Office of the Chief Coroner
Bureau du coroner en chef

NORTHWEST TERRITORIES CORONER SERVICE

2023 ANNUAL REPORT

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INTRODUCTION

The Coroner Service falls under the Territorial Department of Justice for administrative purposes and operates pursuant to the authorities conveyed by the *Coroners Act*, which was initially enacted in 1985 but has been subject to amendment since. The Office of the Chief Coroner is located in Yellowknife and oversees all death investigations. As of December 31, 2023, there were 19 coroners throughout the Northwest Territories, providing service in the communities and regions in which they reside.

All sudden and unexpected deaths occurring in the Northwest Territories must be reported to a coroner. The Coroner Service is responsible for the investigation of reportable deaths in order to determine the identity of the deceased, and the facts concerning when, where, how, and by what means they came to their death. The Coroner Service is supported in its efforts by the Royal Canadian Mounted Police, the Fire Marshal's Office, the Workers' Safety and Compensation Commission, the Transportation Safety Board, and various other agencies that also work closely with the Service.

The Chief Coroner is Garth Eggenberger. Mr. Eggenberger has been with the Coroner Service since 1987.

There are no facilities in the Northwest Territories staffed to perform autopsies. When an autopsy is required, the remains are transported to Edmonton, where the procedure is performed by the Chief Medical Examiner's Office. Following the post-mortem examination, the remains are sent to Foster and McGarvey Funeral Home, which holds a contract for preparation and repatriation. Toxicology services are provided to the Coroner Service by the Graham R. Jones Forensic Toxicology Laboratory.

HISTORY OF CORONER 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, but the evolution of the office is more evident after the Norman Conquest, when the coroner played 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 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 inquire into sudden and unexpected deaths. The coroner was charged with the responsibility of establishing the facts surrounding a death - a duty that provides the basis for all coroner systems in use today.

The duties of the coroner have been modified over the centuries, but the primary focus continues to be the investigation of sudden and unexpected deaths. The rapid industrialization of the 19th century and the associated increase in workplace accidents, led to demands that the coroner also serve a preventative function. This remains an important responsibility of the Coroner Service.

There are two death investigation systems in Canada: the coroner system and the medical examiner system. The coroner system assigns the coroner four major 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 to determine the cause and manner of death. The coroner receives the information from a variety of sources before examining the investigative material, determining facts, and coming to a quasi-judicial decision concerning the death of an individual. The coroner can also make recommendations that may prevent similar deaths.

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

EDUCATION

The NWT Coroner Symposium is held annually to impart the principles of sudden death investigation and to provide continuing education to coroners, health care workers, police officers and others who contribute to the team effort involved in investigating sudden and unexpected deaths in the NWT.

MANNER OF DEATH

The Coroner or an Inquest Jury determines the cause and manner of death. All deaths investigated by the Coroner Service are classified in one of five distinct categories: Natural, Accidental, Suicide, Homicide or Undetermined.

NATURAL - A death which is consistent with the normal or expected course of events, occurring in conformity with the deceased's known or recorded medical history and not caused by any outside event or agency - human or otherwise.

ACCIDENTAL - An unexpected result of an action or actions by a person which results in death to himself or herself, or a death that results from the intervention of a non-human agency.

SUICIDE - A death is a suicide when a person takes his or her own life with intent to do so.

HOMICIDE - A homicide is a death caused directly or indirectly by another person. (Homicide is a neutral term that does not imply fault or blame.)

UNDETERMINED - A death that cannot be classified into one of the above categories is simply classified as "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 of non-human origin.)*

CORONERS ACT – REPORTING 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 Northwest Territories, or as a result of events that occur in the Territories, where the death

(a) occurs as a result of apparent violence, accident, suicide or other apparent cause other than disease, sickness, old age or medical assistance in dying provided accordance with section 241.2 of the *Criminal Code*;

(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 anaesthesia;

(e) occurs as a result of the deceased

(i) having incurred or contracted a disease or sickness,

(ii) having sustained an injury, or

(iii) having been exposed to a toxic substance,

as a result of or in the course of any employment or occupation of the deceased;

(f) is a stillbirth that occurs without the presence of a health care professional;

(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;

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

(i) occurs while the Director of Child and Family Services has the rights and responsibilities of a parent under the *Child and Family Services Act* in respect of the person of the deceased.

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

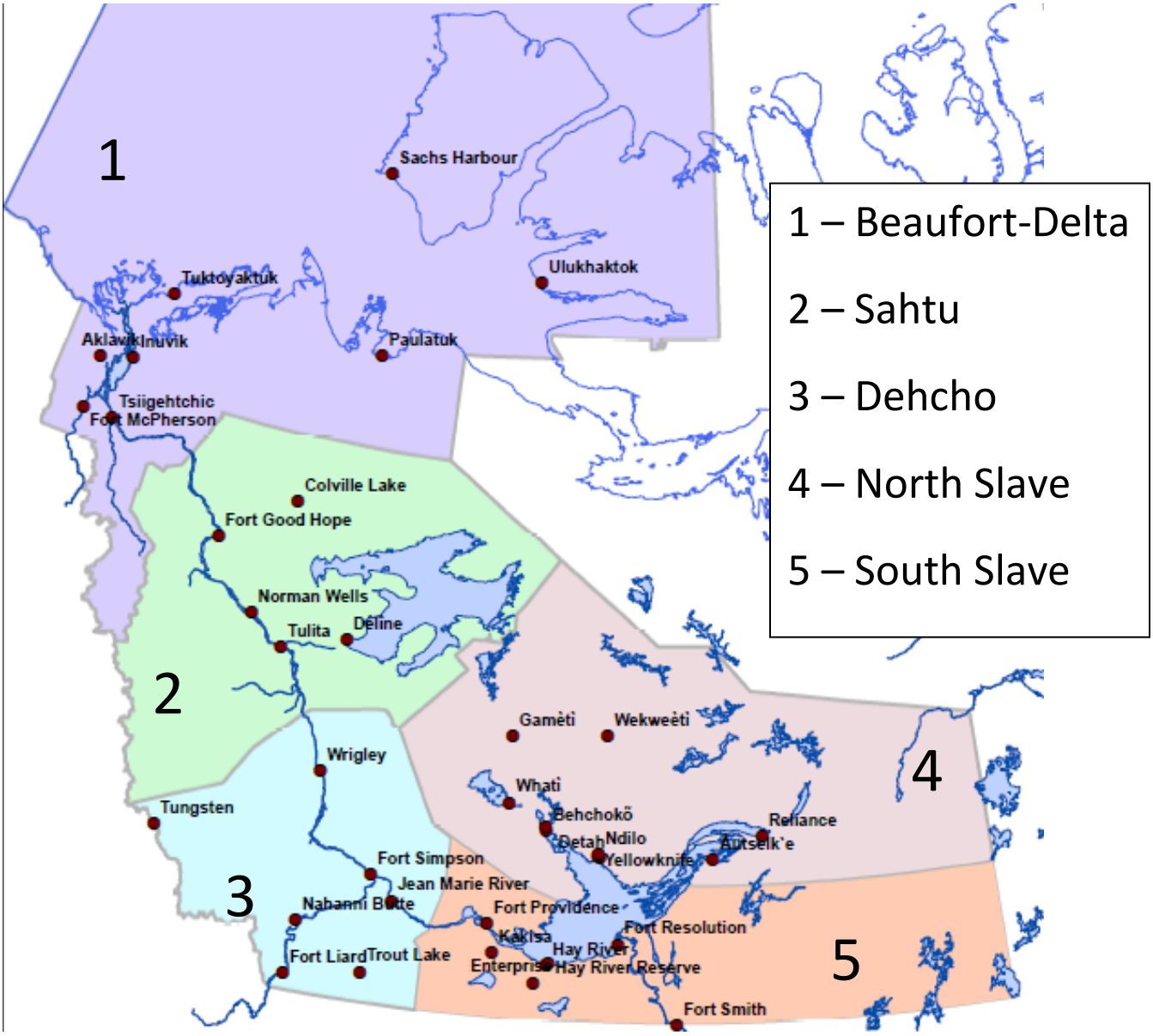
Duty of police officer

(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. S.N.W.T. 2010,c.16,Sch.A,s.9 (3); S.N.W.T. 2015, c.22,s.5; S.N.W.T. 2017,c.16,s.3(2),(3).

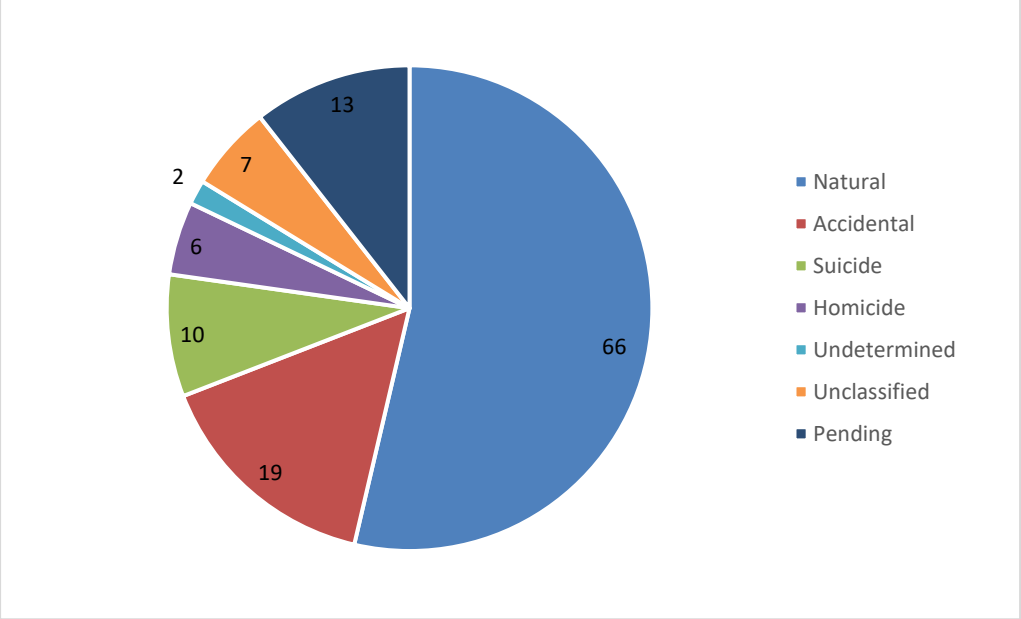
NWT REGIONS


1
2
3
4
5
Sachs Harbour
Ulukhaktok
Tuktoyaktuk
Aklavik
Inuvik
Paulatuk
Tsiigehtchic
Fort McPherson
Colville Lake
Fort Good Hope
Norman Wells
Tulita
Déline
Gamèti
Wekweètì
Wrigley
Whatì
Tungsten
Behchokǫ̀
Ndilo
Dettah
Yellowknife
Reliance
Ts'ude nilee
Fort Simpson
Jean Marie River
Nahanni Butte
Fort Providence
Kakisa
Fort Resolution
Hay River
Enterprise
Hay River Reserve
Fort Liard
Trout Lake
Fort Smith
1 – Beaufort-Delta
2 – Sahtu
3 – Dehcho
4 – North Slave
5 – South Slave

2023 CASE STATISTICS

TOTAL CASES

Total Cases			
Manner of Death	Number *	Cases %	Population % **
Natural	66	53.66%	0.1477%
Accidental	19	15.45%	0.0425%
Suicide	10	8.13%	0.0224%
Homicide	6	4.88%	0.0134%
Undetermined	2	1.63%	0.0045%
Unclassified	7	5.69%	N/A
Pending	13	10.57%	0.0291%
Total	123	100%	0.2753%



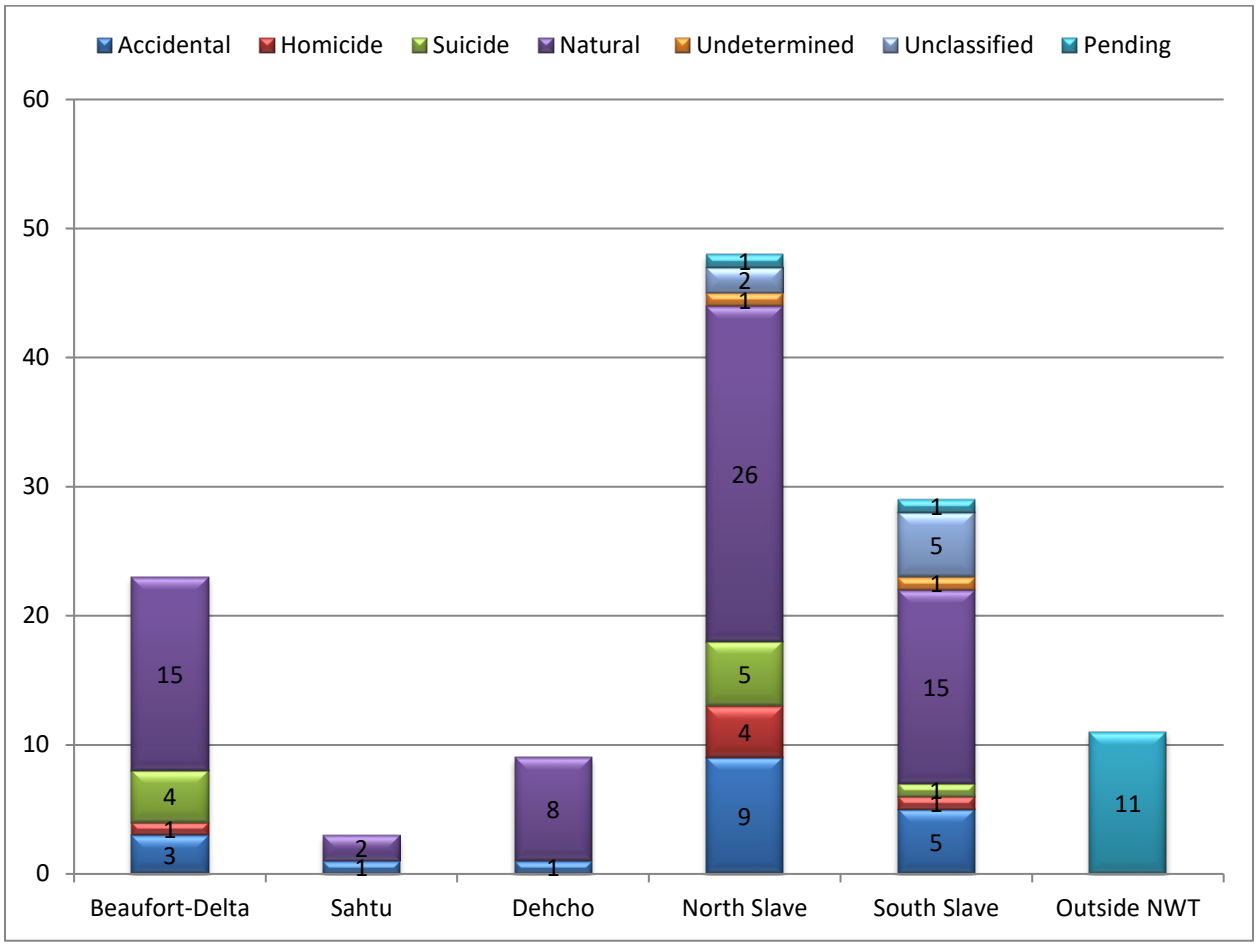
Unclassified cases are not represented in the population figures since they are non-human in origin. In 2023, seven cases were determined to be unclassified.

*The NWT Coroner Service assisted with ten Alberta deaths and one Nunavut death. Out of the eleven deaths that occurred outside of the NWT, three of these deaths occurred during evacuations.

** Based on an NT population estimate of 44,681 retrieved October 15, 2024, at http://www.statsnwt.ca/population/population-estimates/.

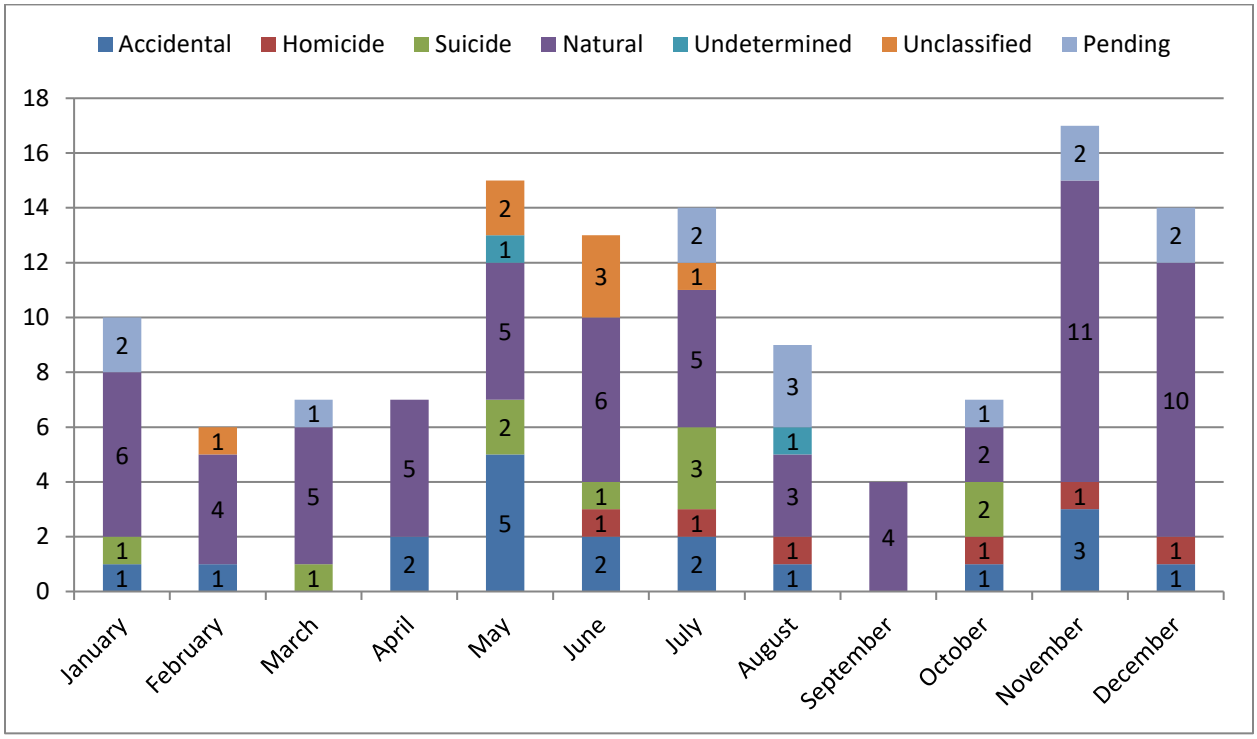
CASELOAD BY MANNER AND REGION

Region	Accidental	Homicide	Suicide	Natural	Undetermined	Unclassified	Pending	Total
Beaufort-Delta	3	1	4	15				23
Sahtu	1			2				3
Dehcho	1			8				9
North Slave	9	4	5	26	1	2	1	48
South Slave	5	1	1	15	1	5	1	29
Outside NWT							11	11
Total	19	6	10	66	2	7	13	123



CASELOAD BY MANNER AND MONTH

Month	Accidental	Homicide	Suicide	Natural	Undetermined	Unclassified	Pending
January	1		1	6			2
February	1			4		1	
March			1	5			1
April	2			5			
May	5		2	5	1	2	
June	2	1	1	6		3	
July	2	1	3	5		1	2
August	1	1		3	1		3
September				4			
October	1	1	2	2			1
November	3	1		11			2
December	1	1		10			2
Total	19	6	10	66	2	7	13

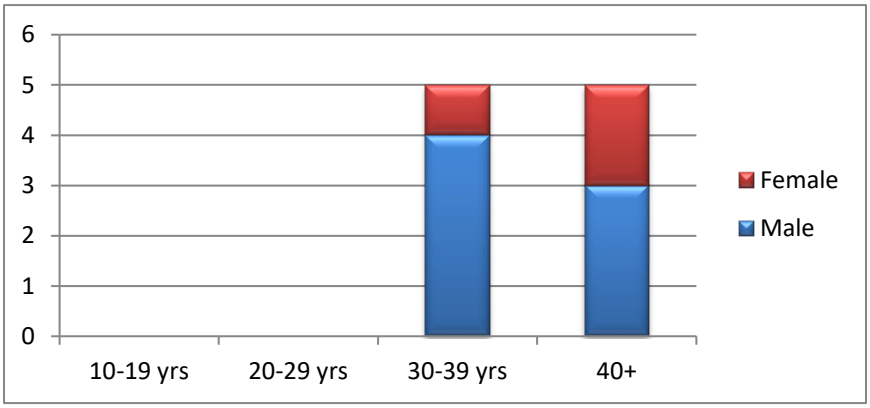


SUICIDE

SUICIDE refers to any death from a self-inflicted injury where there is apparent intent to cause death. In 2023 there were a total of 10 suicides out of a total of 123 deaths, accounting for 8.13% of deaths that year.

BY AGE AND GENDER

Age Group	Male	Female	Total
10-19 yrs			
20-29 yrs			
30-39 yrs	4	1	5
40+	3	2	5
Total	7	3	10



In 2023 there were ten suicides; most of these suicides were male and all were over the age of thirty.

SUICIDE CONTINUED

Suicides by Month, Region, Method, Alcohol, and Drug Involvement

Month	Region	Method	Alcohol Involvement	Drug Involvement
January	South Slave	Hanging	Yes	No
March	North Slave	Hanging	Yes	No
May	North Slave	Hanging	Yes	Yes
May	Beaufort-Delta	Gunshot Wound	Yes	No
June	Beaufort-Delta	Gunshot Wound	No	No
July	Beaufort-Delta	Gunshot Wound	No	No
July	North Slave	Overdose	No	Yes
July	North Slave	Hanging	No	No
October	North Slave	Gunshot Wound	No	No
October	Beaufort-Delta	Hanging	No	Yes

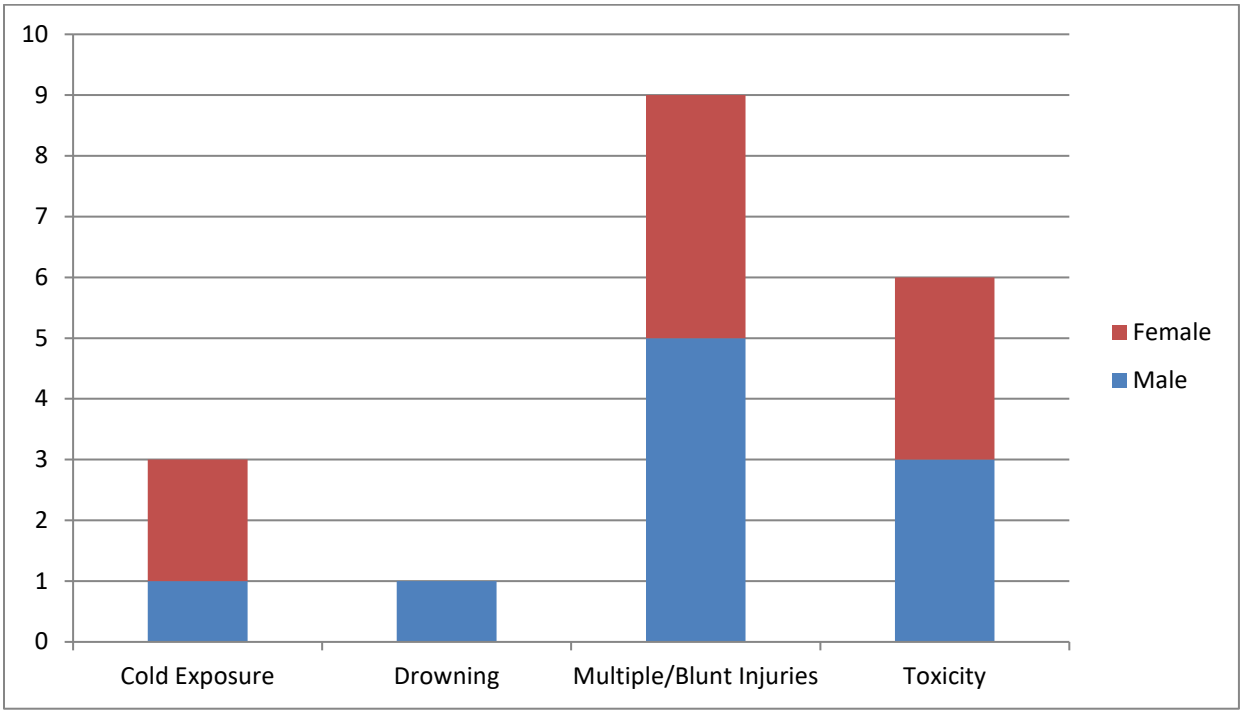
In 2023, most suicides occurred in the North Slave Region followed closely by the Beaufort-Delta. The most common method is hanging followed by gunshot wounds. Five out of the ten suicides had alcohol and/or drugs as a contributing factor in these deaths.

ACCIDENTAL

BY CAUSE AND GENDER

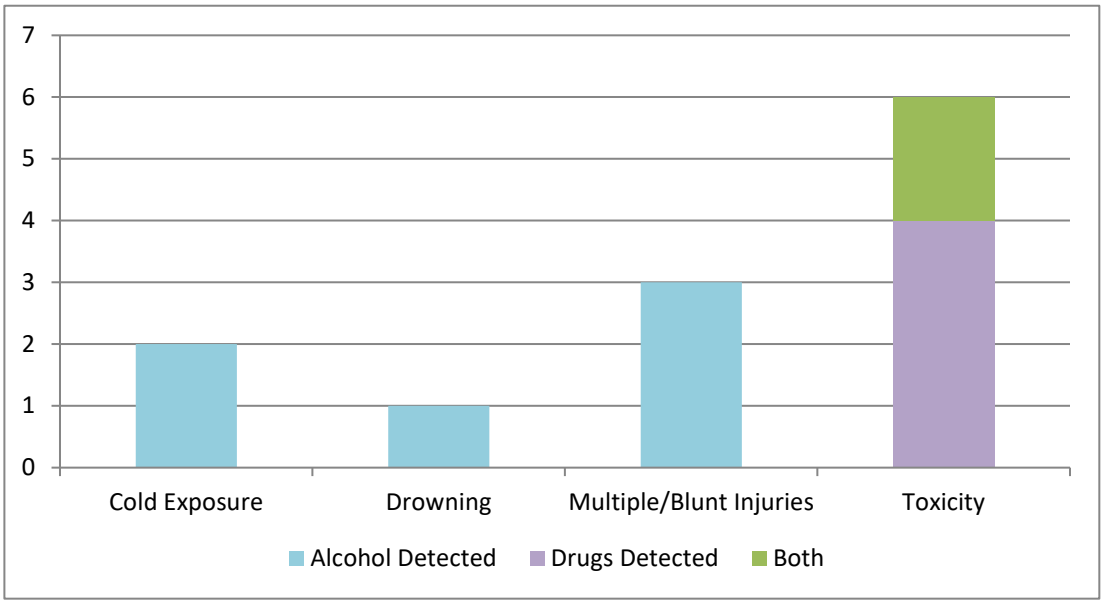
Cause of Death	Male	Female	Total
Cold Exposure	1	2	3
Drowning	1		1
Multiple/Blunt Injuries	5	4	9
Toxicity	3	3	6
Totals	10	9	19

Accidental deaths accounted for approximately 15.45% of reported deaths in 2023. The majority of accidental deaths (10 of 19 or 53%) were males.



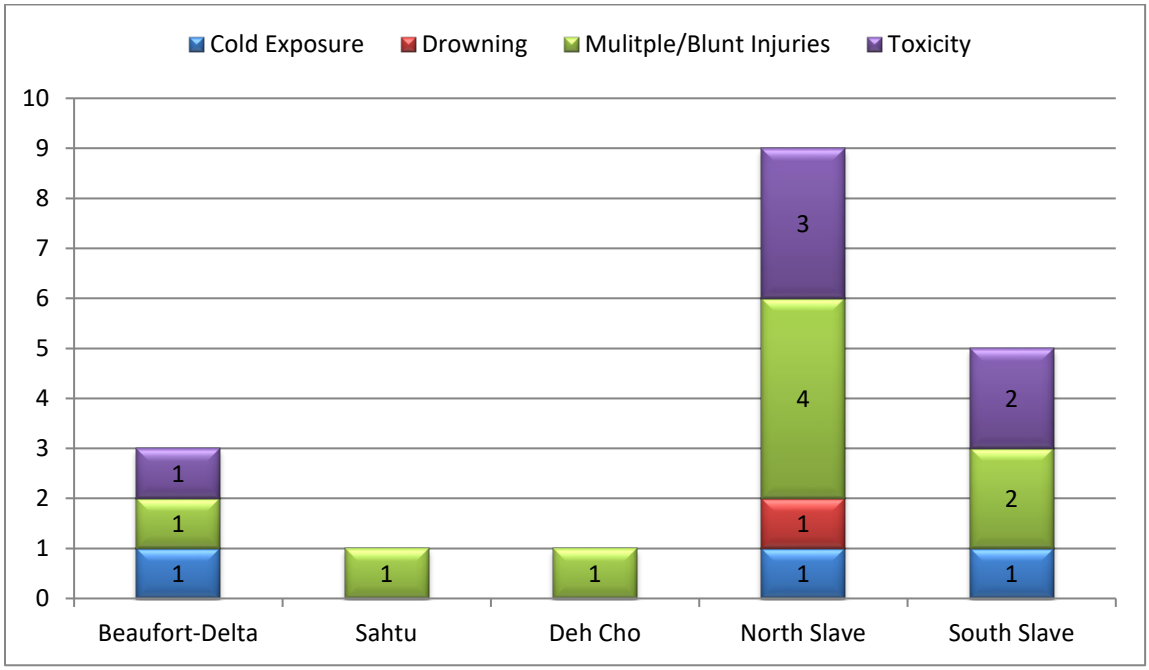
ACCIDENTAL CONTINUED

BY METHOD AND ALCOHOL/DRUGS



Twelve of the nineteen (63%) accidental deaths were alcohol and/or drug related.

BY REGION AND METHOD



Most accidental deaths occurred in the North Slave Region (47%).

HOMICIDE

HOMICIDES BY AGE AND GENDER

Age Group	Male	Female	Total
0-19	1	0	1
20-29	1	1	2
30-39	2	0	2
40-49	1	0	1
Total	5	1	6

In 2023, there were six homicides. Homicides accounted for 4.88% of reported deaths. Most of the homicide deaths were males at 83%.

HOMICIDES BY REGION

Region	Total
Beaufort-Delta	1
Sahtu	0
Dehcho	0
North Slave	4
South Slave	1
Total	6

HOMICIDES BY METHOD

By Method	Total
Fire	1
Gunshot Wound	1
Stabbing	4
Total	6

The majority of homicides occurred in the North Slave Region (67%) and the most common method was stab wounds (67%).

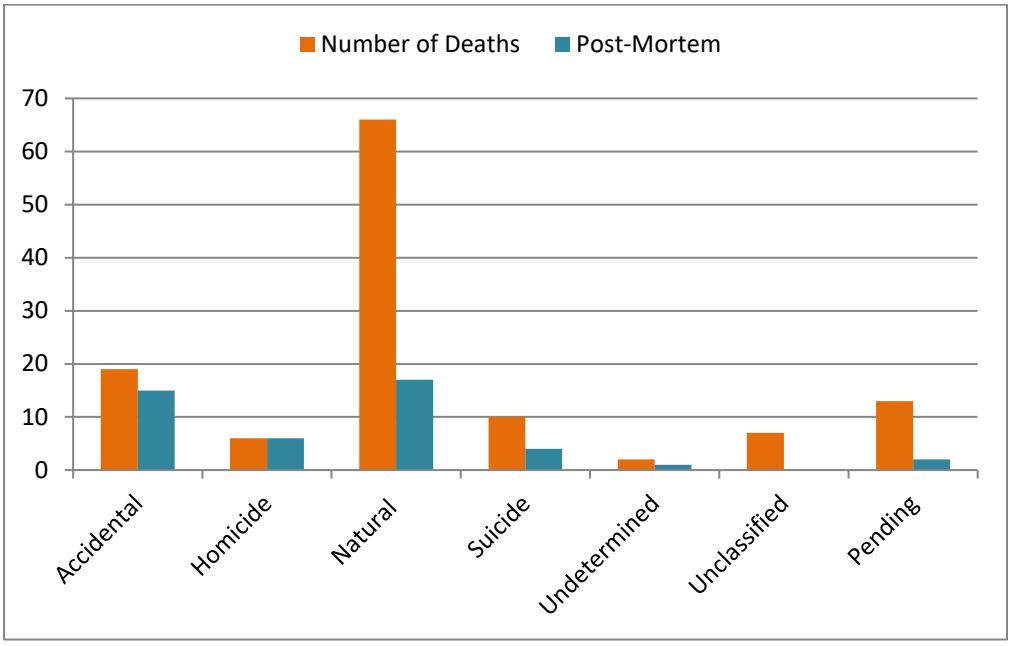
NATURAL AND NON-CORONER CASES

In 2023 there were a total of 66 natural deaths, 62 of which were coroner cases and 4 of which were non-coroner cases. Non-coroner cases are natural deaths that are reported to the Coroners Service but are not captured by the reporting criteria required under the *Coroners Act*.

Coroner	Non-Coroner	Natural
62	4	66

POST-MORTEMS BY MANNER

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. An autopsy may also be a means of determining the identity of the deceased. A total of 45 autopsies were conducted in 2023.



CORONER APPOINTMENTS

The Chief Coroner has the statutory authority to recommend the appointment and removal of coroners. It is desirable for each community to have resident coroners, and recruitment of local coroners is facilitated by the Office of the Chief Coroner and the Government of the Northwest Territories. The Chief Coroner then forwards a recommendation for appointment to the Minister of Justice. The applicant's MLA is also advised of the proposed appointment. Coroners are appointed by the Minister of Justice for a three-year term.

As of December 31, 2023, there were 19 coroners across the Northwest Territories, with 9 men and 10 women.

There are currently no coroners residing in the communities of Aklavik, Colville Lake, Fort Good Hope, Gameti, Whati, Wekweètì, Fort Providence, Enterprise, Lutselk'e, Nahanni Butte, Tulita, Tsiigehtchic, Paulatuk, and Wrigley.

CONCLUDING CORONER INVESTIGATIONS

All coroner cases are generally concluded either by a coroner's report or by inquest. The most common method used is the "Report of Investigating Coroner".

REPORT OF INVESTIGATING CORONER

The Report of Investigating Coroner is a document outlining the results of a coroner's investigation. It summarizes and clarifies the facts and circumstances surrounding the death. The Report establishes the identity of the deceased, classifies the manner of death, and may include recommendations for the prevention of similar deaths. The report is completed in all death investigations except for cases where an inquest is being held. At an inquest the jury verdict takes the place of the Report of Investigating Coroner.

Recommendations are often made and are forwarded to the appropriate department, agency, or person in hopes of providing information and advice that may prevent similar deaths. Reports of Investigating Coroners containing recommendations are distributed as required, and responses are monitored. A synopsis of selected reports containing recommendations is attached (See Appendix "A").

INQUESTS

Coroner cases that are not concluded by a Report of Investigating Coroner would usually be inquired into through a Coroner's Inquest. An inquest is a formal quasi-judicial proceeding that allows for the public presentation of evidence relating to a death.

An inquest proceeding features a presiding coroner and a six-member jury selected in accordance with the *Jury Act*. The inquest hears testimony from sworn witnesses and allows represented parties to participate in cross-examination and to make oral arguments. The jury may make recommendations to prevent future deaths in similar circumstances.

A coroner must hold an inquest when the deceased had been involuntarily detained in custody at the time of the death, unless the coroner is satisfied that the death was due to natural causes and was not preventable. An inquest can also be held when, in the opinion of a coroner, it is necessary:

a) to identify the deceased or determine the circumstances of the death,
b) to inform the public of the circumstances of the death where it will serve some public purpose,
c) to bring dangerous practices or conditions to the knowledge of the public and facilitate the making of recommendations to avoid a preventable death; or
d) to inform the public as to dangerous practices or conditions to avoid preventable deaths.

A synopsis of selected reports containing recommendations resulting from inquests is attached (See Appendix "B").

APPENDIX "A"
SUMMARY OF SELECTED CORONER REPORTS CONTAINING RECOMMENDATIONS (CONCLUDED IN 2023)

THERE WERE NO CORONER REPORTS CONTAINING RECOMMENDATIONS IN 2023.

APPENDIX “B”
SUMMARY OF CORONER’S INQUESTS

EXPRESSIONS OF APPRECIATION

The NWT Coroner Service wishes to express appreciation to the RCMP, health care professionals, and the many other investigative partners that cooperated with and assisted coroners conducting death investigations over the past year. The Service would also like to thank the coroners who demonstrate - often under very difficult conditions - a high level of dedication and professionalism.