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OFFICE OF THE CHIEF CORONER

NORTHWEST TERRITORIES CORONER SERVICE

2013 ANNUAL REPORT

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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 *Coroners Act* established the territorial jurisdiction of the coroner. 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, sorting out 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.

INTRODUCTION

The Coroner Service falls within the Territorial Department of Justice for organizational and administrative purposes. The Office of the Chief Coroner is located in Yellowknife and oversees all death investigations. Currently there are 34 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 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, the remains are sent to Foster & McGarvey Funeral Homes 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.

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 deaths in the NWT.

MANNER OF DEATH

The Coroner or an Inquest Jury determines 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 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 apparent 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/her or a death that results from the intervention of a non-human agency.

SUICIDE refers to any death from a self-inflicted injury where there is an 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). In the context of a coroner report or jury verdict, 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 cause death. Coroners are instructed to make every effort to classify a death in one of the other 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 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.***

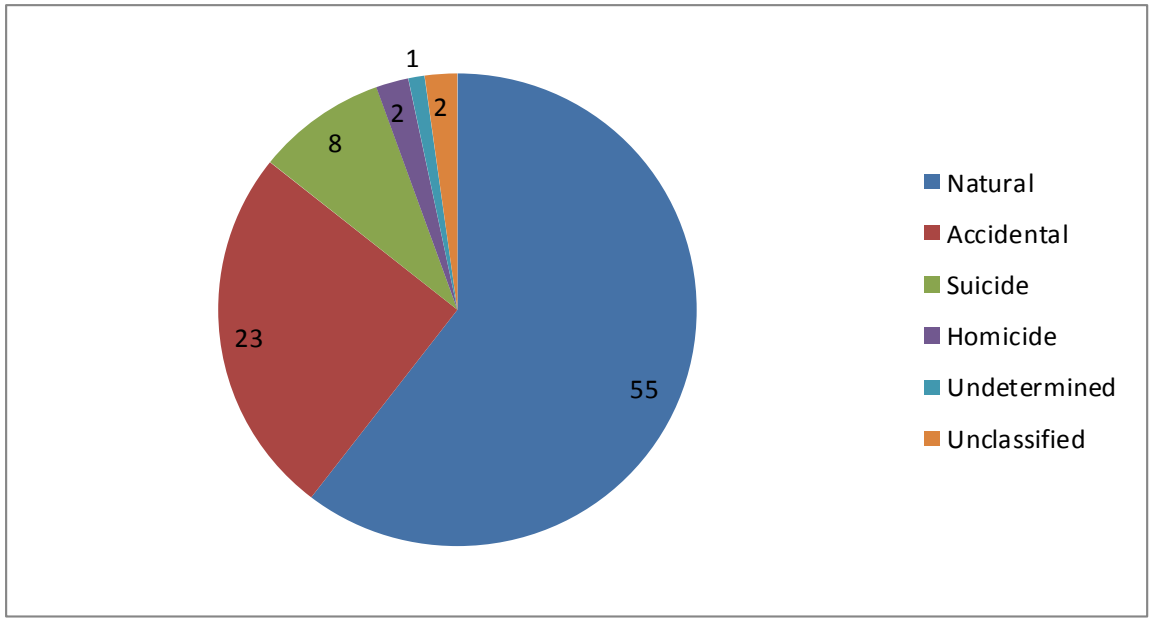
NWT REGIONS

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

2013 CASE STATISTICS

TOTAL CASES

Total Cases			
Manner of Death	Number	Cases %	Population % *
Natural	55	60.44%	0.1286%
Accidental	23	25.27%	0.0482%
Suicide	8	8.79%	0.0207%
Homicide	2	2.20%	0.0046%
Undetermined	1	1.10%	0.0023%
Unclassified	2	2.20%	N/A
Total	91	100%	0.2044%

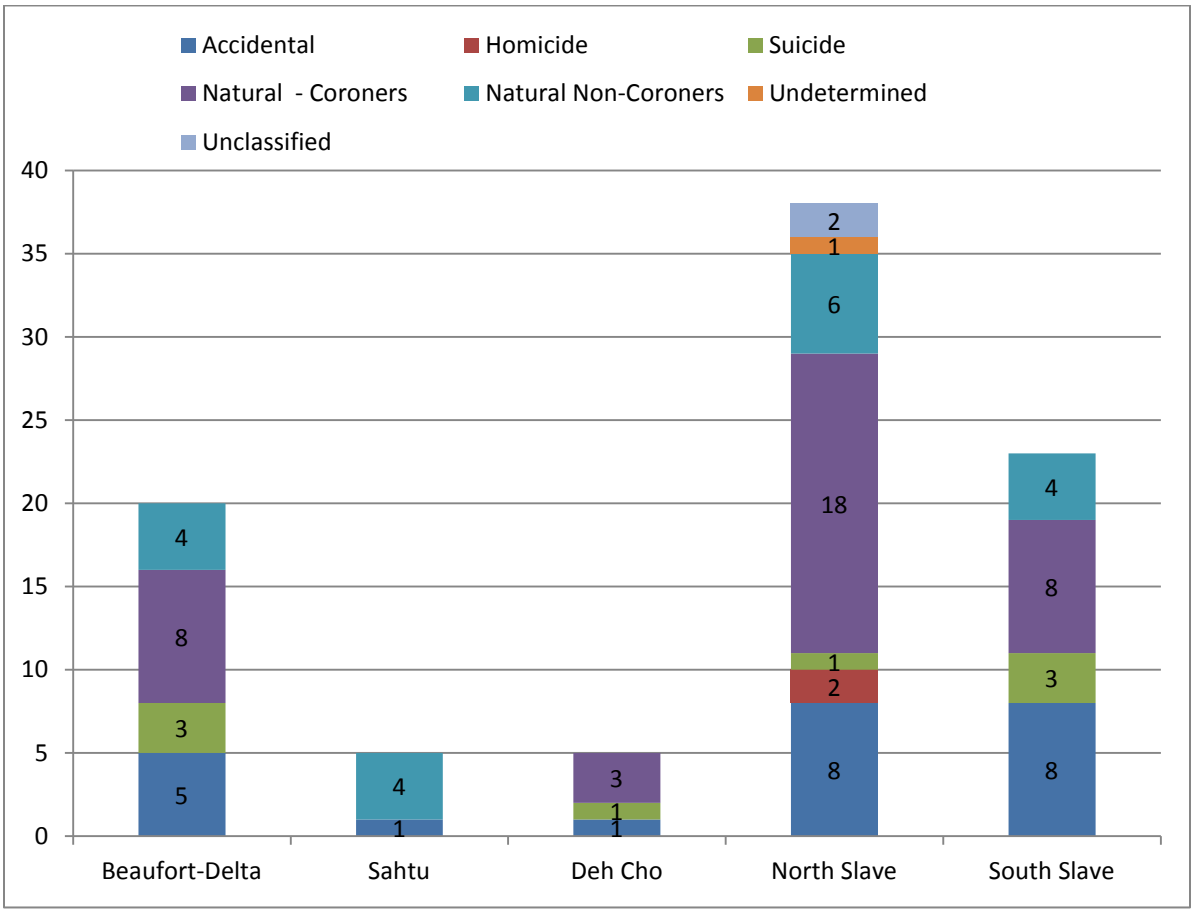


Unclassified cases are not represented in the population figures since they are non-human in origin. In 2013, two cases were determined to be unclassified.

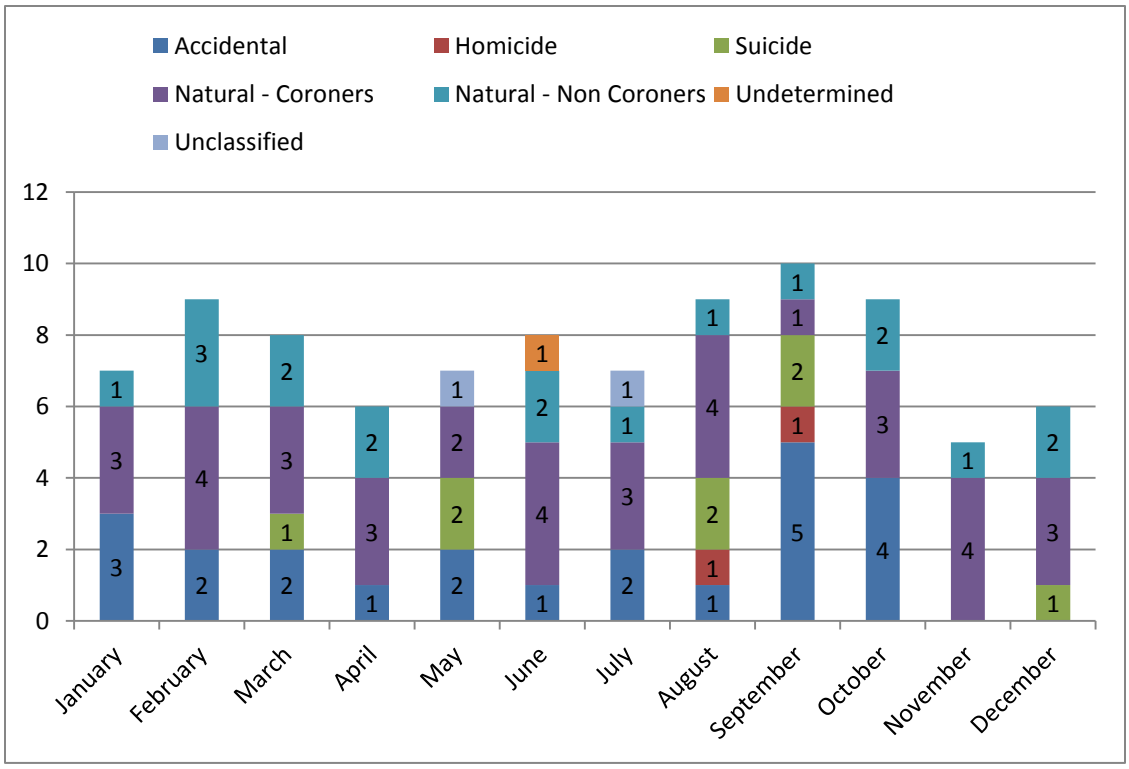
*Based on an Annual NT population estimate of 43,537 retrieved April 23, 2014 at http://www.statsnwt.ca/population/population-estimates/PopEst_Jul2013.pdf

CASELOAD BY MANNER AND REGION

Region	Accidental	Homicide	Suicide	Natural		Undetermined	Unclassified	Total
				Coroner	Non-Coroner			
Beaufort-Delta	5		3	8	4			20
Sahtu	1				4			5
Deh Cho	1		1	3				5
North Slave	8	2	1	18	6	1	2	38
South Slave	8		3	8	4			23
Total	23	2	8	37	18	1	2	91



CASELOAD BY MANNER AND MONTH

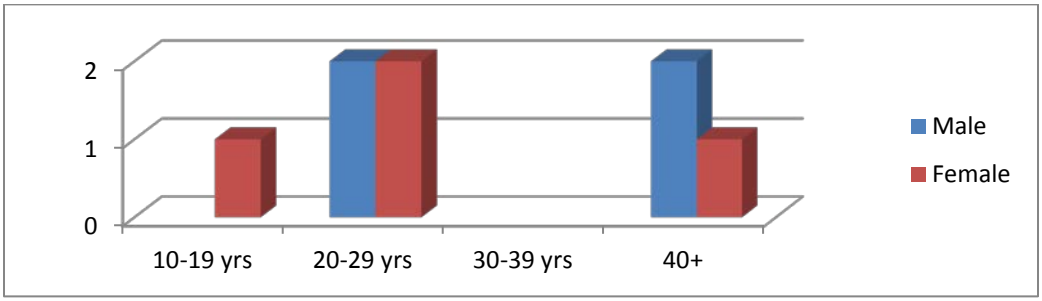


Month	Accidental	Homicide	Suicide	Natural		Undetermined	Unclassified	Total
				Coroners	Non-Coroners			
January	3			3	1			7
February	2			4	3			9
March	2		1	3	2			8
April	1			3	2			6
May	2		2	2			1	7
June	1			4	2	1		8
July	2			3	1		1	7
August	1	1	2	4	1			9
September	5	1	2	1	1			10
October	4			3	2			9
November				4	1			5
December			1	3	2			6
Total	23	2	8	37	18	1	2	91

SUICIDE

BY GENDER AND AGE

Age Group	Male	Female	Total
10-19 years		1	1
20-29 years	2	2	4
30-39 years			
40 + years	2	1	3
Total	4	4	8



In 2013 there were eight suicides; four males and four females. Four of these suicides occurred in people between the ages of 20 -29.

BY MONTH, METHOD, AND ALCOHOL INVOLVEMENT

Month	Region	Method	Alcohol Involvement	Drug Involvement
March	Beaufort-Delta	Self-inflicted Gunshot	Yes	No
May	South Slave	Acute Carbon Monoxide Poisoning	No	No
May	South Slave	Hanging	Yes	No
August	Deh Cho	Hanging	Yes	No
August	South Slave	Self-Inflicted Gunshot	Yes	Yes
September	Beaufort-Delta	Hanging	Yes	Yes
September	Beaufort-Delta	Drug Overdose	Yes	Yes
December	North Slave	Self-Inflicted Gunshot	Yes	Yes

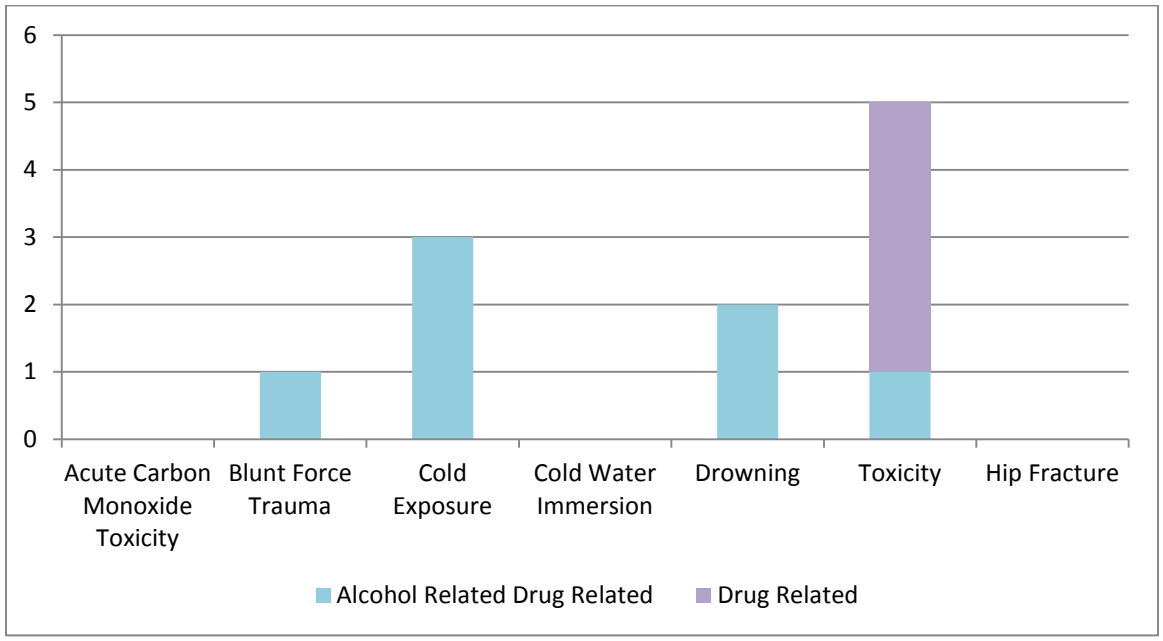
Three of the eight suicides occurred in the Beaufort-Delta region in 2013. Toxicology examination confirmed the presence of alcohol in seven of the eight suicides.

ACCIDENTAL

BY CAUSE AND GENDER

Cause of Death	Male	Female	Total
Acute Carbon Monoxide Toxicity	1	1	2
Blunt Force Trauma	4	1	5
Cold Exposure	2	1	3
Cold Water Immersion	3		3
Drowning	3		3
Toxicity	5	1	6
Hip Fracture		1	1
Totals	18	5	23

Accidental deaths accounted for approximately 25.27% of reported deaths in 2013. The majority of accidental deaths (18 of 23 or 78%) were males, and 11 of 23 or 48% were alcohol and/or drug related.



HOMICIDE

BY AGE AND GENDER

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

BY REGION

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

In 2013, there were two homicides, both males. Homicides accounted for 2.2% of the reported deaths in 2013.

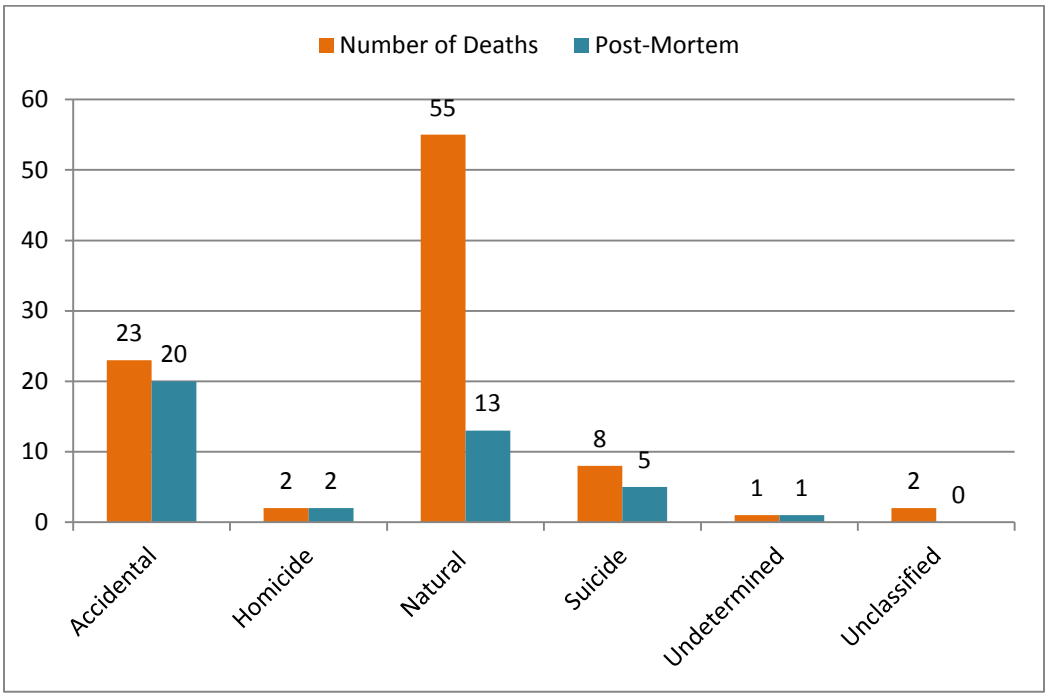
NATURAL AND NON-CORONER CASES

In 2013 there were a total of 55 natural deaths, 37 of which were coroner cases and 18 of which were non-coroner cases. Non-coroner cases are natural deaths that are reported to the Coroner Service but are not captured by the reporting criteria specified under the *Coroners Act*.

Coroner	Non-Coroner	Natural
37	18	55

POST-MORTEMS BY MANNER

A post-mortem examination is conducted when the cause and/or manner of death cannot otherwise be determined or when it appears appropriate to conduct the procedure. The post-mortem may also be a means of determining the identity of the deceased. A total of 41 post-mortem examinations were conducted in 2013.



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 the office of coroner. 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 for appointment. 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 2013, there were 34 coroners across the Northwest Territories, with 19 men and 15 women. The coroners and the communities in which they reside are listed as follows:

Community	Coroners
Aklavik	Arnulf Steinwand
Behchoko	Tracey Foster Debaie
Deline	Elizabeth Takazo
Fort Liard	Robert Firth
Fort McPherson	Winnie Greenland
Fort Providence	Matthew Ballantyne
Fort Smith	Pat Burke, Marion Berls, Tony Jones
Fort Simpson	John Herring, Karen Simon
Hay River	Doug Swallow, Jim Forsey
Ulukhaktok	Gary Bristow
Inuvik	Wayne Smith, Heather Wheating, Gary McBride
Lutsel K'e	Alfred Lockhart
Norman Wells	Dudley Johnson, Lindsey Blake
Sachs Harbour	Joseph Carpenter
Tulita	Edward McPherson
Tuktoyaktuk	Anita Pokiak, Noella Cockney
Yellowknife	Garth Eggenberger, Wendy Eggenberger, Cathy Lee Menard, Ian McCrea, Adelle Guigon, Soura Rosen, Ruth McLean, Karen Brown, George Doolittle, Joanne Reed

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 valuable information 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").

CORONERS 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 court 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 of 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 2013)

Case # 1

A 33-year old female and her long time common-law husband were found deceased in their cabin. The investigation revealed that she had been a victim of domestic violence throughout this relationship.

COMMENTS AND RECOMMENDATIONS:

The issue of domestic violence continues to be a concern for the NWT. The impact of Domestic and Family Violence on individuals and communities is devastating. Domestic violence deaths almost never occur without warning. In most cases, there have been repeated incidents of violence and indicators of risk as well as opportunities for agencies and individuals to intervene before the death.

When viewed as an escalation of predictable patterns of behaviour, death resulting from domestic and family violence can be seen as largely preventable. A variety of domestic and family violence interventions and responses have been developed in many of our northern communities, but through our investigation we were never able to determine if these programs or services had been utilized.

The Coroner Service made the following recommendations to the Minister of Health and Social Services:

1. Consider using a universal screening tool for family violence in NWT Health Centers and emergency rooms.
   (While screening for family violence alone will not decrease the incidence of family violence, it does provide an opportunity to link victims with necessary supports and services.)

2. To support efforts to coordinate community responses to family violence. Victims, children in their care and perpetrators all require a continuum of services that are accessible and responsive.
   (All levels of community and government have a role in keeping community members safe from family violence. This will involve addressing the attitudes and beliefs that underlie violence.)

3. To continue to support a long term, sustained social marketing campaign which is directed at changing attitudes, beliefs and ultimately behaviours related to family violence. .
   (Territorial efforts are needed to challenge attitudes and beliefs that normalize, condone or encourage violence.)

The NWT Coroner Service made the following recommendation to the Royal Canadian Mounted Police:

1. To consider being more proactive in utilizing existing remedies and tools to increase victim safety. This includes conducting ODARA risk assessments (Ontario Domestic Assault Risk Assessment) and using that information to actively refer to victim services, safety plan and/or facilitate emergency protection as designates under the Protection Against Family Violence Act.
   (The more a victim comes to the attention of police, the more likely their level of risk is increasing.)

Case # 2

A 63-year old female attended the community health center with complaints of abdominal pain and nausea. She was difficult to assess as she was incoherent, combative and mentally confused. She became unresponsive and all attempts at resuscitation were unsuccessful.

COMMENTS AND RECOMMENDATIONS:

Prescription drug related deaths have become an increasing concern in the Northwest Territories. In recent years the Coroner Service has seen a rise in deaths attributed to prescription drugs. In most cases, these drugs were prescribed for individuals with a chronic condition and/or chronic pain.

The Coroner Service made the following recommendation to the Beaufort-Delta Health and Social Services Authority:

1. It is recommended that the Beaufort-Delta Health and Social Services Authority review the medical care given to this patient.
   (Given the patients long-term use of prescription acetaminophen and well-documented chronic ethanol abuse, a review of best practices in conjunction with policy and procedures is warranted in this case.)

APPENDIX "B"
SUMMARY OF CORONER'S INQUESTS

Verdict of Coroner's Jury

Deceased: Karen Ann Marie Higona Lagiak-Lander

Date and time of Death: March 14, 2012 at 18:30 pm

Place of Death: Yellowknife Stanton Territorial Hospital

Cause of Death: Part 1 Multiple Gunshot Wounds

Part 2 Alcohol Abuse, Chronic Depression,

Borderline Personality Disorder, Suicidal Ideation

Manner of Death: Undetermined

Circumstances under which death occurred:

On March 14, 2012, Karen Lander was reaching a breaking point. Having faced eviction and the apprehension of her children and other stress factors, Karen proceeded to barricade herself in a friend's home with multiple firearms. RCMP arrived on the scene and after the situation did not improve, it a standoff ensued, ultimately leading to Karen's unfortunate death by gunshot.

RECOMMENDATIONS:

Yellowknife Health and Social Services Authority ("YKHSSA"):

1. That the YHSSA consult with other health and social service providers and community organizations, to develop a "team approach" for assisting clients with multiple addictions and mental health issues; a consent form should be issued and signed by the client if necessary to be shared so all parties can communicate in helping to get matters resolved;

2. That the YHSSA implement a specific community support group (counsellor, doctor, psychiatrist, nurse, etc.) for people of First Nations and the North suffering from mental health problems and addictions or abuse;

3. That the YHSSA provide training to all staff to assist them in identifying and addressing cultural considerations when assessing Inuit and Aboriginal patients expressing suicide related issues;

Government of the Northwest Territories:

4. That the GNWT review its policies and procedures to ensure that it does not reduce market rent when children are apprehended if they are involved in a plan of care with the Department of Health and Social Services that includes that the children will be returned to the parent(s). In cases where child(ren) will remain under the permanent care of the Director of Child and Family Services for a period of time and where no plan of care has been made, The GNWT should ensure that one full calendar month notice is given to the client before a reduction in market rent is made;

5. That the GNWT open a rehabilitation center for alcohol and drug abuse in Yellowknife, Northwest Territories so citizens of Yellowknife have a rehabilitation center readily available to them;

Stanton Territorial Health Authority ("STHA") and Physicians:

6. That the STHA develop policies and procedures with emergency room ("ER") administration to ensure that family physicians of patients who attend the ER with suicide related issues receive timely and complete information of the attendance from the ER within 24 hours;

7. That the STHA review the Designated Patient Profile form and consider using the form as a way of flagging and/or highlighting patients who attend the ER on a recurring basis with suicide related issues, to better track potential escalation;

8. That the STHA dedicate full-time psychiatric nurses with priority to conducting an initial assessment of patients attending the ER with suicide related issues, including an assessment of the patient before being discharged from the hospital, as well as consultation with the patient if needed, as a means of building trust, rapport and consistency with recurrent patients with suicide related issues;

9. That the STHA provide training to all ER nurses and physicians to assist them in identifying and addressing cultural considerations when assessing Inuit and Aboriginal patients expressing suicide related issues;

10. That the STHA make available a community based nurse/occupational therapist to assist in making appointments and/or referrals for patients who have been admitted to the ER;

Royal Canadian Mounted Police:

11. That the RCMP "G" Division review its equipment and ensure that the Division maintains a full range of non-lethal equipment that would be available to all other divisions for deployment in situations with barricaded and potentially armed and suicidal subjects;

12. That the RCMP review and revise its training materials and courses to ensure that all full and part-time Emergency Response Team ("ERT") members receive comprehensive training including: Training in criteria governing the use of non-lethal weapons as well as training in the effective operational use of non-lethal weapons in situations with barricaded and potentially armed and suicidal subjects;

13. That the RCMP review how communication is relayed to officers in the field for a clear understanding of orders and expectations;

14. That the RCMP develop policies and procedures to ensure ongoing contact with qualified mental health workers, where available, throughout negotiations with barricaded and potentially armed and suicidal subjects;

15. That the RCMP ensure initial and ongoing contact with family members where available throughout negotiations with barricaded and potentially armed or suicidal related issues;

16. That any RCMP officer who escorts a person to the ER with suicide related issues should speak with psychiatric nurse before leaving the patient in their care;

EXPRESSIONS OF APPRECIATION

The NWT Coroner Service wishes to express our appreciation to the RCMP, health care professionals, and our 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 have frequently shown - often under less than optimal conditions - a high level of dedication and professionalism.