

# Office of the Chief Coroner

Annual Report  
**2016**

## **2016 Annual Report**

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The Honourable Carl Urquhart  
Department of Public Safety  
Fredericton  
New Brunswick

Dear Minister:

Pursuant to Section 43 of the *Coroners Act*, I have the honour to submit the Forty-Fifth Annual Report of the Chief Coroner for the period January 1, 2016 to December 31, 2016.

Yours very truly,

GREGORY J. FORESTELL  
Chief Coroner  
Province of New Brunswick

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## **Our Mission**

Coroner Services is an independent and publicly accountable investigation of death agency. Coroner Services is mandated by statute to review all suspicious or questionable deaths in New Brunswick, conduct inquests as may be required in the public interest and does not have a vested interest of any kind in the outcome of death investigations.

## **Historical Background**

### **Origin of the Office of the Coroner**

The office of the coroner is one of the oldest institutions known to English law.

One of the early functions of the office was to enquire into sudden and unexpected deaths. It was the duty of the coroner to establish the facts relating to the death. The coroner used a jury to enable him to ascertain this and to determine whether foul play was involved in the death; if so, the town or village was liable for an additional fine if no felon could be found responsible for this death. This particular function of the office of coroner (to determine the facts surrounding a death), as modified throughout the years, survives as the basis for all coroner systems, which are presently existing in common law jurisdictions.

In the ensuing seven hundred years, no improvement has been made upon the basic questions and they remain: “who was the deceased? How, when, where and by what means did he die?”

An inquest is not a forum to resolve civil disputes nor to conduct prosecutions. An inquest is not a trial and a coroner is not a judge. The proceedings are inquisitorial as opposed to accusatory or adversarial.

Coroners in New Brunswick have been instructed to protect the civil rights of all persons who may have had some connection with the death of the deceased and to ensure that the coroner’s jury has not expressed any conclusion of civil or criminal responsibility or named any person or persons responsible for any act or omission which may have contributed to the death.

# **The New Brunswick Coroner System**

## **Organizational Structure**

In New Brunswick, Coroner Services falls under the Department of the Public Safety for administrative purposes. Supervision of the service is the responsibility of the Chief Coroner who is assisted by a full time Deputy Chief Coroner.

The five full time staff who serve as Regional Coroners in Fredericton/Woodstock, Moncton/Miramichi, Saint John, Bathurst/Campbellton and Edmundston, report to the Chief Coroner.

In addition to the five Regional Coroners, a cadre of experienced investigative staff from other branches with the Department of Public Safety serve as Investigating Coroners. This group provides services primarily on nights and weekends.

Fee-For-Service Coroners continue to provide additional investigative capacity and geographic coverage.

The Regional Coroners provide guidance to the Investigating Coroners and Fee-For-Service Coroners and participate in the development and delivery of training.

## **Notification Requirement**

In New Brunswick the only death exempt from notification to a coroner is one where the person dies of disease or sickness while under treatment of a duly qualified medical practitioner (as long as the death: (i) did not occur during or as a result of pregnancy; (ii) was not sudden and unexpected; and (iii) was not under circumstances which may require an investigation). Coroner Services is responsible for the investigation of all reported deaths in order to determine for each case the identity of the deceased and the facts as to how, when, where and by what means the deceased came to his/her death. The system, therefore, is a vital part of public safety in initially determining whether such reported deaths are due to natural causes, accident, suicide or homicide.

## **Investigative Capacity of Coroner Services**

For investigational purposes Coroner Services has available on request the services of the Royal Canadian Mounted Police or municipal police acting within their respective jurisdictions. Also available to Coroner Services are the services of pathologists located at Regional Laboratories situated at Fredericton, Saint John, Moncton, Campbellton, Miramichi, Bathurst and Edmundston and also the services of the Provincial Forensic Toxicologist located at Saint John.

The identification of a death as a “Type II” case, which needs the special consideration of a forensic pathologist, results in the utilization of the forensic service and requires that the body be transported to Saint John for the autopsy.

Where circumstances warrant, specialized expertise may be provided from outside the Province on complex cases for evidentiary or identification purposes.

### **Purpose of Coroner’s Investigation**

The purpose of the coroner’s investigation for many years was directed towards the investigation of the actual medical cause of death. Now the medical cause of death is only one of many factors to be considered. The non-medical factors causing death are equally important, and in many cases, call for remedial measures to correct conditions hazardous to public safety.

### **The Inquest Decision**

One of the most difficult decisions a coroner has to make is whether or not to hold an inquest.

The Chief Coroner may order an inquest into a death. In some circumstances, a coroner may hold an inquest when required to do so in writing by a Judge of The Court of Queen’s Bench of New Brunswick, a member of the Executive Council or the Chief Coroner

In September 2008, the *Coroners Act* was amended to require a coroner to hold an inquest when a worker dies as a result of an accident occurring in the course of his or her employment at or in a woodland operation, sawmill, lumber processing plant, food processing plant, fish processing plant, construction project site, mining plant or mine including a pit or quarry.

The holding of an inquest has the effect of drawing public attention to the many contributing causes of sudden and unexpected deaths. It is expected that the Coroners Jury will make recommendations directed toward the avoidance of death in similar circumstances.

The Chief Coroner is responsible for bringing the findings and recommendations arising out of inquests to the attention of appropriate persons, agencies and government departments.



## **Summary**

Coroner Services investigates about 22.4 percent of the total of approximately 7,200 deaths per year in the Province. A high percentage of the investigated deaths are determined to be from natural causes. The coroner, in approximately 30.3 percent of the cases, orders autopsies and inquests are ordered in slightly less than one percent of all investigated deaths.

For the period covered by this Report, the Registrar of Vital Statistics recorded 7,217 deaths in the Province of which 1,612 or 22.3% were reported to a coroner. By comparison in the previous year there were 7,290 deaths in the Province of which 1,491 or 20.5% were reported to a coroner.

Appreciation is expressed to all law enforcement agencies and to all other related agencies who have, through the year, co-operated and assisted in the investigations which have been processed through Coroner Services. Also, gratitude is expressed to all coroners who have shown, once again, a high level of dedication and professionalism, frequently under adverse conditions.

The Chief Coroner invites comments or suggestions for modifying or improving any part of the report or regarding any aspect of the overall delivery of coroner services in the Province.

Comments should be directed to:

### **The Office of the Chief Coroner**

P. O. Box 6000  
Fredericton, New Brunswick  
E3B 5H1  
Phone (506) 453-3604  
Fax (506) 453-7124

## **Statistical Summary of Investigated Deaths**

The information provided in this Annual Report is presented for the calendar year 2016.

Annual Reports of the Chief Coroner were presented by calendar year from 1972 to 1992. In 1992/93, the Chief Coroner changed the reporting period to fiscal year to coincide with the implementation of a new computer system. In 2005, the Chief Coroner made the decision to revert to calendar year to coincide with statistical reporting by other Coroner and Medical Examiners across Canada. This will facilitate data sharing and comparison with other provincial and federal government agencies.

Since January 1, 1987 deaths reported to and investigated by Coroner Services have been classified in five distinct categories: natural, accident, suicide, homicide and undetermined.

The **natural** category covers all deaths by disease or illness of natural origins.

The **accident** category includes deaths due to unintentional or unexpected injury. It includes deaths resulting from complications reasonably attributed to the accident.

The **suicide** category covers all cases where the deceased intentionally caused their own death.

The **homicide** category covers all cases where a person intentionally causes another's death.

The **undetermined** category covers any death where it is impossible to determine whether the death was accidental, suicide, homicide or natural. Coroners are instructed to make all possible efforts to classify deaths in one of the other categories before considering this category. An example of a difficult case, which might fall in this category, is that of drug overdose where it is impossible to determine whether death was accidental, suicide or homicide.

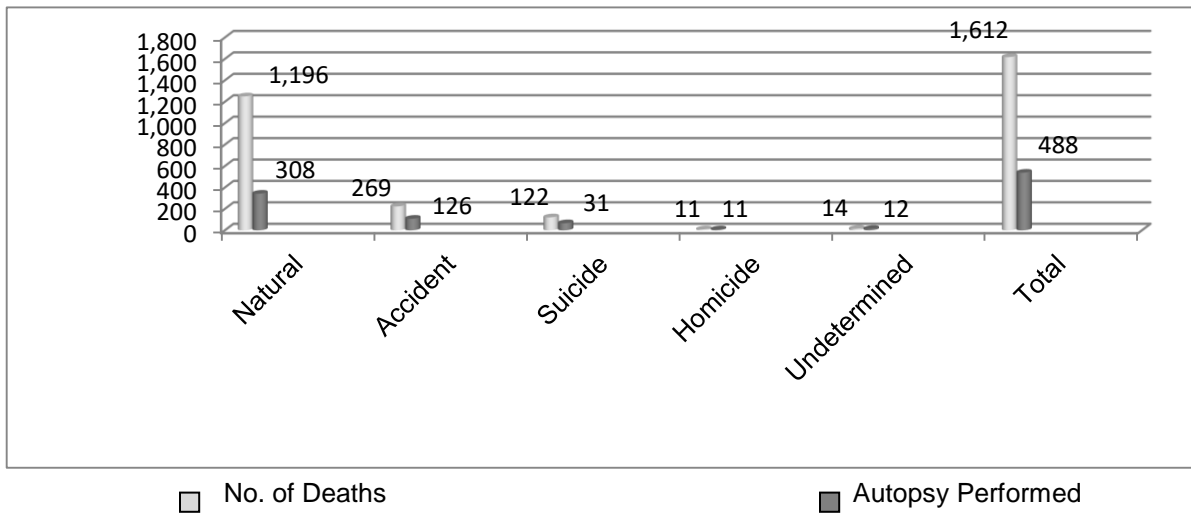
The tables included in this report identify the **Environment**, that is the principal **location** of where the death occurred and the **Death Factor**, that is an action, force, instrument or disease which led directly toward death.

**PROVINCIAL SUMMARY - SCHEDULE A-1**  
from 2016.01.01 to 2016.12.31

Classification	No. of Deaths	% of Deaths	Rate per 100,000 Population	Autopsy Performed	% of classification
Natural	1,196	74.2	157.9	308	25.8
Accident	269	16.7	35.5	126	46.8
Suicide	122	7.6	16.1	31	25.4
Homicide	11	0.7	1.5	11	100.0
Undetermined	14	0.9	1.8	12	85.7
<b>Total</b>	<b>1,612</b>	<b>100.0</b>		<b>488</b>	

**Based on a population of 757,384**

**PROVINCIAL SUMMARY - SCHEDULE A-1**  
from 2016.01.01 to 2016.12.31



NOTE : Based upon Statistics Canada postcensal population estimates for N. B. census divisions (released March 8, 2017). Sub-county estimates are based on the 2011 Census population share of the county.

**Provincial Summary - Deaths Investigated by Classification, by Month - Schedule A-2**  
from 2016.01.01 to 2016.12.31

Classification	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Natural	109	103	109	89	118	85	105	90	87	104	97	100	1,196
Accident	16	17	21	27	18	21	23	24	34	22	25	21	269
Suicide	5	7	9	7	11	14	15	15	12	7	9	11	122
Homicide	2	3	0	1	2	0	1	1	0	1	0	0	11
Undetermined	1	0	1	4	0	0	2	3	1	1	0	1	14
<b>Total</b>	<b>133</b>	<b>130</b>	<b>140</b>	<b>128</b>	<b>149</b>	<b>120</b>	<b>146</b>	<b>133</b>	<b>134</b>	<b>135</b>	<b>131</b>	<b>133</b>	<b>1,612</b>

**DEATHS INVESTIGATED BY JUDICIAL DISTRICT - SCHEDULE A-3**  
from 2016.01.01 to 2016.12.31

	Judicial Districts										Province
	Bathurst	Campbellton	Edmundston	Fredericton	Miramichi	Moncton	Saint John	Woodstock			
Natural	104	53	79	168	68	220	475	29			1,196
Accident	28	18	16	44	23	68	61	11			269
Suicide	19	9	15	7	8	43	19	2			122
Homicide	0	2	2	1	2	1	3	0			11
Undetermined	2	0	0	2	3	6	1	0			14
<b>Total</b>	<b>153</b>	<b>82</b>	<b>112</b>	<b>222</b>	<b>104</b>	<b>338</b>	<b>559</b>	<b>42</b>			<b>1,612</b>
<b>% of Provincial Total</b>	<b>9.5</b>	<b>5.1</b>	<b>6.9</b>	<b>13.8</b>	<b>6.5</b>	<b>20.9</b>	<b>34.7</b>	<b>2.6</b>			<b>100</b>
<b>Population</b>	<b>74,956</b>	<b>30,999</b>	<b>39,824</b>	<b>141,227</b>	<b>46,610</b>	<b>214,298</b>	<b>171,962</b>	<b>37,508</b>			<b>757,384</b>
<b>Death Rate per 100,000 population</b>											
Natural	138.7	170.9	198.4	118.9	145.9	102.7	276.2	77.3			157.9
Accident	37.4	58.1	40.2	31.2	49.3	31.7	35.5	29.3			35.5
Suicide	25.3	29.0	37.7	5.0	17.2	20.1	11.0	5.3			16.1
Homicide	0.0	6.5	5.0	0.7	4.3	0.5	1.7	0.0			1.5
Undetermined	2.7	0.0	0.0	1.4	6.4	2.8	0.6	0.0			1.8
<b>Total deaths by trauma (accident, suicide, homicide)</b>	<b>47</b>	<b>29</b>	<b>33</b>	<b>52</b>	<b>33</b>	<b>112</b>	<b>83</b>	<b>13</b>			<b>402</b>
<b>Rate per 100,000 population</b>	<b>62.7</b>	<b>93.6</b>	<b>82.9</b>	<b>36.8</b>	<b>70.8</b>	<b>52.3</b>	<b>48.3</b>	<b>34.6</b>			<b>53.1</b>

**PROVINCIAL SUMMARY**  
**ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE B-1**  
 from 2016.01.01 to 2016.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Bathurst	1	0	2	1	4	1	2	0	2	3	3	1	4	4	18	10	28	10.4	10	7.9
Campbellton	0	0	1	0	3	0	0	1	4	0	2	0	3	4	13	5	18	6.7	8	6.3
Edmundston	1	0	0	0	1	0	1	1	2	0	1	0	4	5	10	6	16	5.9	5	4.0
Fredericton	0	1	4	1	1	1	2	1	2	1	4	3	11	12	24	20	44	16.4	22	17.5
Miramichi	0	0	2	0	1	1	3	0	1	0	6	0	2	7	15	8	23	8.6	8	6.3
Moncton	2	1	9	2	3	0	4	3	12	4	4	3	13	8	47	21	68	25.3	31	24.6
Saint John	0	2	5	1	2	2	4	2	10	5	2	2	13	11	36	25	61	22.7	32	25.5
Woodstock	2	1	2	0	1	0	0	0	2	1	1	0	1	0	9	2	11	4.0	10	7.9
Males	6		25		16		16		35		23		51		172		269		100.0	
% Total - Males	2.2		9.2		5.9		5.9		13.0		8.6		19.0		63.8		100.0		126	
Females	5		5		5		8		14		9		51		97		269		126	
% Total - Females	1.9		1.9		1.9		3.0		5.2		3.3		19.0		36.2		100.0		126	
Total for Age Group	11		30		21		24		49		32		102							
% of Classification Total	4.1		11.2		7.8		8.9		18.2		11.9		37.9							

**PROVINCIAL SUMMARY**  
**ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2**  
 from 2016.01.01 to 2016.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Drowning - Open Water	0	0	1	0	0	0	2	0	2	0	2	0	0	0	7	0	7	2.6	4	3.2
Drowning - Other - Marsh, Dam, etc.	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.4	1	0.8
Therapeutic Misadventure	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.4	0	0.0
Electrocution	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.4	1	0.8
Trauma of Vehicle Collision	1	2	8	2	3	2	3	1	9	4	3	1	5	0	32	12	44	16.5	21	16.6
Trauma of Vehicle Upset/Rollover	2	0	6	1	2	0	1	1	2	0	1	0	0	0	14	2	16	5.9	12	9.5
Trauma of Vehicle/Pedestrian Collision	0	1	1	1	0	0	0	1	3	0	2	0	4	2	10	5	15	5.7	5	4.0
Trauma of Recreational Vehicle Collision	0	0	0	0	0	0	2	0	1	0	1	0	0	0	4	0	4	1.5	1	0.8
Trauma of Recreational Vehicle Upset/Rollover	0	1	0	0	0	0	1	0	0	0	1	0	0	0	2	1	3	1.1	3	2.4

**PROVINCIAL SUMMARY**  
**ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2**  
 from 2016.01.01 to 2016.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Trauma of Air Crash	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2	0	2	0.7	1	0.8
Carbon Monoxide Poisoning	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	2	0.7	2	1.6
Exposure to cold	1	0	0	0	0	0	0	0	1	0	0	0	1	0	3	0	3	1.1	3	2.4
Fire – Structural	1	0	0	0	0	0	0	0	3	0	2	2	2	1	8	2	10	3.7	8	6.3
Fire - Self	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.4	0	0.0
Fall or jump – same level	0	0	0	0	1	0	1	0	4	2	5	3	31	44	42	49	91	33.6	10	7.9
Fall or jump – different level height; eg. bridge, building	0	0	0	0	0	0	0	0	1	1	0	0	2	3	3	4	7	2.6	1	0.8
Blunt Trauma, Accidental	0	0	1	0	0	0	0	0	2	0	1	0	0	0	4	0	4	1.5	2	1.6
Blunt Trauma	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.4	1	0.8
Cuts from Hand or Power Tools	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.4	1	0.8



**PROVINCIAL SUMMARY**  
**ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2**  
 from 2016.01.01 to 2016.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Caught in Machinery	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.4	1	0.8
Object Caught in Throat	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	2	0.7	0	0.0
Explosion	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.4	1	0.8
Asphyxia	0	1	0	0	1	0	0	0	0	2	0	2	0	0	3	3	6	2.2	5	4.0
Aspiration	0	0	0	0	1	0	0	0	0	0	0	0	1	0	2	0	2	0.7	2	1.6
Alcohol Intoxication	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.4	1	0.8
Alcohol and Drug	0	0	0	0	0	0	0	0	1	0	0	1	0	0	1	1	2	0.7	2	1.6
Drug	0	0	6	1	3	3	5	4	3	5	0	3	0	1	17	17	34	12.7	31	24.5
Drug (street)	0	0	1	0	1	0	1	1	2	0	0	0	0	0	5	1	6	2.2	6	4.8
<b>Males</b>	6		25		16		16		35		23		51		172		269		100.0	
<b>Females</b>	5		5		5		8		14		9		51		97		269		100.0	
<b>Total for Age Group</b>	11		30		21		24		49		32		102							

**PROVINCIAL SUMMARY**  
**ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3**  
 from 2016.01.01 to 2016.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Work Place	1	0	0	0	0	0	0	0	1	0	3	0	0	0	5	0	5	1.9	4	3.2
Factory, Plant, Warehouse (inside)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.4	1	0.8
Commercial Fishing	0	0	0	0	0	0	1	0	0	0	1	0	0	0	2	0	2	0.7	0	0.0
Commercial Drivers – Truck, Taxi, School Bus, etc.	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.4	1	0.8
Farm or Ranch	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.4	1	0.8
Open water (river, lake, stream, brook)	0	0	1	0	1	0	1	0	2	0	1	0	0	0	6	0	6	2.2	6	4.8
Beach / Shoreline	0	0	1	0	0	0	0	0	1	0	0	0	0	0	2	0	2	0.7	2	1.6
Boating – personal watercraft, jet ski, etc.	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.4	0	0.0

**PROVINCIAL SUMMARY**  
**ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3**  
 from 2016.01.01 to 2016.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Snowmobiling (anywhere off public road) - driver	0	0	0	0	0	0	1	0	1	0	1	0	0	0	3	0	3	1.1	1	0.8
ATV driver - on public road	0	0	0	0	0	0	1	0	0	0	1	0	0	0	2	0	2	0.7	1	0.8
ATV driver – off public road	0	1	0	0	0	0	1	0	0	0	0	0	0	0	1	1	2	0.7	2	1.6
Aircraft - (on board)	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2	0	2	0.7	1	0.8
Public Road - driver	0	1	11	0	3	2	4	1	5	3	3	0	4	0	30	7	37	13.8	18	14.2
Public Road - passenger	3	1	1	3	0	0	0	0	1	1	0	1	1	0	6	6	12	4.5	8	6.3
Public Road – motorcycle driver	0	0	2	0	1	0	0	1	4	0	0	0	0	0	7	1	8	3.0	4	3.2
Public Road – bicycle (not motorized vehicle)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.4	0	0.0
Public Road - pedestrian	0	0	1	0	0	0	0	1	1	0	2	0	4	2	8	3	11	4.1	4	3.2

**PROVINCIAL SUMMARY**  
**ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3**  
 from 2016.01.01 to 2016.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Railway - Not on Board (crossing tracks)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.4	0	0.0
Hospital Other (ward, ICU, etc.)	0	0	0	0	0	0	0	0	0	0	1	0	1	3	2	3	5	1.9	0	0.0
Living inside, residence or on property	1	2	7	1	7	3	7	5	13	7	8	7	28	29	71	54	125	46.4	66	52.3
Inside, Other than Residence (mall, restaurant, other public building)	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.4	0	0.0	
Seniors Complex	0	0	0	0	0	0	0	0	0	0	0	0	2	1	2	1	3	1.1	0	0.0
Homes for Special Care	0	0	0	0	0	0	0	0	0	2	0	1	1	5	1	8	9	3.3	0	0.0
Nursing Home	0	0	0	0	0	0	0	0	0	0	0	0	8	9	8	9	17	6.3	1	0.8
Hotel / Motel	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0.4	1	0.8

**PROVINCIAL SUMMARY**  
**ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3**  
 from 2016.01.01 to 2016.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Urban Outdoors -- public place & other (not residence)	0	0	0	0	0	0	0	0	3	0	0	0	2	1	5	1	6	2.2	1	0.8
Rural Outdoors (not built up place or near residence)	1	0	0	1	0	0	0	0	1	0	1	0	0	0	3	1	4	1.5	3	2.4
Males	6		25		16		16		35		23		51		172		269	100.0	126	100.0
Females	5		5		5		8		14		9		51		97					
Total for Age Group	11		30		21		24		49		32		102							

**PROVINCIAL SUMMARY**  
**SUICIDE DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE C-1**  
 from 2016.01.01 to 2016.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F							
Bathurst	0	0	0	0	0	1	5	0	4	2	2	1	4	0	15	4	19	15.6	7	22.6	
Campbellton	0	0	0	0	1	0	2	0	4	1	0	1	0	0	7	2	9	7.4	2	6.5	
Edmundston	0	0	2	1	4	0	2	0	3	0	1	0	2	0	14	1	15	12.3	0	0.0	
Fredericton	1	0	2	1	1	0	1	0	0	0	0	0	1	0	6	1	7	5.7	0	0.0	
Miramichi	0	0	0	0	2	0	1	1	2	0	2	0	0	0	7	1	8	6.6	0	0.0	
Moncton	2	1	9	2	3	0	9	3	4	2	4	1	2	1	33	10	43	35.2	10	32.3	
Saint John	1	0	4	0	2	2	3	0	3	2	1	0	0	1	14	5	19	15.6	12	38.7	
Woodstock	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	1	2	1.6	0	0.0	
Males	4		17		13		23		21		10		9		97						
% Total - Males	3.3		13.9		10.6		18.8		17.2		8.2		7.4		79.4		122	100.0	31	100.0	
Females	1		4		3		4		8		3		2		25						
% Total - Females	0.8		3.3		2.5		3.3		6.6		2.5		1.6		20.6						
Total for Age Group	5		21		16		27		29		13		11								
% of Classification Total	4.1		17.2		13.1		22.1		23.8		10.7		9.0								

**PROVINCIAL SUMMARY**  
**SUICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE C-2**  
 from 2016.01.01 to 2016.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Hanging	3	1	9	2	6	0	13	1	11	1	4	0	1	0	47	5	52	42.7	6	19.4
Electrocution	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.8	0	0.0
Cuts, Stabs	0	0	1	0	1	0	1	0	2	0	0	0	0	0	5	0	5	4.1	1	3.2
Drowning Open Water	0	0	1	0	0	0	0	0	0	0	1	0	1	1	3	1	4	3.3	4	12.9
Asphyxia	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0.8	1	3.2
Strangulation	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0.8	1	3.2
Carbon Monoxide Poisoning - Vehicle Exhaust	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.8	0	0.0
Carbon Monoxide Poisoning	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.8	0	0.0
Poison or Solvent	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0.8	1	3.2

**PROVINCIAL SUMMARY**  
**SUICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE C-2**  
 from 2016.01.01 to 2016.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Shooting - Rifle	1	0	1	0	1	0	2	0	3	0	4	0	5	0	17	0	17	14.0	2	6.5
Shooting - Shotgun	0	0	3	0	3	0	1	0	1	0	1	0	1	0	10	0	10	8.3	2	6.5
Shooting - Handgun	0	0	0	0	0	0	1	0	0	0	0	0	1	0	2	0	2	1.6	0	0.0
Alcohol and Drug	0	0	0	0	0	0	1	0	0	0	0	1	0	1	1	2	3	2.5	0	0.0
Drug	0	0	1	0	1	2	1	3	3	4	0	2	0	0	6	11	17	13.9	11	35.5
Fall or jump – different level, eg. bridge, bldg.	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2	2	1.6	1	3.2
Trauma of Vehicle Upset/Rollover	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0.8	0	0.0
Trauma of Vehicle/Pedestrian Collision	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.8	1	3.2



**PROVINCIAL SUMMARY**  
**SUICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE C-2**  
 from 2016.01.01 to 2016.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F							
Sharp Force Trauma	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0.8	0.0	
Blunt Trauma	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0	0.8	0.0	
Males	4		17		13		23		21		10		9		97		122	31	100.0	100.0	
Females	1		4		3		4		8		3		2			25					
Total for Age Group	5		21		16		27		29		13		11								

**PROVINCIAL SUMMARY**  
**SUICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE C-3**  
 from 2016.01.01 to 2016.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Custody Federal Institution	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.8	0	0.0
Living inside, residence or on property	4	1	12	2	11	2	16	4	15	38	9	3	8	1	75	21	96	78.7	21	67.7
Rooming / Boarding House / Halfway House / Group Home	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.8	0	0.0
Homes for Special Care	0	0	0	0	1	0	0	0	1	0	0	0	0	0	2	0	2	1.6	0	0.0
Work Place	0	0	1	0	0	0	1	0	0	0	0	0	0	0	2	0	2	1.6	0	0.0
Public Road - Driver	0	0	0	1	0	0	1	0	1	0	0	0	0	0	2	1	3	2.5	1	3.2
Public Road- Pedestrian	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.8	1	3.2
Non Public Road - Driver	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.8	1	3.2
Railway – Not on Board (Crossing Tracks)	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.8	0	0.0

**PROVINCIAL SUMMARY**  
**SUICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE C-3**  
 from 2016.01.01 to 2016.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F								
Open Water (river, lake, stream, brook)	0	0	1	0	0	1	0	0	0	0	0	0	1	1	2	2	4	3.3	3	9.7		
Ocean	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.8	1	3.2		
Urban Outdoors - public place and other (not residence)	0	0	1	1	0	0	1	0	0	0	0	0	0	0	2	1	3	2.5	2	6.5		
Rural Outdoors (not built up place or near residence)	0	0	2	0	0	0	3	0	1	0	0	0	0	0	6	0	6	4.9	1	3.2		
<b>Males</b>	4		17		13		23		21		10		9		97		122		31		100.0	
<b>Females</b>	1		4		3		4		8		3		2		25		122		31		100.0	
<b>Total for Age Group</b>	5		21		16		27		29		13		11									

**PROVINCIAL SUMMARY**  
**HOMICIDE DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE D-1**  
 from 2016.01.01 to 2016.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Campbellton	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	2	18.2	2	18.2
Edmundston	0	0	0	0	0	0	1	0	0	0	1	0	0	0	2	0	2	18.2	2	18.2
Fredericton	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	9.1	1	9.1
Miramichi	0	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	2	18.2	2	18.2
Moncton	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	9.1	1	9.1
Saint John	0	0	2	0	0	0	0	1	0	0	0	0	0	0	2	1	3	27.2	3	27.2
Males	0	0	2	2	2	2	2	2	1	1	1	1	1	1	9	0	9		0	
% Total - Males	0.0	0.0	18.2	18.2	18.2	18.2	18.2	18.2	9.1	9.1	9.1	9.1	9.1	9.1	81.9	0	11	100.0	11	100.0
Females	0	0	0	0	0	0	1	1	0	0	0	0	1	1	0	2	0	0	0	0
% Total - Females	0.0	0.0	0.0	0.0	0.0	0.0	9.1	9.1	0.0	0.0	0.0	0.0	9.1	9.1	18.2	0	0	0	0	0
Total for Age Group	0	0	2	2	2	2	3	3	1	1	1	1	2	2	0	0	0	0	0	0
% of Classification Total	0.0	0.0	18.2	18.2	18.2	27.2	18.2	27.2	9.1	9.1	9.1	9.1	18.2	18.2						

**PROVINCIAL SUMMARY**  
**HOMICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE D-2**  
 from 2016.01.01 to 2016.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Blunt Trauma, Beating	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	9.1	1	9.1
Blunt Trauma	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	9.1	1	9.1
Sharpe Force Trauma	0	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	2	18.2	2	18.2
Cuts, Stabs	0	0	0	0	1	0	0	1	0	0	1	0	0	0	2	1	3	27.2	3	27.2
Shooting – Shotgun	0	0	0	0	0	0	1	0	0	0	0	0	1	2	2	0	2	18.2	2	18.2
Strangulation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	9.1	1	9.1
Undetermined	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1	0	1	9.1	1	9.1
Males	0	0	2	0	2	2	2	1	1	1	1	1	1	9	9	0	11	100.0	11	100.00
Females	0	0	0	0	0	0	1	0	0	0	0	0	1	2	0	2	2	100.0	2	100.00
Total for Age Group	0	0	2	0	2	2	3	1	1	1	1	1	2	11	11	0	11	100.0	11	100.00

**PROVINCIAL SUMMARY**  
**HOMICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE D-3**  
 from 2016.01.01 to 2016.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Living Inside, Residence or on Property	0	0	1	0	2	0	2	1	0	0	0	1	0	1	1	7	2	9	9	81.8
Rural Outdoors (not built up place or near residence)	0	0	1	0	0	0	0	0	1	0	0	0	0	0	2	0	2	2	2	18.2
Males	0		2		2		2		1		1		1		9					
Females	0		0		0		1		0		0		1			2		11	11	100.0
Total for Age Group	0		2		2		3		1		1		2							

**PROVINCIAL SUMMARY**  
**NATURAL DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE E-1**  
 from 2016.01.01 to 2016.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Bathurst	0	2	0	1	0	1	2	2	13	4	22	15	18	24	55	49	104	8.7	33	10.7
Campbellton	0	0	0	0	0	0	1	2	12	5	10	1	16	6	39	14	53	4.4	16	5.2
Edmundston	0	0	0	0	2	1	4	2	9	4	13	3	27	14	55	24	79	6.6	15	4.9
Fredericton	1	0	4	0	4	3	4	2	20	4	25	8	46	47	104	64	168	14.0	77	25.0
Miramichi	0	1	0	0	4	1	6	2	6	3	11	2	25	7	52	16	68	5.7	19	6.2
Moncton	0	2	3	1	3	3	9	8	17	5	26	23	73	47	131	89	220	18.4	69	22.3
Saint John	3	7	1	3	3	3	12	6	38	23	85	53	135	103	277	198	475	39.8	67	21.8
Woodstock	0	0	0	0	0	0	1	0	3	2	8	3	4	8	16	13	29	2.4	12	3.9
Males	4		8		16		39		118		200		344		729					
% Total - Males	0.3		0.7		1.3		3.3		9.9		16.7		28.8		61.0		1,196	100.0	308	100.0
Females	12		5		12		24		50		108		256		467					
% Total - Females	1.0		0.4		1.0		2.0		4.2		9.0		21.4		39.0					
Total for Age Group	16		13		28		63		168		308		600							
% of Classification Total	1.3		1.1		2.3		5.3		14.0		25.8		50.2							

**PROVINCIAL SUMMARY**  
**NATURAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE E-2**  
 from 2016.01.01 to 2016.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Object Caught in Throat	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	0	0.0
Medical Procedure	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	2	2	0.2	0	0.0
Live Birth (1 day)	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0.1	0	0.0
Natural Disease	4	11	8	5	16	12	39	24	117	50	199	107	344	255	727	464	1191	99.5	308	100.0
Chronic Use of Alcohol	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	0	0.0
Males	4		8		16		39		118		200		344		729		1196	100.0	308	100.0
Females	12		5		12		24		50		108		256			467				
Total for Age Group	16		13		28		63		168		308		600							



**PROVINCIAL SUMMARY**  
**NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3**  
 from 2016.01.01 to 2016.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Factory, Plant, Warehouse (inside)	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	1	0.3
Factory, Plant, Warehouse (outside)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	1	0.3
Work Place	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0.1	1	0.3
Farm or Ranch	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	1	0.3
Logging / Tree Cutting - Commercial	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0.0
Seniors Complex	0	0	0	0	0	0	0	0	0	0	0	1	8	6	8	7	15	1.2	1	0.3
Community Residence	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	2	2	0.2	0	0.0
Nursing Home	0	0	0	0	1	0	0	0	0	0	5	4	22	32	28	36	64	5.3	7	2.4
Homes for Special Care	0	0	0	0	0	0	1	1	0	0	1	2	11	17	13	20	33	2.7	4	1.3
Unlicensed Residential Homes (retirement, rest, etc.)	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	1	2	0.2	0	0.0

**PROVINCIAL SUMMARY**  
**NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3**  
 from 2016.01.01 to 2016.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Living inside, residence or on property	3	6	5	5	11	12	31	22	106	47	174	95	271	192	601	379	980	81.8	260	84.5
Rooming/Boarding House/Halfway Home/Group Home	0	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	2	0.2	0	0.0
Inside, other than residence (mall, restaurant, other public building)	0	0	1	0	0	0	0	0	0	0	2	0	6	2	9	2	11	0.9	1	0.3
Hotel / Motel	0	0	1	0	1	0	1	0	1	0	0	0	2	0	6	0	6	0.5	3	1.1
Hospital Emergency - NON DOA	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0.1	0	0.0
Hospital Post Op (Recovery Room)	0	0	0	0	0	0	0	0	0	0	1	0	1	0	2	0	2	0.2	1	0.3
Hospital Other (ward, ICU, etc.)	1	4	0	0	0	0	1	0	2	1	4	1	5	2	10	11	21	1.7	1	0.3
Psychiatric Hospital	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	2	0.2	1	0.3
Custody Provincial Institution	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	0	0.0

**PROVINCIAL SUMMARY**  
**NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3**  
 from 2016.01.01 to 2016.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Cruise Ship	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	2	2	0.2	0	0.0
Beach/Shoreline	0	0	0	0	0	0	0	0	0	0	0	0	2	1	2	1	3	0.3	2	0.6
Open Water (river, lake, stream, brook)	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	1	2	0.2	2	0.6
Camping / Tenting	0	0	0	0	0	0	0	1	3	0	2	0	1	0	6	1	7	0.6	4	1.3
Other Outdoor recreation	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0.0
Public Road – Driver	0	0	0	0	1	0	2	0	1	0	4	0	0	0	8	0	8	0.7	5	1.6
Public Road - Passenger	0	1	0	0	0	0	0	0	1	0	0	0	0	0	1	1	2	0.2	2	0.6
Public Road - Pedestrian	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	1	0.3
Snowmobiling (anywhere off public road) - driver	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	0	0.0

**PROVINCIAL SUMMARY**  
**NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3**  
 from 2016.01.01 to 2016.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Urban Outdoors- public place and other (not residence)	0	0	1	0	2	0	0	0	0	0	0	6	1	15	1	16	1.2	7	2.4	
Rural Outdoors (not built up place or near residence)	0	0	0	0	0	0	0	0	1	0	2	0	3	6	0	6	0.5	2	0.6	
Males	4		8		16		39		118		200		344	729						
Females	12		5		12		24		50		108		256	467		1,196	100.0	308	100.0	
Total for Age Group	16		13		28		63		168		308		600							

**PROVINCIAL SUMMARY**  
**UNDETERMINED DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE F-1**  
 from 2016.01.01 to 2016.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F							
Bathurst	1	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1	2	14.3	1	8.3	
Fredericton	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	1	2	14.3	2	16.7	
Miramichi	0	2	0	0	0	0	0	0	0	1	0	0	0	0	0	3	3	21.4	2	16.7	
Moncton	2	2	1	0	0	0	0	0	0	0	1	0	0	0	4	2	6	42.9	6	50.0	
Saint John	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	7.1	1	8.3	
Males	3		2		0		0		0		2		0		7						
% Total - Males	21.4		14.3		0.0		0.0		0.0		14.3		0.0		50.0		14	100.0	12	100.0	
Females	4		0		0		1		1		1		0			7					
% Total - Females	28.7		0.0		0.0		7.1		7.1		7.1		0.0			50.0					
Total for Age Group	7		2		0		1		1		3		0								
% of Classification Total	50.0		14.3		0.0		7.1		7.1		21.4		0.0								

**PROVINCIAL SUMMARY**  
**UNDETERMINED DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE F-2**  
 from 2016.01.01 to 2016.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F							
Trauma of Vehicle / Pedestrian Collision	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	7.1	1	8.3	
Drug	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	7.1	0	0.0	
No Anatomical Cause	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	2	2	14.3	2	16.7	
Undetermined	3	3	1	0	0	0	0	1	0	0	2	0	0	0	6	4	10	71.4	9	75.0	
Males	3		2		0		0		0		2		0		7		14	100.0	12	100.0	
Females	4		0		0		1		1		1		0			7					
Total for Age Group	7		2		0		1		1		3		0								

**PROVINCIAL SUMMARY**  
**UNDETERMINED DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE F-3**  
 from 2016.01.01 to 2016.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Rural Outdoors (not built up place or near residence)	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	7.1	1	8.3
Living inside, residence or on property	2	4	1	0	0	0	0	1	0	1	0	1	0	0	3	7	10	71.6	8	66.8
Homes for Special Care	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	7.1	1	8.3
Public Road - Pedestrian	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	7.1	1	8.3
Crib, Play Pen, Slide, Swing	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	7.1	1	8.3
Males	3		2		0		0		0		2		0		7		14	100.0	12	100.0
Females	4		0		0		1		1		1		0			7				
Total for Age Group	7		2		0		1		1		3		0							

## Schedule F

### Undetermined Deaths (Means of death impossible to determine)

There were fourteen deaths classified as Undetermined.

#### Two were in the Bathurst Judicial District:

##### Case #1

Death Factor: Undetermined  
Environment: Living Inside, Residence or on Property  
Age Group: 0 - 10  
Sex: Male  
An autopsy was performed.

##### Case #2

Death Factor: Undetermined  
Environment: Living Inside, Residence or on Property  
Age Group: 40 - 50  
Sex: Female  
An autopsy was not performed.

#### Two were in the Fredericton Judicial District:

##### Case #1

Death Factor: No Anatomical Cause  
Environment: Living Inside, Residence or on Property  
Age Group: 60 - 70  
Sex: Female  
An autopsy was performed.

##### Case #2

Death Factor: Undetermined  
Environment: Rural Outdoors (not built up place or near residence)  
Age Group: 60 - 70  
Sex: Male  
An autopsy was performed.



**Undetermined Deaths  
0(Means of death impossible to determine)**

**Three were in the Miramichi Judicial District:**

**Case #1**

Death Factor: Undetermined  
Environment: Living Inside, Residence or on Property  
Age Group: 0 - 10  
Sex: Female  
An autopsy was performed.

**Case #2**

Death Factor: Undetermined  
Environment: Living Inside, Residence or on Property  
Age Group: 0 - 10  
Sex: Female  
An autopsy was performed.

**Case #3**

Death Factor: Drug  
Environment: Living Inside, Residence or on Property  
Age Group: 50 - 60  
Sex: Female  
An external body examination was performed.

**Six were in the Moncton Judicial District:**

**Case #1**

Death Factor: No Anatomical Cause  
Environment: Living Inside, Residence or on Property  
Age Group: 0 - 10  
Sex: Female  
An autopsy was performed.

**Undetermined Deaths (continued)**  
**(Means of death impossible to determine)**

**Case #2**

Death Factor: Undetermined  
Environment: Living inside, residence or on property  
Age Group: 0 - 10  
Sex: Female  
An autopsy was performed.

**Case #3**

Death Factor: Undetermined  
Environment: Living inside, residence or on property  
Age Group: 0 - 10  
Sex: Male  
An autopsy was performed.

**Case #4**

Death Factor: Undetermined  
Environment: Crib, Play Pen, Slide, Swing  
Age Group: 0 - 10  
Sex: Male  
An autopsy was performed.

**Case #5**

Death Factor: Undetermined  
Environment: Living Inside, Residence or on Property  
Age Group: 30 - 40  
Sex: Male  
An autopsy was performed

**Case #6**

Death Factor: Undetermined  
Environment: Homes for Special Care  
Age Group: 60 - 70  
Sex: Male  
An autopsy was performed

**Undetermined Deaths (continued)**  
**(Means of death impossible to determine)**

**One was in the Saint John Judicial District:**

Death Factor: Trauma of Vehicle/Pedestrian Collision  
Environment: Public Road - Pedestrian  
Age Group: 20 - 30  
Sex: Male  
An autopsy was performed

**Summary of Inquests and Recommendations**

One inquest was held during the reporting period. This report mentions the replies received by the Office of the Chief Coroner as of May 2016, in response to the recommendations on inquests conducted in 2015.

**Inquest No. 1 – Glen Wareham**

An inquest was held in Moncton, New Brunswick, on October 17, 2016, into the death of Glen Edward Wareham, 28, who died on April 29, 2010 while an inmate at the Shepody Healing Centre, Dorchester, New Brunswick.

Wareham had a history of sexual abuse from a very young age perpetrated by various adults in positions of authority and responsibility over him, various forms of continuous and frequent self-injurious behaviour and mutilation, substance abuse and subsequent criminal activity. He was arrested and charged with two counts of robbery and other associated charges to which he pled guilty and was sentenced to three and a half years in federal incarceration. Due to the complexity of his mental health issues and the self-injurious behaviour, he was sent directly to the Shepody Healing Centre in November 2003.

Throughout his incarceration, in an attempt to protect him from injuring himself and as a last resort, Mr. Wareham was held in various forms of restraints for long periods of time. This posed a dilemma to his treatment team throughout his stay in federal institutions. The use of restraints did not impede or affect his treatment or therapy.

In April 2006, Mr. Wareham was statutorily released on parole with residency requirements to Halifax, Nova Scotia, and within days was declared unlawfully at large. He was apprehended after committing six armed robberies to which he pled guilty and was sentenced to 8½ years and was again returned to the Shepody Healing Centre. His self-injurious behaviour began again immediately upon his apprehension.

## **Inquest No. 1 – Glen Wareham (continued)**

In August 2007 Mr. Wareham was transferred to the Regional Treatment Centre (RTC) – Pacific Region after his treatment team had exhausted all treatment options to their knowledge and was looking for a second opinion, to provide Mr. Wareham an opportunity for a fresh start and to provide respite to the staff at the Shepody Healing Centre.

Mr. Wareham was transferred back to the Shepody Healing Centre in October 2008 as staff at RTC Pacific exhausted all treatment regimens known to them. His transfer to Pacific Region was only meant to be for a period of one year.

Mr. Wareham continued his self-injury which culminates in his being found with his abdomen sliced open, his bowel protruding and perforated and leaking stool and bile. He was taken to The Moncton City Hospital on January 7, 2009, where he remained until his death on April 29, 2010. During this time he was assessed by two consultant physicians for pain management options and for comfort and supportive care for his terminal condition.

During his incarceration, Mr. Wareham completed 172 documented incidents of self-harm.

The inquest heard from various members of his treatment team that his situation was very complex and that identifying a specific diagnosis was next to impossible. Most attested to the fact that he was not suicidal and was not suffering from depression nor was he psychotic. Substance Abuse Disorder was most definitely a factor as were aspects of impulse control disorder. He also displayed some signs/symptoms or behaviours of a severe case of factious disorder.

Regardless of the diagnosis, his care team tried many different therapies when Mr. Wareham was not being treated physically for his self-injuries. Mr. Wareham was receptive to treatment including Cognitive Behavioural Therapy and Dialectical Behaviour Therapy. It was important to treat him for his underlying conditions in an effort to stem his self-harm.

Despite the fact that nothing seemed to work long-term, and that two different treatment teams seemed to exhaust all their efforts, no expertise outside the Correctional Service Canada and the consultants it engages directly, were sought. Wherever Mr. Wareham was housed he received a great deal more attention than any other inmate. Many witnesses stated that he pushed the system beyond its limits. His case was very unique in that never before or since had any of his service providers seen anything to the

## **Inquest No. 1 – Glen Wareham (continued)**

degree of severity observed nor to the frequency to which Mr. Wareham had harmed himself. Despite this, it was offered by a few witnesses that he would not have received the same degree of services in a community setting.

More than one witness suggested that the correctional system was not appropriate for the care of inmates with severe mental health issues/conditions that Mr. Wareham displayed and that security was always the first consideration when developing a treatment plan. Even if the reverse were possible, training on mental health issues and how to support and care for inmates with these issues was needed.

The inquest heard about Mr. Wareham's two attempts to get parole by exception during the last months and weeks of his life and his desire to be sent back to Cape Breton to be closer to his mother. These attempts proved unsuccessful for many reasons despite a concerted team effort.

Dr. Landry described Mr. Wareham's last days and how he subsequently completed the Registration of Death in which he recorded Mr. Wareham's cause of death as a consequence of dehydration as a consequence of irreversible ileus or frozen bowel, bowel perforation and self-injury. He classified the death as natural.

There were three National Boards of Investigation (BOI) conducted by Correctional Service of Canada, two of which resulted in several recommendations. Testimony was provided on the resultant actions stemming from the BOIs, if they were accepted and the rationale for those rejected. Background was provided on the training implemented and planned, for correctional officers, for mental health service providers and the training required by all correctional staff to better equip all staff with the increased mental health needs of inmates entering the system and those already there.

The jury did not make any recommendations.

## **Other Cases of Interest**

The deceased was a 77-year-old male who resided in a licensed nursing home. He had been residing there for approximately 5 years prior to his death on November 12, 2015. The deceased had a 30-year history of multiple sclerosis and was feeling well and was mobile with the use of his wheelchair until November 5.

## **Other Cases of Interest (continued)**

As part of his treatment plan he was prescribed the drug Baclofen which because of difficulties swallowing the drug was required to be placed in suspension. This process must be accomplished through the process of compounding by a trained pharmacist. The compounding prescription was 2mg/ml in 5 ml of suspension. Due to an error by the compounding pharmacist the drug administered beginning November 3, 2015 was 10mg/ml in 5ml suspension or 5 times the amount prescribed. As a result, the deceased began displaying signs of confusion, disorientation and subsequently went unconsciousness.

The investigation showed that the incorrect prescription was administered from November 3, 2015 until it was discovered on November 9 when a nursing home staff member thought there was something different about the look/color of the medication. That dose was skipped and the remaining medication was returned to the pharmacy where the error was discovered. It was determined that the deceased was administered approximately 15 or 16 doses during that time. Under physicians order the medication was stopped however the symptoms continued and the deceased was transported to the hospital where he died on November 12. Following an autopsy including toxicological analysis the cause of death was determined to be acute bronchopneumonia with contributing factors of long standing multiple sclerosis with neurological deficits and baclofen overdose and the death was ruled an accident.

Given the circumstances of the death the Chief Coroner initiated an in-depth review of the circumstances leading up to and the actions taken regarding prevention following the date of death. The objective of the review was to consider all post incident investigations and included the following:

### **Document Review**

- Coroners investigation report including autopsy and toxicology reports
- Nursing Home Incident Record
- Pharmacy Medication Incident Report including worksheet for baclofen suspension
- Nursing Home Major Incident Follow-up Report
- Social Development Adult Protection Investigation Report
- Social Development, Nursing Home Services Major Incident Report
- New Brunswick College of Pharmacists Complaint Report

## **Other Cases of Interest (continued)**

### **Interviews**

- Executive Director of the deceased's nursing home
- Owner/Pharmacist of the involved pharmacy

### **Consideration of possible recommendations.**

The Chief coroner found that the nursing home incident record and major incident follow-up report determined that all staff acted appropriately. All policies and procedures regarding the administration of medications was reviewed with all appropriate staff.

The pharmacy conducted a root cause analysis of their compounding procedures identifying areas for added quality control which included additional checks by staff and pharmacists, changing all formulation compounding sheets to a common "per ml" unit in efforts to reduce future errors. The pharmacy has also added a random audit policy that sees every 100<sup>th</sup> compound sent to an independent testing facility for analysis.

The Social Development Adult Protection investigation found that the nursing home was compliant with the established nursing home standards. The investigator found no evidence of neglect and that the nursing home acting accordingly in response to this incident resulting in death.

The major incident investigation by Social Development Nursing Home Services concluded that there were no areas of non-compliance by the nursing home. However, they did make a recommendation that Nursing Home Services develop guidelines and/or requirements for outsourcing pharmaceutical compounding services within Regulated Nursing Homes.

The New Brunswick College of Pharmacists received a complaint concerning the pharmacy and pharmacist involved with this incident which resulted in a reprimand, counsel and monitoring on quality improvements and publication of the account of the complaint and the college's decision on its website until January 31, 2020. The college also communicated the results of the complaints process with pharmacy professionals throughout New Brunswick in an effort to reiterate their responsibilities when it comes to compounding procedures and quality control.

### **Other Cases of Interest (continued)**

The Institute for Safe Medication Practices (ISMP) Canada is an independent not-for-profit organization committed to the advancement of medication safety in healthcare settings. On May 25, 2017 in Volume 17 Issue 5 of the ISMP Canada Safety Bulletin in which they profile the death of an 18-month child, they made several recommendations on the preparation of compound medication processes and through collaboration with the National Association of Pharmacy Regulatory Authorities, to inform the updated standards of practice regarding compounding safety.

Based on the results of all the investigations into the circumstances of this death including the recommendations made by Social Development Nursing Home Standards division, The New Brunswick College of Pharmacists and the Institute for Safe Medication Practices Canada, the Chief Coroner is satisfied that there is nothing more to be done to prevent death or serious injury under similar circumstances in the future.