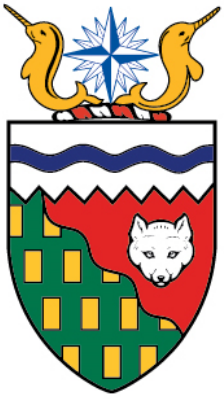

Office of the Chief Coroner
Bureau du coroner en chef

NORTHWEST TERRITORIES CORONER SERVICE

2020 Annual Report
Including
10 Year Review
2011 - 2020

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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. The Chief Coroner, Deputy Chief Coroner and an Administrative Coroner oversee and support the coroners in the communities.

Chief Coroner Cathy L. Menard retired in September 2020 after 24 years in the Coroner Service. Albert Garth Eggenberger was acting Chief Corner for the duration of the year.

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 Coroner Service.

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 McKenna 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.

Following the 2020 annual report is a ten-year review of the deaths in the NWT. There was a 10-year review in 2010 and this report is available for download on the Coroner Service website https://www.justice.gov.nt.ca/en/boards-agencies/coroner-service/.

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).

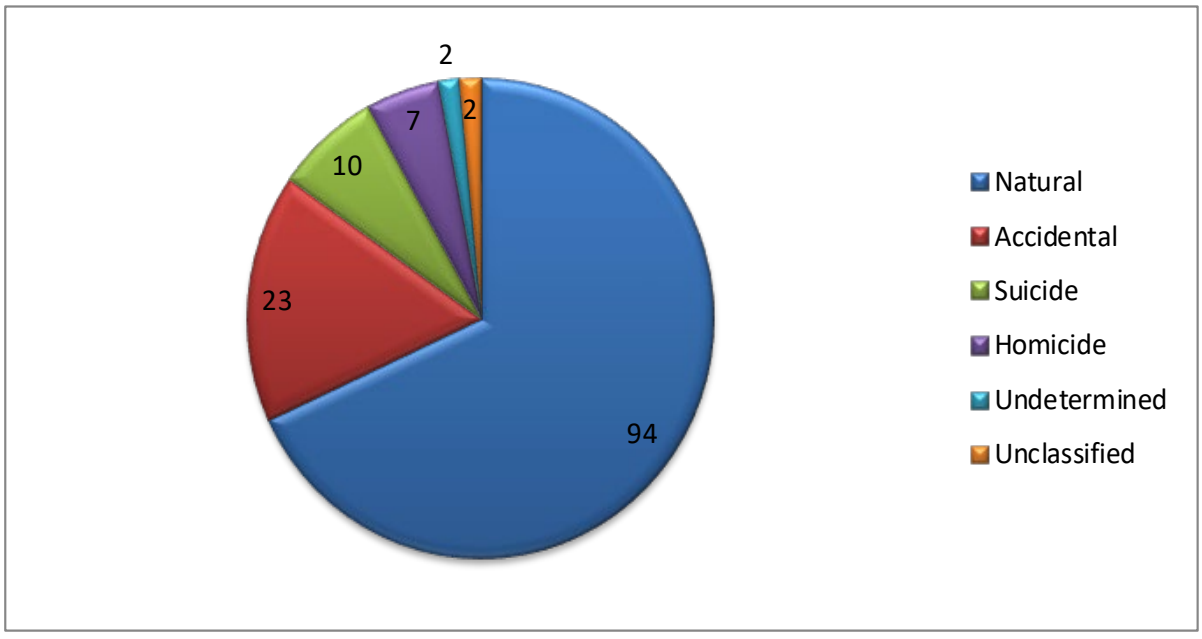
NWT REGIONS

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

2020 CASE STATISTICS

TOTAL CASES

Total Cases			
Manner of Death	Number *	Cases %	Population % **
Natural	94	68.12%	0.2081%
Accidental	23	16.67%	0.0509%
Suicide	10	7.25%	0.0221%
Homicide	7	5.07%	0.0155%
Undetermined	2	1.45%	0.0044%
Unclassified	2	1.45%	N/A
Total	138	100%	0.3056%



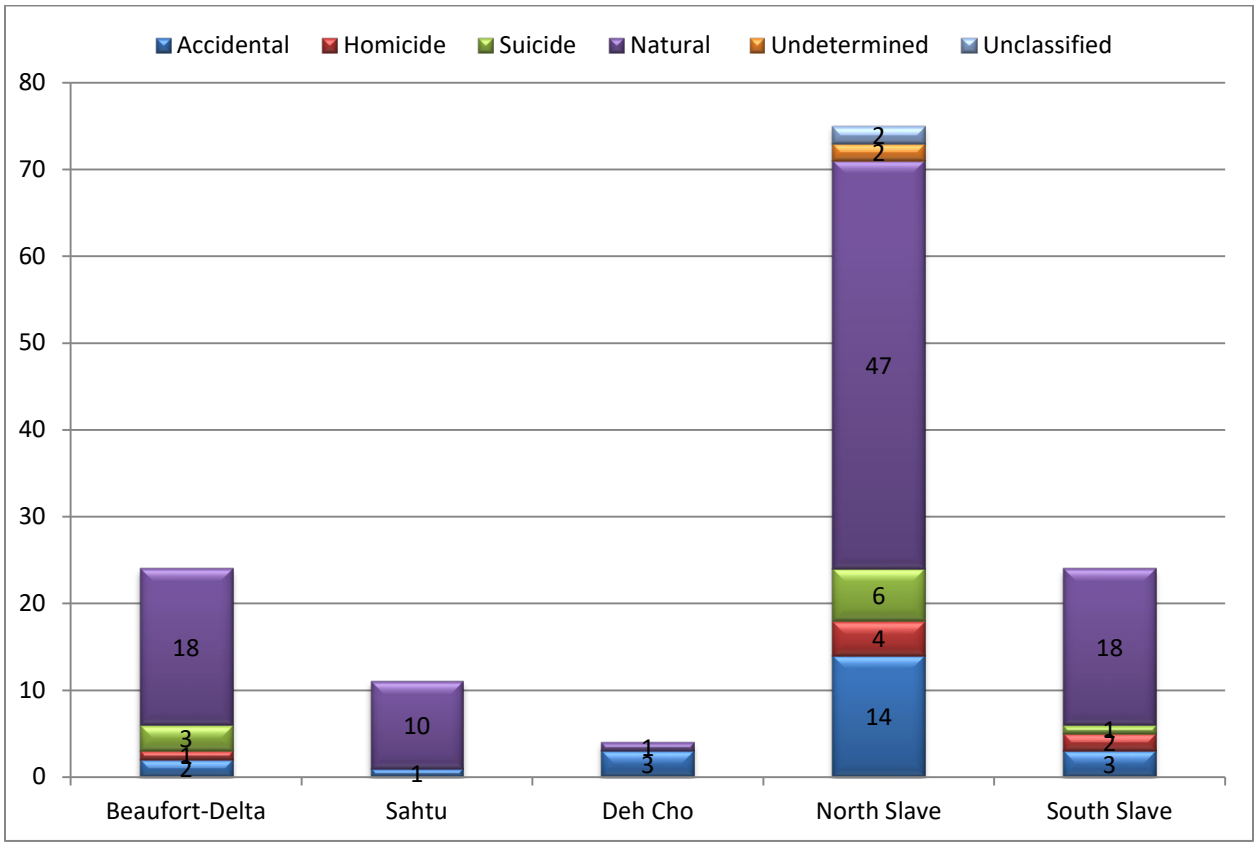
Unclassified cases are not represented in the population figures since they are non-human in origin. In 2020, two cases were determined to be unclassified.

*The NWT Coroner Service assisted with one Alberta death.

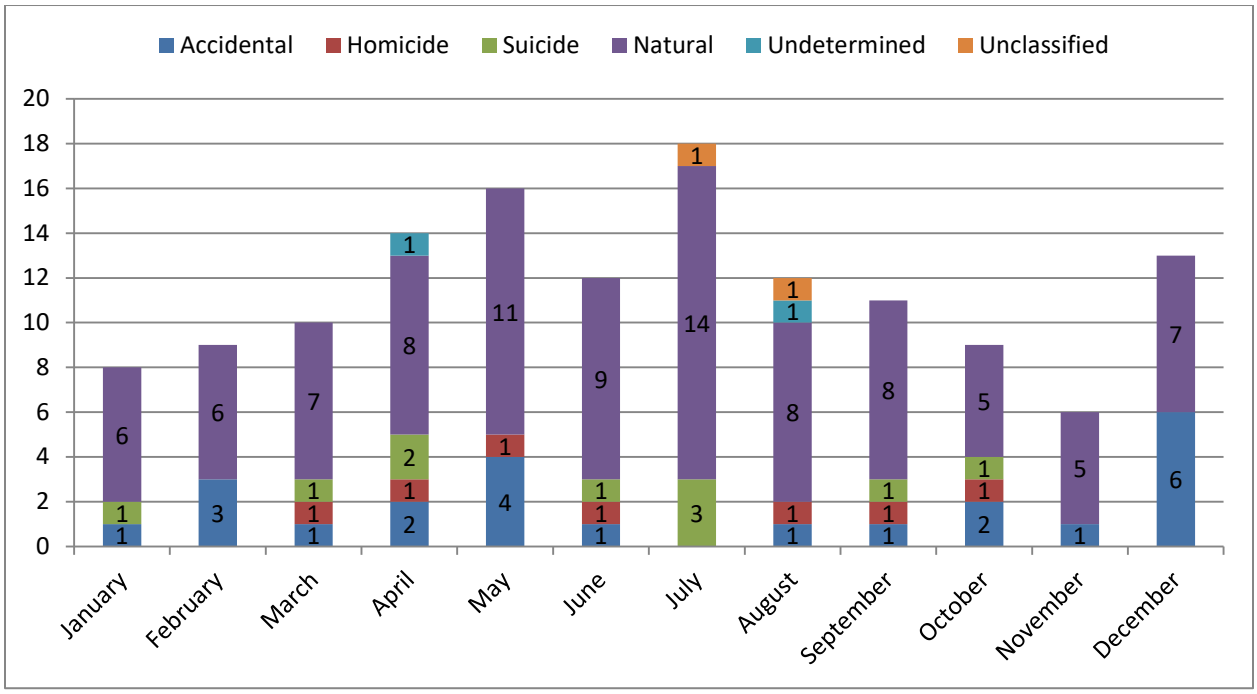
** Based on an NT population estimate of 45,161 retrieved October 1, 2021, at http://www.statsnwt.ca/population/population-estimates/

CASELOAD BY MANNER AND REGION

Region	Accidental	Homicide	Suicide	Natural	Undeter-mined	Unclassified	Total
Beaufort-Delta	2	1	3	18			24
Sahtu	1			10			11
Deh Cho	3			1			4
North Slave	14	4	6	47	2	2	75
South Slave	3	2	1	18			24
Total	23	7	10	94	2	2	138



CASELOAD BY MANNER AND MONTH



Month	Accidental	Homicide	Suicide	Natural	Undeter-mined	Unclassified	Total
January	1		1	6			8
February	3			6			9
March	1	1	1	7			10
April	2	1	2	8	1		14
May	4	1		11			16
June	1	1	1	9			12
July			3	14		1	18
August	1	1		8	1	1	12
September	1	1	1	8			11
October	2	1	1	5			9
November	1			5			6
December	6			7			13
Total	23	7	10	94	2	2	138

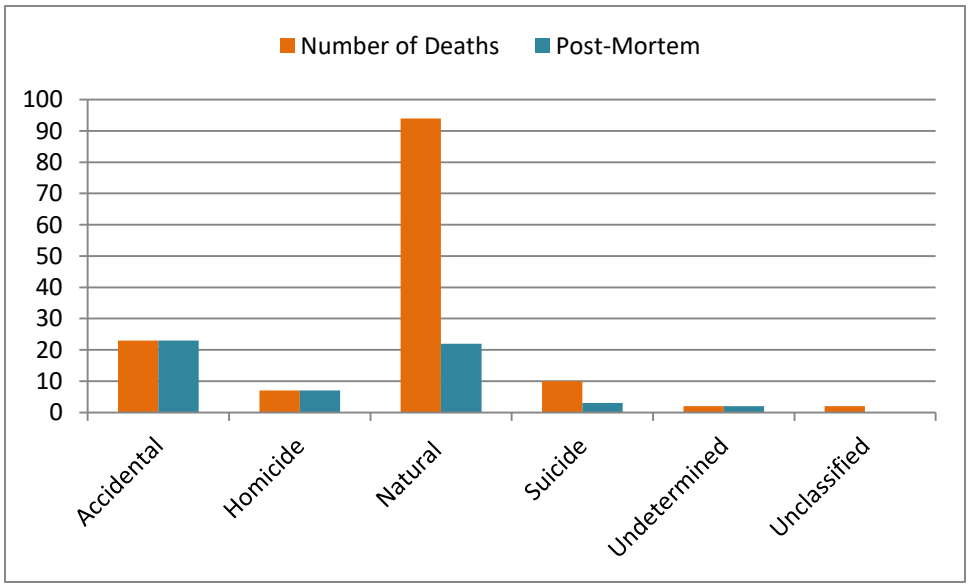
NATURAL AND NON-CORONER CASES

In 2020 there were a total of 94 natural deaths, 64 of which were coroner cases and 30 of which were non-coroner cases. Non-coroner cases are natural deaths that are reported to the Coroners Service but are not captured by the reporting criteria required under the *Coroners Act*.

Coroner	Non-Coroner	Natural
64	30	94

POST-MORTEMS BY MANNER

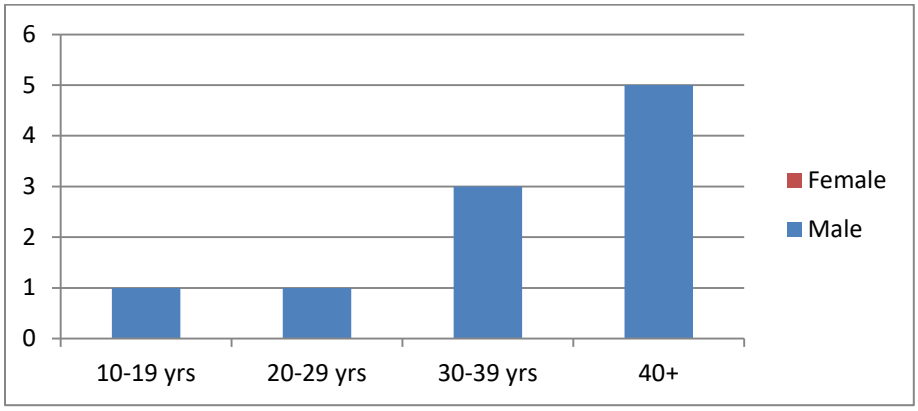
A post-mortem is conducted when the cause and/or manner of death cannot otherwise be determined or when it appears appropriate to conduct the procedure. An autopsy may also be a means of determining the identity of the deceased. A total of 57 autopsies were conducted in 2020.



SUICIDE

BY GENDER AND AGE

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



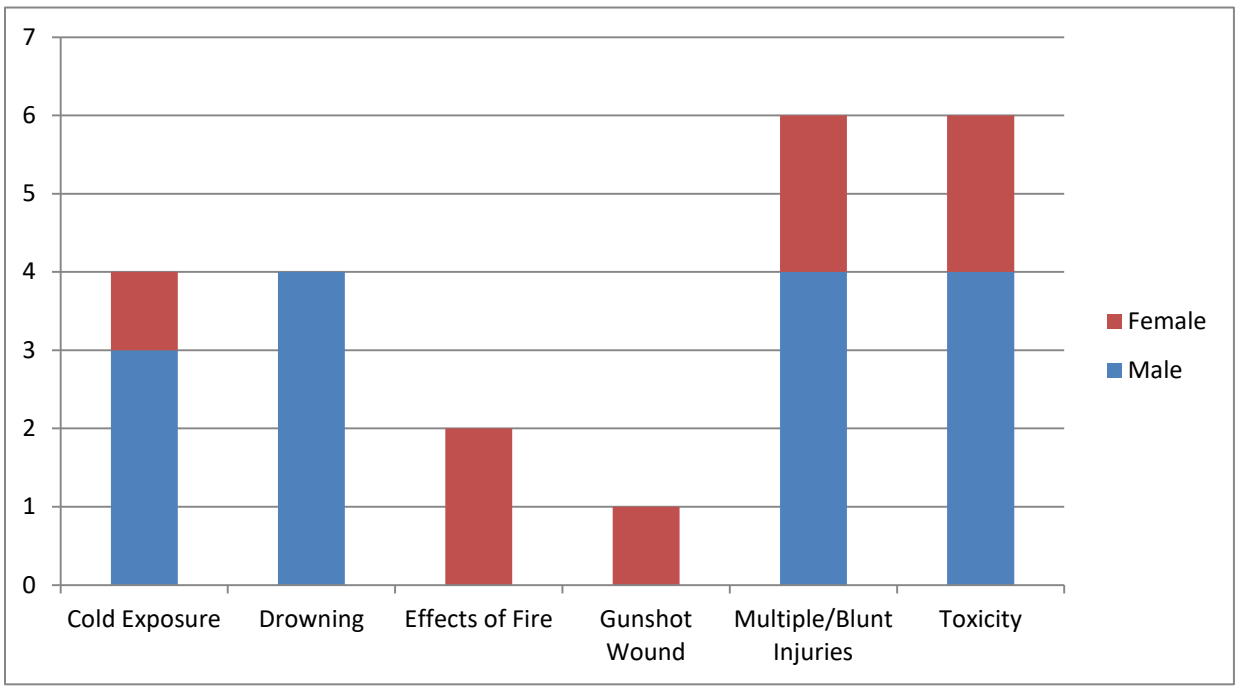
In 2020 there were ten suicides; all were male. Toxicology examination confirmed the presence of alcohol and/or drugs in seven of the ten suicides.

ACCIDENTAL

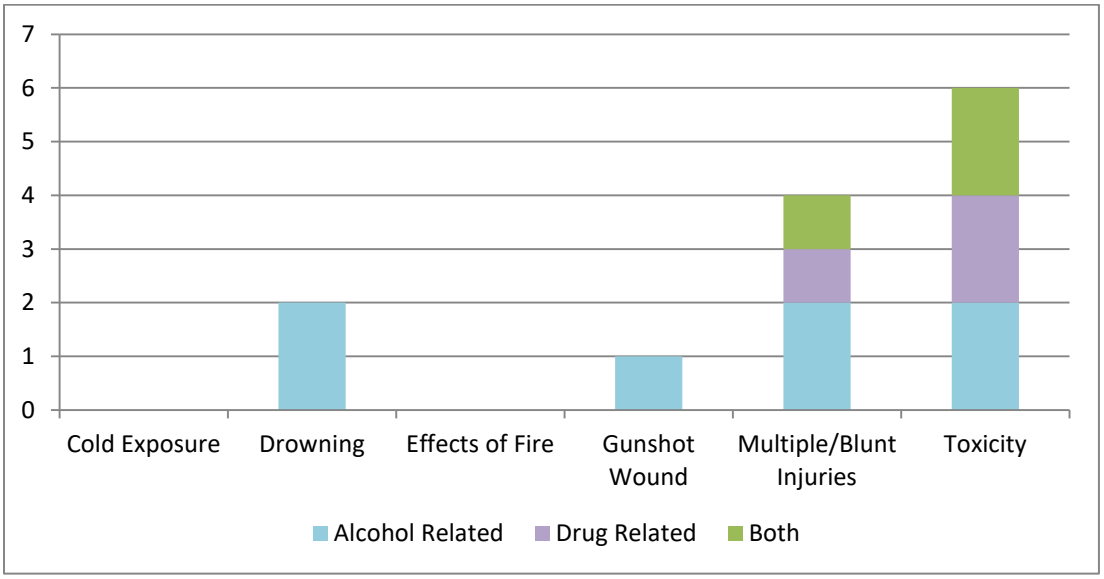
BY CAUSE AND GENDER

Cause of Death	Male	Female	Total
Cold Exposure	3	1	4
Drowning	4		4
Effects of Fire		2	2
Gunshot Wound		1	1
Multiple/Blunt Injuries	4	2	6
Toxicity	4	2	6
Totals	15	8	23

Accidental deaths accounted for 16.67% of reported deaths in 2020. The majority of accidental deaths were males (15 of 23 or 65%), and 13 were alcohol and/or drug related (13 of 23 or 56.5%).



ACCIDENTAL Cont'd



HOMICIDE

BY AGE AND GENDER

Age Group	Male	Female	Total	Alcohol and/or Drugs Present
0-19		1	1	
20-29	1	2	3	2
30-39	3		3	3
Total	4	3	7	5

HOMICIDE Cont'd

BY REGION

Region	Total
Beaufort-Delta	1
Sahtu	
Deh Cho	
North Slave	4
South Slave	2
Total	7

In 2020, there were seven homicides. Homicides accounted for 5.07% 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 of December 31, 2020, there were 31 coroners across the Northwest Territories, with 14 men and 17 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 OF INVESTIGATING CORONER

The Report of Investigating 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 Investigating 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 of Investigating 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 2020)

THERE WERE NO CORONER REPORTS CONTAINING RECOMMENDATIONS FOR 2020.

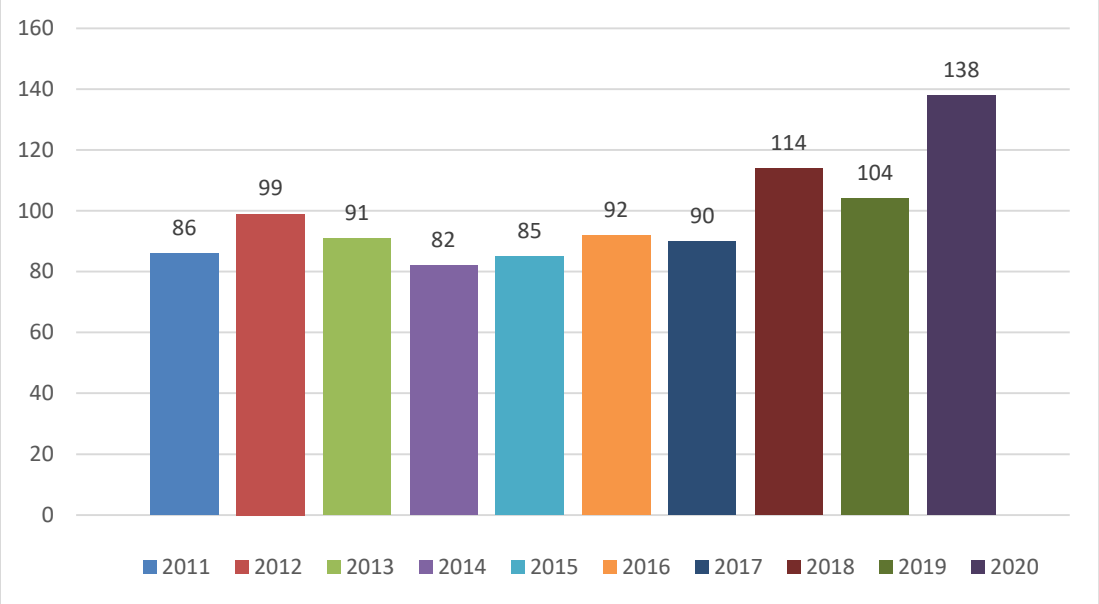
APPENDIX "B"
SUMMARY OF CORONER'S INQUESTS

THERE WERE NO CORONER'S INQUESTS IN 2020

NWT CORONER SERVICE 10-YEAR REVIEW 2011 - 2020

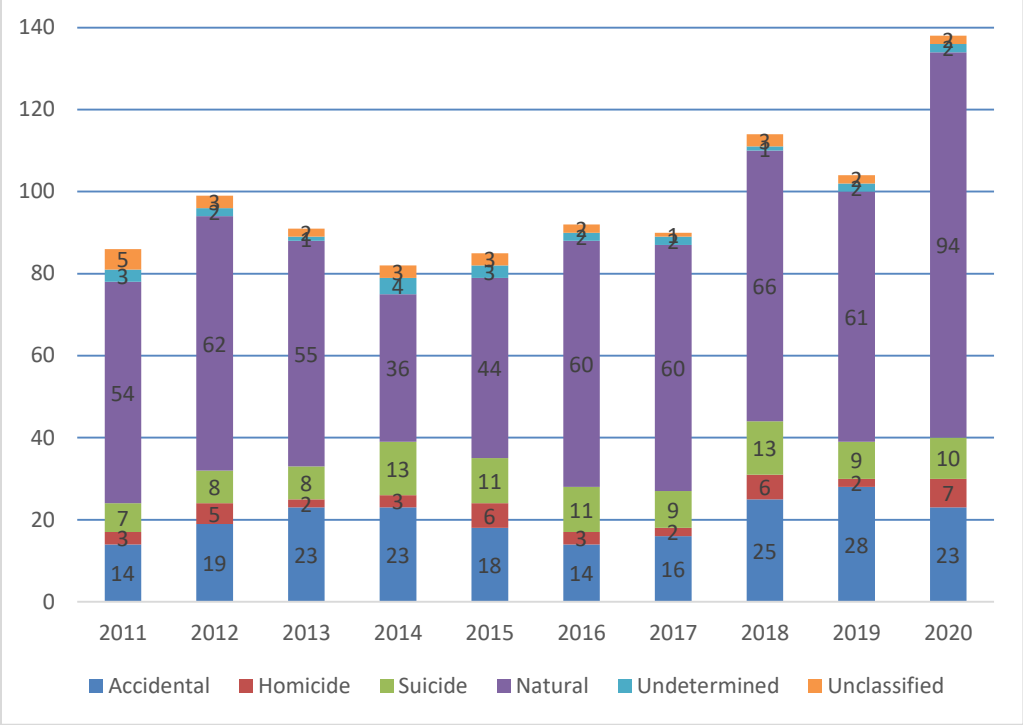
2011 – 2020 CASE STATISTICS

TOTAL DEATHS



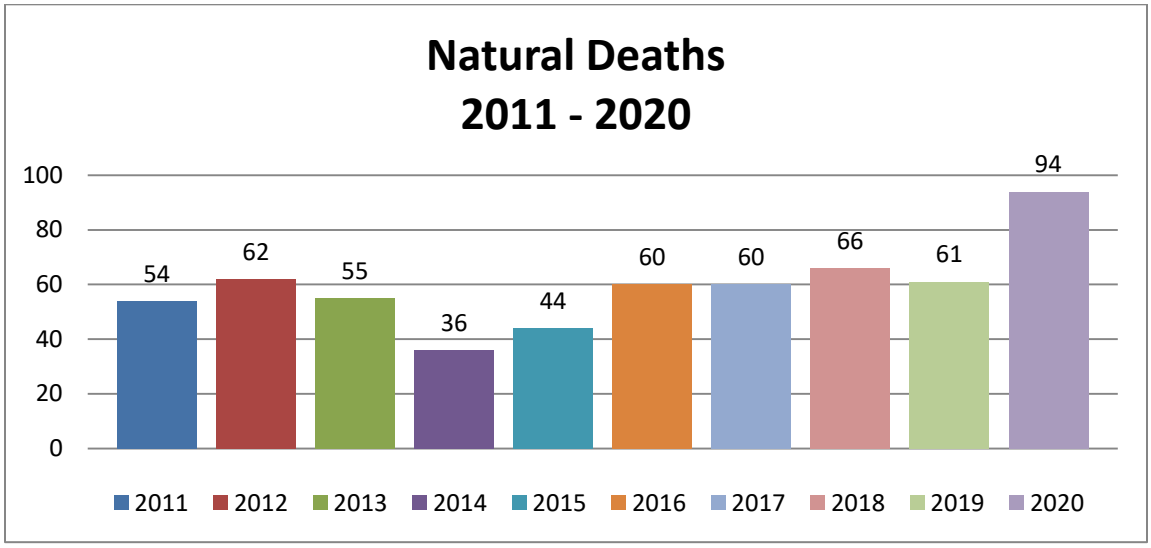
There has been an average of 98 cases reported to the Coroner's Service each year.

CASELOAD COMPARISON



2011 – 2020 NATURAL DEATHS COMPARISON

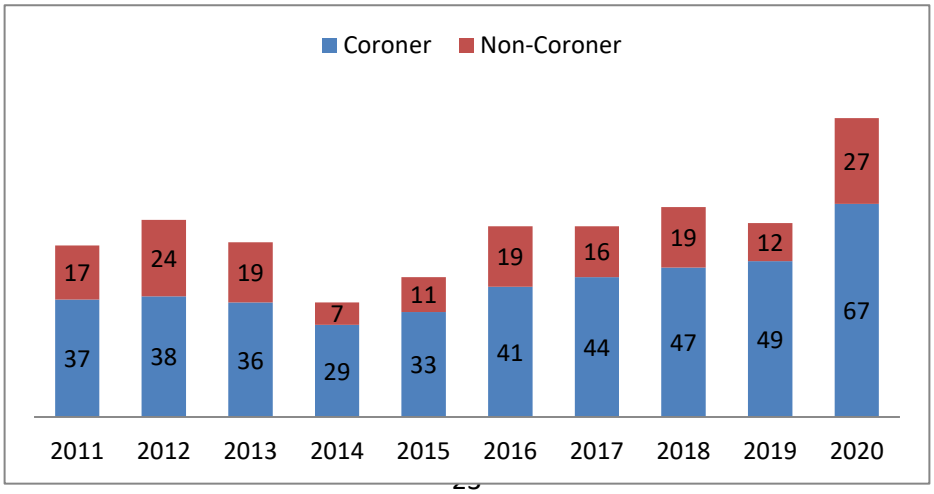
NATURAL covers all deaths primarily resulting from a disease of the body and not resulting from injuries or abnormal environmental factors. Natural deaths accounted for 60% of all deaths reported, with an average of 59 per year.



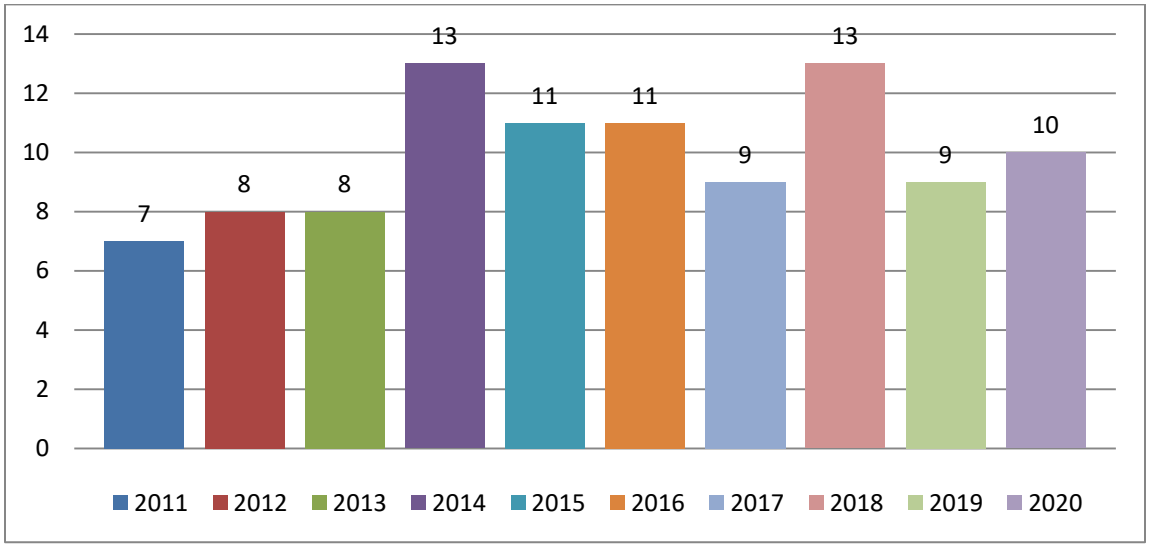
CORONER & NON-CORONER CASES

Non-Coroner cases are natural deaths that are reported to the Coroner's Service but do not fall under the reporting criteria required under the *Coroners Act*. They must therefore be "Natural" in manner.

Coroner	Non-Coroner	Natural
421	171	592



2011 – 2020 SUICIDE DEATH COMPARISON



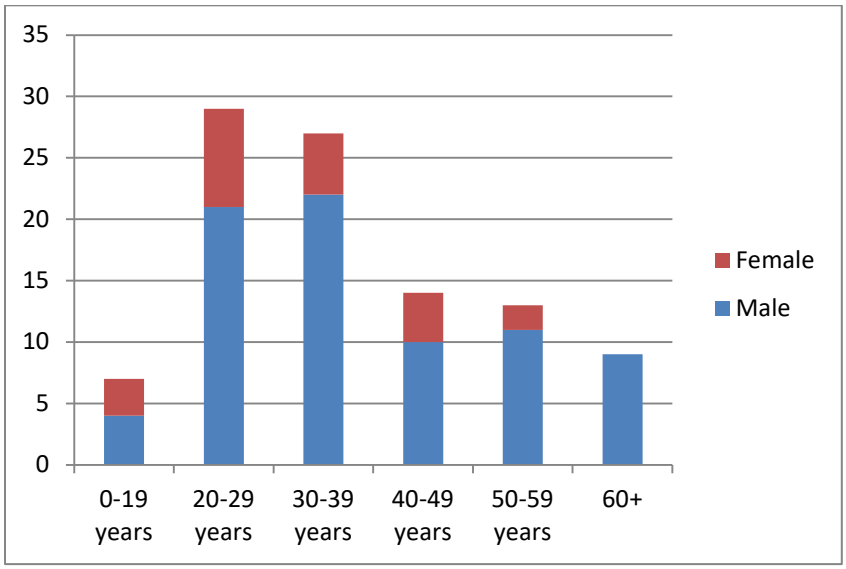
SUICIDE refers to any death from a self-inflicted injury where there is apparent intent to cause death. There were 99 suicide deaths in this review period accounting for 10% of all deaths reported. The 10-year review shows a trend between 8 and 11 deaths by suicide each year. However in 2014 and 2018 there were 13 deaths by suicide; and in 2011 there were 7 deaths.

SUICIDES BY METHOD

Method	Total
Hanging	41
Gunshot Wound	37
Drug Toxicity	11
Incised Wounds	4
Stab Wound	1
Asphyxia	1
Carbon Monoxide Toxicity	1
Other Toxicity	1
Blunt Force Trauma	1
Drowning	1
Total	99

The most common method is hanging (41%) followed by gunshot wounds (37%).

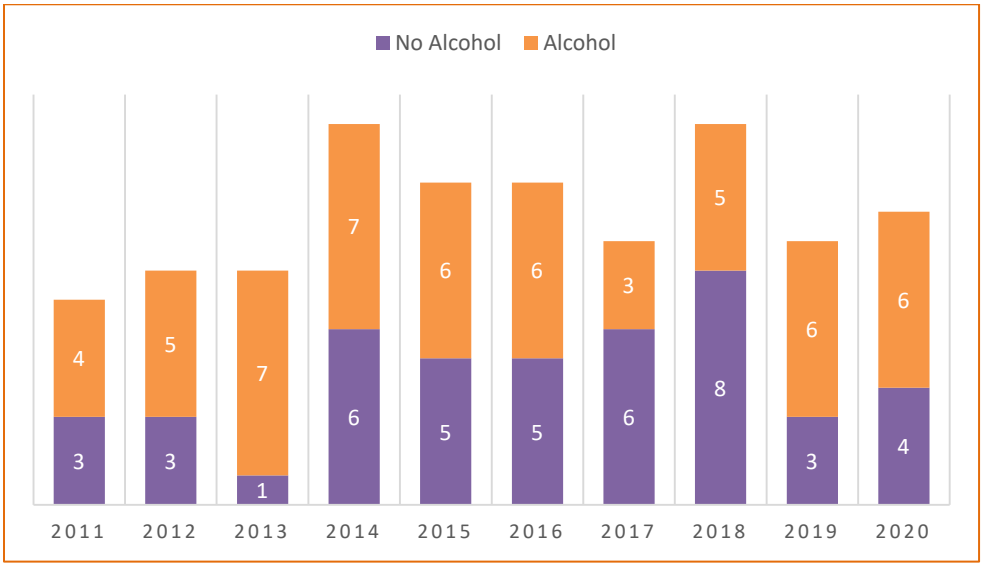
SUICIDES BY AGE AND GENDER



Age Group	Male	Female	Total
0-19 years	4	3	7
20-29 years	21	8	29
30-39 years	22	5	27
40-49 years	10	4	14
50-59 years	11	2	13
60+	9	0	9
Total	77	22	99

The majority of deaths by suicide were males (78%). The majority were between the ages of 20-39.

SUICIDE DEATHS INVOLVING ALCOHOL



The 10-year review found the highest number of suicide deaths with alcohol as a contributing factor occurred in 2013 when 7 out of 8 cases involved alcohol. Of the 99 suicides over the 10-year period, 55 involved alcohol (56%).

SUICIDES BY MONTH

Year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
January				1	1			2	1	1	6
February	1	1		1	2		2		1		8
March			1		1	1	2	1		1	7
April					1	1	1	1	1	2	7
May	1		2	3	2	2	2	4	2		18
June		1		1	1		1			1	5
July	1			1	3	2	1			3	11
August		2	2	3		1		1	2		11
September						2		2	1	1	6
October		2	2	1						1	6
November	1	1		1		1		1	1		6
December	3	1	1	1		1		1			8
Total	7	8	8	13	11	11	9	13	9	10	99

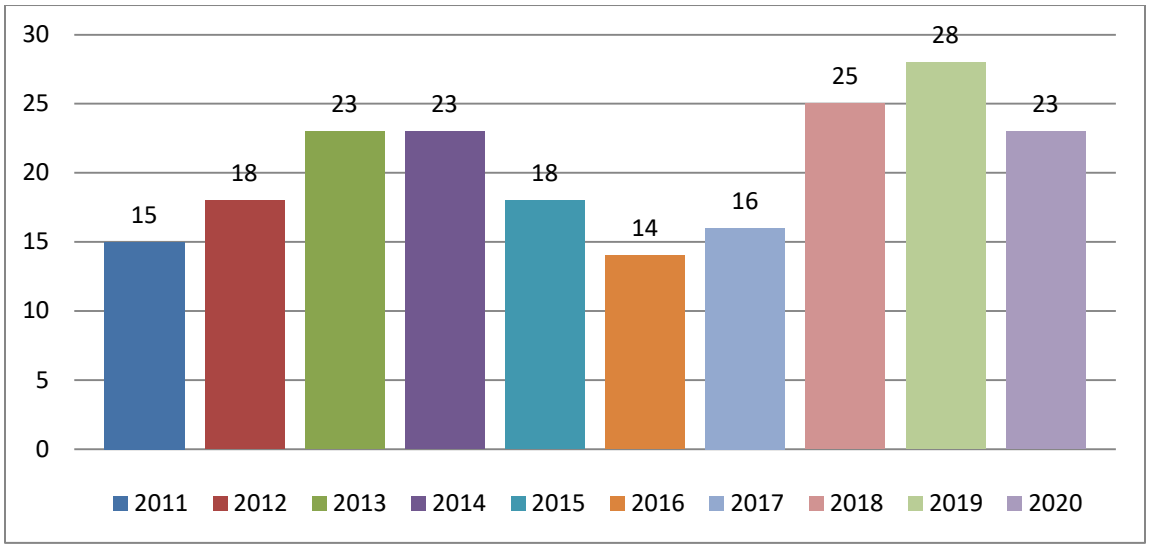
The 10-year review found the highest number of suicides occurred in May.

SUICIDES BY REGION

Region	Total
Beaufort-Delta	33
Sahtu	5
Dehcho	12
North Slave	34
South Slave	15
Total	99

The majority of deaths by suicide occurred in the North Slave region followed by the Beaufort-Delta region. The Sahtu region had the least number of suicides reported between 2011 and 2020.

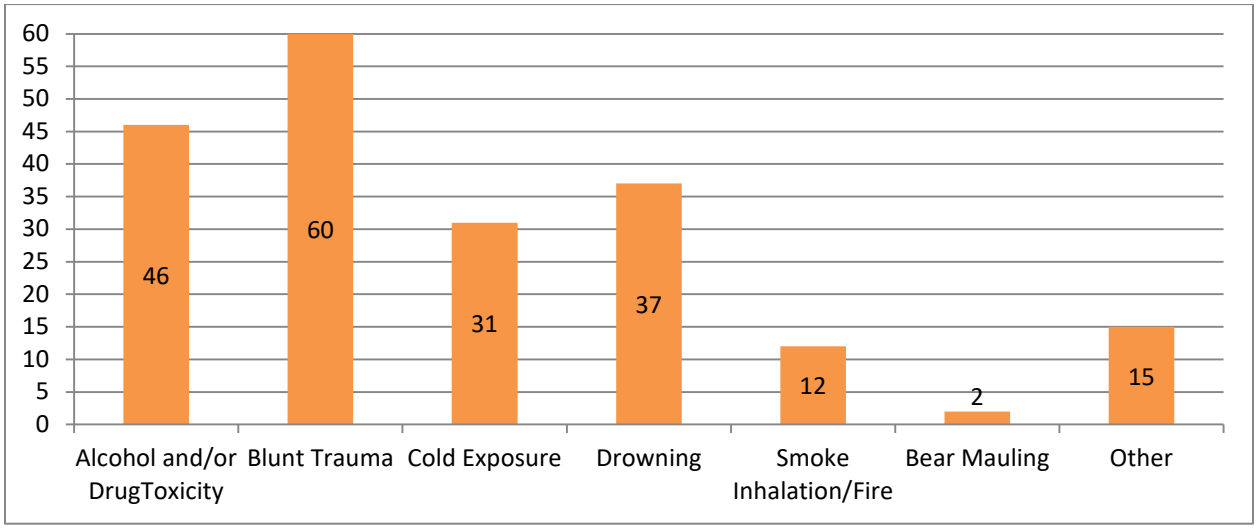
ACCIDENTAL DEATH COMPARISON 2011 – 2020



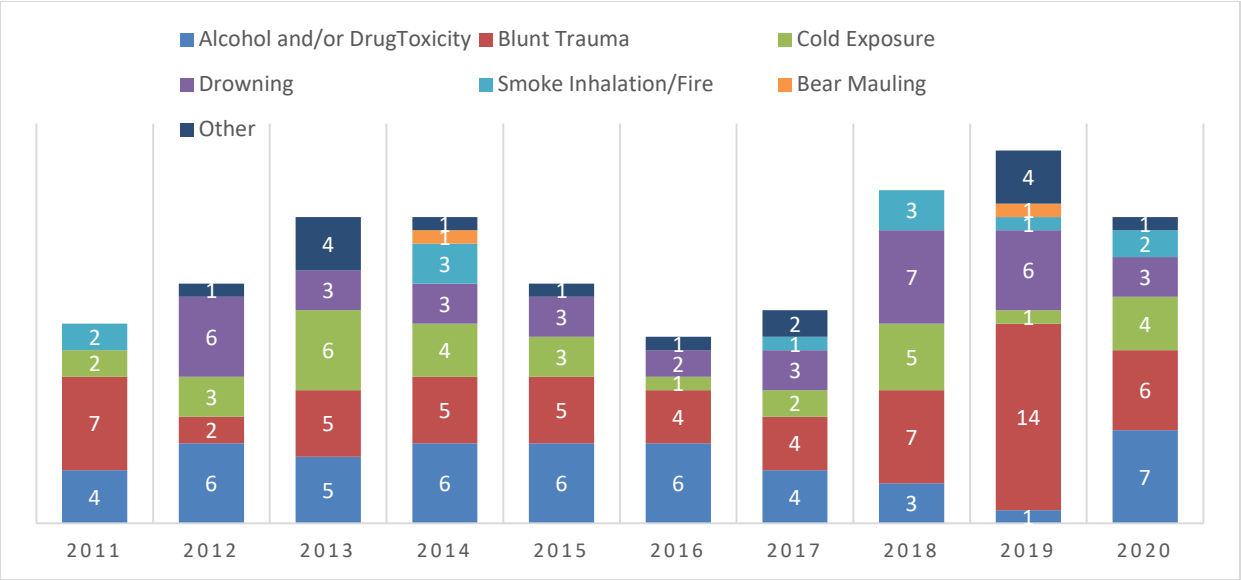
ACCIDENTAL covers all accidental deaths including motor vehicle incidents where there is no obvious intent to cause death. This classification includes any death resulting from an action or actions by a person which result in the unintentional death to him/herself or any death of any person that results from the intervention of a non-human agency.

Accidental deaths accounted for 21% of all deaths reported between 2011 and 2020, with an average of 20 cases per year. The majority were blunt trauma at 29.5%.

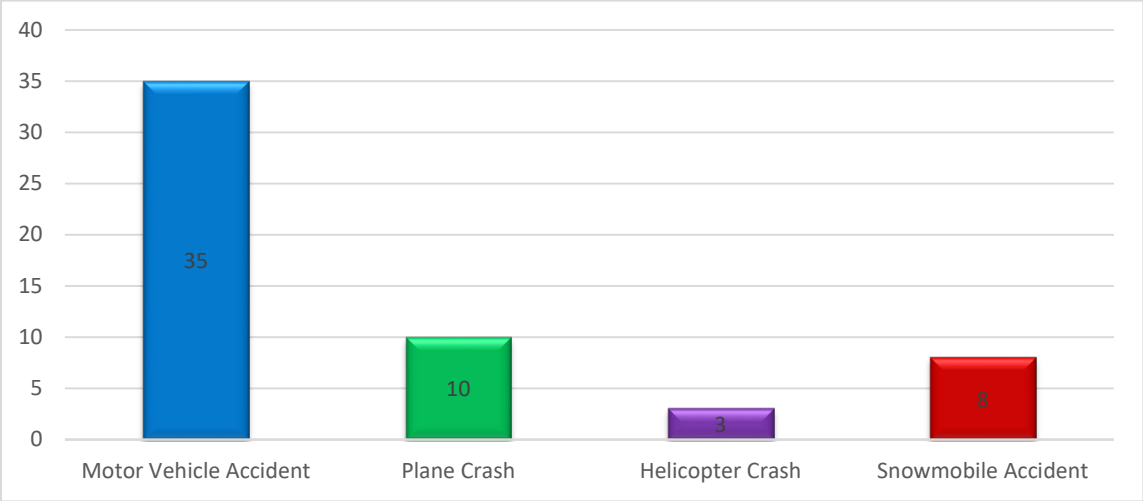
ACCIDENTAL DEATH BY METHOD



ACCIDENTAL DEATH COMPARISON BY METHOD AND YEAR



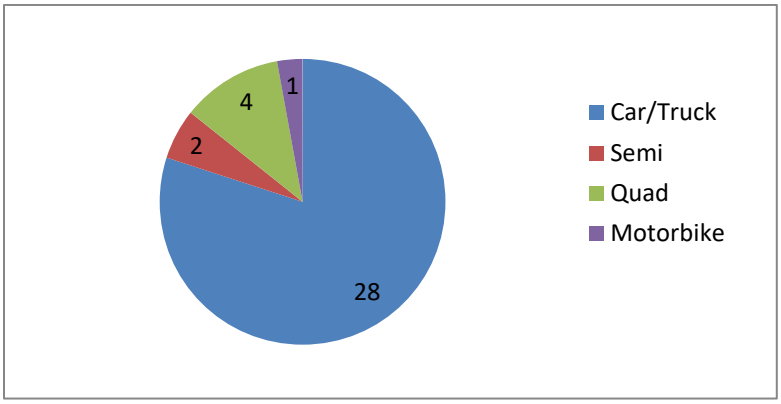
Other Accidental Deaths include: choking, complications of surgery, smothering, asphyxia, carbon monoxide poisoning, other toxicity, and electrocution.



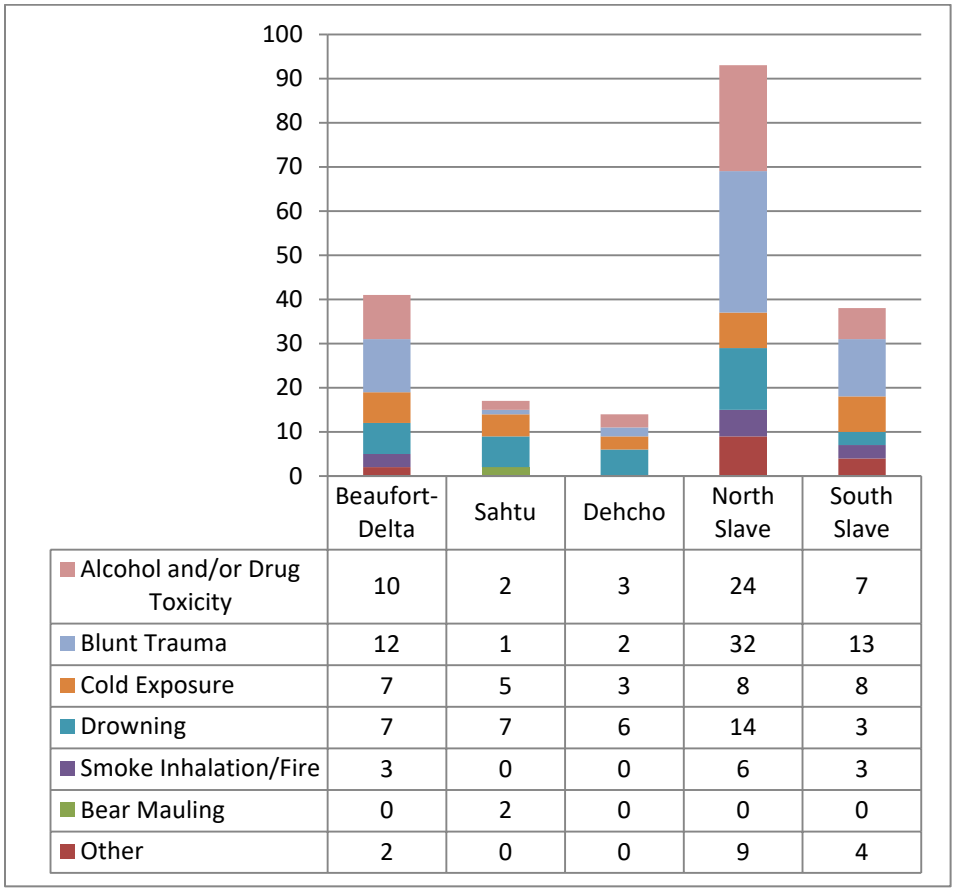
Seven of the blunt trauma cases and three of the drownings were the result of plane crashes and three of the cold exposure cases were the result of a helicopter crash.

There were a total of eight snowmobile deaths; two were drownings from the result of going through ice. Seven of the eight snowmobile deaths were alcohol related.

There were a total of thirty-four motor vehicle incidents (MVI). Four MVI involved pedestrian deaths and four involved quad ATVs. Of the thirty-four MVI deaths, thirty were blunt trauma deaths and four were drownings. Alcohol was present in 23 of the MVI deaths.



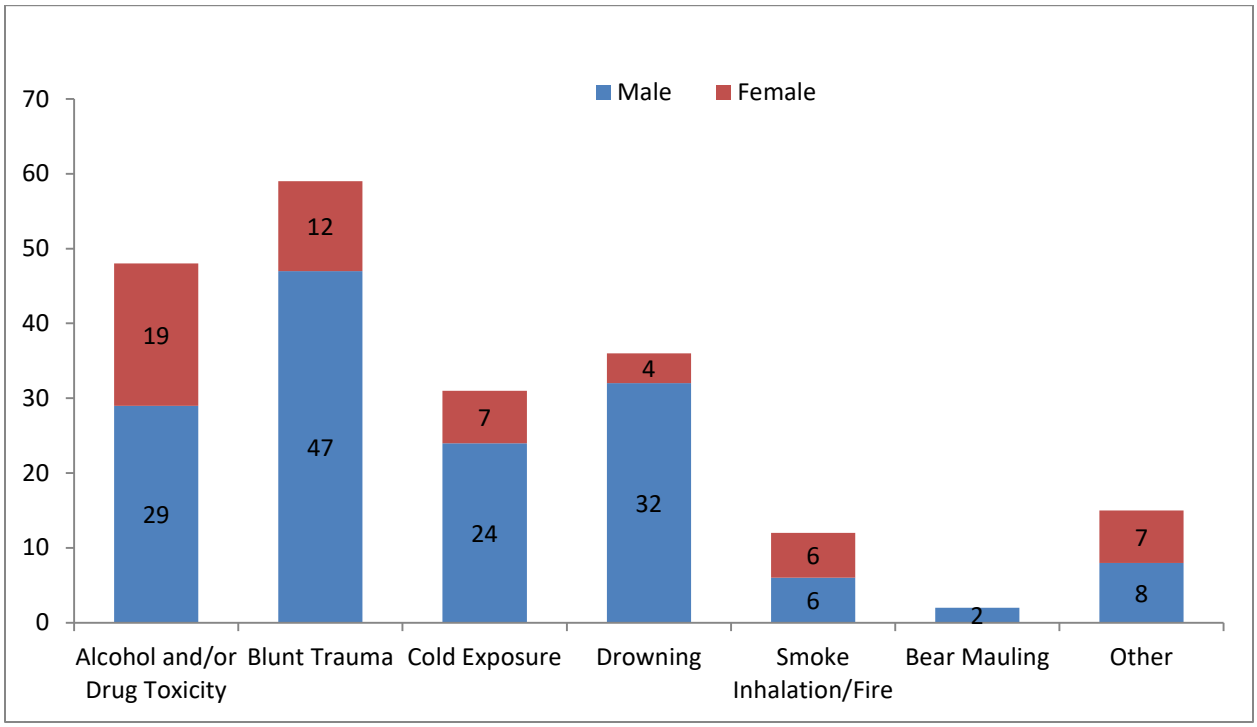
ACCIDENTAL DEATHS BY METHOD & REGION



	Beaufort-Delta	Sahtu	Dehcho	North Slave	South Slave
Alcohol and/or Drug Toxicity	10	2	3	24	7
Blunt Trauma	12	1	2	32	13
Cold Exposure	7	5	3	8	8
Drowning	7	7	6	14	3
Smoke Inhalation/Fire	3	0	0	6	3
Bear Mauling	0	2	0	0	0
Other	2	0	0	9	4

The majority of accidental deaths occurred in the North Slave region with 93 deaths, followed by the Beaufort-Delta at 41 deaths. At 14, the Dehcho region had the lowest number of accidental deaths reported between 2011 and 2020, followed by the Sahtu region with 17 deaths.

ACCIDENTAL DEATHS BY METHOD & GENDER

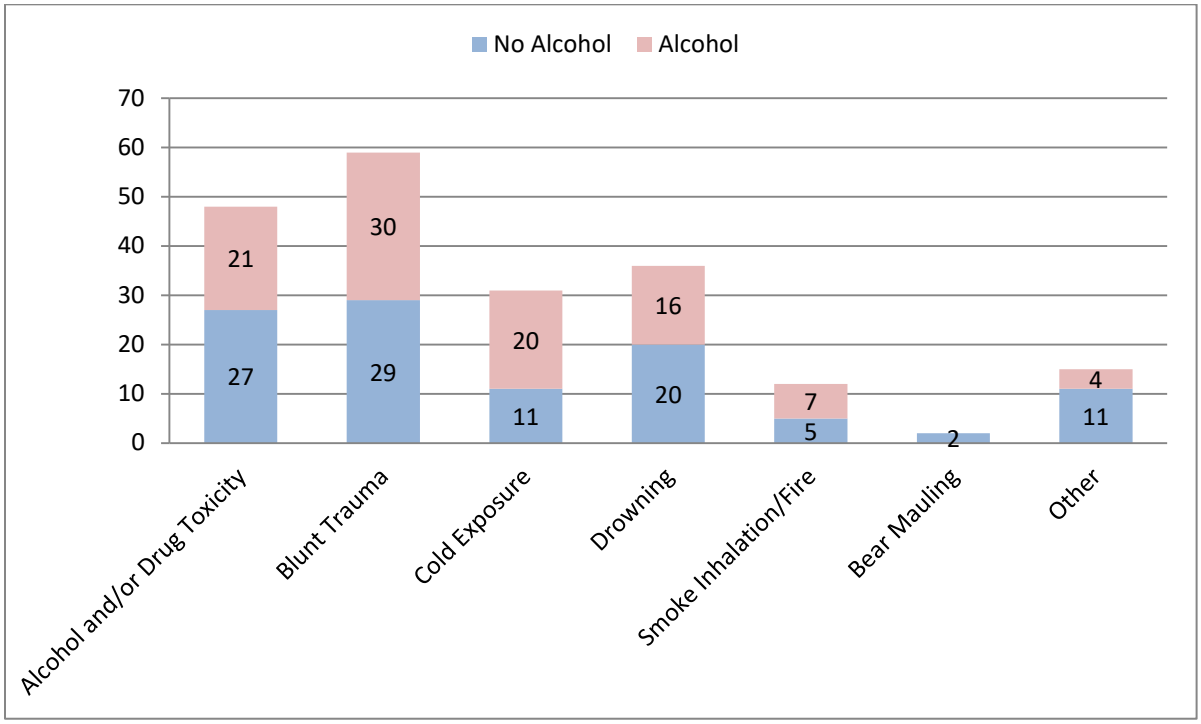


ACCIDENTAL DEATHS BY AGE & GENDER

Age Group	Male	Female	Total
0-19 years	10	6	16
20-29 years	28	12	40
30-39 years	28	5	33
40-49 years	21	8	29
50-59 years	32	12	44
60+	29	12	41
Total	148	55	203

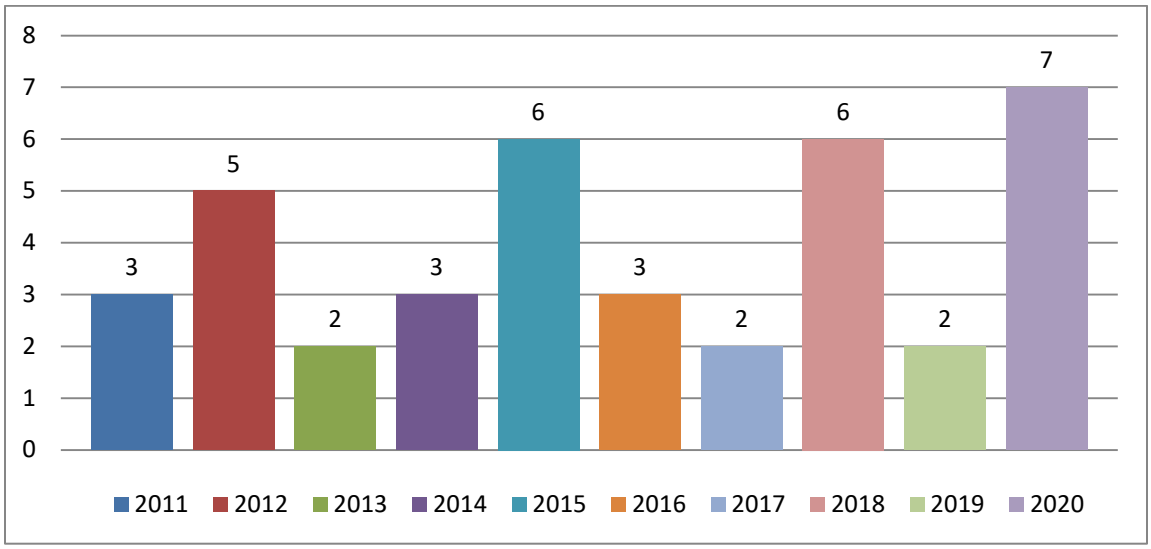
The majority of accidental deaths were males at 73%.

ACCIDENTAL DEATHS INVOLVING ALCOHOL



Of the 203 accidental deaths, alcohol was present in 98 cases (48%). Alcohol was most often seen in blunt trauma accident deaths followed by cold exposure deaths.

HOMICIDE DEATH COMPARISON 2011 – 2020



HOMICIDE includes any death resulting from injuries caused directly or indirectly by the actions of another person (with the exception of unintentional motor vehicle accidents). Homicide is a neutral term that does not imply fault or blame.

Homicide deaths accounted for 4% of all deaths reported with an average of four cases per year. The majority were stab wounds at 38% followed by blunt trauma at 36%.

Out of the 39 homicide cases, 17 were the result of domestic violence. Ten of these were intimate partner cases.

HOMICIDE DEATH BY METHOD

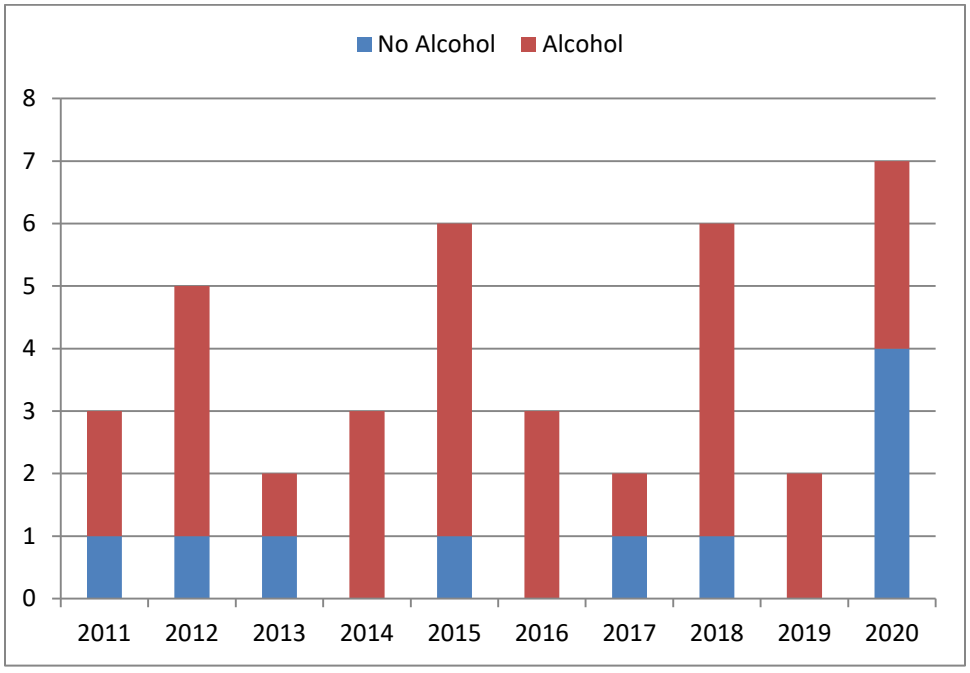
Cause	Total
Blunt Trauma	14
Stab Wounds	15
Gunshot Wound	3
Strangulation/Asphyxia	4
Other	3
Total	39

HOMICIDE DEATH BY AGE AND GENDER

Age Group	Male	Female	Total
0-19 years	0	2	2
20-29 years	7	3	10
30-39 years	9	1	10
40-49 years	5	4	9
50-59 years	1	1	2
60+	4	2	6
Total	26	13	39

The majority of homicide deaths were males at 67%. 51% were between the ages of 20-39 years old.

HOMICIDE DEATHS INVOLVING ALCOHOL



Of the 39 homicide deaths, toxicology examination of the deceased confirmed alcohol was present in 29 deaths (74%).

HOMICIDE DEATH BY MONTH

Year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
January				1							1
February	1				1						2
March				1		1				1	3
April					1	1		1	1	1	5
May										1	1
June		3			1			1		1	6
July								1			1
August			1					1		1	3
September		1	1		1		1		1	1	6
October					1			1		1	3
November	1				1			1			3
December	1	1		1		1	1				5
Total	3	5	2	3	6	3	2	6	2	7	39

The 10-year review found the highest number of homicides occurred in June and September with six deaths each, followed by April and December with five deaths each. These four months account for 56% of homicides.

HOMICIDE DEATH BY REGION

Region	Total
Beaufort-Delta	6
Sahtu	3
Dehcho	3
North Slave	15
South Slave	12
Total	

38% of homicide deaths occurred in the North Slave region with 15 deaths.

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 Coroner Service would also like to thank the coroners who demonstrate - often under very difficult conditions - a high level of dedication and professionalism.