Office of the Chief Coroner

Annual Report 2020



2020 Annual Report

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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 Forty-Nineth Annual Report of the Chief Coroner for the period January 1, 2020 to December 31, 2020.

Yours very truly,

JÉRÔME OUELLETTE Chief Coroner Province of New Brunswick

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Our Mission

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

Historical Background

Origin of the Office of the Coroner

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

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

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

An inquest is not a forum to resolve civil disputes nor to conduct prosecutions. An inquest is not a trial and a coroner is not a judge. The proceedings are 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 Justice & Public Safety serve as Investigating Coroners. This group provides services primarily on nights and weekends.

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

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

Notification Requirement

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

Investigative Capacity of Coroner Services

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

The identification of a death as a "Type II" case, which needs the special consideration of a forensic pathologist, results in the utilization of the forensic service and requires that the body be transported to Saint John 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 21.7 percent of the total of approximately 7,500 deaths per year in the Province. A high percentage of the investigated deaths are determined to be from natural causes. The coroner, in approximately 33.7 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 7,486 deaths in the Province of which 1,637 or 21.9% were reported to a coroner. By comparison in the previous year there were 7,793 deaths in the Province of which 1,747 or 22.4% 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 2020.

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

Classification	No. of Deaths	% of Deaths	Rate per 100,000 Population	Autopsy Performed	% of classification
Natural	1,209	73.8	154.7	329	27.2
Accident	298	18.2	38.1	165	55.4
Suicide	108	6.6	13.8	36	33.3
Homicide	16	1.0	2.0	16	100.0
Undetermined	6	0.4	0.8	6	100.0
Total	1,637	100.0		552	

from 2020.01.01 to 2020.12.31

Based on a population of 781,476

PROVINCIAL SUMMARY - SCHEDULE A-1

from 2020.01.01 to 2020.12.31



NOTE : Based upon Statistics Canada postcensal population estimates for N. B. census divisions (released September 28, 2021). Sub-county estimates are based on the 2019 Census population share of the county.

onth - Schedule A-2	
м М	
Classification, b	2020.12.31
d by (01 to
Investigated	om 2020.01.
- Deaths	fr
Summary	
rovincial	

Total	1,209	298	108	16	Q	1,637
Dec	122	21	5	~	0	149
Nov	120	33	4	0	0	157
Oct	94	26	15	0	0	135
Sept	86	29	2	~		136
Aug	95	31	15	~	0	142
July	81	26	10	7	0	119
June	12	24	13	2	0	110
May	129	25	11	S	ю	173
April	98	22	ъ	~	~	115
Mar	112	16	7	~	-	137
Feb	85	18	10	2	0	115
Jan	116	27	9	0	0	149
Classification	Natural	Accident	Suicide	Homicide	Undetermined	Total

DEATHS INVESTIGATED BY JUDICIAL DISTRICT - SCHEDULE A-3 from 2020.01.01 to 2020.12.31537

			Judi	cial Districts					
	Bathurst	Campbellton	Edmundston	Fredericton	Miramichi	Moncton	Saint John	Woodstock	Province
Vatural Accident Suicide Aomicide Judetermined	87 25 1 1 25	51 21 00 0	81 20 22 02	168 45 20 4	69 25 3	300 87 30 3	419 64 18 12	8 11 8 10 00 00 10 10 10 10 10 10 10 10 10 10	1,209 298 108 16
Fotal	123	80	117	238	104	424	504	47	1,637
% of Provincial Total	7.5	4.9	7.1	14.5	6.4	25.9	30.8	2.9	100
Population	78,810	30,810	41,234	147,099	45,386	226,082	174,985	37,070	781,476
Death Rate per 100,000 population Natural Accident Suicide Homicide Undetermined	110.4 31.7 11.4 1.3	165.5 68.2 0.0 0.0	196.4 48.5 33.9 4.9 0.0	114.2 30.6 13.6 0.7	152.0 55.1 6.6 0.0	132.7 38.5 13.3 1.3	239.4 36.6 10.3 0.6	91.7 29.7 5.4 0.0	154.7 38.1 13.8 0.8
Total deaths by trauma (accident, suicide, homicide)	35	59	96	69	35	121	84	13	422
Rate per 100,000 population	44.4	94.1	87.3	46.9	77.1	53.5	48.0	35.1	54.0

Judicial Districts	0 - 19 M F	20-30 M F	31 - 40 M F	41 - 50 M F	51 - 60 M F	61 - 70 M F	Over 70 M F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Bathurst	0 0	- 0	1 0	000	2	5 1	1 13	10	15	25	8.4	7	4.2
Campbellton	0	3 9	2 0	0	3 0 8	ю 1	5 3	16	5	21	7.0	7	4.2
Edmundston	0	0	2 0	3 0 8	1	4 2	2 5	12	ω	20	6.7	13	7.9
Fredericton	1	2 4	2	2	3 2	1 4	13 7	24	21	45	15.1	24	14.6
Miramichi	4	0	4	3 1	2 0	1	1 6	15	10	25	8.4	18	10.9
Moncton	2	2 2	2 7	ю 8	5 4	11 4	16 17	49	38	87	29.2	37	22.5
Saint John	2	5 1	4 2	е 9	10 2	75	4 11	38	26	64	21.5	51	30.9
Woodstock	1	3	1 2	2	0	2 0	0 0	6	2	1	3.7	ω	4.8
Males	10	19	18	24	26	34	42	173					
% Total - Males	3.4	6.4	6.0	8.1	8.7	11.4	14.1	58.1		298	100.0	165	100.0
Females	8	6	13	11	6	18	62		125				
% Total -Females	1.0	3.0	4.4	3.7	3.0	6.0	20.8		41.9				
Total for Age Group	13	58	31	35	35	52	104						
% of Classification Total	4.4	9.4	10.5	11.7	11.7	17.4	34.9						

% of Classification	0.6	0.0	14.6	4.9	2.4	1.	3.7	12	0.6
Autopsies	-	0	24	ω	4	£	9	2	-
% of Classification	0.3	0.3	13.5	3.5	2.0	3.0	2.8	0.7	0.3
Total	-	-	40	10	Q	Ø	ω	N	-
Total Females	0	-	17	-	0	4	~	0	0
Total Males	-	0	23	0	Q	ى	7	N	-
Over 70 M F	0	0	2	0 0	6	0	0	0	6
61 - 70 M F	0	0	3 A	2 0	1 0	.	6	0	0
51 - 60 M F	0	0	2	0	2 0	5	0	0	0
41 - 50 M F	0	0	3	1 0	0 0	.	6	۲ 0	0
31 - 40 M F	1 0	0 0	3	2 1	0 0	0	0	1 0	0
20 - 30 M F	0 0	0 0	4 1	3 0	1 0	0	2 0	0 0	0 0
0 - 19 M F	0	0	£ 0	1 0	0	0	ر	0 0	0
Death Factor Description	Excited Delirium Syndrome	Therapeutic Misadventure	Trauma of Vehicle Collision	Trauma of Vehicle Upset/Rollover	Trauma of Vehicle/Pedestrian Collision	Trauma of Recreational Vehicle Collision	Trauma of Recreational Vehicle Upset/Rollover	Carbon Monoxide Poisoning	Carbon Monoxide Poisoning - Vehicle Exhaust

Death Factor Description	0 - 19 M F	M 20-3	₩ ≥ 	31 - 40 I F	41 - 50 M F	₹ 21- 1-	о 00 г	61 - 70 M F	S Over	er 70 F	Total Males	Females	Total	% of Classification	Autopsies	% of Classification
Exposure to Cold	0 0	0 0	-	0	0 1	-	0	0 0	-	0	З	1	4	1.3	з	1.8
Crushed and/or Buried	0 0	1	0	0	0	0	0	0 0	0	0	-	0	~	0.3	0	0.0
Drowning - Open Water	0 0	1	-	0	2 0	7	-	0	б	0	0	F	10	3.5	0	5.6
Drowning - Bathtub	0	0	6	0	0	0	- -	0	0	-	0	2	2	0.7	2	1.2
Drowning - Pond/Quarry	0 0	0 0	0	0	1 0	0	-	0 0	0	0	-	0	-	0.3	٢	0.6
Drowning - Ice Covered Water	0 0	0 0	0	0	0	1	-	0 0	0	0	-	0	~	0.3	٢	0.6
Fire – Structural	0	-	6	0	0	-		2 2	7	0	9	ю	თ	3.0	ω	4.9
Fall or jump – same level	0	0 0	0	-	1	7		7 3	29	53	39	60	66	33.3	11	6.8
Fall or jump – different level height; eg. bridge, building	0	0	0	-	0 0	0	0	1 0	-		N	2	4	1.3	7	1.2
Blunt Trauma, Accidental	1	-	-	0	0 0	-	0	2 0	0	0	9	F	7	2.4	3	1.8

	0 - 19	50	- 30	31 - 40	4	- 50	51 -	60	61 - 70	ð	er 70	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Β		Σ	ц	M	Σ	ш	Σ	ш	M	Σ	L						
0 1		0	0	0 0	0	0	0	0	0 0	0	0	0	L	1	0.3	1	0.6
0	0	0	0	0	0	0	0	0	-	-	~	ю	N	Ð	1.7	.	0.6
0	0	0	0	0	-	0	0	0	0	0	0	-	0	-	0.3	4	0.6
0	0	0	0	0 0	0	0	0	0	3 2	-	0	4	2	9	2.0	വ	3.1
0	0	~	0	0 0	0	0	0	0	-	0	0	-	-	2	0.7	2	1.2
0	0	0	0	0	-	0	-	0	0	0	0	ĸ	0	ю	1.0	ъ	6. 2
0	0	0	0	0	0	0	0	0	0 0	0	0	0	-	٦	0.3	٢	0.6
0	0	0	0	0 0	۲	0	٦	0	0 0	0	0	2	0	2	0.7	2	1.2
0	0	2	3	5 3	5	4	4	2	6 4	0	-	22	17	39	12.9	36	21.9
0	0	~	ю	2 2	9	0	ъ	.	-	0	0	14	7	21	7.0	20	12.2

						0.01.01	0 2020.12.						
Death Factor	0 - 19	20 - 30	31 - 40	41 - 50	51 - 60	61 - 70	Over 70	Total	Total	Total	% of	Autopsies	% of
Description	⊥ ∑	LL ∑	L Z	u ∑	u ∑	L ∑	⊥ ∑	Iviales	remares		Classification		Classification
Shooting - Shotgun	0 0	0	0 0	0 0	0 0	0 0	0 0	1	0	-	0.3	-	0.6
Males	10	19	18	24	26	34	42	173					
Females	ю	ω	12	1	თ	18	29		125	298	100.0	165	100.0
Total for Age Group	13	27	30	35	35	52	101						

Environment Description	M - 19	20 - 30 M F	31 - 40 M F	41 - 50 M F	51 - 60 M F	61 - 70 M F	Over 7 M F	0 Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Work Place	0 0	0 0	0 0	0 1	1 0	0 0	0 0	-	4	2	0.7	٢	0.6
Open water (river, lake, stream, brook)	0	0	6	6	5	0	-	9	0	Q	2.0	Q	3.6
Boating – personal watercraft, jet ski, etc.	0 0	0 0	0 0	1 0	1 0	0 0	0	5	0	2	0.7	4	0.6
Hospital Other (ward, ICU, etc.)	0	0 0	0 0	0 0	0 0	1	4	5	4	6	3.0	0	0.0
Public Road - Driver	1	4	4 3	1 2	-	4 2	- -	16	12	28	9.5	17	10.4
Public Road – motorcycle driver	1 0	2 0	1 0	2 1	1 0	3 0	0	10	۲	11	3.7	7	4.2
Public Road – passenger	4 0	1 1	0 0	0 0	0 1	0 1	0	ດ	4	6	3.0	9	3.7
Public Road - pedestrian	0	1 0	0 0	0 0	1 0	0 0	1 0	3	0	ε	1.0	2	1.2
Public Road – bicycle (not motorized vehicle)	10	0 0	0 0	0 0	1 0	0 0	0	5	0	2	0.7	.	0.6
Public Transit (bus, train, etc.)	0 0	0	0 0	0	1	0	0	-	0	-	0.3	0	0.0

PROVINCIAL SUMMARY	ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3	from 2020.01.01 to 2020.12.31
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Environment Description	0 - 19 M F		20 - 30 M F	Ω α	- 40 F	41 - 50 M F	51 - 60 M F	61 - 70 M F		Over 70 M F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
ATV driver – on public road	1	0	0 (0	~	0	1	0		0 0	2	2	4	1.3	2	1.2
ATV driver – off public road	0 0		0	0	0	1 0	2 0	1 0		0 0	5	0	5	1.7	ε	1.8
ATV passenger – on public road	0 0		-	0	0	0 0	0 0	0 0		0 0	۲	Ļ	2	0.7	2	1.2
ATV passenger – off public road	1	0	0 (0	0	0 0	0 0	0 0		0 0	۲	Ļ	2	0.7	2	1.2
Snowmobiling (on public road) - driver	0)	0	0	0	1	0 0	0		0	1	0	1	0.3	۲	0.6
Snowmobiling (anywhere off public road) – driver	0 0	-	0	0	0	0 0	0 0	ر		0 0	2	۲	3	1.0	F	0.6
Snowmobiling (anywhere off public road) – passenger	0	0	0	0	0	0	6	0		0	-	0	~	0.3	0	0.0
Living inside, residence or on property	1 2	ري ا	9	11	œ	14 5	11 5	20 13	7	1 27	83	99	149	50.0	95	57.7

	% of	Classification	0.0	2.4	0.6	0.0	1.8	9.0	1.2
	Autopsies		0	4	~	0	e	۲-	2
	% of	Classification	1.7	5.5	7.0	0.3	1.0	0.3	د : ن
	Total		£	16	21	-	ю	۲	4
	Total	Leillales	4	8	16	0	-	0	2
	Total	Males	٦	8	5	-	2	٦	2
	Over 70	ц М	1 4	6 8	3 15	0	0 0	0 0	1 1
	61 - 70	L V	0 0	0 0	2 0	0	0 0	1 0	0 0
	51 - 60	⊥ ⊻	0 0	1 0	0	0	0 0	0 0	0 1
	41 - 50	⊥ ∑	0 0	1 0	0 0	0	1 0	0 0	1 0
	31 - 40	⊥ ⊻	0 0	0 0	0 0	0	0 1	0 0	0 0
	20 - 30	ш Х	0 0	0 0	0 0	0	0	0 0	0 0
	0 - 19	L Z	0 0	0	0	0	0 0	0 0	0 0
-	Environment	Description	Seniors Complex	Homes for Special Care	Nursing Home	Inside, other than residence (mall, restaurant, other public building)	Hotel / Motel	Farm or Ranch	Urban Outdoors – public place & other (not residence)

	CIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3	from 2020.01.01 to 2020.12.31
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Environment Description	0 - 19 M F	20 - 30 M F	31 - 40 M F	41 - 50 M F	51 - 60 M F	61 - 70 M F	Over 70 M F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Rural Outdoors (not built up place or near residence)	0 0	1	1 0	0	1	1 0	2 0	Q	-	7	2.3	2	4.2
Males	10	19	18	24	26	34	42	173		298	100.0	165	100.0
Females	e	o	13	11	თ	18	62		125				
Total for Age Group	13	28	31	35	35	52	104						

PROVINCIAL SUMMARY SUICIDE DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE C-1 from 2020.01.01 to 2020.12.31

	0 - 19	20 - 30	31 - 40	41 - 50	51 - 60	61 - 70	Over 70	Total	Total	Total	% of	Autopsies	% of
Judicial Districts	L ∑	L ∑	L Z	L ∑	ш 2	L Z	LL ∑	Males	remales		Classification		Classification
Bathurst	0 0	0	1	2 0	3 0	0 0	2	8	-	6	8.3	e	8.3
Campbellton	1	0	2	1	۲ ۲	0	1	9	2	œ	7.4	4	11.1
Edmundston	0	1	L L	2	з Т	4 0	1	12	2	14	13.0	ю	8.3
Fredericton	0	о х	3 0 8	5 0	4	1	2	18	2	20	18.5	4	11.1
Miramichi	1	2	0	0	1	0	1	5	2	7	6.5	-	2.8
Moncton	2	8	1	7	5 0	2	5	25	5	30	27.7	5	13.9
Saint John	1	3 1	0	1 0	5 0	5 1	1	16	2	18	16.7	15	41.7
Woodstock	1 0	0 0	0 0	0 1	0 0	0 0	0 0	1	-	5	1.9	4	2.8
Males	9	17	8	13	22	12	13	91					
% Total - Males	5.6	15.7	7.4	12.0	20.4	11.1	12.0	84.2					
Females	0	m	-	5	4	2	7		17	108	100.0	36	100.0
% Total - Females	0.0	2.8	0.9	4.6	3.7	1.9	1.9		15.8				
Total for Age Group	Q	20	თ	18	26	14	15						
% of Classification Total	5.6	18.5	8.3	16.7	24.1	13.0	13.9						

from 2020.01.01 to 2020.12.31

% of Classification	36.0	0.0	5.6	0.0	0.0	5.6	2.8	0.0	0.0
Autopsies	13	0	2	0	0	2	٢	0	0
% of Classification	47.1	1.9	2.8	0.9	1.9	1.9	0.9	6.1	0.9
Total	51	2	ę	-	7	2	-	2	-
Total Females	6	0	0	-	-	٢	0	0	0
Total Males	45	2	e	0	-	L	-	2	~
Over 70 M F	7 0	0 0	0 0	0 0	0 0	0 0	0 0	1 0	0 0
61 - 70 M F	5 0	1 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
51 - 60 M F	7 1	1 0	1 0	0 0	0 0	1 1	1 0	0	1 0
41 - 50 M F	8 3	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
31 - 40 M F	9 0	0 0	1 0	0 0	0	0 0	0 0	0 0	0 0
20 - 30 M F	8 2	0 0	1 0	0 1	1 0	0 0	0 0	0 0	0 0
0 - 19 M F	4 0	0 0	0 0	0 0	0 0	0 0	0	0	0
Death Factor Description	Hanging	Cuts, Stabs	Drowning - Open Water	Asphyxia	Asphyxia due to oxygen depletion	Fire - Structural	Fire - Vehicle	Fall or jump – different level, eg. bridge, bldg.	Trauma of Vehicle Upset/Rollover

Death Factor Description	M 0-19	20 - 30 M F	31 - 40 M F	41 - 50 M F	51 - 60 M F	61 - 70 M F	Over 70 M F	T otal Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Shooting - Rifle	2 0	3 0	0 0	2 0	2 0	3 0	1 0	13	0	13	12.0	3	8.3
Shooting - Shotgun	0	1	0	0	2	2	1	7	0	7	<u>б</u> .5	-	2.8
Shooting - Handgun	0	0	0	0	1	1 0	0	N	0	7	0.1	7	5.6
Alcohol and Drug	0 0	1 0	0 0	0 1	1 0	0 0	0 0	N	1	ю	2.8	в	8.3
Drug	0 0	2 0	0 0	3 1	3 2	0 2	3 2	11	7	18	16.6	6	25.0
Males	9	17	8	13	22	12	13	91		108	100.0	36	100.0
Females	0	n	÷	ى ا	4	7	5		17				
Total for Age Group	9	20	6	18	26	14	15						

% of	Classification	5.6	2.8	63.8	2.8	0.0	5.6	0.0	0.0
Autopsies		N	-	23	-	0	2	0	0
% of	Classification	1.9	0.0	72.2	0.0	0.9	1.0	0.9	6.0
Total		N	-	78	-	Ļ	2	-	-
Total	Leinares	۲	0	12	F	٢	2	0	0
Total	Marco	F	F	99	0	0	0	-	F
r 70	ш	0	0	-	0	0	۲	0	0
Ove	Σ	0	0	10	0	0	0	0	0
61 – 70	L ∑	0	0	1 1	0	0 1	0 0	0	0
51 – 60	L ∑	0	1	16 4	0 0	0 0	0 0	- 0	0 0
41 – 50	LL ∑	0	0	с Х	0	0 0	0 0	0 0	1 0
31 – 40	L ∑	1 0	0 0	5 1	0 0	0 0	0 0	0 0	0 0
20 – 30	ц Z	0	0	13 2	0 0	0 0	0 1	0 0	0 0
19	ш	0	0	0	0	0	0	0	0
- 0	Σ	0	0	4	0	0	0	0	0
-	Environment Description	Open Water (river, lake, stream, brook)	Beach/ Shoreline	Living inside, residence or on property	Community Residence	Hotel/Motel	Hospital Other (ward, ICU, etc.)	Community Mental Health Centre	Service Station, Garage, Mechanic

FROVINCIAL SUMMARY SUICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE C-3 from 2020.01.01 to 2020.12.31
PROVINCIAL SUMMARY SUICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE C-3 from 2020.01.01 to 2020.12.31

						0.10.040	10 2020.	- 0.4					
Environment Description	0 - 19 M F	20 - 30 M F	31 - 40 M F	41 - 50 M F	51 - 60 M F	61 - 70 M F	Over 70 M F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Public Road – Driver	1 0	6	1	0	1	0 0	0 0	4	0	4	3.7	2	5.6
Public Road - Pedestrian	0 0	0 0	0 0	0 0	0 0	0 0	1 0	٢	0	1	0.9	0	0.0
Urban Outdoors - public place and other (not residence)	0 0	1 0	1 0	1 0	0 0	2 0	1 0	9	0	6	5.6	З	8.2
Rural Outdoors (not built up place or near residence)	1 0	2 0	0 0	3 0	3 0	0 0	1 0	10	0	10	9.3	2	5.6
Males	9	17	8	13	22	12	13	91		108	100.0	96	100.0
Females	0	З	٢	Q	4	2	2		17				
Total for Age Group	9	20	6	18	26	14	15						

			Refere	ence peri	od 2010 -	- 2019				
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
United States	12.1	12.3	12.5	12.6	13.0	13.3	13.4	14.0	14.2	13.9
Canada	11.6	11.3	11.3	11.5	12.0	12.3	11.0	11.4	10.4	10.7
NB	14.0	13.7	15.1	10.9	15.4	16.2	15.9	12.4	14.8	10.3
SN	10.4	11.4	12.2	12.3	11.4	13.1	13.2	14.2	12.5	12.5
PE	0.6	8.6	7.3	10.8	7.2	4.8	6.4	11.0	4.7	11.5
NL	12.5	10.7	8.3	10.7	14.1	12.2	14.1	17.5	13.9	12.0

Suicide - Comparison chart between Atlantic Provinces, Canada and the United States

0.0 PROVINCIAL SUMMARY HOMICIDE DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE D-1 from 2020.01.01 to 2020.12.31

de la ciele de	0 - 19	20 - 30	31 - 40	41 - 50	51 - 60	61 - 70	Over 70	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Judicial Districts	⊾ ∑	ц М	⊾ ∑	⊥ ∑	⊾ ∑	⊾ ∑	⊾ ∑	Maico			Classification		QIassilloallol
Bathurst	0 0	00	0	0 0	0	1	0 0	-	0	~	6.3	٢	6.3
Edmundston	0	0	0	0	0 0	0	0	0	2	7	12.5	0	12.5
Fredericton	0	о 8	1	0	0	0	0	4	0	4	25.0	4	25.0
Miramichi	0	1	1	1	0 0	0	0	e	0	e	18.7	S	18.7
Moncton	0	1 0	0	0	0 0	1	0	N	2	4	25.0	4	25.0
Saint John	0	2	0	0	0	0	0	N	0	N	12.5	2	12.5
Males	0	2	5	-	0	7	0	12					
% Total - Males	0.0	43.8	12.5	6.3	0.0	12.5	0.0	75.1		16	100.0	16	100.0
Females	0	-	2	-	0	0	0		4				
% Total - Females	0.0	6.3	12.5	6.3	0.0	0.0	0.0		25.1				
Total for Age Group	o	ω	4	7	ο	7	o						
% of Classification Total	0.0	50.0	25.0	12.5	0.0	12.5	0.0						

PROVINCIAL SUMMARY	IOMICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE D-2	from 2020.01.01 to 2020.12.31
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Death Factor Description	М 0-19 Г	20 - 30 M F	31 - 40 M F	41 - 50 M F	51 - 60 M F	61 - 70 M F	Over 70 M F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Blunt Trauma	0 0	0 0	0 0	0 0	0	1 0	0 0	-	0	-	6.3	۲	6.3
Cuts, Stabs	0 0	1 0	2 1	0	0 0	0	0 0	4	2	9	37.4	9	37.4
Shooting - Rifle	0 0	2 0	0	0 0	0	0	0 0	7	0	7	12.5	7	12.5
Shooting - Handgun	0	1	0 0	1 0	0	0 0	0 0	2	٢	3	18.8	ε	18.8
Shooting - Unspecified	0	3 0	0	0 0	0 0	0 0	0 0	3	1	4	25.0	4	25.0
Males	0	۷	7	٢	0	2	0	12		16	100.0	16	100.00
Females	0	٢	2	L	0	0	0		4				
Total for Age Group	0	œ	4	2	0	2	0						
				_	_								

PROVINCIAL SUMMARY	: GROUP, GENDER AND ENVIRONMENT - SCHEDULE D-3	from 2020.01.01 to 2020.12.31	
PROVINCIA	HOMICIDE DEATHS BY AGE GROUP, GEN	from 2020.01.	

s % of Classification	68.7	18.8	12.5		100.0	
Autopsies	11	m	N		16	
% of Classification	68.7	18.8	12.5		100.0	
Total	11	ю	N		16	
Total Females	4	0	0		4	
Total Males	7	m	2	12		
Over 70 M F	0	0	0	0	0	0
61 - 70 M F	2 0	0	0	2	0	2
51 - 60 M F	0 0	0 0	0	0	0	0
41 - 50 M F	ر	0	0	F	~	N
31 - 40 M F	0	5	0	2	5	4
20 - 30 M F	4	6	0	7	~	ω
0 - 19 M F	0	0	0	0	0	0
Environment Description	Living Inside, Residence or on Property	Urban Outdoors - public place and other (not residence)	Rural Outdoors (not built up place or near residence)	Males	Females	Total for Age Group

PROVINCIAL SUMMARY NATURAL DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE E-1 from 2020.01.01 to 2020.12.31

% of Classification	5.8	2.7	3.0	22.8	4.3	29.5	29.8	2.1			0.000			
Autopsies	19	თ	10	75	14	67	98	2			6 X C			
% of Classification	7.2	4.2	6.7	13.9	5.7	24.8	34.7	2.8		5 0 0	0.000			
Total	87	51	81	168	69	300	419	34			e02'I			
Total Females	38	18	29	62	30	66	167	13			456	37.7		
Total Males	49	33	52	106	39	201	252	21	753	62.3				
Over 70 M F	20 24	16 8	26 19	50 36	15 16	99 59	131 88	6 2	364	30.1	259	21.4	623	51.5
61 - 70 M F	12 6	11 7	18 7	32 10	15 8	59 21	65 41	8	220	18.3	102	8.4	322	26.6
51 - 60 M F	85	3 2	6 3	8 12	7 3	30 10	36 26	7	66	8.2	63	5.2	162	13.4
41-50 M F	5 1	-	2 0	6 2	2	6 3	12 6	4 0	38	3.1	14	1.2	52	4.3
31 - 40 M F	3 0	1	0	5 2	0	4	4 2	0	17	4.1	9	0.5	23	1.9
20 - 30 M F	1 0	1 0	0 0	3 0	0 1	2 3	4 1	0 0	11	0.9	5	0.4	16	1.3
0 - 19 M F	0 2	0	0 0	2	0 0	1 2	ю 0	1 0	4	0.3	7	0.6	11	0.0
Judicial Districts	Bathurst	Campbellton	Edmundston	Fredericton	Miramichi	Moncton	Saint John	Woodstock	Males	% Total - Males	Females	% Total - Females	Total for Age Group	% of Classification Total

	% of Classification	99.1	0.3	9.0	100.0		
	Autopsies	326	L	2	329		
	% of Classification	99.5	0.1	0.2	100.0		
	Total	1206	L	2	1,209		
	Total Females	455	0	-		456	
	Total Males	751	L	L	753		
	Over 70 M F	364 259	0 0	0 0	364	529	623
	61 - 70 M F	219 102	0 0	1 0	220	102	322
	51 - 60 M F	99 63	0 0	0 0	66	63	162
	41 - 50 M F	38 14	0 0	0 0	38	71	25
	31 - 40 M F	16 6	1 0	0 0	21	9	53
	20 - 30 M F	11 5	0 0	0 0	11	5	16
	0 - 19 М П	4 6	0 0	0 1	4	7	11
-	Death Factor Description	Natural Disease	Epilepsy	Undetermined	Males	Females	Total for Age Group

PROVINCIAL SUMMARY NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3 from 2020.01.01 to 2020.12.31

Environment Description	0 - 19 F	20-30 M F	31 - 40 M F	41 - 50 M F	51 - 60 M F	61 - 70 M F	Over 70 M F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification	10
symnasium/Health :lub	0	0	0	0	0 0	0 1	0	0	-	-	0.1	-	0.3	
Seniors Complex	0	0	0	0	0 0	1 2	5 15	9	17	23	1.9	0	0.0	
Vursing Home	0 0	0	0	0	2 0	6 3	21 30	29	33	62	5.1	ю	6.0	
Homes for Special Care	0 0	0 0	0 0	0 0	3 4	2 2	9 14	14	20	34	2.7	5	1.5	
Unlicenced Residential Homes (retirement, rest, etc.)	0 0	0 0	0 0	0 0	0 0	0 0	0 1	0	۲	-	0.1	0	0.0	
Living inside, residence or on property	2 З	10 5	17 6	33 13	83 56	190 89	305 192	641	366	1007	83.2	294	89.5	
Rooming/Boarding House/Halfway House/Group Home	0 0	0 0	0 0	0 0	2 0	1 0	0 0	Э	0	е	0.2	ო	6.0	
nside, other than esidence (mall, estaurant, other oublic building)	0	0 0	0	0 0	2 0	0 2	1 0	3	2	5	0.4	4	2.1	

	% of Classification	0.3	1.2	6.0	0.0	0.0	0.0	6.0	£.0	6.0
	Autopsies	۲	4	L	0	0	0	L	٢	٢
ULE E-3	% of Classification	0.2	1.7	0.3	0.1	0.2	0.1	0.1	0.2	0.5
оснер	Total	5	20	4	٢	2	٢	L	2	9
	Total Females	0	2	L	0	0	-	0	0	0
2.31	Total Males	5	13	3	۲	2	0	٢	2	6
ANU E 020.1;	er 70 F	0	з	1	0	0	0	0	0	0
to 2	o ∑	-	5	-	-	-	0	0	0	З
GENU 0.01.01	61 - 70 A F	0	1	0	0 (0	1 0	0 (0	0
202		0	L)		0		0	0		
	1 - 60 F	0	-	0	0	0	0	0	0	0
ц с		0	1	0	0	0	0	-	0	7
A Y	- 50 F	0	0	0	0	0	0	0	0	0
2 2	<u>4</u>	-	-	0	0	0	0	0	0	0
	- 40 F	0	0	0	0	0	0	0	0	0
ן ב	ωΣ	0	0	0	0	0	0	0	0	0
RAI	ш 30	0	0	0	0	0	0	0	0	0
	M 20	0	0	0	0	0	0	0	0	0
²	- 11	0	2	(0	0				(
	0 - 19 - 19	0	-	0	0	0	0 (0	0 (0
1						~	_		•	
	Environment Description	Hotel / Motel	Hospital Other (ward, ICU, etc.)	Hospital Operating Room	Hospital Post Op (recovery room)	Hospital Emergenc – NON DOA	Psychiatric Hospita	Factory, Plant, Warehouse (inside)	Work Place	Custody Federal Institution

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PROVINCIAL SUMMARY NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3 from 2020.01.01 to 2020.12.31

	0 - 19		20 - 30	31	- 40	41 -	50	51 - 60	9	1 - 70	Ove	ir 70	Total	Total	Total	. % of	Autopsies	% of
Environment Description	Σ	ш	LL ∑	Σ	ш	Σ	ш	LL ∑	Σ	Ŀ	Σ	ш	Males	Females		Classification		Classification
Camping / Tenting	0		0	0	0	0	0	- 0	0	0	-	0	N	0	N	0.2	-	0.3
Beach/Shoreline	0		0	0	0	0	0	0 0	0	0	7	0	2	0	2	0.2	٢	0.3
Commerical Drivers – truck, taxi, school bus, etc.	0		0 0	0	0	~	0	0	0	0	0	0	.	0	~	0.1	-	0.3
Public Road – Driver	0 0		0	0	0	0	0	0	4	0	З	٢	7	£	8	0.7	٢	0.3
Public Road - Passenger	0		0	0	0	0	0	0	0	0	0	-	-	0	-	0.1	0	0.0
Public Road - Pedestrian	0 0		0 0	0	0	0	-	0	-	0	-	0	5	2	4	0.3	٣	0.3
Public Road – Motorcycle Driver	0 0		0	0	0	0	0	10	0	0	0	0	-	0	-	0.1	0	0.0
Public Transit (bus, train, et.c)	0		0	0	0	0	0	0	0	-	0	0	0	-	~	0.1	0	0.0

Environment Description	M 0-19 F	20 - 30 M F	31 - 40 M F	41 - 50 M F	51 - 60 M F	61 - 70 M F	Over 70 M F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Urban Outdoors- public place and other (not residence)	0	-	0	5	-	0 M	4	5	N	13	1.0	Q	<u>م</u> ت
Rural Outdoors (not built up place or near residence)	0 0	0	0	0	0 0	0	0	-	0	-	0.1	0	0.0
Males	4	7	17	38	66	220	364	753					
Females	7	£	Q	14	63	102	259		456	1,209	100.0	329	100.0
Total for Age Group	11	16	23	52	162	322	623						

PROVINCIAL SUMMARY NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3 from 2020.01.01 to 2020.12.31

PROVINCIAL SUMMARY	UNDETERMINED DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE F-1	from 2020.01.01 to 2020.12.31
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% of Classification	16.7	16.7	50.0	16.7		100.0				
Autopsies	-	-	e	~		Q				
% of Classification	16.7	16.7	50.0	16.7		100.0				
Total	~	-	S	۲		9				
Total Females	0	0	0	0			0	0.0		
Total Males	~	-	б	۲	g	100				
Over 70 M F	0	0	0	0	0	0.0	0	0.0	0	0.0
61 - 70 M F	1 0	0 0	0 0	0 0	~	16.7	0	0.0	-	16.7
51 - 60 M F	0 0	0	1 0	0	~	16.7	0	0.0	~	16.7
41 - 50 M F	0 0	0 0	0 0	0 0	0	0.0	0	0.0	0	0.0
31 - 40 M F	000	0	1 0	1 0	5	33.2	0	0.0	7	33.2
20 - 30 M F	0 0	0 0	0	0	~	16.7	0	0.0	-	16.7
А 0 - 19 П	0 0	1 0	0 0	0	~	16.7	0	0.0	~	16.7
Judicial Districts	Bathurst	Fredericton	Moncton	Saint John	Males	% Total - Males	Females	% Total - Females	Total for Age Group	% of Classification Total

PROVINCIAL SUMMARY	UNDETERMINED DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE F-2	from 2020.01.01 to 2020.12.31
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	Ċ	2	
	Autopsies		
	% of	Classification	
	Total		
	Total		
12.31	Total	Males	
)1 to 2020.	Over 70	LL ∑	
2020.01.0	61 - 70	⊥ ∑	
from	51 - 60	⊥ ⊻	
	41 - 50	ц Х	
	31 - 40	⊥ ∑	(
	20 - 30	⊥ ∑	
	0 - 19	L ∑	

% of Classification		16.7	16.7	16.7	50.0	6 6 7		
Autopsies		L	L	L	3	u	þ	
% of Classification		16.7	16.7	16.7	50.0	0007	0.00	
Total		٢	٢	٢	3	ى س	þ	
Total Females		0	0	0	0		0	
Total Males		٢	٢	٢	3	9		
Over 70	⊥ ∑	0	0	0	0 0	0	0	0
61 - 70	⊥ ∑	1 0	0 0	0 0	0 0	1	0	-
51 - 60	L ∑	0 0	1 0	0 0	0 0	L	0	
41 - 50	⊥ ∑	0 0	0 0	0 0	0	0	0	0
31 - 40	⊥ ∑	0 0	0 0	0 0	2 0	2	0	2
20 - 30	⊥ ∑	0 0	0 0	1	0 0	-	0	~
0 - 19	⊥ ≥	0 0	0 0	0 0	1 0	1	0	-
Dooth Footor	Description	Drowning – Open Water	Crushed and/or Buried	No Anatomical Cause	Undetermined	Males	Females	Total for Age Group

PROVINCIAL SUMMARY UNDETERMINED DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE F-3 from 2020.01.01 to 2020.12.31

% of Classification	33.2	16.7	16.7	16.7	16.7		0.00	
Autopsies	N	-	-	٢	٢	ų	þ	
% of Classification	33.2	16.7	16.7	16.7	16.7	000	0.000	
Total	N	-	.	L	٢	y	þ	
Total Females	0	0	0	0	0		0	
Total Males	5	۲	۲	1	1	9		
Over 70 M F	0 0	0 0	0 0	0 0	0 0	0	0	0
61 - 70 M F	0 0	0	0 0	1 0	0 0	٢	0	۲
51 - 60 M F	0	0	0	0 0	0 0	۲	0	~
41 - 50 M F	0 0	0	0	0 0	0 0	0	0	0
31 - 40 M F	1 0	0	0	0 0	1 0	2	0	N
20 - 30 M F	0	0	0 0	0 0	0 0	L	0	~
M 0 - 19 F	6	0	0	0 0	0 0	Ţ	0	~
Environment Description	Living inside, residence or on property	Rural Outdoors (not built up place or near residence)	Urban Outdoors – public place and other (not residence)	Ocean	Custody – Provincial Institution	Males	Females	Total for Age Group

Schedule F

Undetermined Deaths (Means of death impossible to determine)

There were six deaths classified as Undetermined.

One was in the Bathurst Judicial District:

Death Factor:Drowning – Open WaterEnvironment:OceanAge Group:60 - 70Sex:MaleAn autopsy was performed.

One was in the Fredericton Judicial District:

Death Factor:UndeterminedEnvironment:Living Inside, Residence or on PropertyAge Group:0 - 10Sex:MaleAn autopsy was performed.

Three were in the Moncton Judicial District:

Case #1

Death Factor:	No anatomical cause
Environment:	Rural Outdoors (not built up place or near residence)
Age Group:	20 - 30
Sex:	Male
An autopsy was pe	erformed.

Case #2

Death Factor:UndeterminedEnvironment:Custody – Provincial InstitutionAge Group:30 - 40Sex:MaleAn autopsy was performed.

`Undetermined Deaths (Means of death impossible to determine)

Case #3

Death Factor:Crushed and/or BuriedEnvironment:Urban Outdoors – public place and other (not residence)Age Group:50 - 60Sex:MaleAn autopsy was performed.

One was in the Saint John Judicial District:

Death Factor:UndeterminedEnvironment:Living Inside, Residence or on PropertyAge Group:30 - 40Sex:MaleAn 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.

Mario Roy

The investigation, conducted on November 24 and 25, 2020, 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.

Mario Roy was working for Érablière TDG Somers of Saint-Quentin.

On September 7, 2018, Mr. Roy and André Bouchard were felling trees in a selective cut. Mr. Roy was cutting down the trees while Mr. Bouchard was transporting them with a skidder.

At around 11:00 a.m., Mr. Bouchard left with his load of trees while Mr. Roy continued to cut. When he returned with the skidder, he found him unconscious on the ground. It was obvious at that point that he had been hit by a tree. Mr. Bouchard assisted him and called emergency services.

The paramedics provided first aid, and he was transported to the hospital in Saint-Quentin, where he was pronounced dead.

As a result of the WorkSafeNB investigation, no charges or lawsuits were brought against the employer.

During the investigation a total of eight witnesses were heard before a jury of five. The jury formulated the following five recommendations:

- 1. That the legislative amendments proposed by WorkSafeNB to section 354 of Regulation 91-191 be adopted into law as soon as possible.
- 2. That the employer provide logging teams with an appropriate means of communication (e.g., satellite phone if necessary), located directly on the site (in the skidder).

Mario Roy (continued)

- 3. That standard provincial training be developed and made available to employers. This training should be based on the document "Logging and Silviculture Operations." Employers should review this training with all their employees every year and maintain a training log.
- 4. Establish a relationship between WorkSafeNB and all small businesses (fewer than 20 employees) that includes inspections at fixed regular intervals.
- 5. That the term "working alone" be better defined in the Regulation (92-133) in order to significantly reduce the response time in an emergency.

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

Recommendation #1

That the legislative amendments proposed by WorkSafeNB to section 354 of Regulation 91-191 be adopted into law as soon as possible.

The President and CEO agrees with this recommendation and will provide the required support to affected stakeholders to ensure that Government is well positioned to pass the Logging and Silviculture Operations legislative amendments in Part XXI of the Regulation 91-191. Once passed, they will ensure that the amendments are implemented in a timely and effective way.

Recommendation #2

That the employer provide logging teams with an appropriate means of communication (e.g., satellite phone if necessary), located directly on the site (in the skidder).

The President and CEO stated that emergency communication procedures are currently addressed in Section 5 of Regulation 2004-130 *First Aid Regulation - Occupational Health and Safety Act.* The requirements are:

5(1) An employer shall ensure that an emergency communication procedure is established in order for employees to summon assistance in the event of an illness or accident of an employee.

Mario Roy (continued)

- 5(2) The communication procedure shall:
 - (a) be in writing,
 - (b) describe how to contact assistance,
 - (c) provide directions to the place of employment and instructions as to how to access the place of employment, and
 - (d) be posted in a conspicuous place at the place of employment.
- 5(3) Where the posting of the emergency communication procedure is not practicable, an employer shall ensure that each employee is informed of the contents of the emergency communication procedure.

This recommendation was sent to the employer but to date, the Office of the Chief Coroner has not received a response.

Recommendation #3

That standard provincial training be developed and made available to employers. This training should be based on the document "Logging and Silviculture Operations." Employers should review this training with all their employees every year and maintain a training log.

The President and CEO has proposed amendments to Part XXI of Regulation 91-191 on Logging and Silviculture that will require employees and their supervisors to be trained with respect to tools, equipment, machines, devices, materials, procedures and techniques to a standard that is acceptable to WorkSafeNB. To ensure an effective outcome, they intend to consult with affected industry and employee stakeholders in establishing an acceptable training standard. Program development, availability to employers, annual review with employees, and maintaining a training log will be incorporated into the discussions with stakeholders.

Recommendation #4

Establish a relationship between WorkSafeNB and all small businesses (fewer than 20 employees) that includes inspections at fixed regular intervals.

The President and CEO stated that WorkSafeNB's current strategy includes a focus on small businesses from a prevention, compliance, and enforcement perspective. Given that there are more than 25,000 workplaces in the Province with fewer than 20 employees, it is challenging to establish individual relationships with each workplace.

Mario Roy (continued)

Recommendation #5

That the term "working alone" be better defined in the Regulation (92-133) in order to significantly reduce the response time in an emergency.

While Regulation 92-133 does not currently define the term "working alone", the President and CEO stated that WorkSafeNB has developed a guideline to assist employers in safely managing circumstances where workers are required to work alone including defining working alone using several workplace situations. The web link to the guide is provided for ease of access (https://ohsguide.worksafenb.ca/topic/alone.html).

The President and CEO stated that WorkSafeNB is committed to reviewing this recommendation to determine whether the Regulation needs to be amended to include a definition of working alone.