NORTHWEST TERRITORIES CORONER'S SERVICE 2004 ANNUAL REPORT

OFFICE OF THE CHIEF CORONER

Oct 10, 2005

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 2004 Annual Report for the year beginning January 1, 2004 and ending December 31, 2004.

Yours truly,

Percy A. Kinney
Chief Coroner
Northwest Territories

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

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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 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 35 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 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.

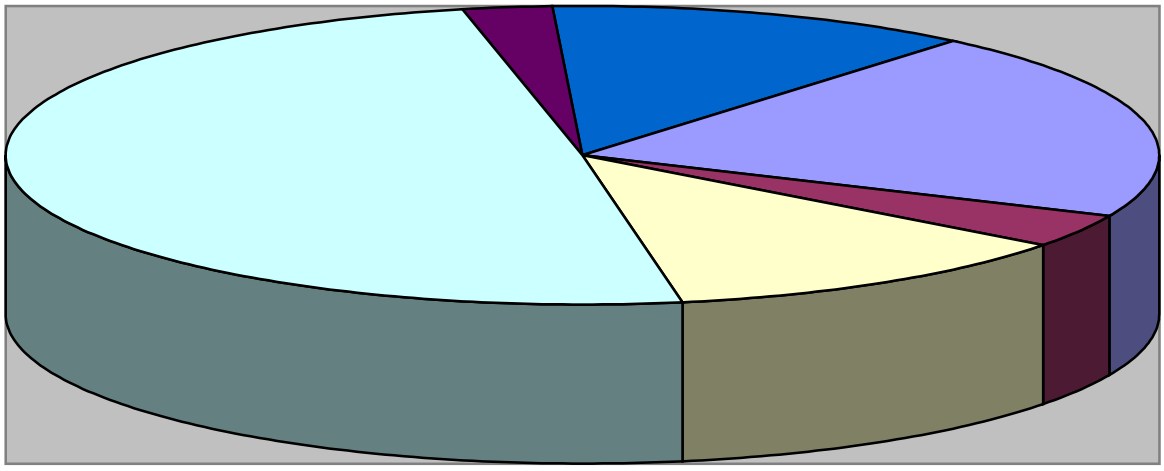
Coroners are instructed to make every effort to classify a death in one of the other existing categories before considering a classification of undetermined.

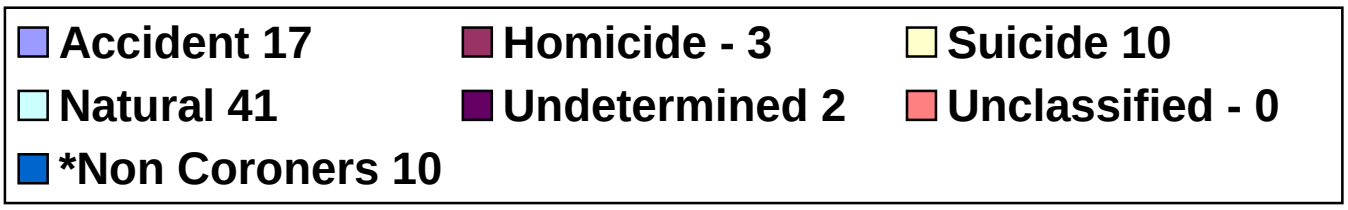
*(**UNCLASSIFIED** is reserved for any case work that ultimately does not result in another classification. It is primarily used for found remains which are analyzed and determined to be non-human.)*

CASE STATISTICS

TOTAL CASES

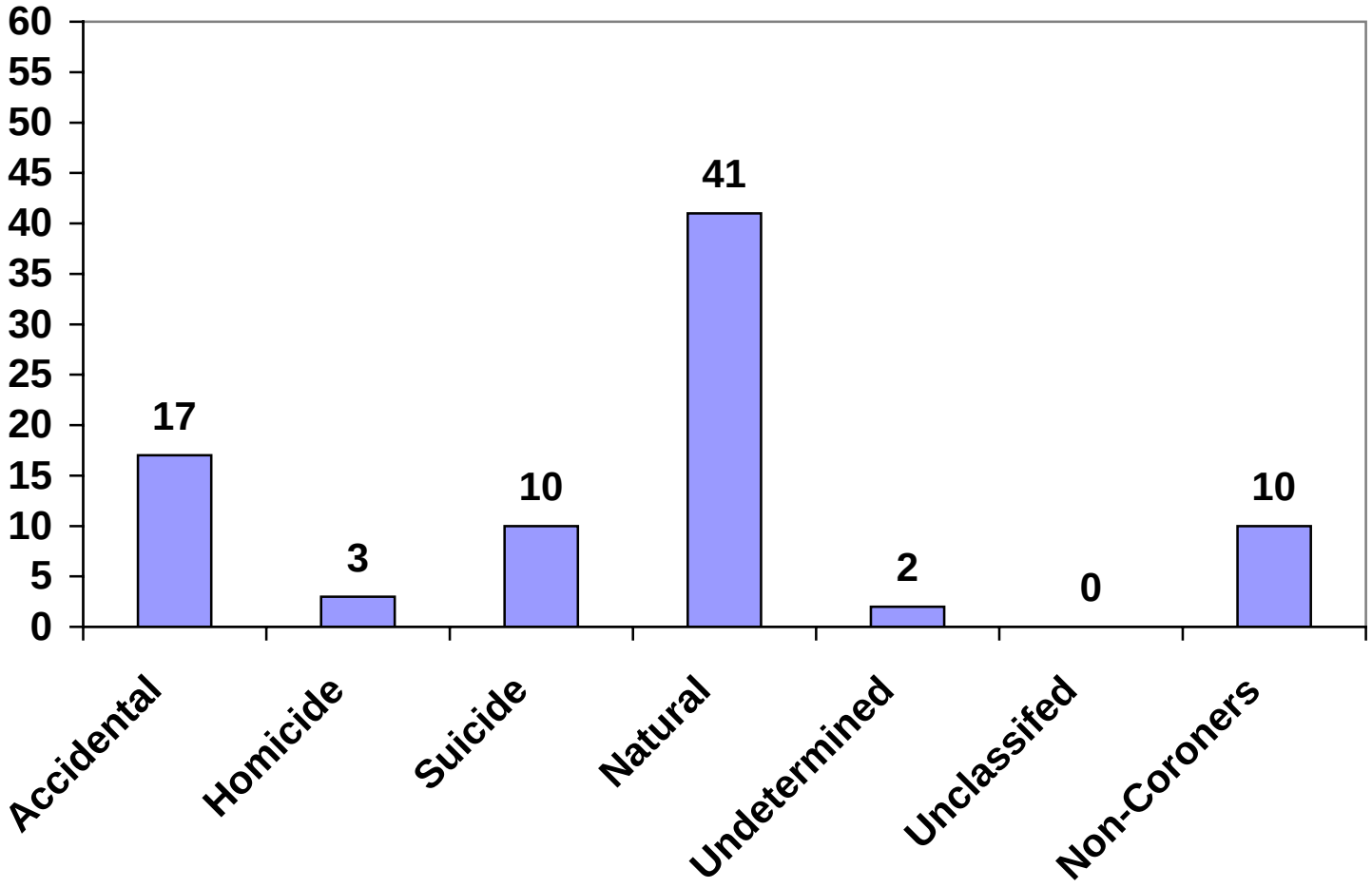
Manner of Death	Number	Percent %	Rate per 100,000
Accidental	17	20.48	0.41
Homicide	3	3.61	0.07
Suicide	10	12.05	0.24
Natural (includes Non-Coroner cases)	51	61.45	1.23
Undetermined	2	2.41	0.05
Unclassified	0	0.00	0.00
TOTALS	**83**	**100.00**	**2.00**





*** 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**

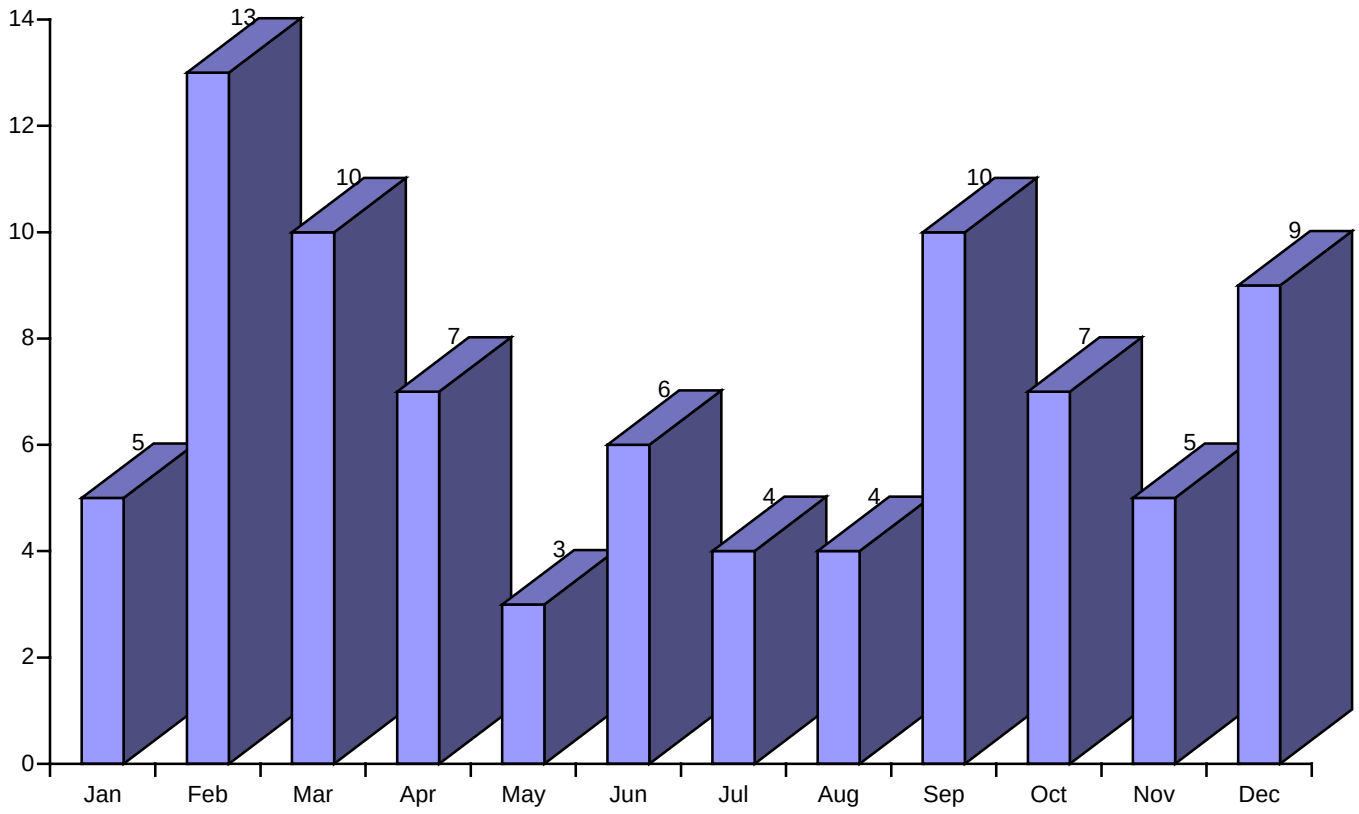
CASELOAD BY MANNER OF DEATH



CASELOAD BY MANNER OF DEATH/COMMUNITY

Community	Accidental	Homicide	Suicide	Natural	Undetermined	Unclassified	Non-Coroners	Total
Aklavik				1			2	3
Deline							1	1
Fort McPherson	1	1	1	1				4
Fort Providence				3			1	4
Fort Simpson				3				3
Fort Smith	3		2	1				6
Gameti				1				1
Hay River	2			1				3
Inuvik	2			7	2			11
Norman Wells	1							1
Rae/Edzo							1	1
Tuktoyaktuk	4							4
Yellowknife	4	2	6	17			4	33
Wha Ti				1				1
Fort Liard				2				2
Fort Good Hope			1	1			1	3
Ekati Minesite				1				1
Dettah				1				1
TOTALS	**17**	**3**	**10**	**41**	**2**	**0**	**10**	**83**

CASELOAD BY MONTH



CASELOAD BY MANNER/MONTH

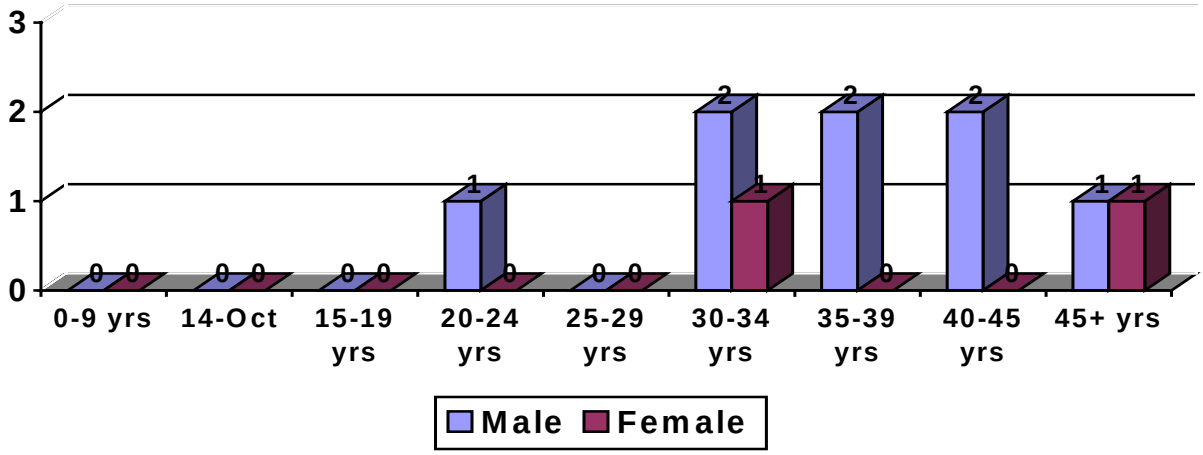
Month	Accident	Homicide	Suicide	Natural	Undetermined	Unclassified	Non-Coroners	TOTALS
January		1	1	1	1		1	5
February	3			8			2	13
March	1		2	6			1	10
April		1	1	4			1	7
May			1	2				3
June	2		1	2			1	6
July	2		1	1				4
August	1			3				4
September	5		1	3	1			10
October	1	1		3			2	7
November				4			1	5
December	2		2	4			1	9
TOTALS	**17**	**3**	**10**	**41**	**2**		**10**	**83**

SUICIDE BY GENDER/AGE

Age Group	Male	Female	Total
0-9 yrs			
10-14 yrs			
15-19 yrs			
20-24 yrs	1		1
25-29 yrs			
30-34 yrs	2	1	3
35-39 yrs	2		2
40-44 yrs	2		2
45 + yrs	1	1	2
TOTALS	**8**	**2**	**10**

Of the 10 suicide deaths in 2003, all but 2 were male, (80%). The greatest number of deaths occurred in persons 35 + years of age.

The suicide rate has remained fairly consistent over the last 4-5 years but remains elevated over the last decade with 12 deaths in 2003, 9 deaths in 2002, 10 deaths in each of 2001 and 2000 as compared to 16 in 1999, 7 in 1998, 6 in 1997, 5 in 1996 and 7 in 1995.

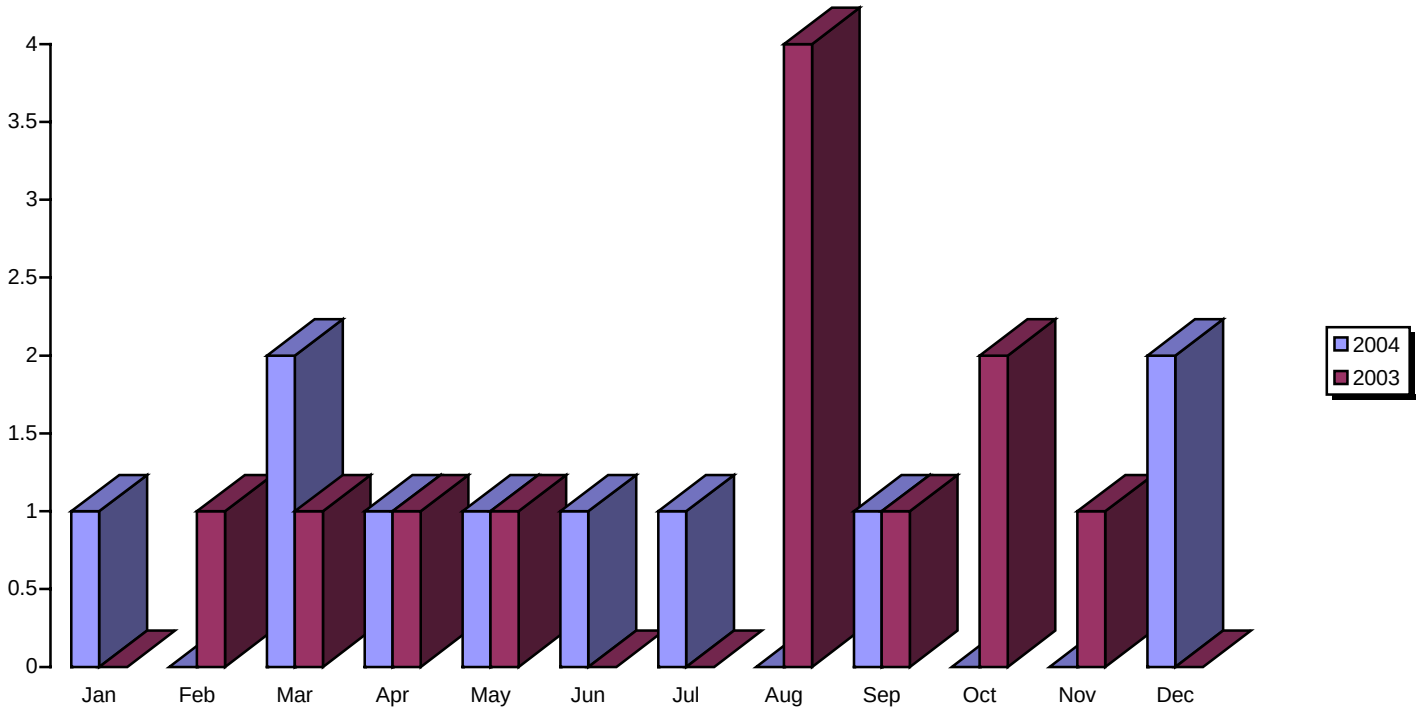


SUICIDES BY MONTH/COMMUNITY/GENDER/AGE/METHOD

Month	Community	Gender	Age	Method	Alcohol
January	Yellowknife	Male	43	Drug overdose	yes
March	Yellowknife	Male	35	Stab wound	no
March	Yellowknife	Male	52	Hanging	yes
April	Fort Smith	Female	32	Hanging	no
May	Fort McPherson	Male	30	Hanging	yes
June	Yellowknife	Male	43	Motor Vehicle Crash	no
July	Fort Smith	Male	39	Carbon Monoxide Poisoning	no
September	Yellowknife	Male	23	Hanging	yes
December	Fort Good Hope	Male	34	Hanging	no
December	Yellowknife	Female	46	Hanging	yes

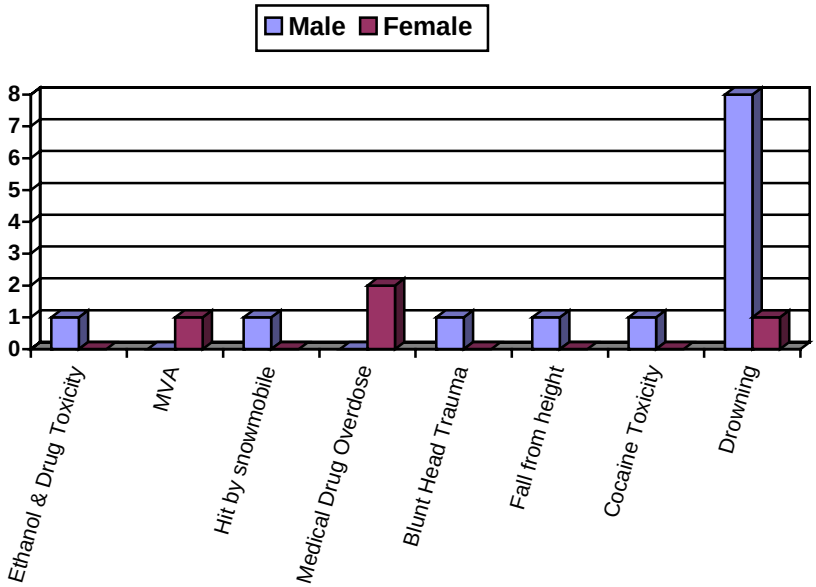
Hanging was the predominant method of suicide accounting for more than half ((6 of 10 = 60%) of all suicides. An overwhelming majority of suicides were conducted by males as compared to females (8-2) Alcohol was involved in half (5 of 10 or 50%) of all suicide cases in 2004.

SUICIDES BY MONTH 2003 - 2004 COMPARISON



JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
1		2	1	1	1	1		1			2	10
10%		20%	10%	10%	10%	10%		10%			20%	100%

ACCIDENTAL DEATH BY CAUSE/GENDER



Cause of Death	Male	Female	Total	Alcohol Related
Ethanol and Drug Toxicity	1		1	1
Motor Vehicle Accident		1	1	
Hit by snowmobile	1		1	
Medical Drug overdose		2	2	
Blunt Head Trauma	1		1	
Fall from height	1		1	1
Cocaine Toxicity	1		1	
Drowning	8*	1	9	1
TOTALS	**13**	**4**	**17**	**3**

Accidental deaths accounted for approximately 20% of all deaths reported to the Coroner's Service in 2004. The majority of the deaths (13 of 17, or 76%) were males.

* 5 of the drowning deaths are presumed with no bodies recovered, therefore alcohol content is not known for these case. Of the remaining 12 cases, alcohol was involved in 3 of them or 25%.

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 no reported deaths by SIDS in 2004. However, there was 1 non-SIDS death of a premature infant of less than 21 weeks gestation.

There was also one stillborn reported to the Coroner's Service in 2004.

NATURAL & NON-CORONER CASES

Natural	Non-Coroner	Coroner
51	10	41

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 will be 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 must occur by a natural disease process.

AUTOPSIES

JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
4	7	5	2	2	2	3	2	3	4	4	4	42

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 42 autopsies were conducted in 2004.

RECRUITING

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 35 Coroners across the Northwest Territories; 13 are aboriginal. There are 23 male (8 aboriginal) coroners and 12 female (5 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, Michael Maggeean,

Deline - William Duke, Elizabeth Takazo

Fort Good Hope - Tommy Kakfwi

Tulita - Edward McPherson

Holman - Gary Lewis

Inuvik - Jamie Lee Carpenter, Maureen Gowans, Gerry Kisoun

Norman Wells - Dudley Johnson, Valerie McGregor

Tuktoyaktuk - Anita Pokiak, Barney Masazumi

Lutselk'e - Emily Saunders

Wha ti - Carolyn Coey-Simpson

Rae - Arnie Steinwand

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

Sachs Harbour - John Keogak

Fort McPherson - Kendra Francis

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

CONTAINING

RECOMMENDATIONS

CASE # 1

In July of 2001, a 27 year old man was working with another 33 year old iron worker on the south side of the new Diamond Processing Plant being constructed at a northern diamond mine site. The two men were working in and operating from a "Grove" rubber tired man-lift to access the side of the building.

The workers were working out of the "basket area" at the top of the extended arm of the man-lift when the unit was seen to tip and fall over on it's side. The two workers, who were fasten into the basket railing by safety harnesses, rode the unit down to the ground where it came to rest on a solid rock outcrop.

Both men were dead on impact. Their helmets were located nearby and appeared to have been knocked off during the impact. Both men had visible and fatal trauma to the head.

The chassis of the man-lift was laying on it's side. The boom and extension appeared to have damage at several points along it's length as it bent and twisted as a result of the impact. The lift and the building were both examined as part of the investigation.

The investigation revealed that the man-lift had been structurally inspected by a crane inspection company and issued a certificate in March of 2001. The unit was then sent to the mine site for operation. The inspection does not include a review of the mechanical or electrical components of the unit.

The daily "Pre Operational Checklist for Man-lifts": used by the workers appeared to be a generic model used for all types of lifts. The man-lift unit used by the deceased had an additional boom which should have required additional review as indicated in the manufacturer's operating manual.

The manual suggests that specific training on each individual model be employed to ensure the safe operation of the unit since some of the controls and operating procedures may vary from unit to unit.

The manual also indicated this particular model had interlocks and/or limit switches designed to minimize the risk of over-extending a boom beyond the vehicle's balance point. The manual also lists the proper method of testing the unit to ensure the interlocks/limit switches are operating properly.

Tests on the equipment following the incident indicated that the basket area of the man-lift was in fact configured or extended outside of the safe working parameter. As the lift was turned toward the wall of the structure, it moved the vehicle's centre of gravity outside of the wheel base of the unit, causing it to fall over. It appears likely that this was possibly due to the failure of the interlock/limit switches on the machine, and/or the mis-alignment/adjustment of those devices.

As a result of the incident, The Mine Safety Division issued a number of Corrective Orders to the employer. The orders referred to issues regarding the proper procedures for operation, inspection and testing of all equipment and the training and verification of competency of workers operating such equipment.

Charges were also laid by the WCB against the employer of the two men for allowing them to operate unsafe

equipment. The charges were later dismissed in court.

The Office of The Chief Coroner further recommended that a certification protocol be developed for the training and competency testing of all workers engaged in the operation of man-lifts and a requirement be developed which stipulates that all personnel operating such equipment be licensed by a recognized sanctioning body.

CASE # 2

In October of 2001, a 49 year old man was the owner/pilot of a McDonnell-Douglas 369HS helicopter that crashed approximately 7 miles from the Fort Simpson airport while approaching for a landing at a nearby helipad. A lone passenger in the aircraft survived the crash with serious but non-life threatening injuries. Both occupants were wearing the available lap and shoulder harnesses at the time of the impact.

RCMP, the local coroner and the Transportation Safety Board (TSB) were notified and attended to the scene to investigate.

The investigation revealed that the helicopter was returning to Fort Simpson from a hunting camp. The trip was a VFR (visual flight rules) flight and the weather was suitable for a VFR flight with the local temperature approximately 8° C. The aircraft left the hunting camp at approximately 4:00 pm.

Just before 7:00 pm and approximately 25 miles from the airport, the pilot noticed that the fuel gauge was showing more fuel than anticipated given the length of the trip. He began to follow a cut line and then a roadway so that the helicopter would be in a better position to make a forced landing if required.

As the aircraft approached the Fort Simpson Airport, the engine on the helicopter flamed out due to fuel starvation even though the gauge indicated there was still fuel remaining in the main fuel tank. The pilot attempted a forced landing on a nearby road but the aircraft struck some trees and fell to the ground landing on the pilot's side of the helicopter.

The examination of the aircraft showed that the main fuel tank contained only a small amount (2-3 cups) of fuel, but the auxiliary tank was at near capacity at 132.5 pounds of fuel. The open/close valve on the tank was noted to be damaged and in the closed position.

The post mortem revealed that the deceased had lethal internal injuries. Toxicology was negative for the presence of any alcohol, intoxicating drugs or elevated levels of carbon monoxide.

Transport Canada issued a safety information letter to ensure that operators are aware of the requirement to complete any modifications which are undertaken. In addition, the operator of the company which engaged the owner/pilot advised that they will place additional warning notices advising pilots that auxiliary fuel switches should be engaged at no less than 100 pounds of fuel.

An additional concern was noted during the investigation regarding the monitoring of the helicopter's ELT signal. The ELT functioned as required and began omitting a radio signal that was picked up by the search and rescue satellite (SARSAT) and monitored by the Department of National Defence's Rescue Co-ordination Centre in Trenton, Ontario. However, the local Community Aerodrome Radio Station (CARS) at the Fort

Simpson Airport was unable to receive the signal which was well within the 15 nautical mile mandatory frequency area. Subsequent tests confirmed that the local CARS was unable to receive the 121.5 MHz signal.

A recommendation was made by The Office of the Chief Coroner to Transport Canada to ensure that the CARS in Fort Simpson will be upgraded so that it has the capacity to receive and monitor ELT transmissions within the 15 nautical mile limit as required.

CASE # 3

In February of 2002, a 38 year old man was repairing a snowcat (a large tracked vehicle) on an ice road with another man when both were struck by a tractor-trailer unit that was approaching from the opposite direction. The other worker suffered minor injuries but the decedent received significant head trauma.

The coroner's office, RCMP, members of the WCB and the National Energy Board were notified and attended.

Because of the obvious trauma and nature of the injury, no autopsy was ordered. Fluid samples were obtained for toxicology examination which revealed there was no alcohol or intoxicating drugs detected.

The two workers were repairing the snowcat which was parked off to the side of the ice road. They had parked their pickup truck beside the snowcat further out from the side of the ice road (the road is about 40 metres wide). The pick up truck was facing traffic with the headlights on. The workers were using the headlights to partially light the work area where they had attached booster cables from the pickup truck to the snowcat.

It appears that as the tractor trailer approached, the driver attempted to pass to the right of the pickup truck which would put him on a collision course with the snowcat. The lights of the pickup truck may have hampered the driver's ability to see the snowcat and the two workmen. Police noted the pick up's headlight were on in the "highbeam" mode when they arrived at the scene. There is no evidence of braking or swerving by the tractor trailer unit.

The conditions at the time of the incident included darkness, clear skies but blowing snow with wind at approximately 30 kph and an ambient temperature of about - 40 C. The roadway at the location of the incident was straight, flat and slippery.

The deceased was not wearing any reflective clothing or markings and there were no warning flares or markers posted for observation by approaching vehicles.

The WCB laid several charges against 3 of the companies involved in the incident. All charges were later stayed.

A number of directives and recommendations were issued by the controlling agencies in regards to operational and other various concerns.

The Office of The Chief Coroner also recommended that each company involved undertake an independent audit of their safety practices and protocols in an effort to ensure that their current policies and procedures are practical, appropriate and sufficient for the work type and conditions that northern workers commonly experience

The coroner in this case made a recommendation to the company employing the workers that they consider adopting the same safety rules and regulations currently in use by the GNWT Department of Transportation while working or driving on ice roads.

CASE # 4

In June of 2003, this 32 year old female teacher with a history of asthma and hypothyroidism was seen to collapse suddenly in her classroom and become unresponsive. Co-workers came to her aid and began resuscitation efforts. The local nurse was contacted and she instructed that the woman be transported to the health centre.

The decedent was taken to the health centre where resuscitation efforts continued to no avail. A doctor arrived from Inuvik and directed the administration of the medical care. The woman was pronounced dead approximately 3 hours following her collapse.

RCMP and the coroner's office were notified of the death. RCMP and a coroner from Inuvik attended to the community and began an investigation.

The deceased has a history of asthma and used a "puffer" (i.e. inhaler) on occasion for the condition. She was also recently diagnosed with a hypothyroid condition and was placed on medication approximately 5 days before her death.

At autopsy, no injuries or natural disease processes could be identified to account for the death. There was no evidence that she had suffered a sudden lethal asthma attack (i.e. over inflation of lungs or mucous plugged airways).

There was evidence consistent with a history of mild asthma (i.e. microscopic changes in lung tissue).

The thyroid gland contained conditions consistent with a diagnosis of Hashimoto's thyroiditis which was not considered to be the cause of death. The post mortem thyroid hormone level was within the normal range. Toxicology tests found no evidence of alcohol or intoxicating drugs.

The autopsy, including toxicology and microscopic examination of all major organs and tissues failed to reveal a definitive cause of death. The death was deemed to be natural but from an unknown cause.

A number of concerns were raised regarding the circumstances which occurred after the collapse of the deceased at the school. Much of the concern was focussed around the issue of response by the local health personnel, their protocols, equipment and it's condition and operation.

The Office of the Chief Coroner made a number of recommendations to the GNWT Department of Health and the local Health Services Board. Among them was the need to develop and implement a protocol to assist community nurses in evaluating an appropriate response to a local emergency. The protocol developed should be flexible enough to allow nurses to use their own judgement and experience as part of the evaluation process.

The agencies should also help develop a general Medical Emergency Response Plan in consultation with municipal authorities. The plan could be based on any existing local emergency disaster plan in place and could provide for a list of resources available and the procedure to be used for quick access to those resources for emergency medical response.

Every centre should be equipped with a portable defibrillator unit and those with oxygen capability must also be provided trained in the operation and maintenance of the infrastructure. This should include not only the tools to maintain operation but a protocol for regular checks and tests of the systems to ensure it's preparedness in an emergency.

A Review should be undertaken of each community's portable equipment list to ensure that each is adequately prepared for emergency response on scene.

Physicians responding to a community crisis should be equipped with a SAT phone or other communication device along with a protocol for receiving patient information to maximize their immediate participation on arrival.

In addition, it was felt that the municipality should ensure all municipal employees are offered CPR training on a regular basis. Part of the training program should be the development and wide distribution of a list of those trained in the procedure

It was also felt that employees at the education venues should be offered similar CPR training.

CASE # 5

In December of 2003, this 47 year old male pilot with a history of hypertension was found slumped over in the front seat of his truck after it had come to a stop following an erratic path while on the airport tarmac.

Co-workers and witnesses removed him from the vehicle, began CPR and called for an ambulance. Airport firefighters arrived at the scene and provided resuscitation efforts until the ambulance arrived a short time later. The deceased was transported to the hospital where he was later pronounced dead by the attending physician.

RCMP and the coroner were notified of the death and began an investigation which revealed that the man had just arrived for work that morning. He had driven his truck over to one of the planes to drop off a package.

As he drove away, co-workers noted the vehicle to be moving erratically and indicated that it had sideswiped at least two parked aircraft. When the vehicle came to a stop, the man was found unresponsive inside. He had been complaining for a few weeks of pain in his chest and left arm. He had also undergone an EKG recently which showed an abnormality and the readings were under review.

Earlier that morning while at home, he went outside to shovel snow and had complained about severe chest pain. It was suggested that he go to the hospital but he elected to report to work instead.

A review of his medical file indicated he suffered from hypertension (i.e. high blood pressure) and was taken medication regularly to treat the condition. He also had a family history of heart problems.

Given the circumstances, no autopsy was ordered but fluid samples were obtained for toxicological examination. Toxicology tests indicated no evidence of alcohol or intoxicating drugs

The Coroner determined that the deceased died as a result of a probable myocardial infarction (i.e. heart attack) as a result of long standing atherosclerotic cardiovascular disease. His hypertension was considered to be a contributing factor in the death.

The Office of The Chief Coroner made a recommendation to the GNWT Department of Transport suggesting that all airport fire and rescue departments be equipped with portable defibrillator units. Airport rescue staff should also be properly trained in the operation of the units.

CASE # 6

In May of 2003, this 52 year old man was noted to have shallow breathing while resting from a trip into the woods. His condition deteriorated until he was minus any vital signs. RCMP and the coroner attended to the scene and began an investigation.

The man was laying on his back on a bed of branches. He was covered with a light sleeping bag. The decedent was fully clothed with the exception of his boots which were noted to be laying nearby. A camp fire was also noted to be burning nearby.

The investigation revealed that the deceased and two other men were dropped off at a roadside bush trail approximately 17 miles from Yellowknife. It was their intention to walk into a local tourist camp approximately 6 miles inland. The deceased had been drinking in a local bar earlier in the evening and had joined the others in the trip in the hopes of securing employment as a guide at the lodge.

En route through the trail, the decedent started to complain that he was cold and was having difficulty walking. At some point along the trail he stumbled in a bog area and proceeded to get his feet and socks wet.

The trio elected to camp for the night and the decedent was placed on a bed of tree boughs and covered with a light sleeping bag. His boots were removed in an attempt to dry them near the fire.

In the early morning it was noted that he was suffering from laboured breathing. One of the men he was with continued on to the camp to request assistance be sent out by helicopter.

There was some difficulty in locating the campsite during the initial flight of the helicopter. A subsequent flight was required to locate the decedent.

At autopsy, there were markings consistent with injuries produced by exposure to the cold. There were no natural disease processes and no further injuries present to cause or contribute toward the death.

Toxicology tests revealed an intoxicating level of alcohol in the samples provided. It is important to note that the blood alcohol level would have been significantly higher when the decedent began his trek into the bush several hours earlier.

It was determined that the man died as a result of cold exposure and that alcohol intoxication was a contributing

factor in his death.

There was some confusion and concern in regards to the initial medivac helicopter flight that was undertaken. The information provided demonstrated that the procedures and protocols used when activating a helicopter based medivac were in need of review, therefore, the coroner made a recommendation for the drafting and implementation of a policy and procedure that will allow for a simple, quick and responsive dispatch of medical helicopters when required.

CASE # 7

In May of 2003, this 44 year old woman was in a canoe with a male friend when the canoe tipped over and deposited both into the frigid water. She was unable to extricate herself and succumbed to the cold temperature.

The three remaining individuals at the camp were unable to summon assistance and the incident was not reported to the RCMP until a helicopter arrived a day late to transport the party back to the community. The body had been placed in a nearby cabin during the wait.

RCMP and the local coroner attended to the scene by helicopter. The body was laying in a nearby cabin and appeared to have been redressed in clean, dry clothes.

The witnesses told police that after arriving at the location, they began working to open the camp for the season. They were drinking during the evening and then went to sleep.

The next morning, the work continued and the deceased and a companion decided to go down to the riverside and it was suggested that the two take out a canoe. Although they had no life jackets, they decided to continue

They paddled up the river but found the way blocked by willows so they reversed their path and continued into the mouth of the river which was in the process of spring break up. They continued to travel to the ice edge where the man attempted to step out onto the ice floe. As his foot fell through the ice, the canoe tipped over sending both individuals into the cold water.

The two initially held onto the overturned canoe and called for help. They tried to swim over to the nearest shore Another member of the party had heard their calls for help and had come down to the shore and noted the pair were in trouble. He entered the water and swam over to an area near an ice floe in an attempt to get nearer to the decedent who continued to struggle in the water. The other camper eventually made it to a nearby shore line.

The rescuer saw the woman go under a small ice pad at which point he ran across it to the other side and pulled her out when she surfaced. He attempted CPR in an effort to start her breathing which he said appeared laboured and shallow. He retrieved the canoe, placed her in it and returned to the shoreline. He summoned the forth party member to assist him in the resuscitation efforts but to avail. He then used the canoe to retrieve the other man on the far shore.

They transported the woman back to the camp site, redressed her (she had lost some of her clothing during the ordeal) and secured her in a nearby cabin. They then waited for the helicopter to return.

At autopsy, there were abrasions on the surface of the body consistent with dragging her over candle ice during the rescue. There were no other injuries present that could cause or contribute toward death. There was significant narrowing of the arteries which supply the heart (i.e. atherosclerotic coronary artery disease) which may have limited her ability to respond effectively during the crisis.

Toxicology examination indicated an intoxicating level of alcohol in the blood. The coroner determined that the woman died as a result of cold water immersion It was felt that acute alcohol intoxication and atherosclerotic coronary artery disease were contributing factors in the death.

Two main issues came to light during this investigation. One deals with the delay in retrieving the individuals from the remote location and the other deals with the supplies the group was equipped with.

The Office of the Chief Coroner made a recommendation to the local land corporation who sponsored the trip that they ensure members are properly equipped with life jackets, first aid packs, communications equipment and additional food in case of delays.

They were also requested to develop and enforce a strict no alcohol policy on sponsored trips.

The local helicopter company was requested to review and adapt as required any policy regarding the pickup and delivery of personnel to ensure that they are picked up and transported according to the schedule. It is suggested that a computer based system be put in place that will inform base operators of scheduled pick ups and departures.

CASE # 8

In April of 2004, this 32 year old woman with a history of drug and alcohol abuse 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.

Staff called the RCMP who attended to the scene. The Office of the Chief Coroner took jurisdiction over the case from Yellowknife.

The investigation revealed the decedent had a history of drug and alcohol abuse. She had attempted suicide by pills several years earlier. The decedent went 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 the Fort Smith Hospital the next day.

Arrangements were made for her to attend to a treatment program at Poundmaker's Lodge in Alberta. The lodge has certain requirements for admittance. It is not a detoxification centre and clients must have been sober for at least 72 hours. 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 lodge is slatted for certain days. The woman was scheduled to be sent to the lodge on April 14th after completing all of the requirements.

An 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 decedent 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 the woman about every 15 minutes until approximately 3:30 am when she appeared to be sleeping. She was found deceased a half hour later.

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

No autopsy was ordered but samples were taken for toxicology examination. The tests revealed there was no alcohol in the sample provided. A metabolite of Benzodiazepine (Desmethyldiazepam) was detected in the urine sample along with Metoclopramide.

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 this patient

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 her 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 Office of The Chief Coroner supports all of the recommendations and urges the parties involved to strongly consider their implementation.

In addition, the Office of the Chief Coroner made 3 recommendations to the GNWT Department of Health and the local health authority. It was suggested that the health authority conduct an audit of the facility to identify

potential hazards which may facilitate suicide.

The Department of Health and Social Services was encouraged to 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.

In addition, the Office of The Chief Coroner renewed it’s recommendation that the Department develop and implement a plan for a properly equipped and staffed alcohol and drug detoxification centre in 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.