Report on the death of Juanita Shaw in Police custody in Dunedin on 23 August 2007

INDEPENDENT POLICE CONDUCT AUTHORITY

INTRODUCTION

1. At approximately 1.20pm on 23 August 2007 Juanita Shaw, aged 36, was found dead in a cell at the Dunedin Police Station. The principal cause of death was inhalation of vomit due to, or as a consequence of, an overdose of methadone.

2. As required under section 13 of the Independent Police Conduct Authority Act 1988, the Police notified the Authority of the death, and the Authority conducted an independent investigation. This report sets out the results of that investigation and the Authority's findings.

BACKGROUND

Summary of events

3. Ms Shaw was a habitual drug user who had used heroin intravenously and was a participant in a methadone programme.

4. Methadone is an opioid analgesic used to treat or prevent pain and to treat addiction to opioid drugs. It produces effects similar to morphine. Those on a methadone programme receive their methadone medication in liquid form and usually must drink it in front of a pharmacist or doctor.

5. Ms Shaw's prescription, which was given to her daily by a pharmacist, was 45mls of methadone to treat her heroin addiction and help with back pain. She was also prescribed two Quetiapine tablets (for a possible psychiatric disorder, one to be taken in the morning and one in the evening); four Clonidine tablets (for sleep disturbance, two to be taken in the morning and two in the evening); one Diazepam tablet (to wean off sleeping pills, to be taken in the morning) and one iron and vitamin C tablet (for iron deficiency, to be taken in the morning).

6. Ms Shaw's history suggests that she was able to obtain prescription drugs which had not been prescribed to her, as well as illegal substances.

7. On 8 June 2007 a warrant was issued for Ms Shaw's arrest for failing to appear in Court on drug and fraud charges.

8. Police established that she had daily appointments with a South Dunedin pharmacist to collect her methadone medication and, on 23 August 2007, an officer waited near the pharmacy for Ms Shaw to arrive. Two other officers were in the vicinity.

9. At about 8.50am the Police learned that Ms Shaw's car was nearby. As two officers approached her, Ms Shaw drove off. A short pursuit ended with Ms Shaw's car crashing. Although not injured she became very aggressive and was arrested on the outstanding warrant and placed in handcuffs.

10. She was then taken to the Dunedin Central Police Station at about 9am and placed in a holding cell and the handcuffs removed. After that she was taken to the medical room and searched by a female officer. She had been asking for her prescribed medication from the outset of her apprehension and arrangements were made to collect it from the pharmacist.

11. The Police database (NIA) contained a number of alerts about Ms Shaw, including *"suicidal tendency"* and *"self harm"*. However, NIA was not checked at the time of her processing by either the arresting officer or the watchhouse keeper. The arresting officer noted on the custody/charge sheet that Ms Shaw was on a methadone programme.

12. The watchhouse keeper observed that Ms Shaw was agitated and assumed her agitation was due to her not having had her prescribed medication and assessed her as *"in need of care"* on the required Health and Safety Management Plan - requiring that she be frequently monitored.

13. At approximately 9.56am Ms Shaw was placed in an observation cell and then frequently monitored, that is directly observed at least five times per hour at irregular intervals.

14. A doctor was not summoned to check Ms Shaw's general condition or to administer her prescription as the watchhouse keeper did not believe she required a doctor and a doctor was not required to administer methadone.

15. After Ms Shaw was placed in the cell, her handbag was searched and more than 20 loose pills were discovered in it, as well as an empty bottle.

16. An officer collected Ms Shaw's prescription medication from the pharmacy and was advised how to administer it. The medication was then delivered to the watchhouse keeper.

17. At approximately 10.22am Ms Shaw asked for and was given a blanket and a book from her bag. At 10.37am the watchhouse keeper gave her breakfast. The pharmacist's bag contained a bottle of liquid methadone and two small pill containers. The watchhouse

keeper was unsure about the tablets to be given to Ms Shaw so he confirmed with the pharmacist that she was to be given the contents of a pill container labelled 'morning medication' which consisted of five tablets — one Diazepam, one iron and vitamin C, two Clonodine and one Quetiapine.

18. Ms Shaw drank the methadone. The tablets were tipped into her hand and she took them with water, except for the Diazepam tablet which was later found in the bottom of the container. The Watchhouse Controlled Drug Register was correctly completed, recording the medication given and the time.

19. At 12.58pm the watchhouse keeper placed food in the cell and noted that Ms Shaw appeared to be snoring lightly. He tried to rouse her by pushing her foot with his but there was no response. He also called out to her without effect.

20. About 1.20pm officers walking past Ms Shaw's cell noticed that she "*did not look well*". On examination she was found not to be breathing. She was placed in the recovery position and an ambulance called. CPR was started, but on arrival the ambulance officers pronounced her dead.

21. Ms Shaw's car was searched. She had been living in it and it contained all her possessions. Police found five used syringes and a syringe containing 1.5mls of pink fluid, a spoon and a bottle of liquid labelled 'folic acid'. Three of the used syringes were found to contain methadone and benzylopiperazine (BZP). There were indications of methadone and BZP in the other two used syringes. The liquid in the other syringe contained methadone and BZP. The residue on the spoon contained methylphenidate. The liquid in the bottle contained methadone.

22. During the subsequent Police enquiry, two associates of Ms Shaw said she had expressed suicidal intentions and that she kept a container of pills with her in case she was detained by Police, as she did not want to return to prison.

23. The Police investigation also established that Ms Shaw had attempted suicide by way of medication overdose on at least five occasions.

Post mortem and toxicology

24. A post mortem examination established that the principal cause of death was inhalation of vomit due to, or as a consequence of, an overdose of methadone.

25. There was no evidence of alcohol.

26. Methadone was present at higher levels than expected, given the prescription amount.

27. BZP was present in Ms Shaw's urine but not in her blood, indicating that she had used BZP several hours before her death. Diazepam and Quetiapine were indicated at levels consistent with therapeutic use.

Coroner's findings

28. The Coroner found that death was caused by *"inhalation of vomit due to or as a cause of an overdose of methadone"*.

29. The Coroner was unable to conclude that Ms Shaw took methadone with the intention of committing suicide. In that regard he said:

> *"Exactly when and how Juanita Shaw acquired and consumed the additional methadone is speculative, but I am forced to the assumption that she had taken methadone prior to her apprehension. This methadone appears to have been mixed with BZP".*

POLICE POLICIES, PRACTICES AND PROCEDURES

Assessment and monitoring of prisoners

30. The Police have a responsibility to ensure the care and safety of all persons in their custody. All persons detained or arrested are required to be evaluated for risk. This evaluation begins as soon as the person is in custody and includes checking the Police national database for any warning signs indicating suicidal tendencies.

31. Police General Instruction P100(4) and the Manual of Best Practice (Processing and Supervising Prisoners, Duties and Responsibilities, Watchhouse Keeper) require that an evaluation of a person received into custody "*must be undertaken using the Watchhouse Keepers Evaluation of Condition of Person in Custody section of the Custody/Charge Sheet*", and "*When the person is evaluated as being in need of care or in need of care and constant monitoring, the Health and Safety Management plan must be completed*". The assessment has to then be approved by the watchhouse keeper's supervisor.

32. At the time of this incident Police General Instruction P203 (*Monitoring People in Police Custody and Prisoners*) required people in Police custody to be classified into one of three categories depending on the risk they posed to themselves and/or others. The categories were:

    1) not in need of specific care;

    2) in need of care; or

    3) in need of constant care and monitoring.

33. General Instruction P203(2) provides that:

> *"All people in police custody that are identified as being in need of care, because of their health or mental condition, or presence of warning signs indicating suicidal tendency, are to be frequently monitored… 'Frequent monitoring' means to directly observe at least 5 times per hour at irregular intervals."*

34. General Instruction P203(4) states that:

> *"Persons in police custody who are identified as being in need of constant monitoring, because of the presence of warning signs indicating suicidal tendency or adverse health, or the presence of a mental condition; are to be placed in a suicide resistant cell and directly observed without interruption. 'Constant monitoring' means to watch or directly observe without interruption. This definition does not include CCTV as a method of constant monitoring".*

35. The Instructions require that if a person is assessed as *"in need of care"* or *"in need of care and constant monitoring"*, a Health and Safety Management Plan (HSMP) is to be completed and endorsed by the watchhouse supervisor. The person is also to be given a tear-resistant gown and placed in a suicide cell and is to be seen by a Police medical officer, Duly Authorised Officer or Community Assessment Team member as soon as practicable.

THE AUTHORITY'S FINDINGS

Assessment Process

36. Staffing issues at the time resulted in the unusual situation of a senior sergeant having to make the arrest and undertake the requisite checks. The arresting officer did not check the Police national database (NIA) for alerts regarding Ms Shaw.

37. Nor did the watchhouse keeper undertake the required NIA checks. He categorised Ms Shaw as *"in need of care"*, on the basis of her agitated behaviour, her arrest for drug possession and his knowledge of her as a drug addict.

38. On that basis, Ms Shaw was assessed as needing to be frequently monitored. The NIA alerts for *"self-harm"* and *"suicidal tendencies"*, and in particular her two recent suicide attempts, would have indicated that she was required to be assessed as *"in need of care and constant monitoring"*.

39. The watchhouse supervisor, a senior sergeant, did not check and approve the assessment on either the custody/charge sheet or the Health and Safety Management Plan. The supervisor was aware that Ms Shaw was on methadone as the arresting officer had asked him how it was to be administered. However, the senior sergeant left soon after to attend to other duties and was unaware of the reason for Ms Shaw being placed in an observation

cell and unaware that her methadone prescription had been picked up from the pharmacist and administered.

40. The watchhouse keeper dealt with Ms Shaw with little supervision.

FINDING
There were significant failings in the assessment of Ms Shaw.

Adequacy of checks while in custody

41. Ms Shaw was checked five times at irregular intervals in accordance with the assessment of her as being *"in need of care"* and needing to be frequently monitored.

42. The last check of Ms Shaw was made at 12.58pm. She was not checked in the twenty or so minutes before her death.

FINDING
On the basis of the assessment that Ms Shaw was to be frequently monitored, Police complied with their stated policy in terms of the number of checks conducted.

The administering of methadone by an officer

43. General Instruction P111(7) states that where medication is prescribed, it shall be "*administered as specified*". The watchhouse keeper complied with this policy in providing Ms Shaw with her prescribed amount of methadone. He called the pharmacist to ensure the prescription was correct.

FINDING
The watchhouse keeper complied with policy in respect of administering methadone to Ms Shaw.

Adequacy of care

44. A general search was conducted of Ms Shaw because Police did not check NIA and thus were not alerted to the need to strip-search her.

45. As Ms Shaw was assessed as requiring frequent monitoring, General Instruction P203(3) required that she be placed in a suicide resistant cell and issued with a tear-resistant gown. Ms Shaw was placed in an observation cell but was not issued with a tear-resistant gown.

46. General Instruction P100(7) required those who were considered to be *"in need of care"* or *"in need of care and constant monitoring"* to be examined by a Police medical officer, a Duly Authorised Officer or Community Assessment Team member as soon as practicable. This did not occur.

47. A strip-search or placing her in a gown might have revealed recent needle marks, evident on Ms Shaw's lower limbs, and signalled the need to call a doctor.

> FINDING
> The officers responsible for Ms Shaw's care and safety failed to adhere to the relevant General Instructions.

Medical assistance

48. As soon as it was noticed that Ms Shaw was not breathing, officers commenced CPR until ambulance officers arrived. All but one of the officers who applied CPR had current first aid certification. The other officer's first aid certificate had just expired.

> FINDING
> The medical assistance provided by the officers was immediate and appropriate.

DISCIPLINARY AND REMEDIAL ACTION

49. The Police considered whether there was any criminal liability on the part of the officers involved in Ms Shaw's detention and decided there was not.

50. The Police National Disciplinary Committee recommended that two senior sergeants and a senior constable be counselled and be the subject of performance plans.

51. The Committee also recommended that the training of all Police involved with custodial management of prisoners be current and that supervisors be reminded of their responsibilities.

52. The Authority notes that the recommendations in paragraphs 50 and 51 have been actioned.

CONCLUSIONS

53. There were significant failures in the assessment of risk to Ms Shaw.

54. The officers responsible for Ms Shaw's care and safety failed to adhere to best practice and the relevant General Instructions.

55. These failures amounted to neglect of duty on the part of the arresting officer, the watchhouse keeper and his supervisor.

56. The officers were not however responsible for Ms Shaw's death, which resulted from asphyxiation, due to or caused by a methadone overdose. Police administered only the prescribed dose of methadone in accordance with the pharmacist's instructions. As the Coroner found, based on the toxicology report that the level of methadone in Ms Shaw's blood and liver was above the level of a daily prescribed dose, there is an assumption that Ms Shaw had taken methadone before her arrest, as well as BZP.

RECOMMENDATIONS

57. The Authority recognises that the Police are currently reviewing the prisoner management process. In addition the Authority recommends that:

(a) prisoners should be awakened regularly as part of frequent monitoring;

(b) a prisoner requiring medication should be seen by a doctor;

(c) medication should be administered by a doctor or an appropriately qualified nurse;

(d) the Police consider amending:

- General Instruction P203(3) to include a requirement to conduct a strip search; and
- General Instruction 203(4) so that any prisoner assessed as "in need of care and constant monitoring" is issued with a tear-resistant gown.

HON JUSTICE L P GODDARD
CHAIR
INDEPENDENT POLICE CONDUCT AUTHORITY

October 2009

About the Authority

WHO IS THE INDEPENDENT POLICE CONDUCT AUTHORITY?

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

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

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

The Authority has two investigating teams, made up of highly experienced investigators who have worked in a range of law enforcement roles in New Zealand and overseas.

WHAT ARE THE AUTHORITY'S FUNCTIONS?

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

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

On completion of an investigation, the Authority can make findings and recommendations about Police conduct.

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