



CANADA
Province of Alberta

Report to the Minister of Justice and Attorney General Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the _____ Court House
in the _____ City _____ of _____ Lethbridge _____, in the Province of Alberta,
(City, Town or Village) (Name of City, Town, Village)
on the _____ 12th _____ day of _____ November _____, _____ 2008 _____, (and by adjournment
year
on the _____ day of _____, _____),
year
before _____ Timothy G. Hironaka _____, a Provincial Court Judge,
into the death of _____ DENNIS ALLAN KAREY _____ 23 _____
(Name in Full) (Age)
of _____ Lethbridge, Alberta _____ and the following findings were made:
(Residence)

Date and Time of Death: _____ April 30, 2005 at 9:06 a.m. _____

Place: _____ Lethbridge Correctional Centre _____

Medical Cause of Death:

("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – The Fatality Inquiries Act, Section 1(d)).

Methadone Toxicity

Manner of Death:

("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – The Fatality Inquiries Act, Section 1(h)).

Accidental

Circumstances under which Death occurred:

The deceased was an inmate at the Lethbridge Correctional Centre. He consumed methadone obtained from his cellmate who was on the methadone treatment program and who had smuggled his methadone back to their cell and provided it to the deceased.

Recommendations for the prevention of similar deaths:

The Board of Inquiry conducted by the Lethbridge Correctional Centre in May, 2005 made the following recommendations as remedial and preventative safeguards, intended to minimize opportunities and risks of methadone poisoning:

1. That the Adult Centre Operations Branch and all correctional centres involved in a methadone maintenance program, amend policy and practice to include that a correctional officer or correctional service worker monitor the offenders during the administration of the drug. Further, a procedure will be implemented requiring all offenders be searched prior to return to their living unit.
2. That a factual and comprehensive information sheet be developed by the Provincial Health Care Coordinator to educate staff as to the lethality of the ingestion of methadone by individuals who have not built up a tolerance through long time opiate drug use. Each institution will establish a manner of distribution/dissemination of this information to all staff.
3. That all correctional staff be reminded of policy 20.05.01 (Medical Emergency Code 99) with respect to immediately initiating a code 99 in cases of a medical emergency.
4. That all health care managers hold in-service and training with all health care staff regarding methadone administration emphasizing the extreme vigilance and care required in dispensing such a lethal medication to ensure it is consumed.

Evidence heard by this Inquiry indicates that all of these recommendations have already been implemented and should prevent other occurrences such as this one.

The only other recommendation that this Inquiry makes is to add a clause or clauses to the Methadone Treatment Contract making it clear that:

- a. sharing methadone is prohibited, and
- b. sharing methadone may endanger the health/life of the person with whom the methadone is shared.

DATED _____ December 3rd, 2008 _____,

at _____ Lethbridge _____, Alberta.

A Judge of the Provincial Court of Alberta