BRITISH COLUMBIA

Ministry of Justice

VERDICT AT INQUEST

File No.: 2010 :0364:0314

An Inquest was held at Burnaby Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates January 16, 17, 18, 2013

before Liana Wright, Presiding Coroner,

into the death of SLATTEN Robert Wayne 31 ☒ Male ☐ Female
(Last Name, First Name, Middle Name) (Age)

and the following findings were made:

Date and Time of Death: October 19, 2010 between 1200 and 1911

Place of Death: Fraser Reg Correctional Centre Maple Ridge, BC
(Location) (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Acute Methadone Intoxication

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b)

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☐ Accidental ☐ Homicide ☐ Natural ☐ Suicide ☒ Undetermined

The above verdict certified by the Jury on the 18th day of January AD, 2013.

Liana Wright
Presiding Coroner's Printed Name

Presiding Coroner's Signature

SLATTEN	Robert Wayne
Surname	**Given Names**

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Liana Wright
Inquest Counsel:	Rodrick MacKenzie
Counsel/Participants:	Pamela Manhas /Fraser Regional Correctional Centre
Court Reporting/Recording Agency:	Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded eight exhibits as entered. Fourteen witnesses were duly sworn and testified.

PRESIDING CORONER'S SUMMARY:

The following is a brief summary of the circumstances of the death as presented to the jury at the inquest. The summary and my comments respecting the recommendations, if any, are only provided to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

On October 19th, 2010, Robert Wayne Slatten was incarcerated at the Fraser Regional Correction Centre. Mr. Slatten was housed in his cell with another inmate who was on the Methadone Program. At approximately 7:30 that morning, a licensed practical nurse who was dispensing medications mistakenly gave Mr. Slatten a dose of Methadone that had been intended for his cellmate. Mr. Slatten was not on the Methadone Program; therefore, he did not have a tolerance for this drug. Mr. Slatten had presented his cellmate's photo identification card which the nurse testified she had checked before dispensing the Methadone. The nurse was on her second shift in the facility and was still on orientation. Due to another nurse calling in sick for that day shift, she was assigned to dispense medications to the inmates.

It is not known how Mr. Slatten came to obtain his cellmate's identification card. The cellmate had been released from the correctional facility and he could not be located. The jury further heard that the cellmate refused to cooperate with the investigation.

The medication error was not initially known. Mr. Slatten had returned to his cell and was noted to be sleeping on his bed during checks made by correctional officers that afternoon. He was discovered unresponsive on his bed at approximately 6:45 that evening. Despite attempts at resuscitation by correctional staff, fire department personnel and paramedics, Mr. Slatten could not be revived and was pronounced deceased.

JURY RECOMMENDATIONS:

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

To: Brent Merchant
Assistant Deputy Minister
Ministry of Justice - Corrections Branch
7th Floor - 1001 Douglas Street
Victoria BC V8W 9J7

1. It is recommended that the Correctional Officer responsible for the cell assignments must review all prior ALERTS on CORNET prior to confirming any cell assignment.

   Coroner's Comments: CORNET *is a computer database for Correctional Services of BC. It contains information regarding inmates, including critical and routine alerts. There was a notation in* CORNET *stemming from an earlier incident, that Mr. Slatten not be housed with a cell mate on the Methadone Program.*

2. It is recommended that BC Corrections adopt the practice of treating critical ALERTS in a SEPARATE CATEGORY from routine ALERTS.

3. It is recommended that the Log Book entries regarding inmate checks include descriptive language including inmate position and chest or breathing movements rather than the entry 'visual check'.

4. It is recommended that with respect to inmate checks, that more vigilance be paid to their well-being and level of consciousness in the hours following the administration of methadone and/or narcotics.

5. It is recommended that Correctional Officers be jointly responsible for identifying inmates along with Health Care staff prior to the administration of medications.

6. It is recommended that BC Corrections implement training to front line staff to reinforce the existing policy and standard operating procedures with respect to Methadone, and that it be followed up by careful onsite monitoring, even by a third party.

7. It is recommended that BC Corrections discontinue the practice of assigning responsibility of notifying next of kin upon an unexpected inmate death to RCMP and implement a policy of delegating a specific staff member to perform this function in an expeditious and compassionate manner.

To: Deputy Commissioner Craig Callens
Commanding Officer, RCMP 'E' Division
657 West 37th Avenue
Vancouver BC V5Z 1K6

8. It is recommended that the RCMP be required to conduct a thorough and comprehensive investigation including interviewing all individuals directly involved in any unexpected death of a BC Corrections inmate.