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OFFICE OF THE CHIEF CORONER

NORTHWEST TERRITORIES CORONER SERVICE

2012 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 and various 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 38 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 Coroner 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 29 years.

The Deputy Chief Coroner is Soura Rosen, who joined the Coroner Service in 2012.

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***

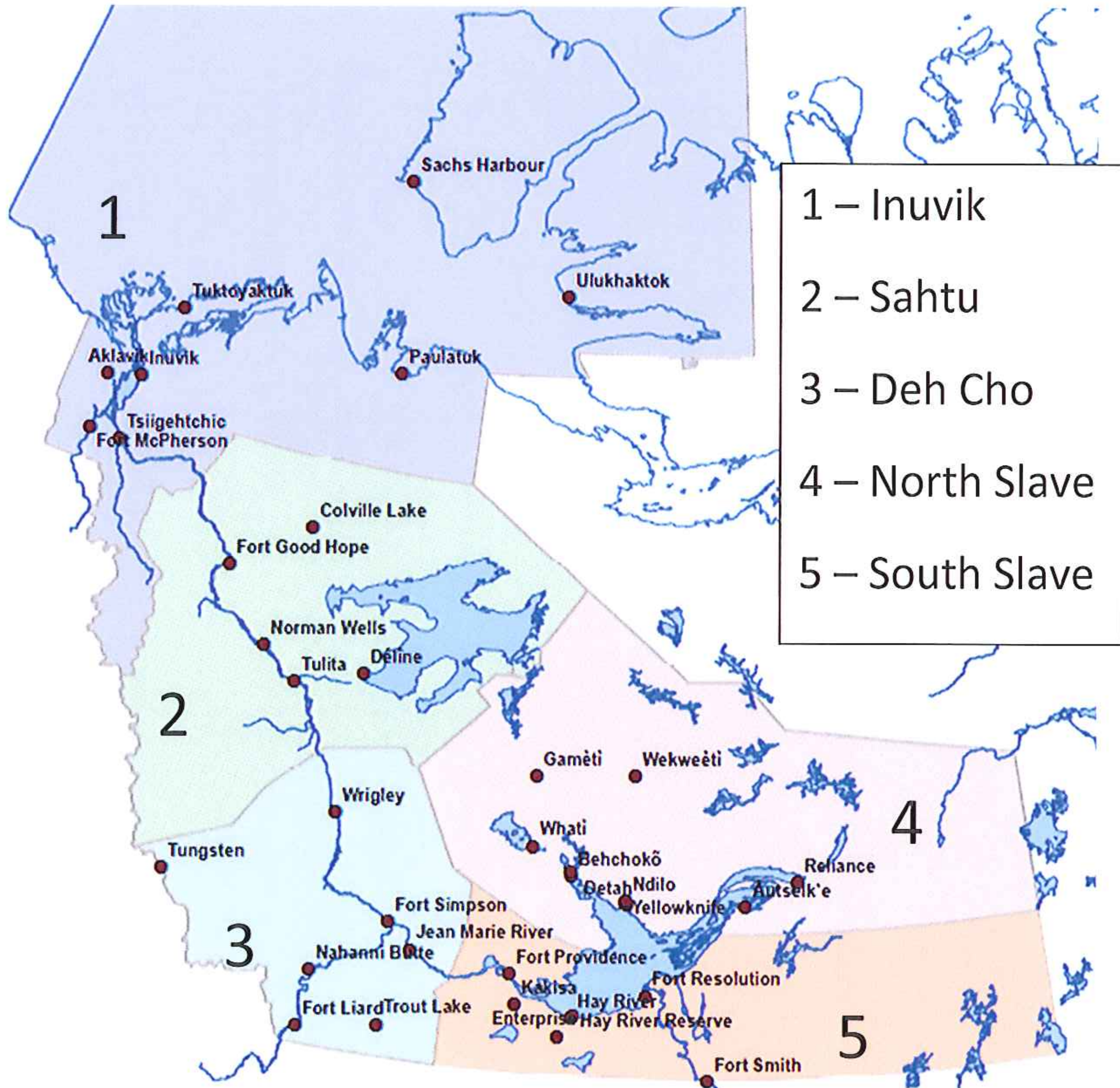
(a) occurs as a result of apparent violence, accident, suicide or other than disease, sickness or old age;
(b) occurs as a result of apparent negligence, misconduct or malpractice;
(c) occurs suddenly and unexpectedly when the deceased was in apparent good health;
(d) occurs within 10 days after a medical 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

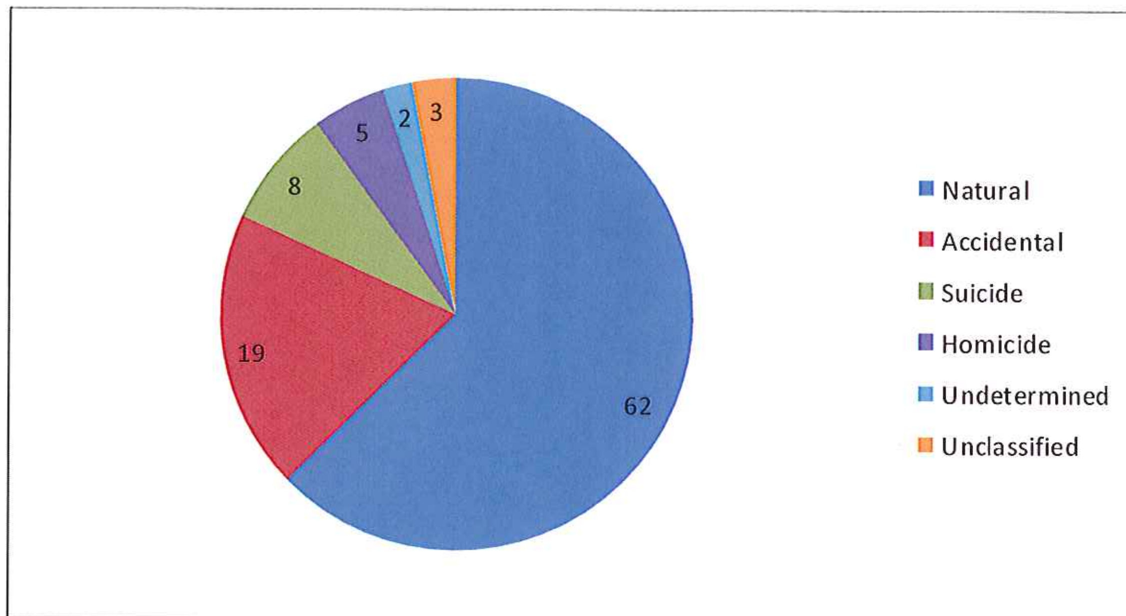


Obtained from http://www.enr.gov.nt.ca/_live/documents/content/Administrative_regions.pdf

2012 CASE STATISTICS

TOTAL CASES

Total Cases			
Manner of Death	Number	Cases %	Population % *
Natural	62	62.63%	0.1407%
Accidental	19	19.19%	0.0461%
Suicide	8	8.08%	0.0185%
Homicide	5	5.05%	0.0115%
Undetermined	2	2.02%	0.0023%
Unclassified	3	3.03%	N/A
Total	99	100%	0.2191%

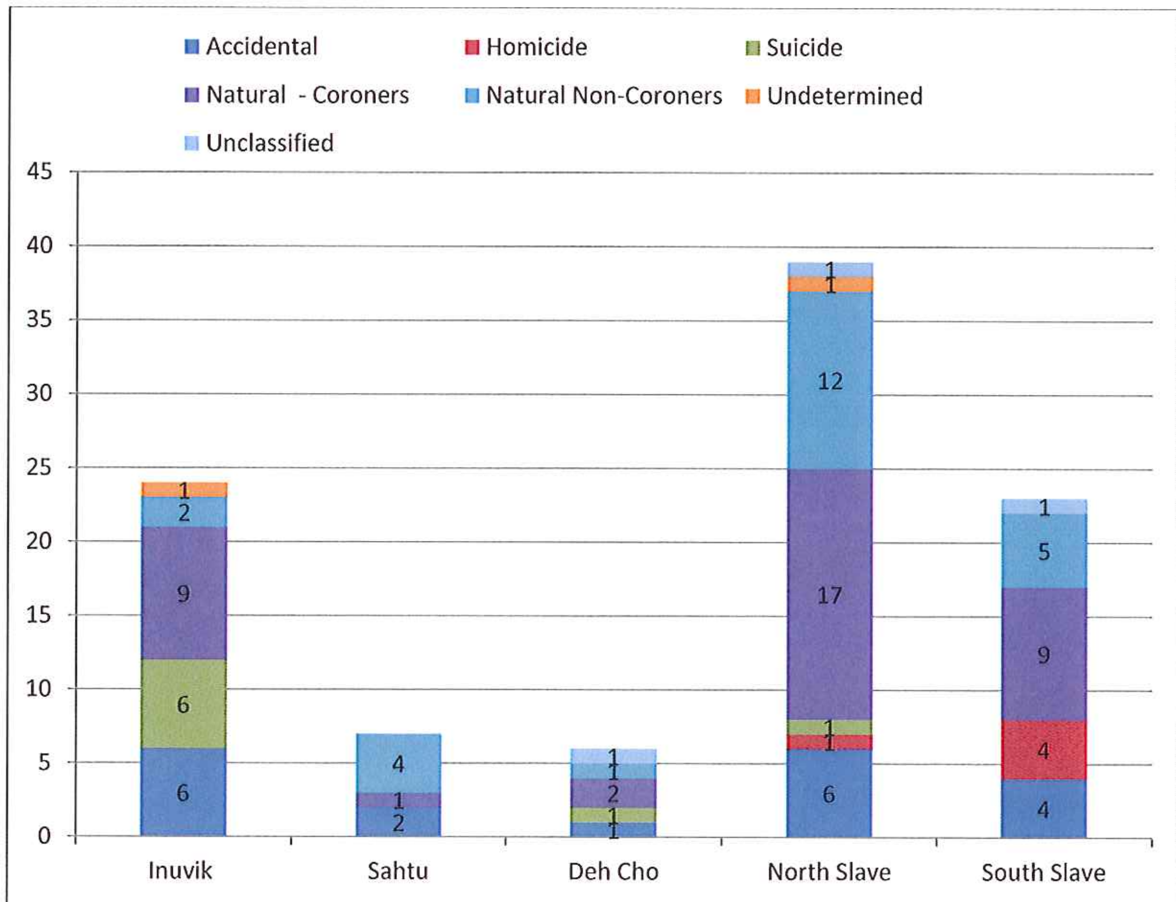


Unclassified cases are not represented in the population figures since they are non-human in origin. In 2012, three cases were determined to be unclassified.

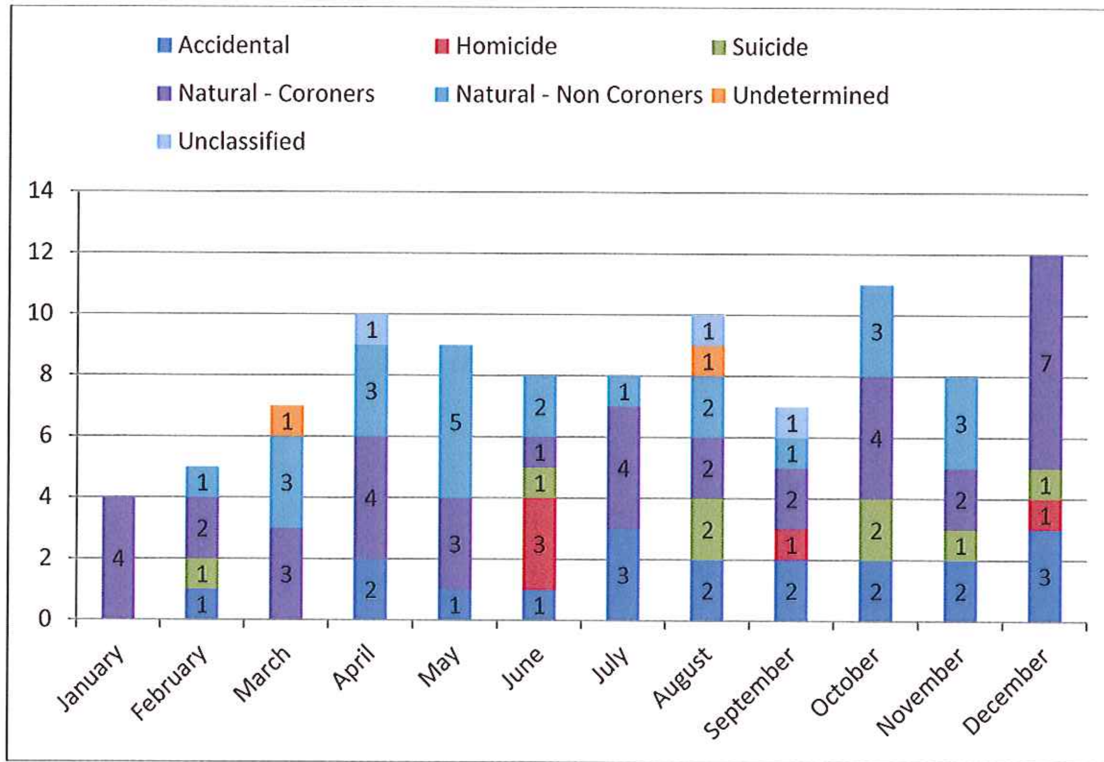
*Based on an Annual NT population estimate of 43,349 retrieved May 30, 2013 at http://www.statsnwt.ca/population/population-estimates/

CASELOAD BY MANNER AND REGION

Region	Accidental	Homicide	Suicide	Natural		Undetermined	Unclassified	Total
				Coroners	Non-Coroners			
Inuvik	6		6	9	2	1		24
Sahtu	2			1	4			7
Deh Cho	1		1	2	1		1	6
North Slave	6	1	1	17	12	1	1	39
South Slave	4	4		9	5		1	23
Total	19	5	8	38	24	2	3	99



CASELOAD BY MANNER AND MONTH

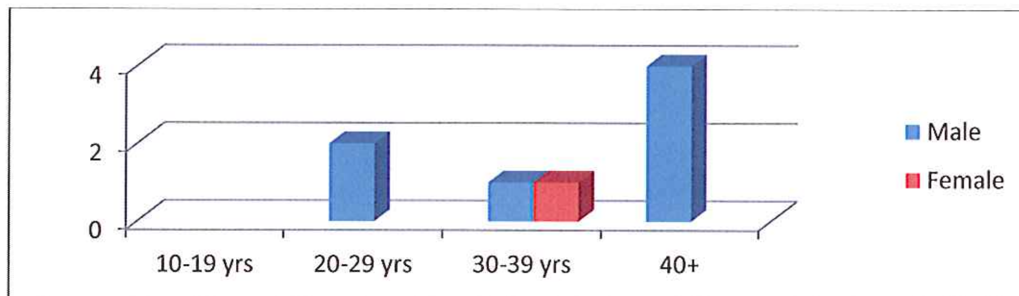


Month	Accidental	Homicide	Suicide	Natural		Undetermined	Unclassified	Total
				Coroners	Non-Coroners			
January				4				4
February	1		1	2	1			5
March				3	3	1		7
April	2			4	3		1	10
May	1			3	5			9
June	1	3	1	1	2			8
July	3			4	1			8
August	2		2	2	2	1	1	10
September	2	1		2	1		1	7
October	2		2	4	3			11
November	2		1	2	3			8
December	3	1	1	7				12
Total	19	5	8	38	24	2	3	99

SUICIDE

BY GENDER AND AGE

Age Group	Male	Female	Total
10-19 years			
20-29 years	2		2
30-39 years	1	1	2
40 + years	4		4
Total	7	1	8



In 2012 there were eight suicides; seven males and one female. Four of these suicides were males over the age of 40.

BY MONTH, METHOD, AND ALCOHOL INVOLVEMENT

Month	Region	Gender	Age	Method	Alcohol Involvement	Drug Involvement
February	Tuktoyaktuk	Male	31	Self-inflicted Gunshot	Yes	No
June	Inuvik	Male	22	Self-inflicted Gunshot	No	No
August	Yellowknife	Male	41	Hanging	No	No
August	Fort Liard	Male	27	Hanging	Yes	No
October	Inuvik	Female	30	Hanging	Yes	Yes
October	Inuvik	Male	42	Self-inflicted Gunshot	Yes	No
November	Paulatuk	Male	60	Self-inflicted Gunshot	Yes	No
December	Inuvik	Male	55	Hanging	No	No

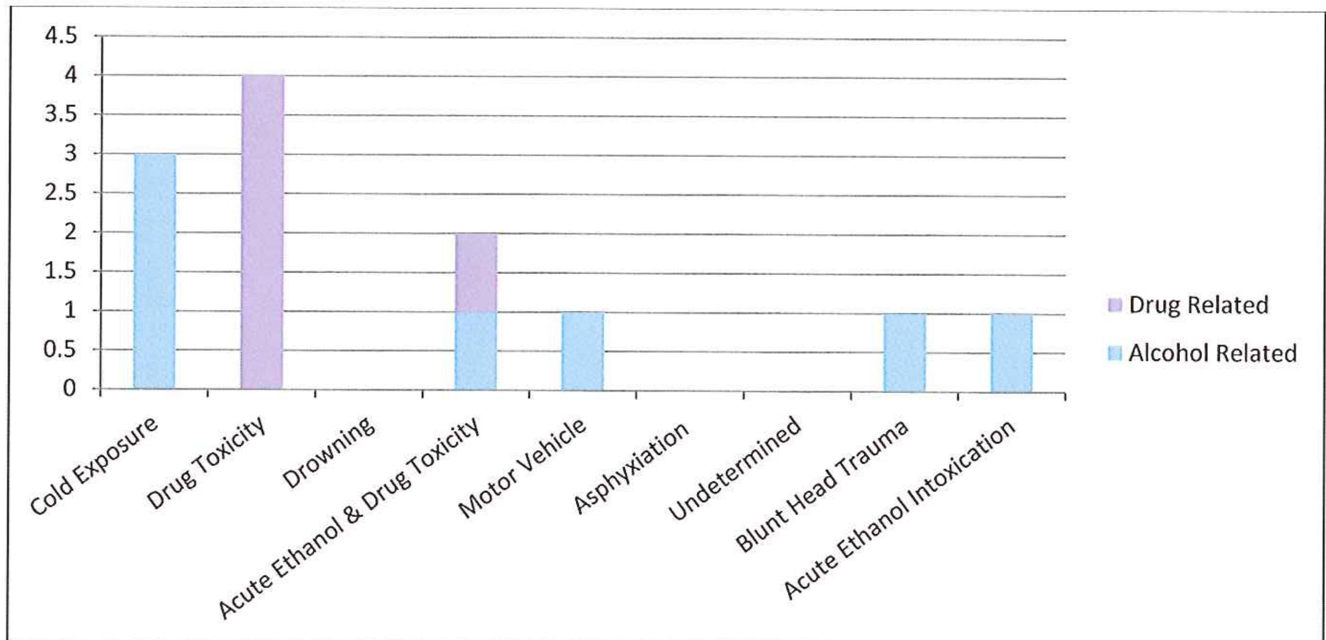
Six of the eight suicides occurred in the Inuvik region in 2012. Toxicology examination confirmed the presence of alcohol in five of the eight suicides.

ACCIDENTAL

BY CAUSE AND GENDER

Cause of Death	Male	Female	Total	Alcohol Related	Drug Related
Cold Exposure	2	1	3	3	
Drug Toxicity		4	4		4
Drowning	5	1	6		
Acute Ethanol & Drug Toxicity		1	1	1	1
Motor Vehicle	1		1	1	
Asphyxiation	1		1		
Undetermined		1	1		
Blunt Head Trauma	1		1	1	
Acute Ethanol Intoxication	1		1	1	
Totals	11	8	19	7	5

Accidental deaths accounted for approximately 19.19% of all deaths reported in 2012. The majority of deaths (11 of 19 or 58%) were males. Seven of the nineteen or 37% of accidental deaths were alcohol related. All Cold Exposure, MVA, and Blunt Head Trauma incidents were alcohol related.



HOMICIDE

BY AGE AND GENDER

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

BY REGION

Region	Total
Inuvik	
Sahtu	
Deh Cho	
North Slave	1
South Slave	4
Total	5

BY METHOD

By Method	Total
Blunt Cranial Trauma	1
Stabbing	3
Strangulation	1
Total	5

In 2012, there were five homicides, four females and one male. Toxicology Examination confirmed a presence of alcohol in four of the homicides. Homicides accounted for 5.05% of the reported deaths in 2012.

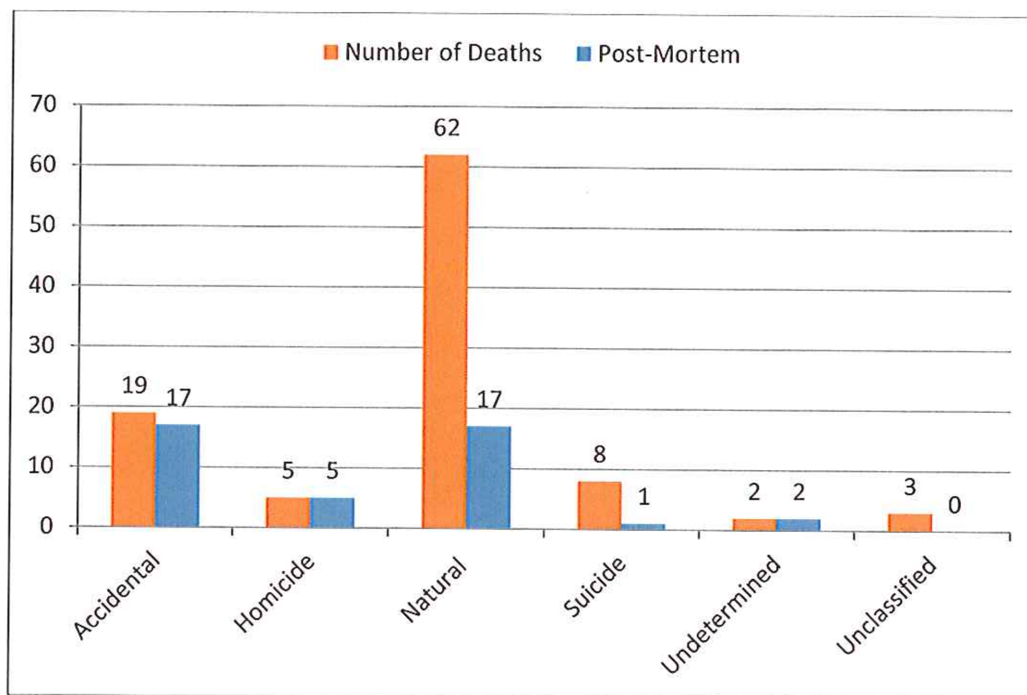
NATURAL AND NON-CORONER CASES

In 2012 there were a total of 62 natural deaths, 38 of which were coroner cases and 24 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
38	24	62

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 42 autopsies were conducted in 2012.



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, 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 position 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 2012, there were 38 Coroners across the Northwest Territories, including 23 men and 15 women. The coroners and the communities in which they reside are listed as follows:

Community	Coroners
Aklavik	Arnulf Steinwand
Behchoko	Tracey Lynn Debaie
Deline	Elizabeth Takazo
Fort Liard	Robert Firth
Fort McPherson	Winnie Greenland
Fort Providence	Robert Head
Fort Smith	Pat Burke, Marion Berls, Tony Jones, Steven Shelton, Andrew Turner
Fort Simpson	John Herring, Karen Simon
Hay River	Doug Swallow, Jim Forsey
Ulukhaktok	Gary Bristow
Inuvik	Wayne Smith, George Doolittle
Lutsel K'e	Alfred Lockhart
Norman Wells	Dudley Johnson, Lindsey Blake
Sachs Harbour	Joseph Carpenter
Tsiigehtchic	James Cardinal
Tulita	Edward McPherson
Tuktoyaktuk	Anita Pokiak, Noella Cockney
Whati	Joanne Reed
Yellowknife	Garth Eggenberger, Jennifer Eggenberger, Wendy Eggenberger, Tamara Hynd, Cathy Lee Menard, Ian McCrea, Adelle Guigon, Eric Kieken, Randy Straker, Soura Rosen, Ruth McLean

There are no coroners currently residing in the communities of Colville Lake, Fort Resolution, Fort Good Hope, Gameti, Paulatuk, Enterprise, Nahanni Butte 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 to:

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 shall 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 2012)

Case # 1

This 31-year old female was found beaten and deceased in her home. The RCMP and the Coroner were notified. It was determined that the cause of death was Blunt Cranial Trauma, and the death was classified as a Homicide.

COMMENTS AND RECOMMENDATIONS:

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

1. In consultation with representatives of the GNWT, Tlicho Government, RCMP and other invested organizations, develop a "Community Plan and Policy" for dealing with those communities that have limited resources to create programs, services and initiatives that will effectively provide supports to prevent domestic violence and domestic violence homicides.

In the wake of this domestic violence death, consultation needs to be done with front line and informal support services to identify, understand and address the barriers that prevent/discourage bystanders/communities from standing up/speaking out when they see violence.

2. To develop a Public Education Campaign to promote awareness of Domestic and Family Violence.

A long–term sustained strategy to increase public awareness and change attitudes toward domestic and family violence is needed. The campaign could be similar to drinking and driving or smoking campaigns.

Case # 2

A 29-year old nurse was found unresponsive in a friend's apartment after a night of partying. The RCMP and the coroner were notified. It was determined that the cause of death was Multiple Drug and Ethanol Toxicity and the death was classified as Accidental.

COMMENTS AND RECOMMENDATIONS:

The NWT Coroner Service made the following recommendation to Stanton Territorial Health Authority:

1. It is recommended that the Stanton Territorial Health Authority complete an independent audit during the lifetime of all medevac service contracts to ensure policies and proper procedures are being followed for quality assurance purposes.

Case # 3

This 2-year-old child was brought to the health center in her community with a high fever and subsequent rash development. After the initial evaluation at the heath centre a medevac was called at 0025hrs. The Standard Operating Center that operates the medevac dispatch was unable able to obtain a weather report for the community. An altimeter reading was provided to the flight coordinator in Yellowknife. At approximately 510hrs the medevac left for the community returning to Yellowknife at 840hrs. The child's condition deteriorated and she was medically transported to Stanton Territorial Hospital where she was pronounced dead. The RCMP and the Coroner were notified. It was determined that the cause of death was Sepsis due to Neisseria Meningitides and the death was classified as Natural.

COMMENTS AND RECOMMENDATIONS:

In many airports in the Northwest Territories the only method of reporting aviation weather is through the auspices of the local Community Aerodrome Radio Station (CARS) operator. There is no requirement for 24 hours coverage at many of the CARS stations. In many circumstances this can cause cancellations or delays of scheduled flights, charters, and medevac flights in these communities.

The NWT Coroner Service made the following recommendations to the GNWT Minister of Transportation, Transport Canada, and NAV Canada.

1. For these organizations to work together collaboratively and to jointly fund and install Automated Weather Observations System (AWOS) to supplement the weather capabilities at airports in Northwest Territories.

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 NWT coroners who have frequently shown - often under less than optimal conditions - a high level of dedication and professionalism.