Office of the Chief Coroner

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New Nouveau Brunswick

2023 Annual Report

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The Honourable Robert Gauvin
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-second Annual Report of the Chief Coroner for the period January 1, 2023 to December 31, 2023.

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 two (2) Deputy Chiefs (operation and administration).

The seven 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 seven 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 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 *Coroners Act* was further amended in 2023 to include mandatory inquests from police-involved deaths, non-natural deaths in custody and non-natural deaths in psychiatric facilities.

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 percent of the total of approximately 8,000 deaths per year in the Province. A high percentage of the investigated deaths are determined to be from natural causes. The coroner, in approximately 35 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 8,664 deaths in the Province of which 1,837 or 21.2 percent were reported to a coroner. By comparison in the previous year there were 9,110 deaths in the Province of which 2,027 or 22.3 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 2023.

Annual Reports of the Chief Coroner are presented by calendar year to coincide with statistical reporting by other Coroner and Medical Examiners across Canada. This facilitates 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 2023.01.01 to 2023.12.31

Classification	No. of Deaths	% of Deaths	Rate per 100,000 Population	Autopsy Performed	% of classification
Natural	1,296	70.5	155	398	30.7
Accident	394	21.4	47	218	55.3
Suicide	134	7.3	16	27	20.1
Homicide	8	0.4	1	8	100.0
Undetermined	5	0.3	1	4	80.0
Total	1,837	100.0	220	655	35.7

NOTE : Based upon Statistics Canada postcensal population estimates of 834,691 for N. B. census divisions, prepared by Finance and Treasury Board October 28, 2024.

Provincial Summary - Deaths Investigated By Classification, By Month- Schedule A-2
from 2023.01.01 to 2023.12.31

Classification	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Natural	138	103	115	104	116	95	98	88	109	102	105	123	1,296
Accident	44	31	33	40	34	21	39	26	29	28	32	37	394
Suicide	8	10	4	13	13	13	17	11	16	11	10	8	134
Homicide	0	0	1	0	0	1	1	1	0	4	0	0	8
Undetermined	1	0	1	0	0	0	0	0	0	1	2	0	5
Total	191	144	154	157	163	130	155	126	154	146	149	168	1,837

Deaths Investigated By Judicial District - Schedule A-3
from 2023.01.01 to 2023.12.31

	Judicial Districts								
	Bathurst	Campbellton	Edmundston	Fredericton	Miramichi	Moncton	Saint John	Woodstock	Province
Count	171	83	159	260	160	548	402	54	1,837
Natural	116	60	110	189	106	378	299	38	1,296
Accident	35	17	27	50	37	138	79	11	394
Suicide	20	6	21	19	14	28	21	5	134
Homicide	0	0	0	1	2	3	2	0	8
Undetermined	0	0	1	1	1	1	1	0	5
% of Provincial Total	9%	5%	9%	14%	9%	30%	22%	3%	100%
Rate per 100,000 population	**211.6**	**262.6**	**374.8**	**166.4**	**336.2**	**217.1**	**217.6**	**140.3**	**220.1**
Natural	142.9	189.8	259.3	121.0	222.8	149.8	161.9	98.7	155.3
Accident	43.1	53.8	63.6	32.0	77.8	54.7	42.8	28.6	47.2
Suicide	24.6	19.0	49.5	12.2	29.4	11.1	11.4	13.0	16.1
Homicide	0.0	0.0	0.0	0.6	4.2	1.2	1.1	0.0	1.0
Undetermined	0.0	0.0	2.4	0.6	2.1	0.4	0.5	0.0	0.6
Total deaths by trauma (accident, suicide, homicide)	55	23	48	70	53	169	102	16	536
Rate per 100,000 population	67.7	72.8	113.1	44.8	111.4	67.0	55.2	41.6	64.2

Provincial Summary - Accidental Deaths By Age Group, Gender, Judicial District - Schedule B-1
from 2023.01.01 to 2023.12.31

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	2	4	1	2	0	4	1	2	3	3	2	8	3	23	12	35	8.9	14	6.4
Campbellton	2	0	0	0	2	2	1	0	2	0	3	1	2	2	12	5	17	4.3	11	5
Edmundston	0	0	2	0	4	1	3	2	1	0	2	0	6	6	18	9	27	6.9	13	6
Fredericton	0	0	3	1	4	3	3	1	7	2	4	1	15	6	36	14	50	12.7	30	13.8
Miramichi	1	0	3	0	4	3	2	2	5	0	4	1	8	4	27	10	37	9.4	22	10.1
Moncton	2	1	12	3	9	10	14	0	17	6	8	5	25	26	87	51	138	35	62	28.4
Saint John	2	1	4	2	8	8	11	6	7	5	9	4	4	8	45	34	79	20.1	57	26.1
Woodstock	1	0	1	0	1	0	3	0	1	0	1	0	1	2	9	2	11	2.8	9	4.1
Males	8		29		34		41		42		34		69		257					
% Total - Males	2		7.4		8.6		10.4		10.7		8.6		17.5		65.2					
Females	4		7		27		12		16		14		57			137	394	100	218	55.3
% Total - Females	1		1.8		6.9		3		4.1		3.6		14.5			34.9				
Total for Age Group	12		36		61		53		58		48		126							
% of Classification Total	3		9.1		15.5		13.5		14.7		12.2		32							

Provincial Summary - Accidental Deaths By Age Group, Gender And Death Factor - Schedule B-2
from 2023.01.01 to 2023.12.31

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						
Alcohol and Drug	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Alcohol Intoxication	0	0	0	0	1	0	0	1	2	0	0	0	0	0	3	1	4	1	4	1.8
Alcohol Poisoning	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	0.3	1	0.5
Alcohol	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0.3	1	0.5
Allergic Reaction	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.3	0	0
Animal Bites, Kicks, etc.	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0.3	1	0.5
Asphyxia	0	0	0	0	0	1	0	1	1	1	1	1	2	1	4	5	9	2.3	2	0.9
Aspiration	0	0	0	0	0	0	1	0	0	0	0	0	2	1	3	1	4	1	1	0.5
Blunt Trauma, Accidental	0	2	3	1	0	5	1	0	4	0	4	4	4	0	16	12	28	7.1	16	7.3
Blunt Trauma	0	0	1	0	0	0	0	0	1	0	0	0	0	0	2	0	2	0.5	2	0.9
Burns - Acid, Caustic	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.3	1	0.5
Burns - Heat	0	0	0	0	0	0	0	0	1	0	1	0	3	0	5	0	5	1.3	2	0.9
Carbon Monoxide Poisoning	0	0	0	0	1	0	0	0	2	0	2	0	1	0	6	0	6	1.5	6	2.8
Chronice use of Prescribed Medicines	0	0	0	0	0	0	2	0	0	0	0	0	0	0	2	0	2	0.5	1	0.5

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						
Crushed and/or Buried	0	0	0	0	2	0	1	0	0	0	0	1	0	0	3	1	4	1	2	0.9
Drowning - Ice Covered Water	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Drowning - Open Water	0	0	0	0	1	0	1	0	1	0	1	0	4	0	8	0	8	2	4	1.8
Drowning - Other - Marsh, Dam, etc.	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2	0	2	0.5	2	0.9
Drowning - Pond/Quarry	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.3	1	0.5
Drowning - Private Pool	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.3	1	0.5
Drug (street)	1	1	10	3	12	12	18	3	12	1	5	1	0	0	58	21	79	20.1	64	29.4
Drug	0	0	2	1	8	4	4	2	6	9	4	3	1	1	25	20	45	11.4	42	19.3
Exposure to Cold	0	0	0	0	0	0	0	0	1	1	1	0	2	2	4	3	7	1.8	5	2.3
Fall or jump - different level, eg. bridge, bldg.	0	0	0	0	0	0	2	0	1	0	3	1	4	5	10	6	16	4.1	4	1.8
Fall or Jump - same level	0	0	0	0	0	0	1	1	3	1	3	0	33	35	40	37	77	19.5	5	2.3
Fire - Structural	0	0	1	0	0	0	0	0	0	0	1	1	2	1	4	2	6	1.5	6	2.8
Fire - Vehicle	1	0	0	0	0	0	0	0	0	0	1	0	0	0	2	0	2	0.5	2	0.9
Infectious Disease	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.3	0	0
Medical Procedure	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.3	0	0
Natural Disease	0	0	0	1	0	0	1	0	0	0	0	1	3	4	4	6	10	2.5	2	0.9

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						
Object Caught in Throat	0	0	0	0	0	0	0	0	2	0	0	0	2	0	4	0	4	1	0	0
Positional Asphyxia	0	0	0	0	0	0	1	0	1	1	0	0	0	0	2	1	3	0.8	3	1.4
Shooting - Rifle	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.3	1	0.5
Suffocation	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.3	1	0.5
Trauma of Recreational Vehicle Collision	2	0	1	0	0	0	3	0	2	0	2	0	0	0	10	0	10	2.5	8	3.7
Trauma of Recreational Vehicle Upset/Rollover	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	1	2	0.5	1	0.5
Trauma of Vehicle Collision	3	0	4	0	3	2	0	2	1	2	1	0	2	1	14	7	21	5.3	13	6
Trauma of Vehicle Upset / Rollover	1	1	5	1	3	1	2	1	0	0	1	0	1	0	13	4	17	4.3	9	4.1
Trauma of Vehicle/Pedestrian Collision	0	0	1	0	0	0	1	0	0	0	0	0	2	3	4	3	7	1.8	2	0.9
Undetermined	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	0	0
Males	8		29		34		41		42		34		69		257					
Females	4		7		27		12		16		14		57			137				
Total for Age Group	12		36		61		53		58		48		126				394	100	218	55.3

Provincial Summary - Accidental Deaths By Age Group, Gender And Environment - Schedule B-3
from 2023.01.01 to 2023.12.31

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 - off public road	0	0	0	0	0	1	0	0	1	0	0	0	0	0	1	1	2	0.5	2	0.9
ATV driver - on public road	0	0	0	0	2	0	3	0	2	0	1	0	0	0	8	0	8	2	6	2.8
ATV passenger - on public road	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0.3	0	0
Beach/Shoreline	0	0	0	0	1	0	0	0	0	0	0	0	1	0	2	0	2	0.5	2	0.9
Boating - personal watercraft, jet ski, etc.	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.3	1	0.5
Camping/Tenting	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.3	0	0
Commercial Drivers - Truck, Taxi, School Bus, etc.	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.3	0	0
Custody Federal Institution	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Custody transportation	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.3	1	0.5
Farm or Ranch	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.3	1	0.5
Homes for Special Care	0	0	0	0	0	1	0	0	0	0	0	1	2	4	2	6	8	2	2	0.9
Hospital Emergency - NON DOA	0	0	0	1	0	0	0	0	0	0	1	0	0	0	1	1	2	0.5	1	0.5
Hospital Operating Room	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.3	0	0
Hospital Other (ward, ICU, etc.)	1	0	0	0	0	0	0	0	1	0	0	0	9	1	11	1	12	3	2	0.9
Hotel/Motel	0	0	0	0	2	0	1	0	2	0	0	0	0	0	5	0	5	1.3	2	0.9
Inside vehicle	0	0	0	0	1	0	0	0	1	0	0	0	0	0	2	0	2	0.5	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						
Inside, Other than Residence (Mall, Restaurant, other public building)	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	2	2	0.5	1	0.5
Living Inside, Residence or on Property	0	3	9	4	12	15	22	8	23	12	22	11	34	29	122	82	204	51.8	126	57.8
Non Public Road - Driver	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.3	1	0.5
Nursing Home	0	0	0	0	0	0	0	0	0	0	0	0	8	13	8	13	21	5.3	0	0
Ocean	0	0	0	0	1	0	0	0	1	0	0	0	0	0	2	0	2	0.5	0	0
Off Road Motorcycling (motocross, dirt bike, etc)	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Open Water (river, lake, stream, brook)	0	0	0	0	0	0	1	0	0	0	0	0	1	0	2	0	2	0.5	2	0.9
Other Outdoor Recreation	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.3	0	0
Other Private Residence/Property	0	0	1	0	1	1	1	0	1	1	0	0	1	1	5	3	8	2	6	2.8
Powerboat	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.3	0	0
Public Road - bicycle (not motorized vehicle)	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.3	1	0.5
Public Road - Driver	4	0	9	0	4	6	2	2	3	1	3	1	3	0	28	10	38	9.6	21	9.6
Public Road - Motorcycle Driver	0	0	3	0	1	0	1	0	1	0	0	0	0	0	6	0	6	1.5	2	0.9
Public Road - Motorcycle Passenger	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.3	1	0.5
Public Road - Passenger	2	1	3	1	0	2	0	1	0	2	0	1	0	1	5	9	14	3.6	10	4.6
Public Road - Pedestrian	0	0	0	1	0	0	2	0	1	0	0	0	2	2	5	3	8	2	4	1.8

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						
Rural Outdoors (not built up place or near residence)	0	0	2	0	1	0	2	0	0	0	0	0	1	2	6	2	8	2	5	2.3
Seniors Complex	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	2	0.5	0	0
Service Station, Garage, Mechanic	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.3	1	0.5
Snowmobiling (Anywhere Off Public Road) - driver	0	0	0	0	0	0	2	0	0	0	1	0	0	0	3	0	3	0.8	3	1.4
Snowmobiling (On Public Road) driver	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Swimming - private pool	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.3	1	0.5
Urban Outdoors - public place and other (not residence)	0	0	1	0	6	0	3	0	0	0	0	0	3	0	13	0	13	3.3	7	3.2
Work Place	0	0	0	0	1	0	1	0	1	0	2	0	0	0	5	0	5	1.3	2	0.9
Males		8		29		34		41		42		34		69	257					
Females		4		7		27		12		16		14		57		137				
Total for Age Group		12		36		61		53		58		48		126			394	100	218	55.3

Provincial Summary - Suicide Deaths By Age Group, Gender And Judicial District - Schedule C-1

from 2023.01.01 to 2023.12.31

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	1	2	0	2	1	5	0	2	1	3	1	16	4	20	14.9	0	0
Campbellton	0	0	0	0	0	0	3	0	1	0	2	0	0	0	6	0	6	4.5	1	3.7
Edmundston	0	0	0	1	5	0	4	1	2	1	4	0	3	0	18	3	21	15.7	3	11.1
Fredericton	1	1	2	1	1	0	3	0	5	2	2	1	0	0	14	5	19	14.2	8	29.6
Miramichi	0	0	2	0	4	0	1	1	2	1	1	2	0	0	10	4	14	10.4	3	11.1
Moncton	0	1	7	0	1	1	3	0	5	3	2	3	2	0	20	8	28	20.9	2	7.4
Saint John	0	0	2	1	4	1	4	1	4	0	2	0	1	1	17	4	21	15.7	7	25.9
Woodstock	0	0	1	0	1	1	1	0	0	0	1	0	0	0	4	1	5	3.7	3	11.1
Males	2		15		18		21		24		16		9		105		134	100	27	20.1
% Total - Males	1.5		11.2		13.4		15.7		17.9		11.9		6.7		78.3					
Females	2		4		3		4		7		7		2			29				
% Total - Females	1.5		3		2.2		3		5.2		5.2		1.5			21.6				
Total for Age Group	4		19		21		25		31		23		11							
% of Classification Total	3		14.2		15.7		18.7		23.1		17.2		8.2							

Provincial Summary - Suicide Deaths By Age Group, Gender And Death Factor - Schedule C-2
from 2023.01.01 to 2023.12.31

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						
Asphyxia	1	1	1	1	4	0	5	0	6	0	3	3	2	0	22	5	27	20.1	3	11.1
Asphyxia due to Oxygen Depletion (Helium Gas)	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1	2	1.5	0	0
Blunt Trauma	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.7	1	3.7
Carbon Monoxide Poisoning - Vehicle Exhaust	0	0	0	0	0	0	0	0	1	0	1	0	0	0	2	0	2	1.5	0	0
Cuts, Stabs	0	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	2	1.5	1	3.7
Drowning - Open Water	0	0	1	0	0	0	0	0	0	0	1	0	1	0	3	0	3	2.2	2	7.4
Drowning - Pond/Quarry	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.7	0	0
Drug	0	0	0	2	1	0	1	0	3	3	0	1	0	2	5	8	13	9.7	7	25.9
Fall or jump - different level, eg. bridge, bldg.	0	0	1	0	0	0	2	0	0	0	1	0	0	0	4	0	4	3	2	7.4
Hanging	1	1	8	1	8	3	6	2	7	2	3	1	3	0	36	10	46	34.3	4	14.8
Other Gases and Fumes	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.7	0	0
Poison or Solvent	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	0.7	0	0
Shooting - Handgun	0	0	1	0	0	0	0	0	1	0	2	1	0	0	4	1	5	3.7	4	14.8
Shooting - Rifle	0	0	2	0	2	0	2	1	3	0	3	1	1	0	13	2	15	11.2	2	7.4
Shooting - Shotgun	0	0	0	0	2	0	3	0	1	1	1	0	1	0	8	1	9	6.7	1	3.7

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						
Strangulation	0	0	1	0	0	0	0	0	0	0	1	0	0	0	2	0	2	1.5	0	0
Males	2		15		18		21		24		16		9		105					
Females	2		4		3		4		7		7		2			29				
Total for Age Group	4		19		21		25		31		23		11				134	100	27	20.1

Provincial Summary - Suicide Deaths By Age Group, Gender And Environment - Schedule C-3
from 2023.01.01 to 2023.12.31

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						
Beach/Shoreline	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.7	0	0
Custody Police Cell/Lock Up	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0.7	0	0
Homes for Special Care	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.7	0	0
Hospital Emergency - DOA	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.7	0	0
Hotel/Motel	0	0	0	0	0	0	1	0	0	0	1	0	0	0	2	0	2	1.5	0	0
Inside vehicle	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0.7	1	3.7
Inside, Other than Residence (Mall, Restaurant, other public building)	0	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	2	1.5	0	0
Living Inside, Residence or on Property	2	0	11	3	12	2	15	3	21	4	10	6	6	2	77	20	97	72.4	16	59.3
Open Water (river, lake, stream, brook)	0	0	2	0	0	0	1	0	0	0	1	0	0	0	4	0	4	3	3	11.1
Other Private Residence/Property	0	1	0	0	0	0	1	0	0	0	1	0	0	0	2	1	3	2.2	2	7.4
Psychiatric unit of Hospital	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0.7	0	0
Public Road - Driver	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.7	1	3.7
Public Road - Pedestrian	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.7	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						
Rural Outdoors (not built up place or near residence)	0	0	0	0	2	1	2	0	1	1	2	1	1	0	8	3	11	8.2	3	11.1
Urban Outdoors - public place and other (not residence)	0	0	2	0	2	0	0	0	0	1	0	0	0	0	4	1	5	3.7	1	3.7
Work Place	0	0	0	0	1	0	0	1	0	0	0	0	0	0	1	1	2	1.5	0	0
Males	2		15		18		21		24		16		9		105					
Females	2		4		3		4		7		7		2			29				
Total for Age Group	4		19		21		25		31		23		11				134	100	27	20.1

Provincial Summary - Homicide Deaths By Age Group, Gender And Judicial District - Schedule D-1
from 2023.01.01 to 2023.12.31

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	0	0	0	0	0	0	0	0	0	0	0	0
Campbellton	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	0	0	0	0	0	0	1	0	1	12.5	1	12.5
Miramichi	0	0	0	1	0	0	1	0	0	0	0	0	0	0	1	1	2	25	2	25
Moncton	0	0	1	0	0	1	0	0	0	1	0	0	0	0	1	2	3	37.5	3	37.5
Saint John	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2	0	2	25	2	25
Woodstock	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Males	0		2		2		1		0		0		0		5					
% Total - Males	0		25		25		12.5		0		0		0		62.5		8	100	8	100
Females	0		1		1		0		1		0		0			3				
% Total - Females	0		12.5		12.5		0		12.5		0		0			37.5				
Total for Age Group	0		3		3		1		1		0		0							
% of Classification Total	0		37.5		37.5		12.5		12.5		0		0							

Provincial Summary - Homicide Deaths By Age Group, Gender And Death Factor - Schedule D-2
from 2023.01.01 to 2023.12.31

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						
Cuts, Stabs	0	0	0	0	1	0	0	0	0	1	0	0	0	0	1	1	2	25	2	25
Sharp Force Trauma	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	12.5	1	12.5
Shooting - Shotgun	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	12.5	1	12.5
Shooting - Unspecified	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2	0	2	25	2	25
Trauma of Vehicle Collision	0	0	0	1	0	0	1	0	0	0	0	0	0	0	1	1	2	25	2	25
Males	0		2		2		1		0		0		0		5					
Females	0		1		1		0		1		0		0			3				
Total for Age Group	0		3		3		1		1		0		0				8	100	8	100

Provincial Summary - Homicide Deaths By Age Group, Gender And Environment - Schedule D-3
from 2023.01.01 to 2023.12.31

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						
Living Inside, Residence or on Property	0	0	1	0	2	0	0	0	0	1	0	0	0	0	3	1	4	50	4	50
Public Road - Motorcycle Driver	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	12.5	1	12.5
Public Road - Motorcycle Passenger	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	12.5	1	12.5
Urban Outdoors - public place and other (not residence)	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1	2	25	2	25
Males	0		2		2		1		0		0		0		5					
Females	0		1		1		0		1		0		0			3				
Total for Age Group	0		3		3		1		1		0		0				8	100	8	100

Provincial Summary - Natural Deaths By Age Group, Gender And Judicial District - Schedule E-1
from 2023.01.01 to 2023.12.31

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	0	2	4	11	1	12	12	41	28	71	45	116	9	28	7
Campbellton	0	0	0	0	3	0	4	1	4	4	12	9	14	9	37	23	60	4.6	21	5.3
Edmundston	0	0	1	0	1	1	6	2	4	1	25	15	31	23	68	42	110	8.5	23	5.8
Fredericton	0	1	1	1	3	3	5	1	16	4	31	24	66	33	122	67	189	14.6	74	18.6
Miramichi	1	0	0	1	1	0	2	3	11	0	22	9	32	24	69	37	106	8.2	29	7.3
Moncton	1	3	2	0	8	5	11	6	28	13	63	29	110	99	223	155	378	29.2	101	25.4
Saint John	2	1	0	3	5	2	11	6	34	12	51	22	85	65	188	111	299	23.1	103	25.9
Woodstock	0	0	0	0	0	0	2	1	9	2	7	0	11	6	29	9	38	2.9	19	4.8
Males	6		6		22		43		117		223		390		807		1296	100	398	30.7
% Total - Males	0.5		0.5		1.7		3.3		9		17.2		30.1		62.3					
Females	5		5		11		24		37		120		287			489				
% Total - Females	0.4		0.4		0.8		1.9		2.9		9.3		22.1			37.8				
Total for Age Group	11		11		33		67		154		343		677							
% of Classification Total	0.8		0.8		2.5		5.2		11.9		26.5		52.2							

Provincial Summary - Natural Deaths By Age Group, Gender And Death Factor - Schedule E-2
from 2023.01.01 to 2023.12.31

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						
Alcohol	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.1	0	0
Blunt Trauma - Accidental	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0
Drug (street)	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	1	0.3
Drug	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0.1	1	0.3
Exposure to Heat	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.1	0	0
Fall or Jump - same level	0	0	0	0	0	0	0	0	1	0	0	1	3	3	4	4	8	0.6	1	0.5
Medical Procedure	0	0	0	0	1	0	0	0	0	0	1	0	0	0	2	0	2	0.2	2	0.5
Natural Disaster	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0
Natural Disease	5	4	6	5	19	11	42	24	116	36	220	118	382	283	790	481	1271	98.1	384	96.5
No Anatomical Cause	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0.1	1	0.3
Sudden Unexpected Death Syndrome	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.1	1	0.3
Trauma of Vehicle Upset / Rollover	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.3
Undetermined	1	1	0	0	0	0	0	0	0	0	1	0	3	0	5	1	6	0.5	6	1.5
Males	6		6		22		43		117		223		390		807					
Females	5		5		11		24		37		120		287			489				
Total for Age Group	11		11		33		67		154		343		677				1296	100	398	30.7

Provincial Summary - Natural Deaths By Age Group, Gender And Environment - Schedule E-3

from 2023.01.01 to 2023.12.31

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						
Camping/Tenting	0	0	0	0	0	0	0	0	0	0	1	0	2	0	3	0	3	0.2	1	0.3
Commercial Drivers - Truck, Taxi, School Bus, etc.	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.3
Cruise Ship	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.1	0	0
Custody Federal Institution	0	0	0	0	0	0	0	0	1	0	0	0	1	0	2	0	2	0.2	0	0
Federal Institution	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	1	0.3
Homeless Shelter	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	1	0.3
Homes for Special Care	0	0	0	0	1	0	0	0	1	2	4	2	5	4	11	8	19	1.5	4	1
Hospital Emergency - DOA	0	0	0	0	0	0	1	0	0	0	0	1	1	0	2	1	3	0.2	2	0.5
Hospital Emergency - NON DOA	0	0	0	0	1	0	0	0	0	0	0	2	8	6	9	8	17	1.3	2	0.5
Hospital Operating Room	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	0	0
Hospital Other (Ward, ICU, etc.)	1	1	1	1	1	2	0	1	3	0	3	4	7	11	16	20	36	2.8	7	1.8
Hotel/Motel	0	0	0	0	0	0	1	0	2	0	1	2	1	0	5	2	7	0.5	4	1
Inside vehicle	0	0	0	0	0	0	0	0	0	0	2	0	0	1	2	1	3	0.2	0	0
Inside, Other than Residence (Mall, Restaurant, other public building)	0	0	0	0	0	0	0	0	2	0	0	1	2	0	4	1	5	0.4	1	0.3

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						
Jogging (outside)	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	1	0.3
Living Inside, Residence or on Property	5	4	5	4	17	8	35	21	100	35	187	102	328	233	677	407	1084	83.6	346	86.9
Non Public Road - Driver	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.3
Nursing Home	0	0	0	0	0	0	0	0	0	0	2	3	21	25	23	28	51	3.9	0	0
Other Outdoor Recreation	0	0	0	0	0	0	1	0	1	0	3	0	0	0	5	0	5	0.4	2	0.5
Other Private Residence/Property	0	0	0	0	1	0	0	0	2	0	2	0	2	0	7	0	7	0.5	3	0.8
Public Road - bicycle (not motorized vehicle)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	1	0.3
Public Road - Driver	0	0	0	0	0	0	0	0	0	0	6	0	1	0	7	0	7	0.5	4	1
Public Road - Motorcycle Driver	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.3
Public Road - Passenger	0	0	0	0	1	0	0	1	1	0	0	0	1	1	3	2	5	0.4	3	0.8
Public Road - Pedestrian	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2	0	2	0.2	1	0.3
Rooming/Boarding House/Halfway Home/Group Home	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1	1	2	0.2	1	0.3
School - Employee (Teacher, Janitor)	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.3
Seniors Complex	0	0	0	0	0	0	0	0	0	0	0	1	5	4	5	5	10	0.8	1	0.3
Urban Outdoors - public place and other (not residence)	0	0	0	0	0	0	2	0	2	0	3	2	4	0	11	2	13	1	5	1.3
Work Place	0	0	0	0	0	1	1	0	0	0	2	0	0	1	3	2	5	0.4	3	0.8

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						
Males	6	6	22	43	117	223	390	807					
Females	5	5	11	24	37	120	287		489				
Total for Age Group	11	11	33	67	154	343	677			1296	100	398	30.7

Provincial Summary - Undetermined Deaths By Age Group, Gender And Judicial District - Schedule F-1
from 2023.01.01 to 2023.12.31

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	0	0	0	0	0	0	0	0	0	0	0	0
Campbellton	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Edmundston	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	20	1	25
Fredericton	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	20	0	0
Miramichi	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	20	1	25
Moncton	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	20	1	25
Saint John	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	20	1	25
Woodstock	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Males	2		0		2		0		0		0		0		4					
% Total - Males	40		0		40		0		0		0		0		80		5	100	4	80
Females	0		0		0		1		0		0		0			1				
% Total - Females	0		0		0		20		0		0		0			20				
Total for Age Group	2		0		2		1		0		0		0							
% of Classification Total	40		0		40		20		0		0		0							

Provincial Summary - Undetermined Deaths By Age Group, Gender, Death Factor - Schedule F-2

from 2023.01.01 to 2023.12.31

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						
Asphyxia	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	20	1	25
Exposure to Cold	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	20	1	25
Blunt Trauma	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	20	1	25
Undetermined	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2	0	2	40	1	25
Males	2		0		2		0		0		0		0		4					
Females	0		0		0		1		0		0		0			1				
Total for Age Group	2		0		2		1		0		0		0				5	100	4	80

Provincial Summary - Undetermined Deaths By Age Group, Gender And Environment - Schedule F-3
from 2023.01.01 to 2023.12.31

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						
Living Inside, Residence or on Property	2	0	0	0	0	0	0	1	0	0	0	0	0	0	2	1	3	60	3	75
Open Water (river, lake, stream, brook)	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	20	0	0
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	20	1	25
Males	2		0		2		0		0		0		0		4					
Females	0		0		0		1		0		0		0			1				
Total for Age Group	2		0		2		1		0		0		0				5	100	4	80

SCHEDULE F

Undetermined Deaths
(Manner of death impossible to determine)

There were five deaths classified as Undetermined.

One was in the Moncton Judicial District:

Death Manner: Undetermined
Environment: Rural Outdoors (not built up place or near residence)
Age Group: 31-40
Sex: Male
An autopsy was performed.

One was in the Edmundston Judicial District:

Death Manner: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 41-50
Sex: Female
An autopsy was performed.

One was in the Fredericton Judicial District:

Case #1
Death Manner: Undetermined
Environment: Rural Outdoors (not built up place or near residence), Open Water (river, lake, stream, brook)
Age Group: 31-40
Sex: Male
A forensic anthropology exam was performed.

One was in the Miramichi Judicial District:

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

One was in the Saint John Judicial District:

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

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. Agencies are not compelled to reply however we hope that the recommendations made out of these inquests will generate a change that will prevent future such deaths.

Recommendations and agency responses from eight inquests held in 2023 appear below.

TROY BOURQUE

A mandatory inquest into the death of Troy Bourque was held January 16 and 17, 2023 in Saint John. Bourque died on October 10, 2019, from injuries sustained during his employment with Devon Lumber in Fredericton.

The five-member jury heard from eleven witnesses during the inquest and made the following recommendations:

1. Establish formal weekly safety meetings and ongoing training with monthly worksite inspections.

2. Create a standard operating procedures manual that states procedures to be followed in the event of an accident, mechanical failure or maintenance.

3. Review where safety equipment and emergency stops are located and review standard operating procedures on a regular basis with all employees.

The presiding coroner made the following recommendation:

4. WorkSafeNB should continue to focus on “lockout, tag-out” procedures during routine inspections at sawmill operations.

Recommendation #1

Establish formal weekly safety meetings and ongoing training with monthly worksite inspections.

Devon Lumber Response:

On top of our WorkSafe New Brunswick site inspection, we do regular inspections on our equipment during downtimes or mill changes. Our maintenance team looks over all functions of equipment checking both functionality and safety. Our weekly safety meetings are informal as we are a small crew. It is just as productive to talk to small groups of employees at a time.

The members of our monthly safety meetings are also part of the maintenance team, therefore management and maintenance are always in the know should equipment not function properly. It is also part of our rules and regulations in our employee handbook that all suspected problems are to be reported to the onsite mill supervisor immediately.

Recommendation #2

Create a standard operating procedures manual that states procedures to be followed in the event of an accident, mechanical failure or maintenance.

Devon Lumber Response:

We have an extensive Employee handbook outlining standard operations procedures for accidents, mechanical failures, and maintenance. Also, all equipment is signed with the proper lock out procedure for its specific use.

Recommendation #3

Review where safety equipment and emergency stops are located and review standard operating procedures on a regular basis with all employees.

Devon Lumber Response:

Emergency stops are reviewed as the mill changes, during maintenance shutdowns, and by members of the monthly safety meetings. During mill upgrades and maintenance shutdowns, our electrical contractor also tests the safe operation of all switches, including E-Stops and Lockout points.

Recommendation #4

WorkSafeNB should continue to focus on "lockout, tag-out" procedures during routine inspections at sawmill operations.

WorkSafe NB Response:

WorkSafeNB is supportive of this recommendation. WorkSafeNB routinely inspects sawmills and similar operations. During inspections, health and safety officers focus on machine safety which not only includes tag and lock out operations, but also guarding, training of employees working on machines, and maintenance. In the last three years, there were 131 inspections in this industry that have resulted in 16 orders on tag and lockout. We are committed to continuing to focus resources on tag and lockout procedures during inspections of sawmills and similar operations.

HILLARY HOOPER

An inquest into the death of Hillary Hooper was held March 13-15, 2023, in Saint John. Hooper died on December 9, 2020, following an incident at the Saint John Regional Hospital where she was a patient at the time.

The five-member jury heard from sixteen witnesses during the inquest and made the following recommendations:

1. That 4DNorth use bedding that tears easily and will not support a person's weight if used as a noose. This recommendation is made with consideration given to the requirement for frequent laundering in hospital settings.

2. Replace bathroom doors in patient rooms with doors that cannot be locked.

3. Fix door 62 so it closes properly.

4. Replace patient room doors with pocket doors, accordion doors or doors that open out into the hallway equipped with quick release hinges to prevent patients from locking doors.

5. Consider installing security cameras in patient rooms. This recommendation is made recognizing that there are issues pertaining to patient privacy.

6. That any time a patient's door is blocked that attention be given to that room immediately.

7. That in order to prevent hospital beds from being used to block doors, that they be secured with a locking mechanism that can only be released by authorized personnel.

8. Consideration be given to searching patients upon admission to 4DNorth, (pat-down, searching bags and pockets in order to detect potential weapons, drugs, mobile phones, etc.) This recommendation is made with recognition of issues pertaining to patient privacy.

9. That staffing be increased during night shifts beyond three registered nurses. Additional staff need not be registered nurses. Licensed practical nurses, personal support workers and security staff may be options. This recommendation is made with recognition of current staffing challenges and shortages.

10. That a code blue crash cart be situated on 4DNorth.

11. That a short stay unit be implemented as part of the psychiatric services available at the Saint John Regional Hospital. Said unit to include dialectical-behavior therapy as part of its treatment protocol, with linkage to community-based dialectical-behavior therapy for follow-up, post discharge.

The presiding coroner added the following recommendations:

12. That Horizon Health Network continue to explore the possibility and support the implementation of crisis stabilization units in its hospitals.

13. That Horizon Health Network provide an information session on local resources available for people with borderline personality disorder to its physicians. A list of these resources should be displayed and available to physicians.

14. That Horizon Health Network adopt or make a continuous assessment of suicide urgency. A form should be used in any medical clinic or emergency department where a patient presents themselves in either a mental health crisis or self-reports being suicidal. The network should also evaluate the form to see if there is merit in also using it on units.
15. That the Department of Justice and Public Safety support the office of the chief coroner in establishing a suicide fatality review committee.

Recommendation #1

That 4DNorth use bedding that tears easily and will not support a person's weight if used as a noose. This recommendation is made with consideration given to the requirement for frequent laundering in hospital settings.

Horizon Health Network Response:

Consideration was given to this recommendation; however, we have chosen not to proceed with implementation at this time. While these sheets are available, consideration must be given to other linens such as blankets, bed covers, hospital gowns and patients own clothing. Logistically, it would be difficult to separate the different types of bedding used on a psychiatry unit versus another unit in the hospital setting. To remove all clothing, blankets, towels etc., from a mental health unit would create a very restrictive environment, and not all patients require such measures. All units are designated to maximize safety, therapeutic environments that include ligature-resistant fixtures to mitigate any harm.

Patients at risk of self-harm are assessed utilizing the Columbia Suicide Risk Assessment Tool. Based on this assessment, clinical staff plan interventions which may include placing an at-risk patient in a hospital gown in a seclusion/safe room with limited bedding. The result of the suicide risk assessment and, as per Horizon Health Network's Least Restraint policy ensures that a patient who is assessed as being at higher risk for self-harm has restricted access to the general unit including bed linens and is observed more closely with constant observation via one-on-one staffing and camera monitoring. It is important to balance the need for safety with the need to create a comfortable and therapeutic inpatient environment that does not unnecessarily restrict and stigmatize patients experiencing mental health concerns, which could deter individuals from accessing inpatient care when needed. All patients identified at risk of suicide are re-assessed before any transition in care from any service area; before increase in privileges or granting of passes; before discharge; or with any change in clinical status as per Addiction and Mental Health Standards.

Recommendation #2

Replace bathroom doors in patient rooms with doors that cannot be locked.

Horizon Health Network Response:

Patient bathroom door locks have been removed.

Recommendation #3

Fix door 62 so it closes properly.

Horizon Health Network Response:

Completed by adjusting the hinge the week following the incident.

Recommendation #4

Replace patient room doors with pocket doors, accordion doors or doors that open out into the hallway equipped with quick release hinges to prevent patients from locking doors.

Horizon Health Network Response:

Patient room doors have never locked, and bathroom door locks have been removed. All doors are equipped with anti-ligature mechanisms which alarm if pressure is applied or, where anti-ligature mechanisms are not present the tops of the doors have been cut to minimize the risk of suspension. Locks on bathroom doors have been removed and we are investigating purchasing hinges by obtaining cost quotes for all psychiatric units that allow doors to swing in or out or "Double-Acting Doors".

Recommendation #5

Consider installing security cameras in patient rooms. This recommendation is made recognizing that there are issues pertaining to patient privacy.

Horizon Health Network Response:

Following the completion of a jurisdictional scan of recent research there is no consistent evidence found that video surveillance - apart from an increased sense of security - increases safety in patient rooms. Consultations then occurred with Horizon Health Networks Regional Director of Ethics and Chief Privacy Officer who both highlighted concerns related to violation of patient's human rights. Policies already exist to ensure that a person assessed with an elevated suicide risk will be observed more closely or

even placed in the seclusion/safe room with constant observation for their own safety. It is important to balance the need for safety with the need to respect patient privacy and autonomy. Being under constant video surveillance can negatively impact some individual's mental health and exacerbate certain symptoms. For these reasons, we will not be implementing this recommendation.

Recommendation #6

That any time a patient's door is blocked that attention be given to that room immediately.

Horizon Health Network Response:

This recommendation has been completed. Intentional hourly rounding occurs to attend to routine patient needs and rounding/observational checks are increased based on immediate patient needs and/or concerns. All patients/clients are assessed by a psychiatrist prior to admission with one of four levels of observation/assessment assigned as per Horizon Addiction and Mental Health Standards:

1. Routine Hourly
2. Close – 30 Random-frequent checks no further apart than 30 minutes
3. Close – 15 Random-frequent check no further apart than 15 minutes
4. Constant 1 to 1 observation with a team member always observing the patient

All patients\clients requiring checks every 15 minutes or constant observation have a daily assessment by the psychiatrist. Any team member taking a patient requiring close observation off the unit is responsible for continuing required observation of the patient and documentation when the patient leaves and returns the unit. Nursing and/or psychiatrist re-assess each patient for any changes in condition and their required level of observation. Observational care of all patients/clients is as per Addiction and Mental Health Standards and Horizon policies including Least Restraint HHN-PC-010; and Observational Care HN-PC-013.

Recommendation #7

That in order to prevent hospital beds from being used to block doors, that they be secured with a locking mechanism that can only be released by authorized personnel.

Horizon Health Network Response:

Such mechanisms exist; However, after reviewing this recommendation with our staff, physicians, and code blue response team, we have identified safety concerns related to the time required to locate the key and unlock the bed in case of emergency. In the case of a code blue on the unit, it is important to be able to move the bed to in debate and perform other needed procedures. The time it takes to locate a key and unlock the bed could lead to delays in rendering life-saving aid. Given the risks identified by securing

beds in the hospital setting we will not be implementing this recommendation.

Recommendation #8

Consideration be given to searching patients upon admission to 4DNorth, (pat-down, searching bags and pockets in order to detect potential weapons, drugs, mobile phones, etc.) This recommendation is made with recognition of issues pertaining to patient privacy.

Horizon Health Network Response:

A review and revision of Horizon's search of Patients/Clients Policy HHN-SA-044 was completed, with the assistance of frontline staff and unit leadership, and including Risk Management, Ethics, and Privacy. The Horizon policy is implemented.

Recommendation #9

That staffing be increased during night shifts beyond three registered nurses. Additional staff need not be registered nurses. Licensed practical nurses, personal support workers and security staff may be options. This recommendation is made with recognition of current staffing challenges and shortages.

Horizon Health Network Response:

Following a jurisdictional scan, ratios of one staff/four patients to one staff/six patients is common practice in similar units across Canada. Current staffing complement is five personnel on evening (1530-2330 hrs) shift (ratio of one staff/five patients) which is when the incident occurred. Night shift (2330-0730 hrs) staffing complement is 3 personnel for a ratio of one staff/eight patients. The reduction staffing during this shift is due to decreased patient needs as most sleep through the night. In addition, staffing complement across all Horizon inpatient psychiatric units can be increased on a case-by-case basis based on nursing assessment of patient acuity and or physician orders. The assigned frequency of observational care is continued on every shift as per the Observational Care Policy.

Recommendation #10

That a code blue crash cart be situated on 4DNorth.

Horizon Health Network Response:

Every patient care floor at the SJRH as a crash cart however, not every nursing unit has their own crash cart. The crash cart available to 4DN is one unit away and thus easily accessible by code team. Code blue team members are responsible for using the equipment on the carts and must be trained in Advanced Cardiac Life Support (ACLS). These staff work in either Emergency Department's, Intensive Care Units or, Cardiac

Care Units. For carts to be stationed in every nursing unit, ACLS training would be required for all our nursing staff, and this is not a North American standard. Registered nurses on general nursing units could not maintain competency in ACLS skills would be seldom used. To improve patient outcomes, all nursing staff are trained in Basic Life Support (BLS) and Automated External Defibrillators (AED) have been placed on each floor of the SJRH. Research demonstrates that to support positive patient outcomes, staff must administer CPR and use early defibrillation. Considering effective code blue procedures established at the SJRH and in keeping with standards for code blue teams, horizon will not be implementing this recommendation.

Recommendation #11

That a short stay unit be implemented as part of the psychiatric services available at the Saint John Regional Hospital. Said unit to include dialectical-behavior therapy as part of its treatment protocol, with linkage to community-based dialectical-behavior therapy for follow-up, post discharge.

Horizon Health Network Response:

Horizon Health Network faces constraints with obtaining physical space and other needed resources (e.g., psychiatry time to design and support such a unit). Furthermore, there are already pressures around occupancy at 4DN and which could be further exacerbated by the creation of such a unit. The 4DN and psychiatric unit has been overcapacity many times in recent years, and discharges to community are proving to be more and more challenging. Evidence for the efficacy of a short stay unit as preferred treatment for individuals with Borderline Personality Disorder is inconclusive. Use of unlocked safe rooms (seclusion rooms) are available on all units and can provide a private, safe space for patients whereby the door is open and unlocked and they are away from the general unit. This is sometimes referred to by staff as ‘open seclusion’ which provides a safe space for patients who may require less restrictive observational care well improving safer transition for patients transferring to the general unit. Unlocked safe rooms provide a safer for space for patient when stabilizing while under observation without being locked in. For these reasons, we will not be implementing this recommendation, however, the development of a guidelines document to support care of individuals with this diagnosis on our psychiatric units is being explored. These guidelines would focus on enhancing or boosting the patient’s coping skills, for instance, emotional regulation using the Dialectical Behavior Therapy STEPPS model. The interdisciplinary team, and collaboration with the patient, co- develops a therapeutic care plan with the community team for continuity of care.

Recommendation #12

That Horizon Health Network continue to explore the possibility and support the implementation of crisis stabilization units in its hospitals.

Horizon Health Network Response:

Following an in-depth review of current needs in the Saint John area a report entitled 'Addiction and Mental Health Recommendation 20 - Addiction and Mental Health Continuum of Crisis Care in New Brunswick: Horizon Health Network - Saint John Crisis Care Centre Approach: Data Analysis and Recommendations' was commissioned. Given the implementation of one-at-a-time therapy an expanded Addiction and Mental Health teams in Emergency Department's, a decision was made, in collaboration with the Department of Health, that a stand-alone service was not required at this time; nor supported by the analysis of available data. Improved access to mental health interventions through the one-at-a-time therapy offerings (available within 1-3 days at various community sites and improved mental health collaborative care teams in the emergency department (24/7) have led to enhanced crisis stabilization services across the Saint John region in recent years.

Recommendation #13

That Horizon Health Network provide an information session on local resources available for people with borderline personality disorder to its physicians. A list of these resources should be displayed and available to physicians.

Horizon Health Network Response:

Resource is on Borderline Personality Disorder were collated by zone, with a plan to distribute these resources to physicians via local Family Medicine Department Chiefs, Nurse Practitioners via Primary Health Care leadership as well as the New Brunswick Medical Society.

Recommendation #14

That Horizon Health Network adopt or make a continuous assessment of suicide urgency. A form should be used in any medical clinic or emergency department where a patient presents themselves in either a mental health crisis or self-reports being suicidal. The network should also evaluate the form to see if there is merit in also using it on units.

Horizon Health Network Response:

A suicide care pathway for patients presenting to Emergency Departments with addiction and/or mental health concerns was implemented. The inpatient psychiatry setting is the next stage of this initiative. The validated tool being used is the Columbia Suicide Risk Screening and full assessment to inform any immediate and longer-term interventions to minimize risk and strengthen protective factors and safety planning. Audits are conducted to ensure assessment compliance and education on suicide risk assessment and lethal means mitigation has been developed for staff. Other areas within Horizon Health Network are exploring the use of these tools however services outside of HHN are not being considered given these services are outside of HHN purview while suicide risk assessment tools are helpful in creating a care plan, they do not negate the need for thorough psychiatric assessments.

Recommendation #15

That the Department of Justice and Public Safety support the office of the chief coroner in establishing a suicide fatality review committee.

Horizon Health Network Response:

Horizon Health Network does not have authority over justice and public safety however, the Department of Health, Addiction and Mental Health division, employees a Suicide Prevention Coordinator who regularly interacts with New Brunswick's Corner's Offices.

Justice and Public Safety Response:

Shortly before the inquest, the Minister of Public Safety directed the Chief Coroner to pilot a Suicide Fatality Review Committee and the inquest recommendation emphasizes the need for such a forum. The committee was launched in late 2023 following the development of robust suicide investigation forms and associated training for immediate use by all coroners that would support the work of the committee and improve data collection; the development of a training program for committee members, and the determination of what cases would be reviewed by the committee. Deaths by suicide vary annually, ranging from 90-136 in the last decade, and this is not a practicable volume for thorough committee review. At this time, cases reviewed are limited to those in which the deceased accessed health, mental health or additions services in the three months prior to the death. At this time, cases of youth suicide continue to be reviewed by the Child Death Review Committee.

SKYLER BRENT SAPPIER-SOLOMAN

An inquest into the death of Skyler Brent Sappier-Soloman was held May 16-18, 2023, in Saint John. Sappier-Soloman died on January 31, 2022, in hospital, following an illness at the Saint John Regional Correctional Centre where he was an inmate at the time.

The five-member jury heard from twenty-three witnesses during the inquest and made the following recommendations:

1. Develop a standard operating procedure to guide decision-making based on risk level and clarify the roles and responsibilities of Corrections Health Services nursing personnel and Justice and Public Safety correctional officers when a patient requires transfer from a correctional facility to a hospital. Procedures to determine the method of transportation to a hospital facility should be developed. These should be based on a medical assessment of a patient's risk levels and distinguish between non-urgent and urgent risk levels, and whether an ambulance or correctional services van are appropriate for transportation.

2. Investigate the possibility of using the EPOC Blood Analysis System. This medical equipment would provide quick access to basic bloodwork results. Further, the Saint John Regional Correctional Centre should consider the use of electrocardiograms within Corrections Health Services. Electrocardiograms can help inform decisions related to client care, including the necessity of transfers to the hospital. Further, the Saint John Regional Correctional Centre should examine the feasibility of these tools, especially in relation to human resources, scopes of practice, and training needs.

3. Explore the potential addition of a paramedic to the Corrections Health Services staffing model. A review of the use of paramedics in Corrections Health Services in other facilities across Canada will provide valuable information about the feasibility and effectiveness of adding such a role to the service. The associated skill set could potentially enhance the care team, contributing to positive care outcomes for urgent health needs.

4. Improve policies and procedures regarding transport and when to call an ambulance.

5. Improve policies and procedures regarding when to seek hospital care.

6. Improve record-keeping. Correctional officers should document if an inmate requested painkillers, saw a nurse, or made a medical complaint. This should be noted to monitor shift turnover.

7. Have the inmate's vitals charted every time they are checked, even if they are unremarkable.

8. Provide medical attention and mental health services when they are needed.

9. Update contact information once an inmate arrives at the facility.

10. Have a nurse on an overnight shift from 11 p.m. to 7 a.m.

11. Install video and audio devices in the medical unit cells for nurses and/or correctional officers.

12. Nurses should be able to enter as well as verbally and physically check on an inmate while they are in a medical unit cell.

13. Create a policy or procedure to enter any medically related interaction and information regarding an inmate on a computer where specific user identifications are used.

14. Conduct monthly follow-ups regarding note taking. Once a month, shift supervisors should conduct an audit, review, and sign every correctional officer's notebook.

15. Ensure an inmate is checked every fifteen minutes and that they have been asked how they are doing when they are placed in a medical unit cell, which would include a visual check. Any changes in the inmate's condition should be immediately reported to the medical staff.

16. Establish policies and procedures to provide effective communications between the Saint John Regional Hospital and the Saint John Regional Correctional Centre to ensure the status of inmates is relayed to the institutions when they are admitted.

17. Ensure that all the contact numbers of next of kin are verified during inmate admissions and that the list is updated.

18. Develop a more efficient process for providing temporary absences to hospitals versus providing a hard copy.

19. Ensure all video surveillance timestamps are synchronized and accurate.

20. Ensure the Saint John Regional Correctional Centre has all-wheel-drive or 4-wheel-drive vehicles for the winter months.

21. Conduct a review of the policy on plowing contracts. Driveways, parking lots, and pathways must be kept clear during storms, not only after they end. Ease of access for transportation or ambulances must be maintained.

Recommendation #1

Develop a standard operating procedure to guide decision-making based on risk level and clarify the roles and responsibilities of Corrections Health Services nursing personnel and Justice and Public Safety correctional officers when a patient requires transfer from a correctional facility to a hospital. Procedures to determine the method of transportation to a hospital facility should be developed. These should be based on a medical assessment of a patient's risk levels and distinguish between non-urgent and urgent risk levels, and whether an ambulance or correctional services van are appropriate for transportation.

Horizon Health Network Response:

This recommendation was completed. - Horizon currently has a standard operating procedure "Transfer of Clients in Corrections Health Services", which addresses the risk level and roles and responsibilities associated with patient transport. The Transfer of Corrections Health Services Standard Operating Procedure has been provided and communicated to the SJRCC.

Justice and Public Safety Response:

While it is standard practice for Adult Custody Services (ACS) to assist and support Health in risk assessment, Health is responsible to lead decisions in determining the level of risk and the modality of transportation. When Health is not on-site to appropriately assess the severity of patient care, ACS will continue to utilize ambulance services in emergency situations. Discussions have occurred with Health to aid ACS in risk assessment.

Recommendation #2

Investigate the possibility of using the EPOC Blood Analysis System. This medical equipment would provide quick access to basic bloodwork results. Further, the Saint John Regional Correctional Centre should consider the use of electrocardiograms within Corrections Health Services. Electrocardiograms can help inform decisions related to client care, including the necessity of transfers to the hospital. Further, the Saint John Regional Correctional Centre should examine the feasibility of these tools, especially in relation to human resources, scopes of practice, and training needs.

Horizon Health Network Response:

The feasibility of the utilization of the above diagnostic and ECG equipment at the SJRCC was investigated. Based on SJRCC's current general primary care nursing model this recommendation was not implemented. Accreditation Canada recommends this type of equipment be used in healthcare facilities utilizing acute care staffing models. The use of diagnostic labs/ECGs also requires specialized training, which includes regular usage and upkeep to maintain competencies.

Recommendation #3

Explore the potential addition of a paramedic to the Corrections Health Services staffing model. A review of the use of paramedics in Corrections Health Services in other facilities across Canada will provide valuable information about the feasibility and effectiveness of adding such a role to the service. The associated skill set could potentially enhance the care team, contributing to positive care outcomes for urgent health needs.

Horizon Health Network Response:

The feasibility of this recommendation was reviewed and as a result of the current paramedic shortage, recruitment and retention challenges, this recommendation will not be implemented at this time.

Recommendation #4

Improve policies and procedures regarding transport and when to call an ambulance.

Horizon Health Network Response:

This recommendation has been completed through the Transfer of Corrections Health Services Standard Operating Procedure as per the response to Recommendation #1.

Recommendation #5

Improve policies and procedures regarding when to seek hospital care.

Horizon Health Network Response:

This recommendation has been completed through the Transfer of Corrections Health Services Standard Operating Procedure as per the response to Recommendation #1.

Recommendation #6

Improve record-keeping. Correctional officers should document if an inmate requested painkillers, saw a nurse, or made a medical complaint. This should be noted to monitor shift turnover.

Horizon Health Network Response:

This recommendation falls under the responsibility of Justice & Public Safety.

Justice and Public Safety Response:

Documentation is standard operating procedure and refresher training is underway at all provincial correctional institutions. Management has engaged in a policy review with all staff in regard to documentation. Furthermore, this scenario has been added to our 2024 BEST (bi-annual emergency simulation training) schedule.

Recommendation #7

Have the inmate's vitals charted every time they are checked, even if they are unremarkable.

Horizon Health Network Response:

This recommendation was completed. Documentation Standards were reviewed with staff.

Recommendation #8

Provide medical attention and mental health services when they are needed.

Horizon Health Network Response:

This recommendation has been completed. Medical attention including mental health is provided.

Recommendation #9

Update contact information once an inmate arrives at the facility.

Justice and Public Safety Response:

Next of kin and contact information questions are standard procedure during all admissions intakes. ACS will continue to confirm next of kin at each admission. This is a client-dependent process.

Recommendation #10

Have a nurse on an overnight shift from 11 p.m. to 7 a.m.

Horizon Health Network Response:

This recommendation was reviewed with a goal of implementing within 6 months.

Recommendation #11

Install video and audio devices in the medical unit cells for nurses and/or correctional officers.

Justice and Public Safety Response:

ACS supports this recommendation and is exploring the requirement for audio / CCTV cameras in critical areas. The department has engaged in discussions regarding the capacity for institutions to move to audio capable cameras in high-risk areas. A review must take place to ensure no privacy laws are violated. Once the review is complete, our intention is to move ahead with the implementation of these devices in all adult Institutions. Body Worn Camera systems for front-line officers became fully operational July 2023.

Recommendation #12

Nurses should be able to enter as well as verbally and physically check on an inmate while they are in a medical unit cell.

Horizon Health Network Response:

This recommendation is currently in place as there is an established policy/process where an officer is present when the nurse enters the cell to verbally and or physically check on the inmate.

Justice and Public Safety Response:

This recommendation is current practice in provincial correctional institutions as requested by nursing staff. Medical staff have full access to clients.

Recommendation #13

Create a policy or procedure to enter any medically related interaction and information regarding an inmate on a computer where specific user identifications are used.

Horizon Health Network Response:

Upon consideration, an electronic documentation system is currently not available or feasible at this time. The current documentation procedure involves the use of paper-based documents, which contain the medical information of an inmate when being transferred to another facility.

Justice and Public Safety Response:

All clinical/medical staff continue to have full access to our client information system where ACS staff place all their notes and information regarding clients that are being monitored for health/clinical reasons. Health has been provided full access to JPS Client Information System where all notes are stored.

Recommendation #14

Conduct monthly follow-ups regarding note taking. Once a month, shift supervisors should conduct an audit, review, and sign every correctional officer's notebook.

Justice and Public Safety Response:

As per ACS standard operating procedures, information is captured daily in operation logbooks for the facility, as well as medical services logs and segregation logs. Living unit notes and general information are captured in the Client Information System. All information is reviewed by Institution Sergeants daily. ACS has reviewed introducing notebooks and has determined that due to notes being stored in multiple locations, notebooks are not required for Correctional staff. In addition, we have concluded that current platforms for notes meet the recommendation.

Recommendation #15

Ensure an inmate is checked every fifteen minutes and that they have been asked how they are doing when they are placed in a medical unit cell, which would include

a visual check. Any changes in the inmate's condition should be immediately reported to the medical staff.

Horizon Health Network Response:

This recommendation falls under the responsibility of Justice & Public Safety.

Justice and Public Safety Response:

The practice of 15-minute checks is already in place. A policy review was completed in March 2024 to add script requiring correctional staff to ask how client is feeling. Staff training has also been completed on this.

Recommendation #16

Establish policies and procedures to provide effective communications between the Saint John Regional Hospital and the Saint John Regional Correctional Centre to ensure the status of inmates is relayed to the institutions when they are admitted.

Horizon Health Network Response:

This recommendation has been completed through the Transfer of Corrections Health Services Standard Operating Procedure as per the response to Recommendation #1.

Justice and Public Safety Response:

Currently, Health maintains that privacy of client cannot be breached, therefore communicating information to SJRCC staff is not permitted. However, after reviewing section 39.1 of the Personal Health Information Privacy and Access Act (PHIPAA), ACS feels that there is opportunity to share information. Discussions are ongoing with Health.

Recommendation #17

Ensure that all the contact numbers of next of kin are verified during inmate admissions and that the list is updated.

Justice and Public Safety Response:

This is standard operating procedure for Operational Support Unit staff during client intake. ACS has added a process to have the Correctional Case Manager (CCM) confirm this information in their first meeting with the client. This began in March 2024 after we increased the number of CCMs at each institution.

Recommendation #18

Develop a more efficient process for providing temporary absences to hospitals versus providing a hard copy.

Justice and Public Safety Response:

ACS has reviewed this recommendation and found that the process of hand delivering Temporary Absences to hospitals is the method that best supports privacy regulations.

Recommendation #19

Ensure all video surveillance timestamps are synchronized and accurate.

Justice and Public Safety Response:

Camera systems in all provincial correctional institutions have recently been upgraded. In addition, maintenance schedules have been set up to ensure all cameras systems are synchronized and accurate. This will occur twice a year when the time changes.

Recommendation #20

Ensure the Saint John Regional Correctional Centre has all-wheel-drive or 4-wheel-drive vehicles for the winter months.

Justice and Public Safety Response:

ACS has assessed all vehicles and determined they are suitable for winter driving. All male adult custody centres have new assets for suitable winter driving.

Recommendation #21

Conduct a review of the policy on plowing contracts. Driveways, parking lots, and pathways must be kept clear during storms, not only after they end. Ease of access for transportation or ambulances must be maintained.

Justice and Public Safety Response:

ACS has reviewed current contracts and have determined services are appropriate. All current contracts include keeping emergency access points/roads maintained during storms. In addition, correctional institutions will ensure emergency points are cleared of snow and ice as required.

BRUCE LAGACE

An inquest into the death of Bruce Lagace was held October 10 and 11, 2023 in Saint John. Lagace died on November 24, 2021, from injuries sustained as a truck driver delivering to American Iron and Metal in Saint John.

The five-member jury heard from thirteen witnesses during the inquest and made the following recommendations:

1. On arrival, the receiver should ensure the customer has signed updated procedures and protocols.

2. Safety procedures should be reviewed by a third party periodically and updated when needed.

3. There should be a clear procedure for communicating transfers of duty.

4. The driver should not stay in the vehicle during the off-loading process.

5. The driver should remain in the safe area until the site employee indicates it is safe to return to the vehicle.

6. The cleaning process should be completed in designated cleaning areas.

7. There should be punitive measures for safety infractions.

American Iron and Metal did not provide feedback on these recommendations.

LEXI DAKEN

An inquest into the death of Lexi Daken was held November 6-8, 2023, in Fredericton. Daken died on February 24, 2021, from suicide.

The five-member jury heard from sixteen witnesses during the inquest and made the following recommendations:

1. Better hospital communication with patients. Brochures that would outline services available with contact information.

2. Standardized patient discharge information sheet could be given to patient with relevant medical information from visit (e.g. diagnosis, medication, care plan).

3. Regarding “contract for safety”: (a) We recommend consistent and specific wording for the contract. (b) We recommend parent or legal guardian to be present and involved with the contract to safety for youth.

4. Community Mental Health Services to specify next follow up appointment (date or date

and time).

5. Recommend signage in waiting room to reassure and support patients who are waiting (regarding mental health).

6. Additional resources made available for community mental health services.

7. Increased awareness and education for youth and the public regarding the Mental Health Services available and increased marketing of mental health services available and have information easily accessible.

8. Additional resources should be made available for community mental health services.

Recommendation #1

Better hospital communication with patients. Brochures that would outline services available with contact information.

Horizon Health Network Response:

As a result of this recommendation, Horizon requested that leadership with the Integrated Service Delivery team with Government of New Brunswick update their website and provincial ISD brochure that provides an overview of services available for children and youth and to develop a distribution plan to ensure the updated brochures are widely available across school and community sites. This is underway.

Also in response to this recommendation, Horizon created an infographic in English and French that is being shared on patient and community information boards, social media channels, and on websites in the coming weeks and months. This infographic (attached) highlights the many options for assistance available to children and youth in Horizon. It will be kept updated for long term use. This infographic was widely distributed in the following formats:

• As a poster in Emergency Departments
• As digital content for our digital screens in Emergency Departments and waiting rooms
• Shared via various social media channels
• Promoted widely as a newspaper ad
• Included on Horizon and others websites via homepage updates (banner, button) and content updates
• Included in our monthly community e-newsletter
• It was also shared with school districts who can post in on school bulletin boards, in newsletters, on websites, etc.

At the same time, Horizon updated child and youth information on both the GNB and Horizon websites as well as Bridge the GaPP for GNB and Horizon (work complete). The updated website simplifies access phone numbers for easier access to needed services. Horizon communications also added two employee profiles to the website to better help clients understand the services available to them.

Horizon also developed a process for information distribution for youth attending EDs across Horizon. If children and youth visit the emergency room our addiction and mental health teams in the emergency room forward their chart on to their Child and Youth addiction and mental health clinicians office via fax. During office hours, new protocols in place ensure these charts are reviewed by the clinician or an alternate if the clinician is out of office or unavailable.

Recommendation #2

Standardized patient discharge information sheet could be given to patient with relevant medical information from visit (e.g. diagnosis, medication, care plan).

Horizon Health Network Response:

Horizon already has various information sheets/tools that a child or youth would take home after a visit to the emergency department, including discharge information, a prescription or medication list, safety plan, and appointment cards. As a result of this recommendation, Horizon developed a customized envelope that will hold all of the needed documents the client will receive to take home after their visit, with a checklist on the outside of the envelope to ensure staff include all the needed documents for the child or youth's follow up care. The envelope will also feature emergency and crisis contact information and other information about services and supports.

Clerks to confirm contact information with patients.

Horizon Emergency Departments already have a standard operating procedure that includes a double check of address, phone number and other important contact information. This procedure was reviewed with all staff at the DECRH Emergency Department to ensure it is used consistently.

Recommendation #3

Regarding "contract for safety": (a) We recommend consistent and specific wording for the contract. (b) We recommend parent or legal guardian to be present and involved with the contract to safety for youth.

Horizon Health Network Response:

After considering this recommendation, Horizon Health Network's Quality of Care and Safety of Patients Committee declined this recommendation. The practice of contracting to safety, although once standard practice, is no longer the recommended practice for managing suicide risk. Developing a safety plan with children or youth at risk of suicide is the current best practice, and Horizon has a suicide risk assessment policy that ensures safety planning occurs with all patients who are assessed as at risk. Horizon acknowledges that staff outside of the Addiction and Mental Health programs and services may not be as familiar with safety planning as a best practice. For this reason,

Addiction and Mental Health is organizing a recorded education session on Safety Planning with At-Risk Children and Youth for non-Addiction and Mental Health Emergency Department staff. This session will be recorded and will be mandatory for all Emergency Department physicians at the DECRH.

In regards to parents being present for the safety planning, this will be dependent upon whether the parent/guardian is present at the Emergency Department, the age of the patient, and whether the patient consents.

Recommendation #4

Community Mental Health Services to specify next follow up appointment (date or date and time).

Horizon Health Network Response:

Horizon Addiction and Mental Health Emergency Department teams already have a process in place to ensure all patients receive an appointment for community follow-up after an Emergency Department visit. Currently, the Emergency Department staff request the Community team to call the child or youth (or parents) to arrange the follow up visit and book the appointment. In future, an interactive registration and booking system that is accessible to staff in the emergency department would allow for just-in-time booking on site.

Recommendation #5

Recommend signage in waiting room to reassure and support patients who are waiting (regarding mental health).

Horizon Health Network Response:

Horizon already features important information about available mental health and addiction support on patient screens in the Emergency Department waiting areas. In addition, Horizon now includes the new child and youth infographic referenced above, which is posted on walls and screens in the Emergency Department.

Recommendation #6

Additional resources made available for community mental health services.

Horizon Health Network Response:

In the year following Lexi Daken's death, the Department funded additional full-time positions in Community mental health and the following year, funding was provided for new positions to introduce One-at-a-Time Therapy service that gives children and youth quick and easy access to counselling and crisis support. 26.5 FTE were added in 2021-

2002 and 2002-2023 for OAAT provincially in the child and youth sector (53 FTE total). As well, Horizon continues to monitor wait times throughout the year and, if needed, can request additional positions through the annual Department of Health budget request process. If demographics shift, and volumes indicate that additional clinical positions are required to meet demands, budget requests are submitted for additional positions.

Recommendation #7

Increased awareness and education for youth and the public regarding the Mental Health Services available and increased marketing of mental health services available and have information easily accessible.

Horizon Health Network Response:

As mentioned in #1 (above), Horizon has updated all of our brochures and websites to ensure information is easily accessible to children, youth and their families. We have developed an eye-catching child and youth services infographic and distributed it across the province via print, web-based and social media channels. We will continue to expand and improve upon our communication with children and youth as communication methods to reach these populations are constantly shifting.

Recommendation #8

Additional resources should be made available for community mental health services.

Department of Health Response:

Child and Youth Services Branch at the Department of Health is working on a yearlong provincial awareness campaign. This campaign will focus mainly on addressing stigma, using a recovery lens, empowering the audience and providing education. The campaign will have a few different targeted audiences including the child and youth population.

Secondly, the Branch has also been working on a Community Health Care Promotion initiative in partnership with the Primary Health Care Branch. This initiative aims at creating awareness around health care access within New Brunswick. Presentations have been offered to numerous stakeholders, clinicians and non-government organizations and include promotional material to help New Brunswickers navigate our health care system.

The Branch has been meeting with school districts and community partners to identify priorities and explore resources available. This group is currently working towards providing educators with an updated suicide prevention and mental health resource bundle targeting grade 9 students and their families to normalize conversations and increase awareness on prevention and access to addiction and mental health services available in New Brunswick.

RYAN ANDREW NOWLAN

A mandatory inquest into the death of Ryan Andrew Nowlan was held November 21 and 22, 2023 in Saint John. Nowlan died on December 31, 2021, from injuries sustained during an RCMP intervention following a call for police service at Nowlan's residence.

The five-member jury heard from twelve witnesses during the inquest and made the following recommendations:

1. There should be more extensive and continual training for law enforcement in regards to domestic violence.

2. Ensure all officers involved in a domestic dispute have adequate background knowledge on a suspect prior to entering the premises.

3. People with a history of restraining orders pertaining to domestic violence could be required to receive treatment by a mental health professional.

4. When possible, avoid further contact between the victim and perpetrator in domestic disputes.

5. Avoid re-entry of potential high-threat areas to retrieve non-vital belongings.

6. Victims of domestic violence should have better access to resources.

Recommendation #1

There should be more extensive and continual training for law enforcement in regards to domestic violence.

RCMP Response:

J Division has now made it mandatory for members to participate in a J Division IPV/ ODARA training. Courses are scheduled up to the end of June 2024 and we will be identifying dates for September to December 2024. Currently, 58.5% of J Division has received the ODARA training and 43.5% have received the IPV training. J Division is aiming to have 80% of members trained by December 31st 2024.

Recommendation #2

Ensure all officers involved in a domestic dispute have adequate background knowledge on a suspect prior to entering the premises.

RCMP Response:

National police for violence in relationship states:

2.1.1. In determining the appropriate course of action, consider all the circumstances,

including but not limited to: allegations of aggression, history, pattern of abuse, frequency/escalation of violence and the relationship, the presence of children, the use of weapons, the presence of pets, and safety planning.

3.1.1.1.2. Ensure the Canadian Police Information Centre (CPIC), Police Reporting and Occurrence System (PROS)/Police Records Information Management Environment (PRIME-BC)/Versadex Halifax, and Canadian Firearms Registry Online checks are completed; and

3.1.1.1.3 obtain as much information as possible from the Operational Communication Centre (OCC) and/ or sources, e.g. partners.

J Division policy states:

> 1.2 suspect history
>
> 1.2.1 Suspect's Criminal Violence History: Conduct all indices checks including CPIC, PIP, PROS, and CFRO. Determine criminal history of accused. Does the suspect have a history of investigations, charges or convictions for threats, violence, and/or sex assaults? (BAIL)
>
> 1.2.2 Previous Domestic Violence History: Is there a history of violence or abusive behavior in the relationship or with the previous intimate partner? Is there history of threats of violence, actual violence or abusive behavior against other members of the household including children, other family members or family pets? (BAIL)

The above points will be disseminated to the membership as a reminder when dealing with IPV files.

A comprehensive review of the divisional IPV policies will be take place including 2.4. Violence in Relationships (VIR), Appendix 2-4-3 Violence in Relationships - Investigative/Release Procedures and Appendix 2-4-4 Police-Based Risk Assessment for Domestic and Intimate Partner Violence (D/IPV) New Brunswick protocol.

The above points will be disseminated to the OCC and Risk Managers as a reminder when they oversee the initial response to IPV investigations.

Recommendation #3

People with a history of restraining orders pertaining to domestic violence could be required to receive treatment by a mental health professional.

RCMP Response:

Not applicable to the J Division RCMP.

Recommendation #4

When possible, avoid further contact between the victim and perpetrator in domestic disputes.

RCMP Response:

Divisional policy states:

4.2.3 Locate and separate the disputants, if feasible.
During the comprehensive review of Divisional policy, CROPS will amend the Divisional IPV policy to ensure an emphasis is placed on NOT allowing the victim and perpetrator to be in contact.

Recommendation #5

Avoid re-entry of potential high-threat areas to retrieve non-vital belongings.

RCMP Response:

During the comprehensive review of the divisional IPV policy, CROPS will amend accordingly to indicate that members are not to return to high-risk situation to retrieve non-vital belongings.

Recommendation #6

Victims of domestic violence should have better access to resources.

RCMP Response:

A new sexual crime unit is being created and resources will be tabulated throughout the various regions of NB. The service will be for victims of IPV and victims of sexual crimes. Initiatives such as therapeutic dogs at IPV centres are planned.

J Division RCMP are working with outside agencies on IPV files and trauma informed responses. These stakeholders include Sexual Violence NB, KIDS and other not for profit groups who are experts in the field of intimate partner violence.

WILLIAM RUSSELL

A mandatory inquest into the death of William Russell was held December 4 and 5, 2023 in Fredericton. Russell died on February 11, 2021, from injuries sustained while working for Marwood Limited in Tracyville.

The five-member jury heard from nine witnesses during the inquest and made the following recommendations:

1. Utilize mature industries and other jurisdictions in Canada to determine safety standards, best practices, regulation and legislation that will help New Brunswick companies understand and implement safety management systems in a clear, specific and easy-to-understand way.

2. Templates and examples could be made available to companies for inspection and documentation requirements. This would be in lieu of the Occupational Health and Safety Act just saying that documentation or inspection is required.

3. More detail should be included in the act or regulation on what is required for training, documenting training, and data on which employees are up to date or who is late for training. Additionally, there should be more detail on the delivery, communication and sign-off for standard operation procedures.

Recommendation #1

Utilize mature industries and other jurisdictions in Canada to determine safety standards, best practices, regulation and legislation that will help New Brunswick companies understand and implement safety management systems in a clear, specific and easy-to-understand way.

WorkSafe NB Response:

WorkSafeNB currently meets this recommendation.

WorkSafeNB participates on numerous national committees and organizations. WorkSafeNB staff participate in and frequently lead national standards development groups. WorkSafeNB staff participate in regional, national and international working groups for industrial accident investigations. From these efforts, WorkSafeNB works with the provincial government to update legislation and standards references. Apart from specific updates based on new information or standards, WorkSafeNB undertakes a complete review of legislation on a five-year cycle including stakeholder consultation to ensure that OHS legislation maintains high health and safety standards for New Brunswick workplaces.

Recommendation #2

Templates and examples could be made available to companies for inspection and documentation requirements. This would be in lieu of the Occupational Health and Safety Act just saying that documentation or inspection is required.

WorkSafe NB Response:

WorkSafeNB currently meets this recommendation.

WorkSafeNB has many templates and guides available through field staff and on our website to assist workplaces in achieving a high standard of health and safety compliance. WorkSafeNB has staff who continuously review and monitor resources available to workplaces to ensure best practices are reflected. When legislation is updated or created, supporting documents are reviewed, updated and created as necessary. These documents are widely available and widely promoted as being available.

Recommendation #3

More detail should be included in the act or regulation on what is required for training, documenting training, and data on which employees are up to date or who is late for training. Additionally, there should be more detail on the delivery, communication and sign-off for standard operation procedures.

WorkSafe NB Response:

WorkSafeNB currently meets this recommendation.

The Occupational Health and Safety Act and the regulations includes training and record keeping requirements. The legislation uses the terms procedures and Codes of Practice, which provide the same information has standard operating procedures. Existing legislation requires employees to be trained on those procedures and Codes.

DANIEL MOORE

A mandatory inquest into the death of Daniel Moore was held December 6 and 7, 2023 in Fredericton. Moore died on July 10, 2021, from injuries sustained while as a carpenter working at a residential construction site.

The five-member jury heard from eight witnesses during the inquest and made the following recommendations:

1. All job sites should have one licensed carpenter on site.

2. All job sites should have one worker trained in first aid.

3. Building permits for new home construction must be associated with a licensed carpenter.

4. Members of the Canadian Home Builders Association of New Brunswick should take refresher safety courses every one to two years.

5. Roof trusses should be assembled on the ground whenever possible.

6. In rafters, any strapping used as temporary connectors between trusses should be 2x4.

7. The height for equipment designed to stop falls should be less than three meters when over concrete; three meters is fine over plywood floors.

8. More random inspections by building inspectors should be done.

Recommendation #1

All job sites should have one licensed carpenter on site.

WorkSafe NB Response:

WorkSafeNB staff recently met with staff from the Apprenticeship and Occupational Certification program and the Department of Justice and Public Safety. At these meetings, all recommendations coming out of this inquest were discussed, including this one. Currently, a license for carpenters does not exist under Justice and Public Safety legislation and carpenters is a voluntary occupation under the Apprenticeship and Occupational Certification Act. WorkSafeNB, Justice and Public Safety and Apprenticeship and Occupational Certification will continue to monitor safety job site performance in NB and bring changes forward as required.

Recommendation #2

All job sites should have one worker trained in first aid.

WorkSafe NB Response:

WorkSafeNB currently meets this recommendation.

First Aid Regulation 2004-130 requires trained first aiders. The regulatory requirement already exists to require a first aider on every job site and depending on the number of employees on site may require multiple providers. In the regulation, construction is defined as “high hazard work” and may require additional first aid providers.

Recommendation #3

Building permits for new home construction must be associated with a licensed carpenter.

WorkSafe NB Response:

This recommendation was shared with the Department of Justice and Public Safety as it is outside WorkSafeNB's scope. The Building Code Administration Act relates to technical safety of the built environment. In its current form it does address the qualifications of permit holders or designates, while the carpenter designation remains voluntary. Similarly to recommendation number 1, WorkSafeNB, Apprenticeship and Certification and the Department of Justice and Public Safety will continue to monitor safety job site performance in NB. WorkSafeNB will continue to review and analyze data related to carpenters. WorkSafeNB will support any decision made by the apprenticeship program and/or Public Safety regarding this recommendation.

Recommendation #4

Members of the Canadian Home Builders Association of New Brunswick should take refresher safety courses every one to two years.

WorkSafe NB Response:

WorkSafeNB will share this recommendation with the various home builders' associations in the province and with the New Brunswick Construction Safety Association. OHS legislation does require training based on the activity of the employer and these requirements will be maintained and enforced. WorkSafeNB will support and assist these organizations as necessary.

Recommendation #5

Roof trusses should be assembled on the ground whenever possible.

WorkSafe NB Response:

WorkSafeNB currently meets this recommendation.

Following this inquest, WorkSafeNB created training materials for the safe erection of roof trusses in cooperation with the New Brunswick Construction Safety Association. These materials are widely available in the construction industry, including homebuilders.

Recommendation #6

In rafters, any strapping used as temporary connectors between trusses should be 2x4.

WorkSafe NB Response:

WorkSafeNB does not support this recommendation.
Although 2x4 lumber is sturdier than strapping, it is not intended as a walking surface and is unsafe to be used as such.

Recommendation #7

The height for equipment designed to stop falls should be less than three meters when over concrete; three meters is fine over plywood floors.

WorkSafe NB Response:

WorkSafeNB does not support this recommendation at this time.

There is currently no evidence indicating that there is a greater risk of injury when falling onto concrete as opposed to plywood. The New Brunswick requirements mirror those in other Canadian provinces and territories. Amendments like these are usually instigated through updated standards by various standards agencies. WorkSafeNB and other OHS regulatory bodies throughout Canada participate on technical committees within the standards agencies.

Recommendation #8

More random inspections by building inspectors should be done.

WorkSafe NB Response:

WorkSafeNB shared this recommendation with the Department of Justice and Public Safety, who is responsible for the administration of the Building Code Administration Act. Currently, the Act does not permit building inspectors to enforce aspect of the National Building Code and assorted standards, which relate to the built environment. Building inspectors are not empowered to enforce the Occupational Health and Safety Act, however the Department of Justice and Public Safety has committed to sharing communication related to construction worker safety with all building inspectors through the Building Code Administrator.

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.

Recommendations made by the Committee are distributed to appropriate agencies for responses, and are presented to the Minister, who will table them before the Legislature.

In 2023, the committee completed 17 death reviews for deaths occurring between 2020-2022.

Case # / Report date	Demographic information	Coroner Case (CC)/ Social Development involved (SD)	Manner	Cause of death	Recommendations
#1 21-Feb-23	6-year-old male	CC	Accident	Traumatic brain injury sustained in a motor vehicle accident	None
#2 21-Feb-23	1-day-old male	CC	Natural	Neonatal pneumonia	None
#3 28-Feb-23	3-week-old male	SD	Natural	Birth abnormalities	None
#4 28-Feb-22	13-year-old female	CC/SD	Suicide	Severe traumatic brain injury due to a fall	1 recommendation (see below)
#5 21-Mar-23	18-year-old male	CC	Homicide	Gunshot wounds to the chest	None
#6 28-Mar-23	18-year-old female	CC	Suicide	Ligature neck compression	1 recommendation (see below)
#7 12-Apr-23	8-month-old male	CC	Natural	Viral infection with congenital heart disease	None
#8 13-Apr-23	3-month-old female	CC/SD	Accidental	Mechanical asphyxia due to overlay (co-sleeping)	6 recommendations (see below)

#9 4-May-23	15-year-old female	SD	Natural	Pulmonary hemorrhage; died at IWK in NS jurisdiction	None
#10 5-May-23	14-year-old female	CC/SD	Natural	Seizure disorder	None
#11 14-Sep-23	2-month-old female	CC	Natural	Prematurity	None
#12 14-Sep-23	12-year-old male	CC	Accident	Drowning	None (see note below)
#13 16-Nov-23	2-month-old female	CC	Undetermined	No anatomical cause of death	None
#14 20-Nov-23	10-day-old male	CC/SD	Undetermined	No anatomical cause of death	None
#15 7-Dec-23	1-year-old male	CC/SD	Natural	Complications of a seizure disorder	None
#16 7-Dec-23	2-week-old male	CC/SD	Accident	Asphyxiation due to unsafe sleeping position	None

#17 7-Dec-23	18-year-old male	CC	Accident	Extensive internal organ damage due to high-speed motor vehicle accident	None

Recommendations and Responses

Case #4

Recommendation

Due to the complexity of the case and the amount of un-answered questions raised during this review, the committee recommends that the Office of the Chief Coroner holds a public inquest into this death.

Office of the Chief Coroner Response:

An inquest was held on November 4-6, 2024. The recommendations and agency responses from that inquest will be published in the 2024 Annual Report.

Case #6

Recommendation

The Child Death Review Committee recommends that the Office of the Chief Coroner provides guidelines regarding the writing of summaries to ensure that every summary is thorough.

Office of the Chief Coroner Response:

All coroners have now completed accredited report writing training through the US-based Death Investigation Training Academy; this and other courses are now part of core coroner training and will be required for all new coroners going forward.

A summary report writing template has also been developed and is in active use across the province.

Case #8

Recommendation #1

That Social Development meets with Directors from New Brunswick's Indigenous Nations

to create a Structured Decision-Making Model assessment that would be inclusive of the Indigenous population and would consider barriers, needs, intergenerational trauma, strengths, and protective factors specific to the population.

Social Development Response:

Social Development values its collaborative relationship with the NB First Nations Directors. In response to this recommendation, Social Development has updated its Child and Youth Protection Standards, specifically: Safety Planning now includes guidelines that when a Structured Decision-Making Safety Assessment is completed and a participant in a Safety Plan is Indigenous, the associated First Nation's Child and Family Services agency to arrange a meeting. The purpose of the meeting will be to discuss the safety plan to determine if the safety plan secures the safety of the children or youth in the home, and to consider risk and protective factors specific to the Indigenous population. As well as, to plan what steps are needed by both SD and FN CFS to ensure that all safety measures are in place and can be monitored if needed. (standards are in final approval process).

Recommendation #2

That Social Development in cases where a child who is receiving services dies while in the care of their parents, and in cases where parents would have other children in their care, that in addition to consulting the police to inquire if at first glances there is a criminal aspect, would then verify with the coroner following the autopsy that there is no concerns brough to light that could affect the surviving children.

Social Development Response:

Social Development is committed to partnering with others to ensure the overall safety and well being of children and youth. In response to this recommendation, Social Development has updated its Child and Youth Protection Practice Standards (Investigation) to include guidelines when there's been a suspicious death of a child and there are other children in the home to contact the police and the coroner, to discuss their concerns, as part of the investigation. (standards are in the final approval process).

Recommendation #3

That Social Development provides an information session to the Office of the Chief Coroner, more specifically to all Regional Supervising Coroners, on their services and how to contact them if there is a need to make a referral.

Social Development Response:

Social Development is committed to ensuring professionals understand their duty to report any child or youth protection concern. In response to this recommendation, Social Development will provide an Information Session by a Child and Youth Protection consultant and consultant responsible for child death reviews on an annual basis to share how the coroner can request information to assist their investigation, and when to make a referral (i.e. when there are other

children in the home).

Recommendation #4

That the Office of the Chief Coroner establishes guidelines regarding the information that can be shared with Social Development while the department conducts a death investigation on a child that was receiving their services. Information should be kept strictly on any ongoing protection issue the coroner might have observed.

Office of the Chief Coroner Response:

Section 34.1.d of the Personal Health Information Privacy and Access Act authorizes the coroner to share personal health information regarding a deceased if it is for the specific purpose of public safety or to protect a group of people. This permits the coroner to share information with Social Development (SD) when there are children in the home or there are others at risk of harm or death and SD could mitigate that risk. Coroners are informed about this via memo and should additionally be reminded by their supervisor in such cases. This information sharing is in addition to the general responsibility of police, coroners, and other responders to alert SD if they believe a children may be at risk of harm.

Recommendation #5

That the Department of Justice and Public Safety, through the Office of the Chief Coroner, release publicly the percentage of infants that pass in the province with unsafe sleeping condition deemed a factor during the Safe Sleep Week that takes place yearly in March. This would support national efforts by Baby's Breath Canada, The Canadian Pediatric Society, Parachute Canada, Health Canada, and the Public Health Agency of Canada who promote Safe Sleep Week.

Department of Justice and Public Safety Response:

The Office of the Chief Coroner has since posted an awareness release on the Government of New Brunswick's social media platforms outlining the ABC's of safe sleep. In doing so, the Office of the Chief Coroner is raising awareness and providing the public with safe sleep practice information and will continue this practice on an ongoing basis to educate with the goal of preventing future such deaths.

Recommendation #6

That Public Health re-evaluate their book series "Loving Care" that is being provided to new parents. Particularly page 70 of their book where they talk about "Safe Places to Sleep". Bed-Sharing should not be included in the book as a safe practice. When bed sharing is mentioned, it should include a discloser that bed sharing increases the risk of sudden infant death syndrome. Public Health should consult the statement released by the Government of Canada. The release is called "Message from the Minister of Health on Canada's Second Annual Safe Sleep Week 2023", released March 13th, 2023. Public Health

should re-evaluate their approach to safe sleep based on the information provided in this news release. Safe sleep should be discussed with expecting mother and actively part of the case plan for any mother accessing their services post-birth.

Public Health Response:

The *Loving Care* books are reviewed annually and were revised in late 2023 to provide clearer messaging regarding safe sleep. Revisions included expanded content on safe sleep practices to reduce the risk of SIDS and guidance on bed-sharing risk reduction.

Public Health resources (e.g. *Loving Care,* the provincial breastfeeding guide, and GNB website) do not recommend bed-sharing. While bed-sharing is not recommended, it is known to be a common practice among parents. Therefore, Public Health has taken a harm reduction approach, providing risk reduction messaging in provincial resources. This aligns with the approach taken by the Public Health Agency of Canada and Health Canada. Public Health routinely promotes safe sleep messaging through social media channels using organic posts and paid campaigns.

Regional Public Health dieticians and nurses discuss safe sleep practices with clients who receive home visits through the Healthy Families, Healthy babies program.

Case #12

Prior to the case being assigned to the Child Death Review Committee, the municipality had taken action to eliminate the danger of future deaths, and there was no longer a need for this recommendation to be made.

DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE

The Domestic Violence Death Review Committee was originally founded in 2009, and was enshrined in legislation in 2023. 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 distributed to appropriate agencies for response, are presented to the Minister who will tabled them before the Legislature.

In 2023, the committee completed 2 death reviews for deaths occurring between 2020- 2021. There was 1 domestic violence death in New Brunswick in 2023 however the DVDRC cannot begin its review until all investigations and criminal proceedings are concluded.

Recommendations and Responses

Report #1

Recommendation #1

The Domestic Violence Death Review Committee recommends that the New Brunswick Association of Chiefs of Police, in collaboration with the Office of the Chief Coroner take a proactive approach and create a sub-committee that will include IPV coordinators from both rural and urban areas of New Brunswick. The committee should be co-chaired by the chair of the DVDRC and by a designated IPV coordinator. This would provide a platform to share knowledge and challenges when dealing with D/IPV situations. The sub-committee would report to the NBACP.

New Brunswick Association of Chiefs of Police Response:

The NBACP fully support this recommendation and have implemented its part in the

process. NBACP will act in an advisory role to the committee of IPV coordinators put forward by individual police forces/RCMP and will receive for consideration among Chiefs the committee's output.

Office of the Chief Coroner Response:

The Office of the Chief Coroner agrees there is significant value in establishing a committee to proactively address the risk of domestic violence resulting in fatalities. While the Domestic Violence Death Review Committee is established by the Chief Coroner under the *Coroners Act,* and while the committee is chaired by a Deputy Chief Coroner, the committee itself is comprised of a number of subject matter experts in policing, law, medicine, academia, First Nations, and domestic violence. Coroners are not themselves experts in domestic violence per se, and Coroner Services may be better positioned to serve in a consultative role and support the IPV coordinators in establishing its committee.

Recommendation #2

The Domestic Violence Death Review Committee recommends to the New Brunswick Association of Chiefs of Police that an ODARA refresher should be required and completed every 5 years by its members.

New Brunswick Association of Chiefs of Police Response:

The NBACP does not have direct authority over directing police forces or the RCMP operationally or administratively on training. It is recommended that the recommendation be amended to recognize the authority of each municipal force and RCMP in the province.

Chief Coroner Response:

This recommendation will be shared directly with municipal/regional police chiefs and with the RCMP commanding officer for their consideration in keeping with their authority over training.

Recommendation #3

The Domestic Violence Death Review Committee recommends to the New Brunswick Association of Chiefs of Police that police officers across the province receive training regarding coercive control not only to be able to identify it, but on how to properly document it in their file.

New Brunswick Association of Chiefs of Police Response:

The NBACP does not have direct authority over directing police forces or the RCMP operationally or administratively on training. It is recommended that the recommendation be amended to recognize the authority of each municipal force and RCMP in the province.

Chief Coroner Response:

This recommendation will be shared directly with municipal/regional police chiefs and with the RCMP commanding officer for their consideration in keeping with their authority over training.

Recommendation #4

The Domestic Violence Death Review Committee recommends to the New Brunswick Association of Chiefs of Police that intervention in D/IPV files from the intimate partner violence coordinator from each detachment should have universal protocols in place that would dictate how to document the interventions done in a file.

New Brunswick Association of Chiefs of Police Response:

The NBACP does not have direct authority over directing police forces or the RCMP operationally or administratively on training. It is recommended that the recommendation be amended to recognize the authority of each municipal force and RCMP in the province.

Chief Coroner Response:

This recommendation will be shared directly with municipal/regional police chiefs and with the RCMP commanding officer for their consideration in keeping with their authority over training.

Recommendation #5

The Domestic Violence Death Review Committee recommends that the New Brunswick Chiefs of Police Association in partnership with the Office of the Attorney General provides a refresher to all police officers in New Brunswick of the protocols in place when dealing with D/IPV cases.

New Brunswick Association of Chiefs of Police Response:

The NBACP does not have direct authority over directing police forces or the RCMP operationally or administratively on training. It is recommended that the recommendation be amended to recognize the authority of each municipal force and RCMP in the province.

Office of the Attorney General Response:

The Office of the Attorney General is currently reviewing this recommendation with police chiefs and RCMP and will work collaboratively to develop and implement refresher training for police officers handling Domestic/Intimate Partner Violence files.

Report #2

No recommendations were made in this case, because it was confirmed that there had only been a single contact with police 5 years prior that was not related to domestic violence and that there had been no engagement with any support agencies (as confirmed by Victim Services, Social Development, Mental Health and Addiction Services). Next of kin declined to participate in the review.