

**NORTHWEST
TERRITORIES
CORONER'S SERVICE
2002 ANNUAL
REPORT**



OFFICE OF THE CHIEF CORONER

May 9, 2003

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 2002 Annual Report for the year beginning January 1, 2002 and ending December 31, 2002.

Yours truly,

Percy A. Kinney
Chief Coroner
Northwest Territories

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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 “crownor,” 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 work.

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 supervises investigations. Currently, there are 35 appointed "fee for service" 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 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 the deceased came to their death. The 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. He was reappointed as Chief Coroner by the Minister of Justice, the Honourable Roger Allen in April of 2002. His current appointment is for three years.

The Deputy Chief Coroner is Cathy Menard. Ms. Menard is a long time justice employee and began her work at the coroner's office in February of 1996.

There are no facilities in the Northwest Territories to perform a post mortem. When an autopsy is required, the body is transported to Edmonton for the post mortem examination. Following the post mortem, the remains are sent to Foster & McGarvey 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. Currently efforts are underway to secure contracts with all facilities involved with the NWT Coroners Service.

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.

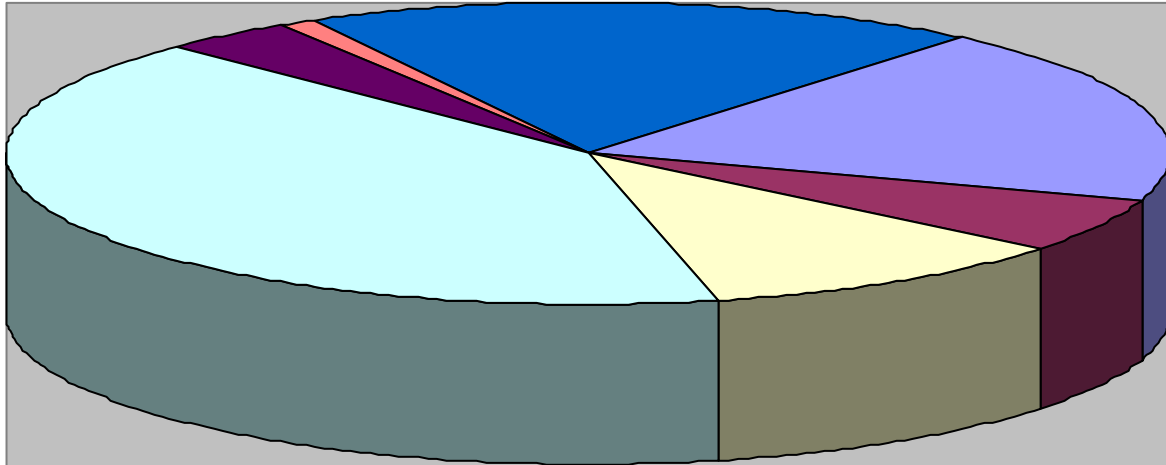
(UNCLASSIFIED is reserved for any case work that ultimately does not result in another classification. It is primarily used for found remains which are analyzed and determined to be non-human.)

CASE STATISTICS

TOTAL CASES

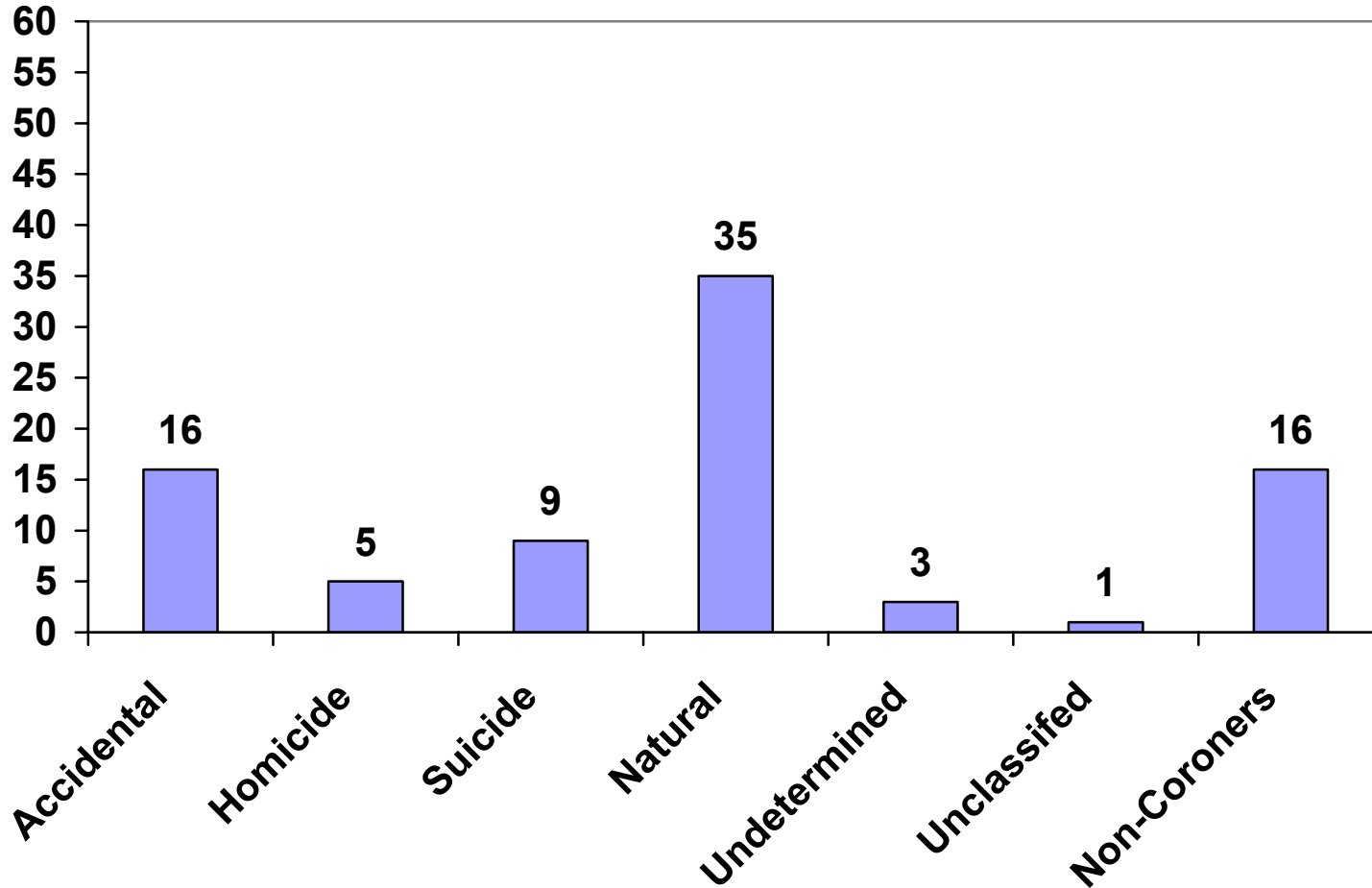
Manner of Death	Number	Percent %	Rate per 100,000
Accidental	16	18.82	0.38
Homicide	5	5.88	0.12
Suicide	9	10.59	0.21
Natural (includes Non-Coroner cases)	51	60.00	1.21
Undetermined	3	3.53	0.07
Unclassified	1	1.18	0.02
TOTALS	85	100.00	2.01

Based on population of 42,035. (Estimate - GNWT Bureau of Statistics)



Accident - 16	Homicide - 5	Suicide - 9
Natural - 35	Undetermined - 3	Unclassified - 1
Non-Coroners - 16		

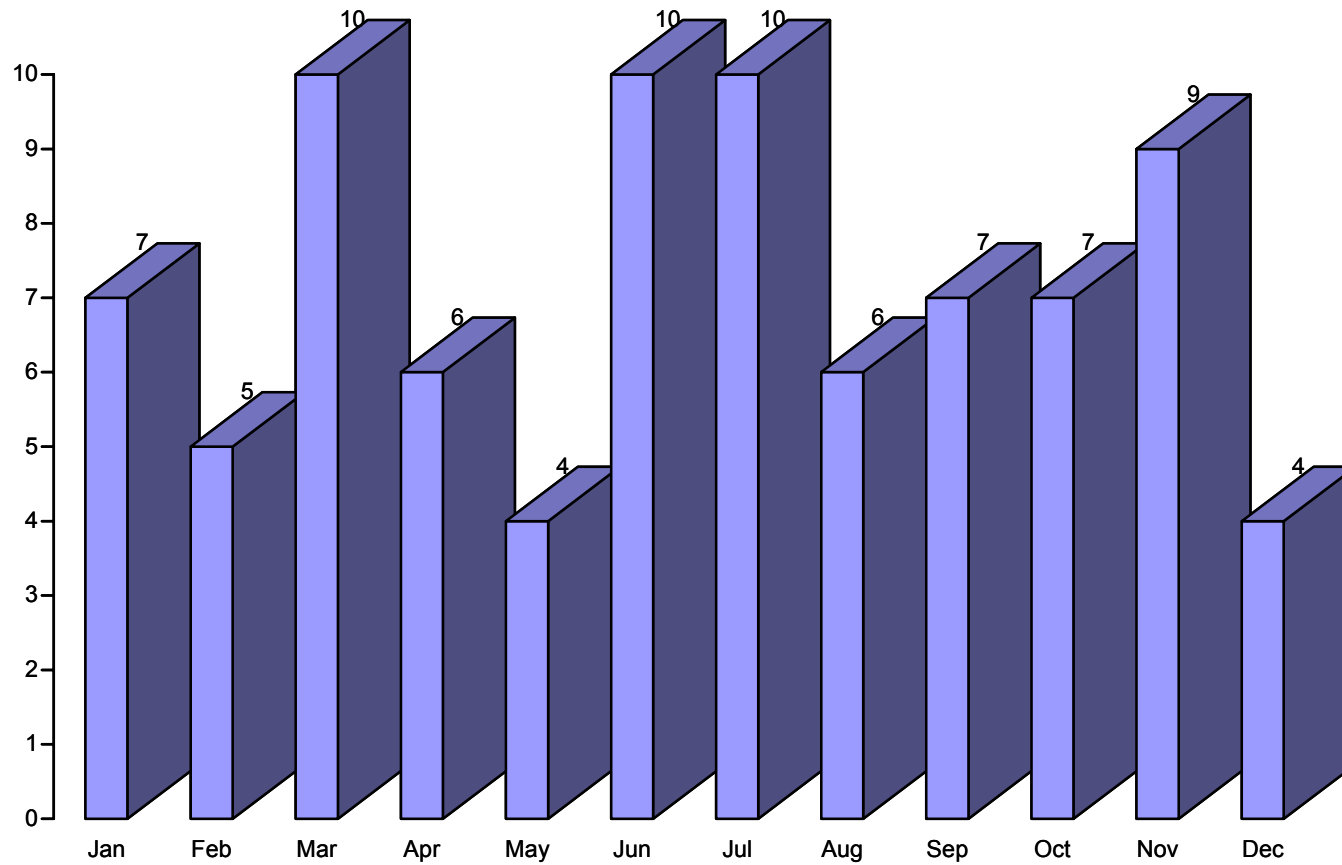
CASELOAD BY MANNER OF DEATH



CASELOAD BY MANNER OF DEATH/COMMUNITY

Community	Accidental	Homicide	Suicide	Natural	Undetermined	Unclassified	Non-Coroners	Total
Aklavik	3	0	0	0	0	0	0	3
Deline	0	0	1	0	0	0	1	2
Fort McPherson	1	1	0	1	0	0	0	3
Fort Providence	0	0	0	3	0	0	0	3
Fort Simpson	0	0	0	1	0	0	1	2
Fort Smith	1	0	1	3	0	1	0	6
Fort Resolution	0	0	0	1	0	0	0	1
Gameti	0	0	0	0	0	0	1	1
Hay River	0	1	0	3	1	0	0	5
Holman	1	0	0	0	0	0	0	1
Inuvik	1	0	2	4	0	0	2	9
Norman Wells	1	0	0	1	0	0	0	2
Paulatuk	0	0	0	0	2	0	0	2
Rae/Edzo	1	1	0	1	0	0	1	4
Snowbird Rapids	0	0	0	1	0	0	0	1
Tsiigehtchic	0	0	0	0	0	0	1	1
Tungsten Mine	0	0	0	1	0	0	0	1
Tuktoyaktuk	2	0	1	0	0	0	1	4
Wrigley	1	0	0	0	0	0	0	1
Yellowknife	4	2	4	15	0	0	8	33
TOTALS	16	5	9	35	3	1	16	85

CASELOAD BY MONTH



CASELOAD BY MANNER/MONTH

	Accident	Homicide	Suicide	Natural	Undetermined	Unclassified	Non-Coroners	TOTALS
January	2*	1	1	2	0	0	1	7
February	1	0	0	3	0	0	1	5
March	2	0	3	4	0	0	1	10
April	1	0	0	4++	0	0	1	6
May	1	0	0	2	0	0	1	4
June	0	1	0	5	1+	0	3	10
July	3	1	0	1	2+	0	3	10
August	0	0	2	3	0	0	1	6
September	3	0	0	1	0	0	3	7
October	2	0	0	3	0	1	1	7
November	1	2**	3	3	0	0	0	9
December	0	0	0	4	0	0	0	4
TOTALS	16	5	9	35	3	1	16	85

* One case was a Northern Alberta Death where the NWT Coroner's Service assisted.

** One death occurred in Alberta following medical transportation.

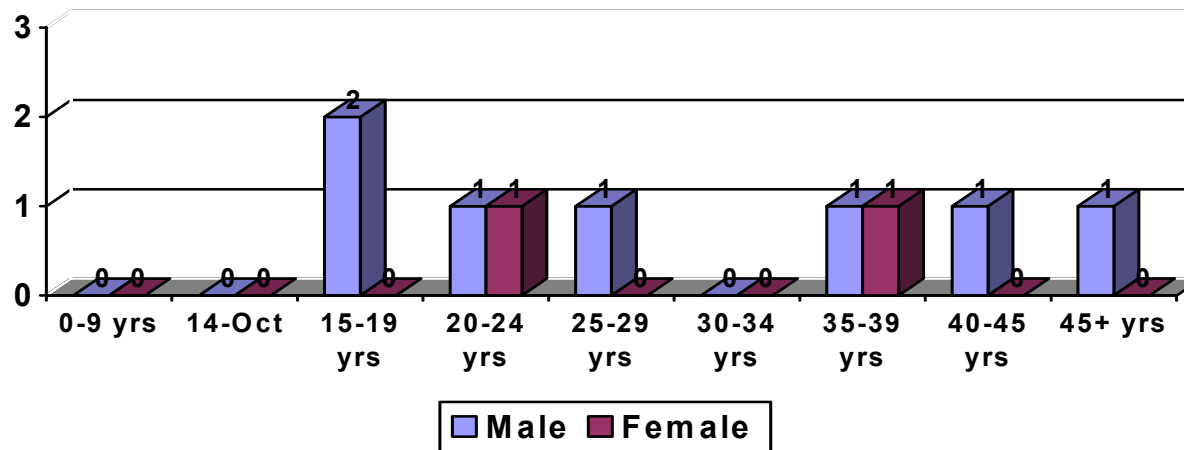
+ Deaths where from found partial human remains where the cause of death is unknown.

++ One death occurred in the Yukon following medical transportation.

SUICIDE BY GENDER/AGE

	Male	Female	Total
0-9 yrs	0	0	0
10-14 yrs	0	0	0
15-19 yrs	2	0	2
20-24 yrs	1	1	2
25-29 yrs	1	0	1
30-34 yrs	0	0	0
35-39 yrs	1	1	2
40-44 yrs	1	0	1
45 + yrs	1	0	1
TOTALS	7	2	9

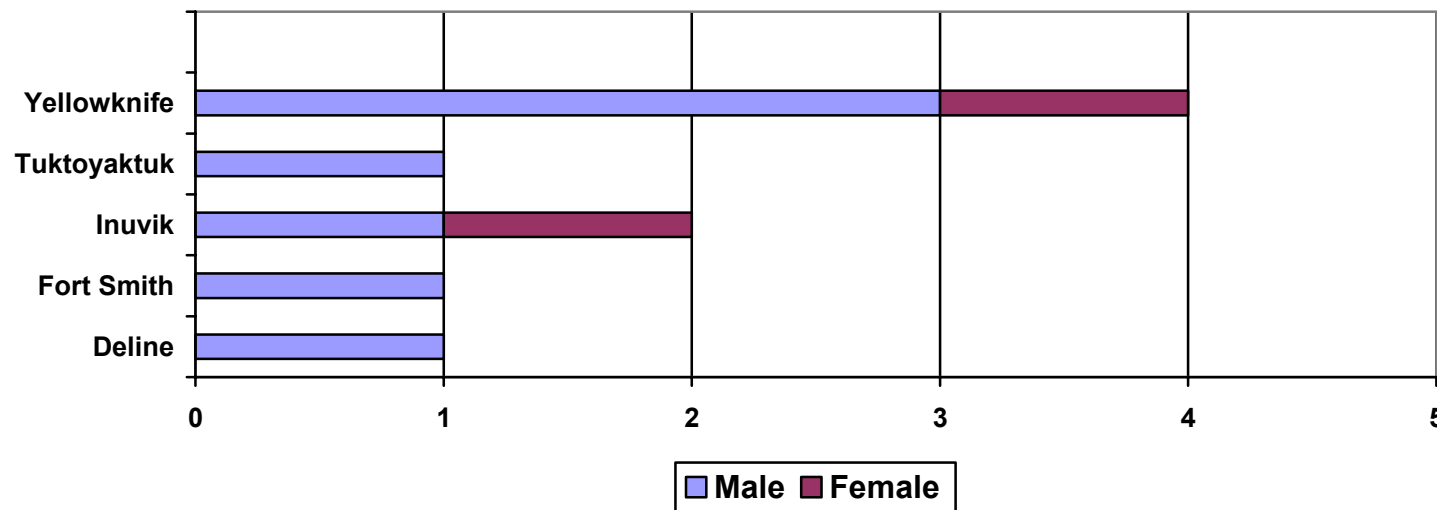
Of the 9 suicide deaths in 2002, 78% were males. The greatest number of deaths occurred in the following age brackets: 15-19, 20-25 and 35-39 years of age. The suicide rate has remained fairly consistent over the last 3 years but remains elevated over the last decade with 10 deaths in each of 2001 and 2000 as compared to 16 in 1999, 7 in 1998, 6 in 1997, 5 in 1996 and 7 in 1995.



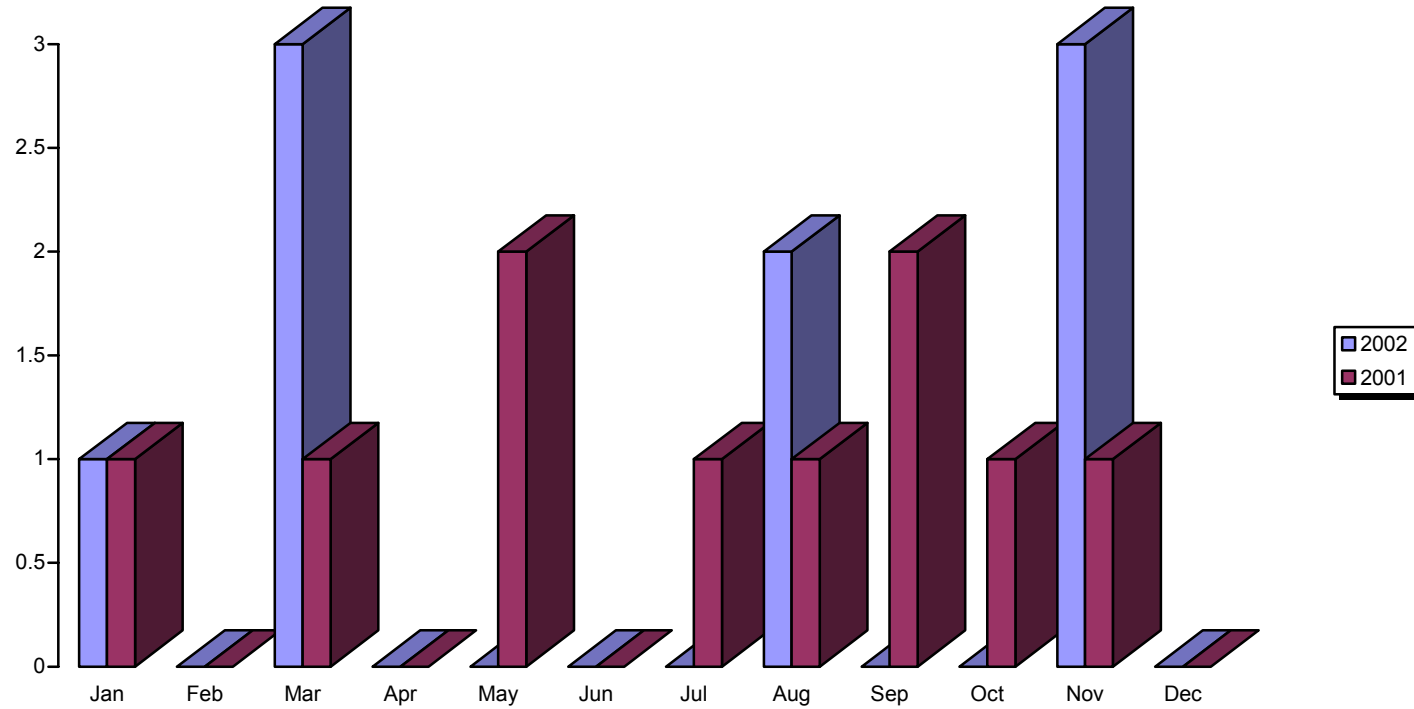
SUICIDES BY MONTH/COMMUNITY/GENDER/AGE/METHOD

Month	Community	Gender	Age	Method	Alcohol
January	Yellowknife	Male	18	Hanging	No
March	Yellowknife	Male	36	Firearm	No
March	Yellowknife	Female	36	Overdose	No
March	Deline	Male	44	Firearm	Yes
August	Inuvik	Female	20	Hanging	Yes
August	Fort Smith	Male	20	Hanging	Yes
November	Tuktoyaktuk	Male	15	Firearm	No
November	Inuvik	Male	74	Hanging	No
November	Yellowknife	Male	26	Hanging	No

Hanging was the predominant method of suicide. An overwhelming majority of suicides were conducted by males (7 to 2) as compared to females. Alcohol was involved in 3 of the 9 cases in 2002. (33%)

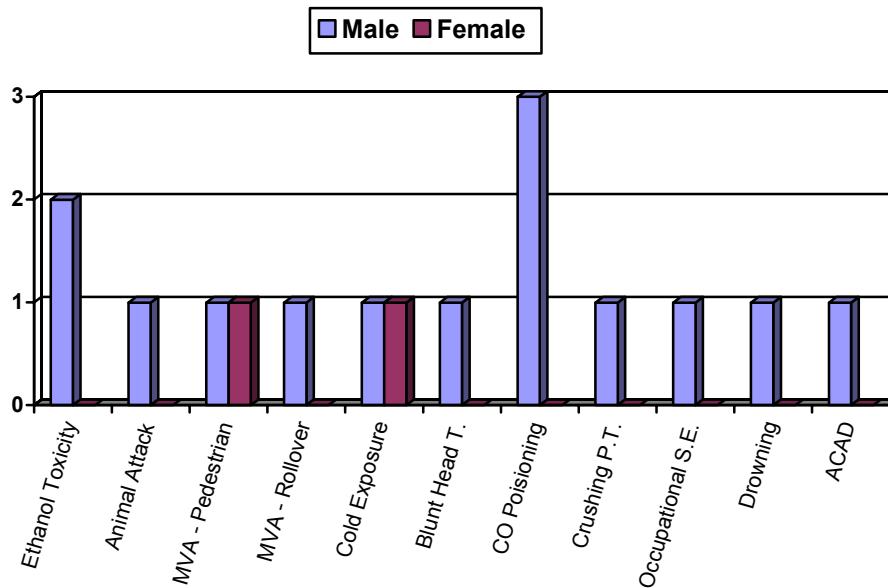


SUICIDES BY MONTH - 2001-2002 COMPARISON



JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
1	0	3	0	0	0	0	2	0	0	3	0	9
11%	0%	33%	0%	0%	0%	0%	22%	0%	0%	33%	0%	99%

ACCIDENTAL DEATH BY CAUSE/GENDER



Cause of Death	Male	Female	Total	Alcohol Related
Ethanol Toxicity	2	0	2	2
Animal Attack	1	0	1	0
MVA - Pedestrian	1	1	2	0
MVA - Rollover	1	0	1	0
Cold Exposure	1	1	2	1
Blunt Head Trauma	1	0	1	1
Carbon Monoxide	3	0	3	0
Crushing Pelvic Trauma	1	0	1	0
Occupational silica exposure	1	0	1	0
Drowning	1	0	1	0
Atherosclerotic Coronary Artery Disease	1	0	1	0
TOTALS	14	2	16	4

Accidental deaths accounted for approximately 19% of all deaths reported to the Coroner's Service. The majority of the deaths (14 of 16 = 88%) were males.

Alcohol was involved in 4 of the 16 (25%) accidental deaths.

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 2002. However, there was 1 non-SIDS death of a child under 1 year of age in 2002 which was classified as accidental.

Also of concern in infant deaths is the common practice of family members sharing the same bed. In some rare cases this practice can lead to overlaying, where an infant may be smothered.

NATURAL & NON-CORONER CASES

Natural	Non-Coroner	Coroner
50	16	34

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.

POST MORTEMS

JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
2	1	5	3	2	4	4	2	3	4	3	1	34

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 post mortem may also be a means of determining the identity of the deceased.

A total of 34 post mortems were conducted in 2002.

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 Chief Coroner, 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 Hamlet/Town/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; 11 of which are aboriginal. There are 23 male (6 aboriginal) coroners and 12 female (4 aboriginal) coroners.

The Coroners and the communities they reside are as follows:

Fort Liard - Alan Harris

Fort Smith - John Herring, Peter Shaw, Pat Burke, Sandy Napier, Murray Scott

Hay River - Don Tourangeau, Bruce Sutherland, Doug Swallow, Heather Johnson

Deline - Kelvin Dolphus

Fort Good Hope - Ron Pierrot

Tulita - Edward McPherson

Holman - Parry Cowan

Inuvik - Jamie Lee Carpenter, Maureen Gowans, Danny Horassi, Gerry Kisoun, Cheryl Sharpe

Norman Wells - Dudley Johnson

Paulatuk - Keith Dodge

Tuktoyaktuk - Anita Pokiak

Lutsel k'e - Emily Saunders

Wha ti - Carolyn Coey-Simpson

Rae - Arnie Steinwand

**Yellowknife - Beth-Ann Williams-Steinwand, Garth Eggenberger, Jennifer Eggenberger,
Wendy Eggenberger, Roland Gosselin, Laurell Graf, Fred Whittlinger, Percy
Kinney, Cathy Menard**

Vancouver - Larry Campbell

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's 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 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 preventable death; or
- d) inform the public of dangerous practices or conditions in order to avoid preventable deaths.

If a coroner determines that an inquest is not necessary, the next of kin or another interested person may request that an inquest be held. The Coroner shall consider the request and issue a written decision. This 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.

One inquest was held in the Northwest Territories during this reporting period. A synopsis of the procedures and the jury verdicts are attached. (See Appendix "B")

APPENDIX “A”

SUMMARY OF CORONERS’

REPORTS CONTAINING

RECOMMENDATIONS

CASE # 1

This 23 year old man died in hospital after his clothing got caught in the auger pipe of a seismic drill rig which he was working on. His co-worker, who was not at the controls at the time, noticed the victim was entangled in the unit. He managed to release him from the machine and called for assistance on the radio.

An ambulance and a helicopter were dispatched to the area. The co-worker assisted the victim into the cab of the drill rig and departed the scene to meet with the emergency vehicles at a crossroad. Upon arrival at the crossroad a medic performed an initial assessment of the man's condition. He was fitted with a cervical collar, placed on a backboard and transferred to the medical vehicle.

While in the vehicle the medic asked the victim what had happened. He responded that he was adding the drill bit (lead rod) and operating the controls while the driller was working elsewhere. He stated that he was caught by the rotating drill in chest area.

The deceased was transferred to a helicopter for the flight to Inuvik. The helicopter landed on the road by the hospital and the victim was quickly taken into the facility.

Emergency medical procedures continued while an arrangement was made for a medivac to Edmonton. The victim's condition continued to deteriorate and he was pronounced dead at 14:56. The cause of death was determined to be compressional asphyxia

The drill rig had been inspected by company personnel prior to the incident and found to be in proper working condition. Two separate inspections were performed on the equipment following the accident. No defects were found that may have contributed to the accident, however, some new procedures were put in place by the companies involved.

Recommendations were made regarding any modifications to equipment and procedures and the training, testing and documentations of such amendments.

A recommendation was also made regarding work hours and shift rotations.

CASE # 2

This 22 year old man shot himself in the head after firing several shots earlier and killing two other community members.

Police secured the weapon and scene and called for assistance from the "G" Division Major Crimes Unit and the Coroner's Office.

The investigation revealed that the deceased had been partying at a relative's home when he became angry and attempted to stab someone with a kitchen knife. He was overpowered by others and the knife was removed without inflicting any injury. The deceased remained angry and was believed to be highly intoxicated.

He left the party and was seen returning to the area a short time later carrying a shotgun. He was confronted in a nearby field by another community resident. Two other men came from behind in an attempt to disarm the man. He then pointed the gun at himself and threatened suicide. One of the men managed to disarm him before anyone was hurt even though the firearm discharged during the event. The shotgun was removed from the area by one of the men.

The man went to another family member's residence and returned with what appeared to be a rifle. This time he was confronted with approximately 10 people at the outdoor location. He had words with one of them and after a few moments he raised the weapon and fired at the man killing him instantly. He then shot another man and killed him as well. He pointed and fired the weapon at approaching police units who were responding to complaints.

The police quickly returned to the detachment to retrieve their rifle. While inside the detachment, one of the Officers was injured in the leg by shrapnel when another round was fired at the detachment. Police then headed back to the location where it was apparent the decedent had suffered a self inflicted gunshot wound.

Toxicology examinations revealed the deceased was highly intoxicated at the time of his death. The shooter's death was ruled a suicide while the death's of the other two men were classified as homicides.

Over the past 2 years (2001 and 2002) There was a total of 12 deaths by firearm (homicide and Suicide). Of those 12 deaths, 11 were with committed with unsecured firearms. A recommendation was made to the GNWT that the government develop an awareness strategy regarding the dangers and liability related to the unsafe storage of firearms.

CASE # 3

This 36 year old man was discovered on the roadside of the southbound side of Highway 3. Witnesses initially thought he may have been hit by a vehicle and notified the RCMP. A second call to police indicated a rifle was also at the scene and that the individual appeared to be deceased.

RCMP arrived at the scene and along with the Coroner began an investigation. It appeared that the deceased had suffered a fatal gunshot wound to the head. The decedent was noted to be fully clothed and lying face down on the shoulder of the highway at the entrance of a driveway to a cabin on the side of the road.

A shotgun was noted to be by his side on the ground. It was determined that the weapon belonged to a resident of the cabin he was visiting.

There was only one set of footprints in the snow leading up to the deceased and they were consistent with the footwear that he was wearing. There was no indication of a struggle and no evidence of foul play.

Statements were taken from several individuals living or visiting in the nearby cabins. Photos were taken of the scene and the deceased.

Toxicology tests were conducted on fluid samples and they were negative for the presence of alcohol or other intoxicating drugs. The death was ruled a suicide.

Another recommendation was made to government regarding increased public awareness of the unsafe storage of firearms.

CASE # 4

This 37 year old man with a history of alcoholism, drug use and depression was found by a family member slumped over in a chair. An ambulance was called and the man was rushed to the health centre and pronounced dead shortly thereafter.

RCMP were called and attended along with the Coroner to the health centre and the residence to begin an investigation. The deceased was shown to have no visible injuries or evidence of trauma. The residence revealed no evidence of a struggle and no signs of any foul play.

The investigation revealed that the deceased had recently arrived in the community to stay with family. Although he had a history of drug and alcohol abuse, it was believed that he had been sober for the past several months of his life.

His health seemed to be on the decline. He was fatigued, moody and lacked any appetite. He had arranged to be seen by a physician and was placed on medication for depression. Blood tests taken during the visit revealed no other concerns.

A medication bottle containing the decedent's medication had been found at the residence which appeared to have been re-labeled. The physician and date did not coincide with his recent medical visit.

He was noted to have vomited the evening before his death and had been complaining of pain and numbness in his left leg. He had spent most of the day sitting in a chair and watching TV. He asked for and received a drink of water and when he was checked on approximately an hour later, he was non-responsive.

An autopsy was ordered and determined that there was an abnormality present since birth in one of the valves of the heart. Normally these valves have three leaflets but this condition resulted in the deceased having only two. One of the leaflets in the valve had a bacterial infection that caused it to rupture. This resulted in heart failure and caused his death.

Toxicology tests revealed no evidence of any alcohol or intoxicating drugs. The manner death was classified as natural.

A copy of the Coroner's Report was sent to the local health centre and a recommendation was made regarding the "re-labeling" of medication.

CASE # 5

This 40 year old man died in a hospital after returning from a day pass. The man had been undergoing treatment for fever, poor liver function and an unknown underlying illness.

The investigation revealed that the decedent had been in the hospital complaining of throat hoarseness, cough, blood tinged sputum and respiratory difficulties. He had previously undergone surgery for deviated nasal septum. His diagnosis was never clearly determined.

He had been let out on a day pass to visit with friends/family. It was reported that he slept much of that time. His appearance had deteriorated over the last several months.

When he returned to the hospital later that evening, he was brought in by wheelchair. He was weak and continuing to experience difficulty. He was placed into the ICU and his condition was closely monitored.

He went into cardiac arrest twice but was resuscitated the first time. On the second occasion all efforts at resuscitation failed. He was pronounced dead at 04:58.

An autopsy was ordered and revealed there was extensive liver damage produced by the virus which causes infectious mononucleosis. The presence of the virus was confirmed by special tests on the liver biopsy. The eventual test which confirmed the diagnosis took several days to complete. The death was classified as natural.

The Coroner made a recommendation regarding the reporting structure of southern laboratories and northern medical centres.

CASE # 6

This 80 year old man with a long history of chronic obstructive pulmonary disease (COPD), hypertension and alcohol abuse, was found dead by a family member in his home.

Health care representatives and the RCMP were notified and attended to the residence. There was no evidence of any struggle and no indication of foul play.

Because of the medical history of the deceased and the circumstances of the death, no autopsy was ordered. Samples were obtained for toxicology. No alcohol or intoxicating drugs were detected.

The investigation revealed that the deceased had been suffering from COPD for many years and had received treatment for depression but had often been non-compliant with his medication. During the last two weeks of his life he had been mostly bedridden and ate very little.

The nurse had seen him a few days earlier when he had taken to staying in bed and was not eating. He denied any pain but stated he did not feel like eating. He had agreed to apply for

residence at an extended care facility.

The decedent had fallen while attempting to go to the bathroom. He stated that he felt like vomiting but did not. He had eaten small quantities of food but appeared tired and wanted to sleep. The nurse attended to the home and left after ensuring that his condition was stable.

Later that morning the nurse was informed that he was experiencing breathing difficulties and appeared to have stopped breathing. The nurse attended to the home and pronounced death at 01:20 hours.

The coroner determined that the man died as a result of long standing chronic obstructive pulmonary disease and classified the death as natural.

A recommendation was made to solicit better education and training for health care workers regarding depression and mental illness in the elderly.

APPENDIX “B”

SUMMARY OF CORONER’S

INQUEST INCLUDING

RECOMMENDATIONS

REPORT OF THE JURY VERDICT

Vawn Ruthven

DATE AND TIME OF DEATH: March 14, 2002
PLACE OF DEATH: Yellowknife, NT
CAUSE OF DEATH: acute diphenhydramine toxicity
MANNER OF DEATH: Suicide

Vawn Ruthven, was a 36 year old woman who was a voluntary patient of the Stanton Territorial Hospital Psychiatry Unit at the time of her death which occurred at some time between the hours of 09:30 and 16:30 hours on March 14, 2002.

Ms. Ruthven had a long history of depression, panic attacks, abuse of over the counter medication and suicide ideation. She had been admitted to the Stanton Psychiatric unit on at least three occasions over the last 12 months of her life. On each of these occasions she was admitted as a voluntary patient.

Plans had been made by her doctors and funding had been secured in December of 2001 to have her attend a treatment program for her depression, panic attacks and drug abuse at the Dual Diagnosis Program at the Homewood Centre in Ontario, but Ms. Ruthven was not able to complete the program.

During her latest admission to the Psychiatry Unit on February 14, 2002, a plan of care was created that focused on her addiction issues with a view to empowering her to be able to complete a 30 day Drug and Alcohol Rehabilitation Program in Grand Prairie, Alberta providing funding could be secured.

On March 13, 2002, while on close observation, Ms. Ruthven was granted an escorted pass to allow her to attend a Narcotic Anonymous Meeting downtown. She called an acquaintance and arranged to be picked up. She left the hospital at approximately 19:30 hours that night and returned at approximately 21:30 hours but did not go back to the ward.

After being dropped off at the front door of the hospital, She went to a local hotel and checked in. At some point during the evening she returned to her residence, obtained some of her husband's prescription medication, took the phone off the hook and returned to the hotel.

Early the next morning she attended to 2 local pharmacies and purchased several packages of over the counter sleep medication, anti-nauseant and some small quantities of prescription medication. She then returned to the hotel some time after 09:30 hours and consumed several different types of medications including a lethal amount of the sleep medication.

Her absence had been reported to the RCMP at approximately 00:40 hours on March 14, 2002, and a search ensued but her body was not discovered until approximately 16:30 hours after police showed her picture to a hotel employee.

The Inquest heard from 17 witnesses and 17 exhibits were entered as evidence. The jury deliberated for approximately 6 hours before returning with a unanimous verdict and the following recommendations:

TO THE STANTON TERRITORIAL HEALTH AUTHORITY

Review the revised "Release from Responsibility While on Temporary Pass Acknowledgement of Escort" form, consideration to the following:

- a) The form should include one column for expected time of return of the patient.
- b) The form should include one column for the actual time of return that is recorded and initialled by a psychiatric unit staff.
- c) The form should include one column for signature of escort upon return to the unit with the patient.

Ensure that all staff are trained on the appropriate use of the form "Release from Responsibility While on Temporary Pass/Acknowledgement of Escort".

A card should be developed which indicates the responsibilities of the escort and which provides the phone number of the unit. This card would be given to all escorts on all occasions when signing a patient out of the unit

Develop a card which indicates the phone number and contact information of the unit. This card should be given to the patient upon leaving the hospital on a pass.

The hospital should review its policy regarding voluntary/involuntary status for patients on close and constant observation.

Psychiatric patient files should contain contact numbers for at least 2 next of kin. Consider including patient photo in psychiatric patient files with patient consent.

Develop a protocol for communication between the Stanton Territorial Hospital and the RCMP. This discussion should recognize the requirement of the RCMP to have information about the patient in order to locate the patient. It should also recognize the legal and ethical requirement of the hospital to respect patient confidentiality unless there is a substantial risk of serious harm to the patient or another person.

Ensure all psychiatric caregivers fully understand the rules of confidentiality and how they apply to patients at risk of serious harm to themselves or to others.

Develop a “quick-check” system, such as a colour-coded board to allow for the quick determination of a patient’s observation level, pass status and type of admission, i.e. voluntary/involuntary

Explore the development of a new observation level policy which clearly defines each level and correlates the risk assessment of a patient to the patient’s restrictions and privileges. It may be helpful to reference the Royal Columbian Hospital Levels of Observation Protocols.

Develop a written procedure which details the steps to be followed in the event of a missing psychiatric patient.

TO THE RCMP

(Note: see a previous recommendation regarding the development of a communication protocol between the Stanton Territorial Hospital and the RCMP.)

Develop and maintain a current contact list of hotels and other places of refuge

Replace any officer on long term absence such as maternity leave to ensure staffing levels remain constant.

TO RETAIL VENDERS OF SLEEP AID PRODUCTS IN THE NWT

Consider restricting customer access to over-the-counter sleep medication.

TO THE GOVERNMENT OF THE NORTHWEST TERRITORIES

Make it a priority to ensure the number of resident psychiatrists in the NWT is in keeping with national averages.

Widen the scope of services available through the NWT’s existing treatment centre to include programs that focus on drug addictions.

Fund the establishment of a medical detoxification facility in the NWT.

Ensure the funding allocated to the treatment of mental illnesses and addictions more accurately reflects the prevalence of these illnesses in the patient population.

Remove funding barriers for patients who require out-of-province treatment of mental illnesses and addictions.

Develop and fund a full time Patient Care Coordinator position at the Stanton Territorial hospital.

CORONERS ACT

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.