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OFFICE OF THE CHIEF CORONER

NORTHWEST TERRITORIES CORONERS SERVICE

2011 ANNUAL REPORT

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HISTORY OF CORONERS 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 enquire 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 pressure demanding that the coroner also serve a preventative function. This remains an important responsibility of the Coroners Service.

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 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 Coroners 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 a variety of other experts when required.

INTRODUCTION

The Coroners 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 36 coroners throughout the Northwest Territories, providing service in the communities and regions in which they reside.

All sudden and unexpected deaths occurring in the Northwest Territories must be reported to a coroner. The 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 they came to their death. The Coroners 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 Coroners Service.

The Chief Coroner is Cathy L. Menard. Ms. Menard has been with the Coroners Service since 1996. She has been in the public service for 28 years.

The Deputy Chief Coroner is Tamara Hynd, who joined the Coroners Service in 2010.

There are no facilities in the Northwest Territories staffed to perform autopsies. When an autopsy is required, the body is 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 Home which holds a contract for preparation and repatriation. Toxicology services are provided to the Coroners 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

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, 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 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). 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 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 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.***

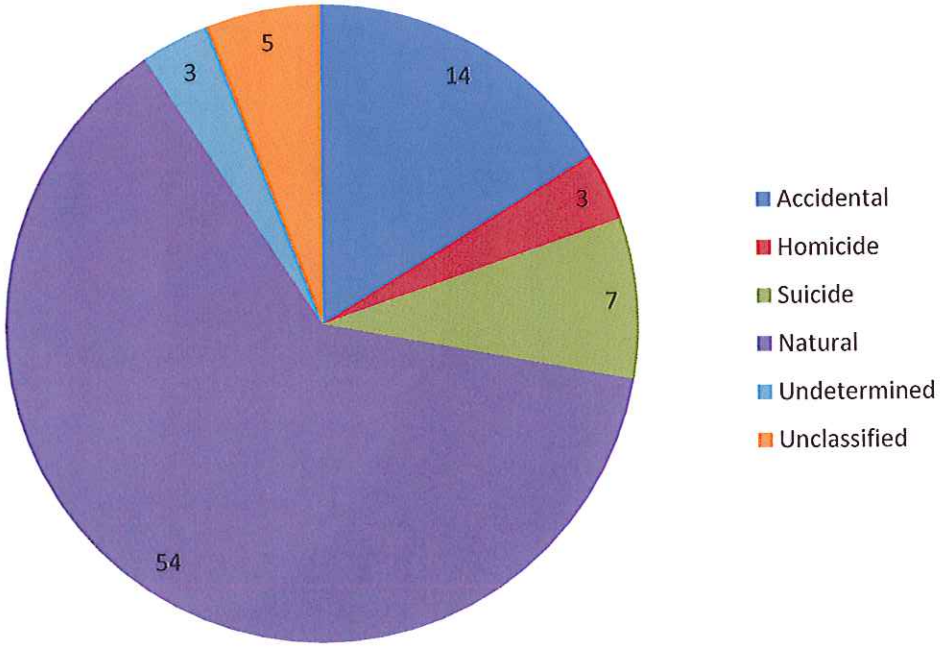
NWT REGIONS

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

2011 CASE STATISTICS

TOTAL CASES

Total Cases			
Manner of Death	Number	Cases %	Population % *
Accidental	14	16.3%	0.0338%
Homicide	3	3.5%	0.0072%
Suicide	7	8.1%	0.0169%
Natural	54	62.8%	0.1302%
Undetermined	3	3.5%	0.0072%
Unclassified	5	5.8%	N/A
Total	86	100%	0.1782%

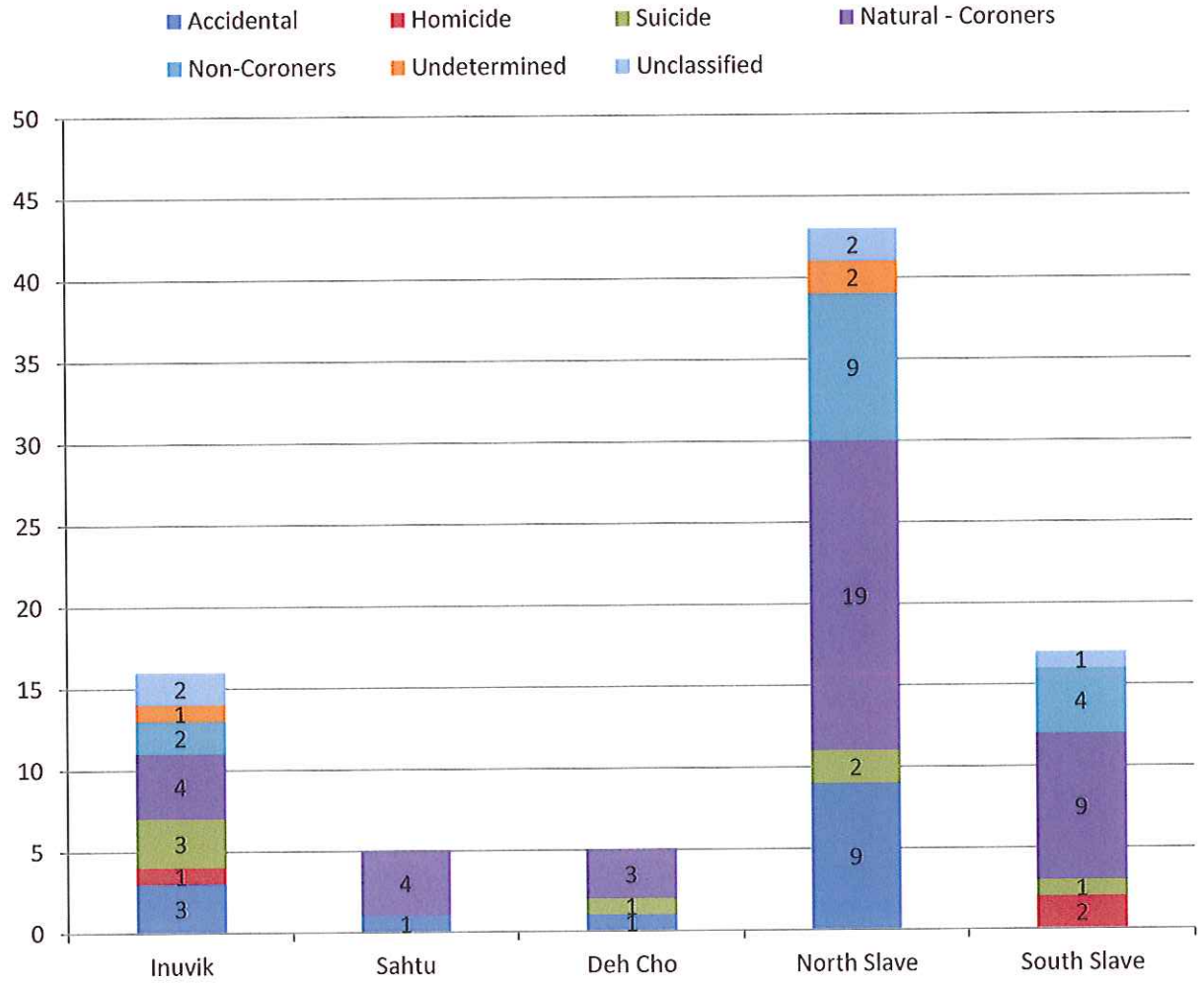


Unclassified cases are not represented in the population figures since they are non-human in nature. In 2011, there were 5 cases determined to be unclassified.

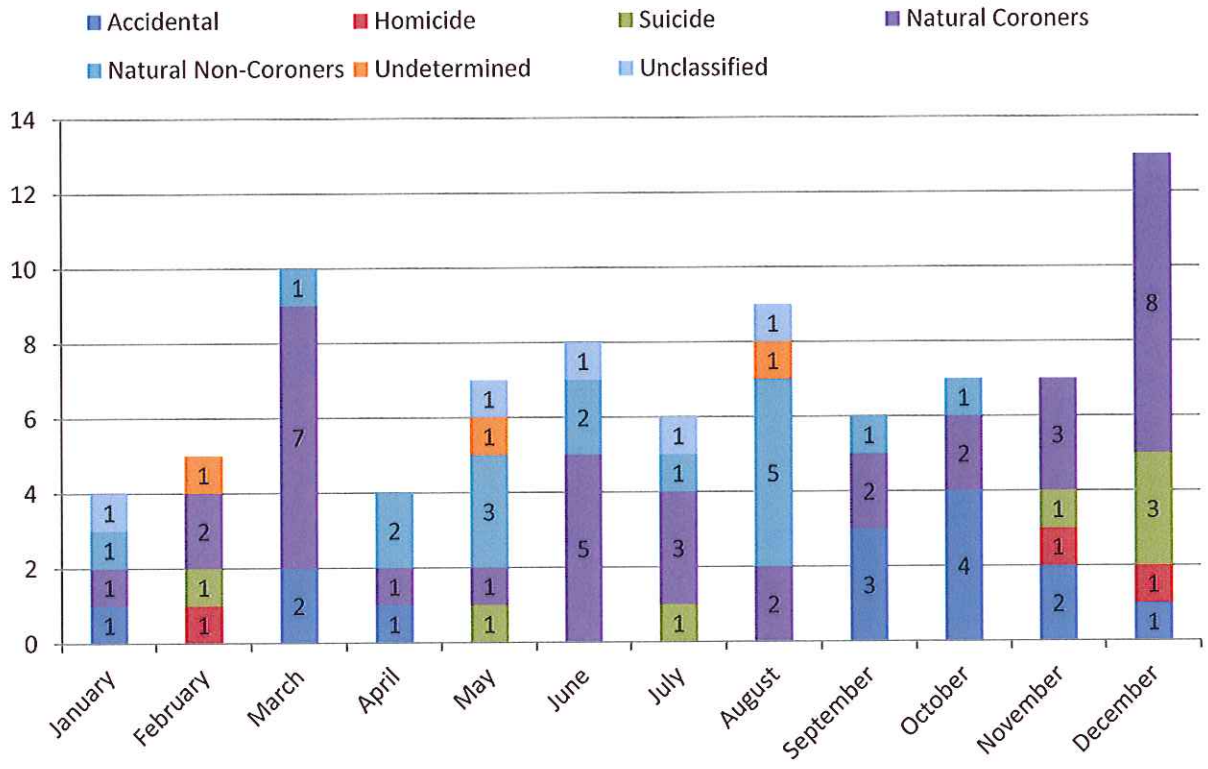
*Based on an NT population of 41,462 retrieved July 16, 2011 at http://www12.statcan.gc.ca/census-recensement/2011/as-sa/fogs-spg/Facts-pr-eng.cfm?Lang=Eng&TAB=1&GK=PR&GC=61

CASELOAD BY MANNER AND REGION

Region	Accidental	Homicide	Suicide	Natural		Undetermined	Unclassified	Total
				Coroners	Non-Coroners			
Inuvik	3	1	3	4	2	1	2	16
Sahtu	1			4				5
Deh Cho	1		1	3				5
North Slave	9		2	19	9	2	2	43
South Slave		2	1	9	4		1	17
Total	14	3	7	39	15	3	5	86



CASELOAD BY MANNER AND MONTH

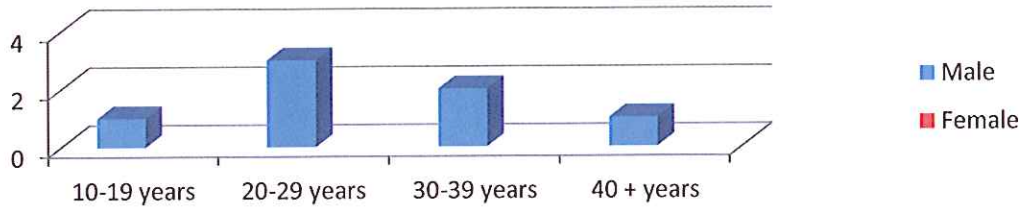


Month	Accidental	Homicide	Suicide	Natural		Undetermined	Unclassified	Total
				Coroners	Non-Coroners			
January	1			1	1		1	4
February		1	1	2		1		5
March	2			7	1			10
April	1			1	2			4
May			1	1	3	1	1	7
June				5	2		1	8
July			1	3	1		1	6
August				2	5	1	1	9
September	3			2	1			6
October	4			2	1			7
November	2	1	1	3				7
December	1	1	3	8				13
Total	14	3	7	37	17	3	5	86

SUICIDE

BY GENDER AND AGE

Age Group	Male	Female	Total
10-19 years	1		1
20-29 years	3		3
30-39 years	2		2
40 + years	1		1
Total	7	0	7



In 2011 there were seven suicides; all male. Three of these suicides were males between the age of 20 and 29.

BY MONTH, METHOD, AND ALCOHOL INVOLVEMENT

Month	Region	Gender	Age	Method	Alcohol Involvement	Drug Involvement
February	Fort Smith	Male	22	Self-inflicted Gunshot	No	Yes
May	Fort McPherson	Male	27	Self-inflicted Gunshot	Yes	No
July	Tuk	Male	18	Self-inflicted Gunshot	Yes	No
November	Nahanni Butte	Male	56	Self-inflicted Gunshot	No	No
December	Tuk	Male	38	Self-inflicted Gunshot	Yes	No
December	N'dilo	Male	23	Hanging	Yes	No
December	YK	Male	32	Drug Overdose	No	Yes

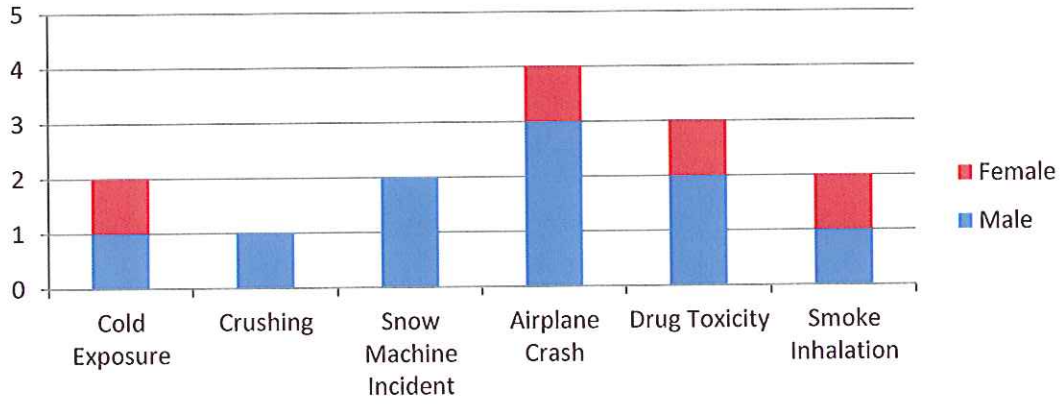
Self-Inflicted Gunshot accounted for five of the seven suicides in 2011. Toxicology examination confirmed the presence of alcohol in four of the seven suicides.

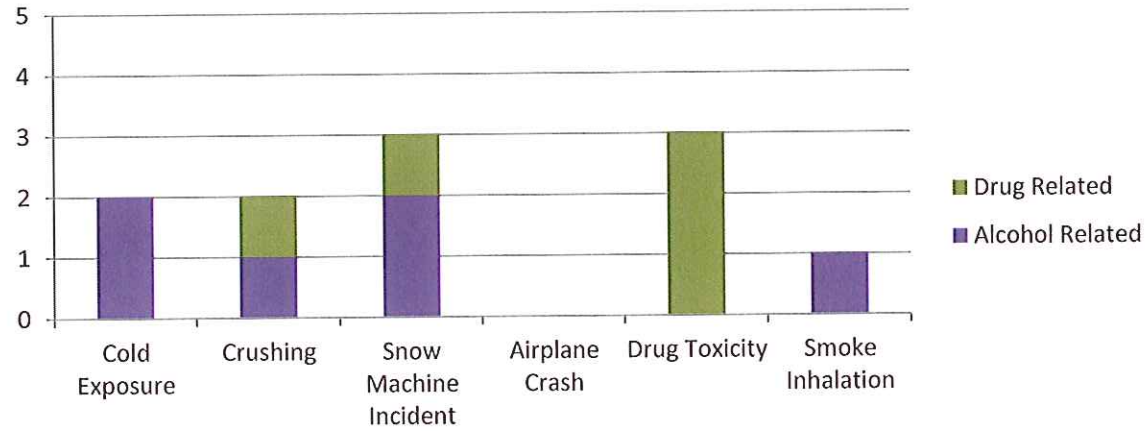
ACCIDENTAL DEATHS

BY CAUSE AND GENDER

Cause of Death	Male	Female	Total	Alcohol Related	Drug Related
Cold Exposure	1	1	2	2	
Crushing	1		1	1	1
Snow Machine Incident	2		2	2	1
Airplane Crash	3	1	4		
Drug Toxicity	2	1	3		3
Smoke Inhalation	1	1	2	1	
Totals	10	4	14	6	5

Accidental deaths accounted for approximately 16% of all deaths reported in 2011. The majority of deaths (10 of 14 or 71%) were males. All Cold Exposure, Crushing, and Snow Machine Incidents involved alcohol.





HOMICIDE DEATHS

BY AGE AND GENDER

Age Group	Male	Female	Alcohol Involved	Total
0-19 years	0	0	0	0
20-29 years	0	0	0	0
30-39 years	0	1	1	1
40-49 years	1	0	0	1
50-59 years	0	0	0	0
60+	1	0	1	1
Total	2	1	2	3

BY REGION

Region	Total
Inuvik	1
Sahtu	
Deh Cho	
North Slave	
South Slave	2
Total	3

BY METHOD

Method	Total
Gunshot	2
Blunt Cranial Trauma	1
Total	3

In 2011, there were 3 homicides, 2 males and 1 female. Toxicology Examination was confirmed in two of the homicides. Homicides accounted for 3.5% of the reported deaths in 2011.

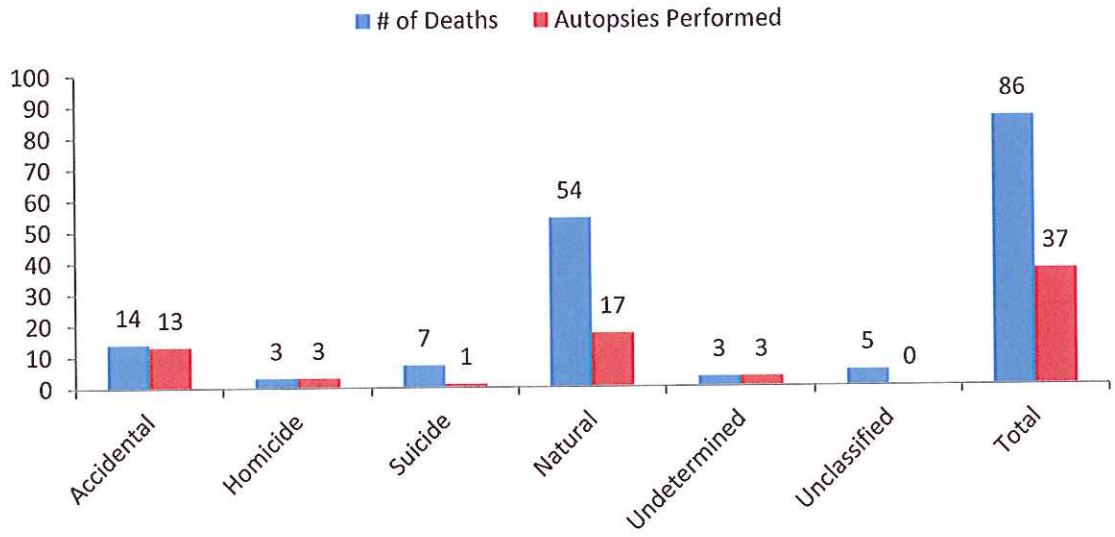
NATURAL AND NON-CORONER CASES

In 2011 there were a total of 54 natural deaths, 37 of which were coroner cases and 17 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
37	17	54

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 37 autopsies were conducted in 2011.



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, RCMP, municipal and/or 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 notified of the intended appointment. Coroners are appointed by the Minister of Justice for a three year term.

In 2011, there are 41 Coroners across the Northwest Territories, consisting of 23 men and 18 women. The coroners and the communities in which they reside are listed as follows:

Community	Coroners
Aklavik	Arnulf Steinwand
Behchoko	Tracey Lynn Debaie
Fort Good Hope	Ester Charney
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
Inuvik	George Doolittle, Catherine Cockney, Gerald Kisoun, Elizabeth Drescher, Wayne Smith, Cynthia Wicks
Lutselk'e	Alfred Lockhart
Norman Wells	Dudley Johnson, Valerie McGregor
Sachs Harbour	Joseph Carperenter
Tsiigehtchic	James Andrew Cardinal
Tulita	Edward McPherson Jr.
Tuktoyaktuk	Anita Pokiak, Barney Masuzumi
Whati	Joanne Reed, Carolyn Coey-Simpson
Yellowknife	Garth Eggenberger, Jennifer Eggenberger, Wendy Eggenberger, Tamara Hynd, Cathy Lee Menard, Clifford Krause, Adelle Guigon, Eric Kieken, Randy Straker, Erin Allooloo

There are no coroners currently residing in the communities of Colville Lake, Fort Resolution, Gameti, Paulatuk, Ulukhaktok, Enterprise, Nahanni Butte, Wrigley and Deline.

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 a similar death. 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 a similar death. 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 Coroners Inquest. An Inquest is a formal court preceding 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) 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.

Should a coroner determine 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 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 2011)

Case # 1

Emergency personnel were called to a residence where a 14-year old female was found hanging by a family member in 2009. Upon arrival of emergency personnel she was taken to the Health Centre where despite continued efforts, her death was pronounced. It was determined that she had died as a result of hanging and the death was classified as Suicide.

COMMENTS AND RECOMMENDATIONS:

The NWT Coroner Service makes the following recommendations to the Department of Health and Social Services:

1. It is the suggestion of the Office of the Chief Coroner of the Northwest Territories that the report titled "Report on the Child and Family Services Act: Building Stronger Communities" is an important step forward, and sets a clear path and direction for an enhanced, multi-level and inter-ministerial system of service provision to build the capacity of children and families throughout the territory.

Case # 2

In 2010, a 14 year old male was found hanging by a family member. The RCMP and Coroner Service were notified. It was determined that he had died as a result of hanging and the death was classified as Suicide.

COMMENTS AND RECOMMENDATIONS:

1. We recommend that the Department of Health and Social Services ensure that youth are regularly updated regarding their file. Given the limited resources in some of the communities, provisions should be made to provide youth with a continuum of supports. This will ensure that the safety and well-being of the youth are looked after.

2. We recommend and support that the Department of Health and Social Services continue providing Suicide Prevention Campaigns to Youth.

Case # 3

This 62-year-old woman was an inpatient at Woodland Manor when she complained of severe abdominal pain and nausea. She was taken to the hospital where attempts were made to stabilize vital signs and diagnose the current problems. Vital signs continued to deteriorate and plans were made to medevac her to Edmonton, however prior to the medevac she was pronounced dead. It was determined that she died as a result of peritonitis due to a perforation of the colon following a colonoscopy and hot snare polypectomy procedure, and the death was classified as Accidental.

COMMENTS AND RECOMMENDATIONS:

The NWT Coroner Service makes the following recommendations to the Chief Medical Health Officer, Stanton Territorial Health Authority and the Hay River Health and Social Service Authority:

1. A recommendation is made that the Chief Medical Health Officer, Stanton Territorial Health Authority, and the Hay River Health Authority review the medical care given to this patient. *(Given the patient's procedure, potential for complications, and undiagnosed condition afterwards.)*

2. A recommendation is made that when a patient is transferred between departments and hospitals, relevant medical records accompany that patient. *(Given the patient had no accompanying records and each department had no knowledge of what had happened in the previous department.)*

3. A recommendation is made that the medical records contain the medical procedures needed or given, their results, and a list of signs/symptoms of expectations or complications that may arise. And further, that in the event of negative symptoms what course of action needs to be taken. *(Given that the patient was displaying symptoms of peritonitis as a complication of the colonoscopy procedure, and that there was no prior history for staff to assess the condition, it went undiagnosed.)*

Case # 4

In 2010, this 2- year old female was found partially suspended from a blanket that was used as a curtain. Her father untangled her and drove her to the health centre where despite resuscitation efforts, she was pronounced dead. It was determined that she had died as a result of hanging and the death was classified as Accidental.

COMMENTS AND RECOMMENDATIONS:

The NWT Coroner Service makes the following recommendation to the Fort Smith Health and Social Services Authority:

1. That during home visit programs, staff consider reinforcing with families the importance of completing a thorough environmental scan regarding the safety of their home.

Case # 5

In 2009, a 49- year old male was acting as a safety officer, observing two co-workers removing a pump from a tailings pond. The two co-workers left the area once finished and left the safety officer behind. When they returned later they found his vehicle still there, and footprints leading to the tailings pond. The man was found floating approximately one foot under a sheet of one-half inch ice. He was removed from the water and placed on to the shore. He was transferred to the medic station by ambulance where, despite continued efforts, he was pronounced dead. It was determined that the individual had died as a result of drowning and the death was classified as Accidental.

COMMENTS AND RECOMMENDATIONS:

The Office of the Chief Coroner made the following recommendations to the Tlicho Investment Corporation, Public Works and Government Services, and Indian and Northern Affairs Canada:

1. That an adequate fencing and warning signage be placed on site to prevent access to the surface of a body of water that could pose a hazard, and to clearly indicate the position of a person relative to the shoreline of that body of water.

2. That while near ice, personnel should have on a high visibility floater vest and proper waterproof clothing under their winter gear. They should also have a dry change of clothes stored either in their vehicle or in a rescue shack which should be located near the body of water.

3. That there should be a system of remote location reporting in place, including calling in at regular intervals. Additionally, procedures should be put in place outlining actions to take if a worker has not called in as scheduled.

4. That surface rescue teams to be trained in water/ice rescues on a regular basis. Water rescue equipment should be put together and be ready at all times of the year for those sites that have a body of water that could pose a hazard.

APPENDIX "B"
SUMMARY OF CORONERS INQUESTS

Verdict of Coroners Jury

Deceased: Raymond Stewart Eagle

Date and time of Death: January 5, 2010 at 03:00 am

Place of Death: Yellowknife Stanton Territorial Hospital

Cause of Death: Part 1 Atherosclerotic Coronary Artery Disease

Part 2 Remote Cranial Trauma

Manner of Death: Natural

Circumstances under which death occurred:

On August 3, 2006, Mr. Raymond Eagle was found with an injury on his head and lying on the road in Yellowknife. He was taken by ambulance to the Stanton Territorial Hospital emergency room where he was treated and medically cleared. Mr. Eagle was taken into RCMP custody and remained there until it was found that he was in distress. He was then transported by ambulance back to the emergency room. He was medically evacuated to the University of Alberta Hospital. While there, he was treated for an acute subdural hematoma. He was stabilized and returned to the Stanton Territorial Hospital in Yellowknife. He remained in extended care in a comatose state until his death on January 5, 2010, due to Atherosclerotic Coronary Artery Disease.

RECOMMENDATIONS:

1. **Department of Health and Social Services:** Establish a Community Consultative Group consisting of members from the medical community, Stanton Territorial Hospital, the RCMP, the Salvation Army, and other agencies and interested parties to explore the possibility of establishing:
    a. A drug, alcohol and substance rehabilitation centre in Yellowknife, and
    b. A "half-way house" or similar residence; staffed by qualified professionals to care for people who have substance abuse issues and are homeless, when they are referred there by either medical staff or the RCMP.

2. **Commissionaires:** Recommend that at shift change, the matron/guards be required to do a physical cell check together and review all C-13 forms and incident reports.

3. **RCMP and Commissionaires:** On the walls of the "cells" area, provide written guidelines and information posters on subjects such as: head trauma symptoms, rouseability chart, blood alcohol poisoning, drug overdose, and other common medical concerns.

4. **RCMP and Commissionaires:** Ensure assessment of responsiveness occurs in a manner that is consistent with operational policies.

5. **Stanton Territorial Hospital:** On the 'Service Report' discharge and follow-up instructions, include "discharge to" that is similar to the accompanied 'Emergency Minor Treatment Record'. In the least, include a box for RCMP on discharge.

6. **All Parties:** Ensure all forms are completed. Do not leave blank areas and use the most current version of forms.

7. **RCMP and Commissionaires:** Ensure that guards closely observe and record in a log book prisoner movements and conditions, where practical. Requested that a column be added to the log books to identify methods of observation.

8. **RCMP and Stanton Territorial Hospital:** Develop a protocol to facilitate, within ethical boundaries and applicable legislation, the sharing of information about persons whose care and custody is transferred between them.

9. **Stanton Territorial Hospital:** Work with its professional care providers, nurses, physicians, and their governing bodies to establish understandings and protocols about information sharing to outside agencies; all the while maintaining compliance with their professional obligations regarding patient care confidentiality. Special consideration should be made for vulnerable members of society to ensure they receive the follow-up care they require.

10. **RCMP:** That all personnel on shift responsible for the care of prisoners must fully read and understand the information contained on the C-13 form for each prisoner.

11. **RCMP, Stanton Territorial Hospital, and Commissionaires:** Formalize interagency processes related to the handling of intoxicated persons.

12. **Stanton Territorial Hospital:** Review and amend as necessary the 'Emergency Department Short Stay Admission Alcohol Abuse/Detoxification' form and the process which would trigger its use. Consider including a "does not apply" box.

13. **Stanton Territorial Hospital:** If a patient is unable to provide consent prior to medical evacuation, all reasonable attempts will be made to contact the next of kin.

14. **Stanton Territorial Hospital:** Review and amend as necessary the 'Stanton Regional Hospital Emergency Guidelines Modified Criteria for Management of Mild Head Injury Flowchart and the process which would trigger its use.

15. **RCMP and Commissionaires:** Ensure matrons/guards are provided with continuous training opportunities and support to remain current on policies and procedures.

16. **Department of Health and Social Services, RCMP, Stanton Territorial Hospital, and Commissionaires:** For all recommendations seek out and consider input from front line staff prior to implementation.

EXPRESSIONS OF APPRECIATION

The NWT Coroners Service wishes to express our appreciation to the RCMP, health care professionals, and our many other investigative partners that cooperated and assisted coroners in conducting our 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.