## Office of the Chief Coroner

## Annual Report 2019

## 2019 Annual Report

## Published by:

Office of the Chief Coroner
Department of Justice \& Public Safety
Province of New Brunswick
P. O. Box 6000

Fredericton, New Brunswick E3B 5H1
Canada
November 2020
Cover:
Service New Brunswick

Typesetting:
Office of the Chief Coroner
Printing and Binding:
Service New Brunswick

ISBN 978-1-4605-2671-2

ISSN 0848-5666

Printed in New Brunswick

The Honourable Hugh J. A. (Ted) Flemming, Q.C.
Department of Justice \& Public Safety
Fredericton
New Brunswick

Dear Minister:
Pursuant to Section 43 of the Coroners Act, I have the honour to submit the FortyEighth Annual Report of the Chief Coroner for the period January 1, 2019 to December 31, 2019.

Yours very truly,

## JÉRÔME OUELLETTE

Chief Coroner
Province of New Brunswick
Table of Contents Page
Mission Statement ..... 5
Historical Background ..... 5
Origin of the Office of the Coroner ..... 5
The New Brunswick Coroner System ..... 6
Organizational Structure ..... 6
Notification Requirement ..... 6
Investigative Capacity of Coroner Services ..... 6
Purpose of Coroner's Investigation ..... 7
The Inquest Decision ..... 7
Summary ..... 8
Statistical Summary of Investigated Deaths ..... 8
Schedule "A.1" - Total Deaths by Classification ..... 10
Schedule "A.2" - Total Deaths by Month ..... 11
Schedule "A.3" - Total Deaths by Judicial District ..... 12
Schedule "B.1" - Accidental Deaths by Age Group, Gender and Judicial District ..... 13
Schedule "B.2" - Accidental Deaths by Age Group, Gender and Death Factor ..... 14
Schedule "B.3" - Accidental Deaths by Age Group, Gender and Environment ..... 18
Schedule "C.1" - Suicide Deaths by Age Group, Gender and Judicial District ..... 22
Schedule "C.2" - Suicide Deaths by Age Group, Gender and Death Factor ..... 23
Schedule "C.3" - Suicide Deaths by Age Group, Gender and Environment ..... 25
Schedule "D.1" - Homicide Deaths by Age Group, Gender and Judicial District ..... 27
Schedule "D.2" - Homicide Deaths by Age Group, Gender and Death Factor ..... 28
Schedule "D.3" - Homicide Deaths by Age Group, Gender and Environment ..... 29
Schedule "E.1" - Natural Deaths by Age Group, Gender and Judicial District ..... 30
Schedule "E.2" - Natural Deaths by Age Group, Gender and Death Factor ..... 31
Schedule "E.3" - Natural Deaths by Age Group, Gender and Environment ..... 32
Schedule "F.1" - Undetermined Deaths by Age Group, Gender and Judicial District ..... 36
Schedule "F.2" - Undetermined Deaths by Age Group, Gender and Death Factor ..... 37
Schedule "F.3" - Undetermined Deaths by Age Group, Gender and Environment ..... 38
Schedule "F" - Undetermined Deaths ..... 39
Summary of Inquests and Other Recommendations ..... 40

## Our Mission

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

## Historical Background

## Origin of the Office of the Coroner

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

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

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

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

## The New Brunswick Coroner System

## Organizational Structure

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

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

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

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

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

## Notification Requirement

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

## Investigative Capacity of Coroner Services

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

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 or Moncton for the autopsy.

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

## Purpose of Coroner's Investigation

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

## The Inquest Decision

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

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

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

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

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

## Summary

Coroner Services investigates about 22.7 percent of the total of approximately 7,700 deaths per year in the Province. A high percentage of the investigated deaths are determined to be from natural causes. The coroner, in approximately 30.2 percent of the cases, orders autopsies and inquests are ordered in slightly less than one percent of all investigated deaths.

For the period covered by this Report, the Registrar of Vital Statistics recorded 7,793 deaths in the Province of which 1,747 or $22.4 \%$ were reported to a coroner. By comparison in the previous year there were 7,679 deaths in the Province of which 1,649 or $21.5 \%$ were reported to a coroner.

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

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

Comments should be directed to:

## The Office of the Chief Coroner

P. O. Box 6000

Fredericton, New Brunswick
E3B 5H1
Phone (506) 453-3604
Fax (506) 453-7124

## Statistical Summary of Investigated Deaths

The information provided in this Annual Report is presented for the calendar year 2019.
Annual Reports of the Chief Coroner were presented by calendar year from 1972 to 1992. In 1992/93, the Chief Coroner changed the reporting period to fiscal year to coincide with the implementation of a new computer system. In 2005, the Chief Coroner made the decision to revert to calendar year to coincide with statistical reporting by other Coroner and Medical Examiners across Canada. This will facilitate data sharing and comparison with other provincial and federal government agencies.

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

The natural category covers all deaths by disease or illness of natural origins.
The accident category includes deaths due to unintentional or unexpected injury. It includes deaths resulting from complications reasonably attributed to the accident.

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

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

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

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

## PROVINCIAL SUMMARY - SCHEDULE A-1

from 2019.01.01 to 2019.12.31

| Classification | No. of Deaths | \% of Deaths | Rate per 100,000 <br> Population | Autopsy <br> Performed | \% of <br> classification |
| :--- | ---: | :---: | :---: | :---: | :---: |
| Natural | 1,306 | 74.8 | 168.2 | 361 | 27.6 |
| Accident | 315 | 18.0 | 40.4 | 135 | 43.0 |
| Suicide | 102 | 5.8 | 13.1 | 39 | 38.2 |
| Homicide | 17 | 1.0 | 2.2 | 16 | 94.1 |
| Undetermined | -7 | $\underline{0.4}$ | 0.9 | $\underline{6}$ | 85.7 |
| Total | 1,747 | 100.0 |  | 557 |  |

Based on a population of 776,827

## PROVINCIAL SUMMARY - SCHEDULE A-1

from 2019.01.01 to 2019.12.31


NOTE : Based upon Statistics Canada postcensal population estimates for N. B. census divisions (released June 6, 2020). Sub-county estimates are based on the 2019 Census population share of the county.
Provincial Summary－Deaths Investigated by Classification，by Month－Schedule A－2

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DEATHS INVESTIGATED BY JUDICIAL DISTRICT - SCHEDULE A-3
from 2019.01.01 to 2019.12.31537

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ACCIDENTAL DEATHS BY AGE GROUP，GENDER AND JUDICIAL DISTRICT－SCHEDULE B－1

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| PROVINCIAL SUMMARY <br> ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2 from 2019.01.01 to 2019.12.31 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Death Factor Description |  | 19 $F$ |  |  |  | -40 $F$ |  |  |  |  |  |  |  |  | Total Males | Total Females | Total | \% of Classification | Autopsies | \% of Classification |
| Drowning - Open Water | 0 | 0 | 1 | 0 |  | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 3 | 1 | 4 | 1.3 | 4 | 3.0 |
| Drowning - Public Pool | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0.3 | 0 | 0.0 |
| Trauma of Vehicle Collision | 3 | 1 | 16 | 0 | 7 | 1 | 2 | 1 | 1 | 2 | 10 | 3 | 4 | 3 | 43 | 11 | 54 | 17.2 | 21 | 15.7 |
| Trauma of Vehicle Upset/Rollover | 3 | 2 | 2 | 1 | 2 | 0 | 1 | 0 | 1 | 1 | 2 | 0 | 1 | 1 | 12 | 5 | 17 | 5.4 | 11 | 8.2 |
| Trauma of Vehicle/Pedestrian Collision | 0 | 0 | 1 | 0 | 0 | 0 |  | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 1 | 3 | 1.0 | 3 | 2.2 |
| Trauma of Recreational Vehicle Collision | 0 | 0 | 2 | 0 | 0 | 0 | 2 | 0 | 4 | 0 | 2 | 0 | 0 | 0 | 10 | 0 | 10 | 3.2 | 5 | 3.7 |
| Trauma of Recreational Vehicle Upset/Rollover | 0 | 0 |  | 0 |  | 0 |  | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 3 | 1 | 4 | 1.3 | 2 | 1.5 |
| Carbon Monoxide Poisoning | 0 | 0 | 0 | 0 | 0 | 0 |  | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 2 | 0 | 2 | 0.6 | 2 | 1.5 |
| Carbon Monoxide Poisoning - Vehicle Exhaust | 0 | 0 | 0 | 0 |  |  |  | 0 |  | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0.3 | 0 | 0.0 |

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

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ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3

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HOMICIDE DEATHS BY AGE GROUP，GENDER AND DEATH FACTOR－SCHEDULE D－2

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HOMICIDE DEATHS BY AGE GROUP，GENDER AND ENVIRONMENT－SCHEDULE D－3

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|  | PROVINCIAL SUMMARY <br> NATURAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE E-2 from 2019.01.01 to 2019.12.31 |  |  |  |  |  |  |  |  |  |  |  |  |
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| Death Factor Description | $\begin{aligned} & 0-19 \\ & M \quad F \end{aligned}$ | $\begin{aligned} & 20-30 \\ & M \quad F \end{aligned}$ | $\begin{aligned} & 31-40 \\ & M \quad F \end{aligned}$ | $\begin{aligned} & 41-50 \\ & M \quad F \end{aligned}$ | $\begin{aligned} & 51-60 \\ & M \quad F \end{aligned}$ | $\begin{aligned} & 61-70 \\ & M \quad F \end{aligned}$ | $$ | Total Males | $\begin{gathered} \text { Total } \\ \text { Females } \end{gathered}$ | Total | $\begin{gathered} \text { \% of } \\ \text { Classification } \end{gathered}$ | Autopsies | \% of Classification |
| Natural Disease | 83 | $5 \quad 2$ | 149 | 3221 | 10655 | 242114 | 385309 | 792 | 513 | 1305 | 99.9 | 360 | 99.7 |
| Malnutrition | 00 | 00 | 00 | 00 | 00 | 00 | 01 | 0 | 1 | 1 | 0.1 | 1 | 0.3 |
| Males | 8 | 5 | 14 | 32 | 106 | 242 | 386 | 792 |  | 1,306 | 100.0 | 361 | 100.0 |
| Females | 3 | 2 | 9 | 21 | 55 | 114 | 310 |  | 514 |  |  |  |  |
| Total for Age Group | 11 | 7 | ${ }^{23}$ | 53 | 161 | 356 | 696 |  |  |  |  |  |  |



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NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3

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| $\begin{array}{cc} 8 & 4 \\ \frac{1}{n} & \Sigma \end{array}$ | $\begin{aligned} & 0 \\ & \sim \end{aligned}$ |  | - | $\begin{aligned} & 0 \\ & 0 \end{aligned}$ | $\begin{aligned} & 0 \\ & 0 \end{aligned}$ |
| $\begin{array}{ll} \circ & ц \\ \frac{1}{\gamma} & \Sigma \end{array}$ | $\begin{aligned} & 0 \\ & \sim \end{aligned}$ |  |  | $\begin{aligned} & 0 \\ & 0 \end{aligned}$ | $\begin{aligned} & 0 \\ & 0 \end{aligned}$ |
| $\begin{array}{ll} \text { o } & 4 \\ \frac{1}{m} & \Sigma \end{array}$ | $\begin{aligned} & \circ \\ & 0 \end{aligned}$ |  |  |  |  |
| $\begin{array}{ll} \circ & 4 \\ \vdots & \\ \stackrel{\sim}{\sim} & \Sigma \end{array}$ | $\begin{aligned} & 0 \\ & 0 \end{aligned}$ | $\circ$ | $\circ$ |  |  |
| $\begin{array}{ll} \circ & 4 \\ \vdots & \\ 0 & \Sigma \end{array}$ |  |  |  |  | $\begin{aligned} & 0 \\ & 0 \end{aligned}$ |
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| $\circ$  <br> 1 u <br> in $\Sigma$ | $\begin{array}{llll} 0 & 0 & 0 & 0 \\ - & 0 & - & - \end{array}$ | $\infty$ | ホ̛ | $\bigcirc$ | $\bigcirc$ | m | ¢ |
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| $\begin{array}{lll}\text { ¢ } \\ \stackrel{y}{*} & 4 \\ \bar{m} & \Sigma\end{array}$ | $\begin{array}{llll} 0 & 0 & 0 & 0 \\ 0 & 0 & 0 & 0 \end{array}$ | － | $\bigcirc$ | － | $\bigcirc$ | $\bigcirc$ | $\bigcirc$ |
| $\begin{array}{ll}\text { O} & 4 \\ \stackrel{\sim}{c} & \Sigma \\ \sim\end{array}$ | $\begin{array}{llll} 0 & 0 & 0 & 0 \\ 0 & 0 & 0 & 0 \end{array}$ | － | $\bigcirc$ | $\bigcirc$ | $\bigcirc$ | $\bigcirc$ | $\bigcirc$ |
| $\begin{array}{ll}\circ & 4 \\ \vdots \\ 0 & \Sigma\end{array}$ | $\begin{array}{llll} - & 0 & 0 & 0 \\ 0 & - & 0 & 0 \end{array}$ | － | $\stackrel{\text { }}{+}$ | － | $\stackrel{\text { ¢ }}{+}$ | ～ | $\stackrel{\circ}{\sim}$ |
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| PROVINCIAL SUMMARY <br> UNDETERMINED DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE F-2 <br> from 2019.01.01 to 2019.12.31 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Death Factor Description | $\begin{gathered} 0-19 \\ M \quad F \end{gathered}$ |  | $\begin{aligned} & 20-30 \\ & M \quad F \end{aligned}$ |  | $\begin{gathered} 31-40 \\ M \quad F \end{gathered}$ |  | $\begin{gathered} 41-50 \\ M \quad F \end{gathered}$ |  | $\begin{array}{cc} 51-60 \\ M \quad F \end{array}$ |  |  |  | Over 70 M F |  | Total Males | Total Females | Total | \% of Classification | Autopsies | \% of Classification |
| Drug |  | 0 |  | 0 |  | 0 |  | 1 |  | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 14.3 | 1 | 16.7 |
| Undetermined | 1 | 1 |  |  |  | 0 |  | 1 |  | 0 | 0 | 0 | 0 | 0 | 4 | 2 | 6 | 85.7 | 5 | 83.3 |
| Males | 1 |  | 0 |  |  | 0 |  | 0 | 3 |  |  |  |  | 0 | 4 |  |  |  |  |  |
| Females | 1 |  | 0 |  |  | 0 |  | 2 | 0 |  |  |  |  | 0 |  | 3 |  |  |  |  |
| Total for Age Group | 2 |  | 0 |  |  | 0 |  |  | 3 |  |  |  |  | 0 |  |  |  |  |  |  |



# Schedule F <br> Undetermined Deaths <br> (Means of death impossible to determine) 

There were seven deaths classified as Undetermined.
Three were in the Fredericton Judicial District:

## Case \#1

Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group:
Sex: 0-10

An autopsy was performed.
Case \#2

Death Factor: Undetermined
Environment: Living Inside, Residence or on Properyt
Age Group: $\quad 40-50$
Sex: Female
An autopsy was performed.

## Case \#3

Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 50-60
Sex: Male
An autopsy was performed.
Two were in the Moncton Judicial District:

## Case \#1

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

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

## Case \#2

Death Factor: Drug
Environment: Living Inside, Residence or on Property
Age Group: $\quad 40-50$
Sex: Female
An autopsy was performed.
One was in the Saint John Judicial District:

## Case \#1

Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: $\quad 50-60$
Sex: Male
An autopsy was performed.
One was in the Woodstock Judicial District:

## Case \#1

Death Factor: Blunt Trauma
Environment: Living Inside, Residence or on Property
Age Group: $\quad 50-60$
Sex: Male
An autopsy was performed.

## Summary of Inquests and Recommendations

One inquest was held during the reporting period. This report mentions the replies received by the Office of the Chief Coroner in response to the recommendations on the inquest conducted during the year.

## Wanny Pelletier

Wanny Pelletier, just 17, was an employee of Groupe Savoie Inc. in Saint-Quentin. On Thursday, December 22, 2016, Mr. Pelletier went to the plant for his shift. Assigned to clean the wood pellet plant equipment, he began his work as usual. At around 18:30, he was found caught in the conveyor. Mr. Pelletier was taken to the Edmundston Regional Hospital where he succumbed to his injuries at 13:28 on December 26, 2016. Following the investigation, WorkSafeNB initiated legal proceedings on two charges against Groupe Savoie Inc. under the Occupational Health and Safety Act.

First charge:
The employer must provide the supervision that is necessary to ensure an employee's health and safety (paragraph 9(2)(c.3).

Second charge:
An employer shall ensure that a machine is erected, installed, assembled, started, operated, used, handled, stored, stopped, serviced, tested, cleaned, adjusted, maintained, repaired and dismantled in accordance with the manufacturer's specifications (subsection 235(1) of Regulation 91-191

On November 5, 2018, Groupe Savoie Inc. pleaded guilty to the first charge of not being able to provide the supervision that is necessary to ensure its employees health and safety. On February 12, 2019, Groupe Savoie Inc. was sentenced to pay a fine of \$125,000.

The investigation, conducted on June 24 and 25, 2019, was held in accordance with subsection 7b) of the Coroners Act, which specifies that a coroner shall hold an inquest when a worker dies as a result of an accident occurring in the course of his or her employment at or in a woodland operation, sawmill, lumber processing plant, food processing plant, fish processing plant, construction project site, mining plant or mine, including a pit or quarry.

A total of 22 witnesses were heard by a five-person jury, which made the following recommendations:

1. Orientation at the work station should be done by the same supervisor on the same shift.
2. If a supervisor/controller is absent from his or her work station, an alternate should be in the control room until his or her return.

## Wanny Pelletier (continued)

The Presiding Coroner made the following recommendation:
That WorkSafeNB implement a hazard alert awareness campaign in the lumber processing industry in the province of New Brunswick regarding potential hazards in these industries.

These recommendations were sent to the President and Chief Executive Officer of WorkSafeNB.

## Recommendation \#1

Orientation at the work station should be done by the same supervisor on the same shift.

## Recommendation \#2

If a supervisor/controller is absent from his or her work station, an alternate should be in the control room until his or her return.

WorkSafeNB supports these recommendations. However, it is their opinion that the two recommendations from the jury are recommendations that needs to be addressed by the employer Groupe Savoie Inc. As a result, Group Savoie Inc. should receive these recommendations for their consideration.

Coroner Services has communicated the responses from WorkSafeNB to Groupe Savoie Inc. who indicated their intention to implement same.

## Presiding Coroner recommendation:

That WorkSafeNB implement a hazard alert awareness campaign in the lumber processing industry in the province of New Brunswick regarding potential hazards in these industries.

WorkSafeNB agrees with this recommendation and is partnering with the New Brunswick Forest Safety Association (NBFSA) for its implementation. NBFSA is a not-for-profit organization aimed at eliminating workplace accidents in the forest industry through education and training. The initiative will include the following actions:

- Developing a hazard alert that will address the importance of verifying that all safety features are in place following repairs to a machine. NBFSA will include the hazard alert as part of their machine safety course (currently under development by NBFSA).
- WorkSafeNB will promote on social media the safety courses offered by NBFSA.

