



**IPCA**

Independent Police  
Conduct Authority

Whaia te pono, kia puawai ko te tika

# **Review of Police Custodial Management**

*March 2015*

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# 1 Introduction

## THE ROLE OF THE INDEPENDENT POLICE CONDUCT AUTHORITY

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1. Under the Independent Police Conduct Authority Act 1988, the Authority has the function of receiving complaints alleging misconduct or neglect of duty by any Police employee, or concerning any practice, policy or procedure of the Police affecting the person or body of people making the complaint. The Authority may then determine what action to take in relation to a complaint, such as to investigate the complaint itself, or refer the matter back to Police for investigation by the Police.
2. The Commissioner of Police is required by section 13 of the Independent Police Conduct Authority Act 1988 to notify the Authority whenever “*a Police employee acting in the execution of his or her duty causes, or appears to have caused, death or serious bodily harm to any person.*” The Authority may then conduct an independent investigation into the incident if it is satisfied that there are reasonable grounds to do so in the public interest.<sup>1</sup>
3. In addition, the Authority has entered into a Memorandum of Understanding with Police under which the Commissioner of Police may notify the Authority of incidents involving criminal offending or serious misconduct by a Police employee, where that matter is of such significance or public interest that it places or is likely to place the Police reputation at risk. The Authority may act on these notifications in the same manner as a complaint.
4. The incidents which have been reviewed for the purposes of this report have come to the attention of the Authority through both complaints and notifications from Police.

### Optional Protocol to the Convention against Torture

5. The review detailed in this report was conducted not only as part of the Authority’s statutory role to oversee Police conduct, but also in pursuance of the Authority’s role as a National Preventive Mechanism (NPM) under the Optional Protocol to the Convention against Torture (OPCAT).<sup>2</sup> The OPCAT is designed to assist States in meeting their obligations to take effective measures to prevent torture and ill treatment. It does so by the establishment of a dual system of preventive monitoring by both international and national monitoring bodies.
6. The Authority, in its NPM role, is a national monitoring body with jurisdiction to monitor the treatment of people who are held in Police cells or otherwise in Police custody.
7. Pursuant to this role, the Authority is currently working with Police to develop National Standards for Police custodial facilities, including the care and management of prisoners. It is intended that these standards will be finalised by 30 June 2015. When they are in place, the

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<sup>1</sup> Section 12(1)(b).

<sup>2</sup> Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (signed 18 December 2002, entered into force 22 June 2006).

Police will report to the Authority annually on the extent to which they are complying with those standards, and the Authority will periodically conduct audits of those reports. The issues raised in this report are being taken into account during the development of the standards.

## THE ROLE OF POLICE

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8. The Police's traditional role is the maintenance of law and order. This is reflected in many of the Police functions listed in the Policing Act 2008, including: keeping the peace; maintaining public safety; law enforcement; and crime prevention.<sup>3</sup>
9. Police perform many functions beyond this traditional role, including: conducting search and rescue operations; education; and emergency management. Given this multi-functional role, Police are often referred to as a 24/7 emergency service.
10. Many of these broader functions are directed towards minimising potential harm. In particular, Police deal with an increasing number of people who have not necessarily committed an offence, but who are vulnerable due to intoxication, mental impairment and/or suicidal tendencies. The impact of these broader functions is experienced particularly acutely in the custodial management context, and gives rise to many of the issues discussed later in this report.

## REVIEW OF POLICE CUSTODIAL MANAGEMENT

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11. In 2013–2014 the Independent Police Conduct Authority conducted a review of 31 incidents that occurred in Police custody during the years 2012–2014. These incidents include cases of injury, self-harm and suicide attempts that have come to the attention of the Authority as a result of a complaint, or a referral under section 13 of the Independent Police Conduct Authority Act 1988 or under the Memorandum of Understanding in place between Police and the Authority.
12. The Authority has analysed the identified incidents and assessed the policies, practices and procedures of the Police for managing people in custody.

### The purpose and scope of this report

13. The purpose of this report is twofold: to identify systemic issues and recurring problems in Police custodial management practices and procedures that may have been contributing factors in the incidents of injury or self-harm reviewed for this report; and to facilitate debate about the appropriate initiatives to address those issues and problems.
14. The report is divided into seven key parts:
  - information on Police custodial management;

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<sup>3</sup> Section 9.

- the Police’s powers of arrest and detention;
  - the ways in which people may be held in Police custody;
  - the legal duty of care owed by Police to people in custody;
  - Police policy which governs the care and management of people in custody;
  - the recurring problems in Police custodial management; and
  - the systemic and organisational deficits which, in the Authority’s view, have contributed to these problems.
15. Although the 31 cases reviewed for this report constitute a small proportion of the total number of people detained by Police each year, it should be noted that these are only the cases where something has gone wrong. The Authority is satisfied that the systemic issues which contributed to these incidents have a wider application than the 31 reviewed cases. For instance, the Authority’s discussions with Police and Area Mental Health Services staff have clearly shown that the problems with the way Police respond to mentally impaired persons are commonplace.
16. This report does not propose specific changes to existing policy or practice. This is for two reasons. First, the Authority has not analysed the various policy options that could be used to address the issues identified. Second, some of the weaknesses in the current system cannot be attributed to Police alone and in order to be effectively addressed require an inter-agency response. It is beyond the jurisdiction of the Authority to propose reforms that affect agencies other than the Police.

## THE AUTHORITY’S PREVIOUS WORK ON POLICE CUSTODIAL MANAGEMENT

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17. This report follows the Authority’s 2012 *Deaths in Custody – A Ten Year Review*, which examined the circumstances of 27 deaths that occurred in Police custody in the period 2002–2012. It identified recurring issues and made a number of recommendations to Police regarding improvements to Police policies and procedures in order to reduce the likelihood of deaths in custody. In the report, the Authority recommended that Police:
- 1) ensure that the training provided to staff reinforces the dangers associated with restraining people in a prone position with their hands tied behind their back;
  - 2) ensure that the training provided to staff reinforces the risks of positional asphyxia and other restraint-related medical conditions, and the appropriate tactical options for dealing with people who may be affected by these conditions;
  - 3) amend the custody/charge sheet to include a prompt to search the detainee and to record the outcome of the search;
  - 4) amend the risk evaluation in the electronic custody module and the custody/charge sheet so that the questions relating to the medical condition of the detainee are

grouped together (including questions about injury, illness or pain) and separated from the suicide risk indicators;

- 5) amend the risk evaluation in the electronic custody module and the custody/charge sheet to include questions in respect of the level of consciousness of the detainee and the possible presence of a head injury;
- 6) amend the electronic custody module and the custody/charge sheet to indicate that detainees who are unconscious or semi-conscious, unable to answer the risk assessment questions, and/or physically unable to look after themselves must be taken to hospital (as per the *Managing Prisoners* policy);
- 7) provide custody staff with clearer guidelines in relation to the checking and rousing of detainees (particularly those under the influence of alcohol or drugs);
- 8) provide custody staff with objective guidance (in the *Managing Prisoners* policy, the electronic custody module and the custody/charge sheet) as to when a detainee should be assessed as being in need of care and frequent or constant monitoring;
- 9) amend the *Managing Prisoners* policy so that it clearly states that detainees assessed to be in need of care and frequent or constant monitoring must be examined by a Police Medical Officer, duly authorised officer (DAO) or community assessment team (CAT) member;
- 10) amend the "*Health and Safety Management Plan*" form so that it clearly states the requirement for custody staff to call a Police Medical Officer, DAO or CAT member to examine a detainee because he or she has been found to be in need of care and frequent or constant monitoring, and includes a prompt for the custody officer to create a NIA alert when the detainee has been assessed to be in need of care while in custody;
- 11) amend the Police *Managing Prisoners* policy to direct that custody staff are required to record and explain any decision not to contact a family member or other appropriate person when they are going to release a detainee that has been found to be in need of care (and frequent or constant monitoring) while in custody;
- 12) amend the *Managing Prisoners* policy to direct that custody staff are required to record and explain any decision not to contact a health professional for advice as to whether a detainee's medication should be administered by a health professional;
- 13) amend the *Managing Prisoners* policy so that, in addition to being required to create NIA alerts when a detainee is known to have suicidal tendencies, custody staff are required to create a NIA alert when it is known that the detainee is a drug user or suffers from an ongoing medical condition;
- 14) develop a formal shift handover process in respect of the care of detainees for inclusion in the *Managing Prisoners* policy;
- 15) continue to remove all potential hang points and CCTV blind spots, and to assess all Police cells, including holding cells and day rooms, for suicide risks;

- 16) work with the Ministry of Health towards extending the watch-house nurse programme so that custody staff nationwide have better access to medical advice for the care of detainees;
- 17) continue developing a national training module to meet the requirements of employees assigned to duties in the watch-house, with particular emphasis on responsibilities for the evaluation of risk and the care and protection of persons in custody (as the Authority previously recommended in its report on the death of Francisco Javier de Larratea Soler, published on 1 July 2011);
- 18) work with the Ministry of Health and other appropriate stakeholders towards the establishment of detoxification centres or temporary shelters in order to provide appropriate medical care for heavily intoxicated persons;
- 19) resume working with the Authority towards the establishment of a framework for near miss reporting; and
- 20) engage with the Authority to develop an OPCAT awareness strategy and advance the agreed plan to develop an IPCA/Police OPCAT panel. The OPCAT awareness strategy and joint panel will provide a platform for raising staff awareness about custodial issues and enable effective implementation of custody-related recommendations.

18. Police have fully implemented recommendations 1, 2 and 9. A number of other recommendations have been partially implemented or are addressed by Police practice and procedure in other ways:

- concerning recommendation 3, the custody/charge sheet does not include a prompt to search a detainee, but the *Managing Prisoners* policy requires officers to search every detainee received at the watch-house and to record prisoner searches in the custody management console;
- concerning recommendation 4, the risk evaluation form includes a group of questions about whether a detainee has any health conditions, but in the questions dealing with indicators of previous suicide or attempted suicide in custody, it asks if the detainee has any “*Signs of being in pain*”, which more appropriately falls under the health conditions category;
- concerning recommendation 7, the *Managing Prisoners* policy was amended so that when detainees do not respond to a type of check, officers must perform a more in-depth type of check until they establish the prisoner’s wellbeing; and
- concerning recommendation 10, the *Managing Prisoners* policy was amended so that officers must seek a medical examination for detainees assessed as requiring care, but whether an alert is created is assessed by the custody supervisor, with that assessment automatically recorded on the Police computer so that officers can access it the next time the person is received in custody and assessed.

19. In respect of recommendation 15, Police are in the final stage of a 10-year project to remove ligature points from Police cells nationwide. Police have also informed the Authority that some of the recommendations are being addressed in the following ways:
- Police updated the *Mechanical Restraints* chapter of the Police manual to include more detailed guidance on the risks which contribute to positional asphyxia;
  - Police are in the process of replacing restraint boards, used to tie down aggressive or violent detainees, with restraint chairs nationwide;
  - where practicable Police employ full time staff at major custody units, rather than rotating officers into custody roles for short periods of time (usually six months), to ensure consistency of custodial management training and expertise in custody staff;
  - Police National Headquarters and the Ministry of Health have discussed 'sobering up services' (as opposed to Detoxification Centres), and some District Health Boards and Police districts have trialled a variety of these services; and
  - under the 'Joining Forces Programme' Police and the Department of Corrections continue to work together to improve their custodial management procedures, processes and training.
20. However, Police have not made changes to policy or practice which directly implement recommendations 5, 6, 8, 11, 12, 13 and 14.

## Glossary of terms

Abbreviation/term	Explanation
AO	Authorised officers are non-constabulary Police employees authorised to exercise many of the powers of Police constables, except the power of arrest.
CAT	Community Assessment Teams provide assessment and short-term treatment services for people who may be mentally disordered, or who are experiencing a serious mental health crisis. They are also known as the Community Assessment and Treatment Team, Crisis Assessment Treatment Team, or Psychological Emergency Team.
CMC	The Custody Management Console is the NIA programme used to manage people detained at Police custody facilities. It displays information about each detainee including, if applicable, their level of risk and care required in custody. It is used in conjunction with the NIA Electronic Custody Module.
Constabulary	Police employees who have graduated from the Royal New Zealand Police College (RNZPC) and have taken the Constable's oath under section 22 of the Policing Act 2008. The constabulary officers most involved in managing people in custody are constables, sergeants, senior sergeants and inspectors.
DAO	Duly Authorised Officers are chosen by Directors of Area Mental Health Services to perform the functions and exercise the powers conferred on them under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Usually a registered nurse, DAOs must be trained and competent to deal with mentally disordered people.
Detainee	A person in Police custody.
DCU	District Custody Units are the central facility in some Police districts where all people detained in overnight Police custody are taken.
ECM	The Electronic Custody Module is the part of NIA that Police use when they process and evaluate detainees at Police custody units. It is used in conjunction with the NIA Custody Management Console.
Frontline response staff	Police constabulary officers, with the powers and duties attached to that office, and who are available to attend incidents and offences.
HSMP	The <i>Health and Safety Management Plan</i> is the form that custody officers complete when they assess that a detainee requires care and frequent or constant monitoring while in Police custody. When completed properly, the HSMP outlines what actions Police custody unit staff need to take to care for the detainee and minimise risks, and records that staff's actual action.
Mental disorder	Mental disorder is defined in the Mental Health (Compulsory Assessment and Treatment) Act 1992 to mean an abnormal state of mind characterised by delusions, or by disorders of mood or perception or volition or cognition, that is of such a degree that it poses a serious danger to the health or safety of the person affected or seriously diminishes his or her capacity to care for himself or herself.
Mental distress	After receiving feedback from focus groups, in 2014 Police adopted the term mental distress to describe people who Police interact with because of concerns about their mental health. In this report the term is confined to people who, as a result of their mental impairment or disorder, behave in a distressed manner.
Mental impairment	This term is not defined in legislation. Police policy refers to its ordinary meaning: " <i>a person who has sustained loss to their mental functioning for any reason.</i> " It includes mental disorder and intellectual disability and in the Police context may include mental distress.
NIA	The National Intelligence Application is the New Zealand Police computer system

	which Police officers use most often.
PMO	A Police Medical Officer is a general practitioner on a roster who Police may call to ask for assistance with medical matters. This may include assessing and treating physical injuries in a custody unit, forensically examining victims and taking blood from people suspected of driving while intoxicated in a Police station, or certifying that life is extinct where appropriate. Police may also call a PMO to assess the risk for people with suspected mental health issues.

## 2 Overview of Police Custodial Staff and Facilities

### INTRODUCTION

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21. To provide context for this review, this part provides information on the staff and facilities that Police use to manage people in custody.<sup>4</sup> It is in two sections:
- the types of Police employees working in Police custodial facilities, and an outline of their training; and
  - the types of Police custodial facilities and how they are staffed.
22. The information provided in this part covers the twelve Police districts in New Zealand: Northland; Waitematā; Auckland City; Counties Manukau; Waikato; Bay of Plenty; Eastern; Central; Wellington; Tasman; Canterbury; and Southern.

### POLICE CUSTODIAL STAFF AND TRAINING

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23. This section describes the two types of Police officers involved in Police custodial management: frontline response staff and authorised officers. It then outlines the general custodial management training they each receive.

#### Police frontline response staff

24. Police frontline response staff are constables deployed to undertake a broad range of general frontline Police duties.
25. Prior to becoming sworn constables, all Police recruits must complete 18 weeks training at the Royal New Zealand Police College (RNZPC).

#### Authorised officers

26. Authorised officers are non-constabulary Police employees authorised to exercise certain powers of Police constables, except the power of arrest, under a warrant from the Commissioner of Police. Those who work in a custody role are authorised to perform the role of 'Police jailer and escort'.<sup>5</sup>

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<sup>4</sup> This information was provided by individual Police Districts in response to a request by the Authority. This section therefore reflects the information provided.

<sup>5</sup> Policing Act 2008, s 24 and pt 1, Sch 1.

27. The powers of authorised officers warranted as a Police jailer and escort under the Policing Act 2008 include powers to:<sup>6</sup> search detainees;<sup>7</sup> take identifying information from them;<sup>8</sup> and care for intoxicated people in Police custody.<sup>9</sup>
28. Police do not have a standardised national training programme for authorised officers. Individual Police districts determine the content of authorised officer training. The duration of individual district training programmes range from:
- three weeks (one district, Counties Manukau); to
  - two weeks (four districts); and
  - approximately one week (seven districts).

### **Custodial Management Suicide Awareness training**

29. Custodial Management Suicide Awareness (CMSA) training is a national mandatory requirement for all Police employees involved in the detention or arrest of people, or their care in custody. Police employees must hold a current First Aid Certificate to undertake CMSA training.
30. The duration of the CMSA training is four and a half hours. The topics it covers are:
- the duty of care Police owe to people in custody; and
  - how to identify suicidal warning signs in Māori and non-Māori people in Police custody.
31. Based on the documentation used in the CMSA programme, and provided to the Authority, it is apparent that CMSA training does not directly address the risk assessment or management of detainees who are mentally impaired or under the influence of alcohol, other drugs and/or solvents.

### *Further custodial management training for constables*

32. Constables complete CMSA training when they undergo initial training as recruits. After graduation, constables must complete a one hour online CMSA 'refresher training' course every two years.
33. Some districts provide additional training to constables immediately before they are deployed to work in a custody facility:

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<sup>6</sup> Schedule 1(1). Under section 26 of the Act, authorised officers have the same responsibilities and obligations of a constable when exercising these powers.

<sup>7</sup> Search and Surveillance Act 2012, s 11.

<sup>8</sup> Policing Act 2008, s 32.

<sup>9</sup> Section 36.

- Northland District provides specialised custodial training in the use of the restraint chair;<sup>10</sup>
- Auckland City District requires incoming sergeants to sit alongside the outgoing sergeant for three days to gain an understanding of custodial processes; and
- Counties Manukau District provides sergeants (who are the only constables in the watch-house) with the District standard operating procedures for custodial management and the desk file, and a one day induction with an experienced custody sergeant.

34. However, in most districts and custody facilities additional custodial management training for constables who work in the watch-house takes the form of on the job training.

#### *Further custodial management training for authorised officers*

35. Authorised officers complete the same CMSA training package as constables when they undergo their initial training in each district.

36. The majority of districts also provide training in:

- the Police *Managing Prisoners* policy and the management of detainees;
- staff safety training and tactics, including defensive tactics, the lawful use of force, mechanical restraints, and law and policy relating to searches of detainees;
- law and policy on the powers of authorised officers to take identifying information from detainees, to care for intoxicated people in Police custody (see further paragraphs 58–59) and transporting detainees; and
- the processing of detainees using the Police National Intelligence Application.

37. Some districts supplement this with further training:

- Auckland City District supplements the CMSA programme with sessions in which recruits review extracts from CCTV footage of incidents in custody;
- Southern District provides training on the care and protection of intoxicated people; and
- Counties Manukau District uses training books developed by a senior custody officer which address the risk assessment process and processing mentally impaired detainees.

#### **Mental health awareness training**

38. Police constabulary recruits complete two mental health specific training modules.

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<sup>10</sup> The restraint chair is an inclined chair that uses leg, wrist, waist and chest mechanical restraints to immobilise a person.

39. The first one hour session is led by recruit instructors and covers the roles and responsibilities of Police under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health (CAT) Act 1992).
40. Police redesigned the second two hour session on mental health awareness in 2014. It is now facilitated by mental health service users who are trained to deliver the Health Promotion Agency's "Like Minds, Like Mine" training in a Police context. It covers:
- understanding mental health, and the effect of stigma and discrimination;
  - a Māori and cross-cultural component;
  - empathy;
  - practical advice on responding to the behaviour of a person experiencing mental distress (not diagnosis); and
  - scenarios where staff practise applying theory and being empathetic.
41. As at February 2015, all RNZPC recruit trainers and 260 recruits had completed the re-designed mental health awareness and suicide prevention training session.
42. In addition to these training components, Police will pilot three mental health e-learning modules designed by Otago University in May 2015. Police will train all frontline staff and are considering training other relevant staff, for example, front counter and communications staff, and authorised officers. These modules will be 30 minutes each in duration and cover the same topics as the initial Police recruit training on mental health awareness and Police officers' roles and responsibilities under the Mental Health (CAT) Act 1992.
43. As noted above, authorised officers do not complete these modules. The only district which provides training to authorised officers in dealing with mentally impaired people is Counties Manukau.

## TYPES OF POLICE CUSTODIAL FACILITIES

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### Types of Police custodial facilities

44. Custody facilities are also referred to by the terms 'watch-house' or 'custody suite'. The physical layout of these facilities includes the public counter, the sallyport (secure entryway), holding cells, the detainee receiving and processing area and the cell block.
45. The 437 places of detention Police operate nationwide fall into three categories.<sup>11</sup>
- Police cells which exist at most Police stations. Some cell facilities may only hold detainees temporarily until they can be transported to an overnight custody facility.

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<sup>11</sup> 371 Police cell facilities, including District Custody Units, and 66 court cells.

- District Custody Units (DCU), larger facilities where custody is centralised and where Police take all people they intend to detain overnight. There are DCUs in Henderson, Auckland City, Counties Manukau, Rotorua, Wellington, and Christchurch.
- District Court cells where the Ministry of Justice is responsible for the facility and Police are responsible for detainees.

46. All DCUs and some larger Police cell facilities are gazetted as Police jails under the Corrections Act 2004.<sup>12</sup> Police jails may temporarily hold sentenced or remanded prisoners who would otherwise be in the custody of the Corrections Department (see further paragraph 80).

### Staffing of custodial facilities

47. Police now assign authorised officers to custody functions at many custody facilities. This is distinct from the previous system, in which constables were temporarily assigned to work in custody facilities, usually for a period of about six months. Police constables in custody facilities are now predominantly employed as supervisors.

48. As a result, the main custodial facilities in each district are now generally managed by a Police senior sergeant and staffed by authorised officers, supervised by Police sergeants. For instance:

- at the Auckland City DCU, Police employ five Police sergeants and two relieving Police sergeants who supervise 20 authorised officers. Each shift comprises one Police sergeant who supervises four authorised officers.
- At the Nelson Police Station (a designated Police jail), Police employ one sergeant, four authorised officers and three casual on-call authorised officers, and one constable to relieve for absent authorised officers.
- At the Invercargill Police Station (also a Police jail), Police employ one sergeant who supervises two authorised officers during shifts which are expected to be busy, and one during normally quieter shifts.

49. Some districts employ a mix of authorised officers and constables in non-supervisory roles in custody facilities. For instance, in Bay of Plenty District the Rotorua DCU is staffed by five constables and 21 authorised officers. This is so that the constables may relieve when a sergeant takes leave.

50. Police cells in many smaller locations and in more rural areas are only staffed by constables. This is the case, for instance, in Ashburton and Timaru.

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<sup>12</sup> Corrections Act 2004, s 32.

## 3 Police Powers of Arrest and Detention

### INTRODUCTION

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51. This part of the report discusses the law relating to Police custodial management. In particular, it discusses Police powers of arrest and detention, as well as the powers ancillary to these, and the various circumstances in which people may be held in Police custody.

### POWERS OF ARREST

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52. The standard way a person comes into Police custody is when they are arrested. There are a number of statutory powers under which a Police officer may arrest a person.

#### Breach of the peace

53. Under section 42 of the Crimes Act 1961 a Police officer is justified in arresting any person they witness committing a breach of the peace. Section 315 of the Crimes Act 1961 empowers an officer to arrest without a warrant and take into custody any person the officer has found disturbing the public peace, or has good cause to suspect has committed either a breach of the peace or any offence punishable by imprisonment.
54. It is important to note that these provisions do not provide a Police officer with a power to enter private property in order to arrest someone who has committed or is suspected of having committed a breach of the peace. Nor is a breach of the peace in itself an offence. Arrest for a breach of the peace arguably only allows Police to detain the person for a reasonable period while inquiries are carried out to determine whether the person has committed an offence.

#### Summary offences

55. Section 39 of the Summary Offences Act 1981 empowers a Police officer to arrest without a warrant and take into custody any person who the officer has good cause to suspect has committed an offence against many of the provisions of the Summary Offences Act 1981. Arrest in relation to sections 17–20, 25 and 32–38 of the Summary Offences Act 1981 requires the officer to witness the person doing any act which the officer reasonably believes is an offence against those provisions.

#### Other powers of arrest

56. Other Acts which empower a Police officer to arrest include (but are not limited to):

- the Domestic Violence Act 1995, under which an officer may arrest a person who they have good cause to suspect has contravened a protection order;<sup>13</sup>
- the Land Transport Act 1998, under which an officer may arrest without a warrant a person who they have good cause to suspect has committed an offence against certain provisions of the Act, such as driving under the influence of alcohol and/or drugs,<sup>14</sup> or assaulting an officer in the course of the officer’s official duties;<sup>15</sup> and
- the Alcoholism and Drug Addiction Act 1966, under which an officer may arrest any person ordered by the court to be detained under the Act.<sup>16</sup>

## POWERS OF DETENTION

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57. A person may also enter Police custody as a result of detention without arrest. There are a number of statutory powers under which Police may detain a person without arrest.

### Power to detain intoxicated people

58. Under section 36 of the Policing Act 2008, a Police officer may detain without arrest and take into custody any intoxicated person found in a public place who the officer reasonably believes cannot be cared for by being taken to their place of residence or a temporary shelter. Any intoxicated person detained under this provision must be released from custody as soon as their intoxication decreases to the point where they can look after themselves or after twelve hours, whichever is sooner.<sup>17</sup>

59. The Act defines an intoxicated person as someone who is *“observably affected by alcohol, other drugs, or substances to such a degree that speech, balance, co-ordination, or behaviour is clearly impaired.”*<sup>18</sup>

### Powers to detain people suffering from mental impairment

60. Section 41 of the Crimes Act 1961 empowers a Police officer to detain a person who has threatened or attempted suicide in order to prevent the commission of suicide or acts amounting to suicide. This power may only be exercised in an emergency, where the threat of suicide is imminent, and may not be exercised when the person is simply mentally impaired or there is only a potential risk of suicide.

61. The Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health (CAT) Act 1992) provides for the assessment, treatment and care of people who have, or are

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<sup>13</sup> Section 50.

<sup>14</sup> The relevant provisions are sections 58–62 of the Act.

<sup>15</sup> Section 120.

<sup>16</sup> Alcoholism and Drug Addiction Act 1966, s 14.

<sup>17</sup> The Act defines a temporary shelter as any place not operated by the Police where an intoxicated person may be provided with care and protection.

<sup>18</sup> Section 36(4).

suspected of having, a mental disorder. Under the Mental Health (CAT) Act 1992, Mental Health Services are primarily responsible for providing these services. Police may only provide assistance, and detain people, to the extent provided for in the Act.

62. Section 41 of the Mental Health (CAT) Act 1992 empowers a Police officer to assist a duly authorised officer (DAO) in certain circumstances. DAOs are health professionals with appropriate competence in dealing with mentally disordered people.<sup>19</sup> They act as the “*first point of community contact for mentally distressed persons in the community and those people concerned about the mental health of another person*”,<sup>20</sup> and respond to general enquiries about available mental health services and assessment and treatment under the Mental Health (CAT) Act 1992.<sup>21</sup>
63. DAOs may call Police to ask for officers to assist them to:<sup>22</sup>
- have a person examined by a medical practitioner;<sup>23</sup>
  - forcibly transport the person to a medical practitioner for examination;<sup>24</sup> or
  - take or return proposed patients or patients to a place of assessment or treatment.<sup>25</sup>
64. In all these circumstances, officers may enter a private residence and detain the person for the time it takes to complete the purpose of detention, or for up to six hours, whichever is shorter.<sup>26</sup>
65. Section 110C of the Mental Health (CAT) Act 1992 similarly empowers a Police officer to assist a medical practitioner, statutorily defined as a registered doctor,<sup>27</sup> to:<sup>28</sup>
- examine a person who the medical practitioner reasonably believes is mentally disordered;
  - administer a sedative by restraining the person; or
  - carry out an urgent assessment examination.

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<sup>19</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s 93(2). DAOs are usually a registered nurse specialising in mental health treatment. However, many are not nurses and may not be registered health practitioners. See *Guidelines for the Role and Function of Duly Authorised Officers: Mental Health (Compulsory Assessment and Treatment) Act 1992* (Wellington, Ministry of Health, November 2012) at 16.

<sup>20</sup> *Guidelines for the Role and Function of Duly Authorised Officers: Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health, November 2012) at 1.

<sup>21</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s 37.

<sup>22</sup> Section 41(1).

<sup>23</sup> Section 38(4)(b).

<sup>24</sup> Section 38(4)(d).

<sup>25</sup> Section 40(2).

<sup>26</sup> Section 41.

<sup>27</sup> Section 2 defines a “*medical practitioner*” as “*a health practitioner who is, or is deemed to be, registered with the Medical Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of medicine.*”

<sup>28</sup> Sections 110–110B.

66. In each instance a Police officer may enter premises and detain the person if requested to do so by the medical practitioner. Police may detain the person either at the premises or at a place determined by the medical practitioner, for the time it takes to complete the assessment or for six hours, whichever is shorter.
67. Finally, section 109 of the Mental Health (CAT) Act 1992 empowers a Police officer to detain any person who they reasonably believe to be mentally disordered, and who has been found in a public place, in order for a medical practitioner to examine the person at a Police station or hospital. Officers may only exercise this power when they think it is in the interests of the person or public to do so. Again, they may only detain the person for the time it takes the medical practitioner to examine the person or for six hours, whichever is shorter.
68. An important aspect of section 109 is that it requires officers to have a medical practitioner conduct the medical examination of the potentially mentally disordered person. The requirements of the provision are not satisfied if only a DAO assesses the person. However, a DAO may be called to arrange the examination by the medical practitioner.
69. As is indicated by the previous paragraphs, the Mental Health (CAT) Act 1992 does not empower a Police officer to independently enter private property or detain a potentially mentally disordered person on private property. A Police officer may only do so when a doctor or DAO requests them to.<sup>29</sup> The Act is therefore limited in the powers it confers on a Police officer. This limitation on Police involvement in mental health crises was *“based primarily on the philosophy that mentally disordered persons are sick but not criminal.”*<sup>30</sup> Officers are empowered to deal with apparently mentally disordered people who are in a public place, but cannot independently deal with people who appear to be experiencing mental disorder but are in a private residence.<sup>31</sup>

## FURTHER POLICE POWERS OF DETENTION

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70. The Search and Surveillance Act 2012 empowers a Police officer to detain a person without arrest, they are:
- when exercising a search power in relation to a place or vehicle and the officer needs to determine if there is a connection between a person at the place or vehicle being searched and the object of that search;<sup>32</sup>
  - when removing a person from a search scene in order to secure it;<sup>33</sup> or

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<sup>29</sup> In “Arresting and Detaining the Mentally Disordered: An Analysis of the Statutory Powers” (1994) NZ Recent Law Review 297, at 304 the Author notes *“it is crucial that there be communication between DAOs and the Police ... Failure to ascertain the statutory authority purporting to be invoked by the DAOs may result in unlawful apprehension and detention ...”*

<sup>30</sup> At 305.

<sup>31</sup> At 305.

<sup>32</sup> Search and Surveillance Act 2012, s 118.

<sup>33</sup> Section 116.

- when exercising a power to search a person.<sup>34</sup>

## WARRANT POWERS

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71. The above statutory powers may be exercised without a warrant. In addition to these powers, a court may issue a warrant giving a Police officer the power to arrest. There are various grounds on which a warrant to arrest can be issued, such as: non-appearance at a court hearing;<sup>35</sup> bail-related breaches;<sup>36</sup> and non-payment of fines.<sup>37</sup>

## POWERS INCIDENTAL TO ARREST AND DETENTION

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72. A Police officer may exercise a number of other associated powers in circumstances where they are lawfully exercising a power of arrest or detention.

### Use of force

73. Sections 39 and 41 of the Crimes Act 1961 empower officers to use force reasonably necessary to effect an arrest, and to prevent suicide or any offence likely to cause immediate and serious injury to any person.
74. Similarly, under section 122B of the Mental Health (CAT) Act 1992 officers may, when exercising the powers of detention provided for in the Act and discussed above (see paragraphs 61–67), use force that is reasonably necessary in the circumstances.

### Searching of detainees

75. Under section 11 of the Search and Surveillance Act 2012, officers are empowered to search any person who is lawfully in Police custody and going to be locked up, that is, placed behind a closed or locked door that prevents them from leaving such as a Police cell, charge room or vehicle. After a person has been locked up, they may only be searched again in certain circumstances, for instance, if officers believe the person possesses a harmful object.<sup>38</sup>

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<sup>34</sup> Section 125.

<sup>35</sup> See, for example, Criminal Procedure Act 2011, ss 120–124.

<sup>36</sup> Bail Act 2000, s 37.

<sup>37</sup> Summary Proceedings Act 1957, ss 88–88AC.

<sup>38</sup> Search and Surveillance Act 2012, s 11. Section 85 of the Act authorises a rub down search of a person arrested or detained to ensure that the person is not carrying anything that may be used to harm themselves or others, or facilitate escape.

## 4 Circumstances of Police Custody

76. People may be held in Police custody in a variety of circumstances.
77. First, from the point of arrest or detention, a person is detained and therefore in Police custody while they are being transported to a custodial facility.
78. Secondly, they may be held in a Police custodial facility until they are released or otherwise dealt with under an applicable statutory provision. For example, they may be detained until they are charged and taken to court for an offence, or while they await or undergo an assessment under the Mental Health (CAT) Act 1992.
79. Thirdly, they may be held in Police custody after they have been remanded in custody by the court, either while they are awaiting transport to a correctional facility or after they have been brought back from a correctional facility and are awaiting a court appearance.
80. Finally, Police may assume temporary custody of sentenced or remand prisoners who are normally in the custody of the Department of Corrections. This custody occurs in two circumstances. First, Police may assume temporary custody of such prisoners at Police stations if they are in transit to or from prison.<sup>39</sup> Second, Police may have custody of them at Police cells that have been designated 'Police jails' under the Corrections Act 2004.<sup>40</sup> Corrections prisoners may be held at Police jails when local prisons exceed capacity. The Act limits the period of time such prisoners may be detained in Police jails to seven days, unless that is extended by the chief executive, after consultation with the Commissioner of Police, to 14 days. A Visiting Justice may extend this period a further 14 days on application by the chief executive.<sup>41</sup>
81. In all of the above circumstances of Police custody, Police responsibility for the arrested or detained person's care, safety and security begins when they enter Police custody. It does not end until they are released or transferred into the care of another agency, individual or family member. This is reflected in Police policy, which defines a prisoner as *"any person in lawful Police custody which begins from the time of arrest or receipt into custody, to release or transfer to another agency."*

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<sup>39</sup> Corrections Act 2004, s 35.

<sup>40</sup> Under the Corrections Act 2004, a Police custody facility may be declared a Police Jail for the purposes of detaining sentenced prisoners. Twenty-eight Police stations are designated for this purpose.

<sup>41</sup> Corrections Act 2004, s 34.

## 5 Duty of Care and other Applicable Law

### POLICE DUTY OF CARE

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82. For the entire duration of a person's time in Police custody – from the point of arrest or detention and until they are released – Police owe them a legal duty of care to take all reasonable steps to ensure their care, safety and wellbeing.

83. Historically, the Police duty of care was found in the common law, and was defined as:<sup>42</sup>

*“... by taking him into custody and detaining him at the Police station the Police assumed a duty to take all reasonable care for his safety ... there is a duty on the person having custody of another to take all reasonable steps to avoid acts or omissions which he could reasonably foresee would be likely to harm the person for whom he is responsible.”*

84. The Police duty of care is now codified in section 151 of the Crimes Act 1961. As discussed below, the duty is recognised and given effect to in Police policies and general instructions relating to arrest, detention and the care of people in custody.

### Statutory provisions

85. Section 151 of the Crimes Act 1961 states:

*Every one 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.*

86. The Act defines a 'vulnerable person' as *“a person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person.”* The Act also defines 'necessaries' as the basic requirements of life, such as food, water and adequate warmth.

### Criminal liability

87. An omission to fulfil the duty under section 151 may be sufficient for criminal liability, where there is a resulting death or injury, or there is a risk of harm, under a number of different offence provisions. These include:

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<sup>42</sup> *Police v Amos* [1977] 2 NZLR 564 at 569 (SC).

- criminal nuisance, where a person fails to perform their legal duty when they know this failure would endanger the life, health or safety of another person or the public;<sup>43</sup>
- manslaughter, where a person fails to perform a legal duty, without lawful excuse, that results in the death of the person to whom the duty was owed;<sup>44</sup>
- injuring, where a person fails to perform a legal duty and injures another person in circumstances where, if death had occurred, they would have been guilty of manslaughter;<sup>45</sup> and
- ill-treatment or neglect of a child or vulnerable adult, where a person who has care or charge of the victim fails to perform their legal duty when this is likely to cause suffering, injury, adverse health effects, mental disorder or disability.<sup>46</sup>

88. Under section 150A(2) of the Crimes Act 1961, liability for any of these offences will only arise if the failure is “*a major departure from the standard of care expected of a reasonable person.*” This is commonly referred to as a gross negligence standard. A person who simply fails to provide a reasonable standard of care, without more, cannot be convicted.

### Civil liability

89. Civil liability for a breach of the duty of care is also limited. Section 317 of the Accident Compensation Act 2001 prohibits people from bringing civil proceedings for damages for personal injury caused by negligence. Section 319 allows proceedings for exemplary damages, but only where the person who has caused the injury either intended the harm or appreciated the risk of harm and has “*deliberately and outrageously*” run that risk.<sup>47</sup>

90. A person who is injured as a result of another’s simple failure to provide a reasonable standard of care, without more, may therefore have no civil remedy.

91. However, the absence of criminal or civil liability in cases of simple negligence does not make the legal duty under section 151 of the Crimes Act 1961 inapplicable. It simply means that the injured person’s remedies for a breach of that duty are limited to other avenues.

## HUMAN RIGHTS OBLIGATIONS

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### New Zealand Bill of Rights Act 1990

92. The Police legal duty of care exists alongside other legal obligations owed by the Police to people in custody including those provisions that protect basic human rights and freedoms and are contained in the New Zealand Bill of Rights Act 1990 (NZBORA).

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<sup>43</sup> Crimes Act 1961, s 145.

<sup>44</sup> Section 171.

<sup>45</sup> Section 190.

<sup>46</sup> Section 195.

<sup>47</sup> *Couch v Attorney-General* [2010] NZSC 27, [2010] 3 NZLR 149.

93. Under section 9 of the NZBORA, every person detained in Police custody has the right not to be tortured or ill-treated. Section 23 protects the right of every individual in custody to be treated with *“humanity and with respect for the inherent dignity of the person.”*
94. In addition, section 23 codifies a number of other rights of people who are arrested or detained. These are the rights to:
- be informed of the reason for arrest or detention at the time of arrest or detention;
  - consult and instruct a lawyer without delay and be told of that right;
  - have the validity of the arrest or detention determined and be released if it is not lawful;
  - be charged promptly or released [only applicable to situations of arrest];
  - be brought before a court or tribunal as soon as possible [only applicable to situations of arrest]; and
  - refrain from making any statement and be informed of that right.
95. These provisions give effect to New Zealand’s international legal obligations.<sup>48</sup> New Zealand also has international legal obligations to investigate instances of serious injury, possible torture or ill-treatment and deaths in custody.<sup>49</sup>

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<sup>48</sup> See International Covenant on Civil and Political Rights (signed 16 December 1966, entered into force 23 March 1976), Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (signed 10 December 1984, entered into force 26 June 1987).

<sup>49</sup> Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, arts 12 and 16.

## 6 Applicable Police policy

### OVERVIEW OF APPLICABLE POLICE POLICY

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96. The Police have in place a number of inter-related policies designed to give effect to the Police legal duty of care owed to people in custody. Primarily, the care of people in custody is governed by the national *Managing Prisoners* policy, itself a chapter of the National Police Manual.
97. The *Managing Prisoners* policy states that it operates and should be read in conjunction with related policies, including the *Transporting Prisoners*, *Use of Force* and *New Zealand Bill of Rights* policies in the Police manual.
98. The *Managing Prisoners* policy was implemented in July 2011. This followed a Police review of their policies and procedures regarding the management of people in custody. Prior to this, the care of detainees in Police custody was governed by the Police's General Instructions and Manual of Best Practice. At the local level this included district and watch house-specific instructions, including suicide prevention policies.
99. The *Managing Prisoners* policy applied during each of the incidents reviewed for this report. The obligations imposed by the policy, in order to give effect to the legal duty of care owed by officers, are discussed below, as well as other Police policy where relevant.

### RISK ASSESSMENT OBLIGATIONS

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100. The legal duty of care owed by Police involves more specific obligations, given effect to in current Police policy. Primarily, from the point at which Police custody begins and until it ends, officers are required to assess people in custody for any risks to their health and safety. People in custody may be at risk to themselves or others for a number of reasons, including their physical or mental health, intoxication and drug use. After assessing the risk presented by a particular person in custody, officers must determine the level of care the person requires and implement appropriate safeguards to manage and mitigate any identified risk.

#### Police processing and record-keeping tools

101. Police use the Electronic Custody Module (ECM) in the National Intelligence Application (NIA), both of which are computer programmes, to process and formally risk-assess detainees received into custody at the watch-house. The ECM steps custody officers through different screens to capture data regarding the detainee's identity, the reason for their detention, and a risk evaluation of their wellbeing in custody, based on factors including their mental and physical health, level of sobriety, and demeanour.
102. During the risk assessment process, Police consult warning flags or 'alerts' in NIA about the detainee being assessed. This is intended to assist officers in the risk assessment process. The most relevant alerts in the custodial management context are those which record previous

self-harm or behaviour indicating suicidal tendencies. Alerts may also relate to other risk factors, for instance a detainee's history of drug or alcohol abuse. The ECM does not contain direct links to relevant alerts. Custody officers must run a separate search and look at a separate module (window) in NIA containing the person's risk information.

103. To enable the effective use of NIA for the purpose of risk assessments, Police policy requires officers to create NIA alerts for detainees following certain incidents. To illustrate, the *Managing Prisoners* policy provides that:

*“Information about suicidal tendencies must be entered and stored in NIA with the safety alert ‘Self-Harm / Suicidal Tendency’ whenever Police become aware (through any reliable means)<sup>50</sup> that a person:*

- *is reasonably likely to attempt suicide, or*
- *has a known history of suicide attempt anywhere, whether in Police custody or not.*

*The employee learning of suicidal tendencies must promptly (always before finishing duty on the shift they became aware) enter information about suicidal tendencies by submitting a ‘Suicidal Tendencies Notification’ form.”*

104. This notification is then automatically sent to the Police Vetting and Validation Service Centre which enters the NIA safety alert. Police Professional Conduct staff then ‘quality assure’ the safety alert.
105. Police constables may also access this information via their smartphones and tablets while on patrol. Watch-house officers will be notified of these alerts during the risk assessment of a detainee received in custody, provided they check the detainee's NIA record as required by Police policy (see further paragraph 119).

## Arrest and detention

106. This stage of Police custody is primarily covered by the *Police Arrest and Detention* policy. It details Police's legal powers and obligations regarding the requirements of arrest and detention, the Police powers associated with arrest, and the obligations of Police with respect to the rights of detainees and legal duty of care.
107. The *Arrest and Detention* policy provides that, at the point of arrest or detention, officers have a responsibility to protect detained people and keep them safe from self-harm and/or suicide, or harm from others (for example, other detainees). Arresting officers must be alert for signs

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<sup>50</sup> Police CMSA training states that ‘reliable means’ includes: the opinion of a DAO or Police Medical Adviser; and the decision of an officer or their supervisor based on information supplied on a detainee's custody sheet, a person's behaviour and demeanour, or intelligence from informed sources.

that, and make enquiries to determine whether, a person might need special care, or could harm themselves or attempt suicide while in Police custody.

108. Arresting officers must continually assess and monitor detained people so that they may determine:
- their physical and mental health, particularly whether they have any medical condition or warning signs indicating suicidal tendencies or risks of self-harm;
  - the level of threat the person may pose to Police employees or other people in custody; and
  - any risk posed to them by other people in custody (e.g. because of the nature of the charge against them or their sexual orientation, affiliations or vulnerability to intimidation).
109. This obligation to risk-assess and monitor people in Police custody is similar to, but distinct from, the requirement that detainees are formally received and assessed after their delivery to a Police station, as provided in the *Managing Prisoners* policy and discussed below (see from paragraph 112 below).
110. Arresting or detaining officers must then take all reasonable steps necessary to manage any identified risk while the person is in their care. Any information gathered about the person relevant to their care and safety should be recorded and communicated to the watch-house keeper or any other employees who take over responsibility for the person's custody.
111. Arresting or escorting officers are responsible for a detainee's safe custody until they are searched and handed over to custody staff. At the point of transfer, arresting officers must advise receiving officers of any concerns they have for the detainee's wellbeing in custody.

### Reception and processing at Police stations

112. The custody supervisor, usually a Police sergeant, is charged with responsibility for ensuring that all detainees received at the watch-house are lawfully detained, that custody is the appropriate course of action and that custodial monitoring requirements have been met in all cases.
113. The *Managing Prisoners* policy requires that detained people are formally assessed on their receipt at Police stations. This is more commonly referred to as 'processing' a detainee. Officers use the ECM to process detainees. They must also record in the ECM the detainee's arrival and movements in custody at the watch-house, and any checks performed on detainees assessed to require care in custody (see further below, paragraphs 121–124).
114. Upon their delivery to the watch-house, detainees may be placed in a holding room or cell when awaiting assessment. They must not be left unobserved where practicable, because any risks posed by the detainee will most likely be unidentified at that stage. The policy states that

when a detainee is left alone in a holding room before assessment, officers should consider handcuffing them to prevent self-harm and observe them at least five times per hour.

115. Using the ECM, officers must then conduct a formal risk assessment of every detainee to determine the steps necessary to ensure their care and safety, and any warning signs of suicidal tendencies, while in Police custody. The formal assessment is intended to enable officers to determine:

- the detainee’s physical or mental health (including risks arising from alcohol or drug consumption or physical or mental disability);
- whether they have any medical condition requiring medication or monitoring in custody;
- warning signs indicating suicidal tendencies or risk of self-harm;
- the level of threat that the person may pose to Police employees or other people in custody; and
- any risk posed to them by other people in custody (for example, because of the nature of the charge against them or their sexual orientation, age, affiliations or vulnerability to intimidation).

116. Arresting or detaining officers must also record their comments about any risk the detainee may pose.

117. Police use the custody/charge sheet on the ECM to carry out this evaluation. Police introduced the current version of this form in 2005, which is intended to enable a more in-depth evaluation of detainees than previous custody evaluation documentation. It contains a “*Watchhouse Keeper’s Evaluation of Condition of Person in Custody*” section, which includes questions about the detained person’s health and wellbeing, such as:<sup>51</sup>

- health conditions like diabetes/heart disease/epilepsy/depression;
- their mental health history (that is, whether they have been under the care of Mental Health Services in the previous six months);
- any prescribed medication; and
- suicide risk factors, including whether the person:
  - has previously been arrested or detained in a Police cell;
  - is an at-risk youth;
  - is male;
  - has previously attempted to commit suicide;

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<sup>51</sup> Many of these items rely on information provided by the detainee to the questions, since Police do not have access to a detainee’s health records.

- has been arrested because of a domestic incident or has a history of family violence.
118. In its *Deaths in Custody* report, the Authority noted that the custody/charge sheet does not mention other important risk factors, including whether the detainee: is unconscious, unresponsive or unable to be woken; has a head injury; and/or is incoherent or confused.<sup>52</sup> Police have not amended the custody/charge sheet to include these factors.
119. Arresting officers and custody staff must also check NIA when they are assessing a person's health and safety while in Police custody. Arresting officers and custody staff are required to conduct this check at the earliest opportunity. As mentioned above in paragraph 102, NIA contains any warning flags or 'alerts' that may assist in the risk assessment of a detainee.
120. The officer receiving the detainee must then determine the person's risk category using this and any other information they have about them. This information is sourced from:
- the officer's own observations of the person's verbal and physical behaviour;
  - custody module data;
  - witnesses at a scene;
  - the person's family friends and colleagues;
  - health professionals; and
  - partner agencies, for example the Department of Corrections or Child, Youth and Family.
121. The *Managing Prisoners* policy sets out three categories of risk that determine how people in Police custody are classified and subsequently monitored. These are detainees:
- not in need of specific care: "*must check every 2 hours*";
  - in need of care and frequent monitoring: "*Frequent monitoring – observe at least five times an hour at irregular intervals*"; or
  - in need of care and constant monitoring: "*Constant monitoring – directly observe without interruption.*"
122. All detainees who are restrained in custody using a restraint board or restraint chair are required by the Police *Mechanical Restraints* policy to be subject to care and constant monitoring.
123. The *Managing Prisoners* policy also defines the types of checks that may be carried out:
- physical check: "*Enter the cell and physically wake the prisoner to establish well-being*";

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<sup>52</sup> Independent Police Conduct Authority *Deaths in Custody – A Ten Year Review* (June, 2012) at [259].

- verbal check: “Verbally rouse the prisoner to establish well-being and if there is no response complete a physical check”; and
  - observation check: “Observe through a cell view port to check the prisoner’s well-being, ascertaining breathing and condition. If unable to confirm this, complete a verbal check”.
124. The policy also states that monitoring a detainee via CCTV does not substitute for a physical check and “does not replace the required visits for prisoners.” Therefore, while not clearly stated in the *Managing Prisoners* policy, the type of check that must be carried out in relation to detainees assessed to require *care and frequent monitoring* is an observation check, and officers must check such detainees five times an hour by viewing them through their cell window. Watching them via CCTV, while a valuable aid, does not constitute a valid check.<sup>53</sup>
125. The ECM prompts officers to check detainees according to their risk category. When a check is required, the detainee’s name flashes on the ECM computer window and a beeping sound is emitted. Officers make a record in the ECM every time they perform a check. However, the ECM does not prompt officers to record the *type* of check they have performed, such as a verbal as opposed to physical check, or any further information about the condition of the detainee.
126. A detainee will only appear on the ECM once processed. Therefore, officers will not be prompted to check detainees who have not yet been processed, risk assessed and entered into the ECM.
127. When a person is assessed to need *care and frequent or constant monitoring*, officers must complete a “*Health and Safety Management Plan*” form (HSMP form) in relation to the detainee. The HSMP form:
- provides notice to the detainee that he or she has been found to be in need of care;
  - prompts Police to ensure that mandatory procedures are completed before placing the person in a cell and offers options for managing the person;
  - lists a variety of contacts to assist with the provision of care to the person in custody; and
  - records relevant information such as medication and approved changes to the plan for managing the detainee.
128. Every person in Police custody who is assessed to need care due to their health, medical condition or any suicidal warning signs must be examined as soon as is practical by a DAO,

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<sup>53</sup> In its *Deaths in Custody* Report, the Authority noted that a previous version of the policy “does not clearly state when the different types of checks should be carried out.” Other Police policy relevant in the custody context, for instance the *Mechanical Restraints* policy, states that the definitions of frequent and constant monitoring do not include the use of CCTV.

community assessment team (CAT) member or Police medical officer (PMO).<sup>54</sup> The result of the assessment must be recorded in writing by the health professional. The HSMP form also contains a section for officers to record the result of the assessment.

### Managing risk with violent, intoxicated, drug-affected, and suicidal people

129. The *Managing Prisoners* policy sets out steps that officers must take when dealing with certain categories of detainees. In particular, it stipulates how officers should deal with detainees who pose a risk to others because they are violent or dangerous, and those who may be at risk due to alcohol and/or drug use, mental impairment including suicidal thoughts, or physical illness.
130. The policy does not address what officers should do if they are unable to process and risk assess a detainee, for instance if the detainee is aggressive or unwilling to respond to the risk assessment questions. However, the Canterbury and Waitematā District local orders provide that detainees who cannot be evaluated for any reason, such as intoxication, aggression or lack of cooperation, must be subject to care and frequent monitoring until they can be evaluated.

### People at risk to others

131. The *Managing Prisoners* policy states that a custody supervisor or a minimum of two custody employees should be present when dealing with a violent or dangerous detainee. Officers may use mechanical restraints on the detainee where appropriate and necessary to ensure the safety of everyone present (see further paragraphs 153–154 below). Violent or dangerous detainees should be segregated from other detainees where possible and, because they can become suicidal, should be monitored and their level of risk reassessed regularly.

### People at risk to themselves

132. If a person received at the watch-house is unconscious due to either intoxication, drug use or some unknown reason, the policy states that *“it is critical that they are taken to hospital quickly.”* This requirement is equally applicable to people dealt with by Police outside the watch-house environment, such as those arrested or detained in a public place.
133. Where officers are uncertain whether a person is unconscious due to the above factors, the policy cautions officers, *“If you have any doubt, take the person directly to hospital. Calling an ambulance can involve further delay and should only be done if this is the best course of action.”*
134. For semi-conscious people, defined as *“unable to answer any questions during the initial assessment process or physically unable to look after themselves”*, the policy requires officers

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<sup>54</sup> Community assessment teams provide assessment and short-term treatment services for people experiencing a serious mental health crisis. Police Medical Officers are registered doctors contracted to provide medical advice to Police about people in custody on a case-by-case basis.

to call an ambulance to take the person to hospital. Officers must take semi-conscious detainees directly to hospital if they expect any delay in the arrival of the ambulance.

135. Officers must follow standard reception procedures for intoxicated but conscious people. The detainee's degree of intoxication is taken into account along with any other risk factors during the risk assessment process.
136. In relation to suicidal people, the policy notes that Police have a legal obligation to prevent the suicide of people in custody, and that section 41 of the Crimes Act 1961 empowers officers to use force that is reasonably necessary to do so.
137. The policy states that all people who attempt suicide in custody must be either:
  - referred to a mental health professional for assessment; or
  - dealt with under the provisions of the Mental Health (CAT) Act 1992.
138. The policy then details the process that officers must follow when they discover a suicide attempt, and that their three priorities are: to stop the attempt; to provide immediate medical attention; and to ensure safe practices are used.<sup>55</sup>

### Alcoholism and drug addiction

139. The Police manual contains an *Alcoholism and Drug Addiction* policy, which provides guidance for the detention and treatment of people under the Alcoholism and Drug Addiction Act 1966 and, more relevant to this report, for dealing with people who are intoxicated due to alcohol, drugs or solvents.
140. This policy contains separate guidance on different degrees of intoxication. These are:
  - unaffected by alcohol: *"oriented; knows and clearly states name, date and place"*;
  - mildly affected by alcohol: *"oriented; knows and able to state name, date and place"*;
  - extremely affected: *"confused, or able to state name, date and place **with difficulty**"* (emphasis in policy); and
  - dangerously affected by alcohol: *"not able to be understood; moans and groans; no sensible words; and nil response at all"*.
141. In relation to the appropriate procedure for dealing with intoxicated people, the policy refers to the *"Dealing with intoxicated or drug affected persons"* section of the *Managing Prisoners* policy.

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<sup>55</sup> The policy defines a suicide attempt as: *"where a person with intent to commit suicide undertakes a physical act to meet the goal. Mere words or threats are not deemed an attempt. There must be an accompanying physical act."*

142. The policy also provides guidance on the Police power to detain intoxicated people under section 36 of the Police Act 2008, and the limitations on this power like the maximum 12-hour detention period (see paragraphs 58–59 above). The policy also provides questions that officers should consider when detaining an intoxicated person at a Police station, notes that intoxication can hide underlying medical conditions, and gives case studies on the deaths of intoxicated people in Police custody.

### People with mental impairments

143. As well as the *Managing Prisoners* policy, the Police manual contains a *People with Mental Impairments* policy.

144. These policies are largely separate. The only cross reference between the two policies appears in the *Managing Prisoners* policy, which refers to the *People with Mental Impairments* policy in situations where officers release mentally disordered people into the care of a health professional.

145. The *People with Mental Impairments* policy details the legislation and procedures that officers must adhere to when dealing with people with mental impairment. ‘Mental impairment’ is not statutorily defined, and its ordinary meaning is given in the policy as “a person who has sustained loss to their mental functioning for any reason.” This includes mental disorder as defined in the Mental Health (CAT) Act 1992 and intellectual disability.

146. This policy largely provides guidance on the powers of Police officers when assisting mental health professionals, including the powers of detention under the Mental Health (CAT) Act 1992 discussed above (see paragraphs 61–67). The policy explicitly refers to the limitations on officers’ powers under the Act, in particular that officers have no power to enter private property or to detain a person on private property unless assisting a DAO or medical practitioner.

147. The policy also specifically states that Police stations should only be used for assessments under the Mental Health (CAT) Act 1992 if there is absolutely no alternative; for instance, no medical surgery nearby. In addition, in circumstances where a detained person, who has not been arrested or committed an offence, is violent or a hospital does not have a bed and Police are asked to detain the person at a Police station, officers should only do this as a last resort.

148. The policy also details, with reference to the *Managing Prisoners* policy, appropriate Police procedure for dealing with suicidal people, including how officers should respond to suicide attempts or threats in circumstances outside the custodial management context. The policy lists the following key risk factors for suicidal behaviour:

- recent loss;
- loved ones dying or committing suicide;
- isolation;

- previous attempts;
  - depression or bipolar disorder; and
  - serious physical illness.
149. The policy refers to the *Arrest and Detention* chapter of the Police manual in relation to Police officers' obligations when taking suicidal people into custody. It also refers to the *Managing Prisoners* policy for additional suicidal indicators for people in custody, and for Police procedure for supervising suicidal people in Police custody.
150. This policy provides guidance for officers to deal with intoxicated people who also have a mental disorder. In circumstances where an officer believes that an intoxicated person has a mental disorder, the policy instructs them to call a DAO to arrange, if necessary, for an assessment examination under section 109 of the Mental Health (CAT) Act 1992.
151. The policy further states that intoxication does not invalidate the assessment of the person's mental state. It instructs officers that if the DAO is unwilling to examine the person until they are sober, the officer should *"point out that a delay could mean that the person will be released without assessment when the six-hour period provided for assessment has elapsed."* The 'six-hour' period refers to the maximum period of detention under section 109 of the Act. If the officer is unsuccessful in persuading the DAO to conduct an assessment, or to have the person detained in a psychiatric institution prior to assessment, the policy states that the officer will have to hold the person in the cells until the DAO considers the person is sober. This largely contradicts the immediately preceding instruction to officers.
152. In 2014 Police and the Director of Mental Health clarified the roles and responsibilities of Police officers and mental health staff in a joint communication to respective staff. In addition to reiterating other expectations within the Mental Health (CAT) Act 1992, the communication restated the requirement for DAOs to assess detainees regardless of whether they are intoxicated.

### Restraint of people in custody

153. Police may control a person in custody using mechanical restraints to restrict their movements to reduce the risk of injury to them, officers or other people. These restraints include: handcuffs (metal and plastic); restraint boards; restraint chairs; and the use of different combinations of restraints. The Police *Mechanical Restraints* policy details the circumstances in which each may be used, and the requirements for doing so.
154. Officers must complete a *"Health and Safety Management Plan"* form for any person restrained in a spitting hood, on a restraint board or restraint chair, or in certain combinations of restraints. People who are restrained using one of these must be subject to care and constant monitoring. A person can only be restrained by one of these restraints for over two hours if this is authorised by a Police medical officer (PMO) following their assessment of the person's wellbeing. The PMO must also record the advice they gave on whether and how the person can be safely restrained for over two hours.

## Reassessment and monitoring

155. The Police's duty of care requires officers to continually reassess the health and wellbeing of people in Police custody. Accordingly, the risk assessment process does not end once a detainee is processed and placed in a cell. It continues through the duration of custody.
156. This is recognised in the *Managing Prisoners* policy, which states that frequent re-assessment of a detainee's health and safety in custody is essential to determine if:
- the person's risk category has changed; and
  - their custody should be managed differently (e.g. the level of monitoring changed).
157. In particular, officers should always reassess a detainee's health and wellbeing when a change in their circumstances occurs, including when the detainee is:
- 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; and
  - transferred from court or the Department of Corrections to a Police jail.
158. When officers determine that a detainee's risk category has increased, they must accordingly adjust the person's custodial management to the appropriate level of monitoring. If the detainee was previously not assessed as at risk, officers must arrange for a medical examination of the detainee by a DAO, CAT member or Police medical officer.
159. If officers consider that a person's risk category has decreased, to reduce the required level of monitoring they must get approval from the DAO, CAT member, or PMO who confirmed the previous risk assessment.

## 7 Common Problems in Police Custodial Management

160. This part of the report details the recurring problems and challenges faced by officers that the Authority has identified as arising in the Police custodial management context. It does so by reference to the relevant policy obligations that are designed to give effect to the Police duty of care. Some sections in this part also begin with relevant data about the numbers of people taken into Police custody from January 2011 to December 2014.
161. The next part of the report discusses the systemic causes underlying these problems and challenges. As there may be multiple causes underlying a single issue, the report addresses these separately.

### INFORMATION ON PEOPLE IN POLICE CUSTODY

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162. Tables 1 and 2 below provide information about the overall numbers of detainees in Police custody.

#### All custody episodes recorded in NIA Electronic Custody Module (ECM)

163. On the following page Table 1 shows the number of detainees in Police custody who were processed at a Police custody facility using the Police NIA ECM (explained above in paragraphs 101–105). The data in Table 1 does not include records of:
- people detained by Police who were released before a detention record was created;<sup>56</sup>
  - intoxicated people taken directly home by a Police officer;
  - prisoner transfers between custody units; or
  - people held in a Police station outside of the custody facility, for instance while awaiting mental health assessments in interview rooms.

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<sup>56</sup> Police may detain a person temporarily without entering them into the ECM. For instance, if the person is intoxicated and detained briefly before Police officers return them to their home (or other safe location).

**Table 1: Number of detainees in Police custody (1 January 2011–December 2014)**

District	2011	2012	2013	2014
Northland	5,289	5,617	5,137	4,572
Waitemata	13,325	12,795	11,130	9,227
Auckland City	12,308	12,573	10,878	10,635
Counties-Manukau	21,044	18,722	17,354	14,599
Waikato	10,893	12,721	11,169	10,581
Bay of Plenty	17,308	15,882	14,268	13,176
Eastern	10,495	11,303	10,637	9,846
Central	11,284	11,954	11,672	11,020
Wellington	17,437	15,588	13,091	12,246
Tasman	739	4,347	4,714	4,130
Canterbury	7,495	13,176	11,171	10,084
Southern	8,117	7,960	6,920	6,241
<b>New Zealand</b>	<b>135,734</b>	<b>142,638</b>	<b>128,141</b>	<b>116,357</b>

164. Table 1 shows that, despite a 4.8% increase in the total number of Police detentions between 2011 and 2012, the total number of Police detentions decreased by 16.7% during the period covered.

#### All custody episodes containing an offence

165. Table 2 shows the number of detainees who were processed at a Police custody facility using the Police NIA ECM, and who were in custody in relation to a crime or traffic offence. These numbers do not include detentions for offence-related incidents that can follow offences, such as warrants to arrest, breaches of bail and a fines warrant.

**Table 2: Total custody records (1 January 2011–December 2014) containing one or more offence (including traffic offences)**

District	2011	2012	2013	2014
Northland	3,653	4,043	3,629	3,177
Waitemata	9,303	9,053	7,655	6,601
Auckland City	8,400	8,399	6,339	5,769
Counties-Manukau	11,971	9,833	9,196	7,601
Waikato	6,994	8,496	7,382	6,158
Bay of Plenty	11,564	10,637	9,618	8,803
Eastern	6,600	7,433	6,576	5,933
Central	8,140	8,561	8,368	7,493
Wellington	11,616	10,302	8,323	7,606
Tasman	537	3,272	3,534	2,973
Canterbury	5,077	9,391	7,469	6,631
Southern	5,830	5,913	5,342	4,806
<b>NEW ZEALAND</b>	<b>89,685</b>	<b>95,333</b>	<b>83,431</b>	<b>73,551</b>

166. Table 2 shows that, despite a 5.9% increase in the total number of detainees in Police custody in relation to offences between 2011 and 2012, the total number of Police detentions for offences decreased by 21.9% during the period covered.
167. In 2014 63.2% of detentions were triggered by an offence. While most people detained in Police custody were arrested and detained for an offence and/or detained for an offence-related incident (for example breach of bail, and warrants to arrest), some people were detained without arrest. For example, they were detained for detoxification and/or while awaiting a mental health assessment.
168. The following sections describe the recurring problems arising in relation to people in custody.

## ABSENCE OF RISK ASSESSMENT

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169. The legal duty of care owed by Police to people in custody requires officers to assess detained people for any risks to their health and wellbeing using the steps set out in the *Police Arrest and Detention* and *Managing Prisoners* policies, discussed above in paragraphs 106–128. It is intended that officers will identify risk factors and put in place appropriate risk management strategies to mitigate any identified risk.
170. The risk assessment process begins at the point a person is taken into custody. Arresting or detaining officers must continually assess and monitor detainees to determine whether they need special care or attempt to harm themselves while in Police custody. Custody officers must then formally assess the detainee, using the tools and risk evaluation questions in the ECM, when they are delivered to and processed at a Police station.
171. This formal risk assessment process must be followed for all detainees received at the cells, and conducted as soon as reasonably practicable upon their delivery to the station. In particular, it must be performed before any other actions, such as Police interview, are taken in relation to them.
172. Detainees must then be monitored according to their assessed category of risk. As discussed above in paragraph 121, those not requiring care must be checked every two hours; those in need of frequent monitoring must be checked five times an hour; and those in need of constant monitoring must be continuously directly observed.

### Initial failure to process and assess risk promptly

173. In the cases reviewed for this report, the Authority has identified multiple instances where officers failed to conduct a risk assessment of detainees at the earliest opportunity.
174. In a number of these cases custody officers did not process detainees at the time they were delivered to the watch-house. For example, intoxicated or aggressive detainees were sometimes placed in a cell to sober up or ‘cool off’ prior to being formally processed by custody staff:

- In March 2013, an intoxicated woman was arrested and delivered to the Counties Manukau DCU. After she spoke to her lawyer, authorised officers attempted to process her, but she was uncooperative and aggressive, and refused to answer the risk assessment questions. Due to this, the officers placed her straight in a cell, and did not complete the reception and risk assessment process. As a result, the officers did not note the previous occasions where the woman had been in Police custody and assessed as suicidal. The woman then remained in the cell for over two hours, without any formal monitoring requirements in place, before an officer discovered that she had attempted suicide.
- In September 2012 a heavily intoxicated man was taken to the Christchurch Central Police station and placed in a holding cell but not processed. After about 25 minutes, during which authorised officers performed other duties and intermittently checked on him in the holding cell, the man fell over, severely aggravating a pre-existing spinal condition.

175. These examples demonstrate two consequences that can result from officers not performing timely risk assessments. First, it can sometimes lead to a vulnerable and at-risk detainee being held in Police custody without appropriate risk management strategies in place, including formal monitoring requirements or examination by a medical professional. Second, because detainees are not entered into the ECM and custody management console until officers process them, it means that a gap may exist in the record of their time in custody before their processing. Any activities which occurred in relation to them during this period cannot subsequently be confirmed by the custody record.

### Failure to reassess risk

176. After a detainee has been processed and placed in a cell, officers are required to continually reassess the detainee's health and wellbeing until their release from Police custody. This is to determine whether the detainee's risk category has changed and, correspondingly, whether their custody should be managed differently. In particular, officers must reassess a detainee's level of risk when a material change in their circumstances occurs. This obligation is contained in the *Managing Prisoners* policy (see paragraphs 155–159), and is designed to give effect to the Police duty of care.

177. In the cases reviewed for this report, the Authority has identified a number of instances where officers did not reassess a detainee's risk category after a material change in their circumstances in custody. For instance:

- In August 2013 Hastings Police arrested a woman and took her into custody at the Hastings Police Station watch-house. Officers later described the woman's demeanour during the receiving and risk assessment process as chatty and good-natured. She had a NIA suicidal tendencies alert, but the officers did not check NIA when they processed her. She was assessed as not at risk while in custody. About half an hour after she was received, officers informed the woman that she would be charged with burglary and her bail would be opposed. The custody officer on duty noticed that the woman's

demeanour changed when she was told this and said an *“alarm bell went off in his head and he kept a closer eye on her.”* However, he did not formally reassess the woman or put in place monitoring requirements for her. A little over two hours later the woman was found to have attempted suicide.

- In January 2013 a woman remanded into Police custody in Lower Hutt was found by custody staff to have consumed an unknown number of an unknown type of pill. The woman told officers that she had only taken four sleeping pills. The officers accepted this explanation and assessed the woman as not at risk in custody. Over the next hour in custody the woman became increasingly drowsy and officers had to shout to keep her awake. However, the woman’s risk category was not reassessed before she was delivered to prison for overnight custody. A short time after her transfer to the prison the woman was admitted to hospital for an acute codeine overdose.
- In January 2013, officers arrested a man on various charges and took him into custody at Kerikeri Police Station, where he was processed, not assessed to be at risk, and then interviewed. The processing officers noticed but were unable to remove the inner cord from the man’s shorts. A short time after the man had been processed one of the officers saw that he had a NIA suicidal tendencies alert on his NIA record. After being placed in a cell the man’s behaviour also changed when he was refused bail, and he was described as *“angry and kicking the cell door”*. However, officers did not reassess his risk category. Almost one hour after this the man was found hanging from his cell door by the shorts cord, having attempted suicide.

## INADEQUATE EVALUATION OF VARIOUS RISK FACTORS

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178. As discussed above, people in Police custody may be a risk to others or themselves for a number of reasons, but most commonly due to their own physical or mental health, or alcohol and/or other drug use. Sometimes when officers go through the required risk assessment process, they do not make appropriate use of the information they gather from that process, and as a result do not put adequate risk management strategies in place.

### Failure to use risk assessment tools

179. The risk assessment process is intended to assist officers to identify risks to a detainee’s health and safety while in custody. It does so by directing officers to take certain steps in response to objectively verifiable risk factors, such as previous attempts at suicide recorded in a detainee’s NIA file. Where these factors exist, officers are directed to err on the side of caution and assess a detainee as requiring care while in custody.

180. The Authority has identified a number of cases in which officers did not use the risk assessment tools as directed by Police procedure and policy. This occurred in a number of ways.

181. First, sometimes officers did not create a NIA *‘Self-Harm/Suicidal Tendency’* alert for a detainee when required to do so, as discussed above in paragraphs 103–104. For instance:

- In September 2013 Tauranga Police arrested a man in relation to a number of traffic offences and delivered him to Tauranga Police Station where he was processed and placed in a cell. A short time later, officers found the man in his cell with a t-shirt tied around his neck. He was removed to an observation cell before his release and transfer into the care of Tauranga Mental Health Services. Officers did not create a NIA suicidal tendencies alert in relation to this incident. Eight days later the man was arrested for disorderly conduct and for the purpose of a mental health assessment. Due to his aggressive state the man was placed in a holding cell at Tauranga Police Station until his release about five and a half hours later. The watch-house supervising officer later said to the Authority that given the man's agitation, if a NIA alert had been present and known to the officers, it may have been appropriate to place the man on care and frequent monitoring.
182. Secondly, in a number of the cases reviewed by the Authority officers failed to check a detainee's NIA record during the receiving process for alerts relevant to their wellbeing in custody, for instance suicidal tendencies alerts.
183. Thirdly, there are cases in which officers identified risk factors, but failed to respond to them in the manner directed by policy. This sometimes led to incidents of harm or injury in custody. For instance:
- In December 2013 an intoxicated 18-year-old man was arrested and taken into custody at the Auckland DCU. The man was received at the DCU and assessed as not at risk while in custody. This was despite the presence of multiple risk factors which arguably required the assessing officer to err on the side of caution and assess the man as requiring special care in custody. These factors included two NIA suicidal tendencies alerts and the man's psychiatric history. In addition, the officer who evaluated the man recorded that he was *"too [intoxicated] and irrational to answer questions."* The man subsequently made multiple attempts at suicide while in Police custody.
  - In October 2012 Police in Masterton arrested a man after treatment by Area Mental Health Services. This followed the man's recent attempted suicide. In custody the man was assessed to require care and constant monitoring. A short time after this the man was treated at hospital after complaining of breathing difficulties. Upon his return to Police custody the constable on duty at the watch-house did not remove the man's hospital pyjamas and place him in a suicide resistant gown *"due to his happy demeanour and the fact that he was going to be constantly monitored."* The following morning the man attempted to suffocate himself by tying the pyjamas around his neck.
  - In March 2012 Police arrested a man and took him into custody at New Brighton Police Station. The arresting officer had also arrested the man five days earlier. Based on his knowledge of the man's drug use, the arresting officer strip searched the man, finding nothing that the man could use to self-harm in custody. Despite being *"aware that he was a danger to himself and others"*, the officer then left the man in an interview room unmonitored, and did not process the man or put in place any monitoring requirements.

About 40 minutes after being taken into custody the man self-harmed with an object he found in the interview room.

184. Fourthly, officers commonly conducted a risk assessment of a detainee and identified various risk factors, for instance previous suicide attempts, but nevertheless assessed the detainee as not requiring care in custody based of their demeanour at the time of the risk assessment. For instance:

- In December 2013 a 17-year-old man was taken into custody at Wellington Central Police Station following his arrest for breaching a bail condition. He was assessed to present no risk, despite the presence of multiple risk factors, including self-harm alerts. He later self-harmed in custody. The receiving custody officer later stated that he considered the man as not at risk because, *“at the time [of processing] he answered my questions sufficiently.”*
- In November 2012 Counties Manukau Police arrested a man for breaching his bail and detained him in custody at the Counties Manukau DCU. The officer who processed and risk assessed the man saw that he had a NIA self-harm alert dating back to 2002, and a custody record from an incident four days earlier in which he had wanted Police to shoot him. The officer did not appreciate the significance of these factors, and placed more weight on the verbal assurances of the detainee, who was described as calm, friendly and cooperative, stating that he would not attempt to self-harm in custody. The officer assessed the man as not at risk while in custody. The custody sergeant reviewed this assessment and came to the same conclusion. About one and a half hours later the man was found in his cell, having attempted suicide. Upon his return to Police custody at the DCU, officers assessed the man to be at risk and to require care and frequent monitoring. However, given the man’s recent suicide attempt and previous history, officers should arguably have assessed the man to require constant monitoring.

185. Finally, it is common for officers bringing potentially mentally impaired and/or suicidal people to the Police station for a mental health assessment to deliberately not process the person into the watch-house due to their concern for the detainee’s wellbeing in the custodial cell environment. However, because they are not processed they are not formally risk assessed in the ECM, and appropriate monitoring requirements and other risk management strategies are not implemented.

### Alcohol, other drugs and/or solvents

186. Police officers commonly arrest, or detain and take into custody, people who are under the influence of alcohol, other drugs and/or solvents. Intoxication is often the reason a person has initially come to Police attention.

187. Recent data indicates that about 161 people processed through Police custody per day are intoxicated.<sup>57</sup> The following tables provide further information about the numbers of intoxicated detainees dealt with by Police.

#### *Information on detainees and intoxication*

188. Table 3 shows the number of people in Police custody who were under the influence of alcohol, drugs and/or other solvents, regardless of the reason for custody.

**Table 3: People in custody (1 January 2011–December 2014) that were under the influence of alcohol, other drugs and/or solvents (including under section 36 of the Policing Act 2008)**

District	2011	2012	2013	2014
Northland	2,354	2,410	1,927	1,562
Waitemata	5,237	4,826	4,238	3,108
Auckland City	6,413	6,589	5,198	4,759
Counties-Manukau	8,402	7,292	6,676	4,704
Waikato	4,789	6,244	5,759	4,065
Bay of Plenty	7,421	6,883	5,798	4,900
Eastern	4,016	5,077	4,258	3,542
Central	4,933	5,208	4,953	4,167
Wellington	7,836	7,332	6,389	5,205
Tasman	369	2,333	2,380	1,851
Canterbury	3,292	6,891	5,286	4,347
Southern	3,653	3,624	3,219	2,808
<b>New Zealand</b>	<b>58,715</b>	<b>64,709</b>	<b>56,081</b>	<b>45,018</b>

189. Table 3 shows that almost two in every five people (38.79%) detained by Police (for whatever reason) were assessed by custodial staff to be under the influence of alcohol, other drugs and/solvents.<sup>58</sup>

#### *People detained for the purpose of detoxification*

190. Table 4 shows the total number of people who Police officers detained for the purpose of detoxification after they were found in a public place, in accordance with section 36 of the Policing Act 2008 (explained in greater detail in paragraphs 58–59 above).

<sup>57</sup> Provisional Alco Link data: year to June 2014.

<sup>58</sup> Custodial staff select this risk factor when processing a detainee from an “Under the influence of” dropdown menu in the NIA ECM.

**Table 4: Number of people in custody (1 January 2011–December 2014) for detoxification only**

District	2011	2012	2013	2014
Northland	123	105	108	125
Waitemata	287	325	328	153
Auckland City	251	330	394	431
Counties-Manukau	471	467	397	246
Waikato	416	526	546	561
Bay of Plenty	523	529	449	345
Eastern	443	525	478	458
Central	294	380	393	420
Wellington	453	477	526	447
Tasman	37	198	204	190
Canterbury	227	481	492	448
Southern	125	155	148	153
<b>New Zealand</b>	<b>3,650</b>	<b>4,498</b>	<b>4,463</b>	<b>3,977</b>

191. Table 4 shows that only a small proportion (3.4%) of total detentions in 2014 were solely for the purpose of sobering up an intoxicated person.
192. Taken together, Tables 3 and 4 show that most intoxicated people in Police custody were not detained for the purpose of detoxification (91.2%). Only 8.8% of people in Police custody who were under the influence of alcohol, other drugs and/or solvents had been detained solely for the purpose of detoxification.

#### *Problems arising in relation to intoxicated people in Police custody*

193. The significance of intoxication as a risk factor is recognised in Police policy, which is designed to provide officers with guidance to recognise degrees of intoxication, and the appropriate steps to take to manage their intoxication.
194. In almost half of the cases reviewed for this report, the arrested or detained person was identified as being under the influence of alcohol and/or other drugs. However, officers often failed to appreciate the significance of a detainee's degree of intoxication, and the corresponding risk to their safety in custody. As a result, the officers assessed the detainee as not requiring special care while in custody. For instance:
- In January 2013, a woman who had been remanded in custody overnight for sentencing was in Police custody prior to her transport to prison. Custody officers found the woman to have consumed an unknown number of pills of an unknown variety, but did not identify the risk presented by this situation and seek medical treatment for the woman. (See further above, paragraph 177).
195. In other instances, officers assessed an intoxicated detainee to be at risk, but did not appreciate the degree of risk presented by the detainee's level of intoxication. As a result, the officer assigned the detainee an inadequate risk category, and put in place inadequate risk management strategies.

196. Intoxication can also hide other risk factors that Police look for during the risk evaluation process, such as pre-existing injury or medical conditions. This occurred in the case mentioned above involving the heavily intoxicated man who aggravated a pre-existing spinal condition when he fell in the holding cell at the Christchurch watch-house (see paragraph 174), and in other cases, for instance:

- In October 2014 Police arrested a heavily intoxicated man for fighting in downtown Christchurch. The arresting Police officers saw that blood from the man's nose, which had stopped bleeding, was on his face and hands. The man was delivered to the Christchurch DCU where he was searched and placed in a holding cell before processing. In the holding cell the man smeared blood on the walls and then lay down against the cell door. About forty-five minutes after his delivery to the DCU officers roused the man, who had become uncommunicative and difficult to understand, and moved him to an at-risk CCTV monitored cell. The officers and DAO who moved the man discovered seven stab wounds in his back and side.
- In August 2012, officers in Hastings arrested an intoxicated man for disorderly behaviour. During his arrest, the man attempted to pull away from the arresting officer, tripped and fell, striking his head on the pavement. The man refused to go to hospital with ambulance staff and was subsequently taken into Police custody at the Hastings Police Station cells. Based on his intoxication, the man was assessed as at risk and requiring care and frequent monitoring. The risk presented by his head injury was not recognised, and the officers who interacted with him considered that he was just a heavily intoxicated person 'sleeping it off' in Police custody. When the man's condition had not improved after about eight hours, paramedics were called and the man was taken to hospital. There it was determined that he had suffered a fractured skull and emergency surgery was performed.

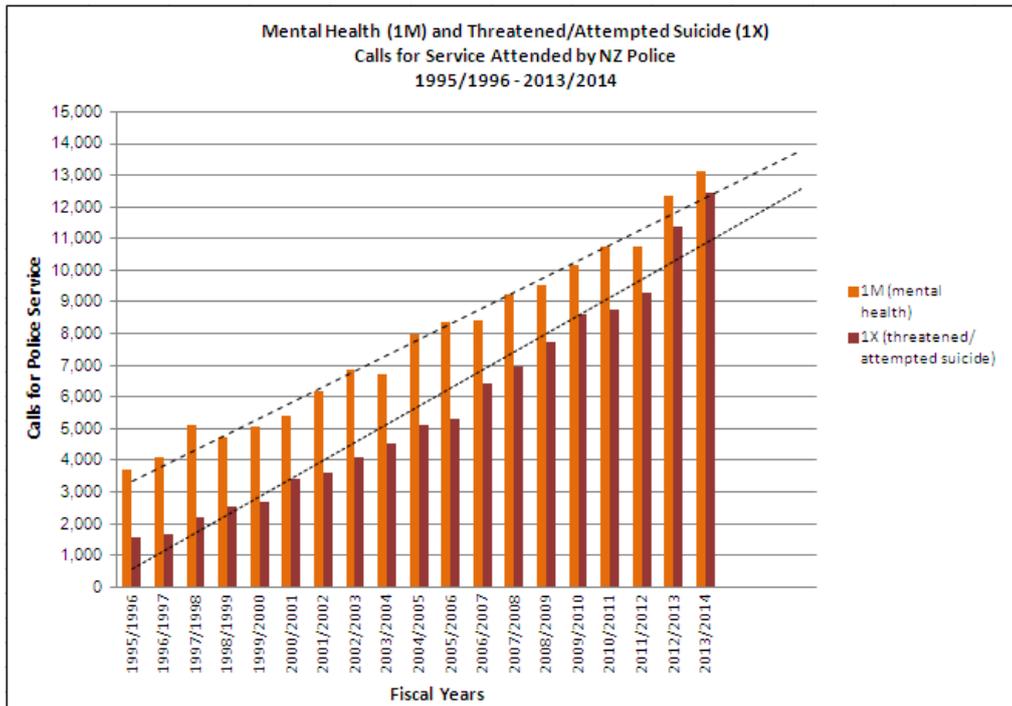
197. As discussed below (see paragraphs 212 and 324), it is common for intoxicated detainees to present with other risk factors, for instance mental impairment or suicidal tendencies. In such cases there is a risk that officers may not identify or appreciate the significance of these other risk factors due to the detainee's intoxication.

### **Mental impairment and/or suicidal tendencies**

198. The mental health of detainees is another highly significant risk factor that officers must frequently consider in relation to people in custody. Police officers regularly deal with and hold in custody people with mental impairment or suicidal tendencies. The following sections provide information about the number of mental-health related incidents dealt with by Police.

#### *Information on mental health calls attended by Police*

199. Figure 1 shows the number of mental health-related calls, as opposed to individuals, attended by Police between 1995/1996 and 2013/2014.



200. Figure 1 shows that in 2013/2014 Police officers attended and submitted incident reports on over 25,500 calls to help people in mental health crisis and/or who threatened or attempted suicide.<sup>59</sup> It also shows that in the last five fiscal years<sup>60</sup> the number of mental health calls Police attended increased by an average of 5% each year. In the same period the number of calls for threatened or attempted suicides increased at 8% per year. In 2013/2014 this resulted in Police attending an additional 1,800 calls.

201. International research suggests that there is a higher than average prevalence of mental health issues in victim and offender populations. Together with Massey University, Police have lodged a research application with the Health Research Council to fund research to look at the prevalence of mental health issues in these populations.

### *Detentions for the purpose of a mental health assessment*

202. The increased demand for Police services through mental health-related calls in the last few years is reflected in an increase in the number of people who are detained in Police custody as a result of a mental health-related incident.

203. Police use the following codes to record in the Police NIA system that an incident involved a mental health issue and/or an attempted or threatened suicide: 1M “mental health”; and 1X “threatens/attempts suicide”. In custody terms, Police officers use the 1M and 1X codes to record that a person was detained for a mental health assessment.

<sup>59</sup> Figure 1 is derived from a count of the closure code for these incidents, i.e. how Police officers describe the nature of the call, once they have attended and assessed the situation. The code at event closure may differ from the apparent nature of the call when Police Communications Centre staff first record the event.

<sup>60</sup> 2008/2009 to 2013/2014.

204. Table 5 shows the total number of detention custody records containing a 1M and/or 1X incident.

**Table 5: All detentions triggered by a 1M mental health and/or 1X threatens/attempts suicide incident (1 January 2011–December 2014)**

District	2011	2012	2013	2014
Northland	96	132	144	195
Waitemata	128	170	150	94
Auckland City	150	291	351	437
Counties-Manukau	1,080	1,237	1,063	931
Waikato	521	624	699	654
Bay of Plenty	784	892	940	919
Eastern	359	325	509	502
Central	461	649	639	678
Wellington	663	768	925	1,072
Tasman	34	178	265	226
Canterbury	66	90	121	124
Southern	246	231	99	117
<b>New Zealand</b>	<b>4,588</b>	<b>5,587</b>	<b>5,905</b>	<b>5,949</b>

205. The numbers in Table 5 include people who were recorded as detained for the purpose of a mental health assessment but ultimately not assessed. They do not include detainees who were arrested for an offence or detained for another purpose, such as detoxification, and also received a mental health assessment.

206. Table 5 shows that the number of people Police detained for a mental health assessment has increased by 22.9% in the period covered by this review. When Table 5 is compared with Table 1 (see paragraph 163), this shows that in 2014 5.1% of total Police detentions were triggered by a mental health-related incident and/or a threatened or attempted suicide-related incident.

207. While the total number of people detained by Police during the 2011–2014 period decreased by 16.7%, in the same period the number of people detained for the purpose of detoxification increased by 8.2%, and the number of people detained in Police custody in relation to a mental health and/or a threatened or attempted suicide incident increased by 22.9%.

208. When the numbers of detentions containing a 1X code are excluded from the numbers in Table 5, it shows that the majority of detentions in that Table involve only a mental health-related incident. This is illustrated in Table 6, which shows the number of detainees that Police officers recorded were detained only for a 1M mental health-related incident.

**Table 6: Custody records containing only a 1M incident code (1 January 2011–December 2014)**

District	2011	2012	2013	2014
Northland	67	86	90	125
Waitemata	79	110	89	37
Auckland City	93	163	223	289
Counties-Manukau	584	547	495	505
Waikato	317	397	424	361
Bay of Plenty	417	434	421	368
Eastern	271	239	303	268
Central	186	313	302	321
Wellington	285	309	390	423
Tasman	10	31	73	62
Canterbury	10	10	9	19
Southern	37	32	24	37
<b>NEW ZEALAND</b>	<b>2,356</b>	<b>2,651</b>	<b>2,843</b>	<b>2,815</b>

209. Table 7 shows the number of detentions involving both a 1M mental health-related incident and an offence. When examined with Table 6, it shows that 1M detentions which also involved an offence are a small proportion of total detentions involving a mental health-related incident.

**Table 7: Custody records including 1M incident code and 1 or more offences (1 January 2011–December 2014)**

District	2011	2012	2013	2014
Northland	6	5	10	10
Waitemata	12	30	28	36
Auckland City	18	44	63	69
Counties-Manukau	64	43	43	137
Waikato	24	39	60	76
Bay of Plenty	63	68	95	110
Eastern	30	14	60	62
Central	26	26	35	43
Wellington	24	38	59	111
Tasman	0	7	15	21
Canterbury	3	0	2	0
Southern	2	3	3	7
<b>NEW ZEALAND</b>	<b>272</b>	<b>317</b>	<b>473</b>	<b>682</b>

210. Tables 6 and 7 show that in 2014 80.5% of detentions by Police in relation to a mental health incident involved no offence, while only 19.5% also included a record of an offence.

### *Problems arising in relation to mentally impaired people in Police custody*

211. As with alcohol and/or other drugs, Police officers often do not appreciate the significance of signs which indicate a detainee may be at risk due to either their mental health or suicidal tendencies. For instance:

- In February 2012 officers in Ashburton arrested a man for breaching his bail conditions and delivered him to Ashburton Police Station. The man became agitated during processing when he learned that the Police officers had assessed that he required care, and struck his head hard against the wall multiple times. An officer directed a Taser at the man and he calmed down. The officers did not appreciate the significance of the man's behaviour, and considered he was only being aggressive. He was interviewed and then placed in a cell, but officers did not complete the man's risk assessment documentation, and did not ensure that proper monitoring or care arrangements were in place. Over an hour later the man self-harmed by biting open the vein in his upper arm.

212. In addition, it is common for detainees to present with multiple risk factors. For instance, a heavily intoxicated or drug-affected detainee may also present a suicide risk, and the suicide risk indicators may be more or less obvious. For instance:

- In December 2013 officers in Counties Manukau attended a petrol station in response to a report that a male and female were refusing to leave the station, claiming that they were being followed and going to be kidnapped. The officers spoke to the man, and found that he was under the influence of methamphetamine and behaving erratically and *"appeared unstable, paranoid and delusional."* The man requested to go to the Police station, and the officers detained him in order to take him to the Counties Manukau DCU to be assessed by a DAO once sober. At the DCU, 25 minutes after being placed in a holding cell, custody officers found the man attempting suicide.

213. In some cases custodial staff underestimate the risk that detainees present, and assign them a risk category and corresponding lower level of monitoring than their actual risk requires. For instance:

- In December 2013 Police in Auckland arrested an 18 year old man and delivered him to the Auckland City DCU. The processing authorised officer identified on the *"Watchhouse Keeper's Evaluation of Condition of Person in Custody"* form that the man: may have required care due to his mental state; was irrational and anxious; presented with multiple suicide risk indicators; had two NIA suicide attempt alerts; and was *"too [intoxicated] and irrational to answer questions."* Despite the historical and current risk factors, the processing officer assessed that the man did not require care in custody. The man subsequently attempted suicide multiple times while in Police custody.
- In December 2013 Counties Manukau Police officers detained a heavily intoxicated woman for the purpose of a mental health assessment by a DAO, following her attempted suicide. She also made multiple suicidal statements to officers at the scene of her detention and while being transported to the Counties Manukau DCU. After her

delivery to the DCU, the woman was placed in a holding cell and fell asleep. Officers then processed the woman, but she was too intoxicated to answer the risk evaluation questions. She was assessed to require care and frequent monitoring and placed in a CCTV-monitored observation cell. However, due to the woman's degree of intoxication and demonstrably suicidal nature, she arguably required a higher degree of care in the form of constant monitoring. About one hour after she was processed the woman was found attempting suicide.

214. Instances where officers do not appreciate that a detainee may be at risk due to their mental health or suicidal tendencies must be considered in light of the difficulty that custodial staff face when balancing risk information from the time of the assessment with historical information about detainees. That is, a risk may be indicated either because there is a current threat to attempt suicide or the detainee presents with symptoms of severe depression, or because there is a history of suicide attempts. For instance, suicide alerts may be ten years old and no longer considered to be an accurate reflection of the detainee's mental wellbeing.

## INADEQUATE RISK MANAGEMENT STRATEGIES

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215. Once officers assess a detainee to be at risk, they are required to put in place appropriate risk management strategies to mitigate the detainee's particular risk while in custody. One example of a risk management strategy is the requirement to monitor detainees according to their risk category.

### Failure to properly monitor detainees

216. The legal duty of care owed by Police requires arresting officers to continually assess and monitor detained people to determine their wellbeing in custody and, once they have been formally assessed using the ECM at the Police station, officers are required to monitor them according to their assessed category of risk (see paragraphs 121 and 172 above). Before detainees are assessed using the ECM, the *Managing Prisoners* policy requires that, where practicable, officers do not leave them unobserved when they are placed in a holding room or cell before assessment (see paragraph 114).
217. In some cases, officers have not monitored detainees held in a holding room or cell before their formal assessment. For instance, in a March 2012 case, Police in New Brighton detained a man with known mental health and drug abuse issues and left him unsupervised in an interview room, due to a lack of available cells, while completing custody paperwork. During this time the detainee self-harmed.
218. The most common problem in this area is a failure by officers to properly monitor detainees in cases where they have been assessed as requiring 'care and frequent monitoring'. In a number of the cases reviewed, officers did not comply with the policy requirement to check the detainee five times an hour, at irregular intervals.
219. Officers also sometimes do not properly check at-risk detainees using the types of checks that may be carried out under the *Managing Prisoners* policy (see paragraphs 121–124 above). For

example, they do not check detainees by observing them through the cell window and instead monitor them by watching them on the CCTV monitor.

220. Even when officers do comply with the policy requirement to check detainees five times an hour at irregular intervals, they may not properly appreciate the detainee's current risk because the nature of the check they perform does not allow them to do so. This is because the nature of the check performed – visual, verbal or physical – is left to the individual discretion of the officer and does not depend on any objective factors. For instance, officers often perform visual checks of at-risk detainees who are asleep by looking through the cell window. This provides the officer with little information about them. Also, detainees who could be adversely affected by alcohol or drugs may require regular waking (physical checks) to assess their level of consciousness and determine whether they require medical intervention. However, current Police policy does not adequately address this.

### Failure to seek medical assessment of detainees assessed as at risk in custody

221. A further risk management strategy provided for in the *Managing Prisoners* policy is the requirement that detainees who are assessed as being at-risk and requiring care must be examined by a DAO, CAT staff or Police medical officer as soon as possible (see above, paragraph 128). Officers must then record the result of the assessment in the detainee's "Health and Safety Management Plan" form.
222. In a number of the cases reviewed for this report officers did not adhere to the requirement to have at-risk detainees medically examined.
223. First, when they arrested or detained a detainee who was at risk and required immediate hospitalisation or medical examination, most commonly due to alcohol and/or drug consumption, officers sometimes took the person to be detained in the Police custody unit instead. For instance:
- In December 2013 officers attended a home in Pukekohe in response to a report from a counselling line operator that the female resident had attempted suicide. The officers found the woman in her bedroom with a small rope around her neck. She was very intoxicated, and told Police she had consumed two bottles of vodka that day. The officers took her to the Counties Manukau DCU to sober up and then be assessed by a DAO. The officers did not take the woman to hospital, despite her high degree of intoxication.
224. Secondly, when officers did not process the detainee, or conduct a formal risk assessment as soon as reasonably practicable upon his or her delivery to the custody unit, they correspondingly failed to organise a required medical examination. For instance:
- In September 2012 a heavily intoxicated man fell and injured his back while in custody at the old Christchurch Police Station watch-house. The man's degree of intoxication arguably required officers to have him medically assessed. However, upon his delivery to the watch-house he was placed in a holding cell and not correctly processed or risk

assessed before his injury occurred. Officers did not turn their minds to the need to seek a medical assessment based on the man's degree of intoxication (see further above, paragraph 174).

225. Thirdly, officers sometimes did not assess the detainee as being at risk and requiring care while in custody, despite a need for medical examination, because of the detainee's degree of intoxication. For instance:

- In December 2013 Police arrested a heavily intoxicated man and delivered him to the Auckland City DCU. At the DCU the man was received and assessed not to require care in custody, despite the receiving custody officer noting that the man was too intoxicated and irrational to answer the risk evaluation questions. The man subsequently attempted suicide. Custody officers then assessed the man as requiring care and constant monitoring and called the Area Mental Health Services to attend (see further paragraph 213).

226. Finally, officers sometimes did not seek a medical assessment of detainees who had been properly processed and assessed as at risk and requiring care. For instance:

- In the December 2013 case discussed above involving the heavily intoxicated woman detained by Police in Pukekohe (see paragraph 223), officers assessed the woman to be at-risk and to require care and frequent monitoring once delivered to the Counties Manukau DCU. The woman answered "*I don't know, I'm too pissed*" to most of the risk evaluation questions. However, a medical assessment was not sought for the woman, despite her being assessed to be in need of care. The woman subsequently attempted suicide in custody.
- In July 2013 Cambridge Police arrested a woman for assault and wilful damage to property and delivered her to the Cambridge Police Station. At the station the woman was agitated, hyper-ventilating and swearing loudly, and officers later described her behaviour as fluctuating between calm and totally irrational. Due to this, the officer who had arrested the woman decided in good faith to place her in an interview room, rather than a Police cell, under the supervision of another officer. At this point the woman had not been formally processed. However, despite holding concerns for the woman's mental wellbeing, the officer did not call a DAO to conduct a mental health assessment. The woman was subsequently injured when she struggled with officers after refusing to enter a cell.
- In August 2012 a Hastings man who fell over during arrest and, unbeknown to officers, suffered a skull fracture, was assessed at the Hastings watch-house as requiring care and frequent monitoring due to his heavy degree of intoxication. However, officers, both on arrest and at the watch-house, did not perceive that he required a medical assessment of his head injury (see further above, paragraph 196).

## Deficiencies in record-keeping of activities in relation to detainees

227. Officers are required by the *Managing Prisoners* policy to record in the ECM everything that happens in relation to detainees, such as their reception and release, checks and the provision of meals. This is important to ensure that officers carry out the functions necessary to fulfil their duty of care, and to ensure that an accurate record of a detainee's time in custody is available in the event an incident occurs.
228. In the course of its review the Authority has identified problems in officers' record-keeping in the ECM. First, when officers perform a check on a detainee, in many cases they simply record in the ECM 'Check', without additional information about the type of check performed or the person's condition. Secondly, the ECM allows officers to record that a certain activity, for instance a check performed or meal provided, has taken place in relation to all detainees in custody at the time. As a result, the ECM record may contain insufficient or inaccurate detail about what occurred in relation to individual detainees during their time in custody.
229. These deficiencies are illustrated in the October 2014 case discussed above, involving the heavily intoxicated man whose seven stab wounds were not discovered until about 45 minutes after he was delivered to the Christchurch DCU. In that case, officers did not begin to process the man until his stab wounds were discovered. As a result no record was made of his time in custody prior to this. Once the man was taken to hospital officers did not remove his record from the ECM. Consequently, when officers recorded that they had checked and provided all the detainees in custody with a meal, the ECM recorded that the man had been checked and given a meal, despite his being at Christchurch hospital.

## PROBLEMS IN DEALING WITH VULNERABLE PEOPLE APPROPRIATELY

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230. In the Authority's view, mentally impaired and other vulnerable people are not always dealt with by Police in a manner that is conducive to their mental and physical wellbeing. This can increase their distress and place them at greater risk of harm while in Police custody.
231. This problem involves two related aspects: the actions of individual Police staff; and the physical environment within which they are operating. As discussed in more detail below (see paragraphs 258–345), both stem from the fact that Police are required to assist in performing a health function that does not sit comfortably with their predominant law enforcement function.

### The actions of individual Police staff

232. Police officers commonly do not have the necessary expertise, and are therefore poorly equipped, to deal with situations involving people who are apparently at-risk due to intoxication or mental impairment. This lack of expertise gives rise to three problems:
- inappropriate or unlawful initial detention;
  - inappropriate management of vulnerable people in custody; and

- detention for a longer period than the law permits.

### *Inappropriate initial detention*

233. As detailed in part 3 above (see paragraphs 51–71), there are a number of provisions under which Police may arrest or detain someone who is intoxicated due to alcohol, other drugs and/or solvents, mentally impaired or suicidal. These include an arrest for breach of the peace (which involves actual violence or a public disturbance that leads others to fear harm to themselves) or for disorderly behaviour. Police may detain intoxicated or mentally impaired people for the purposes of detoxification or mental health assessment respectively, so long as they have been found in a public place or, in relation to mentally impaired people, if they have been requested to do so by a DAO.<sup>61</sup>

234. These powers are limited and often a poor fit with the situations that Police officers encounter. Nevertheless, as the emergency service most likely to attend these incidents, officers are often expected by family members or other members of the public to take action to resolve the situation and often feel that taking the person into custody is the only realistic option available to them.

235. Though they act in good faith in doing so, the detention may exacerbate the presenting problem and its lawfulness is often at best uncertain, and sometimes clearly absent. Officers routinely transport people to the Police watch-house, even though this may be an inappropriate environment for the person. For instance:

- In February 2014 Counties Manukau Police attended a home in response to a report of fighting, where they found a man who appeared extremely intoxicated lying on the porch. The man was yelling and behaving in an aggressive and erratic manner, and the officers were told he had been punching objects. The man's family were unsure whether he would be safe remaining at the house, and the officers said that, in their view, he would be safest at the Counties Manukau DCU. There he could be monitored and released once sober. The officers thought the man posed a risk to himself and others, and did not want to leave him at the address. They also did not want to expose hospital or ambulance staff to his aggressive behaviour. Consequently, they decided to arrest and detain the man for breach of the peace and detoxification, despite his being on private property. In these circumstances, though the officers were acting in the man's best interests and his arrest was lawful, it was not an appropriate response in the circumstances.<sup>62</sup>
- In December 2013 officers attended a home in Counties Manukau in response to a report from a counselling line operator that the female resident had attempted suicide. The officers found the woman in her bedroom with a small rope around her neck. She was very intoxicated, and told Police she had consumed two bottles of vodka that day.

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<sup>61</sup> Policing Act 2008, s 36 and Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 38(4)(b), 38(4)(d), 40(2) and 109.

<sup>62</sup> This incident is the subject of the Authority's public report *Death in Police custody of SENTRY TAITOKO* (March 2015).

The officers detained the woman to take her to the Counties Manukau DCU to sober up and then have an assessment by a DAO. In its review of the case, the Authority found that it was unclear if the woman consented to go with the officers. However, if she did not, because she was on private property the officers were not empowered to detain her for the purpose of detoxification. Equally, because she was on private property, the officers had no power to detain her for a mental health assessment under the Mental Health (CAT) Act 1992, unless requested to do so by a DAO at the scene. The woman later attempted suicide in Police custody.

236. In some cases, DAOs directed Police to transport mentally impaired and/or suicidal people to Police stations to await assessment. While Police stations are supposed to be places of last resort for mental health assessments, operational practice does not reflect this. This is discussed further below in paragraphs 278–298.

237. The difficulties confronted by Police are particularly acute when they are dealing with apparently mentally impaired people who are intoxicated. DAOs sometimes refuse to conduct assessments until such people are sober. Police therefore detain them and take them into custody until they are sober enough to enable the assessment to be conducted. For instance:

- In December 2013, Counties Manukau officers responded to a report that a male and female were refusing to leave a petrol station and claiming that they were being followed and were going to be kidnapped. The attending officers concluded that the male was under the influence of methamphetamine and behaving in a paranoid and delusional manner. He requested to go to the Police station, and the officers detained him to be assessed by a DAO at the Counties Manukau DCU once sober (see further paragraph 212).
- In August 2013, Police in central Hamilton arrested a heavily intoxicated man for disorderly behaviour. After his arrest the man was placed in a Police van. He was found to have attempted suicide in the van about 30 minutes later, and taken to hospital by an ambulance. After he was treated for his physical injuries, officers sought to have the man assessed by the CAT team. However, due to his intoxication CAT staff would not assess the man. Police subsequently transported the man to the Hamilton Police station watch-house for monitoring until he was sober enough for mental health staff to conduct a mental health assessment.

238. Sometimes, people who are heavily intoxicated or suffering from severe mental impairment are detained in Police custody even though they require hospitalisation or other medical treatment. For instance:

- In the February 2014 case discussed above involving the heavily intoxicated man detained by Counties Manukau Police (see paragraph 235), the officers took the man into custody and delivered him to the Counties Manukau DCU because they considered that he was too “aggressive” and he would pose too great a risk to ambulance and hospital staff. However, the man’s behaviour was due to his dangerous level of intoxication, which required hospitalisation or medical treatment. The officers should

only have used Police custody as a last resort, after seeking medical advice about the man's condition.<sup>63</sup>

- In November 2013 a heavily intoxicated man was arrested in central Auckland for breach of the liquor ban. The man's degree of intoxication meant that he required medical treatment and, given his condition, custody in a Police cell was inappropriate. However, this only became clear after officers had taken the man to the Auckland City DCU, where he suffered a seizure and stopped breathing.

### *Inappropriate management of vulnerable people in custody*

239. The management of vulnerable people in custody often does not constitute an appropriate response to their mental condition or state of intoxication.
240. First, while most officers try to treat mentally impaired detainees in a patient and sensitive manner, they do so while processing and managing the person using the same procedure that is applied to ordinary offenders. The person is delivered to the custodial facility and must wait in a holding cell until officers are ready to process them. When this occurs they are led in front of the processing desk and searched by the officers who detained them in front of custody staff. Custody staff then process the person and assess their risk while they stand in a designated area, usually marked out by red tape on the floor in front of the processing desk.
241. Officers then provide the person with a "Notice to Person in Custody" form to sign, which states the reason they are in Police custody and their rights while in custody. This form is clearly designed for a person who has been arrested pursuant to a warrant or following an offence, or remanded in custody, and it lacks specific provision for people detained for a mental health assessment. Consequently, much of its language is inappropriate. For example, it tells detainees that their relatives may be informed of the offence for which they have been arrested and whether they are bailable as of right. Also, at the time the cases covered by this report took place, if the person had been detained for a mental health assessment, the Police code, "1M – Mental Case", was inserted into the form.<sup>64</sup> After this process is complete, detainees are taken to a cell until they are assessed.
242. Processing mentally impaired detainees using the same procedure that is used for ordinary offenders can lead to two problems: it can lead officers to deal with vulnerable and mentally impaired people in a routinised way as if they were an offender and to miss relevant risk assessment information; and it can be confusing and upsetting for people who are already mentally distressed, and further detrimental to their wellbeing.
243. Secondly, Police lack appropriate methods and strategies for managing mentally impaired people who act in a way that poses a risk to themselves or others. Instead, officers deal with

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<sup>63</sup> As noted above, this incident is the subject of the Authority's public report *Death in Police custody of SENTRY Taitoko* (March 2015).

<sup>64</sup> As of March 2015, Police have changed the code descriptions in Police's NIA and CARD computer systems of: 1M "mental incident"/mental case" to "mental health"; and, 1X "attempted suicide" to "threatens/attempts suicide".

these situations by using containment and control strategies designed to deal with violent or aggressive detainees. For instance:

- In August 2014 Police in Christchurch arrested a man and took him to the Christchurch DCU. In the holding cell, the man was spoken to by the custody sergeant, who asked the man if he was thinking about attempting suicide in the cells. The man said yes, and the sergeant told the man that people *“who attempt to harm themselves in the cells are moved to a cell and monitored through an open door by a staff member for their entire stay, repeated attempts of self-harm involved being strapped to a restraint chair and being unable to move from that position until released.”* However, the man was not behaving in a manner that required him to be placed in a restraint chair. It was therefore not appropriate to refer to the restraint chair, and the comment was distressing to the man.
- In August 2013, officers in Wellington assisted ambulance officers to transport a man to Wellington hospital who had threatened suicide. The man became agitated and aggressive at hospital, and the accompanying officer detained him under section 109 of the Mental Health (CAT) Act 1992 for a mental health assessment at the Wellington DCU. Following this, due to the man’s aggressive and unpredictable behaviour in an interview room at the DCU, officers decided to detain him in a cell until CAT staff arrived. Upon being told this, the man began to self-harm by banging his head against the walls, so officers placed him on a restraint board in order to *“keep himself and others safe.”* Shortly after this, CAT staff and a psychologist arrived and determined that the man was intoxicated on prescription medication. They decided to assess him after the effects of the medication had worn off. The man then remained in Police custody during which he was restrained on a restraint board for over three hours.
- In February 2012 Police in Ashburton arrested a man and detained him in a cell at Ashburton Police Station. The man self-harmed and was taken to Ashburton hospital. He was then transported to custody at Christchurch Central Police Station, where he was assessed to require care and constant monitoring. The man self-harmed again and was taken to Christchurch Hospital, and then transferred to the care of Area Mental Health Services (AMHS). After his release from AMHS Police arrested the man and again detained him in custody at Christchurch Central Police Station. He self-harmed a third time and was taken to hospital. Upon his return to custody the man was assessed by a DAO, who instructed the custody supervisor to place him on a restraint board. The man remained on the restraint board for over eight and a half hours, which exacerbated his mental distress. One officer described that during the night the man was *“swearing and irrational ... erratic and unpredictable ... [he] continually screamed during the night, his mood was up and down all night.”*

244. The approaches used by officers in these cases illustrate that regular Police strategies for dealing with troublesome offenders are often inappropriate for vulnerable and mentally impaired people in Police custody. They may intensify the person’s distress and cause them to

react violently, placing themselves or others at risk.<sup>65</sup> However, the use of these tactics is largely unavoidable because officers lack the necessary expertise to deal with such people appropriately.

### *Detention for longer than permitted by law*

245. The final problem faced by Police when dealing with vulnerable people is that officers sometimes detain them for longer than lawfully permitted.

246. As discussed above in paragraphs 61–69, the Mental Health (CAT) Act 1992 empowers Police to detain an apparently mentally disordered person, either when they find that person in public or when they are assisting a DAO or doctor, for the purpose of a mental health assessment. In either case the maximum length of detention is six hours. If the assessment is not conducted during that period, the person must be released. In addition, the Policing Act 2008 allows officers to detain intoxicated people found in public for no longer than 12 hours, as discussed in paragraphs 58–59.

247. However, Police sometimes detain vulnerable people for longer than the statutorily prescribed period. For instance:

- In August 2014 Police in Counties Manukau attended a home in response to one of the occupants calling Police before suddenly hanging up. The caller returned home shortly after officers arrived at the address. She appeared intoxicated and refused to get out of the car. She was clearly mentally distressed. Officers detained the woman under section 109 of the Mental Health (CAT) Act 1992 in order to have her assessed by a DAO at the Counties Manukau DCU. The woman’s initial detention was lawful, but Police were only able to detain her for six hours or until she was assessed by a DAO. At the DCU the DAO initially refused to assess the woman as they considered that she was affected by drugs. Police subsequently detained the woman for more than 11 hours because they did not want to release her until the DAO assessment had been undertaken. However, this period of detention was over five hours longer than that permitted by section 109 of the Mental Health (CAT) Act 1992.
- In July 2013 Counties Manukau Police attended a reported domestic dispute allegedly arising from a woman’s attempt to jump from a moving vehicle earlier that day. Officers found the woman on the street in a distressed state. They tried but were unable to get a DAO to attend the scene due to the woman’s alleged intoxication. The woman was subsequently arrested for breach of the peace and detained for a mental health assessment. She was transported to the Counties Manukau DCU. Based on the purpose of her detention for a mental health assessment, Police could detain the woman for no longer than six hours under the Mental Health (CAT) Act 1992. However, Police subsequently detained her for nine hours until the mental health assessment was

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<sup>65</sup> Kristie R Blevins, Vivian Lord and Beth Bjerregaard “Evaluating Crisis Intervention Teams: possible impediments and recommendations” (2014) *PIJPSM* 37(3) 484–500 at 485.

conducted, and then for a further two and a half hours until someone could arrive to pick her up.

248. In some cases, Police justified the length of detention by stating that the person could be detained for six hours under the Mental Health (CAT) Act 1992, and an additional 12 hours for detoxification under section 36 of the Policing Act 2008. However, this is not correct. As outlined above (see paragraphs 58 and 67), each provision only allows officers to detain a person found in a public place. When a person has been detained for a mental health assessment and taken to a custody unit, they are no longer in a public place. Police cannot therefore rely on the detoxification power to extend the duration of their detention.

### The physical custodial environment

249. The construction and nature of Police custodial facilities make them an inappropriate and often harmful environment for vulnerable people, particularly those experiencing mental distress.

250. First, it is a noisy, uninviting and harsh environment. This is because the physical construction of Police custodial facilities is designed to contain and facilitate the effective management of those who may pose a risk to others, rather than to calm those who are agitated, disoriented or frightened.

251. This is highlighted by recent Police research involving mental health services users. It found that for people who are experiencing mental distress, Police stations are *“high sensory environments, and that high sensory environments exacerbate people’s distress.”*

252. The Authority considers that a number of the instances of self-harm detailed in the above cases have occurred in circumstances where the Police custodial environment, in conjunction with the manner in which officers have dealt with the mentally impaired person, has exacerbated the person’s distress. For instance:

- In August 2013 Police in Wellington assisted ambulance staff to transport a mentally impaired man to hospital for a mental health assessment. When the man became upset and abusive at hospital he was detained by an officer under section 109 of the Mental Health (CAT) Act 1992 and transported to Wellington Central Police Station to await assessment by the CAT team. Officers initially placed the man in an interview room but he became increasingly agitated and tipped over a table. When told that he would be placed in a cell, one officer described that the man *“immediately went ‘straight up,’ exhibiting maximum anxiety.”* As he was walked to a cell the man clenched his fists and violently head-butted the wall several times before he was restrained.
- In the February 2012 case discussed above, a man arrested by officers in Ashburton became agitated during processing at the Police Station after learning that he had been assessed to require care. He responded by self-harming, and officers subdued him by threatening to deploy a Taser. After he was interviewed, the man was placed in a cell without appropriate risk management strategies in place and was able to self-harm over

a period of about half an hour before officers noticed on CCTV. The cell in which the man had been placed was not appropriate given his mental condition, and Ashburton Police Station, at the time, was not suitable to hold detainees who have been assessed to require care.

253. The unsuitability of the custodial cell environment for vulnerable people is recognised by officers, but cells are used anyway due to a lack of alternatives. By way of example, in July 2013 Counties Manukau Police detained a woman for the purpose of a mental health assessment and she remained in custody for over nine hours until the assessment could be conducted. Following this the woman made a complaint regarding her detention. The officer who dealt with her complaint said that during a meeting with her:

*“I acknowledged that a Police cell is less than ideal as a place to hold people who require mental health intervention, but [said] that there was currently no viable alternative.”*

254. Secondly, in some of the reviewed cases at-risk detainees have been held in custody in areas not designed for at-risk detainees, such as Police interview rooms. They have then been able to self-harm in some way. For instance:

- In August 2013 Police in central Hamilton arrested an intoxicated and aggressive man for disorderly behaviour. This followed an argument between the man and his ex-partner. The man was initially held in a Police van while an officer completed paperwork in relation to his arrest. The man was then transferred to a Police prison van for transport to Hamilton Central Police Station. The Police van cage area was not the same standard as that in Corrections Department transport vans designed to preclude suicide attempts. About thirty minutes later the officer driving the van checked the man and found that he had attempted suicide using his belt.
- In March 2012 Police in New Brighton arrested a man and detained him in an interview room, due to a lack of available cells, while completing custody paperwork. The arresting officer was aware that the man was a risk to himself, but he was left unsupervised in the interview room. A short time later the man was found having cut himself deeply twice in the forearm with a small piece of metal.

## 8 Causes of Police Custodial Management Problems and Issues

255. In the Authority's view, this catalogue of overlapping problems in Police custodial management is attributable more to systemic and organisational deficits than individual poor practice. These deficits relate to:

- an absence of appropriate alternatives to Police detention for dealing with vulnerable people;
- the lack of a timely response by Mental Health Services to mentally impaired persons in Police custody;
- a lack of adequate training and expertise for Police officers working in the custody area;
- gaps in Police policies and practice; and
- the demands placed on officers by high workloads in custody areas.

### LACK OF APPROPRIATE ALTERNATIVES TO POLICE DETENTION

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256. One of the key problems underlying the failures discussed in the previous section is that the Police are often required to deal with people who are difficult because of suspected mental impairment, intoxication or drug use, and end up taking them into Police custody because there is a lack of appropriate alternatives. Such people are often highly vulnerable and at risk of harm from themselves or others, and the conditions of Police custody sometimes increase rather than minimise their vulnerability.

257. This problem is discussed below in relation to intoxicated and mentally impaired people detained by Police.

#### Alcohol, other drugs and/or solvents

258. In situations involving people whose degree of intoxication gives rise to a need for intervention, there are three general ways in which Police can intervene.

259. First, if the intoxicated person has committed an arrestable offence or a breach of the peace, they may be arrested and detained in Police custody and subsequently taken to Court in relation to an offence. However, Police can only enter private property to effect an arrest if the offence is punishable by imprisonment, and officers have reason to believe that the person will leave to avoid arrest or that evidence will be lost if Police do not enter immediately.<sup>66</sup>

260. Secondly, as discussed above in paragraphs 58–59, Police may detain and take into custody an intoxicated person who is in a public place, and who officers reasonably believe cannot be cared for by being taken home or to a temporary shelter. If these options are not available,

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<sup>66</sup> Search and Surveillance Act 2012, s 8.

officers may detain the person at the Police station until the person is sober, but for no longer than 12 hours.<sup>67</sup>

261. Thirdly, if the person's intoxication is such that it poses a risk to their life or safety and requires an emergency response, the Police may enter private property in order to take such action as is necessary to avert the emergency.<sup>68</sup> This may include calling an ambulance or transporting the person to an emergency department themselves. Beyond that, a Police officer does not have any general statutory power to detain, or use force in respect of, a person who is on private property.
262. While these powers appear to be fairly broad, a Police officer may face a number of obstacles and challenges in exercising them.
263. First, while officers may take the person to a hospital emergency department or call an ambulance to do so, hospital staff or paramedics may be reluctant or unprepared to accept responsibility for the person for a number of reasons:
- they may be violent or aggressive, and pose an immediate threat to the safety of hospital staff. Although hospital staff are likely to have access to security officers in the event of a threat to their safety, those staff may not be immediately available and in any case have a limited ability to exercise force.
  - Even if the person is not presently aggressive, hospital staff may be concerned that they are volatile or unpredictable, and may come to pose a threat to the safety of staff or other patients.
  - They may be highly disruptive to the operation of the emergency department and may have an adverse effect on the wellbeing of other patients, since most emergency departments do not have separate units or rooms in which the person can be segregated.
264. In addition, whatever the prevailing emergency department practice in the particular district, Police officers generally believe that violent or disruptive intoxicated people will not be accepted or that an emergency department is not an appropriate place for them, particularly during busy periods. When asked about the origin of their belief, officers commonly state that it is based on their previous experience of having violent or intoxicated detainees turned away by emergency departments.
265. For instance, one Police officer spoken to by the Authority in relation to a heavily intoxicated and agitated man detained by Police and taken to the watch-house stated:

*"The hospital wouldn't have taken him ... from my experience the hospital's very, very against taking anybody in who's warring and thrashing around like that."*

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<sup>67</sup> Policing Act 2008, s 36.

<sup>68</sup> Search and Surveillance Act 2012, s 14.

266. In another case involving an intoxicated and aggressive man in Police custody at the Police station, an officer spoken to by the Authority stated:

*“With regards to a mental health assessment and/or medical practitioner, I was not prepared to subject them to [the prisoner] while he was in his aggressive state. I practise, and this is confirmed by the outcome of the ... incident in the Whakatane cells some years ago, that while a prisoner is outwardly aggressive, so long as they are not self-harming, I simply leave them in whatever cell they are in until such time as the individual calms down. This is in the interest of both the prisoner and staff safety.”*

267. Similarly, a CAT team nurse spoken to the Authority in relation to her experience with this issue, stated:

*“We have people that are brought to the Police station because the emergency department won’t have them. Often people will be taken to the emergency department and they’ll be acting out in such a way that they will be removed and taken to the Police station for detoxification.”*

268. As a result, it has become common practice for Police officers to take heavily intoxicated people into custody and transport them to Police cells until they sober up.

269. Secondly, there are generally no alternative facilities, other than Police custodial facilities, to which the person can be taken for assessment and care. For instance, temporary shelters for the care and treatment of intoxicated persons have not been established as contemplated by the Policing Act 2008 and the legislation it replaced.<sup>69</sup> Because officers lack alternative locations to take such people, it has become standard practice for Police to detain them in a Police cell while they sober up.

270. As a result, Police custody has become the default option to deal with heavily intoxicated people, whether or not they are violent or agitated. For example, in one case involving a heavily intoxicated man detained at the Counties Manukau DCU the custody sergeant later stated that, *“We have become a default detox facility. We have intoxicated people here every week, it’s not new unfortunately.”* He went on to state:

*“I think that it should be the same across our country that intoxicated people should not be in [Police] cells. It is practice that has been around for a long time, though it is certainly not policy.”*

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<sup>69</sup> Section 37A of the Alcoholism and Drug Addiction Act 1966 (the predecessor to the Policing Act 2008) stated that when a Police officer comes across an intoxicated person they reasonably believe is incapable of protecting themselves, the officers should take that person home if possible, and if not, they should take the person to a temporary shelter or detoxification centre. See also the Authority’s *Deaths in Custody – A Ten Year Review* at [175]–[178].

271. The fundamental problem with this practice is that the Police custodial environment is often inappropriate for such people and poses its own risks. Of course, in the majority of cases a person's intoxication will not cause any adverse consequences, and this contributes to further normalising the practice of using Police cells as default detoxification facilities. However, occasionally things go wrong, and when they do Police are poorly equipped to deal with it.

272. A mental health nurse spoken to by the Authority stated:

*"From my experience there's been huge amounts of people that are agitated and in the Police station. They'll eventually go to sleep and wake up and all is well ... and in this situation, unfortunately, that didn't happen."*

273. She added:

*"[Police] just haven't got the facilities and that just puts a huge amount of pressure [on them] ... But, people like that shouldn't be left in the Police station to start with but that's what happens and it happens everywhere unfortunately."*

#### *Recent Police initiatives in managing the custody of intoxicated people*

274. In some districts Police have implemented, or are in the process of implementing, changes to practice in order to address the problems around managing the custody of intoxicated people.

275. First, some districts have adopted strategies to ensure that people whose degree of intoxication requires intervention do not enter or remain in Police custody. For instance, Auckland City and Counties Manukau Districts now require that *"if the person appears dangerously affected by alcohol ... an ambulance must be called as the person may lapse into unconsciousness or be suffering from a drug overdose or undiagnosed medical condition."* In addition to this, Police in Counties Manukau, Auckland City and Waikato are also actively working with hospital and ambulance services to *"find workable solutions for dealing with intoxicated people"*, and have agreed that when necessary Police will call for ambulance staff who, if required, will utilise paramedics to sedate volatile intoxicated detainees.

276. Secondly, some districts have changed their practices to ensure that they monitor intoxicated people in custody and identify any change in their level of risk. For example, when a person is brought into the Counties Manukau DCU for detoxification, custodial staff must check the person and reassess their degree of intoxication every two hours. Following reassessment, if custodial staff decide to retain the person in custody, they must record this and the reason for their decision in the ECM.

#### *Summary*

277. In summary, Police are the public's primary point of contact to deal with people who are affected by alcohol or other drug consumption. In the absence of other suitable alternatives, their default response is to take them to the Police cells until they sober up. While some recent attempts have been made to ensure that those who are assessed as requiring medical

treatment receive it promptly and that better monitoring of intoxicated people occurs, the majority are simply left in the cells to “sleep it off”. This is a problematic way of dealing with such people and poses considerable risks, as custodial staff do not have, and cannot be expected to have, the knowledge or skills to recognise warning signs that the person may require medical assistance.

## Mentally impaired people

278. As with intoxicated people, Police may arrest mentally impaired people who may require mental health assessment and treatment if they have committed an arrestable offence or a breach of the peace. Officers may then arrange for the person to be assessed by a mental health professional while they are in custody awaiting a court appearance.
279. In the absence of an offence or breach of the peace, the powers of Police officers are limited unless they are assisting a DAO or medical practitioner at the scene. Although they have some common law powers to take necessary action to preserve life and safety, their independent statutory powers of detention are confined to two circumstances: when the person has threatened or attempted suicide (see paragraph 60); and when the person appears to be mentally disordered and is found in a public place (see paragraph 67). In particular, Police officers do not have the statutory power to enter private property unless there is a risk to the person’s life or safety requiring an emergency response,<sup>70</sup> and they do not have the statutory power to detain a person who is on private property.
280. The legislative framework in the Mental Health (CAT) Act 1992 instead appears to contemplate that a person who is at risk and/or unable to take care of themselves because of a mental health crisis will primarily be dealt with by mental health professionals. In particular, as noted above in paragraphs 61–64, there is an expectation that DAOs will be the first point of community contact and will arrange the treatment appropriate to the person’s condition at home or in hospital. DAOs may call the Police to assist them only for the purpose of having the person examined by a medical practitioner, forcibly transporting the person to a medical practitioner for examination, or taking or returning a person to a place of assessment or treatment.
281. The reality in most Police districts is quite different. Although mentally impaired people or their friends and family may ring the relevant DHB numbers to seek help, they also commonly ring 111. Unless the mentally impaired person requires the immediate attendance of an ambulance, the 111 call will result in the dispatch of Police frontline response staff. In 2013/2014, the Police attended 42,109 calls for assistance solely on the basis of a mental health crisis. Police communication centres received and resolved a further 20,392 calls over the phone, without dispatching an officer. That is, once the call takers/dispatchers assess that the call does not fit the criteria for dispatching Police frontline response staff to the person, there is usually no further action taken.

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<sup>70</sup> Search and Surveillance Act 2012, s 14.

282. When Police respond to such calls, they have several options theoretically open to them. However, a number of problems prevent Police officers from effectively taking such steps.
283. First, Police may contact the Area Mental Health Services and request that the on-call DAO attend the scene. However, DAOs have sometimes taken a considerable time to arrive at the scene (perhaps up to 2–3 hours), thus tying up Police resources that are required elsewhere. That problem may arise because:
- DAOs are sometimes thinly spread and cover a significant geographical area. In rural areas they may have significant distances to travel and in urban areas they may have to deal with congestion.
  - If they are the on-call DAO at night, they may be the only person on duty.
  - They may be tied up with more urgent calls for assistance.
  - They may have to travel from home to their office to access the patient's records before visiting them for the assessment.
284. As a result of these logistical difficulties and the fact that DAOs have been assaulted when attending mentally impaired people in previous instances, the Police have advised that in many Police districts DAOs have been reluctant to attend private places to conduct mental health assessments at all. Instead, they have adopted the practice of asking the Police to attend on their own and detain and transport the person to the Police station so that the detainee can be assessed there when time allows.
285. DAOs are also unwilling to conduct mental health assessments of people who have a significant degree of intoxication until they have sobered up.
286. Secondly, though officers can transport the person to a hospital emergency department or call an ambulance to do so, they may decide not to do so for a number of reasons:
- If the person is volatile or intoxicated, they often refrain from taking this option for many of the same reasons as those discussed above in relation to intoxicated people (see paragraphs 263–268).
  - Police officers have commonly found that if they do take the person to an emergency department, the hospital expects them to stay there until the person has been assessed so that they can deal with any behaviour problems that arise. While officers are still looking after the person, they are unavailable to be reassigned to other emergency calls for service.
  - Nationally, emergency department practices in accepting people for mental health assessment are inconsistent, and some emergency departments are more willing and able to accept people for mental health assessment because they have on-site mental health staff.

- Though a DHB may have a policy to accept people for mental health assessment, emergency department staff may be reluctant to set aside time to liaise with Area Mental Health Services (AMHS) staff to conduct the assessment because in previous instances there has been a delay in getting a response from AMHS staff.
  - The areas used to hold people in most emergency departments are semi-public, and they may offer little privacy to the person being assessed.
287. Thirdly, while officers may themselves transport the person to an alternative appropriate place of safety for assessment, there are generally no suitable facilities established for this purpose. Before Police established larger DCUs, officers commonly transported the person to the nearest Police station to sit in a room with an officer until the DAO arrived, but this again tied up a Police resource that may have been required elsewhere.
288. As a result of these problems, the default response of a Police officer in most Police Districts is to take the person into custody and transport them to the Police cells until they are assessed by a DAO.
289. This is confirmed by recent research in Wellington Police District,<sup>71</sup> which found that out of 283 mental health crisis assessments requested by Police over a 3 month period, one (0.03%) was done in someone's home, 30% were done in an Emergency Department and 70% were done at the Police station. Prior to this, in September 2014, Police took a national week-long sample of mental health-related calls (1M and 1X),<sup>72</sup> which were not related to an offence, and found that 59% of the mental health assessments requested by Police during that week were conducted in Police stations.
290. This prevailing practice is entirely understandable. When Police are called as a 24-hour emergency service to deal with a mentally impaired person, family and friends of that person generally expect that the attending officers will do something to assist. In addition, the officers themselves commonly feel obliged to take effective action to resolve the situation as quickly as practicable and, in the absence of an appropriate alternative, take the mentally impaired person into custody.
291. Further research undertaken by Police found that the main reasons officers gave for detaining mentally impaired people in these circumstances are that:<sup>73</sup>
- they believe that they have a 'duty of care' to prevent people from harming themselves or others, and 'err on the side of caution' to ensure that this does not occur; and

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<sup>71</sup> Emma Fleming "Response patterns for Police attendance at mental health (1M and attempted/threatened (1X) incidents for Wellington District" (New Zealand Police Mental Health Team, Wellington, October 2014).

<sup>72</sup> These codes correspond to: 1M "mental health"; and 1X "threatens/attempts suicide".

<sup>73</sup> Police Organisational Assurance Group *Police Response to People with Mental Impairment* (July 2012) at [2.2.8].

- they feel driven to resolve such incidents as quickly as possible so that they may attend other, possibly more critical events, and consider it inefficient to wait with the person until the DAO attends.
292. However sensible and pragmatic this response may appear to be, it gives rise to five fundamental problems.
293. First, the detention itself may sometimes be unlawful. Where the person is on private property, there is no directly applicable power of detention. The Police commonly attempt to resolve this by purporting to arrest the person for a breach of the peace or for the offence of behaving in a disorderly manner.<sup>74</sup> These arrest powers are an awkward fit with many of the situations involving mentally impaired people that the Police encounter. For instance, it is often debatable whether a disturbance by a mentally impaired person meets the test for a breach of the peace, since it must be shown that their conduct involved actual violence or a public disturbance that leads others to fear harm to themselves.
294. Secondly, even if there is a power to detain because the person is in a public place or is committing a breach of the peace or disorderly behaviour, they must be charged within a reasonable time or released. They cannot subsequently be detained for assessment under section 109 of the Mental Health (CAT) Act 1992 because, at the time of their detention for that purpose, they are in the Police cells, which is not a public place.
295. Thirdly, where there is a power of detention under section 109 because the mentally impaired person is in a public place, the Police are then required to arrange an assessment by a medical practitioner within six hours. In practice, however, initial assessments are done by DAOs who are not medical practitioners, and a subsequent assessment by a medical practitioner is undertaken only if that is considered necessary. That is contrary to the terms of the legislation and renders the detention unlawful.
296. Fourthly, the power of detention under section 109 is limited to six hours. In fact, there are many cases where DAOs fail to do an assessment within six hours, particularly when the person is intoxicated. Even if they do the assessment within six hours, a medical practitioner then needs to come to the Police station, which often extends the period of detention beyond the permitted period. The custody sergeant may then feel the need to continue detaining the person until a family member has arrived to collect them rather than releasing them onto the street. Indeed, a Police report on one of the cases reviewed for this report stated that *“It is common for DAOs to offer a caveat such as a requirement for the person to be released into the care of a family member and this will create a delay while arrangements are made.”* It is therefore common for section 109 detentions that are initially lawful to become unlawful.
297. Finally, regardless of the legality of detention, for a number of reasons Police cells are arguably an inappropriate environment for a person whose sole reason for detention is that they are having a mental health crisis, including:

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<sup>74</sup> Summary Offences Act 1981, s 4(1).

- when a person experiences a mental health crisis their senses are often heightened, and the harsh, high sensory Police watch-house environment is likely to exacerbate their condition and increase their distress when they are already disoriented and frightened;
- detention by Police may increase self-stigma, feelings of low self-worth and suicidal thoughts;
- the involvement of Police with mentally impaired people can contribute to public perceptions that they pose a risk to others; and
- access to appropriately trained health professionals for people with unknown or unmet health needs may be delayed.

298. Police have acknowledged the unsuitability of Police cells for mentally impaired people by informing officers of the organisation's "*strong preference not to take people to Police stations for safekeeping*" when they have not committed an offence and are not a risk to anyone else. Indeed, officers have told the Authority that they sometimes avoid formally processing mentally impaired persons through the Police cells because they recognise that they are not criminals but only mentally impaired and requiring care, and that placing them in a cell criminalises them and stigmatises their condition.<sup>75</sup> They have also expressed concern that watch-house cells are inappropriate environments for people who are suffering mental impairment and/or suicidal, and exacerbate their mental health issues.

#### *Recent Police initiatives in dealing with mentally impaired people*

299. Police are working at national and district level, and with relevant stakeholders, to address these problems.
300. On 1 July 2014 Police established a mental health team at Police National Headquarters in Wellington. The team was set up to identify ways for Police to improve their response to mentally impaired people and to work with other agencies to improve the inter-agency delivery of services to them.
301. Some Police Districts have also entered into Service Level Agreements (SLAs) with local District Health Boards (DHBs). These agreements provide a framework for the relationship between the two bodies and provide protocols and processes for Police and DHB staff to follow when dealing with each other and attending incidents.
302. To take one example, the SLA between the Waitematā DHB and Police District provides detailed protocols in relation to: requests for Police assistance from DHB staff and vice versa, including the information that must be provided and the manner of response; the expectations on Police when they are delivering people to the emergency department; and an escalated decision making process to help resolve issues. DAO and CAT team staff told the Authority that

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<sup>75</sup> Police Organisational Assurance Group *Police Response to People with Mental Impairment* (July 2012) at [2.5.2].

the defined escalation process is particularly beneficial, and allows both agencies to identify the reasons for problems that arise in practice and to work together to resolve them.

303. In addition, Police and DHB staff members in many districts are now devoting considerable time and effort into building and maintaining their inter-agency relationships. In discussion with the Authority, both Police and DHB staff members said this fosters understanding of each agency's respective roles, powers and legal obligations, from front-line to managerial level.
304. As part of these developing relationships, some districts have put considerable effort into ensuring that DAOs are readily available to attend scenes. For instance, in Waitematā District, when Police receive a call about a person potentially experiencing mental health crisis, they notify Mental Health Services. Police and the DAO then coordinate arrival timeframes over the phone. If Police arrive first they contact the DAO and discuss the nature of the person's behaviour. If the person needs to be seen by the DAO, they agree on how to deal with the incident. Usually Police wait for the DAO to arrive. But if it will ensure a timelier assessment, they take the person to meet the DAO or medical practitioner. If this involves taking the person to the emergency department, the agencies have agreed Police will not wait more than one hour with the person.
305. In the event that DAOs are unable to attend a scene, efforts are also being made to ensure the early resolution of incidents, and reduce the number of people taken for mental health assessment where this is unnecessary. For instance, in Waikato District, when Police attend a person experiencing a possible mental health crisis, they are expected to call mental health staff from the scene, who then speak to the person and determine whether any immediate assessment is required. This may result in mental health staff attempting to resolve the person's problem over the phone, or arranging to see them later in the day or the next morning, so that no further Police involvement is required.
306. Some Districts have also made major efforts to reduce the number of people in mental health crisis who are taken to the Police cells for assessment. For example, in Waitematā District the inter-agency expectation is that only those who are potentially violent or assaultive will be taken to Police cells. DAOs are more often assessing people in their homes while the Police are present, and emergency departments in Waitakere and North Shore are more willing to hold people for assessment (although generally only if the Police wait at the hospital until the person is assessed, so that they can deal with any behaviour problems that arise). The Waitematā SLA includes a "*Protocol for NZ Police delivering person to WDH B Emergency Departments*" form, which officers must complete in each case. The form records information including the reason and legal authority for the person's arrest or detention and the reason why Police are delivering them to hospital. DAO and CAT team staff told the Authority that as a result of these improved working practices, combined with better communication and collaboration, the number of people taken straight to Police cells has dropped significantly.
307. Some changes are also being made to improve the way Police and Mental Health Services respond to people in rural areas, which present challenges in terms of distance, lack of infrastructure and smaller staff numbers. For instance, in Waikato District, if a call about a potentially mentally impaired person in the Coromandel is received after hours, Police usually

attend but maintain regular contact with the CAT team. The CAT team then decides, based on available resources, if they are able to attend. If not, the agencies have in place an agreement that if Police must transport the person for assessment, the CAT team will meet the Police car halfway between their respective locations.

308. At a national level, Police are working with the Office of the Director of Mental Health to develop a protocol which is intended to guide the ways in which Police and Mental Health Services respond to people in mental distress. The protocol sets out the principles within which each agency is expected to operate when responding to a mental health crisis. The agencies are also engaged in a project to review the distinct ways each organisation collects data relating to service to mentally impaired people. This is to better understand patterns of service demand on each organisation and the ways they respond to demand. Finally, the Office of the Director of Mental Health is also considering the ways that Area Mental Health Services can work with emergency departments to ensure more consistent practice with regard to emergency departments accepting people for mental health assessment.

### *Summary*

309. In summary, the expectations placed on Police when they are called to deal with a mentally impaired person experiencing a crisis do not fit with relevant law and policy. Their default response has been to take the person to the Police cells to await assessment by a mental health professional. This sometimes occurs without legal authority. More significantly, it places that person in an environment wholly unsuited to the nature of their condition and runs the risk of exacerbating the immediate severity of their condition and causing them long-term distress and harm.
310. While Police and Mental Health Services have been working more closely together in recent years and many Districts have introduced initiatives that have alleviated the problem, it nevertheless remains the reality that the Police response to many, if not most, of those experiencing a mental health crisis is inappropriate and often unlawful.

## **TIMELINESS OF POLICE ACCESS TO APPROPRIATE SERVICES FOR PEOPLE IN CUSTODY**

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311. A person who has been detained by Police and taken to the Police station for a mental health assessment is initially subject to the receiving process described in earlier sections of this report (see from paragraph 112 onwards and 240–241 above). Ordinarily, officers then call a DAO to come to the station to assess the person and determine whether they require further examination by a medical practitioner. The person is detained in a cell until the DAO or medical practitioner gets to the station to assess them. As noted above, this detention must not exceed six hours (see paragraphs 64–67 and 246).
312. There are a number of problems which prevent the effective and timely running of this process.
313. First, it is not uncommon for the DAO to take a significant period of time to arrive at the Police station, as detailed in some of the cases discussed in paragraphs 245–247 above. The reasons

for this are the same as those that prevent them from attending the person's home (see paragraphs 283–284 above): they may be the only DAO on call; they may be tied up with more urgent calls for assistance; and they may have to travel from home to their office to access the patient's records before visiting the Police station for the assessment (although some Police watch-houses now have DHB terminals that enable records to be accessed from there). In addition, if the person is intoxicated or affected by drugs, the DAO may not come to the station to assess them until they are sober because they consider that the person's intoxication will prevent an accurate assessment.

314. This problem is detailed in the two cases discussed in paragraph 247. The second in particular illustrates both of these problems. The case involved an officer who attended a situation involving an intoxicated and apparently mentally impaired woman. After attempting to contact the DAO and waiting about one hour, the officer said that *"the DAO eventually returned my calls and refused to come out due to [the woman's] level of intoxication."* As noted above, Police subsequently detained the woman for about nine hours before the DAO attended the station, and for a further two and a half hours until someone arrived to pick her up. Consequently, her detention was about five and a half hours longer than lawfully permitted. In addition, Police failed to meet their obligation under section 109 of the Mental Health (CAT) Act 1992 to arrange for an assessment by a medical practitioner.
315. In metropolitan areas, watch-house nurses stationed at larger DCUs enable these assessments to be done more quickly.<sup>76</sup> However, though the use of watch-house nurses to conduct assessments has been to good effect, this was not the purpose for which the watch-house nurse programme was originally set up.<sup>77</sup> When this initiative began as a pilot programme in 2008, their intended role was two-fold: to assist Police to better manage the risks of people in Police custody who have mental health, alcohol or other drug problems; and to identify agencies for referral to help detainees deal with these problems after they have been through court.
316. Secondly, section 109 of the Mental Health (CAT) Act 1992 contemplates that Police will always *"arrange for a **medical practitioner** to examine the person at that place as soon as practicable."*<sup>78</sup> A medical practitioner is defined by the Act as *"a health practitioner who is, or is deemed to be, registered with the Medical Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of medicine"*. In other words, the assessment must be done by a doctor. A DAO may assess the person and arrange for them to be seen by a doctor, but the section does not contemplate that the person will only be assessed by a DAO. In reality, however, the standard practice is at odds with the law.
317. Thirdly, when the initial assessment by a DAO is delayed, any subsequent assessment by a doctor often ends up being outside the statutory time limit of six hours.

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<sup>76</sup> Watch-house nurses are stationed at the Counties Manukau, Hamilton, Rotorua and Christchurch District Custody Units.

<sup>77</sup> Watch-house nurses began operating at the Christchurch Central Police Station watch-house in 2008.

<sup>78</sup> Section 109(1)(b), emphasis added.

318. Fourthly, the majority of mental health assessments occur in Police stations. Following a person's assessment at the station, officers often perceive problems with their safe release from the Police station into the community. In some instances officers may not be able to contact the person's family members, and their family members may in turn be reluctant to pick the person up or take them home. Consequently, and for understandable reasons, Police continue to keep the person in custody, without their consent, until someone comes to the station to pick them up. As a result, in many instances Police detain the person for longer than is contemplated and allowed by law.

#### *Recent Police initiatives to improve access to services for people in custody*

319. In some districts Police are working with DHB mental health staff to improve the timeliness of mental health assessments, and to ensure that people detained for mental health assessment do not remain in custody beyond the statutory time limit.

320. Some districts have implemented protocols to ensure that DAOs do not refuse to attend Police calls to see mentally impaired persons in Police cells on the basis they are intoxicated. For example, Waikato Area Mental Health Services have in place a protocol with Police whereby the DAO will always attend to see the person first, and then after speaking to them determine if the person is too intoxicated to be assessed. If they determine the person is too intoxicated at the time, the DAO agrees with Police a management plan both to ensure that the person is assessed within the six hour period and to enable them to be appropriately dealt with in the meantime.

## **EXPERTISE AND TRAINING OF POLICE STAFF**

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### **Lack of expertise amongst officers**

321. The Authority considers that officers are not well equipped to identify and accurately assess some of the circumstances that pose a risk to a detainee's health and wellbeing in custody and to deal with these circumstances. This specifically applies to detainees who are under the influence of alcohol, drugs or solvents or are mentally impaired and/or suicidal.

#### *Alcohol, other drugs and/or solvents*

322. Police officers often lack the expertise necessary to accurately assess the degree of risk presented by a detainee's level of intoxication or drug consumption, and to determine the strategies necessary to manage this risk. This manifests itself in a number of ways.

323. First, detainees exhibit intoxication differently, and the effects of their intoxication may become more pronounced as their body absorbs the alcohol and/or drugs consumed prior to their arrest or detention. Their level of intoxication may therefore not be immediately apparent. Officers may misjudge the degree of risk posed by the level of intoxication presented by the detainee's behaviour, and fail to implement appropriate risk management strategies.

324. Secondly, intoxication or drug consumption can hide other risk factors and prevent their detection by officers during the risk assessment process. These risk factors can include internal

injury, pre-existing health conditions and mental illness. In the cases reviewed for this report, examples included a skull fracture, a pre-existing spinal condition, and head injuries caused in a fight prior to the detainee's detention.

325. Thirdly, because Police officers frequently deal with intoxicated and drug-affected people, the vast majority of whom do not come to harm as a result of their intoxication, they may be inclined to subconsciously raise the threshold against which they assess the extent to which such people are at risk.
326. For instance, in one case involving a seriously intoxicated detainee detained in the Counties Manukau DCU the custody sergeant stated that:

*“To put it in perspective we have large numbers of intoxicated prisoners through the cells and mostly they come in and sleep it off ... We have people who are unconscious and unresponsive brought into the DCU regularly. They tend to be put in a cell and sleep it off. We have become a default detox facility.”*

327. An officer from another case reviewed for this report also told the Authority that intoxicated people *“are more often than not deemed not at risk [and] so no ‘Prisoner Health and Safety Management Plan’ will be done and therefore no monitoring other than is standard.”*
328. This under-estimation of risk is demonstrated by those cases where intoxicated or drug-affected detainees who were aggressive or uncooperative were placed into detention cells without any risk assessment (see paragraphs 174–175 above).

### *Mental illness and suicidal tendencies*

329. Police officers lack expertise to deal with mentally impaired people in two respects.
330. First, officers are not well equipped to detect the presence of mental impairment or suicidal tendencies in some people. This is particularly the case if the warning signs or risk indicators are not obviously apparent and there is no known history of mental illness or suicidal tendencies. Even when officers do detect some mental impairment, they nevertheless lack the expertise necessary to accurately assess its nature and the risk it poses to the person's wellbeing. Nor may they recognise the adverse impact of the Police custodial environment. Statements like the following, made by the manager of a local Mental Health Service to the Authority in relation to a case reviewed for this report, illustrate this:

*“The Police aren't trained mental health clinicians so they can only take, if they don't know the people they're dealing with, they're only going on sort of layman's observations of behaviour. They won't be aware of how much alcohol or other substances a person might have consumed and what the consequences, in terms of physical and mental health outcomes for that person, might be.”*

331. This can affect how officers deal with mentally impaired people at the arrest or detention stages of custody, and during processing at the watch-house.

332. Secondly, officers lack the skills and strategies to deal with mentally impaired people in a way that effectively reduces their mental distress and de-escalates situations. This is demonstrated in some of the cases discussed above (see paragraphs 239–244). In these cases, the tactics and strategies of the officers were inappropriate and likely exacerbated the detainee’s distress.
333. Custodial staff generally recognise their limited knowledge and expertise in this respect. For instance, in one of the reviewed cases, and in relation to the policy requirement that officers only change an at-risk detainee’s monitoring status following a medical examination, a Police sergeant with significant custodial management experience stated:

*“It’s a no brainer. You do not downgrade a monitoring status. You can’t. I don’t have the qualifications, I’m just a uniform cop ... I’m not a mental health professional or a doctor. That’s just basics.”*

334. Police officers are often the first point of contact for people who pose a risk to themselves or others due to some apparent mental illness. Given this reality, it is essential that officers are equipped with the skills and understanding necessary to identify, assist and appropriately deal with such vulnerable people at all stages of the custody process.

### Lack of adequate training

335. This problem has been exacerbated by the absence of or gaps in training for officers. In many districts, the additional custodial management training received by Police officers assigned to work in custodial facilities (described above at paragraphs 24–34) has been minimal at best, in relation to both sergeants and constables. For instance:
- A custody sergeant spoken to about a February 2014 incident commented about the training received before working in the Counties Manukau DCU that he worked for a week alongside the outgoing custody sergeant and that, *“There is no formal training and as with so many roles in the Police you learn as you go. In this case coming into the DCU I was given an induction and I have the reference desk file and a copy of the standard operating procedures that were sent to me electronically.”*
  - In an August 2013 Wellington case, where officers did not deal appropriately with an at-risk detainee, it was determined that the primary cause was a lack of formal induction or training for Police sergeants responsible for the management of detainees in custody at Wellington Central Police Station, for their role as custody supervisors.
  - A lack of additional training for constables was also apparent in some of the other cases reviewed by the Authority. For instance, in an August 2013 case involving an attempted suicide in the Hastings Police Station cells, the constable on duty at the time later described his May 2013 custodial management training, prior to undertaking duties in the cells, as a one and a half hour discussion about the Hawke’s Bay Custody Unit document. He described this as a *“question and answer session.”*
  - In an August 2012 case involving an intoxicated man detained in the Hastings Police Station cells who, unknown to any of the officers that dealt with him, had a fractured

skull, the Police officers working in the watch-house had not received specific custodial management training. One of these constables later described his learning to work in the watch-house as “*basically by the seat of my pants.*”

336. Many constables do not have any desire to undertake watch-house duties, but are obligated to do so when rotated into the role for a set period, usually about six months. This also means that when they are subsequently rotated from watch-house duties to other Police duties, any experience they have gained and can share with other officers is lost.
337. Police have sought to address these issues by using authorised officers as full-time custody staff. However, while the training received by authorised officers has been more extensive, it is still too limited. Police do not have a standardised national authorised officer training programme. While all authorised officers must complete the Custodial Management Suicide Awareness training programme (described above in paragraphs 29–31), the length and content of additional authorised officer training varies between Police districts. Very few districts provide training in the care and protection of intoxicated people, and only one district provides training in the assessment and care of mentally impaired people.
338. The consequence is that both sworn Police officers and non-sworn authorised officers can have an inadequate awareness of the law and policy applicable to the custodial management environment. For instance, research conducted by Police has found that many Police officers were not familiar with the *People with Mental Impairments* policy (discussed above in paragraphs 143–151).<sup>79</sup>
339. Moreover, a lack of knowledge of relevant policy can foster working practices that do not adhere to policy. This may explain the development of the practice of placing heavily intoxicated and/or aggressive detainees straight into a cell without a proper risk assessment (discussed above in paragraphs 174–175).

#### *Recent Police initiatives in training*

340. Police have recently developed a training package on intoxication and mental health. It emphasises that dangerously intoxicated people should not be held in Police cells and explains that in instances where the person is violently intoxicated, officers may restrain them in a restraint chair and call a paramedic to sedate the person. This training package is being delivered to DCU supervisors in Northland, Waitematā, Counties Manukau and Rotorua Districts, and has been provided to the Police National Headquarters Operations Group and to Professional Conduct Managers for use in all DCUs.
341. Police have also recently redesigned the mental health awareness training received by Police recruits and by existing staff involved in custody in order to improve their ability to deal appropriately with mentally impaired people. These changes are described above in paragraphs 38–42.

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<sup>79</sup> Police Organisational Assurance Group *Police Response to People with Mental Impairment* (July 2012) at [3.3.2].

342. Finally, Police have undertaken to progress national custodial training for authorised officers and custodial staff (both constables and supervisors) in 2015/2016. Police are also reviewing their First Aid training and considering whether it should include more information on intoxication and mental health issues.

### Inadequate understanding of risk assessment

343. As discussed above, the form that custodial staff must complete when assessing a detainee's risk while in custody is intended to provide them with objective information to assist them in that task. However, there is no real guidance or training as to how to use the information when making their decisions. As a result, the Authority considers that custodial staff do not always conduct robust risk assessments.

344. First, custodial staff commonly place greater weight on their subjective impression of the detainee's demeanour at the time of processing than on the objective information recorded on the form, such as NIA alerts relating to previous suicide attempts. This may be justified if the objective information is old and staff discover through further questioning that the detainee's current circumstances have rendered that historical information less relevant. More often, however, officers simply commit the common human error of believing that their own judgement is more reliable than externally verifiable data as to risk. This is perhaps not surprising, given that there is no available information on the extent to which the data recorded on the risk assessment form is a good predictor of risk, and no guidance about when personal judgement should override it.

345. Secondly, officers sometimes conduct risk assessments in a routine and mechanical manner. That is, they complete the relevant risk assessment documentation, and fill in the relevant sections based on answers provided by detainees to the risk assessment questions, but do not go beyond these answers to sufficiently investigate their particular circumstances and determine the relevance of risk factors to those circumstances. They may consequently assign a risk category that appears to be at odds with the information recorded in the risk assessment documentation.

## GAPS IN POLICE POLICY AND PRACTICE

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### Gaps in Police policy

346. The *Managing Prisoners* policy does not provide guidance on what steps officers should take when the condition or behaviour of detainees does not allow them to be processed and their level of risk assessed. This lack of policy guidance has contributed to the practice of officers placing such detainees straight into a cell.

347. As described above in paragraphs 174–175, this can lead to vulnerable and at-risk detainees being held in Police custody without appropriate risk management strategies in place, such as formal monitoring requirements or examination by a medical professional. It also means that,

until they are entered into the ECM, any interaction with them will not be recorded, effectively creating a gap in the record of their time in custody.

### Lack of robust monitoring controls

348. The Authority considers that the current Police system for monitoring detainees who have been assessed as being at-risk in custody is generally adequate. In particular, the two risk categories that may be assigned to them – care and *frequent* monitoring or care and *constant* monitoring – are fit for purpose. However, the effectiveness of these categories depends upon proper implementation, and current practice regarding the implementation of the care and *frequent* monitoring system is inadequate in two respects.
349. First, although the system requires the detainee to be checked five times an hour at irregular intervals, the officer monitoring the ECM may confirm that a check has occurred merely by clicking the necessary tab under the detainee’s name on-screen. As a result, it is possible for that check to be recorded as having been performed, even if the officer has not done it at all or has done it only by looking at the detainee via the CCTV monitor (which is contrary to policy).
350. Secondly, when officers record in the ECM that a check of a detainee has been completed, they are not required to record any further information describing how the detainee was when checked. As a result, it is not possible to retrospectively determine from the custody record what happened when the check was completed by an officer.

### Recent Police initiatives

351. In the Counties Manukau DCU, Police have implemented requirements designed to address these problems.
352. All detainees are entered into the Police NIA ECM upon arrival. If, due to their physical condition, a detainee cannot communicate they must be taken to hospital. If the detainee is simply uncooperative and refuses to answer the risk assessment questions, they must be placed on frequent monitoring.
353. When officers perform a check on a detainee assigned to care and *frequent* monitoring, they must record the nature of the check (physical, visual or verbal rousal) and any specific observations communicated to them by the officer who performed the check about the detainee’s condition and response to the check. At least once every hour, they must also enter the cell, physically wake the detainee to establish wellbeing, and communicate with the detainee. This is recorded by the officer monitoring the ECM at the security as ‘EPC’ (Enter, Physical, Communication).
354. In addition, Counties Manukau has implemented a requirement that detainees detained at the DCU for detoxification must be checked and reassessed every two hours to determine their level of sobriety. If officers decide to keep the person in custody for continued detoxification, they must record this and the reasons behind the decision in the ECM.

## WORKLOAD

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355. The demands placed on custody officers when watch-house cellblocks are at full capacity, especially if there are inadequate staffing levels, are common contributors to the failures discussed in the preceding section.
356. These conditions can contribute to failures by custody officers to properly process and assess detainees, and to subsequently monitor at-risk detainees according to their assessed category of risk. For instance:
- In August 2013 a woman detained in Hastings Police Station attempted suicide. When she had been received at the station the only custody officer on duty had assessed her not to be at risk, but in doing so had failed to check NIA, on which the woman held a suicidal tendencies alert in relation to a previous suicide attempt while in Police custody. At the time, the custody officer was the sole officer on duty during a busy shift. He was dealing with the mental health crisis team in relation to another detainee, and a Police doctor in relation to a diabetic detainee. He was also monitoring another detainee who required care and frequent monitoring, and responding to phone calls and inquiries at the station's public counter. The officer later described the watch-house as *"like a bloody pressure cooker."*
  - In a March 2013 incident at the Counties Manukau DCU, where a detainee attempted suicide after becoming angry during the receiving process and being placed in a cell before it was complete, the custody sergeant later noted that, *"This shift was very busy, being Easter, and [we] were dealing with other prisoners coming in and releasing detoxed people."*
  - In November 2012 a man was detained at Counties Manukau DCU following his arrest for breaching conditions of his bail. He was taken to hospital following a suicide attempt in the cells, and then returned into Police custody the next day following his discharge from hospital. Prior to his court appearance two days later, the man again attempted suicide in a cell at the District Court custody facility. That day the court cells were at capacity and insufficiently staffed, which compromised the ability of custody officers to properly monitor the man prior to his second suicide attempt (see paragraph 184 above).
357. In another case where officers failed to perform the five checks an hour required by the detainee's care and frequent monitoring status, and the detainee subsequently self-harmed, the officer who had failed to monitor the detainee later stated:

*"I could not always make the 5 checks an hour on [the detainee] as I was the only one on duty in the watch-house and several times I had to tend to complaints at the front counter ... I also had in the cells at the time a couple of other inmates, one of which also had suicidal tendencies. I spent most of the time between 7pm and 8.30pm going between them..."*

358. In a further case, in which a detainee who required care and frequent monitoring was not checked for 49 minutes before officers found him in a state requiring emergency medical treatment and called an ambulance, the custody sergeant at the time stated that:

*“We were extremely busy. I had 5–6 prisoners waiting to be received in the holding cells [and] to be processed ... At this point we hadn’t been able to assess the level of care that [they] required. Nor had we been in a position to ensure that they had been properly searched and could be placed in cells or bailed as appropriate. We were just really busy.”*

359. As was the case in the example in paragraph 357, some Police watch-houses are not staffed by full-time custody personnel and supervisors. This is due to resource constraints. Nevertheless, as illustrated, an insufficient level of custody officers can compromise the standard of care received by detainees during busy periods at watch-houses.

## 9 Conclusions

360. People come into Police custody for a variety of reasons. These include arrest for suspected offending, or detention for the purposes of detoxification or mental health assessment. From the moment they take custody of a person, Police have a duty of care to take all reasonable steps to ensure that person's wellbeing in custody. This includes identifying any possible risks to their wellbeing, and taking appropriate steps to manage those risks.
361. As detailed in this report, following its review of 31 cases from the years 2012–2014, the Authority has identified a number of recurring problems in Police custodial management.
362. First, officers do not always process and formally assess detainees promptly following their delivery to the Police watch-house. This is often because the detainees are intoxicated or aggressive and cannot answer questions. While the Authority recognises that it is difficult to assess the risks posed by intoxicated or uncooperative detainees, the fact that they are sometimes placed in a cell (perhaps to sober up or calm down), without any decision as to the degree of monitoring they require, inevitably increases the likelihood that they may suffer avoidable harm.
363. Secondly, even if a risk assessment is undertaken promptly, officers do not always reassess the risk posed by detainees when there has been a material change in their condition or behaviour while in custody.
364. Thirdly, the information gathered during the risk assessment process is frequently not evaluated properly. For instance:
- officers sometimes do not use the risk assessment tools in the manner directed by Police procedure and policy, and this includes not properly recording suicide attempts in the Police NIA computer database, failing to check NIA for alerts relevant to a detainee's wellbeing in custody, and placing greater weight on demeanour than on objective risk factors in determining the level of risk;
  - officers sometimes do not appreciate the significance of a detainee's degree of intoxication and the corresponding risk to their safety in custody;
  - a detainee's intoxication sometimes impedes the identification of other risk factors, such as a pre-existing injury;
  - officers do not always appreciate the significance of signs that a detainee may be at risk due to their mental health and/or suicidal tendencies; and
  - officers sometimes underestimate the risk to detainees who present with multiple risk factors, such as intoxication and mental impairment and/or suicidal tendencies.
365. Fourthly, in some cases officers assess a detainee to be at risk but do not subsequently implement adequate strategies to manage that risk. This includes:

- not monitoring detainees in accordance with Police policy monitoring requirements, most commonly by failing to check detainees assessed as requiring 'care and frequent monitoring' five times an hour;
  - failing to have detainees taken to hospital or otherwise medically examined when this is required by policy or their presenting condition; and
  - not adequately recording in the Police electronic custody module all activities that occur in relation to a detainee during their time in custody.
366. There are a variety of systemic reasons for these shortcomings: officers lack the knowledge and expertise to identify and accurately assess the risk factors relevant to a detainee's wellbeing in custody, and receive relatively little training in custodial management; national Police policy contains no guidance on how to deal with detainees who cannot be processed and assessed in the normal way; the systems for recording how detainees assessed as requiring care and frequent monitoring are actually being monitored are usually inadequate; and high workloads in custodial facilities can prevent officers from undertaking proper monitoring or risk management.
367. Police are taking active steps to address these problems. They have appointed many non-sworn authorised officers with their own training in custodial management (although this training is done at a district level and is not nationally consistent), and they have introduced new mental health awareness training for Police recruits and are introducing new training for existing frontline Police staff. A number of districts have also implemented new stricter requirements for the care and monitoring of detainees. This includes more detailed guidance about when medical assistance for a detainee is to be sought, particularly when a detainee is intoxicated.
368. However, improvements in training, and changes to Police policy and practice to ensure more robust risk assessment and monitoring, will simply not suffice to address the problems that Police encounter in dealing with mentally impaired people. Often these people have committed no offence. They are detained and taken to the Police cells because they are experiencing a mental health crisis and require an assessment, but there is no mental health worker immediately available to undertake that assessment. Occasionally that detention is unlawful because the person was on private property, where the Police have no power to detain them in the absence of an offence or a breach of the peace.
369. The Police custodial environment to which they are taken is designed and constructed to facilitate the effective management of those who pose a risk to others and is an entirely inappropriate environment in which to hold a person in mental distress. It is high sensory, uninviting and frequently noisy. The problems arising from the lack of training and skills of custody officers in dealing with at-risk detainees are accentuated when people are mentally distressed. As a result, while officers strive to deal with such people patiently and professionally, their mental distress is often exacerbated.
370. When a mentally impaired person has been taken into Police custody at a watch-house, Police also face problems in ensuring that they are assessed in a timely fashion. This can occur

because mental health workers are attending to other crisis calls or are unwilling to examine an intoxicated person. The consequence is that the mentally impaired people are not seen urgently, and are frequently detained for longer than the maximum six hour period stipulated by the Mental Health (CAT) Act 1992. Moreover, the person is generally examined in the first instance by a DAO who is a nurse, and is only seen by a psychiatrist if the DAO deems this to be necessary. This is contrary to the statutory obligation on Police to have the person assessed by a registered medical practitioner.

371. For these reasons, the Authority considers that, unless they are violent or pose an obvious and immediate threat to the safety of others, all practicable steps should be taken to avoid having mentally impaired people detained in Police cells solely for the purpose of receiving a mental health assessment. It is unacceptable that, in many Police districts, this is the standard default inter-agency response to a public call for Police assistance.
372. The Authority acknowledges that the Police themselves do not regard the current position as appropriate. They have too often been left in the position of having to take a mentally impaired person to the Police cells because they lack appropriate alternatives. They may be expected by family or friends to take effective action, and they may also feel that they have a duty of care to ensure that the person is looked after so that their mental distress can be attended to. If they contact Mental Health Services, they are likely to find that a mental health worker is unable or unwilling to attend to the person at the scene in a timely manner. If they take the person to hospital, emergency department staff may be reluctant to hold the person until they can be assessed because they are perceived to be volatile and disruptive. Moreover, because officers may have experienced these responses in the past, or have the belief that this is likely to be the response, they may feel that it is pointless to explore the viability of these alternatives.
373. It must be said that some of the problems identified in this report are a consequence of poor Police practice, which has been generated by a common Police belief that various other emergency services will be unwilling to take and deal with people in mental distress. This has resulted in Police taking people into custody when this has not been appropriate.
374. However, the deficiencies identified in this report are not primarily of the Police's own making. When they take people suffering a mental health crisis into custody, they are meeting a social need by default, because they provide a 24-hour emergency response. The fact that this response has harmful and unacceptable consequences is not just a Police problem; it is a community problem that requires a co-ordinated multi-agency solution. While that solution must allow for particular regional needs (and in particular the differences between metropolitan and provincial/rural areas), it should be implemented in a nationally consistent fashion.
375. As discussed earlier in this report (see paragraphs 299–307 and 319–320), a number of Police districts and DHBs have already been working together to develop and implement a variety of solutions, many of which have been incorporated into detailed Service Level Agreements. While the Authority applauds these initiatives, they do not go far enough. They have been

piecemeal, provided only a partial remedy to the underlying problems, and they have had no national oversight or co-ordination.

376. While the Authority believes that much more can and should be done to address this issue, it recognises that, in many rural areas, there are challenges posed by geography, with a low volume of crisis mental health calls and substantial travelling distances. As a result, it is inevitable that for the foreseeable future some people awaiting a mental health assessment will be held in Police custody. The challenge is to ensure that this is kept to a minimum and that, when it does occur, Police custodial staff have sufficient training and skills to ensure that the Police custodial environment does not unduly exacerbate their distress and cause them lasting harm.

## 10 Recommendations

377. As outlined above (see paragraph 7), the Authority is working with the Police to develop a set of National Standards governing Police custodial facilities. Since it is expected that many of the issues raised in this report will be addressed when those standards are in place, it would not be appropriate for the Authority at this time to make detailed recommendations concerning those issues.
378. Instead, pursuant to the section 27(2) of the Independent Police Conduct Authority Act 1988, the Authority recommends that:
- 1) the Police introduce more systematic and nationally consistent training for both sworn staff and authorised officers working in custodial facilities, particularly in relation to :
    - a) the risk assessment and treatment of intoxicated and mentally impaired persons; and
    - b) how to recognise the signs that a prisoner requires urgent medical attention (such as the symptoms of drug overdose/head injury).
  - 2) the other issues raised in this report are addressed as part of the development of the National Standards governing Police custodial facilities; and
  - 3) the Police work with the Ministry of Health and other agencies to identify options for minimising the number of mentally impaired people who are detained in Police cells to await a mental health assessment.



**Judge Sir David Carruthers**

Chair  
Independent Police Conduct Authority

27 March 2015

## About the Authority

### WHO IS THE INDEPENDENT POLICE CONDUCT AUTHORITY?

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

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

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

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

### WHAT ARE THE AUTHORITY'S FUNCTIONS?

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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 on whether any Police conduct, policy, practice or procedure (which was the subject of the complaint) was contrary to law, unreasonable, unjustified, unfair, or undesirable. The Authority may make recommendations to the Commissioner.



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