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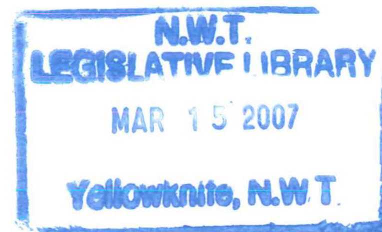
Northwest Territories Coroner's Service 2005 Annual Report



OFFICE OF THE CHIEF CORONER

October 30, 2006

Donald M. Cooper, Q.C., Deputy Minister
Department of Justice
Government of the Northwest Territories
Yellowknife, NT X1A 2L9

Dear Sir:

It is my honour to submit the Northwest Territories Coroner's Service 2005 Annual Report for the year beginning January 1, 2005 and ending December 31, 2005.

Yours truly,

Percy A. Kinney
Chief Coroner
Northwest Territories

Box 1320 Yellowknife, NT X1A 2L9 • 873-7460 PH • 873-0426 FAX

TABLE OF CONTENTS

HISTORY OF CORONER'S SERVICE 1

INTRODUCTION 2

MANNER OF DEATH 3

CASE STATISTICS 4
- TOTAL CASES 4
- CASELOAD BY MANNER 5
- CASELOAD BY MANNER/COMMUNITY 6
- CASELOAD BY MONTH 7
- CASELOAD BY MANNER/MONTH 8
- SUICIDE BY GENDER/AGE 9
- SUICIDE BY MONTH/COMMUNITY/GENDER/AGE/METHOD 10
- SUICIDE BY MONTH 2004-2005 COMPARISON 11
- ACCIDENTAL BY CAUSE/GENDER 12
- SUDDEN INFANT DEATH SYNDROME 13
- NATURAL & NON-CORONERS 13
- POST MORTEMS BY MONTH 13

RECRUITING/CORONER LIST 14

CONCLUDING CORONER'S INVESTIGATIONS BY CORONER'S REPORT 16

CONCLUDING CORONER'S INVESTIGATIONS BY INQUEST 17

APPENDIX "A" (A Summary of Coroner's Reports Containing Recommendations) 18
- Case #1 19
- Case #2 21
- Case #3 22
- Case #4 23

Coroner's Act-Reporting Deaths 25

HISTORY OF CORONER'S SERVICE

The office of the Coroner is one of the oldest institutions known to English law. The role of the "coroner" in England has been noted in references dating back to the time of the Saxon King Alfred in 925 A.D. However, the historical development of the office can be traced back to a time near the Norman Conquest when the Coroner was to achieve an important role in the administration of justice.

It is generally accepted that the office was not regularly instituted until the end of the 12th century. One of the first detailed statutes concerning coroners was the Statute of Westminster of 1276. The title of the office has varied from "coronator" during the time of King John to "crowner," a term still used occasionally in Scotland.

One of the earliest functions of the Coroner was to enquire into sudden and unexpected deaths where in some cases, a fee was to be paid to the crown. The Coroner was charged with the responsibility of establishing the facts surrounding a death, a duty that provides for the basis for all coroner systems in use today.

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

There are two death investigation systems in Canada: the Coroner system and the Medical Examiner system. The Coroner system has four main roles to fulfill: investigative, administrative, judicial and preventative. The Medical Examiner system involves medical and administrative elements. The Coroner and the Medical Examiner both collect medical and other evidence in order to determine the medical cause and manner of death. The Coroner receives the information from a variety of sources. The Coroner examines the investigative material, sorts out facts and comes to a judicial decision concerning the death of an individual. The Coroner can also make recommendations that may prevent a similar death.

In the Northwest Territories, the Coroner's Service provides a multi-disciplinary approach to the investigation of death by lay coroners appointed by the Minister of Justice. NWT coroners are assisted by the Royal Canadian Mounted Police and a variety of other experts when required.

INTRODUCTION

The Coroner's Service, for organizational and administrative purposes, falls within the Department of Justice. The Chief Coroner is located in Yellowknife and oversees all death investigations. Currently, there are 37 appointed coroners throughout the Northwest Territories. They provide service in the communities and regions in which they reside.

In the Northwest Territories, all sudden unexpected deaths must be reported to a coroner. The Coroners Services responsible for the investigation of all reportable deaths in order to determine the identity of the deceased and the facts concerning when, where, how and by what means the deceased came to their death. The Coroner's Service is supported through efforts by the Royal Canadian Mounted Police, Fire Marshall's Office, Workers' Compensation Board, Transport Safety Board and various other agencies who work closely with the Coroner's Office.

The current Chief Coroner is Percy Kinney. A coroner in Yellowknife since 1993, he has occupied the position of Chief Coroner since February of 1998.

The Deputy Chief Coroner is Cathy Menard. Ms. Menard joined the Coroner's Service in February of 1996. She has been with the Department of Justice for over 20 years.

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

MANNER OF DEATH

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

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

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

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

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

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

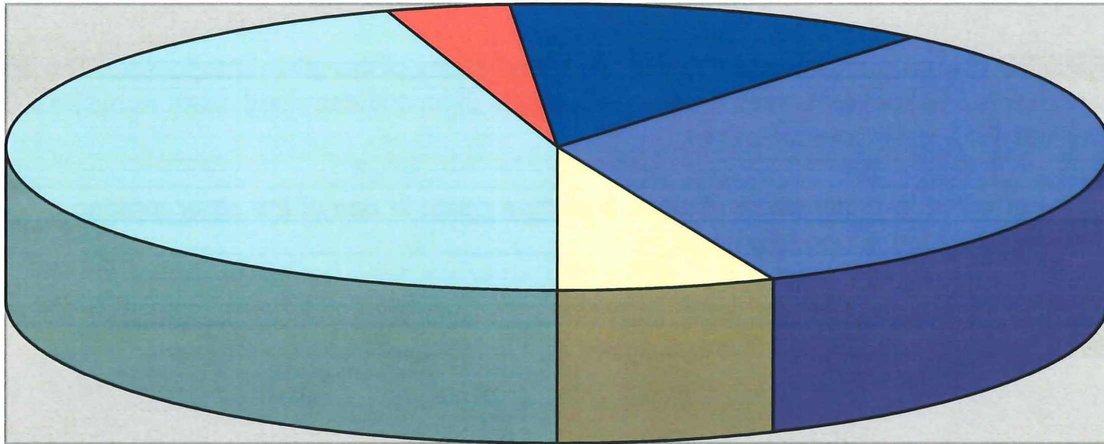
Coroners are instructed to make every effort to classify a death in one of the other existing categories before considering a classification of undetermined.

*(**UNCLASSIFIED** is reserved for any case work that ultimately does not result in another classification. It is primarily used for found remains which are analyzed and determined to be non-human.)*

CASE STATISTICS

TOTAL CASES

Manner of Death	Number	Percent %	Rate per 100,000
Accidental	25	35.72	0.60
Homicide	0	0.00	0.00
Suicide	5	7.14	0.12
Natural (includes Non-Coroner cases)	37	52.86	0.89
Undetermined	2	2.86	0.05
Unclassified	1	1.42	0.00 **
TOTALS	**70**	**100.00**	**1.66**

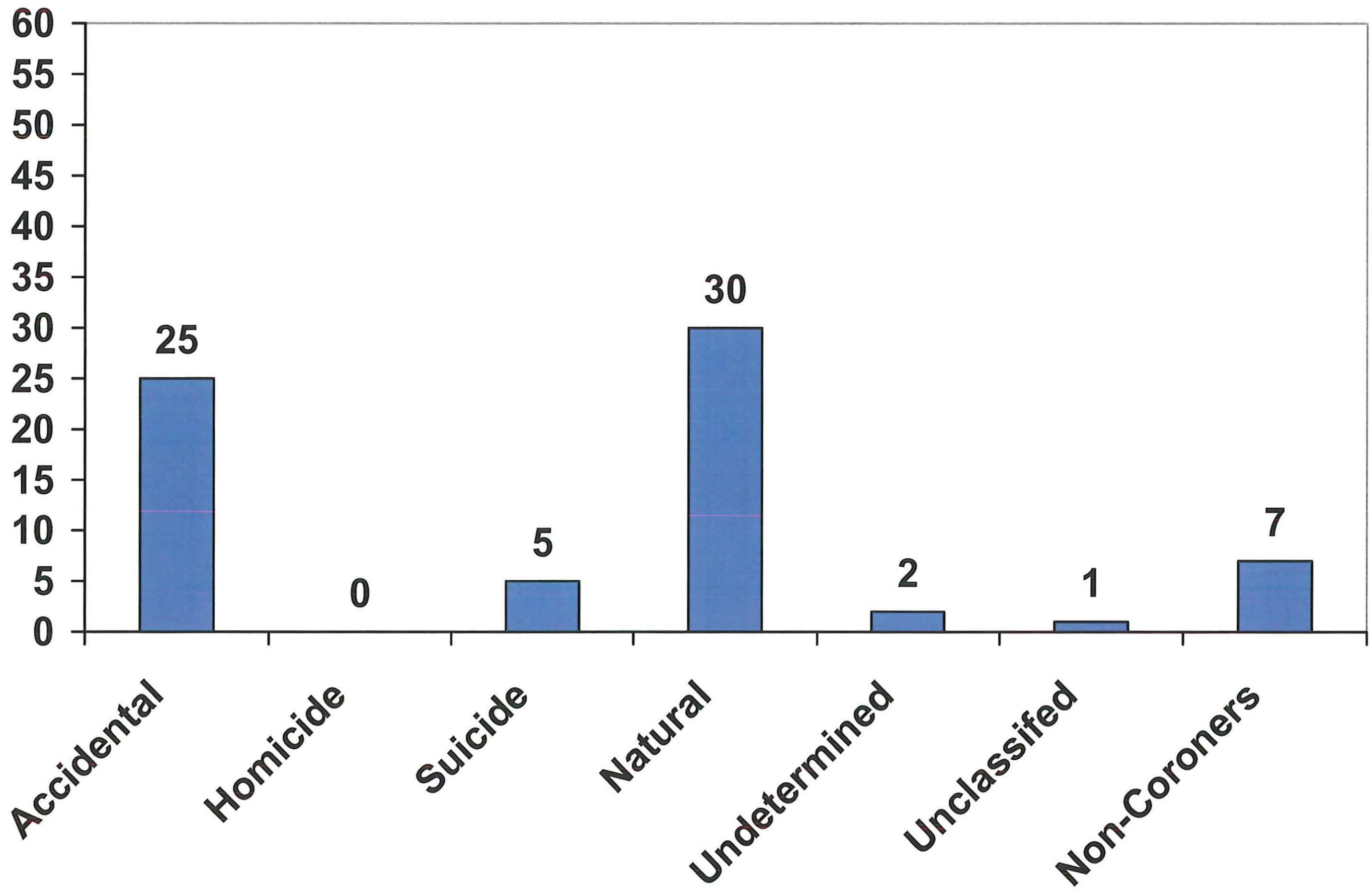


Accident 25 **Homicide 0** **Suicide 5**
Natural 30 **Undetermined 2** **Unclassified 1**
***Non Coroners 7**

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

**** Unclassified cases are not represented in the "Rate per 1000,000" population figures since they are non-human in nature. They do however make up 1.42% of cases investigated**

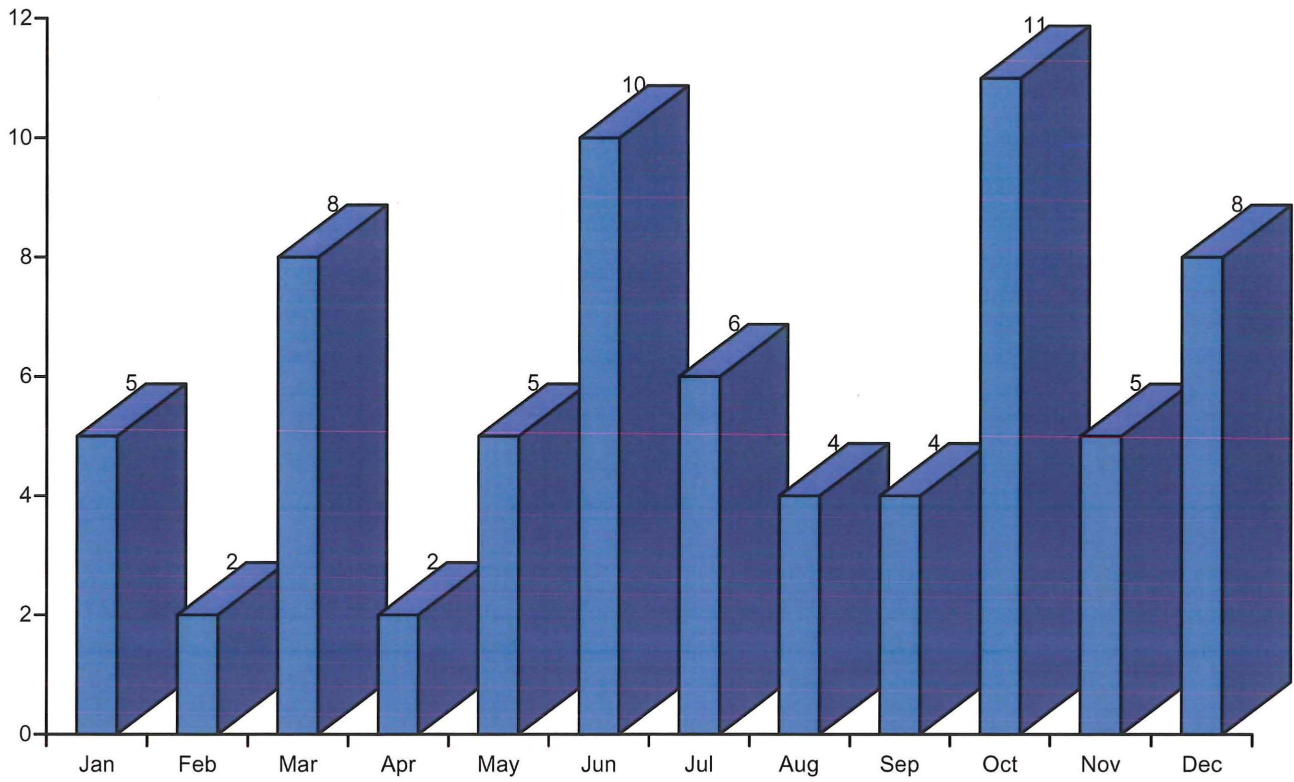
CASELOAD BY MANNER OF DEATH



CASELOAD BY MANNER OF DEATH/COMMUNITY

Community	Accidental	Homicide	Suicide	Natural	Undetermined	Unclassified	Non-Coroners	Total
Diavik Mines				1				1
Deline				1				1
Fort McPherson			1	3				4
Fort Providence	1							1
Fort Simpson	4			2			1	7
Fort Smith	3		1					4
Fort Resolution				2				2
Hay River	2			3				5
Inuvik	5			3				8
Enterprise	2							2
Rae/Edzo			1	1			2	4
Tuktoyaktuk				3	1		1	5
Ulukhaktok			1		1		1	3
Paulatuk	1							1
Fort Good Hope								
Tulita			1					1
Yellowknife				1			1	2
TOTALS	7			10		1	1	19
	25	**0**	**5**	**30**	**2**	**1**	**7**	**70**

CASELOAD BY MONTH



CASELOAD BY MANNER/MONTH

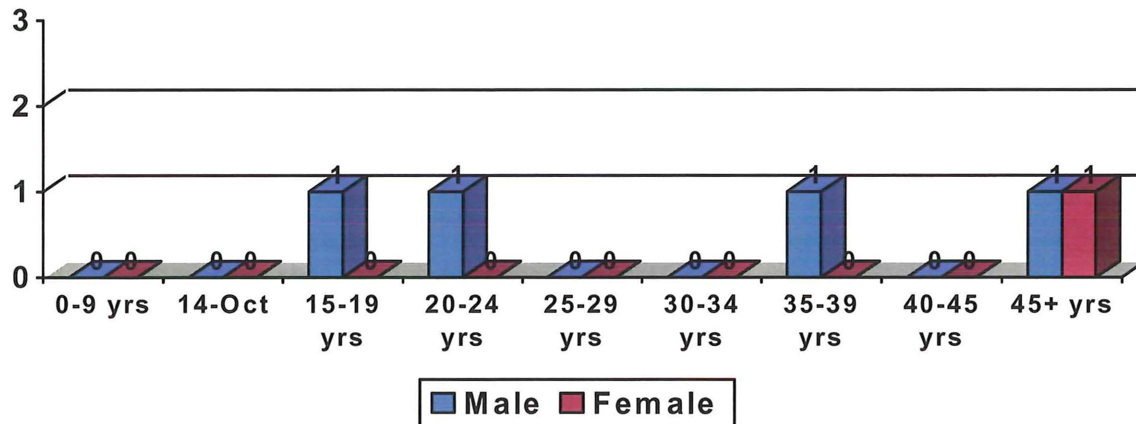
Month	Accident	Homicide	Suicide	Natural	Undetermined	Unclassified	Non-Coroners	TOTALS
January	1		1	2			1	5
February				2				2
March	3			4			1	8
April				1			1	2
May	4			1				5
June	3		1	4	1	1		10
July	3			1			2	6
August				3	1			4
September	2		1	1				4
October	6		1	3			1	11
November	0		1	4				5
December	3			4			1	8
TOTALS	**25**	**0**	**5**	**30**	**2**	**1**	**7**	**70**

SUICIDE BY GENDER/AGE

Age Group	Male	Female	Total
0-9 yrs			
10-14 yrs			
15-19 yrs	1		1
20-24 yrs	1		1
25-29 yrs			
30-34 yrs			
35-39 yrs	1		1
40-44 yrs			
45 + yrs	1	1	2
TOTALS	**4**	**1**	**5**

Of the 5 suicide deaths in 2005, 4 were male, (80%). 2 of the suicides occurred in persons 45 + years of age.

The suicide rate had remained fairly consistent over the last 4-5 years. This is the first significant drop in numbers for the past several years and is consistent with the numbers seen in the mid-1990's (10 deaths in 2004, 12 deaths in 2003, 9 deaths in 2002, 10 deaths in each of 2001 and 2000, 16 in 1999, 7 in 1998, 6 in 1997, 5 in 1996 and 7 in 1995).

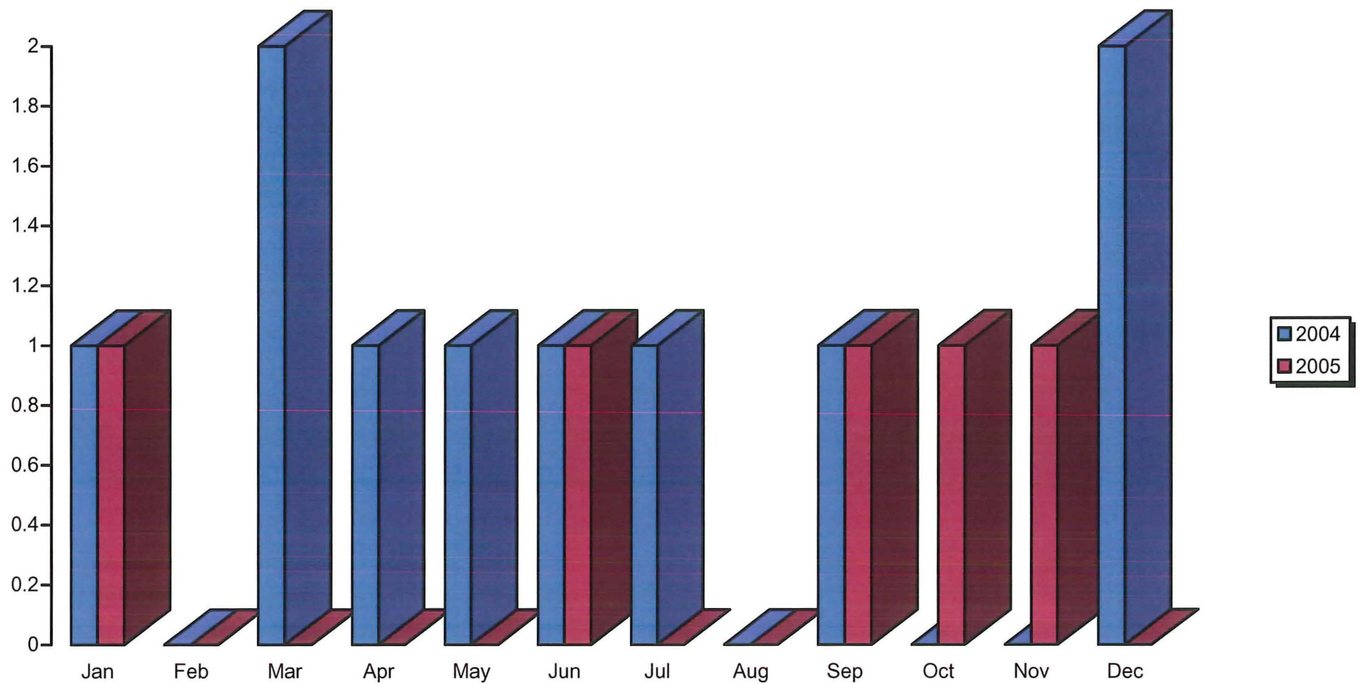


SUICIDES BY MONTH/COMMUNITY/GENDER/AGE/METHOD

Month	Community	Gender	Age	Method	Alcohol
January	Fort Smith	Male	58	hanging	no
June	Rae/Edzo	Female	45	firearm	no
September	Ulukhaktok	Male	36	firearm	no
October	Fort McPherson	Male	20	hanging	yes
November	Fort Good Hope	Male	18	hanging	no

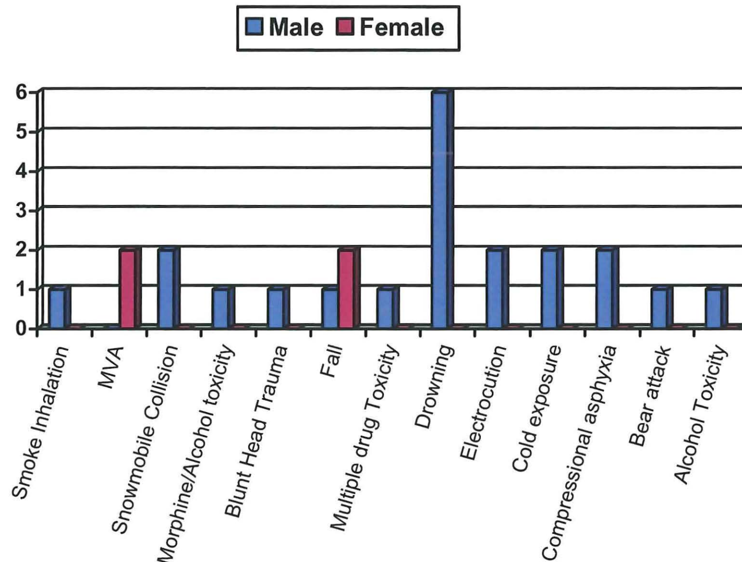
Hanging was the predominant method of suicide (3 of 5 = 60%). The majority of suicides were conducted by males as compared to females (4-1) Alcohol was involved in only 1 of the suicide cases in 2005.

SUICIDES BY MONTH 2004 - 2005 COMPARISON



JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
1					1			1	1	1		5
20%					20%			20%	20%	20%		100%

ACCIDENTAL DEATH BY CAUSE/GENDER



Cause of Death	Male	Female	Total	Alcohol Related
Smoke Inhalation	1		1	1
Motor Vehicle Accident		2	2	
Snowmobile Collision	2		2	2
Morphine/alcohol toxicity	1		1	1
Blunt Head Trauma	1		1	
Fall	1	2	3	
Multiple drug Toxicity	1		1	
Drowning	6		6	3
Electrocution	2		2	1
Cold Exposure	2		2	1
Compressional asphyxia	2		2	
Bear attack	1		1	
Alcohol toxicity	1		1	1
TOTALS	**21**	**4**	**25**	**10**

Accidental deaths accounted for approximately 35.8% of all deaths reported to the Coroner's Service in 2005. The majority of the deaths (21 of 25, or 84%) were males.

Of the 25 cases reported, alcohol was involved in 10 of them or 40%.

SUDDEN INFANT DEATH SYNDROME

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

There were 2 reported deaths by SIDS in 2005. Both were males approximately 4 months old and both deaths occurred in the month of October.

NATURAL & NON-CORONER CASES

Natural	Non-Coroner	Coroner
30	7	37

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

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

AUTOPSIES

JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
3	2	4	1	2	6	2	2	1	5	1	3	32

A post mortem is conducted when the cause and/or manner of death cannot otherwise be determined or when it appears appropriate to conduct the procedure. The autopsy may also be a means of determining the identity of the deceased.

A total of 32 autopsies were conducted in 2005.

CORONER APPOINMENTS

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

Currently there are 37 Coroners across the Northwest Territories; 16 are aboriginal. There are 25 male (10 aboriginal) coroners and 12 female (6 aboriginal) coroners.

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

Fort Liard - Alan Harris

Fort Smith - Pat Burke, Sandy Napier, Murray Scott, Don Tourangeau

Fort Simpson - John Herring, Peter Shaw

Hay River - Doug Swallow, Brian Johnson, Roderick O'Brien

Deline - Elizabeth Takazo

Fort Good Hope - Tommy Kakfwi, Ester Charney

Tulita - Edward McPherson Jr.

Aklavik – Arnie Steinwand

Inuvik - Maureen Gowans, Gerry Kisoun, Brian Fraser MacDonald

Norman Wells - Dudley Johnson, Valerie McGregor

Tuktoyaktuk - Anita Pokiak, Barney Masazumi

Lutselk'e – Alfred Lockhart

Wha ti - Carolyn Coey-Simpson

Tsiigehtchic – James Andrew Cardinal

Yellowknife - Bethan Williams, Garth Eggenberger, Jennifer Eggenberger, Wendy Eggenberger, Fred Whittlinger, Percy Kinney, Cathy Menard

Sachs Harbour - John Keogak

Fort McPherson - Kendra Francis, Jamie Lee Carpenter, Winnie Greenland

Colville Lake - Wilbert Kochon

CONCLUDING CORONERS' INVESTIGATIONS

REPORT OF CORONER

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

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

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

INQUESTS

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

A coroner must hold an inquest when the deceased was involuntarily detained in custody at the time of the death. An inquest can also be held when, in the opinion of a coroner, it is necessary to:

a) identify the deceased or the circumstances of death;

b) inform the public of the circumstances of death where it will serve some public purpose;

c) bring dangerous practices or conditions to the knowledge of the public and facilitate the making of recommendations to avoid a preventable death; or

d) inform the public of dangerous practices or conditions in order to avoid future preventable deaths.

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

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

APPENDIX "A"

SUMMARY OF SELECTED CORONERS' REPORTS

(CONCLUDED IN 2005)

CONTAINING RECOMMENDATIONS

CASE # 1

In April of 2004, a 32 year old woman was found hanging in the bathroom shower of her hospital room by a nurse who had went to check on her. Personnel at the centre removed the victim from the hanging point and commenced CPR to no avail. She was pronounced dead a short time later.

It appeared the decedent had used the shoulder strap from a tote bag to fashion a noose and tied the other end to a shower rod. The markings on the deceased neck were consistent with the shoulder strap found at the scene.

The investigation revealed the decedent had a history of drug and alcohol abuse. She had attempted suicide by pills several years earlier.

The woman had gone to see a local Alcohol and Drug counsellor and stated she wanted to go into a detoxification program to try and maintain sobriety. She was admitted to hospital the following day.

Arrangements were made for her to attend to a treatment program in Alberta which had specific requirements for admittance. It was not considered to be a detoxification centre and clients must have been sober for at least 72 hours prior to admittance. They are required to undergo a physical examination, X-ray, TB test and express a desire to change their lifestyle.

Intake of new clients at the treatment centre is slated for certain days. The deceased was scheduled to be sent to the lodge on April 14th 2004 after completing all of the requirements.

A local alcohol and drug counsellor visited with the woman on the evening prior to her death. She stated she was upset about some personal family problems but made no indication of any self harm.

Following the visit, the woman went to a smoking area and commented to another hospital patient that she just wanted to "take a plane ride and disappear".

She was last seen alive by a nurse at the facility. The nurse talked with the decedent and engaged her in a verbal "contract" against any self harm. The nurse stated she checked on her about every 15 minutes until approximately 3:30 am when she appeared to be sleeping. She was found suspended from the shower curtain a half hour later.

An unsigned and undated note was found in her hospital room. The note referred to family members and stated her intent.

No autopsy was ordered but samples were taken for toxicology examination. Her addiction problem was a paramount concern in her life.

A number of issues were raised during the investigation of this death. The toxicology tests revealed 2 medications were present in the urine sample provided. The first drug noted, a metabolite of Benzodiazepine (Desmethyldiazepam) is consistent with the treatment of alcohol detoxification. The drug is routinely used for the treatment of alcohol withdrawal and is in keeping with the treatment expected for the deceased.

The second medication found was Metoclopramide, a drug used in the treatment of certain digestive disorders and sometimes used for the treatment of nausea and vomiting.

The charted information and subsequent Coroner's request for a list of medications prescribed in this case demonstrated that Librium (Benzodiazepine), Ativan, (also a Benzodiazepine with a mild tranquillizer) and Maxeran (a form of Metoclopramide) were prescribed to the decedent during her hospitalization.

Although it cannot be directly related to the actions of the decedent in taking her own life, it should be noted that in some rare cases Metoclopramide can cause or effect symptoms related to mental depression.

Symptoms of depression from mild to severe, including suicide ideation and suicide have been reported with the use of Metoclopramide. This medication should only be used if the expected benefits are thought to outweigh the potential risks.

A Special Committee with the Department of Health and Social Services reviewed the circumstances surrounding this case and made a total of 8 recommendations to the Fort Smith Health and Social Services Authority.

The recommendations range from issues involving staffing and training to protocol and record keeping. The coroner's office supports all of the recommendations and urges the parties involved to strongly consider their implementation.

In addition, the Office of the Chief Coroner makes the following recommendations:

① **To the Fort Smith Health and Social Services Authority;** Conduct an audit of the facility in Fort Smith to identify potential hazards which may facilitate suicide (i.e remove or adapt potential hanging points, staff access to "locked" bathrooms, etc.) and implement a plan to eliminate such hazards. *(Rationale: Specific hanging points such as shower rods should be replaced with collapsable rods which would bend, break or become dislodged when any significant weigh is imposed. The identification and adaptation of similar hazards will assist in reducing suicide opportunities).*

② **To the Department of Health and Social Services;** Develop and distribute a warning notice and any subsequent protocol or best practices felt appropriate for calling attention to the potential danger of prescribing Metoclopramide (Maxeron, Reglan, etc.) to patients where mental depression or suicidal tendencies or ideation may be of concern. *(Rationale: Since currently detox patients are dealt with in a general hospital environment in the NWT, it would be prudent to inform staff of any potential drug reactions when medications are used in similar circumstances).*

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. *(Addictions treatment centres often utilized by the NWT often require the client to be sober upon admission. Hospitals in the NWT are not properly staffed or equipped to provide for the level of medical detoxification care that is required in many instances in the North. The development of a protocol and facility specifically designed to meet the needs of the people of the north is paramount to arresting and reducing the alarming growth of drug and alcohol abuse in the Northwest Territories).*

CASE # 2

In October of 2004, a 56 year old woman with a history of lung cancer was found unresponsive on the couch in her home by her spouse. The woman was then transported to the health centre. CPR was commenced upon arrival and continued until the woman was pronounced dead a short time later.

The coroner also attended to the scene and seized a number of medications. There were no signs of a struggle and no indication of any foul play.

The investigation revealed that the deceased had returned to the community a few days prior to her death. She had been undergoing chemotherapy treatment in Edmonton and had been recently diagnosed with lung cancer.

Upon returning from work, her spouse noted that she had developed laboured breathing and stated that he saw foam and fluid emanating from her mouth and nose.

With the assistance of neighbours, the woman was transported to the local health centre where resuscitation efforts were employed until a physician in Inuvik pronounced her dead at 12:30 pm.

Although it was originally thought her death might be from the cancer, a call to her physician in Edmonton revealed the cancer appeared to be localized and the woman was scheduled to return for additional therapy in a few weeks. The death remained sudden and unexpected.

An autopsy was ordered to be held in Edmonton and the body of the deceased was prepared and transported to Alberta for the procedure.

At autopsy, there was a tumour located in the right lung but there was no evidence of any spreading of the disease beyond the localized site. There were scattered thin atherosclerotic plaques in the coronary arteries producing a maximum of 50% narrowing in some areas. There were no injuries or other natural disease processes present to cause or contribute toward the death. There was evidence of non-digested medication tablets in the stomach contents.

Toxicology tests revealed a lethal level (1.08 mg/l) of the pain narcotic Oxycodone (i.e. Percocet®, Percodan® Oxycontin® etc.) in the blood. A therapeutic level (1.12 mg/l) of Trazodone (i.e. an anti-depressant) was also noted to be present.

Other medications (i.e. acetaminophen, ibuprophen etc.) were also detected in the samples.

The coroner determined that the woman died as a result of oxycodone toxicity and classified the death as accidental.

It is important to note that this was the 4th death in recent years related to overdoses of oxycodone. Much like the rest of Canada, the north is experiencing a significant rise in oxycodone related deaths. In the interest of addressing this issue, the Office of the Chief Coroner made 3 recommendations to the Department of Health and Social Services regarding the distribution and use of oxycodone in the NWT.

CASE # 3

In February of 2005 a 68 year old woman with a history of type II diabetes, a recent knee replacement surgery, a right sided CVA in 2000, TB, hypertension, COPD and a number of other suspected ailments, was found dead in her residence by family members a few hours (approx. 5:30 am) after being treated and released at the local health centre.

According to medical notes, the family notified the nurse on call very early in the morning, however no action was taken until a second nurse was informed of the death about an hour later. The coroner's office and the RCMP were then notified of the death.

The investigation revealed that the deceased had been brought to the health centre the night before her death, complaining of abdominal pain, nausea and vomiting. She was given Gravol® and Tylenol® 3. She returned in a weakened condition a short time later with the same symptoms. The health record indicates she was given 50 mg of Demerol® (i.e. meperidine) and 50 mg of Gravol® (i.e. diphenhydramine) as well as 5 mg of morphine.

Medical notes indicate that the woman was feeling better and requested to go home to rest. Family recollections are that she was told to go home and rest. In either case, the woman was transported on a backboard to her home and placed in her bed. She was found dead a few hours later.

An autopsy was ordered to be held in Edmonton and the body of the deceased was prepared and transported to Alberta for the procedure.

At Autopsy, there was significant narrowing of the blood vessels that supply the heart (i.e. atherosclerotic coronary artery disease). The blockages were up to 90% in some areas. There was evidence of pulmonary edema and congestion. There was also evidence of the formation of atherosclerosis in the aorta. There were no injuries present to cause or contribute toward the death.

Toxicology was negative for any alcohol. Therapeutic levels of codeine (i.e. a narcotic pain reliever), meperidine (i.e. a pain reliever) and normeperidine (i.e. a breakdown product of meperidine) were found in the samples.

There was no morphine detected but there was a significantly high level of diphenhydramine (i.e. a medication found in Gravol® and other "over the counter medicines") found in the blood. The level was not thought to be high enough to cause death but would have some toxic effects. Since the health records only reflect therapeutic levels given to the deceased, it remains unknown as to where or when she obtained and consumed additional quantities of the medication. It is also unknown as to why the woman was not given the morphine as indicated in the medical chart.

Although not directly related to the cause or manner of death in this case, concern was raised over the level of treatment provided to this women in her final hours and several questions from the family were put forward to the health authority. In addition, the "missing" morphine in this case and concerns over other reports of "missing" medication has prompted investigations by other agencies.

A meeting was held with the family of the deceased, the Chief Coroner and several health care professionals to outline where the health care system could be improved and to develop directives to be put in place to ensure that the circumstances regarding her care are not repeated. Several key recommendations were put forward.

CASE # 4

In December 2005, a 27 year old man and a 32 year old man were the operators of a pair of snowmobiles that crashed head on while travelling on a frozen lake. Other snowmobile operators travelling with the men were on the scene within moments and noted no pulse or respiration detected on either victim. RCMP, EMT's and the coroner were notified and representatives from these agencies attended the scene.

Police arrived on the scene and noted a wide spread debris field and two deceased males lying in the snow. Photos were taken of the scene and witness statements were obtained by the police. Damage to the two machines was extensive and was consistent with a high speed head on collision

The bodies of the two men were prepared and transported to the Stanton Territorial Hospital Morgue in Yellowknife where additional photos and examinations were undertaken.

Both snowmobiles were seized along with helmets and other items and debris. The machines would undergo a mechanical inspection to determine their status and operating capability.

It was determined that very little evidence regarding snowmobile tracks or skid marks were discernible or preservable because of the condition of the lake surface due to deep snow and traffic. Therefore a Traffic Collision Analyst was not summoned to the scene, however, one would be utilized later to help determine the operational status of the brakes and lamps of the two machines.

The investigation revealed that the two men were members of a larger group that had been drinking and snowmobiling throughout the late evening and early morning. The conditions at the time of the incident included an extremely dark sky do to overcast and misty conditions with a temperature of - 4 to -9 degrees Celsius

At approximately 4:00 am the group stopped for a few moments. Two of the snowmobilers decided to race across the lake. When they reached the shoreline, the pair swapped machines and took off back in the opposite direction. It was indicated that they were wearing helmets at the time.

The snowmobile that was leading crashed head on with another machine facing in the opposite direction. The driver of the second machine involved in the crash was also believed to be wearing a helmet at the time of the incident.

There was some initial confusion as to whether both machines were in motion at the time of the collision. It was thought that perhaps one may had stopped on the lake and shut his machine off, thereby disengaging the lights. However, a mechanical inspection of the units and the Traffic Collision Analyst's Report indicate that the taillights and brakelights on the snowmobile were on and operational at the time of the collision.

The issue of whether the machine was actually in motion is more difficult to determine. Mechanical tests on one of the machines indicated the speedometer was fixed at 68 miles per hour following the crash. The throttle was engaged as determined by an analysis of the drive belt and clutch.

It could not be determined with any degree of certainty whether or not the other machine was in motion at the time of the impact. In summation, it was concluded that both machines were in good working order, both machines were running at the time of the collision and both drivers were wearing helmets.

Because of the extent of the head injuries, no autopsies were ordered. Toxicology examination and witness statements revealed both deceased had consumed alcohol and were over the legal limit allowed for the operation of a motor vehicle.

Neither driver was reported to have any specific or diagnosed natural medical condition that could have caused or contributed toward the accident

The coroner determined that both drivers died as a result of blunt head trauma suffered in the collision. Acute ethanol intoxication is considered to be a significant contributing factor in the death. The coroner ruled the deaths as accidental.

This tragic incident is the latest in a long line of snowmobile related deaths that occur all too often in the NWT. It remains an issue in the north, that snowmobiles continue to be viewed in a different light than other motorized vehicles.

Drinking and driving or racing on snowmobiles appears to be more socially acceptable in our society than drinking and driving an automobile. The coroner's office contends that part of that perception is the lack of comprehensive snowmobile legislation in the north.

The coroner's office renewed it's recommendation that the GNWT Department of Transportation draft and implement effective and comprehensive snowmobile legislation throughout the NWT.

REPORTING OF DEATHS

Duty to Notify

8. (1) Every person shall immediately notify a coroner or a police officer of any death of which he or she has knowledge that occurs in the Territories, or as a result of events that occur in the Territories, where the death

(a) occurs as a result of apparent violence, other than disease, sickness or old age;

(b) occurs as a result of apparent negligence, misconduct or malpractice;

(c) occurs suddenly and unexpectedly when the deceased was in apparent good health;

(d) occurs within 10 days after a medical procedure or while the deceased is under or recovering from anesthesia;

(e) occurs as a result of

(i) a disease or sickness incurred or contracted by the deceased,

(ii) an injury sustained by the deceased, or

(iii) an exposure of the deceased to a toxic substance, as result or in the course of any employment or occupation of the deceased;

(f) is a stillbirth that occurs without the presence of a medical practitioner;

(g) occurs while the deceased is detained or in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution; or

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

Exception

(2) Notwithstanding subsection (1), a person need not notify a coroner or a police officer of a reportable death where the person knows that a coroner or police officer is already aware of the death

Duty of police officer

(3) A police officer who has knowledge of a reportable death shall immediately notify a coroner of the death.

Special reporting arrangements

(4) The Chief Coroner may make special arrangements with medical facilities, correctional facilities and the Royal Canadian Mounted Police for the efficient notification of reportable deaths by persons in those facilities or that organization.