



Verdict of Coroner's Jury Office of the Chief Coroner

The Coroners Act – Province of Ontario

Surname: Sprague
Given names: Adam
Aged: 25

Held at: Orangeville
From the: October 16, 2013
To the: May 7, 2014

By: Dr. Jack Stanborough, Coroner for Ontario
having been duly sworn/affirmed, have inquired into and determined the following:

Name of Deceased: Adam Sprague
Date and Time of Death: November 11, 2010, 8:20 a.m.
Place of Death: Orangeville Police Service, 390 C Line, Orangeville, Ontario L9W 3Z8
Cause of Death: Acute Oxycodone toxicity.
By what means: Accident

(original signed by Foreman and Jurors)

This verdict was received on May 7, 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:

Adam Sprague

Jury Recommendations

To the Ministry of Community Safety and Correctional Services; Office of the Chief Coroner; Ontario Association of Chiefs of Police; Centre for Addiction and Mental Health and Ontario Provincial Police:

1. Within 12 months from the date of this verdict, establish a working group to enhance the safety of prisoners held in police custody. The working group will determine existing evidence-based best practices for assessing and monitoring prisoners while in police custody. It will also establish practice to improve the ability of persons, who book and monitor prisoners, to recognize the potential for (and existence of) high risk situations in which prisoners may become medically compromised due to the ingestion of drugs and alcohol. The working group will consider:
 - The use of drug screening devices to detect/confirm if an individual has consumed drugs.
 - Standardized training to help police officers recognize the clinical manifestations of drug intoxication.
 - Standardization of prisoner booking forms to ensure that information is obtained regarding prisoners who may be high risk.
 - Standardized training of police personnel regarding the proper care of impaired prisoners, including positioning and ensuring that prisoners who appear to be asleep are responsive to external stimuli.
 - First aid training of police officers regarding the injection of naloxone for unconscious prisoners with shallow or no breathing.

To the Ministry of Community Safety and Correctional Services; Ontario Association of Chiefs of Police; Ontario Police College; and O.P.P. Provincial Police Academy:

2. Within 12 months from the date of this verdict, create a working group to reinforce and standardize training and working practices for assessing and monitoring prisoners while in police custody. The working group will have the following responsibilities:
 - Establish provincial standards for special constables.
 - Develop and implement an accredited training program for special constables; and
 - Determine the appropriate level, duration and venue for mandatory training for special constables.
3. To enhance the safety of prisoners held in police custody and to increase the awareness of police (and special constables) about the health risks faced by impaired prisoners in their custody, consider including the scenario of Mr. Sprague's death as a case study in the curriculum of the accredited program for special constables and in any police training at the Ontario Police College.

To the Ministry of Community Safety and Correctional Services and the Ministry of the Attorney General:

4. To enhance oversight and competence of special constables, and to reinforce the skills that are required by persons who monitor prisoners in police custody, amend the provisions of the Police Services Act to include special constables where applicable.
5. To enhance oversight of police services and to ensure compliance with adequacy standards established by the Ministry, amend the provisions of Regulation 3/99 *Adequacy and Effectiveness of Police Services* of the *Police Services Act*, to include enforcement of recommendations made pursuant to Ministry inspections. Amendment to the regulation should outline appropriate consequences if recommendations are not implemented in a timely fashion.

To the Ministry of Community Safety and Correctional Services and the Ontario Association of Chiefs of Police:

6. To enhance the safety of prisoners, all monitoring equipment should have constant recording of audio and video.
7. All monitoring equipment shall be checked on a regular basis to ensure functionality.

To the Ministry of Community Safety and Correctional Services:

8. To enhance the safety of prisoners in police custody, inspections should be conducted every three years (at a minimum) to determine compliance of police services with provincial adequacy standards relating to prisoner care and control. These inspections will include:
 - A review of record-keeping of prisoner checks.
 - A requirement that a formal policy is in place for auditing compliance with prisoner care and control.
 - A requirement for police officers, dealing with individuals who have significant substance abuse issues, to submit that information as a flag on the database kept by that service e.g., NICHE RMS, CPIC.
 - A requirement for the police service to provide a written report, with supporting documentation and approved by its board, within six months of the inspection report. That report should, at a minimum, outline the steps that have been taken to comply with the recommendations set out in the inspection report.
 - To ensure compliance with recommendations, a return inspection will be made within twelve months of the delivery of the service improvement plan.
9. To enhance the safety of persons in police custody, revise the Policing Standards Manual (2000) LE-016 Prisoner Care and Control, within twelve months of the date of this verdict, to include:

- A mandatory minimum for the intervals between physical checks for all prisoners in custody.
- A definition of “physical check” and when such a check should include a person in custody.
- A requirement that, in the event of a prisoner death, an internal debriefing be conducted by the involved police service regarding its procedures, processes and practices. The debriefing and subsequent report will be done within three months of the completion of the investigations in compliance with all applicable legislation. It will be distributed to the police services board as well as the Police Services Advisor of the Ministry of Community Safety and Correctional Services.

To the Orangeville Police Service:

10. To provide an intoxicated person with a place of safety other than police custody, the police officer should explore, prior to arrest, if the individual as an alternative place to stay with a sober person capable of ensuring his or her health and wellbeing;
11. Pending provincial standardization of prisoner booking sheets, to ensure that all relevant information is obtained from prisoners before they are lodged in the custody area, the prisoner tracking sheet, within six months from the date of this verdict, must be amended as follows:
 - A place to indicate that a mandatory database search has been conducted on NICHE RMS and the SIP portion of CPIC (including the results of that search).
 - The addition of drug or alcohol use a flag in the high risk section (at top of booking sheet).
 - A place to indicate that a prisoner has been asked about the consumption of drugs or alcohol (and the response to that inquiry).
 - A place to indicate that, where an individual has been detained under the Liquor License Act, he/she has been asked about an alternative place to stay (as opposed to being placed in a cell).
12. Pending provincial standardization of training in prisoner care and control, to ensure that police personnel (including special constables) are trained to care for impaired persons in their custody, conduct a training session, within six months of this verdict, that includes, at a minimum, information in the current OPP Prisoner Care Training Workbook developed by the Provincial Police Academy.
13. To ensure that incoming officers-in-charge (or persons designated to monitor prisoners) have all information on prisoners in custody, a physical check of all prisoners be conducted at shift change in the presence of the incoming and outgoing officers-in-charge.
14. 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. All policies and procedures should be available to all staff online.

15. To ensure that all personnel (including civilians) are up to date with existing policies and procedures, the supervisor must conduct an annual review with all staff (separate from block training) with sign-off by supervisor and staff.
16. To ensure that all personnel (including civilians), who have been on leave for six months or more, are aware of any change of policy or practice while on leave, are provided with instruction and face-to-face training on the change(s) when they return. Sign-off by supervisor and staff is mandatory.
17. To ensure proper prisoner care and control, monitoring systems should include audio capabilities.
18. When new equipment is introduced at the Orangeville Police Service, all personnel responsible for using the equipment must be trained by a qualified person on its use.
19. To enhance oversight of compliance with existing and revised policies on prisoner care and control, within six months of this verdict, establish a formal auditing procedure that will identify any failure to comply with existing policies. Once this auditing procedure is implemented, any failure to comply will be recorded and reported to the Board.
20. Pending revision of the Policing Standards Manual (2000) LE-106, regular physical checks of all prisoners should occur every fifteen minutes. Prisoners not obviously awake should be roused every thirty minutes, at a minimum.
21. To reinforce the importance of regular physical checks of prisoners and to advise prisoners of existing policy, ensure that signs with similar content as those used by the OPP (a copy attached to these recommendations) are prominently posted in the cells, booking area and court office of the Orangeville Police Station.
22. Within six months of this verdict, amend Section 1(4) of Procedure LE-016 (July 2013) to direct the Officer in Charge to ask all persons under arrest about alcohol or drug ingestion and to tell the arrested person that failure to disclose ingestion of alcohol or drugs may result in potential overdose and death and compromise the ability of the police service to provide appropriate care.
23. When any prisoner is lodged in the cells and an on-duty police officer is not available to provide continuous monitoring, a special constable must be called into the station to monitor the prisoner. When a high-risk prisoner has been identified at booking, the Officer in Charge must take steps to ensure the availability of a second member in the station to ensure officer and prisoner safety.
24. To inform all Orangeville Police Service personnel of the issues identified during this inquest, with thirty days of this verdict, provide a copy of this Verdict and Recommendations to all personnel through e-mail or by posting it in a place accessible to all personnel.
25. To enhance understanding of risk factors associated with the care of intoxicated prisoners, use the Adam Sprague scenario, in consultation with the Chief Coroner's Office, to train officers and/or special constables on the issue to prisoner care and control.
26. To enhance oversight of the Police Services Board regarding the response taken by the Service to this Verdict and Recommendations, within six months of this verdict,

the Chief shall report to the Orangeville Police Services Board on the status of the Service's response.

To the Orangeville Police Services Board:

27. Ensure that copies of all Orangeville Police Service policies are filed with the Board
28. The Board Chair or designate must attend the annual board meetings of the Ontario Association of Police Service Boards.
29. Within one year of this verdict, after consultation with the Chief, the Board must report to the Chief Coroner of Ontario about the steps that have been taken to implement the jury's recommendations and make that response available to the Orangeville community.
30. To inform all Orangeville Police Service Board members of the issues identified during this inquest, within thirty days of this verdict, provide a copy of this Verdict and Recommendations to all Board members.

To the Minister and Ministry of Community Safety and Correctional Services, Ontario Association of Chiefs of Police and Ontario Association of Police Services Board:

31. To ensure proper functioning of police services boards, establish a working group within twelve months from the date of this verdict with the following responsibilities:
 - Provide direction to police service boards about the appropriate level of direction and scrutiny they may exercise over police operations.
 - Provide standardized training to police service board members regarding their responsibilities as board members.
 - Consider minimum qualifications for membership on police service boards.
 - Determine the applicability of the Morden Report, June 2012 to police services boards across the province.
 - Determine the amendments required to the provisions of the Police Services Act and the Ontario Regulation 421/97 Members of Police Services Boards – Code of Conduct of the Police Services Act to ensure that, where changes are made in practice as recommended in the Morden Report, police service boards will be in compliance with legislation.

To the Chief Coroner's Office:

32. To ensure timely communication to police services and police services boards regarding ongoing risk factors associated with prisoner care and control, distribute all jury recommendations relating to deaths in police custody to the Ontario Association of Chiefs of Police, Ontario Association of Police Services Boards and to the Ministry of Community, Safety and Correctional Services for distribution to all Police Service Boards, Police Chiefs and correctional institutions.

To the Ontario Association of Chiefs of Police, Ontario Association of Police Services Boards and the Ministry of Community, Safety and Correctional Services.

33. To ensure that all police services and police service boards in the province are aware of ongoing risk factors associated with prisoner care and control, distribute all jury recommendations relating to deaths in police custody (received from the Chief Coroner's Office) to members of your associations within 30 days of their receipt.