IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

Police fail in their duty of care to Allen Ball in Hāwera

Summary of the Incident

1. At about 11pm on Friday, 31 May 2019 Police received a call from Ms Y, who alleged her partner, Mr Ball, had assaulted her. She said Mr Ball had been drinking heavily and had threatened to commit suicide before leaving the house on foot.

2. Responding officers found Mr Ball a short time later, by a shed near the house. When asked, Mr Ball denied taking anything other than alcohol, and officers remained unaware he had consumed pharmaceutical drugs. They arrested him, placed him in a patrol car, and took him to Hāwera Police Station.

3. Officers said, during the short journey, Mr Ball appeared to fall asleep while being questioned. When they arrived at the Police station, at 11.58pm, the officers could not wake him. They used pain compliance techniques on him but he remained unresponsive. Officers carried him into the station on a blanket and placed him in the recovery position on a cell floor.

4. At about 2.30am, an officer found Mr Ball's condition had deteriorated. Officers called an ambulance and performed CPR; however, Mr Ball was pronounced dead at 2.53am. Later that morning, an empty bottle of codeine was found about two metres from where Mr Ball had been located by the shed.

5. The cause of Mr Ball's death was found to be extremely high levels of codeine and tramadol, and alcohol toxicity. An expert in forensic toxicology says that if he had received medical attention sooner, it is very likely Mr Ball would not have died.

6. Police investigated and charged Officers A, C and E with manslaughter. They were found not guilty by a jury in May and June 2021.

7. Police informed the Authority, who conducted an independent investigation into Mr Ball's death.

Issues examined by the Authority

8. The Authority's investigator interviewed Officers A, C, D, E, and F. All Police documentation and CCTV footage was reviewed. We also reviewed training material and Court testimony regarding training.

Issue 1: Was it appropriate to transport Mr Ball to Hāwera Police Station following his arrest and did officers respond appropriately to his condition?

Issue 2: Was Mr Ball appropriately assessed and monitored in custody?

Issue 3: Did officers provide prompt medical assistance when Mr Ball was found unresponsive in his cell?

Issue 4: Do Police provide adequate training for officers involved in detaining people in custody units where there are no dedicated custody officers?

The Authority's Findings

9. The Authority's investigation is not for the purpose of determining whether the officers are criminally liable for their actions. Our task under section 27(1) of the Independent Police Conduct Authority Act 1988 is to:

> *"form an opinion on whether or not any decision, recommendation, act, omission, conduct, policy, practice, or procedure which was the subject matter of the investigation was contrary to law, unreasonable, unjustified, unfair, or undesirable".*

10. In forming our opinion, we adopt a standard of proof that is lower than the criminal standard. That is because our task relates to oversight of Police conduct, not the application of the criminal law. In matters alleging serious misconduct by officers, we are always mindful that the strength of the evidence upon which we base that opinion must be high. That said, we use the same standard of proof applied in the civil courts in New Zealand – the balance of probabilities (which means more likely than not).

11. The Authority found:

1) it was initially appropriate to take Mr Ball to Hāwera Police Station;

2) when officers arrived at the Police station, and Mr Ball was found to be unresponsive, they should have taken him directly to hospital;

3) Officers A and C should not have ignored the Electronic Custody Module's instructions to arrange for Mr Ball to be taken to hospital;

4) Mr Ball should have been taken to hospital with the assessment of 'partially responsive'. Failure to do so was a breach of policy;

5) Mr Ball should have been classed as 'unresponsive' rather than 'partially responsive'. His assessment should have been revisited during his time in custody;

6) officers should have given more consideration to Mr Ball's self-harm threat, especially when his condition rapidly deteriorated;

7) Officer A did not provide sufficient guidance in his role as acting Field Training Officer for Officer C;

8) Officer E failed to appropriately direct and supervise the officers under her control;

9) Mr Ball was not placed on the correct monitoring regime. He should have been constantly monitored;

10) even under the frequent monitoring regime, officers did not complete the required number of checks;

11) conducted checks should have been more thorough;

12) Officers A, C and E all failed to perform their roles adequately and failed Mr Ball, who was dependent on them for his care;

13) Officers D and F, who were also aware of Mr Ball's unresponsive condition, failed to perform the obligation they had to arrange medical care for him;

14) officers should have been quicker to call an ambulance and retrieve the AED when they found Mr Ball's physical condition to have deteriorated; and

15) Police need to continue to develop and ensure delivery of appropriate training for officers involved in detaining people in custody units where there are no dedicated custody officers.

Analysis of the Issues

ISSUE 1: WAS IT APPROPRIATE TO TRANSPORT MR BALL TO HĀWERA POLICE STATION FOLLOWING HIS ARREST AND DID OFFICERS RESPOND APPROPRIATELY TO HIS CONDITION?

12. Officers A and B spoke to Ms Y and the couple's son while Officers C and D and an observer looked for Mr Ball.[1]

13. Officer C says he had looked Mr Ball up on the Police database before arriving at the property, noting there was an old alert that Mr Ball was a drug user, which related to cultivating cannabis. As Officer C was searching, he heard over the radio that Mr Ball was feeling suicidal.

[1] The observer was considering joining the Police and was accompanying Officer C in his duties to see what the role entailed.

The dispatcher told officers: "*Male was threatening to 1X [self-harm] when infmt [informant] last saw male. No access to firearm. Didn't mention 1X method.*"

14. Officer C found Mr Ball a short distance behind the house by an old cow shed. He believed Mr Ball was intoxicated because he was stumbling a little bit and "*then he tripped over a wire that was on the ground which any person that… wasn't under the influence of alcohol would've stepped over quite easily*."[2] Mr Ball's speech was "*reasonably slurred*", though he "*was communicating fine with me and he was coherent the whole time… he could stand on his own two feet....*"

15. Officer C asked Mr Ball if he was okay because of Ms Y's comments that he had threatened to self-harm. Mr Ball told him he had been drinking a lot of bourbon. Officer C asked him if he had taken anything else "*enough [times] to put my mind at ease that he hadn't consumed anything other than alcohol.*" Mr Ball told Officer C he was fine, he had not taken anything else, and that the Police should leave him alone.

16. Officer E, who was the supervising sergeant, arrived with Officer F. Officer E says when she approached Mr Ball, he was: "*a little abrasive and didn't really wish to engage in my conversation. He was pacing back and forth.*"

17. Officer F says Mr Ball's body language indicated that he was becoming uncomfortable. He says:

> *"[Mr Ball] started shuffling or edging towards the building… He was folding his arms and appeared to be looking for a way of escaping. He continued to say 'I don't need to come with you'…."*

18. Officer E moved away and Officer C, who had developed some rapport with Mr Ball, continued talking with him. Officer E recalls hearing Officer C ask Mr Ball if he had taken any medication "*numerous times*".

19. Officer C then placed Mr Ball under arrest for the alleged assault, about 30 minutes after Police had been called to the house. Although Mr Ball briefly pulled away, he was placed in handcuffs without further incident.

20. Officer A told us Mr Ball appeared to be a typical drunk male who was arguing with his partner. Mr Ball was not overly aggressive, but was argumentative, saying he did not think he had done anything wrong. Officer A says Mr Ball acted as though the officers were inconveniencing him.

Was it appropriate to take Mr Ball to Hāwera Police Station at this point?

21. Hāwera Police Station, which was the closest station, does not have a dedicated custody officer to process or monitor people taken into custody.[3]

[2] The wire was an electric fence that was about 40cm off the ground.
[3] Custody officers are non-sworn Police employees who have responsibility for managing health, safety, and secure custody of detainees.

22. Officer E explained to us that normal practice was for intoxicated people to be initially taken to Hāwera Station to sober up for "*an hour or two"* while paperwork was completed, then they were moved to New Plymouth Police Station. New Plymouth has better custody facilities and dedicated custody staff which enable them to detain people for longer periods of time. It takes about one hour to drive from Hāwera Police Station to New Plymouth Police Station. At trial, Officer G, the response manager for South Taranaki, said at the time of Mr Ball's death, it was "*very infrequent, if at all*" that people were detained at Hāwera Station overnight.

23. Officer D says he thought this was "*just a normal arrest*" and Mr Ball was "*just a drunk sleeping it off".* Therefore, the plan was to speak to Mr Ball about the allegation when he woke up then arrange for him to go through to New Plymouth Police Station.

24. We accept the decision to take Mr Ball to Hāwera Police Station was appropriate at this point based on the state of Mr Ball at the time and because it was the closest station. In the condition he was in, it was reasonable for them to plan to allow him time to sober up before interviewing him.

What happened during the car journey to the Hāwera Police Station?

25. Officers D, A and C transported Mr Ball to Hāwera Police Station. Officer D drove and Officer A sat in the front passenger seat. Officer C sat beside Mr Ball in the back seat for the 10 to 15 minute drive. He advised Mr Ball his rights under the New Zealand Bill of Rights Act 1990 and tried to ask him questions. However, about 3 or 4 minutes into the journey Mr Ball appeared to fall asleep and began snoring.

26. Officer C says there was a strong aroma of alcohol on Mr Ball's breath in the car. He says Mr Ball was:

> *"… talking fine, answering questions. His speech was starting to slur a little bit more but…nothing concerning… he sort of said that he'd had five or six glasses and he mixed it with some Coke and that he was fine and that we shouldn't have anything to worry about… he was just at the point where the alcohol would put him to sleep like any other human being I've seen out on the piss…."*

27. When asked if he had any concerns with the speed at which Mr Ball suddenly fell asleep, Officer C said: *"I've had no training to say otherwise."*

28. Officers A and D were also not concerned with how quickly Mr Ball fell asleep. Officer D assumed Mr Ball fell asleep because he was intoxicated. Officer A told us it is normal for people who are put into patrol cars to not want to talk: *"… they'll just go into that sort of mode; they'll just go to sleep, or they just won't engage…."* He recalls Mr Ball was breathing heavily, snoring a lot, and groaning.

What was Mr Ball's condition when they arrived at Police station?

29. Mr Ball would not wake up when Officer C shook him to tell him they had arrived at the station. Officers tried to get a response by using pain compliance techniques.

30. The purpose of pain compliance techniques is to determine how responsive someone is. The 'People in Police Detention' policy that was in place at the time, states:[4]

> *"If the person is…*
>
> - ***Partially responsive*** *– responds to pain only (e.g. nail-bed pressure) ...* ***THEN*** *- Treat this as a medical emergency and arrange for the person to be taken to hospital.*
>
> - ***Unresponsive*** *- does not respond to any stimuli ...* ***THEN*** *- This is a medical emergency and immediate hospitalisation is required. If you expect a delay in the ambulance's arrival or the person's condition calls for immediate action, use a Police vehicle."*

31. Officer C did a 'sternum rub', using his knuckles to rub and apply pressure to Mr Ball's sternum. He also dug his fingers into Mr Ball's collarbone (clavicle). Officer C says he felt Mr Ball's shoulder twitch but that was all, which "*tells me they've felt it… that there's some sort of alertness there*". Officer C continued to believe Mr Ball was "*a little bit drunk*".[5]

32. Officer A pinched Mr Ball's ear, with a "*forceful squeeze",* but he did not respond. This did not cause Officer A to be concerned. He says: "*… if they're that drunk and they're that asleep, they won't respond…."* Officer A does not recall Mr Ball responding to any of the pain compliance techniques used. No further attempts were made to rouse Mr Ball at this point.

33. Officer D also says Mr Ball's lack of response to the use of pain compliance techniques did not alarm him. He did not consider that Mr Ball may have taken something other than alcohol and says the officers made light of him not waking up.

34. Officer D moved the patrol car nearer to the station door and parked it at an angle so it was "*closer and easier*" for them to move Mr Ball. This implies none of the officers believed Mr Ball was conscious or capable of leaving the car and entering the custody area on his own.

35. Officer F arrived a short time later with Officer E. He saw the three officers struggling to support Mr Ball who was half out of the patrol car. Mr Ball was not responding to voice appeal or the officer's instructions. Officer F told the Court:

> *"Mr Ball seemed unconscious. His limbs were limp and he was clearly stuck and couldn't get himself out of the car and needed to be assisted. It appeared that his foot, feet were stuck under the front left passenger seat and while supporting Mr Ball somebody went around and managed to get Mr Ball's feet loose from underneath the seat, left front seat."*

[4] See paragraphs 196 to 209 for relevant custodial policy. Police have renamed this policy. It is now the 'People in Police Custody' policy. Police policy is frequently updated. Officers are notified through various means, including the Police online bulletin board and emails.

[5] Officer C had attended several first aid courses in his previous role as a firefighter. However, he told us this training did not cover dealing with intoxicated people such as Mr Ball, as it was more specific to the role of a firefighter.

36. Officer F told us his first thought was that Mr Ball was deliberately making it difficult for the officers to move him. This belief was more prevalent in his thinking than that Mr Ball's condition had deteriorated. Mr Ball was breathing and he thought it looked like his eyes were open or half open, so Officer F considered him to be "*a little bit lucid*".

37. However, Officer F also told us he was surprised by the change in Mr Ball's state because he had been "*quite lucid, totally co-operative and verbally engaging*" when he saw him at his property before he got into the patrol car. "*The other constables didn't say what happened that made him unconscious or semi-conscious or in that state….*"

38. Officer F did not question the officers about the change in Mr Ball's condition and was unaware pain compliance techniques had been used before he and Officer E arrived at the Police Station. He says his main priority was to get Mr Ball out of the rain and comfortable so he could be assessed properly.

39. Officers A and C took Mr Ball out of the patrol car and lay him down on the ground beside the car. Mr Ball was snoring. Officer C removed his handcuffs from Mr Ball's wrists. Officer F says: *"[Mr Ball's] arms were limp, and he did not resist in any way."* No other restraints were used on Mr Ball while in custody.

40. Officer E says she did not have any concerns regarding Mr Ball's level of responsiveness, despite being told he did not respond to pain compliance techniques. She did not think his condition was unusual and the fact he was sleeping on the ground did not "*ring any alarm bells*". She says they dealt with intoxicated people every week and numerous people who "*play silly buggers*" with Police. She indicated to us that the other officers thought it was a bit of a joke that Mr Ball had fallen asleep while they were asking him questions.

41. Officer F says it was raining lightly and the officers wanted to move Mr Ball inside as quickly as possible. He says: *"Mr Ball seemed to be unconscious, he was breathing but he was not responding to us or assisting us [to] move him into the cells."* Mr Ball was extremely heavy and awkward to carry so Officer F went and got a tear-resistant blanket to support his weight and give them a better grip. Five officers and the observer then carried Mr Ball into the station on the blanket.

42. Officer F says as they struggled to get Mr Ball through a door, he looked down at Mr Ball and his eyes were half open and it looked like he was smiling. Officer F commented to the other officers: *"I'm not sure whether he's putting this on or, you know, is he playing silly buggers?"*

43. The officers say they considered Mr Ball to be a typically intoxicated person, similar to those regularly encountered during the course of their duties. However, Officers B, C, D E and F have never had to carry an intoxicated person into a custody person in the same manner as with Mr Ball. It is therefore hard to conceive this is the level of intoxication they regularly encountered.

44. Officer A says that he has dealt with people more intoxicated than Mr Ball, but they can usually be roused to a degree, and even if they don't respond they can still take their own weight. He recalls previously dealing with a detainee in a similar situation. However, in making a comparison to this case, it was evident to us that dealing with intoxicated people who could not be roused or carry their own weight was not actually very common for Officer A.

45. Officer D told us there was nothing unique or different in terms of the way Mr Ball presented to the officers compared to other intoxicated detainees he had dealt with. However, soon after Mr Ball was removed from the car, CCTV footage captured Officer D saying:

> *"I've never seen anything like it. F**king it was the best lock up, straight in the car, give him his rights, [makes snoring sound]."*

46. The CCTV footage does not show the officers' earlier actions when using pain compliance techniques to rouse Mr Ball, as Mr Ball was still inside the patrol car; but it does show officers removing Mr Ball from the car and carrying him into the station. Mr Ball appears completely unresponsive.

47. At this point, officers should have revisited their decision to take Mr Ball into the station and taken him directly to the hospital at this point. The following factors should have been considered:

- Mr Ball's condition had rapidly deteriorated within a period of about 20 minutes. He went from being able to speak coherently and walking to the car on his own, to being unresponsive;
- Mr Ball had not responded to pain compliance techniques;
- Mr Ball could not carry his own weight and six people had to carry him into the custody suite on a blanket; and
- officers were aware Mr Ball had told Ms Y that he was suicidal.

48. We cannot put this poor decision making down to stress or undue pressure. When talking with us, none of the officers suggested they felt stressed by the situation with Mr Ball while dealing with him. In fact, CCTV footage shows some of the officers engaged in banter and laughed at the situation at times.

49. Officers A, C and D were present most of the time Mr Ball was in custody at the station. Officers B, E and F were also present at times. At one stage there were five officers present for an hour or so. There were more than enough staff to apply the necessary care to Mr Ball and, in any case, it only required one of them to call an ambulance.

FINDINGS ON ISSUE 1

It was initially appropriate to take Mr Ball to Hāwera Police Station.

When officers arrived at the Police station, and Mr Ball was found to be unresponsive, they should have taken him directly to hospital.

ISSUE 2: WAS MR BALL APPROPRIATELY ASSESSED AND MONITORED IN CUSTODY?

50. Mr Ball was put in the cell closest to the custody desk and was placed on the floor to ensure he did not injure himself by falling off the bed. Officers put him in the recovery position. His right foot was lying in the doorway and his left foot was resting on his right calf. His face was towards the back of the cell, facing the bed. This would have made it difficult, if not impossible, for officers to observe his face from the doorway in order to recognise any signs of distress.

51. Mr Ball was searched and had items such as jewellery removed. His pants were removed as they were wet from him being outdoors in wet grass.

52. Officer F told us:

> *"Being in the state [Mr Ball] was, semi-conscious or unconscious, we got him into the cell, put him into the recovery position, by lying him on his right side, so if he did vomit he could expel it without choking. He was safe at that stage."*

53. Officer F says Mr Ball was breathing freely and began snoring shortly afterwards: "*It was deep and rhythmic sounding and I thought that he was comfortably asleep."* Officer E says that at this point there were no 'warning bells' to make her believe she needed to call an ambulance.

54. Officers put a blanket on Mr Ball, gave him a pillow, and some stood watching him for a few minutes.

55. Officer C initially nudged Mr Ball's foot, moving it inside the cell before closing the door. Mr Ball's toes can be seen on CCTV, unmoving, through the gap at the bottom of the door. Officer C opened the door to check on him a few minutes later and left it open with Mr Ball's foot in the doorway.[6] Based on the lack of foot movement, Mr Ball appeared unresponsive.

56. It is possible Mr Ball's foot could be seen from the custody desk, but officers needed to physically go closer to the cell door to properly observe him.

57. As there was no dedicated custody officer, Officer C processed Mr Ball, entering information into the Electronic Custody Module (ECM).[7] Officer C says the evaluation questions were answered based on his observations and the conversation he had with Mr Ball at his property as Mr Ball was unable to answer them himself.

58. Officer C had processed ten detainees in total before this event. Analysis of the ECM shows that of these, four were recorded as being under the influence of alcohol and one was recorded as being under the influence of drugs. Four were recorded as 'alert' and one as 'drowsy'.

[6] No other detainees were present in the cell block.
[7] The Electronic Custody Module (ECM) is where staff record risk information, any special care instructions, and everything that happens in relation to a detainee, from their processing to their release.

59. While Mr Ball was being taken to the station, Officer B who had stayed at the house to get statements from Ms Y and their son, established Mr Ball had drunk about one litre of bourbon that night, starting at 5pm. Ms Y told her it was not unusual for Mr Ball to drink this amount daily.

60. Officer A rang Officer B while she was taking the statement at the house. He says she told him about the one litre of bourbon during this call. Officer C recalls that it was when they were driving back to the station that they learned this information. When processing Mr Ball, Officer C recorded he was under the influence of alcohol with the note: *"High level of intoxication. 1L of Bundaberg Bourbon consumed."*

Were appropriate decisions made when entering Mr Ball's details into the ECM?

61. A couple of minutes after Officer C began processing Mr Ball, Officers A and D briefly discussed the assessment with him before Officer D left the custody area. Processing includes an alcohol assessment and a custody evaluation where the evaluator looks at five risk areas: under the influence of, behavioural signs, signs or history of, physical health, and levels of consciousness.

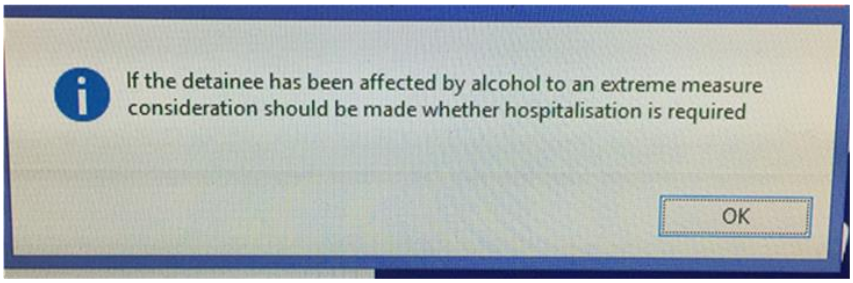
62. CCTV footage audio captured the following discussion:

> Officer D: "*So bro we need to do (inaudible) assessment."*
>
> Officer C: *"Aww yeah."*
>
> Officer D: *"(inaudible) he can't answer it because he's fucking chopped."*
>
> Unidentified Male voice: *"It'll be a one."*[8]
>
> Officer D: "*It will be because mate, it's frequent – saw he was breathing."*
>
> *(inaudible)*
>
> Officer A: *"Saw the chest moving (inaudible)."*

63. Officer C marked *"yes*" when the ECM asked if officers were aware of any medical or psychological reasons that may indicate Mr Ball may require special care or may be at risk while in custody. He recorded the reason: "*[Mr Ball's] made 1X [suicide] threats, but this could be due to intoxication.*" This is an indication of the degree to which he believed Mr Ball's condition was due to his level of intoxication, rather than that he was actually at risk of self-harming. This is consistent with the belief all the officers appear to have held throughout Mr Ball's time in custody, which dominated their thinking to the point they did not consider factors other than intoxication through alcohol.

64. The degree Mr Ball was affected by alcohol was recorded as *"extreme*", which is the highest level of intoxication available on the custody module. This was an accurate assessment. When *"extreme"* is entered into the alcohol assessment section, a system-generated message pops up:

[8] We are unsure exactly what 'one' was referring to.



65. This pop-up alert prompts the receiver to **consider** whether they should take the detainee to hospital. It is not instructing that they **must** take them.

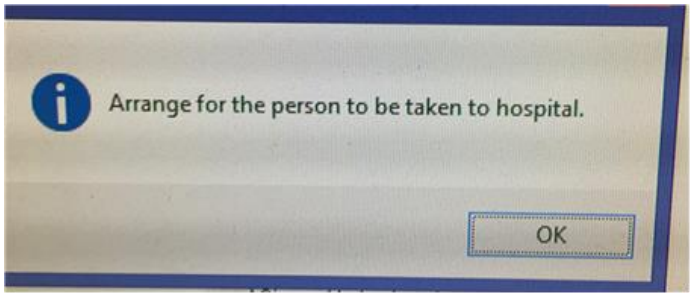
66. Officer C cleared the message by clicking 'Okay' because of his assumption Mr Ball was asleep due to being intoxicated. He does not remember speaking to any colleagues about the pop-up message.

67. Officer C says this was the first time he had ever seen a pop-up alert show up within the electronic custody module. (None of the ten detainees Officer C had previously entered into custody would have triggered a pop-up alert.)

68. Officer C says, he saw the message and considered: *"… is it a must right now, or are we going to be putting an aggravated person, when he comes round, into hospital care?"*

69. The fact Mr Ball may have become agitated at the hospital is not sufficient reason for officers not to take him there. Police could have provided staff to deal with any potentially aggressive behaviour when he 'came round' and hospital security would have been available to assist.

70. Officer C then recorded Mr Ball as being "*partially responsive"* in the ECM. The system generated a pop-up alert, which **instructed**:[9]



71. Officer C told us he could not remember seeing this message and did not remember clicking 'Okay' to clear the message. When an alert pops up, the user has to click 'Okay' to go to the next screen, therefore, Officer C must have done this. It is difficult to reconcile Officer C's ability to remember the first pop-up alert, but not the very important second one.

[9] Pop-up alerts appear when 'extreme' is entered for level of intoxication, and when the level of consciousness selected is 'drowsy or confused', 'partially responsive', or 'unresponsive'.

72. By clicking 'Okay' the system is over-ridden, meaning when officers checked Mr Ball and entered it into the ECM, no further alerts would pop-up, saying medical treatment should have been sought.

73. The Police database (NIA), which Officer C uses daily, has a number of pop-ups. These occur, for example, when a name is incorrectly spelt or to prompt the user to enter more information in a particular section. The ECM system also provides prompts for users to assist them in processing the detainee; however, its pop-up alerts are slightly different in appearance.

74. Officers A, C, D and E made a collective submission to our draft report, through the Police Association. They submitted: "*… prompts* [pop-up alerts] *are generally seen as of little significance and easily clicked away."* Officer C said he had not been trained in attending to these pop-up alerts, nor taught their importance. They submitted that process, discretionary, and mandatory pop-up alerts should not look the same; that effective pop-up alerts should be placed in a prominent position, with a different size, colour or shape.

75. It was submitted that all the attending officers thought Mr Ball was a 'sleeping drunk', and that this formed an unconscious bias and herd mentality.[10] An example of this would be officers unconsciously allowing evidence, such as Ms Y's view that Mr Ball was not suicidal, to confirm their belief he had only consumed the litre of bourbon and therefore, was 'a sleeping drunk'. As a collectively-held unconscious bias, this would inhibit any challenging of the way that evidence was interpreted. It was submitted that the ECM pop-up alert which instructed Officer C to arrange for Mr Ball to be taken to hospital: "… *was not sufficient for humans confident in their view, [their unconscious bias] supported by others, [the herd mentality] to override that prompt."*

76. We do not accept there was any reasonable justification for ignoring the two important pop-up alerts. Regardless of how they were visually presented, their content was of a much more significant nature than regular NIA pop-ups. While it is arguable that unconscious bias impinged on their decision making, prompts, such as the two pop-up alerts, are designed to break unconscious bias, to guide officers and instruct them on what action they need to take. In our view, all officers have an individual and personal responsibility to read and act on pop-up alerts. The messages were very clear, to the point the second pop-up alert gave a direct instruction. We do not believe training was required to understand or act on them.

77. Officer C should have raised them with a supervisor if he was unsure whether to seek medical treatment. Ignoring these two pop-up alerts had significant consequences.

78. Officer C says there was nothing unusual or concerning about Mr Ball's condition and compared him with the one intoxicated detainee he had previously processed (six days before). However, apart from being intoxicated, the two cases were clearly not similar. The previous detainee had been able to stand and talk to Officer C before falling asleep in the cell.

[10] Unconscious bias refers to a bias that we are unaware of. Implicit or unconscious bias happens by our brains making incredibly quick judgements and assessments of people and situations without us realising. Herd mentality is the tendency of the people in a group to think and behave in ways that conform with others in the group rather than as individuals.

79. Shortly after placing Mr Ball in the recovery position and leaving him, Officer C accidentally dropped his cell phone on Mr Ball's head while checking him. Officer C says Mr X did not respond in any way to checks he conducted on him throughout his time in custody and did not react to the phone being dropped on him.

80. Officer C told us he did not discuss Mr Ball's level of responsiveness with any of his colleagues. However, the audio recording discloses he did.

81. The individual officers say they were aware Hāwera Station had audio recording available, however, before our interviews, Police believed there was no sound on the CCTV footage. The system they used to review the footage did not identify any audio. Consequently, our investigator was unaware of the audio at the time he interviewed the officers. We later discovered there **was** audio, when we reviewed the footage, using software that was different from that used by Police. We alerted Police to the existence of audio.

82. Officer A was supervising Officer C while he completed Mr Ball's processing in the custody area. During our interview with Officer A, we showed him the level of consciousness screen from the electronic custody module where it says: 'Partially responsive, responds to pain, (e.g. nail bed pressure).' We asked him: *"Did you see that during the booking-in procedure?"* Officer A responded: "*No, I wasn't really taking a look at the screen side of things, I was just overseeing, without looking at the screen…."*

83. However, the CCTV audio located after our interviews, captured Officer C telling Officer A about the pop-up alert. Footage shows that Officer A moved closer to look at the screen. Their conversation was as follows:

> Officer C: *"I reckon he's unresponsive. He doesn't respond to anything, any pain, any stimulation."*
>
> Officer A: *"Partially responsive".*
>
> Officer C: *"Arrange for the person to be taken to hospital."*
>
> Officer A: *"What sort of (inaudible) in their veins?"*
>
> Officer C: *"Partially responsive (inaudible) partially responsive."*
>
> Officer A: *"Mmm. It's all or nothing. He's in the recovery position, aye?*
>
> [Officer A walks away to check Mr Ball]
>
> Officer A: *"Just cover it off – can look at it later.*

84. Officer E entered the charge room while Officer A was checking on Mr Ball during this conversation, however neither officer told her about the pop-up alert that had just been on the screen.

85. Both pop-up alerts provided clear instructions for officers. They reiterated the instructions given in Police policy. Officers A and C should not have ignored the instruction to take Mr Ball to hospital.

Was Mr Ball correctly assessed as being 'partially responsive'?

86. Officer C told us he did not think Mr Ball was 'unresponsive'. He believed Mr Ball had some responsiveness because of when he twitched his shoulder when he pressed his fingers into Mr Ball's collarbone while in the carpark, and because he was snoring. However, this is contradicted in the above conversation (paragraph 83), which was captured on CCTV footage at 12.20am. It indicates Officer C did consider Mr Ball to be unresponsive while processing him, despite taking Officer A's advice to assess him as being 'partially responsive'.

87. All of the other officers say they considered Mr Ball to be 'partially responsive' throughout his entire time in custody. Although Officer C took responsibility for processing Mr Ball, his assessment and actions appear to reflect what all of the officers considered appropriate:

- Officer A told us:

  > *"In between [Mr Ball's] snoring and that, like if you went in there and said something, he's like [groan], or he'd groan to ya, which kind of indicated that he was understanding what you're saying."*

  These responses are not apparent on the CCTV audio.

- Officer D says he believed Mr Ball was 'partially responsive' because he was snoring.

- Officer E accepted Officer C's assessment. She says she was not familiar with the pop-up alerts in the system and was not made aware of the specific pop-ups that had come up on the screen that night.

88. Whilst we acknowledge confirmation bias could have unintentionally and unconsciously fed into the officers' belief Mr Ball was partially responsive, we do not believe it absolves individual responsibility. Police officers should be able to make ongoing, accurate assessments of risk, and make decisions independently.

89. When Mr Ball had been at the station about 40 minutes, Officer E used her left foot to move Mr Ball's foot, holding it there for about 8 seconds. When she let go of his foot, it fell back into the same position, indicating he was unresponsive. However, no change was made to the ECM and he was still considered 'partially responsive'. Officer E moved Mr Ball's foot to see if he responded. We cannot, therefore, reconcile her decision to ignore his total lack of response.

90. Officer E then talked with Officer C about Mr Ball drinking one litre of straight bourbon. Although some of the conversation is inaudible, the shared sentiment appears to be they were surprised at the amount of alcohol Mr Ball had drunk and indicated that it was not a situation they regularly encountered.

91. About 15 minutes later, Officer C kicked Mr Ball's foot four times, in short succession. Once again, Mr Ball did not respond to his foot being impacted. No changes were made in the ECM to his level of responsiveness.

92. When Mr Ball had been at the station for about 1 hour and 20 minutes, Officer E nudged his foot again and asked Mr Ball if he wanted a drink of water. Mr Ball continued snoring. Officer E shook her head and smiled, and the following conversation took place:

> Officer C: *"10/0 cuz no good?"*[11]
>
> Officer E*: "(Inaudible) one."*
>
> Officer C: *"Still responsive? (laughs)"*
>
> Officer E: *"Yeah."*
>
> Officer C: *"(laughs) Fucking hell."*

93. Officer E says she stood for a period of time to assess whether Mr Ball was "*up to being transported to New Plymouth*". She was going to be taking Officer F to Stratford, so considered taking Mr Ball with them, and passing him into the care of the New Plymouth officers. However, she made the decision that Mr Ball needed to sober up and that they could not put him in a prison wagon as the cells were too confined. She says she told the officers she would make another assessment when she returned from Stratford, which is about half an hour away from Hāwera.

94. Before Officer E arrived back at Hāwera Police Station, Mr Ball's condition had deteriorated and an ambulance was called.

95. Mr Ball should have been classed as 'unresponsive'. Officers should have revised their classification and treatment of Mr Ball when they checked him and he was unresponsive.

Did officers comply with policy?

96. Policy relating to the care of detainees says:

> *"Intoxication can mask underlying medical conditions which can go undetected when custody personnel assume the person just needs to 'sober up'. Note: Loud snoring is a sign the person is deeply unconscious."*

97. Officers seemed to be unaware of the policy and incorrectly assumed snoring was simply a sign of being asleep. They say they were not taught in training that snoring may be a sign someone is unconscious.

[11] 10/0 is common Police jargon used to describe a dead person.

98. The managing director for Triple One Care Limited, who provide Police with their first aid training, says snoring is covered in training, despite there being nothing in their manual specifically around snoring. When giving evidence at the officers' trial, he agreed that the average Police officer does not have the level of training to assess the noises people may make while asleep/unconscious. He agreed snoring is generally benign and simply indicates a person is asleep. However, he said someone who is drunk is normally rousable, whereas Mr Ball was not.

99. While we cannot reconcile the officers' insistence they were not taught anything about how snoring should be interpreted and Triple One Care's evidence that it was taught, we would find it remarkable that it wasn't, bearing in mind the policy on the matter.

100. Policy is very clear about what officers should do if a detainee is 'partially responsive' or 'unresponsive'. It states:

> *"Always consider the detainee's level of consciousness. Immediate hospitalisation is required if they are unresponsive – this is a medical emergency. Detainees who are only partially responsive, should also be taken to hospital."*

101. Officers did not comply with policy.

Was sufficient consideration given to Mr Ball's comment to Ms Y, that he was suicidal?

102. Ms Y told a 111 call-taker that Mr Ball had told her he was going to kill himself. The call-taker asked: *"Did he say how he was going to kill himself*?" and she replied: *"Nah he's just being a fucken idiot to be honest."* Ms Y also told Officers A and B about the threat, and again said she did not believe he would harm himself.

103. When they arrived at the station, Officer E established there was no suicide alert on Mr Ball's file. When discussing the amount of bourbon Mr Ball had consumed, she also asked Officer C: *"[Mr Ball] made threats to [Ms Y] that he was gonna do something silly?"* He responded: *"Yeah he reckons that he was gonna 1X [commit suicide]."* Officer E said they would hold Mr Ball for detoxification and the Crisis Team could do an assessment in the morning.[12]

104. Officer E told Police her thinking around this was that Mr Ball had told Officer C he was not feeling suicidal and that he was "*all good*". However, she thought he should be assessed by the Crisis Team as a precaution to establish his state of mind. She was aware that when Officer B returned from taking Ms Y's statement, they would probably have more information. However, there were no changes made to Mr Ball's care as a result of Ms Y's statement.

105. Although Mr Ball's threat of self-harm prompted Officer E to consider him in need of an assessment by the Crisis Team, none of the officers considered Mr Ball may have attempted to carry out his reported threat of suicide. The officers continued to be oblivious to the situation unfolding in front of them due to their assumption Mr Ball's condition was a result of his level of alcohol intoxication. Officers appear to have placed too much reliance on Mr Ball telling them

[12] The Crisis Assessment Team (CAT) are health professionals who assess those with a potential mental disorder and arrange appropriate care.

he had not taken anything other than alcohol, and possibly on Ms Y's belief that his threat was not a serious one.

106. At 8am, the morning of Mr Ball's death, detectives investigating the circumstances of Mr Ball's death found an empty prescription bottle of codeine near the shed where Mr Ball had been arrested and discovered Mr Ball's codeine was missing from the house. Tramadol was also kept in the house.

107. Officers should have given more consideration to Mr Ball's threat, especially when his condition deteriorated rapidly. None of the officers appear to have considered he may have overdosed on drugs. They should have been more thorough, establishing whether Mr Ball was using prescription or other types of drugs, and if so, what quantities he took and whether these were accounted for at his address. Mr Ball's condition alone was sufficient to have required hospital treatment but the combination of that, his threat to self-harm, and the officers' lack of information about what drugs he may have accessed, should certainly have caused officers to take Mr Ball to hospital or to call an ambulance.

Did Officer C receive adequate supervision when completing the ECM evaluation?

108. In custody units where there is a dedicated custody officer, the arresting officer passes over responsibility to them to classify the detainee, conduct a full evaluation, and monitor them. At Hāwera Police station there was no-one in this role, so Mr Ball remained Officer C's responsibility. As Officer C was a probationary officer, a Field Training Officer supervised him.[13] Officer E ultimately had overall responsibility during the shift, as the supervisor.

109. We asked Officer E who had responsibility for Mr Ball when she left the station during the final hour. She said normally the arresting officer would have overall responsibility, however, as Officer C had only completed his training at the Police College six months prior, one of the more senior officers would help him.[14] Officer E explained the officers would "*all sort of just step up and do their bit…. because of [Officer C's] length of service now he relies on the more senior members to guide him.*"

110. Officer D was Officer C's usual Field Training Officer, mentoring him and providing frontline training. Officer D had other work to do, so it was decided Officer A would supervise Officer C while he processed Mr Ball, which was a reasonable decision. Officer A is an experienced officer who is also a Field Training Officer. Officers A and C indicated to us that they were aware of the arrangement and that Officer A was agreeable to it.

111. Officer A was present for some of the time Officer C entered the information into the ECM, going in and out at times. He was positioned about two metres away from the computer screen Officer C was working on and stood next to him at times. Officer C recalls Officer A was completing something on his phone and working on other paperwork, while Officer C was processing Mr Ball. This indicates Officer A was not concentrating solely on Mr Ball's evaluation.

[13] See paragraph 159 regarding Field Training Officers.
[14] At the time of this incident, Officer C had actually been a probationary officer for four months.

112. Officer A says Officer C "*didn't really ask any questions*" of him and did not demonstrate any uncertainty while completing the custody module. He told us he "*wasn't really taking any notice of the screen"* and could not remember what was displayed on it. We cannot reconcile what Officer A told us with the CCTV footage. As discussed in paragraph 83, CCTV shows Officer A discussing Mr Ball's level of consciousness and the corresponding pop-up alert with Officer C, while looking at the computer screen.

113. Officer A should have ensured Officer C followed the instructions on screen and arranged for Mr Ball to be taken to hospital. As recorded on CCTV, Officer C's suggestion of an assessment of 'unresponsive' was instead downgraded to 'partially responsive' during the course of their discussion. The officers made a wrong decision in downgrading Mr Ball; one that did not equate with the known facts.

114. Officer E was aware of the situation and of Mr Ball's condition. Ultimately, it was her responsibility to ensure Mr Ball was accurately assessed and that staff complied with policy, arranging for Mr Ball to be taken to hospital.

Was Mr Ball properly monitored?

Was Mr Ball placed on the correct monitoring regime?

115. Mr Ball was assessed as being in need of 'frequent monitoring'. All of the officers present while Mr Ball was in custody say they were satisfied this was an appropriate monitoring regime.

116. Policy currently says: "*All detainees must be considered to be 'at risk' until an evaluation takes place"* and that those with signs they may be at risk of suicide must be constantly monitored. We believe Police policy should include that any detainee who is physically incapable of answering questions, such as Mr Ball was, should also be placed on constant monitoring.

117. Policy says when a detainee is classed as being in need of 'frequent monitoring', they must be checked at least five times an hour, at irregular intervals. If they are in need of 'constant monitoring', they must be observed "*without interruption*".

118. There is conflicting information on the ECM evaluation. In the 'level of consciousness' section, Officer C has written: "*Allen is snoring in the cell with constant monitoring. Was also placed in recovery position in cell on floor."* However, the monitoring regime has: "*In need of care and frequent monitoring*". Officer C was not able to recall his thinking around this.

119. CCTV audio records the following conversation which shows Officer C was conscious of Mr Ball's condition but ignored the seriousness of it, on Officer A's advice:

> Officer C: "*Health conditions. I might go change that needed care of frequent monitoring I've got a constant monitoring put in place."*
>
> Officer A: "*Haah (Inaudible) cover off that he's very, very 1K* [intoxicated]…
>
> *… yeah drunk detox. Yeah I think frequent would be enough that's definitely 5/10 minutes anyway so."*

120. A short time later, Officer C can be heard telling the observer:

> *"We… might get a little bit crucified for the fact that I haven't put him on constant monitoring because of the level of consciousness of level of umm drink I guess but he's making kind of all the right noises. If he spewed then we can change it up, change it to constant monitoring but at this stage (inaudible) stuff (inaudible) … that's him in cell one frequent monitoring."*

121. This attitude is consistent throughout the incident. Officers made flippant comments and took a 'wait and see' approach, rather than a pro-active one.

122. Officer E says she was about to be dispatched to another job when Officer C came in with *"four or five pages"* from the custody module for her to review and approve. She recalls Officer C telling her Mr Ball was responding to fingernail stimuli, however, none of the officers recall using fingernail stimuli. The ECM printout shown to Officer E would have included the standard wording: *"Partially responsive – responds to pain (e.g. nail bed pressure)."* It is possible that this caused Officer E to assume this was the pain compliance test that had been performed.

123. Officer E says she saw Mr Ball was assessed as being in need of 'frequent monitoring' and agreed with this based on her own assessment of him. She did not see that the custody sheet said he was snoring in the cell with *constant monitoring*. Officer E says she accepted what she was told verbally and did not read all the paperwork before signing it.

124. Officer E had overall responsibility for the care of Mr Ball and accepted the judgement of an inexperienced officer, despite also having herself seen Mr Ball in his unresponsive state. Officer E should have been more thorough in reading the custody papers before signing them and should have challenged Officer C's decision.

125. Notwithstanding the fact that he should have been taken to hospital, Mr Ball needed to be constantly monitored due to his earlier comment threatening to self-harm and his unresponsiveness. His inability to answer the evaluation questions himself was another indicator of this. 'Frequently monitored' was the incorrect regime for Mr Ball.

Did officers check Mr Ball five times an hour, in accordance with the frequent monitoring regime?

126. Although all checks should be recorded in the ECM, some were not. According to the ECM printout and the CCTV footage, the following checks were conducted after Mr Ball was placed in his cell at 12.13am:

Time	Source of evidence	Check conducted by	Officer's actions	Mr Ball's Condition
12.15am	Record in ECM	Officer C	Went into cell. Officer C's cell phone drops onto Mr Ball's head.	*"Snoring"*
12.21am	CCTV	Officer A	Shortly after the 'partially responsive' alert pops up. Looks briefly from cell	

			door. Officer F then stands and watches Mr Ball for about 18 seconds.	
12.35am	Record in ECM	Officer C	Officers do not leave the custody counter to check on Mr Ball.	*"Snoring, chest moving"*
12.41am	CCTV	Officer E	Officer E stands at cell door and uses her foot to move Mr Ball's foot, holding it for about 8 seconds.	No response evident on CCTV.
12.43am	Record in ECM	Officer C	(Record based on Officer E's check above).	*"Still snoring in cell. Pinched feet no response"*
12.55am	Record in ECM	Officer E	Officer E is not present for this check; however, Officer C is seen to conduct check below.	*"Still snoring, laying in the recovery position on the floor"*
12.56am	CCTV	Officer C	Stands at cell door and kicks Mr Ball's foot four times.	No response evident on CCTV.
1.03am	Record in ECM	Officer D	No check conducted.	"*Still snoring"*
1.05am	CCTV	Officer E	Watches from cell doorway for slightly over 1 minute.	
1.06am	Record in ECM	Officer C	(Most likely based on Officer E's check above)	*"Snoring"*
1.18am	CCTV	Officer C	Enters cell and leans over Mr Ball, appearing to touch his head. Goes to computer, but no record in ECM.	
1.21am	CCTV	Officer E	Stands at cell door and calls Mr Ball's name. Nudges his foot. Asks if he wants water. Officer C is at the computer but no record in ECM.	No response evident on CCTV.
1.23am	CCTV	Officer A	Walks across hallway behind vacant charge room and asks: "*Is he still alive?"*	
1.35am	CCTV	Officer E	Enters charge room, glances at desk, then leaves. Does not go to Mr Ball.	
1.36am	Record in ECM	Officer C	No check conducted.	*"Snoring, still on his side in*

				the recovery position"
1.47am	CCTV	Officer C	Stands at cell door and watches for about 8 seconds then enters cell and watches for another 8 seconds. Goes to computer but no record in ECM.	
2.05am	CCTV	Officer A	Stands in cell door and watches Mr Ball for about one minute.	Said he saw his chest rising.
2.35am	CCTV	Officer A	Final check. Leads to officers attempting to resuscitate Mr Ball and calling an ambulance.	

127. The correct number of checks were completed during the first hour that Mr Ball was in the cell, though no officer appeared to go to Mr Ball's cell for the 12.35am check. No checks were recorded in the ECM after 1.36am. Only three checks appear to have been conducted during the second hour, which does not comply with policy.

128. Officer A recalls checking Mr Ball but says he did not enter the checks into the ECM as required because "*sometimes you get distracted".*

129. There do not appear to have been any checks conducted between the following times:

Time	**Length of time where no checks were conducted**
1.21am to 1.47am	26 minutes
1.47am to 2.04am	18 minutes
2.05am to 2.35am	30 minutes

130. The time between these checks was too long. If Mr Ball had been checked between 2.05am and 2.35am, an ambulance may have been called earlier, and potentially lifesaving treatment provided.

Were the checks thorough?

131. Policy requires officers to observe detainees to check their well-being. If they are unable to confirm their well-being by observing them, they must complete a verbal check by attempting to engage in conversation. If there is no response, they must then complete a physical check.

132. Police policy says:

> *"Detainees 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 and Crimes of Torture Act 1989."*

133. A person who cannot be woken should not be kept in a cell. They should be taken to hospital. As Mr Ball remained at the station, at the very least, attempts should have been made to physically rouse him at each check due to his level of intoxication and condition.

134. Considering Officer C said Mr Ball did not respond in any way during the checks he conducted, we asked him what he did to try to get a response from him. Officer C said:

> *"I've given him a bit of a shake on the ground, nothing… to the extent of pain compliance. My main checks were to make sure that he was still breathing and that he hadn't vomited and that he was still sleeping and then the snoring was a sign in my head at that time that he still had a working airway."*

135. A doctor who specialises in drugs and alcohol reviewed the CCTV footage and gave evidence at the trial. He made the following comment regarding Mr Ball's lack of response after having the phone dropped on his head:

> *"He's clearly unconscious because a blow like that, you'd almost expect to see a reflex action. So, so if he's awake, he'd probably say "fuck off" and be really upset that a phone landed on his head. So we know that he's not that level. But even if he was in a rousable state, when you hit someone, you know, your legs do this involuntary twitch and particularly actually if you've lost some of your other controls. But we never see, his legs never move. So, I mean I was unaware that something had hit him because you don't see any activity of his body at all."*

136. Mr Ball remained in the same position throughout his whole time in the cell, and even when he did not respond to his foot being kicked or moved, officers did no further investigations.

137. Officers should have been more thorough in their checks, making more of an effort to rouse Mr Ball.

Overall assessment

138. Detainees are considered vulnerable adults, and Police have a specific legal duty of care towards them. Section 151 of the Crimes Act obligates Police to maintain the health and safety of detainees, providing them with 'necessaries' such as medical treatment.[15]

139. Officers A, D, and E expressed concern about the inadequacy of Police training. They told us the training does not cover everything they need to know about what to look for when detaining someone who is unresponsive.

140. The officers had all received first aid training, where they are taught to seek medical treatment for anyone who appears partially unresponsive or unresponsive.

[15] See paragraphs 192 to 195 for relevant law.

141. We reviewed the training (discussed in Issue 4) that each officer received during their time with the Police. Although we are unable to determine exactly whether their training covered snoring, we believe the training sufficiently prepared officers to be able to:

- conduct their own risk assessment on Mr Ball;
- identify that he was unresponsive; and
- seek help for him, from a medical professional.

142. Police policy provides clear instructions regarding a person's level of responsiveness and the expectation that they organise medical treatment when partially unresponsive or unresponsive. Officers had ready access to this policy and updates about it via the online Police bulletin board and emails.

143. Officers did not organise medical treatment for Mr Ball, regardless of the following factors:

- Mr Ball had threatened to commit suicide;
- Mr Ball rapidly became unresponsive during the trip to the Police station;
- two pop-up alerts were given by the ECM, telling officers to arrange for Mr Ball to be hospitalised;
- Mr Ball was unresponsive during checks; and
- policy gives clear guidance that detainees who are 'partially responsive' or 'unresponsive' require medical care.

144. The hierarchical organisation of Police also ensures officers have someone of a higher rank that can provide advice if they choose to seek it. Officers A and E had an obligation to ensure Officer C completed Mr Ball's assessment accurately.

145. It is concerning that all of the officers believed Mr Ball to merely be intoxicated, and that they were all either ignorant of, or dismissive of policy. When we spoke with Officer E, she admitted she had not read the custody policy in its entirety before.

146. Ultimately, officers are responsible for the decisions they make about the people in their care, regardless of whether they believe the training to be adequate or not. The officers disregarded policy and instructions, making them negligent in their care of Mr Ball, who was reliant on them to provide him with urgent assistance. We conclude:

- Officers A, C and E failed to ensure Mr Ball was accurately assessed and monitored; and
- Officers D and F were aware of Mr Ball's unresponsive condition and that he had not been taken to hospital, so also should have ensured he received medical care.

FINDINGS ON ISSUE 2

Officers A and C should not have ignored the ECM's instructions to arrange for Mr Ball to be taken to hospital.

Mr Ball should have been taken to hospital with the assessment of 'partially responsive'. Failure to do so was a breach of policy.

Mr Ball should have been classed as 'unresponsive' rather than 'partially responsive'. His assessment should have been revisited during his time in custody.

Officers should have given more consideration to Mr Ball's self-harm threat, especially when his condition rapidly deteriorated.

Officer A did not provide sufficient guidance in his role as acting Field Training Officer for Officer C.

Officer E failed to appropriately direct and supervise the officers under her control.

Mr Ball was not placed on the correct monitoring regime. He should have been constantly monitored.

Even under the frequent monitoring regime, officers did not complete the required number of checks.

Conducted checks should have been more thorough.

Officers A, C and E all failed to perform their roles adequately and failed Mr Ball, who was dependent on them for his care.

Officers D and F, who were also aware of Mr Ball's unresponsive condition, failed to perform the obligation they had to arrange medical care for him.

ISSUE 3: DID OFFICERS PROVIDE PROMPT MEDICAL ASSISTANCE WHEN MR BALL WAS FOUND UNRESPONSIVE IN HIS CELL?

147. Officer A conducted the final check at 2.35am. He stood at the cell doorway and watched Mr Ball for 10 seconds, then nudged his foot. He noticed Mr Ball's chest area was not rising and falling, which is *"a sign to check when people are in our care"*. Officer A watched for another 18 seconds as he thought it could be due to the position Mr Ball was lying in. There was no distinct breathing, and his snoring had stopped. He went into the cell and watched Mr Ball for another 1 minute and 10 seconds, while leaning over him and saying his name. Officer D came in around this time. Officer A could feel a faint pulse in Mr Ball's wrist and could not locate a pulse in Mr Ball's neck.

148. Officer C arrived 2 minutes after Officer A began the check. Within 40 seconds of his arrival, Officer C gave the instruction to call an ambulance. He then immediately retrieved the Automated External Defibrillator (AED) and connected it to Mr Ball. The AED gave the direction to start CPR within 2 minutes. Officer C performed CPR on Mr Ball until the paramedics arrived, 7 minutes after they were called.

149. Officer D requested an ambulance through the Police Northern Communications Centre while Officer B rang Ms Y to see if she was aware if Mr Ball had taken any drugs. Ms Y did not know.

150. During their first aid training, officers are taught that the sooner a person can be defibrillated, the better chance they have of surviving. The training manual states: *"For every minute of delay in receiving a defibrillating shock, a person's chance of surviving the event decreases by 10%."* All of the officers involved in Mr Ball's detainment were up-to-date with their first aid training.

151. Mr Ball was observed for about 2 minutes and 40 seconds before the decision was made to call the ambulance. Although Officer C acted swiftly to retrieve the AED, the delay in assessing Mr Ball meant it was about 4 minutes and 40 seconds from when Officer A first found Mr Ball had deteriorated, until CPR began.

152. We accept the officers were in a high-pressured situation, however, it took too long for them to call the ambulance and retrieve the AED.

FINDING ON ISSUE 3

Officers should have been quicker to call an ambulance and retrieve the AED when they found Mr Ball's physical condition to have deteriorated.

ISSUE 4: DO POLICE PROVIDE ADEQUATE TRAINING FOR OFFICERS INVOLVED IN DETAINING PEOPLE IN CUSTODY UNITS WHERE THERE ARE NO DEDICATED CUSTODY OFFICERS?

What training do Police provide?

153. The Health and Safety Act 2015 places responsibility on the employer and the employee to ensure workplaces are safe.[16] Police are obligated under the Act to ensure sufficient training is provided to staff.

154. Police policy is designed to ensure their legal duties are fulfilled. It specifically addresses the health and safety of people in their care, and staff are obliged to adhere to it.

155. In the smaller custody units, such as Hāwera, there are a significant number of officers performing custodial duties who have not received any induction training and have little or no previous experience working in a custody unit. In addition to not having custodial management experience, many of these staff are new officers with limited operational experience.

What custodial management training is provided to sworn staff?[17]

Recruit foundation training

156. Police recruits are currently trained in the management of arrested and detained people during a four-hour, face-to-face, 'Custodial Management and Health Risks Awareness' (CMHRA) tutorial while at the Royal New Zealand Police College (RNZPC).

[16] See paragraphs 188 to 191 for relevant law.
[17] Formal training is provided for non-sworn officers who work in a dedicated role within a custody environment (Authorised Officers) in the way of a full time, three-week course at the RNZPC.

157. Recruits are expected to learn how to:

- perform the appropriate actions for managing people in custody according to policy;
- recognise the warning signs that a person is at risk and in need of care, and incorporate this in the Health and Safety Plan they develop for the detainee; and
- identify what risk assessment information to record and handover to another agency, individual, or family member.

158. During the tutorial, recruits are referred to the 'People in Police Detention' policy and relevant law. They work through custodial scenarios and can use a range of risk assessment checklists to help identify risks posed by detainees. They are also shown how to complete a custody evaluation and plan. A PowerPoint presentation containing relevant information is used throughout the tutorial, and recruits are provided with a reference book to keep.

159. When officers graduate from Police College, they become probationary officers for two years. During this time, they receive on-the-job training from other officers (Field Training Officers) and supervisors. The quality of on-the-job training is reliant on the understanding and experience of the Field Training Officer or supervisor and their ability to impart the correct knowledge.

Online refresher course

160. After their initial training, all officers are required to complete an online custodial management refresher course every two years. This specifically addresses suicide prevention and health risk awareness.

161. The online refresher course takes between 15 to 30 minutes to complete. A note tells the officers they will need to refer to the Police instructions (policy) during the training. The assessment comprises 20 questions and participants must achieve 100% to pass. If they get any questions incorrect, they are prompted to retry those particular questions until they achieve 100%.

162. Officers are given a scenario regarding an intoxicated detainee with a history of mental health issues who is threatening to self-harm and has a cut to his forehead.[18] The officers are asked to consider what decisions they should make regarding his care in custody.

163. The course includes material such as what to consider when completing a risk assessment, what the four levels of consciousness are, determining an appropriate monitoring regime, and the expectations around conducting checks.

164. Officers told us this refresher course is often done during a night shift and that there is a tendency to skip through the tutorial and just answer the assessment questions.

[18] This scenario has been used in training since 2017.

165. Essentially, officers who are not dedicated custody staff, receive between 15 to 30 minutes every two years of focused custodial management training. Supervisors and districts may choose to provide their own custodial training, at their discretion.

First aid training

166. Triple One Care Limited provide Police with a New Zealand Qualifications Authority (NZQA) qualification first aid course. Recruits receive the foundational course while at Police College and every Police officer is required to complete a face-to-face refresher course every two years. The first aid training aligns with the 'People in Police Detention' policy. The eight-hour courses consist of theory and attendees participate in practical, Police-specific scenarios. Officers must complete written assessments and demonstrate they are competent in CPR and providing first aid.

Notification of changes to policy

167. When there is a new policy or a policy is changed, it is advertised on the online bulletin board, Panui, and the Ten One Police magazine. It is also emailed to relevant managers for them to alert their staff to the change. On average, there are a total of 538 'hits' on Panui/Ten One articles that relate to policy, despite there being about 10,000 Police staff. Police need to continue to look for ways to ensure staff receive information about new policies and policy updates.

Authority view

168. As stated above, we believe the officers caring for Mr Ball failed in their duty of care. However, Mr Ball's death while in custody has also highlighted, as have previous cases,[19] that there are inadequacies in Police training regarding custodial management. For example, none of the officers involved in caring for Mr Ball had adequate knowledge of the 'People in Police Detention' policy.

169. Detainees are reliant on officers to provide them with care while they are in custody. They are often in a high-risk, vulnerable position and Police staff are the only people available to assist them. Therefore, Police need to ensure frontline staff are adequately trained in order to perform the role in a custody unit where there is no dedicated custody staff. There are many complexities and factors to consider when managing people in custody which cannot be adequately covered in the short time currently allotted to training.

170. The current manner of online delivery is also inadequate. Face-to-face custodial management training is needed to allow facilitators to assess the needs and understanding of officers and to discuss and address any issues.

[19] IPCA case references 12-0167, 10-1812, 08-0880. Recommendations regarding training were also included in the Thematic Report: 'Death in Custody – a Ten year Review', released in 2012.

171. Although on-the-job training is an effective way to support and teach officers in the first two years with Police, it is reliant on the person teaching the probationary officer having a good understanding of correct practice that aligns with policy.

172. Police, as an organisation, need to:

- ensure all staff have a sound knowledge of the 'People in Police Detention' policy;[20]
- monitor and ensure staff compliance with the 'People in Police Detention' policy;
- train staff more effectively in evaluating and caring for people in custody; and
- continue to look for ways to ensure information about new policies and policy updates is received and understood by staff.

Previous IPCA recommendations to Police

173. Since 2011, we have made four recommendations to Police regarding the training of staff who deal with people in custody.[21] Police accepted these recommendations in 2015 and 2016. The focus of these recommendations has been on non-sworn Authorised Officers who work in dedicated custody roles in Police custody units.

174. We have monitored actions taken by Police to address the recommendations. In consultation with us, Police have developed a national training module on watch-house (custodial unit) duties. This was initially developed in 2015 and has evolved with ongoing review by both Police and us. The most recent iteration of this module was launched in August 2020. Notwithstanding these developments, the deficiencies in training are highlighted by the fact the officers included in this report have not yet seen this. We will continue to monitor this recommendation to confirm its full implementation.

175. Police have made a significant attempt to action the 2015 recommendation:

> *"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).*

176. One of the roles of the Authority is to be a National Preventative Mechanism. It is our responsibility to monitor the conditions and treatment of people in Police custody units to ensure human rights standards are being met. In this capacity, we have also highlighted to Police the need for more suitable training in custodial management.

[20] The name of the policy has since changed to 'People in Police Custody'.
[21] See paragraph 210 for the other three previous IPCA recommendations.

FINDING ON ISSUE 4

Police need to continue to develop and ensure delivery of appropriate training for officers involved in detaining people in custody units where there are no dedicated custody officers.

Subsequent Police Action

177. In June 2020, Police launched the Custody Enhancement Programme (CEP), which reviewed all deaths in custody. They have created a quality assurance system and have renewed equipment. They have made significant changes to the ECM, making it more user-friendly. The CEP is also looking to establish a Custody Governance Model, with a new national team looking at frontline capability and support for the establishment and training of district custody co-ordinators.

178. In May 2019, Police also updated the policy regarding people in Police custody. Of note, from the outset, officers are reminded that "*NZ Police have a primary duty of care of its workers and others affected by our work"* and that failure to comply with the 'People in Police Custody' policy may result in Police employees being subject to enforcement under the Health and Safety at Work Act 2015.

Training

179. Police have informed us that the Central Police District (which includes Hāwera) has a comprehensive custody training and induction package for staff working in custody. This was created in September 2020 and disseminated across the district to the area custody leads. It consists of a reference document that links electronically to the relevant Police custody policy and various other websites that directly relate to custody.

180. The purpose of this was to ensure that all staff working in custody, whether that be in their 'overnight' custody stations or in their smaller 'holding' custody areas, all had a reference document to refer to. Staff are now made familiar with the document during their induction into custody roles and are encouraged to use the document as a refresher when required. Along with this, an induction form was created so that all staff working in custody were suitably inducted. There is an expectation that all staff working in custody, whether that be those who process detainees at smaller stations or long-term custody staff, are inducted to that particular custody area and that there is a record of that. The Authority will be monitoring this.

181. The CEP is in the process of creating a national custody training package, but until this occurs, Police will continue using the district reference document. It is believed that Central District will be assisting the CEP in piloting the training package once it has been drafted.

Audio recording capability

182. Within a week of discovering the CCTV footage from Hāwera Police Station had audio (March 2020), there was a national directive to urgently review all custody CCTV cameras to ensure the audio capability was disabled. The reason given was: *"this is not the intent of our CCTV capability and clearly it is illegal (interception of private conversations)".* However, it is legal to have audio capability in custody areas, providing there is clear signage telling people in that area an audio recording is being made.

183. We are disappointed that Police took this action when it would have taken little effort to exhibit basic signage.

184. We are extremely concerned that custody areas in Police stations do not have audio capability enabled. In the case of Mr Ball's death, the audio played a significant part in establishing the facts of what had occurred that night. If the only information available was what appeared to be happening based on visual footage and what the officers said to Police and to us, vital facts would have been missed. The discussion officers had around the pop-up alerts, Mr Ball's level of consciousness, and comments regarding his intoxicated state, enabled a fuller and more accurate 'picture' to be established. We believe audio capability provides some assurance that interactions between offenders and Police officers are transparent.

ECM pop-up alerts

185. When an officer is completing a custody evaluation, the pop-up alert has changed regarding the level of consciousness. If either the 'partially responsive' or 'unresponsive' option is recorded, the custody record now locks. The pop-up message says:

> *"Due to the detainee's level of consciousness this custody record is locked. Contact a supervisor to approve action taken and unlock the custody record. If you have Supervisor approval at this time, select [Yes] to unlock the custody record, otherwise select [no]."*

The screen remains locked until a supervisor enters their identification. This ensures the supervisor is made aware of the condition of a detainee.

186. A custody record now also locks when the system recommends 'in need of care and constant monitoring' or 'in need of care and frequent monitoring'. As above, a supervisor is required to approve the action taken and unlock the custody record.

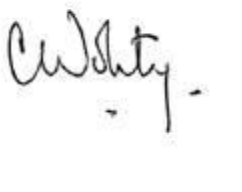
Recommendations

187. The Authority recommends that Police:

1) provide all officers who work in custody units with the same level of training that is currently provided to Authorised Officers;

2) enable audio recording in the receiving-counter areas of all custody units; and

3) update their 'People in Police Custody' policy to instruct officers to place a detainee on constant monitoring if they are physically unable to answer evaluation questions.



Judge Colin Doherty

Chair
Independent Police Conduct Authority

16 December 2021

IPCA: 18-2775

Appendix – Laws and Policies

LAW

Health and Safety Act 2015

188. Under section 36 of the Health and Safety at Work Act 2015, a person conducting a business or undertaking (PCBU) must ensure: "*so far as is reasonably practicable, that the health and safety of other persons is not put at risk from work carried out as part of the conduct of the business or undertaking."*

189. A PCBU must ensure staff receive "*information, training, instruction, or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking".*

190. Section 45 instructs workers to take reasonable care that their actions or omissions do not have an adverse effect on the health and safety of other people. They must adhere to the policies, procedures and instructions of the PCBU.

191. Under section 47, a person commits an offence if they are "*reckless as to the risk to an individual of death or serious injury or serious illness*".

Crimes Act 1961

192. Section 151 of the Crimes Act 1961 states that everyone with *"actual care or charge"* of a vulnerable adult, who is unable to provide himself or herself with *"necessaries"* is under a legal duty to provide that person with necessaries, and to take reasonable steps to protect that person from injury.

193. 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."* All detainees are, therefore, vulnerable people under the Act. The Act also defines 'necessaries' as the basic requirements of life, such as food, water and adequate warmth.

194. Failing to fulfil this duty may be sufficient for criminal liability where there is a resulting death or injury, or where there is a risk of harm, by way of criminal nuisance, manslaughter, injuring (where, if death had occurred, there would be liability for manslaughter), or ill-treatment of a vulnerable adult.

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

'People in Police Detention' policy

196. Policy says:

> *"Police employees are responsible for the safety of themselves and others, and also the care and security of everyone detained including at scenes, during transport, within Police stations and cells at courts."*

197. Police are responsible for the care, safety and security of a person from the moment they are arrested or detained, until they are released or transferred into the care of another agency, individual, or family member.

198. Officers must consider detainees to be 'at risk' until an evaluation takes place, with those with signs of suicide risk being constantly monitored. Those without signs of suicide risk must be frequently monitored. *"If the detainee is unable to be evaluated for any reason, then this monitoring regime remains until the evaluation is completed in its entirety."*

Monitoring

199. Detainees should be monitored, with checks being in accordance with their risk evaluation:

- If they require no specific care, they must be checked at least every two hours.
- If they require frequent monitoring, they must be checked at least 5 times per hour, at irregular intervals; and
- If they require constant monitoring, they must be directly observed without interruption.

200. The level of monitoring can be increased at any time but can only be reduced on the advice of a health professional.

201. There are three types of checks that can be carried out:

- Observation - Observe through a cell view port. If their well-being cannot be confirmed, conduct a verbal check.
- Verbal check - Verbally rouse the detainee. If well-being cannot be established, and if there is no response, conduct a physical check.
- Physical check

202. It is not sufficient to use CCTV to carry out checks.

203. Detainees should only be physically roused if their risk assessment *"indicates they need specific care, are intoxicated, or exhibit any risk identifiers".*

Level of consciousness

204. Officers must always consider the detainee's level of consciousness. *"Immediate hospitalisation is required if they are unresponsive – this is a medical emergency. Detainees who are only partially responsive, should also be taken to hospital."*

205. When specifically dealing with detainees who may be affected by drugs, alcohol, or medical complications, if the person is:

- *"Alert - able to engage in a coherent conversation ... THEN - Follow the procedures for custody area staff.*
- *Drowsy or confused - responds to voice and able to reply. May need some assistance to walk ... THEN - Follow the procedures for custody area staff. Be aware that the level of consciousness may change over time due to intoxication or medical complications.*
- *Partially responsive - responds to pain only (e.g. nail-bed pressure) ... THEN - Treat this as a medical emergency and arrange for the person to be taken to hospital.*
- *Unresponsive - does not respond to any stimuli ... THEN - This is a medical emergency and immediate hospitalisation is required. If you expect a delay in the ambulance's arrival or the person's condition calls for immediate action, use a Police vehicle."*

206. Policy advises that employees need to be aware of the risks posed by the mixture of alcohol, drugs and current or pre-existing medical issues.

> *"Intoxication can mask underlying medical conditions which can go undetected when custody personnel assume the person just needs to 'sober up'." Note: Loud snoring is a sign the person is deeply unconscious."*

Roles and responsibilities

207. The arresting or detaining officer is responsible for the detainee until they are handed over to custody area staff. They remain responsible until the detainee is formally processed and evaluated in the Electronic Custody Module (ECM), unless they transfer responsibility to another officer, agency or person. The arresting or detaining officer must:

- carry out an initial risk assessment;
- advise the detainee of their rights, asking them to read and sign the 'Notice to person in Custody' form;
- search the detainee;

- conduct a check in the Police database (NIA) as soon as possible, taking note of any flags that may be relevant to the detainee's safe custody or risks.[22] Pass this information on to anyone receiving the detainee.
- advise receiving custody area staff of the reason the person is in being detained, whether they can be bailed or released, and of any special care needed;
- ensure risk information and special care instructions are recorded in the ECM; and
- help the custody staff place the detainee safely in a cell.

208. The responsibilities of custody officers include, they must:

- enter the detainee's details and complete the ECM evaluation as soon as possible;
- ensure risk information and special care instructions are recorded in the ECM;
- ensure the detainee is entered into the ECM and a full risk evaluation is carried out as soon as practical;
- evaluate and classify the detainee as:
    - being not in need of specific care;
    - needing care and frequent monitoring; or
    - needing care and constant monitoring
- monitor and maintain the checks of the detainee, according to their evaluation, remembering that the detainee's status may change and require re-evaluating;
- consider the level of consciousness in all cases, and whether the person should be transferred to a health facility; and
- call a health professional for advice or assistance, if a detainee has been injured, asks to see a doctor, or if the custody officer thinks it is necessary.

209. If a detainee dies while in custody, Police must immediately freeze the scene and ensure all the evidence is preserved, including CCTV footage and custody documentation.

[22] The National Intelligence Application (NIA) is a Police database which holds information about individuals who have come into contact with Police.

PREVIOUS RECOMMENDATIONS

210. As well as the mentioned 2015 recommendation, the Authority has previously made the following recommendations to Police:

- 2012 - Continue developing a national training module to meet the requirements of employees assigned to duties in the watch house, with particular emphasis on responsibilities for the evaluation of risk and care and protection of persons in custody.
- 2011 - 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.
- 2013 - That custody officers receive training relating to the duties, responsibilities and authority attached to their role. This training should encompass the Children, Young Persons and their Families Act 1989 and the relevant Police Manual chapter on Youth Justice.

About the Authority

WHO IS THE INDEPENDENT POLICE CONDUCT AUTHORITY?

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

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

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

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

WHAT ARE THE AUTHORITY'S FUNCTIONS?

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

- receives complaints alleging misconduct or neglect of duty by Police, or complaints about Police practices, policies and procedures affecting the complainant in a personal capacity;
- investigates, where there are reasonable grounds in the public interest, incidents in which Police actions have caused or appear to have caused death or serious bodily harm.

On completion of an investigation, the Authority must form an opinion about the Police conduct, policy, practice or procedure which was the subject of the complaint. The Authority may make recommendations to the Commissioner.

THIS REPORT

This report is the result of the work of a multi-disciplinary team of investigators, report writers and managers. At significant points in the investigation itself and in the preparation of the report, the Authority conducted audits of both process and content.

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