Office of the Chief Coroner
Bureau du coroner en chef

NORTHWEST TERRITORIES CORONER SERVICE

2018 ANNUAL REPORT

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INTRODUCTION

The Coroner Service falls under the Territorial Department of Justice for administrative purposes, and operates pursuant to the authorities conveyed by the *Coroners 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. As of December 31, 2018 there were 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 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 over 30 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 the Graham R. Jones Forensic Toxicology Laboratory.

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, but the evolution of the office is more evident after 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 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 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 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 similar deaths.

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 herself, or a death that results from the intervention of a non-human agency.

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

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

UNDETERMINED - A death that cannot be classified into one of the above categories is simply 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 apparent cause other than disease, sickness, old age or medical assistance in dying provided accordance with section 241.2 of the *Criminal Code*;

(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 the deceased

(i) having incurred or contracted a disease or sickness,

(ii) having sustained an injury, or

(iii) having been exposed to a toxic substance,

as a result of or in the course of any employment or occupation of the deceased;

(f) is a stillbirth that occurs without the presence of a health care professional;

(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;

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

(i) occurs while the Director of Child and Family Services has the rights and responsibilities of a parent under the *Child and Family Services Act* in respect of the person of the deceased.

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. S.N.W.T. 2010,c.16,Sch.A,s.9 (3); S.N.W.T. 2015, c.22,s.5; S.N.W.T. 2017,c.16,s.3(2),(3).

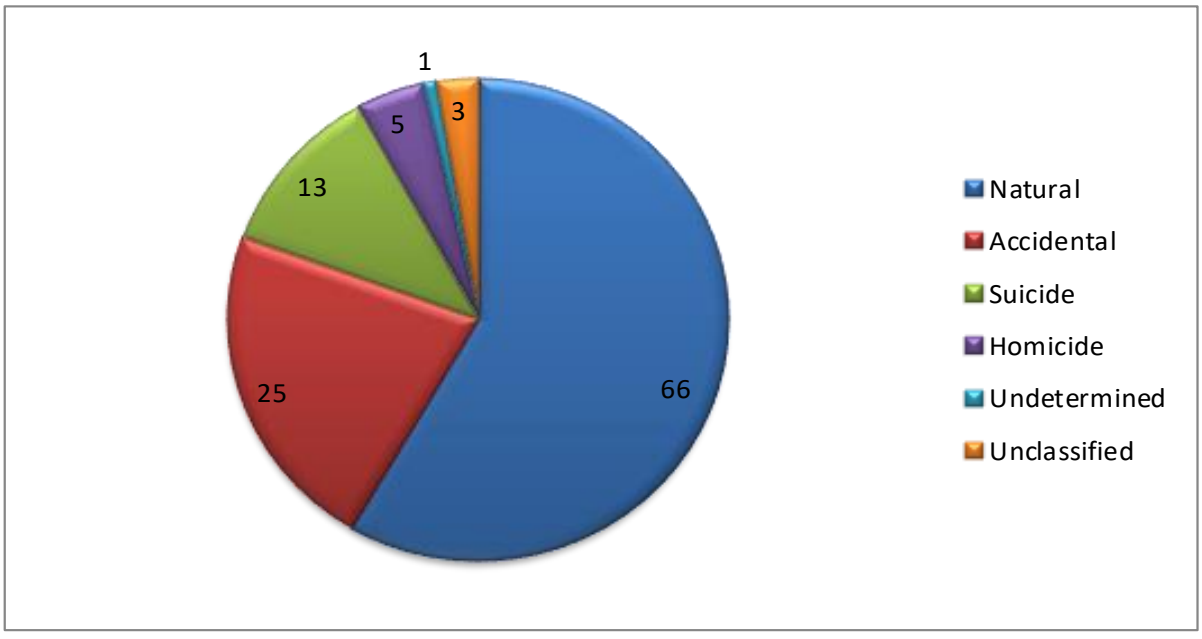
NWT REGIONS

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

2018 CASE STATISTICS

TOTAL CASES

Total Cases			
Manner of Death	Number *	Cases %	Population % **
Natural	66	57.89%	0.1471%
Accidental	25	21.93%	0.0557%
Suicide	13	11.40%	0.0290%
Homicide	5	4.39%	0.0111%
Undetermined	1	0.88%	0.0022%
Unclassified	3	2.63%	N/A
Pending	1	0.88%	0.0022%
Total	114	100%	0.2540%



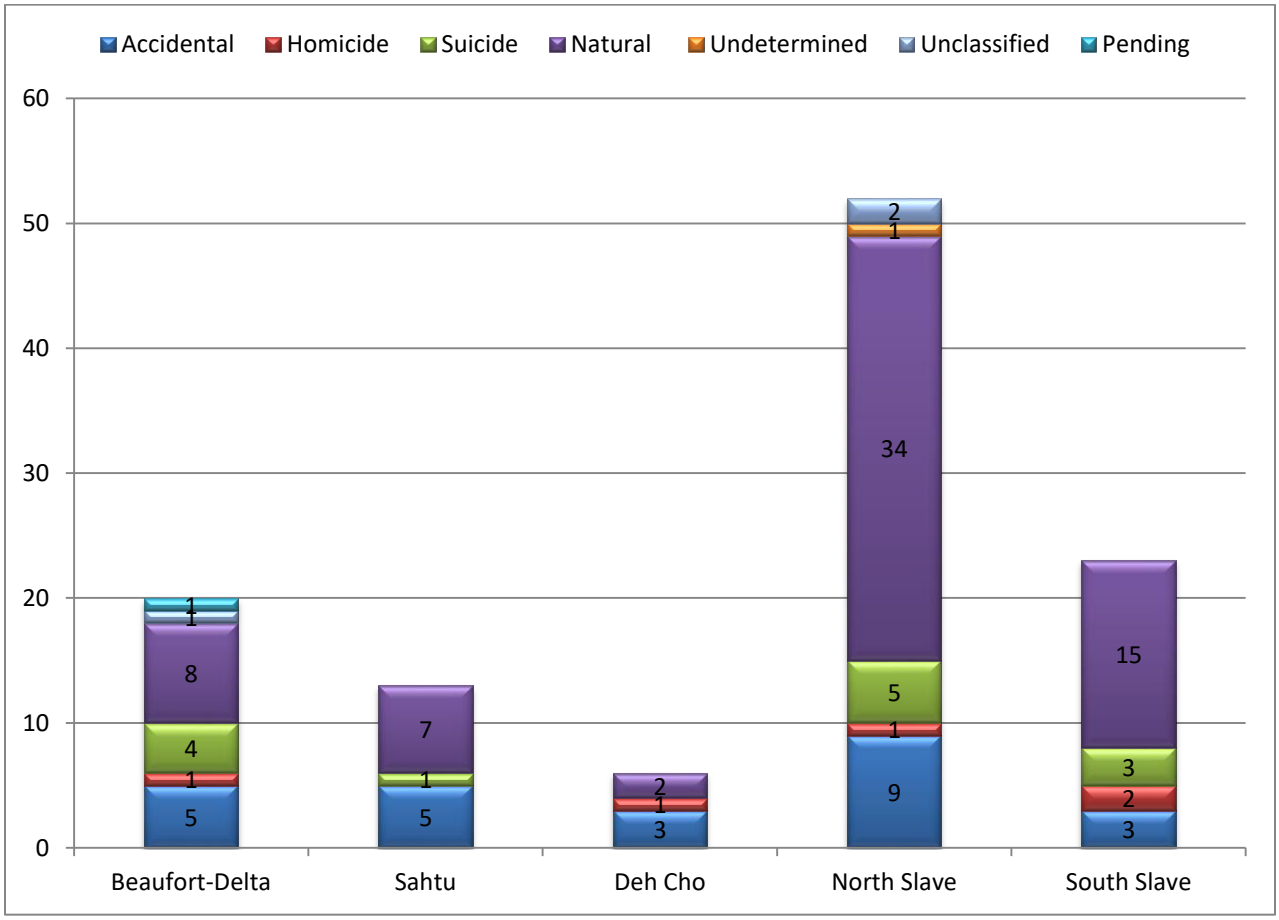
Unclassified cases are not represented in the population figures since they are non-human in origin. In 2018, three cases were determined to be unclassified.

*The NWT Coroner Service assisted with an Alberta death and a Yukon death.

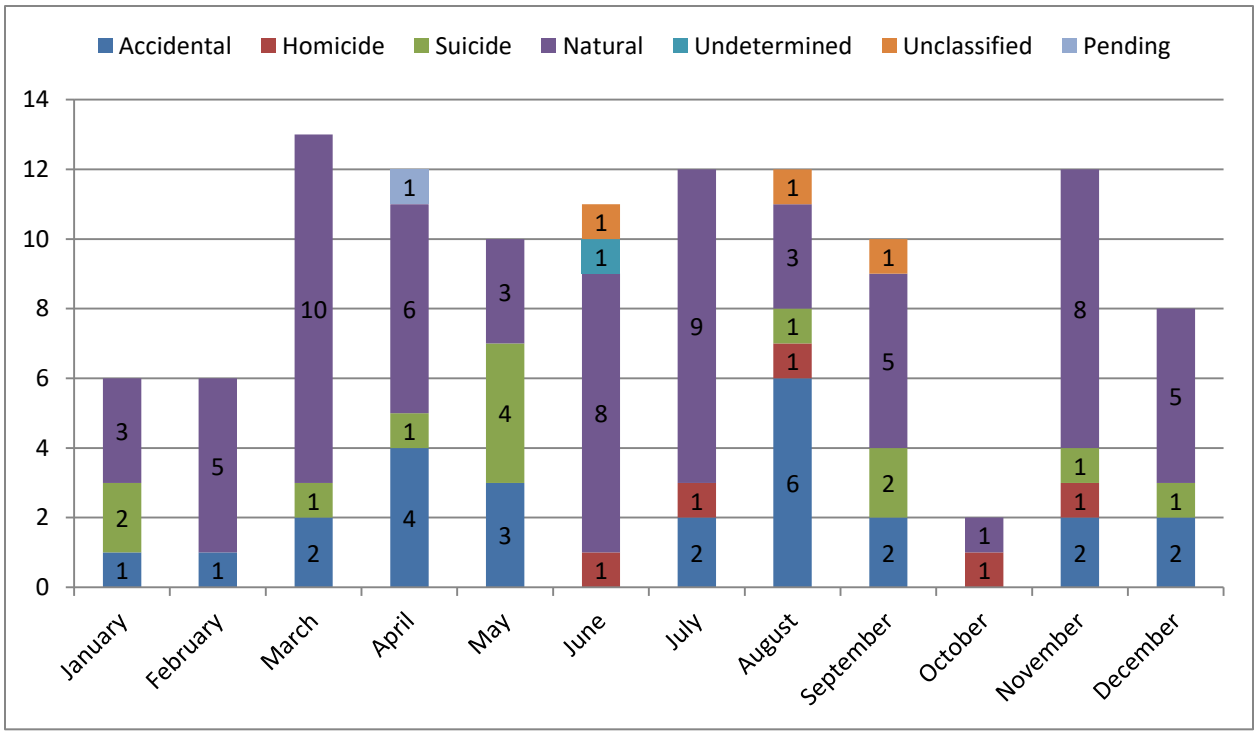
** Based on an NT population estimate of 44,875 retrieved October 1, 2019 at http://www.statsnwt.ca/population/population-estimates/

CASELOAD BY MANNER AND REGION

Region	Accidental	Homicide	Suicide	Natural	Undeter-mined	Unclassified	Pending	Total
Beaufort-Delta	5	1	4	8		1	1	20
Sahtu	5		1	7				13
Deh Cho	3	1		2				6
North Slave	9	1	5	34	1	2		52
South Slave	3	2	3	15				23
Total	25	5	13	66	1	3	1	114



CASELOAD BY MANNER AND MONTH

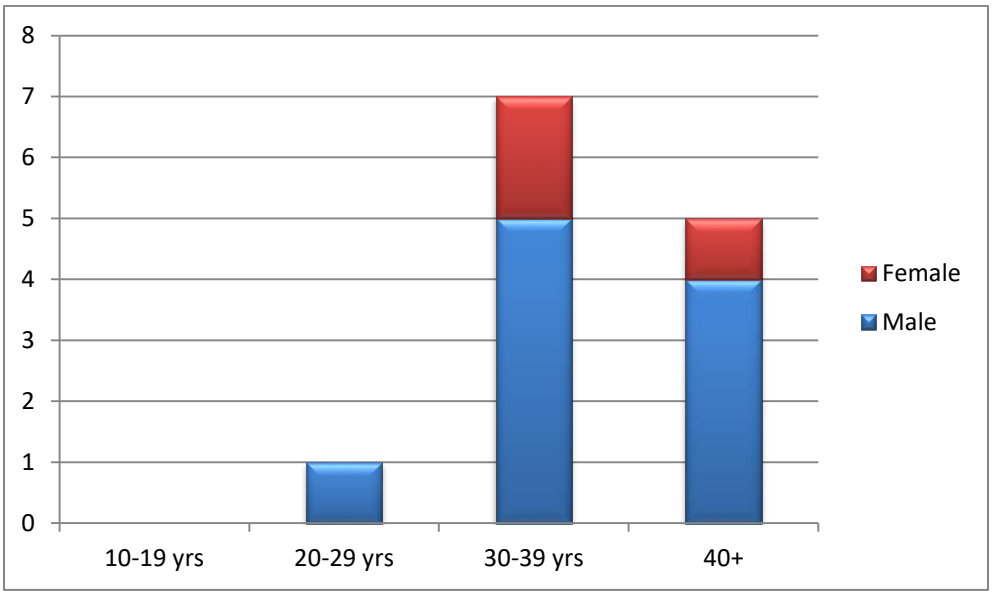


Month	Accidental	Homicide	Suicide	Natural	Undeter-mined	Unclassified	Pending	Total
January	1		2	3				6
February	1			5				6
March	2		1	10				13
April	4		1	6			1	12
May	3		4	3				10
June		1		8	1	1		11
July	2	1		9				12
August	6	1	1	3		1		12
September	2		2	5		1		10
October		1		1				2
November	2	1	1	8				12
December	2		1	5				8
Total	25	5	13	66	1	3	1	114

SUICIDE

BY GENDER AND AGE

Age Group	Male	Female	Total
10-19 years			
20-29 years	1		1
30-39 years	5	2	7
40 + years	4	1	5
Total	10	3	13



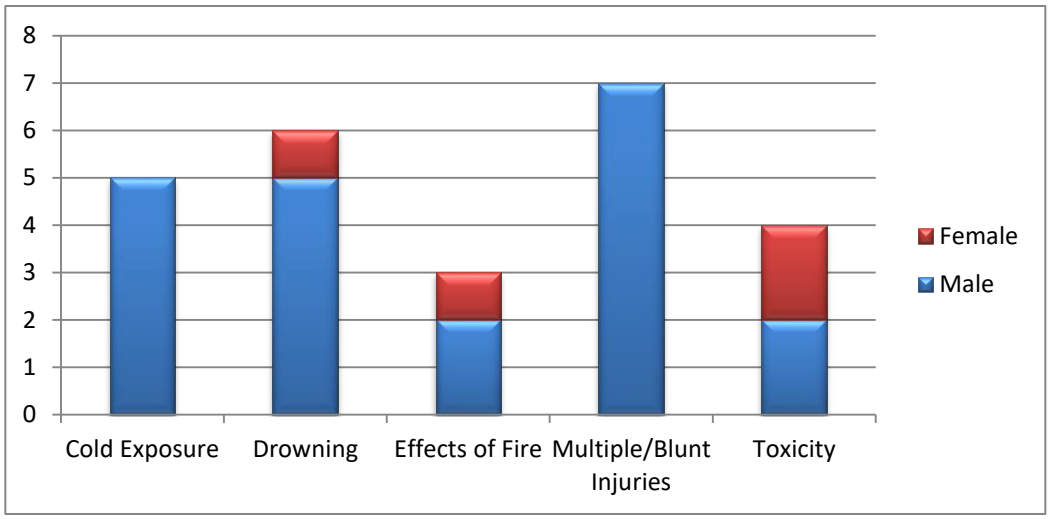
In 2018 there were thirteen suicides; ten males and three females. Nine of these deaths involved men over the age of 30. Toxicology examination confirmed the presence of alcohol and/or drugs in six of the thirteen suicides.

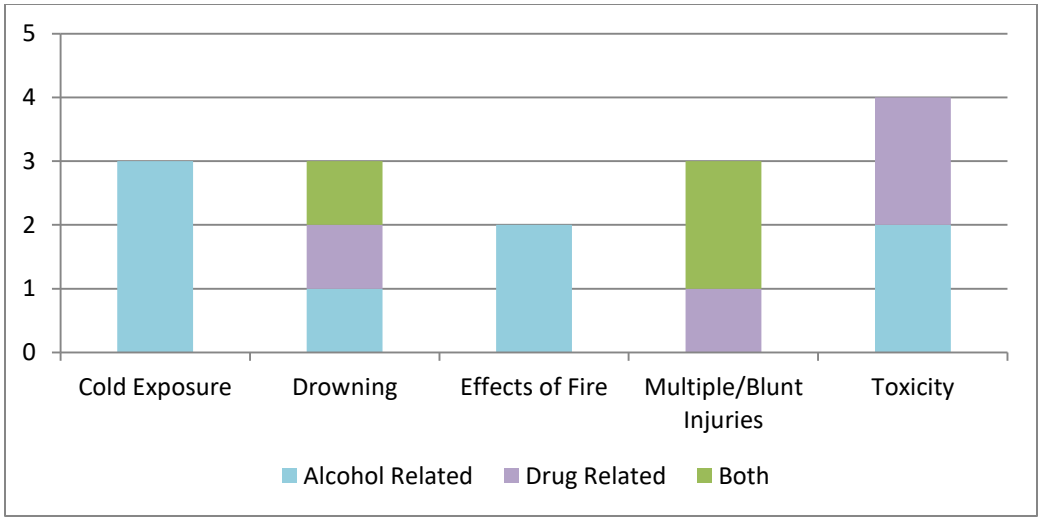
ACCIDENTAL

BY CAUSE AND GENDER

Cause of Death	Male	Female	Total
Cold Exposure	5		5
Drowning	5	1	6
Effects of Fire	2	1	3
Multiple/Blunt Injuries	7		7
Toxicity	2	2	4
Totals	21	4	25

Accidental deaths accounted for 21.93% of reported deaths in 2018. The majority of accidental deaths were males (21 of 25 or 84%), and 15 were alcohol and/or drug related (15 of 25 or 60%).





HOMICIDE

BY AGE AND GENDER

Age Group	Male	Female	Total	Alcohol and/or Drugs Involved
0-19				
20-29	1		1	1
30-39	2		2	2
40-49	1		1	1
50-59				
60+	1		1	
Total	5		5	4

BY REGION

Region	Total
Beaufort-Delta	1
Sahtu	
Deh Cho	1
North Slave	1
South Slave	2
Total	5

In 2018, there were five homicides. Homicides accounted for 4.39% of 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 local government and the local RCMP detachment. The Chief Coroner then forwards a recommendation for appointment to the Minister of Justice. The applicant's MLA is also advised of the proposed appointment. Coroners are appointed by the Minister of Justice for a three-year term.

As at December 31, 2018, there were 36 coroners across the Northwest Territories, with 16 men and 20 women.

There are currently no coroners residing in the communities of Colville Lake, Fort Good Hope, Fort Liard, Gameti, Whati, Wekweètì, Enterprise, Nahanni Butte, Tsiigehtchic, Paulatuk 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 and Certificate of Coroner".

REPORT AND CERTIFICATE OF CORONER

The Report and Certificate 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 and Certificate of Coroner.

Recommendations are often made and are forwarded to the appropriate department, agency or person in hopes of providing information and advice that may prevent similar deaths. Reports and Certificates 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 and Certificate of Coroner would usually be inquired into through a Coroner's inquest. An inquest is a formal quasi-judicial proceeding that allows for the public presentation of evidence relating to a death.

An inquest proceeding features a presiding coroner and a six-member jury selected in accordance with the *Jury Act*. The inquest hears testimony from sworn witnesses, and allows represented parties to participate in cross-examination and to make oral arguments. 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, unless the coroner is satisfied that the death was due to natural causes and was not preventable. An inquest can also be held when, in the opinion of a coroner, it is necessary:

a) to identify the deceased or determine the circumstances of the death;
b) to inform the public of the circumstances of the 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 as to dangerous practices or conditions in order to avoid preventable deaths.

APPENDIX "A"
SUMMARY OF SELECTED CORONER REPORTS CONTAINING RECOMMENDATIONS (CONCLUDED IN 2018)

Case # 1

This 19-year old male was operating a vibrating roller packer, which was being used to compact a new access road. The packer tipped off the road and rolled onto its side. The packer came to rest on top of the operator and he was deceased at the scene.

It was determined that the cause of death was Multiple Blunt Injuries and the manner of death was Accidental.

Comments and Recommendation:

The Coroner Service made the following recommendations to:

Workers' Safety and Compensation Commission and its safety partners, including but not limited to: NWT Federation of Labour
Northwest Territories and Nunavut Construction Association
Northern Safety Association

1. In coordination with safety partners, to develop a public education campaign to promote the Powered Mobile Equipment Code of Practice, with emphasis on ensuring proactive safety cultures in the workplace and explaining how employers can implement programs to assess and properly document worker qualifications and competencies.

   (This Powered Mobile Equipment Code of Practice has already been developed by the WSCC, and includes key tools and resources that employers can readily put to use.)

2. In coordination with safety partners, encourage employers to engage in independent third party audits of their safety programs.

   (To ensure that employers are meeting industry best practices)

The Coroner Service made the following recommendation to Workers' Safety and Compensation Commission:

3. To commission a study to review the efficacy of the use of both safety equipment and communication devices designed to lessen the chance of injury or death and increase the survivability of the operators of heavy equipment in the event of a collision or roll-over. Ideally this would include (but not be limited to) a feasibility study of built-in inclinometer gauges with audible and visual alerts, and two-way radios.

   (To ensure that early warning systems are in place and that the means to instantly call for assistance are readily available.)

APPENDIX "B"
SUMMARY OF CORONER'S INQUESTS

THERE WERE NO CORONER INQUESTS DURING 2018.

ACCOMPLISHMENTS

The Coroner Service continues to be involved with a number of multi-jurisdictional initiatives including projects relating to Domestic Violence Homicides and the Canadian Opioid Crisis.

The Coroner Service participates in a number of research agreements each year, and provides research data to different organizations, such as the AB/NWT lifesaving Society, the Traffic Injury Research Foundation, and the Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations.

The Coroner Service participated in NWT Airport Emergency mock exercises in Hay River and Lutselk'e in 2018.

In September 2018 the Coroner Service participated in Operation Nanook with the Canadian Armed Forces.

A number of presentations on the Coroner Service were delivered to Health Authorities and to the private sector.

The Coroner Service developed a detailed comprehensive Coroner Investigative Guide for the use of community coroners in the field.

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 conducting death investigations over the past year. The Service would also like to thank the coroners who demonstrate - often under very difficult conditions - a high level of dedication and professionalism.