Office of the Chief Coroner

ANNUAL REPORT 2024

New Nouveau Brunswick

2024 Annual Report

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The Honourable Robert Gauvin
Minister of Public Safety

Dear Minister:

Pursuant to Section 43 of the *Coroners Act*, I have the honour to submit the 53rd Annual Report of the Chief Coroner for the period January 1, 2024, to December 31, 2024.

Yours very truly,

Marie-Pier Picard
Acting 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 the 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 700 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 and Public Safety for administrative purposes. Supervision of the service is the responsibility of the Chief Coroner who is assisted by two 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, reported to the Chief Coroner through a Deputy Chief Coroner in fiscal 2024.

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 in which 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 (RCMP) 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, as well as 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 must make is whether or not to recommend an inquest to the Chief Coroner, who can then make the decision to proceed or not. Additionally, the Chief Coroner may make the decision to order an inquest into a death without a recommendation from a coroner.

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 that an inquest be held 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 in cases of 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 inquest 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.

Death Review Committees

Death review in New Brunswick, such as the Child Death Review Committee (CDRC) and the Domestic Violence Death Review Committee (DVDRC), plays a vital role in understanding and preventing premature death in the province. These multidisciplinary committees, operating under the Office of the Chief Coroner, are tasked with reviewing deaths that occur with specific circumstances.

The CDRC, established in 1997 and formally enshrined in the *Coroners Act* in 2022, reviews all deaths of individuals under 19 that are coroner's case or involve children who had recent contact with the Department of Social Development. Its mandate includes identifying trends and risk factors, recommending systemic improvements and preventative measures.

Similarly, the DVDRC, formed in 2009, reviews death resulting from domestic or intimate partner violence, including homicides and suicides. By analyzing theses cases, the committee identifies systemic gaps, and risk factors and provides recommendations to government and community

agencies aimed at preventing future domestic and intimate partner violence fatalities.

In 2024, the Office of the Chief Coroner established a third provincial death review committee following an inquest recommendation. The committee is named the Suicide Death Review Committee and is still considered a pilot as it is not enshrined in legislation. The committee is structed similarly to the CDRC and the DVDRC and reviews all deaths in adults that are attributed to suicide for the purposes of identifying trends and risk factors. The committee also has the authority to make recommendations to prevent future deaths.

These committees are crucial for their preventative impact. Their work can inform policy, enhance professional training, and fosters inter-agency collaboration. Death Review Committees are indispensable tools for death prevention. By learning from past tragedies, they help shape safer systems.

SUMMARY

Coroner Services investigates about 22 per cent 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 per cent of the cases, orders autopsies; inquests are ordered in less than one per cent of all investigated deaths.

For the period covered by this report, the Registrar of Vital Statistics recorded 8,701 deaths in the province of which 1,571 or 18.05 per cent were reported to a coroner. By comparison, in the previous year, there were 8,664 deaths in the province of which 1,837 or 21.3 per cent 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 2024.

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 takes an action that could reasonably be known to cause 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.

Autopsies refer to anatomical autopsies and forensic autopsies.

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. Additional breakdowns are provided for sex (i.e. the sex assigned at birth), age group in years, and autopsy status (i.e. whether someone underwent a Type 1 or Type 2 autopsy).

Provincial Summary - Schedule A-1
from 2024.01.01 to 2024.12.31

Classification	No. of Deaths	% of Deaths	Rate per 100,000 Population	Autopsies Performed	% of classification
Natural	1,049	67	123	349	33
Accident	373	24	44	212	57
Suicide	123	8	14	25	20
Homicide	19	1	2	18	95
Undetermined	7	0	1	5	71
Total	1,571	100	184	609	39

NOTE : Based upon Statistics Canada postcensal population estimates of 854,355 for N. B. census divisions, prepared by Finance and Treasury Board October 16, 2025.

Provincial Summary - Deaths Investigated by Classification, by Month- Schedule A-2
from 2024.01.01 to 2024.12.31

Classification	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Natural	111	90	91	99	68	86	78	76	77	78	83	112	1,049
Accident	28	22	30	23	30	30	47	26	37	32	38	30	373
Suicide	9	6	13	11	7	7	14	10	8	12	17	9	123
Homicide	0	1	1	2	3	1	2	1	3	1	3	1	19
Undetermined	0	1	0	1	1	0	2	1	1	0	0	0	7
Total	148	120	135	136	109	124	143	114	126	123	141	152	1,571

Deaths Investigated by Judicial District - Schedule A-3
from 2024.01.01 to 2024.12.31

	Judicial Districts								
	Bathurst	Campbellton	Edmundston	Fredericton	Miramichi	Moncton	Saint John	Woodstock	Province
Count	**153**	**75**	**116**	**257**	**126**	**391**	**402**	**51**	**1,571**
Natural	104	48	79	160	91	243	296	28	1,049
Accident	37	19	26	69	23	110	75	14	373
Suicide	11	8	11	19	10	32	25	7	123
Homicide	0	0	0	7	2	5	5	0	19
Undetermined	1	0	0	2	0	1	1	2	7
% of Provincial Total	10%	5%	7%	16%	8%	25%	26%	3%	100%
Rate per 100,000 population	**187.2**	**236.4**	**266.8**	**160.6**	**262.4**	**148.9**	**213.6**	**132.1**	**183.9**
Natural	127.2	151.3	181.7	100.0	189.5	92.5	157.3	14.9	122.8
Accident	45.3	59.9	59.8	43.1	47.9	41.9	39.8	7.4	43.7
Suicide	13.5	25.2	25.3	11.9	20.8	12.2	13.3	3.7	14.4
Homicide	0.0	0.0	0.0	4.4	4.2	1.9	2.7	0.0	2.2
Undetermined	1.2	0.0	0.0	1.3	0.0	0.4	0.5	1.1	0.8
Total deaths by trauma (accident, suicide, homicide)	48	27	37	95	35	147	105	21	515
Rate per 100,000 population	58.7	85.1	85.1	59.4	72.9	56.0	55.8	54.4	60.3

Provincial Summary - Accidental Deaths by Age Group, Sex, Judicial District - Schedule B-1
from 2024.01.01 to 2024.12.31

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	2	5	0	1	2	1	1	5	0	2	1	8	7	24	13	37	10	14	6.6
Campbellton	1	0	2	0	0	1	2	0	0	1	4	0	6	2	15	4	19	5.1	9	4.2
Edmundston	2	1	5	2	1	1	1	0	2	1	0	3	3	4	14	12	26	7	14	6.6
Fredericton	2	1	13	2	4	4	3	4	5	3	4	4	13	7	44	25	69	18.6	44	20.8
Miramichi	0	0	3	1	2	0	4	1	1	2	4	0	2	3	16	7	23	6.2	15	7.1
Moncton	3	1	12	4	15	4	15	3	10	5	9	4	14	11	78	32	110	29.1	53	25.0
Saint John	3	1	5	4	12	4	10	4	6	4	8	2	9	3	53	22	75	20.2	49	23.1
Woodstock	0	0	3	0	3	0	2	1	2	0	0	2	0	1	10	4	14	3.8	14	6.6
Males	13		48		38		38		31		31		55		254					
% Total - Males	3.5		12.9		10.2		10.2		8.3		8.3		14.7		68.1					
Females	6		13		16		14		16		16		38			119	373	100	212	100
% Total - Females	1.6		3.5		4.3		3.8		4.3		4.3		10.2			31.9				
Total for Age Group	19		61		54		52		47		47		93							
% of Classification Total	5.1		16.4		14.5		13.9		12.6		12.6		24.9							

Provincial Summary - Accidental Deaths by Age Group, Sex and Death Factor - Schedule B-2
from 2024.01.01 to 2024.12.31

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	0	0	1	0	0	2	0	0	1	2	3	0.8	3	1.4
Alcohol Intoxication	0	0	0	0	1	0	0	0	1	0	1	1	0	0	3	1	4	1.1	3	1.4
Animal Bites, Kicks, etc.	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.3	1	0.5
Asphyxia	0	1	1	0	2	0	0	0	1	0	2	2	1	0	7	3	10	2.7	7	3.3
Aspiration	0	0	0	1	0	0	0	1	0	1	2	0	0	0	2	3	5	1.3	4	1.9
Blunt Trauma, Accidental	2	0	5	1	2	3	6	0	3	0	5	2	3	1	26	7	33	8.8	16	7.5
Blunt Trauma	0	0	2	0	0	0	0	0	0	0	1	0	0	0	3	0	3	0.8	2	0.9
Burns - Heat	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Carbon Monoxide Poisoning	0	0	0	0	0	0	0	0	0	0	2	1	1	0	3	1	4	1.1	1	0.5
Chronic use of Prescribed Medicines	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.3	0	0

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Crushed and/or Buried	0	0	1	0	1	0	0	0	1	0	0	0	1	0	4	0	4	1.1	2	0.9
Drowning - Bathtub	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.3	1	0.5
Drowning - Ice Covered Water	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2	0	2	0.5	1	0.5
Drowning - Open Water	0	0	5	0	0	0	1	0	1	0	1	0	1	1	9	1	10	2.7	9	4.2
Drowning - Pond/Quarry	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.3	1	0.5
Drowning - Private Pool	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.3	1	0.5
Drug (street)	0	1	12	3	16	6	12	5	7	3	1	0	1	0	49	18	67	18	54	25.5
Drug	0	0	6	0	5	4	5	7	4	6	2	1	1	0	23	18	41	11	39	18.4
Exposure to Cold	0	0	0	0	1	0	0	0	0	0	0	0	0	1	1	1	2	0.5	2	0.9
Fall or jump - different level, eg. bridge, bldg.	0	0	0	0	0	0	0	0	1	0	1	2	7	2	9	4	13	3.5	2	0.9
Fall or Jump - same level	0	0	0	0	0	0	0	0	2	0	4	2	20	23	26	25	51	13.7	3	1.4

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Fire - Structural	0	0	0	0	0	0	2	0	0	0	1	0	3	1	6	1	7	1.9	4	1.9
Fire - Vehicle	0	0	3	0	0	0	0	0	0	0	0	0	0	0	3	0	3	0.8	3	1.4
Medical Procedure	0	0	0	0	0	0	1	1	0	0	0	0	1	1	2	2	4	1.1	1	0.5
Natural Disease	0	0	0	0	0	0	0	0	0	1	2	1	1	2	3	4	7	1.9	2	0.9
Object Caught in Throat	0	0	0	0	0	0	0	0	0	1	2	1	0	0	2	2	4	1.1	1	0.5
Positional Asphyxia	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Sharp Force Trauma	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Suffocation	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.3	0	0
Trauma of Air Crash	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.3	1	0.5
Trauma of Recreational Vehicle Collision	2	0	1	2	0	0	0	0	1	0	0	0	0	0	4	2	6	1.6	3	1.4
Trauma of Recreational	1	0	0	0	2	0	2	0	3	0	0	1	0	0	8	1	9	2.4	7	3.3

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						
Vehicle Upset/Rollover																				
Trauma of Vehicle Collision	4	2	6	4	4	2	5	0	1	4	1	0	7	4	28	16	44	11.8	21	9.9
Trauma of Vehicle Upset / Rollover	3	2	6	2	0	1	3	0	3	0	1	0	1	0	17	5	22	5.9	10	4.7
Trauma of Vehicle/Pedestrian Collision	0	0	0	0	2	0	0	0	0	0	0	0	2	1	4	1	5	1.3	4	1.9
Males	13		48		38		38		31		31		55		254					
Females	6		13		16		14		16		16		38			119				
Total for Age Group	19		61		54		52		47		47		93				373	100	212	100

Provincial Summary - Accidental Deaths by Age Group, Sex and Environment - Schedule B-3
from 2024.01.01 to 2024.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Aircraft - (on board)	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.3	1	0.5
ATV driver - off public road	0	0	1	0	0	0	1	0	2	0	1	1	0	0	5	1	6	1.6	3	1.4
ATV driver - on public road	2	1	1	0	2	0	0	0	2	0	0	0	0	0	7	1	8	2.1	4	1.9
ATV passenger - off public road	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0.3	0	0
ATV passenger - on public road	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Beach/Shoreline	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Boating - personal watercraft, jet ski, etc.	1	0	0	0	0	0	0	0	1	0	1	0	0	1	3	1	4	1.1	2	0.9
Camping/Tenting	0	0	1	0	0	1	1	0	1	0	0	0	0	0	3	1	4	1.1	3	1.4
Construction	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Custody Federal Institution	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Factory, Plant, Warehouse (outside)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Federal Institution	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Homeless Shelter	0	0	0	0	2	0	1	0	1	0	1	0	0	0	5	0	5	1.3	4	1.9
Homes for Special Care	0	0	0	0	0	0	0	0	1	0	0	1	3	3	4	4	8	2.1	1	0.5
Hospital Emergency - NON-DOA	0	0	0	0	0	0	2	0	0	0	0	0	1	0	3	0	3	0.8	1	0.5
Hospital Other (ward, ICU, etc.)	1	0	0	0	0	0	0	1	0	1	1	1	4	5	6	8	14	3.8	0	0
Hospital Other (Ward, ICU, etc.)	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.3	0	0
Hotel/Motel	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Inside vehicle	1	0	4	1	0	1	0	0	0	0	1	0	0	1	6	3	9	2.4	4	1.9
Inside, Other than Residence (mall, restaurant, other public building)	0	0	0	0	0	0	0	1	0	0	0	1	1	1	1	3	4	1.1	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						
Living Inside, Residence or on Property	0	2	13	5	13	8	16	11	13	11	16	10	28	14	99	61	160	42.9	102	48.1
Non-Public Road - Passenger	0	0	0	0	1	0	0	0	0	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	1	0	4	5	5	5	10	2.7	0	0
Off Road Motorcycling (motocross, dirt bike, etc.)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	0	0
Open Water (river, lake, stream, brook)	0	0	4	0	1	0	1	0	2	0	0	0	1	0	9	0	9	2.4	9	4.2
Other Outdoor Recreation	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.3	1	0.5
Other Private Residence/Property	0	0	2	0	3	0	2	0	2	0	1	0	0	0	10	0	10	2.7	9	4.2
Public Road - Driver	3	2	8	1	5	1	5	0	3	3	1	0	6	1	31	8	39	10.5	22	10.4
Public Road - Motorcycle Driver	0	0	2	0	1	0	1	0	0	0	2	0	1	0	7	0	7	1.9	3	1.4
Public Road - Motorcycle Passenger	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	2	2	0.5	2	0.9

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Public Road - Passenger	2	1	4	4	0	2	3	0	1	0	0	0	1	2	11	9	20	5.4	10	4.7
Public Road - Pedestrian	0	0	0	1	2	1	0	0	0	0	1	1	2	1	5	4	9	2.4	5	2.4
Rural Outdoors (not built-up place or near residence)	2	0	2	0	2	1	0	1	0	0	1	0	0	0	7	2	9	2.4	4	1.9
Sail boating	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.3	1	0.5
School - Pupil (not employee)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Seniors Complex	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	3	3	0.8	0	0
Snowmobiling (Anywhere Off Public Road) - driver	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.3	1	0.5
Snowmobiling (On Public Road) driver	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.3	0	0
Urban Outdoors - public place and other (not residence)	0	0	1	0	3	0	2	0	1	0	0	1	1	0	8	1	9	2.4	7	3.3
Workplace	0	0	0	0	1	0	1	0	0	0	1	0	1	0	4	0	4	1.1	3	1.4

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	13		48		38		38		31		31		55		254					
Females	6		13		16		14		16		16		38			119				
Total for Age Group	19		61		54		52		47		47		93				373	100	212	100

Provincial Summary - Suicide Deaths by Age Group, Sex and Judicial District - Schedule C-1
from 2024.01.01 to 2024.12.31

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	2	0	1	0	1	0	1	0	3	0	2	1	10	1	11	8.9	3	12.0
Campbellton	0	1	0	0	0	1	0	0	1	0	3	1	0	1	4	4	8	6.5	1	4.0
Edmundston	0	0	0	0	3	1	2	0	3	0	0	1	1	0	9	2	11	8.9	1	4.0
Fredericton	0	1	2	0	5	1	4	0	3	0	1	1	1	0	16	3	19	15.4	6	24.0
Miramichi	1	0	2	0	1	0	2	1	2	0	0	0	0	1	8	2	10	8.1	4	16.0
Moncton	0	1	5	1	3	2	3	3	10	0	2	2	0	0	23	9	32	26.0	5	20.0
Saint John	2	1	2	1	3	0	6	0	7	1	0	1	1	0	21	4	25	20.3	4	16.0
Woodstock	0	0	0	0	2	0	0	0	2	0	0	0	3	0	7	0	7	5.7	1	4.0
Males	3		13		18		18		29		9		8		98					
% Total - Males	2.4		10.6		14.6		14.6		23.6		7.3		6.5		79.6					
Females	4		2		5		4		1		6		3			25	123	100	25	100
% Total - Females	3.3		1.6		4.1		3.3		0.8		4.9		2.4			20.4				
Total for Age Group	7		15		23		22		30		15		11							
% of Classification Total	5.7		12.2		18.7		17.9		24.4		12.2		8.9							

Provincial Summary - Suicide Deaths by Age Group, Sex and Death Factor - Schedule C-2
from 2024.01.01 to 2024.12.31

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	0	0	0	0	0	0	0	1	0	0	0	1	1	0.8	1	4
Alcohol and Drug	0	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	2	1.6	1	4
Asphyxia due to Oxygen Depletion (Helium Gas)	0	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	2	1.6	1	4
Asphyxia	0	1	3	0	2	1	1	1	3	0	0	0	2	0	11	3	14	11.4	3	12
Aspiration	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.8	1	4
Carbon Monoxide Poisoning - Vehicle Exhaust	0	0	1	0	0	0	1	0	0	0	1	1	0	0	3	1	4	3.3	0	0
Carbon Monoxide Poisoning	0	0	0	0	0	0	1	0	0	0	1	0	0	0	2	0	2	1.6	1	4
Chronic Use of Prescribed Medications	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.8	0	0
Cuts, Stabs	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.8	0	0
Drowning - Open Water	0	0	0	0	0	0	1	0	1	0	0	0	2	2	4	2	6	4.9	4	16
Drug (street)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.8	1	4.0

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51-60		61-70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Drug	0	0	0	0	0	2	2	1	1	1	0	3	0	0	3	7	10	8.1	5	20.0
Fall or jump - different level, e.g. bridge, bldg.	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	2	2	1.6	1	4.0
Hanging	2	2	4	1	11	1	6	1	8	0	5	1	1	0	37	6	43	35.0	0	0
Natural Disease	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.8	1	4.0
Poison or Solvent	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1	1	2	1.6	0	0
Shooting - Handgun	0	0	1	1	0	0	0	0	1	0	0	0	0	0	2	1	3	2.4	1	4.0
Shooting - Rifle	0	0	0	0	1	1	1	0	6	0	1	0	2	0	11	1	12	9.8	1	4.0
Shooting - Shotgun	0	0	1	0	3	0	2	0	3	0	1	0	1	0	11	0	11	8.9	2	8.0
Strangulation	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.8	0	0
Trauma of Vehicle Collision	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2	0	2	1.6	1	4.0
Trauma of Vehicle/Pedestrian Collision	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.8	0	0
Males	3		13		18		18		29		9		8		98					
Females	4		2		5		4		1		6		3			25				

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						
Total for Age Group	7		15		23		22		30		15		11				123	100	25	100

Provincial Summary - Suicide Deaths by Age Group, Sex and Environment - Schedule C-3
from 2024.01.01 to 2024.12.31

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						
ATV driver - on public road	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.8	1	4.0
Beach/Shoreline	0	0	0	0	1	0	1	0	0	0	0	0	0	1	2	1	3	2.4	3	12.0
Factory, Plant, Warehouse (inside)	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.8	0	0
Homes for Special Care	0	0	0	0	0	0	0	0	1	0	1	0	0	0	2	0	2	1.6	0	0
Hotel/Motel	0	0	1	0	0	1	0	0	1	1	0	0	0	0	2	2	4	3.3	0	0
Inside vehicle	0	0	2	0	0	0	1	0	1	0	1	1	0	0	5	1	6	4.9	0	0
Living Inside, Residence or on Property	3	2	7	1	12	4	9	4	20	0	5	4	5	0	61	15	76	61.8	15	60.0
Non-Public Road - Driver	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0.8	0	0
Non-Public Road - Pedestrian	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.8	1	4.0
Nursing Home	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.8	0	0
Ocean	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.8	1	4.0
Open Water (river, lake, stream, brook)	0	0	0	0	0	0	0	0	1	0	0	0	2	0	3	0	3	2.4	1	4.0

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						
Other Private Residence/Property	0	0	0	0	1	0	1	0	0	0	0	0	0	0	2	0	2	1.6	0	0
Public Road - Driver	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.8	0	0
Public Road - Pedestrian	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.8	0	0
Railway - not on board	0	1	0	0	0	0	0	0	1	0	0	0	0	0	1	1	2	1.6	0	0
Rural Outdoors (not built-up place or near residence)	0	0	1	0	2	0	3	0	2	0	2	1	1	0	11	1	12	9.8	2	8.0
Urban Outdoors - public place and other (not residence)	0	1	0	0	1	0	2	0	1	0	0	0	0	0	4	1	5	4.1	1	4.0
Males	3		13		18		18		29		9		8		98					
Females	4		2		5		4		1		6		3			25				
Total for Age Group	7		15		23		22		30		15		11				123	100	25	100

Provincial Summary - Homicide Deaths by Age Group, Sex and Judicial District - Schedule D-1
from 2024.01.01 to 2024.12.31

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	0	1	2	0	1	0	0	2	0	0	1	0	4	3	7	36.8	7	38.9
Miramichi	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1	1	2	10.5	2	11.1
Moncton	1	0	0	0	1	0	2	0	1	0	0	0	0	0	5	0	5	26.3	5	27.8
Saint John	0	0	0	1	1	0	0	0	2	1	0	0	0	0	3	2	5	26.3	4	22.2
Woodstock	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Males	1		0		4		4		3		0		1		13					
% Total - Males	5.3		0		21.1		21.1		15.8		0		5.3		68.4					
Females	0		2		0		1		3		0		0			6	19	100	18	100
% Total - Females	0		10.5		0		5.3		15.8		0		0			31.6				
Total for Age Group	1		2		4		5		6		0		1							
% of Classification Total	5.3		10.5		21.1		26.3		31.6		0		5.3							

Provincial Summary - Homicide Deaths by Age Group, Sex and Death Factor - Schedule D-2
from 2024.01.01 to 2024.12.31

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						
Blunt Trauma - Altercation	0	0	0	0	1	0	1	0	1	0	0	0	0	0	3	0	3	15.8	2	11.1
Blunt Trauma, Beating	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	5.3	1	5.6
Blunt Trauma	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	2	2	10.5	2	11.1
Cuts, Stabs	0	0	0	0	0	0	1	0	0	0	0	0	1	0	2	0	2	10.5	2	11.1
Sharp Force Trauma	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	5.3	1	5.6
Shooting - Handgun	0	0	0	0	1	0	1	0	0	1	0	0	0	0	2	1	3	15.8	3	16.7
Shooting - Rifle	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	5.3	1	5.6
Shooting - Shotgun	1	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	2	10.5	2	11.1
Shooting - Unspecified	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	5.3	1	5.6
Strangulation	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	5.3	1	5.6
Undetermined	0	0	0	1	0	0	1	0	0	0	0	0	0	0	1	1	2	10.5	2	11.1

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						
Males	1		0		4		4		3		0		1		13					
Females	0		2		0		1		3		0		0			6				
Total for Age Group	1		2		4		5		6		0		1				19	100	18	100

Provincial Summary - Homicide Deaths by Age Group, Sex and Environment - Schedule D-3
from 2024.01.01 to 2024.12.31

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						
Community Residence	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	5.3	1	5.6
Homes for Special Care	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	5.3	0	0
Living Inside, Residence or on Property	0	0	0	0	3	0	0	0	2	3	0	0	0	0	5	3	8	42.1	8	44.4
Other Private Residence/Property	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	5.3	1	5.6
Public Road - Pedestrian	0	0	0	1	0	0	1	0	0	0	0	0	0	0	1	1	2	10.5	2	11.1
Rural Outdoors (not built-up place or near residence)	0	0	0	1	0	0	1	1	1	0	0	0	0	0	2	2	4	21.1	4	22.2
Urban Outdoors - public place and other (not residence)	0	0	0	0	0	0	1	0	0	0	0	0	1	0	2	0	2	10.5	2	11.1
Males	1		0		4		4		3		0		1		13					
Females	0		2		0		1		3		0		0			6				
Total for Age Group	1		2		4		5		6		0		1				19	100	18	100

Provincial Summary - Natural Deaths by Age Group, Sex and Judicial District - Schedule E-1
from 2024.01.01 to 2024.12.31

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	1	0	0	1	0	4	1	6	3	19	11	30	28	60	44	104	9.9	20	5.7
Campbellton	0	0	0	0	5	0	0	0	6	1	9	4	13	10	33	15	48	4.6	17	4.9
Edmundston	0	1	1	0	0	0	0	0	3	6	25	8	22	13	51	28	79	7.5	28	8.0
Fredericton	1	3	2	0	5	0	6	3	11	5	35	12	47	30	107	53	160	15.3	74	21.2
Miramichi	1	0	0	0	1	1	6	3	10	3	14	8	28	16	60	31	91	8.7	33	9.5
Moncton	2	0	4	1	6	3	14	6	28	9	41	13	70	46	165	78	243	23.2	108	30.9
Saint John	0	1	1	0	4	1	16	8	27	16	49	29	91	53	188	108	296	28.2	56	16.0
Woodstock	0	0	0	0	1	0	0	1	6	1	8	1	6	4	21	7	28	2.7	13	3.7
Males	4		8		23		46		97		200		307		685		1,049	100	349	100
% Total - Males	0.4		0.8		2.2		4.4		9.2		19.1		29.3		65.3					
Females	6		1		5		22		44		86		200			364				
% Total - Females	0.6		0.1		0.5		2.1		4.2		8.2		19.1			34.7				
Total for Age Group	10		9		28		68		141		286		507							
% of Classification Total	1.0		0.9		2.7		6.5		13.4		27.4		48.3							

Provincial Summary - Natural Deaths by Age Group, Sex and Death Factor - Schedule E-2
from 2024.01.01 to 2024.12.31

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						
Aspiration	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	0	0
Chronic Use of Alcohol	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2	0	2	0.2	0	0
Chronic Use of Prescribed Medications	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	0	0
Drug (street)	0	0	0	0	0	0	1	0	1	0	1	0	0	0	3	0	3	0.3	3	0.9
Drug	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	1	2	0.2	1	0.3
Fall or Jump - same level	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0
Natural Disaster	0	0	1	0	0	0	0	0	0	0	0	1	1	1	2	2	4	0.4	2	0.6
Natural Disease	4	6	7	1	22	4	44	22	95	44	196	85	304	198	672	360	1,032	98.4	342	98
Object Caught in Throat	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0
Undetermined	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1	1	2	0.2	1	0.3
Males	4		8		23		46		97		200		307		685					

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						
Females	6		1		5		22		44		86		200			364				
Total for Age Group	10		9		28		68		141		286		507				1,049	100	349	100

Provincial Summary - Natural Deaths by Age Group, Sex and Environment - Schedule E-3
from 2024.01.01 to 2024.12.31

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						
After Hours Clinic	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0
Ambulance	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	0	0
ATV driver - off public road	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	1	0.3
Camping/Tenting	0	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	2	0.2	1	0.3
Community Residence	0	0	0	0	0	0	2	0	3	0	0	0	3	1	8	1	9	0.9	3	0.9
Gymnasium/Health Club	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0
Homeless Shelter	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0.1	1	0.3
Homes for Special Care	0	0	0	0	0	1	1	2	3	0	3	1	4	5	11	9	20	1.9	4	1.1
Hospital - For Pronouncement	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	2	0.2	0	0
Hospital Emergency - DOA	0	0	0	0	0	0	0	0	0	0	1	0	1	1	2	1	3	0.3	1	0.3
Hospital Emergency - NON-DOA	0	0	0	0	0	0	0	0	0	1	3	0	5	2	8	3	11	1.0	0	0

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Hospital Operating Room	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.1	0	0
Hospital Other (Ward, ICU, etc.)	0	1	0	0	0	0	0	0	0	1	3	3	2	5	5	10	15	1.4	4	1.1
Hospital Post Op (Recovery Room)	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.1	0	0
Hotel/Motel	0	0	0	0	1	0	0	0	0	0	3	0	0	0	4	0	4	0.4	3	0.9
Inside vehicle	0	0	1	0	0	0	0	0	2	0	2	0	1	0	6	0	6	0.6	3	0.9
Inside, Other than Residence (mall, restaurant, other public building)	0	0	0	0	0	0	0	0	0	0	2	0	1	0	3	0	3	0.3	1	0.3
Living Inside, Residence or on Property	4	5	7	1	22	3	39	20	76	40	161	75	267	161	576	305	881	84.0	298	85.4
Logging/Tree Cutting - Commercial	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	1	0.3
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	1	0	1	1	8	15	10	16	26	2.5	3	0.9
Open Water (river, lake, stream, brook)	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Other Outdoor Recreation	0	0	0	0	0	0	0	0	2	0	1	0	1	0	4	0	4	0.4	2	0.6
Other Private Residence/Property	0	0	0	0	0	0	0	0	2	0	2	2	0	1	4	3	7	0.7	4	1.1
Public Road - bicycle (not motorized vehicle)	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	0	0
Public Road - Driver	0	0	0	0	0	0	1	0	0	1	3	0	2	1	6	2	8	0.8	3	0.9
Public Road - Passenger	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	1	2	0.2	0	0
Public Road - Pedestrian	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	1	2	0.2	0	0
Rural Outdoors (not built-up place or near residence)	0	0	0	0	0	0	1	0	1	0	5	2	1	0	8	2	10	1.0	6	1.7
Seniors Complex	0	0	0	0	0	0	0	0	0	0	0	1	2	2	2	3	5	0.5	2	0.6
Service Station, Garage, Mechanic	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0
Urban Outdoors - public place and other (not residence)	0	0	0	0	0	1	1	0	3	1	5	0	3	0	12	2	14	1.3	7	2
Workplace	0	0	0	0	0	0	0	0	2	0	0	0	1	0	3	0	3	0.3	0	0

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Male	Total Female	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Males	4		8		23		46		97		200		307		685					
Females	6		1		5		22		44		86		200			364				
Total for Age Group	10		9		28		68		141		286		507				1,049	100	349	100

Provincial Summary - Undetermined Deaths by Age Group, Sex and Judicial District - Schedule F-1
from 2024.01.01 to 2024.12.31

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	1	0	0	0	0	0	1	1	14.3	1	20
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	1	0	0	0	0	1	0	0	0	0	0	0	0	1	1	2	28.6	2	40
Miramichi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Moncton	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	14.3	1	20
Saint John	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	14.3	0	0
Woodstock	0	1	0	0	0	0	0	0	0	0	0	0	1	0	1	1	2	28.6	1	20
Males	0		0		0		2		0		0		1		3					
% Total - Males	0		0		0		28.6		0		0		14.3		42.9					
Females	2		0		0		1		1		0		0			4	7	100	5	80
% Total - Females	28.6		0		0		14.3		14.3		0		0			57.2				
Total for Age Group	2		0		0		3		1		0		1							
% of Classification Total	28.6		0		0		42.9		14.3		0		14.3							

Provincial Summary - Undetermined Deaths by Age Group, Sex, Death Factor - Schedule F-2
from 2024.01.01 to 2024.12.31

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						
Natural Disease	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	14.3	1	20
Undetermined	0	2	0	0	0	0	2	0	0	1	0	0	1	0	3	3	6	85.7	4	80
Males	2		0		0		2		0		0		1		3					
Females	0		0		0		1		1		0		0			4				
Total for Age Group	2		0		0		3		1		0		1				7	100	5	100

Provincial Summary - Undetermined Deaths by Age Group, Sex and Environment - Schedule F-3
from 2024.01.01 to 2024.12.31

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						
Beach/Shoreline	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	14.3	0	0
Living Inside, Residence or on Property	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	2	2	28.6	2	40
Other Private Residence/Property	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	14.3	1	20
Rural Outdoors (not built-up place or near residence)	0	0	0	0	0	0	1	0	0	0	0	0	1	0	2	0	2	28.6	1	20
Urban Outdoors - public place and other (not residence)	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	14.3	1	20
Males	2		0		0		2		0		0		1		3					
Females	0		0		0		1		1		0		0			4				
Total for Age Group	2		0		0		3		1		0		1				7	100	5	100

SCHEDULE F

Undetermined Deaths
(Manner of death impossible to determine)

There were seven deaths classified as Undetermined.

Two were in the Woodstock Judicial District:

Case #1
Death Manner: Undetermined
Environment: Rural Outdoors (not built-up place or near residence)
Age Group: 70 plus
Sex: Male
A forensic anthropology exam was performed.

Case #2
Death Manner: Undetermined
Environment: Other Private Residence/Property
Age Group: 0-19
Sex: Female
An autopsy was performed.

Two were in the Fredericton Judicial District:

Case #1
Death Manner: Undetermined
Environment: Rural Outdoors (not built-up place or near residence)
Age Group: 41-50
Sex: Male
An autopsy was performed.

Case #2
Death Manner: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 0-19
Sex: Female
An autopsy was performed.

One was in the Moncton 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 Saint John Judicial District:

Death Manner: Undetermined
Environment: Beach/Shoreline
Age Group: 41-50
Sex: Male
A forensic anthropology exam was performed.

One was in the Bathurst Judicial District:

Death Manner: Undetermined
Environment: Urban Outdoors - public place and other (not residence)
Age Group: 51-60
Sex: Female
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 five inquests held in 2024 appear below.

Louis Gagnon

An inquest into the death of Louis Gagnon was held Feb. 20-22 at the Campbellton courthouse. Gagnon died on Jan. 27, 2020, as a result of injuries sustained while working at the Belledune Generating Station. The inquest found Gagnon's death was the result of an accident. The five-member jury heard from 14 witnesses and made the following recommendations to high-risk industries and to WorkSafe NB:

1. That before any project begins, a competent person or competent persons should be appointed to inspect the positioning and strength of the anchors and other support equipment (both existing and newly installed) required for the project, using the appropriate tools.

2. That the entry of anyone into a confined space should be announced, so that those present are informed and the person entering is added to the attendance register.

3. That employers and employees ensure they have the necessary and appropriate materials to perform the assigned task in a safe environment.

4. That the line of fire should be clearly marked (for example, by red tape) with a label indicating the reason for the tape and the name of the person who placed the tape and has the authority to grant permission to enter the danger zone.

5. That the line of fire should be visually indicated during tailgate meetings. If the line of fire changes during the day, work should stop and a meeting should be held to identify the new line-of-fire zone.

6. That there should be direct and regular verbal communication among all persons assigned to the same project and radio communication if the distance is too great to see or hear the persons concerned.

7. That employers ensure that anyone working on rigging systems are trained by a person certified in all equipment and materials that could be used on a project and that this training is always up to date.

The presiding coroner made one additional recommendation:

8. That NB Power for any project either internal or contracted out, where mechanical pulling is required, requires the establishment of a pull plan completed by engineers. The pull plan should include, but not be limited to:
    i. Theoretical calculation and physical verification of the applied tension on any anchor points.
    ii. What material/equipment should be used.
    iii. How and where to install said material/equipment accompanied with visual images for the plan.
    iv. Pull step with a checklist.
    v. Inspection protocols following the installation of the material/equipment prior to the start of the work.
    vi. Establish a formal process that must be followed if any deviation to the original plan needs to be made.

Recommendation #1

That before any project begins, a competent person or competent persons should be appointed to inspect the positioning and strength of the anchors and other support equipment (both existing and newly installed) required for the project, using the appropriate tools.

NB Power responded that, as a result of the incident in question and prior to the inquest, procedures and work methods were updated to ensure that all concrete anchors will be inspected and/or installed, tested and used in accordance with the manufacturer's specifications. Individuals performing the inspection or installation of anchors must have the appropriate training, in addition to hands on training and/or past experience with said anchors. Other support equipment, such as rigging, will be inspected by qualified individuals in accordance with NB Power's response to Recommendation 7.

Recommendation #2

That the entry of anyone into a confined space should be announced, so that those present are informed and the person entering is added to the attendance register.

NB Power responded that the announcement of workers entering a confined space could be a distraction to workers in the space. This distraction could result in workers taking the focus off the task at hand. This would result in an uncontrolled hazard.

In order to comply with the requirements of paragraph 262.04 (e) (v) of Regulation 91-191 under the *Occupational Health and Safety Act*, NB Power ensures that an attendant, during a confined space entry, keeps track of entrants entering and exiting the confined space. As a result of the incident in question, NB Power modified HSEE-03-17 Confined Space, its health and safety standard with regard to confined spaces, in March 2022 to provide that, in cases where the entry point of the confined space is in the line of fire, work must be stopped to allow entrants to enter and exit the confined space safely.

NB Power is currently revamping its confined space program to ensure that the above noted modification is emphasized in both the standard and in the training for all entrants and confined space supervisors.

Recommendation #3

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

NB Power responded that it utilizes several processes and procedures to ensure work is completed safely and with the appropriate materials. The initial phase of any significant activity would start with the preparation of a work order to complete a task. As the work order is developed, consideration would be given to safety requirements and any required materials. Additionally, if the work is considered to involve a high hazard, a more rigorous, a more rigorous analysis and plan is developed. This is called a Job Hazard Analysis (JHA) and includes a cross-functional group of stakeholders to identify, remove and/or mitigate any hazards.

To supplement the normal planning process or JHA, a tailboard is completed prior to the commencement of work each day and at the beginning of a new task. This is a final check in of the impacted individuals to verify that work conditions are as expected, and staff are prepared to perform the planned tasks. Additionally, it is expected that all basic Personal Protective Equipment (PPE) will be utilized for every task and any specialized PPE will be utilized as required, per procedures. Finally, a validation of the above is completed via a field safety visit program which mandates supervisors perform a specific field safety visit to ensure expectations are being followed. This visit is in addition to normal supervisory expectations.

Recommendation #4

That the line of fire should be clearly marked (for example, by red tape) with a label indicating the reason for the tape and the name of the person who placed the tape and has the authority to grant permission to enter the danger zone.

NB Power responded that its Corporate Health and Safety Standard HSEE-03-34 Barrier Tape and Tag provides clarity with regard to work within Danger – Do NOT Enter zones. That standard presently provides that:
(a) Red tape will be used to give notice of areas where the hazard is considered life threatening or disabling. (Line of Fire, drop zone, openings in the floor, overhead loads, etc.)
(b) Only those personnel who are involved in the work and are aware of the hazards are allowed in these areas.
(c) Permission from the contact person on the tag must be obtained before entering an area with red barricade tape.

The expectation is that access to the red tape area by NB Power staff or contractors will only be allowed by the contact person on the tag when the hazard is eliminated or controlled.

In cases where the line of fire cannot be marked due to factors such as the scope of the hazard area (i.e. stringing a transmission line) or topography (i.e. valley or bodies of water), readily identifiable landmarks will be used to define the area within the line of fire.

NB Power also developed a Line of Fire Awareness package that was rolled out to all employees in August 2022 to raise awareness with regard to line of fire hazards and the appropriate controls. The Line of Fire Awareness package is reviewed by each NB Power Joint Health and Safety Committee and shared at all local safety meetings during January-March each year. This package is also reviewed with NB Power staff

and contractors prior to outages. Computer based training for line of fire will be available to contractors thought their ISNetWorld account. NB Power's expectation is that contractors will complete the training prior to the start of project work.

Recommendation #5

That the line of fire should be visually indicated during tailgate meetings. If the line of fire changes during the day, work should stop and a meeting should be held to identify the new line-of-fire zone.

NB Power responded that, in addition to the Line of Fire Awareness package referred to in response to Recommendation 4, NB Power is currently in the process of adopting an energy-based hazard recognition approach to aid employees in identifying line of fire hazards and the appropriate controls. This methodology will be incorporated into the JHA process and the tailboard process.

Line of fire hazards are mostly associated with tension such as cable pulling work, or rotating equipment such as drive shafts and pulleys, gears and sprocket, and power tools. In many cases, the line of fire will change as the orientation of the equipment or tool changes. When practicable, line of fire areas will be visually marked with red tape to encompass the anticipated range of equipment and took orientation. If the use of red tape is not practicable for the reasons noted in response to Recommendation 4, readily identifiable landmarks will be used to delineate the line of fire. Should the line of fire extend beyond the anticipated range, work will be stopped, the Danger – Do Not Enter zones will be modified and the change in the line of fire will be communicated to NB Power's staff and/or contractors.

Recommendation #6

That there should be direct and regular verbal communication among all persons assigned to the same project and radio communication if the distance is too great to see or hear the persons concerned.

NB Power responded that, with regard to confined space work, the confined space attendant maintains two-way communication with the entrant(s) and has a means of two-way communication with the entry supervisor and emergency response team leader. The two-way communication is either done verbally, in smaller spaces, or with radios, in larger spaces.

Direct (face to face) and regular verbal communication among all persons assigned to a project occurs throughout the workday. On project sites where line of site or distance is an impediment to regular direct (face to face) verbal communication, radio communication is provided, as required.

WorkSafeNB responded that it supports this recommendation. At the time of Mr. Gagnon's death, WorkSafeNB had been working on an amendment to ensure that rigging is only done by a competent person. Those amendments came into force in 2022. Competency is a higher standard than training alone. Complementary to training, for a person to be deemed competent under the regulation, that person shall be knowledgeable and experienced in the assigned work, have legislative knowledge and be aware of the hazards connected with the work.

At a national level, the standards development organization, Canadian Standards Association (CSA), identified a gap in the competency of riggers across the country and have proposed the development of a standard. WorkSafeNB is a supporter of the development of the standard and we have shared this

Coroner's inquest recommendation with CSA to assist with securing support and funding for the creation of this important standard. WorkSafeNB has also offered to support CSA in any way toward the creation of this standard.

Recommendation #7

That employers ensure that anyone working on rigging systems are trained by a person certified in all equipment and materials that could be used on a project and that this training is always up to date.

NB Power responded that it utilizes external vendors to provide training on rigging systems to NB Power staff at all generating stations except Point Lepreau Nuclear Generating Station where there is a qualified trainer for rigging within NB Power's staff. The vendor is required, pursuant to their contract, to be certified to provide such training and their certification is verified by NB Power's Health and Safety department. NB Power uses a Learning Management System (LMS) to track training qualifications for NB Power staff and notifications are sent to staff prior to the expiry of their qualifications; this is also tracked by our work safety/training coordinators. For external contractors, in the International Suppliers Network (ISN) is used to track training qualifications that are required to perform an activity; this is also verified by NB Power's Health and Safety department.

Recommendation #8

That NB Power for any project either internal or contracted out, where mechanical pulling is required, requires the establishment of a pull plan completed by engineers. The pull plan should include, but not be limited to:

i. Theoretical calculation and physical verification of the applied tension on any anchor points.
ii. What material/equipment should be used.
iii. How and where to install said material/equipment accompanied with visual images for the plan.
iv. Pull step with a checklist.
v. Inspection protocols following the installation of the material/equipment prior to the start of the work.
vi. Establish a formal process that must be followed if any deviation to the original plan needs to be made.

NB Power responded that cable pulls plan requiring mechanical assistance associated with transmission and distribution lines are clearly outlined in NB Power's Standard Work Methods 8.02.02 which have been developed and are managed by NB Power's engineering group.

Cable pull plans requiring mechanical assistance associated with NB Power's generating stations will be developed by NB Power's internal engineering group or by an external engineering firm.

In all cases, cable pull plans requiring mechanical assistance will be completed following NB Power's Health and Safety Standard HSEE-03-51 "Managing the line of fire" which includes:

- Theoretical calculations of pull tensions
- Indication that applied tension is expected
- A clear visual indication of where the equipment/material is to be installed
- A checklist of step-by-step process for the cable pull plan

- A full inspection of equipment/material once installed and ready for the pull
- Stop and regroup if any deviation of the original plan is required as per NB Power's health and Safety Standard on Tailboards Conference/Pre Job Brief (PJB).

Darrell Mesheau

An inquest into the death of Darrell Mesheau was held April 8-9 in Fredericton. Mesheau died in the waiting room of the emergency department of the Dr. Everett Chalmers Regional Hospital on July 12, 2022.

The five-member jury heard from 11 witnesses and made the following recommendations:

1. All stakeholders should collaborate and show ownership in the resolution of the bed-blockage issue; in particular, the backlog of Social Development patients having a significant effect on the efficiency of an operating emergency department.
2. The eight recommendations of the quality-of-care committee should be fully implemented, funded, and delivered by providing appropriate staffing levels.
3. Staff should be equipped with hand-held electronic sources to record patient vitals.

Recommendation #1

All stakeholders should collaborate and show ownership in the resolution of the bed-blockage issue; in particular, the backlog of Social Development patients having a significant effect on the efficiency of an operating emergency department.

This recommendation is endorsed by Horizon Health Network. The health authority is responsible to care for Alternate Level of Care patients (ALC) within its facilities. It is noted the placement of ALC patients is the responsibility of The Department of Social Development. The health authority continues to face challenges related to the number of ALC patients with over 30% of its in-patients waiting for placement. Horizon continues to collaborate with the Departments of Social Development and Health to address these challenges.

Actions taken by Horizon to improve the efficiency of its Emergency Departments (EDs) include:

- In Horizon, including the Fredericton area, a Patient Flow Coordinator and Patient Flow Manager are in place. Their role includes assessing patients presenting to the ED who are associated with long-term care (Special Care Home, Nursing Home, etc), to determine if there are interventions that can be put in place to avoid admission to hospital. The patient flow staff also have the ability to send patients home with support services and have Social Development staff follow-up in the community.

- Horizon meets regularly with the Dept. of Social Development to discuss complex cases to efficiently navigate the required processes to place patients in appropriate care facilities.

    - At the Dr Everett Chalmers Regional Hospital, a Medical Transition Unit has been established, creating an additional 13 spaces that are utilized to offload admissions from the ED while

patients wait for an assigned bed on an inpatient unit.

- Patient Flow centers have also been implemented in four of the regional hospital Emergency Departments to assist in the improvement of the CTAS wait times.

- Two diversion clinics have been opened in Moncton and Perth Andover, with a third clinic being proposed for the Miramichi Area. The clinics provide an alternative location for patients requiring non urgent care. (Stable CTAS 3, 4 and 5).

- Several projects are underway, and include:
    - Fredericton area patient flow staff complete required long term care assessments with the goal to increase the placement approval time and to decrease the time of discharge from hospital to Long Term Care (LTC) facilities.
    - Collaboration with the Extra-Mural Program to better support residents of Special Care Homes with the goal of avoiding a visit to the ED.
    - A process to deploy portable x-ray machines into LTC facilities to decrease the number of LTC patients presenting to the ED for diagnostic imaging.

Social Development responded that it agrees with this recommendation. Social Development staff are involved in a number of working groups and projects with staff of the Horizon and Vitalité health networks, Department of Health, and Extra-Mural/Medavie Health Services to identify short-, medium, and long-term solutions to the hospital capacity challenges due to ALC patients. This concern was also raised in "What We All Want," a comprehensive review of the long-term care sector by the New Brunswick Seniors' Advocate.

Recommendation #2

The eight recommendations of the quality-of-care committee should be fully implemented, funded, and delivered by providing appropriate staffing levels. The eight recommendations and Horizon Responses appear below as 2.1-2.8

2.1 Identify and implement a strategy to ensure all waiting room patients are reassessed according to the Canadian Triage and Acuity System ("CTAS") reassessment guidelines outlined in the Horizon Emergency Department Standards. This would include but is not limited to:

a) Dedicated healthcare personnel resource (i.e., Licensed Practical Nurse or Personal Care Attendant) for monitoring of the waiting room according to CTAS reassessment guidelines including contingency for meal breaks.

This recommendation has been implemented. Dedicated resources are assigned to the ED wait room. These resources include Patient Care Attendants (PCAs) who are assigned 24 hours, seven days a week and Licensed Practical Nurses (LPN) who are assigned during specific hours. PCA's and LPN's work collaboratively to monitor patients and communicate patient status changes with ED healthcare team for appropriate care and treatment. CTAS reassessments are completed by Licensed Practical Nurses and Registered Nurses.

b) Adequate available equipment for real time assessment and documentation of vital signs.

Equipment utilized for real time assessments and documentation of vital signs has been implemented in Horizon Emergency Departments. This includes mobile workstations with a tablet where staff document patient information in real time and equipment to check patient vitals.

2.2 Develop a regional policy to establish a standardized process for the triage of a patient who arrives via Ambulance New Brunswick ("ANB") including times of hospital overcrowding. This would include but not limited to:

a) Standardizing triage assessment on arrival/announcement of incoming ANB patients.

A standardized triage assessment is completed on arrival of all patients regardless of mode of transport. This process and assessment are outlined in Horizon's clinical Emergency Department Standard. The standards outline the triage process in compliance with the Canadian Triage and Acuity Scale (CTAS), which determine the severity of the presenting problem, the priority by which the patient is to be seen by a physician or other healthcare provider, and access to appropriate resources.

b) Criteria for patients awaiting triage that maybe left in the waiting room.

Patients presenting to the ED will be triaged as soon as possible. As noted in the response of 2.1 a), dedicated resources are placed in the ED wait rooms to monitor the patient's condition and will alert the nursing staff if concerns arise prior to triage. At the Dr. Everett Chalmers Regional Hospital ED, a pre-triage assessment initiative was implemented to improve service to patients who are waiting for triage. The process involves an LPN receiving the patient's Medicare number and chief complaint, which is then entered into the electronic health information record. A list of patients awaiting triage is generated at the triage nurses' station and the Registered Nurse assigned to triage reviews this list between each patient triage assessment completion, to identify patients who may need to be triaged sooner. If the pre-triage LPN and PCA is concerned about a patient, they will notify the triage RN immediately. This initiative is being evaluated to determine if funding will be requested to continue the program.

c) Providing the triage nurse with ANB documents that will be included in the Emergency Department patient chart.

Paramedics provide a verbal report to the receiving triage nurse on arrival in all emergency departments throughout Horizon. In addition, a copy of their completed ANB patient care report is provided to the receiving staff to be included in the patient chart for continuity of care. The nurse receiving the patient care report the report to validate the report was received from Paramedics.

2.3 Create a standardized patient flow process to mitigate risk of health decline and facilitate CTAS level 3 patients through the Emergency Department by enabling pre-investigation workup prior to seeing a healthcare provider.

This recommendation has been implemented.

Regional Medical Directives for several common medical concerns have been developed and implemented in the ED for example: ear irrigation, chest pain (Adult), temperature (Adult), Mild to Moderate Pain (Adult) etc. These medical directives provide nursing staff the ability to provide initial treatment and order diagnostic testing prior to physician assessment. Medical Directives are regularly

reviewed and updated.

Flow centers have been integrated into all four regional emergency departments that incorporate LPNs. Patients triaged as CTAS 3 (urgent), 4 (less urgent), and 5 (non-urgent) are assessed and treated in these areas. In the Fredericton area, Physician Assistants have been incorporated into flow centers to assist with the flow of patients.

In the Fredericton area, an Urgent Treatment Centre (UTC) has opened in the Brookside Mall to provide additional assistance in managing the high number of patients presenting to the ED. The UTC operates from Monday to Friday, 8 a.m. to 8 p.m. and follows CTAS guidelines to assess and treat a variety of acuity levels, including CTAS 3 (urgent) patients. It is staffed by Physicians, Licensed Practical Nurses, Registered Nurses and clerical staff.

2.4 Establish a regional policy that identifies the criteria and process to facilitate transfer of non-urgent boarded (inpatient) admissions during Emergency Department overcrowding.

Effective patient flow is crucial for reducing risk related to patient safety, improving health outcomes, and increasing patient satisfaction. Each Hospital ED has an overcapacity policy that outlines measures to take, which follow the principles outlined in the Overcapacity and Escalation guidelines. Overcapacity is when facility demands exceed current facility capacity resulting in the inability to administer efficient and effective care.

Horizon's overcapacity guidelines, which are currently in the final stages of approval, provide the tools required to systematically manage facility needs including processes to identify varying levels of escalation. Departments routinely evaluate the demands placed on the ED and adjust their actions accordingly.

Specific actions related to the DECRH are as follows:

- A Patient Flow Coordinator has been added and is responsible for monitoring inpatient beds and facilitating release of patients that no longer require admission.
- All staff involved in patient flow, discharge planning and admitting have been co-located into one common area in the hospital. This "command centre" concept is evidence-based and promotes faster communication, collaboration and coordination of bed placement throughout the facility. There is a plan to create a similar format at The Moncton Hospital and Saint John Regional Hospital before June 30, 2025.
- A Discharge Lounge has been created and is staffed by an LPN that can accommodate up to four patients, while they wait on their discharge. This increases the turn-around-time for patients waiting for admission to an inpatient be. This space can also be used for appropriate patients to wait for their inpatient bed.
- A 13 bed Medical Transition Unit (MTU) has been created for admitted patients who are waiting for an appropriate inpatient bed.
- Some outpatient services have been relocated to other areas providing additional inpatient space for patients, creating 19 additional inpatient beds.

2.5 Create a standardized patient flow process to mitigate risk of health decline and facilitate CTAS level 3 patients through the Emergency Department by enabling pre-investigation workup prior to seeing a healthcare provider.

This recommendation has been implemented. As noted in recommendation 2.3, Medical Directives

have been implemented providing direction to nursing staff to treat and order diagnostic tests.

2.6 Review and identify strategies to supplement existing Emergency Department resources on the night shift with triaging and patient flow during hospital overcrowding:

a) Dedicated triage RN focusing only on triage during the night

This recommendation has been implemented whereby a dedicated triage position is in place during the night shift.

b) Adding physician or other healthcare personnel (for example Nurse Practitioners, Physician Assistants) with expanded hours.

This recommendation is endorsed and implemented within Horizon's current resources. Please see response to recommendation 2.3.

As mentioned above (2.3), Flow Centers have been integrated into all four regional emergency departments whereby patients triaged as CTAS 3 (urgent), 4 (less urgent), and 5 (non-urgent) are assessed and treated. LPNs have been incorporated into the flow centres. In the Fredericton area, Physician Assistants have been incorporated into flow centers to assist with flow of patients. Physician coverage has also been increased in the overnight period to align with hours/models in other similarly sized regional facilities.

2.7 Review timely electronic documentation requirements with Emergency Department staff for vital signs, procedures, etc., to ensure accurate patient care is documented.

This recommendation has been completed. Timely documentation is a standard of nursing practice. This training is provided during ED health care provider's orientation and annual performance evaluations. On an ongoing basis, documentation requirements are reviewed at staff meetings, communication huddles, and email communications. Compliance is monitored through chart reviews providing health care providers feedback and identifying opportunities for improvement.

2.8 Establish a standardized process of collecting data from patient's time of arrival in the Emergency Department to the triage time for qualifying trends of longer wait times to be identified and appropriate interventions put in place to improve patient flow through the department.

Work is continuing to identify the best method to collect this data. As noted in 2.2 B, a pre-triage initiative has been implemented at the DECRH on a trial basis. Once the patient's Medicare card is swiped, it creates a data point in the documentation system that is trackable. The time the patient is triaged is also recorded, providing a time range. In Moncton and Miramichi, this data is manually entered. Saint John has electronic charting which captures and documents arrival time in real time.

Recommendation #3

Staff should be equipped with hand-held electronic sources to record patient vitals.

Horizon responded that this recommendation has been endorsed and is being completed through

mobile workstations as described in response to 2.1 B. Each workstation includes a tablet whereby staff document patient information in real time.

Jason Barnaby-Gloade

An inquest into the death of Jason Barnaby-Gloade was held May 27-28, 2024 in Campbellton. Barnaby-Gloade was found unresponsive in a cell at the Dalhousie Regional Correctional Centre and pronounced dead at the Campbellton Regional Hospital on May 28, 2022.

The inquest found Barnaby-Gloade died by suicide. The five-member jury heard from 11 witnesses and made the following two recommendations:

1. That Dalhousie Regional Correctional Centre continue to make available ongoing training for correctional officers and medical staff on recognizing the presence of suicidal thoughts and continue to update their intervention plans.

2. That Dalhousie Regional Correctional Centre continue to provide to correctional officers and medical staff ongoing training in regard to Indigenous sensitivities.

One recommendation was made by the presiding coroner:

3. That the Department of Justice and Public Safety evaluate the risk that television cables may represent and find ways to address and eliminate that risk.

Recommendation #1

That the Dalhousie Regional Correctional Centre continue to make available ongoing training for correctional officers and medical staff on recognizing the presence of suicidal thoughts and continue to update their intervention plans.

Justice and Public Safety Adult Custody Services (ACS) responded that ACS provides ongoing Applied Suicide Intervention Skills Training (ASIST) for all correctional officers in New Brunswick. ASIST is an evidence-based program designed to equip participants with the skills to recognize when someone may be thinking about suicide, conduct a skilled intervention, and collaborate on the development of a safety plan. The goal is to ensure that individuals at risk are connected with appropriate ongoing support and resources.

Please note that medical services staff are employed by the regional health authorities, as such, any training related to suicide intervention is provided by Horizon Health Network and Vitalité Health Network.

Recommendation #2

That Dalhousie Regional Correctional Centre continue to provide to correctional officers and medical staff ongoing training in regard to Indigenous sensitivities.

Justice and Public Safety responded that the Government of New Brunswick (GNB) partnered with Four Seasons of Reconciliation to offer an online course that promotes a renewed relationship

between Indigenous peoples and Canadians through learning about truth and reconciliation. This course assists GNB in upholding its commitment to implement the Truth and Reconciliation Commission Calls to Action and is mandatory for all employees.

Ongoing cultural awareness and indigenous sensitivity training occurs for all correctional staff.

ACS is also in the process of enhancing the learning materials provided in our Academy for new recruits.

Recommendation #3

That the Department of Justice and Public Safety evaluate the risk that television cables may represent and find ways to address and eliminate that risk.

Justice and Public Safety responded that immediately following the death of Mr. Barnaby-Gloade, ACS initiated a province-wide review of the television cable shelving systems. The review identified one other correctional centre with similar shelving that had small holes allowing items to be passed through. Maintenance teams were promptly engaged and holes were welded shut to prevent misuse.

Each death-in-custody is a tragic event. The Department of Justice and Public Safety and Adult Custody Services remains committed to ongoing improvements and the implementation of the Coroner's Inquest recommendations. Collaboration with the Department of Health will continue to ensure the well-being of individuals in custody.

Darrell Richards

An inquest into the death of Darrell Richards was held June 3-5, 2024 at the Saint John courthouse. Richards died in hospital on July 1, 2022, from injuries sustained while working at the American Iron and Metal (AIM) facility in Saint John, which is no longer operating.

The inquest found Richards died as the result of an accident, with the cause being hypovolemic shock.

The five-member jury heard from 16 witnesses and made four recommendations related to safety, communication, purchasing and inspection as follows:

1. That the continuation of appropriate training and certifications, and that supervision remain a priority and compliant with WorkSafeNB.

2. That communication must be initiated by AIM headquarters and distributed throughout all AIM satellite sites. Employee communication is a valuable tool to help prevent workplace accidents.

3. That AIM New Brunswick research all suppliers with a request for appropriate credentials and background checks, and request a description of materials and indication of hazards pertaining to the products.

4. That AIM New Brunswick implement an inspection program to aid in the identification of hazardous materials, and continue to quarantine and label hazardous materials accordingly until appropriate documentation is obtained with and approved safe-work procedure.

AIM New Brunswick did not respond to correspondence requesting their responses to the jury's recommendations.

WorkSafeNB responded that its compliance and enforcement team is aware of the recommendations to the employer and is ensuring adherence to the recommendations within the authority conferred to our health and safety officers under the *Occupational Health and Safety Act*.

WorkSafeNB further noted, however, that as of approximately one year ago, following a major fire at Mr. Richards' workplace, American Iron and Metal, the employer's license to operate has been revoked by the provincial government and the site is no longer an active workplace. WorkSafeNB is monitoring this situation and if operations do resume at that facility, we will be undertaking regular inspections to ensure compliance with the *Occupational Health and Safety Act* and regulations.

Hailey Pierce

An inquest into the death of Hailey Pierce was held November 4-6, 2024 in Moncton. The 13-year-old died at the Moncton Hospital on April 13, 2022, as a result of injuries sustained in a school bus incident in the Dorchester district of Tantramar.

The five-member jury heard from 15 witnesses and made the following 12 recommendations:

1. An additional adult or monitor should be seated at the rear of a bus. Driving should be the sole focus of the driver.

2. Assigned seating, or be able to seat students toward the front of the bus as needed, much like how classrooms are organized.

3. A mechanical interlock that does not allow emergency doors to be opened while the bus is travelling over a certain speed.

4. More internal support within schools, such as additional resource teachers, guidance counsellors and education assistants.

5. Any teachers or individuals working with children in a school setting be given training on how to handle student mental health situations.

6. Appoint a single primary psychiatrist to be in charge of a patient's mental health medications to approve changes to prescriptions.

7. Alternative learning environments be available outside of the traditional school setting for students struggling with mental health due to the school environment causing stress.

8. Better resources for students who are deemed high risk, such as those admitted to a psychiatric hospital, or an extended period of time to monitor patients and their progress and reactions to medications, with follow up appointments and evaluations by the assigned psychiatrist.

9. Better communication between medical organizations within the province regarding a patient's medical history.

10. Separate areas within emergency departments that are more private and calm for mental health patients waiting to be seen.

11. A more proactive approach to communication between professionals involved with a patient to identify changes and potential gaps in their care.

12. Sufficient support be available to parents or guardians to provide assistance in dealing with mental health within the family.

Recommendation #1

An additional adult or monitor should be seated at the rear of a bus. Driving should be the sole focus of the driver.

The Office of the Chief Coroner did not receive a response at the time of the publishing of this report.

Recommendation #2

Assigned seating, or be able to seat students toward the front of the bus as needed, much like how classrooms are organized.

The Office of the Chief Coroner did not receive a response at the time of the publishing of this report.

Recommendation #3

A mechanical interlock that does not allow emergency doors to be opened while the bus is travelling over a certain speed.

The Office of the Chief Coroner did not receive a response at the time of the publishing of this report.

Recommendation #4

More internal support within schools, such as additional resource teachers, guidance counsellors and education assistants.

The Office of the Chief Coroner did not receive a response at the time of the publishing of this report.

Recommendation #5

Any teachers or individuals working with children in a school setting be given training on how to handle student mental health situations.

The office of the Chief Coroner did not receive a response at the time of the publishing of this report.

Recommendation #6

Appoint a single primary psychiatrist to be in charge of a patient's mental health medications to approve changes to prescriptions.

Horizon Health responded that patients who present to the Emergency Department are seen by the Psychiatrist on-call. This is not necessarily their primary treating Psychiatrist. As part of a therapeutic intervention, medications are reviewed and evaluated on their efficacy by the Psychiatrist. Based on the patient's presentation, information gathered, and the symptoms they are experiencing the Psychiatrist may

be required to complete a medication adjustment. Although it is not possible to create a process whereby only one Psychiatrist is allowed to prescribe medication to a client, we have processes in place, where the note from the patient's visit in the Emergency Department are sent to their treating Psychiatrist, so they are aware of the visit and any changes that may have occurred with the patient's treatment plan.

Recommendation #7

Alternative learning environments be available outside of the traditional school setting for students struggling with mental health due to the school environment causing stress.

The Office of the Chief Coroner did not receive a response at the time of the publishing of this report.

Recommendation #8

Better resources for students who are deemed high risk, such as those admitted to a psychiatric hospital, or an extended period of time to monitor patients and their progress and reactions to medications, with follow up appointments and evaluations by the assigned psychiatrist.

Horizon Health responded that Addiction and Mental Health Collaborative Care Teams are embedded in Horizon Emergency Departments. In 2022 these Emergency Department Addiction and Mental Health (EDAMH) teams were enhanced with additional staffing resources. The EDAMH team follows clinical standards that guide clinicians to use standardized risk assessments, and interventions, which results in continuity of care for the client.

During the assessment, vital information is collected from the patient, family, and health record to inform any further required assessments. Information gathered from the assessment, pre-established admission criteria, and the patient's needs are used to determine the client's treatment plan that could include admission to hospital. It is noted that only Psychiatrists have privileges to admit a patient to a psychiatric unit and make their decisions based on evidence-based interventions and standardized pathways. Pathways are developed and implemented for both existing clients of Addiction and Mental Health outpatient services and new clients.

When a new patient requires follow-up with Addiction and Mental Health Services, clinical coordinators in the EDAMH program, contact a member of the Community Addiction and Mental Health Team. There are processes in place to ensure the client has received the referral for their appointment.

When a pre-existing client visits the Emergency Department and are seen by the EDAMH team, the visit is documented in the Addiction and Mental Health electronic documentation system. A standardized transfer of information form is then sent to the community Addiction and Mental clinic. The appropriate staff are informed and follow-up with the client. This ensures continuity of care and communication between the Emergency Department and Addiction and Mental Health Services in the community.

Recommendation #9

Better communication between medical organizations within the province regarding a patient's medical history.

Horizon Health responded that the Department of Health is currently leading a provincial project reviewing the current electronic medical record systems in the Regional Health Authorities. There are currently multiple different systems across the province. The Clinical documentation system used with Addiction and Mental Health is part of this project moving towards one patient, one record. Both Horizon Health Network and Vitalité Health Network are collaborating extensively on this project. In the interim, standardized transfer of information processes between care providers are established and followed.

Recommendation #10

Separate areas within emergency departments that are more private and calm for mental health patients waiting to be seen.

Horizon Health responded that dedicated space is currently available in Emergency Departments at The Moncton Hospital, Dr. Everett Chalmers Regional Hospital and the Saint John Regional Hospital. Horizon's Facility Management Team is currently analyzing existing Emergency Department space at the Miramichi Regional Hospital.

Recommendation #11

A more proactive approach to communication between professionals involved with a patient to identify changes and potential gaps in their care.

Horizon Health responded that communication processes are implemented between health care professionals in hospital, community Addiction and Mental Health Services, physicians, and other agencies (Department of Education, Department of Social Development) who are caring for an Addictions and Mental Health Client.

Recommendation #12

Sufficient support be available to parents or guardians to provide assistance in dealing with mental health within the family.

Horizon Health responded that, as part of the Provincial Integrated Service Delivery, Child and Youth (C&Y) Teams are responsible for providing support and treatment to children and youth from age 0-21. The expectation is to work with parents and caregivers as appropriate. Family therapy models are being explored by our C&Y teams to expand the support to the family/guardians of patients receiving services. It should be noted that we follow the *Mature Minors Act* which means if the youth have capacity, they can determine if they wish to have their parents or caregivers involved in their treatment. Capacity is defined as having the ability to make an informed decision. Assessing this ability is multifactorial including assessing one's ability to understand the relevant information, the ability to appreciate the situation and its consequences, the ability to reason, and the ability to communicate and express a choice. Assessing capacity can only be done by a select number of professionals.

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 *Coroners Act*.

The Child Death Review Committee examines the deaths of all individuals under the age of 19 where the death was investigated by a coroner 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 one to two 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 2024, the committee completed 9 death reviews for deaths occurring between 2022- 2024.

2024 Child Death Cases reviewed					
Case No.	**Demographic information**	**Coroner Case (CC)/ Social Development (SD) involved**	**Manner**	**Cause of death**	**Recommendations**
1.	18-year-old male	CC/SD	accidental	Polytrauma with multiple organ injuries sustained in a high-speed motor vehicle accident	none
2.	15-year-old-female	CC	natural	Complex medical condition including cancer	none
3.	13-day-old infant	CC/SD	accidental	Asphyxia due to unsafe sleep position	none
4.	2-year-old	CC	accidental	Methadone toxicity	4
5.	2-week-old infant	CC	accidental	Asphyxia due to bed/sharing unsafe sleep surface	none
6.	7-year-old	SD	natural	Pontocerebellar hypoplasia type 2	none
7.	1-year-old	SD	natural	Influenza	none
8.	16-year-old	SD	natural	Complication of cerebral palsy	none
9.	10-year-old	CC/SD	natural	Seizure disorder	none

Recommendations and Responses - Case #4

Recommendation #1

That the New Brunswick College of Pharmacist change their "Practice Directive: Opioid Agonist Treatment (OAT)". Take home doses should be provided in the form of suboxone to make it less attractive to young children and vulnerable people.

The New Brunswick College of Pharmacists responded that the College published its Opioid Agonist Treatment Practice Directive (OAT Practice Directive or "OAT-PD") in the summer of 2022, following extensive collaboration and consultation. The directive was developed using multiple evidence-based resources, including a jurisdictional scan of both Canadian and international practices. Two key references that informed the OAT-PD were "Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders"1 and "Opioid Agonist Therapy; A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder."2

The OAT-PD is updated as evidence and best practices evolve. The most recent update to the OAT-PD occurred in December, 2024, following revised recommendations from the Canadian Research Initiative in Subject Matters (CRISM) regarding first line agents for Opioid Agonist Treatment (OAT). Whereas methadone had previously been categorized as the second line treatment option, CRISM now recommends both methadone and buprenorphine/naloxone as first-line therapies.

Current evidence supports the use of take-home methadone doses for patients who are stabilized on an appropriate maintenance regimen. While safety concerns must be carefully considered, requiring all patients receiving methadone treatment to attend a pharmacy daily for witnessed dosing is not consistent with available evidence and best practices.3 4 5

Furthermore, mandating that all stabilized patients transition from methadone to buprenorphine-naloxone in order to access take-home doses is both impractical and potentially harmful, as it may increase the risk of relapse.6 7

A limited review of past coroner inquest and inquiry reports revealed no recommendations supporting a prohibition of methadone take home doses. Additionally, data suggests that pediatric opioid exposures are more commonly associated with other prescription or illicit opioids than to methadone.

For these reasons, the College is unable to implement the first recommendation of the Child Death Review Committee. However, we will refer this recommendation to the provincial Department of Health for consideration. Given its broader mandate and its oversight of the New Brunswick Drug Plans and Formulary, the Department is best positioned to lead any initiative of this scope. Significant changes to treatment protocols would require leadership from the Department, in collaboration with relevant stakeholders.

Should the Department of Health decide to pursue this recommendation, the College would be pleased to collaborate.

Recommendation #2

That the New Brunswick College of Pharmacist include in their "Practice Directive: OAT" that a knowledge sheet should be provided to the patient with information on the risk this medication poses to children and vulnerable people when the patient being treated with an opioid agonist treatment is approved for take home doses.

The New Brunswick College of Pharmacists responded that the College will make the following enhancements to the OAT-PD aimed at improving patient education and the security of take-home doses:

a. A patient knowledge sheet will be added as an appendix to the OAT-PD. Pharmacy professionals will be required to present and review this sheet with patients at the time they are first approved for take-home doses of methadone or buprenorphine/naloxone. The sheet, to be developed by the College, will highlight the risks these medications pose, particularly to children and other vulnerable individuals.
b. The administration/dispensing record will be updated to include a column for pharmacy professionals to document on the patients record when take home doses are dispensed, confirming that:
    - the patient has provided an appropriate lockbox, and the patient has demonstrated the lockbox being unlocked when returning carry bottles, and locked when receiving new doses.
c. Lockboxes will be required to have a unique identifier (such as a number or patient initials) permanently affixed to ensure clear linkage between each patient and their designated lockbox.

These proposed amendments to the OAT-PD will be presented to Council for approval at its next meeting, scheduled for April 28, 2025. Following approval, the College staff will enable those changes for implementation by registrants who are providers of methadone.

Recommendation #3

That the College of Physician and the Nurses Association of New Brunswick direct pediatrician and primary care provider to talk about the dangers of prescription medication to infants with their care takers; especially when the infant starts getting mobile.

The New Brunswick College of Physicians and Surgeons responded that we did follow the recommendations of the Child Death Review committee and shared the following information in our May 2025 quarterly newsletter. This communication from the college goes to all physicians and students registered with the College of Physicians and Surgeons of New Brunswick.

The Nurses Association of New Brunswick responded that NANB sent a direct email to all nurses (Registered Nurses and Nurse Practitioners). We believe that communicating this information to all nurses was important as the Registered Nurse is often the point of direct client contact in acute care facilities, community settings, and client homes. We have included the communication circulated via direct email to all nurses. It was also included in our monthly e-bulletin and shared on social media.

In addition, we did reach out to the New Brunswick College of Pharmacists and the College of Physicians and Surgeons of New Brunswick to inquire if they had any additional information that would be of value to share.

Recommendation #4

That the New Brunswick Association of Chiefs of Police and the New Brunswick Royal Canadian Mounted Police provide a refresher to their members, in the manner deemed appropriate by their organization, that child deaths should be treated as suspicious. Especially in cases where the cause of death is not evident E.g.: trauma from a car crash as opposed to a death in a residential setting.

RCMP responded that in order to properly satisfy the recommendation of the committee, we will publish a modern provincial policy detailing investigative steps to be taken for Child Death Investigations. Within the policy, it states “A child is defined in Criminal Code as a person under the age of 12 years. When no trauma is visible and the cause of death is not evident, treat the death as suspicious.”

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 and are presented to the Minister who will table them before the Legislature if it is sitting or will file them with the Clerk if the house is not in session.

In 2024, progress on several committee files was delayed because reviews can only be initiated once related investigations and court proceedings have concluded. As a result, the committee was only able to begin reviewing cases later in the year, and those reviews could not be completed before year-end.