



**IPCA**

Independent Police  
Conduct Authority

Whaia te pono, kia puawai ko te tika

# **Death in Police custody of Sentry Taitoko**

*March 2015*

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## Introduction

1. At around 5.16am on Sunday 23 February 2014, Police found Sentry Taitoko unresponsive and struggling to breathe in a cell at the Counties Manukau District Custody Unit (DCU). Police had taken Mr Taitoko into custody about four hours earlier for breach of the peace and detoxification. Paramedics were called to the cell and attempted to resuscitate Mr Taitoko but he was pronounced dead at 6.10am.
2. The Police notified the Independent Police Conduct Authority of the death, and the Authority conducted an independent investigation. This report sets out the results of that investigation and the Authority's findings and recommendations.
3. The Authority has examined issues relating to: whether it was appropriate for Police to take Mr Taitoko into custody; how Mr Taitoko was restrained by Police and whether excessive force was used; the method used to transport Mr Taitoko to the DCU; whether Police complied with their policies for managing people in the cells; whether the conditions in Mr Taitoko's cell were appropriate; whether Police fulfilled their duty of care to Mr Taitoko; and the Police's interaction with Mr Taitoko's family.
4. The Authority notes that, although factual information regarding health professionals' contact with Mr Taitoko while he was in Police custody is included in this report, the Authority has no jurisdiction to review or comment on the actions of any person other than Police involved in this case.

## Glossary of terms

Abbreviation/term	Explanation
CPR	Cardiopulmonary resuscitation
Custody officer	Authorised officer, a non-sworn Police employee tasked with managing prisoners at Police custodial facilities
DAO	Duly Authorised Officer, a mental health professional
DCU	The District Custody Unit at Counties Manukau Police Station
ECM	Electronic Custody Module
ESR	Institute of Environmental Science and Research
HSMP	Health and Safety Management Plan
LSD	Lysergic acid diethylamide – a hallucinogenic drug
NBOMe	25B-NBOMe – a hallucinogenic drug
PMO	Police Medical Officer, i.e. Police doctor

## Index of officers and health professionals

Field Staff	Roles/Comment
Officer A	Acting sergeant Took part in Mr Taitoko's arrest
Officer B	Took part in Mr Taitoko's arrest
Officer C	Took part in Mr Taitoko's arrest
Officer D	Custody sergeant
Custody Officer E	Custody officer
Custody Officer F	Custody officer
Custody Officer G	Custody officer Worked the security desk
Custody Officer H	Custody officer
Officer I	Temporary constable
Officer J	Shift supervisor – senior sergeant
Mental Health and Addictions (MHA) nurse	Saw Mr Taitoko in the cell, advised custody staff that he needed to be seen by a doctor
Police doctor	Advised custody sergeant that Mr Taitoko was too violent to be taken to hospital
National Co-ordinator of Forensic Medicine	Responsible for the training, peer review, and ongoing education of 68 Police doctors throughout the country
Police criminal investigator	Led the criminal investigation into Mr Taitoko's death
Family liaison officer	Advised Mr Taitoko's family of the death

## Background

### EVENTS LEADING UP TO MR TAITOKO'S ARREST

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5. On the evening of Saturday 22 February 2014, Sentry Taitoko, aged 20, was at a friend's house in Manurewa. At some stage that evening Mr Taitoko took a synthetic drug similar to LSD, known as NBOMe. Toxicology tests later found that Mr Taitoko had also consumed alcohol, cannabis and methamphetamine.
6. Mr Taitoko's brother (referred to in this report as Mr W), along with friends Mr X and Ms Y, found Mr Taitoko at the house in Manurewa sometime after midnight. Mr Taitoko initially greeted them but quickly became confused. He told Ms Y that he did not feel like himself, and he acted strangely by constantly fidgeting and moving around. Other people at the house said that Mr Taitoko was "on a trip".
7. Mr Taitoko soon began having hallucinations and he occasionally screamed in reaction to things he thought he had seen. He also removed his shirt, grabbed at his throat and became increasingly unsteady on his feet. Eventually he ran to the end of the driveway and started punching the gravel with his right hand.
8. Mr W, Mr X and Ms Y later told the Authority that Mr Taitoko was usually a "happy" person, even when drinking or using drugs, and they had never seen him behave like this before. They were worried about him and decided to take him home. When Mr W tried to lift Mr Taitoko up from the driveway to get him into Ms Y's car, Mr Taitoko began kicking and screaming. Ms Y later said: "... he was completely gone. It was like he was so scared of what he was seeing, he thought it was right in front of him."
9. Mr Taitoko continued trying to break free but eventually Mr W and Mr X managed to put him in Ms Y's car. Mr W had to hold on to Mr Taitoko to stop him from lashing out and trying to get out of the car while Ms Y drove them home. They considered taking Mr Taitoko straight to hospital, but were concerned they would not be able to get him there safely and thought it best to take him home first.
10. When they arrived at Mr W's house, where Mr Taitoko was living at the time, Ms Y went inside to talk to Mr W's partner, Ms Z. The others got out of the car and Mr Taitoko began yelling and swearing. He punched a concrete power pole outside the house and was grabbing his neck, apparently trying to rip his own head off his shoulders. Ms Y later said:

*"... it was quite loud because Sentry was yelling, he was screaming, [Mr W] was swearing at him, trying to calm him down, and then [Mr X] was trying to calm both of them down so it would've sounded like there was like an argument going on. ... So I think that's why the Police got called."*
11. Mr W grabbed hold of Mr Taitoko to stop him from hurting himself, and Mr Taitoko went limp. Mr W and Mr X then gradually carried him through the gate and up onto the porch. At some

point Mr Taitoko's shoes came off. When they reached the porch Mr Taitoko appeared to be exhausted and lay down on his back with his arms and legs spread out, breathing deeply. Ms Y and Ms Z joined them on the porch and Ms Y observed that Mr Taitoko seemed "tired and scared".

## THE ARREST

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12. At around 1.00am, Police received an emergency call from one of Mr W's neighbours reporting that men were fighting in the street. Officer A (an acting sergeant) and Officers B and C drove towards Mr W's house in two marked Police cars and arrived within about five minutes.
13. When the officers drove up the street they did not see any fighting but heard a loud yell nearby. The officers parked opposite Mr W's address and walked up to the house. It was a warm and humid night, and on the way to the house the officers noticed a pair of shoes on the footpath and a hooded sweatshirt on the roof of a car parked in front of the address. The car's windows had been left rolled down.
14. The officers found Mr W, Ms Y and Ms Z standing on the porch beside Mr Taitoko (Mr X had gone inside the house). Mr Taitoko was lying on his back "like a starfish", occasionally yelling out and waving his arms and legs around. He was wearing only knee-length shorts and socks, and had blood on his knuckles and grazes on his right knee.

15. Officer C later described Mr Taitoko's actions:

*"Sentry would be still and just lay there then he would have an outburst which included him yelling something which I could not understand. He would bend forward, yell then throw his head and arms back onto the porch. His head would hit the wooden porch and make a loud thud. ... Sentry was also throwing his arms and legs around.*

*Sentry would have these outbursts every 10 to 15 seconds and the outbursts would last for about 7 seconds."*

16. The officers asked the group what was going on and they said they had just picked Mr Taitoko up from a friend's house in Manurewa. Mr W asked the officers why they were there, and they explained that they had been called to the address by a neighbour. Officer B asked Mr W why Mr Taitoko's knuckles were bleeding and he said Mr Taitoko had been out on the road punching objects.
17. Officer B then spoke to Ms Y and Ms Z, and Officer C spoke to Mr W, to find out what had happened that evening.
18. Meanwhile Officer A shone his torch on Mr Taitoko to check him for injuries and Mr Taitoko screamed when the light shone in his eyes. Officer A later said he did not see any bleeding around Mr Taitoko's head but "his eyes were rolling around and I could see the white in his

*eyes rolling back. My assessment of [Mr Taitoko] at that point was that he was extremely intoxicated."*

19. Mr W told Officer C that Mr Taitoko was his brother and, when asked, said that Mr Taitoko did not suffer from epilepsy or a mental health condition. He informed the officer that Mr Taitoko had been drinking for five days straight but denied that Mr Taitoko had taken drugs. Officer C was aware that Mr W could be saying this in order to protect his brother from getting into trouble with the Police. Mr W said that his brother was alright and just needed to lie down and get some air.
20. In the meantime Ms Z told Officer B that she was the occupier of the house and had just been woken up by the arrival of Mr W, Mr Taitoko and the others. They discussed what should happen with Mr Taitoko, and Ms Z said she was concerned about her young children seeing their uncle in the state he was in. She was also unsure whether Mr Taitoko would be safe if he remained at the house.
21. Officer B told Ms Z that, in his view, the safest place for Mr Taitoko would be the Counties Manukau District Custody Unit (DCU), where he could be monitored and released later that morning once he had sobered up and was capable of caring for himself. He later said in a Police statement:

*"I reached this view due to Sentry's state of intoxication, his erratic and aggressive behaviour, and also the fact that [Ms Z] had advised me that she did not believe that she could properly care for Sentry in the state that he was in.*

*... He was in an uncontrollable state and it was as if he didn't even know we were there. ... I walked over to Sentry as he lay on the deck and tried to communicate with him. I asked what his name was and asked if he knew where he was. Sentry did not respond to any of my questions and continued in the yelling and kicking and waving of his arms."*

22. Meanwhile Officer A spoke to Mr W briefly while Officer C went up to the porch to look at Mr Taitoko. Officer C later said:

*"I noticed that Sentry's eyes were open but glazed over. I leant over him and looked at his eyes. It was like he was looking straight through me. He was breathing fine and still continuing in his yelling with his arms and legs thrashing out. He was still throwing his head back and it was making contact with the wooden porch."*

23. Officer C then asked Mr W whether he would be able to look after Mr Taitoko and he said he was happy for the officers to leave his brother there and he would take care of him. Around this time more officers arrived at the house, responding to the call about fighting in the street, but Officer A told them they were not needed and they left.

24. Officers A, B and C briefed each other on the information they had gathered. Officers A and B concluded that Mr Taitoko was unable to care for himself and posed *“a high risk not just to himself but to the occupants of the address and also potentially members of the public.”* They decided they could not leave Mr Taitoko at the house because the occupier, Ms Z, was worried that she could not look after him to the extent he needed. Although Mr W told the officers that he would look after his brother, the officers believed that Mr W was also intoxicated and could not provide the necessary level of care.
25. Officers A and B discussed whether they should:
- a) call an ambulance for Mr Taitoko;
  - b) transport Mr Taitoko to hospital themselves; or
  - c) take Mr Taitoko into custody and transport him to the Counties Manukau DCU.
26. Officer A did not think it was appropriate for them to call an ambulance, or to take Mr Taitoko to the hospital themselves, because that would expose the ambulance and hospital staff to Mr Taitoko’s *“very aggressive”* behaviour and compromise their safety. He believed that the only option was for the officers to transport Mr Taitoko to the DCU. He told the Authority:
- “I think [Mr Taitoko’s] behaviour was probably the one [thing] that indicated to me that, once in an ambulance, you know, it’s the same behaviour that [when] we try to uplift him, he went off the charts. So that was, I decided no, that’s not a possibility and that’s not an option, and then we talked about [taking him] straight to hospital. Again, we were with the same dilemma. Have they got the facilities to cope with him? Can they sedate him? Are they allowed to sedate him? And at that stage, I felt that, you know, we’ve sort of, we got the cameras here [at the Counties Manukau DCU], we’ve got the cells here, they are monitored and I felt at that stage that that’s our best course of action. To bring him here where he can be monitored.”*
27. Another consideration was that it was a very busy Saturday night and the officers were concerned that if they called an ambulance they would probably be waiting for some time.
28. Consequently the officers decided to arrest Mr Taitoko for detoxification and breach of the peace (see paragraphs 252-257 for relevant law and policy). Officers A and B later told the Authority that they discussed their powers to arrest Mr Taitoko and, although he was on private property, believed they had the power to take him into custody for his own protection and because he was disturbing the peace with his yelling, which could be heard from the street. They also considered that Mr Taitoko may have been fighting before the Police arrived.
29. Officer B explained to Mr W, Ms Y and Ms Z that they were not charging Mr Taitoko with an offence but were taking him into custody for detoxification and he would be released later that day. Officer A later said: *“The brother and females present had no objections to the decision made and in fact seemed relieved with this decision.”*

30. Mr W told the Authority that he wanted to look after Mr Taitoko himself, and was not happy with the Police's decision to take him away but felt like he was not able to do anything about it. Mr W, Ms Y and Ms Z all said that the officers assured them that Mr Taitoko would receive medical attention and would be monitored at the DCU.

## TRANSPORT TO DCU

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31. Officer B approached Mr Taitoko, who was still lying on the porch, and placed one handcuff on his left wrist. As soon as the officer touched him, Mr Taitoko began thrashing around and yelling. All three officers took hold of him but Officer B was unable to handcuff his other wrist due to his resistance.
32. Officers B and C tried to make Mr Taitoko stand but he could not support his own weight and continued to lash out with his arms and legs. The officers then carried Mr Taitoko off the porch and towards the front of the property, with one officer holding his legs while the other two held him on each side. Officer A instructed the other officers to be careful of Mr Taitoko's head.
33. They placed Mr Taitoko down on the grass beside the road and Officers A and B put him in the recovery position. Mr Taitoko was still thrashing around and yelling incomprehensibly, and the officers decided that they would not be able to safely transport him in a patrol car.
34. Officer A called for a prisoner van to be sent, but no one was available to drive the van to their location, so Officer A decided to drive to the Manurewa Police Station himself and return with the van. He directed Officer B to control Mr Taitoko's legs and Officer C to control the upper part of his body in order to keep him on his side in the recovery position.
35. After Officer A left to get the prisoner van, Officer B advised Mr Taitoko of his rights but he did not respond and appeared not to understand what was happening. Mr Taitoko continued his pattern of having frequent short 'outbursts', during which he would yell and lash out with his arms and legs.
36. Officers B and C struggled to keep Mr Taitoko in the recovery position because he was wriggling around and kept trying to roll onto his back. Officer B asked Ms Y, who was standing nearby, to bring him some water. He later said:

*"She returned with some water in a bottle and I attempted to pour some water on Sentry's head to cool him down and try to stop him from lashing out. It was very humid and with all the aggressive actions he was doing, he was getting hot and sweating. When I poured the water on him he responded by shaking his head back and forth and he appeared to temporarily calm down. Then around 20 or 30 seconds later he was back to his usual pattern of thrashing around and lashing out."*

37. Ms Y told the Authority that while Officers B and C were restraining Mr Taitoko on the ground, Officer C put his knee on Mr Taitoko's neck. She said she advised the officers that Mr Taitoko

was struggling to breathe and his face was turning purple, and the officer then removed his knee. She also said:

*“I didn’t like how they would sit on him and like, one point one officer was fully sitting on him. Like his knees were on each side of him and he had pretty much almost sat on his ribcage.*

*... they would press him further into the ground, like he wasn’t trying to resist them or anything. It was just like they were trying to keep him in control but while doing that they were hurting him at the same time.*

*... He was constantly getting, like, he was banging his head on the ground so they would like shove his head with their knees, not their hands. They would put their knees on top of his head and like shove him into the ground. Instead of like, you know, trying to put something under his head ....”*

38. Officer C denied that he or Officer B placed a knee on Mr Taitoko’s neck, and also denied that Ms Y said anything to them about Mr Taitoko struggling to breathe.<sup>1</sup> In a statement he said:

*“I was crouched behind Sentry. My right knee was supporting his lower back area to prevent him from rolling out of the recovery position. My left foot was positioned behind his shoulder blade area with my shin and knee on an angle above his right ear as he lay on his side. My left knee did not make contact with Sentry’s neck or head. During this period every so often I would drop my left knee onto the ground positioning it behind Sentry’s shoulders. At no time did my left knee come into contact with Sentry’s neck. I moved my left knee at different times to give myself a rest. While this was happening I was using my arms to control Sentry’s arms and upper body.*

*... I was focussed on Sentry while we were restraining him and at no time did his face turn purple. His breathing appeared regular and he continued to yell and scream during the time he was restrained in the recovery position. At no time did I have any concern that Sentry could not breathe adequately.”*

39. Officer C tried to reassure Mr Taitoko by telling him *“It’s alright”*, and that they were Police and were going to look after him. Mr Taitoko still had *“glazed eyes”* and did not respond.
40. The officers recalled that it took five to ten minutes for Officer A to return with the prisoner van, but Mr W, Ms Y and Ms Z thought it took longer (20-30 minutes). The Authority has determined that the Manurewa Police Station is about a five-minute drive from Mr W’s house and, accounting for urgent duty driving, considers that it would have taken around five to ten minutes for Officer A to return.

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<sup>1</sup> The pathologist who conducted the post-mortem for Mr Taitoko advised the Authority that he did not have any injuries consistent with someone placing a knee across his neck.

41. Officer A parked the van beside the footpath, close to the officers and Mr Taitoko. Officer B placed the remaining handcuff on Mr Taitoko's right wrist, so that he was handcuffed with his hands behind his back. All three officers lifted Mr Taitoko into the van. Officer B later said:

*"While we were doing this he was still attempting to lash out at us by kicking out and wriggling his body. Sentry was swinging his head side to side and yelling. I still could not understand him."*

42. The back of the van is divided into two compartments for prisoners, and Mr Taitoko was placed inside the left compartment. The officers decided that Mr Taitoko could not be seated safely in the van, due to his behaviour and the risk that he would fall off the seat and injure himself. For that reason they positioned him on the floor of the van, lying on his side and facing the seats with his back to the internal dividing wall.<sup>2</sup>
43. Mr Taitoko continued yelling and began kicking the walls of the van. He soon rolled onto his front. The officers were aware of the risk of 'positional asphyxia', a condition which can affect a person who is lying face down with their hands tied behind their back, and Officer A instructed Officer B to monitor Mr Taitoko through a window while they drove to the DCU. Officer A turned on some lights and a fan to give Officer B a clear view of Mr Taitoko and cool down the back of the van.
44. Before the officers left the address, Ms Y gave them a clean t-shirt for Mr Taitoko. She and Mr W told Mr Taitoko they would see him later and he replied "Yo".
45. Officer A activated the van's flashing lights and siren and drove to the Counties Manukau Police Station, followed by Officer C in a patrol car. During the approximately seven-minute journey Mr Taitoko continued to scream and kick the walls of the van. Officer B later said: "At one stage [Mr Taitoko] was deliberately hitting his head against the floor of the van but I couldn't see any blood appearing from this action." Officer B was in a separate compartment from Mr Taitoko and therefore was unable to restrain him from hurting himself.

## ARRIVAL AT THE DCU

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46. The night shift at the Counties Manukau DCU consisted of a custody sergeant, Officer D, and Custody Officers E, F, G, and H. Officer I was also on duty until 3.00am. At the time Officer D had around six months' experience as a custody sergeant (three months leading up to 23 February 2014 and three months in 2006). Custody Officer E had four years' experience as a custody officer, while Custody Officer F had four months' experience and Custody Officers G and H had only been in the job for one month. Officer I had worked as a temporary constable in the custody unit for six years.
47. Officer D and the custody officers later recalled that it was a very busy Saturday night, with a constant stream of people being brought in to be processed and placed in the cells, many of

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<sup>2</sup> The pathologist commented that: "The edges of that transport vehicle are all metal, there's some very sharp edges, so it's not an ideal vehicle for transporting someone who's in a state of hyperkinetic drug reaction." He was of the view that Mr Taitoko may have suffered bruises when Police were trying to get him in and out of the van.

whom were reportedly intoxicated and uncooperative. Custody Officers E, F and H and Officer I were receiving prisoners while Custody Officer G was working on the security desk.

48. The prisoner van carrying Mr Taitoko arrived at around 1.45am and parked outside the entrance to the DCU. Officers A and B exited the van and signalled to some custody officers inside the DCU to help them carry Mr Taitoko into the cells. Custody Officers E and F went out and Officers A and B briefed them that they had a very intoxicated and aggressive man.
49. Usually when the DCU receives a prisoner, he or she is placed in a holding cell while the arresting officer completes a charge sheet explaining why the person was arrested. Once the charge sheet is completed, a custody officer questions the prisoner and enters information into the Electronic Custody Module (ECM), a computer system which is used to manage the prisoners in the DCU. During this process the custody officer conducts a risk assessment based on the information provided about the prisoner's health and background, decides on the level of care required (either 'not in need of specific care', 'in need of care and frequent monitoring', or 'in need of care and constant monitoring'), and selects an appropriate cell to place the prisoner in.
50. However the Police's *Managing Prisoners* policy states that intoxicated prisoners who are unconscious or semi-conscious must be taken to hospital by ambulance or Police vehicle. That did not occur in this case, despite the fact that Mr Taitoko met the criteria of a 'semi-conscious' prisoner (*"i.e. unable to answer any questions during the initial assessment process or physically unable to look after themselves"*).
51. Instead Mr Taitoko was treated as a 'violent' prisoner due to his behaviour. When violent and out of control prisoners arrive at the DCU, they are generally placed straight into a CCTV-monitored cell and only processed later, once they have calmed down.
52. Custody Officers E and F went inside the DCU and opened several doors so that the officers would have a clear path to a CCTV-monitored cell. Custody Officer F then returned to the van and the officers opened the back door to get Mr Taitoko out. Custody Officer F later said in a Police statement:

*"I saw a male lying on the ground between two bench seats. He was handcuffed and had his hands behind his back. He was flopping around like a fish and was lying on his stomach. He was aggressive but that aggression was not directed at any of us. He was just going mental, bashing his head and shouting. I don't remember what he was shouting but he wasn't making any of the normal threats towards us that I am used to hearing."*

53. Officers A and B pulled Mr Taitoko out of the van, and attempted to walk him into the DCU. Mr Taitoko was unable to walk and dragged his feet, so Officer C and Custody Officer F picked up his legs and all four officers carried him into the DCU holding him horizontal to the ground, face down and head first. Officer A later said: *"[Mr Taitoko] started lashing out towards me with his head like he was trying to bite me, I then secured his head by placing my thumb and index finger around his jaw line."*

54. As they went through the reception area and towards the monitored cell, Mr Taitoko was still thrashing about and yelling. Custody Officer E observed that Mr Taitoko was not a large man but was *“fully out of control”* and the officers were struggling to hold on to him.
55. Officer A instructed the officers to carefully place Mr Taitoko face down in the middle of the cell. The officers held Mr Taitoko down on the floor, and Custody Officers E, F and H assisted in searching him and removing his belt, socks and shorts (these items were taken from him for safety reasons), leaving him in his boxer shorts. During this process Mr Taitoko continued to shout and lash out. Officer C then slowly removed the handcuffs and the officers all left the cell one by one.
56. Officer B observed Mr Taitoko kneeling in the cell and looking around: *“He was not saying a word during this and he appeared almost delusional in that he seemed to have no idea of where he was.”*
57. None of the officers recalled seeing blood or bruises on Mr Taitoko’s face at this time, or any injuries other than the grazes to his knuckles and knee which they had seen earlier. Officer B noted that Mr Taitoko did not appear to have any noticeable injuries to his head despite consistently banging his head against the floor of the van.
58. Officer B said that after putting Mr Taitoko in the cell:
- “I remember I was very hot and physically quite tired from restraining him. I was sweating and needed to wipe my face with a paper towel. I noticed that [Officer C] and [Officer A] were also sweating.”*
59. Officers A and B spoke to the custody sergeant, Officer D, and advised him that Mr Taitoko was very intoxicated and aggressive. Officer D later recalled being told that Mr Taitoko’s family had called Police because he was out of control. He understood that Police do not have the power to remove people from private property in order to take them into custody for detoxification, but thought Mr Taitoko’s family had asked Police for assistance and wanted him taken away.
60. Officer B then completed a charge sheet and a minor offence report for Mr Taitoko. He recorded on the charge sheet that Mr Taitoko was *“very intoxicated”*, and in the minor offence report (for breach of the peace) he stated that Police had found Mr Taitoko on the footpath outside his address and detained him for detoxification due to fears for his safety. The report also noted that Mr Taitoko was unable to respond to Police instructions.
61. Shortly afterwards Officers A, B and C left Mr Taitoko in the care of the custody staff at the DCU. When interviewed by the Authority, all three officers believed they had done all they could to ensure Mr Taitoko’s safety and thought that taking Mr Taitoko to the DCU was the right decision in the circumstances. Officer B also commented that their options were very limited due to Mr Taitoko’s *“aggressive and unpredictable behaviour”*.

62. The cell Mr Taitoko was placed in is an empty room, with no bed, sink, or toilet. The lack of facilities in the cell makes it more suitable for violent and out of control prisoners, because they are less likely to injure themselves or damage property with no fixtures in the room.
63. When the Authority inquired about the air conditioning in the DCU, Police advised that air is brought into the cells from outside. It follows that when it is a warm night (as it was when Mr Taitoko was in the cell), warm air is circulated into the cells.
64. There are large windows at the front of the cell and a CCTV camera is placed in the back corner, overlooking the cell and the corridor. The CCTV camera footage of the cell is relayed to a screen which is visible from the security desk in the DCU. During its investigation the Authority examined the recorded CCTV footage of Mr Taitoko's cell. The lens of the camera in Mr Taitoko's cell was dirty and so the image is not clear in some places, but most of the cell area and corridor is visible.
65. Custody Officer G was working the security desk and was responsible for monitoring the CCTV footage of the cells as well as answering phones, unlocking doors and gates, and recording information in the ECM (for example, noting any visits from lawyers, doctors or family, and the provision of meals and medication to prisoners). Custody Officer G was also tasked with responding to alerts on the ECM about checks on prisoners that needed to be completed.
66. When Mr Taitoko was placed in the cell, Custody Officer G began keeping an eye on him (though no ECM alerts regarding checks were yet in place for Mr Taitoko). He later said:
- "I remember looking at him on the monitor thinking he was like a fish out of water. He was sitting up, flopping down, hitting his head on the wall and the floor, he was just thrashing around. It didn't look like he was trying to hurt himself intentionally, it was like he just had no control over his body and just wasn't even on the same planet."*
67. Officer D and Custody Officers E and F also saw Mr Taitoko run into the wall, hitting his head. Officer D observed Mr Taitoko through the window of the cell and noticed that he was talking to himself but making no sense. The officer was concerned about Mr Taitoko's behaviour and later said that during his policing career he had never seen someone behaving like this:
- "It was like he was bouncing off the walls. He was doing it numerous times. He would hit his head on the wall, fall over, hit his head on the floor and then get up and start all over again. To me it looked like he was hitting his head quite hard."*
68. Analysis of the recorded CCTV footage shows that Mr Taitoko was constantly moving in the cell, and fell and hit his head on the walls or floor of the cell 83 times from 1.47:29am until 2.16:37am. Most of these falls were from a kneeling or sitting position but eight were from a standing or semi-standing position. No one was continually observing Mr Taitoko, so none of the custody staff would have noted the total number of falls that occurred. As well as hitting his head, Mr Taitoko repeatedly knocked his sides and shoulders as he flopped on the ground

or into the walls. Over time the walls of the cell became smeared with blood from Mr Taitoko's nose and from grazes on his body.

### Mattresses placed in the cell

69. The Counties Manukau District Shift Supervisor, Officer J (a senior sergeant), visited the DCU at around 2.10am. He looked into Mr Taitoko's cell and saw that he was rolling around on the floor, occasionally hitting his head on the ground or the wall. He noticed that Mr Taitoko was sweating and his nose was bleeding, but saw no other obvious injuries that required attention. He later said that Mr Taitoko appeared "*possessed*" and unable to control himself.
70. Officer J spoke with Officer D, who advised him that Mr Taitoko was very intoxicated and violent when he was brought into the cells, and that he had to be carried in and had not yet been formally assessed due to his behaviour.
71. A Duly Authorised Officer (DAO) was working at the DCU around this time, dealing with another prisoner. The DAO noticed Mr Taitoko bouncing off the walls of his cell and decided to conduct a health check of him on his computer. He subsequently advised Officer D that Mr Taitoko was noted to have been drinking alcohol since he was 11 years old.
72. The DCU did not have any restraint boards or restraint chairs, or a padded cell, so Officers D and J discussed 'hog-tying' Mr Taitoko to prevent him from harming himself.<sup>3</sup> However Officer J was not in favour of that option and did not think it would stop Mr Taitoko from rolling around and knocking his head on the floor. Instead he asked for mattresses to be placed in Mr Taitoko's cell to protect him from injury.
73. Officer D and Custody Officers E and F retrieved four plastic-coated mattresses from a storage room and entered Mr Taitoko's cell at 2.16:37am. Officer D and Custody Officer F held Mr Taitoko down while Custody Officer E lined the floor of the cell with the mattresses. The officers then placed Mr Taitoko on top of one of the mattresses at the back of the cell and left the room. Mr Taitoko lay down for a while but was soon rolling around again and repeatedly trying to sit up or stand.
74. Officer J later said he would have liked to place mattresses up the walls of the cell as well as on the floor but it was not really practical to do so. He recalled that the mattresses were quickly smeared with Mr Taitoko's blood and sweat.
75. Officers D and J discussed the level of monitoring Mr Taitoko would receive. Officer J thought constant monitoring was not necessary because they had no information that Mr Taitoko was suicidal. It would also tie up a custody officer and require the cell door to be left open which would pose a risk to the DCU staff. He believed that frequent monitoring (five checks per hour), as well as the additional CCTV monitoring, would be sufficient.

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<sup>3</sup> 'Hog-tying' involves handcuffing a person and restraining his or her ankles with plastic ties, then using another plastic tie to link the handcuffs and the ankle restraints together.

76. Officers D and J agreed that Mr Taitoko would not be released from custody until he was seen by a doctor, and Officer J left the DCU soon afterwards. Custody Officer G continued to observe the CCTV footage of Mr Taitoko's cell from the security desk and saw that he was still "flapping" and "windmilling" around with his arms going everywhere. He later said: *"In my opinion I thought he was on drugs or meth."*
77. The floor of Mr Taitoko's cell could not quite fit all four mattresses, so the last one was placed partially folded up against the front wall of the cell. Within five minutes, as Mr Taitoko was thrashing around on the floor, the mattress moved further and further up the wall and gaps appeared between the mattresses on the ground.
78. At 2.23:22am the mattress standing up against the front wall fell on top of the mattress beside it, which enabled more of the cell floor to be exposed as Mr Taitoko continued 'flopping' around in the cell and pushing the mattresses around. From 2.17:39am (when the officers left the cell) until 3.21:15am (when Mr Taitoko was observed by a Police doctor – see paragraph 90), Mr Taitoko fell and hit his head on the exposed floor or wall of the cell around 31 times (including five times from a standing or semi-standing position). He also fell from a sitting or kneeling position and hit his head on a mattress approximately 65 times.

### Risk assessment

79. Meanwhile the custody officers were busy receiving and processing other prisoners. At around 2.47am, an hour after Mr Taitoko had arrived at the DCU, Custody Officer E retrieved Mr Taitoko's charge sheet and entered his information into the ECM. Since Mr Taitoko was not fit to answer any questions himself, the custody officer filled out the risk evaluation section with the information he knew. He noted that Mr Taitoko was:
- male, Maori and 'Youth at risk' (all risk factors for suicide);
  - very intoxicated and *"possibly under the influence of some drug"*;
  - irrational, agitated, very affected by possible drug use and *"fully out of control"*; and
  - unfit to answer questions about any health conditions.
80. Custody Officer E also wrote that Mr Taitoko:

*"Had to be carried to cell S4 by 4 staff and searched on the ground. He is flipping out in cell S4. We have put mattresses on the ground to prevent him from hurting himself. [Officer J] is aware. Ambos to check on him when calm."*

81. As a result of the risk evaluation Custody Officer E determined that Mr Taitoko was *"in need of care"*. He later said:

*"This was based on the fact that I knew nothing about him as we hadn't been able to talk due to his state and obtain that information. I had no idea if he had*

*any health or mental health issues and if he might be suicidal. He also appeared to be on drugs.”*

82. Custody Officer F then completed a Health and Safety Management Plan (HSMP) form which stated that Mr Taitoko was in need of care and frequent monitoring (that is, at least five checks per hour at irregular intervals). He wrote that Mr Taitoko was: *“Brought in very agro and out of control. Was unable to understand what was being said. Due to drug use.”* He signed the form at 3.00am.

### Medical advice

83. At around this time, a mental health and addictions nurse (MHA nurse) arrived at the Counties Manukau DCU and heard about Mr Taitoko. The MHA nurse was not on duty at the time (she was on a ‘ride-along’ with two general duty police officers) but she had worked at the DCU since 2007 and had 43 years of experience as a registered nurse.
84. While talking to a couple of DAOs, she was told that there was a *“really violent”* man in the cells and mattresses had been put in his cell to keep him safe. She found this unusual and went to have a look at him (the CCTV footage shows her looking in the cell from 3.15:21am to 3.16:08am). She later said in a Police statement:

*“The man was lying down spinning around. He was doing quite jerky movements, like an athetoid movement. An athetoid movement is one that you see with people who have disorders of the neurological system. You see it in people with head injuries and with some types of epilepsy. It usually means that the brain isn’t functioning as it should for some reason.*

*My initial thought was that he was in a state of delirium. Delirium is a state where the function of the brain has been altered for some reason. It can be caused by a number of factors such as cancer, dehydration, drug and alcohol abuse, head injuries and a myriad of other illnesses.*

*Most people who are aggressive have a focus for their aggression but in this man’s case there was a lack of focus on anyone else, his environment or himself. There was an apparent loss of contact with reality entirely.”*

85. The MHA nurse noted that the mattresses on the floor were smeared with blood and that Mr Taitoko’s face was very red, indicating that he had a high temperature:

*“Those things combined made me think that the most likely explanation for his behaviour was a state of excited delirium. Excited delirium is a type of delirium where the patient is kinetically active. Kinetically active means that there is a lot of movement exhibited by the patient.*

*I know that delirium is a medical state that requires medical attention as soon as possible. If medical intervention is not sought there is a high incidence of patients dying.”*

86. The MHA nurse went to the reception area of the DCU and told Officer D that she thought Mr Taitoko needed medical attention. She advised him that: *“... it seemed to me that his behaviour was more than just an intoxicated state and had become a medical issue. I didn’t use the term excited delirium at the time.”*

87. Officer D informed the MHA nurse that a Police doctor was on his way to visit some other prisoners, and she said to make sure the doctor saw Mr Taitoko as well. Shortly afterwards, as the MHA nurse was leaving the DCU, she saw the Police doctor arrive in the car park.

88. The Police doctor had been called at 3.00am and arrived at the DCU at around 3.18am. He had 27 years’ experience as a Police Medical Officer (PMO). Upon arriving in the DCU, Officer D asked him to have a look at Mr Taitoko in his cell while on the way to treat another prisoner. In a statement to Police, the Police doctor said:

*“At no time was I formally asked to see Mr Taitoko as such. I was asked to see him informally as I walked past the window. Sometimes Police informally ask me for my views on a matter. In these cases there is usually no written report and no invoice.”*

89. In another statement, the Police doctor asserted that:

*“Sometimes it appears the powers on high are trying to save money and don’t get us to look at people formally and we don’t bill them. Sometimes Police staff are a bit vague about whether they are wanting me to formally look at someone or not.”*

90. Officer D told the Authority he believed that by speaking to the Police doctor, and by asking for (and receiving) his advice, he had formally engaged him. He said that he was *“very clear”* that he wanted the doctor to look at Mr Taitoko and:

*“I would have expected an invoice from the PMO in relation to Mr Taitoko and if one was presented I, as the shift DCU Supervisor, had authority to authorise it for payment. The PMO made a decision not to provide an invoice, which was his decision.”*

91. Officer J also advised that costs were not an issue for front line staff and: *“If a prisoner needs to be seen by a doctor, he/she will be seen regardless of cost.”*

92. The Police doctor looked into Mr Taitoko’s cell (from 3.21:15am to 3.23:11am) and saw that he was thrashing about a bit and making noises. He later said: *“[Mr Taitoko] wasn’t violent towards anyone but his actions were rapid and forceful and there would have been an element of risk for me had I entered the cell.”*

93. He made observations from outside the cell to determine if Mr Taitoko's behaviour was likely to be caused by a head injury, drug reaction or epilepsy – the most common causes of such behaviour in Police cells. He assessed that Mr Taitoko did not have a head injury (Police had not mentioned any head injury to him), and considered that Mr Taitoko's 'thrashing' was not typical of epileptic seizure activity. He later said:

*"Even though I wasn't assessing Mr Taitoko formally I could see that his behaviour was unusual and my interpretation was that it was likely that this man had taken some kind of stimulant or psychotropic drug that made him out of touch with reality which was causing him to thrash about. Alcohol doesn't tend to have the same effect as it makes you soporific."*

94. Officer D recalled that the Police doctor told him Mr Taitoko's behaviour was extreme and he would not be able to examine him at that stage. Officer D recorded the Police doctor's 'visit' to Mr Taitoko in the ECM at 3.20am, and wrote: "[Police doctor] assessed TAITOKO from outside the cell. TAITOKO under the influence of unknown substances. Will be seen by [Police doctor] prior to being released in the morning."

95. The Police doctor then treated two other patients before very briefly viewing Mr Taitoko again from outside his cell at around 4.05am. He thought Mr Taitoko was looking a little bit better as he was less violent and was not thrashing around as much: *"The expectation at that time was that he would improve if this was drug induced, as the drug level in his body decreased over time."*

96. The shift supervisor, Officer J, returned to the DCU around this time to conduct a formal inspection of the prisoners in the cells. The Police doctor discussed Mr Taitoko with Officers D and J, and they asked whether they should send Mr Taitoko to hospital. The Police doctor said:

*"... I did not think sending him to hospital was necessary at that stage as he appeared to be improving and treatment in a hospital would be difficult given his current status of violent outbursts. From past experience I knew that if we sent someone to hospital who was violent or very difficult to manage the hospital often refused to admit them. We have sent violent people there before and the hospital has said that they were not willing to endanger their staff with a violent patient."*

*I also told the supervisor that I didn't think that sending him to the hospital would be particularly useful as he was thrashing about and had blood on him and it would be very difficult for any doctor to examine him, take his pulse, shine a light in his eyes, or carry out a formal neurological exam."*

97. The Police doctor told the Authority that at the time he believed they were talking "hypothetically" about Mr Taitoko, and that if he had been asked to carry out a formal examination he would have attempted to check Mr Taitoko's vital signs and asked more questions about whether he might have suffered a head injury. However the Police doctor also said that he believed he would have obtained "spurious" results if he tried to check Mr

Taitoko's pulse or pupils himself because "... obviously his pulse would have been elevated due to the large amount of physical activity".

98. Officer D told the Authority that he did not understand how the discussions with the Police doctor could have been taken as being "hypothetical". Officer J said they discussed examining Mr Taitoko "in real terms" and agreed that it was unrealistic "due to the violent nature of Mr Taitoko".
99. At the time the Police doctor considered that Mr Taitoko would be "safe enough" if left in the cell and monitored through constant video surveillance and frequent checks. He later explained in a Police statement that:

*"... my understanding was that there would be ongoing surveillance of this man including physical checks. I thought that they would go into the cells and wake him if he went quiet. ... I said this guy should be fine but he should be closely monitored. In a hospital situation regular monitoring would involve checking level of consciousness and checking pulse. That is different to what the Police do for monitoring."*

100. When interviewed by the Authority, the Police doctor said:

*"I did insist that [Mr Taitoko] was monitored closely. And I think when I spoke at the hospital later, that, that term is open to interpretation and in fact when I had close monitoring explained to me by the Police it was quite different than what I expected it to mean as a doctor. And that sort of illustrates the difficulty in using terms that mean something to one person but not to another."*

*... what I meant [by 'close monitoring'] was that they would be watching him on the screens, but I expected someone would go in there and actually see him, you know, open the door and see him and at least maybe touch him, approximately four times an hour. But at regular intervals, about every 15 minutes. Now, I didn't say that to them because I felt that's probably what they would do."*

*... what surprised me was that even the Police's constant monitoring only means having somebody outside the cell door looking at somebody. Well, if someone can die on you quite easily, when you're outside the cell door looking at them, because they're sleeping, and they're sleeping, and now they're dead and you sort of look at them and you still think they're sleeping, but they're actually dead and they could be dead for an hour before you realise, going in there and touching them, that they're actually dead. So the police's constant monitoring would not cut it in a hospital for monitoring a patient ...."*

101. The Police doctor acknowledged that it was reasonable for the Police to rely on his advice that it was okay for Mr Taitoko to stay in the cell:

*“... my assessment was from the little view of him that I had, that he was similar to several other suspects, patients, clients that we’ve seen before who generally, if they’re left to their own devices and don’t hurt themselves, sleep off whatever drug they’re under the influence of and get better. And in the vast majority of the cases, that’s what happens. And unfortunately in this case it didn’t.”*

102. The Police doctor told the Authority that he was not aware of the Police’s *Managing Prisoners* policy, which states that intoxicated prisoners who are semi-conscious and unable to answer any risk assessment questions should be taken to hospital. When interviewed by Police the doctor also appeared to be unaware of the section of the ‘Manual of Best Practice for Police Medical Officers’ which advises: *“If you suspect that severe intoxication has produced an adverse effect on a subject, it is best to arrange transport to a hospital, preferably in an ambulance.”* He commented that the decision to take the person to hospital should be made at the time of arrest: *“When Police transport someone [to the cells] we make assumptions. People could assume that he wasn’t so intoxicated.”*

103. Officers D and J also discussed restraining Mr Taitoko with the Police doctor and he advised them that he did not think it would be helpful. He later explained that:

*“It is reasonable to restrain violent people who are, for want of a better word, ‘sane’, because they are rational and won’t hurt themselves against the restraints. Someone who is under the influence of drugs, is irrational or psychotic will not do that. They will just keep fighting against the restraints so restraining can often be more dangerous than not restraining.”*

104. During the Police doctor’s discussion with Officers D and J, Officer D suggested calling Mr Taitoko’s family to try to find out what drugs he had taken and the Police doctor said that would be a good idea. They agreed that the Police doctor would return at 10.30am to examine Mr Taitoko before he was released from custody.

105. Officer D started to call the number for Mr Taitoko’s address but saw that it was 4.00am and decided to call the family later because he did not want to wake them up.

## Monitoring

106. As noted earlier, Custody Officer E began entering Mr Taitoko’s information into the ECM at 2.47am. At 2.58am Mr Taitoko was recorded as being in custody, searched and assigned a cell (though this had in fact happened over an hour earlier), and at 3.00am Custody Officer F determined that Mr Taitoko required frequent monitoring.

107. From that point onwards, alerts started appearing on the ECM notifying Officer G at the security desk that Mr Taitoko needed to be checked five times an hour at irregular intervals. The ECM records show the following checks from 3.00am up until 5.12am:

Check completed at	Check carried out by	Comment recorded
3.09am	Officer D	Check
3.22am	Officer G	Lying on floor
3.38am	Officer G	Lying on floor
3.53am	Officer G	Lying on floor
4.06am	Officer J	Check by Snr
4.06am	Officer G	Lying on floor
4.18am	Officer G	Lying on floor on stomach
4.33am	Officer G	Lying on floor on stomach - breathing
4.45am	Officer G	Lying on floor on stomach - breathing
4.58am	Officer G	Lying on floor on stomach/right side – breathing
5.12am	Officer G	Asleep on stomach/right side - breathing

108. Officer G said:

*“When the alert for Sentry’s check came up I would look up at the monitor displaying the image of his cell and see what he was doing. I would record that I had made a check into the custody module and add any comments next to that such as observations I made of Sentry.*

*... All of my checks were done by viewing the monitor containing the live feed from his cell and I did no physical checks myself. I didn’t delegate anyone to do a physical check on Sentry.*

*... Somebody who is on frequent monitoring can be checked using the monitor at the security desk.”*

109. When the Authority interviewed the officers responsible for taking care of Mr Taitoko in the cells, it became clear that some had different understandings of what type of check was required. Officer J believed that frequent monitoring required five ‘physical’ or ‘observation’ checks per hour (see paragraph 276 for definitions of monitoring terms), but Officer D said checks had to happen every 15 minutes and could be either visual checks from outside the cell door or checks carried out by the officer at the security desk looking at the CCTV footage on the monitor.

110. Custody Officer E said: *“I think we may have to go to the door when we do these checks, but you can also nominate those checks out to other staff members working.”* Custody Officer H agreed that when an officer is working the security desk they can ask another officer to complete a cell check for them (as they are not supposed to leave the security desk), but: *“If you can see the person on the CCTV you tend to look at that or through the window into the [monitored] cells to check on them.”* Officer I also understood that the officer working the security desk would carry out the monitoring via CCTV or looking through the window of the

control room to the cells, but if a physical check was required another officer would be asked to visit the cell.

111. The Police's *Managing Prisoners* policy only requires the prisoner to be "observed" during a frequent monitoring check, and does not specify when or how often a physical or verbal check should be carried out (see paragraphs 274-277 for policy). However the policy does require Police to "carry out a check of a prisoner that is commensurate with the health and safety risk they are deemed to pose at the time" and states that CCTV "does not substitute for a physical check and must not be depended on. It does not replace the required visits for prisoners."
112. Custody Officer G later said that he was "absolutely confident" that he could see Mr Taitoko breathing on the CCTV monitor. He did not think it would have made a difference for him (or another officer) to have visited the cell and looked through the door to complete the checks on Mr Taitoko.
113. After the Police doctor first observed Mr Taitoko at 3.21:15am, Mr Taitoko's movements in the cell gradually lessened and he made fewer attempts to sit up (he fell from a sitting position and hit his head on the mattress six times, and on the floor twice). He continued to roll around and thrash his legs and arms about. From about 4.00am onwards he remained lying on his right side and stomach, with his upper body on a mattress and his legs on the floor pointing towards the front of the cell.
114. The CCTV footage of the DCU cells only records when there is movement. The recorded footage of Mr Taitoko's cell begins at 1.45:33am and continues uninterrupted until 4.26:18am, when it jumps to 5.15:39am. This indicates that Mr Taitoko was lying still in the cell (without enough movement to trigger recording) for a period of 49 minutes and 21 seconds, and that no one visited the cell during that time to check on him. Only CCTV checks were completed and relied on during that time.

## MR TAITOKO'S COLLAPSE

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115. At around 5.15am Custody Officer E decided to check on Mr Taitoko in the cell. The officer had been very busy processing other prisoners for the past few hours and told the Authority he had not had time to eat a meal during his shift.
116. The recorded CCTV footage shows Custody Officer E looking through the cell door at 5.15:44am. Mr Taitoko was still lying on his right side and stomach, with his right arm outstretched in front of him and his head resting on the mattress above his arm.
117. Custody Officer E noticed blood on Mr Taitoko and called for Officer D come and look at him. The officers asked Custody Officer G to open the cell door and entered the room at 5.17:41am. Custody Officer E saw that Mr Taitoko's eyes were rolling around in his head and noticed a bruise on his forehead which he had not seen before. He said:

*"... when I was in there I could hear that [Mr Taitoko's] breathing was heavy and rapid. There was blood all around his mouth and nose area. I'm not sure*

*where that came from. I was concerned that he was breathing this blood in and out.”*

118. Officer D also noticed that Mr Taitoko’s breathing was “short and gargled” and thought he might be inhaling blood which had pooled on the mattress beneath his face and under his outstretched arm. He pushed Mr Taitoko’s left shoulder back and put him in the recovery position to clear his airway.
119. Custody Officer G was asked to call an ambulance and Custody Officers E and F monitored Mr Taitoko’s breathing until the paramedics arrived in the cell at 5.27:34am. The paramedics assessed Mr Taitoko and found that he had a pulse but was unresponsive.
120. One of the paramedics called the Ambulance Communications Centre and requested backup from an advanced paramedic. Mr Taitoko’s condition quickly deteriorated and the custody officers removed some of the mattresses from the cell because a solid surface was needed to perform CPR. The paramedics then used a defibrillator on Mr Taitoko and the custody officers took turns performing chest compressions on him.
121. During this time Officer D contacted Officer J to inform him of Mr Taitoko’s condition and two advanced paramedics arrived on the scene. The paramedics administered drugs to Mr Taitoko in an attempt to resuscitate him but unfortunately this was unsuccessful. After about 40 minutes of chest compressions the paramedics judged that further resuscitation attempts would be pointless and stopped at around 6.10am. Ten minutes later one of the advanced paramedics formally confirmed that Mr Taitoko had died.

## POLICE INVESTIGATION

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122. Police have completed a criminal investigation into Mr Taitoko’s death, and a policy, practice and procedure review.

### Toxicology

123. Mr Taitoko’s blood and urine was tested by the Institute of Environmental Science and Research (ESR) for the presence of alcohol and drugs.
124. The ESR report states that no alcohol was detected in Mr Taitoko’s blood, but there was an alcohol level of 65 milligrams per 100 millilitres of urine, which:

*“... indicates that at some time prior to his death, Mr Taitoko had a blood alcohol of at least 50 milligrams per 100 millilitres. For comparison purposes, the legal blood alcohol limit for a New Zealand driver 20 years old or over is 80 milligrams per 100 millilitres.”<sup>4</sup>*

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<sup>4</sup> The legal blood alcohol limit for a New Zealand driver 20 years old or over has since changed to 50 milligrams of alcohol per 100 millilitres of blood.

125. Mr Taitoko had a methamphetamine level of 0.6 milligrams per litre of blood, a tetrahydrocannabinol (THC) level of approximately 0.5 micrograms per litre of blood, and a 25B-NBOMe level of approximately 0.8 micrograms per litre of blood.
126. The ESR report notes that NBOMe compounds have psychedelic effects similar to those of LSD, and can lead to *“acute toxicity with symptoms such as cardiovascular complications, agitation, seizures, hyperthermia and organ failure”*. The use of NBOMe compounds has been associated with sudden death.

### Pathologist’s findings

127. The cause of Mr Taitoko’s death is ultimately for the Coroner to determine.
128. The pathologist’s report for the Coroner concluded that the direct cause of Mr Taitoko’s death was *“acute intoxication due to the combined effects of methamphetamine and probable synthetic drug with associated excited delirium syndrome.”*
129. Other significant conditions contributing to the death (but not related to the condition causing it) were noted as *“multiple blunt force injuries”* and *“partial obstruction of upper airway by blood”*.
130. The pathologist commented that:

*“Autopsy revealed multiple blunt force injuries to his head, neck, torso, upper and lower extremities.*

*... During his confinement he repeatedly fell from standing and kneeling positions sometimes onto the concrete floor of the cell suffering the majority of the blunt force injuries demonstrated at examination. The formation of contusions and the presence of significant scalp haemorrhage can cumulatively and significantly reduce the amount of circulating blood available to carry oxygen. Witness statements also document that his face was apparently within an indentation created by his weight in a mattress pad placed in his cell a few hours prior. There is autopsy evidence that Sentry aspirated some of the blood that apparently pooled in this indentation.”*

### Excited delirium

131. The pathologist and the MHA nurse who had observed Mr Taitoko in the cell both referred to ‘excited delirium’, which is a term that can be used to describe a reaction to drugs such as cocaine and methamphetamine. The symptoms of the condition include insensitivity to pain, struggling against restraint beyond the normal point of exhaustion, unusual strength, disorientation, overheating, fast heart rate, and violent and bizarre behaviour. Excited delirium can result in sudden death and has been cited in a number of deaths in Police custody, particularly in the United States of America and the United Kingdom.

132. When the Authority asked some of the officers involved in this case whether they knew about excited delirium, Officers A and D and Custody Officer E said they had never heard of the condition before and did not recall any training on it. Officer B recalled learning a little bit about excited delirium at Police College, but said it did not occur to him at the time that Mr Taitoko could be suffering from it. Officer J had been trained on excited delirium many years previously when he was a Police officer in the United Kingdom, but did not remember any training on it since he joined New Zealand Police. He commented that excited delirium was very rare and it would be difficult for an officer to remember their training if they did not regularly encounter people suffering from the condition.
133. The MHA nurse said that in her opinion the best treatment for someone suffering excited delirium is to “... restrain him, sedate him, hydrate him and then investigate the cause of the delirium so that could be treated.” She explained that:

*“Restraint would only be used to facilitate the rest of the treatment. It would not be used otherwise as it would contraindicate in someone like that, that is, it could cause more physical distress to the person and escalate to an adverse outcome.*

*That cause of action carries its own risk without immediate life support back up and resuscitation facilities due to the risk of respiratory arrest, cardiac arrest or both. It is not something that can be done at the DCU without the full resources of an advanced paramedic and more preferably would be done at a fully serviced hospital. There are no medications suitable for sedation or emergency equipment of that level at the DCU.”*

134. The Authority also spoke to the National Co-ordinator of Forensic Medicine for New Zealand Police, who said that any prisoner who needed to be sedated should first be taken to hospital:

*“My personal view has always been that while we do have the facility to provide some degree of policing in a hospital, we do not have the facilities to provide a hospital in Police cells.”*

## FAMILY CONCERNS WITH THE POLICE’S ACTIONS

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135. Mr Taitoko’s family and friends told the Authority that they were concerned about the way Mr Taitoko was treated by Police while he was in custody and they believed Police were negligent in taking care of him. The family also felt that Police lacked compassion towards them and did not adequately explain the investigation process, particularly the procedure for identifying Mr Taitoko’s body.
136. In the hours following Mr Taitoko’s death on 23 February 2014, Police appointed family liaison officers (accompanied by kaumātua) to notify his family. They met with Mr Taitoko’s brother, Mr W, who was understandably very upset but wanted to be the one to identify Mr Taitoko’s body. At around 1.00pm one of the family liaison officers called the Police criminal investigator

to say that he was going to take Mr W to the mortuary to carry out the formal identification process.

137. However, soon after that call, the Police criminal investigator realised that the post-mortem would have to take place first because Mr Taitoko's hands, feet and head had been covered to preserve any possible forensic evidence. The identification process could not occur before the post-mortem because that would have meant interfering with and compromising the forensic evidence.
138. The Police criminal investigator called the family liaison officer to advise him of that decision. The family liaison officers, kaumātua and Mr W were already on their way to Auckland Hospital to complete the identification. The family liaison officer was initially told that the post mortem would only take one and a half to two hours, and he decided that they would wait in Auckland rather than driving Mr W back to Manurewa. The Police criminal investigator told the Authority:

*“Unfortunately, the post-mortem examination took longer than we anticipated. I think it was upward of three or four hours, which caused some distress to [Mr W] and I certainly accept that. It would distress me if I was in that situation as well.”*

139. After being informed about the delay in completing the post-mortem, the family liaison officer decided it would be best to take Mr W home to be with his family and pick him up later when it was possible to conduct the identification process. Several hours later Mr W and other family members were taken to the hospital to carry out the identification.
140. At the hospital some family members asked the officers how and why Mr Taitoko had died but the officers were unable to answer because the cause of death had not yet been determined and Police were still investigating what had happened while Mr Taitoko was in the cells.
141. Police subsequently held meetings with the family to discuss their concerns, explain why the identification process had to be delayed, and apologise for any distress that was caused.



## The Authority's Investigation

### THE AUTHORITY'S ROLE

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142. Under the Independent Police Conduct Authority Act 1988, the Authority's functions are to:
- receive complaints alleging misconduct or neglect of duty by any Police employee, or concerning any practice, policy or procedure of the Police affecting the person or body of persons making the complaint; and to
  - investigate, where it is satisfied there are reasonable grounds for doing so in the public interest, any incident in which a Police employee, acting in the course of his or her duty has caused or appears to have caused death or serious bodily harm.
143. The Authority's role on the completion of an investigation is to determine whether Police actions were contrary to law, unreasonable, unjustified, unfair, or undesirable.

### THE AUTHORITY'S INVESTIGATION

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144. As required under section 13 of the Independent Police Conduct Authority Act 1988, Police notified the Authority on 23 February 2014 of Mr Taitoko's death. The Authority immediately commenced an independent investigation.
145. In addition to reviewing information produced during the Police investigations into Mr Taitoko's death, the Authority visited the Counties Manukau DCU to view the cell where Mr Taitoko died and interviewed 24 people including civilian witnesses, the officers involved in Mr Taitoko's arrest, the officers working at the DCU, the pathologist and the National Co-ordinator of Forensic Medicine for New Zealand Police.
146. The Authority has maintained regular contact with Mr Taitoko's family throughout the course of its investigation.

### ISSUES CONSIDERED

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147. The Authority's investigation considered the following issues:
- 1) Was it appropriate for Police to take Mr Taitoko into custody?
    - a) Was the detention of Mr Taitoko lawful?
    - b) Should the Police have taken Mr Taitoko to hospital?
  - 2) Did Police use excessive force when dealing with Mr Taitoko:
    - a) ... during arrest?
    - b) ... during transport and in the cells?

- 3) Did Police transport Mr Taitoko to the DCU in a safe manner?
- 4) Did Police comply with their policies in respect of:
  - a) ... intoxicated prisoners?
  - b) ... searching?
  - c) ... risk assessment?
  - d) ... medical examination?
  - e) ... monitoring?
- 5) Were conditions in the Police cell appropriate?
- 6) Did Police fulfil their duty of care to Mr Taitoko?
- 7) Was the Police's liaison with Mr Taitoko's family adequate?

## The Authority's Findings

### ISSUE 1: WAS IT APPROPRIATE FOR POLICE TO TAKE MR TAITOKO INTO CUSTODY?

#### A: Was the detention of Mr Taitoko lawful?

148. Police found Mr Taitoko lying on the porch of a private property in an extremely intoxicated state. They had been called to the house by a neighbour, who reported fighting after hearing and seeing two men (including Mr Taitoko's brother) attempting to restrain Mr Taitoko in the street. After assessing the situation and speaking to Mr Taitoko's brother and friends, Officers A and B decided to arrest Mr Taitoko for breach of the peace and detoxification.
149. Officers A and B believed they had the power to arrest Mr Taitoko for breach of the peace because he was yelling and disturbing the neighbourhood. They also said they considered that Mr Taitoko might pose a risk to people at the house and possibly even members of the public. However it appears their main concern was that Mr Taitoko was unable to look after himself and they did not think anyone at the house could provide the level of care he needed. For that reason they also took him into custody for detoxification so he could be monitored at the DCU.
150. The Authority acknowledges that the officers believed they were acting in the best interests of Mr Taitoko and the people living at his address. However the Authority's view is that the officers did not have legal authority to take Mr Taitoko into custody for detoxification under section 36 of the Policing Act 2008 because, while he was *"incapable of protecting himself ... from physical harm"*, he was not found in a public place and was not trespassing on private property (see paragraphs 256-257).
151. The other ground for Mr Taitoko's arrest was breach of the peace, namely violence or a real threat of violence which is *"severe enough to cause alarm to ordinary people and threaten serious disturbance to the community"* (see paragraphs 252-255 for an explanation of relevant law and policy). While the Authority finds that Mr Taitoko's actions in the presence of the officers (lying on the porch, yelling and flailing his arms and legs) did not amount to a breach of the peace, the Authority accepts that Police had good cause to suspect that Mr Taitoko had breached the peace before they arrived on the scene.
152. Nonetheless the Authority considers that, since Mr Taitoko was clearly not in control of his own actions and did not even seem to register the presence of anyone else around him, arresting him for breach of the peace was not an appropriate response to the situation the officers were confronted with. Mr Taitoko was not deliberately violent towards anyone and it is clear from the statements of the officers and Mr Taitoko's brother and friends that the real concern was for Mr Taitoko's health rather than the risk that he would inflict harm on anybody if left alone.

## FINDINGS

Police did not have legal authority to take Mr Taitoko into custody for detoxification. It was lawful to arrest Mr Taitoko for breach of the peace but this was not an appropriate response in the circumstances.

### B: Should the Police have called an ambulance and/or taken Mr Taitoko to hospital?

153. Police policy on 'Dealing with intoxicated or drug affected people' states that an intoxicated prisoner who is unconscious or 'semi-conscious' (physically unable to look after themselves) should be taken to hospital by ambulance, or by Police vehicle if waiting for the ambulance would cause a delay (see paragraph 271 for the relevant section of the *Managing Prisoners* policy).
154. The Police's *Alcoholism and Drug Addiction* policy also provides that if a person appears to be "dangerously affected" by alcohol (not able to be understood/moans and groans/no sensible words/nil response at all), an ambulance must be called as the person may lapse into unconsciousness or be suffering from a drug overdose or undiagnosed medical condition (see paragraphs 264-265 for policy).
155. In this case, even if the officers had not arrested Mr Taitoko, the Authority finds that they should have called an ambulance or transported him to hospital themselves due to the obvious concerns for his health.
156. The officers were reluctant to call an ambulance or take Mr Taitoko to the hospital because they considered his behaviour to be too "aggressive" and believed he would pose too great a risk to ambulance and hospital staff. The Authority notes the Police doctor also commented that, in his experience, the hospital "often" refused to admit people who are violent or difficult to manage (see paragraph 96 and the Authority's comments at paragraphs 160-164).
157. However the officers appear to have overlooked the fact that Mr Taitoko's "aggressive" behaviour was caused by an extreme, and dangerous, level of intoxication. This was a medical emergency rather than a situation involving a violent offender. Mr Taitoko was not attacking or directing his aggression at anyone in particular; he only 'lashed out' when people touched him or tried to restrain him. Furthermore the officers had seen him hitting his head repeatedly and this in itself should have prompted them to seek immediate medical attention.
158. If the officers had called an ambulance or taken Mr Taitoko to hospital, the medical staff may have been able to sedate him and treat him for his extreme level of intoxication. Police officers could have accompanied Mr Taitoko to hospital to assist with restraining him and reduce the level of risk to the medical staff. If the medical staff had nonetheless refused to treat Mr Taitoko, then it would have been appropriate for Police to take him to the DCU as a last resort. However, in this case the arresting officers did not give any medical staff the chance to assess him in the first place.

159. While it is possible that Mr Taitoko would have died even if he had received timely medical treatment, the Authority considers that Police custody should only be used as a last resort for heavily intoxicated people, after medical advice has been sought.

## FINDING

The arresting officers should have called an ambulance or transported Mr Taitoko to hospital.

### Comment on systemic issues affecting the Police response

160. Although the Authority has found that the officers should have called an ambulance or taken Mr Taitoko to hospital, the Authority acknowledges that the arresting officers believed that they were doing the best thing to keep Mr Taitoko safe and thought that he would be properly cared for at the DCU (see paragraph 26). Police have advised the Authority that it is common practice for officers to take dangerously intoxicated people to the DCU for care in the absence of acute detoxification centres.
161. Police are regularly faced with violent and drug- or alcohol-affected people, or those suffering from mental health problems, and there is an expectation from the public that Police will take action to assist the person and prevent them from causing harm to anyone else.
162. The Authority understands, from its investigation of this case and others, that some Police officers are of the view that taking such people into custody is the only option available to them because:
- a) calling an ambulance for these types of people is not realistic because it will take too long to arrive;
  - b) when the paramedics do arrive they will refuse to treat the person because they are unable or unwilling to cope with the 'violent' behaviour;
  - c) Police cannot take such people to the hospital themselves, because the emergency department staff are also unwilling and unprepared to deal with people who are in a 'violent' state; and
  - d) if Police call Mental Health Services, they will be instructed to take the person into custody anyway because the DAO will refuse to assess the person at the scene and refuse to assess people if they are intoxicated.
163. The Authority's impression is that the extent to which these perceptions are accurate varies around the country. However the Authority accepts that, given these perceptions (which are sometimes correct), Police are often placed in a difficult position where they have concerns for people's mental health or level of intoxication, and they believe they have no choice but to take such people into custody until they are calm or sober enough to receive medical assessment and treatment.

164. For further discussion on this issue, see Part 8 of the Authority’s Review of Police Custodial Management (released at the same time as this report). The Authority notes that Police have been working at both a local and national level to address problems around managing the custody of intoxicated people.

## ISSUE 2: DID POLICE USE EXCESSIVE FORCE WHEN DEALING WITH MR TAITOKO?

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### A: During arrest

165. After the officers arrested Mr Taitoko, they had to pick him up and carry him towards the street so they could place him in a Police vehicle. Mr Taitoko struggled during this process and initially only one handcuff could be placed on him. Officer A then left Officers B and C to hold Mr Taitoko down on the grass in the recovery position while he went to fetch a prisoner van.
166. Ms Y told the Authority that one of the arresting officers (Officer C) put his knee across Mr Taitoko’s neck, and only removed it after she told him Mr Taitoko’s face was turning purple. She was concerned that Mr Taitoko was struggling to breathe and said Officers B and C were hurting Mr Taitoko in the process of restraining him.
167. Officers B and C denied that Ms Y told them Mr Taitoko was struggling to breathe or that his face turned purple. They pointed out that Mr Taitoko was able to continue yelling throughout the time they were restraining him, and for some time afterwards.
168. The officers also explained that it was difficult for them to hold Mr Taitoko in the recovery position because he kept thrashing around. Officer C said that he was crouched behind Mr Taitoko and occasionally dropped his left knee to the ground behind his shoulders, but denied that his knee ever came into contact with Mr Taitoko’s head or neck.
169. The pathologist later advised the Authority that Mr Taitoko did not have any injuries consistent with someone placing a knee across his neck.
170. The Authority also notes that Mr Taitoko may have been less sensitive to pain and abnormally strong due to his reaction to the drugs he had taken, and that subsequently the level of force the officers had to use to restrain him effectively may have appeared excessive to a bystander.
171. The Authority is satisfied that the officers did not use excessive force during the arrest and did not injure Mr Taitoko’s neck or obstruct his breathing while they were trying to keep Mr Taitoko in the recovery position.

### FINDING

Police did not use excessive force during Mr Taitoko’s arrest.

## B: During transport and while in the cells

172. When the prisoner van arrived, the officers lifted Mr Taitoko inside and placed him in a compartment by himself. According to the officers, they arrived at the DCU within about seven minutes.
173. Recorded CCTV footage of the DCU entrance shows the officers pulling Mr Taitoko out of the prisoner van and carrying him into the monitored cell. The footage of the cell shows the officers holding him down while he was searched and clothing was removed from him. The officers then left the cell. Mr Taitoko was held down again about 30 minutes later, when mattresses were placed inside the cell in an attempt to protect him from hurting himself. After that, no officers entered the cell until Custody Officer E checked on him at 5.16am.
174. Although Mr Taitoko's body was found to have a large number of bruises and scrapes during the post-mortem, the Authority has found no evidence to suggest that Mr Taitoko was assaulted by Police or that excessive force was used.
175. The injuries most likely occurred due to Mr Taitoko lashing out and throwing himself around while he was suffering a reaction to the drugs he had consumed earlier that evening. This is confirmed by the CCTV footage of him inside the cell, which shows him falling onto the floor and into the walls numerous times. Mr Taitoko had also suffered self-inflicted injuries before Police arrested him (and while he was being transported in the prisoner van, as discussed below).

### FINDING

Police did not use excessive force on Mr Taitoko when transporting him to the DCU or while he was in the cells.

## ISSUE 3: DID POLICE TRANSPORT MR TAITOKO TO THE DCU IN A SAFE MANNER?

176. In order to transport Mr Taitoko to the DCU, the officers handcuffed him with his hands behind his back and placed him on the floor of a compartment in the back of the prisoner van. The officers believed this would be safer than trying to place him on the seat because there was no way of securing Mr Taitoko in a seated position and it was likely he would fall off.
177. The officers tried to place Mr Taitoko on his side but he soon rolled onto his front. Prisoners lying face-down with their hands tied behind their back are at greater risk of 'positional asphyxia' (see paragraph 263 for relevant policy); in this case the officers were aware of the risk and Officer A ensured that Officer B monitored Mr Taitoko while they drove to the DCU.
178. Mr Taitoko continued to thrash around, kick out and scream during the journey, and Officer B saw him deliberately hitting his head against the floor of the van. As he was in a separate compartment, there was no way to restrain Mr Taitoko from hurting himself.

179. The pathologist later told the Authority that some of the bruises on Mr Taitoko's body could have occurred when Police were trying to get Mr Taitoko in and out of the van, and commented that: *"The edges of that transport vehicle are all metal, there's some very sharp edges, so it's not an ideal vehicle for transporting someone who's in a state of hyperkinetic drug reaction."*
180. The Authority's view is that the method used to transport Mr Taitoko was not adequately safe for a prisoner in his condition. However, no safer form of transport was available and the officers took steps to reduce the risks.

## FINDING

Although the prisoner van was not ideal for transporting a prisoner in Mr Taitoko's condition, the officers took steps to reduce the risks and there was no safer form of transport available.

## ISSUE 4: DID POLICE COMPLY WITH THEIR POLICIES FOR MANAGING PEOPLE IN THE CELLS?

### A: Intoxicated prisoners

181. As discussed earlier, Police policy on *Managing Prisoners* states that when receiving an intoxicated prisoner who is unconscious or semi-conscious (unable to answer any questions during initial risk assessment process or physically unable to look after themselves), Police must arrange for an ambulance to take the person to hospital, or use a Police vehicle to take the person to hospital if they *"expect a delay in the ambulance's arrival or the person's condition calls for immediate action"*.
182. The *Alcoholism and Drug Addiction* policy also states that when a person appears to be *"dangerously intoxicated"*, an ambulance must be called. When considering whether or not to detain an intoxicated person at a Police station, officers must consider whether the person (i) can stand unaided, (ii) is capable of a coherent conversation and (iii) understands where they are – if the answer to any of these questions is no, then Police must *"seek help from local medical services."*
183. When Mr Taitoko arrived at the DCU, he could not walk and had to be carried into the cell by four people. The custody sergeant, Officer D, and the custody officers quickly realised that Mr Taitoko was extremely intoxicated and had no control of his body. He was yelling unintelligibly and hurting himself by repeatedly hitting his head and body on the walls and floor of the cell. The officers also suspected that he had taken drugs.
184. Mr Taitoko was clearly unable to answer any risk assessment questions and physically unable to look after himself. As required by Police policy, the officers at the DCU should have immediately called for an ambulance or arranged for the arresting officers to transport Mr Taitoko to hospital.

185. The Authority acknowledges that there were concerns that Mr Taitoko was “too violent” for ambulance or hospital staff to deal with, and that it has become standard practice for Police to take dangerously intoxicated people who are violent to the DCU due to a common perception that medical staff will refuse to take them. However, as noted above, this should not have prevented Police from at least attempting to obtain assistance from medical staff.
186. During the Authority’s investigation, one officer said that he did not believe the DCU officers had breached policy, because the *Managing Prisoners* policy’s instructions on dealing with violent prisoners (see paragraph 272) are different from the instructions for dealing with intoxicated and drug-affected people; the officers were dealing with Mr Taitoko as a violent prisoner and therefore did not need to comply with the requirements for dealing with intoxicated prisoners. The Authority does not accept this argument, because if that was the case then Police would be justified in ignoring obvious health concerns (such as drug overdose or head injury) because the prisoner was acting ‘violently’ – even when the violent behaviour may itself be caused by the health issue.
187. Simply placing Mr Taitoko in a CCTV-monitored cell and leaving him to calm down was not the appropriate action to take for a prisoner in Mr Taitoko’s condition. The custody staff should have recognised that he required urgent medical assessment and was at risk of death or serious harm due to the substances he had consumed.

## FINDINGS

Police did not comply with the requirements of the *Managing Prisoners* policy or the *Alcoholism and Drug Addiction* policy in respect of intoxicated prisoners.

The custody sergeant, Officer D, should have called for an ambulance or arranged for him to be transported to hospital.

## B: Searching

188. Normal procedure in Police custody facilities is for the arresting officers to search a prisoner in the presence of custody staff before the prisoner is formally processed and placed in a cell. Any items that could be used by prisoners to harm themselves or others must be removed (see paragraphs 266-267 for policy).
189. In this case Mr Taitoko was placed directly into a monitored cell and the arresting officers and custody officers searched him before leaving him there. The custody officers took Mr Taitoko’s socks and belt from him because they could potentially be used for self-harm. They also took Mr Taitoko’s shorts because he had not gone through a metal detector and they wanted to be sure there was nothing concealed in them which he could use to harm himself or Police staff.

## FINDING

Police complied with the *Managing Prisoners* policy by searching Mr Taitoko and removing potentially dangerous items from him before leaving him in the cell.

### C: Risk assessment

190. The *Managing Prisoners* policy requires Police to formally assess all prisoners received into custody to identify any health or safety risks and determine the level of care they need (see paragraphs 268-270 for policy).
191. Mr Taitoko was placed in a cell at around 1.45am but Custody Officer E only completed his risk evaluation about an hour later because it was very busy at the DCU. Mr Taitoko was assessed to be 'in need of care', and subsequently Custody Officer F completed a Health and Safety Management Plan (HSMP) for him which stated that he required frequent (rather than constant) monitoring.
192. Mr Taitoko's risk assessment and HSMP noted that he was intoxicated, agitated, irrational, unfit to answer questions, unable to understand anything that was said to him, had to be carried to the cell and appeared to be under the influence of drugs. Custody Officer E also recorded that they had put mattresses into the cell to prevent Mr Taitoko from hurting himself and that "Ambos" would be called to check on him when he was calm.
193. The Authority considers that the risk assessment carried out by the custody officers was inadequate because:
- It was only undertaken about one hour after Mr Taitoko had been placed in the cell. The Authority acknowledges that the custody staff were extremely busy, with a constant stream of people being brought into the DCU. Nevertheless, given Mr Taitoko's condition, he should have been given priority and the risks to his health should have been formally assessed as soon as possible after he arrived at the DCU.
  - The formal risk assessment apparently did not include the fact that Mr Taitoko was constantly moving, not in control of his body, sweating, had hit his head repeatedly when falling in the cell, and was bleeding from the nose.
194. Officer J explained that when he discussed the required level of monitoring with Officer D, he thought constant monitoring was unnecessary because they had no information suggesting that Mr Taitoko was suicidal. However the Authority's view is that the fact Police had been unable to obtain any risk assessment information from Mr Taitoko (and the fact that he was unable to communicate about his state of mind or any injuries he had suffered) was a factor in favour of instituting constant monitoring. Mr Taitoko was also in effect self-harming by hitting himself on the walls and floor of the cell, and that danger was not fully counteracted by lining the cell with mattresses.

195. If Mr Taitoko had been constantly monitored from the time he was placed in the cell, then the DCU staff would have been more aware of his condition and would have known exactly how many times he was falling and hitting his head on the walls and floor of the cell. This may have prompted them to seek urgent medical attention.
196. Officer D, Officer J and the custody staff were concerned about Mr Taitoko's behaviour but seem to have believed that he just needed to be left in the cell to calm down and sober up. While they took some steps to address the risks they identified before and after the formal risk assessment was completed (such as placing mattresses in the cell, recording that Mr Taitoko would be seen by a medical professional when calm, and placing him on a frequent monitoring regime), they underestimated the danger Mr Taitoko's extreme state of intoxication posed to him.

## FINDINGS

Police should have carried out a formal assessment of Mr Taitoko as soon as possible after he was received.

The risk assessments conducted by the custody staff were inadequate. Given the clear risks to his health, Mr Taitoko should have been placed on a constant monitoring regime.

## D: Medical examination

197. Prisoners found to be 'in need of care' must be examined by a health professional "*as soon as practical*", and the result of that examination must be recorded in writing (see paragraph 273 for policy).
198. In this case, Officer D did not call a Police doctor to the cells specifically to examine Mr Taitoko, but asked one to have a look at Mr Taitoko in his cell while he was on his way to treat another prisoner. This happened about 20 minutes after Mr Taitoko's HSMP was completed (and over 90 minutes after he was first brought into the DCU).
199. The Police doctor looked into Mr Taitoko's cell for about two minutes at 3.21am but was of the view that Mr Taitoko was too "*violent*" to be examined or taken to hospital. The Police doctor later said that he was not formally asked to examine Mr Taitoko, and therefore did not complete a written report or an invoice. He never entered the cell, and did not fully assess Mr Taitoko as he would have if there had been a formal request for his services.
200. Officer D recorded the Police doctor's visit on the ECM but did not update Mr Taitoko's HSMP to note when the Police doctor was called and when he arrived in the cell.
201. The Police doctor later spoke with Officers D and J at around 4.05am and said he did not think it was necessary to send Mr Taitoko to hospital. Officer D arranged for the Police doctor to return at 10.30am to examine Mr Taitoko before he was released from custody.

202. The Authority accepts that Officers D and J believed they had engaged the Police doctor to provide the necessary medical attention for Mr Taitoko and finds that, from 3.21am, it was reasonable for Police to rely on the Police doctor's advice that Mr Taitoko did not need to go to hospital – despite the fact that the Police doctor had not actually conducted a physical examination or completed a written report as required by the *Managing Prisoners* policy.
203. Nonetheless Police remained responsible for Mr Taitoko's care and had a duty to look after him appropriately while he remained in the cells.

## FINDINGS

Officer D arranged for a Police doctor to look at Mr Taitoko shortly after he was assessed to be 'in need of care'. However, a physical examination did not take place.

From 3.21am onwards, it was reasonable for Police to rely on the Police doctor's advice that Mr Taitoko could remain in the cell and did not need to be taken to hospital.

## E: Monitoring

204. From 3.00am, when the HSMP for Mr Taitoko was completed, a frequent monitoring regime was put in place of five checks per hour at irregular intervals (see paragraphs 190-196 for the Authority's findings on the level of monitoring that should have been in place). Prior to that there was no formal monitoring schedule, but Mr Taitoko was observed from time to time (on more than five occasions) by Officers D and J and the other custody officers, thus complying with the requirements of the frequent monitoring regime.
205. The only time anyone entered Mr Taitoko's cell, from when he was placed in it until 5.17am, was when officers went in briefly to line the cell with mattresses. The CCTV camera in the cell stopped recording from around 4.26am onwards, which indicates that nobody even looked through the cell door during that time because there was no movement to trigger the recording.
206. Custody Officer G was at the security desk and was responsible for responding to the ECM alerts that Mr Taitoko needed to be checked. He completed nearly all these checks himself by viewing the CCTV monitor and did not ask anyone to visit Mr Taitoko's cell and complete a check.
207. Police policy states that *"CCTV, while a valuable aid, does not substitute for a physical check and must not be depended on. It does not replace the required visits for prisoners."* The Authority observes that in this case the recorded CCTV footage was not clear because the lens of the camera was dirty, and that while it was possible to tell that Mr Taitoko was breathing, it would have been difficult to ascertain how comfortably he was breathing or whether Mr Taitoko had any injuries or bruises just by viewing the footage periodically. In particular, it was not clear until Custody Officer E visited the cell that blood was pooling under Mr Taitoko's face and he was breathing it in.

208. Custody Officer G was an inexperienced custody officer and was apparently unaware that checks on prisoners should not be carried out simply by looking at the CCTV screen. Officer D and some of the other custody officers on duty also did not know that they were required to at least go to the door of the cell and personally observe the prisoner to check his or her well-being.
209. The *Managing Prisoners* policy describes three different types of checks, namely:
- a) **Observation check:** look in the cell to check the prisoner’s breathing and condition; if unable to confirm this then carry out a ...
  - b) **Verbal check:** verbally rouse the prisoner to establish their well-being; if no response then carry out a ...
  - c) **Physical check:** enter the cell and physically wake the prisoner to establish well-being. The policy warns that continual waking of the prisoner without due cause could be considered inhumane, but allows for situations when waking the prisoner regularly is considered necessary because *“their risk assessment indicates they need specific care, are intoxicated or exhibit any risk identifiers.”*
210. The Police doctor commented that he expected the custody staff would closely monitor Mr Taitoko and would carry out physical checks by regularly entering the cell and rousing him to check on his condition. This did not occur. The Police doctor did not discuss his expectations for monitoring with Officer D.
211. There was a perception among the custody staff at the Counties Manukau DCU that Mr Taitoko was like many other intoxicated prisoners who had passed through the cells and just needed to ‘sleep it off’. But it can be very dangerous to leave an extremely intoxicated person alone to sleep, as they may choke on vomit or gradually slip into a non-responsive state. The *Managing Prisoners* policy recognises this danger:
- “... Alcohol and drugs affect people differently and the full effects may take many hours after last consumption. People under the influence of drink or drugs may become more intoxicated over time and this should be a considered factor in the nature of the check undertaken.”*
212. The *Alcoholism and Drug Addiction* policy also advises:
- “**Caution:** It is vital that the person is not isolated, and their condition is monitored frequently to re-assess whether they can continue to be held at the Police station, or if an ambulance should be called or they should be moved to a hospital or other location.”*
213. However, while the *Managing Prisoners* policy states that Police must *“carry out a check of a prisoner that is commensurate with the health and safety risk they are deemed to pose at the time”*, it does not provide any specific guidance regarding how often intoxicated prisoners should receive physical or verbal checks, rather than just observation checks.

214. In this case Mr Taitoko's movements gradually lessened and he was lying still (but breathing) in the cell for around 50 minutes before Custody Officer E visited the cell to check on him at 5.16am.
215. The Authority finds that the custody staff did not monitor Mr Taitoko appropriately given his dangerously intoxicated state. Once the frequent monitoring regime was formally commenced, almost all of the checks were carried out solely by looking at the CCTV footage. This type of check was against policy and was not sufficient to manage the risk posed by Mr Taitoko's condition.

## FINDINGS

Police did not comply with the *Managing Prisoners* policy in respect of monitoring prisoners. The checks that were carried out were inadequate for someone in Mr Taitoko's condition.

### ISSUE 5: WERE CONDITIONS IN THE POLICE CELL APPROPRIATE?

216. Mr Taitoko was placed in an empty, CCTV-monitored cell. Unfortunately the lens of the CCTV camera was dirty which resulted in a poor-quality picture. Although Police should not have been relying solely on the CCTV footage in any event, the unclear image would not have assisted Custody Officer G who was responsible for monitoring the CCTV screens at the security desk.
217. The cell was suitable in that there were no fixtures (such as a bed, sink or toilet) for Mr Taitoko to hit himself on in his agitated state. However Mr Taitoko was still able to hurt himself on the hard floor and walls of the cell. There was no padded cell or restraint chair available at the Counties Manukau DCU,<sup>5</sup> so Police tried to counter that problem by lining the floor of the cell with mattresses. This solution was inadequate because gaps appeared between the mattresses and Mr Taitoko continued to hit his head on the walls and floor.
218. Another factor was that warm air from outside was being circulated into the cell. Mr Taitoko was overheating and sweating due to the drug reaction he was suffering, and being confined in a warm cell would not have helped his condition. Mr Taitoko also did not have any access to water (but may not even have been capable of drinking it if it was available to him).
219. As already noted above, the Authority's view is that a person in Mr Taitoko's condition should not have been kept at the DCU. Police are not medically trained and are not equipped to provide the level of care and monitoring needed for a dangerously intoxicated person (see Parts 7 and 8 of the Authority's Review of Police Custodial Management).

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<sup>5</sup> Police have advised the Authority that all DCUs now have restraint chairs and qualified operators. The Authority notes the Police doctor's comments that restraint may be harmful for people in Mr Taitoko's condition, and the MHA nurse's comments that restraint should only be used to enable sedation and further treatment (see paragraphs 100 and 130).

## FINDING

Conditions in the cell were not appropriate for a prisoner in Mr Taitoko's condition.

### ISSUE 6: DID POLICE FULFIL THEIR DUTY OF CARE TO MR TAITOKO?

220. Police owe a legal 'duty of care' to all people arrested, detained or placed in their custody. This duty begins from the moment the person is detained and applies until the person is released from custody or transferred into the care of another agency. In essence, this duty requires Police to keep the person safe and protect them from injury. Law and policy relating to this duty of care is explained in more detail in paragraphs 258-262.
221. The Authority acknowledges that Police were concerned about Mr Taitoko's health and took actions to protect him including:
- a) the arresting officers taking him to the DCU, where they believed he would be safer than being left at home (because they considered him too 'violent' to be taken to hospital);
  - b) the DCU officers placing him in a CCTV-monitored cell and lining the floor of his cell with mattresses;
  - c) carrying out a risk assessment and placing Mr Taitoko on a frequent monitoring regime (though the monitoring was not properly carried out);
  - d) Officer D asking a Police doctor to look at Mr Taitoko (though he was not physically examined).
222. Nonetheless while Mr Taitoko was in Police custody he was able to fall and hit his head repeatedly (even after the mattresses were placed in the cell) and suffered multiple self-inflicted injuries to his body, including a bleeding nose. Although officers in the DCU saw him hitting his head and suspected that he had taken drugs, medical attention was not sought until 90 minutes after he was brought into the cells. Ultimately Mr Taitoko was left alone in a cell to succumb to the effects of his extreme intoxication until he was found lying with blood pooling near his mouth, which appears to have restricted his breathing.
223. The Police's *Managing Prisoners* policy should have ensured that Mr Taitoko received urgent medical attention at the time of his arrest or when he arrived at the DCU, but practical concerns around the safety of ambulance and hospital staff resulted in the policy not being followed. In the Authority's opinion, Police should have at least attempted to obtain medical treatment for Mr Taitoko due to his extreme intoxication and the repeated knocks to his head. Only if the ambulance or hospital staff had refused to treat him would it have been appropriate to keep him in the Police cells.
224. Police had a legal duty of care to Mr Taitoko under section 151 of the Crimes Act 1961 that required them to take reasonable steps to protect Mr Taitoko from harm (see paragraph 260).

The Authority finds that, by failing to seek urgent medical attention for Mr Taitoko at the outset, and to carry out appropriate checks on his condition while he was in the cell, Police failed to fulfil this duty. However, in the circumstances, the Police's actions were not so grossly negligent as to give rise to criminal liability.

225. While making this finding, the Authority recognises that Mr Taitoko may have died even if Police had urgently sought and obtained medical treatment for him. Although Mr Taitoko may still have died, his death should not have occurred while he was in Police custody.

#### FINDING

Police failed to fulfil their duty of care to Mr Taitoko.

#### ISSUE 7: WAS THE POLICE'S LIAISON WITH MR TAITOKO'S FAMILY ADEQUATE?

226. Mr Taitoko's family's concerns with the Police's actions are explained above at paragraphs 135-141.
227. The Authority is satisfied that Police explained the investigation process to the family as well as they could in the difficult circumstances, and finds that the delay in conducting the identification process for Mr Taitoko was unfortunate but necessary to preserve forensic evidence for the post-mortem.
228. Police responded to the family's concerns by meeting with them to explain the delay.

#### FINDING

The Police's liaison with Mr Taitoko's family was adequate.

## Subsequent Police Action

### COUNTIES MANUKAU DCU

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229. Police have advised the Authority that since Mr Taitoko's death, the Counties Manukau DCU has obtained a restraint chair and trained staff to operate it. All major Police custodial hubs now have restraint chairs, enabling safer medical examinations of violent prisoners.
230. All of the Counties Manukau DCU staff, Duty Inspectors, Duty Senior Sergeants and trainers have been debriefed regarding Mr Taitoko's death. The Counties Manukau DCU has adopted the same practice as the Auckland DCU in respect of intoxicated people, which is 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."*
231. Practice at the Counties Manukau DCU has also changed so that prisoners are entered into the ECM (Electronic Custody Module) more quickly. People brought in for detoxification are required to be checked every two hours to reassess their degree of intoxication, and if officers decide to retain the person in custody they must record this and the reason for their decision in the ECM.
232. Custody staff have been reminded of their obligation to visit the cell when checking a prisoner, and are now rostered so that they regularly work together in the same group. The DCU has also established a cleaning programme for the CCTV cameras in the cells.

### CO-OPERATION WITH HEALTH CARE PROVIDERS

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233. Counties Manukau Police are actively working with hospital and ambulance services to *"find workable solutions for dealing with intoxicated people"* and have met with staff from Middlemore Hospital, and with the National Co-ordinator of Forensic Medicine and the Clinical Director of the Department of Emergency Medicine at Waikato Hospital, to discuss how Police, Police medical officers (PMOs) and hospital emergency departments should work together to deal with extremely intoxicated and unresponsive people.
234. Some of the conclusions drawn from these discussions were that:
- a) Intoxication is a health issue and Police cells are not the appropriate place for seriously intoxicated people. Hospital emergency departments should not be flooded with all intoxicated people from the cells, but Police should call an ambulance for intoxicated people who are extremely sedated or exhibiting signs of delirium (or should take them directly to hospital).
  - b) Police will be expected to assist medical staff in restraining an extremely intoxicated and agitated or 'violent' person until he or she is effectively sedated. Any use of restraint (such as the restraint chair) must be strictly monitored.

- c) It is not safe to chemically sedate a person in the cells, other than when suitably qualified ambulance crew are present to aid airway support and transfer to hospital.
- d) The National Co-ordinator of Forensic Medicine and Clinical Director of the Department of Emergency Medicine should set up a sedation protocol for people suffering from “*agitated delirium*”.
- e) Any request for a PMO to see a prisoner is a formal request requiring full examination and must be documented. There should be a common understanding of what the observation requirements are, and any changes to the prisoner’s condition must be noted and appropriate action taken.

235. For further information regarding the Police’s initiatives to address the problems around managing the custody of intoxicated people, see Part 8 of the Authority’s Review of Police Custodial Management.

236. The Authority commends this work at the District level. However, as the Police have acknowledged to the Authority, a response only at the local level will lead to a fragmented resolution of the issues without national consistency. The Authority therefore recommends that Police ensure that the conclusions described in paragraph 234 are implemented nationally, and that other improvements to the way in which intoxicated people are dealt with be explored in conjunction with Health and other agencies (see paragraph 251(1)).

## POLICE MEDICAL OFFICERS

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237. The National Co-ordinator of Forensic Medicine has provided the PMOs with definitions of the terms used by Police (‘constant monitoring’ and ‘frequent monitoring’), and the Best Practice Manual for PMOs has been updated to include this information. The National Co-ordinator of Forensic Medicine has also advised the PMOs that, if there is any doubt, they must confirm whether or not Police are actually requesting a medical assessment of a prisoner.

## TRAINING

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238. Counties Manukau Police have developed a training package on intoxication and mental health issues which emphasises the need to keep dangerously intoxicated people out of Police cells and explains that, in the case of violent intoxication, Police may use a restraint chair and call a paramedic to sedate the person. This training package is being delivered to DCU supervisors in Counties Manukau, Rotorua, Northland and Waitemata, and has been sent to the Police National Headquarters Operations Group and to Professional Conduct Managers for use in all District Custody Units.

239. The Operations Group intends to carry out a review of national training for DCU supervisors and custody officers. Police are also currently reviewing their First Aid training and considering whether it should include more information on intoxication and mental health issues.

## TRANSPORTATION OF PRISONERS

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240. Police are working with Corrections to establish common vehicles which are safer for transporting prisoners. However Police have advised that the new van design will not be significantly safer for transporting prisoners who are thrashing around or suffering from a drug reaction like Mr Taitoko.

## ONGOING DISCUSSIONS WITH POLICE REGARDING CUSTODY ISSUES

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241. The Authority is currently working with Police to develop National Standards for custodial facilities,<sup>6</sup> and will continue to engage with Police and other agencies to address the issues arising in this and other similar cases.

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<sup>6</sup> It is intended that these standards will be finalised by 30 June 2015. When they are in place, the 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.



## Conclusions

242. The Authority has determined that Police did not have legal authority to take Mr Taitoko into custody for detoxification, and although it was lawful to arrest him for breach of the peace, this was not an appropriate response in the circumstances. However the Authority acknowledges that the arresting officers would have been liable to criticism if they had not taken some action and believed that taking Mr Taitoko to the Police cells was the only option available to them.
243. Police did not use excessive force during Mr Taitoko's arrest, while they were transporting him to the Counties Manukau DCU, or while he was in the cells. Mr Taitoko's injuries were self-inflicted and occurred while he was experiencing a bad reaction to the drugs he had consumed. Although the vehicle used by Police to transport Mr Taitoko to the DCU was not ideal for someone in his condition, the arresting officers took steps to reduce the risks and there was no safer method of transport available.
244. By not calling an ambulance or transporting Mr Taitoko to hospital in a Police vehicle, the arresting officers and the DCU custody sergeant failed to comply with the requirements of the *Managing Prisoners* policy and the *Alcoholism and Drug Addiction* policy in respect of dangerously intoxicated prisoners. This failure was unjustified.
245. Once Mr Taitoko had been placed in a cell, Police complied with the searching requirements of the *Managing Prisoners* policy but there was a delay of over an hour before a formal risk assessment was completed. The risk assessment, the level and type of monitoring, and the conditions in the Police cell were all inadequate for someone in Mr Taitoko's condition.
246. From 3.21am, it was reasonable for Police to rely on the doctor's advice that Mr Taitoko could remain in the cell and did not need to be taken to hospital (although the doctor expected that Police would monitor him more closely than they did).
247. Police breached their legal duty of care to Mr Taitoko because they did not seek urgent medical care when they first encountered him, and subsequently failed to carry out appropriate checks on his condition.
248. However the Police's liaison with Mr Taitoko's family after his death was adequate.



## Recommendations

249. This case has highlighted a number of fundamental cross-agency and systemic organisational issues that need to be addressed as a matter of high priority. In particular, it is clear that the current arrangements for dealing with people who are severely intoxicated, drug-affected or otherwise mentally impaired are inappropriate.
250. The Authority has completed a Review of Police Custodial Management, with a view to generating debate about appropriate policy options to remedy the deficiencies that exist. In that review 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 the review 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.
251. There are also a number of specific recommendations arising from this case. Pursuant to section 27(2) of the Independent Police Conduct Authority Act 1988, the Authority recommends that the New Zealand Police:
- 1) Work with the Ministry of Health and other agencies to explore ways in which to improve the current methods of dealing with extremely intoxicated (and sometimes violent) prisoners.
  - 2) Ensure that the National Standards governing Police custodial facilities (which are currently being developed):
    - a) require custody staff to record detailed information in the electronic custody module (ECM) describing how they carried out a check of a prisoner and the prisoner's condition at the time of the check;
    - b) provide additional specific guidance to custody staff on the nature of the checks that must be undertaken in order to ascertain the well-being of a prisoner who is under frequent or constant monitoring; and
    - c) include a requirement for regular cleaning of CCTV camera lenses.

- 3) Ensure that Police Medical Officers (PMOs) are aware of:
  - a) the requirement for a full and written assessment for any prisoner deemed to be 'in need of care'; and
  - b) the requirement for Police to call an ambulance for dangerously intoxicated prisoners, or transport them to hospital.

A handwritten signature in black ink, appearing to read 'David Carruthers', written in a cursive style.

**Judge Sir David Carruthers**

Chair  
Independent Police Conduct Authority

27 March 2015

## Applicable Laws and Policies

### POWERS OF ARREST

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#### Breach of the peace

252. Section 315(2) of the Crimes Act 1961 provides that Police may arrest without a warrant any person who is found disturbing the public peace or who Police have good cause to suspect of having committed a breach of the peace.
253. The courts in New Zealand have not clearly defined the scope of breach of the peace. It is clear that it encompasses violence or disorder, and behaviour that provokes fear of violence or disorder, in a public place. It also appears to encompass behaviour in a private place if that causes a disturbance, or provokes fear of violence or disorder, in a public place. There is recent English case law to suggest that it may go further and capture some offending in a private place (for example, some types of domestic violence), although it is by no means clear whether, and to what extent, this applies in New Zealand.
254. The *Public Order Policing* chapter in the Police Manual contains a section on 'Behaviour offences' which states that breach of the peace "*is essentially violence or threatened violence*":

*"There is a breach of the peace whenever harm is actually done or likely to be done to:*

- *a person, or*
- *a person's property, in that person's presence, or*
- *a person is in fear of being so harmed through an assault, an affray, a riot, unlawful assembly or other disturbance - R v Howell (Errol) [1982] QB 416 (CA), at 427.*

*... The conduct complained of must be severe enough to cause alarm to ordinary people and threaten serious disturbance to the community. In determining whether it is of this nature, regard must be had to the nature and quality of the conduct, its likely consequences and the context in which it is taking place: R (Laporte) v Chief Constable of Gloucestershire Constabulary [2006] UKHL 55; [2007] 2 AC 105 (HL); see also Dyer v Brady, Bullen, Jones and Munro [2006] HCJAC 72; [2006] SCCR 629."*

255. The *Arrest and Detention* chapter of the Policing Manual provides that:

*"Breaches of the peace occur when these events are taking place or being threatened:*

- *serious disturbances or other forms of violence*
- *serious damage to property.*

*You can arrest someone under section 315(2) Crimes Act who you witness breaching the public peace and the breach is continuing or you think it is likely to be renewed.*

*However, as there is no specific offence for disturbing or breaching the peace, once you have arrested the person you need to determine what other charges, if any, should be filed against the person.*

*You must decide about other charges within a reasonable time of the arrest (e.g. one or two hours). Release the person immediately if you decide no charges will be filed.”*

### Detoxification powers

256. Section 36 of the Policing Act 2008 provides:

*“(1) A constable who finds a person intoxicated in a public place, or intoxicated while trespassing on private property, may detain and take the person into custody if—*

- (a) the constable reasonably believes that the person is—*
  - (i) incapable of protecting himself or herself from physical harm; or*
  - (ii) likely to cause physical harm to another person; or*
  - (iii) likely to cause significant damage to any property; and*
- (b) the constable is satisfied it is not reasonably practicable to provide for the person’s care and protection by—*
  - (i) taking the person to his or her place of residence; or*
  - (ii) taking the person to a temporary shelter.”*

257. For the purposes of section 36, ‘intoxicated’ means: “... observably affected by alcohol, other drugs, or substances to such a degree that speech, balance, coordination, or behaviour is clearly impaired”. A ‘temporary shelter’ is: “... a place (other than a place operated by the Police) that is capable of providing for the care and protection of an intoxicated person”.

### DUTY OF CARE

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258. Police owe a legal ‘duty of care’ to take reasonable care of all people arrested, detained or placed in their custody. This duty begins from the moment the person is detained and applies until the person is released from custody or transferred into the care of another agency.

259. The Police duty of care was historically found in the common law, and is now enshrined in section 151 of the Crimes Act 1961. The duty is recognised in Police policies and instructions relating to arrest and to the care of people in custody.

## Statutory provisions

260. Section 151 of the Crimes Act 1961 provides:

*“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.”*

261. 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”*. ‘Necessaries’ refers to the basic requirements of life, such as food, water and adequate warmth.

262. Under section 150A(2) of the Crimes Act 1961, deaths or injuries arising from a failure to perform the legal duty in section 151 gives rise to criminal liability only if the failure is *“a major departure from the standard of care expected of a reasonable person”* (commonly described as a *“gross negligence standard”*). A person who simply fails to provide a reasonable standard of care, without more, cannot be convicted of offences such as manslaughter or injuring.

## MECHANICAL RESTRAINTS

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263. Officers may use mechanical restraints (such as handcuffs) while transporting prisoners. The Police’s *Mechanical Restraints* policy states:

*“You should consider restraining arrested or detained persons in your custody when you transport them in a Police vehicle. This is to prevent interference with the driver or escape from custody by exiting the moving vehicle. Due to extreme risk of positional asphyxia you must not transport anyone in a Police vehicle who is restrained by a combination of either a rear wrist and ankle restraint, or a waist restraint belt and ankle restraint, linked by a plastic tie.”*

### ***“Caution - positional asphyxia***

*Be aware that a person whose legs and wrists are restrained has an increased risk of asphyxiation. Positional asphyxia is a clear and material risk and the person must be kept under constant monitoring and never allowed to lie face down.*

*Positional asphyxia arises when a restrained person is unable to obtain sufficient oxygen to meet physiological requirements. This is likely to occur as a result of a number of risk factors, such as:*

- increased oxygen requirement in a highly stressed or agitated person*
- pressure on abdomen and chest will restrict the mechanics of breathing*
- restriction of the airway (facial covering or pressed against a surface)*

- *alcohol or drugs may inhibit respiration even if the person is not obviously sedated.*

*You must be acutely aware of these risk factors and avoid, as best you can, creating breathing restrictions when you use any technique, but particularly where you use one or more of the following:*

- *a spitting hood*
- *a combination of either a rear wrist and ankle restraint, or a waist restraint belt and ankle restraint, linked by plastic ties*
- *a restraint chair.*

*In a situation of risk, you must constantly monitor to ensure adequate breathing is maintained.”*

## ALCOHOLISM AND DRUG ADDICTION POLICY

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264. The *Alcoholism and Drug Addiction* chapter of the Police Manual describes the following levels of intoxication:

<b>Degree of intoxication</b>	<b>Indicators</b>
<i>Unaffected by alcohol</i>	<ul style="list-style-type: none"> <li>• <i>Oriented.</i></li> <li>• <i>Knows and clearly states name date and place.</i></li> </ul>
<i>Mildly affected by alcohol</i>	<ul style="list-style-type: none"> <li>• <i>Oriented.</i></li> <li>• <i>Knows and able to state name date and place.</i></li> </ul>
<i>Extremely affected</i>	<ul style="list-style-type: none"> <li>• <i>Confused, or able to state name date and place with difficulty.</i></li> </ul>
<i>Dangerously affected</i>	<ul style="list-style-type: none"> <li>• <i>Not able to be understood.</i></li> <li>• <i>Moans and groans.</i></li> <li>• <i>No sensible words.</i></li> <li>• <i>Nil response at all.</i></li> </ul>

265. The policy also states:

***“Detention at Police stations***

*... If the person appears dangerously affected by alcohol as defined in this chapter, an ambulance must be called as the person may lapse into unconsciousness or be suffering from a drug overdose or undiagnosed medical condition.*

*If there is a delay Police may elect to take the person to a detoxification centre, hospital or medical facility where they can be cared for.*

**Caution:** *It is vital that the person is not isolated, and their condition is monitored frequently to re-assess whether they can continue to be held at the Police station, or if an ambulance should be called or they should be moved to a hospital or other location.*

**Safety consideration in Police detention**

*Consider these questions when detaining an intoxicated person at a Police station:*

- *Can the person stand unaided?*
- *Is the person capable of a coherent conversation?*
- *Does the person understand where they are?*

*If the answer to any of these is "no", then you should seek help from local medical services."*

## MANAGING PRISONERS POLICY

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### Searching prisoners

266. The *Managing Prisoners* chapter of the Police Manual requires arresting officers to search a prisoner thoroughly in the presence of custody staff before handing them over to be received into the cells.
267. Police must remove any items from the prisoner that are evidence or are *"likely to cause injury or death (to the prisoner or anyone else) or that may assist escape (e.g. belt, tie and shoelaces)."*

### Risk assessment

268. The *Managing Prisoners* policy provides that: *"Everyone in Police custody must be formally assessed on their receipt at Police stations using the custody module to determine requirements for their care and safety and any warning signs indicating suicidal tendencies."*
269. This assessment is intended to identify any risks relating to the prisoner's physical and mental health (including medical conditions and risks arising from alcohol or drug consumption), and warning signs indicating suicidal or self-harm tendencies.
270. Following the risk assessment the officer processing the prisoner will determine whether he or she is 'not in need of specific care', 'in need of care and frequent monitoring' or 'in need of care and constant monitoring'.

### Dealing with intoxicated or drug-affected prisoners

271. The *Managing Prisoners* policy instructs officers to follow these steps when dealing with intoxicated or drug-affected people during processing:

<b><i>If the person is ...</i></b>	<b><i>then...</i></b>
<p><i>unconscious as a result of intoxication or a drug overdose or other unknown circumstance</i></p> <p><i>(Signs that the person is suffering from a drug overdose include:</i></p> <ul style="list-style-type: none"> <li><i>• no smell of alcohol on the person's breath or clothes</i></li> <li><i>• dilating of the pupils.)</i></li> </ul>	<p><i>it is critical that they are taken to hospital quickly.</i></p> <p><b><i>Caution:</i></b> <i>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.</i></p>
<p><i>semi-conscious, i.e.: unable to answer any questions during the initial assessment process or physically unable to look after themselves</i></p>	<p><i>arrange for an ambulance to take the person to hospital. If you expect a delay in the ambulance's arrival or the person's condition calls for immediate action, use a Police vehicle.</i></p>
<p><i>intoxicated from whatever cause and is conscious</i></p>	<p><i>follow the usual procedures for receipt and initial assessment taking into account the level of the person's intoxication.</i></p>

### Processing violent or dangerous prisoners

272. Police policy provides that the custody supervisor should be present when processing a violent or dangerous prisoner, and that appropriate mechanical restraints should be used to ensure the safety of everyone present. The prisoner should also be separated from others if possible, and should be regularly monitored and re-assessed.

### Medical examination required if prisoner 'in need of care'

273. The *Managing Prisoners* policy states that:

*"All people identified as in need of care because of their health, medical condition or the presence of any suicidal warning signs must be examined as soon as practical by a:*

- Police medical officer*
- duly authorised officer, or*
- (CAT) -Community Assessment Team member.*

*... This examination will confirm or vary the custody staff' evaluation of the person's risk status.*

*The result of the assessment must be recorded in writing by the health professional."*

## Monitoring prisoners

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

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

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

*"The purpose of a check is to ensure the health, safety and well being of people in the care of Police. Police must carry out a check of a prisoner that is commensurate with the health and safety risk they are deemed to pose at the time. The frequency and type of check must balance the risks identified in the assessment and care of prisoners ....*

*... Alcohol and drugs affect people differently and the full effects may take many hours after last consumption. People under the influence of drink or drugs may become more intoxicated over time and this should be a considered factor in the nature of the check undertaken."*

276. The policy describes the following types of checks on prisoners:

<b><i>Type of check</i></b>	<b><i>Action</i></b>
<i>Physical check</i>	<i>Enter the cell and physically wake the prisoner to establish well-being.</i>  <b>Note:</b> <i>Prisoners should not be physically roused at every check unless their risk assessment indicates they need specific care, are intoxicated or exhibit any risk identifiers. Continual waking without due cause could be deemed as inhumane treatment and a breach of the New Zealand Bill of Rights Act.</i>
<i>Verbal check</i>	<i>Verbally rouse the prisoner to establish well being and if there is no response complete a physical check.</i>
<i>Observation check</i>	<i>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 as above.</i>
<b><i>All checks</i></b>	<i>Be vigilant for weapons, damage and items that could be used to cause injury or damage.</i>

277. The policy notes that: *“CCTV, while a valuable aid, does not substitute for a physical check and must not be depended on. It does not replace the required visits for prisoners.”*





## 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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