a person to the DCU, officers should contact their local CRS/CAT team who have been advised that all such assessments will be done at the Wellington DCU.

101. The Order also states that all persons suffering mental distress who are not violent and aggressive must be taken to local emergency departments. If any of these persons are brought into the DCU, the DCU supervisor will refuse to accept the person and the staff member will be required to take the person to the local emergency department.

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.

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