NORTHWEST TERRITORIES CORONER'S SERVICES

2009 ANNUAL REPORT

TABLE OF CONTENTS

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 established the basis for all Coroner systems in use today.

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

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 falls within the Department of Justice. The Office of the Chief Coroner is located in Yellowknife and oversees all death investigations across the N.W.T. Currently there are 36 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 Coroner's Service is supported through efforts by the Royal Canadian Mounted Police, NWT Health Boards, Fire Marshal's Office, Worker's Safety and Compensation Commission, Transport Safety Board and various other agencies who work closely with the Coroner's Office.

The Chief Coroner is Mr. Garth Eggenberger. Mr. Eggenberger joined the Coroner's Service in May of 1989 and was appointed Chief Coroner on April 1st, 2008.

The Deputy Chief Coroner is Ms. Cathy Menard. Ms. Menard joined the Coroner's Service in February of 1996. She has been with the Department of Justice for 26 years.

There are no staffed facilities in the Northwest Territories to perform autopsies. When an autopsy is required, the body is transported to Edmonton, where the procedure is conducted by the Chief Medical Examiner's Office of Alberta. A medical investigator is available at all times to our office regarding investigations and consultations. 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 Dynalife Medical Laboratories in Edmonton and on occasion by the Chief Medical Examiner's Office in Alberta.

EDUCATION

The NWT Coroner Symposium is held annually in order to impart the principles of sudden death investigation, and continuing education, to Coroners, Health Care Workers, Police Officers and others who are part of the team effort involved in investigating sudden deaths in the NWT.

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 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.

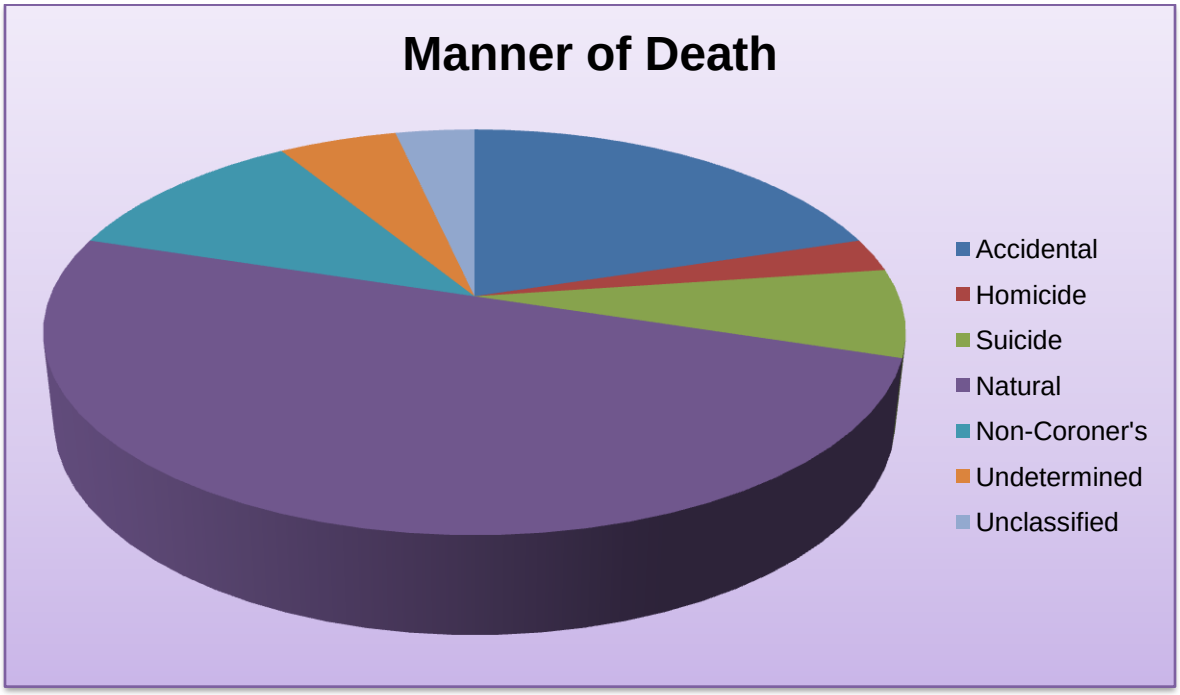
UNDETERMINED is any death which cannot be classified in any of the other categories. The actual cause of death may or may not be known in these cases. An example of an undetermined death would be if the coroner could not rule between two manners of death.

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

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

CASE STATISTICS

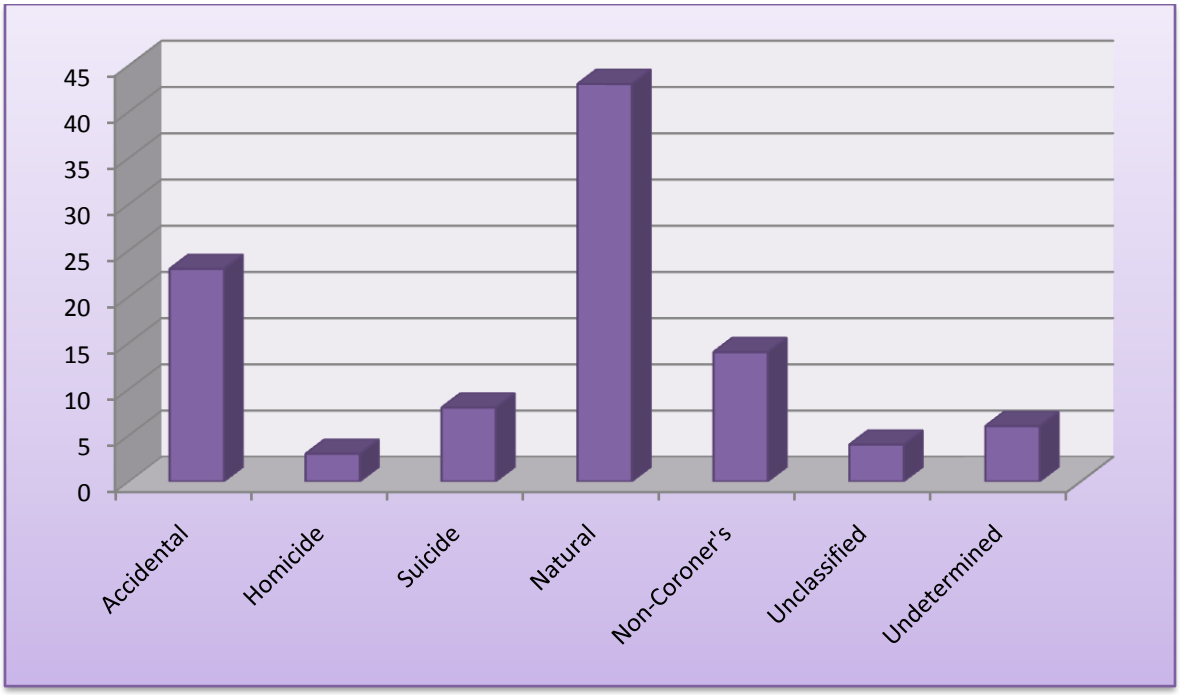
Total Cases			
Manner of Death	**Number**	**Percent (%)**	**Population %**
Accidental	23	22.77	0.053
Homicide	3	2.97	0.006
Suicide	8	7.92	0.018
Natural	57	56.44	0.131
Undetermined	6	5.94	0.014
Unclassified	4	3.96	0.009
Total	101	100.0	0.2125



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

* Based on an NT population of 43, 673 retrieved December 16, 2010 @ http://www.stats.gov.nt.ca/indicators.otp

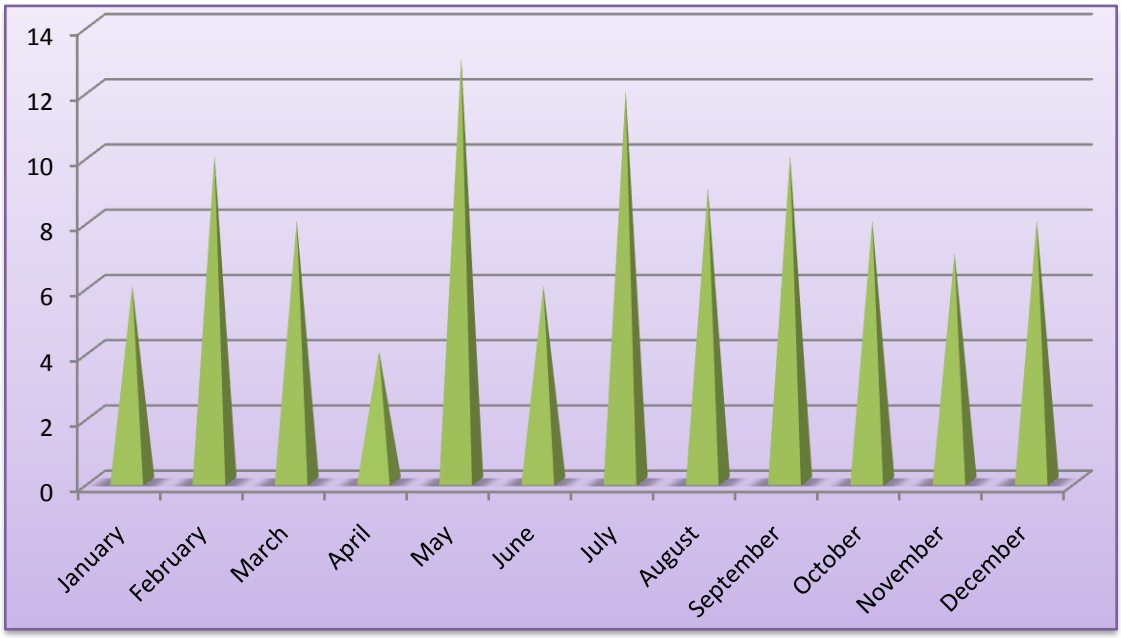
CASELOAD BY MANNER OF DEATH



CASELOAD BY MANNER OF DEATH/COMMUNITY

Community	Accidental	Homicide	Suicide	Natural	Non-Coroners	Unclassified	Undetermined	Total
Aklavik	1			1	1			3
Behchoko	2		1	1	4		1	9
Cambridge Bay			1					1
Colville Lake				1				1
Deline				1	1			2
Gameti		1						1
Fort Good Hope				1				1
Fort McPherson						1		1
Fort Providence	1			1	1			3
Fort Resolution			1					1
Fort Simpson	1			2				3
Fort Smith				4				4
Hay River	1			1				2
Inuvik	2	1		3	3		1	10
Lutsel K'e	1		1					2
Nahanni Butte	2							2
Sachs Harbour	1							1
Trout Lake	1							1
Tuktoyaktuk	3			2	2			7
Tulita	1							1
Ulukhaktok			1	2				3
Whati					1			1
Yellowknife	6	1	3	23	1	3	4	41
Total	23	3	8	43	14	4	6	101

CASELOAD BY MONTH



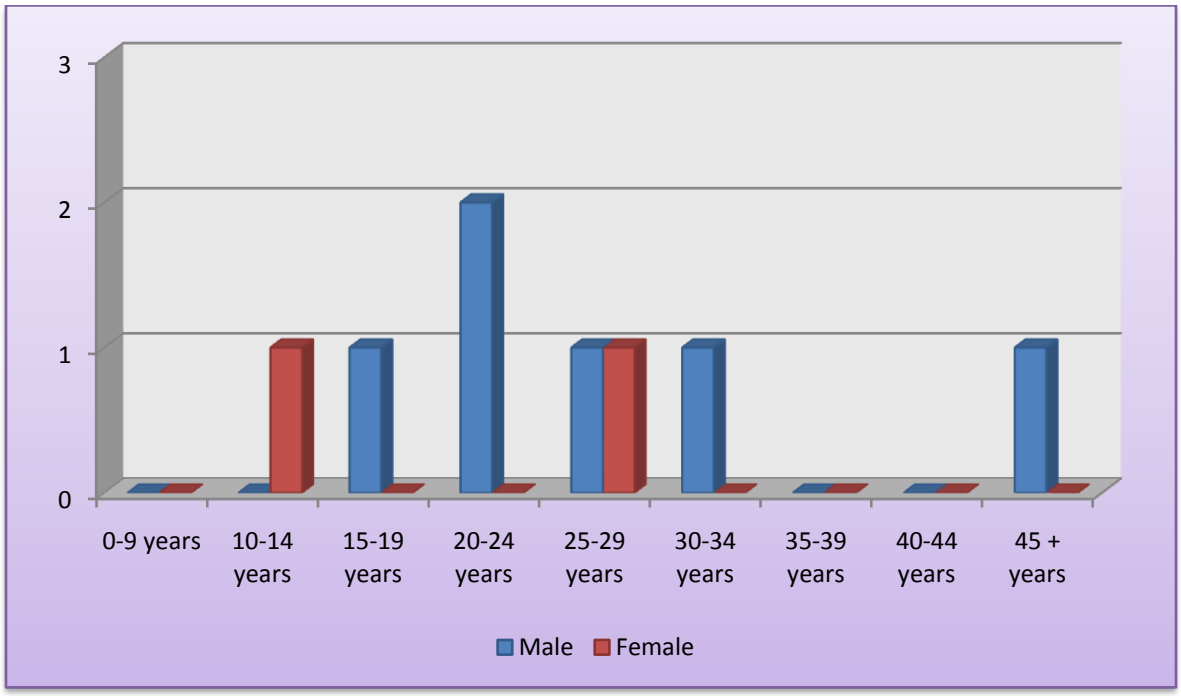
CASELOAD BY MANNER/MONTH

Month	Accidental	Homicide	Suicide	Natural	Non-Coroners	Unclassified	Undetermined	Total
January	2			3	1			**6**
February	2	1	2	5				**10**
March	2			4	2			**8**
April	1		1	1			1	**4**
May	3		1	4	2	1	2	**13**
June	1			4		1		**6**
July	4	1	2	2	2		1	**12**
August	2			5	2			**9**
September	1			4	3	2		**10**
October	3			4	1			**8**
November	1			4	1		1	**7**
December	1	1	2	3			1	**8**
Total	**23**	**3**	**8**	**43**	**14**	**4**	**6**	**101**

SUICIDE BY GENDER/AGE

Age Group	Male	Female	Total
0-9 years			
10-14 years		1	1
15-19 years	1		**1**
20-24 years	2		**2**
25-29 years	1	1	**2**
30-34 years	1		**1**
35-39 years			
40-44 years			
45 + years	1		**1**
Total	**6**	**2**	**8**

In 2009 of the 8 suicide deaths, 6 were male and 2 were female, half of the suicides occurred in the age groups of 20-29 years.

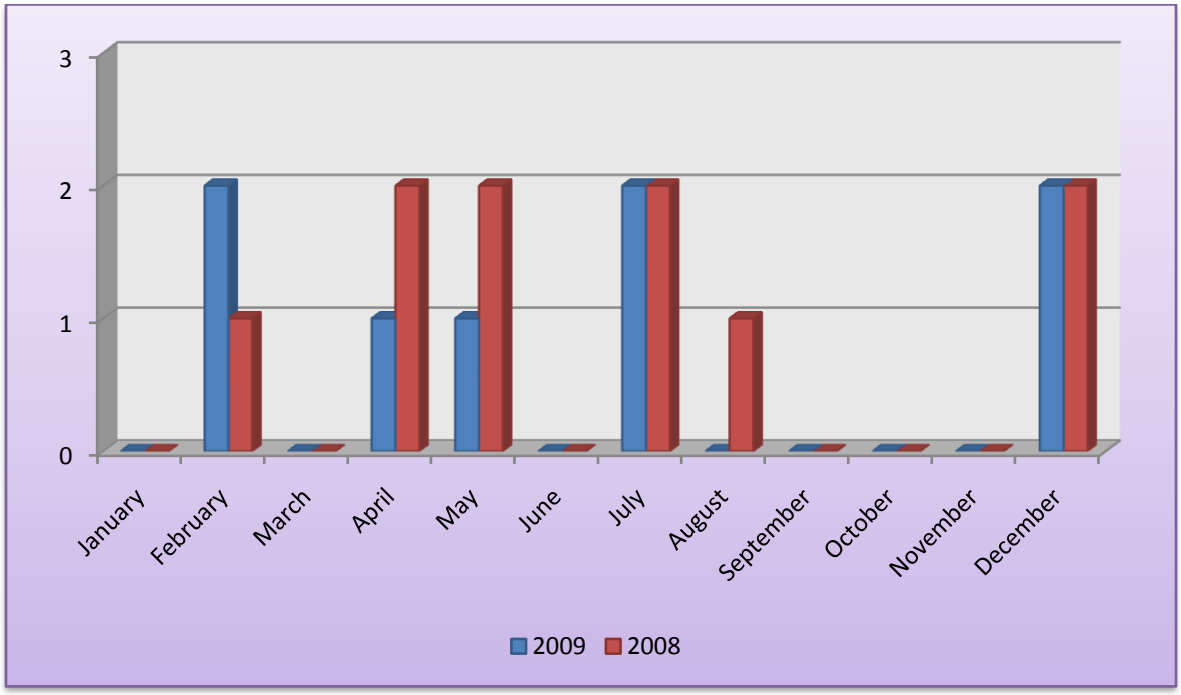


SUICIDE BY MONTH/GENDER/AGE/METHOD

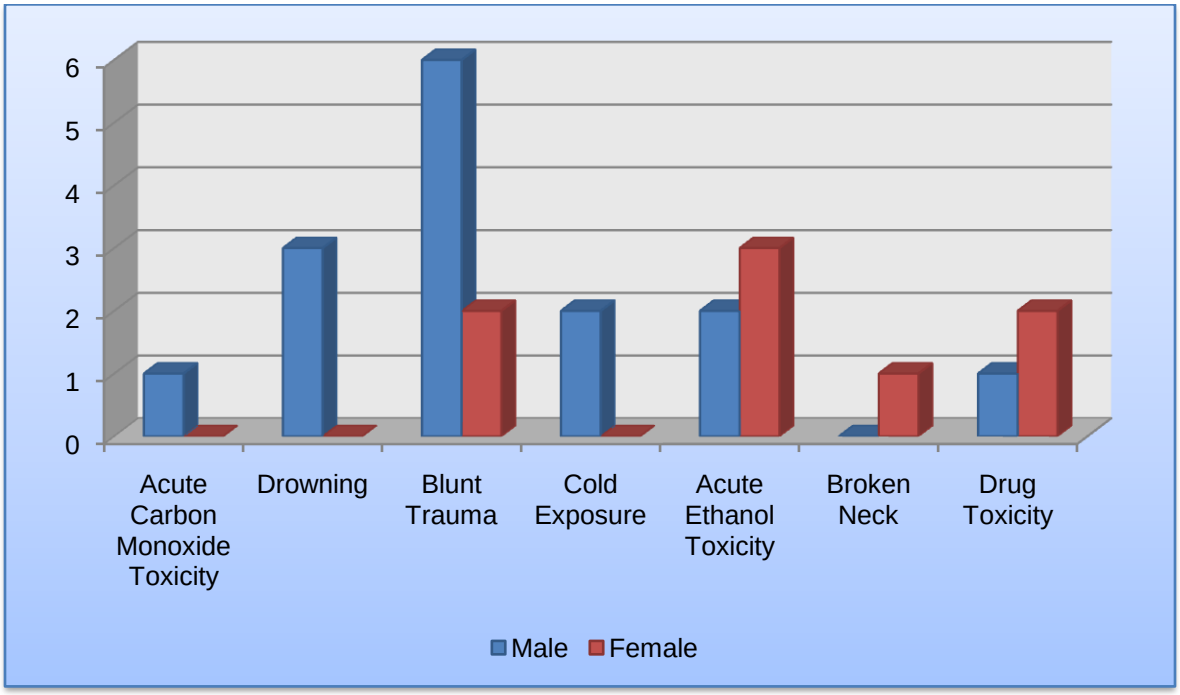
Month	Gender	Age	Method	Alcohol Involvement
February	Male	20	Overdose	No
	Male	16	Hanging	Yes
April	Male	20*	Jumped out of plane	No
May	Male	27	Hanging	No
July	Male	32	Gunshot	No
	Female	14	Hanging	Yes
December	Female	28	Hanging	Yes
	Male	47	Hanging	Yes

Hanging accounted for 5 of the 8 suicides in 2009. Toxicology examination confirmed alcohol in 4 of the 8 suicides. *One of the suicides occurred in Nunavut, and the N.W.T. Office of the Chief Coroner assisted with the investigation.

SUICIDES BY MONTH 2009 – 2008 COMPARISON



ACCIDENTAL DEATH BY CAUSE/GENDER



Cause of Death	Male	Female	Total	Alcohol Related
Acute Carbon Monoxide Toxicity	1		1	
Drowning	3		3	1
Blunt Trauma	6	2	8	5
Cold Exposure	2		2	2
Acute Ethanol Toxicity	2	3	5	5
Broken Neck		1	1	
Drug Toxicity	1	2	3	1
Total	**15**	**8**	**23**	**14**

Accidental death accounted for approximately 23 % of all deaths reported to the Coroner's Service in 2009. The majority of deaths (15 of 23, or 65%) were males.

Blunt Trauma was the cause in 8 of the 23 accidental deaths in 2009 (34.8%).

SUDDEN UNEXPECTED DEATH IN INFANCY

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.

The diagnosis of Sudden Unexpected Death in Infancy (SUDI) is made when there is no cause of death identified at autopsy. A comprehensive death scene investigation is critical to classify SUDI deaths accurately and to help distinguish deaths from SIDS deaths.

In 2009, only one death was attributed to sudden unexpected death in infancy, and it was classified as undetermined.

NATURAL & NON-CORONER CASES

Natural	Non-Coroner	Coroner
43	14	57

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 they die as a result of an incident that occurs in the NWT. Non-Coroner cases are expected, natural deaths that do not fall under the reporting criteria under the *Coroners Act*.

POST MORTEMS

Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
4	6	3	2	4	1	6	5	6	3	2	4

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 46 autopsies were conducted in 2009.

CORONER APPOINTMENTS

The Office of the Chief Coroner has the statutory authority to recommend the appointment and removal, of Coroners. It is desirable for each community to have local Coroners; therefore recruitment of local Coroners is done by the Coroner's Office, the Municipality or Band and the RCMP. Candidates must send our office a copy of their resume, as well as complete an application form outlining any special skills or training that they have which would assist them in the position of Coroner. Written support is received 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 term.

At the close of 2009, there were 36 Coroners across the Northwest Territories; 14 were aboriginal. There were 20 male (6 aboriginal) coroners and 16 female (8 aboriginal) coroners.

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

Aklavik

- Arnulf Steinwand

Behchoko

- Tracey Lynn DeBaie

Deline

- Elizabeth Takazo

Fort Good Hope

- Esther Charney

Fort Liard

- Alan Harris

Fort McPherson

- Winnie Greenland

Fort Providence

- Robert Head

Fort Smith

- Pat Burke, Marion Berls, Tony Jones, Sandy Napier, Steven Shelton, Andrew Turner

Fort Simpson

- John Herring

Hay River

- Doug Swallow, Jim Forsey

Inuvik

- Erin Allooloo, George Doolittle, Gerald Kisoun, Elizabeth Drescher

Lutsel k'e

- Alfred Lockhart

Norman Wells

- Dudley Johnson, Valerie McGregor

Paulatuk

- Bernadette Emma Nakimayak

Tsiigehtchic

- James Andrew Cardinal

Tulita

- Edward McPherson Jr.

Tuktoyaktuk

- Anita Pokiak, Barney Masuzumi

Whati

- Carolyn Coey-Simpson

Yellowknife

- Beth Ann Williams, Garth Eggenberger, Jennifer Eggenberger, Wendy Eggenberger, Fred Wittlinger, Cathy Lee Menard, Maureen Gowans

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 the 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 is completed in all death investigations with the exception of cases where an inquest has been called. At Inquest, the Jury Verdict takes the place of a Report of Coroner.

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

CORONER'S INQUESTS

Coroner cases that are not concluded by a Report of Coroner are ordinarily finalized by the use of a Coroner's Inquest, which is a quasi-judicial hearing held in an open forum. The proceeding utilizes a 6 person jury, who 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 results in recommendations.

A Coroner is obligated by law to hold an inquest whenever the deceased was, at the time of their death, in custody. An inquest can also be held when, in the opinion of a Coroner, it is necessary in order to:

a) Identify the deceased or the circumstances of death;
b) Inform the public of the circumstances of death where it will serve some public purpose;
c) Bring dangerous practices or conditions to the knowledge of the public and facilitate the making of recommendations to avoid a preventable death; or
d) Inform the public of dangerous practices or conditions in order to avoid future preventable deaths.

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

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

APPENDIX "A"

SUMMARY OF SELECTED REPORTS OF CORONER CONTAINING RECOMMENDATIONS

(CONCLUDED IN 2009)

Case # 1

On April 15, 2009, around 13:00 hours, this 27-year-old male was found suspended by a thin rope tied over the top of a closet door. After being cut down, he was transported to the Health Centre where he was stabilized before being sent to Stanton Territorial Health Authority. He was diagnosed with an Anoxic Brain Injury and remained in a depressed state of consciousness throughout his stay at Stanton Territorial Health Authority until his death at 6:15 AM on May 20, 2009.

The Coroner's office was advised and began an investigation. The RCMP in Yellowknife and Kugluktuk were notified. The RCMP had already obtained pictures of the scene and taken statements from the people who attended the scene of the hanging in Kugluktuk.

The decedent was living with his father and mother and had apparently tied a rope around the doorknob on his closet door and then passed the rope over top of the door. He was found by his father who had gone to investigate the unusual sounds coming from the decedent's bedroom. He called for his wife to come and help him cut the rope. Once the rope was cut the decedent's mother phoned the RCMP for assistance. The RCMP phoned to request medical assistance then attended the scene.

A review of the decedent's medical file as well as statements indicated that the deceased was suffering from schizophrenia but was not taking his medication on a regular basis. Two days previously he had called a member of the RCMP to come to talk to him. During this talk the officer was able to get him to take his medication. This is the only time leading up to his death that anyone can ascertain he took his medication. His mother also indicated he had not been eating and his only intake was fruit juice. A number of witnesses had indicated that he had been talking about his older brother and had said he missed him. His brother also committed suicide by hanging.

I find that the deceased died as result of an Anoxic Brain injury due to hanging and I have further classified this death a suicide.

The Office of the Chief Coroner recommends that the Government of the Northwest Territories amend the *Mental Health Act* to allow for earlier intervention when a person stops taking their prescribed medication for a psychiatric illness.

The Office of the Chief Coroner recommends that the Government of Nunavut amend the *Mental Health Act* to allow for earlier intervention when a person stops taking their prescribed medication for a psychiatric illness.

Comments *(Under the present legislation it appears that a person diagnosed with a psychiatric illness and who has been prescribed medication can quit taking their medication at any time without seeing a medical practitioner. In these circumstances, it would seem that the individual's right to continue to live in the community and not the hospital is contingent on them continuing to take their medication.)*

In a number of Provinces they have amended their *Acts* by adding Community Treatment Orders. These orders allow for the treatment in the community of a person with a psychiatric disorder.

Case # 2

This 20 month old male child with a history of respiratory tract infections died while being Medivaced to Stanton Territorial Health Authority from Ulukhaktok. The Coroner's office and the RCMP were notified and began an investigation.

Photos of the decedent were taken and he was prepared for transportation and sent for autopsy. The RCMP took a statement from the decedent's mother.

On March 01, 2008, the decedent was brought to the Ulukhaktok Health Centre with complaints of wheezing and a fever. His condition deteriorated over the next three days. He was medivaced to Inuvik Hospital on March 04, 2008. Swab samples were taken and tested positive for Human Metapneumovirus. The mother indicated that she was told that her son had an ear infection.

On the 5th of March, the decedent attended the Inuvik clinic and then returned home to Ulukhaktok where his condition did not improve. His mother brought him to the Health Centre on the afternoon of March 11, 2008 around 14:00 hours and indicated that his breathing had worsened.

At 15:13 the Doctor was advised of his condition and said he would try to arrange a medivac plane. The Doctor was advised that a medivac plane was not available for several hours. Arrangements were made for the child to be transferred to Stanton Territorial Health Authority The medivac team arrived at the Health Centre at 23:02 and left Ulukhaktok at 00:50 on March 12, 2008 for Yellowknife.

Around twenty minutes into the flight to Yellowknife the decedent stopped breathing, and had no heart-beat. CPR was commenced. The emergency room doctor at Stanton Territorial Health Authority was consulted and he authorized different treatment options, however, at 01:42 the doctor advised the medivac nurse to stop further treatment.

At autopsy the lungs were heavy and wet. A bacterial type pneumonia was identified in the lungs microscopically. There were no other natural diseases or injuries present to account for death.

Blood and body fluids were taken during the autopsy and were submitted for examination. No alcohol was detected. Acetaminophen was present, consistent with a therapeutic dose. The drugs ketamine and midazolam were also detected and were consistent with therapeutic use by the medical personnel.

I find that the decedent died as a result of pneumonia and I further classify the death as Natural.

Recommendations and Comments

I recommend that the Chief Medical Health Officer and the Beaufort Delta Health Authority review the medical care given to this patient.

(Given the patients age, ongoing respiratory problems, the previous history of pneumonia and the deceased's symptoms at the time of the first Medivac, March 04, 2008, observation in a hospital would seem to have been warranted.)

Case # 3

This eleven-year-old female was found unresponsive in bed at her home by her two friends who had spent the night on a "sleep over". The friends advised the girl's parents, who called the nurse and the RCMP. The nurse came to the house but was unable to find any vital signs and pronounced her deceased.

The RCMP and Coroner were notified and began an investigation. The scene and the body were photographed and the body was prepared and transported to Edmonton for autopsy.

A review of the decedent's medical records revealed that she had been taking medication for hypothyroidism. She had suffered a number of seizures in the past, and had been tested with both a CT scan and EEG, both reported normal.

At autopsy, there were no gross natural diseases or injuries present to account for death. Blood and body fluids taken during the course of the autopsy were submitted to the toxicology laboratory. No alcohol or drugs detected.

I find that the decedent died as a result of undetermined natural causes. This is based on no traumatic injuries being present and a negative toxicological examination. This leaves only natural causes as the explanation for the death. There are a number of natural disease processes which can lead to death but leave no signs at autopsy. These are usually related to the heart or brain. Individuals can die suddenly following a seizure.

The most common reason for someone to die suddenly and unexpectedly is a result of cardiac abnormalities (i.e. Cardiac Arrhythmias) due to such conditions as prolonged QT syndrome. Because some of these conditions are potentially inheritable conditions, siblings should be screened for the possibility of these disorders. Given the negative seizure investigation in the past it should be noted that the decedent's past seizures may have been related to a cardiac arrhythmia which spontaneously recovered to normal sinus rhythm. During the arrhythmia there is decreased blood flow to the brain which can trigger a seizure.

I have further classified this death as natural.

Recommendation

1. It is recommended that the Department of Health and Social Services contact any siblings and suggest that they be screened by a physician for the possibility of these disorders.

Case # 4

This 45-year-old male was the occupant of a trailer that was reported to be on fire at approximately 19:00 hours on June 27, 2008. The RCMP arrived at the scene immediately and tried to open the door. The Fire Chief arrived at 19:05 and was able to open the door but due to the smoke was unable to enter the home. When fire fighters arrived at 19:15 they entered the trailer and conducted a search for the occupant. Decedent was found and removed to the outside and an Ambulance was called. When EMS arrived at 19:29 the decedent was found to be not breathing and had no pulse, he was taken to the Inuvik Hospital. He arrived at 19:30 and after 30 minutes of resuscitation he was declared dead at 20:00hours.

The Coroner and the RCMP were notified and began an investigation. Decedent was photographed, an external exam was completed and toxicological samples were obtained. His body was released to his family.

Decedent had spoken to his wife between 13:00 to 13:30 and had told her he would be drinking. His wife attended their residence around 17:30 and found him sleeping on the couch with his clothes on. There was an empty 40oz bottle of rum beside him. His wife cleaned out the ashtrays and put a garbage can with water beside the couch and then left the residence around 18:30 hours, locking the door handle as well as the dead bolt lock.

A review of the decedent's medical file showed he had been treated one month earlier for burns to his left chest wall sustained from a cigarette he dropped while intoxicated.

The results of the toxicological examination of the blood and body fluids showed an alcohol level of 3.59 g/l as compared to the legal definition of .08 g/l for operating a motor vehicle. The examination also revealed a lethal level of Carboxyhemoglobin of 61.5 %.

I find that the decedent died of smoke inhalation with acute alcohol intoxication as a contributing factor. I have further classified the death as Accidental

Recommendations and comments

The Town of Inuvik reviews the Inuvik Fire Department's Standard Operating Procedures to ensure they are compatible with best practices.

Inuvik Fire Department increases the level of emergency medical training given to the Fire Fighters in the Department.

Comments

(In the course of this investigation there were concerns raised regarding the procedures used by the Inuvik Fire Department. There was no first aid rendered to this individual after he was removed from the

fire until the ambulance arrived. There was Oxygen available on the Fire Truck but no one on the fire ground was trained in the use of the equipment.)

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.

The NWT Coroner Services wishes to express our appreciation to the RCMP, health care professionals, and our many other investigative partners that cooperated and assisted with the Coroner's Office in conducting our death investigations over the past year. The Office would also like to thank the NWT Coroners who have frequently shown, under less than perfect conditions, a high level of dedication and professionalism.