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Death in Police custody of Francisco Javier de Larratea Soler

July 2011

EMBARGOED

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IPCA

Independent Police Conduct Authority

Whaia te pono, kia puawai ko te tika

July 2011

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Introduction

1. At about 7.00pm on 19 December 2008, Francisco Javier de Larratea Soler, aged 43, was found dead in a cell at Whakatane Police station. Police officers had taken Mr de Larratea Soler into custody to regain his sobriety after they found him lying on a footpath in an extremely intoxicated condition.

2. As required under section 13 of the Independent Police Conduct Authority Act 1988 (the Act), the Police notified the 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.

Glossary of Officers

Officers	Roles	Comment
Officer A	Constable (arresting officer)	• Took Mr de Larratea Soler into custody for detoxification and searched him. • Completed *Accused Person's Property* section of the *Custody/Charge Sheet* and signed as watchhouse keeper, when he was not in fact assigned this role.
Officer B	Constable (arresting officer)	• Signed the *Custody/Charge Sheet* as arresting officer. • Completed *Watchhouse Keeper's Evaluation of Condition of Person in Custody* and assessed Mr de Larratea Soler as "*not in need of specific care*".
Officer C	Watchhouse keeper 1	• Assigned to undertake the watchhouse keeper duties. • Did not receive or process Mr de Larratea Soler, and did not assess or check him when he arrived at the station. • Saw Mr de Larratea Soler in his cell at 1.14pm, lying on his back, asleep and snoring. He did not enter the cell or give him a meal, and did not wake him to obtain a response. • Left the station to attend an incident at 3pm (supervisor aware). Returned at about 4.45pm when late shift had taken over duties.
Officer D	Shift supervisor 1	• Shift / Area supervisor on duty for the early shift (7am-5pm). • One of two officers responsible for all staff in Eastern Bay of Plenty (including Whakatane, Opotiki, Kawerau, Edgecombe). • One of his roles was watchhouse supervisor; he was responsible for staff and prisoners in the watchhouse. • Officer A informed him that Mr de Larratea Soler was in the cells for detoxification.

Officer D (cont'd)		• Never inspected the prisoner or reviewed and countersigned the *Custody/Charge Sheet*. • Did not ensure that there was a watchhouse keeper at all times. • He was in and out of the station during the shift, including attending an incident at 3.45pm.
Officer E	Police dog handler	• Assisted in the watchhouse when he found himself to be the only officer in the area after Officer C left at 3pm. He answered phones and dealt with public enquiries but did not check on prisoners. • Left the station to attend an incident at 3.45pm.
Officer F	Youth aid officer	• Asked by Officer D to look after the watchhouse when Officers D and E left the station at about 3.45pm. • Did not check the prisoners in the cells.
Officer G	Shift supervisor 2	• Shift / Area supervisor for evening (swing) shift (5pm – 3am). • At time of shift he was responsible for all staff in Eastern Bay of Plenty (including Whakatane, Opotiki, Kawerau, Edgecombe). • One of his roles was watchhouse supervisor; he was responsible for staff and prisoners in the watchhouse. • Checked the prisoners in the cells before his shift started at about 4.30pm. • Saw Mr de Larratea Soler lying face-down, flat on his mattress, but then was distracted by another prisoner so did not open the cell door or attempt to get a response from Mr de Larratea Soler. • Notified by section duty officers when Mr de Larratea Soler was found dead at about 7pm.
Officer H	Watchhouse keeper 2	• Assigned by Officer G to undertake the watchhouse keeper duties from 5pm. • Did not inspect the prisoners at the start of his shift because he knew Officer G had done this. • Did not check the prisoners until about 6pm. Mr de Larratea Soler appeared to be sleeping and he did not try to wake him. • Did not note that he had checked the prisoners in the *Inspection of Prisoners Book*.

Background

FRANCISCO JAVIER DE LARRATEA SOLER

3. Mr de Larratea Soler was a 43 year old Spanish man living in Whakatane. His former partner and their two children lived in the South Island. He had a history of drug and alcohol abuse and had been visiting several doctors to obtain medication related to pain relief and alcohol and drug withdrawal, including sedatives. Police suspect that he was also obtaining methadone illegally prior to his death.

SUMMARY OF EVENTS

4. At about 11.00am on Friday 19 December 2008, police were called to a disorderly situation in Eivers Road, Whakatane. Officer A and Officer B were sent to investigate and on arrival found Mr de Larratea Soler lying on his back on the footpath. He was apparently uninjured, but smelt strongly of alcohol and was dressed only in a pair of jeans. His wallet was on the ground beside him and his t-shirt was in a nearby tree.

5. The officers found Mr de Larratea Soler to be extremely intoxicated. He sat up unassisted when the officers spoke to him, but was swaying and appeared to be confused. When he stood up he was very unsteady on his feet. Officer A guided him to the back seat of the police car.

6. When Mr de Larratea Soler was unable to provide the officers with an address to which he could be taken, he was advised of his Bill of Rights and taken into custody by Officer A. The power to take intoxicated people into custody is available to police under section 36 of the Policing Act 2008, which provides for the care and protection of intoxicated people found in public places (see paragraph 35).

7. The officers then drove Mr de Larratea Soler to the Whakatane Police station, arriving at about 11.25am. Once Officer A had searched him, both officers took Mr de Larratea Soler to the cell block where, although he was still unsteady on his feet, he was able to walk into a cell.

8. Another prisoner in the cell block observed the officers assisting Mr de Larratea Soler into a cell. He described Mr de Larratea Soler as being *"incoherent"* and formed the impression that he was drunk. He recalls hearing the officers say: *"Get in your cell and sleep it off."* The officers then closed the cell door and walked away. The prisoner recalls that within five minutes of having been placed in the cell, Mr de Larratea Soler was snoring loudly. The prisoner could see that Mr de Larratea Soler was lying on his back with his feet up on the folded blankets at the end of his bed.

9. Officer B used identification in the wallet and information from police records to confirm the identity of Mr de Larratea Soler. She began filling in a *Custody/Charge Sheet* with the details of the arrest and ran a check of Mr de Larratea Soler on the police database (NIA). She then signed the *Custody/Charge Sheet* as the arresting officer.

10. Officer A recorded the property he had seized from Mr de Larratea Soler during the search on the custody/charge sheet. He signed that section of the form as the watchhouse keeper.

11. The watchhouse keeper is the officer responsible for receiving people into custody and looking after the prisoners in the cells. The officer who had been assigned the watchhouse keeper duties for the early shift that day was Officer C. He was not in the immediate area when Mr de Larratea Soler arrived at the station and was not involved in receiving or processing him.

12. Officer B also partially completed the part of the *Custody/Charge Sheet* titled *Watchhouse Keeper's Evaluation of Condition Person in Custody*, but did not sign that section of the form. She assessed Mr de Larratea Soler as being "*not in need of specific care*". She made this assessment although:

- Mr de Larratea Soler had been detained under section 36 of the Policing Act because he was considered to be in need of care and protection;
- she had noted that Mr de Larratea Soler was under the influence of alcohol and recorded his level of intoxication as *"extreme"* on the *Custody/Charge Sheet*; and
- she had not asked him any questions about his health or his state of mind because she believed him to be unfit to answer them.

13. Officer A agreed with Officer B's assessment and recorded in the *Inspection of Prisoners Book* that Mr de Larratea Soler had been received into custody at 11.28am. He then advised Officer C that Mr de Larratea Soler was in the cells for detoxification before leaving the station with Officer B to attend other incidents.

14. Although he was the officer responsible for the safety and well-being of the prisoners, Officer C did not visit Mr de Larratea Soler in his cell at that time in order to make his own

assessment of his condition. Nor did he check Mr de Larratea Soler's *Custody/Charge Sheet* to see what information the arresting officers had provided about him.

15. At around 11.45am, Officer C briefly left the watchhouse to escort six prisoners across the road to the District Court. He did not hand over his watchhouse keeper duties to anybody and did not know who was covering for him while he was away from the station.

16. Officer D was the shift supervisor, which included the role of watchhouse supervisor, for the early shift. At about 12.30pm Officer A advised him that Mr de Larratea Soler had been taken into custody to sober up. Officer D did not however visit Mr de Larratea Soler in the cells, nor did he review and sign Mr de Larratea Soler's *Custody/Charge Sheet*, which he was required to do as the watchhouse supervisor.

17. Officer C entered the cellblock to give the prisoners their lunch at 1.14pm. He observed Mr de Larratea Soler lying on his back asleep and snoring loudly, but did not enter his cell or give him a meal. He recorded in the *Inspection of Prisoners Book* that the prisoners had been *"fed OK"*. Around this time a prisoner (the same prisoner discussed in paragraph 8) asked to be moved because of Mr de Larratea Soler's snoring. Officer C and the prisoner observed Mr de Larratea Soler still lying on his back in the cell before the officer refused the request.

18. The prisoner who had asked to be moved noticed that the snoring stopped about one and a half hours later. Approximately one hour after that, at about 3.45pm, he saw that Mr de Larratea Soler was lying face down on the mattress in his cell, in the position in which he was later found deceased.

19. At about 3.00pm the watchhouse keeper, Officer C, left the station because the watchhouse supervisor, Officer D, had asked him to attend an incident. Officer D later said that he was responsible for the watchhouse in Officer C's absence. During this time Officer D was completing paperwork and, for a period of time, was away from the watchhouse attending an incident.

20. Officer E, a police dog handler, was in the watchhouse completing correspondence at that time. Finding himself the only officer in the area he began to answer the phone and deal with enquiries at the public counter. He had not been assigned to watchhouse duties and did not carry out any checks on prisoners.

21. At about 3.45pm Officer D left the station with Officer E to attend an incident. Officer D asked Officer F, a youth aid officer, to look after the watchhouse. Officer F attended to the phone and the public counter for about 45 minutes. She had no idea who the watchhouse keeper on duty was or where he was at that time. Although she had assumed the responsibilities of the watchhouse keeper, she did not visit the cells to check on the prisoners.

22. At about 4.30pm Officer G, the shift supervisor, who had the role of watchhouse supervisor for the evening (swing) shift checked the prisoners in the cells before the start of his shift. At this time there were five prisoners in the cells, one of whom had been assessed as being at risk and was being constantly monitored. Officer G observed Mr de Larratea Soler lying face down in his cell, but was distracted by another prisoner before he could open the cell door or attempt to get a response from him. He did not go back and rouse Mr de Larratea Soler. He noted in the *Inspection of Prisoners Book* that he was on duty and had visited the prisoners at 4.32pm.

23. None of the watchhouse staff from the early shift (Officer C and Officer D) were present at the beginning of the evening shift to conduct a handover of the watchhouse duties to the oncoming staff. The outgoing watchhouse keeper, Officer C, returned from his enquiries outside the station at about 4.45pm, but did not brief the oncoming shift about the prisoners before he finished his shift at 5.30pm.

24. Officer G assigned Officer H to be the watchhouse keeper for the evening shift at about 5.00pm. Officer H was aware that Officer G had checked the prisoners before the start of the shift so he did not make his own inspection.

25. At about 6.00pm Officer H checked the prisoners in the cells. He observed Mr de Larratea Soler for a few seconds and noted that he appeared to be sleeping. He did not attempt to wake him. He then went back to the watchhouse. When interviewed, Officer H said he was distracted by another officer before he could note in the *Inspection of Prisoners Book* that he had checked the prisoners. He did not subsequently record this check.

26. At about 7.00pm two officers on section duties picked up meals for the prisoners and went into the cellblock to deliver them. On entering Mr de Larratea Soler's cell they found they were unable to wake him and noted that he was cold to the touch. One of the officers informed Officer G, who concluded that Mr de Larratea Soler was dead.

27. An ambulance was called but no attempt was made to resuscitate Mr de Larratea Soler because it was clear that he had been dead for some time. A police doctor later called at the station and certified death.

POLICE OFFICERS INVOLVED

28. At the time of the incident:

- Officer A was a general duties officer based at Whakatane. He had served with Police for 8 years.

- Officer B, a general duties officer based at Whakatane, had been with the New Zealand Police for less than 2 years but had served with an overseas police force prior to this.
- Officer C was also a general duties officer based at Whakatane. He had served with Police for 2 years.
- Officer D was a general duties supervisor based at Whakatane. He had 10 years service with the Police, including 2 years as a sergeant.
- Officer E was a police dog handler with 9 years service.
- Officer F was a youth aid officer with 10 years service. She had experience with general duties and had also performed duties as an acting sergeant.
- Officer G was a general duties supervisor based at Whakatane. He had 9 years service, including 9 months service at the level of sergeant.
- Officer H was a general duties officer based at Whakatane. He had served with Police for 15 years, and he was a senior member and field training officer for junior members of his section.

29. All the officers had received training in first-aid and custodial suicide prevention, and their certification was current.

POST MORTEM AND TOXICOLOGY

30. Toxicology results established that Mr de Larratea Soler had used methadone, zopiclone, alcohol and cannabis before his death. Methadone is an opioid analgesic which produces effects similar to morphine and is used to treat or prevent pain and to treat addiction to opioid drugs. Zopiclone is a drug used to treat insomnia.

31. The levels of methadone in Mr de Larratea Soler's blood were within the range associated with methadone-related fatalities, but were also within the range found for regular users of methadone.

32. The post mortem examination concluded that Mr de Larratea Soler's death was due to *"methadone toxicity in association with alcohol and zopiclone"*.

33. The toxicologist stated that alcohol, methadone and zopiclone all act as depressants on the central nervous system and that their combined effects are likely to be greater than one drug used by itself. The pathologist noted that *"with regard to methadone toxicity it has been stated that deep unrousable sleep with snoring is characteristic of a drug induced state associated with a high risk of death"*.

CORONER

34. The Coroner has not yet completed an inquest into Mr de Larratea Soler's death.

INTOXICATED PEOPLE

35. 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."*

36. A person detained in police custody under this provision must be released as soon as they cease to be intoxicated, and cannot be detained for more than 12 hours unless recommended by a health practitioner.

37. 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

38. 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.

39. The Police duty to take reasonable care of detainees has a basis in legislation (for example, sections 8(d) and 36 of the Policing Act 2008 and section 151 of the Crimes Act 1961) and in case law.

40. In the United Kingdom, the police duty of care has been described as:[1]

> *"… a duty on the person having custody of another to take all reasonable steps to avoid acts or omissions which they could reasonably foresee would be likely to harm the person for whom he is responsible."*

41. The duty of care is also reflected in Police policies and instructions relating to the care of people in custody. In December 2008, the care of prisoners was governed at a national level by Police General Instructions (GIs), and locally by district orders and the *Whakatane Watchhouse Desk File*.

ASSESSMENT OF PRISONERS

42. As part of the police duty of care, all people who are detained or arrested must be assessed for risks to their health and safety. GI P100 (Evaluation of Persons Detained in Police Custody and Prisoners) states:

> *"(3) All people received into Police custody are to be evaluated and monitored in respect of:*
>
> *(a) the state of their physical and mental health, the presence of any medical condition and any warning signs indicating suicidal tendencies … ."*

43. GI P100(4) requires that the evaluation of a person received into custody *"… must be undertaken using the Watchhouse Keeper's Evaluation of Condition of Person in Custody section of the Custody/Charge Sheet"*.

44. In order to conduct the *Watchhouse Keeper's Evaluation*, the officer receiving the person into custody must ask specific questions relating to that person's medical history and mental state. On the basis of the answers to these questions, as well as the observations of the arresting officer and any other relevant information, the person in custody is

[1] *Kirkham v Chief Constable of the Greater Manchester* [1990] 3 All ER 246, 253 (CA) per Farquharson LJ.

classified into one of three categories depending on the risk they pose to themselves and/or others.

45. The categories are:

- not in need of specific care;
- in need of care; or
- in need of care and constant monitoring.

46. If the person in custody is assessed to be in need of care or in need of care and constant monitoring, the watchhouse keeper must complete a Health and Safety Management Plan for Person in Custody (HSMP). The assessment and the HSMP must then be approved by the watchhouse supervisor.

47. Extra measures are taken for people judged to be in need of care or in need of care and constant monitoring. If there are concerns about a prisoner's health as a result of the risk evaluation, a police doctor should be called to assess and treat the prisoner as soon as practicable.

48. In December 2008, Bay of Plenty Police District Order No. C:02 outlined the procedures to be adopted in the watchhouse and in part included:[2]

> *"5.1 When a person is delivered to a watchhouse for processing, the arresting member shall immediately advise the Watchhouse Keeper whether or not there is any concern for the safety of that person. Concerns include suicidal warning signs, intoxication, drug effects, medical condition and risk from other prisoners. Risk of harm to Police from the person must also be considered.*
>
> *…*
>
> *5.3 A thorough health and safety evaluation of that person shall be completed by the Watchhouse member or the member processing that person …*
>
> *5.5 If there are any indications or signs that the person may be at risk of harming themselves or others, or there is any doubt, then a thorough assessment is to be carried out using the Health and Safety Management Plan form … ."*

[2] This district order was replaced in February 2010 by a new local order which addresses custodial suicide prevention.

49. Police are also instructed to reassess the condition of people in custody over time, particularly when they are intoxicated. GI P111 (Medical Aid) states:

> *"(1) Prisoners' wellbeing and health require regular monitoring and reassessment. This is especially necessary where any of the following apply:*
>
> - *alcohol or drugs have been consumed … ."*

MONITORING OF PRISONERS

50. GI P110 (Supervision of Prisoners) states:

> *"(2) The checking of persons in police custody or prisoners is primarily to assess their health, safety and security and is not to be accomplished through the use of CCTV."*

51. GI P110(1) provides that: *"All prisoners in police custody are to be checked (visited) at the beginning and at the end of each shift, and at least every two hours during the shift."* This is the minimum level of monitoring required for prisoners assessed to be *"not in need of specific care"*.

52. However a more rigorous checking policy was in place at the Whakatane Police station at the time of Mr de Larratea Soler's death. Part 3 of the *Whakatane Watchhouse Desk File* required the watchhouse keeper to perform a *"Physical check of all prisoners minimum 1 x hourly … "*.[3]

53. People in custody who are assessed to be at risk because of their health or mental state are provided with a higher level of monitoring. According to GI P203 (Monitoring People in Police Custody and Prisoners), a prisoner assessed to be in need of care must be checked at least five times per hour at irregular intervals, and a prisoner found to be in need of care and constant monitoring must be directly observed without interruption.

54. Part 2 of the *Whakatane Watchhouse Desk File* provided that at the beginning of the shift the watchhouse keeper who is coming on duty should:

> *"Check all prisoners together with the oncoming NCO* [Watchhouse Supervisor] *and outgoing Watchhouse Keeper. This must be a physical check (open door and speak to each prisoner) to double check the prisoner is not in possession of anything they can harm themselves or others with … . "*

[3] The Whakatane Watchhouse Desk File was updated in May 2010. It now requires checks to be made only once every two hours instead of once every hour. This is consistent with the national policy (see paragraph 51).

55. GI P105(Documentation) requires that:

> *"(3) All checks (visits) made of prisoners by police members and the movements of prisoners into and out of cells are to be recorded in the Inspection of Prisoners Book."*

SUPERVISION OF THE WATCHHOUSE

56. GI P110(4) states: *"Where a prisoner is to be held at a police station, full time supervision of the cells is to be provided."*

57. The *Whakatane Watchhouse Desk File* stated that:

> *"Watchhouse staff will still be responsible for carrying enquiry files and conducting relevant enquiries. There is an expectation that you will arrange with the on duty NCO* [Watchhouse Supervisor] *for minor enquiries to be conducted either by his/her staff or a short term reliever to be made available so the Watchhouse Keeper can attend to these."*

The Authority's Findings

ISSUES CONSIDERED

58. The Authority considered the following issues.

- Was the detention of Mr de Larratea Soler lawful?
- Was an appropriate risk assessment of Mr de Larratea Soler carried out?
- Were adequate checks of Mr de Larratea Soler carried out while he was in custody?
- Was there appropriate supervision and management of the watchhouse?
- Were the district orders and the *Whakatane Watchhouse Desk File* adequate for dealing with the health and safety issues associated with people taken into custody under the influence of alcohol or drugs?

59. This case has been considered in relation to the Authority's mandate under the Optional Protocol to the United Nations Convention against Torture.

WAS THE DETENTION OF MR DE LARRATEA SOLER LAWFUL?

60. Section 36 of the Policing Act 2008 authorises police to take an intoxicated person into custody when:

- they reasonably believe the person is incapable of protecting himself or herself from physical harm; and
- they are satisfied it is not reasonably practical to provide for the person's care and protection by taking them to their place of residence or to a temporary shelter (see paragraphs 35-37).

61. When Officer A and Officer B found Mr de Larratea Soler lying on the footpath, he was in an extremely intoxicated condition. He was unsteady on his feet, appeared to be

confused and could not communicate effectively. The officers had good reason to believe that he was incapable of protecting himself from harm.

62. The post mortem toxicology report confirmed that there were significant levels of alcohol and drugs in Mr de Larratea Soler's system at the time he was detained by police.

63. Mr de Larratea Soler was unable to provide the officers with an address to which he could be safely delivered, and the temporary shelters contemplated by section 36 of the Policing Act are not currently available to police. The only option left to the officers was to take him into police custody.

FINDING

Officer A and Officer B were justified in taking Mr de Larratea Soler into custody for his own protection.

WAS AN APPROPRIATE RISK ASSESSMENT OF MR DE LARRATEA SOLER CARRIED OUT?

64. The police deal with a great number of intoxicated prisoners. While almost all recover their sobriety given the opportunity to rest and sleep, some have serious underlying health issues.

65. The presence of alcohol may mask health problems (such as a head injury or diabetes), and may also hide the fact that the person has taken drugs. Officers need to be alert to this when conducting risk evaluations of intoxicated prisoners.

66. GI P100 addresses the risk evaluation requirements of a person detained in police custody (see paragraphs 42-48).

67. As required by GI P100(4), Officer B filled in the *Watchhouse Keeper's Evaluation* section of Mr de Larratea Soler's *Custody/Charge Sheet*. She assessed him to be not in need of specific care (see paragraph 12). Officer A agreed with this assessment.

68. However in order to properly complete the risk evaluation, the officer must ask the detainee questions about their health, medical history and state of mind. Officer B did not ask Mr de Larratea Soler any of these questions because she considered him to be too intoxicated to answer them.

69. For this reason most of the *Watchhouse Keeper's Evaluation* was left blank. One of the few risk factors identified was that Mr de Larratea Soler was under the influence of alcohol. Officer B does not appear to have considered whether he was also under the influence of drugs or solvents, although she noted that his level of intoxication was "*extreme"* on another part of the *Custody/Charge Sheet*.

70. Mr de Larratea Soler was taken into custody because Officers A and B believed him to be so intoxicated that he was in need of care and protection. Nonetheless they did not identify his extremely intoxicated condition as a risk in itself.

71. The officers both provided statements the day after Mr de Larratea Soler's death.

72. Officer A said:

> *"A PMAF* [Prisoner Management Assessment Form] *was considered but I didn't think it was necessary as he was not comatose* [sic]*, he could walk, not vomiting, had no injuries apparent and was not complaining and he seemed to understand that once he had sobered up he was free to go."*[4]

73. Officer B said:

> *"...there was no point in me asking all of the questions* [in the *Watchhouse Keeper's Evaluation*] *because he was so drunk and he wouldn't have known what I was talking about. As a result of a NIA check there was nothing to give me concerns about self harm. I didn't ask him anything as I thought he was too drunk.* [Officer A] *and I both discussed this and decided he was too drunk."*

74. The fact that Mr de Larratea Soler was too heavily intoxicated to answer any questions should have caused Officers A and B concern for his health and well-being, such that he should have been deemed in need of care. His inability to answer meant that the officers could not ascertain whether there were any medical or psychological risks. The officers should also have recognised the danger that Mr de Larratea Soler had potentially consumed drugs in addition to alcohol.

75. If Mr de Larratea Soler had been assessed as (at least) in need of care, a HSMP would have been completed and the officers should have sought medical attention for him. The watchhouse staff would also have been required to check Mr de Larratea Soler at least five times an hour, which should have led them to discover that he had slipped into a comatose state. Potentially, his death may have been avoided had he received timely medical treatment.

76. Instead Mr de Larratea Soler was treated as a drunk who simply needed time to sleep in order to sober up. This assessment of his condition was not challenged by any of the officers who assumed responsibility for his care while he was in custody. In particular

[4] The Prisoner Management Assessment Form (PMAF) was replaced by the Health and Safety Management Plan for Person in Custody (HSMP) in March 2005. In this quote Officer A has used an outdated term.

Officer C, the watchhouse keeper, should have made his own assessment of him as soon as practicable.

77. Although the *Custody/Charge Sheet* clearly indicates that the watchhouse keeper should carry out the *Watchhouse Keeper's Evaluation* of the prisoner, in this case it was conducted by one of the arresting officers, Officer B. At the time of Mr de Larratea Soler's death it was common practice at the Whakatane Police station for the arresting officers to complete the prisoner's entire *Custody/Charge Sheet*, including the evaluation.

78. This practice carries the risk that the watchhouse keeper, who is the officer primarily responsible for the care of the prisoners, may simply accept the outcome of the arresting officer's evaluation rather than making him or herself aware of the particular medical or mental health risks associated with each prisoner. It also carries the risk that incidents arising out of the arrest process may unduly influence the assessment process.

79. As the watchhouse keeper on duty, Officer C should have completed and signed the *Watchhouse Keeper's Evaluation* section of Mr de Larratea Soler's *Custody/Charge Sheet*. Alternatively he should have at least reviewed Officer B's evaluation of the prisoner once he became aware Mr de Larratea Soler was in the cells.

80. As the watchhouse supervisor, Officer D should have reviewed and signed Mr de Larratea Soler's *Custody/Charge Sheet*. If he had done this he may have questioned the arresting officers' assessment that Mr de Larratea Soler was not in need of specific care in spite of his extreme level of intoxication.

81. The fundamental flaw in the evaluation process was that a person who, apparently through gross intoxication, was unable to answer questions and the risk to whose safety could therefore not be assessed, was nevertheless held in a cell without frequent monitoring or medical attention.

82. The officers who conducted the evaluation were primarily concerned with assessing whether or not Mr de Larratea Soler was a suicide risk. Consequently, they failed to give due consideration to the danger his intoxicated condition posed to his health and well-being while he was being held in custody.[5]

FINDINGS

Police did not comply with policy when assessing Mr de Larratea Soler's risk.

The risk evaluation was flawed and inadequate.

[5] Intoxication is relevant to both a health risk assessment and a suicide risk assessment.

WERE ADEQUATE CHECKS OF MR DE LARRATEA SOLER CARRIED OUT WHILE HE WAS IN CUSTODY?

Number and timing of checks

83. Mr de Larratea Soler was checked three times during the seven and a half hours he was in custody. After being placed in a cell at 11.28am, he was checked:

- by Officer C at 1.14pm (1 hour and 46 minutes after he was put into the cell);
- by Officer G at 4.32pm (3 hours and 18 minutes later); and
- by Officer H at about 6.00pm (1 hour and 28 minutes later).

84. The monitoring of Mr de Larratea Soler did not comply with GI P110, which required checks to be done every 2 hours, nor with the local instructions that required checks to be done every hour (see paragraphs 51-52). The third check was not recorded in the *Inspection of Prisoners Book* as required by GI P105(3) (see paragraph 55).

85. Officer C was the watchhouse keeper on duty until 5.00pm. After he made the first check of Mr de Larratea Soler at 1.14pm, there was a gap of 3 hours and 18 minutes before the next check took place.

86. During this time Officer C and his supervisor, Officer D, were occupied with enquiries outside the watchhouse. Whilst some steps were taken to task another officer to look after the watchhouse in their absence (see paragraphs 19 - 21), it is apparent that those instructions did not include a request to physically check the prisoners.

87. When Mr de Larratea Soler was found dead at 7.00pm it was clear that he had been deceased for some time. He had stopped snoring at about 2.45pm, and appears to have died soon after. He may have already died before the second and third checks.

88. If police had visited Mr de Larratea Soler hourly, as required by the local instructions, they would have checked him three times by 2.45pm and may have noticed that his condition was deteriorating, if they had tried to speak to him or wake him.

Quality of checks

89. According to GI P110(2), the purpose of a check is to assess the prisoner's "*health, safety and security*".

90. All three checks of Mr de Larratea Soler were brief and by observation only. The officers did not enter his cell to see whether his condition was improving or attempt to rouse him.

91. In order to properly monitor Mr de Larratea Soler's health, the officers should have made physical or response checks of him to assess his level of consciousness and intoxication.

92. Although the General Instructions do not explicitly require that the officers physically check prisoners, the *Whakatane Watchhouse Desk File* did require physical checks (see paragraph 52).

93. Officer C's failure to carry out a physical or response check at 1.14pm was particularly significant, because Mr de Larratea Soler was alive and snoring at that point. Snoring is a risk indicator and if Officer C had tried to wake him and been unable to do so, that should have prompted medical attention.

94. Officer G has stated that he intended to carry out a response check on Mr de Larratea Soler when he checked him at 4.32pm, but was distracted by another prisoner before he could do so. He did not conduct this check after he had attended to the other prisoner. When Officer H checked the prisoners at about 6.00pm, he assumed that Mr de Larratea Soler was sleeping and did not carry out a response check. He said:

> *"From experience if a drunk person was sleeping in a cell we would normally not disturb him as waking them tended to inflame the situation again which causes problems for the watchhouse keeper and other prisoners."*

95. It is apparent that Officer G and Officer H did not check whether Mr de Larratea Soler was breathing when they visited him.

FINDINGS

Police did not comply with national or district policy in relation to the mandatory inspection requirements.

The officers who did check Mr de Larratea Soler did not do so effectively.

WAS THERE APPROPRIATE SUPERVISION AND MANAGEMENT OF THE WATCHHOUSE?

Officer D

96. Officer D's duties included that of watchhouse supervisor when Mr de Larratea Soler was brought into the cells at 11.25am. However, due to his other responsibilities, Officer D was not present in the watchhouse at this time and only became alert to Mr de Larratea Soler's presence when his snoring became an issue.

97. He did not check Mr de Larratea Soler in the cells, nor did he inspect and sign his *Custody/Charge Sheet*. He should have done this by the time his shift ended at 5.00pm.

Shift handover

98. Part 2 of the *Whakatane Watchhouse Desk File* required a formal handover of the watchhouse duties at the beginning of each new shift (see paragraph 54). The watchhouse keeper coming on duty is required to inspect the prisoners together with his or her supervisor and the watchhouse keeper who is coming off duty.

99. In this case, the incoming watchhouse supervisor (Officer G) checked the prisoners at the start of his shift, but neither of the watchhouse keepers (Officer C and Officer H) participated in the inspection. Officer C also failed to brief Officer G and Officer H about the prisoners in the cells before he came off duty. As a result, there was no formal handover of watchhouse duties.

100. Officer G signed the *Inspection of Prisoners Book* to record that he was on duty and had checked the prisoners at 4.32pm.

Staffing and supervision of the watchhouse

101. According to GI P110(4), when a prisoner is held in custody at a police station *"... full time supervision of the cells is to be provided."*

102. In December 2008, there was a watchhouse keeper assigned to each frontline section at the Whakatane Police station, however oversight of the watchhouse and cell block area was not his or her sole responsibility.

103. As well as caring for and monitoring the prisoners in the cells, the watchhouse keeper was tasked with answering the telephone, attending to the public counter, taking statements, data entry and monitoring events on police databases. On 19 December 2008, Officer C was also tasked with the responsibility of taking prisoners to Court.

104. The *Whakatane Watchhouse Desk File* provided that if the watchhouse keeper needed to leave the station in order to attend to enquiries, he or she should arrange with their supervisor for another officer to assume their watchhouse duties (see paragraph 57).

105. At about 11.45am Officer C left the watchhouse unattended for a short time while he transferred prisoners to the District Court. At around 3.00pm he left to conduct enquiries outside the station and did not return until 4.45pm. He did not arrange for another officer to take over his watchhouse keeper duties on either of these occasions.

106. Officer D knew that Officer C had left the station at 3.00pm to conduct enquiries, and did ask other staff to look after the watchhouse, but did not ensure that someone was officially assigned the watchhouse keeper duties in his absence; including checking prisoners.

107. Officers E and F both looked after the watchhouse at this time by answering the phone and dealing with enquiries at the public counter, but neither officer was briefed about the prisoners or visited them in the cells.

108. There should have been an official handover of the watchhouse keeper duties each time a new person assumed responsibility for the watchhouse. The replacement officer should have inspected the prisoners and recorded the transfer of responsibility to them in the *Inspection of Prisoners Book*.

109. Because this did not happen the prisoners were not checked for more than three hours.

110. The supervision of the watchhouse and prisoners was inadequate because the officers charged with this responsibility (Officers D and G), were also tasked to undertake other duties that took them from the police station. In respect of Officer G, he was placed in charge of all staff and incidents that occurred in the Eastern Bay of Plenty. Due to their involvement in other duties, the officers could not give the watchhouse the attention it deserved.

111. In December 2008, there appears to have been a lack of assurance at management level that there was adequate resourcing and supervision of the Whakatane watchhouse; and that policy was being adhered to. Inadequate resourcing puts those in custody at risk and creates a potentially dangerous working environment.

FINDINGS

Officer D's supervision of the watchhouse was inadequate.

Police, at management level, failed to allocate resources so as to provide full time oversight of the watchhouse and cells at the Whakatane Police station.

WERE THE DISTRICT ORDERS AND THE WHAKATANE WATCHHOUSE DESK FILE ADEQUATE FOR DEALING WITH THE HEALTH AND SAFETY OF PEOPLE IN CUSTODY UNDER THE INFLUENCE OF ALCOHOL OR DRUGS?

112. At the time of Mr de Larratea Soler's death there were a number of shortcomings in the *Bay of Plenty District Orders* and the *Whakatane Watchhouse Desk File* in relation to the care and management of prisoners. These included:

- references to repealed legislation, obsolete forms and outdated terminology;
- failure to cover the risk evaluation that must be followed when an intoxicated person is taken into custody; and
- a focus on the risks associated with suicide and self harm but not on the risks associated with other health issues, such as alcohol and drug intoxication.

113. Intoxication from alcohol and other drugs and the associated behavioural problems are major reasons for people coming to the attention of police, and why they are arrested and taken into custody. They are also prominent health risk factors that must be given due consideration and attention.

114. The local instructions relating to the care of people in custody focused primarily on the prevention of suicide and did not sufficiently address the risks associated with prisoners who are heavily intoxicated. In this respect, they did not provide adequate guidance on the care and supervision of prisoners.

FINDING

At the time of Mr de Larratea Soler's death, the *Bay of Plenty District Orders* and the *Whakatane Watchhouse Desk File* were out of date and did not sufficiently address the risks associated with intoxicated prisoners.

OPCAT

115. Following amendments in December 2006 to the Crimes of Torture Act 1989, New Zealand ratified the Optional Protocol to the United Nations Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (OPCAT) on 14 March 2007. The Independent Police Conduct Authority became one of four designated National Preventive Mechanisms (NPMs) in New Zealand, with a specific mandate to monitor and report on conditions of police detention and the protection and treatment of persons detained by police. Through the Central NPM, the New Zealand Human Rights Commission, the Authority provides an annual report on its statutory functions and its findings. The Authority thus has active oversight of issues pertaining to the health and welfare of individuals in the custody of police who are affected by alcohol or other drugs and who, by virtue of their affected state, require specific care and treatment. As such, the death of Mr de Larratea Soler will be included in the Authority's annual report to the Human Rights Commission, which in turn reports to Parliament and to the United Nations.

LEGAL AND DISCIPLINARY MATTERS

116. Section 151 of the Crimes Act 1961 provides that police are criminally responsible for omitting to supply people in their custody with *"the necessaries of life"* without lawful excuse*, "...if the death of that person is caused... by such omission...."* The necessaries of life include medical care.

117. Section 150A of the Crimes Act requires that, in order for a person to be criminally liable for omitting or neglecting to perform their duty under section 151, the omission or neglect must be *"...a major departure from the standard of care expected of a reasonable person to whom that legal duty applies in those circumstances."*

118. While police have a legal duty of care in respect of any person arrested or detained by them, the liability under section 151 requires not only an omission to meet that duty without lawful excuse, but also that a significant act of negligence must be involved.

119. The police considered whether there was any criminal liability for Mr de Larratea Soler's death on the part of the officers involved in his detention and decided there was not. The Authority notes that police obtained a legal opinion from a senior police legal advisor before reaching this conclusion.

120. The police also decided that the failings of officers involved resulted from a lack of training in watchhouse duties and poor practices in place at the Whakatane Police station; therefore none of the individual officers should face disciplinary action.

121. District management conducted a debrief with the officers, in which their various breaches of policy were addressed. The current District Commander has assured the Authority that the processes and responsibilities in relation to the care of prisoners have *"markedly improved"* since Mr de Larratea Soler's death.

REMEDIAL ACTION

122. In July 2008, a new police custodial facility was built in Rotorua. Police have developed processes to transport prisoners from outlying areas such as Eastern Bay of Plenty to the new facility in order to house them overnight.

123. The Whakatane cell block has been renovated and steps have been taken to improve the practices in place at the watchhouse. For example, staff have received refresher training in relation to the management of grossly intoxicated people in custody, and information from the *Custody/Charge Sheets* and the *Inspection of Prisoners Book* is now recorded electronically.

124. The *Whakatane Watchhouse Desk File* was updated in May 2010. Of particular relevance, the updated desk file provides that:

- the watchhouse keeper assumes responsibility for prisoners as soon as they are received into custody and is responsible for completing the *Watchhouse Keeper's Evaluation*;
- when in doubt as to the cause or level of a prisoner's intoxication, watchhouse staff should call for medical assistance;
- the watchhouse keeper no longer leaves the station to conduct enquiries;
- a formal handover of the watchhouse duties (including a physical check of all the prisoners) must occur whenever the watchhouse keeper leaves the watchhouse; and
- weekly audits of the *Custody/Charge Sheets* and the *Inspection of Prisoners Book* are to be conducted by the O/C Station to ensure they are being completed correctly.

125. Police have undertaken a review of the General Instructions relating to the care and management of people in custody. A new chapter on *Managing Prisoners* is being drafted for inclusion in the *Policing Manual*. When this chapter comes into force it will replace the relevant General Instructions. Under the new policy, intoxicated prisoners must be taken to hospital for medical attention if they are unconscious or semi-conscious, that is;

- unable to answer any questions during the initial assessment process; or
- physically unable to look after themselves.

126. Police had a duty of care in respect of Mr de Larratea Soler which was not fulfilled. Although his death may have been inevitable, its occurrence whilst he was in police custody was avoidable.

127. The officers involved in Mr de Larratea Soler's arrest and detention should have taken all types of risk to his health into account, rather than focusing solely on the possibility of self-harm. Had these officers properly considered the risks to his health and provided an appropriate level of care and monitoring, it is likely that Mr de Larratea Soler would have been seen by a doctor and/or transferred to hospital.

128. The deficiencies in Mr de Larratea Soler's care arose from the failings of the officers who were tasked with caring for him. These failings were symptomatic of poor practices at the Whakatane Police station for the assessment, care and monitoring of prisoners.

129. Police, at management level, failed to allocate resources so as to provide full time oversight of the watchhouse and cells at the Whakatane Police station.

130. In December 2008, the district orders and local instructions were seriously flawed, ambiguous and failed to provide clear directions for the management of the watchhouse and for the evaluation of risks and the care and treatment of people in custody.

131. In terms of section 27(1) of the Act, the Authority has formed the opinion that:

- the omissions by Officers B, C, D, G and H to perform their duties in accordance with Police policies, practices and procedures were unjustified and undesirable;
- the failures of District management with regard to the allocation of resources and oversight of the Whakatane watchhouse were unjustified and undesirable;
- cumulatively, these omissions and failures amounted to a breach of the New Zealand Police's duty of care.

Recommendations

132. The Authority accepts that police have taken appropriate remedial action to address the failings of the officers involved in Mr de Larratea Soler's care, and therefore makes no recommendation, pursuant to section 27(2) of the Act, that disciplinary or criminal proceedings be considered or instituted.

133. The Authority makes the following recommendations pursuant to section 27(2) of the Act.

1) That Police adopt as best practice:

   - any person detained pursuant to section 36 of the Policing Act 2008 must be deemed in need of care;
   - prisoners assessed to be in need of care should be roused regularly as part of frequent monitoring (as recommended by the Authority in its report on the death of Juanita Shaw published on 9 October 2009).

2) That officers receiving Custodial Management Suicide Awareness Training are made aware that the care and protection of persons in custody includes an assessment for all risk factors, not solely those relating to suicide prevention.

3) That Police develop a training module to meet the requirements of employees assigned to duties in the watchhouse, with particular emphasis on responsibilities for the evaluation of risk, and the care and protection of persons in custody.

HON JUSTICE L P GODDARD
CHAIR
INDEPENDENT POLICE CONDUCT AUTHORITY
JULY 2011

About the Authority

WHO IS THE INDEPENDENT POLICE CONDUCT AUTHORITY?

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

It is not part of the Police – the law requires it to be fully independent. The Authority is chaired by a High Court Judge and has other members.

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 has highly experienced investigators who have worked in a range of law enforcement roles in New Zealand and overseas.

WHAT ARE THE AUTHORITY'S FUNCTIONS?

Under the Independent Police Conduct Authority Act 1988, the Authority:

- Receives complaints alleging misconduct or neglect of duty by Police, or complaints about Police practices, policies and procedures affecting the complainant;
- 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 can make findings and recommendations about Police conduct.

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