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NORTHWEST TERRITORIES CORONER'S SERVICE

2010 ANNUAL REPORT
INCLUDING
10-YEAR REVIEW
2001-2010

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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 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 demanded that the coroner also serve a preventative function. This remains an important responsibility of the Coroner's 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 Coroner's 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 Coroner's 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 Coroner's 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's 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's Office.

For the first three months of 2010 Garth Eggengerger served as Chief Coroner. Mr. Eggenberger joined the Coroner's Service in May of 1989 and was appointed to a two-year term as Chief Coroner on April 1, 2008.

The Deputy Chief Coroner was Cathy Menard. Ms. Menard joined the Coroner's Service in February of 1996, and has been with the Department of Justice for 27 years. Ms. Menard was appointed Chief Coroner on April 1, 2010 at the expiry of Mr. Eggenberger's term.

In June 2010, Tamara Hynd was hired as Deputy Chief Coroner. Ms. Hynd is a Registered Nurse, complementing the function of the office as medico-legal investigators.

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 Chapel which holds a 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.

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 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 Coroner's 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). 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 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

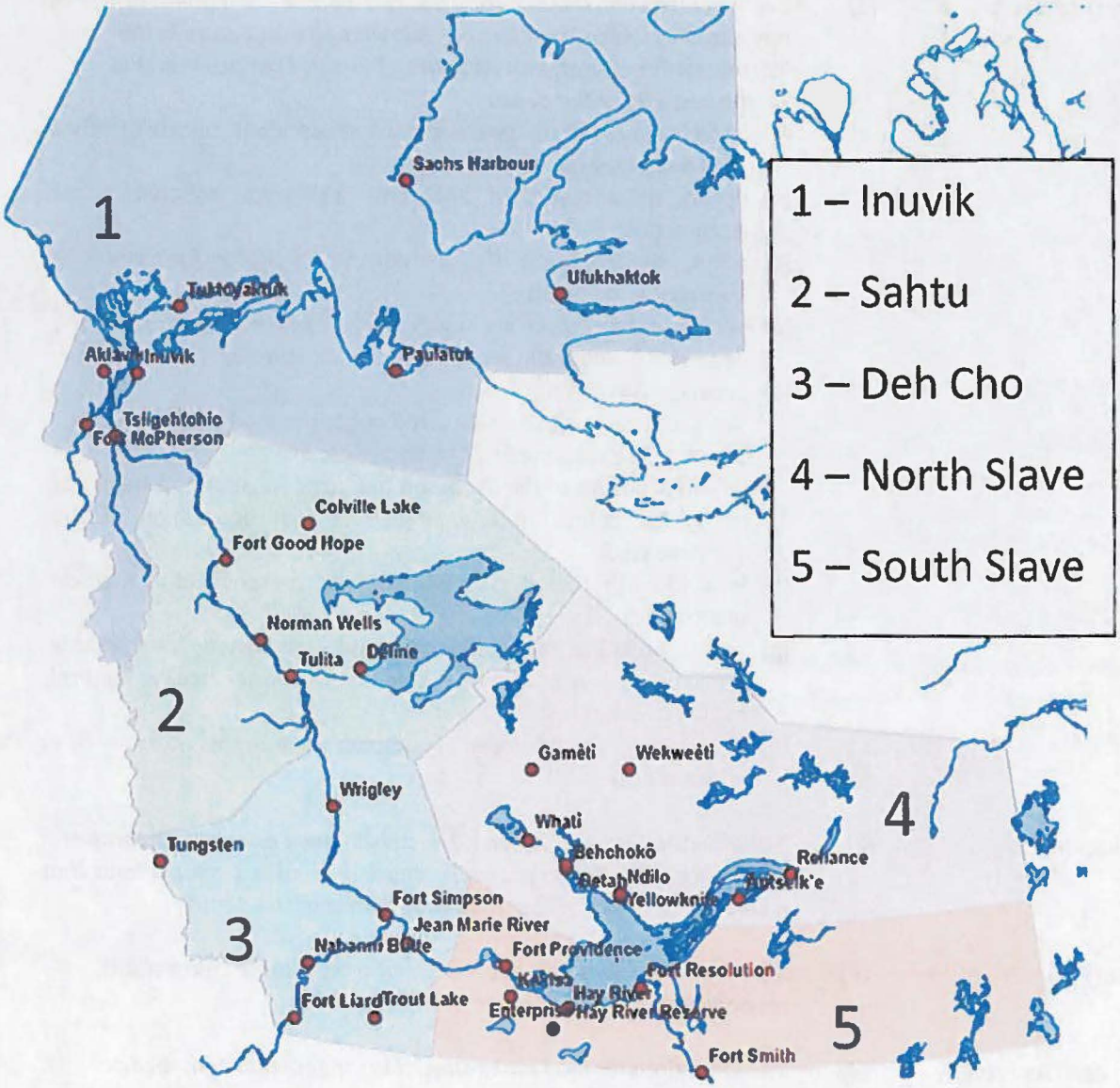
(h) occurs while the deceased is detained by or in the custody of a police officer.

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.***

NWT REGIONS

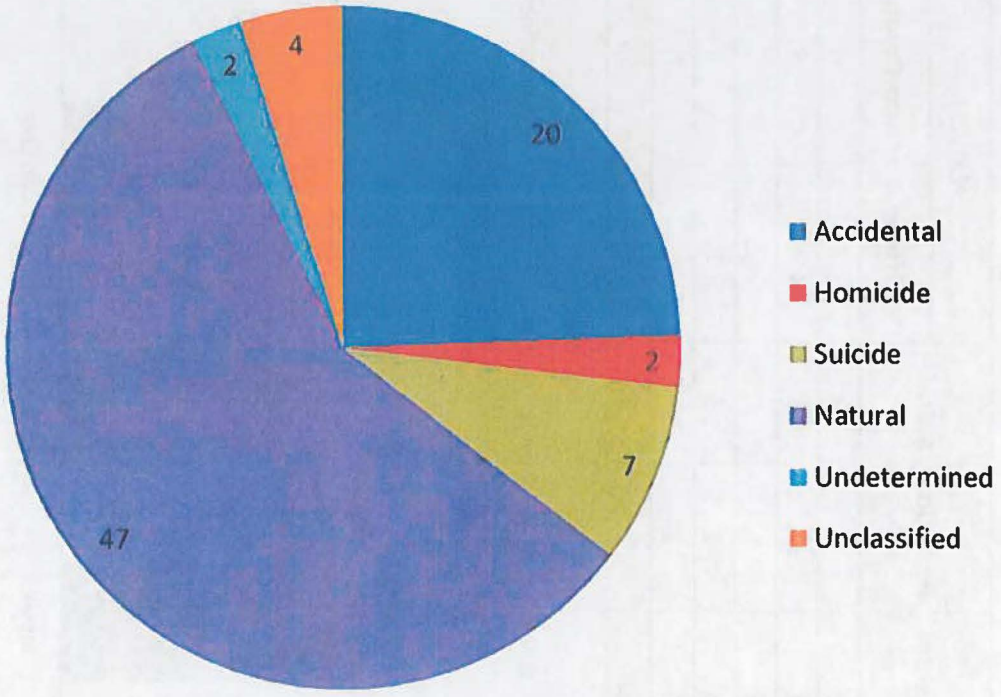


Obtained from http://www.enr.gov.nt.ca/_live/documents/content/Administrative_regions.pdf

2010 CASE STATISTICS

TOTAL CASES

Manner of Death	Number	Cases %	Population % *
Accidental	20	24.4%	0.0457%
Homicide	2	2.4%	0.0046%
Suicide	7	8.5%	0.0160%
Natural	47	57.3%	0.1074%
Undetermined	2	2.4%	0.0046%
Unclassified	4	4.9%	N/A
Total	82	100%	0.1782%



Unclassified cases are not represented in the population figures since they are non-human in nature. In 2010 there were 4 cases determined to be unclassified.

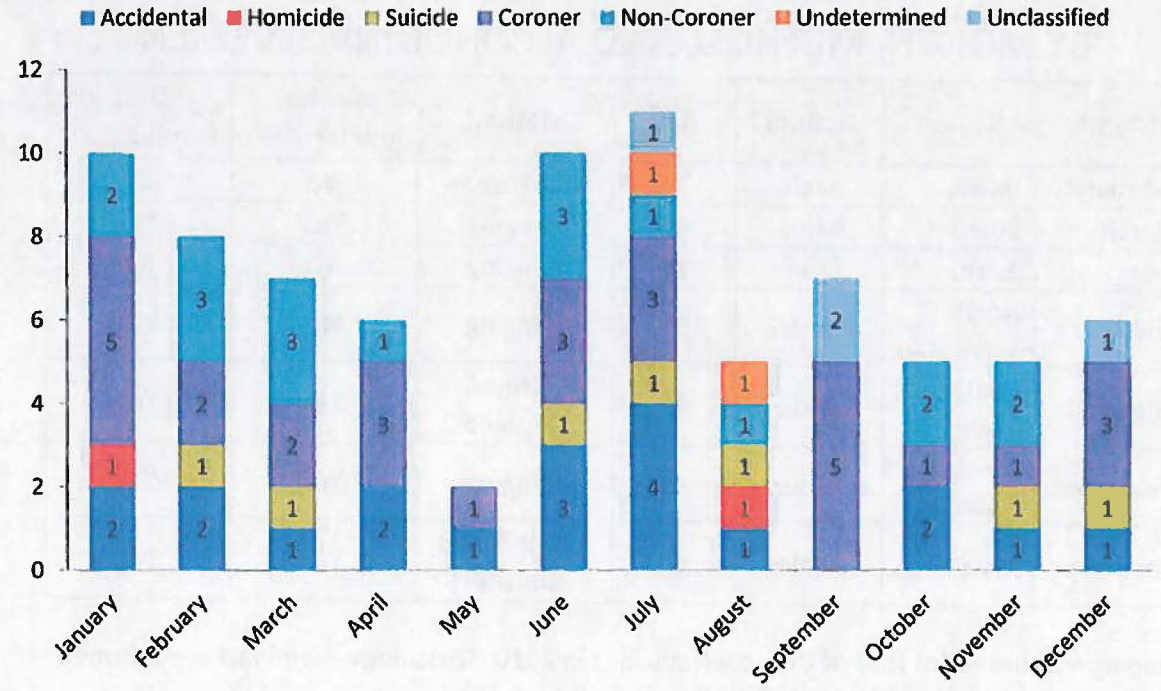
* Based on a population of 43,759 in the NWT for 2010 obtained from stats.gov.nt.ca

CASELOAD BY MANNER AND REGION

Region	Accidental	Homicide	Suicide	Natural		Undetermined	Unclassified	Total
				Coroner	Non-Coroner			
Inuvik	3		3	8	4	1		19
Sahtu	1		1	4	5	1	1	13
Deh Cho	2			2			3	7
North Slave	8	1	3	8	4			24
South Slave	6	1		7	5			19
Total	20	2	7	29	18	2	4	82

CASELOAD BY MANNER AND MONTH

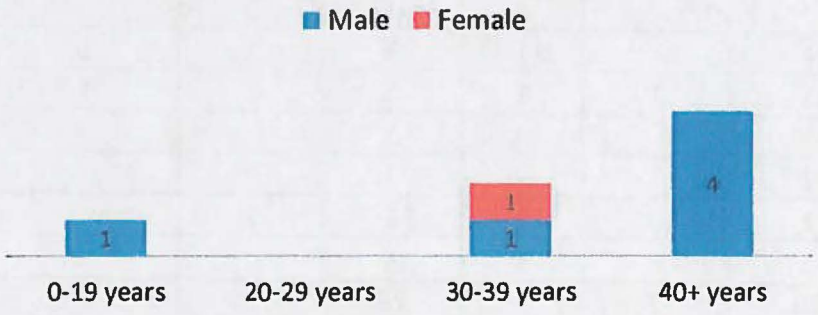
Month	Accidental	Homicide	Suicide	Natural		Un-determined	Un-classified	Total
				Coroner	Non-Coroner			
January	2	1		5	2			10
February	2		1	2	3			8
March	1		1	2	3			7
April	2			3	1			6
May	1			1				2
June	3		1	3	3			10
July	4		1	3	1	1	1	11
August	1	1	1		1	1		5
September				5			2	7
October	2			1	2			5
November	1		1	1	2			5
December	1		1	3			1	6
Total	20	2	7	29	18	2	4	82



SUICIDE

BY GENDER AND AGE

Age Group	Male	Female	Total
10-19 years	1		1
20-29 years			
30-39 years	1	1	2
40+ years	4		4
Total	6	1	7



In 2010 there were seven suicides; six were male and one was female. Four of these suicides were males over the age of 40.

BY MONTH, METHOD, AND ALCOHOL INVOLVEMENT

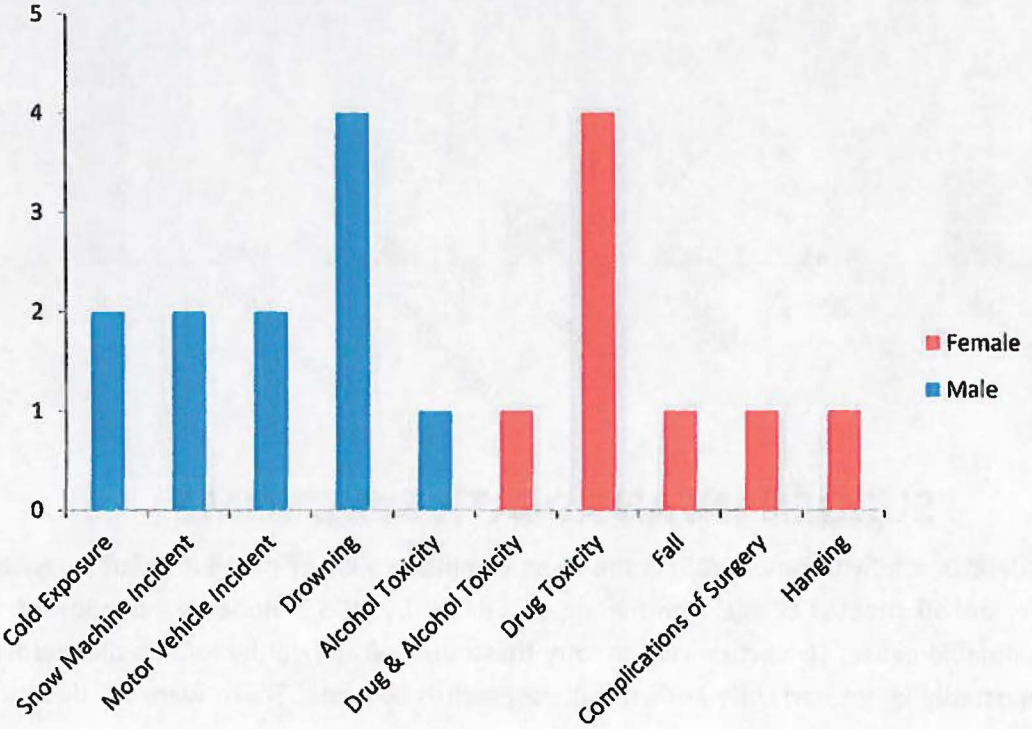
Month	Region	Gender	Age	Method	Alcohol Involvement	Drug Involvement
February	Inuvik	Male	37	Cut Throat	No	No
March	Inuvik	Male	49	Hanging	Yes	No
June	Sahtu	Male	14	Hanging	No	No
July	North Slave	Female	32	Hanging	No	Yes
August	North Slave	Male	47	Crashed Airplane	Yes	Yes
November	North Slave	Male	49	Hanging	Yes	Yes
December	Inuvik	Male	63	Self-inflicted Gunshot	Yes	No

Hanging accounted for four of the seven suicides in 2010. 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	2		2	2	
Snow Machine Incident	2		2	2	1
Motor Vehicle Incident	2		2	1	1
Drowning	4		4	1	1
Alcohol Toxicity	1		1	1	
Drug & Alcohol Toxicity		1	1	1	1
Drug Toxicity		4	4		4
Fall		1	1		1
Complications of Surgery		1	1		
Hanging		1	1		
Hit by Airplane	1		1		
Totals	12	8	20	8	9

Accidental deaths accounted for approximately 24% of all deaths reported in 2010. The majority of deaths (12 of 20 or 60%) were males.



NATURAL AND NON-CORONER CASES

In 2010 there were a total of 47 natural deaths, 29 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's Service but are not captured by the reporting criteria required under the *Coroner's Act*.

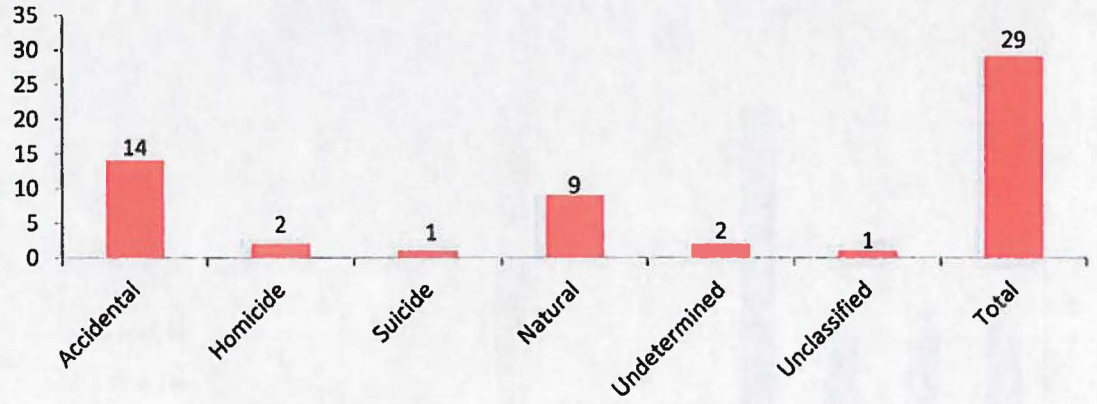
Coroner	Non-Coroner	Natural
29	18	47

POST-MORTEMS BY MONTH

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 29 autopsies were conducted in 2010.

Autopsy	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
2010	5	3	2	3	0	2	6	3	1	2	0	2	29

Autopsy Performed by Method



SUDDEN INFANT DEATH SYNDROME

Sudden Infant Death Syndrome (SIDS) is the most common cause of death in infants between two weeks and six 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. There were no deaths by SIDS in 2010.

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 Coroner's Office, municipal and Band governments, and the RCMP. 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 Band government and their local RCMP detachment. The letters of support and a recommendation for 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.

Currently there are 36 Coroners across the Northwest Territories, consisting of 20 men and 16 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 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
Hay River	Doug Swallow, Jim Forsey
Inuvik	Erin Allooloo, George Doolittle, Catherine Cockney, Gerald Kisoun, Elizabeth Drescher, Wayne Smith, Cynthia Wicks
Lutselk'e	Alfred Lockhart
Norman Wells	Dudley Johnson, Valerie McGregor
Tsiigehtchic	James Andrew Cardinal
Tulita	Edward McPherson Jr.
Tuktoyaktuk	Anita Pokiak, Barney Masuzumi
Whati	Carolyn Coey-Simpson
Yellowknife	Garth Eggenberger, Jennifer Eggenberger, Wendy Eggenberger, Tamara Hynd, Cathy Lee Menard, Clifford Krause

There are no coroners currently resident in the communities of Colville Lake, Fort Resolution, Gameti, Paulatuk and Sachs Harbour.

CONCLUDING CORONER INVESTIGATIONS

REPORT OF CORONER

All coroner cases are generally concluded by either a coroner's report 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. 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").

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 member jury and hears testimony from sworn witnesses. The inquest is not a mechanism to assign blame, resolve civil disputes, or to conduct prosecutions. It is a fact finding proceeding which provides information and leads to recommendations.

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 still 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.

There were no inquests held in the Northwest Territories during this reporting period. (See Appendix "B")

APPENDIX "A"

SUMMARY OF SELECTED CORONER REPORTS CONTAINING RECOMMENDATIONS (CONCLUDED IN 2010)

CASE # 1

This 69-year old man was found unresponsive at the Salvation Army Shelter at 06:00 on December 20, 2009. Emergency Medical Services was called; they attended, initiated CPR, and transported the man to the Stanton Territorial Hospital where he was pronounced dead. It was determined that the deceased had died as a result of Atherosclerotic Cardiovascular Disease and the death was classified as Natural.

COMMENTS AND RECOMMENDATIONS:

The investigation revealed that the Salvation Army requires shelter caseworker employees to complete mandatory staff training in Standard First Aid and CPR-C Level A. This is certainly an appropriate policy and procedure given the many services the Salvation Army provides. The policy however, is not specific as to when the caseworker must complete this training.

Although it would not have assisted the deceased, the investigation revealed that the attendant did not have current and valid Standard First Aid and CPR-C Level A training. Discussions were held with Salvation Army personnel regarding their staff training policy and procedures. It was indicated that while some staff have received training; this type of on-going professional development is not always consistently obtained in accordance with policies and procedures.

Therefore, in accordance with paragraph 5(2) (c) of the *Coroners Act*, the following recommendation was made:

1. **To the Salvation Army:** Ensure that caseworkers/attendants receive Standard First Aid and CPR-C Level A, and that staff training is current and valid.

CASE # 2

This 20-year-old male with a history of alcohol abuse and previous suicide attempts was being transferred from Yellowknife to Calgary via medevac when he suffered a cardiac arrest en route. The medevac aircraft landed in Edmonton, Alberta. The man was transported to Royal Alexandria Hospital and was pronounced dead despite resuscitative efforts. It was determined that the deceased had died as result of Acute Venlafaxine Toxicity and the death was classified as Suicide.

COMMENTS AND RECOMMENDATIONS:

A number of issues were raised during the investigation of this death. The toxicology tests revealed the acute toxicity of the drug Venlafaxine (Effexor). This is an antidepressant used for mental depression. Occasionally it is prescribed for other purposes.

Symptoms of depression, from mild to severe, including an increased risk of suicidal ideation have been reported with the use of Venlafaxine. This medication should only be used if the expected benefits are thought to outweigh the potential risks.

Although it cannot be directly linked to the action of the deceased taking his own life, it should be noted that in some cases Venlafaxine can cause or effect symptoms, worsening depression or suicidal ideation.

The NWT Coroner's Service made the following recommendations:

1. **To the Department of Health and Social Services:** Develop and distribute a warning notice and any subsequent protocol or best practices needed for calling attention to the potential danger of prescribing Venlafaxine (Effexor) to patients where depression or suicidal tendencies or ideation may be of concern.

2. **To the Department of Health and Social Services :** To educate NWT physicians in cases of high risk patients; when prescribing medications the physician should order the pharmacy to dispense only a partial fill of the prescription rather than allowing the patient to fill the full prescribed prescription at one time. *(The deceased was able to completely fill the full three-month prescription at a local pharmacy.)*

3. **To the Department of Health and Social Services:** Develop and implement a plan for a properly equipped and staffed alcohol and drug detoxification centre in the NWT. *(Hospitals in the NWT are neither properly staffed nor equipped to provide for the level of medical detoxification care that is often required. The development of a protocol and facility specifically designed to meet the needs of northerners is essential to reducing the alarming growth of alcohol and drug abuse in the NWT.)*

CASE # 3

This 37 year old male was found unresponsive in bed at home after complaining of chest pain and feeling unwell over the previous two weeks. It was determined that the deceased had died of Undetermined Natural causes and the death was classified as Natural.

COMMENTS AND RECOMMENDATIONS:

The NWT Coroner's Service makes the following recommendations:

1. **To the Department of Health and Social Services:** It was recommended that any siblings or children of the deceased be screened by a physician for the possibility of lethal cardiac arrhythmias and other possible disorders. (It is medically known that some of these medical conditions can be inherited.)

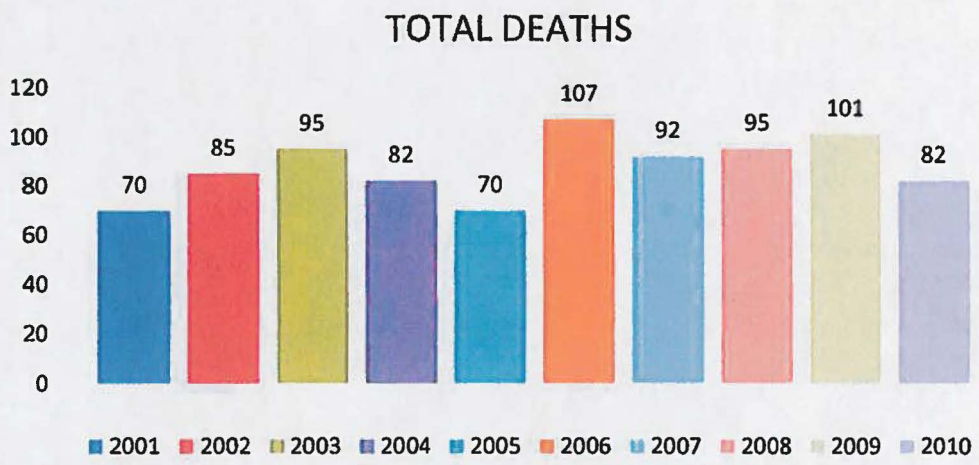
APPENDIX "B"

SUMMARY OF CORONER'S INQUESTS

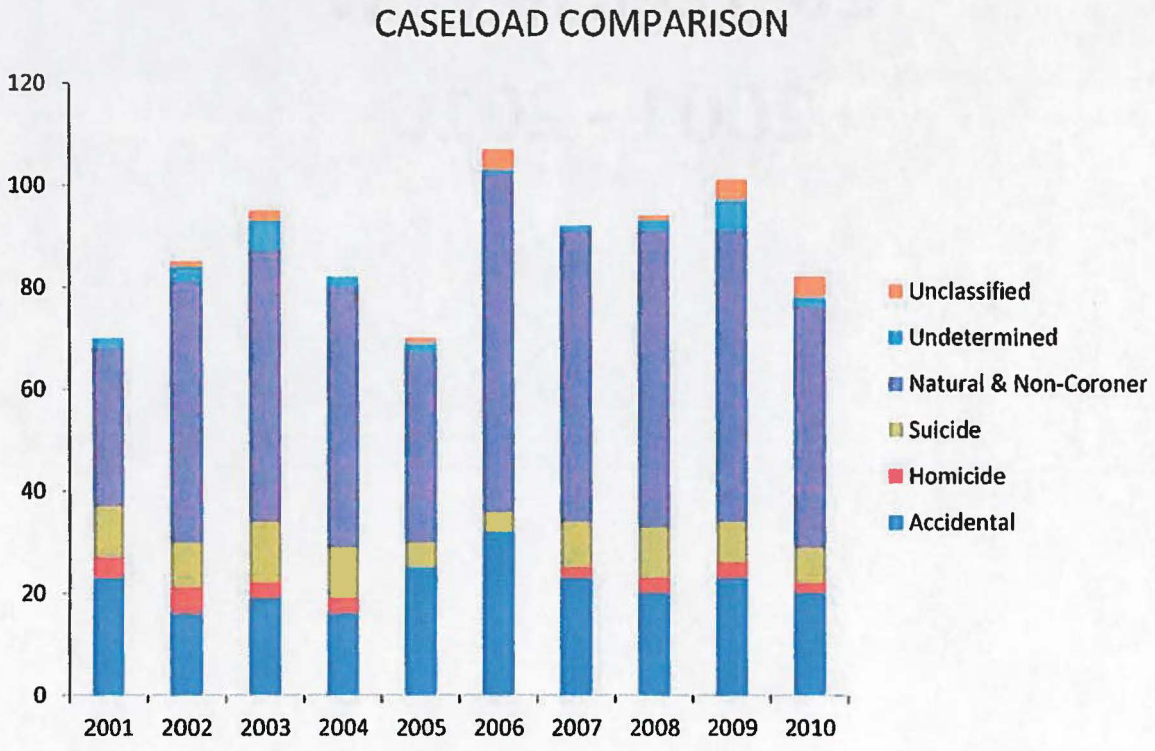
(THERE WERE NO INQUESTS CONCLUDED IN 2010)

NWT Coroner Service
10-Year Review
2001 - 2010

2001 – 2010 CASE STATISTICS

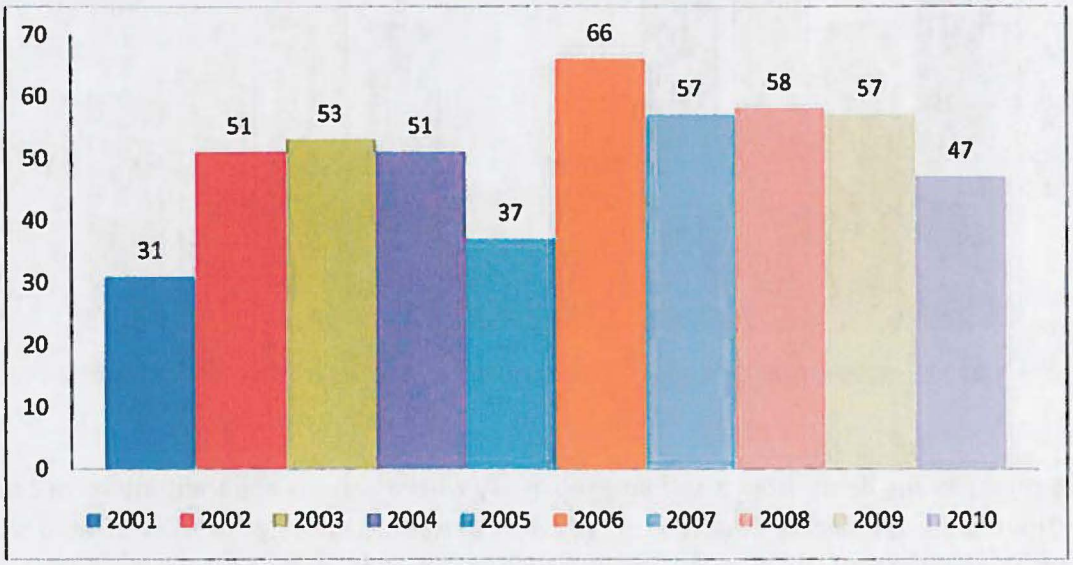


There has been an average of 88 cases reported to the Coroner's Service each year.



2001 – 2010 NATURAL DEATHS COMPARISON

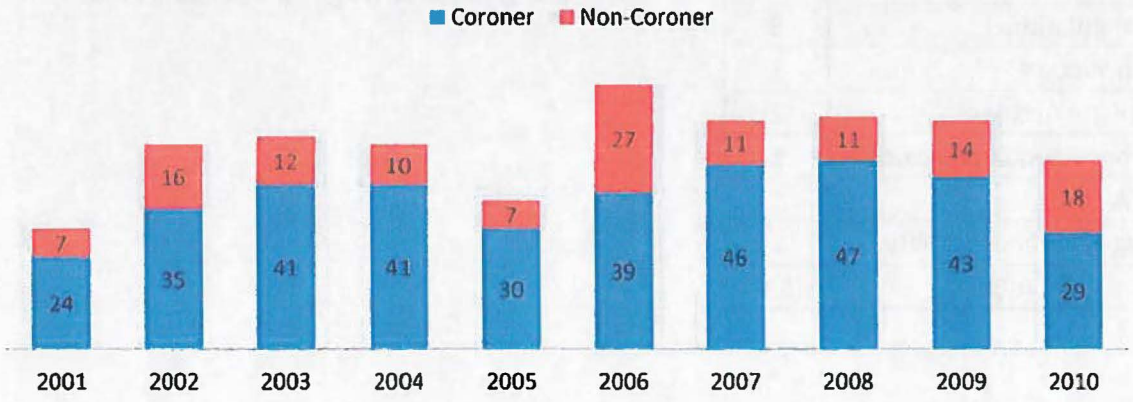
NATURAL covers all deaths primarily resulting from a disease of the body and not resulting from injuries or abnormal environmental factors. Natural deaths accounted for 58% of all deaths reported, with an average of 51 per year.



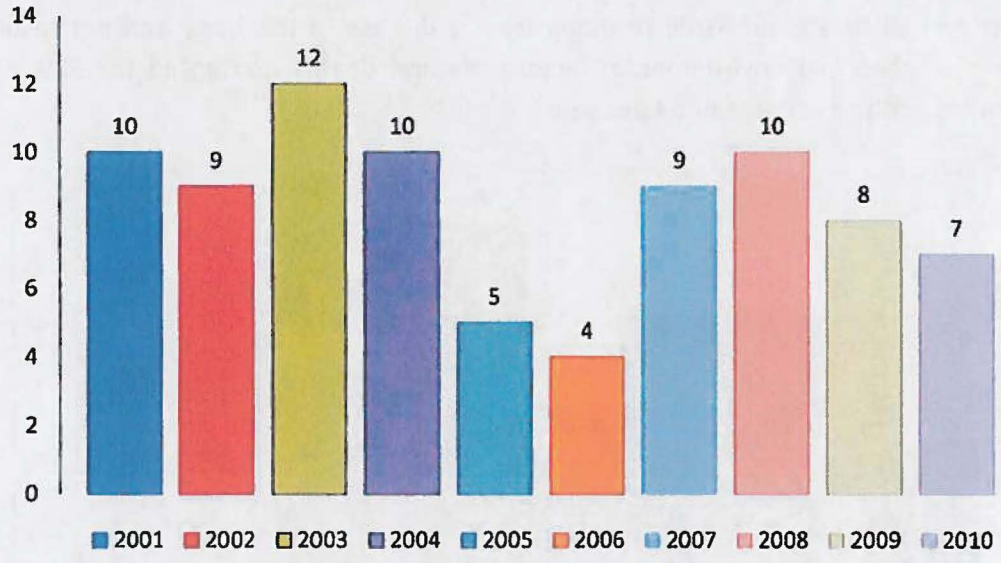
CORONER & NON-CORONER CASES

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

Coroner	Non-Coroner	Natural
375	133	508



2001 – 2010 SUICIDE DEATH COMPARISON



SUICIDE refers to any death from a self inflicted injury where there is apparent intent to cause death. There were 84 suicide deaths in this review period accounting for 10% of all deaths reported. The 10-year review shows a trend between 7 and 10 deaths by suicide each year. However in 2003 there was a larger number with 12 deaths, and in 2005 and 2006 an unexpectedly low incidence at 5 and 4 deaths respectively.

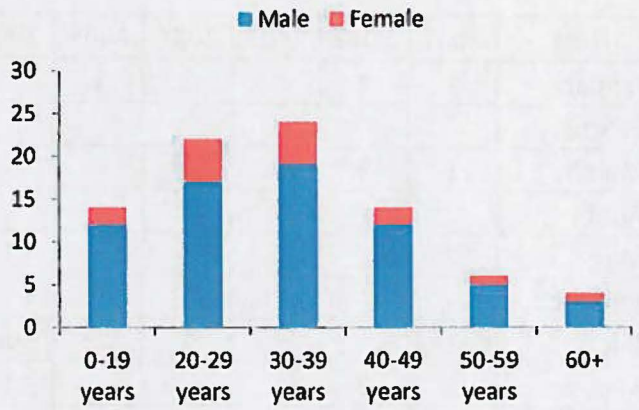
SUICIDES BY METHOD

Method	Total
Hanging	40
Gunshot Wound	27
Drug Toxicity	6
Strangulation	3
Stab Wound	3
Airplane Accident	2
Carbon Monoxide Toxicity	1
MVA	1
Drug & Ethanol Toxicity	1
Total	84

The most common method is hanging (32%) followed by gunshot wounds (48%).

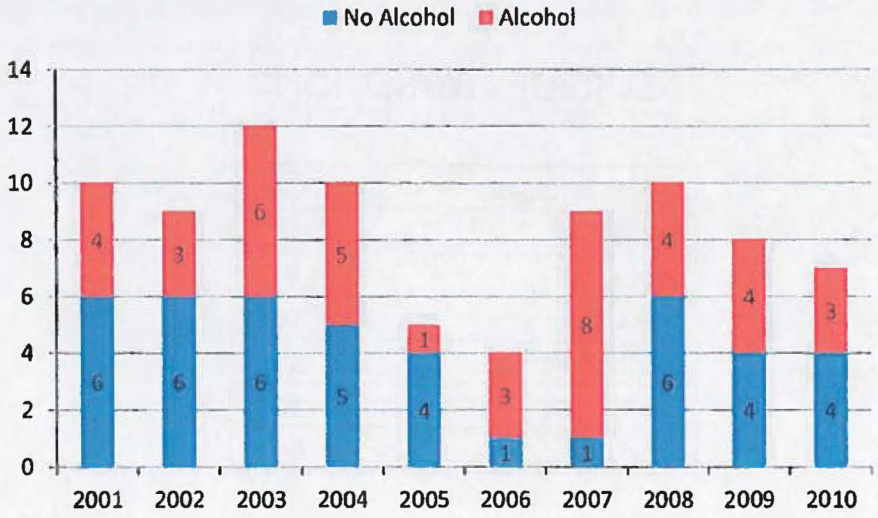
SUICIDES BY AGE AND GENDER

Age Group	Male	Female	Total
0-19 years	12	2	14
20-29 years	17	5	22
30-39 years	19	5	24
40-49 years	12	2	14
50-59 years	5	1	6
60+	3	1	4
Total	68	16	84



The majority of deaths by suicide were males (81%). The majority were aged between 20-39 years of age.

SUICIDE DEATHS INVOLVING ALCOHOL



The 10-year review found the highest number of suicide deaths with alcohol as a contributing factor occured in 2007 when 8 out of 9 cases involved alcohol. Of the 84 suicides over the 10-year period, 41 involved alcohol (49%).

SUICIDES BY MONTH

Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
January	1	1		1	1						4
February			1				1	1	2	1	6
March	1	3	1	2			2			1	10
April			1	1				2	1		5
May	2		1	1		1	1	2	1		9
June				1	1					1	3
July	1			1		1	1	2	2	1	9
August	1	2	4			1	1	1		1	11
September	2		1	1	1		2				7
October	1		2		1	1					5
November	1	3	1		1		1			1	8
December				2				2	2	1	7
Total	10	9	12	10	5	4	9	10	8	7	84

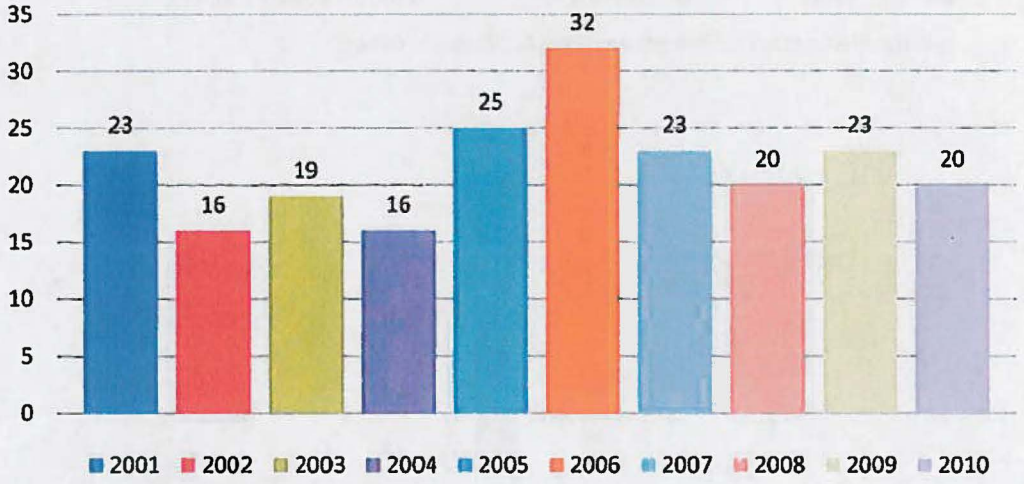
The 10-year review found the highest number of suicides occurred in August.

SUICIDES BY REGION

Region	Total
Inuvik	27
Sahtu	8
Deh Cho	0
North Slave	39
South Slave	10
Total	84

The majority of deaths by suicide occured in the North Slave region followed by the Inuvik Region. The Deh Cho region had no suicides reported between 2001 and 2010.

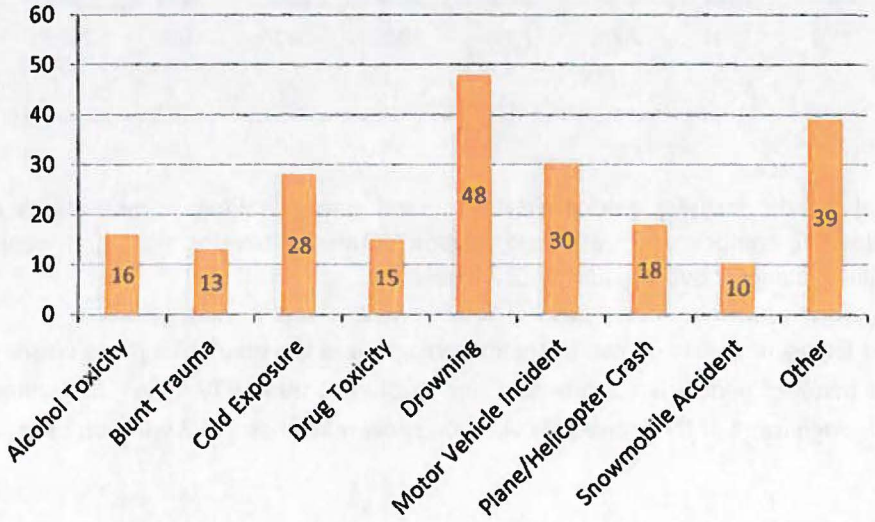
ACCIDENTAL DEATH COMPARISON 2001 – 2010



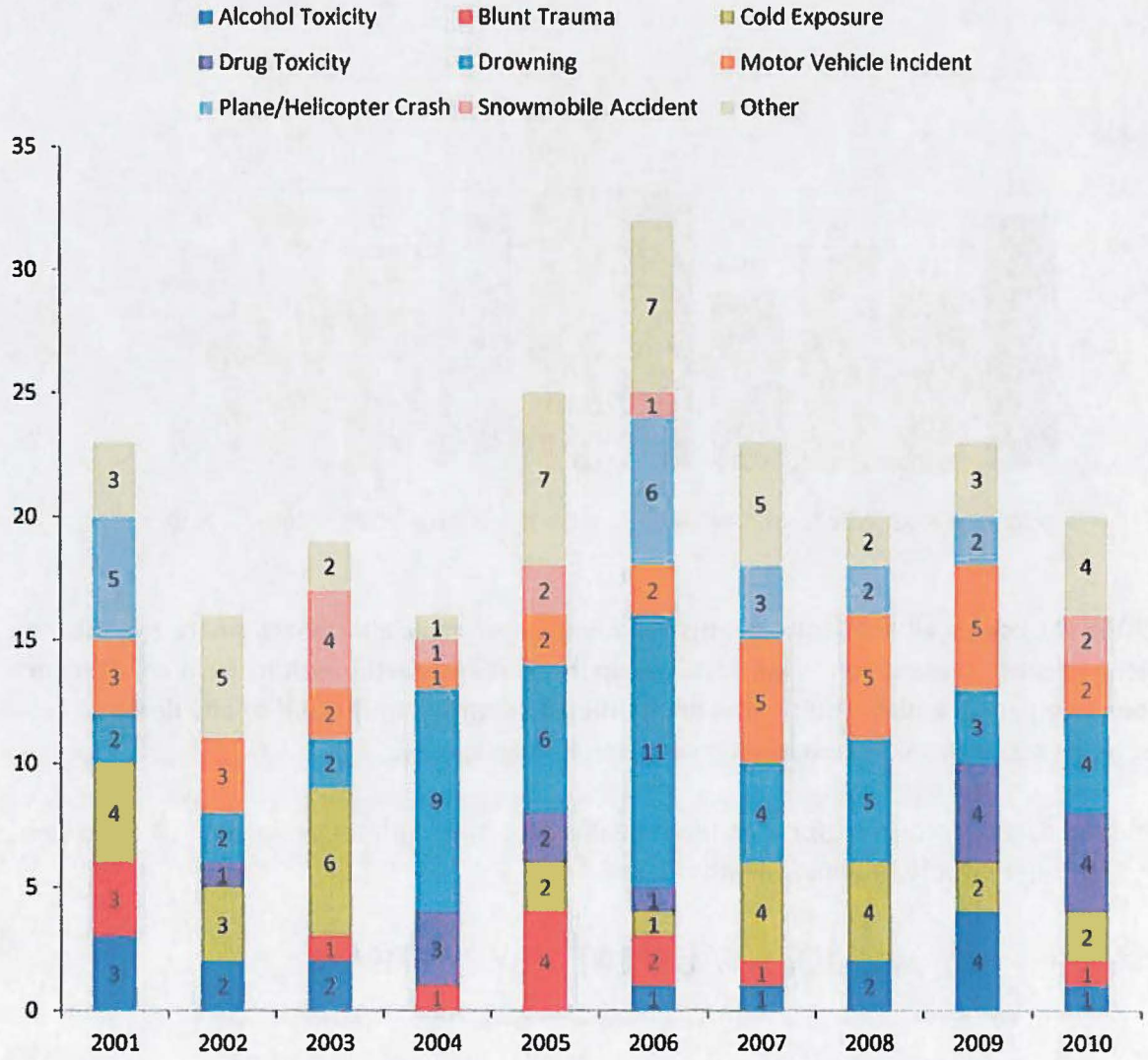
ACCIDENTAL covers all accidental deaths including motor vehicle incidents where there is no obvious intent to cause death. This classification includes any death resulting from an action or actions by a person which result in the unintentional death to him/herself or any death of any person that results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

Accidental deaths accounted for 25% of all deaths reported, with an average of 22 cases per year. The majority were drowning deaths at 22%.

ACCIDENTAL DEATH BY METHOD



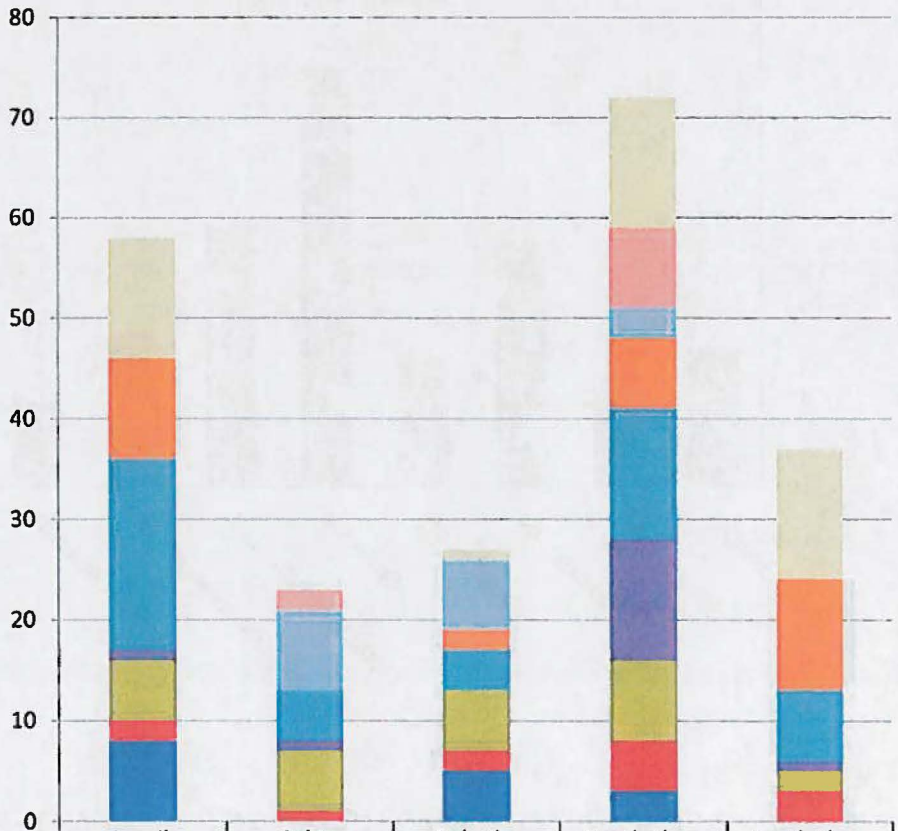
ACCIDENTAL DEATH COMPARISON BY METHOD AND YEAR



Other Accidental Deaths include: animal attack, broken neck, choking, complications of surgery, construction/industrial, compressional asphyxia, carbon monoxide toxicity, drug and alcohol toxicity, electrocution, falling, hanging, overlay, and smoke inhalation.

Three of the cold exposure cases and two of the drownings were the result of a plane crash. Four motor vehicle incidents involved pedestrian deaths and one involved a quad ATV. Seven drownings were the result of going through ice; 4 of the individuals were on snow machines and 3 were on or in other motor vehicles

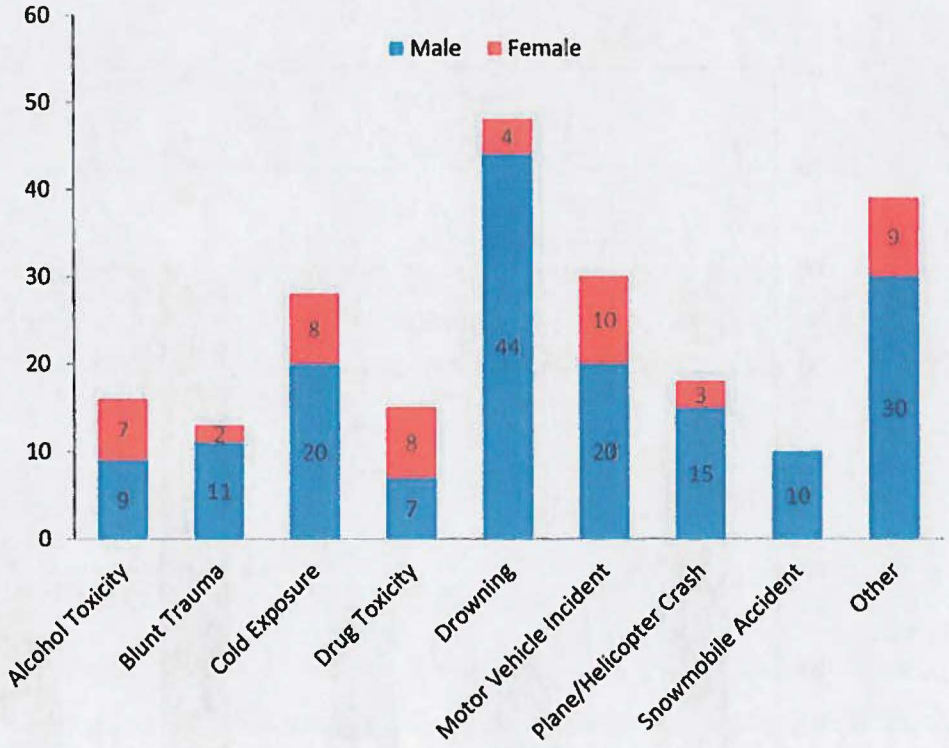
ACCIDENTAL DEATHS BY METHOD & REGION



	Inuvik	Sahtu	Deh Cho	North Slave	South Slave
Other	12	0	1	13	13
Snowmobile Accident	0	2	0	8	0
Plane/Helicopter Crash	0	8	7	3	0
Motor Vehicle Incident	10	0	2	7	11
Drowning	19	5	4	13	7
Drug Toxicity	1	1	0	12	1
Cold Exposure	6	6	6	8	2
Blunt Trauma	2	1	2	5	3
Alcohol Toxicity	8	0	5	3	0

The majority of accidental deaths occurred in the North Slave region with 72 deaths, followed by the Inuvik Region with 58 deaths. At 23, the Sahtu region had the lowest number of accidental deaths reported between 2001 and 2010, followed by the Deh Cho Region with 27 deaths and the South Slave region with 37 deaths.

ACCIDENTAL DEATHS BY METHOD & GENDER

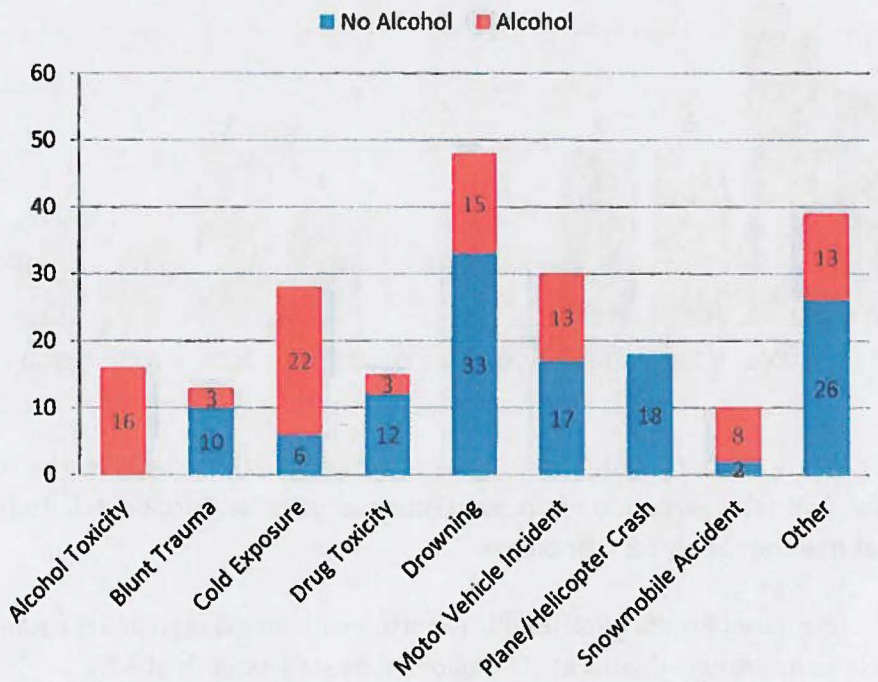


ACCIDENTAL DEATHS BY AGE & GENDER

Age Group	Male	Female	Total
0-19 years	12	13	25
20-29 years	33	7	40
30-39 years	31	6	37
40-49 years	36	8	44
50-59 years	30	7	37
60+	24	10	34
Total	166	51	217

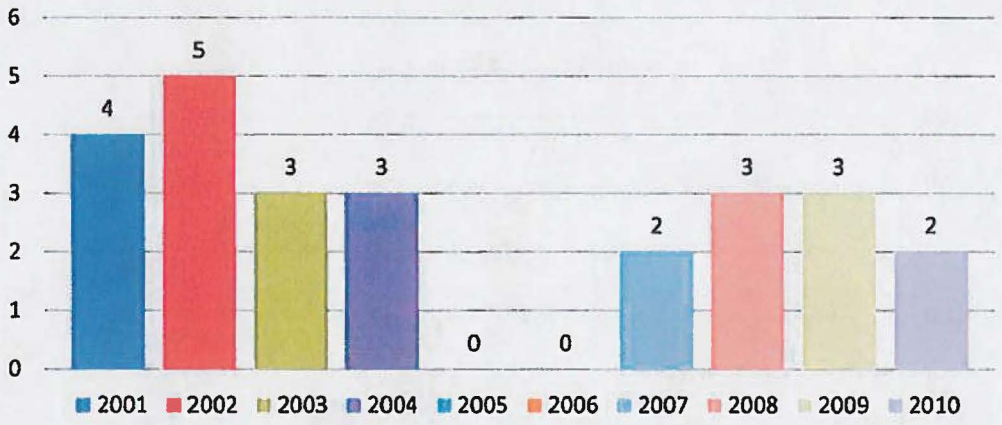
The majority of accidental deaths were males at 77%. Drowning accounted for 22% of all accidental deaths, and males accounting for 92% of drowning deaths.

ACCIDENTAL DEATHS INVOLVING ALCOHOL



Of the 217 accidental deaths, alcohol was involved in 124 (57%). Aside from alcohol toxicity, which had 100% alcohol involvement, it was most often seen in snowmobile accident deaths (80%) and cold exposure deaths (79%).

HOMICIDE DEATH COMPARISON 2001 – 2010



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

Homicide deaths accounted for 3% of all deaths reported with an average of 2.5 cases per year. The majority were blunt trauma deaths at 40% followed by stab wounds at 32%.

ACCIDENTAL DEATH BY METHOD

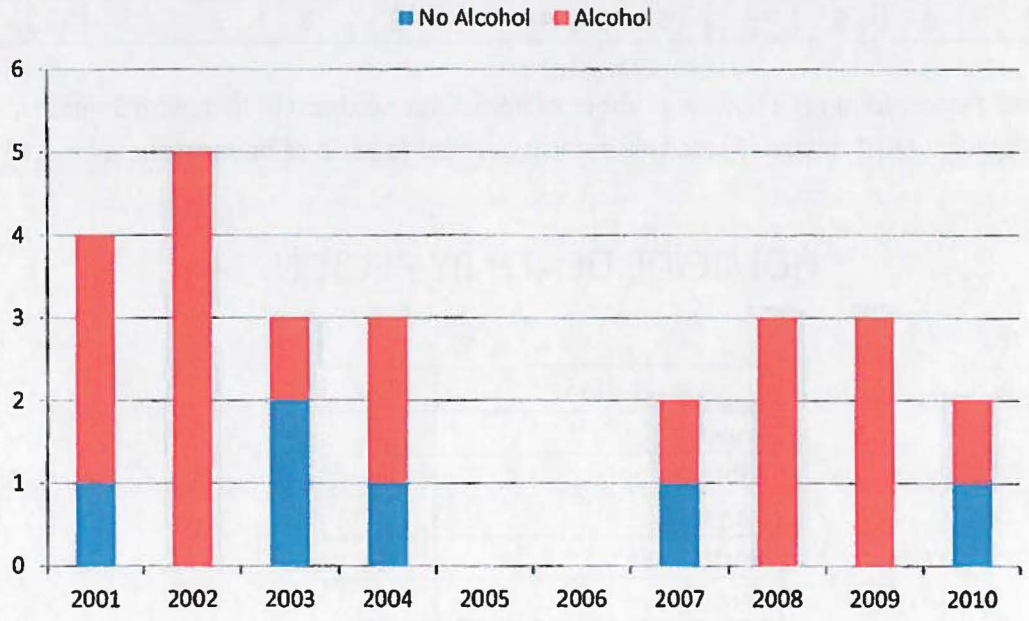
Cause	Total
Blunt Trauma	10
Stab Wound	8
Gunshot Wound	5
Strangulation	2
Total	25

HOMICIDE DEATH BY AGE AND GENDER

Age Group	Male	Female	Total
0-19 years	1	0	1
20-29 years	6	1	7
30-39 years	6	2	8
40-49 years	4	1	5
50-59 years	3	1	4
60+	0	0	0
Total	20	5	25

The majority of homicide deaths were males at 80%. 32% were aged between 30-39 years old.

HOMICIDE DEATHS INVOLVING ALCOHOL



Of the 25 homicide deaths, toxicology examination of the deceased confirmed alcohol was involved in 19 deaths (76%).

HOMICIDE DEATH BY MONTH

Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
January		1		1						1	3
February			1						1		2
March											0
April				1							1
May	1										1
June		1	1				1	2			5
July	2	1							1		4
August										1	1
September											0
October	1			1			1				3
November		2						1			3
December			1						1		2
Total	4	5	3	3	0	0	2	3	3	2	25

The 10-year review found the highest number of homicides occurred in June with 5 deaths, followed by July with 4 deaths. These two months account for 36% of homicides.

HOMICIDE DEATH BY REGION

Region	Total
Inuvik	7
Sahtu	3
Deh Cho	0
North Slave	11
South Slave	4
Total	25

44% of homicide deaths occurred in the North Slave region with 11 deaths.

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 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.