# NORTHWEST TERRITORIES CORONER'S SERVICE 2003 ANNUAL REPORT

**OFFICE OF THE CHIEF CORONER**

July 30, 2004

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 2003 Annual Report for the year beginning January 1, 2003 and ending December 31, 2003.

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 2001-2002 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 ..... 20
- Case #3 ..... 21
- Case #4 ..... 22
- Case #5 ..... 23
- Case #6 ..... 24

APPENDIX "B" (Summary of Coroner's Inquest Including Recommendations) ..... 27
- Report of Jury Verdict ..... 28

*Coroner's Act*-Reporting Deaths ..... 32

# 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 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 36 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 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 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 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 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.

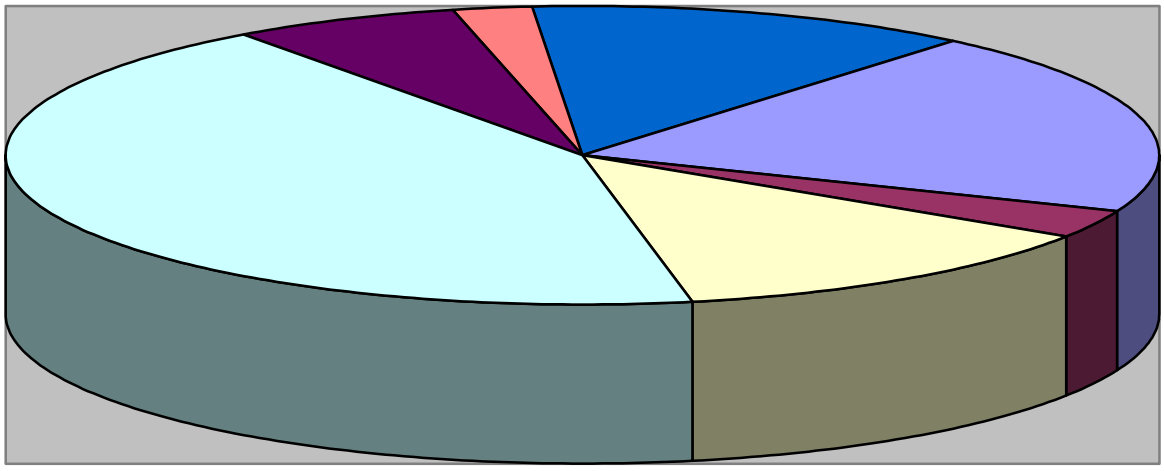
Coroners are instructed to make every effort to classify a death in one of the other existing categories before considering a classification of undetermined.

*(**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

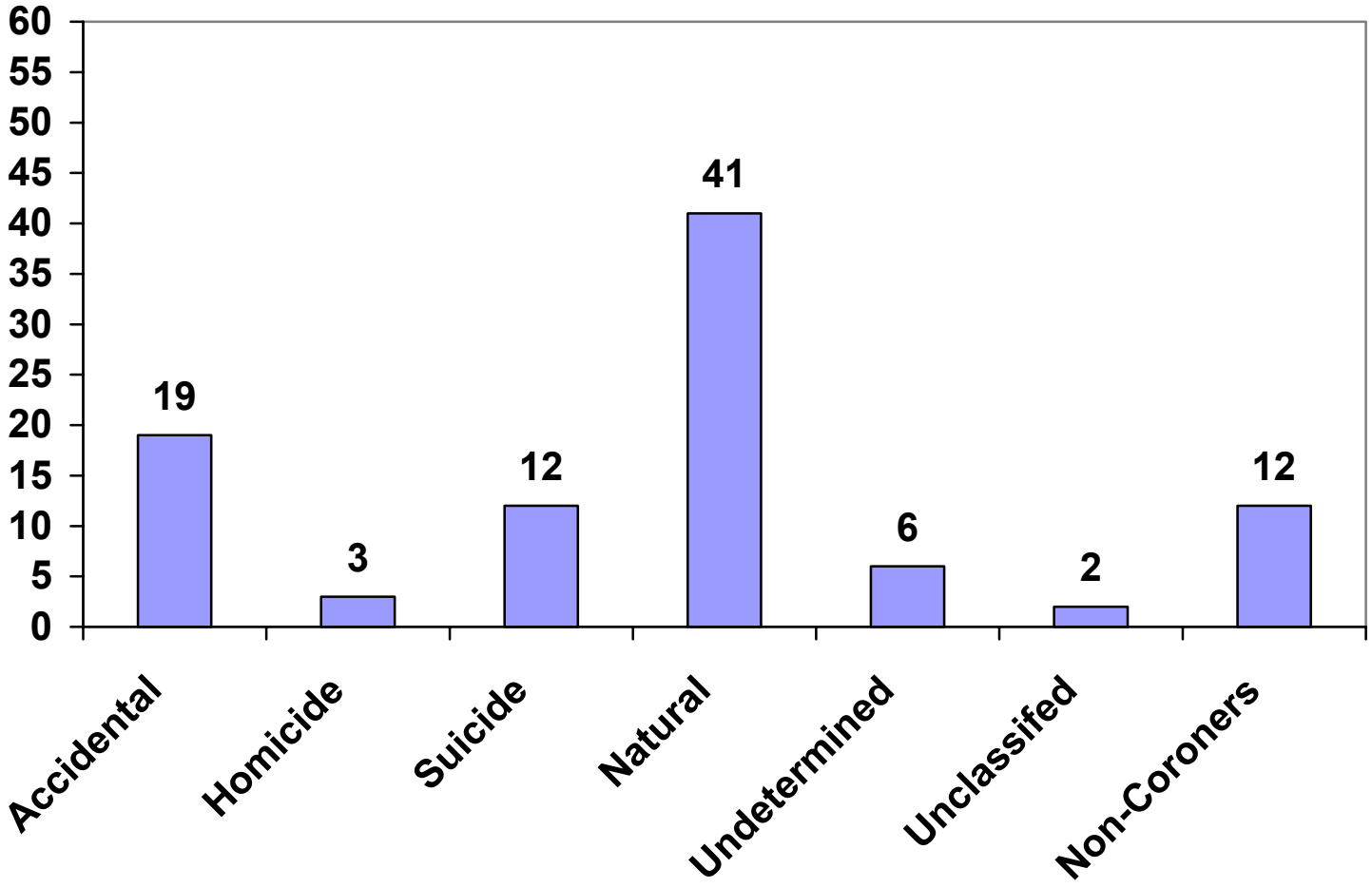
| Manner of Death | Number | Percent % | Rate per 100,000 |
|---|---|---|---|
| Accidental | 19 | 20.0 | 0.46 |
| Homicide | 3 | 3.16 | 0.07 |
| Suicide | 12 | 12.63 | 0.29 |
| Natural (includes Non-Coroner cases) | 53 | 55.79 | 1.28 |
| Undetermined | 6 | 6.31 | 0.14 |
| Unclassified | 2 | 2.11 | 0.05 |
| **TOTALS** | | | |



**Accident - 19** **Homicide - 3** **Suicide - 12**
**Natural - 41** **Undetermined - 6** **Unclassified - 2**
*** Non-Coroners - 12**

*** 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**

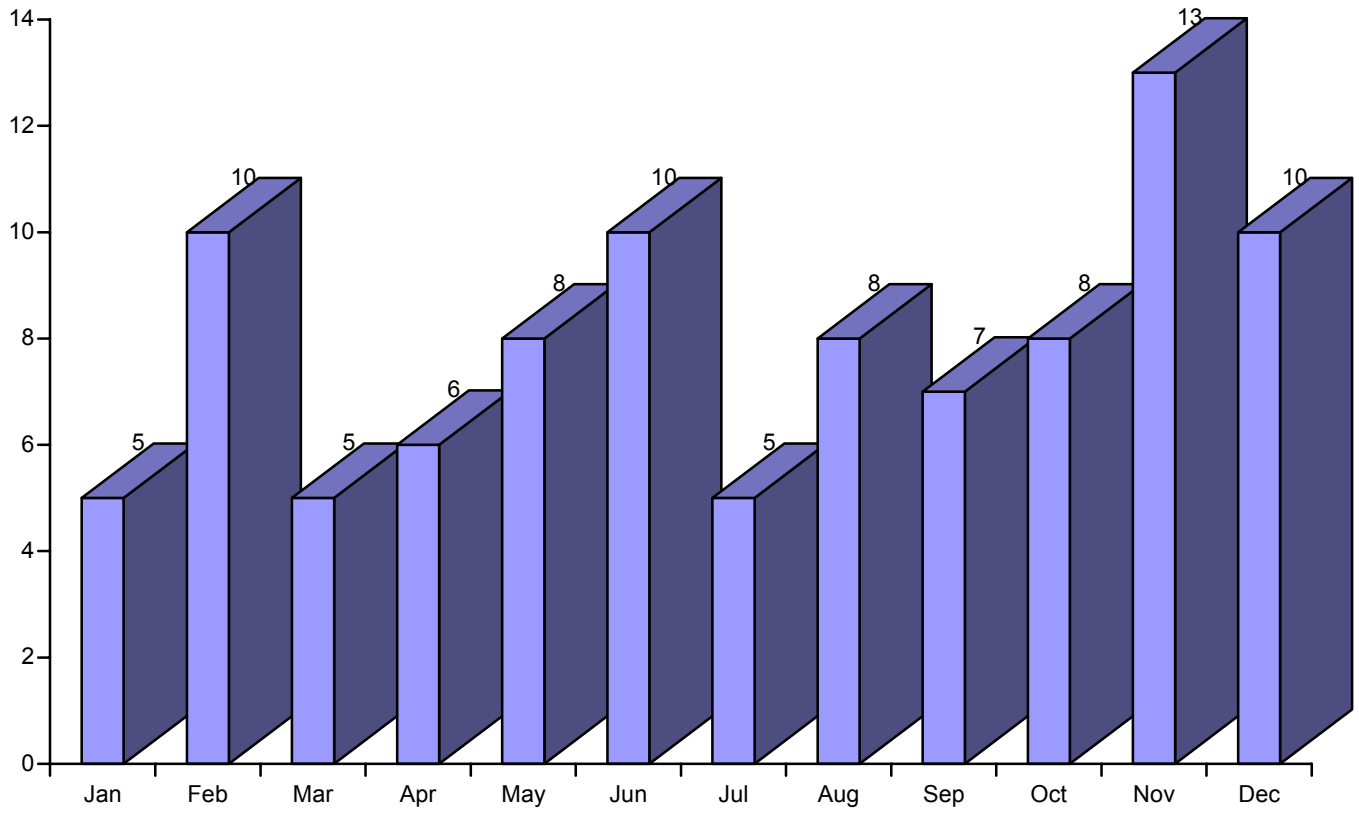
# CASELOAD BY MANNER OF DEATH



# CASELOAD BY MANNER OF DEATH/COMMUNITY

| Community | Accidental | Homicide | Suicide | Natural | Undetermined | Unclassified | Non-Coroners | Total |
|---|---|---|---|---|---|---|---|---|
| Aklavik | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Deline | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 |
| Fort Good Hope | 0 | 1 | 1 | 2 | 0 | 0 | 0 | 4 |
| Fort Liard | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Fort McPherson | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Fort Providence | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 3 |
| Fort Simpson | 3 | 0 | 0 | 1 | 0 | 0 | 1 | 5 |
| Fort Smith | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Fort Resolution | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 3 |
| Lutselk'e | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 2 |
| Hay River | 1 | 0 | 1 | 6 | 1 | 0 | 1 | 10 |
| Holman | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 2 |
| Inuvik | 1 | 0 | 1 | 2 | 1 | 0 | 1 | 6 |
| Nahanni Butte | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Norman Wells | 2 | 0 | 0 | 1 | 0 | 1 | 0 | 4 |
| Paulatuk | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Rae/Edzo | 2 | 0 | 0 | 1 | 1 | 0 | 3 | 7 |
| Rae Lakes | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Tulita | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 3 |
| Tsiigehtchic | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 2 |
| Tuktoyaktuk | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 2 |
| Wha ti | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Wrigley | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Yellowknife | 6 | 1 | 3 | 16 | 3 | 1 | 1 | 31 |
| **TOTALS** | **19** | **3** | **12** | **41** | **6** | **2** | **12** | **95** |

# CASELOAD BY MONTH



# CASELOAD BY MANNER/MONTH

| Month | Accident | Homicide | Suicide | Natural | Undetermined | Unclassified | Non-Coroners | TOTALS |
|---|---|---|---|---|---|---|---|---|
| January | 2 | 0 | 0 | 2 | 0 | 0 | 1 | 5 |
| February | 2 | 1 | 1 | 3 | 1 | 0 | 2 | 10 |
| March | 1 | 0 | 1 | 3 | 0 | 0 | 0 | 5 |
| April | 1 | 0 | 1 | 3 | 0 | 1 | 0 | 6 |
| May | 3 | 0 | 1 | 2 | 0 | 0 | 2 | 8 |
| June | 1 | 1 | 0 | 6 | 1 | 0 | 1 | 10 |
| July | 2 | 0 | 0 | 2 | 1+ | 0 | 0 | 5 |
| August | 2 * | 0 | 4 * | 2 | 0 | 0 | 0 | 8 |
| September | 0 | 0 | 1 | 4 | 2 | 0 | 0 | 7 |
| October | 0 | 0 | 2 | 3 | 0 | 0 | 3 | 8 |
| November | 2 | 0 | 1 | 9 | 0 | 0 | 1 | 13 |
| December | 3 | 1 | 0 | 2 | 1+ | 1 | 2 | 4 |
| TOTALS | 19 | 3 | 12 | 41 | 6 | 2 | 12 | 95 |

***** **One of these cases occurred in Alberta following medical transportation.**

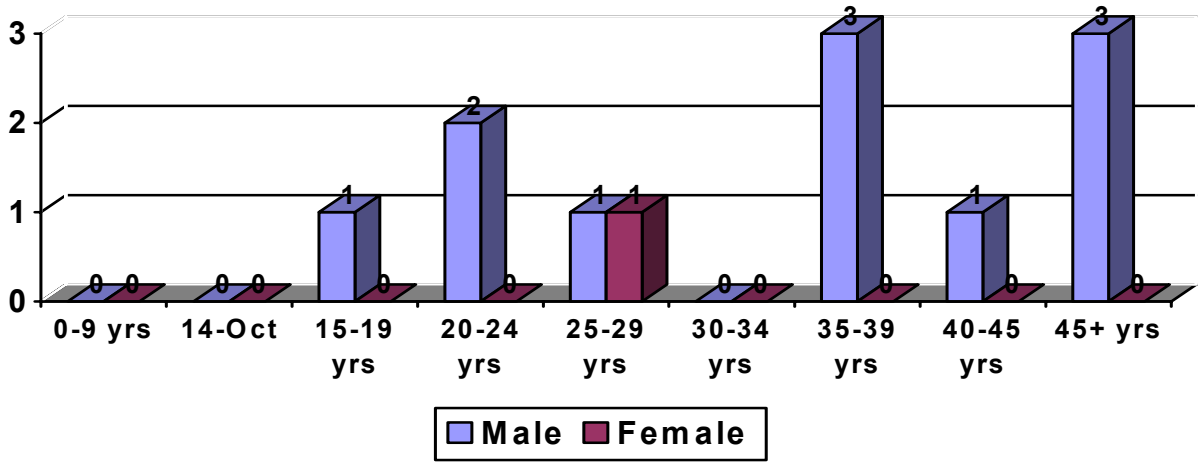
**+** **Case was found partial human remains where the cause of death remains unknown.**

# SUICIDE BY GENDER/AGE

| Age Group | Male | Female | Total |
|---|---|---|---|
| 0-9 yrs | 0 | 0 | 0 |
| 10-14 yrs | 0 | 0 | 0 |
| 15-19 yrs | 1 | 0 | 1 |
| 20-24 yrs | 2 | 0 | 2 |
| 25-29 yrs | 1 | 1 | 2 |
| 30-34 yrs | 0 | 0 | 0 |
| 35-39 yrs | 3 | 0 | 3 |
| 40-44 yrs | 1 | 0 | 1 |
| 45 + yrs | 3 | 0 | 3 |
| **TOTALS** | **11** | **1** | **12** |

Of the 12 suicide deaths in 2003, all but 1 were male, (92% ) The greatest number of deaths occurred in the following age brackets: 35-39 years of age and over 45 years of age. (3 in each category).

The suicide rate has remained fairly consistent over the last 3-4 years but remains elevated over the last decade with 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.

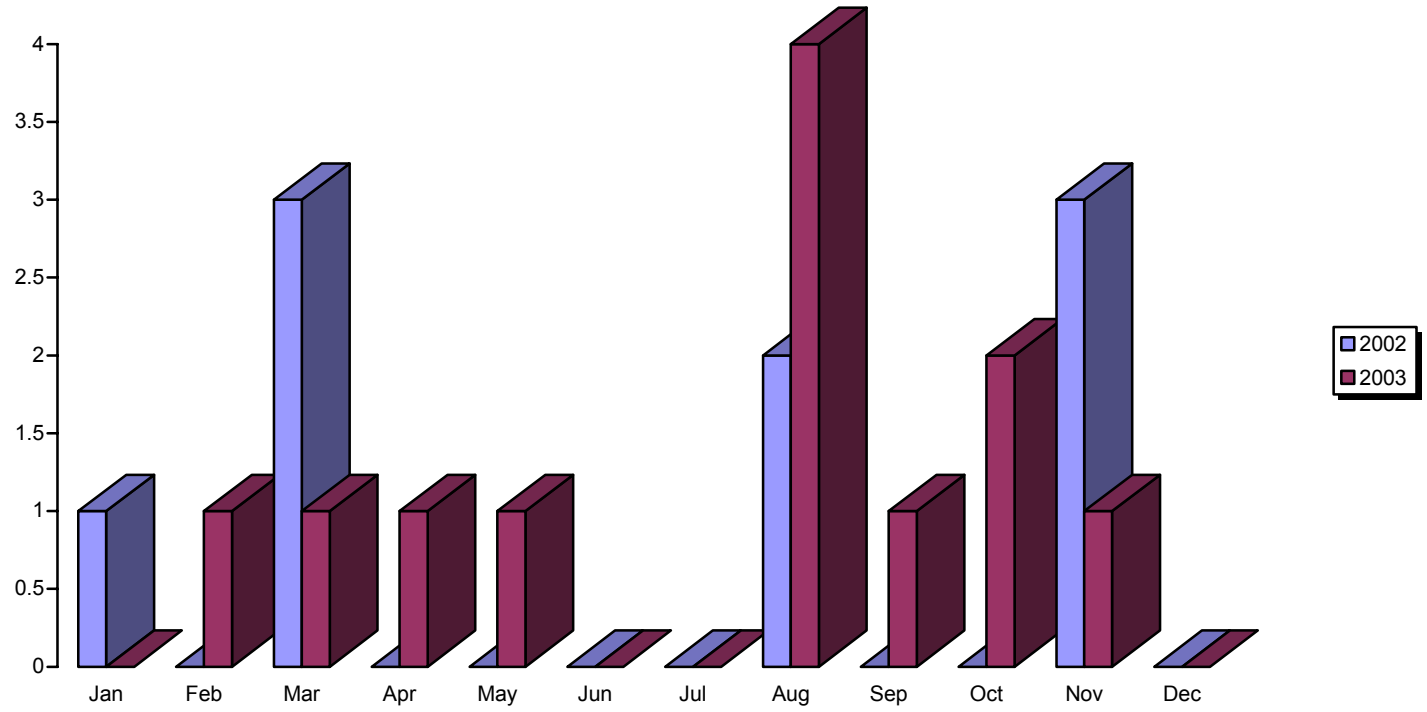


# SUICIDES BY MONTH/COMMUNITY/GENDER/AGE/METHOD

| Month | Community | Gender | Age | Method | Alcohol |
|---|---|---|---|---|---|
| February | Fort Good Hope | Male | 20 | Hanging | yes |
| March | Yellowknife | Male | 51 | Ligature Strangulation | no |
| April | Yellowknife | Male | 47 | Hanging | no |
| May | Rae Lakes | Male | 36 | Hanging | no |
| August | Hay River | Male | 43 | Firearm | yes |
| August | Inuvik | Male | 26 | Hanging | yes |
| August | Fort Resolution | Male | 16 | Firearm | yes |
| August | Wha ti | Male | 21 | Hanging | no |
| September | Yellowknife | Female | 29 | Hanging | yes |
| October | Fort Smith | Male | 67 | Alcohol & Codeine Toxicity | yes |
| October | Tuktoyaktuk | Male | 36 | Hanging | no |
| November | Paulatuk | Male | 38 | Firearm | no |

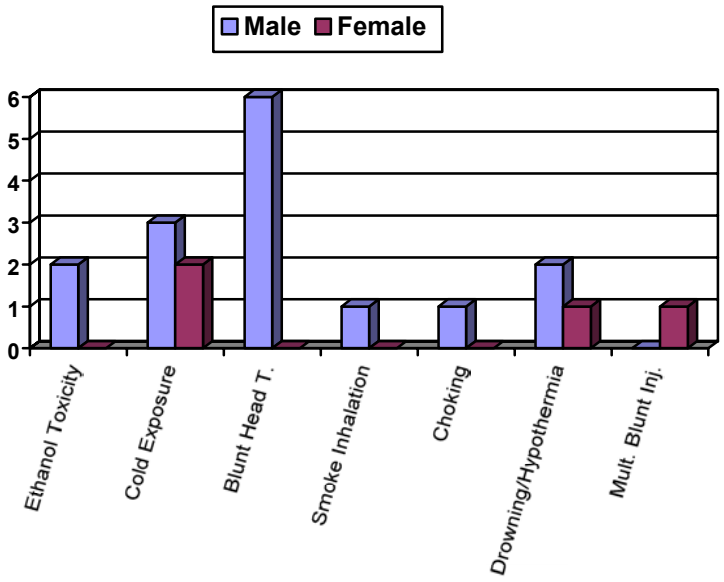
Hanging was the predominant method of suicide accounting to more than half (7 of 12 or 58.3 %) of all suicides. An overwhelming majority of suicides were conducted by males as compared to females (11 t0 1) Alcohol was involved in half (6 of 12 or 50%) of all suicide cases in 2003.

# SUICIDES BY MONTH - 2002-2003 COMPARISON




| JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 1 | 1 | 1 | 0 | 0 | 4 | 1 | 2 | 1 | 0 | 12 |
| 0% | 8.3% | 8.3% | 8.3% | 8.3% | 0% | 0% | 33.3% | 8.3% | 16.6% | 8.3% | 0% | 99.7% |

# ACCIDENTAL DEATH BY CAUSE/GENDER




| Cause of Death | Male | Female | Total | Alcohol Related |
|---|---|---|---|---|
| Ethanol Toxicity | 2 | 0 | 2 | 2 |
| Multiple Blunt Injuries | 0 | 1 | 1 | 0 |
| Choking | 1 | 0 | 1 | 0 |
| Cold Exposure | 3 | 2 | 5 | 5 |
| Blunt Head Trauma | 6 | 0 | 6 | 4 |
| Smoke Inhalation | 1 | 0 | 1 | 1 |
| Drowning/Hypothermia/Immersion | 2 | 1 | 3 | 2 |
| **TOTALS** | **15** | **4** | **19** | **14** |

Accidental deaths accounted for approximately 20% of all deaths reported to the Coroner's Service in 2003. The majority of the deaths (15 of 19 , or 79%) were males.

Alcohol was involved in 14 of the 19 (or 74%) 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 2003. However, there were 3 non-SIDS deaths of infants under 1 year of age in 2003, two of which were classified as natural and the other was undetermined.**

**There was also one stillborn reported to the Coroner's Service in 2003.**

**Often 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 |
|---|---|---|
| 53 | 12 | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 6 | 2 | 2 | 5 | 6 | 2 | 3 | 4 | 1 | 5 | 3 | 39 |

**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 39 autopsies were conducted in 2003.**

# 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 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 36 Coroners across the Northwest Territories; 11 are aboriginal. There are 26 male (8 aboriginal) coroners and 10 female (3 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, Heather Johnson, Michael Maggeean, Roderick O'Brien**

**Deline - Kelvin Dolphus**

**Fort Good Hope - Ron Pierrot, Harold Cook**

**Tulita - Edward McPherson**

**Holman - William Duke, Gary Lewis**

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

**Norman Wells - Dudley Johnson, Parry Cowan**

**Paulatuk - Keith Dodge**

**Tuktoyaktuk - Anita Pokiak**

**Lutselk'e - Emily Saunders**

**Wha ti - Carolyn Coey-Simpson**

**Rae - Arnie Steinwand**

**Yellowknife - Beth-Ann Williams-Steinwand, Garth Eggenberger, Jennifer Eggenberger, Wendy Eggenberger, 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 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.**

**One inquest was held in the Northwest Territories during this reporting period. A synopsis of the procedure and the jury verdict is attached. (See Appendix "B")**

# APPENDIX "A"

# SUMMARY OF SELECTED

# CORONERS' REPORTS

# CONTAINING

# RECOMMENDATIONS

**CASE # 1**

This 21 year old man was driving a snowmobile on Frame Lake when he hit a snowbank that had recently been created when a road was cleared on the lake for the annual dog race. The snowmobile became airborne and the decedent landed on his back/neck on the ice.

Witnesses came to the man's aid and an ambulance was summoned to the scene. The location of the incident made it difficult for the ambulance to access the area. The city's rescue unit snowmobiles were used to bring the man to the shoreline for transportation to the hospital by ambulance where he was pronounced dead a short time later.

The weather at the time was clear but the time of day would provide for little contrast in the snow surface and make for reduced visibility.

The decedent was alone on his Ski-doo Formula STX while 2 others rode on a Ski-doo Skandic. As they ventured out onto the lake, the deceased passed the other snowmobile and was driving at a speed of 80 to 100 kph as estimated by the witnesses on the second snowmobile (the posted speed limit for Frame Lake is 30 kph).

Shortly thereafter, the decedent struck the snowbank. Both the deceased and the snowmobile tumbled through the air landing approximately 14 metres from the snowbank. Both continued to travel forward until coming to rest approximately 25 metres from the point of impact.

The ambulance and rescue unit responded. When they arrived near the scene, the ambulance remained close to the lakeshore while the rescue unit travelled to a nearby lakeside park and unloaded their snowmobiles. They responded to the scene and attended to the victim

Upon their arrival, the decedent had no detectable pulse or respiration. The rescue unit took over the resuscitation efforts and transported the decedent to the lakeshore where he was placed in the ambulance and transported to Stanton Territorial Hospital.

The man was pronounced dead shortly after arriving at the hospital. The coroner was contacted and attended to the emergency department.

Post mortem x-rays of the deceased revealed the presence of a fracture to the first vertebral body with anterior shifting of the head (i.e. a broken neck). There were no other fractures or trauma noted in the head, chest or pelvic regions. No autopsy was ordered but fluid samples were obtained for examination.

Post mortem toxicology showed no evidence of any alcohol but cannabinoids was detected in the urine sample which indicated marijuana use by the deceased sometime in the recent past. This is consistent with evidence that the decedent had consumed marijuana just prior to the accident.

Concerns were raised over the issue of the creation of the snowbanks and the frequent use of high speed by snowmobilers on the lake. It was felt that the snowbank would probably not be a major concern if the posted speed limits are adhered to.

The issue of high speed can only be addressed through enhanced education and enforcement. Both RCMP and the city's Municipal Enforcement Division carry out periodic patrols of the area on snowmobiles but the increasing demand on their time and attention to other matters seriously limits the frequency of routine patrols.

A recommendation was made to the City of Yellowknife that they review their current snowmobile policy and consider either providing the resources necessary for increased surveillance and enforcement of the snowmobile bylaws or further limit their use within the city limits.

**CASE # 2**

This 58 year old woman was a passenger in the second row seat of a minivan which left the highway and rolled at kilometre 160 of Highway #3. A truck driver contacted the RCMP dispatch in Yellowknife at approximately 7:23 pm. Dispatch then relayed the call to the Rae detachment approximately 100 kilometres northeast of the crash site. While Rae RCMP responded to the scene, they requested the dispatcher to send Rae ambulance to the scene.

At approximately 8:52 pm, the victim became unresponsive and stopped breathing. Rae RCMP began CPR. The ambulance had still not arrived.

Additional RCMP and a nurse from Fort Providence arrived shortly thereafter (9:04 PM) and the nurse made contact with a physician in Yellowknife to relay the circumstances and the condition of the female patient. After a brief consultation it was decided to discontinue resuscitation efforts and the woman was pronounced dead at approximately 9:23 pm.

The investigation revealed that the telecoms operator made an error when calling the Rae ambulance and inadvertently called the Hay River Ambulance. When the phone was answered, the telecoms dispatcher assumed she was talking to the Rae ambulance dispatch and requested they attend to kilometre 160 south of Edzo.

The dispatcher did not signify which highway and it appears the ambulance operator may have assumed it was kilometre 160 of highway #1

Sometime later, the Hay River authorities called the RCMP dispatch to confirm the site and asked if they are to attend since it appears to be so far away. RCMP telecoms dispatch stated that an ambulance had been summoned from Rae and that the Hay River ambulance need not respond. Not realizing their mistake, they cancelled the Hay River ambulance and in reality no ambulance service was now responding.

The error was realized sometime later when a confirmation call was made to the Rae ambulance and it was determined that they had not received a previous call and the ambulance was not dispatched.

Because of a delay, the dispatching of the Rae ambulance did not take place until approximately 9:10 pm. An additional ambulance from Yellowknife was dispatched at approximately 9:30 pm. A helicopter medivac was also requested and dispatched at approximately 9:40 pm.

An autopsy revealed the woman had died as a result of multiple blunt injuries. The injuries sustained by the woman were such that the chances of survival would have been considered marginal even with immediate medical attention.

Recommendations were made to the RCMP and local ambulance services to review and adapt their dispatch protocols to minimize the possibility of confusion when requesting or dispatching ambulance services.

Additional recommendations were made to the RCMP and the City of Yellowknife pertaining to the education of dispatch personnel in regards to the local highway system, distances and estimated travelling times.

A recommendation was also made to the GNWT regarding the lack of an ambulance service in Fort Providence.

**CASE # 3**

This 29 year old woman was transported to Stanton Hospital after complaining of shortness of breath. Upon her arrival, she became unresponsive. Resuscitation efforts were employed to no avail and woman was pronounced dead.

The deceased suffered from obesity and was a 2 pack a day smoker but had been prescribed Zyban in early 2003. Pregnancy was also confirmed in May 2003.

The deceased attended to the emergency ward complaining of pain and swelling in her right leg. Following an evaluation a DVT (deep vein thrombosis) was suspected and additional tests were arranged. An ultrasound showed no evidence of a DVT and medication was prescribed for pain and advice to follow up with her doctor if the condition continued.

She returned to the hospital the following day with persistent pain and treatment with Tinzaparin (a blood thinner) was put in place. Another ultrasound was scheduled and the decedent was to receive continued daily administration of Tinzaparin.

The second ultrasound confirmed the presence of a DVT through most of the right femoral vein. Additional blood tests were performed and a repeat ultrasound again demonstrated the presence of a DVT.

A few days later, the woman arrived at the hospital complaining of difficulty breathing. In reviewing the previous tests, the physician indicated the progression of the DVT had stopped. The Tinzaparin treatment continued and a second physician was consulted. Admission to the hospital was recommended and a CT scan was scheduled for the next day.

Doctors consulted and determined that the decedent's de-conditioning and obesity were the likely cause of the shortness of breath and the CT scan was cancelled. A Ventolin puffer was prescribed for the shortness of breath, and the Tinzaparin injections were to be continued. The decedent was advised to return to the emergency department if she developed chest pain or increased shortness of breath. She was given a Discharge Care Plan and instructed to show it to any home care workers or family doctor.

A few days later she went to her doctor's office complaining of nausea, vomiting, shortness of breath, and a dry cough. The doctor suspected a flu-like illness and prescribed cough syrup

Three days later, the deceased was transported to the hospital suffering from acute respiratory distress and died shortly after arrival.

A recommendation was made to the hospital that they make whatever changes are required to ensure that documentation, especially relating to discharge plans from emergency department visits or following admissions are complete and concise.

**CASE # 4**

Three male individuals were found dead in a beached jet boat with the engine still running. They were pronounced dead by a local nurse.

It appeared the three men were using a jetboat with a full canopy to scout the shoreline for lumber to haul down the river. They were seen by a witness who watched them pass by the dock as they headed northbound on the West Channel of the Peel River.

When the men did not return, relatives became worried and asked someone to go and look for them. The boat was found with the three men on board.

A cursory examination of the deceased revealed no evidence of any trauma. The men were located in the cabin of the vessel. All were fully clothed and there were no signs of a struggle and no evidence of any foul play. The three men displayed signs of bright pink lividity which is consistent with a toxic exposure to carbon monoxide.

An autopsy confirmed all three men had elevated toxic levels of carbon monoxide in the blood. Toxicology examinations revealed no alcohol or intoxicating drugs present.

The boat was a 19 foot Eagle Jet boat with a soft canvas top with snap fasteners. The vessel was manufactured in Sylvan Lake in July of 1997. The vessel was equipped with an inboard 351 cubic inch V8 engine and a turbine jet propulsion system. The hour meters on board the vessel indicated operational hours of just over 300.

A custom full canvas top was installed on the vessel extending from the windshield to the stern of the boat and appeared to be well maintained and in good working order.

An extensive examination of the boat was carried out by The Office of The Chief Coroner utilizing the resources of a local retail boat supplier and a representative of the Environmental Health Services Division of The Inuvik Regional Health and Social Services Authority.

The mechanical evaluation of the boat did not find any irregularities, modifications or part failures in the unit. There were no signs of any damage in the engine bay and the exhaust system appeared to be operating normally. There were no loose fillings and no signs of overheating. The engine started fine and warmed up as per expectations with the choke functioning properly. The engine oil pressure and temperature gauges were in the normal operating range. There were no water leaks found in the engine system and no indication of any leaks in the manifold or exhaust systems.

The team was able to duplicate the build up of carbon monoxide in the main compartment of the vessel without actually putting the vessel in motion. A digital carbon monoxide analyzer was placed on the rear bench seat and the motor was operated with the boat fixed in place on the trailer with the stern submerged in water and the canopy in place.

Three tests of approximately 3 minutes each were conducted to determine if carbon monoxide levels were present and elevating in the cabin area.

In each case, soon after the engine was started, carbon monoxide was identified in the cabin area with no indication of leakage from the engine manifold or compartment.

Since the engine was not under load and the vessel was not in motion, it was felt that both these conditions, if present would likely elevate the carbon monoxide levels beyond the test results and clearly increase the carbon monoxide concentrations into the lethal range.

The report concludes that the canopy was used contrary to the recommendations of the manufacturer and that combined with the absence of the rear window canopy, emissions containing carbon monoxide from the exhaust were allowed to accumulate in the cabin.

The results of these tests and the circumstances relating to the deaths were reported to the Canadian Standards Association (CSA) for their review.

A recommendation was made to the boat manufacturer to place large warning labels on the interior of all canopied craft regarding the dangers of Carbon Monoxide and to place CO detectors in all cabin areas as part of the standard/mandatory equipment.

**CASE # 5**

This 53 year old man was pinned between the back of a rubber tired loader and the rear of a 3/4 ton truck while working on the surface at Miramar mine in Yellowknife.

He was initially conscious following the incident but became unresponsive soon after. The ambulance arrived and transported him to Stanton Territorial Hospital where he was pronounced dead.

The investigation showed that the decedent had backed his work truck up the hill and parked it on the roadway a short distance behind the loader. The deceased left the cab of the truck and had focussed his attention at the rear of the truck with his back to the loader.

The deceased was blind in one eye and may not have been able to see the loader when it started to move in reverse. The loader struck the rear of the truck pinning the man between the two vehicles.

The ambulance arrived and their documentation states that the victim had a decreased level of consciousness, appeared unresponsive and was experiencing laboured breathing. They noted a weak pulse and a deformity in the lower left area of the abdomen.

En route to the hospital they indicated his breathing had become more laboured as they reached the hospital doors. He was placed in the emergency room where resuscitation efforts continued until the man was pronounced dead by the ER physician.

X-rays showed a displaced multiple fracture of the pelvis with signs of internal bleeding. Fluid samples drawn for toxicology examination revealed no evidence of alcohol or intoxicating drugs.

The WCB Mining Division investigated the incident and a report was received by the Office of The Chief Coroner. The report concluded that the loader was in proper working condition and that the reverse alarm was operating normally at the time of the accident.

The WCB made 5 orders to the employer in relation to this incident.

In addition, a joint Occupational Health and Safety Committee also made recommendations following their review of the incident:

Although the loader did have a functioning reverse alarm, there was no indication that the carpenter's company vehicle was so equipped. It seems likely that the deceased was aware that the loader was in the vicinity when he backed his truck into place. However, the operator of the loader stated that he did not realize the truck had moved into that position shortly before the accident occurred. Perhaps he may have been alerted to the truck's presence if it had been equipped with a similar alarm.

A recommendation was made that all surface company (and contract) vehicles operating within a mining property be equipped with an audible reverse alarm system.

## CASE # 6

Three passengers on a twin engine charter aircraft died when the airplane that crashed onto a sandbar approximately 1.3 nautical miles from the Fort Liard airstrip.

The aircraft was manned by a single pilot transporting 5 passengers. The plane was on a return trip from Yellowknife when the incident occurred. The aircraft was a twin engine Piper PA-31 Navajo Chieftain.

Search and rescue efforts were mobilized by the Rescue Co-ordination Centre in Trenton, Ontario and military search aircraft were dispatched from Winnipeg and Yellowknife. Although the crash site was less than two miles from the community, the initial search was located much further from the area based on the Emergency Locator Transmitter's data.

RCMP and other local resources were also called into service. The crash site was finally located some 10 hours following the incident and the three survivors were taken to hospital.

The three fatalities were removed from the wreckage and transported to Edmonton for autopsy where it was confirmed that they all died from injuries sustained in the crash.

Because of the late departure and increasing poor weather, the pilot and passengers discussed delaying the flight until the next day. The lone pilot indicated that he was certified for night flying and a decision was made to continue that night.

Although the pilot's period of time since leaving Fort Liard earlier that morning did include a rest period, the quality of that rest period remains uncertain and any potential fatigue he may have experienced on the return flight is not known. He was unable to provide any additional information regarding the flight and the plane was not equipped with a data or cockpit voice recorder.

The last communication during the flight from the pilot was at approximately 10:00 pm in which he did not express any concerns about the flight or the aircraft.

The local CARS in Fort Liard was closed at the time of the flight but aircraft operators have the option of calling out the CARS personnel if they wish for a fee. The company policy at the time was not to do so and no request was made.

The plane was believed to have been heard flying over the community of Fort Liard, however, the first emergency locator transmission initially identified as originating from about 40 miles south of the community. A second ELT position was noted to be 19 miles south east of the community. The actual reason for the positioning errors was unclear but may be due to magnetic interference in the area.

The RCC dispatched a Hercules aircraft from Winnipeg and a twin otter from Yellowknife Both aircraft were equipped with homing equipment. Both arrived in the area and over flew the projected site but were unable to locate the crash site.

On one later pass, the Hercules flew further toward the west and picked up a stronger ELT signal. They were finally able to electronically locate the crash site.

A civilian helicopter was dispatched from Fort Liard and flew low under the weather and was able to make a visual sighting some 10 hours following the incident.

The Transportation Safety Board released a report of their findings and stated that for unknown reasons, the pilot did not maintain adequate altitude during his night circling approach. The pilot had used an unauthorized remote altimeter setting that would have resulted in the cockpit altimeters reading 200 feet higher than the actual altitude.

The aircraft was not fitted with or required to be fitted with a ground proximity warning system and the pilot did not meet the night requirements necessary to carry passengers as specified in the regulations.

Since this incident, the airline has initiated a number of actions. In addition, the Coroner's Office made recommendations to Transport Canada regarding CARS operations and additional equipment requirements.

Recommendations were also made to the Department of National Defence regarding the deployment of Search and Rescue resources, and to the airline that they undertake an independent audit of their current operational protocols.

# APPENDIX "B"

# SUMMARY OF CORONER'S INQUEST INCLUDING RECOMMENDATIONS

# REPORT OF THE JURY VERDICT

## Dana Wentzell (pilot), Kole Crook, Ashley Andrew, Lindsay Andrew (passengers)

| | |
|---|---|
| DATE AND TIME OF DEATH: | Dec 31, 2001, approximately 3:45 pm |
| PLACE OF DEATH: | 65E 47' N by 128E 31' W (30 miles south of Fort Good Hope) |
| CAUSE OF DEATH: | Cold exposure - Multiple Blunt Force Injuries (Crook) |
| MANNER OF DEATH: | Accidental |

On December 31st, 2001, an Ursus Aviation Cessna 172, piloted by Mr. Dana Wentzell left on a return trip to Tulita from Fort Good Hope with three passengers. The pilot had just flown into Fort Good Hope in marginal weather conditions. He elected to continue with the return voyage and the plane was reported overdue to the Department of National Defence Rescue Co-ordination Centre in Trenton, Ontario.

RCMP began a search using local resources while a C-130 Hercules aircraft was dispatched from Winnipeg.

On January 1st, the Hercules aircraft was able to localize the ELT signal from the downed airplane. The location of the crash would prove to be difficult to access and because of the short daylight hours, a decision was made to attempt to access the site at first light.

On January 2nd, military Search and Rescue personnel were flown to the general area above the crash site and were able to transverse the steep slope to the downed aircraft. Upon arrival, they were able to determine that all occupants of the plane were deceased.

They returned to the helicopter and flew back to Norman Wells which was being used as the staging area. The Coroner's Office was notified and efforts were employed to extract the remains and begin the investigation.

The bodies of the deceased were removed from the wreckage over the next two days. Autopsies were held in Edmonton which indicated that one passenger, Mr. Kole Crook had died of injuries sustained in the crash while the other three occupants appeared to have died from cold exposure.

An inquest was ordered to be held in Norman Wells on October 27th 2003. The Inquest heard from 20 witnesses and 6 exhibits were entered as evidence. The jury deliberated for approximately 10 hours before returning with a unanimous verdict and the following recommendations:

## TO TRANSPORT CANADA

1. **Consider allocating audit and enforcement resources not based on complexity but on risk.** *(Rationale: The jury heard evidence that the number of commercial air carriers under their charge is primarily based on the complexity of the operations and not on the risk factor of the operation).*

2. **To require air operators to maintain documented operational safety meetings to cover changes to regulations, seasonal related updates and pro-active discussions.** *(Rationale: The jury felt that to ensure such meetings are regularly held, such meetings should be mandatory and documented).*

3. **A public complaint process such as a 1-800-NUMBER be developed and it's availability be promoted. Seat back cards should be developed and placed in aircraft that fly passenger flights.** *(Rationale: The jury was informed of a process in place for people within the aviation industry to report or lodge a complaint regarding air activity but that no such process was in place for use by the public).*

4. **All northern pilots carry satellite phones.** *(Rationale: self explanatory).*

5. **Any aircraft equipped with shoulder harnesses should have them deemed mandatory during flight.** *(Rationale: The jury was informed that some aircraft are equipped with shoulder restraints for the passengers and/or crew but there use in flight is not mandatory. The jury heard medical testimony that although this particular airplane did not have passenger shoulder restraints, the use of such restraints in some crash incidents may reduce injury).*

6. **Perform a regular audit and update of northern airport and airstrip capabilities and approach local/private aviation service providers on availability of equipment (i.e. de-icers. APU's etc.)** *(Rationale: The jury heard testimony that one of the Hercules crews were unable to confirm if the proper assets and personnel for de-icing their aircraft were available in Norman Wells which caused them to spend their rest period cycle in Whitehorse. It was felt that such information should be gathered and routinely updated and distributed).*

7. **Require all charter passenger flights to file a flight plan similar to what is required on scheduled passenger flights, whenever possible.** *(Rationale: The jury was informed that charter flights are not required to file flight plans with authorities. The jury felt that the requirement of a flight plan should be mandatory as it is with scheduled passenger flights).*

8. **The Pilot Decision Making Course should be improved and updated to include an amendment for northern flying.** *(Rationale: The jury heard that the current mandatory Pilot Decision Making Course is universal and does not currently deal with issues pertaining directly to northern operations).*

9. **406 - GPS assisted Emergency Locator Transmitters should be mandatory on all new commercial aircraft operating in the north and required equipment on current aircraft which routinely operate in the north.** *(Rationale: The jury heard testimony that the 406 unit which transmits GPS co-ordinates would greatly assist in pinpointing the location of downed aircraft and felt that it should be required equipment in the north).*

10. **Implement guidelines for self dispatching in marginal VFR conditions. To include a**

**probationary period for new employees and the necessity of a two person decision.** *(Rationale: The jury was informed that even new pilots in the north can participate in a self dispatch system. It was felt that guidelines for self dispatch should be developed and that new pilots must take part in a consultation process before departing).*

## TO THE GNWT AND MUNICIPAL GOVERNMENTS

11. **Local Emergency Measures Organizations (EMO's) to establish Search and Rescue (SAR) training measures and maintain a current data base for resources and equipment.** *(The jury felt that a resource and equipment data base and local SAR training should be developed and would best be served by maintaining local control through the community EMO's).*

12. **To make available hand held and portable ELT locator equipment including trained individuals to utilize as part of standard EMO equipment.** *(Rationale: The jury felt that availability and training to use locator equipment should be formalized with local control through EMO's).*

13. **CARS stations post weather advisories and reports in a designation, prominent location.** *(The jury heard that pilots currently ask for weather information but it is not necessarily prominently posted).*

14. **GNWT to ensure the reliability of CAR station operations.** *(Rationale: The jury was informed that although the charter was destined for Tulita, no CARS operator was at or scheduled to be at the station. There was also some concern over the availability and dependability of previous operators).*

15. **In consultation with other land owners/users in the NWT such as the Federal Government, aboriginal land claims organizations, etc., consider the development of legislation requiring any owner of a downed aircraft, including the insurer to remove any wreckage deemed to be in a hazardous location or in a hazardous condition.** *(Rationale: The jury was informed that there was no current legislation in place to mandate the removal of the wreckage even though it appeared to be in a hazardous location and condition).*

16. **To promote public awareness concerning proper attire when flying in winter.** *(Rationale: The jury felt that not all the passengers on the flight were properly dressed for cold winter weather should an emergency arrive. It was felt that a public awareness campaign would assist in this regard).*

## THE DEPARTMENT OF NATIONAL DEFENCE

17. **The department review it's operations and re-align, upgrade, re-locate or reassign any personnel, assets, or operational protocols to improve response time to communities in the north.** *(Rationale: The jury heard evidence that the travel time for aircraft responding from southern Canada is often longer than SAR operations located in the mainland provinces).*

18. **Enhance the ability and mobility of 440 squadron in Yellowknife to ensure their participation in northern search and rescue operations. This should be done as a prelude to the previous recommendation.** *(Rationale: The jury felt that 440 Squadron based in Yellowknife should be provided enhanced resources to so that they might provide for a quicker response to northern incidents given their northern location).*

19. **Continue the process of ensuring all organizations involved in Search and Rescue (SAR)**

**implement compatible methods of communication, documentation and procedures.** *(Rationale: The jury heard evidence that some work is ongoing in this area and felt the need to support the continuation of this effort).*

20. **Improve the process of tasking Rangers in order to include them in the Emergency Measures Organization (EMO) resource list.** *(Rationale: The jury felt that the process for requesting the tasking of Rangers in the north was cumbersome and not widely known or understood. They suggest that the process be streamlined and better communicated).*

## RCMP

21. **All RCMP detachments should have sufficient communication equipment for SAR operations (i.e. Sat. Phones).** *(Rationale: The jury heard evidence that communications between ground SAR units, the RCMP and air search units was difficult and non-existent at times. It was felt the RCMP should be better equipped as they play the initial lead role in the early hours of any search operation).*

22. **In a SAR situation, the RCMP shall contact the local EMO in order to utilize their resources and equipment including the set up of a co-ordination and communications centre.** *(Rationale: This recommendation is in keeping with the jury's belief that more local control of SAR operations is needed at the community level. It was felt that a more co-ordinated effort for communications and general search co-ordination is required and that the local EMO would be the best local agency to perform these tasks.*

## NAV CANADA

23. **Flight Service Stations and Community Aerodrome Radio Services (CARS) provide a Notice To Airmen (NOTAM) for icing and low visibility conditions. To be issued in a general broadcast warnings.** *(The jury believed that this is not currently the process being used).*

## URSUS AVIATION

24. **Develop a system to ensure that all company pilots receive all required training including the Icing Airborne Training in a timely manner and that proper documentation is completed.** *(Rationale: The jury was informed that some prerequisite training currently required was either not completed or the training not properly documented. The jury felt some effort to ensure both issues have been addressed is required).*

25. **Ensure that company base station is aware of any flight manifest even if by verbal communication before embarking on a trip.** *(Rationale: The jury heard that manifests are sometimes left with someone at the departing airfield or often just left somewhere at the station when no one is present to accept the document. This leads to difficulty in determining personnel on board a missing aircraft. It was felt that even if a verbal manifest was left at the company headquarters, the list of personnel on board would be easier to obtain).*

# 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.