OFFICE OF THE INSPECTORATE
Te Tari Tirohia

Special Investigation

Report of investigation into a use of force incident at Christchurch Justice and Emergency Services Precinct on 25 November 2019

DEPARTMENT OF CORRECTIONS
ARA POUTAMA AOTEAROA

OFFICE OF THE INSPECTORATE
Te Tari Tirohia

November 2020

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Te Tari Tirohia

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Executive summary

On 24 November 2019, Prisoner A was arrested by Police and spent the night in the Christchurch Justice and Emergency Services Precinct custody suite. Following a Court appearance the next day, he was remanded in custody and due to be transported to Christchurch Men's Prison.

On 25 November 2019, Prisoner A was involved in an incident where he assaulted Police staff.

In the late afternoon that day, he was subject to use of force by Police and Corrections staff to remove him from his cell as he was non-compliant. Police staff used a shield and cable ties and Corrections staff used a waist restraint to secure Prisoner A.

During this incident Prisoner A briefly lost consciousness and received first aid before being taken to hospital. While unconscious, on the floor of the custody suite, his lower body was exposed.

The Inspectorate was notified of the incident by the Prison Director on 26 November 2019 and decided to carry out a special investigation after viewing CCTV footage.

We have made findings and recommendations, which are contained in this report.

The Independent Police Conduct Authority (IPCA) is also carrying out an investigation.

Rochelle Halligan
Tracy Tyro
Inspectors of Corrections

Fiona Irving
Principal Clinical Inspector

Methodology

1. We investigated the circumstances surrounding the transfer of Prisoner A from New Zealand Police ("Police") custody to Department of Corrections ("Corrections") custody. The Terms of Reference for the investigation were approved by the Chief Inspector of Corrections.[1]
2. We interviewed:
    - Corrections Officer A, who assisted in the use of force
    - Corrections Officer B, who assisted in the use of force
    - Senior Corrections Officer, who assisted in the use of force
3. We reviewed:
    - emails relating to the incident
    - incident reports
    - use of force documentation
    - CCTV footage from the Christchurch Justice and Emergency Service Precinct ("the Precinct") custody suite
    - Relevant sections of the Prison Operations Manual (POM)
    - Corrections Health and Safety Policy
    - Corrections Tactical Options Manual of Guidance 2018
    - Precinct Custody Suite Operations Plan, Version 4-2, 21 August 2017
4. We visited the Precinct custody suite.
5. We consulted the Independent Police Conduct Authority (IPCA).
6. Due to Prisoner A's ongoing mental health issues, this investigation did not speak to him.

[1] The Terms of Reference are included in Appendix A.

Background

7. Prisoner A is known to both Police and Corrections. He has a significant history of mental health illness, substance abuse and self-harm, and was supported by mental health services in the community. He is a large, tall man.
8. On 24 November 2019, Prisoner A was arrested by Police and spent the night in the Precinct custody suite. Following a Court appearance the next day, he was remanded in custody and was due to be transported to Christchurch Men's Prison.
9. On 25 November he was involved in an incident in the custody suite.
10. On 26 November, Prison Director Jo Harrex of Christchurch Men's Prison emailed the Inspectorate to advise that a "*serious incident*" had occurred at the custody suite. The email noted that three Corrections staff and three Police were involved in restraining Prisoner A, who "*lost consciousness and briefly stopped breathing*".
11. After CCTV footage of the incident was reviewed, the Inspectorate decided to carry out a special investigation.
12. Chief Inspector Janis Adair contacted the Independent Police Conduct Authority (IPCA) to inquire if that organisation was investigating the incident.
13. The IPCA is conducting an investigation into the incident, from Prisoner A's arrest on 24 November 2019 to the use of force incident on 25 November 2019.
14. Copies of transcripts from interviews conducted by the Inspectorate with the Corrections staff were provided to the IPCA on request.

The incident

15. On 25 November 2019, Prisoner A was involved in an incident with Police in the custody suite, where he attempted to assault a police officer and kicked another police officer in the head while being restrained.
16. Prisoner A was placed in an observation cell and put in a stitch gown for his own safety. He smeared faeces and urine around the cell and was subsequently moved to another observation cell.
17. Corrections Officers A and B and the Senior Corrections Officer, who had been involved in a different incident in a Precinct court room, returned to the custody suite. They were advised by Police staff that Prisoner A would join the Corrections escort to Christchurch Men's Prison. Police advised that Prisoner A had presented with challenging behaviour in the cell.
18. Police and Corrections staff were concerned about Prisoner A's level of compliance, due to the earlier incident and the fact Prisoner A was making punching actions in his cell (described by Officer A in interview as "*shadow punching*").
19. Three Police and the three Corrections staff were involved in the attempt to relocate Prisoner A from his cell to the transport vehicle.
20. At around 4.14pm, Corrections staff talked with Prisoner A via the flap in the cell door. He was asked to wash his hands (as they were covered in faeces) to prepare for movement to the Corrections vehicle for transportation to the prison.
21. After washing his hands, Prisoner A was directed to go to the back of the cell. He complied with the direction. He then knelt facing the rear wall. The cell door was unlocked by the Senior Corrections Officer. As the door was opened, Prisoner A began to stand, so the door was closed again.
22. CCTV footage showed that as the door was opened again and staff entered the cell, Prisoner A made a small movement towards them so the Police Authorised Officer (AO) moved in front of the other staff and used a shield to push Prisoner A into the corner of the cell. Once in the corner, Police and Corrections staff attempted to gain control of Prisoner A's arms. Prisoner A was resisting.
23. The Police AO continued to use the shield against Prisoner A's body. At times it appeared to be close to his neck area, but was used primarily against his torso. At one point, Prisoner A pulled the hair of the Police AO who was pushing on the shield.
24. Attempts by staff to gain control of Prisoner A's arms were obstructed by the shield. Corrections Officer A had the waist restraint ready to be applied.
25. After approximately two minutes, a Police Officer secured a handcuff to Prisoner A's right wrist.
26. Prisoner A was pulled from the corner of the cell, moved across the cell and taken to the ground lying on his stomach.
27. Corrections Officer A attempted to place the waist restraint under him as he went to the ground. The Senior Corrections Officer fell awkwardly and ended up lying under Prisoner A, while two staff were above and to the side of Prisoner A. After about a minute, the Senior Corrections Officer was able to move himself.
28. Corrections staff secured the waist restraint on Prisoner A and the Police AO placed cable ties around Prisoner A's feet.
29. It could not be confirmed by CCTV if Prisoner A was still providing resistance at this time.
30. Corrections Officer B said at interview that he held Prisoner A's head to stop him hitting his face on the concrete and to enable him to breathe. He turned Prisoner A's head to ensure he did not swallow his tongue. Officer B also noticed that Prisoner A had urinated.

31. At around 4.22pm, a staff member[2] noticed that Prisoner A had changed colour. In interview, Corrections Officer A said a Police Officer had said Prisoner A had '*gone blue in the lips*'. Corrections staff reported (in interviews and in their incident reports) that Prisoner A appeared to be struggling to breathe.
32. Prisoner A was pulled out of the cell to the corridor and rolled over onto his back where another Police AO immediately began to administer first aid by attaching a manual resuscitator/Ambu bag.
33. Corrections Officer A unbuckled the waist restraint and a Police AO used a pair of scissors to cut down the front of the stitch gown to provide access to Prisoner A's chest area. Once cut, the gown was opened exposing Prisoner A's naked body.
34. A mental health nurse, who works in the custody suite, provided assistance and went to the staff base, returning with a cloth. In the meantime, a small cloth was thrown from the staff base and was used to wipe Prisoner A's chest and stomach area.
35. A Police Officer pulled the unbuckled waist restraint from under Prisoner A and removed the handcuff from his right wrist.
36. At around 4.27pm, St John Ambulance staff arrived at the custody suite and attended to Prisoner A.
37. Prisoner A remained lying on the floor with his body exposed. He was occasionally moving his head from side to side, but for the most part was still.
38. St John Ambulance staff brought a stretcher into the corridor and preparations were made to move Prisoner A. His body remained exposed until he was placed onto the stretcher at around 4.40pm. He was then covered with a sheet and secured on the stretcher.
39. At around 4.42pm, Prisoner A was escorted by Police staff from the custody suite to Christchurch Hospital for further assessment.
40. At around 7.30pm, Police staff escorted Prisoner A to Christchurch Men's Prison where he was placed in the Intervention and Support Unit on observations not exceeding 15 minutes.

[2] This investigation was unable to establish if it was Police or Corrections staff who first noticed that Prisoner A had changed colour.

Review of responsibilities of Corrections staff working in the custody suite as they relate to the management and care of prisoners being transferred into Corrections care

41. Police and Corrections work together to manage the custody of prisoners in Christchurch Justice and Emergency Services Precinct.

42. Police have overall oversight of the custody suite. The Custody Suite Operations Plan states:

> "*The Custody Suite will be primarily managed by Police. There will be functions carried out within the facility that will be the responsibility of Corrections. This will see a blended model of management with Police maintaining the lead role in the watch house, and court escorting functions.*"[3]

43. While in the custody suite, persons in Police custody are overseen by Police staff and persons in Corrections custody are overseen by Corrections staff. Both Police and Corrections have a role in the transportation of prisoners to a prison, and work together to ensure transportation is carried out efficiently.

44. However, in this case, there was clearly uncertainty for Corrections staff about which agency had the lead responsibility for the prisoner.

45. The Senior Corrections Officer, when asked at interview who had control over the whole situation, said: "*I like to say I did but I didn't.*"

46. Corrections Officer A, when asked at interview whose custody Prisoner A was in at the time, replied "*Oh, the Police as he was an arrest from the floor what they call it. He'd been remanded to the prison and this is why the Police were saying basically he's our [Corrections] prisoner, we've got to do it and [the Senior Corrections Officer] was saying 'no no he's yours, you deal with him'.*"

47. The Senior Corrections Officer stated at interview that the incident had been discussed with '*the Senior at the Police station*' to ensure this type of incident did not occur again. He said they had discussed using pepper spray and formulating a plan to move forward and work together better.

[3] Custody Suite Operations Plan, Version 4-2, page 7.

Review and assess what information was known to inform the decision to relocate Prisoner A from his cell to the transport vehicle

48. Corrections staff understood that the custody of prisoners is transferred from Police to Corrections once the Police transportation documentation is signed by Corrections staff. This would normally occur prior to Corrections placing a prisoner into a vehicle.

49. The Senior Corrections Officer said in interview that, due to the earlier incident in court, he had not signed the transportation documentation. He said this was unusual as the documentation would normally be completed prior to moving prisoners to the vehicle to avoid delays once the vehicle was loaded.

50. At interview, Officers A and B said they assumed that the transportation documentation had been signed.

51. Corrections Officer B and the Senior Corrections Officer both said in interview that if a similar situation with a non-compliant prisoner in a cell occurred at a prison, the prisoner would be kept in the cell if there was no immediate threat or need to move him at that time. Time would be taken to formulate a plan and staff would be properly equipped prior to entering the cell.

Review the decision to relocate Prisoner A and comment on whether other options may have been open to staff in the presenting circumstances

52. There was no formal discussion between Police and Corrections to formulate a plan for the removal of Prisoner A from the cell to his placement in the Corrections vehicle.

53. Correction Officer B said at interview he spoke to the Police Sergeant and asked that pepper spray be considered as an option. He felt if pepper spray was drawn, Prisoner A would likely comply. The Police Sergeant declined, as they did not want a second observation cell to be contaminated.[4]

54. At interview, the Senior Corrections Officer said the Police AO mentioned using the police shield, but the Senior Corrections Officer said he did not support this approach. The Senior Corrections Officer confirmed at interview that he had dealt several times with Prisoner A when he was in a heightened state and felt confident he would be able to enter the cell, along with the other Corrections staff, and place him in handcuffs and a waist restraint without incident.

55. CCTV showed Corrections staff were seen attempting to engage with Prisoner A to test his compliance prior to entering the cell.

56. There appeared to be no operational risk assessment prior to the decision to relocate Prisoner A.[5]

57. There is no evidence that Police and Corrections planned the removal of Prisoner A from the cell (apart from the discussion about pepper spray and the shield) or that other tactical options were considered, such as disengagement or leaving him in the cell until he became more settled.

4 One observation cell was already contaminated due to the smearing of faeces by Prisoner A.
5 Operational risk assessment, TEN-R, Threat, exposure, necessity, response.

Review and assess the actions (including use of force) taken by Corrections staff in relation to the incident

Tactical options

58. Corrections staff do not have the authority to conduct a planned use of force outside the prison environment.

59. The IR.05.Form.03 report on the use of force in this incident recorded that the Police Sergeant authorised Police staff to use force.

60. The use of force was conducted by both Corrections and Police staff.

61. Corrections staff working in the custody suite do not have access to the same equipment they have in a prison. They are not permitted to wear on-body cameras or carry individual use pepper spray while working in the Precinct. Corrections staff are not authorised to use a shield and cable ties in the custody suite.

62. The police shield used during the use of force incident was under control of the Police AO throughout its use.

Post use of force requirements

63. The three Corrections staff confirmed at interview that no formal debrief occurred following the incident. The debrief report,[6] dated 28 November 2019, recorded that the three Corrections Officers were present at a debrief. However, the Senior Corrections Officer did not return to work until two weeks following the incident.

64. The debrief report stated that the Residential Manager said she spoke with Officers A and B a few days later and with the Senior Corrections Officer by telephone.

65. The Senior Corrections Officer stated that no formal debrief occurred with Police but he had a discussion with a Police officer involved with running the custody suite.

66. The report on the use of force[7] was completed by the prison Reception and Movements Manager and dated 29 November 2019, but the use of force was not reviewed by the Principal Corrections Officer until 26 March 2020. The review stated that the use of force was initiated by Police with Corrections supporting and resulted in a medical event.

67. Corrections policy is clear that following a use of force incident, the prisoner should be interviewed within three hours.[8] There is no record that Prisoner A was spoken to, as required. There is no record that Prisoner A was asked if he wanted to make a complaint to Police.

68. The Principal Corrections Officer said, as part of the review, that staff would be interviewed to consider excessive use of force and decency considerations for the prisoner. There is no evidence that these planned staff interviews occurred.

69. The Prison Director signed off the use of force on 30 March 2020. Her comments confirmed that the post use of force interview had not occurred due to Prisoner A coming into prison via the hospital while in Police custody and due to poor information sharing at the time. The Prison Director stated that this was followed up later by the Reception and Movements Manager. The Prison Director also commented that "*it was unclear who the lead agency was in terms of the application of force, however Corrections staff used appropriate and reasonable force proportionate to the circumstances*".

6 IR.05.Form.01. Debrief report.
7 POM IR.05.Form.03 Report on the use of force.
8 POM, IR.05.03 Interview of prisoner.

Incident reports

70. Corrections policy requires that following a use of force incident, reports are to be completed by the end of the shift by each officer involved.[9]

71. Officers A and B completed incident reports on the day of the incident.

72. The Senior Corrections Officer's incident report was entered on his behalf by the Reception and Movements Manager on 6 December 2019.

73. The Senior Corrections Officer said at interview he did not complete the incident report that day as it was late by the time he completed a report related to the earlier incident at the Precinct. He stated that he had planned to complete the incident report for the incident with Prisoner A the following morning. However, he sustained an injury on 25 November 2019 but was not aware of the extent of the injury until the following day and was subsequently off work for two weeks.[10]

74. The incident reports record that Prisoner A refused to comply with instructions. Two reports recorded that Police did not want to use pepper spray as they did not want to contaminate another cell. All incident reports referred to the use of the shield.

75. The incident reports from the Senior Corrections Officer and Officer A recorded that Prisoner A "stood up in a threatening manner". The CCTV footage does not show Prisoner A behaving in a threatening manner at this point.

9 POM, IR05.01, Initial post control and restraint.

10 The Senior Corrections Officer could not confirm which of the two incidents on 25 November 2019 caused his injury.

Review of provision of health care

76. Police took the lead role in the health response to Prisoner A's health event.

77. Corrections staff were not involved in the management of Prisoner A after the arrival of St John Ambulance staff.

78. Prisoner A was transported to Christchurch Hospital Emergency Department where he was assessed by medical staff, monitored for a period of time and discharged. The hospital discharge summary recorded the primary diagnosis for admission was syncope.[11]

79. On arrival at Christchurch Men's Prison at approximately 8pm, a nurse completed a reception health triage assessment through the door of the Intervention and Support unit cell where Prisoner A was located.

80. Following arrival, Prisoner A received support and care from the health team including the Medical Officer, Intervention and Support Project Team and Forensic Service.

[11] Syncope (fainting) is a sudden, brief loss of consciousness. It happens when the brain does not get enough oxygen, causing an individual to pass out. Possible causes of fainting include stress or emotional distress, pain, fear, a sudden drop in blood pressure, low blood sugar due to diabetes, hyperventilation, dehydration, standing in one position for too long or standing up too quickly, physical exertion in hot temperatures, consuming drugs or alcohol, seizures.

Findings

81. The day after the incident, the Prison Director appropriately and proactively notified the Inspectorate to advise that a "*serious incident*" had occurred at the custody suite.
82. There is no instruction or guidance to aid decision making for Corrections staff on methods of extraction of prisoners from cells in the custody suite.
83. It was not clear to Corrections staff which agency had custody of Prisoner A at the time of the incident.
84. There was no formal discussion between Police and Corrections to formulate a plan for the removal of Prisoner A from the cell to relocate him to the Corrections vehicle.
85. De-escalation was not used to any degree prior to force being used and force was not used as a last resort.
86. The actions of the Corrections officers to assist Police in relocating Prisoner A were reasonable, necessary and proportionate.
87. The extraction of Prisoner A from the cell was poorly executed and obstructed by the use of the shield, and the time taken to gain control of Prisoner A was protracted.
88. Prisoner A was provided with prompt and appropriate health care when the medical event became apparent.
89. Prisoner A's dignity was not maintained throughout the incident, as he lay exposed on the floor of the custody suite corridor with many staff present.
90. Prisoner A appropriately received a medical assessment at the hospital following the medical event.
91. Prisoner A was seen by a nurse for assessment when he arrived at Christchurch Men's Prison, as required.
92. There was no formal debrief between Police and Corrections following the incident.
93. There was no debrief for Corrections staff following the incident, although a debrief report stated that all three Corrections staff involved in the incident had attended a debrief.
94. There is no record that staff spoke with Prisoner A following the incident.
95. One incident report was not completed on the day of the incident.
96. The use of force documentation was not completed to the required standard.
97. There was considerable delay in a review of the use of force, which was a missed opportunity for identifying good practice or areas for improvement.

Recommendations

We recommend that:

the Prison Director

i. ensure that the dignity of prisoners is maintained at all times
ii. ensure that a thorough debrief is conducted following a use of force incident
iii. ensure that incident reports and reviews of use of force are completed promptly

the Regional Commissioner

iv. work with Police to ensure Corrections staff understand clear lines of responsibility and accountability for prisoners being managed in the Precinct.

Consultation

98. A draft copy of this report was sent to the National Commissioner for comment on fact, finding and expression, before being finalised.
99. The response received is included in Appendix B.

Acknowledgement

100. We acknowledge the co-operation and assistance provided by the management and staff of Christchurch Men's Prison.

OFFICE OF THE INSPECTORATE
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Appendix A. Terms of Reference

5 December 2019

Our reference:#147966

TERMS OF REFERENCE FOR THE INVESTIGATION OF THE RESTRAINT OF MR [redacted] RESULTING IN A MEDICAL EVENT AT THE CHRISTCHURCH JUSTICE AND EMERGENCY SERVICE PRECINCT (JESP) CUSTODIAL SUITE ON 25 November 2019.

Background

On 25 November 2019 Mr [redacted] was attending Court in Christchurch. Mr [redacted] was required to be escorted from Christchurch Justice and Emergency Service Precinct to Christchurch Men's Prison. Mr [redacted] was non-complaint, resulting in a Use of Force. During this incident Mr [redacted] suffered a medical event.

The Office of the Inspectorate received notification of this incident from the Prison Director on 26 November 2019.

It has been decided that the circumstances surrounding the restraint of Mr [redacted] resulting in a medical event will be investigated by Inspectors of Corrections.

The Investigation

The investigation will be conducted by Rochelle Halligan and Tracey Tyro Inspectors of Corrections for the Office of the Inspectorate. Principal Clinical Inspector Fiona Irving will provide specialist assist to the investigation.

The investigation will have access to all relevant information, documentation, premises and persons pertaining to the incident, and may, with the approval of the Chief Inspector, call on such additional or specialist assistance to the investigation as may be appropriate.

The investigation will be completed, and a report presented to the Chief Executive, through the Chief Inspector, by 5 March 2020.

The matter has separately been referred by Police to the Independent Police Conduct Authority, given the involvement of New Zealand Police staff in this incident.

OFFICE OF THE INSPECTORATE
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Terms of Reference

1. To investigate and report on the circumstances surrounding the transfer of Mr [redacted] from Police to the custody of the Department of Corrections, in particular:

   - Review and assess what information was known to inform the decision to relocate Mr [redacted] from his cell to the transport vehicle.
   - Review the decision to relocate Mr [redacted] and comment on whether other options may have been open to staff in the presenting circumstances.
   - Review, in particular, the actions taken by Corrections' staff in relation to the incident.
   - Review and assess the Use of Force by Corrections' staff in the incident

2. To investigate and report on the extent to which the standards, procedures, operational systems, work practices and internal controls for the proper management of Mr [redacted] were in place and being complied with.

3. To investigate and report on whether the access to and the provision of health care before and after the incident met the required standard.

4. To review and report on the responsibilities of Corrections' staff in the Christchurch Justice and Emergency Service Precinct as they relate to the management and care of prisoners being transferred into Corrections care.

3. To make such recommendations for the improvement of promulgated standards, procedures, operational systems, work practices and internal controls as may be necessary, arising out of the findings of the investigation.

Janis Adair
Chief Inspector
Office of the Inspectorate

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Appendix B. National Commissioner response

DEPARTMENT OF CORRECTIONS
ARA POUTAMA AOTEAROA

10 November 2020

Janis Adair
Chief Inspector
Department of Corrections

By email: janis.adair@corrections.govt.nz

Tēnā koe Janis

Re: Draft report of investigation into a use of force incident at Christchurch Justice and Emergency Services Precinct on 25 November 2019

Thank you for carrying out this investigation and for the opportunity to respond to this report.

I'd like to recognise the Prison Director who promptly alerted your office, and others, to this incident to ensure that necessary lessons could be taken. With Police primarily managing the custody suite significant collaboration between our staff is necessary. I'm confident in most situations people transition smoothly between Police and Corrections custody. It is often however the most difficult of incidents which test our plans the most and where clarity of roles is critical. It is clear from your report that there are lessons for both our agencies. We are committed to working in partnership with Police to provide further clarity about roles and responsibilities and additional guidance about the transition of custody and incident response.

I also note your recommendation about the need to ensure the dignity of prisoners is maintained at all times. While I recognise that staff were primarily focused on the management of the medical emergency and that Police staff had asked for other cell windows to be fogged so that other prisoners in the suite could not see Mr [redacted] it is important that this incident is reflected on to support learning for future incidents. I am again pleased that this lesson has already been shared with staff at Christchurch Men's Prison.

Your report makes four recommendations to help guide improvements.

Recommendations to the Prison Director;

i. ensure that the dignity of prisoners is maintained at all times

The recommendation is accepted and has been completed. There is an expectation that a high level of care is provide to all the men in our care. The long period of exposure was highlighted at the initial review of the CCTV footage and there was a site wide reminder issued then, this will be an ongoing reminder in relation to incident response.

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ii. ensure that a thorough debrief is conducted following a use of force incident

The recommendation is accepted. All staff involved should have had the opportunity to discuss the event together and reflect in a timely manner. Debriefs following serious incidents is an area of continuous improvement and more consideration will be taken to ensure this includes events off-site. On this occasion due to the injury of one officer it was not possible to debrief all three staff together in the days after the event and the Residential Manager did make reasonable attempts to discuss the incident with each individual. Nonetheless we agree that our support of staff could have been improved.

iii. ensure that incident reports and reviews of use of force are completed promptly

The recommendation is accepted. The time delay in incident reports and use of force review is not the standard we want to meet. This is another example where reporting and oversight of offsite incidents needs improving. This process has significantly improved since this incident and we aim to complete the reports and reviews within the identified time frames.

Recommendation to the Regional Commissioner;

iv. work with Police to ensure Corrections staff understand clear lines of responsibility and accountability for prisoners being managed in the Precinct.

The recommendation is accepted. The Regional Commissioner has discussed the recommendation with the District Commander for Canterbury who agrees the Custody Suite Operations Plan should be reviewed. The Operations Plan was agreed in 2017 and while the lessons from this incident will take precedence for the review it is considered a helpful point in time to review the plan in full. It is also hoped that the review can seek to include a suitable protocol for learning from incidents in the custody suite quickly and collaboratively.

The Deputy Prison Director will take the lead for Corrections on contributing to the review of the Operations Plan.

We also work alongside Police in similar facilities in two other centres across New Zealand. My team will work to ensure we implement the same improvements in these facilities.

I trust that you are satisfied with our response to this report. Please advise me if you have any concerns.

Ngā mihi nui

Rachel Leota
National Commissioner

Appendix C: Prison Operations Manual

IR.02 Incident Response

IR.02.02 Determining appropriate intervention strategy

1. The first responding officer, or the most senior staff in attendance, must plan and initiate the action required to eliminate or contain the incident.
2. If there is no immediate or further risk to any person, property or systems, the officer in charge (first responding officer) should attempt to resolve the issue by using non-physical intervention strategies (refer to POM IR.02.Res.01 Intervention strategies), such as:
   a. tactical communication (i.e. de-escalation), or
   b. containment.
3. Staff may use minor non-threatening physical contact (refer to POM IR.02.Res.01 Intervention strategies) to resolve the incident.

IR.02.03 Use of force

1. Staff may use force only when there is no other option.
2. Use of force is the application of approved physical interventions (refer to POM IR.02.Res.01 Intervention strategies and the Tactical Options Manual of Guidance) by Corrections staff in situations where it is necessary to establish and maintain control, and minimise the potential for breaches of security and injury to parties directly involved as well as others.
3. Physical force may be used when dealing with a prisoner if the staff member has reasonable grounds for believing force is necessary:
   a. in self-defence, in the defence of another person, or to protect the prisoner from injury, or
   b. in the case of an escape or attempted escape (including the recapture of any person who is fleeing after escape), or
   c. in the case of an officer, - to prevent the prisoner from damaging property, or in the case of active or passive resistance to a lawful order
   d. when requested by a member of the Police to assist a suitably qualified person to take a finger-prick sample or a buccal sample, from a prisoner who is subject to a data bank compulsion order. Under no circumstances should Corrections Officers initiate the use of force.

IR.02.04 Approval of planned use of force – Control & Restraint (C&R)

1. Before C&R is applied to any person, oral approval must be obtained from the prison director (or manager authorised to exercise this delegation) if the following applies:
   a. prisoner (or other person e.g. visitor) responsible for an incident has been contained, and
   b. there is no immediate threat of harm to any person, and
   c. it is practicable to get approval under the circumstances.
2. The prison director (or delegated manager) must consider whether the use of C&R is reasonably necessary, taking into account the factors listed above (IR.02.03 Use of force), the nature of the situation, and whether all other reasonable alternatives have been attempted and considered.
3. If the prison director (or delegated manager) approves the use of C&R, they must specify what mechanical restraints are to be used.

IR.02.05 Deployment of planned use of force (C & R)

1. The planned use of force team must be made up of at least four officers, and must:
   a. be pre-approved by the prison director (or manager authorised to exercise this delegation)
   b. plan the intervention prior to initiation
   c. involve a team of four officers, who all must:
      i. be properly kitted
      ii. be certified in C&R
      iii. use only approved holds and techniques.
2. A video camera operator must be present and must film the entire incident from start to finish including brief, negotiation, relocation and medical assistance (refer to POM IR.02.Res.03 Video operator instructions).
3. When the application of physical force is necessary, it will be limited to the minimum degree necessary to resolve the situation promptly and safely.
4. If authorised mechanical restraints and/or physical holds are deployed their use must be advised to the prison director (refer to POM IR.02.Res.02 Authorised mechanical restraints and physical holds).
5. If restraints are to be used (other than for escorts) staff must complete IR.02.Form.01 Approval for / Report on use of Mechanical Restraints, and this must be approved by the prison director (or delegated manager).
6. The effectiveness of the use of force shall be continually reviewed to determine whether or not another strategy is more appropriate.
7. The use of force shall be discontinued as soon as the use of force is no longer necessary to ensure the compliance and immediate security of the prisoner.

IR.02.06 Spontaneous use of force

1. A staff member who uses force or officer who uses individual carry pepper spray (ICP) on a prisoner in any circumstances must promptly report the use of force / pepper spray to the prison director (IOMS incident reporting).
2. Staff must advise the unit PCO or on-call manager as soon as possible following the incident (the prison director and Regional Commissioner must also be advised within two hours of the incident occurring).
3. Individual carry pepper spray may only be drawn and used against a prisoner if:
   a. there is a need to respond immediately and
   b. it is not practicable to obtain approval for planned use of force and
   c. the officer has reasonable grounds for believing use of ICP is necessary
      i. in self-defence, in the defence of another person, or to protect the prisoner from injury, or
      ii. in the case of an escape or attempted escape (including the recapture of any person who is fleeing after escape), or
      iii. in the case of an officer, - to prevent the prisoner from damaging property, or in the case of active or passive resistance to a lawful order.
4. An officer issued pepper spray for spontaneous use must also be issued an on body camera.
5. Following the deployment of ICP, staff must follow the IR.05.01 Initial post control and restraint procedure.
6. Any prisoner subjected to pepper spray will be decontaminated at the earliest opportunity once the prisoner is compliant and/or securely contained to ensure the compliance and immediate safety of the prisoner.
7. The use of force shall be discontinued as soon as the use of force is no longer necessary to ensure the compliance and immediate security of the prisoner.

8. Staff shall test the prisoner's compliance at the earliest opportunity, for example after force has been applied.

IR.05.01 Initial post control and restraint

1. The officer in charge of the incident must immediately advise the prison director, on-call officer or supervision officer immediately following incidents where use of force has been used, it refers to;
   a) mechanical restraints for reasons other than the use of handcuffs or a waist restraint used in conjunction with handcuffs while escorting a prisoner other than escorts.
   b) spontaneous use of force, including individual carry pepper spray.
   c) planned control and restraint.
2. The prison director is informed of internal (prison) incident details and must approve the initial follow-up actions (e.g. immediate needs and placement).
3. The officer in charge must advise the prison director, on-call officer or supervision officer if they believe the prisoner telephone system should be disabled for a reasonable period of time, after such an incident.
4. This decision to disable the prisoner telephone call control system should be based on the circumstances, including an assessment of the likelihood of the information being passed on to the next of kin initially by anyone other than the Police.
5. A prisoner subjected to the use of physical force shall be placed on 15 minute logged observations until their at-risk status has been reviewed by the appropriate staff.
6. An information report is completed by all staff witnesses on IOMS before the end of their shift and notification forwarded to the manager of the area in which the incident occurred. Staff required to complete incident reports on IOMS before the completion of their shift must have access to computers as a priority over other computer use.
7. Security officer witnesses are to complete an Information report before the end of their shift and notification forwarded to the PECCS manager of the area in which the incident occurred. However when this cannot occur (inadequate office facilities or time of the incident) they are to obtain verbal approval from the PECCS manager to complete the Information report within the following 24 hour period.

IR.05.02 Health Centre

1. Any prisoner restrained by any restraint of a type (refer to POM IR.02.Res.02 Authorised mechanical restraints and physical holds), for reasons other than escorts, must be examined by a suitable registered health professional within three hours of the beginning of the restraint, and the nurse / Health Centre Manager must ensure that:
   a) inform either the unit PCO or on-call manager of the prisoner's condition
   b) record details in the prisoner's medical file.
2. Any prisoner subject to pepper spray must be assessed by a suitable registered health professional as soon as practicable after the application of that force within the identified three hour health response period.
   a) the health assessment will commence as soon as practicable after decontamination procedures are completed and only when custodial staff deem it safe to do so.

IR.05.03 Interview of prisoner

1. A prisoner subject to the use of physical force must be interviewed within three hours of the physical force being applied.
2. The interviewer identifies any psychological and other support to prisoners requiring it following incidents, including cultural and chaplaincy services.
3. The result of the interview is recorded in the IR.05.Form.01 Debrief report signed and referred to the prison director.

IR.05.04 Incident debrief meetings

1. A team debrief must occur as soon as practicable but within 24 hours of the following incidents:
    a. Death in custody
    b. Collective disruption or riotous behaviour
    c. Escape / Attempted escape
    d. Hostage or siege situation
    e. Self harm – threat to life e.g. attempted suicide
    f. Serious fire or arson (including attempts)
    g. Serious assault by prisoner on staff
    h. Any other incident the prison director deems appropriate for a debriefing.
    i. Serious assault on prisoner
    j. Control and Restraint team assembled and force is used
    k. Use of Force (spontaneous).
2. The Incident Controller, who is likely to be the prison director, or other person authorised by the prison director "debriefing managers" for internal (prison) serious incidents will facilitate the meeting. The debriefing manager should be selected based on the site's requirements and circumstances.
3. The Incident Controller is to advise the PIRT Coordinator of:
    a) the incident
    b) the time and venue of the operational debriefing and
    c) provide a copy of the completed Incident notification report (IOMS).
4. The debriefing manager is responsible for:
    a) ensuring that all key personnel, including custodial staff, managers and Health Services, including relevant external service providers are given the opportunity to attend post incident debriefs
    b) holding a debriefing as soon as practicable after an incident and within 24 hours of the incident
    c) setting aside a private area for the debriefing away from the main work area
    d) ensuring that all reports and forms are completed.
5. For PECC serious incidents the PECCS Manager is responsible for monitoring and ensuring compliance in the management of all aspects of operational debriefing and for providing a facilitator.
    a) The purpose of an operational debriefing is to:
    b) provide staff involved in the incident the opportunity to discuss what happened (facts only)
    c) acknowledge the way that the incident was handled
    d) confirm immediate remedial action that can be taken
    e) identify lessons that can be learned from the way the incident was handled
    f) used to verify whether key processes in the approved emergency plan (where applicable) were followed correctly, and to determine whether or not there is a need to update, amend or make an addition to the emergency plan as a result of the incident
    g) discuss any other issues that the prison director, or staff involved in the incident wish to raise
    h) provides an opportunity for staff involved to ask any questions
    i) identify / clarify staff support opportunities that are available e.g. PIRT.

IR.05.05 Post incident debrief

1. On completion of the debrief meeting the debriefing manager must:
    a) decide whether or not to hold a group specialist briefing with external support (e.g. Police or Critical Incident Expert).
    b) ensuring that any training identified as being required is discussed and forwarded to the relevant Learning and Development Advisor (LADA)
    c) notify cultural and chaplaincy services where support is necessary.
    d) ensure the Debrief report and other required forms are completed and distributed according to the use of force report requirement, including:

e) IR.05.Form.02 Notice of use of a mechanical restraint
f) IR.05.Form.03 Use of force report and non-lethal weapon report, and if required
g) IR.05.Form.04 Request the approval to use mechanical restraint beyond 24hrs.

2. The debriefing manager must place copies of all incident reports and forms on:
   l. the relevant staff files
   m. the prisoner(s) files, and
   n. the Use of Force Register.
3. For reporting purposes any use of force shall be deemed a Control and Restraint incident when a Control and Restraint team is formed and responds to the incident.
4. Forward the original Incident reports and forms to the prison director.

IR.05.07 Post Incident Review

1. All C&R and spontaneous Use of Force incidents, including individual carry pepper spray are to be reviewed as soon as possible after the incident.
2. This review is to be carried out by an officer nominated by the prison director to consider whether the situation was handled in the most appropriate way, what led to the situation, and what strategies need to be put in place to avoid future situations that lead to the use of force.
3. The depth of any such review should reflect the seriousness of the incident, but should in any case cover not only the use of force itself and the outcome, but also what led to the incident, and what steps were taken to avoid the use of force (negotiation etc).
4. Each incident is investigated by prison management as soon as is practical after it has occurred and the results of the investigation documented and reported. The outcome of any such review should be documented and made available to any subsequent investigation.
5. Every incident that harmed or might have harmed a person is investigated as a high priority and the findings documented.
6. Reports of incidents are analysed and the findings used to assist implementation of changes necessary to reduce the risk of similar incidents occurring.
7. The underlying causes of the incident are identified, analysed and action planned to resolve or minimise cause.
8. For internal (prison) incidents, the incident follow-up report is forwarded to the regional commissioner for approval of planned actions, and to ensure follow up.
9. The outcome of any such review should be documented and made available to any subsequent investigation.
10. The reviewing officer places a record of findings in the Use of force register and informs the prison director of the findings.
11. Video recordings from on body cameras and any CCTV footage of any incident involving pepper spray, planned or spontaneous, must be retained and a copy, on a secure USB flash drive within 72 hours of the incident, sent to National Office Chief Custodial Officer's team.

IR.05.08 Use of force register

1. A Use of force register shall be maintained which contains the details of any incident where any use of force is used, including mechanical restraints and / or control and restraint with the following details:
   a) Name of the prisoner
   b) Name of the officer involved in the use of force and the unit
   c) Name of the officer who authorised the use of force
   d) Reasons if prior approval could not be obtained before force was used
   e) Location of the incident
   f) Brief details of the incident
   g) Intervention strategies used prior to the use of force
   h) Details of force used:

I. Controlled removal
II. Control and restraint
III. Mechanical restraint
IV. Pepper spray

i) The result
j) Date and time the suitable registered health professional examined the prisoner
k) Signature of suitable registered health professional
l) Brief details of unit PCO / on-call manager's interview with the prisoner, including date and time
m) Unit PCO / on-call manager's signature
n) Prison director's signature
o) Reviewing officer's comments
p) Signature of reviewing officer and the date.

2. The prison director confirms that all the required steps were implemented and signs the Use of force register to certify that all actions were undertaken within time and in the correct way.

IR.06 Incident reporting

IR.06.01 Immediate reporting

1. Staff on the scene must immediately notify the PCO, or any other manager of any incident, if they are not available, staff will contact the next senior officer on site.
2. The staff member notified is responsible for ensuring that:
   a) all incidents identified in IR.06.Sch.01 Schedule of incident categories, with time reporting code "S", are reported* to the incident line (on 0800 555 500) anytime day or night, immediately after they are discovered and the following details of the incident must be provided:
      i. name of prison
      ii. brief summary of incident (including the extent of any injuries)
      iii. date and time of incident
      iv. full names and PRN of all prisoners involved in incident

      *** Note:** Must be followed by IOMS report (or in the event of IOMS being unavailable an IR.06.Form.01 Manual notification of incident) within 2 hours of the incident being advised.
   b) the following additional information may need to be provided:
      I. prisoner's status (sentenced, accused, etc.)
      II. gender, age and ethnic origin
      III. sentence commencement date (SCD)
      IV. parole eligibility date (PED)
      V. Statutory release date (SRD) or final release date (FRD)
      VI. date of birth (D.O.B)
      VII. security classification rating
      VIII. VNR
      IX. sentence
      X. any gang affiliation
      XI. offences
   a) the Police are notified immediately of any escapes, deaths, including suicide and assaults in which charges are to be or could be laid, or to provide appropriate information.
   b) where appropriate, the Visiting Justice, chaplain, and PIRT leader shall be advised of any incident

c) the regional commissioner and the prison director are advised of a severe or moderate incident (or any incident that is considered on its merits relevant).

3. All incidents categorised with a reporting code of "M" that occur between the hours of 8am to 5pm, must be immediately notified using the Incident Line 0800 555 500. If the incident occurs outside these hours, then the notification to Incident Line is to occur at 8am the next working day.

To assist staff in the notification process they should refer to IR.06.Res.02 Corrections Services Integrated Incident Notification Guidance.