Office of the Chief Coroner

Annual Report 2022

New Nouveau Brunswick

2022 Annual Report

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The Honourable Kris Austin
Department of Public Safety
Fredericton
New Brunswick

Dear Minister:

Pursuant to Section 43 of the *Coroners Act*, I have the honour to submit the Fifty-first Annual Report of the Chief Coroner for the period January 1, 2022 to December 31, 2022.

Yours very truly,

Heather Brander
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/her 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), although 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 the person 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 inquisitional 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 Justice & 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 six 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 six Regional Coroners, approximately 35 Community Coroners, experienced investigative fee-for service staff, provide services primarily on nights and weekends across the province.

The Regional Coroners provide guidance to the Community 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, and Moncton 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 King'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 21.7 percent of the total of approximately 7,500 deaths per year in the Province. A high percentage of the investigated deaths are determined to be from natural causes. The coroner, in approximately 34 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 9,110 deaths in the Province of which 2,027 or 22.3 percent were reported to a coroner. By comparison in the previous year there were 8,076 deaths in the Province of which 1,709 or 21.2 percent 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 2022.

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 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. It is important to understand that the classification of homicide in a Coroner's investigation or inquest is defined as any case of a person dying by the actions of another. It does not imply culpability, which is not within the mandate of the Coroner or the Inquest jury.

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.

The following statistics, where broken down by region, capture data based on the region in which a death occurred and not necessarily the region where the decedent resided. This would occur if, for example, the deceased was visiting another region in the province at the time of death, or if a patient is transferred to a major hospital for specialist treatment and the death occurs at that hospital.

PROVINCIAL SUMMARY - SCHEDULE A-1
from 2022.01.01 to 2022.12.31

Classification	No. of Deaths	% of Deaths	Rate per 100,000 Population	Autopsy Performed	% of classification
Natural	1,509	74.4	186	550	36.5
Accident	364	18.0	45	208	57.1
Suicide	126	6.2	16	50	39.7
Homicide	14	0.7	2	14	100
Undetermined	14	0.7	2	11	78.6
Total	**2,027**	**100.0**	**250**	**833**	**41.1**

NOTE : Based upon Statistics Canada postcensal population estimates of 812,061 for N. B. census divisions, 3rd quarter 2022. Sub-county estimates are based on the 2020 Census population share of the county.

PROVINCIAL SUMMARY - DEATHS INVESTIGATED BY CLASSIFICATION, BY MONTH- SCHEDULE A-2
from 2022.01.01 to 2022.12.31

Classification	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Natural	152	107	124	129	127	131	113	101	117	128	118	162	1,509
Accident	26	21	22	31	24	30	25	42	40	31	32	40	364
Suicide	6	9	11	12	15	9	13	7	9	17	10	8	126
Homicide	1	0	1	1	0	1	0	2	0	3	2	3	14
Undetermined	0	2	0	0	1	1	3	1	2	1	1	2	14
Total	185	139	158	173	167	172	154	153	168	180	163	215	2,027

DEATHS INVESTIGATED BY JUDICIAL DISTRICT - SCHEDULE A-3
from 2022.01.01 to 2022.12.31

	Judicial Districts								
	Bathurst	Campbellton	Edmundston	Fredericton	Miramichi	Moncton	Saint John	Woodstock	Province
Count	**212**	**107**	**146**	**269**	**144**	**599**	**470**	**80**	**2,027**
Natural	155	77	102	203	112	426	375	59	1,509
Accident	37	17	27	47	26	134	67	9	364
Suicide	17	10	15	17	5	28	23	11	126
Homicide	1	2	0	2	1	5	3	0	14
Undetermined	2	1	2	0	0	6	2	1	14
% of Provincial Total	10%	5%	7%	13%	7%	30%	23%	4%	100%
Rate per 100,000 population	**266.9**	**348.0**	**349.0**	**175.7**	**308.7**	**246.8**	**261.3**	**211.7**	**256.5**
Natural	195.2	250.4	243.8	132.6	240.1	175.5	208.5	156.1	190.9
Accident	46.6	55.3	64.5	30.7	55.7	55.2	37.3	23.8	46.1
Suicide	21.4	32.5	35.9	11.1	10.7	11.5	12.8	29.1	15.9
Homicide	1.3	6.5	0.0	1.3	2.1	2.1	1.7	0.0	1.8
Undetermined	2.5	3.3	4.8	0.0	0.0	2.5	1.1	2.6	1.8
Total deaths by trauma (accident, suicide, homicide)	**55**	**29**	**42**	**66**	**32**	**167**	**93**	**20**	**504**
Rate per 100,000 population	69.3	94.3	100.4	43.1	68.6	68.8	51.7	52.9	63.8

PROVINCIAL SUMMARY - ACCIDENTAL DEATHS BY AGE GROUP, GENDER, JUDICIAL DISTRICT - SCHEDULE B-1
from 2022.01.01 to 2022.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Bathurst	2	0	2	0	1	2	5	1	2	3	1	1	8	9	21	16	37	10.2	19	9.1
Campbellton	0	0	3	0	1	0	3	0	1	1	3	0	1	4	12	5	17	4.7	6	2.9
Edmundston	0	1	2	0	1	0	3	0	2	0	6	1	4	7	18	9	27	7.4	16	7.7
Fredericton	1	1	2	1	2	2	1	1	5	1	2	0	13	15	26	21	47	12.9	21	10.1
Miramichi	1	1	1	0	1	0	4	0	2	2	5	2	4	3	18	8	26	7.1	14	6.7
Moncton	6	0	8	5	10	4	13	5	12	3	11	3	21	33	81	53	134	36.8	67	32.2
Saint John	0	1	10	2	11	3	3	3	13	2	5	5	6	3	48	19	67	18.4	57	27.4
Woodstock	1	0	2	0	1	0	0	1	0	1	1	0	2	0	7	2	9	2.5	8	3.8
Males	11		30		28		32		37		34		59		231					
% Total - Males	3		8.2		7.7		8.8		10.2		9.3		16.2		63.4					
Females	4		8		11		11		13		12		74			133	364	100	208	100
% Total - Females	1.1		2.2		3		3		3.6		3.3		20.3			36.5				
Total for Age Group	15		38		39		43		50		46		133							
% of Classification Total	4.1		10.4		10.7		11.8		13.7		12.6		36.5							

PROVINCIAL SUMMARY - ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2
from 2022.01.01 to 2022.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Carbon Monoxide Poisoning	0	0	0	0	0	0	0	0	0	1	1	0	1	0	2	1	3	0.8	3	1.4
Positional Asphyxia	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	2	2	0.5	2	1
Trauma of Vehicle Upset / Rollover	4	0	4	0	0	0	0	0	1	0	2	0	1	1	12	1	13	3.6	9	4.3
Trauma of Vehicle/Pedestrian Collision	0	0	1	0	0	0	0	1	1	0	2	0	0	0	4	1	5	1.4	3	1.4
Trauma of Recreational Vehicle Upset/Rollover	0	0	0	0	2	0	1	0	1	0	0	0	1	0	5	0	5	1.4	5	2.4
Alcohol Intoxication	0	0	0	0	0	0	1	0	1	0	1	0	0	0	3	0	3	0.8	3	1.4
Drug (street)	1	0	8	3	13	4	11	3	5	2	4	2	0	0	42	14	56	15.4	52	25
Chronice use of Prescribed Medicines	0	0	0	0	1	0	1	0	0	0	1	1	0	0	3	1	4	1.1	4	1.9
Drowning - Open Water	0	0	0	0	1	0	1	0	1	0	1	0	0	1	4	1	5	1.4	5	2.4
Drowning - Bathtub	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	0.3	0	0
Drowning - Public Pool	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	0	0

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Drowning - Other - Marsh, Dam, etc.	0	0	0	0	0	0	0	0	3	0	0	0	0	0	3	0	3	0.8	3	1.4
Trauma of Vehicle Collision	2	0	8	0	3	1	2	1	7	0	1	2	0	5	23	9	32	8.8	18	8.7
Crushed and/or Buried	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.3	0	0
Blunt Trauma, Accidental	1	0	3	1	1	0	6	0	6	2	4	1	2	2	23	6	29	8	22	10.6
Electrocution	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.3	1	0.5
Fire - Structural	0	0	0	0	0	1	0	0	1	0	2	0	2	1	5	2	7	1.9	7	3.4
Fire - Vehicle	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.3	0	0
Burns - Heat	0	1	0	0	1	0	0	0	0	0	0	0	0	0	1	1	2	0.5	2	1
Exposure to Cold	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	2	0.5	2	1
Fall or jump - different level, eg. bridge, bldg.	0	0	0	0	0	0	1	0	1	0	2	0	9	3	13	3	16	4.4	3	1.4
Fall or Jump - same level	0	1	0	1	0	0	0	1	2	0	5	2	30	53	37	58	95	26.1	5	2.4
Suffocation	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0.3	0	0
Object Caught in Throat	0	0	0	0	0	0	0	0	0	1	0	0	2	1	2	2	4	1.1	0	0
Aspiration	0	0	0	0	1	0	0	0	1	0	0	0	1	0	3	0	3	0.8	2	1
Asphyxia	1	1	0	0	0	0	0	0	0	0	1	0	1	4	3	5	8	2.2	6	2.9
Drug	1	1	3	1	0	1	5	4	4	6	3	1	1	0	17	14	31	8.5	31	14.9
Alcohol and Drug	0	0	0	1	2	0	0	0	1	0	0	0	0	0	3	1	4	1.1	3	1.4

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Chronic Use of Alcohol	0	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	2	0.5	2	1
Natural Disease	0	0	1	0	2	3	0	0	0	1	2	1	6	0	11	5	16	4.4	9	4.3
Sudden Infant Death Syndrome	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Trauma of Recreational Vehicle Collision	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2	0	2	0.5	2	1
Blunt Trauma	0	0	0	1	0	0	1	0	0	0	1	0	1	1	3	2	5	1.4	3	1.4
Males	11		30		28		32		37		34		59		231					
Females	4		8		11		11		13		12		74			133				
Total for Age Group	15		38		39		43		50		46		133				364	100	208	100

PROVINCIAL SUMMARY - ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3
from 2022.01.01 to 2022.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
ATV driver - on public road	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2	0	2	0.5	2	1
Boating - personal watercraft, jet ski, etc.	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.3	1	0.5
Detoxification Centre	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.3	0	0
Homes for Special Care	0	0	0	0	0	0	0	0	0	0	0	0	1	7	1	7	8	2.2	0	0
Hospital Emergency - NON DOA	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	2	0.5	0	0
Hospital Other (ward, ICU, etc.)	0	0	0	0	0	1	0	0	0	0	2	0	7	5	9	6	15	4.1	2	1
Hotel/Motel	0	0	1	0	0	0	0	0	1	0	0	0	2	0	4	0	4	1.1	2	1
Inside, Other than Residence (Mall, Restaurant, other public building)	0	0	1	1	0	0	0	0	0	1	0	0	1	0	2	2	4	1.1	2	1
Living Inside, Residence or on Property	3	3	11	6	12	4	16	9	16	9	20	9	29	31	107	71	178	48.9	116	55.8
Nursing Home	0	0	0	0	0	0	0	0	0	0	1	1	9	19	10	20	30	8.2	1	0.5
Work Place	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.3	1	0.5
Police Prov. Jail/Detention Centre	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Powerboat	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.3	1	0.5
Public Road - Driver	3	0	7	1	4	2	4	1	8	0	4	0	1	3	31	7	38	10.4	25	12

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Public Road - Motorcycle Driver	0	0	0	0	0	0	1	0	2	0	0	0	1	0	4	0	4	1.1	2	1
Public Road - Motorcycle Passenger	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0.3	1	0.5
Public Road - Passenger	5	0	4	0	0	0	2	0	0	1	1	2	0	4	12	7	19	5.2	9	4.3
Public Road - Pedestrian	0	0	3	0	0	0	2	1	2	0	0	0	0	0	7	1	8	2.2	6	2.9
Public Road - bicycle (not motorized vehicle)	0	0	1	0	0	0	0	0	1	0	0	0	0	0	2	0	2	0.5	2	1
Rooming/Boarding House/Halfway Home/Group Home	0	0	0	0	1	0	0	0	0	0	1	0	0	0	2	0	2	0.5	1	0.5
Rural Outdoors (not built up place or near residence)	0	0	0	0	1	0	0	0	0	1	2	0	0	1	3	2	5	1.4	5	2.4
Snowmobiling (Anywhere Off Public Road) - driver	0	0	0	0	1	0	1	0	0	0	0	0	0	0	2	0	2	0.5	2	1
Snowmobiling (On Public Road) driver	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Urban Outdoors - public place and other (not residence)	0	0	0	0	3	1	3	0	1	0	2	0	3	0	12	1	13	3.6	10	4.8
Open Water (river, lake, stream, brook)	0	1	0	0	1	0	0	0	2	0	0	0	0	0	3	1	4	1.1	4	1.9
ATV driver - off public road	0	0	0	0	0	0	0	0	1	0	1	0	1	0	3	0	3	0.8	2	1
Homeless Shelter	0	0	0	0	1	2	0	0	0	0	0	0	0	0	1	2	3	0.8	3	1.4
Custody - Provincial Institution	0	0	1	0	1	1	1	0	0	0	0	0	0	0	3	1	4	1.1	4	1.9
Beach/Shoreline	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.3	1	0.5

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Seniors Complex	0	0	0	0	0	0	0	0	0	0	0	0	2	3	2	3	5	1.4	0	0
Other Private Residence/Property	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Males		11		30		28		32		37		34		59	231					
Females		4		8		11		11		13		12		74		133				
Total for Age Group		15		38		39		43		50		46		133			364	100	208	100

PROVINCIAL SUMMARY - SUICIDE DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE C-1
from 2022.01.01 to 2022.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Bathurst	1	0	1	0	6	0	1	0	4	1	2	0	1	0	16	1	17	13.5	5	10
Campbellton	0	0	1	0	2	0	0	0	2	0	3	0	2	0	10	0	10	7.9	4	8
Edmundston	1	0	0	1	6	1	1	1	1	0	0	2	1	0	10	5	15	11.9	4	8
Fredericton	0	0	0	1	2	1	5	2	1	1	0	1	2	1	10	7	17	13.5	6	12
Miramichi	0	0	0	1	1	0	0	0	1	0	1	0	1	0	4	1	5	4	2	4
Moncton	0	1	2	1	2	0	0	1	5	0	7	2	6	1	22	6	28	22.2	5	10
Saint John	0	0	1	0	5	1	2	1	3	1	4	1	4	0	19	4	23	18.3	13	26
Woodstock	0	0	1	0	0	0	1	2	1	1	1	1	3	0	7	4	11	8.7	11	22
Males	2		6		24		10		18		18		20		98					
% Total - Males	1.6		4.8		19		7.9		14.3		14.3		15.9		77.8					
Females	1		4		3		7		4		7		2			28	126	100	50	100
% Total - Females	0.8		3.2		2.4		5.6		3.2		5.6		1.6			22.4				
Total for Age Group	3		10		27		17		22		25		22							
% of Classification Total	2.4		7.9		21.4		13.5		17.5		19.8		17.5							

PROVINCIAL SUMMARY - SUICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE C-2
from 2022.01.01 to 2022.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Carbon Monoxide Poisoning	0	0	0	0	0	0	0	0	3	0	1	0	1	0	5	0	5	4	5	10
Alcohol Intoxication	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.8	0	0
Sharp Force Trauma	0	0	0	0	2	0	0	0	0	0	0	0	1	0	3	0	3	2.4	3	6
Drug (street)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.8	1	2
Drowning - Open Water	0	0	1	0	0	0	0	0	4	0	0	0	0	1	5	1	6	4.8	5	10
Cuts, Stabs	0	0	0	0	2	0	0	0	1	0	0	0	1	0	4	0	4	3.2	1	2
Trauma of Vehicle Collision	0	0	0	0	2	0	1	0	0	0	0	0	0	0	3	0	3	2.4	2	4
Shooting - Rifle	0	0	0	0	1	0	0	0	1	0	5	0	8	0	15	0	15	11.9	6	12
Shooting - Shotgun	0	0	0	0	0	0	0	0	1	0	2	0	2	0	5	0	5	4	1	2
Shooting - Handgun	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	2	1.6	1	2
Exposure to Cold	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.8	1	2
Fall or jump - different level, eg. bridge, bldg.	0	1	0	1	0	0	0	0	0	0	0	1	0	0	0	3	3	2.4	1	2
Suffocation	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.8	1	2
Asphyxia	0	0	0	0	3	0	2	1	1	0	0	0	0	0	6	1	7	5.6	3	6
Hanging	2	0	4	2	12	3	6	2	5	1	5	1	2	0	36	9	45	35.7	6	12

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Carbon Monoxide Poisoning - Vehicle Exhaust	0	0	0	0	2	0	0	0	1	0	1	0	1	0	5	0	5	4	2	4
Drug	0	0	0	1	0	0	1	4	0	3	3	5	1	1	5	14	19	15.1	11	22
Males	2		6		24		10		18		18		20		98					
Females	1		4		3		7		4		7		2			28				
Total for Age Group	3		10		27		17		22		25		22				126	100	50	100

PROVINCIAL SUMMARY - SUICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE C-3
from 2022.01.01 to 2022.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	M						
Factory, Plant, Warehouse (inside)	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.8	0	0
Hospital Emergency - NON DOA	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.8	0	0
Hospital Other (Ward, ICU, etc.)	0	0	0	0	0	1	1	0	0	0	0	0	0	0	1	1	2	1.6	0	0
Hotel/Motel	0	0	0	0	0	0	0	0	0	0	1	0	1	0	2	0	2	1.6	0	0
Inside, Other than Residence (Mall, Restaurant, other public building)	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.8	1	2
Living Inside, Residence or on Property	2	0	5	3	16	2	7	6	11	3	16	6	16	1	73	21	94	74.6	33	66
Police Prov. Jail/Detention Centre	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.8	1	2
Public Road - Driver	0	0	0	0	2	0	1	0	0	0	0	0	0	0	3	0	3	2.4	2	4
Public Road - Passenger	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0.8	0	0
Rural Outdoors (not built up place or near residence)	0	0	0	0	2	0	1	1	1	0	0	0	2	0	6	1	7	5.6	3	6
Service Station, Garage, Mechanic	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.8	0	0

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	M						
Urban Outdoors - public place and other (not residence)	0	0	0	1	1	0	0	0	2	1	1	1	0	0	4	3	7	5.6	6	12
Open Water (river, lake, stream, brook)	0	0	1	0	0	0	0	0	3	0	0	0	0	0	4	0	4	3.2	3	6
Ocean	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.8	1	2
Males	2		6		24		10		18		18		20		98					
Females	1		4		3		7		4		7		2			28				
Total for Age Group	3		10		27		17		22		25		22				126	100	50	100

PROVINCIAL SUMMARY - HOMICIDE DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE D-1
from 2022.01.01 to 2022.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	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	0	0	0	1	0	0	0	0	0	1	0	1	7.1	1	7.1
Campbellton	0	0	0	0	1	0	1	0	0	0	0	0	0	0	2	0	2	14.3	2	14.3
Edmundston	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fredericton	0	0	1	0	0	0	0	0	1	0	0	0	0	0	2	0	2	14.3	2	14.3
Miramichi	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	7.1	1	7.1
Moncton	1	0	2	0	2	0	0	0	0	0	0	0	0	0	5	0	5	35.7	5	35.7
Saint John	0	0	1	0	2	0	0	0	0	0	0	0	0	0	3	0	3	21.4	3	21.4
Woodstock	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Males	1		4		5		2		2		0		0		14					
% Total - Males	7.1		28.6		35.7		14.3		14.3		0		0		100					
Females	0		0		0		0		0		0		0			0	14	100	14	100
% Total - Females	0		0		0		0		0		0		0			0				
Total for Age Group	1		4		5		2		2		0		0							
% of Classification Total	7.1		28.6		35.7		14.3		14.3		0		0							

PROVINCIAL SUMMARY - HOMICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE D-2
from 2022.01.01 to 2022.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	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	1	0	1	0	0	0	0	0	0	0	0	0	2	0	2	14.3	2	14.3
Cuts, Stabs	0	0	1	0	1	0	1	0	0	0	0	0	0	0	3	0	3	21.4	3	21.4
Blunt Trauma, Beating	0	0	1	0	0	0	1	0	1	0	0	0	0	0	3	0	3	21.4	3	21.4
Shooting - Shotgun	1	0	0	0	1	0	0	0	0	0	0	0	0	0	2	0	2	14.3	2	14.3
Shooting - Unspecified	0	0	1	0	2	0	0	0	0	0	0	0	0	0	3	0	3	21.4	3	21.4
Blunt Trauma	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	7.1	1	7.1
Males	1		4		5		2		2		0		0		14					
Females	0		0		0		0		0		0		0			0				
Total for Age Group	1		4		5		2		2		0		0				14	100	14	100

PROVINCIAL SUMMARY - HOMICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE D-3
from 2022.01.01 to 2022.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	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	0	0	1	0	0	0	0	0	0	0	1	0	1	7.1	1	7.1
Living Inside, Residence or on Property	1	0	1	0	5	0	0	0	2	0	0	0	0	0	9	0	9	64.3	9	64.3
Rural Outdoors (not built up place or near residence)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	7.1	1	7.1
Urban Outdoors - public place and other (not residence)	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2	0	2	14.3	2	14.3
Custody - Provincial Institution	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	7.1	1	7.1
Males	1		4		5		2		2		0		0		14					
Females	0		0		0		0		0		0		0			0				
Total for Age Group	1		4		5		2		2		0		0				14	100	14	100

PROVINCIAL SUMMARY - NATURAL DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE E-1
from 2022.01.01 to 2022.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Bathurst	1	0	1	2	2	1	5	4	14	8	22	19	46	30	91	64	155	10.3	43	7.8
Campbellton	1	0	1	0	1	1	1	1	6	8	12	8	20	17	42	35	77	5.1	21	3.8
Edmundston	0	0	0	2	1	0	1	1	9	6	21	9	28	24	60	42	102	6.8	21	3.8
Fredericton	1	0	1	1	2	1	10	1	25	8	40	17	56	40	135	68	203	13.5	87	15.9
Miramichi	1	0	1	0	1	1	5	0	13	3	14	10	34	29	69	43	112	7.4	38	6.9
Moncton	0	1	1	0	7	4	8	7	31	15	66	33	133	120	246	180	426	28.2	141	25.7
Saint John	3	3	2	0	4	8	8	10	26	9	69	35	110	88	222	153	375	24.9	166	30.1
Woodstock	0	2	1	0	1	0	3	2	6	3	13	6	14	8	38	21	59	3.9	33	6
Males	7		8		19		41		130		257		441		903					
% Total - Males	0.5		0.5		1.3		2.7		8.6		17		29.2		59.8					
Females	6		5		16		26		60		137		356			606	1509	100	550	100
% Total - Females	0.4		0.3		1.1		1.7		4		9.1		23.6			40.2				
Total for Age Group	13		13		35		67		190		394		797							
% of Classification Total	0.9		0.9		2.3		4.4		12.6		26.1		52.8							

PROVINCIAL SUMMARY - NATURAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE E-2
from 2022.01.01 to 2022.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Medical Procedure	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.1	0	0
Alcohol	0	0	0	0	0	0	0	0	1	0	0	1	0	0	1	1	2	0.1	0	0
Alcohol Intoxication	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	1	0.2
Natural Disaster	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0
Exposure to Heat	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	1	0.2
Fall or jump - different level, eg. bridge, bldg.	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0
Fall or Jump - same level	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	2	0.4
Suffocation	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.2
Asphyxia	0	1	0	0	0	0	0	0	0	0	0	0	1	0	1	1	2	0.1	2	0.4
Chronic Use of Alcohol	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0.1	1	0.2
Medical Device	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.1	1	0.2
Infectious Disease	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	2	0.1	0	0
Live Birth, (1 Day)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.1	0	0
Natural Disease	6	5	8	3	18	16	40	26	129	59	256	136	434	354	891	599	1490	98.7	539	98.4
Epilepsy	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0.1	1	0.2

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Undetermined	0	0	0	0	1	0	0	0	0	1	0	0	0	0	1	1	2	0.1	1	0.2
Males		7		8		19		41		130		257		441	903					
Females		6		5		16		26		60		137		356		606				
Total for Age Group		13		13		35		67		190		394		797			1509	100	550	100

PROVINCIAL SUMMARY - NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2022.01.01 to 2022.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Aircraft - (on board)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	1	0.2
Camping/Tenting	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0
Commercial Drivers - Truck, Taxi, School Bus, etc.	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	1	0.2
Community Mental Health Centre	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0.1	1	0.2
Community Residence	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.1	0	0
Gymnasium/Health Club	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	0	0
Homes for Special Care	0	0	0	0	0	0	0	0	2	3	4	1	7	16	13	20	33	2.2	3	0.5
Hospital - For Pronouncement	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0.1	1	0.2
Hospital Emergency - DOA	0	0	0	0	0	0	0	0	1	1	3	0	0	0	4	1	5	0.3	2	0.4
Hospital Emergency - NON DOA	1	0	1	0	0	0	1	0	3	1	5	3	5	6	16	10	26	1.7	7	1.3
Hospital Operating Room	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0.1	1	0.2
Hospital Other (Ward, ICU, etc.)	2	0	0	0	0	0	0	1	2	1	6	2	16	10	26	14	40	2.7	11	2
Hotel/Motel	0	0	0	0	0	0	0	0	3	0	1	0	0	0	4	0	4	0.3	4	0.7

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Inside, Other than Residence (Mall, Restaurant, other public building)	0	0	0	0	0	0	0	0	2	0	3	2	4	1	9	3	12	0.8	5	0.9
Living Inside, Residence or on Property	4	6	5	5	18	14	34	24	102	48	218	124	368	286	749	507	1256	83.2	477	86.8
Non Public Road - Pedestrian	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0.1	0	0
Nursing Home	0	0	0	0	0	0	0	1	2	2	2	1	22	23	26	27	53	3.5	4	0.7
Work Place	0	0	0	0	0	1	0	0	2	0	2	0	0	2	4	3	7	0.5	4	0.7
Powerboat	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	1	0.2
Psychiatric Hospital	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.2
Public Road - Driver	0	0	0	0	0	0	1	0	3	0	2	0	6	0	12	0	12	0.8	7	1.3
Public Road - Passenger	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	1	2	0.1	2	0.4
Public Road - Pedestrian	0	0	0	0	0	0	0	0	0	0	1	0	1	0	2	0	2	0.1	1	0.2
Rooming/Boarding House/Halfway Home/Group Home	0	0	0	0	0	0	0	0	1	0	0	0	1	0	2	0	2	0.1	1	0.2
Rural Outdoors (not built up place or near residence)	0	0	0	0	0	0	0	0	1	0	0	0	2	0	3	0	3	0.2	2	0.4
Service Station, Garage, Mechanic	0	0	0	0	0	0	0	0	0	1	0	0	1	0	1	1	2	0.1	0	0

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	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	0	0	0	0	0	0	1	0	1	0.1	1	0.2
Unlicenced Residential Homes (Retirement, Rest, etc.)	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.1	0	0
Urban Outdoors - public place and other (not residence)	0	0	0	0	1	0	2	0	2	1	3	1	1	2	9	4	13	0.9	5	0.9
Federal Institution	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.1	1	0.2
ATV driver - off public road	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.2
Homeless Shelter	0	0	0	0	0	0	0	0	1	0	2	0	0	0	3	0	3	0.2	1	0.2
Custody - Provincial Institution	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.1	1	0.2
Non Public Road - Driver	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.2
Beach/Shoreline	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.2
Seniors Complex	0	0	0	0	0	0	0	0	1	0	1	1	5	8	7	9	16	1.1	1	0.2
Males	7		8		19		41		130		257		441		903					
Females	6		5		16		26		60		137		356			606				
Total for Age Group	13		13		35		67		190		394		797				1509	100	550	100

PROVINCIAL SUMMARY - UNDETERMINED DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE F-1

from 2022.01.01 to 2022.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	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	1	1	0	0	0	0	0	0	0	0	1	1	2	14.3	2	18.2
Campbellton	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	7.1	1	9.1
Edmundston	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	2	2	14.3	1	9.1
Fredericton	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Miramichi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Moncton	0	2	0	0	0	1	0	0	1	1	1	0	0	0	2	4	6	42.9	5	45.5
Saint John	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2	0	2	14.3	1	9.1
Woodstock	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	7.1	1	9.1
Males	1		1		2		0		1		1		0		6					
% Total - Males	7.1		7.1		14.3		0		7.1		7.1		0		42.7					
Females	2		0		3		1		1		1		0			8	14	100	11	100
% Total - Females	14.3		0		21.4		7.1		7.1		7.1		0			57				
Total for Age Group	3		1		5		1		2		2		0							
% of Classification Total	21.4		7.1		35.7		7.1		14.3		14.3		0							

PROVINCIAL SUMMARY - UNDETERMINED DEATHS BY AGE GROUP, GENDER, DEATH FACTOR - SCHEDULE F-2
from 2022.01.01 to 2022.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Drug	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	2	2	14.3	2	18.2
Natural Disease	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	7.1	1	9.1
Sudden Infant Death Syndrome	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	7.1	1	9.1
Undetermined	1	0	1	0	2	1	0	1	1	1	1	0	0	0	6	3	9	64.3	6	54.5
No Anatomical Cause	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	7.1	1	9.1
Males		1		1		2		0		1		1		0	6					
Females		2		0		3		1		1		1		0		8				
Total for Age Group		3		1		5		1		2		2		0			14	100	11	100

PROVINCIAL SUMMARY - UNDETERMINED DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE F-3
from 2022.01.01 to 2022.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Farm or Ranch	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	7.1	0	0
Hospital Operating Room	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	7.1	1	9.1
Living Inside, Residence or on Property	1	1	0	0	0	1	0	0	1	1	1	1	0	0	3	4	7	50	6	54.5
Public Road - Passenger	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	1	2	14.3	2	18.2
Rural Outdoors (not built up place or near residence)	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	7.1	0	0
Open Water (river, lake, stream, brook)	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	7.1	1	9.1
Ocean	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	7.1	1	9.1
Males		1		1		2		0		1		1		0	6					
Females		2		0		3		1		1		1		0		8				
Total for Age Group		3		1		5		1		2		2		0			14	100	11	100

SCHEDULE F

Undetermined Deaths
(Means of death impossible to determine)

There were fourteen deaths classified as Undetermined.

One was in the Woodstock Judicial District:

Death Factor: Undetermined
Environment: Living Inside, Residence or on Property; Hospital Emergency - DOA
Age Group: 0-19
Sex: Male
An autopsy was performed.

One was in the Campbellton Judicial District:

Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 31-40
Sex: Female
An autopsy was performed.

Two were in the Bathurst Judicial District:

Case #1
Death Factor: Undetermined
Environment: Public Road, Passenger
Age Group: 31-40
Sex: Female
An autopsy was performed. The file is under the pathologist's review.

Case #2
Death Factor: Undetermined
Environment: Public Road, Passenger
Age Group: 31-40
Sex: Male
An autopsy was performed. The file is under the pathologist's review.

Two were in the Saint John Judicial District:

Case #1
Death Factor: Undetermined
Environment: Rural Outdoors
Age Group: 31-40
Sex: Male
A forensic anthropology exam was performed.

Case #2
Death Factor: Undetermined
Environment: Ocean
Age Group: 20-30
Sex: Male
An autopsy was performed.

Two were in the Edmundston Judicial District:

Case #1
Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 61 - 70
Sex: Female
An autopsy was performed.

Case #2
Death Factor: Undetermined
Environment: Farm or Ranch
Age Group: 41-50
Sex: Female
A forensic anthropology exam was performed.

Six were in the Moncton Judicial District:

Case #1
Death Factor: Undetermined
Environment: Living Inside, Residence or on Property; Hospital Emergency - DOA
Age Group: 0-19
Sex: Female
An autopsy was performed.

Case #2
Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 51-60
Sex: Female
An external exam was performed (Covid restriction).

Case #3
Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 51-60
Sex: Male
An autopsy was performed.

Case #4
Death Factor: Undetermined
Environment: Hospital Operating Room
Age Group: 0-19
Sex: Female
An autopsy was performed.

Case #5
Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 61-70
Sex: Male
An autopsy was performed.

Case #6
Death Factor: Undetermined
Environment: Open Water (river, lake, stream, brook)
Age Group: 31-40
Sex: Female
An autopsy was performed. The file is under the pathologist's review.

SUMMARY OF INQUESTS AND RECOMMENDATIONS

An inquest is a formal court proceeding that allows for the public presentation of all evidence relating to a death. It does not make any finding of legal responsibility nor does it assign blame. However, recommendations can be made aimed at preventing deaths under similar circumstances in the future. This report covers the replies received by the Office of the Chief Coroner in response to the recommendations on these inquests.

Recommendations and agency responses from four inquests held in 2022 appear below. Recommendations and agency responses from a fifth inquest, into the death of Chantel Moore, were published in the 2021 Annual Report.

STEVEN LUTES

A mandatory inquest into the death of Steven Lutes was held June 27 and 28 in Saint John. Lutes died on Jan. 30, 2017 from injuries sustained during his employment with Lead Formwork Ltd. in Fredericton. The five-member jury heard from eight witnesses during the inquest and made the following recommendation:

All high-risk workplaces should require safety supervisors dedicated to on-site safety compliance. High-risk workplaces can be defined by WorkSafe NB.

WorkSafe points to a legislative amendment brought in after Mr. Lutes' death in 2017 that it believes meets the intention of that recommendation.

In 2019, WorkSafeNB worked with the Department of Post-secondary Education, Training and Labour and the Executive Council Office to amend the Occupational Health and Safety Act to both modernize and clarify supervisor obligations in workplaces. This legislation, coupled with the education and materials that WorkSafeNB has provided to workplaces, has increased awareness by management and supervisors themselves of the essential role that those supervisors play in making and keeping workplaces safe.

While there is no way to know if Mr. Lutes' own supervisor, or if Mr. Lutes himself as the site supervisor on that project, would have done things differently and thereby prevented his tragic death, it is reasonable to think that with the knowledge of the higher obligations of supervisors that the outcome would have been different.

While WorkSafeNB undertook an extensive advertising and education campaign in 2019 when the supervisor obligations were modernized and expanded, WorkSafeNB will renew that campaign to promote safety management by all levels of supervisors at workplaces.

While not directly related to the recommendation, it is worth noting that section 17.1 of the Occupational Health and Safety Act imposes requirements for either a health and safety representative or a health and safety committee on project (construction) sites, depending on the size of the project. While these representatives and committee members would not be responsible full-time on a project site to monitor safety, they

provide a valuable resource for the employees regarding health and safety matters and can provide assistance to supervisors in ensuring the health and safety of the employees they supervise.

WorkSafeNB will also undertake to remind employers and employees of both the obligation and value of representatives and committees.

CAMILLE CAYOUETTE

A mandatory inquest into the death of Camille Cayouette was held Sept. 20 and 21 at the Edmundston Law Courts. Cayouette died on Jan. 2, 2019, from injuries sustained while working for Dube Trucking in Saint-Quentin.

The five-member jury heard from 20 witnesses and made five recommendations:

1. Rigorous inspections of the vehicle and trailer should be mandatory prior to each shift for operators under a Class 1 licence. This would include completion and signing of a checklist as a mandatory step rather than simply a best practice.
2. Weekly inspections of vehicles and trailers should be completed by a heavy equipment mechanic, or by a designated maintenance person, and ensure that any breakage is repaired and documented, including brake adjustments.
3. When a hazard has been identified by a supervisor, the logging roads should be closed until proper maintenance.
4. The supervisor or designated maintenance person must ensure that all current and next-shift truck drivers are notified of the road closure or other relevant information.
5. Radio repeaters, with first responder frequency, should be added on J.D. Irving Ltd. towers to fill in gaps.

The following recommendations were made by the presiding coroner:

6. All employees or contract employees operating an oversized truck working on private and Crown land must complete the Anatomy of a Rollover and Your Greatest Risk training courses or an equivalent specifically for winter driving. It will be the employer’s responsibility to offer its training in both official languages.
7. All drivers of oversized trucks will need to meet the criteria established by WorkSafeNB prior to being able to operate this type of truck.

Recommendation # 1

Rigorous inspections of the vehicle and trailer should be mandatory prior to each shift for operators under a class 1 license. This would include completion and signing of a checklist as a mandatory step rather than simply a best practice.

Worksafe responded that the General Regulation 91-191 currently includes the requirement for vehicles to be inspected daily in Section 230.5. No further action is needed.

Recommendation #2

Weekly inspections of vehicle and trailers should be completed by a heavy equipment mechanic, or by a designated maintenance person, and ensure that any breakage is repaired and documented, including brake adjustments.

WorkSafeNB responded that the General Regulation 91-191 includes a requirement for daily inspection of safety devices (includings brakes) in Section 230.5. No further action is needed.

Recommendation #3

When a hazard has been identified by a supervisor, the logging roads should be closed until proper maintenance is completed.

WorkSafeNB responded that in 2022, amendments to the General Regulation introduced a requirement in Section 345.3 for the employer to develop a code of practice for environmental conditions that includes driving in hazardous weather conditions. As this is a new requirement, WorkSafeNB will follow-up with the employer to ensure this recommendation is properly implemented.

Recommendation #4

The supervisor or designated maintenance person must ensure that all current and next shift truck drivers are notified of the road closure or other relevant information.

WorkSafeNB responded that in 2022, amendments to the General Regulation 91-191 also included a requirement for employers to develop a communication plan for forestry operations (Sections 345.1 and 345.2). The communication plan requires employers to inform employees of the hazards in the area they will be working, as well as the actions to eliminate or minimize the hazards. As this is a new requirement, WorkSafeNB will follow-up with the employer to ensure this recommendation is properly implemented.

Recommendation #5

Radio repeaters, with first responder frequency, should be added on J.D. Irving towers to fill in gaps.

WorkSafeNB responded that its authority extends as far as ensuring that the employer has a functioning emergency communication procedure and transportation protocol. However, the employer can supplement their emergency and communication protocols

with radio repeaters with first responder frequencies if they chose. This option would be above and beyond the requirements of the regulation and WorkSafeNB will follow-up with the employer to advise them of this option.

Recommendation # 6

All employees or contract employees operating an oversized truck working on private and Crown land must complete the Anatomy of a Rollover and Your Greatest Risk training courses equivalent specifically for winter driving. It will be the employer's responsibility to offer its training in both official languages.

WorkSafeNB responded that it supports this recommendation. However, it does not have the authority to enforce it's implementation as this is above the training requirement of the regulation. WorkSafe NB will follow-up with the employer advising them that doing so would be best practice which would likely improve driver safety.

Recommendation #7

All drivers of oversized trucks will need to meet the criteria established by WorkSafe NB prior to being able to operate this type of truck.

WorkSafeNB responded that the criteria to operate trucks, including oversized trucks, are included in General Regulation 91-191. The criteria have been shared with the employer so no further action is needed.

DEREK WHALEN

An inquest into the death of Derek James Whalen was held Oct. 17-20 at the Saint John Law Courts. Whalen died accidentally on May 3, 2020, following an incident at the Southeast Regional Correctional Centre in Shediac.

The five-member jury heard from 21 witnesses and made 23 recommendations.

1. Draft a policy to direct that equipment inventory and maintenance interval records are kept and visible to management, and have these records reviewed annually.
2. Secure provincial access to rapid online medical support that will provide access to clinician guidance to on-site nursing staff and/or correctional officers when required.
3. Draft a policy dealing with inmates in unsecured rooms or areas within the facility.
4. Draft a policy to mandate nursing attendance to all 1099 codes (which means: officer needs assistance) to mirror the Horizon Health Network Policy on team composition at "code white" or potentially violent patients. Ensure staffing levels to support this response at all times.
5. Ensure handheld cameras and/or body cameras with audio are functional for all incidents.

6. Provide nursing access to critical medical history through the electronic health record and the Social Services data systems.
7. Ensure a policy is in place that supports standard operating procedures regarding an evidence-based approach to overdose, toxicology and excited delirium.
8. Adopt the use of a challenge response checklist to identify excited delirium during all 1099 events.
9. Mandate the collection of vitals physiology, including pulse rate, respiratory rate, oxygen saturations, blood pressure, blood glucose and temperature as part of a methodical assessment for safety and stability. These physiologic measurements if found to be abnormal, should be collected to allow the identification of a trend.
10. Mandate the collection of clinical data using an organized primary survey or ABCDE assessment and document on the patient report form. The form's usage should be audited.
11. Write a curriculum for nurses working in correctional facilities based on need.
12. Offer training for nurses and correctional officers with case base discussions on recognizing drug overdose, excited delirium, use of force, positional asphyxia, addiction & team-based simulation training in realistic operational environments utilizing low fidelity mannequins (CPR/AED). Should be part of onboarding and then annual refresher.
13. Draft a policy to require the use of body scanner and trace detecting devices upon admission into the facility.
14. Draft a policy to allow registered nurses in correctional facilities to administer chemical restraints.
15. Ensure one correctional officer per functional area is trained on using an electronic control device.
16. Social workers, mental health personnel and addiction services should be available to inmates and staff.
17. Provide access to the Wrap or similar products on-site as an alternative to handcuffs/shackle restraints.
18. Provide nurses with education to perform, at a recognized and approved level, a primary survey to guide subsequent actions and assist in the identification of threats to life. Educational options are: Emergency Medical Responder, Advanced Cardiac Life Support, International Trauma Life Support, Medical First Responder.
19. Ensure correctional officers have the prerequisite skills to identify critical illness and provide effective lifesaving basic interventions. Correctional officers should be trained and remain up to date with their Medical First Responder courses. All correctional officers must have an up-to-date first aid training and it should be documented.
20. Recognize that excited delirium, or other signs of distress such as difficulty breathing, should be treated as a medical emergency. The policy should direct that internal medical service and Emergency Medical Services be called early in the incident. In times when nursing staff are not available, 911 should be called right away.

21. Adopt a “cuffs on, cops off” principle to ensure that inmates are not lying flat on their stomach any longer than necessary.
22. Return spit hoods as a tool to be used when an inmate is spitting at an officer along with required training and monitoring of use.
23. Incident management training should be completed province-wide for correctional services to ensure that the span of control and chain of command are established.

Recommendation #1

Draft a policy to direct that equipment inventory and maintenance interval records are kept and visible to management, and have these records reviewed annually.

Horizon Health Network responded that its BioMed team verifies medical equipment functionality and medical equipment is inventoried (ex: glucometer, defibrillator, etc. and verified by nursing staff monthly. To enhance adherence, Horizon has created a maintenance checklist and the completed document is scanned, sent to the responsible manager, and kept for 12 months.

Correctional Services responded that they have collaborated with Horizon Health Network to ensure the timely development and implementation of the recommendation occurred in their facilities.

Recommendation #2

Secure provincial access to rapid online medical support that will provide access to clinician guidance to on-site nursing staff and/or correctional officers when required.

Horizon Health Network responded that nursing personnel have access to physician/Nurse Practitioner support; however, it must be recognized that Correctional Health Services are not the equivalent of inpatient nursing units. Medical services in correctional centres function like ambulatory or primary care clinics. In a medical emergency, nursing staff and/or correctional officers must call 911.

Recommendation #3

Draft a policy dealing with inmates in unsecured rooms or areas within the facility.

Correctional Services responded that they are in support of a policy to address this issue. They anticipate that the policy will provide corrections staff with a greater knowledge and clear understanding of what actions to take in situations where clients are unsecured. In order to draft a policy that covers the appropriate criteria for a situation like this, they ask that Coroner Services provide us with any developmental material they may have in their possession to help in the drafting process.

Recommendation #4

Draft a policy to mandate nursing attendance to all 1099 codes (which means: officer needs assistance) to mirror the Horizon Health Network Policy on team composition at "code white" or potentially violent patients. Ensure staffing levels to support this response at all times.

Horizon Health Network responded that nursing personnel do not respond to 1099 codes – they intervene as required once the situation is controlled and safety is restored by Justice/Public Safety correctional officers. Health Services staff will continue to provide assessment/intervention/support when the safety of everyone involved is in-hand post-1099 event, if required.

Recommendation #5

Ensure handheld cameras and/or body cameras with audio are functional for all incidents.

Correctional Services responded that there are currently handheld cameras onsite at all correctional facilities throughout the province. Additionally, Correctional Services has initiated the procurement process to fit all correctional officers with AXON body cameras with audio capabilities.

Recommendation #6

Provide nursing access to critical medical history through the electronic health record and the Social Services data systems.

Horizon Health Network responded that nursing personnel do have access to the Electronic Health Record (EHR) and, the Client Service Delivery System (CSDS) which are the data systems used by Addictions and Mental Health.

Recommendation # 7

Ensure a policy is in place that supports standard operating procedures regarding an evidence-based approach to overdose, toxicology and excited delirium.

Horizon Health Network responded that nursing personnel are trained to respond to overdoses and any other medical/psychiatric issue when alerted to identified needs by Correctional officers or when clients are brought to the clinic. However, as previously noted, the Correctional Health Services teams provide primary care interventions and call 911 if any client requires an emergency medical response.

Recommendation #8

Adopt the use of a challenge response checklist to identify excited delirium during all 1099 events.

Correctional Services responded that this recommendation is intended for collaboration between Correctional Services and Horizon Health and requires a cooperative effort in order to accomplish all that is being recommended. Correctional Services is working directly with Horizon Health to ensure that the recommendations brought forward to both Departments are developed and implemented in a timely manner. Correctional Services has completed their involvement in much of what has been recommended to both parties and commits to continuing its collaboration with Horizon to ensure the improved safety of all clients under their care.

Horizon Health Network responded that nursing personnel are trained to assess all medical conditions. If a client is brought to the medical area or, a correctional officer is concerned for a client, nursing personnel intervene accordingly.

Recommendation #9

Mandate the collection of vitals physiology, including pulse rate, respiratory rate, oxygen saturations, blood pressure, blood glucose and temperature as part of a methodical assessment for safety and stability. These physiologic measurements if found to be abnormal, should be collected to allow the identification of a trend.

Horizon Health Network responded that a health assessment, including vital signs (pulse, respirations, blood pressure and temperature), is completed by nursing personnel upon admission to a correctional centre and on an as-needed basis thereafter. The initial health assessment includes the following:

- health history
- current health status and functional abilities
- language and literacy issues
- medication review/reconciliation
- immunization status
- identification of allergies- medication, environmental and food
- system assessment
- alcohol and drug use and misuse
- family (as identified by client) support system
- screening for Tuberculosis
- ongoing health care continuity

Recommendation #10

Mandate the collection of clinical data using an organized primary survey or ABCDE assessment and document on the patient report form. The form's usage should be audited.

Horizon Health Network responded that the health assessment, completed by nursing personnel, is used to obtain required health information, and is documented in the client's file. HHN documentation guidelines are followed by nursing personnel as well as by social workers.

Recommendation #11

Write a curriculum for nurses working in correctional facilities based on need.

Horizon Health Network responded that, further to all nursing personnel having completed an HHN nursing orientation, they participate in orientation to health services in correctional centres. They are also required to complete the following mandatory trainings:

- Active Offer
- Baby-Friendly Initiative Back Injury Prevention Child Abuse and Neglect
- Cleveland Clinic: Communicate with H.E.A.R.T. Emergency Procedures
- First Nations Cultural Competency Video Introduction to Patient Safety Introduction to Risk Management
- Occupational Health and Safety: Due Diligence Respectful Workplace: Making it Happen WHMIS
- Workplace Violence Prevention

As well as:

- Administration of Blood Products
- Falls Prevention and Management for All Staff (must be completed by ALL employees) Falls Prevention and Management for Clinical Staff
- Least Restraint Culture Magnifying How Wounds Heal Magnifying Wound Assessment
- Medication Reconciliation at Care Transitions Medication Safety
- Organ and Tissue Donation
- Ottawa Model for Smoking Cessation for Frontline Staff
- Pain: The Elements of Pain: A Comprehensive Assessment

- Pain: Treatment and Management
- Plum A+ Infusion System with Hospira MedNet Software-SMART Infusion Pump Management Pressure Injuries: Staging, Prevention and Management
- Wound Dressing Protocol

Nursing personnel are encouraged to make any requests for additional training/education to their clinical lead/manager for consideration.

Recommendation #12

Offer training for nurses and correctional officers with case base discussions on recognizing drug overdose, excited delirium, use of force, positional asphyxia, addiction & team-based simulation training in realistic operational environments utilizing low fidelity mannequins (CPR/AED). Should be part of onboarding and then annual refresher.

Horizon Health Network reiterated that its nursing personnel are required to certify/recertify in several domains. It is key to ensure that correctional officers know when to notify nursing personnel that a client may need nursing/medical intervention. There is an opportunity to explore joint trainings to enhance team cohesiveness and collaboration.

Correctional Services replied that it is working directly with Horizon Health to ensure that joint training can be developed and implemented in a timely manner to ensure the improved safety of all clients under their care.

Recommendation #13

Draft a policy to require the use of body scanner and trace detecting devices upon admission into the facility.

Correctional Services responded that two (2) out of five (5) correctional facilities have existing body scanner and ion scanner equipment at admissions in order to enter the facilities. By April 1, 2023, all correctional facilities will have use of the same equipment as required by department policy.

Recommendation #14

Draft a policy to allow registered nurses in correctional facilities to administer chemical restraints.

Horizon Health Network responded that correctional nursing professionals do not use chemical restraints; the administration of chemical restraints is not supported in this environment. Correctional nursing personnel observe and assess clients who are or may be restrained, restricted or have been restrained. Nursing does not participate in the restraining of incarcerated individuals.

Recommendation #15

Ensure one correctional officer per functional area is trained on using an electronic control device.

Correctional Services responded that it has been standard operating procedure that multiple certified electronic control device operators are present on every 12-hour shift rotation. Correctional Services will ensure that this continues to be maintained.

Recommendation #16

Social workers, mental health personnel and addiction services should be available to inmates and staff.

Horizon Health Network responded that social workers are available at the three correctional centres within HHN catchment during business hours and, when possible, clients already open to services prior to their incarceration continue to receive care by connecting with their assigned clinician either virtually or, in-person. As previously noted, nursing personnel are on-duty 16 hours per day, 7 days per week.

Recommendation #17

Provide access to the Wrap or similar products on-site as an alternative to handcuffs/shackle restraints.

Correctional Services responded that wrap and/or similar products are already available onsite at all correctional facilities to use in place of handcuffs/shackle restraints when the situation allows.

Recommendation #18

Provide nurses with education to perform, at a recognized and approved level, a primary survey to guide subsequent actions and assist in the identification of threats to life. Educational options are: Emergency Medical Responder, Advanced Cardiac Life Support, International Trauma Life Support, Medical First Responder.

Horizon Health Network responded that nursing personnel are trained in basic life support (which includes CPR) and recertify yearly. Advanced Cardiac Life Support is required for nursing personnel working in certain acute care inpatient settings, not ambulatory or primary care settings such as Corrections Health.

Recommendation #19

Ensure correctional officers have the prerequisite skills to identify critical illness and provide effective lifesaving basic interventions. Correctional officers should be trained and remain up to date with their Medical First Responder courses. All

correctional officers must have an up-to-date first aid training and it should be documented.

Correctional Services responded that correctional officers currently receive a 2-day medical first aid training. This is moving from the 2-day training to the 5-day Medical First Responder training provided by Saint John Ambulance. All new cadets will be required to have this training upon employment with Correctional Services and all existing officers, across all facilities, will be required to complete the 5-day Medical First Responder training course within the next two years.

Recommendation #20

Recognize that excited delirium, or other signs of distress such as difficulty breathing, should be treated as a medical emergency. The policy should direct that internal medical service and Emergency Medical Services be called early in the incident. In times when nursing staff are not available, 911 should be called right away.

Horizon Health Network responded that correctional nursing staff is usually the first health care responder, when notified by JPS staff, to illnesses, emergencies and/or trauma and are responsible for bringing emergency equipment, performing a comprehensive assessment including determining if the client's condition warrants emergency treatment. Nursing personnel provide direct first aid and/or basic life support until EMS arrives. If the illness or injury does not require transfer to the ED, the nurse may notify a physician or nurse practitioner and obtain further management orders.

Recommendation #21

Adopt a "cuffs on, cops off" principle to ensure that inmates are not lying flat on their stomach any longer than necessary.

Correctional Services responded that it has updated its use of force training so that clients, when in restraints, are placed on side or in sitting position. The client is monitored closely, and restraints are removed when the client no longer presents a threat to themselves or others.

Recommendation #22

Return spit hoods as a tool to be used when an inmate is spitting at an officer along with required training and monitoring of use.

Correctional Services responded that officers have been trained to deal appropriately in such incidents and have access to personal protective equipment (PPE), like face shields for their safety. Measures taken to shield the officer with the use of PPE have been shown to be more effective and less restrictive than the use of spit hoods as this type of restraint presents as too high risk for clients. Research suggests that spits hoods increase the risk

of harm to the individual and could potentially pose a risk of suffocation. The utilization of PPE minimizes the risk to all involved.

Recommendation #23

Incident management training should be completed province-wide for correctional services to ensure that the span of control and chain of command are established.

Correctional Services notes that this recommendation requires collaboration with Horizon Health Network to develop and implement this recommendation in a timely manner as they work together to ensure the improved safety of all clients under their care.

Future planning:

Horizon Health Network provided additional information on its future planning work. Following the Auditor General's report (2018) on Health Services in Correctional facilities, several enhancements have been made to client service delivery. Social workers are now available to provide crisis intervention and, one-at-a-time interventions for clients with addiction and mental health needs. Horizon is seeking to enhance its nursing personnel complement to ensure that two staff on duty per shift. Horizon is working in collaboration with JPS case managers to facilitate transitions back to community while ensuring clients have all available resources prior to being released.

JAMES MARTIN

An inquest into the death of James Martin was held Nov. 8-9 at the Burton Law Courts. Martin died on Aug. 29, 2019, from injuries sustained while working for the Department of Transportation and Infrastructure.

The five-member jury heard from eight witnesses and made two recommendations:

1. All employees involved in bridge construction and maintenance must be trained in all aspects of health and safety pertaining to bridge construction and maintenance. An accountability system must be in place for all employees who do not comply with the standards.
2. Complete daily morning inspections of work site hazards and ensure safety measures are in place to address hazards.

The following four recommendations were made by the presiding coroner:

3. The Department of Transportation and Infrastructure must have an ongoing awareness campaign focused on safety culture on work sites. The "see something,

do something" frame of mind should be embraced by employees, regardless of their employment status (casual, part time, full time, contract).

4. The department must clearly designate who shall assign tasks on a work site and that a formal delegation of work is done. This will ensure that proper followup on assigned tasks is completed.
5. The department must prepare an updated bridge-building manual. This manual should include directives on employee safety. Employee training should be provided with the manual, and a refresher must be done annually.
6. The department must require that employees working on a bridge, regardless of their employment type (such as casual, term and full time), be certified and competent working at heights.

Recommendation #1

All employees involved in bridge construction and maintenance must be trained in all aspects of health and safety pertaining to bridge construction and maintenance. An accountability system must be in place for all employees who do not comply with the standards.

The Department of Transportation (DTI) and Infrastructure responded that since 2018, all new hires are required to take a specific health and safety orientation and there is an annual refresher required for staff. DTI has worked on an accountability system that enables measures to be put in place for employees who do not comply. To that end, a training matrix has been developed by the transportation division to track employee training.

Recommendation #2

Complete daily morning inspections of work site hazards and ensure safety measures are in place to address hazards.

The Department of Transportation and Infrastructure responded that it had initiated a Hazard Assessment Program in September 2018 throughout the department based on industry best practices which includes the development and use of job hazard assessments completed by the supervisor prior to job commencement and field level hazard assessments completed by the work crew prior to the commencement of specific tasks. The purpose of these tools is to identify and control hazards and risks pertaining to jobs and tasks at specific locations as well as communicating the identified hazards and controls. Periodic audits and coaching on documentation have been and continue to be completed by the DTI Health and Safety Team.

Recommendation #3

The Department of Transportation and Infrastructure must have an ongoing awareness campaign focused on safety culture on work sites. The "see something, do something" frame of mind should be embraced by employees, regardless of their employment status (casual, part time, full time, contract).

The Department of Transportation and Infrastructure responded that in 2022, it launched its Vision, Mission, and Values. Included in the five (5) values is safety. Ensuring the right training and resources are available to protect employees and keeping the public safe is a team responsibility at DTI. These values have been promoted and are posted in worksites across DTI.

In addition, DTI's Hazard Assessment Program which includes job hazard assessments and field hazard assessments promotes an active safety culture and ensures that job hazards are reviewed daily.

It is also noteworthy that a video was made after Mr. Martin's passing that was shown to employees and has since been part of the health and safety orientation at DTI. This video emphasizes the importance of safety on worksites and was developed with the participation of family and colleagues of Mr. Martin.

To make the reporting of identified hazards and unsafe conditions more accessible, DTI has developed, with the assistance of Service New Brunswick, an Online Hazard Reporting System available on all mobile devices. Through this system, employees can submit identified hazards, conditions and follow up on status, tracking and trending.

Recommendation #4

The department must clearly designate who shall assign tasks on a work site and that a formal delegation of work is done. This will ensure that proper followup on assigned tasks is completed.

The Department of Transportation and Infrastructure responded that its Hazard Assessment Program which includes job hazard assessments and field hazard assessments promotes an active safety culture and ensures that job hazards are reviewed daily. This is a formal system which ensures that employees know and acknowledge the risks associated with day-to-day work activities. Further, all work units participate in tail gate meetings at the start of the day which ensures that everyone knows their assigned tasks.

Recommendation #5

The department must prepare an updated bridge-building manual. This manual should include directives on employee safety. Employee training should be provided with the manual, and a refresher must be done annually.

The Department of Transportation and Infrastructure responded that, in 2022, its Bridge Maintenance Manual was revised and restructured to include references and links to safe work practices, procedures, and job hazard assessments. DTI is planning to roll out training on the use of the document this year to be ready for the next construction season. Further, since 2018, all new hires are required to take a specific health and safety orientation and there is an annual refresher required for staff.

Recommendation #6

The department must require that employees working on a bridge, regardless of their employment type (such as casual, term and full time), be certified and competent working at heights.

The Department of Transportation and Infrastructure responded that, prior to any work at heights, employees are required to review and participate in training as per NB regulation 91-191. DTI's Hazard Assessment Program, which includes job hazard assessments and field hazard assessments, assists employees in understanding the risks associated with day-to-day activities. If an employee is required to work in an environment which includes heights, DTI has a revised code of practice for working at heights. This includes all aspects of working at heights such as ladder use, scaffold use and working over water.

WorkSafe NB responded that it supports all of the recommendations provided by the jury and the presiding coroner. Also, as all of the recommendations are directed to the Department of Transportation and Infrastructure (DTI), should they require assistance in implementing the recommendations, WorkSafeNB will provide any support requested to ensure the recommendations are successfully implemented.

CHILD DEATH REVIEW COMMITTEE

The Child Death Review Committee (CDRC) was established in 1997 as an Advisory Committee to the Minister responsible for child protection. The expectation was that external experts would review cases and independently advise the Minister on the appropriateness of case, linkages and coordination of services and make recommendations to improve services and prevent future deaths.

The 2009 Mandate of the New Brunswick Government directed that the Child Death Review Committee process moved to the Office of the Chief Coroner. In 2022, the Child Death Review Committee was enshrined in the Coroner's Act.

The Child Death Review Committee examines the deaths of all individuals under the age of 19 where the death was a coroner's case as well as those individuals under the age of 19 who had been in the care of, or whose family were in contact with, the Department of Social Development within 12 months period prior to the death.

The objectives of the committee are:
• To review the manner and cause of death
• To comment upon relevant protocols, policies and procedures, standards and legislation as to whether they were followed and as to their adequacy.
• To comment upon linkages and coordination of services with relevant parties as to whether they were sufficient and adequate.
• To make recommendations that would lead to improvements in order to prevent future deaths and improve the health, safety and well-being of New Brunswick children
• To submit a written report within 60 days of a referral of a death from the Chief Coroner.

Because coroner, pathology, and police investigations can remain ongoing beyond the calendar year, reports are often not conducted until 1-2 years after the death.

In 2022, the committee completed 18 death reviews for deaths occurring between 2020-2022. In the majority of cases where a death was natural or there was no agency involvement with the child, there are no recommendations made by the Committee.

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Report date	Demographic information	Coroner Case (CC)/ Social Development involved (SD)	Classification	Cause of death	Recommendations and Response
31-Mar-22	18 year-old male	CC / SD	Suicide	Asphyxia by drowning	No recommendations made
26-Apr-22	10 year-old female	CC	Natural	Severe myocarditis with cerebral edema and pulmonary congestion	No recommendations made
5-May-22	14 year-old female	CC / SD	Natural	Seizure disorder with a contributing factor of lymphocytic pneumonia	No recommendations made
13-June-22	16 year-old female	CC	Suicide	Drug toxicity	Recommendation to hold an inquest; inquest held Nov 6-8, 2023
25-Aug-22	12 year-old	CC / SD	Undetermined	Sharp force injuries to the neck	Recommendation to hold an inquest; remains under police investigation
14-Sep-22	7 week-old	CC	Natural	Prematurity	No recommendations made
15-Sep-22	1 year, 10 month-old female	SD	Natural	Intestinal rupture resulting in a peritoneal cavity infection	No recommendations made
15-Sep-22	2 week-old male	SD	Natural	Died at IWK due to complications of premature birth	No recommendations made

15-Sep-22	0 day-old male	CC	Natural	Cardiac arrest secondary to abruption of placenta that brought on pre-labour at 19 weeks gestation	No recommendations made
27-Sep-22	1 day-old male	CC	Natural	Severe shoulder dystocia secondary to fetal macrosomia and Type I diabetes	No recommendations made
27-Sep-22	1 month-old female	CC	Natural	Trisomy-18 (Edwards Syndrome)	No recommendations made
27-Sep-22	7 week-old male	CC	Natural	Failure to thrive with underlying genetic abnormalities	No recommendations made
27-Sep-22	14 year-old male	CC	Accident	Extensive multiple blunt force trauma, result of ATV rollover	No recommendations made
27-Sep-22	15 year-old female	CC	Natural	Perforation of gas containing hollow viscus (stomach)	No recommendations made
27-Sep-22	16 year-old male	CC	Accident	Multiple blunt force trauma, from motor vehicle collision.	No recommendations made
28-Sep-22	3 month-old female	SD	Natural	Complications of heart defects	No recommendations made
28-Sep-22	15 year-old female	SD	Natural	Complications due to congenital glycosylation type 1 and seizure disorder	No recommendations made

25-Oct-22	12 year-old female	SD	Natural	Plausible cause of death brough forward by the IWK is catecholaminergic polymorphic ventricular tachycardia.	No recommendations made

In two cases reviewed in 2022, the Committee recommended that, due to the complexity of the case, an inquest be held:

- The first case is of a youth whose manner of death was undetermined, and subsequent to the recommendation being made, the police investigation was re-opened. Due to the ongoing police investigation, an inquest for this case will not be held at this time.
- The second case is that of Lexi Daken, who completed suicide on February 24, 2021. Per the Committee's recommendation, an inquest was held at UNB Law School in Fredericton on November 6 & 7, 2023. The recommendations and agency responses from that inquest will be published in the 2023 Annual Report.

DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE

The Domestic Violence Death Review Committee was originally founded in 2009, and was enshrined in legislation in 2022. The purpose of the Committee is to review deaths of persons that occur as a result of domestic violence, and to make recommendations to help prevent future such deaths in similar circumstances. The Committee is chaired by the Deputy Chief Coroner Administration and its membership includes subject matter experts from law enforcement, Public Prosecutions, health, academia, research, service provision, government and First Nations.

A domestic violence death is defined as a homicide or suicide that results from violence between intimate partners or ex-partners and may include the death of a child or other family members.

The Committee provides a confidential multi-disciplinary review of domestic violence deaths. It creates and maintains a comprehensive database about the victims and perpetrators of domestic violence fatalities and their circumstances. It helps identify systemic issues, problems, gaps, or shortcomings in each case and may make appropriate recommendations concerning prevention. It helps identify trends, risk factors, and patterns from cases reviewed to make recommendations for effective intervention and prevention strategies.

Recommendations made by the Committee are presented to the Minister, are tabled through the annual reporting process in the Legislature, and are distributed to appropriate agencies for response.

Although there were two domestic violence deaths in 2021, **there were no reviews concluded by the Committee in 2022.** DVDRC cannot begin its review until all investigations and criminal proceedings are concluded. It is expected the reports for these deaths will be published in future reports.

There were no domestic violence deaths in New Brunswick in 2022.