NORTHWEST TERRITORIES CORONER'S SERVICES

2008 ANNUAL REPORT

TABLE OF CONTENTS

HISTORY OF CORONER'S 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 was to achieve 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 enquire into sudden and unexpected deaths where in some cases a fee was to be paid to the crown. The Coroner was charged with the responsibility of establishing the facts surrounding a death, a duty that provides for the basis for all Coroner systems in use today.

The *Coroners Act* established the territorial jurisdiction of the Coroner. The duties of the Coroner have been modified over the centuries; however the primary focus continues to be the investigation of sudden and unexpected deaths. With the growth of industrialization in the 19th century, social pressure demanded that the Coroner also serve a preventative function. This remains an important element of the Coroner's Service today.

There are two death investigation systems in Canada: the Coroner system and the Medical Examiner system. The Coroner system has four main 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. The Coroner examines the investigative material, sorts out facts and comes to a 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's Service provides a multi-disciplinary approach to the investigation of death by lay coroners appointed by the Minister of Justice. NWT Coroners are assisted by the Royal Canadian Mounted Police and a variety of other experts when required.

INTRODUCTION

The Coroner's Service, organizations and administrative purposes, falls within the Department of Justice. The Office of the Chief Coroner is located Yellowknife and oversees all death investigations. Currently there are 39 Coroners throughout the Northwest Territories. They provide service in the communities and regions in which they reside.

In the Northwest Territories, all sudden unexpected deaths must be reported to a Coroner. The Coroners 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, the deceased came to their death. The Coroner's Service is supported through efforts by the Royal Canadian Mounted Police, Fire Marshall's Office, Workers' Compensation Board, Transport Safety Board and various other agencies who work closely with the Coroner's Office.

The Chief Coroner is Mr. Garth Eggenberger. Mr. Eggenberger joined the Coroner's Service in May of 1989 and was appointed Chief Coroner on April 1st, 2008.

The Deputy Chief Coroner is Mrs. Cathy Menard. Mrs. Menard joined the Coroner's Service in February of 1996. She has been with the Department of Justice for 26 years.

There are no staffed facilities in the Northwest Territories to perform autopsies. When an autopsy is required, the body is transported to Edmonton for the procedure by the Chief Medical Examiner's Office of Alberta. Following the post mortem, the remains are sent to Foster & McGarvey Funeral Chapel, under contract for preparation and repatriation. Toxicology services are provided to the Coroner's Service by Dynacare Kasper Medical Laboratories in Edmonton and on occasion by the Chief Medical Examiner's Office in Alberta.

MANNER OF DEATH

All Coroner Reports and Jury Verdicts determine the manner of each death. All deaths investigated by the Coroners Service are classified in one of five distinct categories: Natural, Accident, Suicide, Homicide or Undetermined.

NATURAL covers all deaths primarily resulting from a disease of the body and not resulting from injuries or abnormal environmental factors.

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 results in the unintentional death to him/herself or any death to any person that results from the intervention of a non-human agency.

SUICIDE refers to any death from a self inflicted injury where there is apparent intent to cause death.

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.

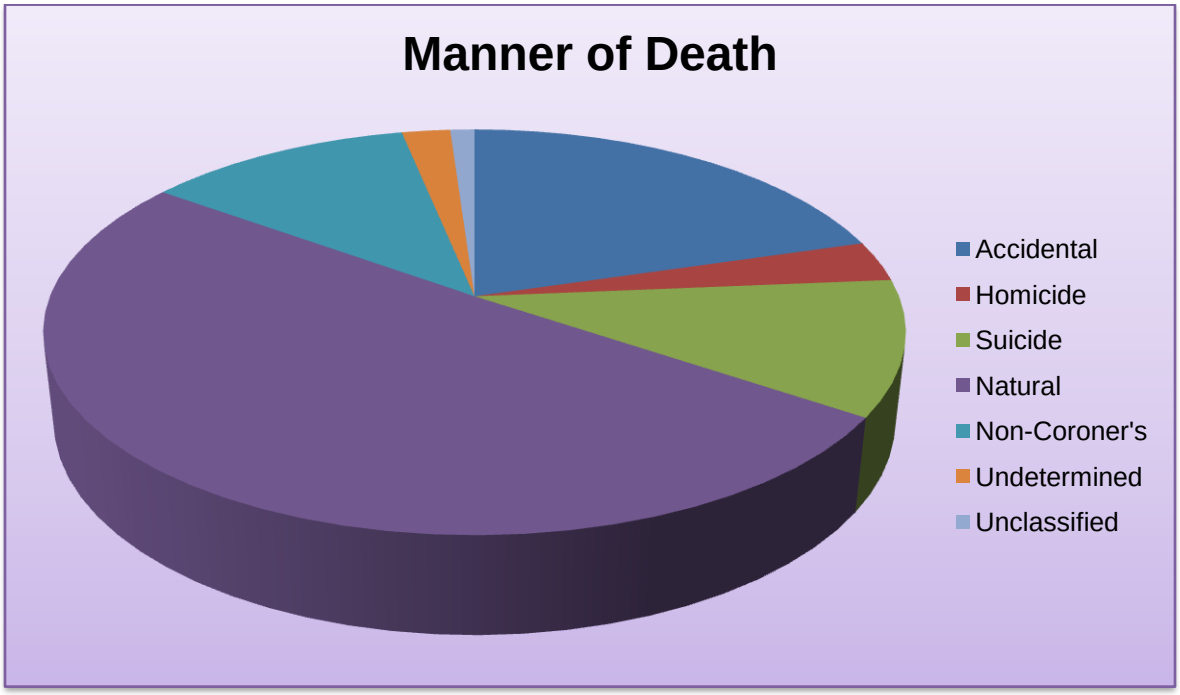
UNDETERMINED is any death which cannot be classified in any of the other categories. The actual cause of death may or may not be known in these cases. An example of an undetermined death would be a drug overdose where it is unclear if the victim intended to die.

Coroners are instructed to make every effort to classify a death in one of the other existing categories before considering a classification of 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 non-human.*

CASE STATISTICS

Total Cases			
Manner of Death	**Number**	**Percent (%)**	**Population %**
Accidental	19	20.4	0.0439
Homicide	3	3.2	0.0069
Suicide	10	10.8	0.0231
Natural	58	62.4	0.1340
Undetermined	2	2.2	0.0046
Unclassified	1	1.1	N/A
Total	93	100.0	0.2125

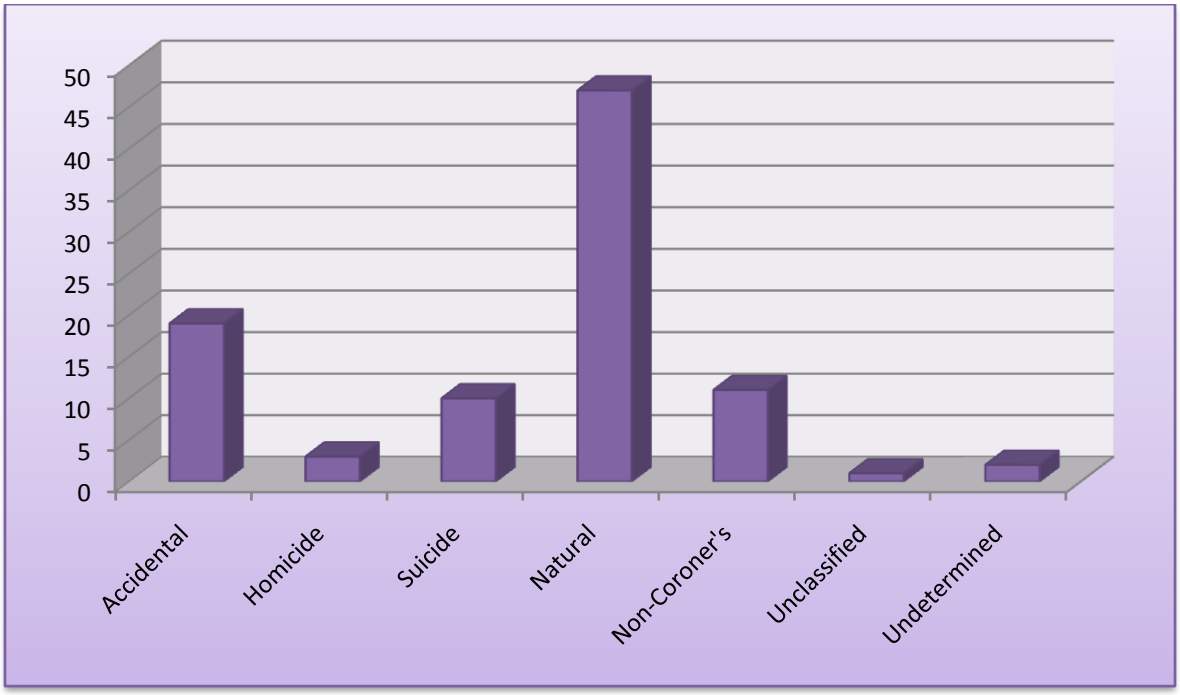


Non-Coroner cases are natural deaths that are reported to the Coroner's Service but do not fall under the reporting criteria required under the Coroner's Act. They must therefore be "Natural" in manner.

Unclassified cases are not represented in the population figures since they are non-human in nature. In 2008 there was one case determined as unclassified.

* Based on a population of 43, 283 in the NT retrieved July 13th, 2009, @ http://www.stats.gov.nt.ca/indicators.otp

CASELOAD BY MANNER OF DEATH

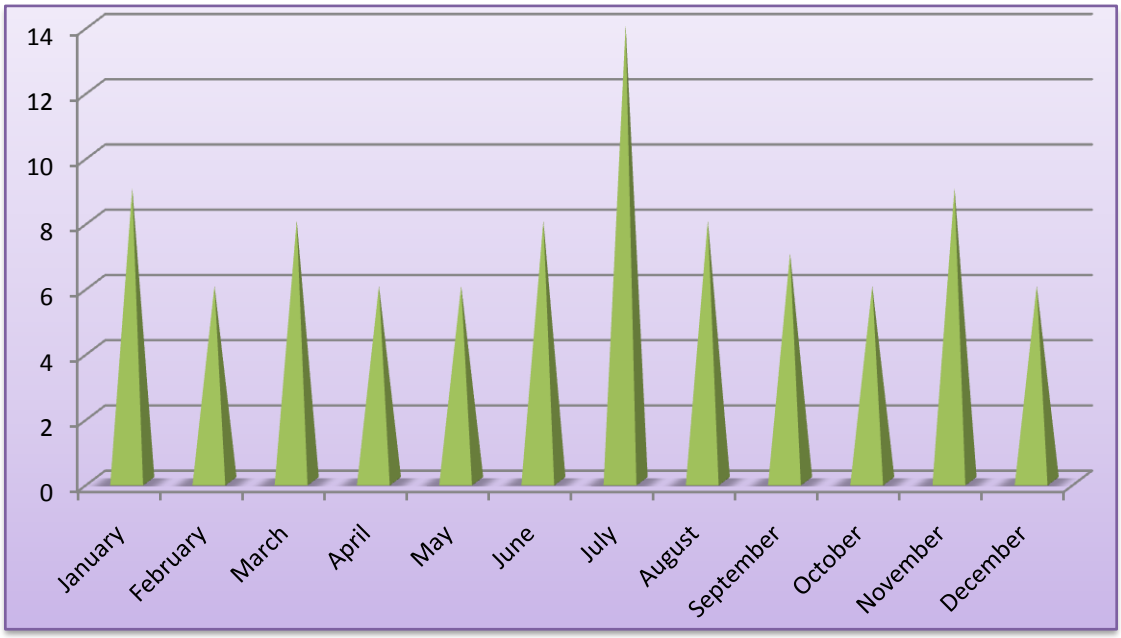


CASELOAD BY MANNER OF DEATH/COMMUNITY

Community	Accidental	Homicide	Suicide	Natural	Non-Coroners	Unclassified	Undetermined	Total
Aklavik							1	1
Behchoko	2	1		3	2			8
Deline			1					1
Fort Good Hope				3	1			4
Fort Liard	1			1	1			3
Fort McPherson				2				2
Fort Providence				1	1			2
Fort Simpson	2			3				5
Fort Smith	2			3				5
Hay River	1		1	5				7
Inuvik	6*			3				9
Lutsel K'e			1					1
Nahanni Butte	1							1
Norman Wells	1							1
Paulatuk	1			1	2			4
Sachs Harbour				1				1
Tsiigehtchic		1						1
Tuktoyaktuk	2			1				3
Tulita							1	1
Ulukhaktok			1					1
Wrigley				1				1
Yellowknife		1	6	19	4	1		31
Total	19	3	10	47	11	1	2	93

* 4 of these deaths occurred simultaneously and were a result of a single boating accident

CASELOAD BY MONTH



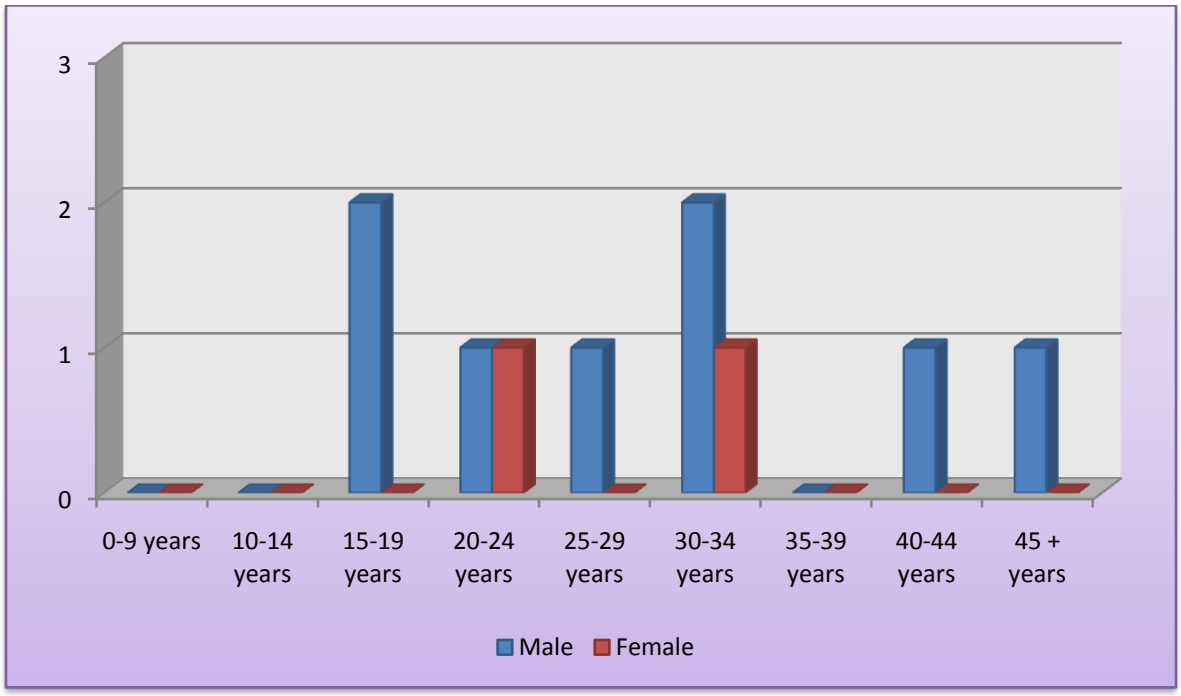
CASELOAD BY MANNER/MONTH

Month	Accidental	Homicide	Suicide	Natural	Non-Coroners	Unclassified	Undetermined	Total
January	2			7				**9**
February			1	4	1			**6**
March	3			5				**8**
April			2	2	1		1	**6**
May	1		2	1	1	1		**6**
June	1	2		5				**8**
July	6		2	3	3			**14**
August	2		1	4	1			**8**
September	3			3	1			**7**
October				4	1		1	**6**
November	1	1		6	1			**9**
December			2	3	1			**6**
Total	**20**	**3**	**11**	**43**	**11**	**1**	**1**	**93**

SUICIDE BY GENDER/AGE

Age Group	Male	Female	Total
0-9 years			
10-14 years			
15-19 years	2		**2**
20-24 years	1	1	**2**
25-29 years	1		**1**
30-34 years	2	1	**3**
35-39 years			
40-44 years	1		**1**
45 + years	1		**1**
Total	**8**	**2**	**10**

Of the 10 suicide deaths in 2008, 8 were male and 2 were female. The majority of suicides occurred in persons 30 – 34 years of age.

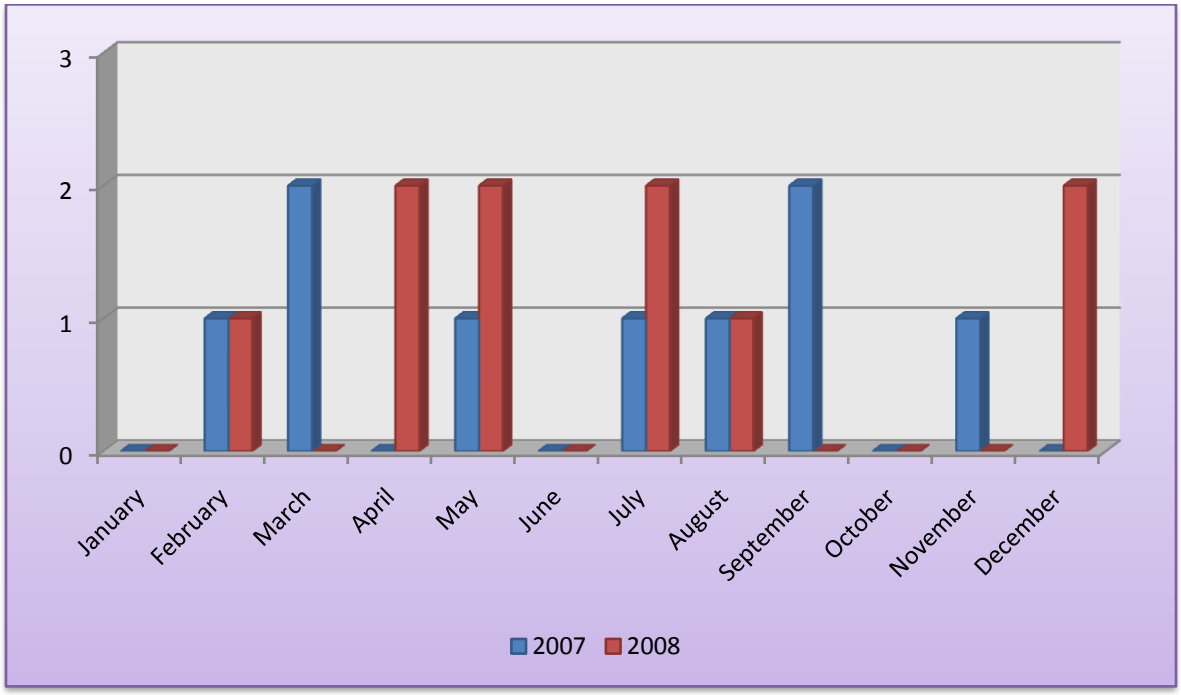


SUICIDE BY MONTH/GENDER/AGE/METHOD

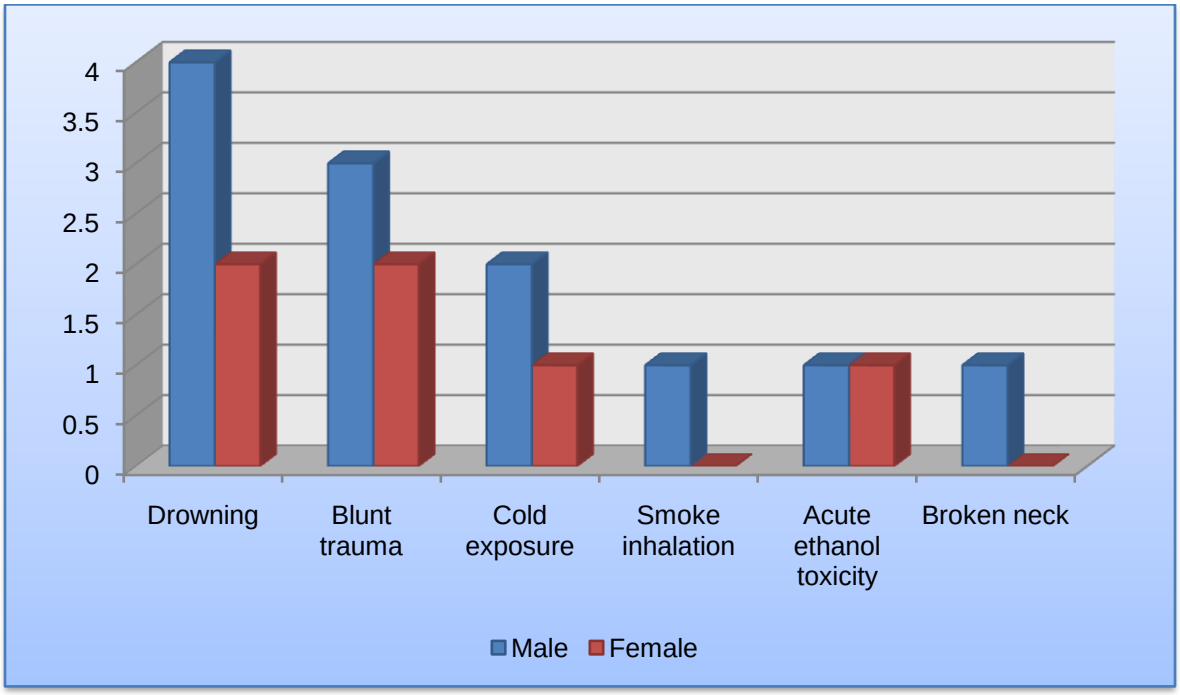
Month	Gender	Age	Method	Alcohol Involvement
February	Male	18	Gunshot	No
April	Male	18	Hanging	No
	Female	24	Hanging	Yes
May	Female	34	Hanging	Yes
	Male	31	Gunshot	No
July	Male	23	Hanging	No
	Male	44	Incised wounds to antecubital fossa	No
August	Male	33	Gunshot	No
December	Male	25	Hanging	Yes
	Male	51	Hanging	Yes

Hanging and self-inflicted gunshot wounds together accounted for 9 of the 10 suicides in 2008.

SUICIDES BY MONTH 2007 – 2008 COMPARISON



ACCIDENTAL DEATH BY CAUSE/GENDER



Cause of Death	Male	Female	Total	Alcohol Related
Drowning	4	2	6	1
Blunt trauma	3	2	5	2
Cold exposure	2	1	3	3
Acute ethanol toxicity	1	1	2	2
Broken neck	1	0	1	0
Smoke inhalation	2	0	2	1
Total	**13**	**6**	**19**	**9**

Accidental death accounted for approximately 20 % of all deaths reported to the Coroner's Service in 2008. The majority of deaths (13 of 19, or 68%) were males.

Drowning was the cause in 6 of the 19 accidental deaths in 2008 (26%).

SUDDEN INFANT DEATH SYNDROME

Sudden Infant Death Syndrome (SIDS) is the most common cause of death in infants between 2 weeks and 6 months of age. The finding of a death by SIDS is done by exclusion of any other identifiable cause. The actual reason why these previously healthy infants die suddenly and unexpectedly is not currently known but research is ongoing.

In 2008, only one death was attributed to Sudden Infant Death Syndrome.

NATURAL & NON-CORONER CASES

Natural	Non-Coroner	Coroner
58	11	47

Under the *Coroners Act*, the Coroners Service is responsible for investigating all sudden, unexpected and unexplained deaths. This does not include palliative care deaths, still births (if attended by a medical practitioner) or deaths that occur in another jurisdiction (i.e. medi-vacs) unless as a result of an incident that occurs in the NWT. A Report of Non-Coroner is issued when a death that is not covered by the *Coroners Act* is reported to a coroner.

All cases deemed as Non-Coroners must be "expected deaths" and must occur by a natural disease process.

POST MORTEMS

Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
5	0	4	2	2	3	4	5	3	1	1	2

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. The autopsy may also be a means of determining the identity of the deceased.

A total of 32 autopsies were conducted in 2008.

CORONER APPOINMENTS

The Office of the Chief Coroner has the statutory authority to recommend the appointment and removal of Coroners. It is desirable for each community to have local Coroners; therefore recruitment of local Coroners is done by the Coroner's Office, the Municipality or Band and the RCMP. Candidates must complete an application form outlining any special skills or training that they have which would assist them in the position of Coroner. Applicants are also required to have written support from their Municipality or Band office and their local RCMP detachment. The letters of support and a recommendation of appointment by the Chief Coroner are then sent to the Minister of Justice for appointment. The applicant's MLA is also notified of the intended appointment. Coroners are appointed by the Minister of Justice for a three year period.

At the close of 2008, there were 36 Coroners across the Northwest Territories; 14 were aboriginal. There were 20 male (6 aboriginal) coroners and 16 female (8 aboriginal) coroners.

The Coroners and the communities in which they reside are as follows:

Aklavik

- Arnulf Steinwand

Behchoko

- Tracey Lynn Debaie

Deline

- Elizabeth Takazo

Fort Good Hope

- Ester Charney

Fort Liard

- Alan Harris

Fort McPherson

- Winnie Greenland

Fort Providence

- Robert Head

Fort Smith

- Pat Burke, Marion Berls, Tony Jones, Sandy Napier, Steven Shelton, Andrew Turner

Fort Simpson

- John Herring

Hay River

- Doug Swallow, Jim Forsey

Inuvik

- Erin Allooloo, George Doolittle, Gerald Kisoun, Elizabeth Drescher

Lutsel k'e

- Alfred Lockhart

Norman Wells

- Dudley Johnson, Valerie McGregor

Paulatuk

- Bernadette Emma Nakimayak

Tsiigehtchic

- James Andrew Cardinal

Tulita

- Edward McPherson Jr.

Tuktoyaktuk

- Anita Pokiak, Barney Masuzumi

Whati

- Carolyn Coey-Simpson

Yellowknife

- Beth Ann Williams, Garth Eggenberger, Jennifer Eggenberger, Wendy Eggenberger, Fred Wittlinger, Cathy Lee Menard, Maureen Gowans

CONCLUDING CORONERS' INVESTIGATIONS

REPORT OF CORONER

All Coroner cases are generally concluded by either a Report of Coroner or by Inquest. The most common method used is the "Report of Coroner".

The Report of Coroner is a document outlining the results of a Coroner's investigation. It provides clarification of facts and circumstances surrounding the death. The Report establishes the identity of the deceased, classifies the death, and includes any recommendations that may prevent a similar death. A Report of the Coroner is completed in all death investigations with the exception of cases where an inquest has been called. At Inquest, the Jury Verdict takes the place of a Coroner's Report.

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

CORONER'S INQUESTS

Coroner cases that are not concluded by a Report of Coroner are ordinarily finalized by the use of a Coroner's Inquest which is a quasi-judicial hearing held in an open forum. The proceeding utilizes a 6 panel jury and hears testimony from sworn witnesses. The inquest is not a mechanism to resolve civil disputes nor is it used to conduct prosecutions. It is a fact finding proceeding which provides information and recommendations.

A Coroner must hold an inquest when the deceased was 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 to:

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

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

There were no Inquests held in the Northwest Territories during this reporting period.

APPENDIX "A"

SUMMARY OF SELECTED CORONERS' REPORTS CONTAINING RECOMMENDATIONS

(CONCLUDED IN 2008)

Case # 1

This 71 year old male attended Hospital on September 14th, 2008, at approximately 1:00 am; his chief complaint upon presentation was of shortness of breath with a productive cough. He had also had significant weight loss over the last three months. There was no physician in this community at that time and after a Nurse consulted with an Emergency Room Doctor in Yellowknife; a decision was made to immediately medically transport him to Yellowknife for further treatment.

The deceased arrived at Stanton Territorial Hospital at approximately 06:00 am on September 14th, 2008, with his condition deteriorating over the next 20 hours. He went into cardiac arrest at 01:00 am on September 15th, 2008; he was resuscitated and maintained on a ventilator until his wife arrived. He was pronounced dead at approximately 11:35 am September 15th, 2008.

The Coroner's Service was notified and an investigation was commenced. A review of the medical file was undertaken. Records indicated he was seen August 18th, 2008, with complaints of shortness of breath and pain in his left shoulder. The medical records also indicated he was a heavy smoker and had been diagnosed with diabetes.

On the 19th of August, 2008, he had had a chest x-ray which showed two opacities in the right lung, one was in the right Hilar region and the other in the medial aspect of the right upper lobe.

The deceased was seen again on September 1st, 2008, with complaints of shortness of breath and chest congestion with a productive cough. He attended the local health center at 5:50 pm on September 13th, 2008, with a complaint of shortness of breath, no appetite and night sweats in the last two weeks. Stanton Territorial Emergency Department was consulted and a Mantoux test for TB and AFBx3 had been ordered; however there was no indication it was done. He was discharged home. Several hours later he returned to the health centre; unable to walk unaided and stated he had been getting progressively weaker over the last few days. He was medivaced to Stanton Territorial Hospital where he died approximately 30 hours later.

Due to the concerns over the possibility of TB, it was decided that the deceased should go for autopsy. He was prepared and sent to Edmonton for the procedure.

At autopsy two cancerous tumors were found in the upper lobe of the right lung (Adenocarcinoma of the lung), with tumors also present in the lymph nodes of the chest (Mediastinal Lymph Nodes). A large quantity of fluid was present in the lungs (pulmonary edema) and there was also evidence of scarring (fibrosis) within two lung lobes.

There was significant narrowing of the blood vessels that supply the heart muscle (atherosclerotic coronary artery disease), together with complete blockage of one of the vessels by a blood clot (coronary thrombosis). There was no evidence of active tuberculosis infection.

After reviewing the information and documentation the Coroner found that the deceased died as a result of Coronary Artery Disease with Adenocarcinoma of the lung thought to be a significant contributing factor to the cause of death.

The death was further classified as Natural.

The Coroner issued recommendations to the Department of Health and Social Services, and the Regional Health Boards to review the medical care given to this patient.

Case #2

A 62 year old male was being medically evacuated to Edmonton for a ruptured abdominal aortic aneurysm when he died. He was brought back to the hospital and the Coroner was notified.

He was an outpatient at the hospital for the sudden onset of testicular pain on January 20th, 2008. He was given medication and released. The deceased later returned to the Hospital and was admitted; his was administered IV medication. He was suffering from nausea and vomiting. Upon examination, his abdomen was soft with bowel sounds being present with pain noted to the lower left quadrant. The left Scrotum was still painful. One X-ray was taken of the chest and two X-rays of the abdominal view. On the abdominal views, there was a moderate amount of stool through the colon. The left psoas margin was indistinct. This was in keeping with the subsequent discovery of the large retroperitoneal hematoma found on CT scan.

An ultrasound was scheduled for January 21st, 2008. The patient was wheeled down to Radiology. While getting ready for the procedure, he became uncooperative, weak and mottled grey in color; because of this the deceased was taken to the ER. His abdomen was becoming distended, and he was in extreme pain. A CT scan was ordered at this time.

The CT showed an 8.8 X 7.1 cm Abdominal Aortic Aneurysm that began at the renal arteries and ended at the bifurcation. There was extensive hemorrhaging into the left perinephric space. Medical evacuation was scheduled to take Mr. Brown to Edmonton, Alberta, the location of the nearest vascular surgeon.

At approximately 1445 hrs, the patient was being transported to Edmonton. At approximately 1547 hrs, he was not breathing, had no palpable pulse, and the heart monitor showed asystole. He was transported back to Stanton Territorial Hospital where he was pronounced dead.

The Coroner determined that this man died as result of the Ruptured Aortic Abdominal Aneurism. The death was classified as natural.

Recommendations were made that a preliminary report should be made immediately available when diagnostic imaging is completed. A further recommendation was, when a patient presents with severe testicular pain and all other avenues explored are negative, Abdominal Aortic Aneurysm should be considered as a possibility and an abdominal CT scan should be ordered.

Case #3

The Fire Department responded to a fire. The fire was in a "saw shed" next to a place of business located in Yellowknife, NT. The saw shed was a one floor building approximately fifty-three meters square and windowless with one access and one overhead door. The structure was reported to be in heavy smoke when fire fighters arrived. During the fire fighting operations the roof of the saw shed collapsed with four fire fighters performing work on the roof and two interior attack fire fighters inside the structure. The roof collapse sent the four fire fighters on the roof sliding inside the structure, and completely buried the two interior attack fire fighters with roof debris and heavy snow accumulations. Immediate action was taken to extricate the four from the structure and within a few minutes, all were removed safely. The collapse was initially reported to incident command and it was then reported that all personnel were okay. A few minutes later it was realized that two interior fire fighters were still missing. Rescue attempts began immediately but this was proving to be an extremely difficult process as the debris and snow from the collapse had to be removed. Both fire fighters were found and extricated; they were transported to hospital and died from their injuries.

The Office of the Chief Coroner made the following Recommendations:

1) To the City of Yellowknife Building Inspection Division and Fire Division it is recommended both engage in a proactive inspection program, including pre-fire planning for structures within their jurisdiction, this includes going into existing buildings, either during a fire inspection, fire alarm testing, or training for the on-call personnel.

(This would give the Yellowknife Fire Department valuable knowledge of building structures within their jurisdiction including building materials.)

2) To the Yellowknife Fire Department and the Municipal Division of the City of Yellowknife it is recommend that the incident tactical commander must set up a command post and direct operations from that command post.

3) To the Yellowknife Fire Department and the Municipal Division of the City of Yellowknife it is recommended that as part of their accountability system, an emergency recall system be implemented by the Yellowknife Fire Department.

(At the time of this incident there appeared to be no evidence of a system or alarm to have alerted the personnel to return to the account ability board, to determine if there were any missing fire fighters.)

4) To the Yellowknife Fire Department and the Municipal Division of the City of Yellowknife it is recommend that the incident command personnel perform an internal peer review annually to ensure their level of skill is maintained.

(This can be accomplished by taking a call where each incident commander was in charge and as a group, review and critique the digital recording. This is not only a review to ensure that the standards are being met, but should be viewed as a learning

opportunity as well as to find out what could have been done better and the opportunity to develop a process for doing just that.)

5) To the Yellowknife Fire Department and the Municipal Division of the City of Yellowknife it is recommended that a Training Program be developed and maintained that ensures that members of all levels of the Fire Department, both lower ranks and all officers maintain their proficiency at their achieved level of skills in both the medical and fire fighting fields.

(The Fire Department is perceived as having the public's safety at the heart of its interest. If the standards to which the members attain are not maintained, the department members and the general public at large are at risk.)

6) To the Yellowknife Fire Department it is recommend that a safety committee be created that is run jointly between the lower ranks and the officers of the Department.

(*This would allow all ranks to bring items that are of concern and have them dealt with in this open forum.)*

7) To the Yellowknife Fire Department and the Municipal Division of the City of Yellowknife it is recommended that Critical Incident Debriefing be mandatory for all fire fighters and dispatch personnel after all major fire or rescue incidents. This is to be conducted by a certified CISD trained personnel.

(This allows the members who were involved to discuss what happened to and around them in an open and non-judgmental forum. The CISD helps to reduce the impact of traumatic events. It helps accelerate the normal recovery process from a traumatic event. It also provides education in stress management and coping techniques. There should be a Critical Incident Stress Debriefing for all members of the YKFD who were involved in this case to help them learn deal with the stress and the loss that this incident created.)

8) To the Office of the Fire Marshall, it is recommended that standards and legislation relating to fire prevention and public protection in the Northwest Territories meet or exceed the National Fire Prevention Association and the National Fire Code of Canada.

Recommendations and Orders were made by the Worker's Compensation Board and the Office of the Fire Marshal, to the Yellowknife Fire Department and the City of Yellowknife.

The Office of the Chief Coroner supports these recommendations. We encourage the parties involved to adopt and implement as quickly as possible.

CORONERS ACT: REPORTING OF 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 Territories, or as a result of events that occur in the Territories, where the death

(a) occurs as a result of apparent violence, 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 anesthesia;

(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.

The NWT Coroner Services wishes to express our appreciation to the RCMP, Health care Professionals, and our many other investigative partners that cooperated and assisted with the Coroner's Office in conducting our death investigations over the past year. The Office would also like to thank the NWT Coroner's who have shown frequently, under less than perfect conditions, a high level of dedication and professionalism.