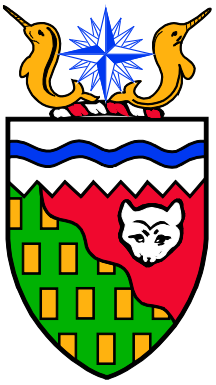

OFFICE OF THE CHIEF CORONER

NORTHWEST TERRITORIES CORONER SERVICE

2014 ANNUAL REPORT

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INTRODUCTION

The Coroner Service falls within the Territorial Department of Justice for organizational and administrative purposes, and it operates pursuant to the authorities conveyed by the *Coroner's Act*, which was initially enacted in 1985 but has been subject to amendment since. The Office of the Chief Coroner is located in Yellowknife and oversees all death investigations. Currently there are 36 coroners throughout the Northwest Territories, providing service in the communities and regions in which they reside.

All sudden and unexpected deaths occurring in the Northwest Territories must be reported to a coroner. The Coroner Service is responsible for the investigation of all reportable deaths in order to determine the identity of the deceased, and the facts concerning when, where, how and by what means they came to their death. The Coroner Service is supported in its efforts by the Royal Canadian Mounted Police, the Fire Marshal's Office, the Workers' Safety and Compensation Commission, the Transportation Safety Board, and various other agencies that also work closely with the Service.

The Chief Coroner is Cathy L. Menard. Ms. Menard has been with the Coroner Service since 1996. She has been with the Government of the Northwest Territories for 31 years.

There are no facilities in the Northwest Territories staffed to perform autopsies. When an autopsy is required, the remains are transported to Edmonton, where the procedure is performed by the Chief Medical Examiner's Office. Following the post-mortem examination, the remains are sent to Foster & McGarvey Funeral Home which holds a contract for preparation and repatriation. Toxicology services are provided to the Coroner Service by DynaLIFE$_{DX}$ Diagnostic Laboratory Services in Edmonton, and by the Chief Medical Examiner's Office in Alberta.

HISTORY OF CORONER SERVICE

The office of the Coroner is one of the oldest institutions known to English law. The role of the "coroner" in England has been noted in references dating back to the time of the Saxon King Alfred in 925 A.D. However, the historical development of the office can be traced back to a time near the Norman Conquest, when the coroner played an important role in the administration of justice.

It is generally accepted that the office was not regularly instituted until the end of the 12th century. One of the first detailed statutes concerning coroners was the Statute of Westminster of 1276. The title of the office has varied from "coronator" during the time of King John to "crowner" - a term still used occasionally in Scotland.

One of the earliest functions of the coroner was to inquire into sudden and unexpected deaths. The coroner was charged with the responsibility of establishing the facts surrounding a death, a duty that provides the basis for all coroner systems in use today.

The duties of the coroner have been modified over the centuries, but the primary focus continues to be the investigation of sudden and unexpected deaths. The rapid industrialization of the 19th century and the associated increase in workplace accidents, led to social demands that the coroner also serve a preventative function. This remains an important responsibility of the Coroner Service.

There are two death investigation systems in Canada: the coroner system and the medical examiner system. The coroner system assigns the coroner four major roles to fulfill: investigative, administrative, judicial, and preventative. The medical examiner system involves medical and administrative elements. The coroner and the medical examiner both collect medical and other evidence in order to determine the medical cause and manner of death. The coroner receives the information from a variety of sources before examining the investigative material, determining facts, and coming to a quasi-judicial decision concerning the death of an individual. The coroner can also make recommendations that may prevent a similar death.

In the Northwest Territories, the Coroner Service provides a multi-disciplinary approach to the investigation of death through the auspices of lay coroners appointed by the Minister of Justice. NWT coroners are assisted by the Royal Canadian Mounted Police, various professionals, and other experts when required.

EDUCATION

The NWT Coroner Symposium is held annually in order to impart the principles of sudden death investigation and to provide continuing education to coroners, health care workers, police officers and others who contribute to the team effort involved in investigating sudden and unexpected deaths in the NWT.

MANNER OF DEATH

The Coroner or an Inquest Jury determines the cause and manner of death. All deaths investigated by the Coroner Service are classified in one of five distinct categories: Natural, Accidental, Suicide, Homicide, or Undetermined.

NATURAL - A death which is consistent with the normal or expected course of events, occurring in conformity with the deceased's known or recorded medical history and not caused by any outside event or agency, human or otherwise.

ACCIDENTAL - An unexpected result of an action or actions by a person which results in death to himself, or a death that results from the intervention of a non-human agency.

SUICIDE - A death is a suicide when a person takes his own life with the intent to do so.

HOMICIDE - A homicide is a death that was caused directly or indirectly by another person. (Homicide is a neutral term that does not imply fault or blame.)

UNDETERMINED - If a death cannot be classified into one of the above categories, it should simply be classified as "undetermined".

*(**UNCLASSIFIED** is reserved for any case work that ultimately does not result in another classification. It is primarily used for found remains which are analyzed and determined to be of non-human origin.)*

CORONERS ACT – REPORTING DEATHS

Duty to Notify ***8. (1)*** ***Every person shall immediately notify a coroner or a police officer of any death of which he or she has knowledge that occurs in the Northwest Territories, or as a result of events that occur in the Territories, where the death***

(a) occurs as a result of apparent violence, accident, suicide or other than disease, sickness or old age;

(b) occurs as a result of apparent negligence, misconduct or malpractice;

(c) occurs suddenly and unexpectedly when the deceased was in apparent good health;

(d) occurs within 10 days after a medical procedure or while the deceased is under or recovering from anaesthesia;

(e) occurs as a result of;

(i) a disease or sickness incurred or contracted by the deceased,

(ii) an injury sustained by the deceased, or

(iii) an exposure of the deceased to a toxic substance, as result or in the course of any employment or occupation of the deceased;

(f) is a stillbirth that occurs without the presence of a medical practitioner;

(g) occurs while the deceased is detained or in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution; or

(h) occurs while the deceased is detained by or in the custody of a police officer.

Exception ***(2)*** ***Notwithstanding subsection (1), a person need not notify a coroner or a police officer of a reportable death where the person knows that a coroner or police officer is already aware of the death***

Duty of police officer ***(3)*** ***A police officer who has knowledge of a reportable death shall immediately notify a coroner of the death.***

Special reporting arrangements ***(4)*** ***The Chief Coroner may make special arrangements with medical facilities, correctional facilities and the Royal Canadian Mounted Police for the efficient notification of reportable deaths by persons in those facilities or that organization.***

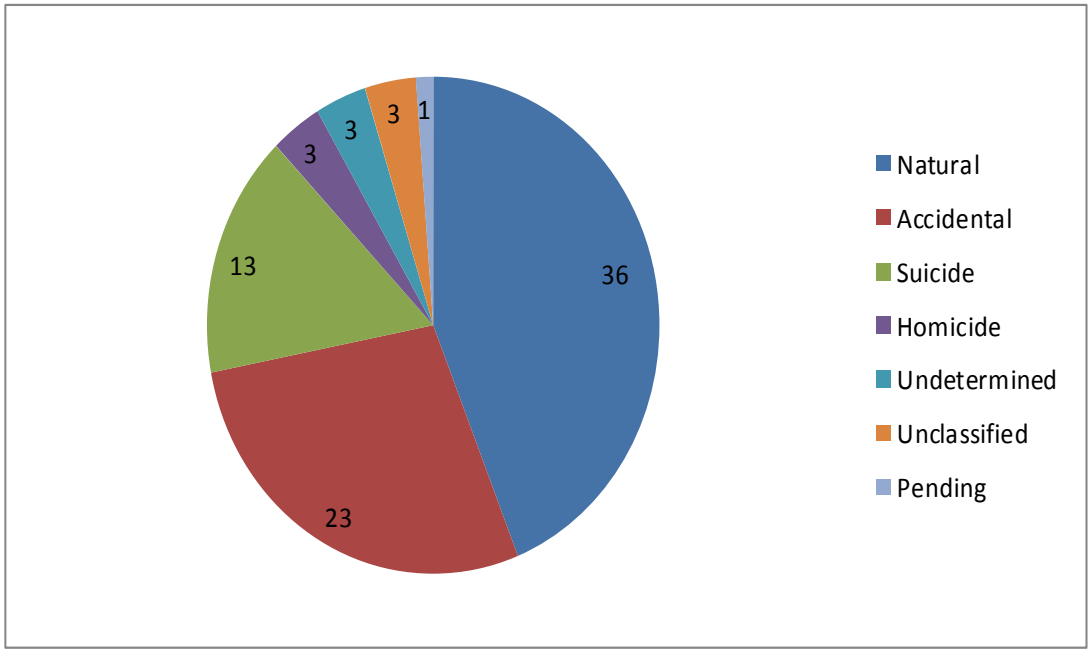
NWT REGIONS

Obtained from http://www.enr.gov.nt.ca/_live/documents/content/Administrative_regions.pdf

2014 CASE STATISTICS

TOTAL CASES

Total Cases			
Manner of Death	Number*	Cases %	Population % **
Natural	36	43.90%	0.0826%
Accidental	23	28.05%	0.0528%
Suicide	13	15.85%	0.0298%
Homicide	3	3.66%	0.0069%
Undetermined	3	3.66%	0.0069%
Unclassified	3	3.66%	N/A
Pending	1	1.22%	0.0023%
Total	82	100%	0.1881%



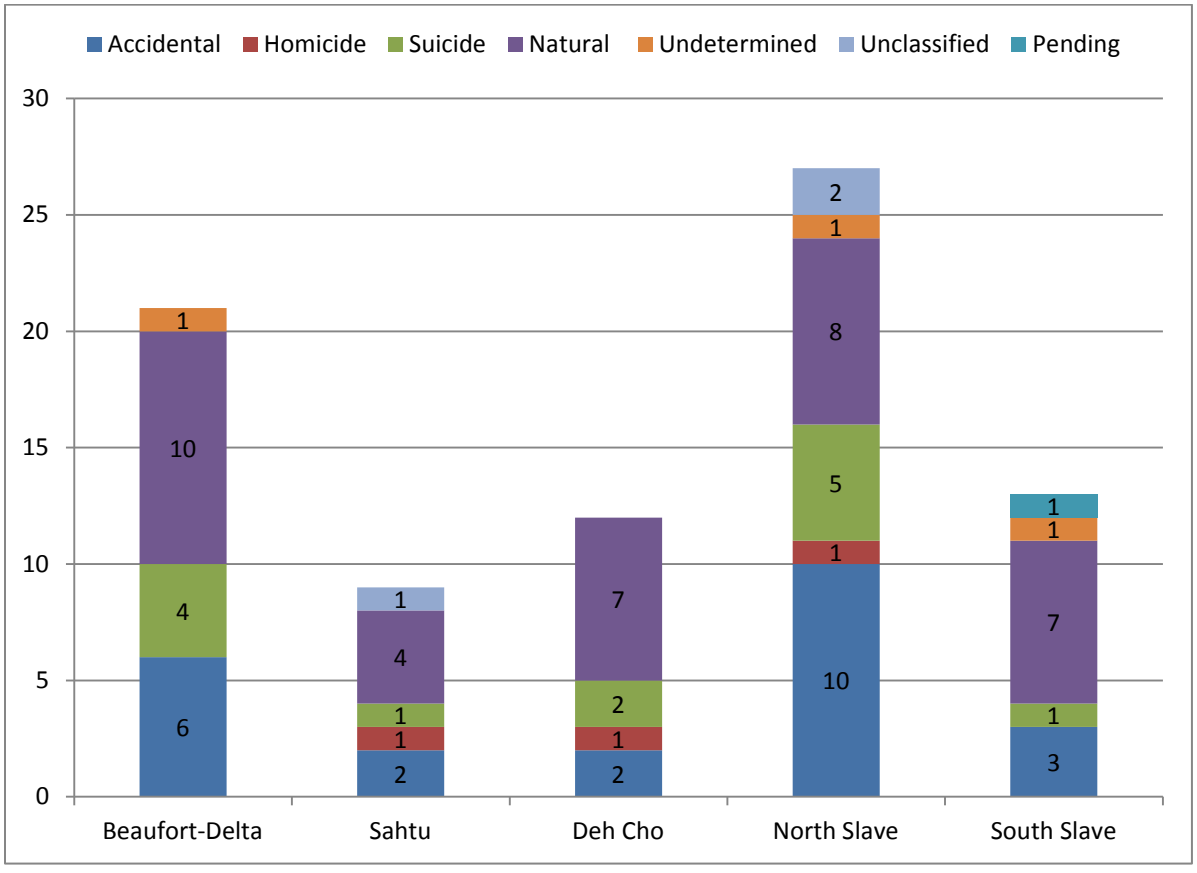
Unclassified cases are not represented in the population figures since they are non-human in origin. In 2014, three cases were determined to be unclassified.

* At the time of the release of this annual report we have one case pending.

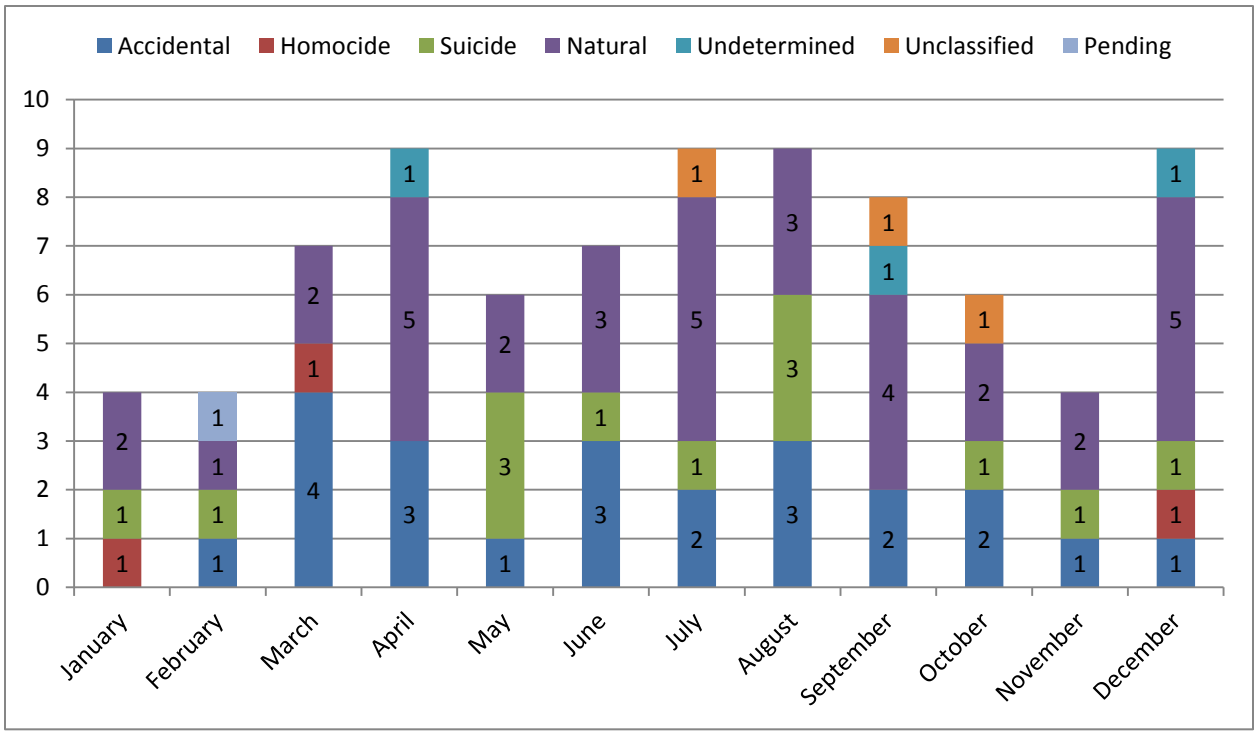
** Based on an Annual NT population estimate of 43,595 retrieved March 26, 2015 at http://www.statsnwt.ca/population/population-estimates/PopEstJan2015.pdf

CASELOAD BY MANNER AND REGION

Region	Accidental	Homicide	Suicide	Natural	Undetermined	Unclassified	Pending	Total
Beaufort-Delta	6		4	10	1			21
Sahtu	2	1	1	4		1		9
Deh Cho	2	1	2	7				12
North Slave	10	1	5	8	1	2		27
South Slave	3		1	7	1		1	13
Total	23	3	13	36	3	3	1	82



CASELOAD BY MANNER AND MONTH

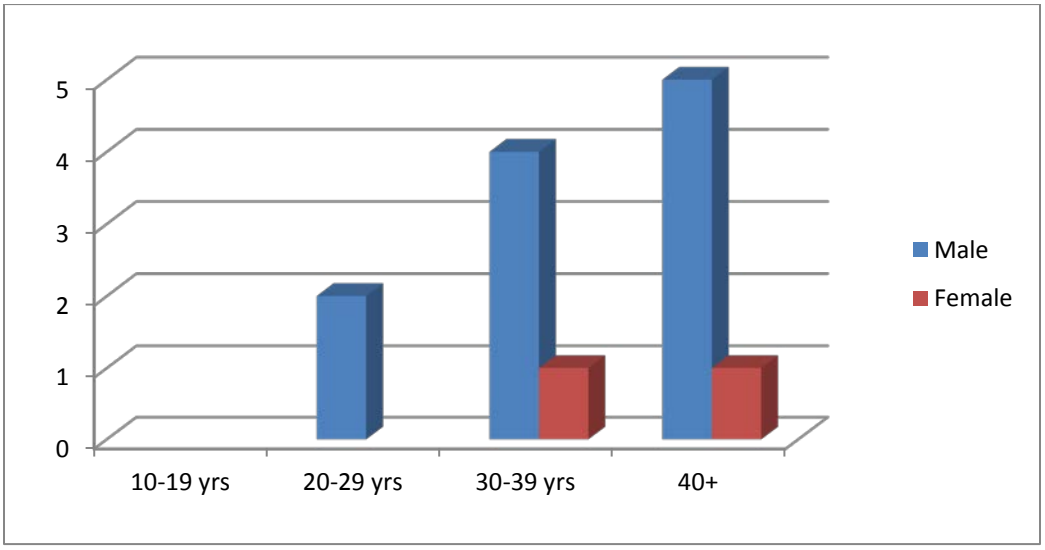


Month	Accidental	Homicide	Suicide	Natural	Undetermined	Unclassified	Pending	Total
January		1	1	2				4
February	1		1	1			1	4
March	4	1		2				7
April	3			5	1			9
May	1		3	2				6
June	3		1	3				7
July	2		1	5		1		9
August	3		3	3				9
September	2			4	1	1		8
October	2		1	2		1		6
November	1		1	2				4
December	1	1	1	5	1			9
Total	23	3	13	36	3	3	1	82

SUICIDE

BY GENDER AND AGE

Age Group	Male	Female	Total
10-19 years			
20-29 years	2		2
30-39 years	4	1	5
40 + years	5	1	6
Total	11	2	13



In 2014 there were thirteen suicides; eleven males and two females. Most of these suicides occurred in men over the age of 30.

Suicide

METHOD, ALCOHOL, AND DRUG INVOLVEMENT

Region	Method	Alcohol Involvement	Drug Involvement
Sahtu	Hanging	Yes	Yes
Dehcho	Hanging	Yes	No
Dehcho	Hanging	Yes	Yes
South Slave	Acute Isopropanol & Methanol Toxicity	No	No
North Slave	Drowning	No	No
North Slave	Self-inflicted Gunshot	No	Yes
North Slave	Self-inflicted Gunshot	No	No
North Slave	Asphyxia	No	No
North Slave	Hanging	Yes	No
Beaufort-Delta	Morphine Toxicity	Yes	Yes
Beaufort-Delta	Self-inflicted Gunshot	Yes	No
Beaufort-Delta	Self-inflicted Gunshot	No	No
Beaufort-Delta	Hanging	Yes	No

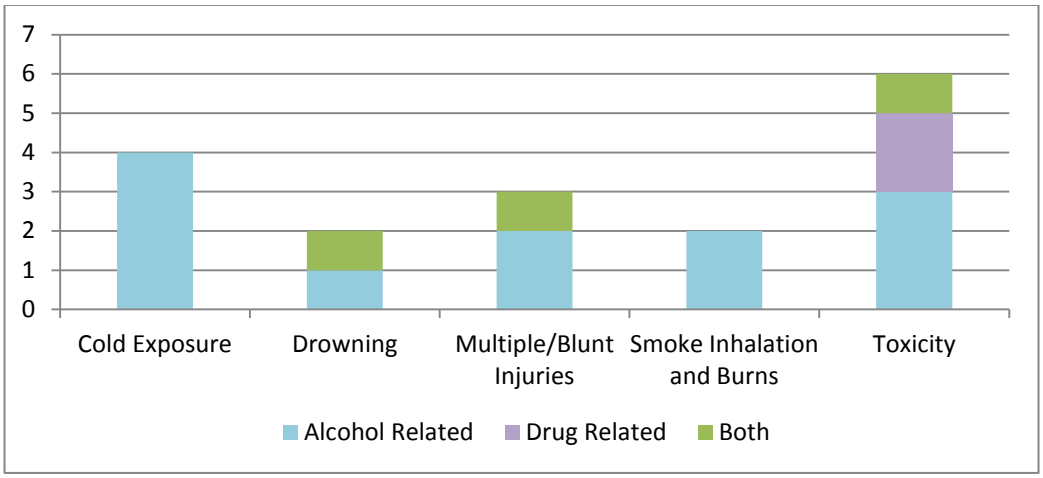
The highest suicide rate was presented in the North Slave region, which had five suicides. Toxicology examination confirmed the presence of alcohol in seven of the thirteen suicides and drugs in four of the thirteen suicides.

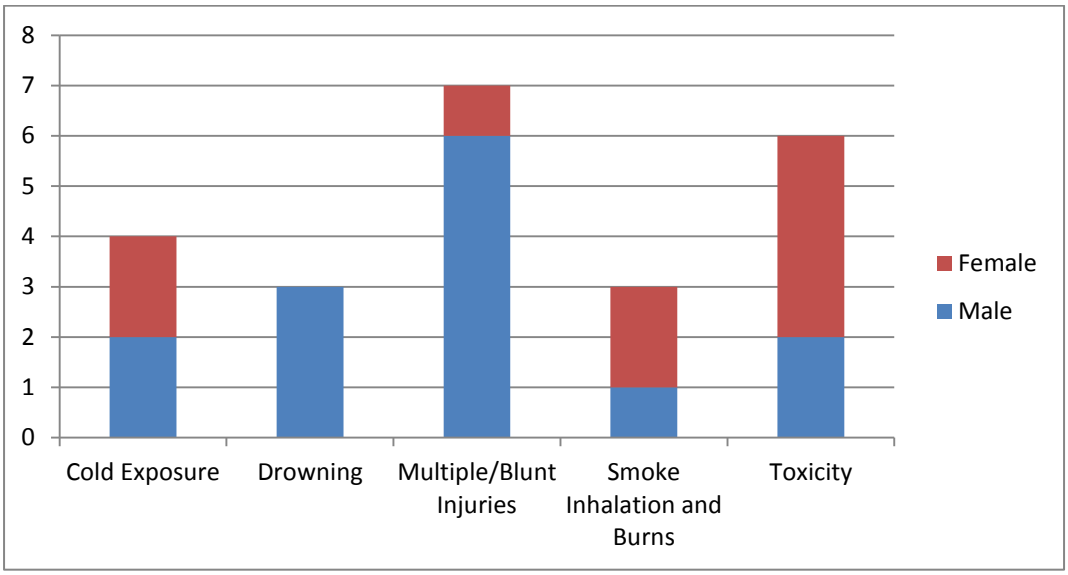
ACCIDENTAL

BY CAUSE AND GENDER

Cause of Death	Male	Female	Total
Cold Exposure	2	2	4
Drowning	3		3
Multiple/Blunt Injuries	6	1	7
Smoke Inhalation & Burns	1	2	3
Toxicity	2	4	6
Totals	14	9	23

Accidental deaths accounted for approximately 28.05% of reported deaths in 2014. The majority of accidental deaths were males (14 of 23 or 61%) and were alcohol and/or drug related (17 of 23 or 74%).





HOMICIDE

BY AGE AND GENDER

Age Group	Male	Female	Alcohol Involved	Total
0-19	0	0	0	0
20-29	0	1	1	1
30-39	1	0	1	1
40-49	1	0	1	1
50-59	0	0	0	0
60+	0	0	0	0
Total	2	1	3	3

BY REGION

Region	Total
Beaufort-Delta	
Sahtu	1
Deh Cho	1
North Slave	1
South Slave	
Total	3

In 2014, there were three homicides; two were male. Homicides accounted for 3.66% of the reported deaths.

CORONER APPOINTMENTS

The Chief Coroner has the statutory authority to recommend the appointment and removal of coroners. It is desirable for each community to have resident coroners, and recruitment of local coroners is facilitated by the Office of the Chief Coroner, the RCMP, and municipal and other local governments. Candidates must complete an application form outlining any special skills or training they have which would assist them in fulfilling their duties as coroners. Applicants are also required to have written support from their municipal or local government and their local RCMP detachment. A recommendation for appointment by the Chief Coroner is then forwarded to the Minister of Justice. The applicant's MLA is also advised of the intended appointment. Coroners are appointed by the Minister of Justice for a three-year term.

In 2014, there were 36 coroners across the Northwest Territories, with 19 men and 17 women.

There are no coroners currently residing in the communities of Colville Lake, Fort Resolution, Fort Good Hope, Gameti, Whati, Paulatuk, Enterprise, Nahanni Butte, Tsiigehtchic, and Wrigley.

CONCLUDING CORONER INVESTIGATIONS

All coroner cases are generally concluded either by a coroner's report or by inquest. The most common method used is the "Report of Coroner".

REPORT OF CORONER

The Report of Coroner is a document outlining the results of a coroner's investigation. It summarizes and clarifies the facts and circumstances surrounding the death. The Report establishes the identity of the deceased, classifies the manner of death, and may include recommendations for the prevention of similar deaths. The report is completed in all death investigations with the exception of cases where an inquest is being held. At an inquest the jury verdict takes the place of the Report of Coroner.

Recommendations are often made and are forwarded to the appropriate department, person, or agency in hopes of providing information and advice that may prevent similar deaths. Reports of Coroner containing recommendations are distributed as required, and responses are monitored. A synopsis of selected reports containing recommendations is attached (See Appendix "A").

INQUESTS

Coroner cases that are not concluded by a Report of Coroner are ordinarily finalized by the use of a Coroner's Inquest. An Inquest is a formal quasi-judicial proceeding that allows for the public presentation of evidence relating to a death.

The proceeding utilizes a six member jury and hears testimony from sworn witnesses. The jury may make recommendations to prevent future deaths in similar circumstances.

A coroner must hold an inquest when the deceased had been involuntarily detained in custody at the time of the death. An inquest can also be held when, in the opinion of a coroner, it is necessary:

a) to identify the deceased or determine circumstances of the death;
b) to inform the public of the circumstances of death where it will serve some public purpose;
c) to bring dangerous practices or conditions to the knowledge of the public and facilitate the making of recommendations to avoid a preventable death; or
d) to inform the public of dangerous practices or conditions in order to avoid future preventable deaths.

Should a coroner determine that an inquest is not necessary, the next of kin or another interested person may request that an inquest be held. The coroner shall consider the request and issue a written decision. This decision may be appealed to the Chief Coroner, who must consider the merits of the appeal and provide a written decision with reasons within 10 days after receipt of the appeal. Subject to the power of the Minister of Justice to request or direct an inquest under section 24 of the *Coroners Act*, the decision of the Chief Coroner is final.

APPENDIX "A"
SUMMARY OF SELECTED CORONER REPORTS CONTAINING RECOMMENDATIONS (CONCLUDED IN 2014)

Case # 1

This 47-year-old female with a history of insulin dependent diabetes, alcohol and drug abuse, hypertension, depression, and chronic pain, was found deceased on her bed. It was determined that the cause of death was Aspiration Pneumonia arising as a result of the combined toxic effects of Multiple Drug Toxicity occurring in an individual with a history of alcohol and drug abuse. The death was classified as Accidental.

COMMENTS AND RECOMMENDATIONS:

The Office of the Chief Coroner requested assistance from the Ontario Coroner Service's Patient Safety Death Review Committee, a panel of experts that reviewed all the compiled investigative material. The Review Committee analyzed the death, and has made recommendations to the Chief Coroner of the Northwest Territories.

The following recommendations were put forward to the NWT Chief Coroner for consideration by the Patient Death Review Committee. The Review Committee felt that there is an urgent need for the Department of Health and Social Services in the Northwest Territories to set standards and provide training on opioid prescribing and to organize services for opioid addicted patients.

The Office of the Chief Coroner of the Northwest Territories accordingly made the following recommendations:

1. The Department Health and Social Services should establish a working group to set standards for physicians and nurse practitioners on the prescribing of opioids and benzodiazepines. The Canadian Guideline needs to be adapted to the NWT setting, where short-term locums provide much of the care and the patient population has a high prevalence of substance use disorders.

2. The Department of Health and Social Services should review its eligibility criteria for Suboxone coverage, to ensure that all patients who need it are able to receive it.

Comment: *Apparently both the Non-Insured Health Benefits (NIHB) and the Department of Health and Social Services have Suboxone on their formularies. However, eligibility criteria vary greatly between the provinces. For example, the Ontario drug plan allows family physicians to prescribe Suboxone in communities where methadone is unavailable. In contrast, in the British Columbia drug plan, Suboxone can only be prescribed by a methadone physician, and only to*

patients who have failed a trial of methadone. Since most small communities in British Columbia do not have methadone prescribers, rural opioid-dependent patients in that province do not have access to Suboxone.

3. The Department Health and Social Services should establish a working group to set guidelines and standards for the medical management of opioid dependence. Current guidelines on Suboxone prescribing and dispensing need to be adapted for the NWT setting.

Comment: *Ontario guidelines recommend daily dispensing of Suboxone under the supervision of a pharmacist during the first few weeks of treatment, in order to reduce the risk of diversion and misuse. This is not practical in small communities, which do not have a pharmacy open seven days a week.*

4. In setting up addiction services, the eight NWT Regional Health Authorities must work closely with communities and band councils.

Comment*: In Sioux Lookout in Ontario, buprenorphine programs are operated independently by band councils, in coordination with local physicians and nurses.*

5. The Department of Health and Social Services should provide training for physicians and nurse practitioners on opioid and benzodiazepine prescribing and on the identification and management of opioid misuse and addiction. The training could be offered through telemedicine.

Comment: *For example, the University of Toronto is preparing a series of three two-hour interactive webinars on prescribing of opioids for chronic pain, and on the identification and management of prescription misuse and addiction. Training on the management of alcohol, tobacco and other substance use disorders could also be provided through distance education methods.*

6. The Department of Health and Social Services for the NWT should provide physicians and nurses with access to a long distance clinical support network to assist them in the management of opioid prescribing and opioid addiction.

Comment: *Ontario has the Northern Ontario Suboxone Support group, and the Medical Mentoring in Pain and Addiction group. Community physicians can pose clinical questions and cases to experts by phone, e-mail or video link. The networks also offer presentations and long-distance group discussions*.

7. The Department of Health and Social Services should arrange for one or more physicians and nurse practitioners to receive more intensive training in Suboxone prescribing, structured opioid therapy, and benzodiazepine tapering.

Comment: *Such training could be offered through a short practicum in addiction medicine in Alberta, Ontario or other jurisdictions.*

Case # 2

This 14 year old female, was last seen in the early hours of the morning by her mother at home. Her mother stated that she thought her daughter had been drinking but that she had gone to bed. When she woke the next morning her daughter was not home. She was found two days later frozen in the snow outside, with a vodka bottle inside her coat. It was determined that she had died of Hypothermia, with Acute Ethanol Intoxication as a significant contributory factor. The death was classified as Accidental.

Comments and Recommendations

A review of the existing Liquor Act legislation was under taken by the Standing Committee on Social Programs in the Legislative Assembly of the Northwest Territories. Bill 24: *An Act to Amend the Liquor Act* was introduced in June 2013 by Norman Yakeleya, MLA for the Sahtu. The purpose of the bill was to allow the Sahtu communities to ask the Minister of Finance to hold a regional vote on limiting sales to individuals at a liquor store in the region. The bill was referred to the Standing Committee on Government Operations for review on June 6, 2013. During public hearings in Sahtu communities, members of the Standing Committee received feedback on the bill as well as comments on a range of issues associated with abuse of alcohol. The standing committee's report entitled "Report on the Review of Bill 24: An Act to Amend the Liquor Act" was tabled in October 2013 and included 15 recommendations, some of which go beyond the scope of Bill 24. The Committee reported that they were persuaded to go beyond the limited scope of the bill by what they heard in the communities. In the report the Standing Committee said that "*The integrity of the government is at stake. The same is true for community leadership. There will be no success in dealing with alcohol abuse without local ownership of the problem, local solutions and local action."*

The Office of the Chief Coroner makes the following recommendations to:

The Honourable Robert McLeod, Premier, Government of the Northwest Territories:

The Standing Committee on Government Operations report 17-7(4), "Report on the Review of Bill 24: An Act to Amend the Liquor Act" raises a number of important issues relating to the abuse of alcohol and sets a clear path and direction for the Government of the Northwest Territories.

I recommend the Government of the Northwest Territories review and give careful consideration to the 15 recommendations that were tabled in October 2013 in the Legislative Assembly.

Case # 3

Emergency personnel were called to Fred Henne Territorial Park beach where a 7 year old male had been found under water. He was carried to the shore where cardiopulmonary resuscitation (CPR) was started immediately by community members. Upon arrival of emergency personnel he was transported to Stanton Territorial Hospital, where despite continued efforts he was pronounced dead. It was determined that the cause of death was Drowning and the death was classified as Accidental.

Comments and Recommendations

The Office of the Chief Coroner requested the assistance of the Royal Lifesaving Society of Canada, Alberta and Northwest Territories ("Lifesaving Society"). The Lifesaving Society reviewed and analyzed the circumstances and made recommendations to the Chief Coroner of the Northwest Territories.

The recommendations from the Aquatic Safety Audit and Incident Analysis are the result of the Lifesaving Society's expert independent and objective review. The reports greatly assisted the NWT Coroner Service in identifying the recommendations aimed at preventing future deaths in similar circumstances.

The Office of the Chief Coroner makes the following recommendation for consideration:

1. The Department of Industry, Tourism and Investment should continue to work with the Lifesaving Society to further enhance its Water Safety public education and awareness messaging for Fred Henne Territorial Park.

2. The Department of Industry, Tourism and Investment should continue to implement the recommendations included in Fred Henne Aquatic Safety Audit, so as to increase the level of protection for the unsupervised waterfront to a level 7.

Comment*: In the Aquatic Safety Audit recommendations were made to increase the level of protection to level 7.*

3. The Department of Industry, Tourism and Investment should consider a strategy to educate users and implement an admission policy at the Fred Henne Territorial Park.

Comment: *This could include signage, and having park officers or contractors ask unattended children to leave the facility.*

4. The Department of Industry, Tourism and Investment should develop public awareness that children under 10 must be within arm's reach of a responsible caregiver.

Comment: *Public awareness can be reinforced through methods such as additional signage and media campaigns.*

5. The Department of Industry, Tourism and Investment should collaborate with the Lifesaving Society to educate users of inflatables toys and devices on the risks and hazards associated with their use.

Comment: *Inflatables can pose a significant safety risk, as they are easily blown around by the wind.*

6. The Department of Industry, Tourism and Investment should develop and post information to inform the users of Fred Henne Territorial Park waterfront about the hazards present in and around the swimming area.

Comment: *This could include informing the public that it is a natural environment subject to changing conditions that affect water temperature, wind, current, marine life, and bottom terrain.*

7. The Department of Industry, Tourism and Investment should continue to support the NWT Water Smart program to increase public awareness and encourage the public to pursue "Swim to Survive" training.

8. The Department of Industry, Tourism and Investment should continue to operate and maintain the lifejacket loaner station that has been implemented at Fred Henne Territorial Park, and consideration could also be given to expanding this program to other waterfronts in the Northwest Territories.

9. The Department of Industry, Tourism, and Investment should work with the Lifesaving Society to complete a Lifeguard Feasibility Study, to determine the feasibility of Fred Henne Territorial Park being a supervised Lifeguard facility.

Comment*: If lifeguards are to be considered as an option, all other levels of protection must be considered as priority and must be implemented.*

Case # 4

This couple in their 50's had been socializing in a campground and then returned to their rented cabin and retired for the night. When the two did not respond to visitors on three occasions at their cabin, the RCMP were notified so they could provide assistance. The RCMP forced entry into the cabin finding the two deceased in the bed. There was a strong odour of propane inside the cabin. It was determined that the cause of death was Acute Carbon Monoxide Toxicity and the death was classified as Accidental.

Comments and Recommendations

The NWT Coroner Services made the following recommendation to the Government of the Northwest Territories:

1. To develop and implement a public awareness campaign with the following objectives:

   · Owners of old propane/gas heating appliances understand the operation and associated risks of improperly installed and/or poorly maintained appliances.

   · Emphasize the responsibilities of landlords, homeowners, and tenants related to propane/gas appliances.

   · Highlight the importance of the proper installation, use, and maintenance of carbon monoxide monitors and smoke detectors.

APPENDIX "B"
SUMMARY OF CORONER'S INQUESTS

THERE WERE NO CORONER INQUESTS DURING 2014.

EXPRESSIONS OF APPRECIATION

The NWT Coroner Service wishes to express appreciation to the RCMP, Health Care Professionals, and the many other investigative partners that cooperated with and assisted coroners in conducting death investigations over the past year. The Service would also like to thank the coroners who demonstrate - often under less than optimal conditions - a high level of dedication and professionalism.