Verdict of Coroner’s Jury  
Office of the Chief Coroner  
The Coroners Act – Province of Ontario

Surname: Clause  
Given names: Robert Howard  
Aged: 33

Held at: 70 Wellington Street, Brantford  
From the: 27th October 2014  
To the: 10th of November 2014  
By: Dr. Jack Stanborough, Coroner for Ontario  
having been duly sworn/affirmed, have inquired into and determined the following:

Name of Deceased: Robert Howard Clause  
Date and Time of Death: March 4, 2011  
Place of Death: Brantford City Jail – Market Street, Brantford, Ontario  
Cause of Death: Acute Oxycodone Toxicity.  
By what means: Accident

(original signed by Foreman and Jurors)

This verdict was received on the 10th day of November, 2014  
Coroner’s Name: Dr. Jack Stanborough  
(original signed by Coroner)

We, the jury, wish to make the following recommendations:

Inquest into the death of:  
Robert Howard Clause
Jury Recommendations
To the Ministry of Community Safety and Correctional Services

1. Within twelve months from the date of this verdict, establish a working group of experts and senior Ministry staff to coordinate and make available to the public a strategic plan for reducing the risks from illicit drug use in custody to include and not limited to:
   - Quantifiable measures of effectiveness, including the reduction of overdose incidents and deaths;
   - Identify harm reduction strategies that will be employed;
   - Public reporting at regular intervals, giving consideration to matters of security and
   - The detection and screening methods to be employed such as x-rays and other new techniques (such as full body scanner) to identify drugs concealed within the person.

2. Within twelve months from the date of this verdict, establish a separate working group to enhance safety so that all inmates recognize the danger of illicit drug possession, use, intoxication and overdose within the custodial facility. The working group will determine existing evidence-based best practices for assessing and monitoring risk associated with the presence of illicit drugs and drug dependent inmates. It will also establish a policy to improve the ability of correctional officers to recognize the potential for (and existence of) high risk situations in which inmates may become medically compromised due to the ingestion of drugs. The working group will consider and develop a policy which will include, but not be limited to:
   - A direction to correctional staff to take action when there is a reasonable suspicion that an inmate may be in possession of illicit drugs, possibly ingested drugs, is intoxicated or showing symptoms of overdose. The action must include an immediate report to Operational Manager.
   - Develop a standardized health care form providing direction to the Operational Manager in the absence of healthcare staff.
   - A specific protocol for observing the inmate including:
     - A specific list of signs and symptoms of an individual experiencing intoxication and overdose.
     - Observation protocols including frequency of checks.
     - Quality of checks to require level of consciousness checks, including a lay person definition and instructions for assessing the inmates orientation and consciousness.
     - Checks to continue to a period of time determined by health care professionals or until a health care professional is able to properly assess the inmates, and
     - An outline of options for intervention where there is a concern for the inmate’s health, including the use of Narcan by a correctional officer and transporting the inmate to a hospital.
     - To ensure there is no ambiguity or misinterpretation, all policies and procedures must be written in plain, concise language to convey a clear and consistent message.

3. Each jail or detention centre develop a Standing Order to address the problem of drugs within the facility including:
   - A review of adequacy of communication sharing, intelligence sharing and the development of relationships with local police services.
• Any building specific problems and limitations that may be contributing to the importing of illicit drugs into the facility, distribution of illicit drugs within the institution and strategies to address these issues.
• Other challenges and responses such as housing of intermittent inmates.
• Internal review of compliance with Ministry policies.
• Report of participation of inmates in rehabilitation programs, and
• Report detailing the incidents and progress regarding detection of illicit drugs, prevention of entrance of such drugs into the facility and the report to be reviewed and initialed by all correctional staff.

4. Each institution should provide annual training for correctional officers to recognize drug addiction, signs and symptoms of drug use, intoxication, overdose as well as the required observation and interventions for those inmates. Training should include, but not limited to:
   • Clinical manifestations of drug intoxications and overdose.
   • The proper care of impaired inmates, ensuring that inmates who appear to be asleep are responsive to external stimuli and a policy that would prevent any staff member from solely relying on an inmate to "vouch" for the health or well-being of another inmate.
   • Proper use of Narcan for unconscious inmates with shallow or no breathing.
   • Testing or certificate processes to ensure the correctional officers' understanding of such training.

5. Ensure that any inmate who reports breathing problems or requests the use of an inhaler:
   • Is the subject of a follow-up inquiry and assessment to ensure that the problem is solved.
   • Where an inmate continues to report breathing problems, the inmate will be monitored closely and health care staff will be immediately notified or the inmate will be transported to the hospital.
   • An inmate who is sleeping or resting on the floor to get relief for breathing problems will be recognized as medically compromised resulting in the inmate being closely monitored and healthcare staff being notified immediately or the inmate transported to the hospital.

6. To enhance the safety of inmates and establish better communication between shift changes, develop a practice of daily briefing for all correctional officers, to include:
   • When inhalers have been provided to an inmate during the previous shift.
   • When there exists any medical concerns of an inmate and/or
   • When an inmate has been placed on an enhanced level of supervision.

7. To enhance the safety of inmates and to increase the awareness of correctional officers of the health risks faced by impaired inmates in their custody, consider including the scenario of Mr. Clause's death as a case study in the curriculum of the accredited training program for correctional officers.

8. Within twelve months from the date of this verdict, develop a communications plan targeted at inmates informing them of:
   • Penalties for possession and trafficking of illicit drugs in custody.
   • The services and supports regarding substance abuse available in custody.
   • The need for enhanced monitoring if there is a suspicion of drug possession or use.
   • The signs and symptoms of overdose and how to ask for help, and
• The risk associated with drug use while in custody or upon discharge, including reduced tolerance levels.

9. To develop improved intake and follow-up protocols for inmates with addiction, including a method to document and track addiction history, participation in programs while in custody, drug related incidents in custody and discharge planning.

10. To ensure safety of the inmates, develop a policy to inform correctional officers and supervisor the results when an inmate has been “dry celled”.

11. To ensure safety of the inmates, Ministry to assess the feasibility of providing 24 hour on site nursing staff or on-call nursing consultation.

12. Within twelve months of the verdict, to review the monitoring procedures for inmates held by a “dry cell”, assess the feasibility and role of video equipment in all custodial institutions.

13. Within twelve months of the verdict, establish a working group to develop training and policies for the use of urine testing as a safety/security tool, not for the purpose of laying criminal charges. Develop a plan so that the shift supervisor is better able to perform such tests without the necessity for nursing staff to be involved.

To the Ministry of Health and Long-Term Care and Ontario Hospital Association:

14. Within twelve months from the date of this verdict, establish a working group to explore the potential for paramedics to administer Narcan without a doctor’s direction.

15. Within twelve months from the date of this verdict, develop guidelines for hospitals within the Province of Ontario to address:

• How to manage police requests for non-medically necessary procedures.
• Management of prisoners who are suspected of concealing drugs or other dangerous items within their body.
• Issues of patient consent, and
• Distribution of patient information to police officers.

To the Brantford Police Service

16. Within twelve months of this verdict, develop and implement a stand-alone policy for individuals in custody suspected of ingesting or carrying illicit drugs and present this policy to the Brantford Police Services Board, if applicable.

17. Develop a highlighted written form to communicate all essential information regarding inmates suspected of concealing drugs in body cavities, and require that such information be verbally communicated to Admission and Discharge jail staff.